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The Jewish Hospital Of St. Louis

Hospital officials and dignitaries at cornerstone ceremonies for the Jewish Hospital building on Kingshighway Boulevard, May 1926. For a look 80 years into the past, see p. 12.

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The Jewish Hospital Of St. Louis

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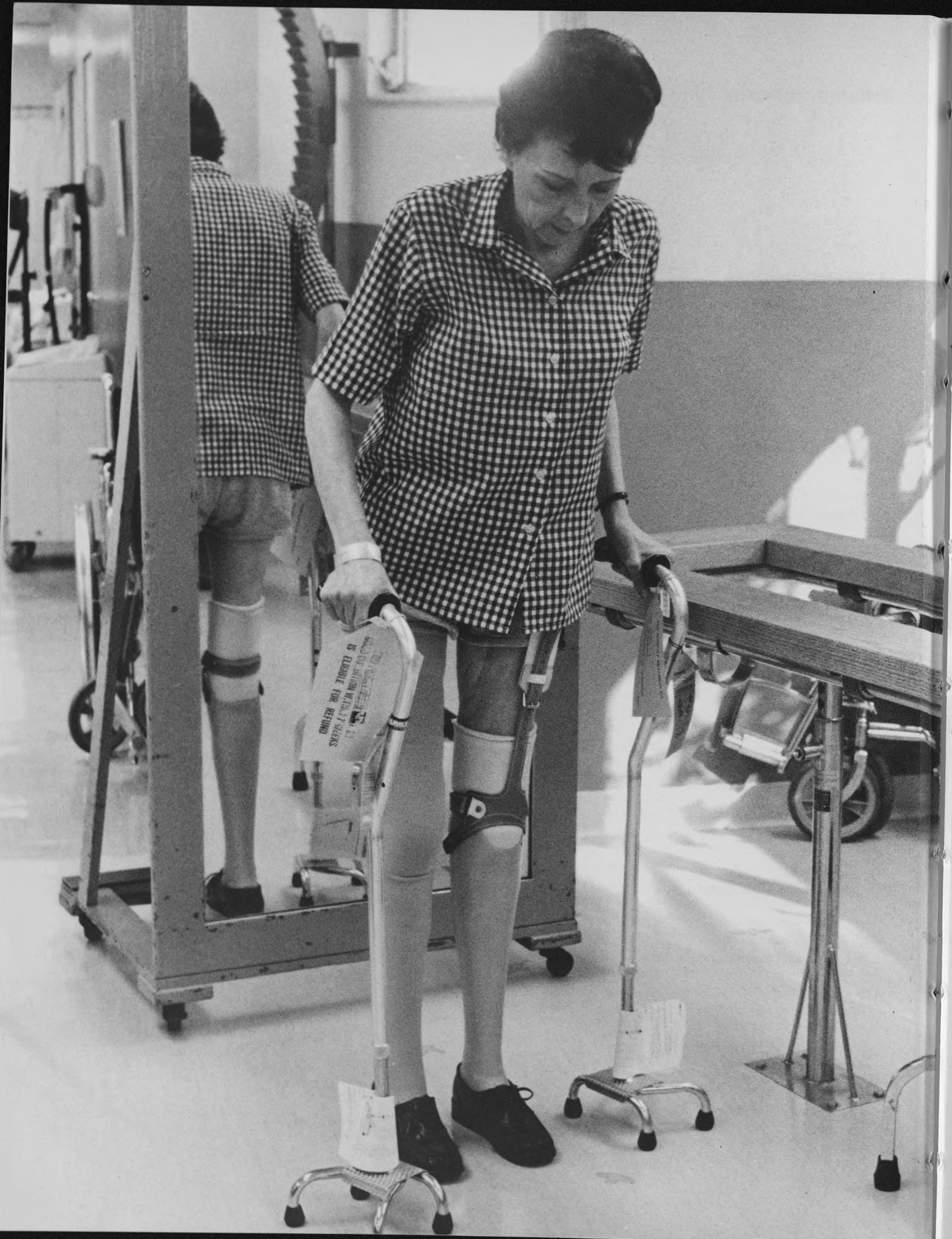

IS ELIGIBLE FOR REFUND

The way back is tougher than the walk towards the mirror where Gerry Newlin can watch her reflection to check for step pacing and posture. Each step is an effort and an accomplishment when walking on two artificial limbs.

Learning to Walk Again

By Denise Pattiz Bogard

Gerry Newlin has a philosophy on life: unexpected things happen, and when they do, you must figure out what your priorities are, what your alternatives are, and then do the best you can. Not a novel approach, but certainly an admirable one considering Ms. Newlin's circumstances. Gerry Newlin has had both of her legs amputated within the past two years.

A victim of advanced peripheral vascular disease, Ms. Newlin first began experiencing severe cramps in her right leg and foot in September 1979. She visited a vascular surgeon who warned her there was a fifty-fifty chance the disease would progress and she would eventually lose the leg. She was admitted to the hospital in December and underwent arteriography, which revealed extensive atherosclerotic changes in the arteries of her right calf. She was operated on twice more. Because of the nature of her disease, causing vessel blockages and insufficient blood flow, the incisions never healed and infection set in. It became obvious that Ms. Newlin, at age 51, was going to lose her right leg.

She remembers with clarity the day in March 1980 when her right leg was amputated. She had been scheduled to undergo another bypass surgery. But the infection worsened and her fever climbed so high the procedure was postponed.

"When the nurse told me they were postponing the surgery, I cried. I knew there was nothing else they could do. I told the nurse I didn't see any point in another operation on a leg that was lost anyway. So I said, 'take it off.'

"The doctor came into my room and said, 'Is there something you want to tell me?' I said, 'Yes, take off my right leg today.'

"And that's what they did. I had reached the point where I was in so much pain, I actually looked forward to the ceasing of pain."

Surgeons amputated below the knee. The incision did not heal, and two weeks later they revised the stump to above the knee.

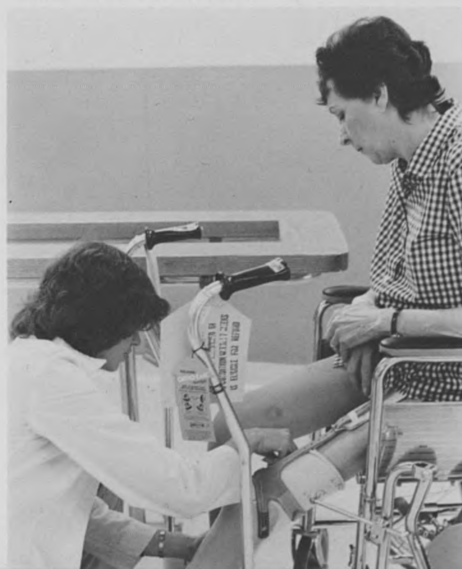
The next year was fraught with complications as Ms. Newlin's vascular insufficiency worsened, causing severe blockage in her intestines and in her left leg, seizures, hypertension and other disorders. She underwent six more major operations. Her physical condition deteriorated rapidly, and she lost her appetite completely. At 5′6″, she went from 140 pounds to 65 pounds in 18 months.

In April 1981, Ms. Newlin was admitted to the hospital because of severe pains in her left leg. One week later, the leg was amputated below the knee.

"It all happened very rapidly with my second leg. It gets to the point with my particular disease that the pain gets so bad you can't stand it anymore."

The healing process on the second stump went much smoother than on the first. She was home within a month, and spent the next five months healing with no major complications. This October, Gerry Newlin was admitted to Jewish Hospital for gait training with two artificial legs.

"I'll go to my grave praising the Jewish Hospital rehabilitation department and physical therapists," Ms. Newlin exclaims two weeks after discharge from the hospital. She says therapist Lisa Waeckerle, PPT, prepared her thoroughly for life at home with two prostheses.



She is pragmatic about her physical loss. She says she went through the "post-amputation blues" this summer for a couple of weeks as the realization of her physical loss hit her. "I would get weepy and think, 'This is it, kid. It's never going to be the same again.'"

This reaction is very common, says **Richard Roettger, PPT,** coordinator of physical therapy. "The amputation, it's like taking away something you own. It's something very personal for you, something you've depended on, that suddenly is no longer there. It's a death, and you mourn it. But, like any loss, you find you can live without it and eventually do well."

Roettger's observations proved true for Gerry Newlin. Before long she was feeling stronger again, adjusting to life in a wheelchair. In fact, Ms. Newlin actually feels fortunate. Having been on the brink of death several times, she is grateful to be alive. And, because of that, she is willing to talk to people about her experiences. When asked to consent to an interview, she agreed without hesitation, but on one condition.

"Will this help others?" she asked. "If it will help others, I'll answer any questions you have. But only if there are others who will benefit by my experience."

There are others, many others, who find themselves in a similar situation as Gerry Newlin. Based on statistics compiled by Harold W. Glattly, M.D., of Washington, D.C., author of "A Statistical Study of 12,000 New Amputees," approximately 300,000 individuals in the United States are missing a part or all of one or more of their extremities.

Who Needs Amputation and Why

According to Dr. Glattly's study, vascular diseases and diabetes, resulting in in-

"In my solitude I do wonder about my future—if I live to an older age. Everything will be so much harder then. I look at my mother growing older, and I think, 'Lord, what will happen to me? Will I be a basket case?'"

sufficient blood circulation, account for 62.3 percent of all amputations. Trauma, accidents where the limb is mangled beyond restoration, cause 26.4 percent of amputations; 6.1 percent result from tumors, usually of the bone, and 5.2 percent are from congenital disorders.

Men are more likely to have a limb amputated than women; 77 percent of Dr. Glattly's sources were men. Amputations of an upper extremity are much less frequent than of the leg—14.6 percent compared with 85.4 percent—because of better circulation and fewer accide its of the upper body.

Tragic as these amputations are, at least today there is hope for rehabilitation. Fifty years ago, such patients had little chance of gaining the ability to use a prosthesis. Infections could not be controlled, above-knee amputations were frequently necessary and the surgical mortality rate averaged 44 percent. Usually, survival and wound healing were the primary objectives of treatment; rehabilitation received little attention. Prosthetic fitting, if recommended at all, was often delayed many months. During this time, the patient succumbed to depression and dependency as the prospect for rehabilitation faded.

Since World War II, research and clinical experience have greatly advanced amputee management, with intricate reconstructive surgical procedures, better control of infections through antibiotic treatments and improved methods for prosthetic fitting. As a result, many patients can be rehabilitated to walk on a prosthesis, or even if in a wheelchair, to perform daily activities and resume their places in the family and community.

Today, the healing process from an amputation of a lower limb until the patient is fitted for a prosthesis takes about four to six weeks. During this time, the patient is taught to walk with a walker and care for the stump at home. When the surgeon determines the stump is sufficiently healed, the patient then visits the hospital's amputee clinic, where he is evaluated for a prosthesis.

The Prosthesis Process

Jewish Hospital's amputee clinic, one of only several in the area, meets every other Wednesday. An average of 10 patients visits the clinic each session, where they discuss their problems and receive advice from **Insook Sunwoo, M.D.,** associate physiatrist, Roettger, representatives from the artificial limb companies and a physical therapist.

"The amputee clinic is a pooling of knowledge," explains Roettger. "A prosthesis isn't something where you just go down and think you can pick one out, because it won't work that way. You need to look at the patient's age, medical conditions, his work, lifestyle—all this determines what kind of prosthesis you recommend."

It usually takes about three to five weeks for the limb to be completed after an order is placed with one of St. Louis' three major limb companies. "It's a complicated procedure to make an individual prosthesis. There is no mass production in that," says **Franz U. Steinberg, M.D.,** director of the department of rehabilitation medicine.

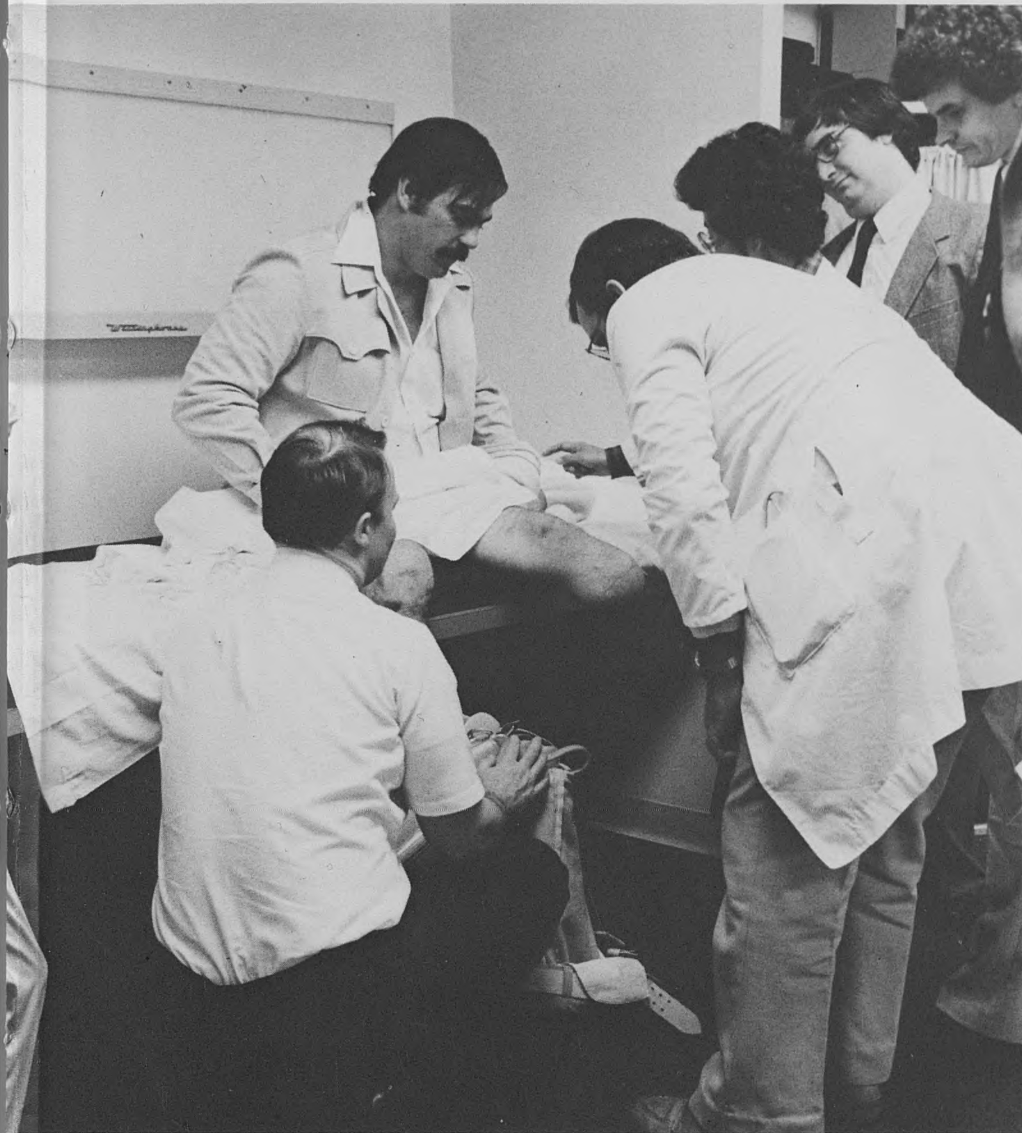
Once the limb is ready, the patient is admitted to the hospital for gait training, which lasts two to three weeks, depending on the physical condition and age of the patient, and whether or not the leg was severed below or above the knee. The energy cost of walking with an above-knee prosthesis is high, and the operation of the artificial knee joint requires coordination that is often beyond the patient's ability.

Gait Training

Gerry Newlin's gait training took two and one-half weeks, a remarkably short training period considering her circumstances. As she says, "Any above-knee operation is twice as bad as a below-knee, and if you've lost two legs, then multiply it again by two."

"You get what you give. If you come in with a long face, that's what you're going to see," says Ms. Newlin, who always had a smile and encouraging word for others in physical therapy.

Ms. Newlin's six-hour-a-day physical therapy began with basic exercises on the mats to improve the flexibility and strengthen the muscles in her legs and torso. Next she put on the two artificial legs and would stand at the parallel bars for two minutes. She would then remove the legs and the therapists would check for red marks and pressure points. From this, they were able to recommend a combination of gauze and pads to place over the stump so the leg fit well and comfortably. Then she began to walk, and as with a baby, every step was an effort and an accomplishment. She would walk at the parallel bars, one step forward and two steps backward, becoming familiar with the feel of the two artificial legs upon which she stood.



Harry Gray, 27, of Palmyra, Mo., was stranded in a ravine for five days last March. As a result of the frostbite he suffered, both legs were amputated below the knee. He visited the Jewish Hospital Amputee Clinic in November, when he discussed problems and received advice from (left to right) Richard Roettger, PPT, coordinator of physical therapy; Sergio Ugalde, M.D., first-year resident in physical medicine and rehabilitation; Insook Sunwoo, M.D., associate physiatrist, and two representatives from artificial limb companies.

"It is a very slow process," Ms. Newlin says. "The therapists watch you carefully to teach you good habits. If you start to do something wrong, they stop it right away."

Ms. Newlin graduated from the parallel bars to the monobar, to four large-pronged canes, to a walker, and finally, at the end, to two smaller four-pronged canes.

On the day of discharge, Gerry Newlin was extremely pleased with her progress and much more hopeful about her future than she had previously allowed herself to be.

"I've accomplished 100-fold more than I thought I would. I came in here with an, 'OK, let's see what they can do with me' attitude, and instead they had me doing everything.

"Of course the acid test will be how I do at home. I wouldn't be honest to say I'm not apprehensive about the challenge to adapt what I've learned here at home and on the outside. Certainly everything will be different. Now I have limbs to contend with and everything will take longer and require more energy than just zipping around in a wheelchair."

The energy needed to walk with a below-knee prosthesis is about 10 percent more than that of normal gait and at a slower pace. Because of the extra coordination needed to operate the knee joint of an above-knee prosthesis, the energy required is from 65 to 100 percent more, at approximately one-half the normal walking speed. Double amputees with at least one above-knee limb require an even higher energy expenditure of closer to 100 percent above normal walking conditions.

Adjusting to an artificial upper limb is completely different. The expenditure of energy is not much greater; however, it is very difficult to operate an artificial arm and hand because of the complexity of the device.

Not every amputee is a suitable candidate for a prosthesis. Dr. Steinberg explains that prosthetic fitting is contraindicated if one of the following conditions exists: 1) mental deterioration which precludes successful training; 2) an advanced neurologic disorder such as severe parkinsonism or a stroke with a significant loss of function; 3) congestive heart failure, angina pectoris or obstructive pulmonary disease severe enough to impose rigid limitations on the patient's effort tolerance; 4) impending gangrene of the other extremity, or ulcers and intractable infections associated with a compromised circulation; 5) irreducible pronounced knee-flexion contractures in below-knee amputees and hip-flexion contractures in above-knee amputees.

The team of physicians, nurses and therapists working with amputees at Jewish Hospital feel strongly that if someone wants a prosthesis and there are no contraindications present, he should be fitted with an artificial limb. Dr. Steinberg also believes that no amputee should be rejected because of age alone. He has successfully trained patients in their 90s to walk on artificial legs.

"With the prosthesis, many amputees can do things, with some modifications, that they did before. They have to work very hard, but farmers go back to farming, bricklayers to laying bricks, pilots to flying," Roettger explains.

"It's an artificial appliance"

But a prosthesis is not the same as the natural limb, which is something every amputee soon realizes. Dr. Steinberg says: "People think if given legs things will be as they were before. It's not going to be like normal walking. It's an artificial appliance taking the place of a normal leg. There is

Roettger discusses Gray's progress with him. Gray is back to farming, horseback riding and driving a tractor, despite his double amputation.

no sensation in the leg, so you have no way of knowing if you are stepping on a pebble or incline. There are no muscles in the prosthesis, so it feels heavy, like wearing a very heavy boot. We must consider all this when deciding whether or not to prescribe a prosthesis."

Furthermore, Roettger adds, the prosthesis is "such an elaborate piece of equipment it can get in the way. It's an added extremity with no feeling."

