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The above picture was taken with the use of one of medical photography's newest techniques—the fish-eye lens. This photographs 180 degrees in all directions which is almost more than the human eye can see. This scene was photographed in one of Flower and Fifth Avenue Hospitals' operating rooms. The motion picture camera is almost ten feet away.
Dr. Wagner in front of the hatch of the Apollo space vehicle (faintly visible above him). The Apollo is one of the vehicles to pave the way toward a successful manned lunar landing by 1971.

BY BERNARD M. WAGNER

Man's New Environment

Head of the Department of Pathology, Dr. Wagner—who has made two trips to the space laboratories in Moscow—has become a recognized expert in the problems attendant to man's exploration of space. He has been a member of the Aeromedical and Bioscience Panel, Scientific Advisory Board, Chief of Staff, U.S. Air Force.
It is now inevitable that man will explore the universe. The technology is pending and a new era is at hand. There are those who cling to the notion that man does not belong in this new environment and that from a scientific basis, equal information can be acquired without the interposition of man between the vehicle and the space object.

Research efforts in support of man in space go back at least to World War I. By the second war, the Air Force had developed considerable research and development skills in human engineering, selection and classification of personnel, training programs and aircraft simulators. Advanced aircraft design required extensive and sophisticated facilities to successfully place man into aerospace and true outer space.

Each Vostok flight grew out of the one which preceded it in an orderly and progressive fashion. The Russian commitment to a carefully planned, step-wise cosmic program with man as the center is now very clear.

Our program, derived from a military missile effort, has treated the biological aspects of space flight as secondary, to be fitted into slots made available by crowding, shifting or reducing internal hardware of the vehicle. Biological exploration in space has been an afterthought. Within the biological scientific community, one group advocates a careful, deliberate approach to space flights using non-human forms. This is in the tradition of the biologist. Another group contends that the classic approach can be jumped by using man in imaginative and daring studies. The end results of these contradictory points of view is a research and development program filled with paradoxes.

Organization of the Soviet Cosmic Program reveals a tight overlap of scientists, politicians and military. The Academy of Sciences and the Academy of Medical Sciences with their numerous research institutes and the universities are coordinated with the Soviet Praesidium, Supreme Soviet and the Central Committee. It is of interest to note that 40% of the membership of the Russian political bodies analogous to our Congress have earned scientific degrees. This contrasts with
If there is a bioastronautics time table, it appears that the next six years require successful Gemini, Saturn and Apollo programs in order to achieve a manned lunar landing not later than 1971. Somewhere in the midst of these demanding efforts we now have a committed Manned Orbital Research Laboratory (MORL or MOL) program. Current plans require launching of MORL from Cape Kennedy as an orbiting satellite in a circular near-earth orbit. The Gemini vehicle will serve as a ferry to bring at least four astronauts to the satellite for a possible stay of 90 days.

In order to accomplish this, the techniques of rendezvous and docking must be perfected. These procedures are exceedingly difficult when one considers the speed of the orbiting satellites in the complete vacuum of space. The more important areas of research to be studied in the space laboratory include the effects of prolonged weightlessness and radiation on human functions. The estimated cost of MORL is close to one billion dollars while the current budget for biological research is 87 million dollars.

**EFFECTS ON MAN STUDIED**

Acceleration forces on launching may reach 7 to 10 g for short exposures. Pressure suit research must continue to give the astronaut maximal protection and survival under all conditions. The specially designed Mercury contour seat has proved effective but is limited. Newer methods of protection include development of seat materials which are light, strong and capable of deformation under unusual stresses. The possible use of water submersion to protect against high g forces is under intensive investigation. Recent studies utilizing completely submerged animals indicate the feasibility of the idea. Also, the water could be utilized for a variety of on-board purposes.

Re-entry will again expose the astronaut to high g forces due to deceleration. The re-entry corridor is narrow with a limited angle of insertion. One type of error could speed the astronaut past the earth back into space, while an opposite error could set up severe tumbling of the vehicle. Within these extremes, life support systems must be redundant enough to sustain the astronaut. An added problem to the re-entry phase will be the condition of the astronaut following prolonged weightlessness.

Weightlessness is a unique environmental parameter to which man has never had to adapt. The Soviet and American experiences indicate that for brief periods man can tolerate weightlessness. During “zero g” man can function adequately as far as we know. Prolonged exposure to this condition presents certain problems concerned with bone dynamics and mineralization, muscle mass, central nervous system functions and cardiovascular physiology.

