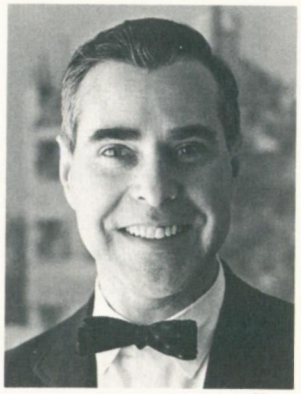
The Buffalo Physician

SUMMER 1970 ☐ VOLUME 4, NO. 2 ☐ SCHOOL OF MEDICINE ☐ STATE UNIVERSITY OF NEW YORK AT BUFFALO

Medical Alumni Officers



Dr. Anthone

Dr. Roland Anthone, clinical assistant professor of surgery at the University, is the new president of the Medical Alumni Association. He is a 1950 graduate of the Medical School. He is on the staff of the Buffalo General, Children's, and Veterans Administration Hospitals. Dr. Anthone succeeds his twin brother, Sidney.

He did his undergraduate work at Harvard College and his residency at the Buffalo General Hospital and Roswell Park Memorial Institute.

Dr. Anthone served 20 months in the armed forces during World War II. He and his wife have three children.

He has published some 20 articles for professional journals and is active in several local , state, and national medical associations.□

A 1954 Medical School graduate is the new vice president. He is Dr. Louis C. Cloutier, a general surgeon. He is president of the Emergency and Sisters of Charity Hospital staffs.

Dr. Cloutier received his bachelor's degree from Canisius College in 1950. After receiving his medical degree he took his internship and residency in general surgery at Sisters of Charity and Emergency Hospitals. Currently he is co-ordinator of the surgery-residency program at Sisters Hospital.

He is a member of the Buffalo Surgical Association, a Fellow of the American College of Surgeons, and a Diplomate of the American Board of Surgeons. Dr. Cloutier and his wife have five children.□

Dr. Cloutier

Dr. O'Brien

Dr. John J. O'Brien is the new secretary-treasurer. The 1941 Medical School graduate is a clinical assistant professor of medicine at the University and on the staff of the Buffalo General and South Buffalo Mercy Hospitals. He has been on the faculty since 1951.

He did his undergraduate work at Canisius College, his internship at the United States Naval Hospital, Philadelphia; and his residency at the Veteran's Administration Hospitals in Buffalo and Batavia. He was in military service from 1941-47.

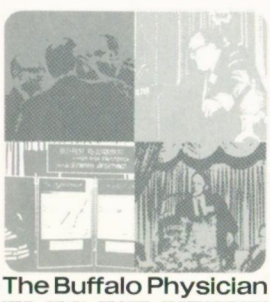
Dr. O'Brien is a past president of the Annual Participating Fund for Medical Education; and the Western New York Society of Internal Medicine; and a Fellow of the American College of Physicians. He is also active in several other professional organizations.□

SUMMER, 1970 Volume 4, Number 2

THE BUFFALO PHYSICIAN

Published by the School of Medicine, State University of New York at Buffalo

IN THIS ISSUE



The Buffalo Physician

The cover features the annual Spring Clinical Days, the biggest event of the year for the Medical Alumni Association. The story of this year's event is on pages 21-27. The pictures were taken by Hugo Unger and the cover was designed by Richard Macakanja.

THE BUFFALO PHYSICIAN, Summer, 1970 — Volume 4, Number 2, published quarterly Spring, Summer, Fall, Winter — by the School of Medicine, State University of New York at Buffalo, 3435 Main Street, Buffalo, New York 14214. Second class postage paid at Buffalo, New York. Please notify us of change of address.

New Health Care System

THE POPULATION EXPLOSION, Harrington Lecturer Dr. John H. Knowles repeatedly emphasized, is our most serious problem. Every other problem — including environmental pollution, better health care — pales when confronted by this explosive force. The general director of the prestigious Massachusetts General Hospital was bypassed as assistant secretary of health and scientific affairs, Health, Education and Welfare because of reported opposition by the American Medical Association. President Nixon named Dr. Roger O. Egeberg, dean of the University of Southern California Medical School, to the post.

Over 40 per cent of all funds earmarked for health services today are used to cover services to the aged 65 and over, he said. But what about the children in this country who have been disenfranchised? In New York City over 300 children are dying from heroin poisons. Each year in this country 400,000 illegitimate children receive no type of health service. "There is a population explosion," he repeated, "and 5½ million women of child-bearing age do not have family planning knowledge available to them. And they do want it. If you are really interested in health," the internist who is an outspoken critic of his profession implored, "you have to be interested in these subjects."

He predicted that one day the spiraling costs for hospital care may well rise to $1,000 per day. This, he pointed out, makes a national health insurance plan inevitable. "We are the last developed country in the world to reach this point. But we must first prove to the citizens in our country that we can structure such a health insurance plan." He pointed to the problem-ridden Medicare and Medicaid programs. Quality ambulatory facilities and low cost health benefits must be provided to our 45 million poor or "we may well have a revolution on our hands." While he feels that the role of government lies in the policy making and funding areas, the "ultimate responsibility for health care must be in the hands of the medical profession."

The over 300 health sciences student/and/faculty audience heard Dr. Knowles indict American medicine which does not operate in a free economic system. "When it comes to medical care, the consumer has only the most tenuous way of judging the quality of the product. He's not in a position to bargain or shop for medical services," he said.

The physician noted that competition in medical services is considered unethical but economists believe the medical industry has more of the characteristics of a monopoly than a competitive business. While he does not feel that government control is the answer, "our best defense is the offense of solving consumers' problems."

He feels that our new health care system will call for a new emphasis on health education and preventive medicine. The changes that he is seeking will first be realized in the minds of medical students. "Here is where the revolution in medicine will be, they will want to get out into the community to *prevent* rather than to *treat* disease."

This is a summary of what Dr. John H. Knowles said at a news conference February 13, and at the third annual Harrington Lecture at the School of Medicine.

Dr. Knowles chats with medical students prior to giving the annual Harrington Lecture.

Tomorrow's hospital, envisions the man who feels that physicians must assume greater responsibility for solving society's troubles, will be an institution which will "feed" satellite health centers located close to the poor in inner city communities. Such a center, he noted, has been established in Boston by the Massachusetts General Hospital to service poor whites. "The poor must be educated to their health rights, but once educated, we must be prepared to deliver."□

Medical Manpower Committee

The School of Medicine has named a special seven-man Committee on Medical Manpower. Chairman of the Committee is Dr. Edward J. Marine, executive associate dean and director of academic programs at the Medical School.

Serving with Dr. Marine will be Drs. Edward H. Wagner, M'65, clinical assistant instructor of medicine; James McDaniel, Jr., clinical associate of gynecology and obstetrics and assistant to the dean of medicine; Richard Carter, clinical assistant professor of social and preventive medicine; John Dower, professor of community pediatrics and associate professor of social and preventive medicine; David L. Davidson, assistant professor of psychiatry; Christopher D'Amanda, M'62, resident assistant professor of medicine and assistant to the Dean of Medicine.

Dr. Marine said the committee is charged with an evaluation of all current efforts in community medicine, ambulatory care and family practice. This includes an analysis of existing and planned facilities and resources in terms of their adaptability to a major new program in family practice and community medicine. The committee will develop specific proposals including facilities, faculty and curriculum in response to the new General Practice Act, passed by the New York State legislature March 25, 1969. The act states in part that medical schools that are a part of a state-operated institution be required to establish and maintain a department of general practice under the direction of a qualified general practitioner. The courses of study, a family care program, clinical experience, preceptorships, internships, and residencies will also be under the supervision of qualified general practitioners.□

The International Federation Meeting

by
Marc Leitner,
Class of 1972

Today the newspapers are filled with reports of the war in Vietnam, the Biafran Nigerian Conflict, and the smoldering hostilities in the Middle East. However, for us as medical students, the only war that should really exist is the fight against poverty and disease, a war with no geographic boundaries, and truly global in scope. The problem of good health care is one of the major concerns of the International Federation of Medical Student Associations (IFMSA). This organization, set up over 18 years ago, consists of national medical student associations of over 40 countries. As the delegate from the Society of International Medicine, I hereby submit my report of the 18th General Assembly of the International Federation of Medical Student Associations which took place in Jerusalem, Israel, August 18-31, 1969.

THE OPENING CEREMONIES included many Israeli dignitaries, the director of the Ministry of Health, the deans of Israel's two medical schools, and representatives from 19 countries.

The two-week conference schedule devoted the first week to reports and discussions from various working committees followed by plenary sessions of the General Assembly which dealt with resolutions formulated in the working committees.

For 18 years, the most successful activity of IFMSA has been its international medical student exchange program whereby over 5,000 medical students annually enjoy international clerkships. But many delegates, including myself, questioned whether this program was sufficient justification for an international organization's existence. Was IFMSA willing to relegate itself to a position of just being an international student travel bureau or could it serve a more useful role?

Basically the discussions centered around the very fundamental question: "What are the medical student's responsibilities and in what way can IFMSA function to fulfill these tasks?"

Two general conflicting philosophies were expressed. One, advocated by the European Common Market countries and expressed by the Italian delegate (other Common Market countries were boycotting the conference) was that political, social, and economic factors that operate in a country are very important in the pathogenesis of disease. There must therefore be changes in these areas if there is going to be any meaningful resolution to health problems. The opposing view, expressed by delegates from Canada, Czechoslovakia, and Ghana, was that IFMSA is strictly an a-political organization dealing only with medical and health problems and should not become involved in anything "political."

Thus, the European Common Market countries oppose IFMSA sending books, drugs, or supplies to a clinic in a developing country because this would only treat the symptoms of a disease and not try to eradicate the underlying cause of the problem.

This conflict over whether IFMSA should become "political" was a frequent source of controversy and the subject of many discussions throughout the entire conference.

SCOH (Standing Committee on Health)

In the past IFMSA has had some very successful projects through the efforts of a few individual countries. Due to lack of interest on the part of its members, such IFMSA programs as the international book and drug appeal were completely ineffective during the past year.

The major committee activity was to set general guidelines and work procedures for MESTUDEC projects (Medical Students to Developing Countries). In my opinion, these projects can become one of the most important activities of IFMSA and serve concretely toward the realization of its goal of solving health problems, especially in the developing countries where they are the most severe. The idea is to have teams of senior medical students going into the "bush" areas of developing countries to set up badly-needed health clinics. By several countries cooperating on the project, clinics could function continuously by staffing them on a rotational basis.

The South African Medical Student Association has already started such a project by sending teams of six students into the surrounding countries of Botswanna and Malawi.

Other countries' programs and their needs follow:

. . . *International Drug Appeal*—Denmark and the United Kingdom heavily contributed drugs which were distributed to World University Service clinics in Sudan, Ceylon, Indonesia, and Honduras.

. . . *Textbook Drive*—A severe need of medical textbooks exists in developing countries, especially Africa. On his trip to Africa, the President of IFMSA reported that the Congo desperately needed French medical textbooks. Sweden ran a successful book appeal for the benefit of Afghanistan.

. . . *Medical Student Involvement*—Canada sent 70 medical students to Jamaica during a three-week period over the summer. The MESTUDEC project for Denmark involved 4-6 students who spent six months in Indian leprosy hospitals.

Because of the closing of their medical school as a result of guerilla fighting, medical students in Laos expressed a desire to continue their training in French-speaking countries.

The only specific health problem discussed was one that I introduced—severe health problems created by the Nigerian Biafran Civil War. I stated that if IFMSA was truly sincere in its objectives to combat health problems and disease, it could not remain silent or inactive in light of the overwhelming human suffering.

Initially there was much opposition to IFMSA involvement in a political situation. But after considerable discussion, the following resolution was accepted:

> Whereas enormous health and medical problems of malnutrition, disease, and starvation exist as a result of the Nigerian-Biafran conflict; we hereby propose that IFMSA/SCOH issue an appeal to its member associations requesting them to organize a campaign to contribute to the existing relief efforts to both sides of the conflict in whatever way each association is capable.
>
> A report of each member association's activity in this area should be sent to the Director of SCOH and the information should be forwarded to SCOP and included in the IFMSA Newsletter.
>
> The Nigerian medical student association, in consistency with the Amsterdam Resolution 29, be requested for its approval before relief is sent to the Nigerian side of the conflict.

SCOME (Standing Committee on Medical Education)

The director of SCOME criticized delegates for paucity of news and information to IFMSA. Consequently they were unable to print the Medical Education Newsletter or complete its booklet on core curriculum.

The committee organized an excellent symposia on Medical Ethics, emphasizing Human Organ Transplantation, at the Hadassah Medical School. A panel of Israeli transplantation experts—internists, surgeons, and psychiatrists—were featured. It was interesting exchanging views with delegates from different parts of

Mr. Leitner

the world on such problems as: "Should human life be preserved at all times, especially in circumstances dealing with cardiac resuscitation?" In my opinion this was perhaps the most meaningful discussion of the entire conference.

Virtually all of the delegates attending the General Assembly felt that to be really meaningful IFMSA has to be more than just a clearing house for exchange of medical students. The major problem is how IFMSA can serve as a voice and act as a force to help medical students meet their responsibilities throughout the world. The answer, a very difficult one, evidenced by the philosophical split between countries who want IFMSA to become more active in the political, social, and economic realm, and those who favor activism on purely medical matters. Its future depends on a compromise between the two camps. I feel that by its very nature, the international body of IFMSA has certain political connotations and cannot operate in a vacuum. It will therefore be influenced by political reality and at certain times must do what it deems necessary despite political consequences. Examples of IFMSA acting as a force in the world community: a letter sent by a past president to the South African government supporting the South African Medical Students Association's efforts to have equal pay scales for all African doctors; efforts by one of its past presidents to free two Spanish medical students arrested for protesting against the Franco government from jail.

Perhaps its entire structure, as it is now constituted, is inappropriate for a truly active international organization. At the grass roots level, the individual medical student is bypassed and does not become involved. This results in apathy by member countries.

The actions of the General Assembly reflect those of an organization in crisis. Rather than elect a new president, an interim director, Geoffrey Lloyd of the United Kingdom, served until the special winter General Assembly was held in Chur, Switzerland. This meeting was open to all countries and all organizations interested in international health to analyze and evaluate the present crisis of IFMSA and to make the necessary changes so as to produce a dynamic international medical student association.

Among the benefits derived from my trip, aside from my fantastic personal experiences of meeting medical students from all over the world and traveling to Israel:

—Availability to the Medical School's registrar's office of valuable information on international summer clerkships, and the procedure of student exchange through IFMSA, as well as addresses of medical students in 20 different countries.

—Valuable information based on other delegates' experiences in setting up MESTUDEC Projects (Medical Students to Developing Countries). We are investigating the possibility of sending a Buffalo medical student team to a developing country such as Paraguay.

—The Society of International Medicine's participation in the relief effort to Biafra has been continued by successfully involving IFMSA in the problem.□

Health Care Changes

CHANGE IS ESSENTIAL in today's system for delivery of health care, a Princeton political scientist said to the pediatrics faculty at Children's Hospital recently. But Dr. Herman M. Somers feels that it is still too early for a compulsory national health plan. "If you pour additional resources into our present system, a bad one as it now stands, you will freeze it." The only pressure for changing any system, he pointed out, is financial strain.

But how do you best reorganize a system in need of a great deal of reform? More experimenting, the Princeton professor of politics and public affairs feels, is the answer. "We need to know more, to demonstrate projects that will work, so that we are sure that we are financing the right thing."

An advisor to the Department of Health, Education and Welfare on both medicare and medicaid, Dr. Somers has served on four presidential commissions and task forces concerned with health problems. He was the second lecturer in the Pediatrics Department's Experiment in Medical Education, a program now in its second year to acquaint both medical students and young physicians with important areas outside of their traditional studies in medicine.

Medicredit, a plan proposed by the American Medical Association, is a way of getting universal financing without making any changes in the health system. "In this plan," he explained, "everyone makes something on it. The government subsidizes insurance premiums paid by the taxpayer to an insurance company of his choice through a system of tax credits. While the poor receive a rebate of 100 percent or equivalent credit, the highest income group also receives a tax credit in the amount of 25 percent." The AMA, he feels, will fight for its plan but it probably will not win. But if it does succeed in holding back other reform, there will probably be a violent reaction. The need for change is so great that he cautioned we may not be able to negotiate.

Many qualities of medical care can be improved, he feels. As a result of the great success of the Kaiser Plan, a managerial masterpiece resulting in a string of hospitals located on the West Coast that offer complete health care to its subscribers, a group of prestigious physicians organized the San Joaquin Valley Plan, their defense mechanism in answer to the Kaiser Plan.

In the licensing of physicians, Dr. Somers said that a periodic reevaluation of medical competence by peers will lead to better health care. But why hasn't group practice grown? Is money really the restrictive factor? No, he says, *joint* patient responsibility is the real test.

Physicians, both individually and collectively, wield a tremendous amount of political influence in the field of medical care. While new arrangements are needed, they continue to offer great resistance to change. New problems that deal with both organization and management face the physician who was attracted to medicine because he did not want to become a businessman. Only society in trouble is receptive to change, he concluded, but it is difficult to attract an environment of change when the affluent outnumber the poor.□

Drs. Somers, Mitchel I. Rubin, Program Coordinator.