The three primary considerations when prescribing an artificial limb are usefulness, safety and cosmetics. Roettger says there are some patients who want the prosthesis primarily for looks, but he says if the patient won't use it, or if it isn't safe, practical or efficient, it becomes "a very expensive decoration in the corner." The cost of a prosthesis: below the knee is $1,300; above knee, $1,800 to $1,900, and a mechanical hand ranges from $1,300 to $2,600.

Surprisingly, body image seems to play a much lower role in the lives of amputees than one might imagine. Dr. Steinberg says the majority of patients he has worked with have not been as concerned with their marred bodies as much as their desire to adjust to the amputation and make the necessary modifications in their lives.

For Gerry Newlin, body image has been almost no consideration at all. "It may sound incredible, but I've never been self-conscious about not having my legs. If it bothers others, that's their problem. My looks bothered me a lot more when I was so skinny. Then I thought people were staring at my skeletal frame.

"And I adore children. They're so beautiful. If they have a question, they'll come right over and ask. I'll see parents in grocery stores trying to jerk them back. Just a couple weeks ago, a little boy asked me, 'Lady, why don't you have any legs?' I answer them. I'll tell people whatever they want to know. But no more than that."

"If it had to happen to me..."

At age 52, Gerry Newlin has no legs. She has a lot of reason to feel sorry for herself, to feel angry, bitter. But only occasionally does she succumb to these feelings. Most times she feels lucky.

"God gave me a terrific sense of humor, and I can make jokes on myself. I'm usually up. I'm not saying I don't have a down day. It's usually triggered by something small. A friend will tell me she washed her windows that day and I'll think that I'll never be able to wash windows again.

"I have a wonderful family (a husband, Robert, two sons, two daughters-in-law and six grandchildren) and terrific friends.

"Also, the important thing is if it had to happen to me I'm glad it happened at this stage in my life. I don't have young kids at home to have to care for, and I'm not so old that I have rheumatism, arthritis or any of the other degenerative conditions. So this was a good time for it to happen. Sure, I'm sorry it happened to me—but I don't have any control over that."

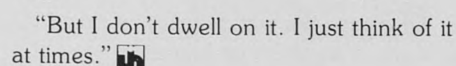
But Gerry Newlin *does* have control over the rest of her life. Two weeks after discharge, she was still adjusting to being at home and struggling to regain her strength. She says she is using the wheelchair primarily, but she still has hopes of depending more on her legs and canes as her strength and confidence build. Her primary goal is to regain as much independence as possible.

Ms. Newlin accomplishes nearly as much as she did before the amputations. She still paints, does almost all the housework, cooks, does much handiwork, retiles the floors, cleans under the stove and does just about anything within the reach of her hands or long-handled objects.

"I must feel like I've accomplished something every day and maybe tackle one major new project each week. I've always been that way. I still am."

Quietly, almost as an afterthought, Ms. Newlin says at the end of the interview, "In my solitude I do wonder about my future—if I live to an older age. Everything will be so much harder then. I look at my mother growing older, and I think, 'Lord, what will happen to me? Will I be a basket case?'

"But I don't dwell on it. I just think of it at times."

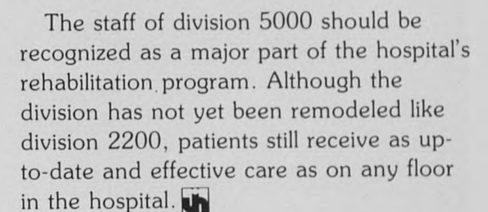


Division 5000: A Rehabilitation Floor

Division 5000 used to be known as the "chronic floor," where many of the patients had no hope for recovery or improvement, or could no longer care for themselves and were ready for a nursing home. This is no longer true. Division 5000, just like division 2200, is a rehabilitation floor.

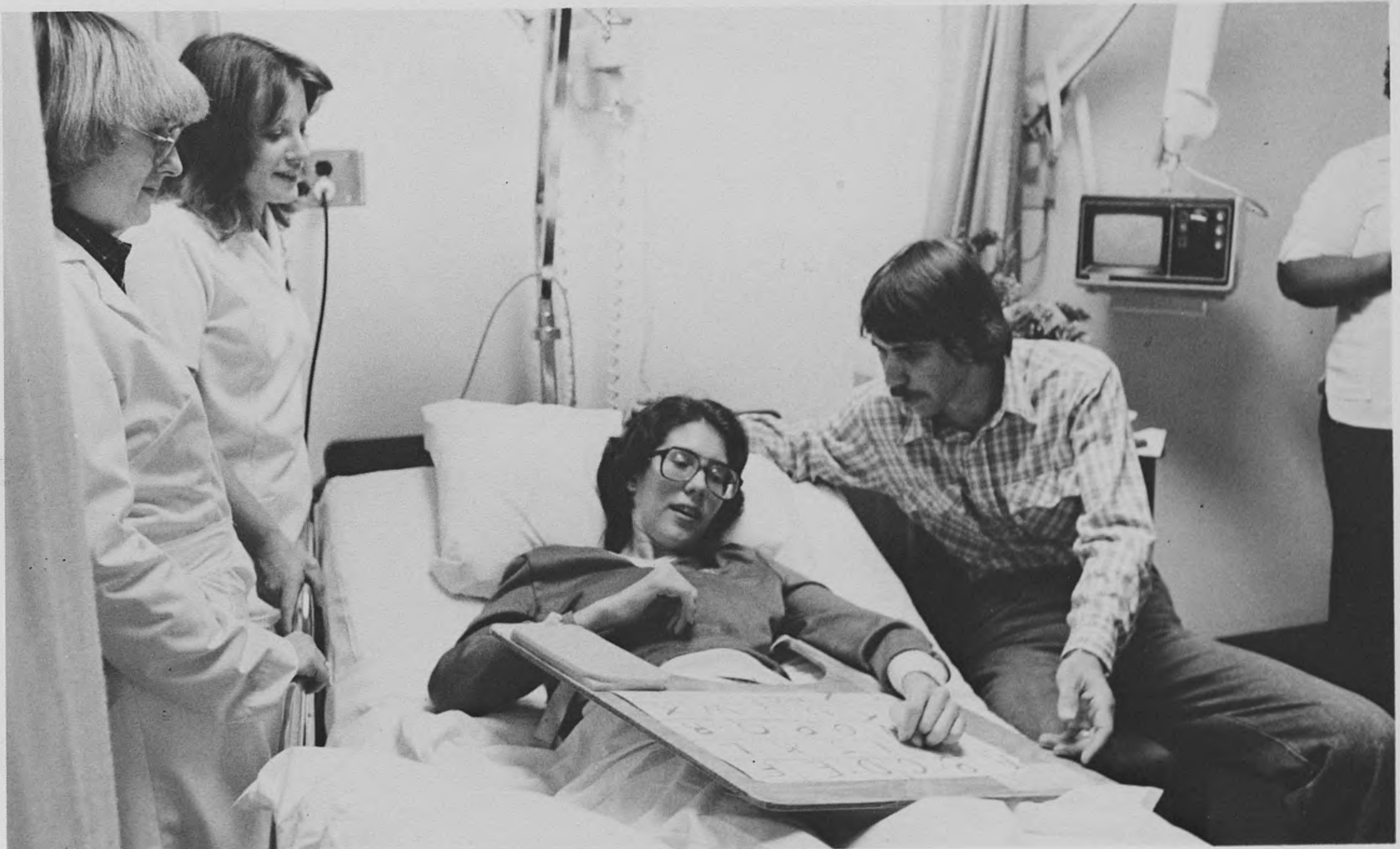
Most people are aware that the hospital has an enviable rehabilitation program, but they associate it only with division 2200. Both divisions admit stroke victims, those with brain injuries, spinal cord injuries and amputees, along with other patients who need retraining to become more independent.

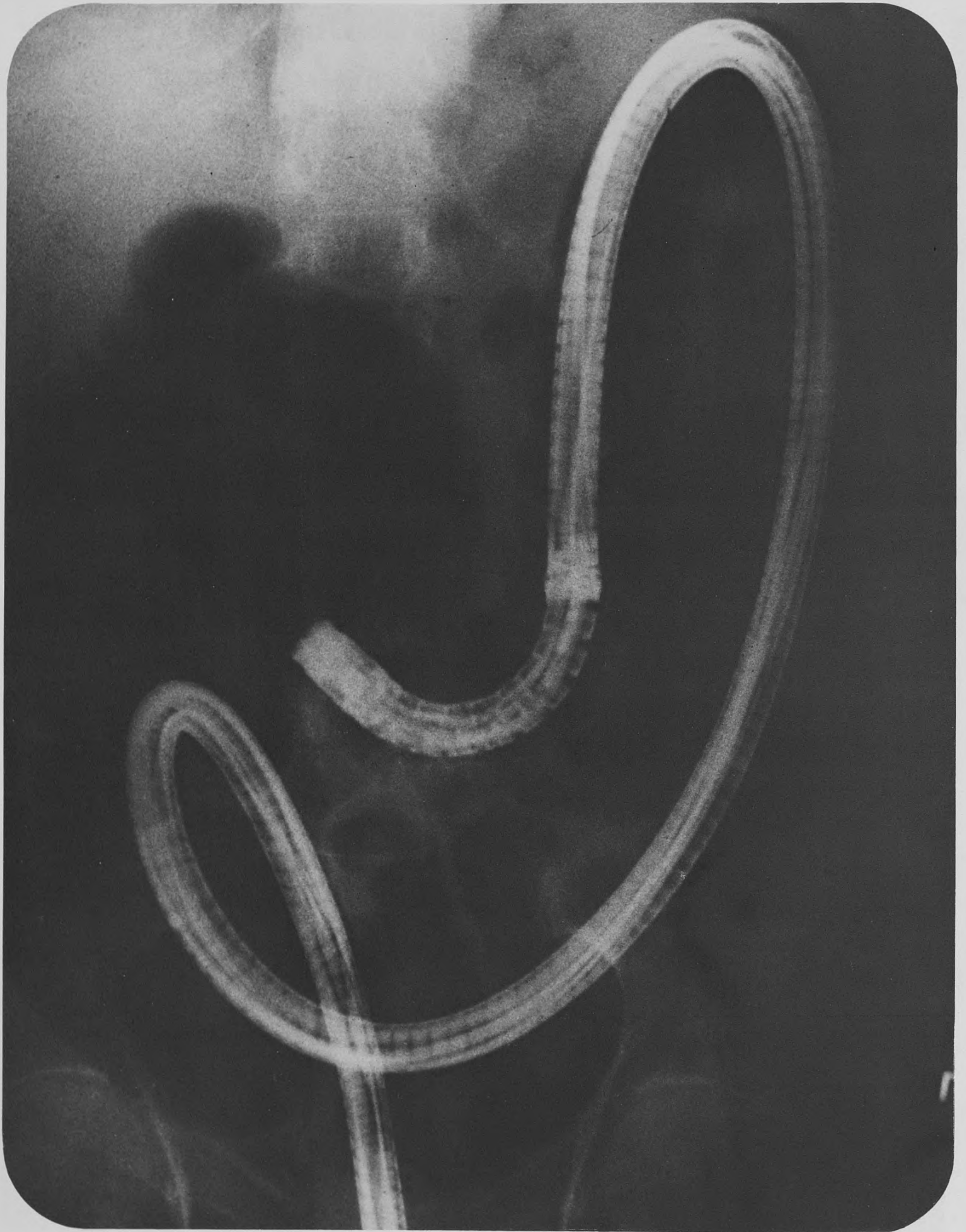
Age alone is not a factor for admission to either rehabilitation floor; division 2200 and division 5000 have patients ranging in age from 14 to 90. Both divisions provide complete health care to patients who are kept busy with rigorous schedules. Rehabilitation work and retraining demands much of both patients and staff, but the rewards of seeing someone with a severe brain injury, for example, learn how to walk, talk and care for himself again, outweigh any hardships.



The staff of division 5000 should be recognized as a major part of the hospital's rehabilitation program. Although the division has not yet been remodeled like division 2200, patients still receive as up-to-date and effective care as on any floor in the hospital.

Mary Beth Schifferdecker, a rehabilitation patient on division 5000, learns to communicate with the aid of an alphabet board. Looking on are her husband James, Linda Leibowitz, R.N., (foreground) and Donna Koth, R.N., assistant head nurse.

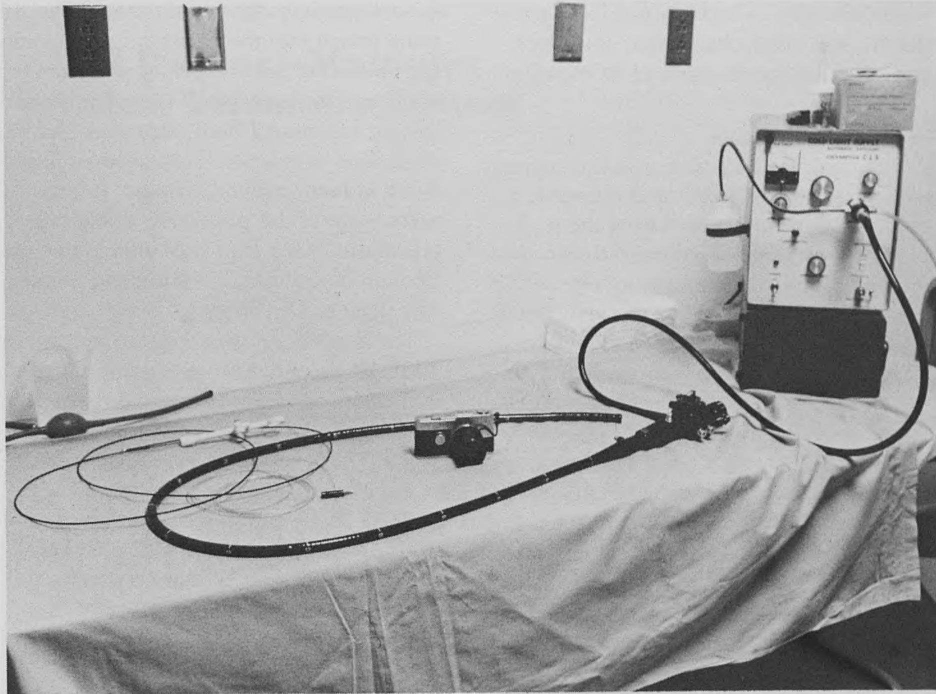




This X-ray photograph shows the endoscope inside the intestine during a lower endoscopy. The physician would be viewing the area at the end of the tube, in the center of the photograph.

Access Without Surgery

By Linda Krohne Nitchman



The endoscope is a rubber-coated instrument, six feet long, with a lens and a light at one end and a viewer at the other, attached by a second hose to a light source. The lensed end of the hose is fed into the gastrointestinal tract, via either the mouth or the rectum.

The hose houses four channels that travel its length. Two of the channels contain fiber-optic bundles; one carries light to the end of the hose, and the other carries the image from the intestine to the viewer. A third channel contains an air and water jet for washing the lens and inflating the stomach or colon with air for better viewing. The fourth channel is used for suctioning fluid or passing instruments.

Advancements in gastrointestinal endoscopy at Jewish Hospital over the past few years have reduced hospital stays, medical costs and lost work time for patients, not to mention pain. Many procedures previously requiring abdominal surgery and resulting two-week hospital stays and six-week recuperation periods can now be performed painlessly on an outpatient basis, without a single drop of blood lost. The patient may return to work the following day.

The endoscope, a highly maneuverable hose-like instrument, provides access to the gastrointestinal tract, the esophagus, stomach, duodenum and colon, through either the mouth or the rectum. Using the endoscope, physicians can examine the linings of these organs and perform a number of procedures to eliminate the need for surgery.

Jewish Hospital was the first in the area to use endoscopy to remove gall stones from bile ducts, to remove various types of tumors and polyps and to remove foreign objects. "The instrumentation (of the endoscope) has been around about 10 years, but the therapeutic applications are rela-

"The big advantage is that they can be done without abdominal operations previously required to perform these procedures."

tively new. The big advantage is that they can be done without abdominal operations previously required to perform these procedures," says **Burton Shatz, M.D.,** and specialist in the field.

Dr. Shatz has been with the department since 1954. In those early years, he served as chief. "We were the first in the area to do colonoscopy and helped devise many of the instruments used."

The endoscope, a highly maneuverable hose-like instrument, provides access to the gastrointestinal tract. . . . through either the mouth or the rectum.

Burton Shatz, M.D.

Among the most important uses of the endoscope is diagnosis or possible prevention of colorectal cancer. "Practically all cancers of the colon start in polyps (abnormal growths in the lining of the stomach and colon), but only a small percentage of polyps are cancer," says Dr. Shatz. Polyps may also bleed, so it is usually advisable to remove them, using a special loop attachment to the endoscope.

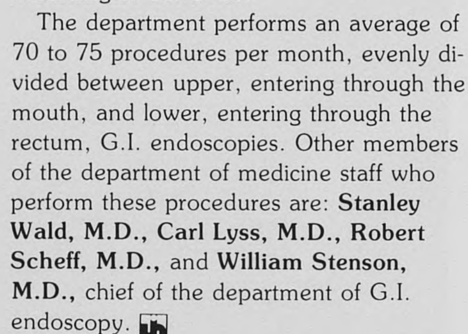
After the growth is removed, a pathologist tests it for cancer. If cancer is found, but is just beginning and limited to the surface of the polyp, no further treatment is required. Follow-up endoscopies are done at frequent intervals to check for recurrence.

The endoscope is used to find and remove gall stones in the bile duct or to grasp and retrieve foreign objects that patients have swallowed. Dr. Shatz has removed coins, a battery, nail files, screw drivers and other objects that could not pass through the intestine to be expelled.

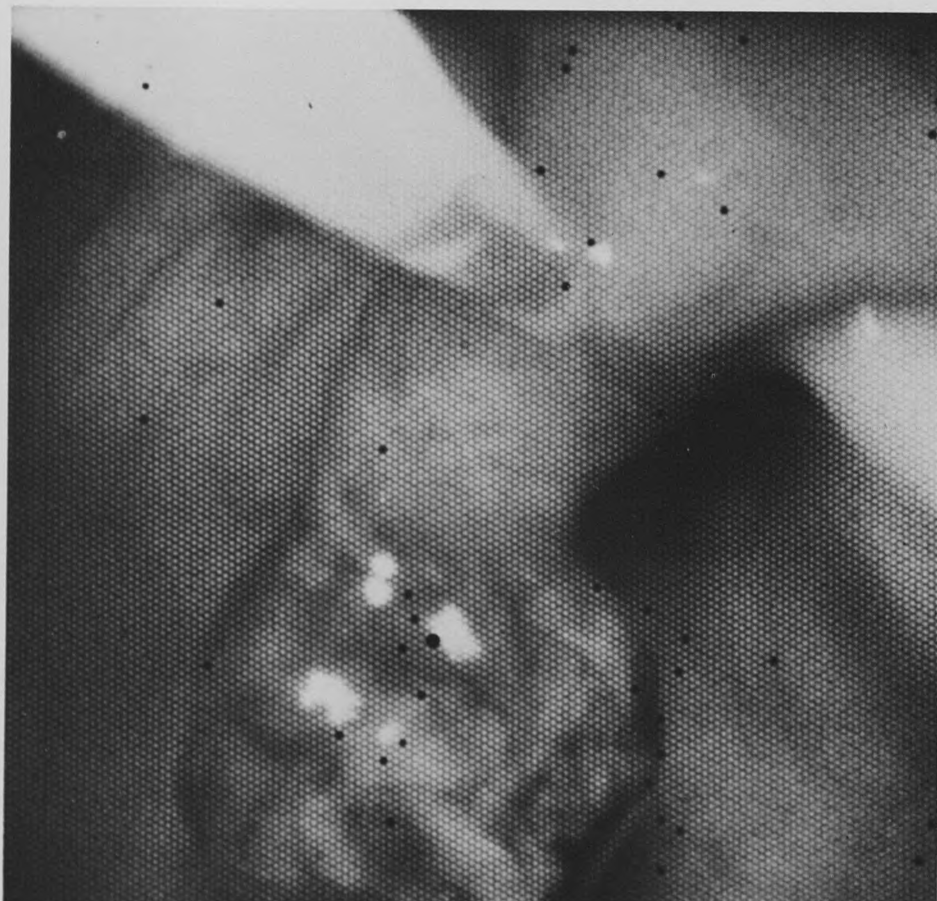
A Diagnostic Tool

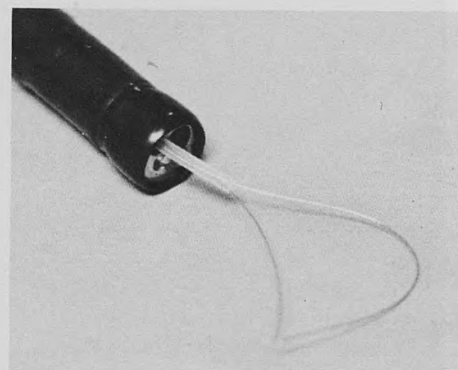
Although the endoscope cannot remove ulcers from the stomach and intestine, it can help to diagnose and treat them. A bleeding ulcer can be cauterized with the endoscope to stop the hemorrhage. Often ulcers and other problems not identifiable on a barium X-ray can be seen with the endoscope, which can also confirm a diagnosis made from an X-ray. However, Dr. Shatz warns, some things are demonstrated by the X-ray that are not diagnosed with the endoscope. "One doesn't exclude the other; they compliment one another," says Dr. Shatz.

