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Modes of Medical Practice

CHIASMA

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Levinsky Takes Reins in UH Medicine

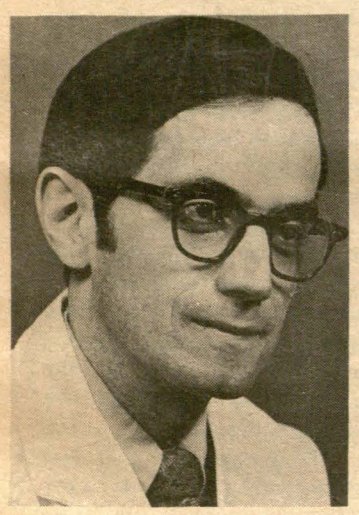


Photo courtesy of BUMC

"We must have three strong chiefs of Medicine working closely together."

—Dr. Norman Levinsky

Dr. Norman Levinsky, Director of the Boston University Medical Service, Boston City Hospital, has been named to assume three positions: Director of the Robert Dawson Evans Memorial Department of Clinical Research; Chief of Medicine at University Hospital; and chairman of the Division of Medicine at Boston University School of Medicine. Succeeding Dr. Robert Wilkins in these posts, Dr. Levinsky will assume his new duties, beginning July 1, 1972.

The announcement of this selection brings to a close nearly eighteen months of work, devoted to finding this most able successor to Dr. Wilkins. Beginning in September of 1970, the search committee conducted a nationwide scrutiny of all potential candidates. Under the direction of Dr. Vincent Lanzoni, associate dean at BUSM, this committee carried on extensive interviews of several of the candidates, before reaching its final recommendation. This selection was approved unanimously by trustee boards of University Hospital, the Medical Center, and Boston University.

Dr. Levinsky plans to bring the medical staffs of Boston City Hospital, University Hospital, and the Veterans Administration Hospital of Boston closer together. "My attitude is that the next stage of development in medicine at Boston University is to integrate the medical services of these three institutions," said Dr. Levinsky. "We must be flexible, and I'm not talking about homogenizing every detail, but the variety of training opportunities and patient treatment is really extraordinary. To implement this and achieve a triumverate of administrative strength, we must have three strong Chiefs of Medicine working closely together."

Of his successor, Dr. Wilkins had this to say: "Dr. Norman Levinsky has proven himself to be a most effective and efficient medical leader and administrator as chief of the Boston University Medical Services at Boston City Hospital. Before assuming that position, he had won an international reputation as a medical investigator in the field of renal physiology and disease. For years, too, he has been recognized and praised by students here and elsewhere as an outstanding teacher of internal medicine."

A graduate of Boston Latin School, Harvard College, and Harvard Medical School, Dr. Levinsky received post-graduate training at Beth Israel Hospital, National Heart Institute, and Boston University School of Medicine. He has been a member of the BUSM faculty since 1960.

Chiasma Analysis:

Security Problems at BUMC: Do You Care?

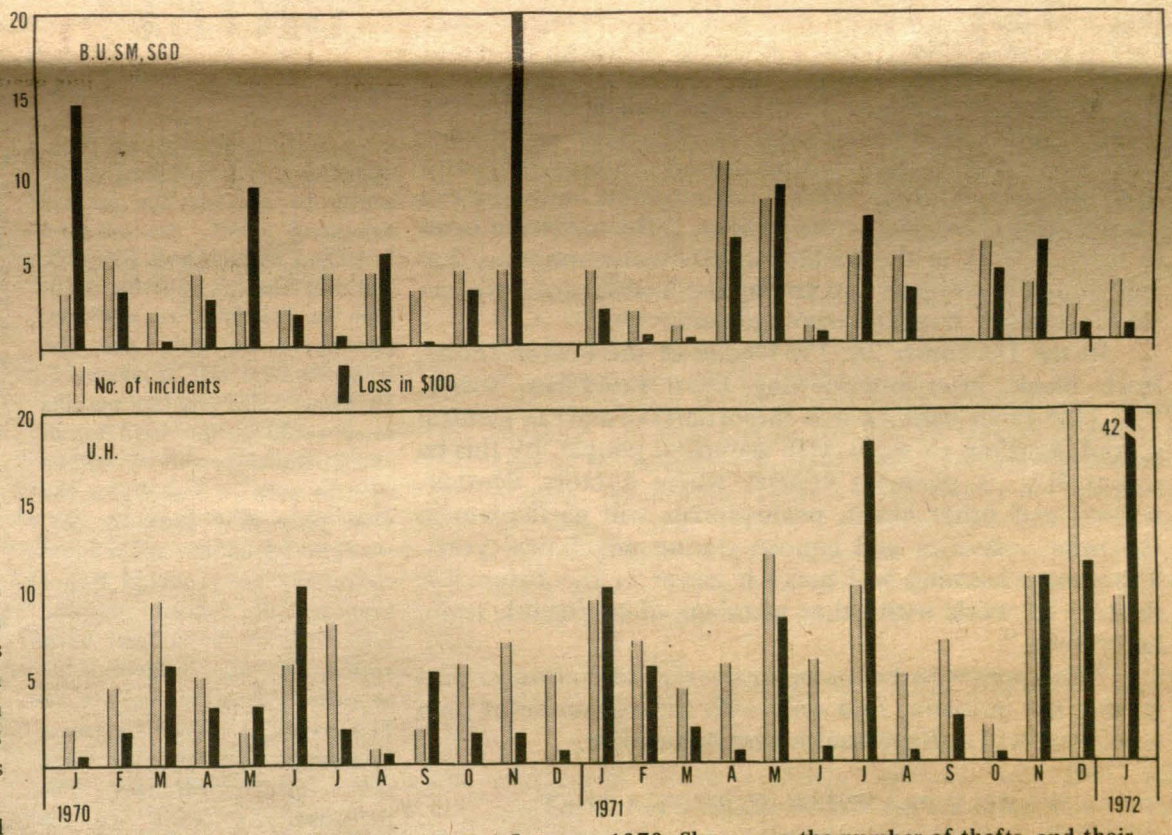
by Noel Blagg and
Bill Toman

In recent weeks much discussion has arisen concerning the "sudden increase in BUMC crime." Students and employees, physicians and deans, have all expressed this concern. As an admission office secretary said: "Honest to goodness—it gets worse by the day!" Chiasma set out to confirm or deny these rumors. Following is our analysis.

The resounding opinion of Boston University Medical Center officials is that crime has not increased recently. The one dissenting administrator is Dr. William McNary, who is sure that crime has increased markedly. Perhaps the most surprising fact about crime at BUMC is that no one could offer more than an opinion about the level of crime. No statistics are compiled by anyone within the medical center. This fact is acknowledged by Mr. John Gracey, Deputy Director of the medical center, to be a big problem. The statistics in this article were compiled by ourselves, from official reports of University Hospital and Medical School security offices. They bear out the fact that Dr. McNary alone recognized the growing problem here at the medical center.

The bar graph shows that from 1970 to 1971 the medical and dental schools suffered a 30% increase in the number of reported thefts, but at the same time a 40% reduction in total value lost. During this same period the loss to the institutions themselves dropped from 90% of total stolen within them in 1970, to 43% in 1971. Faculty, students, and employees bore the brunt of that decrease though, as their personal loss increased from 10% ($605) of the total stolen in 1970 to 57% ($2272) in 1971. At the same time the average personal loss per theft rose from $25.21 to $61.40. The schools themselves again fared better in 1971, showing a decrease in value lost per theft, from $408 to $142. January, 1972 shows the same trends.

University Hospital fared much worse. The number of thefts climbed 66% to 89 for 1971, and the total value stolen rose 10%, from $3435 to $7100. Of this value, 55% was lost by UH itself, compared to 45% for individuals inside UH, in 1970, and rose to UH losses of 62% in 1971. Patients, visitors, medical staff, and students were victims



Larceny at BUMC for 25 months, beginning January, 1970. Shown are the number of thefts, and their value, for each month.

80% of the time in 1970, and 71% in 1971, but their total monetary loss rose 75% from $1625 to $2843. The average personal theft cost $35 in 1970, and rose to $45 in 1971. The hospital's average loss per incident also rose, to $179 (up $10). Even though New Evans building was open only about one and one-half months in 1971, its losses account for 54% of the hospital's losses for that year. Still, UH exhibited a substantial rise in 1971 before the New Evans opened.

"Allegedly," states John Gracey, "police statistics show a decrease in South End crime in the last six months," and adds that the South End's reputation for crime is largely "a myth." "Crime is not so much a problem of location as it is a problem of society." If that is true, the society in the medical center is in real trouble. BUMC as a whole lost over $25,000 in *reported* thefts in 1970, 1971, and January, 1972, and showed an increase of 66% in number of incidents in that same time. The monetary loss climbed 20%. *(See chart on page 7).*

Mr. Gracey also brought out one very important point about medical center crime statistics. He believes there is a "20-50%" omission factor in crime reporting. Although there is actually no way of measuring it, Chiasma agrees. Many of the reports that are filed are sketchy, especially as to the time the theft occurred. In part, this is understandable but much more information could be provided. Not surprisingly, the one thing everyone could do was estimate the value of their loss.