Rapid shifts of the crystalline structure of bone to a soluble form with resultant loss of calcium is a definite possibility during prolonged zero g. Associated with this process of demineralization or osteoporosis is loss of muscle mass leading to muscular atrophy. Fundamental studies concerned with the relationships of muscle and bone function and the factors that maintain an effective equilibrium are necessary. What kind of exercises help the astronaut? Is electrical stimulation of muscle groups a possible answer? What is the nature of the nervous and circulatory components of muscle atrophy and decalcification?

There is reason to believe that the interpretation of different signals by the brain may be attenuated during prolonged weightlessness. While cardiac work is decreased, blood pressure must be maintained. The highly complex, inter-related systems of reflexes are maintained by a variety of physical and chemical sensors. Are the mechanical properties of the walls altered? Do the baroreceptors respond effectively? Is the concept of “cardiac atrophy” tenable?

From our own studies of astronauts, it is obvious that severe post-flight hypotension occurs. The Soviets have been worried about this and Professor V. V. Parin has written extensively on the subject. If it is not practical to control these adaptive responses, then it may be necessary to impart a partial g force to the vehicle. Creating such forces in space presents a problem of considerable magnitude which may delay the space program indefinitely.

**RADIATION A HAZARD**

Manned operations in space will require flights in the Van Allen Belts and there is general agreement that accurate determination of personnel hazards due to the ionizing radiation of these belts must be made. Based on current data, an unshielded man at 1200 kilometers would receive an electron dose of 160 rad/hr to the skin and a proton dose of 0.7 rad/hr total body radiation. Protection against the harmful effects of radiation is best afforded by shielding but this adds weight to the vehicle.

(Continued on page 24)
Chronic disease care, viewed in perspective, has basically evolved from the old poorhouse concept. In New York City, the Department of Hospitals had its poorhouse or "home" which was, of necessity, the overflow facility for the general hospital and served the economically and socially deprived. As the population in the home accumulated, some medical services had to be provided—a little clinic where the doctor could come once a week to examine patients, a few infirmary beds. Eventually, the infirmary and the medical service became more substantial, changing and distorting the original purpose of the institution. Only after the distortion became overwhelming did recognition catch up with the reality. City Home for Dependents, which was replaced by Bird S. Coler Hospital, was called a home although it provided hospital care for many years, and Bird S. Coler Hospital did not fully evolve as a hospital until it was recognized that there was need for a Center for Chronic Disease, not just a fancy medical poorhouse.

BY
MILTON LOWENTHAL

Dr. Milton Lowenthal is Professor and Chairman of the Department of Physical Medicine and Rehabilitation. He was appointed Director of the New York Medical College Center for Chronic Disease at Bird S. Coler Hospital and Home on Welfare Island, N. Y.
When we examine traditional practices, it becomes apparent that the community tends to isolate its helpless and luckless; Welfare Island is a good example of this. The fact that space was available for a chronic disease hospital on the Island was not the only consideration in choosing a site for Coler. We are unhappy in the presence of concentrated misery and it is better to have it out of sight. Knowing this, one of the goals we have at the Center is to return to the community. We are, in effect, trying to find the devices that will permit the community to allow us back in. We cannot sermonize or heap shame on society, but we can perform some vital services to groups outside the Center.

When we direct our attention to the organization of medicine today, we find that it is set up for the care and treatment of the acute episode. In addition, we recognize that in any good medical institution care is organized on a highly specialized basis, so that a patient admitted for service will be diagnosed in terms of his specific organ system involvement. He will be admitted to the cardiac service, the renal service, the vascular service, and to subdivisions of specialists. In the process, he will receive excellent care of his disease, but I recall a social scientist saying: “He does not get real care of his sickness,” if you define sickness as the interaction of the disease and the patient. The result is that he may get his organ system straightened out, but the patient as a person may not be straightened out and his ability to function may remain impaired even though, from a technical viewpoint, he has received the finest medical care available. I stress technical because this is what care has developed into—highly skilled technicians applying their energies to a particular problem. There is no question that we, in this country, have achieved a high level of proficiency in this area.

Chronic disease care, however, if it is to be truly therapeutic, has to reckon with the “sickness.” Focus has to be on the patient, something we all subscribe to, but have not really practiced. Basically, we lack the knowledge, and some of the organizational processes within which we must function limit us in even making a first step.