Jewish Hospital's commitment to teaching is demonstrated in the department of G. I. endoscopy. The endoscope has a special teaching attachment that shows the same image that the physician performing the procedure sees, allowing a student to observe. On the average of four medical fellows are trained here each year and physicians in practice often observe procedures to learn new techniques. A large percentage of the physicians doing this procedure in the St. Louis area have come through here during their training period, according to Dr. Shatz.



The department performs an average of 70 to 75 procedures per month, evenly divided between upper, entering through the mouth, and lower, entering through the rectum, G.I. endoscopies. Other members of the department of medicine staff who perform these procedures are: **Stanley Wald, M.D., Carl Lyss, M.D., Robert Scheff, M.D.,** and **William Stenson, M.D.,** chief of the department of G.I. endoscopy.



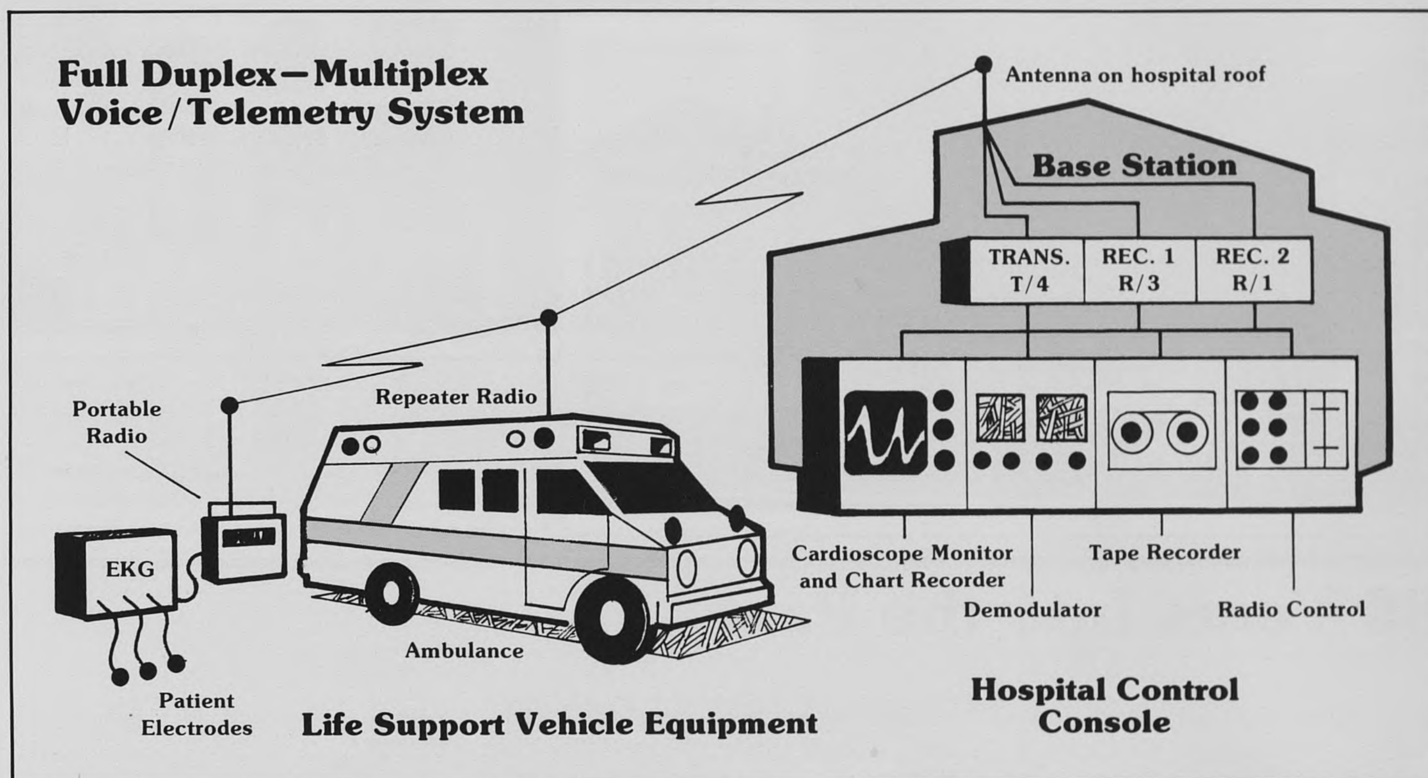


This wire loop is passed through the instrument channel of the endoscope and maneuvered around the polyp. When tightened, the wire removes the growth. Simultaneously, an electrical current is sent through the wire to cauterize the cut and prevent bleeding. Another attachment (not shown) is a tiny jaw-like mechanism that can remove small amounts of tissue for biopsy.

The wire loop around a polyp, the physician prepares to remove the growth, which is mushroom-like in appearance.

Treatment Enroute

The hospital portion of the equipment is the base station and control console (as labeled). The hospital receives calls from the ambulance transmitted via UHF-FM air waves to the antenna on the hospital's roof. The signal is sent through receiving units to the control console in the emergency room. Hospital personnel answer the calls reversing the signal to the ambulance. A portable unit can be used away from the ambulance, inside a home, for example. This unit is connected to electrocardiography equipment for transmitting the patient's heart rate to the E.R., where it is read on the cardioscope and graphed on the chart recorder. The entire conversation is tape recorded for future use.



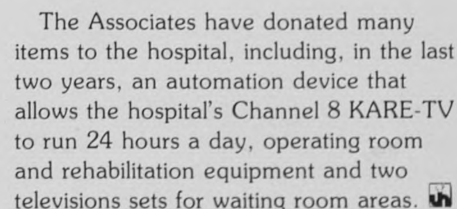
Providing optimal care in the most expedient fashion is the main advantage of Jewish Hospital's new emergency room telemetry system, which sets up radio communication between emergency room staff and incoming ambulance personnel. At a time when every minute counts, paramedics transporting an emergency case can now radio ahead the condition of the patient, send an EKG (electrocardiogram) strip, and receive orders for initiating appropriate care while enroute to the hospital.

Once hospital personnel know the condition of the patient and estimated time of arrival, they can prepare the proper treatment room and equipment and notify specialists to stand by, if necessary, so treatment is further expedited. This early care is critical for cardiac cases, which are frequently seen here because of the hospital's growing reputation as a regional cardiac care center. "At times it could be lifesaving. The appropriate treatment at the appropriate time could also mean less complications for the patient," says Emergency Room Assistant Head Nurse **Dawn Meyer,** chairperson of the telemetry committee for the E.R.

Donated by the Associates in Medicine of The Jewish Hospital of St. Louis, the equipment has a 70-mile range and can reach any ambulance equipped with a mobile unit, which includes nearly all in the area. The emergency room can handle two calls simultaneously, while receiving an EKG.

Calls will be answered by physicians and nursing personnel, with orders given by physicians or as indicated by established procedures. Only certified paramedics can carry out certain treatment orders, including administering drugs. Most ambulance services staff paramedics who are sent out on the more serious calls, such as possible heart attacks, according to Ms. Meyer.

Robert L. Kaufmann, M.D., president of the Associates, says of the gift, "The Associates organization is proud to have the opportunity to provide this equipment. We feel that many lives will be saved by actually beginning the emergency room treatment while the patient is still enroute to the hospital."



The Associates have donated many items to the hospital, including, in the last two years, an automation device that allows the hospital's Channel 8 KARE-TV to run 24 hours a day, operating room and rehabilitation equipment and two televisions sets for waiting room areas.

The original Jewish Hospital at 5415 Delmar Ave. was opened in 1902. Three years later, the two wings on either side were added to accommodate a growing patient population. The new Kingshighway building was dedicated in 1926, and Jewish Hospital's patients were moved from the overcrowded Delmar plant.

80 Years Into the Past

On April 4, 1900, a constitution calling for a Jewish hospital was approved by Secretary of State A.A. Leseurer. The cornerstone was laid for The Jewish Hospital of St. Louis at 5415 Delmar on May 16, 1901; construction was completed exactly one year later.

David A. Gee, hospital president, writes in his recently published *216 S. K. A History of The Jewish Hospital of St. Louis*, "The first hospital building was box-shaped with columned front porch and a small cuppola on top. It measured roughly 40 feet across the front by about 70 feet in depth. Its three stories accommodated 30 beds, operating room, and kitchen. The furnace and student nurses quarters occupied the basement."

Eighty years later, The Jewish Hospital of St. Louis occupies more than 1,124,000 square feet of floor space. The total floor area of the Delmar building would fit neatly into just more than one-third of *one* floor in the Shoenberg Pavilion. The hospital now has 16 operating rooms, 628 beds, separate nursing school at 306 S. Kingshighway, and national, regional and local recognition for its excellence in patient care, emphasis on teaching, affiliation with Washington University Medical School and ongoing research.

The expansions have come slowly, each new step adding its own characteristic to the Jewish Hospital of today. It would be an impossible task to recall each innovation, but some of the more significant changes do deserve mention. They include:

- In 1902 a three-year diploma school of nursing was created. The first class, five students, graduated in 1905. Its original name, the Jewish Hospital Training School for Nurses, was changed to the Jewish Hospital School of Nursing in October 1925.

- At a board of directors meeting on Oct. 14, 1919, specific proposals were made for a new building, at a cost not to exceed $1 million. Within a year the Kingshighway property was obtained for $189,300.

- In 1927 the hospital's patients were moved from the overcrowded Delmar plant to the new Kingshighway building. Of the 4,095 admissions during that year, 1,000 were free and 2,200 were partial pay patients.

Minimum Wage Rates

Year	Hrs./Wk.	Rate
1902	72	$ .16
1928	60	.32
1933	54	.26
1940	54	.32
1947	48	.44
1950	40	.50
1960	40	.81
1970	40	2.00
1977	40	3.00
1981	40	4.20

- The depression years were difficult times for the hospital, often resulting in only 50 percent occupancy, salary and

In 1956, the Kingshighway Pavilion was dedicated. Earl Susman, president of the Jewish Federation of St. Louis, speaks to an audience of 250 persons attending the ribbon-cutting ceremony. Today's Jewish Hospital occupies more than 1,124,000 square feet of floor space.

position cuts, and an open medical staff, allowing any physician in good standing to admit patients to the hospital. The growing world tensions of the 1940s also had their impact here. A greatly expanded doctor draft in March 1941 drew increasing numbers of interns and residents away from the hospital, causing the house staff to drop from 16 doctors to only one in 1943. By January of 1944, 80 nurses had left to serve in the armed forces. A staffing crisis was averted only by the use of large numbers of volunteer workers.

• In the late 1940s, to make up for the bleak depression and war years of neglect, Jewish Hospital underwent major renovation and redecoration.

• May 1951 brought completion of the Community Health Plan providing for merger of the Miriam Rosa Bry Convalescent and Rehabilitation Hospital, the Jewish Sanitorium, the Jewish Medical Social Service Bureau and Jewish Hospital.

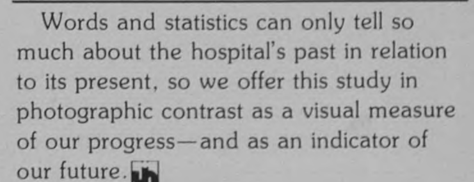
• On Oct. 29, 1952, the hospital's auxiliary was reborn under the co-presidency of **Dorothy Schweich (Mrs. Edward)** and **Louise Loeb (Mrs. Benjamin).** The Gift Gallery was opened that same month, and the tribute fund, which had been created in 1947, began to expand tremendously. Initial auxiliary membership was 850; within a decade, membership was at 3,500.

• On Feb. 4, 1953, a special committee on University Affiliation and Related Matters recommended full-time directors in the departments of medicine and surgery. Relations with the Washington University Medical School were effected.

• In 1963 the Washington University Medical School and Associated Hospitals was organized and consisted of the medical school, Barnes, Jewish, Children's and Barnard Hospitals and the Central Institute for the Deaf. This was followed by a major affiliation between Jewish Hospital and Washington University on Jan. 1, 1964.

• The Yalem Research Building, now housing 50,000 square feet of research laboratories, was completed in 1967.

• In 1968, long-range planning began in earnest, and, after many false starts, a $21.5 million, four-phase building program was outlined. A 603-car parking garage opened for use in November 1971 (construction on a 500-car addition began June 1, 1981), a nine-story patient care building, the Shoenberg Pavilion, opened in August 1974, and a $6 million renovation program of the existing hospital building was launched. Acquisitions to the hospital included the Central Medical Building at 4910 Forest Park Blvd., and the Shoenberg Research Building at 4949 Forest Park Blvd.



Words and statistics can only tell so much about the hospital's past in relation to its present, so we offer this study in photographic contrast as a visual measure of our progress—and as an indicator of our future.

Information Desk

The basic tenet of the information desk has never changed: to provide patient information, directions and to answer visitors' questions. In the middle 1950s, the information desk was located at the entrance of the Steinberg building. Patient cards were arranged neatly in a rotary file, providing easy access to patient information, but requiring constant updating and refiling. Today's information desk workers have it a little easier: they switch on the Medical Information System terminal and within seconds have the patient's name, physician, room number, admitting number, address, age and nearest relative. They also have a nicer view in the spacious Roswell Messing Jr. Lobby of the Shoenberg Pavilion.

Admitting

Admitting has seen rapid changes, too. The number of average daily admissions has increased from 1940's 15 per day to 1981's level of about 45 daily admissions, but the process is much faster. The Medical Information System computers make entering patient and medical data fast and accurate, reducing paperwork tremendously. Insurance verification is instant. At right, Interviewer-Receptionist Joyce Stephens explains medical consent and insurance to an incoming patient. Patient and medical data were entered prior to the patient's arrival. After signing the proper forms, she'll be shown to her room.

Average Total Patient Cost Per Day

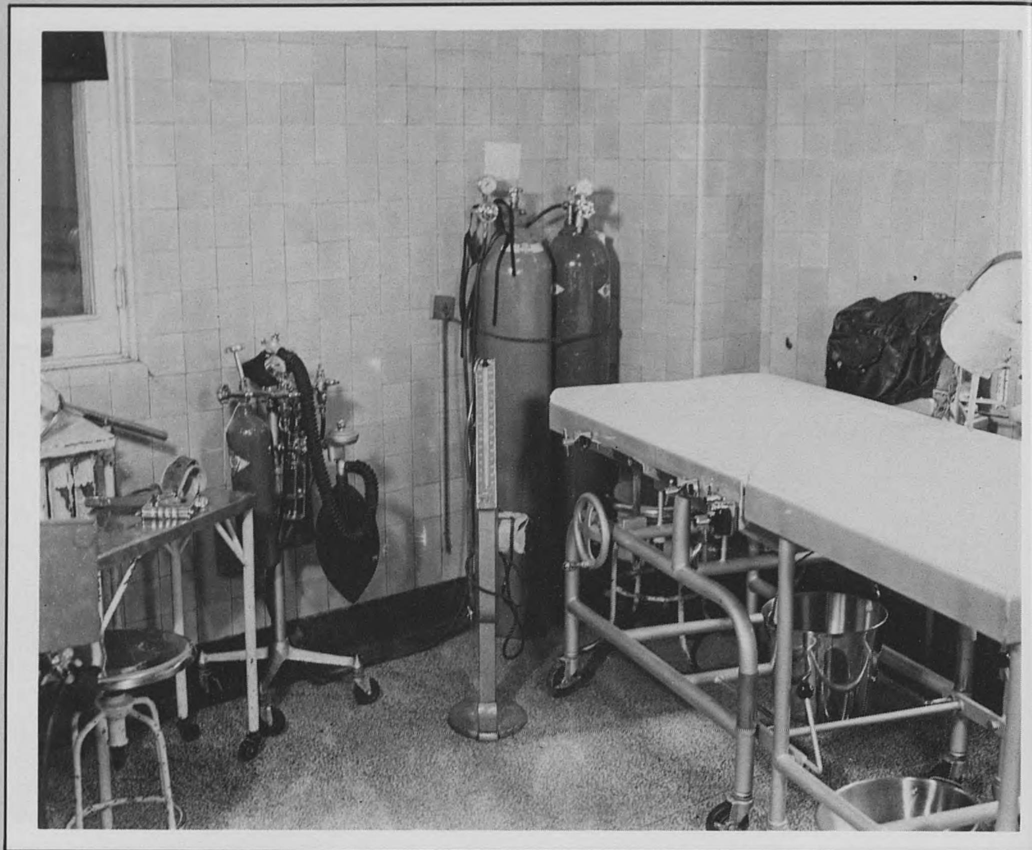
Year	$
1902	$ 1.60
1926	6.86
1935	5.30
1945	6.69
1947	10.94
1960	34.00
1970	99.47
1974	160.08
1977	200.00
1981	511.04

PHYSICIAN
USE ONLY

Kosher
Meals
On Request

Delivery Room

Many obstetrics department staff members remember the old Delivery Room B, as it appeared in 1956. It was located in an area now occupied by the hemodialysis unit on the fourth floor. The room contained an infant warmer, partially shown on left, which, according to Ob/Gyn Head Nurse Vera Rust, "was the first we'd ever had and we were really proud of it." Anesthesia equipment, the small bottle and black rubber bag on a stand, was used to administer ether, now outlawed. The 1982 delivery room also contains anesthesia equipment, at left, but many other types of anesthetic are now available. The infant warmer looks like a tiny bed on the back wall. In 1956 this area was an operating room.

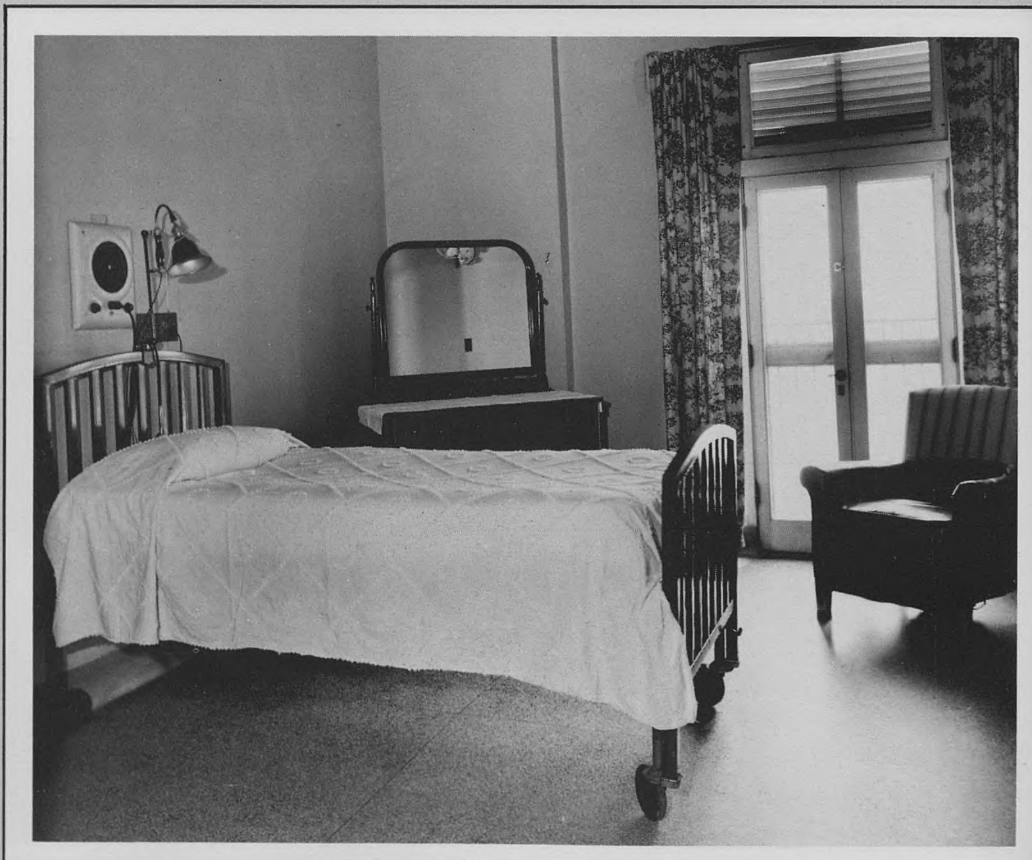


Private Room

In 1902, the board of directors of the new Jewish Hospital of St. Louis adopted bylaws for the protection of the patients and the guidance of employees. One provision called for the payment of $1 per day for private room patients. This was to be paid in advance. The wards were free, except where deemed chargable. By 1940, a "typical" private room, such as this one, cost the patient about $5 a day. Today's private room is $180. Of course, the surroundings are a little more luxurious, the patient has personal showering and bathroom facilities, lounging furniture for visitors and a highly mechanized bed that raises and lowers for patient comfort.