From the information available, it appears that personal losses are especially likely at lunch time in the medical school. People leave their coats, radios, and purses or wallets lying around, and go away leaving their offices or labs unlocked. Within the hospital, time in surgery, x-ray, and other treatment areas invites theft. This is true not only of patients, but of employees and doctors, as evidenced by the number of thefts from patients' rooms and

(Continued on Page 7)

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Editorials

APPROACHING MEDICINE

In the many years since "doctor" meant a horse and buggy G.P., medicine has changed, diversified, and extended out into society through a multiplicity of approaches. We hear much talk about "health care delivery systems" and pleas on behalf of the "health care consumer" which most often point to the coming of group practice. One could get the impression that joining a group is the only solution to the problem. As society is complex and as personalities of medical people are diverse, so are approaches to medical practice varied.

We have many decisions to make which will determine the course of our lives. We are aware of the major specialty choices which confront us, but in addition to selecting one of these, we must also find a compatible mode of practice.

In this issue we present a glimpse of just a few of these options in an atempt to clarify some hazy images. By calling attention to this matter, we hope to stimulate thought and ingenuity in an area of importance to both society and individual.

A SELF-APPRAISAL

One of the most apparent and prevalent failings, woven into the character of most physicians, is an isolating arrogance, preventing the doctor from wanting to fully communicate and work *with* the other members of what should be a health care *team.* The type of physician so described is not unique to University Hospital or City Hospital or any single institution, but appears to be found extensively throughout the entire nation.

The fault which I have dubbed as "isolating arrogance" functions to only the detriment of the patient's health care: The doctor who does not ask or want to listen to the nurse-clinician concerning the care of his ostomy patient; the physician who has not bothered to communicate to the nursing staff how much he has told a dying patient the severity of his illness; the doctors who do not care to inform each other of the blood tests they plan to order so that a patient is repeatedly punctured unnecessarily.

In the community health center article on page five, Dr. Richard Morrill addresses himself to this problem in relation to the community clinic. What he says, I think, holds true for most health care situations: "Optimal care rests, in large part, with the willingness of the physician to function as part of a health care team—to seriously listen to and share information with the non-M.D.'s on the health team: nurses, social workers, dieticians, and others. Many times it is the paramedical or non-professional health team members who are most knowledgeable, and who can contribute to the care of the patient, if the physician cares to listen." Only in this fashion, with open communication and complete co-operation among the health care team can we successfully treat the whole patient.

In the December 26, 1971 issue of the Boston Globe, Herb Black, after interviewing Dean Friedman, wrote: " . . .(the Dean believes it is important) to start in medical school, learning to work with groups of people. By this he means B.U. is planning courses where doctors, dentists, nurses, and other health professionals will participate in the same activities and courses during pre-clinical years. The group learning will make it easier in the future for doctors to work with other members of the health team, he believes."

This appears to be a step in the right direction toward solving the problem. And only with the extinction of such a problem will optimal health care be possible.

FAMILY PLANNING SURVEY-A BUST

A few weeks ago a family planning survey was sent to all medical students. This has stemmed from some of the following statistics. The time in which the present 3.5 billion world inhabitants will double is only *30* years away, reaching the staggering figure of 7 billion by the year 2000, if current population trends continue. Presently the U.S. has a population of about 205 million. The population of the U.S. in 2000 A.D. will amount to *only 280* million people. "Only" has a very ironic ring to those estimating that every one American has about *50* times the negative impact on the earth's life-support systems as does a citizen of India. No one dismisses the problem anymore. If one drives on any expressway or visits any large U.S. city, he can see what overpopulation and unwanted births mean to us today.

Yet when a family planning survey is sent to medical students (soon to become part of a profession that can do most about the problem), the return is poor. What is the reason? Is it that he can't make the effort to open his mail because he thinks it's just another internship offer? Is it that it takes too much of his precious time with no obvious personal gain? Is it not, in fact, becoming true what the older "more experienced" members of the profession say—"they will be like us by the time they begin practicing."

Letters to the Editor

E. BROOKLINE ST. REVISITED

To the editor:

Enclosed is an open letter from Mrs. Genevieve Davis, President of the East Brookline Street Residents' Associates, to BUMC's Plant Manager, Mr. Herbert Klein. While we believe that Mr. John Gracey has acted with honesty and good faith in his meetings with us, in light of Mr. Klein's reluctance to act, we cannot help but wonder about BUMC's motives. It seems as if they are trying to allow the buildings to deteriorate as much as possible until they become such a hazard to the community that we will be only too happy to have them torn down, rather than rehabilitated, as is our request.

Rosemary Sokas
Susan Stanik

Dear Mr. Klein:

This letter is about boarding up the vacant University Hospital owned homes on East Brookline St., and the cleaning of the back alley. We have talked with Mr. Gracey about this on many occasions and he has assured us that he has asked you to take care of the problem.

On January 14th, an employee of the B.U. Mental Health Center called you to ask what was being done. You confirmed with him that Mr. Gracey had asked that action be taken. Aside from your apparent rudeness you indicated that you would take care of the situation. No action has yet been taken. We began working on the hazard in June 1971. It is now February 1972, almost eight months later. We can not wait any longer.

One building, No. 93, can easily be entered through an unsecured back door. All the other buildings are accessible to children, alcoholics, junkies and others by climbing on the back sheds and entering the second floor windows. They must be boarded up. Numbers 95 and 89 must be boarded up entirely because the weather, (rain, cold and snow) makes heating the adjacent occupied buildings difficult and causes water to seep through the walls. Finally the skylights are all unboarded causing further exposure and structural damage. We think it would be in the interest of the Hospital to have this work taken care of.

The back alley way, behind the University owned buildings also presents a dangerous situation, a health hazard and an unsightly mess. Last summer we were assured this would also be cleaned up. No action has been taken.

We do not feel that any of this work is very costly or time consuming. We feel that the B.U.M.C. Administration is in agreement with us on this matter. We would like this work to begin immediately or hear from you why we have had to wait so long, and when it will be done.

Sincerely,
Mrs. Genevieve Davis, President
East Brookline Street
Residents Association

ON THE NEW EVANS

Dear editor:

We have more space to carry on our continuing care of the sick and scientific research of disease. But it appears someone has decided that patients and test tubes are not all that is needed to equip a new *hospital* adequately. Yes, with today's increasing cost of hospital care and medical education and dwindling research money, it has been seen necessary to furnish the New Evans with thick wall-to-wall carpeting, chandeliers, bamboo walls, and marble table tops. Admittedly these are not found in all rooms. They seem more highly concentrated around the area of the "directors" and the Chief of Medicine. We feel that it was highly ostentatious and even frivolous of the administration to build such a palace in the face of today's numerous problems. There used to be a time in era of medical awareness when patient care was foremost. Maybe Boston University Medical Center will again see that day, but it will probably take the closing of the medical school with financial crisis to bring about the awareness of the administrators. If they find they can't staff the hospital, it too will fail. Perhaps at that late time we will find how many millions there are in the Evans Fund. Too *much* too late? Until then Dr. Talbot will just have to keep tossing in his grave.

Sincerely,
Alan S. Peterson
BUSM IV

Ed. Note: The author of this letter made an effort to obtain detailed information on the funding of construction and interior decorating of the New Evans. No such information was made available.

ROOM FOR ONE MORE?

Gentlemen:

Periodically, it becomes incumbent for a student, intern, or resident to give a report or present a paper. Only too often, the audience struggles through awaiting its termination.

During almost forty years of teaching, I have been tormented by the mumbling, hesitant, and unrecognizable presentation, often in fractured language.

Isn't there room in a college or professional school curriculum for training in the spoken, as well as the written word?

Sincerely,
Bernard I. Goldberg, M.D.
Assoc. Prof. of Medicine
(Emeritus)

NEWS BRIEFS

—In response to student request, Mr. John Gracey, Deputy Director of BUMC, told SCOMSA of medical center action to alleviate the **parking situation.** BUMC has enlarged Lot C to include over 250 cars, and will keep it in better repair than in the past. In addition, parking assignments and the sticker system will be revamped. Mr. Gracey also said that parking rates would be increased for all except students, who will still be able to park in Lot C for the same price they currently pay.

—The student referendum concerning the proposed **Honor Code** had the following results: With 60% of the student body voting, 89% were in favor of the proposal. Following this vote, on January 13, the Executive Committee approved the Code with minor changes. The proposal is soon to be considered by the general faculty for final approval.

—In addition, the **SCOMSA Constitution,** also approved by the Executive Committee, is soon to be considered by the general faculty as well as by the students through referendum.

—**Attention first and second year students.** The American Association of Medical Colleges has inserted into Part I of the National Boards a new section concerning the Behavioral Sciences. The exact nature of this new addition is presently unclear. Dean Lanzoni, however, is currently gathering the available information, which soon will be distributed to the students.

—An ad hoc Committee on **National Boards** has recently been formed, which will recommend whether or not a passing Board grade will again be made compulsory for promotion at BUSM.

CHIASMA

CHIASMA is the official student-operated newspaper of Boston University School of Medicine conceived to facilitate communication between students, faculty, alumni, and administration. Contributions from members of the medical community are welcome, but must be signed. Articles should be submitted in double-spaced, typewritten form.

Current Staff: Robert Alexander, Rebecca Backenroth, Noel Blagg, Lynn Curtis, Diana DeCosimo, Dan Dress, Mary Kraft, Stephanie Larouche, Stephen Loverme, Harold Reitman, Rosie Sokas, Bill Toman, Ruth Tuomala. Photos by Gary Wolf and Leon Remis.

Editorial positions for the coming academic year are open to interested medical and graduate students, faculty and alumni.

Address all correspondence to: CHIASMA, Box 104, BUSM, 80 East Concord Street, Boston, Massachusetts 02118.