Water Pollution

WATER POLLUTION is a byproduct of any technological society and is here to stay says Dr. Edward Massaro, a young University biochemist, who is studying the effects of water pollution on the growth and development of fishes and fish populations. "What we must do is to learn how to live with it, to limit it to levels that are compatible with our health and economic well being."

Can we do this? "Well, we can't wait for organisms to evolve and thereby 'fit' into new environments. One way to attack this problem may be biologically, that is, to understand the physiological limits of adaptation of aquatic organisms and to restart its biological cycle in polluted waters with organisms that can survive and reproduce in less than ideal conditions." The assistant professor feels that this may be the only way we can hope to control this major national problem.

"We cannot ask an industry that is employing large numbers of people to leave a city and thus end up with major unemployment and associated problems. Even if industry treats its chemical wastes to its economic limit, it may not be able to keep from polluting water to a level that is deadly to organisms living in the water. But if we can maintain pollution at low levels, find organisms that can survive in polluted environments and introduce them into these waters, we will have gone a long way toward solving the problem of pollution," Dr. Massaro said.

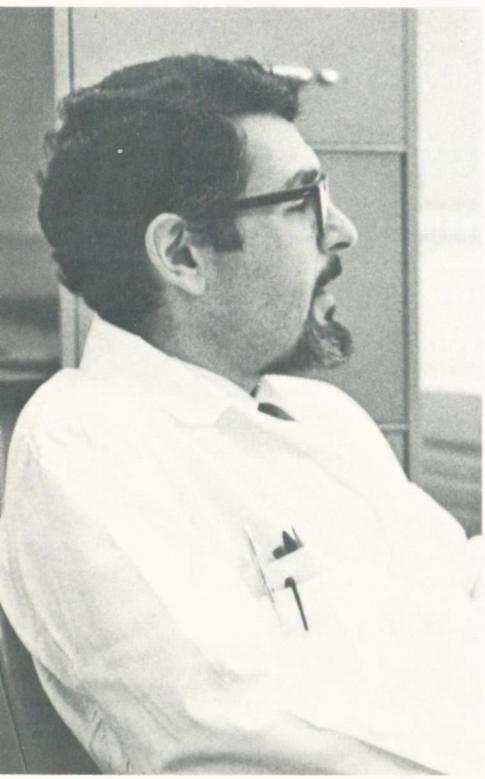
Through a major research effort, the University of Texas graduate feels that it is feasible to look for organisms that may be able to thrive in polluted environments. "Our approach to the water pollution problem is to study the biochemistry and physiology of adaptation in fishes. But an understanding of biological adaptation in general will be necessary to control environmental pollution intelligently." However, he cautioned that this will mean a national expenditure of billions for research; a major commitment by the Federal government, private industry, and individuals as well.

Bodies of water that are now relatively clean probably will become badly polluted. And there are no existing techniques known today that warn us of incipient water pollution. "We need to solve very fundamental questions. For example, how do we detect a change in the environment of a lake before it is too late? A biological probe, such as an alteration in the biochemical makeup of a particular fish species, may be able to tell us when the change — due to some alteration in the quality of the water — is taking place." But he pointed out that we now know too little to make this possible.

Pollutionwise, Lake Erie is in very bad shape. If we can find answers to our questions, we may be able to save the lake. But we must start to do something immediately. If not, Dr. Massaro feels that we would do better to fill it in and erect on it a housing development. In another 20 years it may be one big bog.

Why doesn't the University establish a first-rate department of environmental sciences to attack the pollution problems of lakes and New York State in general?

Dr. Massaro



Industry is not the only polluter of water. It may be caused by the runoffs of agricultural fertilizers and pesticides so necessary to make certain areas inhabitable, or to offshore oil drilling (Santa Barbara and the Gulf Coast) which should be stopped. Certain shell fishes that reside at the mouth of the Connecticut River are now accumulating radioactive materials emitted from a nearby atomic power station, and numerous shellfish beds now harbor hepatitus virus.

Our adjacent oceans are being fished to death by Russia, Scandinavia, and Japan while the United States "zealously" guards only its three-mile off-shore limits. Pollution of our fresh water systems continuously pollutes our continental shelfs. Eventually, at the present rate, we will destroy our ocean's capacity to supply the world's increasing population with sufficient food.

"Nothing is going to take care of itself," Dr. Massaro concluded. "We have got to make a major commitment to solve the pollution problems ourselves."□

Alumni Reception in New York

A total of 41 alumni and faculty and their wives participated in the annual Medical Society of New York Convention and reception February 9 at the Americana Hotel, New York City. Mr. David M. Krajewski, Director of Medical Alumni Affairs, hosted the informal reception.

In attendance were: Doctors Guy S. Alfano, M'50; J. Edwin Alford, M'34; Marvin L. Amdur, M'36; Harry Bergman, M'34; Paul K. Birtch, M'43; Vincent I. Bonafede, M'30; J. C. Brady, M'16; Thomas S. Bumbalo, M'31; Joseph Campo, M'54, and Mrs. Campo; Max Cheplove, M'26, and Mrs. Cheplove; Louis C. Cloutier, M'54; George L. Collins, Jr., M'48; John Constantine, M'34; Thomas S. Cotton, M'39; Kenneth Eckhert, M'35, and Mrs. Eckhert; Donald Ehrenreich, M'53, and Mrs. Ehrenreich; Daniel Fisher, M'24; Soll Goodman, M'37; Bernhardt Gottlieb, M'21; Donald Hall, M'41 and Mrs. Hall.

Also — Doctors Theodore C. Jewett, Jr., M'45; Herbert E. Joyce, M'45; Kenneth A. Kelly, M'50; Hans Kipping, M'47; Robert Kohn, assistant clinical professor of medicine, and Mrs. Kohn; L. Maxwell Lockie, M'29; William Major, M'44; Walter T. Murphy, M'30; Bernard M. Norcross, M'38; James Nunn, M'55, and Mrs. Nunn; James F. Phillips, M'47; Edward C. Rozek, M'41; Sidney M. Schaer, M'44; S. Mouchly Small, Professor and Chairman, Department of Psychiatry; William J. Staubitz, M'42; Clarence A. Straubinger, M'38; Wayne Templer, M'45, and Mrs. Templer; Joseph C. Tutton, M'63; Walter Scott Walls, M'31; David H. Weintraub, M'37; Carlton Wertz, M'15.

Mr. Krajewski will host a medical alumni reception during the AMA Convention at the Palmer House in Chicago June 22 at 6 p.m.□

Effects of Carbon Monoxide

A BUFFALO PHYSIOLOGIST is one of nine contributors to a pioneering work on the effects to man of carbon monoxide, one of our major environmental pollutants. He is Dr. Leon Farhi, professor of physiology at the University, who was invited by the division of medical sciences of the National Research Council to join a cooperative national effort to assess information known about carbon monoxide and to recommend further research that may provide some of the answers to those responsible for the development of a sensible and workable solution to environmental problems.

Said Dr. Farhi, "Our cooperative study revealed that there is no level of carbon monoxide in our environment that is known to be without effect. It is therefore important that we minimize our exposure to this pollutant."

Each contributor to the recently published report worked on a specific aspect of the effect of low levels of carbon monoxide found on city streets and in traffic tunnels. They evaluated new psychologic and physiologic tests to assess the effects and attempted to balance the factors of optimal health to those of economic well being. While too high a level of carbon monoxide is harmful to the health of some, limiting carbon monoxide production too severely may hurt the economy, Dr. Farhi said. With a carbon monoxide-free atmosphere therefore an impossibility, the question we want to answer is "what is a tolerable atmosphere?" With this in mind, Dr. Farhi, in collaboration with Dr. Solbert Permutt of Johns Hopkins University, reported on tissue hypoxia and carbon monoxide.

Dr. Farhi

What is the basic reaction of carbon monoxide to man? Its importance, the report points out, lies in its ability to combine with hemoglobin, the oxygen-carrying pigment of blood. When it combines to form carboxyhemoglobin, it can no longer carry out this function. This reaction however is reversible when exposure to carbon monoxide is reduced and, in time, the hemoglobin will once again be free to carry oxygen from the lungs to the body tissues.

Attention has switched from studying carbon monoxide's acute effects during short-term exposure to its lasting effects during long-term exposure. In the early 1900's its sources were either from coal-burning heating devices or leaking illuminating gas fixtures. It was found that a healthy person could survive from its acute effects with moderately high levels (from 20-40 percent) of blood carboxyhemoglobin for as little as a minute to as long as a week. But today, with cigarette smoke and the internal combustion engine as the two main sources of carbon monoxide, its long-term effect may last anywhere from a month to a lifetime and produce as little as 0.5 percent of blood carboxyhemoglobin. While this appears to be a trivial amount, research shows that there is a decrease in mental performance on breathing low levels of carbon monoxide.

Also being looked at carefully is the circulatory system; recent studies of the effects of long-term, low-level exposure to carbon monoxide suggest circulatory effects. Further studies may prove even more important for those whose functioning has already

been affected by disease or aging. Preliminary studies on deaths from heart attacks raise the possibility that part of the increase in deaths associated with cigarette smoking may be caused by the carbon monoxide content of tobacco smoke.

The report on *Effects of Chronic Exposure to Low Levels of Carbon Monoxide on Human Health, Behavior, and Performance,* published by the National Academy of Sciences and the National Academy of Engineering, raises questions with important implications. Further research is needed to find the answers.□

Eye Bank Anniversary

A 1927 Medical School graduate has been president of the Buffalo Eye Bank for the last 12 years. He is Dr. Milton A. Palmer. The Eye Bank is celebrating its 25th anniversary this year.

Dr. Charles H. Addington, clinical assistant professor of surgery (ophthalmology), heads the medical advisory committee. Since its founding the Eye Bank has received 5,400 eyes, and there has been 2,700 sight restorations through corneal transplants. The other eyes are used for study and research by physicians and medical schools.

The Lions International Clubs of Western New York and northwest Pennsylvania support the Buffalo Eye Bank through legacies and memorial gifts. These come from people in all walks of life. Police and sheriffs' departments assist in the speedy delivery of eyes to the Buffalo Eye Bank.

A library on ophthalmology and eye surgery was given to the Medical School by the Eye Bank. Ophthalmologists from India, Brazil, Tasmania, and several other countries have sought guidance from the Buffalo Eye Bank.

Twenty-five years ago a patient requiring a corneal transplant had to go to New York, Baltimore, or Boston. Today eight local ophthalmologists transplant corneas in Buffalo hospitals.□

Dr. O'Connor Returns From Vietnam

"Service in Vietnam was the most broadening experience of my life." That is what Dr. Thomas P. O'Connor said about his stint in Southeast Asia. He is a 1967 Medical School graduate, who is one of three physicians on the Entrance and Examining Section of the Buffalo Induction Center.

"In Vietnam I spent eight months in the highlands among the primitive Montagnards. These people live in thatched huts on stilts. Underneath the hut the owner keeps his water buffalo or cow." It was here that Captain O'Connor and his staff provided medical aid for the seriously ill or injured Montagnards as well as our fighting men. During his last four months in Vietnam he conducted a dispensary in Saigon.

Although convinced that sooner or later, we must disengage our armed forces from Vietnam, he said, "it will be very difficult to leave nearly 17 million people to the unscrupulous North Vietnamese and Vietcong who are determined to impose, savagely, their rule upon the South Vietnamese."

After his two-year term in the service Dr. O'Connor takes his residency at the Buffalo General Hospital, where he interned.□

The University as a Care Deliverer

by
Dr. Peter F. Regan
and
Dr. S. Mouchly Small

The university has long recognized its obligation to pursue the health sciences as scholarly disciplines and to train health care professionals. But to what extent should the university serve as a deliverer of health care services? Aspects of this question are considered in the following paper co-authored by S. Mouchly Small, M.D., professor and chairman of the Department of Psychiatry (School of Medicine) at the University, and Peter F. Regan, M.D., professor of psychiatry and the University's acting president. The address was originally presented November 21, 1969, before a meeting of the New York State unit of the American Psychiatric Association.

American universities have traditionally emphasized teaching and research as their primary commitments with service as an integral but secondary aspect of their mission. In the past, many functioned as enclaves or sanctuaries where scholars congregated, often in splendid isolation from the world about them, to pursue the classical tasks of storing, creating and transmitting knowledge. Today, universities have been swept into the maelstrom of revolutionary, scientific and technological changes and have become intimately involved in and part of the new social order. There are ever-increasing calls from the public and government for the universities to engage in applied research, to effectively communicate their knowledge and follow it through to the operational level to insure its optimum utilization.

Health services are now considered a human right rather than a privilege by all segments of our society. Medical professionals are no longer sacrosanct and beyond criticism. Scientific spectaculars, such as organ transplantation, continue to evoke exclamatory approval, but it is short-lived as individuals are repetitiously faced with poignant and proximate experiences with pain, illness, disability and death. As the people become more aware of our deficiencies in knowledge and the lack of an effective system of health care delivery, their mounting concern will become increasingly manifest in social and political pressures for improved services.

The role of the university in care delivery poses innumerable troubling and provocative questions. It is clear that the universities and medical schools in our country do have a major responsibility in this area. Yet there are a host of questions asked by sincere and dedicated physicians and administrators concerning the propriety, extent, balance and capability of universities in their commitment to service, teaching and research. Many become almost paralyzed by the enormity of the problem, searching frantically for guidelines and rapid solutions in this *terra incognita.* It is the basic argument of this presentation that the territory of care delivery is not unknown to universities and that relatively clear guidelines do exist.

The Role of the University in Society

As a first step let us review the role of the university in society. On this issue, the essential fact to recognize is that the university's role does not emerge from *within* the academic community; instead it is determined from *without.* Society determines what its needs are and creates institutions to deal with them. It is society which rewards and punishes these institutions according to how well they satisfy its needs. Society provides each of its institutions with resources and responsibilities and expects them to respond dynamically to the changes that engulf our entire body politic. Thus, the universities do not determine their mission in isolation but are, in fact, responsive to the organized communities in which they exist.

In historical perspective, society seems constantly to call upon the universities to satisfy three basic needs: the need for a repository of knowledge at the most advanced levels, in a broad variety of disciplines; the need for an adequate number of citizens educated at this advanced level, and prepared to work in society as intellectual leaders, scholars, or professional practitioners; and the need for keeping the most advanced knowledge and the education of citizens geared to the changing configurations of the society.

Thus, through the centuries, we can see the trends emerge. In the early years of this millennium, the thrust of universities was focused on the production of professional people well prepared to serve the kingly elite. As special needs developed, special additions were made to the universities; one college at Oxford, for example, was founded in order to guarantee an adequate supply of clergymen for Wales.

As the centuries advanced and population grew, a wider leadership was necessary, and universities added a pattern of general education, which would qualify the gentlemen not engaged in professions to serve in more general leadership roles in society. Over the last three centuries, in the face of interacting industrial and scientific revolutions, more and more fields of knowledge were added to disciplines encompassed by universities, until now every major university embraces more than a hundred disciplines and professions. Finally, the societal changes of the last hundred years have led society to demand that larger and larger proportions of its citizens should have the benefit of the most advanced education in the form of specific public programs.

In the United States this change was signalled by the establishment of the land grant colleges in 1862. As pointed out by Don Price, from those colleges grew the experiment station, the extension program and a whole interlocking system of institutions which led to the federal government playing a more effective role in the agricultural economy than the bureaucracy of any supposedly socialized state. Today, universities, as responsive organisms trying to satisfy the ever-changing needs of the society which established and which nurtures them, are being called upon for greater and universal participation in higher education and public health programs among others.

Within this panoramic view, one can see that nations and societies display differences in their expectations from universities with changes in emphasis reflecting public values, needs and demands. With respect to research in the United States, for example, society appears to expect that most basic research will be done within universities but turns to other institutions for the bulk of its applied research needs. Thus the effective transmission of basic research findings to benefit the lives of our citizens depends upon the existence of institutions geared to applied research. This is particularly germane to our discussion of health care. It is this key linkage —applied research on health care—which now confronts American society and American universities with their dilemma.

The remarkable advances in medicine ranging from antibiotics and new vaccines to organ transplants are of limited value unless we can get these wonders to the people. How is this to be accomplished? The bitter truth is that we do not know and that we have no adequate present means for guaranteeing that our citizens will receive the best health care available to them. In fact, the evidence leads to the conclusion that the availability of the highest quality of health care is actually becoming more remote. Life expectancy in the United States is less than that in a dozen other industrialized countries. Natal and neonatal mortality rates in many areas of our country are unconscionably high. Whole communities in our rural areas are without ready access to physicians and hospitals.

Analysis of Related Problems

A recent article by John W. Gardner (*Reader's Digest,* September, 1969), the former Secretary of Health, Education, and Welfare, cites the need to redesign our society with institutions capable of continuous change, renewal and responsiveness. We have plenty of debaters, blamers, provocateurs and glory-seekers, but we do not have enough problem-solvers. As part of our effort to do so let us define some of the pertinent facts and central issues related to the university's responsibilities as a care deliverer. Outstanding among these problems are the role of poverty as a pathogenic influence, the lack and maldistribution of professional manpower, the underrepresentation of disadvantaged minority groups within the professional pool and in our health educational institutions, and the delivery of care to those who are not being served because of our lack of a comprehensive approach.