Bed Complement

Year	#
1902	30
1905	100
1927	250
1942	298
1955	505
1974	587
1977	590
1981	628



Pharmacy

Methods for compounding prescriptions in the hospital pharmacy have changed considerably through the years. In 1940 Mrs. Babbitt weighed and mixed chemical powders and compounded them in a mortar and pestle to create an elixir or capsules. Most of the common compounds are now purchased from drug companies in ready-to-use unit dose packages, and viaflex i.v. bags are often used to administer the drugs. Using a syringe, Diane Baldus, R.Ph., prepares to insert distilled water into a sterile bottle containing a premixed compound. The solution will then be inserted into the i.v. bag. In 1940, the pharmacy was located on the first floor, in the eye clinic's present location, near the emergency room. The pharmacy has since moved to the basement.

Nursing Stations

Forty years of transformation have brought nursing stations from this spartan example of the late 1930s to the spacious, computerized station of 1981. Nursing stations appeared much like this—small rooms with steel desks and chart racks—until about 1953. Comparing the 1930s station to the ultra-modern medical intensive care unit is somewhat unfair, but it gives an idea of the advancements that have come through the years. The MIS computer, at right, is on all nursing stations. Unit secretaries handle much of the paper work and computer workload, leaving nurses more time for patients.

Nursing

Year	# Nurses	Hours/Day	Census	Hours/Patient
1904	7	72	27	2.7
1938	111	783	167	4.7
1944	145	1,007	278	3.6
1975	450	2,010	465	4.3

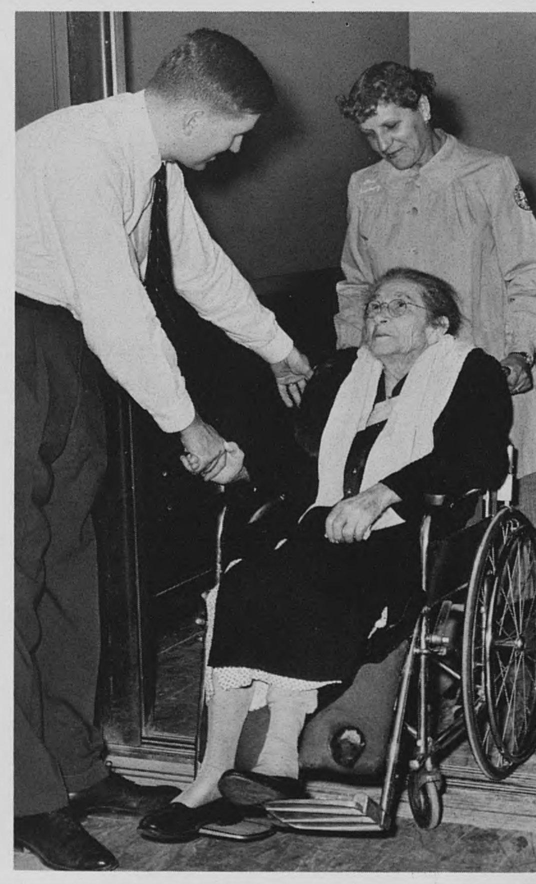
(Reprinted with permission from *216 S.K. A History of The Jewish Hospital of St. Louis*, by David A. Gee, Jewish Hospital of St. Louis, 216 S. Kingshighway, 1981)

EXIT

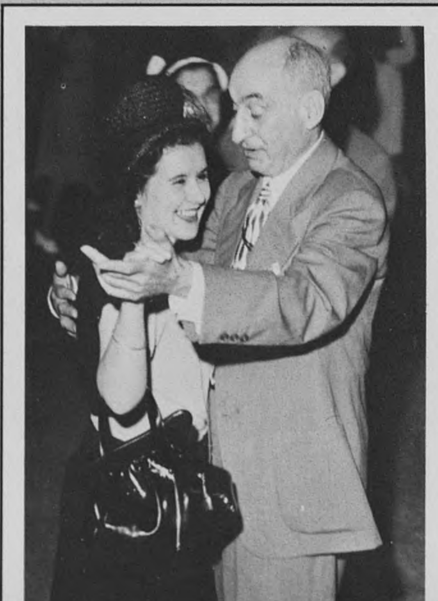
Moments to Recall

The five-member class of 1905: the first to graduate from the Jewish Hospital Training School for Nurses, now Jewish Hospital School of Nursing.

In the past as today, Jewish Hospital has reaped enormous benefits from the tireless dedication of volunteers. In 1939, these volunteers spent hours each day folding linen in the Central Surgical Supply. Today, that same spot houses the hospital's computer center, and central supply is in the basement.



David A. Gee, then assistant director, welcomes Mrs. Irving Lending on Oct. 10, 1956, the day the Jewish Sanatorium patients moved into Jewish Hospital, marking the official merger of the two health care facilities.



Henry A. Friedman, president of the board of directors, dances with Mrs. Louis Tureen, English bride of Louis L. Tureen, M.D., who had just come to live in America. The party where they dance was given by the board of directors at the Westwood Country Club, Wednesday, June 12, 1946, in honor of the men and women of the hospital group who served in the armed forces. Six hundred guests attended.

Edna Peterson, R.N., director of nursing services and the school of nursing for 36 years, greets the roomful of auxiliary members during dedication week, October 1956, at the Starlight Room of the Chase-Park Plaza.

This medical staff orchestra performed at the nurses' holiday party in December 1957. Their efforts were valiant and well-received; unfortunately, the only song they could play was "Hello Dolly"—which they played over and over again. The musicians are (from left) Doctors G. J. Probstein, Julius Elson, Jerome Simon, Ben Mannis, Ben Senturia and Leon Foster.

A proud David A. Gee, hospital president, cuts the ribbon, thus dedicating the Shoenberg Pavilion as the most recent addition of the Jewish Hospital, August 1974.

Proceeds from Clover Ball '82 will go toward the purchase of advanced cardiac diagnostic equipment that will help ensure that the hospital's division of cardiology maintains its national and regional prominence.

The 1982 Clover Ball committee, from left: Ann Lux (Mrs. Paul), vice chairman; Charline Baizer (Mrs. Richard), vice chairman; Helene Goldstein (Mrs. Irving), co-chairman; Marlene Isaacs (Mrs. John III), co-chairman; Letty Korn (Mrs. Jeffrey), vice chairman, and Ginny Rosenberg (Mrs. Harry), vice chairman.

Giving for the Heart

The Jewish Hospital of St. Louis Auxiliary's Clover Ball Committee has announced that proceeds from Clover Ball '82 will go toward the purchase of advanced cardiac diagnostic equipment.

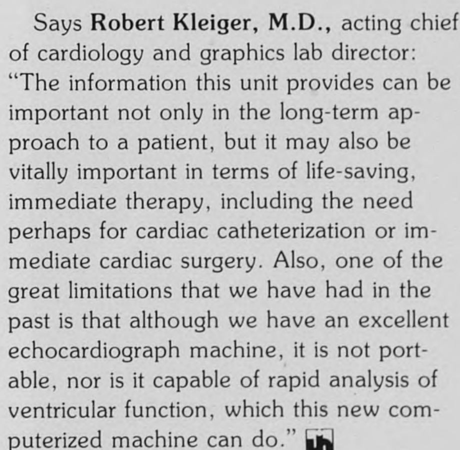
The auxiliary plans to finance two important pieces of equipment that will help ensure that the hospital's division of cardiology maintains its national and regional prominence—an electrophysiologic mapping system and a mobile, semi-computerized echocardiograph.

The electrophysiologic mapping system will be a crucial aid for relieving life-threatening arrhythmias, electrical derangements of the heart that cause rhythm disturbances and ineffective heartbeats. Arrhythmias are among the most common ways patients suffer and die from heart disease. Many patients at Jewish Hospital are helped by drug therapy, but a portion can actually have their arrhythmias eliminated through surgery and appropriate electrophysiologic testing. The mapping system, a complex ensemble of electronic devices, scans the heart's surface and reveals the precise location of abnormal electrical activity. A surgeon, guided by the test results, can then excise the tissue responsible for the errant rhythm with greater precision and effectiveness than other surgical means.

Under the direction of **Rodolphe Ruffy, M.D.,** Jewish Hospital has one of the most active diagnostic centers for heart rhythm disturbances in the St. Louis area and much of the Midwest. The center relies heavily upon anti-arrhythmic drugs, which while offering good control in many cases, cannot eradicate arrhythmias as effectively as surgery sometimes can. "Surgery is often desirable from the start with some patients," says Dr. Ruffy. "Why run them through a series of drugs only to find that they are resistant to them? I anticipate that with this new capability, some patients will be taken to the operating room sooner than we have so far, in the hope that many of them will be rid of their rhythm disturbances and will not have to stay on drugs or, in some cases, on multiple drugs."

The second piece of cardiac equipment, earmarked for the echocardiography laboratory, is a mobile, semi-computerized, cross-sectional echocardiograph that can be used at a patient's bedside. Much like radar, it uses sound waves to probe the heart, giving detailed moving pictures of the heart's function and structure. A probe is applied to the chest like a stethoscope, requiring no surgery or discomfort. A computer produces an actual video picture of the moving heart on a television monitor and allows measurement of key cardiac activities. The unit can detect a variety of irregularities and the most common diseases affecting the population seen at Jewish Hospital. It can also determine which patients should be treated surgically and which should continue medical therapy.

Says **Robert Kleiger, M.D.,** acting chief of cardiology and graphics lab director: "The information this unit provides can be important not only in the long-term approach to a patient, but it may also be vitally important in terms of life-saving, immediate therapy, including the need perhaps for cardiac catheterization or immediate cardiac surgery. Also, one of the great limitations that we have had in the past is that although we have an excellent echocardiograph machine, it is not portable, nor is it capable of rapid analysis of ventricular function, which this new computerized machine can do."



Clover Ball '82

The Clover Ball Philosophy

The Clover Ball is an elaborate event sponsored every five years by the Jewish Hospital Auxiliary to raise funds for a special hospital project. The first Clover Ball, in 1962, gave the hospital new psychiatry department offices. The 1967 event funded the medical intensive care unit, and subsequent Clover Balls have provided an expanded operating observation unit and the CAT scanner.

Universality was the deciding factor in determining projects most worthy of funding from the 1982 Clover Ball, to be held Nov. 20. Says Clover Ball Co-Chairman **Marlene Isaacs (Mrs. John III):** "Our primary purpose was finding something that could benefit any human being—man, woman, or child. Heart disease is definitely a major issue in the world we live in, and it knows no barrier in terms of sex or age."

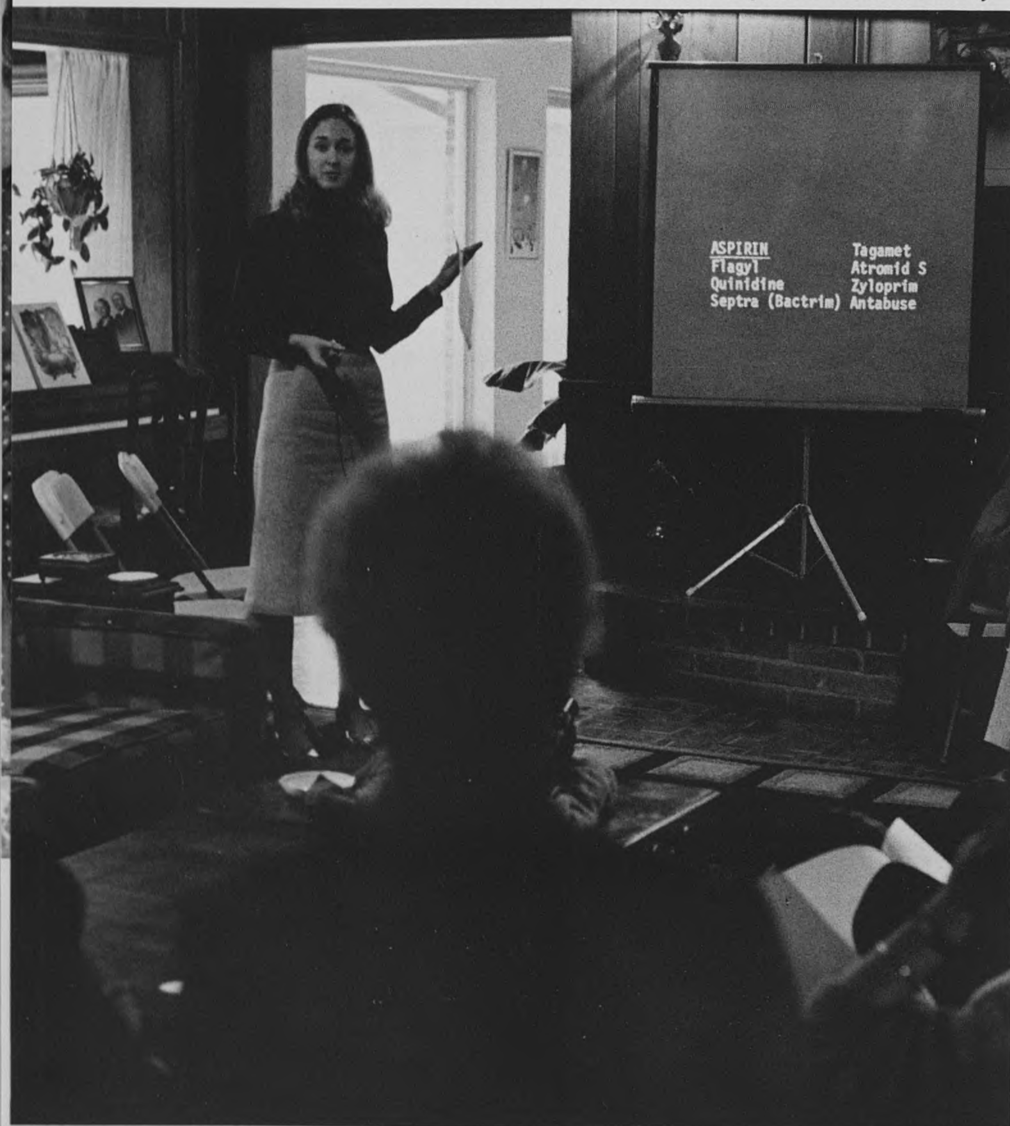
Auxiliary Fall Seminar

The Right Combination

One of the most neglected and potentially harmful areas of medicine—in view of the thousands of prescription and over-the-counter medications now available—is undesirable drug interactions. Whenever two drugs are taken at or near the same time, there will be an interaction, though usually a harmless one. Some drugs are purposely taken together to increase their therapeutic effect, but many medications, particularly those used against heart disease, can dangerously interact with some foods and even plain aspirin.

To explain and clarify the dangers, three Jewish Hospital pharmacists were invited to speak Nov. 19 at the home of **Shirley Cohen (Mrs. Stanley)** at the Jewish Hospital Auxiliary's first fall seminar.

Diane Baldus, R.Ph., presented a slide series on common prescription medication interactions.



David Butler, Pharm. D., and assistant professor at the St. Louis College of Pharmacy, covered the dynamics of drug interactions, explaining that while most drugs cause no interaction worries, "some drugs are known to cause interaction problems, and those are the ones you have to watch out for." The first site of interaction is the stomach, Butler said, where two drugs may have various effects on each other or on the stomach itself. For instance, two drugs may bind and prevent any therapeutic effect, one drug may affect the other and cause it to have different, possibly dangerous, effects, or the two drugs may even cause a change in the stomach lining.

The liver is another interaction site. The liver metabolizes drugs, and some combinations may speed or slow the liver's activity, perhaps causing a medication to remain in the body longer than desirable or metabolizing it too quickly for it to have any benefit.

The kidneys may also be affected by flushing drugs from the bloodstream sooner than they should, thus decreasing a drug's effect. In these ways and more, Butler emphasized, interactions cause drugs to have a changed effect—differently in different people.

Prescription Drug Interactions

Diane Baldus, R.Ph., discussed the most common and serious interactions that may occur with prescription medications.

Marilyn Fishel (Mrs. Marvin) consults the discussion outline provided to all in attendence by the pharmacists.

Most pressing are the sedatives, prescribed for pain, insomnia, or anxiety and depression. All such drugs cause varying degrees of sedation, Ms. Baldus said, and mixing them simply causes an additive effect of increased sedation. Individuals can become over-sedated and may stop breathing. Alcohol, too, is an undesirable companion for any sedative, for it also increases sedation. Such interaction problems, particularly with alcohol and sedatives, Ms. Baldus said, are widespread.

Coumadin, an anticoagulant, is also fraught with dangerous interaction potential. Mixture with even aspirin or massive doses of vitamin D can cause serious internal bleeding. Birth control pills can lose effectiveness when mixed with Ampicillin (an antibiotic) or barbiturates. Those using birth control pills who must take one of these drugs should employ an additional or alternate method. Diabetics can also have interaction problems. Some drugs can interact with oral or intravenous insulin and keep too much insulin available in the body, resulting in a dangerously low glucose level.

Ms. Baldus noted two rules to remember with prescription medications. First, two drugs with similar effects taken together will usually result in an additive effect. For instance, a sleeping pill and a pain medication will cause an increased depressant effect. Second, two drugs with similar side effects will cause an additive amount of the side effect. Two drugs that each cause stomach upset, for example, will cause a double dose of that upset.

Over-the-Counter Interactions

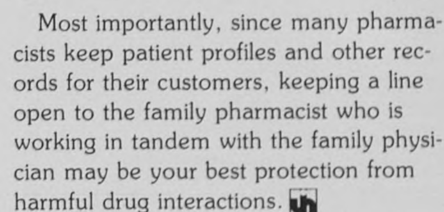
Other interactions with prescription medications, and much more difficult to predict, can occur with over-the-counter remedies, many that contain aspirin or large amounts of alcohol (as a solvent or sleep inducer). According to **Joseph Gruber, R.Ph.,** aspirin* can react in a variety of ways with many prescription drugs, and like alcohol, it is often "hidden" in over-the-counter medications. Antacids and laxatives can also cause problems. For one, they can bind to tetracycline antibiotics, rendering them ineffective. Iron and mineral supplements can also negate tetracyclines.

Cigarette smoking, too, can interact with drugs. Since the liver must detoxify the blood of cigarette agents, it must work at a higher intensity, and this new level can dissipate prescription drugs, necessitating much higher doses.

Some foods, Gruber said, can interact with drugs. Calcium and other dairy products taken with tetracycline antibiotics can form insoluble complexes that prevent the drug's absorption.

All three pharmacists emphasized the importance of recognizing the pharmacist as a health-care professional, knowledgable about drugs and their use. They also suggested telling the pharmacist what other drugs are being taken and to feel free to discuss medications. Patients should also telephone their physicians about unusual feelings and be certain of the drugs being taken, their proper use and possible side effects.

Most importantly, since many pharmacists keep patient profiles and other records for their customers, keeping a line open to the family pharmacist who is working in tandem with the family physician may be your best protection from harmful drug interactions.