New Department Grabs the Limelight

As BUSM expands, the need for new ideas in techniques of medical education increases. A recent development as a result of this need has been the establishment of the new Department of Bio-Communications. According to Audio-Visual Coordinator for the Medical School, Dr. William McNary, the goals of the department are fivefold:

1) To provide to BUSM faculty and students the means of preparing and presenting multi-media educational programs.

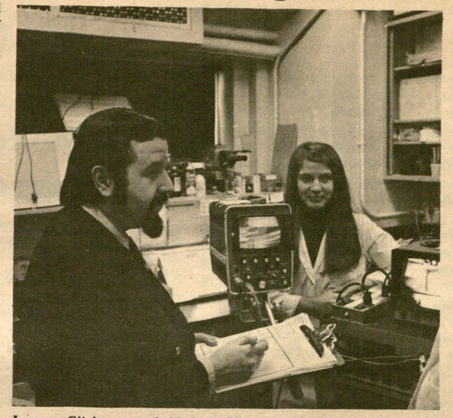
2) To allow instructors at BUSM to participate in national programs through the National Library of Medicine Audio-Visual Center and the Lister Hill Center, which are multi-media programs in medical education.

3) To provide investigators at the school with an on-site media department, where advice may be obtained and demonstrations prepared, and to make equipment throughout the school comparable.

4) To provide training and service for projection and presentation of multi-media programs.

5) To form within the Medical School library a depository of all multi-media materials and a master set of all audio-visual materials available in the school.

Although the department has been formally functioning since only the first of this year, it is currently involved in developing programs for the departments of Pediatrics and Community Medicine.



Jerome Glickman and Medical Photographer, Karen Woodcome, ready video-tape camera.

The Production Coordinator of the Department of Bio-Communications is Jerome Glickman, former Director of Ophthalmic Illustration in the Department of Ophthalmology. A graduate of NYU, he attended the School of Medical Illustration at Massachusetts General Hospital, and received his certificate as a qualified Medical Illustrator in 1962. As one of only about three hundred in his field throughout the country, he represents a select breed of professionals who have both scientific and artistic training and who utilize both in their work. Mr. Glickman has done illustrating for many medical texts, whose subjects range from pediatric ophthalmology to vascular surgery. In addition, he has found the time to produce exhibits of his own paintings, most recently at the Galerie Amadeus in Boston.

At the present time, the work of this newly formed department is strictly a BUSM venture. But both Dr. McNary and Mr. Glickman hope that the entire Medical Center as well as other parts of the University may soon benefit.

An Era Passes

Dr. Chester Scott Keefer, former Dean of the School of Medicine, died on February 3rd, following a lengthy illness. Although formally retiring in 1962, Dr. Keefer had maintained an active role in the University and Medical Center since then as Wade Professor of Medicine and University Professor, Emeritus.

Coming to Boston University School of Medicine in 1940, he served as Chairman of the Division of Medicine, Physician-in-Chief of University Hospital, and Director of the Evans Memorial Department of Clinical Research for nearly two decades.

During the Second World War, Dr. Keefer served as chairman of the National Research Council's Committee on Chemotherapeutics and Other Agents. In that role, he at one time served as the so-called "czar" of penicillin use by civilians. In the early days of mass manufacture of this drug, supplies were still severely limited, and Dr. Keefer was called upon to decide which requests from physicians across the country would be met. All these requests were telephoned or wired to Dr. Keefer in his office at the Evans. For eight months, he was on call around the clock, seven days a week, making crucial decisions of which infants and adults would be allocated the life-saving drug.

For his effective efforts on behalf of the American public, *Dr. Keefer received the Medal of Merit of the United States in 1948. That same year, The* British government awarded him His Majesty's Medal of Freedom.

When Dr. Keefer was called upon to accept the Deanship of the B.U. School of Medicine in 1955, he insisted that the formal title be "Dean and Director" of the school and its associated teaching hospital, Massachusetts Memorial. He thus emphasized what he felt should be the close working relationship between the school and hospital, a relationship which was formalized in 1959 when the Boston University-Massachusetts Memorial Hospital Medical Center was formed. This union, the first step in the formation of B.U. Medical Center in 1962, was presided over by Dr. Keefer as Director. He resigned as Dean and Director of the School of Medicine and Chairman of its Division of Medicine to accept this new position.

Two months ago, Boston University Medical Center honored Dr. Keefer by dedicating the Chester Scott Keefer Auditorium in the new building of the Evans Memorial. At that time, Dr. Ephraim Friedman, Dean of the Medical School, was quoted as saying the following: "Dr. Chester Keefer has been involved in the life of Boston University School of Medicine for so long and in so many capacities that it is difficult to isolate his specific contributions. The entire fabric of the School carries his imprint. It is possible, however, to discern one recurrent theme

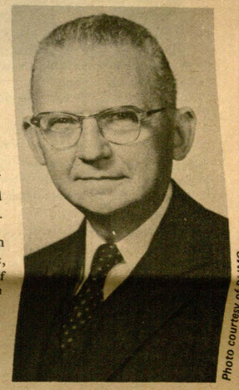


Photo courtesy of BUMC

Dr. Chester Scott Keefer—the entire fabric of the school carries his imprint.

which characterizes his impact on this Medical School, and that is his uncompromising challenge that nothing less than excellence and absolute intellectual honesty be accepted as the norm. For this, he is affectionately revered above all else."

Minority Recruitment: An Ongoing Struggle

by Tom Lambert BUSM II

(This article is the first of two parts. It deals with what BUSM is doing to recruit minority students and what types of problems have been encountered. Next month, the second part will delve into specific obstacles.)

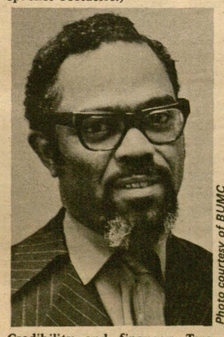


Photo courtesy of BUMC

Credibility and finances: Two major hurdles for Don Taylor's Recruitment Committee.

The ratio of white doctors to the white population of the United States in 1960 was one to six-hundred-and-seventy. But for every black doctor there were five thousand black constituents. For Puerto Rican residents of New York City there was one Spanish-speaking doctor for every forty thousand Bericuans (Puerto Ricans residing in the U.S.) Of the 101 medical schools in the U.S., one-third admitted no blacks while close to half of the blacks attended Howard or Meharry. Boston University Medical School has no Bericuans. This is not surprising in that there are only fifteen Bericuan medical students in the continental limits (out of an estimated total population of four million).

In May of 1968 after the assasination of Martin Luther King a number of people at BUSM became active in trying to recruit more minority students. At this time there were few minority applications, though in the 1950's BUSM had a relatively good-sized minority population. What happened was that other medical schools became very aggressive in recruitment while BUSM did not match this spirit.

Between 1968 and 1970 an *ad hoc* committee on minority recruitment became overburdened so it was formalized and given permanent status at BUSM and CLA. The new *Committee on Recruitment, Education, and Support of Minority Students for Careers in Medicine* then formulated an eight—year comprehensive program and submitted it to the Sloane Foundation for funding. The request for over two-and-one-half million dollars, would cover the total educational costs of starting thirty post-sophomore high school students, attracted from all parts of the country, through three summer school preparation periods and continuing these minority students through all eight years of premedical and medical education. Within the past month, the Sloane Foundation refused to fund the grant request. Thus the eight year comprehensive program has not been implemented and the function of the Recruitment Committee has been impaired. The chairman of the Recruitment Committee, Dr. Louis Sullivan, states that other foundations will be approached for funds. In the meantime, Dean Friedman set up the *Boston Area Recruitment Committee* as a means to draw specifically from the large body of talent that exists in the Boston Area. Unlike the Committee on Recruitment, Education and Support, this committee would deal exclusively with the need to supply the community with doctors native to BUSM's black and Spanish-speaking neighborhood. Mr. Don Taylor, newly appointed Associate Area Director of the Community Health Clinic, was chosen, because of his close working relationship to the minority community, to be chairman. In the process of recruiting minority students, the committee would build much-needed bridges between the medical center and the community. This intention is reflected in the composition of the thirteen-member committee. Students, faculty members, administrators, employees of community agencies, and local residents constitute the group.

The committee faces two serious problems. Various community spokesmen have expressed doubt as to BUSM's credibility. They feel that the community's interests will not be met. Not having the initiative and power, the community, some feel, will be victimized by the institutional strategies of BUSM. The second problem is more tangible—money. Mr. Taylor feels awkward about getting qualified minority applicants, but not getting the necessary finances. The community has indicated that commitment and money are virtually inseparable. But there is much hope, as various private sources are already contributing.

The Boston Area Recruitment Committee has lots of work ahead. Mr. Taylor has emphasized that the Committee must determine "what our role is, what level of student do we want to recruit and what types of supportive programs do we want to develop—tutoring, special classes, etc."

In the next issue, the second article on Minority recruitment will present the most volatile problem facing the committee: Who will determine admissions policies and procedures for the minority students the committee recruits?

Options in the Mode of Medical Practice

The Single Specialty Group Practice

by Robert Carey, M.D.
BUSM '54

Suddenly academic medicine has become deeply concerned with the delivery of medical care. Three major reasons for this interest are: 1) a nation-wide awakening to social responsibility, led at the universities mainly by students; 2) the shift of government concern and funds from basic research to health care delivery; 3) an explosion of new technology increasing at an exponential pace which traditional systems of health care have not been able to deliver to the public's satisfaction.

Furthermore, society has changed almost as drastically as

Photo courtesy of Carney Hospital

"A more flexible kind of group practice has emerged . . . with built-in peer review." —Dr. Robert Carey

the technology. Medical care has come to be considered a right rather than a privilege. The patient is frequently better informed about certain facets of the new technology than his harassed physician. The consumer rightly expects first quality care to be available to *him, preferably within his own* community.