Pathogenic Influence of Poverty

Unusually high rates of illness, disability and mortality are commonly found among those in the poverty group. Of various parameters that one could study, inadequate family income correlates most highly with other common factors which contribute to prolonged maladaptation, excessive morbidity and decreased life expectancy. The poor are plagued with sub-standard housing in high population density areas and show low utilization of preventive care either through lack of knowledge, poorly accessible health facilities or a lack of motivation. Poor families have three times more disabling heart disease, five times more mental disorders, and seven times more visual impairment than the general population. (Reference 1: Policies Statements of the Governing Council of the American Public Health Association adopted November 13, 1968, published in the *American Journal of Public Health,* Vol. 59, 158, January, 1969). Even more appalling

Dr. Regan

is the fact that as many as 60 percent of the population eligible for public assistance does not receive payments. It is apparent that despite great advances in the biomedical sciences, unless we deal with the concomitant socio-economic aspects of health and illness, the meaningful application and utilization of this information with those in greatest need will fail.

Poverty in our affluent society is by no means a rarity. A Census Bureau report issued August 19th of this year, classifies 25.4 million persons in the United States as poor in 1968. One-third of the Nation's Negroes are classed as poor. Quantitatively there are more poor white families, but the blacks and other non-whites suffer the highest prevalence of poverty. Although these figures suggest an improvement, the enormity of the problem is still quite apparent (*The New York Times,* Wednesday, August 20, 1969).

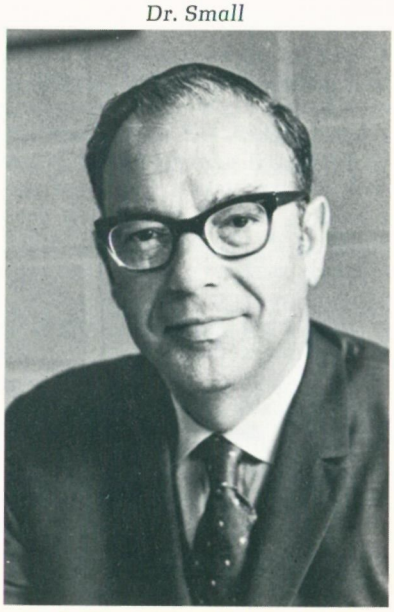
Professional Manpower

It has been estimated that one out of every 20 individuals employed in the labor force is engaged in the health-care industry. Health manpower literally comprises well over 100 different types of careers totalling approximately 4 million persons. Of these, fewer than 300,000 are practicing physicians. The need for more medically trained professionals has been repeatedly asserted in various reports, attested to by numerous unfilled academic and service positions and reaffirmed by our continuing to import many more physicians from other countries than we export. The numerous accusations leveled at the United States epitomized in the phrase "Brain Drain" suggest that our debtor status extends across the board to include experts in many different fields.

Criticism of university medical centers extends beyond the quantitative lack of medical professionals to include lack of sufficient general practitioners or family physicians and maldistribution of those who have completed their medical education. Physicians tend to cluster in the larger population centers where modern facilities and equipment are accessible and where consultations in all specialties are readily available.

It is stated that in six years (1975) we will need an increase of a million persons over those now working in all health professions. (Francis Keppel, National Responsibility for Health Manpower. Proceedings of the Conference on Job Development and Training for Workers in Health Sciences, 1966, p. 11. S. S. Steinberg, E. O. Shatz and J. R. Fishman, New Careers: A Major Solution to the Environmental Health Problem, *American Journal of Public Health,* 59, 1118, July, 1969). With the increasing complexity of medical practice the number of allied health workers per physician will continue to show an upward trend. Thus, it is likely that shortages will continue to exist in medicine *and* in the allied health professions as well.

Dr. Small



There is substantial agreement on the fact that this problem of health care manpower cannot be resolved simply by playing the numbers game. The bitter reality is the fact that we are presently educating fewer people in the health professions than we need to maintain in the present inadequate system, *e.g.,* only 8,000 of the needed 10,000 physicians to maintain our present level of relationship between physicians and population are graduated each year, with the balance being recruited from other countries. Even were it possible to double the size of the present system in less than 20 years, thereby increasing the cost from the present level of more than six per cent of the gross national product to a level greater than 12 per cent of the gross national product, there is no guarantee whatsoever that such a size increase would actually achieve the goal of bringing health care to each individual.

First to perform heart surgery in Buffalo, Dr. John R. Paine (left), received the Roswell Park Medal of the Buffalo Surgical Society from the society president, Dr. Charles E. Wiles, M'45, (right). Dr. Joseph T. Andrews (center), past president, formally presented Dr. Paine at the dinner meeting. He was the 22nd Buffalo surgeon to receive the honor. Dr. Paine retired last year as chairman of the department of surgery at the Medical School. He is now living at Jekyll Island, Georgia. □

Disadvantaged Minority Groups

The difficulty in communicating in a meaningful way with disadvantaged minority groups has received increasing recognition. Suspicion and distrust bred by many years of discriminatory treatment by the "white establishment" has compounded the difficulty. A greater representation of members of minority groups in the medical and allied professions would help immeasurably in opening channels of communication.

An approach which has the advantage of broadening the base of allied health workers, increasing the efficient use of the most highly trained professionals and utilizing minority group members in substantial numbers is the development of programs for the training and employment of local residents in community health service programs. These persons have been referred to as indigenous non-professionals and have proven to be effective bridges with the people heretofore not receiving health services. In psychiatry new careers such as mental health worker or technician coupled with "career ladders" programs both for the new and well established professions will hopefully help to minimize manpower shortages and provide improved contact with the underprivileged.

Evaluation of University's Performance

Given this situation, what are the universities to do? To answer these questions we can best begin by attempting to evaluate how well the universities and their professional schools are meeting society's expectations in the field of health.

■ In terms of maintaining an awareness of the most definitive information about health, they are performing their mission. Information about health care delivery systems, however, is inadequate.

■ In terms of generating a sufficient number of educated people capable of satisfying society's needs for professional personnel, we are doing a commendable but inadequate job. In the medical area alone, we are satisfying only 80 percent of the need, and those who graduate have inadequate preparation and knowledge in the area of health care delivery.

■ With respect to adapting to the changing needs of society, there is little evidence outside schools and departments of public health and departments of psychiatry of concern with methods for coping with the disease as it exists in patients, each one experiencing his illness in a characteristically unique way, nor the treatment of patients as they exist in society. The admissions criteria of university hospitals are phrased in many ways, but they might generally be expressed more bluntly: "Bring us the right disease, and we will give you the best treatment available. If you don't have the right disease, don't call us; we'll call you."

Without in any way minimizing the difficulty of changing this system, what needs to be done is to transform a considerable portion of the clinical care now being provided under the aegis of our universities from an exclusive orientation on disease and basic scientific research, to a balanced orientation designed to study and teach improved methods of health care delivery for all the people in a given area. An appropriate segment of the clinical care conducted by universities can and should be redesigned to provide health care services to the poor and the minorities in facilities which are accessible, acceptable and utilized by them. It takes extraordinary mental gymnastics to justify not doing so from an educational point of view, for how can we expect the students who have never had the learning experience of working in a good health care delivery system to engage in an appropriate practitioner's role?

Models for Transforming the Provision of Health Care Within the University Setting

It is our contention that universities should in fact engage in the applied research necessary for developing better health care delivery systems.

At the conceptual level, one may recognize that a university or group of universities should create those clinical programs which satisfy a number of educational criteria. These are of two types: professional and social.

The clinical programs operated under the aegis of universities may run under several different kinds of patterns. At one extreme, the clinical programs may be funded by university resources, and operated in university-owned facilities, with total university staffing. At the other end of the spectrum, the programs may operate in a wide variety of affiliated agencies (including health departments and voluntary hospitals) where major funding, the provision of facilities, and the provision of basic personnel for the clinical program are the responsibility of the sponsoring agency. At any point on this spectrum, it is clear that the university's role derives primarily from its educational mission. In almost every situation, it is equally clear that the university can assume a potent leadership role; certainly, it does so *de facto* in a university-owned facility, and can assume similar leadership within the terms of most affiliation agreements.

In those pages which follow, an attempt was made to establish those guiding principles which might be used by universities, as they carry on their educational activities in clinical settings. For purposes of simplification, it is assumed that these principles will be similar, irrespective of the detailed sponsorship of the agency in which the education takes place.

In such a context the clinical programs operated under the aegis of a university should reflect the highest standards in the following areas:

1. All patients who enter the clinical programs conducted by a university should receive the highest quality of individual medical care now available. This is a standard now adhered to by all university-conducted programs. And enlarging its scope from a disease orientation to include a social orientation should in no way diminish this level of excellence. Especially in psychiatry, we must be cognizant of both intrapsychic conflicts and those resulting from the interaction between the individual and society, differentiating psychopathology and social pathology.

2. The clinical programs conducted by a university should reflect the contributions that a variety of professional people must make, if care is to be provided to all of our citizens. Thus, there should be a planned teaching and research program concerned with the assignment of responsibilities and authority to various members of the patient care team. At this moment in time, the physician works with an average of 20 other people on such a team, and these may be drawn from more than 100 professions and skills. New methods for interlocking the efforts of this team must be a hallmark of the clinical programs conducted by universities, if the future professionals are to achieve that multiplication of effectiveness necessary to meet the health care needs of the nation.

3. It seems apparent that a clinical program operated under university auspices should reflect a system of regional or sub-regional coordination. A store-front health information center or core area clinic, for example, would constitute a heartless deception if it was not linked to other facilities which could provide comprehensive and specialized services of all kinds. Similarly, an ivory tower citadel is a deception if it is not linked to satellite operations extending through several levels of sophistication, with its roots firmly planted in community health centers located in the neighborhoods in which patients live. The specifics of how best to organize a broad pattern of care delivery which encompasses prevention, ambulatory patients, partial and 24-hour hospitalization, rehabilitation, extended care facilities and home care, requires the kind of experimentation which universities can readily undertake.

4. A university operated clinical program will necessarily involve active participation in the decision-making processes by the community in which it operates. At this point, we should take note of a strange dichotomy which exists in modern society, which can recognize that the faculty of a university can appropriately deal with the board of trustees of a major metropolitan affiliated hospital, but has difficulty in giving more than titular "advisory" responsibility to the representatives of a community in which a so-called "community" health center is established. As the clinical programs of universities extend into operations within the community, ways must be devised in which the people in the neighborhoods and towns which are served have a legitimate and permanent role in the decision-making processes which can affect their lives and the lives of their families and neighbors.

5. The clinical programs operated by universities should be geared to the reality of the nation and the world. While it is self-evident that additional costs and supplementary manpower must be associated with educational clinical programs, in order that appropriate teaching and research can be conducted within those programs, the hard core essence of the programs must be replicable. The core clinical program must be designed and operated in such a fashion that similar programs can be replicated outside of university auspices, without bankrupting the financial or human resources of the nation.

6. If the clinical programs operated by universities are to avoid moving rapidly back to a preoccupation with disease, and to avoid the danger of becoming hot-house plants incapable of survival elsewhere, they must be subjected to continual and objective scrutiny and evaluation. As the health professional schools engage in such programs, they should draw upon the research resources of other university disciplines. Research teams including economists, political scientists, architects, sociologists, and lawyers, to name but a few, must be drawn into an ongoing appraisal of the programs. Only by this means, can the excellence and viability of the programs in application be continually assured.

The clinical programs operated by universities should also satisfy certain social education criteria:

1. They should embrace all points in the socio-economic spectrum of society. There is little doubt that clinical programs now operated by universities tend to focus their clinical efforts on one or another segment of the socio-economic system in the United States. Some university medical centers cater to the affluent white, some to the poverty-stricken black. If a clinical system is to be a proper vehicle for teaching and research, however, it must be more, rather than less, comprehensive. Thus, the population covered by clinical programs operating under university aegis should be designed in such a way as to cover an area which includes several points on the socio-economic spectrum, so that cross-validation of the system's effectiveness can be attained. In the first period of emergence for such systems, the deplorable lack of care now provided to the poor and to the black and Puerto Rican minorities should claim particular attention, as it is difficult to defend even a developing system which tolerates such discrimination.

2. Equal attention must be paid to the age distribution of the population. It is all too easy to turn our attention away from the unglamorous needs of children and the aged—after all, preventive medicine and the care of chronic disease do not provide the virtuoso satisfaction of a spectacular cure of a rare disease. It is just such unglamorous areas, however, that can mean the difference between a good life and a poor life, for tens of millions of citizens. The programs operated by universities, therefore, must pay careful attention to insuring that the design of the health care system reflects the true distribution of the population, and the true needs of people within that population.

3. Health care systems operated by universities should take care to insure adequate geographic distribution. Already, there is apparent a tendency to cluster medical facilities and professional personnel in those geographic areas more marked by comfort and convenience than by unmet patient care needs. With the transportation availability now present in the United States, there is no reason why every clinical program conducted by universities should not provide care to at least a representative sample of the population in the densely crowded urban centers and in the sparsely-populated rural areas which surround them. The helicopter can be as important in transporting patients from the hills of Appalachia to Buffalo or Rochester, for example, as it is on the plains of Texas.

No listing of the criteria which should be incorporated into a clinical program run by a university can expect to be complete or final, nor can it expect to be infallible. It does seem reasonable, however, to think that clinical programs run by universities should be geared to educational excellence and to social reality. The concept which we have proposed can be expressed in terms of a matrix, with checkpoints along educational and social axes. While it may be true that one or another of our nation's university health centers cannot take affirmative action at each one of the checkpoints on the matrix, almost all clinical programs operated by universities can, if the university desires, satisfy most of the criteria called for by the matrix. By coordination among medical schools and universities, there is no reason why adequate insurance at a national level cannot be provided.

With respect to these models, detailed or general, several minor points should be noted:

1. Financially, the role of the university should be to engage in its education and research programs. Insofar as it conducts the clinical programs which have been described or postulated directly, and not through affiliations with other agencies, funding should be provided in a joint fashion. Those portions of the program which are dedicated to the education and research ends should be funded through direct university support. Those portions which are dedicated to the delivery of patient care itself, should be supported by appropriate national resources; in this connection, such resources may be given to the university directly for patient care, may be provided by governmental support programs, or by national health insurance. Whichever method is used, it should be the responsibility of the sponsoring university to insure that the core clinical program (as distinguished from the educational and research association) operates at a cost level commensurate with that of national potential.

2. Nothing could be so destructive to the educational integrity of universities (in satisfying the needs for which society has established them) as to engage in clinical programs which are of larger size than that which is called for by the educational mission of the university. The size of the clinical programs operated by the university indeed must be limited to that size which is the minimum necessary for its educational mission, and not the maximum available to entrepreneurial greediness. Realistically, the size of such a clinical program will always be sufficient to satisfy most of the educational and social criteria which we have put forth in our general model.

Summary

It is all too evident that this nation confronts a paradoxical crisis in its health care delivery system. In the midst of affluence and technical excellence of the highest order, too many of our citizens are deprived of health because we have not learned, and we have not taught, the best methods for delivery of health care. Yet good health care is not only the right of every citizen, but universal availability of comprehensive high quality health care is a goal to be cherished by everyone. It is within our American universities that the potential for this health care has been built up over the last 50 years. At this moment, it is their responsibility to so range their educational and clinical programs and to design and operate those model systems of health care delivery which will bring the fruits of basic research to every citizen, without in any way diminishing the continued excellence that they have already achieved in other areas.

National Intern Matching Program

Everyone in the class is matched. The tension exhibited by the 94 seniors who assembled in G-22 (March 16) to learn the results of the National Internship Matching Plan seemed to ease a bit. *It is better this year than ever before.*

They waited to receive from associate dean Harold Brody the envelope that would reveal the results of the program which attempts to match the preferences of the students with those of the hospitals. A quick exit, for some, to the nearest telephone to inform anxious relatives where "home" would be for the following year.

Over one third, he said, will remain in Buffalo, while 23 others will complete their internships in New York State (21 in New York City, two in Rochester). California, which has received as many as 15 over the past years, matched only six. Fifteen other states accounted for the remaining 31.

Two university programs filled. "Our contribution to medicine at Buffalo General/Meyer Hospitals is 16 and to pediatrics at Children's is eight," he said. Other area hospitals are Meyer (one in psychiatry), Millard Fillmore (one in surgery), Veterans (one in medicine) and Deaconess (three rotating and two in family practice). More than half the class, he pointed out, received their first choice.

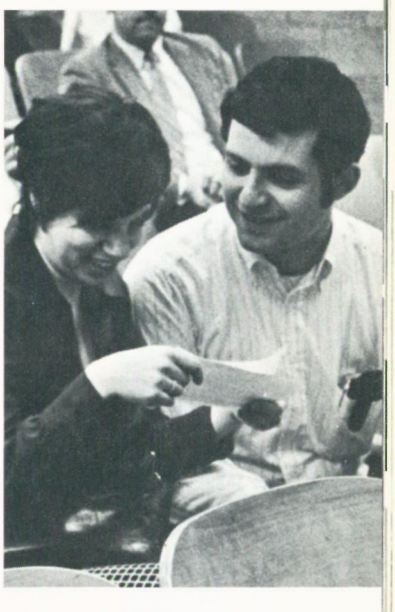
"While 57 will participate in straight programs, 34 are matched in rotating programs," he said. Over two-thirds of the class (74) will intern in hospitals with major medical school affiliations, six will go to those with limited affiliations, one to a hospital with a graduate training program under a medical school, eight to nonaffiliated, and two to public health hospitals.