*On the subject of aspirin: The pharmacists confessed that the medical world is still uncertain of the proper way to take aspirin, i.e., on an empty or full stomach. All agreed that the most important factor is taking aspirin with one, and preferably two, glasses of water. Gruber, admittedly a consumer-activist sort of pharmacist, said that aspirin substitutes and various aspirin compounds may often be expensive and unnecessary. He recommended plain aspirin, if tolerable, or otherwise finding the preparation that works best for you.

Jewish Hospital News Briefs

Jewish Hospital News Briefs

Virginia Littauer, wife of **David Littauer, M.D.,** died in October 1981 in San Diego, Calif. Dr. Littauer was executive director of The Jewish Hospital of St. Louis from 1951 to 1963.

Mahlon Rubin, CPA, member of the hospital's board of directors, received the 10th annual St. Louis University Distinguished Service Award at the Nov. 19, 1981, meeting of the St. Louis Chapter, Missouri Society of Certified Public Accountants.

Joseph F. Ruwitch, member of the hospital's board of directors, has been named to a second term as the Missouri trustee to the American Hospital Association's National Advisory Council of Hospital Governing Boards.

Medical Staff Notes

Jerome M. Aronberg, M.D., wrote a book, *Caring For Your Skin,* published in November, 1981. Dr. Aronberg participated in a panel discussion at the First Annual Symposium on Dermatology for Primary Care Physicians at St. Louis University, Oct. 7, 1981. He also was named president-elect of the St. Louis Dermatological Society for 1982.

Arthur I. Auer, M.D., participated as a faculty member in the symposium on "Non-Invasive Diagnosis of Vascular Disease," March 26 to 27, 1981 in St. Louis. He attended the Southwestern Surgical Congress in Monterey, Calif., May 4 to 6, 1981, where a paper "Femoral-Intrapopliteal Bypass Procedure," which he co-authored with Joseph J. Hurley, Falls B. Hershey and H. Bradley Binnington, was presented. Dr. Auer attended the International Cardiovascular Society/Society for Vascular Surgery Joint Meeting in Dallas, Tx., in June, 1981. He also attended the International Vascular Symposium in London, England, September, 1981, where papers were presented that he co-authored with others: "Femoral to Intrapopliteal Arterial Bypass Grafting for Limb Salvage in Severe Ischemia and Distal Gangrene," "Non-invasive Laboratory Criteria For Management of Transient Ischemic Attacks (TIA) and Suspected Carotid Artery Stenosis," "Non-invasive Doppler Examination To Detect Stenosis of Bypass Vein Grafts," "Data Management For Vascular Services and Laboratories," "The Use of Non-Procedural Computer Language with an Application Generator for Vascular Laboratory Data Processing."

Martin Bergman, M.D., Douglas Biggs, M.D., Mary Foster, R.N., Rodolphe Ruffy, M.D., Richard Shaw, M.D., and **William Southworth, M.D.,** spoke at a one-day seminar on "Pacemakers: A Critical Care Approach," presented at Jewish Hospital for intensive care nurses.

Morton Binder, M.D., was appointed by Gov. Christopher Bond as official observer to the White House Conference on Aging, held Nov. 19 to Dec. 3, 1981, in Washington, D.C.

Saul Boyarsky, M.D., wrote a paper, "Future Goals in Research in Reproductive Surgery," and co-authored a book with Kenneth Polakoski, M.D., titled *Goals in Male Reproductive Research,* which was published in 1981. Dr. Boyarsky spoke at a joint meeting of the American Association for Testing Materials and the National Bureau of Standards and AMA in Gaitlersberg, Md., Sept. 25 to 26, 1981. His topics were "Standards Development for Urological Devices" and "Performance Standards and FDA Regulations." He also attended the American College of Surgeons course, "New Bladder Stimulation Techniques for Urologists and Neurosurgeons," Oct. 13 to 14 in San Francisco, Calif.

William S. Brandhorst, D.D.S., was named president-elect of the Missouri Dental Association during the group's 1981 convention held in April at the Lake of the Ozarks. He will be installed in May, 1982 in Kansas City. Dr. Brandhorst served as an alternate delegate from Missouri to the American Dental Association Convention in Kansas City, Oct. 24 to 29, 1981. He also participated in the American College of Dentists convocation for the installation of new college fellows, on Oct. 24, 1981. He is chairman of the Council on Education for the American Society of Orthodontists.

David A. Caplin, M.D., co-authored a paper with Leroy Young titled "Silastic Tendon Passes," which was published in the *Journal of Plastic and Reconstructive Surgery,* July 1981.

W.J. Catalona, M.D., co-authored a paper, "Embryonal Rhabdomyosarcoma of the Genitourinary Organs," with J. Fleischmann and E.P. Perinetti that was published in the *Journal of Urology* in 1981. Dr. Catalona also co-authored "Induction of human gamma interferon by protein A from staphylococcus aureus," with R.E. McCool, **T.L. Ratliff, Ph.D.,** and M.P. Langford, published in the *Journal of Interferon Research,* 1981. "Rehabilitation Oncology and Sexual Rehabilitation of the Urologic Cancer Patient," a book review by Dr. Catalona, was published in a 1981 issue of the *New England Journal of Medicine.* Dr. Catalona attended the "Advanced Seminar on Bladder and Prostate Cancer" at the University of California in San Francisco, October 1981, where he also served as visiting professor and acted as moderator for the Surgical Form of the American College of Surgeons. He spoke on "Radical Prostatectomy" at the AUA Seminar on Prostate Cancer in New Orleans, La., October 1981.

Murray Chinsky, M.D., attended the May 1981 national convention of the Phi Delta Epsilon Medical Fraternity in Palm Springs, Calif., where he was named national president-elect.

Raymond S. Dean, Ph.D., published a paper, "Personality Dimensions Concomitant with Adolescents' Perceived Body Weight," in the *Journal of Clinical Child Psychology,* summer 1981 issue. He also spoke, Oct. 29, 1981, at the University of Illinois on "Neuropsychological Aspects of Learning Disorders." Dr. Dean attended the National Academy of Neuropsychologists convention in Orlando, Fla., Oct. 14 to 18 and presented two papers: "Total seizure estimates as a predictor of cognitive function," and "Lateral preference and cross model sensory integration."

William R. Fair, M.D., published an article, "Renovascular hypertension-assessment of functional disorders," in the 1981 edition of *Scientific Foundations of Urology*. He has also submitted the following articles for publication in various medical journals: "Treatment of metastatic prostate derived tumor with surgery and chemotherapy," that he co-authored with D. Kadmon and W.D.W. Heston; "The pharmacokinetics of antibiotic diffusion in chronic bacterial prostatitis," co-authored with W.C. Sharer; "Copenhagen rat prostatic tumor ornithine decarboxylase activity and the effect of the ODC inhibitor-difluoromethylornithine on tumor growth," co-authored with W.D.W. Heston and D.W. Lazen. The *IRCS Medical Science*, August 1981 issue, included an article by Dr. Fair, "Identification of a-D-glucosidase as a component of human expressed prostatic secretions."

W. Donald Gay, D.D.S., published a paper titled, "A Simplified Method of Treating Septal Defects," in the April 1981 issue of the *Journal of Prosthetic Dentistry*. He spoke at an October 1981 meeting of the General Practice Residents and Local Dental Society in Ft. Riley, Ks., and Manhatten, Ks., on the subjects, "Maxillofacial Prosthetics, An Overview" and "Combined Fixed and Removable Prosthodontic Cases." Dr. Gay also attended the American Academy of Maxillofacial Prosthetics meeting on "Management of Congenital Deformities and Oncology Patients" on Oct. 18 to 21, 1981 at Stouffer's Riverfront Towers in St. Louis.

Doris C. Gilpin, M.D., presented a paper, "Developmental Deviations in Childhood, Research and Report of a Case," to a meeting of the Centro Psiquiatrico Infantil, A.P., in Mexico City, Mex., Oct. 22, 1981.

Irving I. Gottesman, Ph.D., spoke Nov. 6, 1981 at the Peoria School of Medicine, Peoria, Ill., on "Genetics in Schizophrenia: 1981 Update." At Yale University, New Haven, Conn., Dr. Gottesman presented the topic "Genetic Pieces in the Schizophrenia Puzzle," on Nov. 18, 1981.

After serving the hospital for 40 years, Urologist James Macnish, M.D., has retired from the medical staff. A party in his honor was given Nov. 18 at Whittemore House. Dr. Macnish was presented a plaque, the inscription honoring him as a surgeon, scholar and humanist. From left is Medical Staff Assistant Dottie Nauman, Urology Department Secretary Connie Friedl, Dr. Macnish and Father Ferraro.

On Oct. 19 and 20 The Jewish Hospital of St. Louis, in conjunction with the Washington University School of Medicine and the Waldheim Department of Surgery, hosted the Rupert Turnbull Memorial Lectureship and Medical-Surgical Grand Rounds in the Steinberg Amphitheatre. The lecture was presented by Professor J.C. Goligher, consultant in general and colorectal surgery, Leeds, England, and emeritus professor of surgery, the University of Leeds. Goligher is at left, preparing for his address. Seated next to him are Mrs. Rupert Turnbull and son Robert Turnbull. Goligher's lecture was entitled, "Rupert Turnbull's Contribution to the Surgical Management of Ulcerative Colitis." The late Rupert Turnbull was generally considered among the most masterful of colorectal surgeons.

Randy Hammer, Ph.D., presented a paper, "Sexual Problems in Primary Care" at the Eighth Annual Midwest Comprehensive Continuing Medical Education Program in St. Louis, Sept. 25, 1981.

Jack Hartstein, M.D., was invited by Akira Nakajima, M.D., president of the 35th Congress of Japanese Clinical Ophthalmology, to speak on "Intraocular Lenses and Extended Wear Contact Lenses," at the group's Nov. 22, 1981 meeting in Tokyo, Japan.

Barry Hieb, M.D., chaired a panel discussion on the topic "How Many Computers Does a Cardiology Division Need?", at a Computers in Cardiology Conference, Sept. 22 to 25, 1981 in Florence, Italy.

Robert E. Kleiger, M.D., attended the 47th Annual Scientific Assembly of the American College of Chest Physicians in San Francisco, Calif., Oct. 25 to 29, 1981. He presented two abstracts: "Late Premature Ventricular Complexes; A Marker of Complex Ventricular Ectopic Activity" and "In-Hospital Prognosis of Patients with First Inferior and Anterior Transmural Myocardial Infarction."

Harry Knopf, M.D., was elected to the Missouri Ophthalmological Society, Inc. Board of Directors for the 1981-1983 term. He was also named vice-president of the St. Louis Ophthalmological Society for the 1981-1982 year.

Marvin Levin, M.D., spoke at the Juvenile Diabetes Foundation's Multidisciplinary Symposium on Management of the Insulin-Dependent Diabetic, in North Canton, Ohio, Oct. 14 to 15, 1981. His topics were: "A Modern Approach To Diabetic Foot Care" and "Clinical Problems in Diabetic Foot Care."

Stanley London, M.D., attended the Major League Baseball Physicians meeting Dec. 7 to 8 in Hollywood, Fla. Dr. London is president of the organization.

Neal Neuman, M.D., spoke at a Joint Medical meeting at Rambam Medical Center in Haifa, Israel, Nov. 3, 1981, on "Surgical Treatment of Impotency."

T.L. Ratliff, Ph.D., co-authored a paper with D.E. Talburt titled "Elevated cyclic adenosine 3', 5' monophosphate levels enhance lactic acid production by Streptococcus lactis," which was published in the *Journal of Dairy Science*. With **W.J. Catalona, M.D.,** and R.E. McCool, Dr. Ratliff published in *Nature*, "Interferon induced by S. aureus protein A augments natural killing and antibody-dependent CML." "Induction of human gamma interferon by protein A from staphylococcus aureus," co-authored by Dr. Ratliff, R.E. McCool, Dr. Catalona and M.P. Langford, was published in the *Journal of Interferon Research*. Dr. Ratliff attended the 2nd International Congress for Interferon Research held Oct. 1981 in San Francisco, Calif., and the 18th Annual Reticuloendothelial Society meeting in Milwaukee, Wisc., the same month.

Kenneth Russ, Ph.D., spoke on "Psychological Approaches to Chronic Pain" at the Veterans Administration South Central Regional Medical Education Center at Jefferson Barracks, Mo., July 15, 1981. He spoke on the same subject at a Chronic Pain Outreach meeting, Nov. 2, 1981 at St. Joseph's Hospital in St. Louis. Dr. Russ was named to the Grandfather Credentials Review Committee of the Biofeedback Certification Institute of America in July 1981.

Robert Schaan, M.D., spoke to special education teachers at Wheeler State School in St. Louis on "Medical Problems of the Severely Retarded Child," during a day-long course Oct. 23, 1981. He also participated in a panel discussion on "Convulsive Disorders and A.D.D." Dr. Schaan attended the AAEE and EMG Convention Oct. 1 to 3 in Portland, Ore. He was also appointed a member of the Missouri Committee for Handicapped Children of the American Academy of Pediatrics for the 1981-1982 year.

Charles Silverberg, M.D., attended a course, "Current Concepts in Clinical Cardiology," Sept. 21 to 24, 1981, at Massachusetts General Hospital.

Cyril Sliom, M.D., attended the American Society of Anesthesiologists Convention Oct. 17 to 21 in New Orleans, La.

Jules Snitzer, D.D.S., attended the American Academy of Periodontology 1981 Annual Meeting in Toronto, Ontario, Canada, Oct. 21 to 24, 1981.

Samuel Soule, M.D., writes a monthly column, "Our Medical Ancestors," published in the *Bulletin of the St. Louis Metropolitan Medical Society*. His topics for the past months have been: "Meredith Martin," May issue; "The Conduct of the Medical Life," June issue; "The Big Four of 1850," July issue; "The First Free Dispensary," August issue; "George M.B. Maughs," Sept. issue; and "The Four Doctors Baumgarten," Nov. issue.

Franz U. Steinberg, M.D., presented his paper, "Diagnostic Responsibilities of Rehabilitation Departments—A Second Look," to the American Academy of Physical Medicine and Rehabilitation in San Diego, Calif., Nov. 4, 1981. He was also named chairman of the committee on geriatrics of the American Academy of Physical Medicine and Rehabilitation.

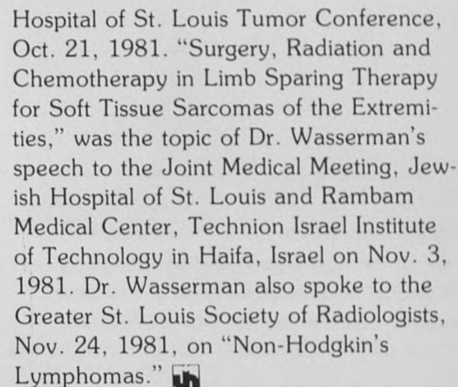
Ronald C. Strickler, M.D., co-authored a paper with **Deborah Gersell, M.D.,** P.E. Cryer and R. Levitt on "Clinical Pathology Conference: Hirsutism progressing to virilization in an older woman," which was published in the *American Journal of Medicine*. "Affinity Labeling of human placental 17_B-estradiol dehydrogenase and 20_a-hydroxysteroid dehydrogenase with 5'-[p-(fluorosulfonyl) benzoyl] adenosine," co-authored by Dr. Strickler and B. Tobias, was published in *Biochemistry*. Dr. Strickler and B. Tobias also co-authored "Study of human placental estradiol-17_B dehydrogenase/20_a-hydroxysteroid dehydrogenase by perparative disc-gel electrophoresis," which was published in *Steroids*.

Roger K. Stoltzman, M.D., co-authored a paper "Diagnostic Concordance Between DSM-III, F and RDC" with Burton Singerman, **Lee N. Robins, M.D.,** John E. Helzer and **Jack L. Croughan, M.D.,** which was published in the *Journal of Clinical Psychiatry*, Nov. 1981 issue. "How Do DSM-III Diagnostic Criteria Differ from the Systems on Which it was Built: RDC and Feighner?" was written by Dr. Stoltzman with Helzer, Dr. Robins, Dr. Croughan and Singerman and published in the Nov. 1981 issue of the *Journal of Clinical Psychiatry*.

Robert Tatkow, M.D., presented his paper, "Surgical treatment of neuromuscular scoliosis," to the St. Louis Neuromuscular Society on Oct. 22, 1981. He also attended a convention of the Scoliosis Research Society in September, 1981 in Montreal, Canada.

Stanley Thawley, M.D., spoke to the Missouri ENT Association on "Endoscopic Voice Restoration" at the Lodge of the Four Seasons, Lake of the Ozarks, in October, 1981.

Todd Wasserman, M.D., co-authored a paper titled, "Primary Radiation Treatment of Colloid Carcinoma of the Breast: A Case Report," with E. Sickles and T.L. Phillips. The paper was published in *Cancer*. "Final Report on the United States Phase I Clinical Trial of the Hypoxic Cell Radiosensitizer, Misonidazole (Ro-07-0582 NSC #261037)," co-authored by Dr. Wasserman, E. Sickles, and T.L. Phillips, was published in *Cancer*. Dr. Wasserman spoke on "Controversies in the Management of Hodgkin's Disease" at The Jewish Hospital of St. Louis Tumor Conference, Oct. 21, 1981. "Surgery, Radiation and Chemotherapy in Limb Sparing Therapy for Soft Tissue Sarcomas of the Extremities," was the topic of Dr. Wasserman's speech to the Joint Medical Meeting, Jewish Hospital of St. Louis and Rambam Medical Center, Technion Israel Institute of Technology in Haifa, Israel on Nov. 3, 1981. Dr. Wasserman also spoke to the Greater St. Louis Society of Radiologists, Nov. 24, 1981, on "Non-Hodgkin's Lymphomas."



The ***216*** *magazine has been awarded first place in the category of external publications, 300-plus bed hospitals, by the Missouri Association for Hospital Public Relations (MAHPR). The judging was based on three consecutive* ***216*** *issues from 1981. Denise Pattiz Bogard, publications director and editor, received the Missouri Muleshoe Award at the annual Missouri Hospital Association convention, held in November at Tan-Tar-A, Lake of the Ozarks. Ms. Bogard gave a presentation at the convention to other MAHPR members on what is involved in producing the bi-monthly* ***216.***

Nov. 21 was "Nurse for a Day" at the Jewish Hospital of St. Louis. The annual event gives prospective area nursing students a look at the nursing profession firsthand. This year, more than 100 persons toured the hospital and nursing school. At top, Nursing Student Stephanie Hoskins leads a group past the nursery. Below, Librarian Alice Bruenjes points out materials available in the school library, including a model skeleton.

Kosher Kitchen Offers One-of-a-Kind Service

The Jewish Hospital of St. Louis offers an exclusive service that cannot be found in any other hospital in the entire metropolitan area, the kosher kitchen. Created in 1932 under the financing of the Burenstein family, the kosher kitchen has never wavered from its original purpose: to offer a kosher meal plan that meets all dietary standards of the Vaad Hoeir/ United Orthodox Community of St. Louis.

Established primarily for patients who keep kosher, the kitchen also services visitors and employees at Jewish Hospital, medical staff members, special-request patients from Children's and Barnes hospitals, and resident medical staff members of the Washington University Medical Center as well as medical students.

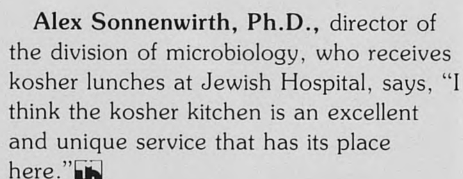
About 120 to 150 kosher meals are prepared each day in two separate kitchen facilities. Three cooks, specially trained in kosher cooking, work in either the meat or milk section, preparing dairy meals that include blintzes, kuegel, salmon croquettes, or meat meals of lamb chops, chicken soup, steak and other kosher delicacies.

Passover Meals

The kosher kitchen is particularly utilized during the week of Passover, when employees, medical staff members, patients and visitors request specially prepared "kosher for Passover" meals. The kitchen also prepares two patient Seder meals, that are officiated by Hospital Chaplain **Rabbi Lawrence Siegel.**

Patients and visitors may receive kosher meals by telling the admissions office, a floor nurse, or calling food services directly. **Rick Mui,** food service production manager, says some patients who do not normally abide by kosher dietary laws request the special meals. "The kosher cooks have fewer meals to prepare than the other cooks, so it is more like home cooking than institutional cooking. Most kosher meals are made from scratch."