Traditional solo general practice with one physician providing all services to a group of patients has no place in today's society. Those few general practitioners still in our community have in virtually all instances voluntarily limited their activities to only certain parts of total health care and work with a hospital and a team of consultants to provide total care.

In other parts of the country multispecialty groups of physicians have formed, with close economic ties, to deliver total health care. In a fee for service system this may encourage over-utilization of consultants since all physicians gain by each consultation. Furthermore, excessive consultation tends to confuse patients and fragment care. Despite its drawbacks multispecialty group practice has worked well in some communities and delivered high quality care in a fee for service system.

In this area with its 3 medical schools, numerous teaching hospitals, and steadily improving surrounding community hospitals, economically-tied multi-specialty group practices, with a few exceptions such as Lahey Clinic, have not flourished. A more flexible kind of group practice has emerged, consisting of specialists grouping together to deliver a specific service. The Overholt Clinic is an example of this kind of specialty group practice. Since the inner city population is, in most instances, either static or declining, specialized physicians interested in delivering care have tended, though at first reluctantly, to follow patients out to the suburbs carrying their expertise to the communities. In many instances they have drastically altered the facilities in these communities to enable them to deliver the new technology as they learned it. It is natural that such specialists would form groups to provide continuous coverage in their specialty, and to assist each other in the delivery of their specific technology.

In 1960, I was invited to practice in a "group" in Arlington which has evolved in an interesting way. Actually, I really started out as a "solo" internist working with an established internist who also was "solo." We were in a remodeled old home into which about 12 certified specialists had been invited over the years. The original founders had carefully invited specific people to provide most specialties for the community, but each remained economically solo. This meant no one was encouraged for economic gain to utilize the services of others in the building. It has kept us free in the fee for service system to seek out for each individual patient the best specific care available in the greater Boston area. Yet the convenience of having multiple specialties, laboratory and x-ray under one roof is enormous for both patient and doctor. Virtually everyone in the building has continued on the faculty of one or more of the Boston medical schools.

It soon became obvious that many specialists needed help within their specialty and with everyone's approval could invite others to join him. The old house grew out and down to accomodate the new arrivals, and the specialty groups evolved in Arlington as they have elsewhere. We have grown to 5 internists with varying subspecialty interests, each initially economically solo. Gradually we shared more and more in the equipment and in technical services. Two years ago we incorporated. This gave us a much better opportunity to work together and enabled us to provide much greater security for ourselves, our families, and for the steadily increasing number of employees every doctor needs. The advantages of sharing the costs and the use of expensive equipment in a group are obvious. To be truly efficient, doctors' offices should be physically attached to the hospital where they do most of their practice. The Doctor's Office Building at B.U. is a response to this need, and we hope soon to have such a doctor's office building at our local hospital in Arlington.

The most important advantage to patients and doctors of group practice is the built-in peer review. If you share records and patient care responsibility, then you are constantly observing and being observed by your peers. There is nothing more damaging to my ego and more comforting to one of my partner's ego than for him to make an obvious diagnosis and correct my therapy accordingly, while I skj. This keeps us all honest and makes the practice of medicine much more rewarding. However, working in a group is not easy. One constantly has to give in order to make it work. One has to accept his lack of omniscience and the difficult fact that in some aspects of care the last *man trained in the new* technology is the most expert. Hence youth must teach and supervise his senior, something unheard of a few years ago, but mandatory in delivery of the best health care.

Recently all 5 members of our internists group have become interested in the enormous advantages of

(Continued on Page 8)

Public Health: A Diverse Experience

by Richard H. Thurm, M.D.
Medical Director, USPHS
Chief, Medical Dept.

The U.S. Public Health Service of the Department of Health, Education and Welfare provides opportunities for physicians interested in patient care, research, public health, administration and teaching. Internships and residency programs are also available. Salary, annual leave, medical care benefits and base privileges are identical to those provided by the Armed Forces.

The principal clinical activities of the Service are at the eight PHS hospitals (located at Boston, Massachusetts; Staten Island, New York; Baltimore, Maryland; Norfolk, Virginia; Galveston, Texas; New Orleans, Louisiana; San Francisco, California and Seattle, Washington), the 51 Indian hospitals (principally in the western states and Alaska) and the National Institute of Health at Bethesda, Maryland.

Life in the USPHS can be a most fulfilling experience. Two years of active duty (beyond internship) meet the selective service obligation, and the salary and benefits are excellent. Assignments are available to U.S. citizens in a variety of programs including clinical and basic research; direct medical care for eligible beneficiaries (seamen, U.S. Coast Guard and dependents of all Armed Services); air pollution control; radiological health; health manpower; dentistry; disease prevention; mental health; Indian health; foreign quarantine; health education; epidemic prevention; international health; chronic disease control; accident prevention; and a variety of other community health, environmental health, and research activities.

Life is a fairly relaxing one in the PHS. The military aspect tends to be played down and in many places one is rarely required to be in uniform. Many MD's supplement their income by moonlighting, since the on-call schedule tends to be extremely light. Leave is quite liberal, and a serviceman and his family can fly military standby almost anywhere in the world for an extremely small fee.

Since the variety of possible assignments is so vast, it is extremely difficult to describe a typical day for a physician in the USPHS. It does, however, tend to be not too strenuous.

Applications and further information can be obtained at the USPHS, 77 Warren St., Brighton, Mass., 782-3400, Ext. 234, or by writing to Commissioned Personnel Operations Division, Office of Personnel and Training, Parklawn Building, Room 4-35, 5600 Fishers Lane, Rockville, Maryland 20852.

ER: The Hospital Hotspot

by A.G. Roy, M.D.

Emergency Room practice is one of many different ways of practicing medicine. It could be solo or group practice—this particularly suits the individuals who would like to have some set hours of work with no further patient responsibility. Women physicians may find this practice attractive. The bulk of the patients who come to the Emergency Room, for all practical purposes, need routine medical care. Emergency Room full time jobs are comparatively easy to get, and ensure a good income also. I will try to explore these points briefly.

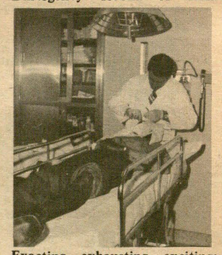
At the present time, individual physicians probably do most of the Emergency Room jobs rather than the groups. This is done as a part-time job, such as daily rotation or hourly shift basis, and in such a case physicians work on the "Fee for Service" basis. Fee for service means that the individual physician has to do the billing and collecting of his fee from the patient (or patient's insurance). This involves considerable paperwork and overhead. Professional Collecting Agencies can do the collection for you on a commission basis. One can earn anywhere from $100 to $500 on a 12 hour shift, depending on the patient load of that particular hospital. Alternatively, a physician can be employed by the hospital on a full time salaried basis, *usually* a five day week job with no night coverage. Salary may vary from $25,000 to $40,000. On the other hand, a group of physicians may employ themselves, or they may be employed by the hospital. The groups are usually responsible for 24 hour coverage. The advantages and disadvantages of group practice are similar to the group practice in any other sub-specialty. Group practice may bring you less gross earnings, but it provides you with more time off, better hours, and several financial fringe benefits. On the other hand, in a group practice, hours are fixed and less flexible than in individual practice, vacation is limited, and it is restrictive.

The hospital administrations are tending more towards employing full time groups, rather than individuals. Many medical journals advertise this type of set up, and they are fairly easy to get.

In many hospitals, night coverage is done by the "moonlighters." They are usually residents working for some extra money, which can be quite considerable.

Any physician who has a license to practice in that particular State can work in the Emergency Room (according to individual hospital policy). This naturally prevents the medical students from working professionally in the Emergency Room. No special training is necessary for working in the Emergency Room, but a surgical background is definitely an advantage. This practice suits an individual who wants set hours with no further patient responsibility. Many retired physicians find working in the Emergency Room profitable. Women physicians with family responsibilities find this type of practice most attractive. Emergency Room practice is not recommended to one who wants the satisfaction of follow-up patient care.

The patients seen nowadays in the Emergency Room are mainly minor sprains, cuts, sore throats, flu, etc. The scarcity of General Practitioners is forcing patients without their own private doctor to come to the Emergency Room. A small



Exacting, exhausting, exciting: Emergency Room Medicine.

percentage of patients will involve acute medical and surgical emergencies, and trauma. This, of course, depends on the type and location of the hospital. All hospitals will have either specialty resident or staff 24-hour coverage for emergency cases.

Emergency Room practice can be exhausting. The chance of failing to diagnose a case with serious consequences is possible because of limited time for examination, and also lack of concentration on one individual patient. Carefulness and alertness will minimize such catastrophies.

Family Medicine Comes of Age

by Alan S. Peterson BUSM IV

In the class of 1972 there are at least seven students definitely entering family practice residency programs this coming July. What is the reason for the increasing interest in this new specialty? Let's look into some history and definitions and then some basic views of the student graduating this year—why hasn't he considered family practice before? What his goals are for the future?

In 1927, Dr. Francis Peabody, Professor of Medicine at Harvard, warned that a pendulum was swinging too far toward specialism. Forty-four years later some medical schools are waking up. During that period of time general practitioners declined from 83% of graduating classes to less than 14% across the country. The AMA has more than three times as many requests for general practitioners as there are doctors to fill them, while they have three times as many surgeons looking for jobs than there are places. In spite of this, many medical schools still have not begun family medicine departments. I am of the opinion that medical schools should be responsible for satisfying health needs of the area in which they are located, and be less intent on increasing their national image by erecting *ivory showplaces* of specialization.