"All of you are to be congratulated," Dr. Brody said to his third and final senior intern matching class. "If there is to be any improvement in internships for future graduates, it will depend on how well you perform."

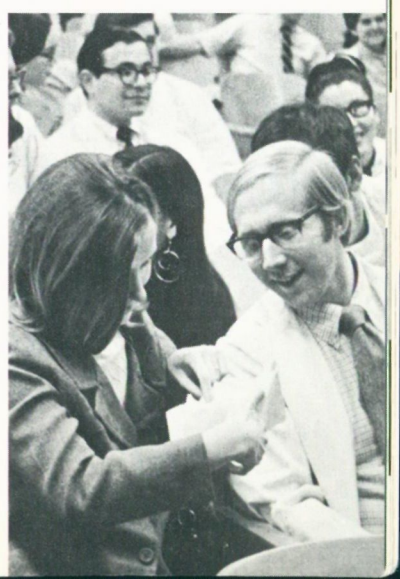
JAMES M. BAKER, *Providence Hospital, Seattle, Rotating General*
WILLIAM F. BALISTRERI, *Cincinnati General Hospital, Cincinnati, Straight Pediatrics*
RONALD H. BLUM, *Baltimore City Hospitals, Baltimore, Straight Medicine*
BRIAN A. BOEHLECKE, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*
DENNIS L. BORDAN, *North Shore Memorial Hospital, Manhasset, Long Island, Straight Surgery*
ELLIOTT BRENDER, *The New York Hospital, New York City, Straight Surgery*

PETER L. CITRON, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*
MARY E. CLEMENS, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Rotating Medicine*
SEBASTIAN CONTI, *St. Lukes Hospital Center, New York City, Straight Surgery*
DONALD P. COPLEY, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*
VINCENT G. COTRONEO, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Rotating Medicine*
SETH C. CRAIG III, *Children's Hospital, Buffalo, Straight Pediatrics*
RICHARD T. CZERNIEJEWSKI, *Children's Memorial Hospital, Chicago, Straight Pediatrics*

ELLIOTT S. DACHER, *Michael Reese Hospital & Medical Center, Chicago, Straight Medicine*
ALLEN DAVIDOFF, *Kings County Medical Center, Brooklyn, Straight Medicine*
WILLIAM P. DILLON, *Children's Hospital, Buffalo, Rotating Ob/Gyn*
FREDERICK R. DOWNS, *Deaconess Hospital, Buffalo, Family Practice*
JULIE L. DRATCH, *Huntington Memorial Hospital, Pasadena, Straight Medicine*
THEODORE N. DRATCH, *Kings County Medical Center, Brooklyn, Straight Medicine*
DENNIS P. DUBOIS, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*
NANCY L. ECKHERT, *Cleveland Clinic Hospital, Cleveland, Rotating Medicine*
CARL ELLISON, *Cincinnati General Hospital, Cincinnati, Rotating General*
ROGER A. EVANS, *Medical College of Virginia, Richmond, Straight Surgery*



STEVEN J. FAIGENBAUM, *Montefiore Hospital & Medical Center, Bronx, Rotating Medicine*
EBEN FEINSTEIN, *Kings County Medical Center, Brooklyn, Straight Medicine*
WILLIAM J. FIDEN, JR., *Deaconess Hospital, Buffalo, Family Practice*
ARNOLD E. FINGERET, *Cincinnati General Hospital, Cincinnati, Straight Pediatrics*
ALAN FINK, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Rotating Medicine*
ALLEN J. FINLEY, *Bronx Municipal Hospital Center, Bronx, Straight Pediatrics*
CHARLES A. FISCHBEIN, *Cincinnati General Hospital, Cincinnati, Straight Pediatrics*
ELLEN FISCHBEIN, *Cincinnati General Hospital, Cincinnati, Straight Pediatrics*
JOHN D. FOLEY, *Children's Hospital, Buffalo, Straight Pediatrics*
ROGER FORDEN, *Children's Hospital, Buffalo, Straight Pediatrics*
LAWRENCE S. FRANKEL, *Georgetown University Hospital, Washington, D.C., Rotating Pediatrics*
DONALD J. GABEL, *Strong Memorial Hospital, Rochester, Straight Ob/Gyn*
ROBERT P. GALE, *University of California Medical Center, Los Angeles, Straight Medicine*
NEIL W. GARROWAY, *Barnes Hospital, St. Louis, Straight Medicine*
FRED E. GENSLER, *Cincinnati General Hospital, Cincinnati, Psychiatry*
JOSEPH D. GENTILE, *Veterans Administration Hospital, Buffalo, Rotating Medicine*
CHARLES GOLDBERG, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*
ARTHUR R. GOSHIN, *E. J. Meyer Memorial Hospital, Buffalo, Rotating Psychiatry*
STEVEN B. GRABIEC, *Children's Hospital, Buffalo, Straight Pediatrics*
ELLIOTT L. GROSS, *Meadow Brook Hospital, New York, Rotating Surgery*



THEODORE J. HAJEK, *Children's Hospital, Buffalo, Straight Pediatrics*
FRANK M. HALL, JR., *Rochester General Hospital, Rochester, Rotating General*
MARVIN W. HARRISON, *University of Oregon Medical School Hospitals, Portland, Rotating*
DAVID S. IRWIN, *U.S. Public Health Service Hospital, Boston, Rotating General*
RICHARD A. JUSTMAN, *University of Chicago Clinics, Chicago, Straight Pediatrics*
MARILYN R. KASSIRER, *St. Elizabeth's Hospital, Boston, Straight Medicine*
DENNIS J. KRAUSS, *Brookdale Medical Center, Brooklyn, Rotating General*
THOMAS V. KRULISKY, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Rotating Medicine*
JOEL KRUMERMAN, *Jackson Memorial Hospital, Miami, Straight Surgery*

(Continued)



ROBERT E. LEE, *University of Connecticut, Medical Sociology*
ALAN I. LEIBOWITZ, *Brookdale Hospital Center, Brooklyn, Straight Medicine*
LAURENCE LESSER, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*
MICHAEL LIPPMAN, *Bronx Municipal Hospital Center, Bronx, Straight Medicine*
BRUCE H. LITTMAN, *New England Medical Center Hospitals, Boston, Straight Medicine*
BARIS LITVAK, *Jackson Memorial Hospital, Miami, Straight Pediatrics*
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SUSAN M. MOSHMAN, *Montefiore Hospital, Bronx, Straight Medicine*
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ALAN M. PODOSEK, *Deaconess Hospital, Buffalo, Rotating General*
BRUCE M. PRENNER, *Presbyterian Hospital, New York, Straight Pediatrics*
JOEL P. PURSNER, *St. Vincents Hospital, Staten Island, Straight Psychiatry*
HERBERT H. RABINER, *Long Island Jewish Medical Center, New Hyde Park, Rotating General*
CAROL (FARBER) REDDY, *Children's Hospital, Buffalo, Straight Pediatrics*
JOHN A. RIDER, *Children's Hospital, Buffalo, Straight Pediatrics*
JEFFREY S. ROSS, *Massachusetts General Hospital, Boston, Straight Pathology*
DAVID J. ROSSMAN, *Temple University Hospitals, Philadelphia, Straight Medicine*
JEFFREY G. ROTHMAN, *University of Pennsylvania Hospital, Philadelphia, Straight Medicine*

DANIEL J. SCHAFFER, *General Rose Memorial Hospital, Denver, Rotating General*
STEPHEN SCHLESINGER, *Children's Hospital of Pittsburgh, Straight Pediatrics*
JOHN G. SECRIST, *U.C.L.A. Medical Center, Los Angeles, Straight Medicine*
SAMI SEHAYIK, *Bronx Municipal Hospital (Einstein), Bronx, Straight Surgery*
ARTHUR M. SEIGEL, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Rotating Medicine*
PETER E. SILVERSMITH, *Millard Fillmore Hospital, Buffalo, Straight Surgery*
JAMES K. SMOLEV, *Johns Hopkins Hospital, Baltimore, Straight Surgery*
BRUCE A. SOBIN, *Long Island Jewish Medical Center, New Hyde Park, Rotating General*
AGNES V. S. SZEKERES, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Rotating Medicine*
BRENDAN D. THOMSON, *Good Samaritan Hospital, Phoenix, Rotating General*
SHAFIC Y. TWAL, *Children's Hospital, Washington, D.C., Straight Pediatrics*
ROBERT M. UNGERER, *Hartford Hospital, Connecticut, Rotating Surgery*
HAROLD M. VANDERSEA, *Deaconess Hospital, Buffalo, Rotating General*
STEVEN F. WEINSTEIN, *University Hospital of San Diego County, San Diego, Straight Pediatrics*
HENRY L. WHITED, *Rhode Island Hospital, Providence, Rotating Medicine*
HOWARD A. WIENER, *New York University Medical Center (Bellevue), New York City, Straight Pediatrics*
ALLAN S. WIRTZER, *Veterans Administration Center, Los Angeles, Straight Medicine*
RONALD W. ZMYSLINSKI, *Buffalo General/Meyer Memorial Hospitals, Buffalo, Straight Medicine*

Spring Clinical Days

Three major challenges facing the physician today — sex education, social hazards, peptic ulcer — were this year's theme at the 33rd alumni Spring Clinical Days that opened on a snowy and 35-degree day at the Hotel Statler.

"What our children want and need to know is here to stay," said national director of sex information and education council Mary S. Calderone. Sex education, she pointed out to the 250 alumni, student and faculty audience, is needed to make a better world. The physician has a key role to play in the community — educating adults and serving as a consultant to schools. But she cautioned that physicians must be aware of sex-related problems. "There are patients who may not realize what these problems are and are now suffering from their effects." For the woman who has lost a breast, had a colostomy or a historectomy performed, and is deeply concerned as to "what this will do to my sexual life," the physician needs to assure her that it will not interfere.

Another high anxiety problem is masturbation, she pointed out. Many physicians do not even understand that as an integral part of the "self" it is harmless. Moderator Harold J. Levy introduced a panel that presented its personal experiences on sex education in the community. "It is far better to give sex information too early," pediatrician Robert J. Ehrenreich said, "than too late." While the Medical Society has initiated a new program in human sexuality for hospitals and schools, "we as physicians are only consultants and it must be the hospital that becomes involved." He believes that the physician's role is to educate the parents, to teach them healthy sexuality attitudes to pass on to their own children. He noted that medical students, perhaps more than ordinary citizens, have sexual hangups.

A sex education activist (as gynecologist Morris Unher calls himself) insisted that a program in sex education is a "must" for children in kindergarten through grade 12. Psychologist Shepard Goldberg concurred that parent education is the key to a sex education program. At best a film is an audiovisual tool and will not do the whole job. "You must therefore answer all questions completely and honestly," he said.

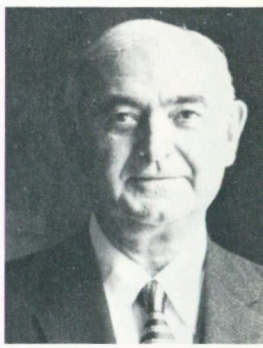
Psychoanalyst Bernhardt Gottlieb pointed out "we may be making history this afternoon. As far as I know this is the first time that we as physicians are looking at ourselves and situations that occur in our everyday life in order to arrive at an understanding of what we can do, not only for our colleagues but others who come to us as drug addicts."

The easy availability of drugs frequently leads to its improper use, a Philadelphia psychoanalyst said. Dr. Ralph B. Little warned that in self medication "you eliminate the doctor/patient relationship." He pointed out that "it can never happen to me" often presages the drug problem in physicians. But, he continued, one

Dr. Bissell

Dr. Calderone

Dr. Evans



Dr. Gottlieb

Dr. Hoerr

Dr. Roth

Medical students attend the sessions.

The annual Stockton Ki

Mrs. Stockton Kimball with Drs. Lockie and Heilbrun.

It was an interesting panel.

Drs. Cheplove, Stafford, Pesch.

nball luncheon at the Statler Hilton.

Drs. Milford Childs, Samuel Bleichfeld.

Drs. Herbert Wells, Oscar J. Oberkircher.

Drs. Morhous and Fugitt during a coffee break.

Drs. Regan, Anthone.

Drs. Block, Goldstein, Gottlieb.

Drs. Anthone, Mindell.

Drs. Cheplove, Milch, Berman.

has to be ripe or preconditioned before he becomes an addict, and the physician may be unaware of his vulnerability. "Expect poor motivation in the beginning of treatment," said the physician who has been involved in a continuing study of drug problems in physicians for the past eight years. "In your initial contact with the patient, be certain that you use the term 'addict' to convey the seriousness of the problem."

Alcohol-addicted physicians, pointed out Roosevelt Hospital internist, LeClair Bissell, drift into other addictions. Suicide attempts, arrests, jail sentences for many of those studied, few sanctions by colleagues appeared to be the picture. She predicted that between 13,000 — 22,400 physicians are or will become alcoholics and after looking around the room cautioned that one out of every 100 physicians sitting there will end up an alcoholic. What can we do about it?

"We as physicians should not join the addict in his own denial. We must show concern and when necessary impose sanctions — loss of job or license. But, don't threaten without offering help and the location of that help."

Physician suicides, psychiatrist Harvey L. P. Resnik pointed out, exceeds the number of graduates from a large medical school. When dealing with a patient with multiple complaints, consider asking him whether he is depressed or has felt so badly that he has considered taking his own life. It is a myth, he said, that by doing so you will precipitate a suicide. The chief of the National Center for Studies of Suicide, who is on leave from the UB Medical School, said "what it does is to open up an avenue of communication."

He cautioned that 80 percent of the suicide attempts — and there is a relation between drugs and alcohol — utilize physician prescriptions. "Control a prescription," he admonished. Psychiatrists have the highest overall suicide rate, he said, followed by otolaryngologists who are significantly older.

"As physicians we are less prone to seek treatment for ourselves. We should be more aware of mental illnes in ourselves and our fellow physicians."

The final session on *modern concepts of treating peptic ulcer* moderated by James F. Phillips opened with an overview of the physiology of gastric secretion. Gastroneurologist William F. Lipp traced its history from Pavlov in 1889 who developed the nervous-cephalic theory of digestive secretion to the Gregory/Tracy team who in 1959 reexplored gastrin and isolated two pure forms. By characterizing natural gastrin and proving its structure by total synthesis they made available both for the first time. Hunter's theory of the viability of tissue as a factor in the age-old question of why the stomach does not digest itself — the food that we eat plus the mucosa preventing this from happening — should lead to the development of the entire peptic ulcer story.

Ulcers do heal, Dr. Samuel Sanes optimistically opened his discussion on the pathology of the peptic ulcer. A peptic ulcer, he pointed out, is a defect in that section of the mucosa in the

alimentary tract that is exposed to acid peptic juice. Focusing on the duodenal ulcer he noted that it takes between 30-60 years for its development for the ratio of five males to every female.

A drug may participate in pathology of ulcers, warned a University of Pennsylvania internist, Dr. James Roth, by inciting localized damage to the mucosa, stimulating mucosal increase, or reducing mucosal resistance and thereby interfering with the healing process. He pointed to the general agreement that aspirin is a dangerous drug and that with its ingestion one or more mechanisms may operate to cause erosion and bleeding. He pointed to phenylbutozone as potentially ulcergenic, the cellular toxicity of caffeine, as well as ACTH and the still controversial adrenal steroids that may interfere with the healing process.

A surgeon from the Cleveland Clinic described his experience in surgical therapy for peptic ulcer. In performing gastroresection, vagotomy, or the several different drainage processes for the chronic duodenal ulcer patient, Dr. Stanley O. Hoerr cautioned that you must pick the operation that is best for the patient. His experience revealed that a vagotomy with the appropriate drainage procedure works in nine out of ten cases and offers the patient the lowest possible risk. He predicted that no matter what you do, 80 percent will heal but there is the 20 percent who don't respond to the stomach rest program of hourly feedings in small quantities.

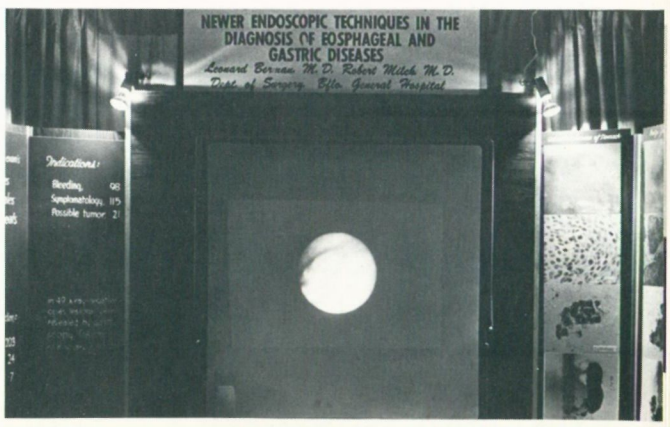
At the annual alumni luncheon the Stockton Kimball Memorial Lecturer emphasized that the "quality of care and continuing education are not just inseparable, they are the same." A program of continuing education, Dr. Robert E. Evans emphasized, is part of a "basic charge to a learned profession, to assure the ability and performance of its members." Two recent court decisions, the York Hospital director of medical education and professional services said, mandate vital involvement at all levels of hospital staff and administration in both quality of care and continuing education. One makes the "governing board, medical staff, and administration responsible for the quality of care within the institution." The other means a doctor "must be able to practice at a national level of competence and his failure to do so can be interpreted as criminal neglect."