The Vaad Hoeir inspects the hospital's kosher kitchen once a week to ensure that all dietary restrictions are being met, kosher products are being bought and the meat and milk dishes are kept separate.



Alex Sonnenwirth, Ph.D., director of the division of microbiology, who receives kosher lunches at Jewish Hospital, says, "I think the kosher kitchen is an excellent and unique service that has its place here."

Laura Levi prepares a meal of lamb chops, baby lima beans and soup in the meat section of the kosher kitchen. Ms. Levi has been cooking in the kosher kitchen since 1973; she learned her trade "by experience," she says.

Juanita Irving prepares nearly 80 cheese blintzes to serve for lunch. She has been the dairy cook for 30 years.

Profiles in Jewish Hospital

Ruth Franc

Ruth Franc (Mrs. Harry) reflects on her 30-year membership with the Jewish Hospital Board of Directors with all the satisfaction of someone who can see the fruits of her efforts.

In the early 1950s, when the Miriam Rosa Bry Convalescent and Rehabilitation Hospital merged with Jewish Hospital, Mrs. Franc fought to obtain a rehabilitation unit here. Franz U. Steinberg, M.D., director of the department of rehabilitation, says without Mrs. Franc's efforts the unit might never have been instituted. Today, the Jewish Hospital claims one of the finest rehabilitation services in the region.

Mrs. Franc is one of a dozen women who helped rejuvenate the auxiliary in 1952. She has been a member of its board since.

Mrs. Franc also served as chairman of the board of directors nursing committee for 10 years and was instrumental in enlisting the auxiliary to help support the nursing school and upgrade the status of nurses at Jewish Hospital.

"When I first came here, my primary goal was to increase the position of the nurses. Then, you know, you get your teeth into something and you can't let go."

Under Mrs. Franc's chairmanship, the nursing committee implemented the area's first "Nurse for a Day" program, an idea that has since been duplicated by many of the other hospitals. Mrs. Franc's committee also was responsible for interesting the auxiliary in nurses' residence improvements and for innovating the annual nursing staff picnic.

In return, the nursing school made Mrs. Franc an honorary "alumna" at the school's 50th reunion. She is the only non-professional so appointed.

"I have always been terribly interested in the hospital. I think it has made great contributions to the health care field in the entire community.

"When you get involved in something you take such a pride in it."

Mrs. Franc's other activities include past membership on the boards of the Jewish Family and Children's Service and the United Fund. "There have been lots of other [commitments] throughout the years, but the hospital has always been my main interest."

Ruth and Harry Franc have been married 47 years. They have one son, Terry, and daughter-in-law, Sondra, and three grandchildren, Scott, Christy and Charles.

Joseph F. Ruwitch

Joseph F. Ruwitch joined the Jewish Hospital Board of Directors in 1955 because of "a vital interest" in community organizations, most specifically, the Jewish Hospital and Jewish Federation.

In looking back on those early days of board membership, Mr. Ruwitch muses fondly of how the hospital was in a "very exciting developmental stage then. It was very exciting and very challenging to be involved at that time."

During the ensuing years, Mr. Ruwitch's interests have, "if at all possible, actually broadened." He was vice president of the hospital board from 1958 to 1959 and again from 1961 to 1963. (He left the board to serve as president of the Jewish Federation of St. Louis from 1959 to 1961, then joined again when his federation term was up.) He served as president of the hospital board from 1963 to 1968. He has been a member of many of the board's committees over the years, including the executive, finance and budget, and nominating committees, and investment subcommittee. In 1965, he established the Joseph F. and Elizabeth R. Ruwitch Endowment Fund.

He says of his Jewish Hospital involvement: "It has really occupied a very big niche in my life. It took a lot of time, and there were a lot of frustrations, but there have been an awful lot of gratifications over the years that have made everything worthwhile."

Joseph and his wife Elizabeth are the parents of two sons, Wallace R., and Joseph F. Jr., M.D., a cardiologist at Jewish Hospital, and a daughter, Jane R. Mitchell. They have six grandchildren.

A graduate of Michigan Law School, Mr. Ruwitch began his career with a corporate law firm in Chicago. He moved to St. Louis in late 1949 to become director of Renard Linoleum and Rug Co., where he has worked since, serving as its vice president and president.

Mr. Ruwitch has worked in the capacity of director, trustee or member of many other organizations as well, including St. Louis University, Jewish Federation, United Way, St. Louis Children's Hospital, St. Louis Symphony, Council of Jewish Federations and Welfare Funds, Washington University Medical Center, and many other civic and charitable groups. He is also the Missouri representative to the American Hospital Association's National Advisory Council of Hospital Governing Boards.

Why all the activities? "I guess I do it because it is one way to share with others who don't have as much."

Sydney M. Shoenberg Jr.

There was never any question for Sydney M. Shoenberg Jr. He always knew he would become involved in the Jewish Hospital of St. Louis and sustain that commitment throughout his life. "It's a family tradition," he says.

The grandson of Moses Shoenberg and son of Sydney M. Shoenberg Sr., Sydney M. Shoenberg Jr. joined the Jewish Hospital Board of Directors in 1946.

"It is this continuity of interest in what I consider to be one of the outstanding institutions in its field that has kept me involved in the operation of the hospital. I think the primary significance to any city is health maintenance services, medical research and education, and I find all of these being performed by Jewish Hospital," says Mr. Shoenberg.

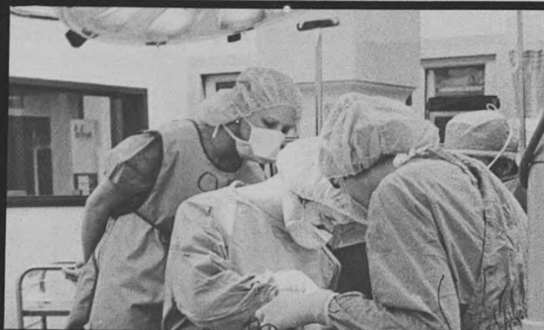
This philosophy has been handed down to Mr. Shoenberg by his father and his grandfather. Moses Shoenberg was one of the original contributors in 1901, making construction of the first 30-bed hospital building on Delmar Blvd. possible. He joined the board of directors in 1907, and served as vice president from 1913 to 1914. His only son, Sydney M. Shoenberg, was elected to the board in 1914. John M. Shoenberg, brother of Sydney M. Shoenberg Jr., joined the hospital board in 1951; he served as vice president in 1954 and as president from 1958 to 1963.

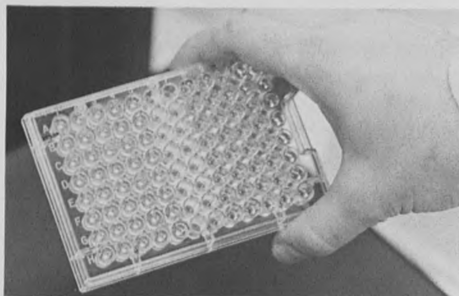
In 1929, Dollie B. Shoenberg, along with her son, Sydney, made a gift of $300,000 in memory of her husband, to enable the hospital to construct a building to house the Moses Shoenberg Memorial School of Nursing.

In 1959, a second residence for nurses was opened in a building purchased with funds provided by the Shoenberg family. The Stella H. Shoenberg Cancer Research Fund was established in 1968 in memory of the mother of Sydney M. Jr., John M. and Robert H. Shoenberg. Shortly thereafter, funds were provided to endow a professorship in the department of medicine to be named the Sydney M. and Stella H. Shoenberg Chair of Medicine at Jewish Hospital and Washington University School of Medicine. Similarly, a chair was endowed in 1974 in memory of John M. Shoenberg to support research in heart disease. Contributions totalling $1 million initiated the funding for the nine-story, Sydney M. Shoenberg Pavillion, dedicated in 1974.

"I derive a great personal satisfaction in witnessing advancements in health care, medicine and the status of the Jewish Hospital in the community."

The Shopping List





The ELISA reader scans and measures 96 wells on the microtiter tray, giving a digital readout on each at left and a tape printout at top right.

The microtiter tray, filled with 60 antigen-coated bearings.

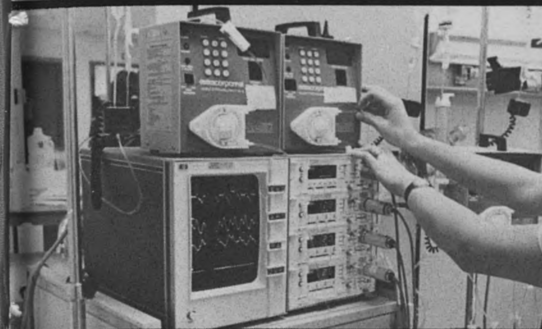
The ELISA Reader

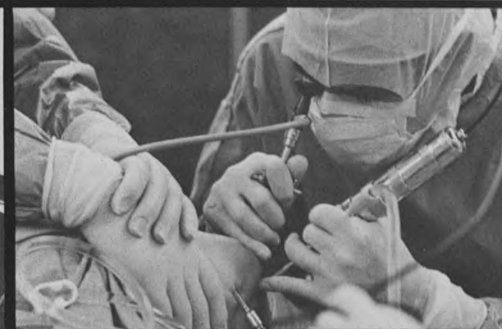
If you want to do things better and faster, technology can be a savior, but it usually comes with a hefty price tag. Occasionally, though, a new piece of equipment comes along that does everything better and costs less. At Jewish Hospital, such a device is the ELISA reader, a sophisticated new testing unit that detects elusive and dangerous infections such as Rubella virus and Herpes Simplex virus with infinitely greater accuracy and lower initial cost than conventional methods.

The ELISA (an acronym for Enzyme-Linked Immunosorbant Assay) equipment and procedure are used now in many institutions primarily as a research tool, but Jewish Hospital's serology laboratory, under the direction of **Alice Weissfeld, Ph.D.,** and **Alex Sonnenwirth, Ph.D.,** is employing the reader for direct patient benefit through improved diagnosis.

The ELISA reader detects, in minute quantities, antibodies produced by the body to fight off infections caused by four agents: Rubella virus, Cytomegalovirus, Herpes simplex virus and *Toxoplasma gondii.*

A patient's blood serum is first mixed with small metal ball bearings coated with



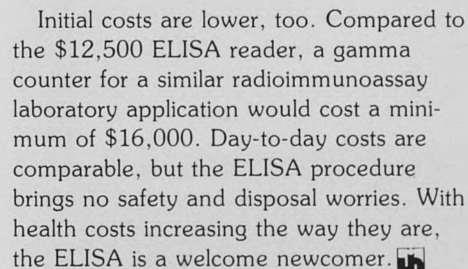


antigens (components) of the infectious agent under suspicion. The bearings are then placed in a chemical that undergoes a color change if the antibodies to the agent are in the serum. If they are, the antibodies will bind to the infectious agent on the bearings and cause the chemical to turn various shades of green, depending on the strength of the reaction. The ELISA reader measures these minute color changes and determines whether antibodies are in the patient's serum. Physicians can then rule out or confirm these infections and take appropriate actions. Rubella (German measles), for instance, can be devastating to the unborn child, and mothers who contract it during pregnancy may elect to terminate the pregnancy.

The ELISA procedure has several advantages over conventional detection methods. It has as great a sensitivity as radioimmunoassays, but without storage and disposal concerns. Radioimmunoassay, which uses radioisotopes to detect diseases, is still the standard means for tracking down infections like hepatitis, but serologists expect to develop ELISA tests for it and other infections.

Another factor is time. The old rubella test, cumbersome and tedious, took a minimum of 48 hours. ELISA takes just four hours, with as much as a 1,000-fold sensitivity increase over the old test. Through strict quality control and standardization, accuracy and consistency are increased as well.

Initial costs are lower, too. Compared to the $12,500 ELISA reader, a gamma counter for a similar radioimmunoassay laboratory application would cost a minimum of $16,000. Day-to-day costs are comparable, but the ELISA procedure brings no safety and disposal worries. With health costs increasing the way they are, the ELISA is a welcome newcomer.



In an effort to provide high-quality medical services, The Jewish Hospital of St. Louis continually purchases new equipment. Because of the ever-increasing costs of medical supplies, gifts to the hospital, whether large or small, are greatly appreciated.

The Shopping List is a special feature citing particular items and their approximate costs, for which various hospital departments have indicated a need. The list specifies areas in which contributions are most necessary to help offset the high costs.

This list offers the community an idea of the many different pieces of equipment every department requires to function efficiently, and also to allow prospective donors to choose a specific gift if they so desire.

Remember, the need is there. Your generosity could help save a life.

For more information on The Shopping List, contact the development office, 454-7251.

Nursing Divisions

Doppler .... **(4 needed)/$350 each**

Anesthesiology

EKG Monitor **$6,000**
Blood warmers .... **(2 needed)/$700 each**
Vaporizers .... **(7 needed)/$1,200 each**

Occupational Therapy

Sewing Machine **$750**
Camera **$550**

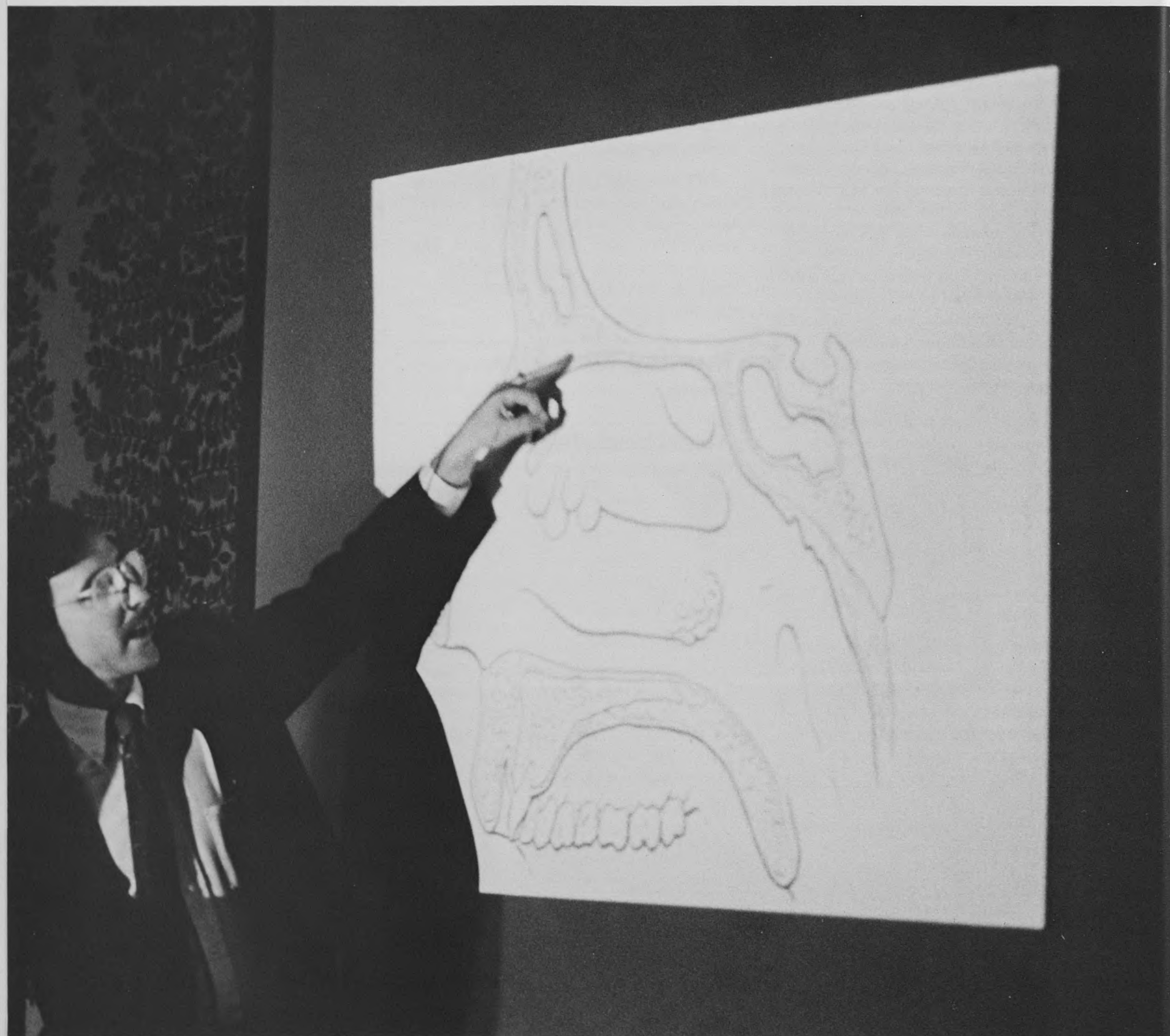
Operating Room / Surgery

Laparascope **$1,525**
Bronchoscope **$5,850**
Co_2 Insufflator **$185**
Operating Table **$10,000**
Operating Room Theatre Lights .... **(2 needed)/$7,500 each**
Patient Monitoring Transducers .... **(10 needed)/$500 each**

OB-GYN

Labor Room Beds **$2,300**
Basinettes .... **(10 needed)/$450 each**
Dopplers .... **(2 needed)/$350 each**

Dr. Shatz shows how an allergen irritating the sinus linings can cause nasal polyps, growths that hang from the walls of the sinus.



What's Your Reaction?

"Thirty percent of the population of the United States does have allergies, and this is no small number," states **Gerald Shatz, M.D.,** allergy specialist and featured speaker at the Associates in Medicine of The Jewish Hospital of St. Louis program, "Everything You Ever Wanted to Know About Allergies . . . But Were Afraid to Ask."

An allergy is an atypical reaction or super-sensitivity to an extremely small amount of an environmental substance called an allergen, according to Dr. Shatz. He outlined the four categories of allergens and discussed how they are diagnosed and treated:

• Inhalant allergens, those that cause respiratory problems, are microscopically small particles, dust, pollen and other pollutants that float in the air. When inhaled, they irritate the linings of the throat, bronchial tubes and lungs of those who are super-sensitive to the particular substance. Severity of the allergy varies greatly from minor hay fever to asthma.

• Ingested allergens include food and oral medications. "The big food allergens are nuts, berries and beans, although they could be anything," says Dr. Shatz. They are manifested through skin eruptions and gastrointestinal problems.

If all else fails, allergy shots can be used. They are extremely effective for certain types of allergens.

• Injected allergens are insect stings—the honey bee, wasp and white- and yellow-faced hornet are most common—and drug injections. These can all cause severe life-threatening and fatal allergic reactions of the cardiovascular system.

• Contact allergens include poison ivy, metals, paint resin and chemicals in the form of cosmetics and soaps, for example. "Our skin is constantly barraged by varieties of these substances," Dr. Shatz says. Swelling of the skin, rash, itching and flushing are reactions to contact allergens.

Diagnosing an allergy requires exhaustive history-taking of a patient. "Ninety percent of the time he will tell you exactly what's wrong with him." Dr. Shatz explained that many allergies are seasonal, involving pollen. Therefore, learning when the patient is most bothered often determines the allergen. A person whose symptoms only show in the early spring is probably allergic to tree or grass pollen. Trees are the first to pollenate, in April. Grasses follow, beginning at the end of April and pollenating for four to six weeks.

A lull in pollens occurs until mid-August, when ragweed—the worst offender of all—begins to pollenate. Ragweed counts run high until the first frost. Mold, another allergen, peaks during and shortly after rainy weather and change of seasons.

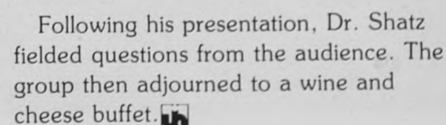
If the allergen cannot be identified through history-taking, a skin scratch test may be made. This involves scratching the skin slightly to introduce a possible allergen. Several allergens are introduced, each into a separate scratch. If the area around a particular scratch swells or shows irritation that substance is an allergen for the patient. Some people are allergic to many substances.

Once the allergen(s) is identified, "we do the simple things first. If they work, we quit," says Dr. Shatz. Avoidence of the allergen, if possible, is the most simple, and the easiest course of action. When the substance cannot be avoided, as with pollen, an over-the-counter antihistamine is prescribed. Ninety percent of the people with allergies can be satisfied with these, according to Dr. Shatz.