Everyone is asking what the difference is between family practice and general practice. The words "family practice" connote *function* of the physician towards the family unit, whereas "general practice" refers only to the *content* of the M.D.'s work. By "content" is meant the specific body of knowledge and skills the doctor has to use.

Family practice actually means the manner in which the M.D. applies his practice. Training in general practice therefore, does not necessarily mean that the physician is prepared to function as a family practitioner in the community treating people as a family unit. Most general practitioners in the past learned to "function" as family practitioners by trial and error experience. Today's family practice programs include specific training.

The AMA has created the 20th medical specialty, Family Practice. To be eligible an M.D. must complete three years in a family practice residency program, *or* have been in active practice for six years *and* have credited to his name 300 hours of postgraduate training as acceptable to the American Board of Family Practice. This is also the first specialty requiring recertification every six years.

Can any general statements be made about the student entering family practice today? Perhaps some of the following may be pertinent. The student entering family practice residency programs, acknowledges the inadequacies of the general practitioner, but believes that his special training can overcome these aided by some further changes in health delivery. All will be receiving an excellent income, though still less than a specialist might. He'll be working hard for what he does get, because among other things house calls are *still* made. His interest in group practice is growing. He looks at the double standard of health care in some of the large cities with disgust. He believes that Government intervention will come to supervise care for those who can't afford it, however, socialized medicine is not highly thought of by him. He sees the absolute necessity of paramedical personnel in his everyday practice.

Today's student and family practitioner of tomorrow is more interested in becoming a part of the more sedate country or suburban areas than the polluted, noisy city with its rat-race pace. He's looking for a place that his children can grow in and with. Is he too idealistic? I think not.

It has been said by many that American medicine has undergone three major changes since the Flexner Report of 1910. The first was that of the G.P., with broad but not deep knowledge of his "field." In the 1940's we saw specialization come of age, as the students saw that the avalanche of medical knowledge could not be mastered sufficiently for their patients *or* their egos. After the Sputnik, scientific research got the prestige and the financial backing.

Now we are embarking into the era of family medicine. This will be an era of fantastic change in terms of care for the entire *family* and entire *person* by one primary physician. He will consult when he believes his knowledge or skill is not adequate. He and his colleagues will utilize *100* other health workers per 10 physicians. (in 1900 there were 6 other health workesr for every *10* physicians.) Is it realistic?

This Fall I myself witnessed one of the most encouraging signs that the fourth era of American medicine is fast coming. There are now 73 approved family practice residency programs in this country. There were only *15* in 1969. But far more encouraging than the mere number of programs is the number of applicants. In just the past year there has been a fantastic interest shown by the graduating medical students towards family

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Multispecialty Prepaid Group Practice

by Joseph L. Dorsey, M.D.
Associate Director of the
Harvard Community Health Plan

Harvard Community Health Plan is a prepaid group practice program originally sponsored and developed by Harvard Medical School and four of its teaching hospitals. The program was designed to find better ways to provide high quality, comprehensive medical services to a broad cross section of the Greater Boston community, to establish effective ways to teach physicians-in-training about ambulatory patient care and to study certain critical issues in health care delivery. Presently, 19,000 members are enrolled in HCHP through arrangements with Massachusetts Blue Cross, ten private insurance companies and the Massachusetts Department of Public Welfare.

The medical staff consists of 40 physicians representing 12 specialties. Primary medical services are provided by internists and pediatricians. Consultants in allergy, dermatology, ENT, neurology, ob-gyn, ophthalmology, orthopedics, psychiatry, radiology and surgery see patients at the Health Center in Kenmore Square. Physicians in the primary care areas devote 50-100% of their time to HCHP activities; physicians in the consultant areas are generally part time, with the amount depending on the volume of need for care in their specialty.

Virtually all hospital and medical services including preventive health services are prepaid (out of hospital drugs and dentistry being the only significant exclusions) and the medical group provides 24 hour care for emergencies. Each family is strongly encouraged to select a personal, primary physician (an internist for the adults and a pediatrician for the children) and to obtain continuous on-going care from that one physician. Over 60% of the patient visits are in these two specialties. All physicians are members of the staffs of the Beth Israel Hospital, Boston Hospital for Women, Children's Hospital or the Peter Bent Brigham and are responsible for any HCHP patients admitted.

Practicing in such a prepaid, multi specialty practice offers the physician many advantages. The sharing of responsibility for patients with consultants in other specialties, who are part of the same medical group, is both a source of continuing education and a stimulus to high quality care. There are no significant financial barriers to receiving care for the patient. The range of covered services, especially a diagnostic lab and x-ray service, and alternatives to costly in-patient care, is most helpful. While the physicians' total hours are comparable to those of people in solo practice they can be ordered so as to allow a more full and regular family life because of the built in coverage arrangements. Fringe benefits are more readily available through an organized group.

The intensive pressure to find a better way to finance and organize health services has cast prepaid group practices in a place of national interest. The involvement of medical schools for the first time in their development, together with the quest for meaningful innovations in the delivery system, has created an atmosphere of challenge and excitement for the physicians.

On the negative side, a physician surrenders a considerable degree of autonomy upon gaining a group. Decisions which were quickly and personally made in one's own office become subject to committee review and decision making. Selection of personnel becomes removed from the immediate hands of the physicians. Inevitably a certain degree of bureaucracy characterizes a program caring for upwards of 20,000 people.

On balance, working in such a prepaid group practice is an extraordinarily positive experience. The attractiveness of the Plan to physicians completing training is evidenced by the large number of applicants for positions especially in the primary care specialties and by a very high retention rate among the original group of physicians.

Community Health Center: Teamwork and Optimal Care

by Dan Dress BUSM II

"As a physician I feel that this form of practice brings me closer to the consumer in the community. In many ways the health care I have is much more effectively delivered through a primary health care delivery setting in a community site."

Thus does Dr. Richard Morrill, a psychiatrist at the

"More effective delivery of health care; not merely ghetto medicine." —Dr. Richard Morrill

Roxbury Comprehensive Community Health Center, capsule his motivations for selecting a community clinic mode of practice.

Dr. Morrill further believes that most people involved in mental health should be working in such primary health care delivery settings, because there, one can reach people and prevent illness much more easily than in the usual specialty psychiatric clinic. "People aren't so afraid to come to a place that is more of a natural setting to them. Consequently, they tend to come earlier, and with less stigma and anxiety," Dr. Morrill maintains. Moreover, this is true for many specialties, because, when a resource is readily available, both physically and psychologically, people tend to come in earlier to get care, and return at the requested appointment times. In contrast, the drop-out rate of referrals between clinics in a large city hospital at times approaches 60-80%.

Dr. Morrill feels strongly that the physician who decides to embark upon community clinic practice should do so on as close to a full-time basis as possible. Only in this way may the patient be able to come and find "his doctor" and not have to structure his needs around the idiosyncratic schedule of the physician. In addition, devoting most of the physician's time in one setting lends to better acquaintance and more efficient working ability with staff members, at the benefit of the patient.

Optimal care in a community health center, this psychiatrist maintains, rests, in large part, with the willingness of the physician to function as part of a health care team—to seriously listen to and share information with the non-MD's on the health team: nurses, "new-professional" community health workers, mental health workers, social-workers, dieticians, and others. At the Roxbury Health Center a family health care team meets weekly, and each member is encouraged to contribute information, in order to develop and carry out a comprehensive family health care plan of action.

Some physicians are utterly afraid that in such a setting in which the decision-making is shared, someone is going to dictate to them just how to perform their medicine. Dr. Morrill maintains that this just is not true. Where environmental factors or the emotional state of the patient are involved, many times it is the paramedical or non-professional health team members who are most knowledgeable, and who can contribute to the care of the patient, if the physician cares to listen. "I think that some older doctors are not used to this, and tend to have an autocratic view of the physician in his setting, and they have trouble adjusting. I think that, generally, the younger doctors we've had here have been much different in that regard."

In this same context, Dr. Morrill agrees that part of the problem one may have in adjusting to the teamwork stems from the physician's professional training. For if one has been trained into a hierarchical view of the physician versus the non-MD, he may very well feel uneasy in a setting requiring close communication and co-operation with paramedical staff members. And, conversely, if one's medical school training initiates him to the health team approach, then the doctor is more likely to want to be a part of a community health center, especially in consideration of the payoff in better medical care to the health consumer.

According to Dr. Morrill, a major problem with many neighborhood health centers involves a lack of health care planning. They open their doors, suddenly develop a booming business, and consequently, the character of the health center changes from one of warmth to that of a mass production

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Towards a More Sensitive Approach

by Alice Rothchild

Alice Rothchild of the second year class was the student representative from BUSM at the November AAMC national convention.

The American Association of Medical Colleges held its annual meeting in Washington D.C. at the end of October. The AAMC is responsible for MCAT's, AMCA's (the application service), publication of the "Journal of Medical Education", and presenting the views of medical education on legislation and national topics. It is also the primary forum and spokesman for medical education in this country.

This year's conference consisted of a series of lectures, discussions and displays on a broad range of topics ranging from research into medical education, to governmental financing, to teaching aids in ophthalmology.