Governing treatment is the standard of medical care for an immediate area, past court decisions indicate. More efficient use of a physician's time in the hospital is needed to benefit his patients, his continuing education, and that of other physicians. Dr. Evans believes that one way to do so would be to lengthen service for hospital staff. This would not only avoid 'total anarchy' that results in administrating a multimillion dollar budget for short tenure personnel but will offer consistent staff operation.

Attendance he feels should be required at these continuing education sessions that should be pertinent to identified medical needs in the hospital. Research, which in all hospitals is vital, should feed back into medical care. It can either focus on biomedical problems or on how best to perform or improve a hospital function, he concluded.

Six members of the 1920 class attend the reunion dinner Friday evening. They are: (standing) — Drs. Cecil L. Schultz, Leon J. Leahy, Salvatore F. Sorgi and Stephen A. Graczyk. Seated are Drs. Carl C. Koester and Alvah L. Lord.

Among the fourteen scientific exhibits displayed, first prize went to Drs. Leonard Berman and Robert Milch's exhibit on *Newer Endoscopic Techniques in the Diagnosis of Esophageal and Gastric Disease*. Drs. Eugene V. Leslie, George J. Alker, Jr., Edward G. Eschner, Victor A. Panaro and Mr. Benjamin J. Kutas' exhibit on *X-ray Subtraction* earned second place while third prize was awarded to the *Clinical Application of Computers* exhibit prepared by Drs. Ronald J. Foote, Elemer R. Gabrieli, Worthington G. Schenk, Jr. and George P. Reading.



Dean LeRoy A. Pesch told the alumni that the last two years seemed more like two decades. "The last year has been rewarding. We have strengthened our ties with our alumni with the appointment of David Krajewski as director of medical alumni affairs. We have more interaction and visibility between the Medical School and our alumni."

The Dean also told the physicians that the Medical School would play an important part of the University's 125th celebration in 1971. He also noted the "hole in the ground at Children's Hospital" is proof of continuing affiliation between the Medical School and the hospital.

Dean Pesch acknowledged alumni support as well as the contributions of the volunteer faculty. He mentioned specifically the financial contributions of Drs. Charles Heyd and Bernhardt S. Gottlieb.

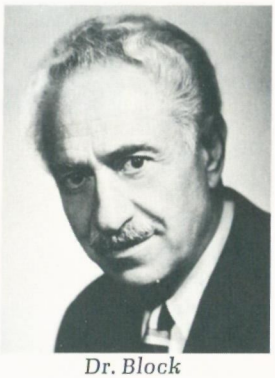
Dr. Peter Regan told the physicians that we need "positive, forward action and educational experimentation so we can keep on going on the tight rope between stability and change — but more rapidly. The threat comes from change that is not an added improving element, but that destroys what is good."

The acting president emphasized that all groups in our society must be drawn more closely together to find new ways of doing things better and faster.

"We need changes to meet the demands of society just as physicians must find new ways of delivering better health care."

Three days after Spring Clinical Days (April 14) Dr. Regan submitted his resignation as executive vice president effective August 31. He will become professor of psychiatry in the Medical School.□


Dr. Graczyk


Dr. Block


Dr. Howard


Dr. Zittel

Ten Class Reunions

A total of 178 physicians and almost as many wives attended 10 class reunions during spring clinical days. The 1920 class had its reunion Friday evening, (April 10) while the other nine classes met the following evening. Mr. David Krajewski, director of medical alumni affairs, organized the dinner reunions.

The physicians attending were:

Class of 1920: Dr. Stephen A. Graczyk, Chairman; Drs. Carl C. Koester, Leon J. Leahy, Alvah L. Lord, Cecil L. Schultz and Salvatore F. Sorgi.

Class of 1925: Drs. Marvin A. Block, William M. Howard, Harold E. Zittel, Co-Chairmen, Drs. William T. Clark, Emerson J. Dillon, Francis J. Gustina, Margaret L. Hogben, Norbert W. Kuch, Lucian C. Rutecki, Milton J. Schulz and Ethan L. Welch.

Class of 1930: Dr. Irving Wolfson, Chairman; Drs. Vincent I. Bonafede, Anthony R. Cherry, Benjamin S. Custer, R. Edward Delbridge, Raymond L. Feldman, Raymond J. Germain, Carleton A. Heist, James G. Kanski, Leo M. Michalek, Walter T. Murphy, Samuel Sanes, Harold H. Saxton, Frank B. Smarzo, Richard G. Taylor and Herbert J. Ulrich.

Class of 1935: Dr. Kenneth H. Eckhert, Chairman; Drs. Carl E. Arbesman, John F. Argue, Willard H. Bernhoft, Russell F. Brace, James H. Gray, Miles W. Kelly, James A. Mark, Domenic S. Mesina, Herman S. Mogavero, Paul N. Stoesser, Carl J. Streicher, Harry N. Taylor, Clayton G. Weig and Philip Willner.

Class of 1940: Dr. Albert C. Rekate, Chairman; Dr. Harold K. Palanker, Toastmaster; Drs. Julian J. Ascher, John M. Benny, Victor M. Breen, Milford N. Childs, Marshall Clinton, Stuart V. Collins, George A. Harer, William Hildebrand, Robert D. Hubbard, Corydon B. Ireland, Bernard W. Juvelier, J. Richard Kline, Warren R. Montgomery, Lyle N. Morgan, Russell E. Reitz, James P. Schaus, Charles H. Severson, Allan W. Siegner, Louis A. Trippe, William O. Umiker, Stanley T. Urban, John D. White and John G. Zoll.

Class of 1945: Dr. H. Paul Longstreth, Chairman; Dr. George W. Fugitt, Jr., Toastmaster; Drs. Richard H. Adler, William S. Andaloro, Raymond S. Barry, Craig L. Benjamin, Norman Chassin, Paul Barry Cotter, James A. DeJute, Martin J. Downey, Jr., George M. Ellis, Alton A. Germain, A. Arthur Grabau, Donald N. Groff, John F. Hartman, Theodore C. Jewett, Herbert E. Joyce, Vito P. Laglia, Victor C. Lazarus, William D. Loeser, Milton J. MacKay, Cornelius A. McGrew, William N. McIntosh, Stuart J. Miller, Eugene J. Morhous, John K. Quinlivan, John G. Robinson, Lillian E. Rowan, Joseph E. Rutecki, Robert C. Schopp, K. Joseph Sheedy, Jacob M. Steinhart, William R. Taylor, Wayne C. Templer, Peter Terzian, Edward L. Valentine, Charles E. Wiles and Jane B. Wiles.

Class of 1950: Dr. Mary Jane Tillou, Chairman; Dr. William S. Webster, Toastmaster; Drs. Guy S. Alfano, Roland Anthone, Sidney Anthone, Herbert L. Berman, Charles Brody, Carl A. Cecilia, Vincent Ciampa, Anthony Conte, Joseph F. Dingman, Adelmo P. Dunghe, James C. Dunn, Charles A. Howe, O. P. Jones (Guest), Richard J. Leberer, Karl L. Manders, Leo E. Manning, Joseph M. Mattimore, Henry L Pech, Roy W. Robinson, George M. Sanderson, Jr., Helen F. Sikorski, George E. Taylor, Hyman Tetewsky, Anne A. Wasson and Myra R. Zinke.

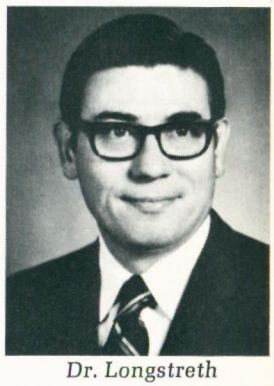
Class of 1955: Dr. Laurence T. Beahan, Chairman; Dr. James R. Nunn, Toastmaster; Drs. William J. Breen, Vincent S. Celestino, James R. Collins, John F. Foley, Albert A. Franco, James M. Garvey, Frank J. Gazzo, Michael J. Gianturco, John H. Kent, Winifred G. Mernan, Anthony B. Schiavi, Ray G. Schiferle, Jr., David F. Weppner and John A. Winter.

Class of 1960: Dr. Roger S. Dayer, Chairman; Drs. Theodore S. Bistany, John M. Budzinski, Gerard J. Diesfeld, Algirdas Gamziukas, Edward J. Graber, Thomas J. Guttuso, Donald A. Hammel, James R. Kanski, Francis J. Klocke, Erwin R. Lamm, John I. Lauria, Marshall A. Lichtman, Robert L. Malatesta, Harry L. Metcalf, Eugene T. Partridge, Daniel A. Rakowski, Charles J. Riggo, William J. Stein and John A. Tuyn.

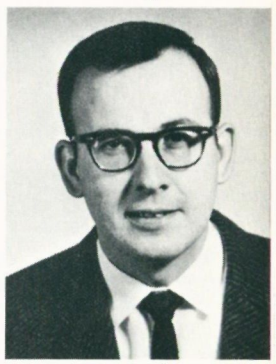
Class of 1965: Dr. Joseph G. Cardamone, chairman; Drs. Anthony V. Grisanti, Patrick J. Houston, Myron H. Marshall, David G. Publow and Robert N. Schnitzler.

Dr. Eckhert

Dr. Rekate



Dr. Longstreth



Dr. Beahan

Dr. Dayer

Ernest Witebsky
A Personal Vignette

by
Dr. James F. Mohn

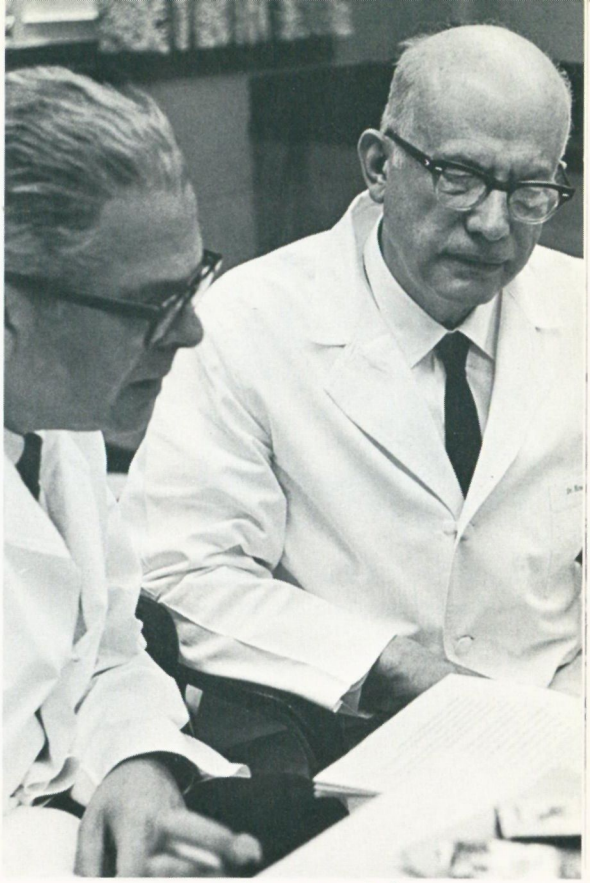
This special tribute was presented at the International Convocation on Immunology Banquet to Honor Dr. Witebsky Monday evening, June 17, 1968 by Dr. Mohn, professor of microbiology. Dr. Witebsky died December 7, 1969.

Had he selected the alternative pathway at that moment of crucial decision in his teen years, we immunologists would not be assembled here to honor him. Instead this gathering might be composed of distinguished musicians. Perhaps his early intense interest in playing the violin, at which he became so skilled that he seriously considered this as a professional career, may have been the direct result of a very outstanding, indeed unique musical influence. As a consequence of the geographic partition agreements made at the conclusion of the first World War, many Germans migrated from Strasbourg to Frankfurt am Main. His father, Dr. Michael Witebsky, an obstetrician, and his uncle, an otolaryngologist, who were long residents in Frankfurt, became physicians to this group.

Most prominent among these refugees was the magnanimous, noble, late Dr. Albert Schweitzer. The families developed social as well as professional contacts and this friendship afforded young Ernest Witebsky the rare privilege of privately listening to Schweitzer as he practiced on the organ. Later in a church in Heidelberg, he had the signal honor of sitting next to him on the organ bench to turn the pages of the music during one of Schweitzer's recitals. Many years later after finishing his medical training he was now so impressed with this facet of Schweitzer's career that he journeyed to Lausanne in 1933 to discuss joining him in Lamberene. But, as he told me personally, he quickly discovered during their discussions that Schweitzer desperately needed physicians who were also carpenters, and in such manual arts Dr. Witebsky possessed no dexterity whatsoever. Most fortunately for us in Buffalo, he decided to immigrate to the United States instead.

To go backward in time now once again to pick up the chronological thread, on graduation, if that is what it is referred to in Germany, from the Goethe Gymnasium in Frankfurt, he matriculated in the University of Frankfurt Medical School. During these first university years and similarly the last year at the gymnasium, he became an avid skiing enthusiast. He was among the first students in 1920 of the internationally famous Austrian ski instructor, Hannes Schneider, who later founded skiing schools in this country. It was at Vorarlberg in the Austrian Tyrol that he came under Schneider's tutelage. This athletic interest continued on completion of his medical studies and every winter from 1926-1933 while he was working in Heidelberg he traveled to St. Moritz to ski.

Alternating as was customary in Germany in his medical school training between Frankfurt and Heidelberg, he received his Doctor of Medicine degree from the University of Heidelberg in 1926. During these formative medical school years, he was profoundly influenced to pursue the study of human blood groups by the late Dr. Ludwig Hirszfeld during the latter's working visit to Heidelberg in 1922-23. As a senior medical student, he presented a student seminar on blood groups in the Department of Medicine in 1924. Research studies on blood group antigens and antibodies were to play a very prominent role in his investigations for the next thirty or more years.



Drs. Milgrom, Witebsky

To digress briefly, it is more than of casual interest to note that his successor as chairman of our department of microbiology, Felix Milgrom, known among some of us as Felix Maximus, was the senior student and long-time associate of Hirszfeld. How interwoven are the threads of our lives!

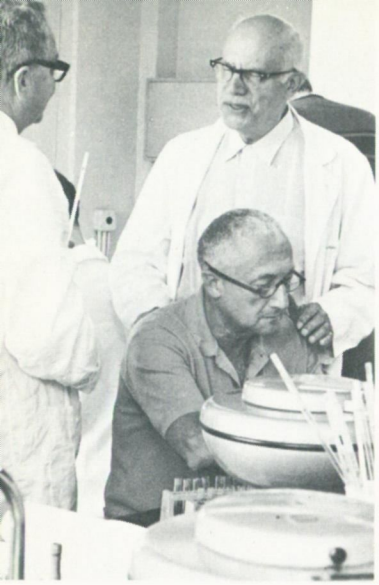
From 1925-1933, Ernest Witebsky was attached to the research division of the Cancer Institute of the University of Heidelberg Medical School, headed by Dr. Hans Sachs, the famous pupil of Paul Ehrlich, first as assistant from 1925-29 and then as Privat Dozeut until 1933. It is significant that his public address in 1929 as part of the ceremony in connection with his promotion to Privat Dozeut dealt with his preliminary experiments on the organ specificity of extracts of the thyroid gland which he attributed to thyroglobulin.

He made an auspicious or inauspicious entry—depending upon the eternal difference in viewpoints between the senior research hierarchy and the young, upstart investigators—into scientific meetings with his first presentation of a paper on his own investigative studies in 1926. The occasion was a meeting on legal medicine presided over by Dr. Fritz Schiff. His paper was preceded by one presented by a now nameless professor from the University of Kiel. This hoch geheimurat reported the results of his study on the blood group distributions among the faculty, especially the professors, at Kiel and among the prisoners in the Kiel jail. He found a higher percentage of the professors to belong to blood group A and a higher frequency of blood group B among the prisoners than among the normal population.

Naturally his conclusion on the basis of such scientific evidence was that group A was a characteristic related to superior intellect and group B one that was linked to criminal behavior. Gulping a few times, I feel quite sure, the young investigator then spoke on the findings of his research that 40% of German swine possessed a group A antigen. As you can well imagine, Sachs was furious at such an audacious performance by a young intern, but as a direct consequence he was forced to take Dr. Witebsky's deep interest in studies of blood groups seriously and he shortly forgave him.

Following this same vein of interest, in 1927 the fresh young man delivered an address on the validity of blood group determinations in cases of disputed paternity before a distinguished assembly of lawyers and judges in the court house at Frankfurt. Far too few blood group geneticists and immunologists are aware that Dr. Witebsky published one of the earliest and best monographs on the existing knowledge of human blood groups in 1932. This was entitled "Die Blutgruppenlehre Unter Besonderer Berucksichtigung Physiologisch-Serologischer Fragestellungen" and appeared in the *Ergebnisse der Physiologie*. As recently as three weeks ago I heard a speaker refer to the great gap between the book by the Italian Lattes which appeared in 1923 and that of Wiener published in 1935.