AIM members and guests attending the Nov. 5 program held in the hospital's Brown Room.

If all else fails, allergy shots can be used. They are extremely effective for certain types of allergens. For pollens, allergy shots have a 78 to 80 percent success rate. The shots are 65 to 70 percent effective for mold and only 20 percent successful for animal dander. They are worthless against smoke, pollution and food allergies. Allergy shots are not medicine, Dr. Shatz explained. They are composed of the very things the person is allergic to, started at a very low dose and doubled on a weekly basis to build an immunity to the allergen. "It takes about six months to build a person up so that he can be exposed to the substance without symptoms," says Dr. Shatz.

Following his presentation, Dr. Shatz fielded questions from the audience. The group then adjourned to a wine and cheese buffet.



Auxiliary Fall Meeting

Discussing Genetic Disorders

Co-chairwomen of the annual fall meeting: Pam Toder (Mrs. Craig) (left) and Margie Horowitz (Mrs. Merle).

The Steinberg Amphitheatre was filled with auxiliary members and guests who attended the annual fall meeting to learn about genetic disorders. The program was entitled "Getting into Genes," and featured presentations and a panel discussion by **James P. Crane, M.D., Theodore Reich, M.D.,** and **Barbara Rohland, M.S.**

Familial Disorders

Theodore Reich, M.D., psychiatrist-in-chief, spoke first on "Inheritance of Common Familial Disorders." Dr. Reich reviewed the astounding progress made in the field of genetics over the past 15 years and how this information has been integrated into research projects at Jewish Hospital.

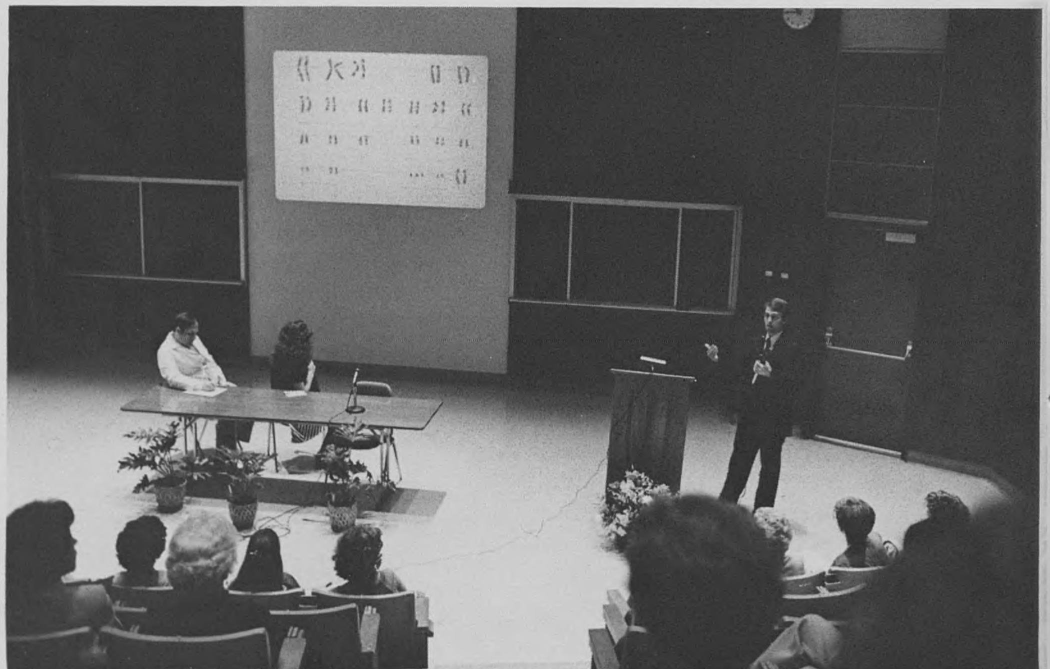
The department of psychiatry is conducting major familial studies on the occurrence of alcoholism, depression, criminality, schizoaffective illness and manic-depressive illness in families to discover transmission patterns, improve the classification of such disorders and to ascertain the interaction of genetic and environmental factors in the development of these disorders.

Dr. Reich said, "Certain lifestyles, such as smoking and drinking, increase risks."

His advice to the audience: use common sense; be aware of illnesses in the family; if a disorder exists, tell the physician during check-ups, and if a lifestyle change can improve your health, do so.

Prenatal Diagnoses

James Crane, M.D., obstetrician/gynecologist-in-chief and head of the genetics unit, spoke on "Prenatal Diagnosis of Genetic Disorders." Dr. Crane began his discussion with some statistics: about 15 million Americans have some birth defect; about 80 percent of these are genetic; about 60 percent of all early miscarriages are due to chromosomal abnormalities; one in 200 infants has a chromosomal abnormality; four percent of newborns have a birth defect, and 40 percent of infant deaths result from genetic factors.



Dr. Crane addresses the audience on chromosomal abnormalities. His talk was illustrated with slides.

One in 200 infants has a chromosomal abnormality; four percent of newborns have a birth defect, and 40 percent of infant deaths result from genetic factors.

A fashion show followed the luncheon. Edie Brown (Mrs. Harvey) served as emcee; Rose Hughes (Mrs. Charles) modeled jeans, a sweater and accessories from the Gift Gallery.

There are three basic genetic causes of congenital defects: chromosomal abnormalities, single gene factors and multifactorial disorders. All humans have 23 pairs of chromosomes, with the last pair the XY sex-determinant. Each chromosome contains thousands of genes, most of which are "good" genes, but some may be "bad" ones. When these bad genes are transmitted, genetic disorders often are the result.

In the case of Down's syndrome, the mother contributes an extra chromosome in two-thirds of the cases, the father in one-third. As the age of the mother increases, so do the risks of Down's syndrome from one in 2,000 mothers age 25, to 10 percent in mothers over age 44. Dr. Crane said when a child is born with Down's syndrome, he usually tests the child for the type of chromosomal abnormality to try to predict if other children born to that couple will also display the disorder.

Another common cause of birth defects is single gene factors. Many of these problems can be diagnosed during pregnancy by amniocentesis, and if the mother is treated early enough, the disease can sometimes be prevented.

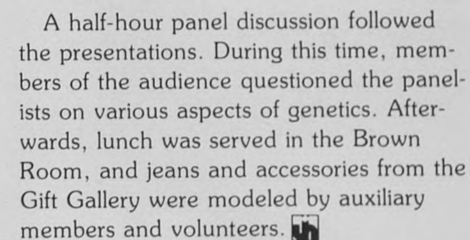
Genetic Counseling

Barbara Rohland, M.S., genetic associate, discussed "Aspects of Genetic Counseling." Ms. Rohland counsels persons seeking genetic information, most of whom are mothers age 35 or over, parents who have already had a child with Down's syndrome or a neural tube defect, and parents who may be carriers for gene level diseases.

The counselors' most frequent clients are couples at risk to have a child with Down's syndrome. Medical and family histories are first obtained from the prospective parents. This includes information from the mother regarding smoking, alcohol consumption and other drug use during pregnancy. Prenatal diagnosis including ultrasound and amniocentesis may then be scheduled. When test results are available, the parents are notified.

Ms. Rohland said that people often cannot anticipate their reactions to news of Down's syndrome until they actually are faced with a decision. The counselors do not give advice in these instances, because it is a very personal decision that can be made only by the parents.

"Our goal is not to create a superior race. We are providers, not creators. Our goal is to provide information and hopefully relieve suffering for families. From this perspective, our service is something we all can be proud of."



A half-hour panel discussion followed the presentations. During this time, members of the audience questioned the panelists on various aspects of genetics. Afterwards, lunch was served in the Brown Room, and jeans and accessories from the Gift Gallery were modeled by auxiliary members and volunteers.

Panelists (from left) Theodore Reich, M.D., Barbara Rohland, M.S., and James P. Crane, M.D.

Dessert included home-made goodies, baked by auxiliary members, from their Cooking in Clover *cookbook.*

The hospital sponsored an open house tour of the newly remodelled division 8300 on Nov. 10. The division, which looks more like a plush hotel than a hospital floor, has four suites, 12 private rooms and three semi-privates. Division 7300, also in the Kingshighway Pavilion, is being remodelled, too. Shoshana Turk, administrative resident, and Elliot Stein, board member, view one of the suites.

Contributions to Jewish Hospital Funds

Generous Contributions

The Brand Foundation has made a contribution to the Oscar Brand Memorial Fund.

Mr. and Mrs. Stanley M. Cohen have made a contribution to the Building Fund (Directors Fund).

Mr. Harris J. Frank has made a contribution to the Building Fund (Directors Fund).

The Harry Freund Memorial Foundation has made a contribution to The Flora D. Freund Nurse Scholarship Fund.

Mr. I. M. Kay has made a contribution to the Discretionary Fund for the Department of Medicine (Directors Fund).

Mr. John D. Levy has made a contribution to the Building Fund.

Mr. and Mrs. Tobias Lewin have made a contribution to the Hortense Lewin Scholarship Fund.

Mrs. Esther Miller has made a contribution—in appreciation for the care given to her late husband, Hymen C. Miller—for monitoring equipment in the department of radiology.

Mr. Sylvan Sandler has made a contribution to the Rupert Turnbull Memorial Lectureship in Colon and Rectal Surgery.

Mr. Gene W. Schneider has made a contribution to the Restricted Endowment Fund of Harry, Gene and Murray Schneider, New Market Hardware Company and Ace Construction and Engineering Company.

Mr. and Mrs. Lester Seasongood have made a contribution to the Seasongood Research Fund and for cancer research.

Mrs. John M. Shoenberg has made a contribution to the John M. Shoenberg Research Fund.

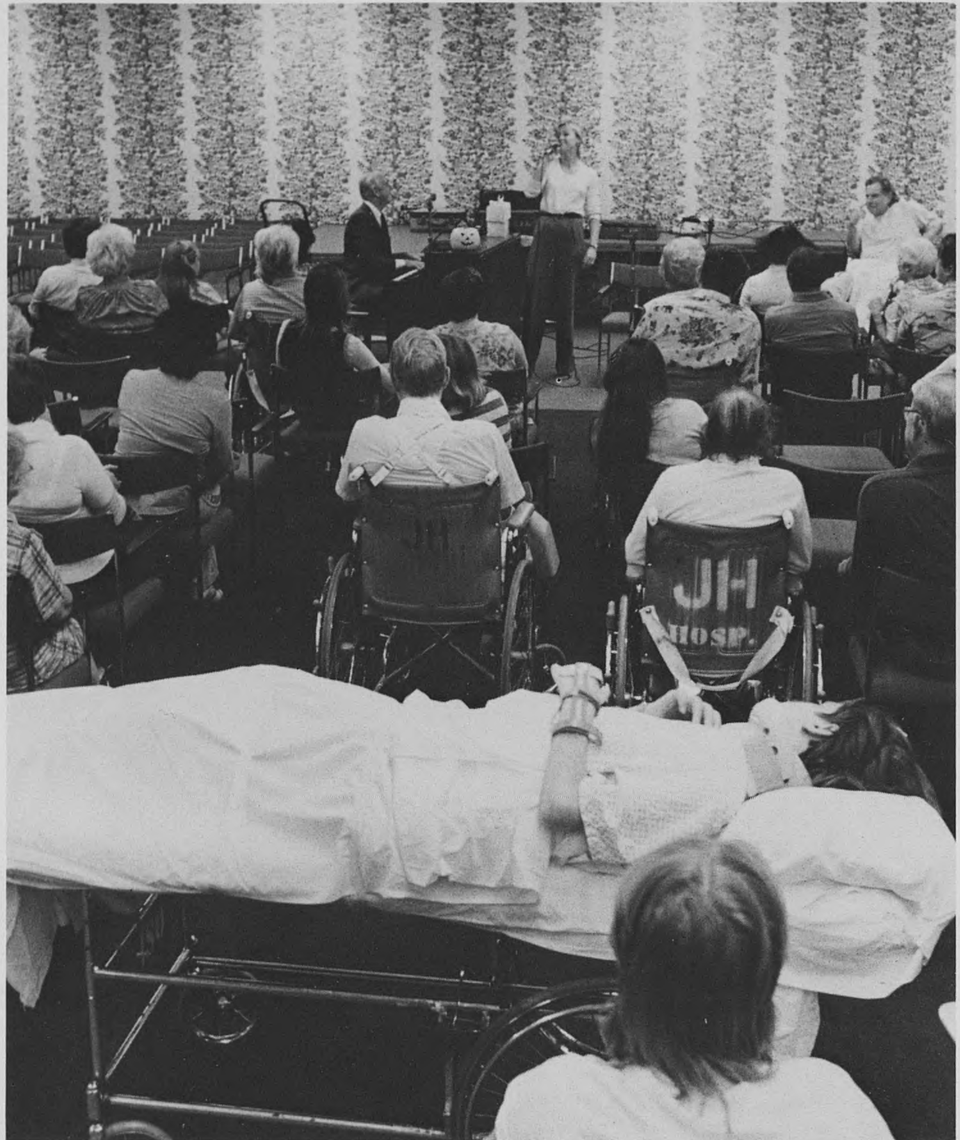
Mr. Sydney M. Shoenberg, Jr. has made a contribution to the Building Fund (Directors Fund).

Mr. and Mrs. Abe Small have made a contribution to establish the Merla and Abe Small Cancer Research Fund.

The Estate of Henry B. Stern has established the Evelyn B. Stern Endowment Fund.

The Jewish Hospital Auxiliary has dedicated a plaque in memory of Irma Blank (Mrs. Paul) "In grateful recognition of her unselfish devotion to the Gift Gallery and the Auxiliary." The plaque hangs in the Gift Gallery, where Mrs. Blank was chairman for five years. Mrs. Blank died last April. Attending the dedication are (from right) Mabel Howell, vice president; Phyllis Langsdorf (Mrs. Kenneth), auxiliary president; and family members Paul Blank, husband; Linda Blank Gray, R.N., daughter, and Joyce Yalem (Mrs. Harold), sister. Not shown is Pat Kaiser (Mrs. Jerry), sister.

Russ David performed for rehabilitation and recreational therapy patients Oct. 20 in the Brown Room. David said he appreciated the care his wife, who was then hospitalized, was receiving at Jewish Hospital and wanted to do something nice by giving a free concert for the patients.



Special Gifts

In Memory Of

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Honoree	Gift / Donors
Special Birthday of Joan Soffer	(Color televisions for patient use) Mr. and Mrs. Gideon Schiller Dr. and Mrs. Thomas Schiller Mr. and Mrs. Stanley Soffer Dr. and Mrs. Alan J. Stein
Special Birthday of Charles J. Steiner	(Evelyn B. Stern Nursing Scholarship Fund) (Tribute Fund) Mr. and Mrs. S. Charles Baer

Special Gifts — Donations

Donor	Gift
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Estate of Joseph Diamond	Tribute Fund
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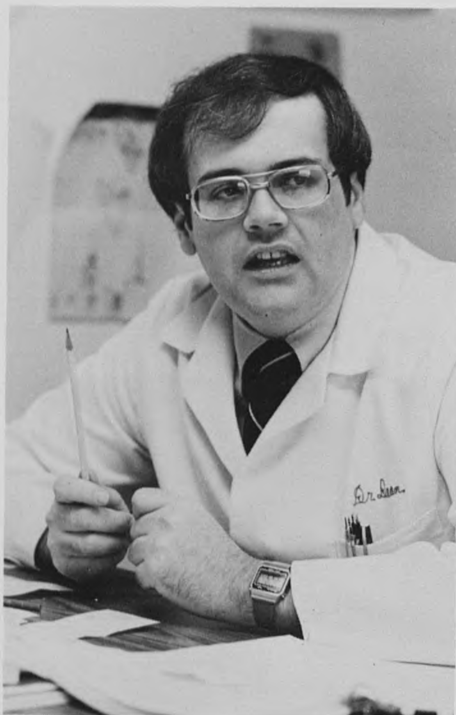
Lawrence K. Roos	Selma K. Roos/Directors Fund
Mahlon Rubin	Directors Fund
Dr. Alexander Schoenfeld	Aloesonic Ultrasound for Department of Rehabilitation Medicine
Estate of Abe Silverman	Building Fund
Mr. and Mrs. Louis Tiger	Fisher Stereo for School of Nursing

Franz U. Steinberg, M.D., director of rehabilitation medicine (right), and Richard Roettger, PPT, coordinator of physical therapy, demonstrate a new portable video recorder and color camera purchased for rehabilitation medicine by the Miriam Lodge #17, UOTS. Representatives of the lodge are Marline Zafft, president (right), and Margie Frank, liaison between the Miriam Lodge and the hospital's rehabilitation department.

Regarding Research:
A Brain Divided

By David Baygents



Raymond S. Dean, Ph.D., is the newest member of the hospital's department of psychiatry, having joined in June 1981. Previously he held positions at the University of North Carolina, the University of Wisconsin and Arizona State University.

Recent technological advances have made studying the human brain easier and more precise than ever before, and fascinating new information about how different regions of the brain work comes almost every year. Although 19th-century investigators naively attempted to develop intricately detailed maps of brain functions (one even suggesting that a given area was for reading English, another for French), scientists now agree that some functions indeed are localized. Speech, recognition of spoken words and motor responses, for instance, are generally confined to their own areas of the brain.

Research also has shown that the brain's two cerebral hemispheres, while symmetrical in many ways, are markedly different in psychological function. The left hemisphere is thought to process information in a more linguistic, sequential and analytical way than the right, which is responsible for visual-spacial operations.

Research with split-brain subjects, where the broad fibrous band connecting the hemispheres has been cut (once a surgical technique for relieving severe epileptic seizures), has revealed fascinating information about the two hemispheres, their function and interrelationship, mental processes and human consciousness. Just last October, the California Institute of Technology's Roger Sperry shared the 1981 Nobel Prize for Medicine for his seminal work and achievements during the past 30 years with split-brain research.

At Jewish Hospital's Division of Psychiatry, Neuropsychologist **Raymond S. Dean, Ph.D.,** is also exploring the human brain, conducting research on laterality (hemispheric preference for certain functions, like writing, kicking a ball, waving) and on psychiatric disorders suspected of having organic or neurochemical origins within specific brain areas.

Laterality and Learning Disorders

Dr. Dean's chief interest in laterality is how it relates to, and may be an indicator or predictor of, children's learning disabilities. Learning disabilities often represent a lack of consistent cerebral dominance, interfering with the learning of age-appropriate classroom skills. Generally, the right and left hemispheres are concerned with independent, specialized information processing, but unlike most normal children, the learning disabled probably have less well-specialized hemispheres. Classified often as bilateral, such children are not, for instance, decisively right- or left-handed* in their activities, and such bilaterality or confused "handedness" transcends daily activities to the brain's processing of information.

In one of his recent studies, Dr. Dean compared lateral preference patterns for 246 normal and 108 learning-disabled elementary school children using his own laterality preference schedule, a 49-item questionnaire that predicts children's preferences for activities involving the eyes, ears, feet and hands. The results showed that learning-disabled children were significantly more bilateral (lacking a strong right or left preference) on factors involving visually guided fine motor activity (use of vision in manipulating small objects), listening, and fine motor foot preference (precise movements of feet). Further research with other bilateral children has supported Dr. Dean's initial argument that bilateralized readers may fail to comprehend written material because of problems in organizing visual input, rather than because of a verbal deficit.

*Although some people feel comfortable doing some tasks with either hand, those tasks usually require training, like switch-hitters in baseball. Tasks requiring little training, done with equal frequency with either hand, eye, ear or foot, may indicate confused handedness, or bilaterality.

One problem with the notion of learning disabilities, Dr. Dean says, is that children are grouped together, under the assumption that their learning problems are similar or identical. "But some of the data that we have lead us to believe that there are distinct sub-groups of learning-disabled children, so we have tried, through sophisticated statistical techniques, to isolate children with different kinds of learning problems. Some of these kids who are having problems in lateralization, for instance, are helped in their reading comprehension by shortening the length of the printed line. It seems this group may have scanning problems; we hypothesize that it's a problem in integrating visual-verbal as opposed to auditory-verbal kinds of material."