Student representatives from each medical school suddenly found themselves part of this organization of deans, department chairmen, and the Council of Teaching Hospitals. Among the students there were numerous regional differences as well as regional chauvinism, and as far as total composition, the four women and four Blacks (seven from the Northeast) were very much in a minority. On the whole, students had little understanding as to what kind of power the AAMC held. We knew that it could not legislate anything, yet the people who design the MCAT's are definitely shaping the definition of a *"desirable" medical student.*

The AAMC assembly very quickly learned that other powers are concerned about medical education. A speech by Senator Kennedy very clearly warned the Assembly that if educators do not act "responsibily", do not concentrate on efficient and high quality education, and do not increase the size of schools, the federal government will soon move to control many of these factors through the power of funding.

At the outset, the students spent a good deal of energy trying to define themselves, devising a structure, and arguing over *Roberts Rules of Order.* There was a great deal of disagreement over what the Council of Deans had decided we were, and our reaction to that decision. Some felt that our major purpose was to establish rules for the organization while others were primarily concerned with developing a platform of resolutions to be presented to the Council of Deans, or rather, to their resolutions committee for initial approval. Previously we had been given 10 out of 173 votes in the Assembly which consists of the Council of Deans, Academic Societies, and Teaching Hospitals. What did these 10 votes mean? And who were the observers who sat quietly at the back of all the students' meetings? We had the distinct impression that we were being watched, tested.

At our second meeting we quickly voted on a recommendation that married students be matched together for internships. It seems that the internship-matching program had decided that it was too costly or difficult to be accomplished with their computers.

We then discovered that we had elected an osteopathic student as one of our officers, technically an illegal move. This led to a discussion of osteopathy; to our surprise and chagrin we discovered that osteopathic medical students have a similar basic science and clinical curriculum. In fact, the schools of osteopathy had once been invited to join the AAMC if they changed themselves into M.D.-granting schools. We also *began to examine the important question of membership.* The consensus was that equal membership to the AAMC must be offered to other health-training schools if progressive directions with respect to curriculum and socialization are to be developed within the organization. A resolution was then prepared, recommending that osteopathic schools be invited to join the AAMC. The resolution was later tabled by the Assembly.

The northeast region had earlier in the afternoon prepared a series of resolutions that soon became the source of a great deal of arguing and struggle. So much so, in fact, that the Organization of Student Representatives never quite got to putting these resolutions to a vote. The regional caucus felt that students were in agreement with each other on issues like minority admissions, the need for courses dealing with preventive medicine as well as environmental health hazards; yet deep differences really existed as to the way of reaching these goals. The resolutions were designed to suggest specific actions that would stimulate more honest discussion. They covered four basic topics: 1) the relation between health teachers and students and the political and environmental context in which they worked; 2) curriculum structure; 3) funding for student education; 4) minority student and women admissions.

Because the first resolution was the only one discussed in depth and because it created a great deal of confrontation, I will present it in further detail. The statement was based on the assumption that any factor having a detrimental effect on the health of the individual must be a subject of concern and opposition by all health workers. Derived from this assumption were three premises and recommended actions: 1) The war in Indochina perverts our priorities and distracts us from our primary commitment to medicine and health. Therefore, the AAMC must actively oppose the war by pressuring the government and war-related industry. Doctors must be encouraged to resist the draft *and refuse to use medical skills* for *military ends, as in the* development of chemical and biological warfare.

2) Destruction of the environment is counter to the goal of a healthy society. Therefore, the AAMC should establish a program dealing with the health hazards of environmental pollution which would include:

a) recommendations to all medical colleges to establish curricula concerning the health hazards of environmental pollution.

b) recommendations that research into the dangers of environmental pollution be encouraged and the results of these studies be made available to the communities in which they are found.

c) a lobbying effort be made in Congress to establish more strict anti-pollution legislation. Furthermore, the AAMC should encourage industry to recognize its responsibility for the pollution of the environment and to take immediate action to remedy this problem.

3) The inequitable distribution and quality of health care delivery is a serious source of disease and human misery. Therefore, the AAMC must develop and distribute a position paper supporting a national health plan whose structure is such that all the resources of the health sciences are available equally to all citizens. The AAMC should support the growth of neighborhood health centers, developing both within and beyond the auspices of medical schools. This would recognize the importance of accessible health care, of educating communities about health, and of the opportunities health students and doctors will have, to become more sensitive to patients' needs.

Following this meeting the students met again, both formally and informally, and a number of ideas emerged. Several committees were established: nominations, finance, liaison with external organizations, rules and regulations, minority affairs (of which I am a member), and political action. We developed modes of communicating among schools in the hope that the committees will compile information from the institutions, and share developments and experiences. We also discussed the importance of student input into other parts of the AAMC. It was decided that representatives ask to go to the regional Group on Student Affairs and to the Assembly meetings in the spring.

Perhaps the most valuable part of the conference, however, was that students from all over the country began to exchange information and decrease their sense of isolation. Some of us found many of our eastern prejudices being challenged. There were several intense discussions about the roles of women, of wives in particular, of Blacks, of the socialization process, the cultural biases of the MCAT's. Students who had been to Viet Nam discussed the effects of the war; a student from Nebraska saw pollution for the first time; some of us began to understand the importance of rural medicine. We found out that some medical schools have courses on the doctor-patient relationship and on the human sexual response; that some students do all their clinical work in small community hospitals. Other schools have special preparatory programs for minority students, or clinical experience starting in the first year and no large lectures. We began to see that many of the new schools have more imaginative programs, that the older schools are often very cautious when it comes to curriculum and philosophy. The sense of alienation and cynicism varied tremendously. In short, the exchange of ideas, the struggling, the differences were very important and represent the beginnings of student input towards a more thoughtful, creative, and sensitive approach to medical education.

Student Neurological Society

by E. Coli

Imagine being led through new frontiers by a friendly person who is one of the world's foremost investigators in the challenging field of neurosciences. Don't just imagine, because magical mystery tours of the brain are a reality every month right here at our own school of medicine.

Dr. Walle Nauta, the eminent neuropsychology professor of M.I.T. spoke on Tuesday, October 12th. His topic was "The Problem of Frontal Cortex" On Monday, November 29, the chairman of the Neuroscience Research Program (NRP) of M.I.T., Dr. Francis O. Schmitt, spoke on "Molecular Membranology." The sixty people who attended each of these lectures were treated to stimulating experiences.

This lecture series, which will continue throughout the year, is presented by the Boston Student Neurological Society. Under the new leadership of Society President Hackie Reitman and Vice President Steve Osborne, both of BUSM II. The organization has undergone a rebirth as shown by the high quality of this year's speakers and the upward trend in attendance and general good support.

"Steve and I are very happy that such great men as Dr. Schmitt and Dr. Nauta were kind enough to give us their time," Hackie Reitman emphasized, "but we are doubly appreciative that the students and faculty who were interested recognized this, and attended in such numbers. The purpose of the Boston Student Neurological Society is to provide this opportunity for learning, stimulation, and personal contact with the leaders of neuroscience."

Steve Osborne explained to *Chiasma* that the Boston Student Neurological Society hopes to expand to envelop all the medical schools and universities so that all interested students will benefit. Steve and Hackie express their appreciation to Dr. Alan Peters for his advice and encouragement.

Future speakers this year include Dr. Herbert Teager, Dr. Norman Geschwind, Dr. Samuel Bogoch, Dr. John E. Dowling, and Dr. Juan De Dios Pozo Olano. Topics will range from perceptual research to the sign-post theory and brain glycoproteins. For more information, just drop a note in Box 344, care of the medical school, or contact Steve Osborne or Hackie Reitman.

He Came Bearing Gifts

by Mary Kraft, BUSM I

Everybody at BUSM knows Eddie McCarthy. He's the man in the white lab coat bustling through the lobby or the student lounge, greeting everyone he encounters by a smiling, "Hi, ."

But what is Eddie McCarthy really like? Chiasma posed this question to Eddie, and he started out with this anecdote:

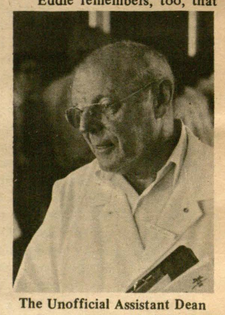
"A freshman a few years ago had trouble getting up in the morning. So I called him up on the phone at 6 every day for a year to wake him. He thanked me by baking me an Irish bread."

Single, with no official title, Eddie is affectionately called the "Assistant Dean" by students. This affection is mutual. Eddie says: "The students are part of my life. I can't say enough for them. I see them when they first come in and I'm the last one they see as I shake their hands at hooding (a class day exercise)."

Eddie arrives at school at 5:30 A.M. His duties include working in the gross lab, the upkeep of the student lounge, and the handling of instruments and books from different pharmaceutical companies. His day is over at 2 P.M., "but if the students need me, I stay on until late afternoon to do what I can for them. I listen to their problems. In the past I've acted as an intermediary to break the ice between hesitant students and faculty.

"I also give tours of the school. Grateful alumni have written me letters of thanks for showing them our new buildings." As a matter of fact, following a tour Eddie gave an alumnus and his son, the school was given a substantial sum to endow a room in the library. "More recent graduates (Eddie has seen thirteen classes awarded M.D.'s) who come back to visit are pleased that I remember their names."

Eddie remembers, too, that



The Unofficial Assistant Dean

medical students appreciate a break in routine, so he sponsored the Halloween party last October. That was the first of what Eddie hopes will become traditional Halloween festivities because, he says, "I enjoy doing it for the students."

Although Eddie's major work is with BUSM students, he added emphatically, "Thanks to the faculty for encouraging me to work with the students; I couldn't do it without them."

Thank you, Eddie. School would be less pleasant without you.

(Continued from Page 1)

staff lockers, etc. The hospital itself appears most likely to lose equipment over weekends and at night.