By 1933 dark clouds of hate had thickened in the skies over Germany and especially over the academic halls with their concentrations of superior intellects, such as the University of



Immunology Summer School

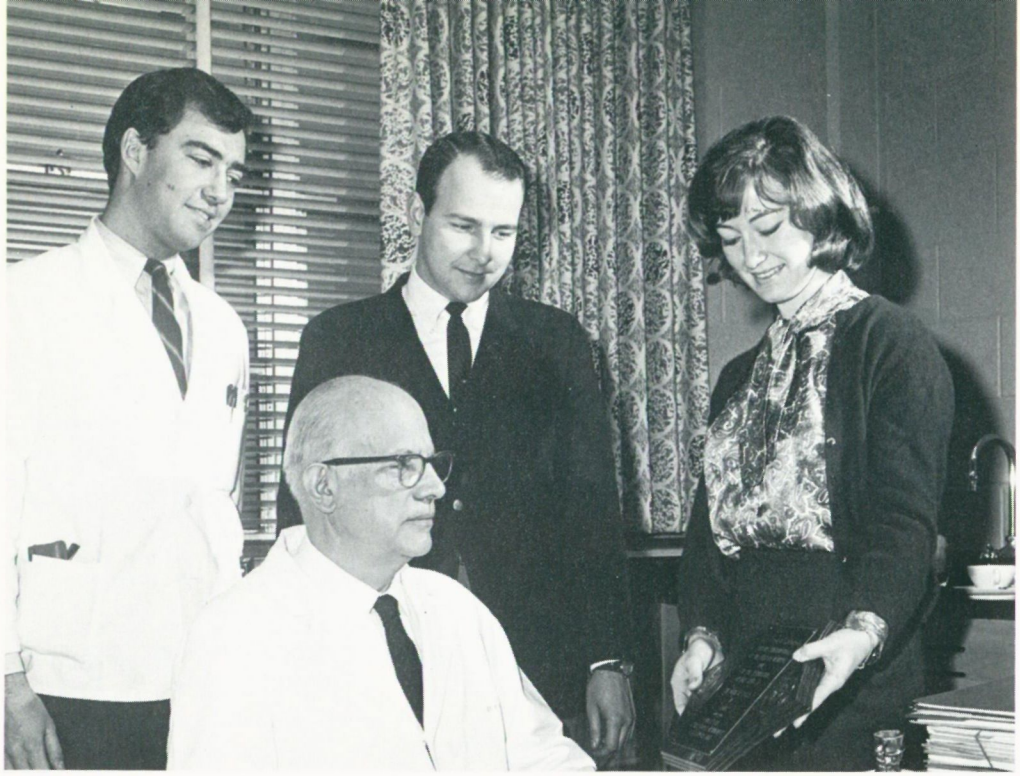
Heidelberg, always a threat to the survival of any political demagogue. The final impetus to a decision to leave Germany came when Dr. Witebsky could not exclude a prominent, local member of the Nazi party from the paternity of an illegitimate child on the basis of his blood group examination. Where should they go? Since his father was a citizen of Geneva and he, Ernest Witebsky, possessed similar dual citizenships (Germany and Geneva) by virtue of Swiss inheritance laws the answer was Geneva.

Where however would he continue his research and how would it be supported? No doors were opened to him in any of the departments a bacteriologist and immunologist would naturally gravitate to. Finally Dr. Franceschetti, the professor of ophthalmalogy at the University of Geneva—isn't that something for us to ponder over—gave him a laboratory in his department of clinical ophthalmalogy. Perhaps this explains the soft spot Ernest Witebsky has had in his heart for opthalmalogists which I discovered after working with him years later. It could hardly be properly referred to as a laboratory since it was in a dark corner of the basement and was devoid of all furniture and any laboratory glassware or other supplies. This he proceeded to furnish in a make-shift fashion and he bought a few pipettes and test tubes from his own funds.

Yet in spite of these physical limitations and the obvious inadequacy of such a research environment, his investigations here in roughly one year's time—from 1933-34—resulted in four publications from the Laboratories of Normal Anatomy and of Clinical Ophthalmalogy. These papers reported his studies on the Forssman antigen with his demonstration of so-called primary serum toxicity.

In 1934 he emigrated from Geneva to the United States to become a research fellow at Mt. Sinai Hospital in New York City. Here he was joined by a former student of his in the University of Heidelberg, Dr. Erwin Neter, an association that continues to this day. In 1935 while working here, Dr. Paul Klemperer, the eminent pathologist, brought Dr. Kornel L. Terplan, then professor of pathology in The University of Buffalo School of Medicine, who was visiting Klemperer to Ernest Witebsky for him to demonstrate his chick embryo-Forssman antibody serum toxicity experiments. This led to an invitation to join Dr. Terplan's department in Buffalo as associate professor of bacteriology, a position he held from 1936-40.

In 1940, he was promoted and his title changed to that of professor of bacteriology and immunology. The University of Buffalo created the Department of Bacteriology and Immunology as a separate entity distinct from the Department of Pathology in 1941 and named Dr. Witebsky its head. This morning we were privileged to hear Dr. Terplan's gracious remarks on Dr. Witebsky's contributions in those early developmental years of our medical school. In recognition of his many accomplishments as a devoted teacher and renowned investigator he was made Distinguished Professor of Bacteriology and Immunology in 1954, a rank held by only three other members of the entire University faculty.



Dr. Witebsky honored by sophomore class January 21, 1967

As a young, slightly overwhelmed, and I'm sure equally bewildered, freshman medical student, in the spring of 1942 Dr. Witebsky invited me to join him in some student research project, if I were at all interested. This extraordinary offer, from my humble position and freshman viewpoint, became the turning point of my professional career.

The "new" department in those days consisted of one room approximately 14 x 20 feet, which during the teaching portion of the year was completely used for making media, cultures, and all other student materials. Much of the research therefore was carried out in the Bacteriology and Serology Laboratories of The Buffalo General Hospital. This was possible because Dr. Witebsky had been appointed bacteriologist and serologist to this university-affiliated hospital in 1936 when he joined the University faculty. This was a tangible expression to me of one of his most fundamental philosophies concerning pedagogy in our basic science—that successful teaching of medical microbiology and immunology was dependent on the triad of teaching, research, and service.

My indoctrination to this field as a student was to serve as a routine, diagnostic bacteriology technician trainee after successful completion of adequate probationary periods in glassware washing and media preparation. Again this approach reflected his strong feeling that successful administration of such a diagnostic laboratory service at a postdoctoral period required personal familiarity with each aspect of the operation.

The entire full-time staff of the medical school department at that time consisted of a devoted technician, Miss Anne Heide, and what we then referred to as a laboratory diener, Mr. August

Dr. Charles Banas presents alumni award to Dr. Witebsky at the 1968 Spring Clinical Days.

Dr. Witebsky meets Her Majesty, Queen Juliana of Holland in the Royal Palace in Amsterdam in June, 1968. Dr. Witebsky received the Cross of Merit from the Netherlands Red Cross.

Fischer. The total budget for supplies required to teach about 70 medical students and 50 dental students was roughly $500 per annum. Things were tight in other ways too.

This was the period of the "conscience cigars." I couldn't believe he had really said that the first time I heard it so I begged his pardon whereupon to my disbelieving ears I heard again "conscience cigars." He must have appreciated I wore a most confused countenance because he promptly proceeded to demonstrate what he meant. One of his real pleasures he told me was smoking cigars, instantly adding that this was a foul habit. Every time he pulled out his desk drawer he was conscience smitten over what his children, Frank and Grace, were being denied for him to afford this personal pleasure. To solve his conscience, therefore, he kept in a drawer right below the more expensive ones, a box of nickel cigars—yes, five cents bought a White Owl cigar then—which were his "conscience cigars," ones he could smoke on such occasions joyfully. The better ones were saved to celebrate successful experiments at which time conscience did not enter into the picture.

The rest is history which is familiar to all of you—I joined the faculty in 1945, followed by Noel Rose in 1951, Sidney Shulman in 1952, Almen Barron in 1954, Ernest Beutner in 1956 and Felix Maximus in 1958. Dr. Witebsky has won many honors in his career, but if he had the choice I seriously believe that deep in his heart he covets most the Chancellor's Medal of the University of Buffalo. This is an award made annually from the bequest of Chancellor Norton, specifically to one who has brought honor to this University and has dignified Buffalo in the eyes of the world. And I would like to read to you the concluding remarks of the late great Chancellor Samuel Paul Capen in 1950 when he awarded this medal.

> His University which now honors him has still another reason for bestowing upon him its accolade. Throughout the prosecution of his work he has exemplified the highest standards of the university scientist. He has been at pains to see that the associates who have assisted him should share with him whatever professional credit might come as a consequence of their joint labors. He has insisted that any profits derived from patents on his discoveries should go to the support of further research and not to his personal gain. Despite his constantly growing reputation and the recognition he has received from all over the scientific world, he has remained the simple, modest scholar whose courtesy and helpfulness and wisdom his colleagues have come to cherish in equal measure with his great scientific attainments.

Well, sir it has taken 26 years to present to me the occasion, the situation, the audience and the opportunity, and now I have it. So I would like to say to you personally how much of my deep affection and appreciation you have for what you have taught me, what it has meant to me and my family and to my associates, and I have for you a non-conscience cigar!□

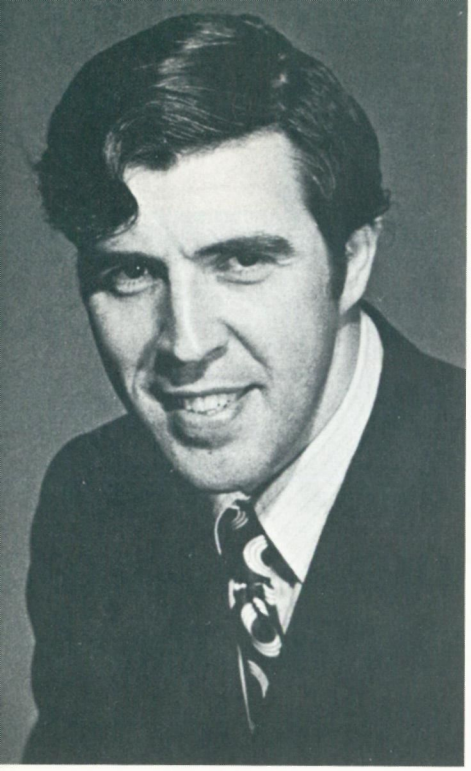
25 Days of Campus Unrest

"On strike, shut it down!" That was the shout heard on campus between February 24 and March 21, the beginning of the spring vacation. During this 25-day period of campus unrest, many classes were boycotted (peaceful and violent) by students and faculty. No Medical School classes were cancelled. There were charges and countercharges by hundreds of individuals and many groups. There were thousands of words spoken and written.

The Medical School's "Project Themis" (a $300,000 Naval Research contract awarded to the physiology department) was one of the focal points of the student demonstrations. Among the other demands were — the immediate resignation of Acting President Regan; self determination for the colleges; support of engineering students and black student demands; open admissions; lifting of the court restraining order; reinstatement of Luigi Bianchi and Jon Hamann, former faculty members; dropping of disciplinary charges stemming from campus demonstrations; removal of Buffalo Police from campus (they were removed after 18 days); and immediate abolition of Air Force ROTC.

The crisis had been brewing for several months, perhaps years. Then suddenly there was active violence — broken windows, police-student skirmishes, arrests, injuries, and other types of vandalism. Many investigations were launched and are still going on by student/faculty groups, the grand jury, as well as other city, county and state committees, commissions and task forces. □

As we go to press the University community is hard at work talking and trying to solve its many problems. There has been peace on the campus. Then on May 5 the students here and across the nation began demonstrating against the war in Cambodia and the four student deaths at Kent State University (Ohio). This national protest is continuing and no one knows when or how it will end. □



Dr. Falsetti

Heart Failure Detection

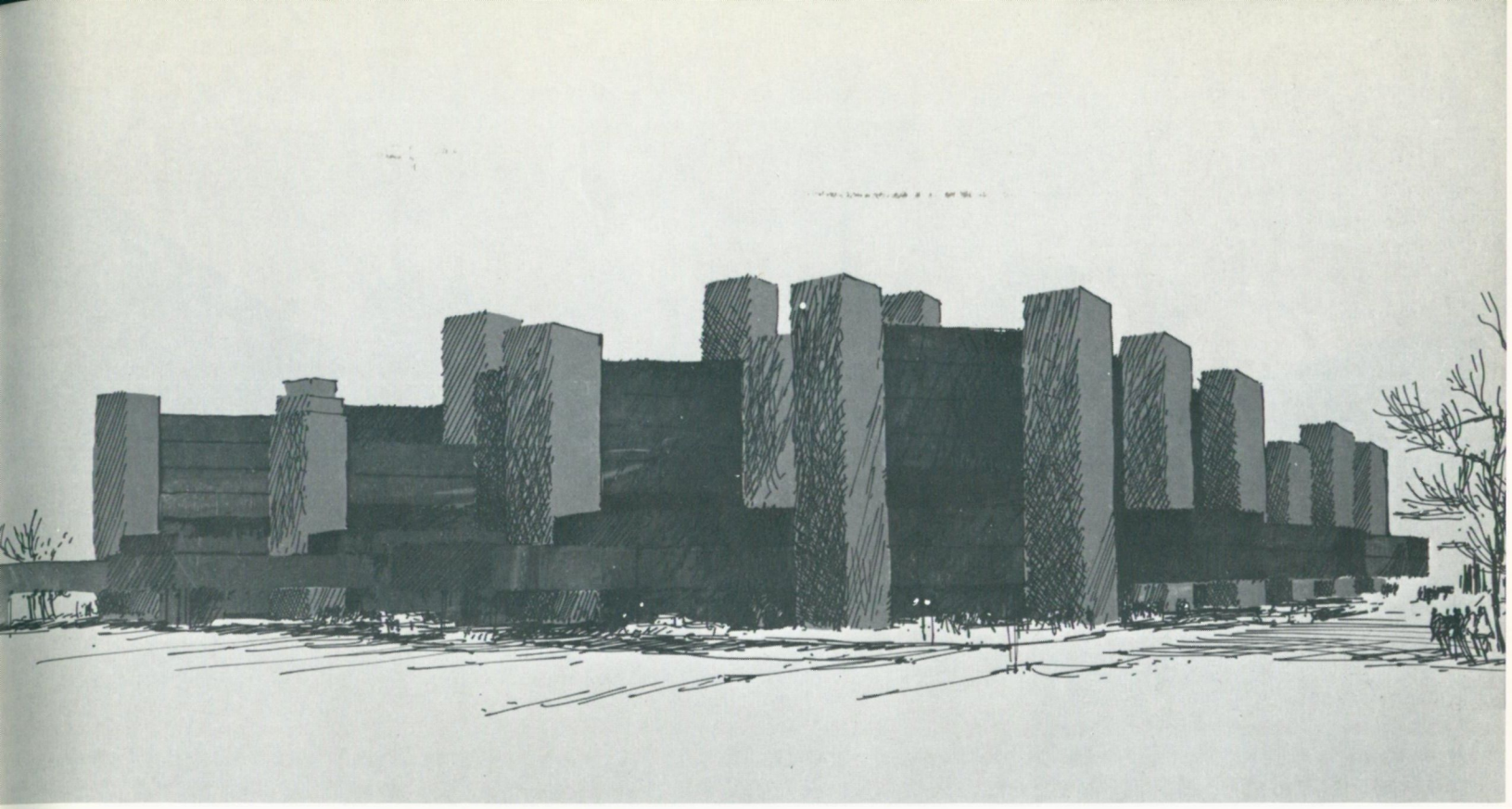
A SENSITIVE PROCEDURE to measure contractility of the heart holds promise for earlier detection of heart failure. It is the result of a combined medical/engineering approach at the University to estimate how well the heart muscle is functioning. A paper on "V_{max} as an Index of Contractile State in Man" was presented March 1 at the 19th Annual Scientific Session of the American College of Cardiology. Co-authors are Drs. Herman L. Falsetti, assistant professor of medicine; Robert E. Mates, professor and chairman of the department of mechanical engineering; David G. Greene, professor of medicine; and Ivan L. Bunnell, associate professor of medicine.

Over a two-year period, a group of 45 patients with various types of heart disease were studied by the investigators. The 16 males and 29 females ranged in ages from 17 to 65 and included those whose heart was forced to pump more blood (volume overload); those with a narrowed heart valve (pressure load); and those with a poor heart muscle (no volume or pressure load).

Dr. Falsetti explained, "Hoping to find a sensitive indicator to the heart's performance, we assessed the various indices of contractility by two methods. The first was by use of cardiac pressure measurements alone. The second was by use of cardiac pressure measurements together with cardiac geometry. In this latter, Dr. Mates was instrumental in developing a simplified mathematical model to describe the pumping action of the heart. A one-plane cineangiography method (movies of the heart), developed in Buffalo by Drs. Greene and Bunnell a decade earlier, made measurements and statistical correlations of heart function possible."