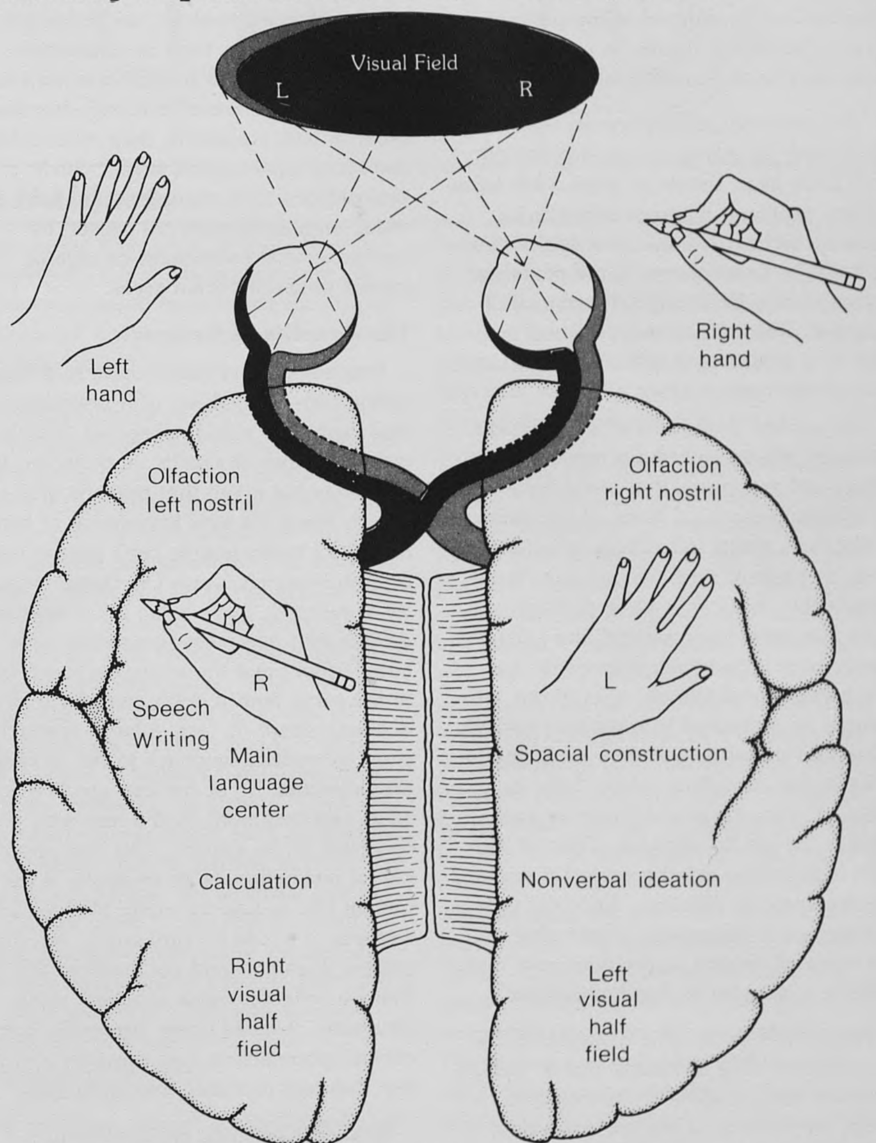
Through further research, Dr. Dean hopes to develop better methods of diagnosing and discriminating among groups of learning-disabled children and eventually to devise ways to alleviate such disorders.

New Diagnostic Tests

Another facet of Dr. Dean's work, and one that could quite possibly affect a much larger group of patients, is his work in constructing specific and positive tests for schizophrenia and depression, and pinpointing the areas of the brain responsible for such disorders. Formerly, diagnoses for these two illnesses were largely subjective and often confusing and ambiguous. Dr. Dean hopes, through standardized, objective tests, to produce more accurate diagnoses of schizophrenia and depression and also take into account possible neurological causes.

"One of the most exciting things for me is the ability to integrate what we had considered to be psychiatric illnesses with neurological function. At one time they were seen really as being quite distinct. In neuropsychology we're looking at the sorts of brain dysfunctions for individuals who have typically been seen as psychiatrically

Sensory Inputs to the Two Hemispheres



With the eyes fixated straight ahead, stimuli to the left of the fixation point go to the right cerebral hemisphere and stimuli to the right go to the left hemisphere. The left hemisphere controls movements of the right hand, and the right hemisphere controls the left hand. Hearing is largely crossed in its input, but some sound representation goes to the same hemisphere as the ear. Olfaction is received on the same side as the nostril. The left hemisphere is dominant for most people; it controls written and spoken language and mathematical calculations. The minor, right hemisphere can understand only simple language. Its main ability seems to involve spatial construction and pattern sense. (After Sperry, 1970)

[Reprinted from Introduction to Psychology, *by Ernest R. Hilgard, Richard C. Atkinson and Rita L. Atkinson. (Harcourt Brace Jovanovich, 1975), p. 50.]*

Beyond diagnostic improvements, research also brings increased understanding of mental and neurological processes, and basic understanding is the starting point toward cures.

ill. Although it is still rather early, our data and those of others show that individuals who we had considered in the past to have a 'functional illness,' a psychiatric illness, also have neurological dysfunctions.

"For instance, schizophrenics who are diagnosed according to our research criteria have been shown to have a left hemispheric problem, whereas depressives seem to be having more of a dysfunction of the right hemisphere. Some evidence gathered with PET and CAT scans indicate that with schizophrenics, there may well be a dysfunction of the left frontal area of the brain."

The newer, more clinical tests are standardized, six- to eight-hour batteries, or behavioral measures, that relate behavior to different functional areas of the brain. These tests reveal individuals who have brain damage or dysfunctions and, more specifically, those who have damage in a particular area. For instance, since the left hemisphere is generally responsible for processing verbal stimuli, tests of this area compel an individual to listen to a verbally presented stimulus, and they must discriminate: is the recording saying "bah" or "cah"? Failure here could indicate problems in the left hemisphere. Tests of the right hemisphere ask the subject if rhythms are the same or different. Since the right hemisphere is apparently responsible for the sense of rhythm, a problem here might indicate a disorder in that hemisphere.

Test results so far offer insight into the neurological basis of mental illness. Schizophrenics tend to score in the impaired range on portions of the test that relate to the left hemisphere. The laterality scale, incidentally, shows depressives to be more bilateral than schizophrenics. "We found," says Dr. Dean, "that with the laterality scale there are at least six distinct factors, and some of them are more predictive of aberrant behavior than others. Factor two, which is a visually guided motor factor, was really quite predictive of depression, whereas schizophrenics were in the normal range. With depressives, we know that when they're very high on depression there is a greater likelihood of a right hemispheric kind of a problem, but after treatment or with remission, they tend to fall back to a more normal level." Such observations may support contentions that many mental illnesses are caused by neurochemical imbalances or organic lesions in specific brain areas.

The Benefits of Research

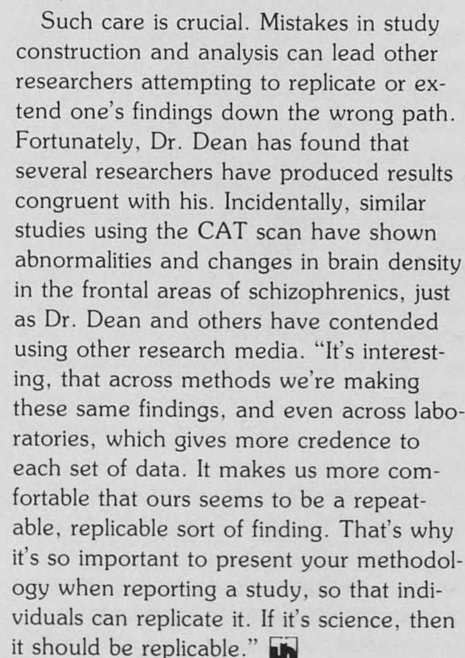
Psychological research deals to a large extent with intangibles, with phenomena that cannot be readily observed. Psychologists must look at results, at behavior, but that does not mean that psychological research brings no new knowledge or benefits. "A lot of lay people can't see the benefit from research," says Dr. Dean, "but a lot of research that's being done here at Jewish with psychiatric inpatients does benefit them and the attending physicians at the same time. I don't consider it all a one-way street. In fact, a lot of research gives immediate feedback to the attending physician that he or she can use in diagnosis and treatment, and it also may give feedback to the patient. This neuropsychological test battery is an example. If the patient had to pay for many of these procedures, it would be very costly, but the patient does not, and yet much of the data that we collect is made available to his physician. A lot of times, especially with chronic populations, one turns up a problem that had not been known to exist."

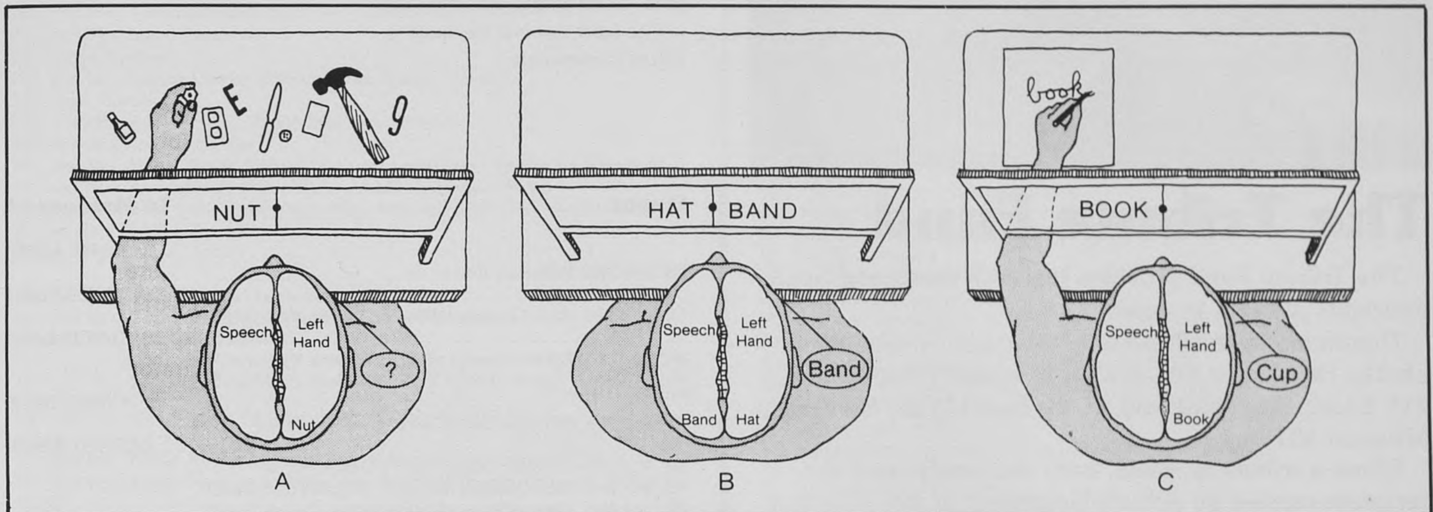
Beyond diagnostic improvements through objective tests, research also brings increased understanding of mental and neurological processes, and basic understanding is the starting point toward cures. As researchers learn more about special brain locations of mental illnesses (if they do exist), then they may be able to design remedial approaches for treatment.

Tests and research on bilaterality have, in fact, proved that laterality is a possible indicator of depression in later life. Some researchers have examined bilaterality in very young children and shown that this is a predictor of more severe future psychoses. If such contentions prove true, there may develop opportunities to screen individuals at high risk of depressive illness, schizophrenia and other mental illnesses.

What many don't realize about research is the tremendous amount of time and planning that goes into it. An incredible amount of time is used simply in designing the study and securing the subjects. With his studies on laterality with depressives and schizophrenics, Dr. Dean and his colleagues had to assemble 36 normals, 36 depressives and 36 schizophrenics, and each one had to fit a detailed and strict diagnostic criteria; those that didn't were excluded. Each one had to be given the test battery—taking six to eight hours per subject. Then all of the data had to be entered into a computer and critically analyzed.

Such care is crucial. Mistakes in study construction and analysis can lead other researchers attempting to replicate or extend one's findings down the wrong path. Fortunately, Dr. Dean has found that several researchers have produced results congruent with his. Incidentally, similar studies using the CAT scan have shown abnormalities and changes in brain density in the frontal areas of schizophrenics, just as Dr. Dean and others have contended using other research media. "It's interesting, that across methods we're making these same findings, and even across laboratories, which gives more credence to each set of data. It makes us more comfortable that ours seems to be a repeatable, replicable sort of finding. That's why it's so important to present your methodology when reporting a study, so that individuals can replicate it. If it's science, then it should be replicable."





Experiments with Split-Brain Subjects

In the normal brain, stimuli entering one hemisphere are rapidly communicated, by way of the corpus callosum, to the other so that our brain functions as a unit. We will see what happens when the corpus callosum is severed so that the two hemispheres cannot communicate.

In situation A the subject with the "split brain" is seated in front of a screen that hides his hands from view. His gaze is fixed at a spot on the center of the screen and the word "nut" is flashed very briefly (for one-tenth of a second) on the left side of the screen. Remember that this visual image goes to the right side of the brain which controls the left side of the body. With his left hand the subject can easily pick out the nut from a pile of objects hidden from view. But he cannot tell the experimenter what word flashed on the screen because language depends on the left hemisphere and the visual image "nut" was not transmitted to the left side. When questioned, the split-brain subject seems unaware of what his left hand is doing! Since the sensory input from the left hand goes to the right hemisphere, the left hemisphere receives no information about what the left hand is feeling or doing. All information is fed back to the right hemisphere which received the original visual input of the word "nut" (Sperry, 1970).

It is important that the word be flashed on the screen for no more than one-tenth of a second. If it remains longer the subject can move his eyes so that the word is also projected to the left hemisphere. If the split-brain subject can move his eyes freely, information goes to both cerebral hemispheres; this is one reason why the deficiencies caused by severing the corpus callosum are not readily apparent in a person's daily activities.

Further experiments support the idea that the split-brain subject is only aware of what is going on in his left hemisphere because it is that hemisphere alone that can communicate through language. Figure B shows another test situation. The word "hatband" is flashed on the screen so that "hat" goes to the right hemisphere and "band" to the left. When asked what word he saw the subject replies "band." When asked what kind of band he makes all sorts of guesses—"rubber band," "rock band," "band of robbers," etc., and only hits upon "hatband" by chance. Tests with other word combinations (such as keycase and suitcase), split so that half is projected to each hemisphere, show similar results. What is perceived by the right hemisphere does not transfer over to the left into the conscious awareness of the split-brain subject. With the corpus callosum severed, each hemisphere seems oblivious of the experiences of the other.

If a split-brain subject is blindfolded and a familiar object (such as a comb, toothbrush, or keycase) is placed in his left hand, he appears to know what it is. For example, he can demonstrate its use by appropriate gestures; but he cannot express this knowledge in speech. If asked what is going on while he is manipulating the object, he has no idea. This is true as long as any sensory input from the object to the left (talking) hemisphere is blocked. But if the subject's right hand inadvertently touches the object, or if it makes a characteristic sound (like the jingling of a keycase), then the speaking hemisphere immediately gives the right answer.

Although the right hemisphere cannot speak, it does have some linguistic capabilities. It recognized the meaning of the word "nut," as we saw in our first example, and it can write a little. In the experiment illustrated in Figure C the subject is first shown a list of common objects such as a cup, knife, book, and glass. This list is not flashed on the screen but is displayed for a long enough time so the words can be projected to both hemispheres. Next, the list is removed and one of the words, for example, "book," is flashed briefly on the left side of the screen so that it goes to the right hemisphere. If asked to write what he sees, the left hand of the split-brain subject will begin writing the word "book." If asked what his left hand has written, he has no idea and will guess at any of the words on the original list (cup). The subject knows he has written something, because he feels the writing movements through his body. But because there is no communication between the right hemisphere that saw and wrote the word and the left hemisphere that controls speech, the subject has no awareness of what he wrote (Nebes and Sperry, 1971).

From *Introduction to Psychology*, by Ernest R. Hilgard, Richard C. Atkinson and Rita L. Atkinson (Harcourt Brace Jovanovich, 1975), P. 52.

The Jewish Hospital Auxiliary has donated funds to refurbish select areas in the school of nursing. Furniture to be replaced was on sale at a discounted price for all employees. Proceeds will be used towards the nursing school's renovation.

The Tribute Fund

The Tribute Fund provides research funds and appliances for patients in need.

Donations to this fund may be made by sending checks payable to The Jewish Hospital Tribute Fund, 216 South Kingshighway, P. O. Box 14109, St. Louis, Missouri 63178.

When a tribute is made, both the sender and the recipient receive an acknowledgement of the donation.

The following memorial and honorial contributions were received from September 25, 1981 through November 27, 1981. Any contributions received after November 27, 1981 will be listed in the next 216.

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Donor — **In Memory of**

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Mr. and Mrs. Allen Lasky (Lisa Bry-James Dreyer Memorial Fund)

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Board of Directors Member Marge May (Mrs. Morton D.) talks with Joan Furlong and Sandra Copen (from left), members of the senior class of the Jewish Hospital School of Nursing. The senior class project this year was to sponsor an exhibit for Lifeline Donor Registry at the community-wide health fair held at South County Shopping Center. Lifeline, started by Mrs. May in 1976, is a not-for-profit organization involved in the registration and donation of organs and tissues for transplantation.

Calendar of Events

January 31	**School of Nursing Graduation:** Temple Israel, by invitation only.
February 2	**School of nursing open house:** Tour of school and hospital for those interested in a nursing career. 7 to 9 p.m., in the school residence. Open to the public.
February 7	**Parkinson's Education Program:** "Importance of Exercise" to the Parkinson's disease patient. 1 to 3 p.m., Steinberg Amphitheater, Jewish Hospital. Reservations required, call 454-7130.
February 8	**Preparation for Childbirth:** Five-week course begins for expectant parents in their sixth or seventh month of pregnancy. Reservations required, call 454-7520.
February 8	**Super Sibling Program:** For children ages 2½ to six and their parents, during the third trimester of pregnancy, to help the family adjust to the expected baby. 10 to 11:30 a.m., by reservation only. Call 454-7130.
February 11	**Mended Hearts:** Support group for persons needing or having had open heart surgery. Guest speaker and refreshments. 7:30 p.m., Brown Room, Jewish Hospital. Open to the public. For more information call 454-7176.
February 21	**Tour of the obstetrics department:** For expectant parents not attending childbirth classes. 1:45 p.m., Shoenberg lobby. For more information call 454-7520.
February 23	**Cesarean Birth Experience:** One session, for expectant parents. For reservations call 454-7520.
March 3	**School of nursing open house:** Tour of school and hospital for those interested in a nursing career. 7 to 9 p.m., in the school residence. Open to the public.
March 10	**Grandparents Refresher Course:** For expectant grandparents to learn the newest techniques and theories in infant care. 10 a.m. to noon. By reservation only, call 454-7130.
March 10	**Associates in Medicine Wine and Cheese Program:** Tentative topic, "Holistic Medicine," 7:30 p.m., Brown Room. Complimentary refreshments, reservations required, call 454-7239.
March 11	**Mended Hearts:** Support group for persons needing or having had open heart surgery. Guest speaker and refreshments. 7:30 p.m., Brown Room. Open to the public. For more information call 454-7176.
March 15	**Preparation for Childbirth:** Five-week course begins for expectant parents in their sixth or seventh month of pregnancy. Reservations required, call 454-7520.
March 17	**Jewish Hospital Auxiliary Educational Seminar Series III:** "Bone Diseases," guest speaker Steven L. Teitelbaum, M.D., 10 a.m. to noon. Auxiliary members only, by reservation. Call 454-7130.
March 21	**Tour of the obstetrics department:** For expectant parents not attending childbirth classes, 1:45 p.m., Shoenberg Lobby. For more information call 454-7520.
March 25	**Cesarean Birth Experience:** One session, for expectant parents. For reservations call 454-7520.

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Rehabilitation patient Georgia Kennedy cuts the cake at an auxiliary-sponsored reception for all rehabilitation patients, physicians, nurses and therapists. The event was held Nov. 30 in the Brown Room in commemoration of 1981 International Year of Disabled Persons. Phyllis Langsdorf (Mrs. Kenneth), auxiliary president, holds the cake, which was served with pastries baked by auxiliary members from recipes featured in the *Cooking in Clover* cookbook. Shirley Seele, administrative resident (behind Ms. Kennedy), helped coordinate the event.

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