In terms of numbers, personal assaults do not seem a major problem. However, the victims, and *potential* victims view it as a great problem. Mr. Gracey believes that many

Photo courtesy of BUMC

"Security is everyone's business at the Medical Center." —Herbert Klein

prospective employees will not even come to the medical center because of its location. He also thinks that Boston City Hospital has a much larger problem with personal assault than does BUMC, and with all crime in general. This may well be true.

Within the medical center itself, and the sidewalks bordering it, no assaults were reported in 1970, and *six* in 1971. As is expected, females were the victims in four of the six cases. While six is not a large number, and there were no known serious injuries, a rise from zero to six assaults in one year certainly is serious, especially if it is an indication of the future. The research building of the medical school and the main entrance to University Hospital were the most dangerous places. Theft was involved in most cases.

In the medical center as a whole, the Robinson, Talbot and Evans buildings were the scene of the greatest number of thefts, followed by the Instructional and Research buildings. In terms of monetary losses, the Research building is first, followed by the Talbot, Instructional, Collamore, Evans, and New Evans Buildings. Again, it is important to note that New Evans accounted for 10% of BUMC's losses for 25 months beginning January, 1970, even though it has been open only two and one-half months of that time.

Within University Hospital, the Talbot building is especially bad, notably its third floor. Coincidentally, the third floor of Robinson is also very theft-prone. These two floors had 29 reported thefts in 25 months, representing about 20% of UH's total. Other trouble spots include the eighth and ninth floors of Evans, the second and third floors in the New Evans, and the first and second floors in the Talbot.

Within the medical school, the eighth floor of the instructional building and the fourth, sixth, and ninth floors of the research building seem to be especially liable. Research-6 accounted for 20% of the total 25-month monetary loss in the medical school. The parking lots of the entire medical center seem to be surprisingly safe, accounting for only 2.7% of the value stolen in the 25 months.

Security Problems at BUMC

Almost all of this was represented by a rash of bicycle thefts in the spring of 1971. The School of Graduate Dentistry is also relatively crime-free, accounting for only 2.5% of total BUMC incidents and 5% of its losses.

The Doctors' Office Building is not included in these statistics, nor is ECU included in UH statistics, as its security, like the DOB presently, was handled by a private agency in 1970. The Extended Care Unit is however included in the 1971 BUMC total statistics, as it was integrated into BUMC in January, 1971. Its effect on the statistics is almost negligible. In the past 13 months, there have been 16 incidents involving $949 loss (less than 4% BUMC total loss).

From all these statistics, it is obvious that a greatly increased problem with theft and personal assault does exist within the medical center. And yet, only one official out of ten interviewed thinks there is an increase in crime. These officials are all either directly involved in the security program, or in the upper echelon of hospital, medical school or medical center administration. It is imperative that the reporting and handling of information about crime in the medical center be improved, and that those administering the security forces, and running the medical center and its institutions be aware of the information and *use* it to prevent crime. It is impossible to improve the situation unless guards *know* where and when crime is most likely, and who is usually the victim!

WHO IS SECURITY?

Within the physical plant of the Medical Center are three separate security forces: one employed by B.U. Medical School, one employed by University Hospital, and a privately contracted service which covers the Doctors Office Building. Although the Medical School and University Hospital forces are financially and operationally distinct, they are conjointly administered by the office of Mr. Herbert Klein, Plant Superintendent of the Medical Center.

Medical School Security is directed by Mr. David Eaton, Mr. Klein's chief assistant for security matters. Sgt. John Coleman is in charge of the daily operations of the force. He and his men have responsibility for securing the Houseman Research Building, the Instructional Building, Building A, and by agreement with the School of Graduate Dentistry, that building also. The parking lot adjacent to the Research Building is also within their area.

Until recently, University Hospital Security was directed by another assistant to Mr. Klein, Mr. Melvin Burtt, who retired on January 31st. University Hospital Security, also, is directed now by Mr. Eaton, with Sgt. Sanborn in charge of daily operations. University Hospital, including the Extended Care Unit, New Evans, and Talbot, plus three parking lots, comprise the area of responsibility for this force.

The possibility of combining the University Hospital and Medical School forces into a single Medical Center Security Force has been under discussion by various administrative persons for some time. Mr. John Gracey, Deputy Director of the Medical Center, Mr. Klein, and Mr. Eaton all spoke favorably of such a consolidation. Mr. Gracey stated, however, that the initiative for unifying the two forces would have to come from Mr. Klein.

The principle argument given for unifying the forces is that the ease and efficiency with which the entire plant could be patroled would be greatly improved. The present system of entangled and adjacent areas of jurisdiction is inefficient, not to mention confusing, to employees and students. Furthermore, such a consolidation would facilitate matters of policy, records, and administration. Mr. Klein stated that some of these problems will be alleviated now that both forces are under the direction of a single man, Mr. Eaton.

The reason most frequently cited for failure to consolidate the security forces is that the Medical School force is unionized. Until recently, the University Hospital force was not. Although they are under separate contracts, both forces now belong to the same union. Mr. Eaton believes the union would be agreeable to combining the forces.

A faculty member with whom we spoke made the further recommendation that the (combined) security force be removed from the Office of Plant Maintenance and be made directly responsible to the Administration of the Medical Center. This, it was pointed out, would allow greater independence in the operations of Security, and also, by virtue of proximity, perhaps engender greater administrative concern for, and action on, security problems.

In the same vein, a security guard suggested providing a separate radio communications channel to security forces. At present, both the maintenance department and security forces use the same frequency. Not only are the guards constantly bombarded with calls about clogged drains, etc., to the point of distraction, but this situation

leaves open a greater possibility of future dishonesty, as many people can follow the movements of the guards.

WHAT CAN THE INDIVIDUAL DO?

Each person involved with the administration of Security with whom we spoke expressed the opinion that there is much that employees and students could do to improve security and prevent thefts at the Medical Center. Mr. Klein stated that "security is everyone's business at the Medical Center." Mr. Gracey offered his belief that "the individual does have a responsibility to the institution in helping with security problems," while Dean Friedman stressed the importance of educating personnel to security problems. Both Sgts. Coleman and Sanborn concurred in this. Herewith are some suggestions that were given:

1) Ensure that offices and laboratories are locked when not in use. If it is impossible to lock doors, be sure that personal belongings are secure.

During a recent Saturday afternoon spot check of a floor in the Medical School which appeared to be particularly prone to thefts, the authors found the door to a laboratory unlocked. The lights were out, and no one was in the vicinity. Security was notified, and the officer who came to lock the door told us that a faculty member had been working in the lab earlier in the day. The officer then said: "I tell people every day to be sure to lock the door when they leave. If only people would cooperate with us." The faculty person involved had suffered a theft of personal property from his lab only a few days before.

Just last week, the authors *again* found the key to the library's Xerox machines left in the unattended unit. While not too serious in themselves, these instances are indicative of the carelessness all too common in the Medical Center.

2) Report suspicious persons to Security immediately. Do not challenge such persons yourself.

A secretary recently had money stolen from her purse which had been left sitting out while she was absent from the office. When we discussed this incident with Sgt. Coleman, he told us that the thief was seen exiting from the office, and that this man had been seen in the area a number of times previously on that day, but that no one had informed Security until after the theft.

3) Report all thefts, or suspected thefts, to Security immediately.

Without reports, it is impossible to assess actual losses occuring within the Medical Center. There is a strong

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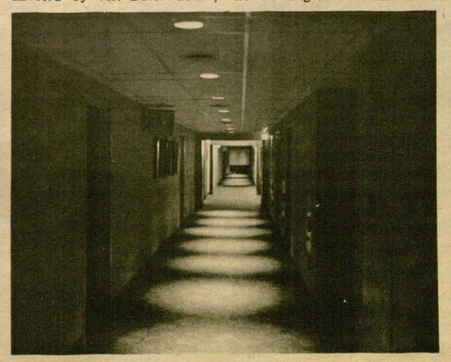

BUMC Crime 1970-72

	1970	1971	Jan.'72	total	1970-1971 %charge
B.U.					
thefts-no.	37	48	3	88	+30%
thefts-value	$6208	$3696	$65	$9969	-40%
assaults	0	2	0	2	+100%
U.H.(—ECU)					
thefts-no.	57	95	9	161	+66%
thefts-value	$3435	$7100	$4160	$14,695	+107%
assaults	0	4	0	4	+100%
B.U.M.C.(+ECU)					
thefts-no.	94	156	16	266	+66%
thefts-value	$9643	$11,603	$4379	$25,625	+20%
assaults	0	6	0	6	+100%

Med. School Receives Scholarship Gift

The Jewish Memorial Medical Associates Foundation has presented the Boston University School of Medicine with a gift of two thousand dollars, earmarked for scholarship aid. According to Miss Mary Whitehead, medical school financial officer, the funds were distributed to one fourth-year and two first-year students at the beginning of the second semester.

The origins of the foundation which donated this scholarship is of interest. Approximately thirty years ago, a group of doctors who practiced at Jewish Memorial Hospital in Roxbury banded together to form the JMH Medical Associates. In the words of Executive Committee member of this organization, Dr. Bernard Tolnick, "the Medical Associates formed out of a labor of love of individuals dedicated to delivering quality medical care to the ward patients of Jewish Memorial Hospital, without fee."

After remaining a non-paid organization for twenty-five years, the Medical Associates in 1967 decided to accept Medicare payments from the ward patients. Thus emerged the Jewish Memorial Medical Associates Foundation, Incorporated. It is noteworthy that the Medicare payments are utilized to give the non-private patient at Jewish Memorial the same quality care as the private patient; to improve medical and surgical care; and to conduct scientific research. In addition, portions of the monies are allocated for educational scholarships and for assisting other non-profit organizations, such as the American Heart Association.