Dr. Falsetti pointed out that consistency with clinical evidence was also an important factor in assessing the various indices of contractility. While this procedure has been applied in children by other investigators, he noted that "ours is the first comparative study of the most commonly measured parameters of contractility. Our procedure — to estimate how much damage there is to the heart muscle — is the most sensitive as well as the most accurate indicator of the heart's performance of all indices for contractility that we have tested."

Dr. Falsetti started his research on stress/strain relationships three years ago under grants from the Western New York Heart Association and United Fund. The results of this preliminary work has been published in the January issue of *Circulation Research*.□



From the Desk of
Dean Le Roy A. Pesch

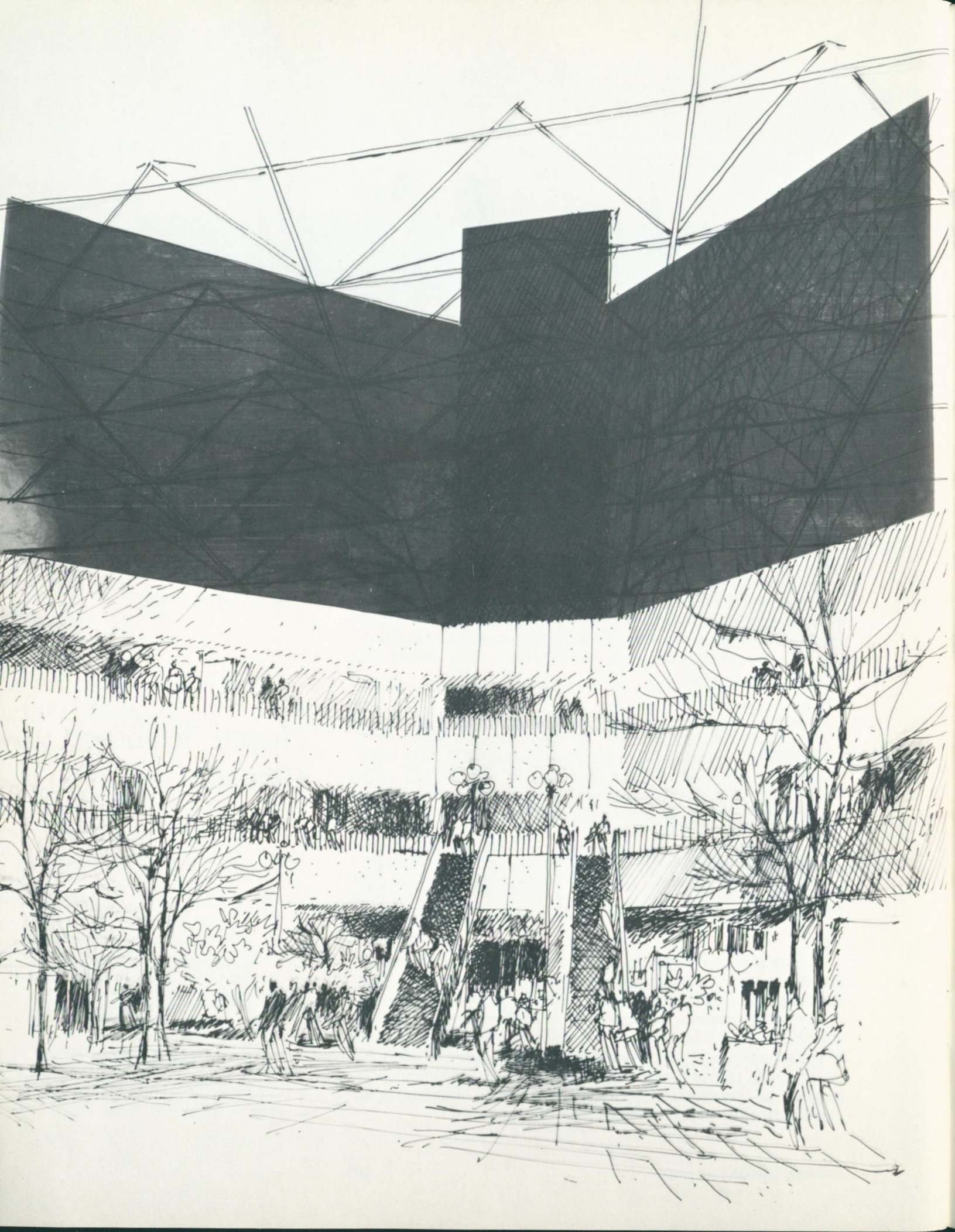
Health Sciences Clinical Center

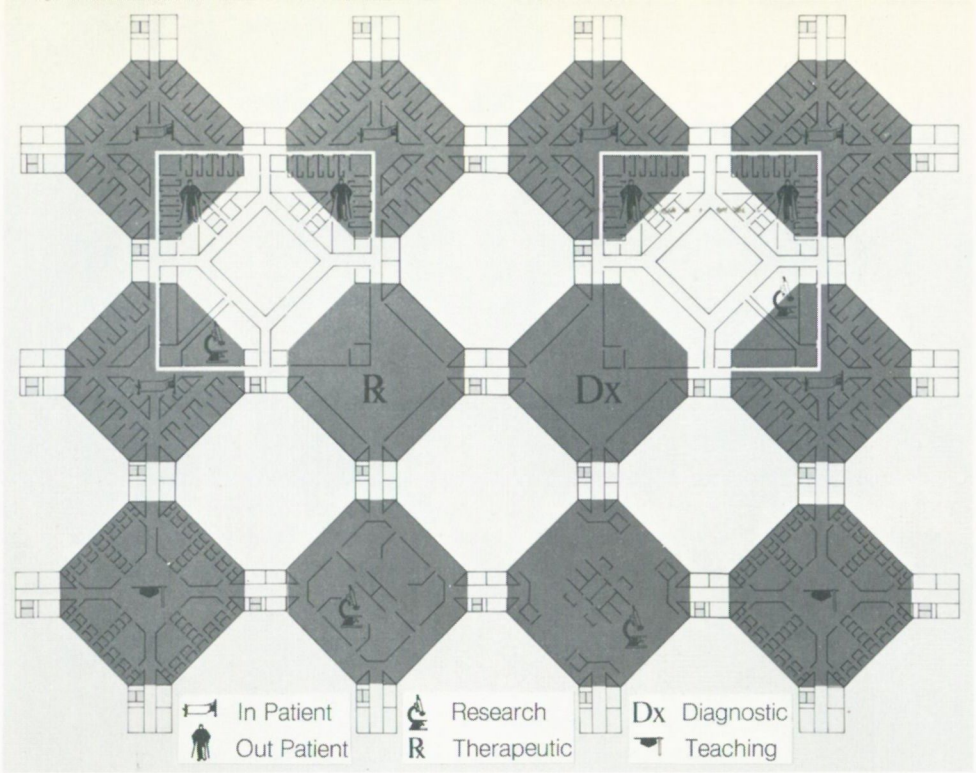
The changing nature of health, including the increasing demand for health care by a more sophisticated public, the rapid increase in medical knowledge, the realization within the profession of the importance of both environmental and personal preventative services and many others has put an acute strain upon the present concept of the hospital.

The new Health Sciences Clinical Center will strengthen exising community health systems and develop new ones. This facility will offer a range of services from general medical care through referral service to the larger medical institutions. It will function primarily on an out-patient basis. It will reach many people in need of health care: those who don't know where to go for help; those who are unable to travel to health care sources; those who are overwhelmed by the nature of the hospital; and those who are unaware of their need for medical attention.

We are planning a facility that is sensitive to the constantly changing needs of physicians, administrators, nurses, and other professional students and patients — as affected by medical and technological progress. The new facility will provide for ongoing activities of health professionals; flexibility to permit conversion of any area to a new use; integration of the expansion or addition of any health related function into the already existing circulation systems (of personnel, supplies, patient, etc.); structural and mechanical efficiency; and human scale environments.

Health Facilities Planning Personnel: Gyo Obata, principal in charge of design; Terrence Cashen, vice president for design; Alvin Lever, vice president for design. The State University Construction Fund.





The concept of the module is being used in the design of the new Health Sciences Clinical Center. Each module provides enough air, light, mechanical services and space for the needs of one person. In this new "activity oriented module" concept we are developing space for a variety of functions — diagnostic treatment centers, ambulatory and in-patient areas, research laboratories, teaching space and common facilities related to patient care and health delivery (food preparation, maintenance, information resources, etc.). Investigations indicate that an area of approximately 10,000 square feet (one-fourth the size of a football field) is a very effective space for the conduct of these various activities.

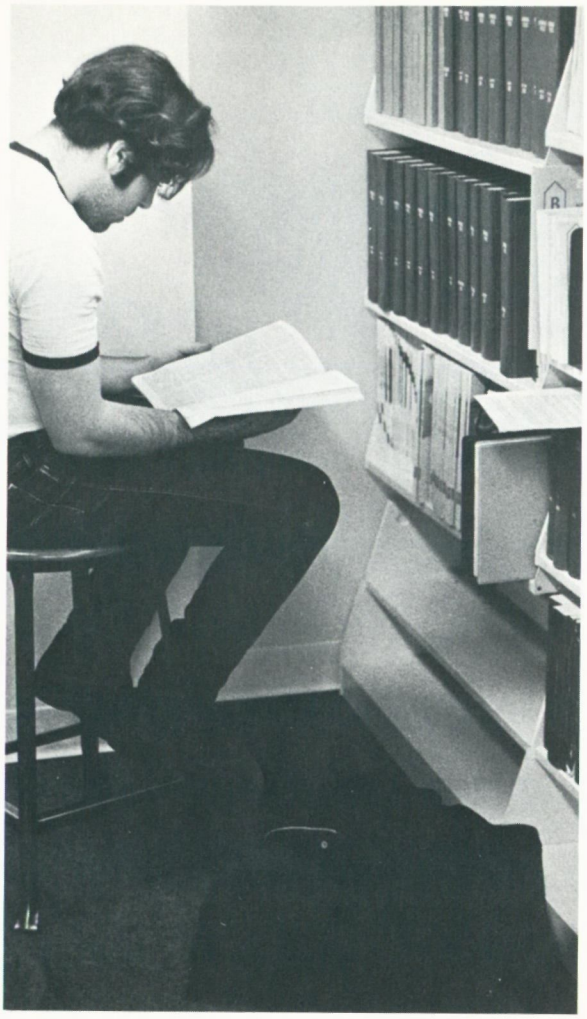
Modules must serve many different uses and must have the built-in capacity to change functions to accommodate new programs. This means every module must be designed to be capable of accepting sophisticated equipment if the program requires it. Since each module is a large open space partitions can be mounted and demounted as the program dictates.

To achieve the program flexibility necessary for major health care facilities it is necessary to establish a network to tie the modules together. Each module is related to four cores which contain stairs, elevators, mechanical and electrical distribution, etc. The cores link modules together vertically and horizontally. Expansion of a particular activity can be accomplished by plugging in more modules to the existing network. This system eliminates disruption and disorganization caused by erratic and incoherent growth.

The network provides the physical basis for connecting related activities. Each module can have as many as six adjacent modules: one above, one below, and four on the horizontal plane. This allows formation of horizontal, vertical and combination activity clusters.

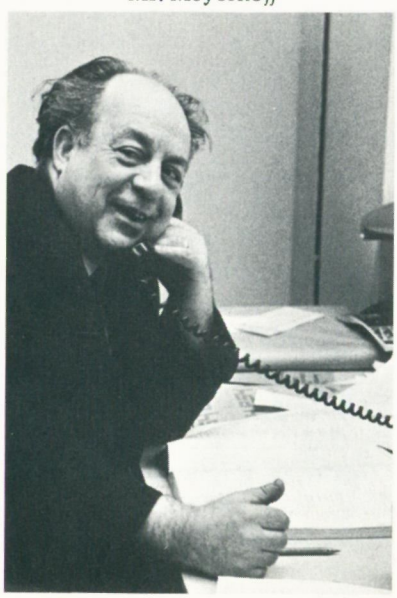
In concept, the entire complex is organized on the modular grid. The open-space volumes between the major functional areas are also modules of approximately 10,000 square feet. At the main levels, these modules provide floor space and additional vertical and horizontal circulation for the core-module network. Above, the module volumes are open and admit light and air into the complex. The network is the basis of all circulation of personnel, patients, students, materials, equipment, etc.

The modular concept does not impose solutions on health care administrators. Rather, it offers them the means to implement their philosophy, growing as programs are planned and the funds to back these activities become available.□



The Health Sciences Library

Mr. Meyerhoff

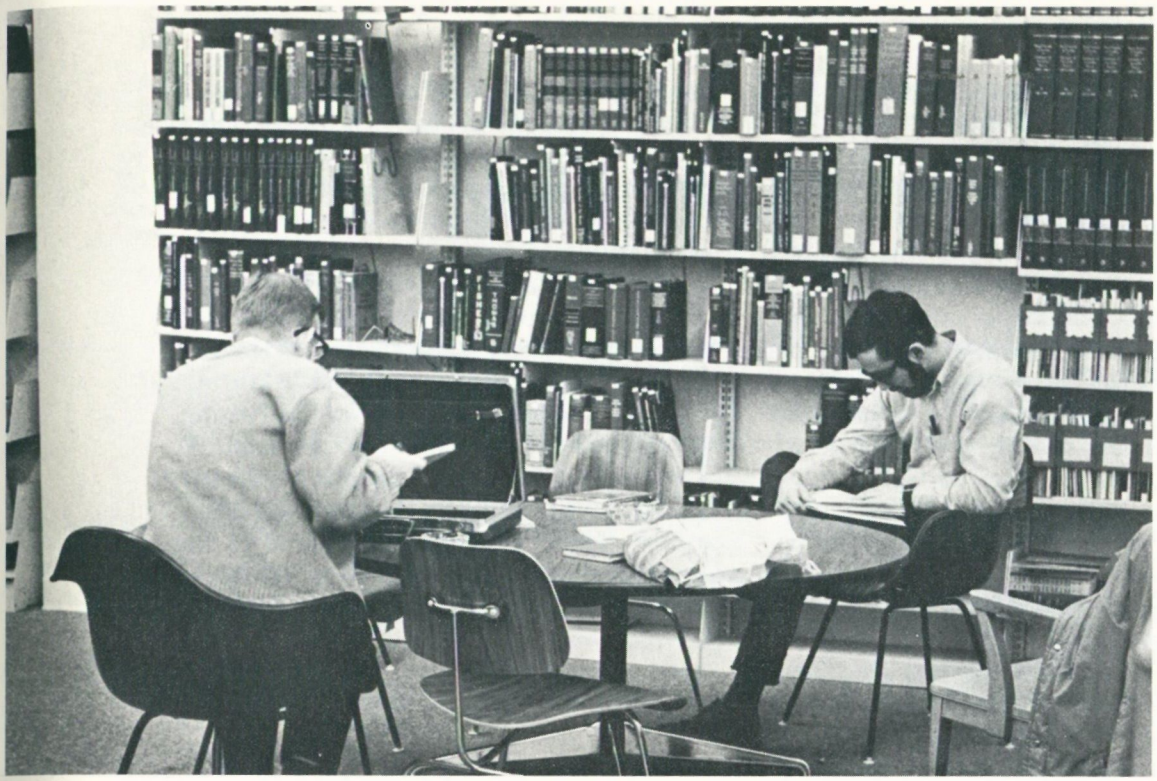


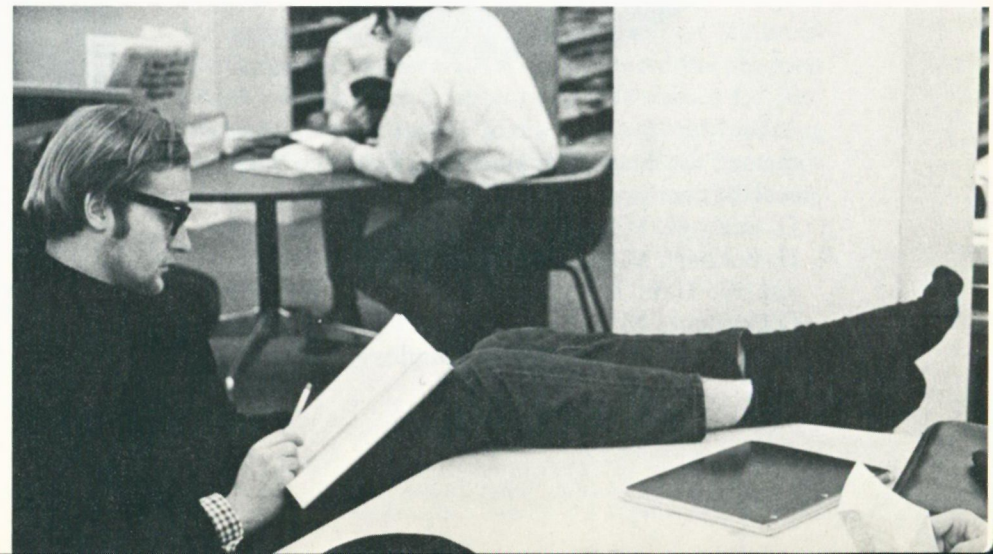
FACULTY AND STUDENTS are impressed with the new improvements of the Health Sciences Library at 141 Capen Hall. Librarian Erich Meyerhoff is happy with the acceptance of the "new look" and the increased use of the library.