In 1967, its first year of existence, the Foundation presented BU and Tufts Schools of Medicine with substantial scholarships gifts. The only stipulation applied to the distribution of the scholarships, is that they be given without regard to race, color, or religion

CORRECTION

In the Nov. 1971 issue of Chiasma, the introductory paragraph to the article, "End Profits–Promote Health" by Peter Mason, BUSM II, was printed with the article, "MONY Supports Healthcare" by an oversight in proofreading. Our apologies.

FAMILY MEDICINE

(Continued from Page 5)

practice residencies. The director of the York Hospital program told me that he has over 10 applicants for *each* position he offers.

What is so enlightening is the fact that New England is leading the country in its nearly total apathy toward the responsibility of fulfilling health care needs of the family as a unit. In other words, the six New England states combined have *two* approved family practice residency programs. One is at Harvard, the other in the Hospital of St. Raphael in New Haven, Connecticut. I must say that family medicine has now arrived and as soon as the New England medical schools realize they are losing some of their better students and future doctors to other areas of the country forever, they'll form departments of Family Medicine quickly.

I'll never forget a conversation that I had with an administrator here a few years ago. When he asked what specialty I was going to enter, I said that I wasn't. He replied, "You're not going to be a family practitioner, are you? There aren't any more of them around." I assured him I was considering that field. He continued, "We've looked back at our alumni and found that most of the G.P.'s were in the lower third of their graduating classes." If that were true in the past, then indeed times are changing. Studies across the country show that students applying for the family practice residencies originate from the upper and middle thirds of the class. Times have changed.

Why have they? Here are a few of the reasons.

A student entering general practice in the past was disheartened by the lack of definable training after internship. All he was was a nebulous sea of self teaching via daily experience, journals, and occasional conferences. He then realized that the demands of his practice won over his ability to "keep up" academically. He was crushed. The new residency programs are, of course, changing this outlook drastically.

The decline of general practitioners in the past had also been hastened by the structure of medical schools and city hospitals. However, now we are beginning to see a more basic outlook into the fundamentals of modern medicine, as the medical schools are fumbling in trying to cram all the specific details and minutiae into the exploding brains of the "technical student."

Where are the general practitioners on the faculty, or where is the department of family practice? Is there a separate *family* medicine service for in and outpatient care in the hospitals? These have *already* changed in areas now with family practice programs.

The graduating student has also been worried about isolation in the "more rural" area of his practice. The family practitioner on one hand loves the rural atmosphere for family living, but fears his skills and knowledge withering on the vine. Group practice is having a highly favorable impact on changing this tremendous fear to a challenging tool. He must have support from more paramedical personnel to lighten his routine, technical, and paper work. Along with these "job" enhancements, he is constantly looking for better schooling for his children as well as more cultural pursuits for his wife and himself.

It is my hope, and my personal goal, that *family practice* will dissolve the current hang up of modern medicine–that "of being praised for its progress and impugned for its inhumanity." Come, join us.

SECURITY

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suspicion that many thefts now go unreported. Not infrequently, thefts that *are* reported are not brought to the attention of Security until several hours (or, in one case, two months) after they are discovered. This obviously makes a building check for suspicious persons useless. Moreover, a copy of the theft report will aid in making a claim if the articles stolen are insured.

4) Record the serial numbers of all equipment, and keep such a record available.

In order to make a report to the Boston Police Department, the Security forces require positive identification of the article stolen. Items stolen in the past have been recovered, but such recovery depends on the certain identification.

These relatively simple measures require minimal effort on the part of employees and students at the Medical Center, but may aid considerably in the efforts of the Security Forces to prevent thefts and to recover stolen articles.

WHAT CAN ADMINISTRATION DO?

Combine the BUMC Security Forces into one unit. The situation of divided responsibility for the same function within the same center is inefficient at best, and dangerous at worst. First, in many instances, guards from one unit respond to incidents in the other's "territory." There are many "border areas," and we feel these may get poor coverage because each security force believes that area to be the responsibility of the other. Secondly, combination of forces, occasionally practiced now in the form of cooperation, in violation of union rules, would increase the effectiveness of security. At present, if the BU guard is busy, it may be some time before he can answer a second call. Union regulations forbid a UH guard from taking that call. In the mean time, a serious crime can be committed. When told of our confusion in trying to analyze exactly who does what in BUMC security, a medical school official responded: "You're probably getting a pretty accurate picture." Combination of forces has been discussed for some time by various officials, but no one has taken the initiative to act. The new structure placing all security under Mr. Eaton is a step in the right direction, but not far enough.

Security should be removed from Buildings and Grounds Department and placed directly under the BUMC Administration. As evidenced by their unawareness that crime has increased in the medical center, we feel the people presently administering the security program do not have the time to do it adequately in addition to their large maintenance responsibilities. Also, we have found that information about crime and security does not adequately filter up to top hospital, medical school, and medical center officials, who have the real power to act towards improvement. One person should have as his chief responsibility the administration of security, and he should report directly to BUSM deans, UH administration, and BUMC officials. In conjunction with this, we recommend:

Security forces should have their own radio communications channel. This should require merely switching the frequency crystal in their walkie-talkies and not alter the present base station arrangement, using the same dispatcher as maintenance. In addition we recommend:

A running compilation of crime data be made. As related earlier, no one could tell us whether crime in the medical center had changed from last year, but only offer opinions. In addition such things as trends in type of crime, time or day of most thefts, the most dangerous areas for thefts or assaults, the total amounts stolen, etc. were unknown. A person appointed head of security, reporting to the highest officials, would have the time and responsibility to keep such statistics, and use them. As an example, Mr. Mullet replied, "We seen to go in fits and spurts," in response to a question about types of crime in the hospital. He is an official in UH administration. If such tendencies were used to control thefts, losses might be greatly reduced.

"Hot-Line" telephones connected only to the switchboard should be installed in the Medical Center. Dean Friedman has already taken initiative in regard to this. There have been cases in the past where security could not be reached because the victim did not have a dime, and the offices were all locked. Such phones should be in strategic locations throughout the medical center. We envision possible locations to include the New Evans lobby, the medical school lobby, fourteenth floor Instructional Building, the Harrison Avenue entrance lobby to the Research Building, the Talbor Building main lobby, the ECU lobby, and the Newton Street entrance to Old Evans.

Efforts to improve Boston Police Department patrols in the BUMC area should be continued. Mr. John Gracey of BUMC administration has been working with City Hospital officials towards this end. He states that he became involved after being told by a student of increased problems students are having in the medical center locale, primarily the assault of a medical student recently in Worcester Square. Through his efforts with BCH, the Boston Police Department has promised to add foot patrolmen between City Hospital, the medical center, and the Northampton MBTA station at peak periods, and reported several more cars already on patrol in the area. In addition new, improved street lighting is being erected on Massachusetts Avenue, and around the medical center.

"Guards are placed in tough situations," says Mr. Gracey, "where they have to deal with some unreasonable people–arguing with professionals over parking places, for example." We appreciate their situation, and believe increased cooperation on the part of all medical center personnel is necessary. We also believe the changes in security we have suggested should be made as soon as possible.

These recommendations involve minimal cost, compared to other solutions possible. As Mr. Gracey puts it, "Someone's going to pay for crime here–either a patient in the form of increased charges or a student in the form of increased tuition." Or worse, a life!

HEALTH CENTER

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factory. The only way to avoid such mismatch of resource with demand is through pre-planning a certain number of staff and the resources to meet the needs of a certain population. "Such health planning is working very nicely in Europe; they're just beginning to think about it in this country." The Office of Economic Opportunity, for example, sponsors the Roxbury Comprehensive Community Health Center to serve a limited surrounding population of about forty thousand, and provides the center with enough staff to render that population quality care.

Dr. Morrill strongly contends that health centers, similar to the one in which he works, should in no way be construed as merely "ghetto medicine." "having non-professional staff members or teams meeting, I think, would be as good an innovation in Newton as they are here. I've heard a lot of my friends complain about being shunted from specialist to specialist in Newton. I think rational people will agree that other kinds of people in the doctor's office can help in the total delivery of care." Perhaps, also, enough rational people will soon realize the advantages of Dr. Morrill's type of health center, treating the *whole* patient in his own community, so that such principles may be more widely applied to clinics throughout the population.

SINGLE SPECIALTY

(Continued from Page 4)

multiphasic health screening and have joined others to form a new corporation, truly multispecialty, dedicated to providing the best in health testing, with computer analysis, to patients at reduced cost. This group has crossed specialty lines and community lines to include physicians from several surrounding communities with particular interest and expertise in this field. Also, business, legal and computer experts are joined in this complex endeavor to provide the new technology to the community.

With the expected demise of the fee for service system giving way to a total prepaid health care program, I foresee further grouping of physicians. The health maintenance organization as pioneered by the Kaiser Permanente Program and locally by the Harvard Community Health Plan, offers exciting possibilities for group practice in a different setting. The county medical society foundations, another kind of group practice, will, hopefully, include meaningful peer review. These may help all physicians to upgrade their delivery of care. Health maintenance organizations geared to communities seem to me to be more logical than plans seeking to provide care to certain economic groups such as a given union or a certain company, as the Harvard Community Health Plan and the Kaiser plans have done. People usually prefer to receive health care within their own community close to their homes and their loved ones. I believe our society can achieve such a system of health care within communities available to all.