A $19,000 Medical Library Resources Grant from the National Library of Medicine triggered the improvements. Everything is new — tables, chairs, desks, files, racks, and lights — not to mention drapes and carpet. It all adds up to a pleasant, noiseless atmosphere that makes for easy and improved study.

"We changed the flow of traffic and are utilizing our floor space (14,490 sq. ft.) to better advantage," Meyerhoff said.

Some 750 people visit the library daily. They are in search for something in one of the 107,585 volumes (two-thirds are journals and one-third books) or from one of the 3,275 periodicals. □



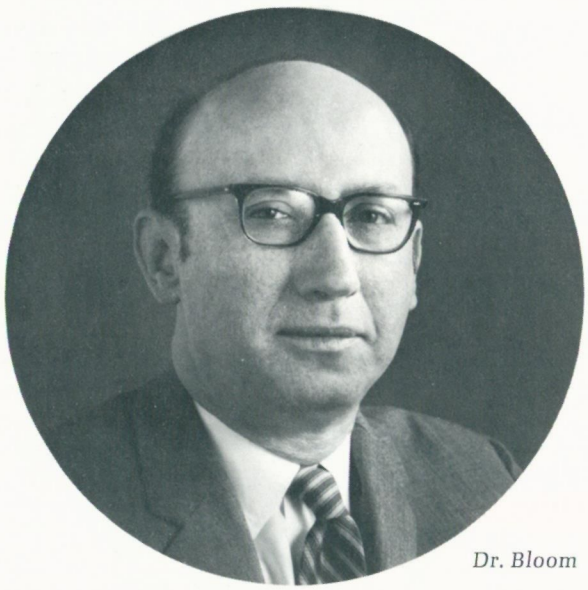


People

Dr. Carel J. van Oss, associate professor of microbiology, has been appointed Honorary Dutch Vice-Consul for Western New York. Previously he had been named in a royal commission by Queen Juliana of the Netherlands.□

Three alumni were elected officers of the Mount St. Mary's Hospital medical staff, Niagara Falls. Dr. Boris A. Golden, M'40 is the new president; Dr. Glenn R. Arthur, M'47, vice president, and Dr. Melvin B. Dyster, M'52, secretary-treasurer.□

The first joint meeting of the 132-year-old New York Academy of Science and a foreign scientific society will be co-chaired by Dr. Ernst H. Beutner, professor of microbiology. The meeting will be in Stockholm May 13-15, and will focus on Developments in the Application of Defined Immunofluorescent Staining.□



Dr. Bloom

Dr. Marvin L. Bloom, M'43, is the new president of the Annual Participating Fund for Medical Education. Other officers are Drs. Harry G. LaForge, M'34, first vice president; Kenneth H. Eckhert, M'35, second vice president; Donald W. Hall, M'41, secretary; and Kevin M. O'Gorman, M'43, treasurer. The immediate past president is Dr. Max Cheplove, M'26. □

Dr. Joseph L. Campo, M'54, is the new president of the medical staff of St. Joseph Intercommunity Hospital, Cheektowaga. Other officers are — Drs. Eugene Cisek, vice president; John S. Sauer, secretary; and Eugene F. Norman, treasurer. □

Four alumni have been elected officers of the Buffalo Gynecologic and Obstetric Society. The new president is Dr. Harry E. Petzing, M'46. Others named are Drs. Carmelo S. Armenia, M'49, vice president; Morris Unher, M'43, secretary; and Donald W. Hall, M'41, treasurer. Three alumni were elected to the executive council — Drs. William A. Potts, M'44; Harold J. Feldman, M'43; and Henry L. Pech, M'50. □

THOUGHTS IN A MICROBIOLOGY LAB
(1968)

The cry of the wheezing guinea pig
Screams through the rainy day's air
To shatter my ears with its impending Death.
It suffers the pain of asphyxiation
To educate us with irrelevancies.
You say that you want to bring humanity
Back into medicine. You say that you
Live for life and the human race.
Physician, heal thyself of thine ills
And stop this wanton murder
Of a lowlier species, and, with this,
Return life not to the dead rodent,
But return life to your dead soul.

— Ken Solomon, '71
State University of New York at Buffalo

(Reprinted from THE NEW PHYSICIAN, June 1969)

Dr. Eric A. Barnard, professor and chairman of biochemistry, is editor of the *Journal of Molecular Evolution*. He is also chairman of the Medical School's negotiating committee with minority group representatives.□

Dr. John F. Moran, assistant professor of biochemistry, has been elected to the Board of Directors of the United Health Foundation of Western New York for a three year term.□

Dr. Charles E. Wenner, research associate professor of biochemistry, is associate editor of *Cancer Research*.□

Co-authors of a book, *"Roentgen Diagnosis of Rheumatoid Arthritis"*, is Dr. Ru-Kan Lin, clinical assistant professor of radiology, and Dr. David L. Berens, clinical associate. Both are on the staff of Buffalo General Hospital.□

Dr. Joseph D. Godfrey, M'31, has been elected vice-president of the American Academy of Orthopaedic Surgeons. He is clinical professor of surgery at the University and team orthopaedist for the Buffalo Bills. Dr. Godfrey is also chief of orthopaedics at Mercy and Children's Hospitals and attending orthopaedic surgeon at Buffalo General Hospital. Dr. Godfrey became a Fellow of the Academy in 1948, the nation's largest organization for specialists in bone and joint surgery. He has directed postgraduate education programs in sports medicine in the Buffalo area the last two years. He is a founder member of the Orthopaedic Research and Education Foundation, a member of the Orthopaedic Association, International Society of Orthopaedics and Traumatology, and Pan American Medical Association, and is a former Governor of the American College of Surgeons.□

Dr. Godfrey

GEORGE MILLER STERNBERG (1838-1915) bacteriologist and epidemiologist of the US Army Medical Corps, was born in Otsego County, New York, the son of a Lutheran minister. He attended the Buffalo School of Medicine and the College of Physicians and Surgeons in New York city. He enlisted in the Federal Army early in the War Between the States and was captured in the Battle of Bull Run. Sternberg held various posts in the Medical Corps and during the Spanish-American War became Surgeon General. Maintaining meanwhile, a deep interest in basic bacteriology and immunology and experimental epidemiology, he recommended Walter Reed to the pathological laboratory at Johns Hopkins University in preparation for his experimental studies on yellow fever in Cuba. Sternberg's most important treatise, *A Manual of Bacteriology*, appeared in 1892 followed by a monograph, *Infection and Immunity*. While in the Surgeon-General's office he supported the program which provided for a corps of female nurses for permanent Army hospitals and sponsored the founding of the Army Medical School. He served as President of the American Medical Association in 1897-1898.

(Composite by G. Bako with permission from the Editor of *The Journal of the American Medical Association*)

People

A 1921 graduate of the Medical School was honored in February for his 21 years as a member of the Erie County Board of Health. He is Dr. Antonio F. Bellanca, a 71-year-old physician, who was appointed to the board in 1948, when the Buffalo Health Department was merged into a county health department.

Dr. Bellanca, who retired December 31, 1969, is confident that he and his colleagues on the board have done an outstanding job for the citizens of the county. He pointed out that the Erie County Health Department has kept abreast of health care advances such as health clinics and immunization programs.

He was president of the Western New York Heart Association in 1953; the Erie County Medical Society in 1954; and is chief of medicine at Columbus Hospital. He served almost four years in the Army in World War II, most of the time as chief of the 40th Medical Station in North Africa.

Looking back on almost 50 years he has enjoyed meeting patients face to face in his office. He doesn't believe he could fit into the computerization that will soon be the pattern of modern medicine.

"The personal touch will be gone. I feel too old and rigid to accept computerized medicine, even though I know we must reconcile ourselves to it if we are to offer good quality medical service to everyone," Dr. Bellanca said.

"I want to continue my own practice on a personal basis. I like to sit down in my office and talk to my patients. This is what I intend to continue doing."□

Three alumni have been re-elected officers at Lafayette General Hospital. They are Drs. Lucien Potenza, M'58, vice president; Mario Collura, M'53, treasurer; and Victor Lazarus, M'45, secretary. Dr. Alexander Perlino was re-elected president. Dr. Franklyn Campagna, M'58, chief of medicine was elected to associate membership.□

Dr. Jules Constant, clinical associate professor of medicine, has authored a new book, *"Bedside Cardiology."*□

Dr. John K. Dustin, clinical assistant professor in medicine, is the new president of the medical staff of Millard Fillmore Hospital. Three alumni were elected to other staff offices. Dr. Kenneth S. Kelly Jr., M'50, is president-elect; Dr. Paul M. Walczak, M'46, is treasurer; and Dr. Donato J. Carbone, M'46, was re-elected secretary. The immediate past president is Dr. Pasquale A. Greco, M'41.□

Dr. Vincent Scamurra, M'50, won the Buffalo Squash Racquets Association's Veterans Tournament for the first time. The former city champion defeated defending champion Jinx Johnson, University Club, in the finals.□

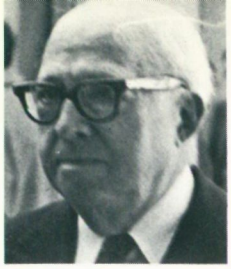
Dr. S. Mouchly Small, professor and chairman of the department of psychiatry, has been elected to "corporate membership" of the Muscular Dystrophy Association. He has been on the national advisory board since its inception.□

Dr. Paul M. Walczak, M'46, is the new president of the New York State Society of Surgeons Inc. He is an attending surgeon at Millard Fillmore Hospital.□

Two physicians were installed Fellows of the American College of Obstetricians and Gynecologists recently. They are: Drs. Ronald E. Batt, M'58, and Theodore Schulman, a clinical instructor.□

Dr. Walter S. Walls, M'31, is the new president of the New York State Medical Society. He is also clinical associate professor of surgery at the University.□

Three alumni and their spouses were in a special group that participated in a combination "business-pleasure" trip to Africa. They were Drs. Thomas Syracuse, M'33, Harry Schweigert, M'39, and Elizabeth Olmstead, M'39. The trip included medical and surgical seminars, a tour of the American Hospital Ship, the SS HOPE, and a camera safari. The physicians also visited hospitals in Rabat, Nairobi, and Tunis.□



Dr. Heyd

In Memoriam

Dr. Charles Gordon Heyd, M'09, died February 4 in New York City at the age of 85. The distinguished surgeon, who retired in 1955, was president of the AMA in 1936-37. He was the oldest living past president.

Dr. Heyd was a former director of surgery at New York Post Graduate Hospital and Medical School, and a professor of clinical surgery at Columbia University. He had also served as president of United Medical Service, a prepaid medical insurance service, from 1948 to 1951.

A native of Brantford, Ontario, he became a United States citizen in 1917. He graduated from the University of Toronto in 1905. After graduating from the UB Medical School, Dr. Heyd took post-graduate work at Harvard, and in London, Berlin, and Vienna. In World War I as a major, he commanded a hospital unit in France.

He was president of the County Medical Society in 1932, the state society in 1933, and was vice president of the American College of Surgeons in 1932-33. He was a former consulting surgeon to Greenwich (Conn.) Hospital and the New York City Police Department. He was also a former president of the Canadian Society of New York.

Dr. Heyd received the Legion of Honor of France in 1932, and was author of *"Liver and Its Relation to Chronic Abdominal Infection,"* and about 200 monographs on surgery.

Dr. Heyd opposed compulsory health insurance and socialized medicine but advocated voluntary medical insurance and public health testing. He urged free state medical service for those who required it but were unable to pay.

He maintained close relationships with the University throughout the years. Dr. Heyd founded the first New York City Area Alumni Club, was its first representative to the General Alumni Association and was a former trustee of the School of Medicine Alumni Association. He played a leading role in explaining the University's merger with State University and the need for continuing alumni support, through a pamphlet entitled "The Challenge of Adaptation," which was widely distributed to his fellow alumni in the early 1960's. □

A clinical professor of medicine, who retired in 1968, died February 14. He was 71-year-old Dr. Donald R. McKay. He was former president of the American College of Chest Physicians, Buffalo Academy of Medicine, and the medical staffs of E. J. Meyer and Millard Fillmore Hospitals. He was director of the Buffalo and Erie County Tuberculosis Association for more than 20 years, and president for seven years. He was also president of the Tuberculosis and Respiratory Disease Association of Western New York. After graduating from the University of Toronto Medical School in 1925, he interned and did his residency at Buffalo City Hospital (predecessor to the Meyer). He stayed on at the Meyer in charge of tuberculosis service until 1939. He was also consulting physician at Millard Fillmore and nine other Western New York Hospitals. He authored many papers on pulmonary disease, held honorary memberships in tuberculosis associations of Brazil and Mexico, and was active in many professional societies at the regional, state, and national levels. In 1960 the American College conferred upon Dr. McKay the degree of master of the College of Chest Physicians.□

Dr. Carlton C. Rausch, M'43, died January 29, after a short illness. The 48-year-old general practitioner was on the medical staffs of Millard Fillmore (obstetrical anesthesia division) and St. Francis Hospitals. Dr. Rausch was a Captain in the Army Medical Corps in World War II and the Korean War. He received a presidential citation for his service in the Philippines. He interned at Millard Fillmore and Buffalo General Hospitals. He was active in several local, state, and national professional associations.□

In Memoriam

Dr. Lauren G. Welch, M'34, died March 17 at the Niagara Falls Memorial Medical Center. The 62-year-old physician was Niagara County Health Commissioner. He was appointed to this position in October of 1969, after serving as assistant commissioner for several years. He was also quarantine medical officer at Niagara Falls International Airport. Dr. Welch enlisted in the U.S. Navy at the outbreak of World War II and was discharged six years later. During his four-year tour of the Pacific theater, he received the Bronze Star and the Purple Heart. Following the war he entered Columbia and Ohio State Universities for postgraduate work in medicine. At one time he was chief of staff of Mt. St. Mary's Hospital in the town of Lewiston and at the former Memorial Hospital of Niagara Falls. Dr. Welch also worked in industrial medicine with the Carborundum Company. He was active in several civic and professional organizations. □

Dr. Carol B. Graham, M'43, a former internist and associate professor at the Medical School, died March 22 at Roswell Park Memorial Institute after a long illness. She retired eight years ago. Dr. Graham was on the faculty for 19 years, specializing in endocrinology. She joined the staff of the E. J. Meyer Memorial Hospital in 1943 and was head of the Endocrine Service when she retired.□

Dr. Gerald W. Grace, M'42, died March 2 of a heart attack. The 54-year-old physician was director of Sisters Hospital Outpatient Department and Canisius College Student Health Office. He was also head physician for Mt. St. Joseph Motherhouse, and on the staff of Emergency Hospital. Dr. Grace was a Captain in the Army Medical Corps in the Pacific during World War II. He was active in several local, state, and national professional associations.□

Dr. Frank A. Kruse, M'15, died March 3 after a brief illness. Two years ago he was honored by the Erie County Medical Society for his 50 years in medicine. Dr. Kruse served with the army in World War I.□

Dr. Anthony Romeo, M'43, died March 6 in the Pamona, California Community Hospital of a heart attack. The 53-year-old physician practiced in Buffalo from 1947 to 1960. He was on the staffs of Millard Fillmore, Deaconess and Columbus Hospitals. Dr. Romeo served in Europe during World War II with the Army Medical Corps.□

Dr. Bernard J. Dolan, M'24, died March 11 in Sisters Hospital after a long illness. The 70-year-old physician had practiced medicine in Buffalo for 41 years, after interning at the E. J. Meyer Hospital. Dr. Dolan was a past president of the staff of Sisters Hospital, and active in several professional organizations.□

Dr. Thomas G. Allen, M'21, died March 17 in Buffalo General Hospital. The 76-year-old physician took over an industrial practice from his father. Dr. Allen served in the medical corps during World War I, and was a draft board physician during World War II. He was active in several professional organizations at the local and national levels. □

Dr. Arthur L. Runals, M'11, died March 19 in Fort Lauderdale, Florida at the age of 81. He was chief of staff and head of the department of surgery at Olean General Hospital, Olean, N.Y. until his retirement in 1953. Dr. Runals was a Fellow of the American College of Surgeons, a member of the Medical Society of the County of Cattaraugus, the Medical Society of the State of New York and the AMA.□

Two 1970 Alumni Association Tours

I. "EXPO-70" TOUR — AUGUST 16 - SEPTEMBER 5 (21-DAYS)

$1,389.00 per person from Buffalo
$1,339.00 per person from Chicago
$1,183.00 per person from San Francisco

(plus $13.72 taxes payable at time of booking)

Stops include: San Francisco, Honolulu, Manila, Hong Kong, Kyoto (Expo-70), Tokyo, Honolulu.

Tour Escort: Henry E. Mark of Hallmark Travel Agency, Inc.

II. "BAHAMAS HOLIDAY" — NOVEMBER 15 - 27 (8-DAYS, 7-NIGHTS)

$285.00 per person (twin room occupancy) at the exclusive KING's Inn & Golf Club, Freeport, Grand Bahama Island

For details write or call:

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State University of New York at Buffalo
Buffalo, New York 14214
(716) 831-4121

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