As our “first step” in establishing a patient-centered program, we have decided to restructure our internal organization and break away from the patterns of the general hospital. First of all, we have eliminated the concept of separate services within the institution and our staffing pattern is based on the interrelationship of five major groups:
1. The internist will concern himself primarily with disease diagnosis and medical treatment. Hopefully, as the internist becomes more experienced in chronic disease care, he will make a contribution not only within the conventional parameters of patient problems in internal medicine, but also in the specialized areas of chronic disease and the conditions which are peculiarly characteristic of the aged. He will be able—even though he is himself a super-specialist—to achieve integration of the disease with the patient, so that he will be diagnosing "sickness" even at the level of internal medicine. It is anticipated that he will also be able to participate in a broader concept of patient care as part of the hospital team. Eventually, however, the internist will be primarily concerned with providing total patient diagnosis and therapy in his own immediate sphere; this will often involve more than one system as the aged and chronically ill have multiple diseases.

2. The physiatrist, working closely with the internist in this process, will make his contribution in terms of translating the disease diagnosis into functional concepts. He will address himself to the questions of how the disease impairs the patient's ability to function, what residual capacities are available, and how they can be approached in terms of improving function.

3. The psychiatrist will be involved with the other two physicians in the behavioral aspects of the "sickness" and will really help to maintain the focus upon the patient. My own feeling is that in spite of the commitment of the internist and the physiatrist to the total patient, they must, of necessity, pursue their
special technical interest and cannot really concentrate entirely on the patient as a person.

4. The social worker will play a very similar role. Her function will be to sustain emphasis in the social service work-up on the patient or "sickness," so that the physicians will be able to make their medical decisions within the framework of the patient rather than within their respective specialties.

5. The nurse will carry out her traditional nursing duties of participating in disease diagnosis and implementation of therapy, both the purely medical and the functional. In order to retain the focus on the patient, the nurse's communications with the physicians and the social worker will have to be exceptionally close since, as everyone agrees, the patient resides in the domain of the nurse during his institutional stay. She will, therefore, have to have her skills improved in the areas of understanding disease, the effect of disease upon function, and the therapeutic implications of the relationship of these factors. She will also have to be very much concerned with the behavioral consequences of the sickness.

With this "five finger exercise" we hope to avoid the fragmentation of the patient which has been an almost inescapable reality in the past.

CHANGING APPROACH TO CHRONIC DISEASE

The next step in achieving a patient-centered program should lead to changing the traditional grouping of patients within the hospital. Obviously, a distribution by disease labels would no longer be appropriate. Such factors as functional status, the rate of progress of a disorder, should be the determinants in such distribution.

At the present time, a chronic disease facility is equivalent to the last slot in a giant sorting mechanism. A patient passes through a series of stages from care at home, to a clinic, to a general hospital—quite frequently, repeated admissions to a general hospital. His experience is often continued deterioration, lack of perspective of the long-term problem, treatment of each acute onslaught as a separate incident; eventually he reaches the point where his physical and economic resources are exhausted. The situation in the community then becomes untenable and at that point he drops into the chronic disease facility slot. He arrives, of course, depleted, so that opportunities for prevention, for maintenance of health in terms of his capacity to function and make use of his personal resources, have almost completely vanished. Opportunities for salvage at Bird S. Coler are, as a consequence, terribly limited.

Quite clearly, a major responsibility of our program should include the prevention of the process by which the patient reaches the chronic disease facility. To reverse this process would require the professional staff to move out and establish close contacts with the community facilities that now serve as the main sources of referral to the chronic disease hospital. Such contracts would include examination of patients early in the course of their acute admission when there are indications that extended care will be necessary. The evaluation would bring to the bedside of the general
In the field of education, the Center is developing affiliations with specialized graduate schools such as The Columbia School of Social Work and the Graduate School of Nursing of New York Medical College. In both cases, the Center will offer opportunities for training in the area of chronic disease for undergraduate and graduate students. These affiliations will differ from the usual use of a facility by a graduate school, namely, assigning students to work with specific patients. The graduate schools will assume responsibility in their respective areas for the clinical activities of the institution, with the teaching an integral part of the professional service. For the field of social work this is a unique concept which promises to contribute much to the building of a patient-centered program.

The Center is part of the medical university concept being developed at New York Medical College, drawing upon the resources of the College and serving, in turn, as a resource for teaching and research. Of paramount importance to the medical university concept is the Center’s development as a community facility. By supporting the concept of community involvement in providing and improving medical care, the College is assuming leadership in the rapidly evolving changes in medical care and education for all the health professions.

In addition to professional support to acute care facilities, the chronic disease hospital should provide similar services to long-term care institutions such as nursing homes and homes for the aged. The emphasis here will have to be on limited health maintenance—activities of daily living—for a population incapable of living independently in the community. In these institutions the emphasis, in terms of education, will be through the professional staff to the non-professional staff who provide most of the services to the patient. For example, we plan to have special training programs for nurse’s aides at Bird S. Coler Hospital with the expectation that these aides will serve within the nursing homes which have direct professional and administrative relations with the Center.
NEW CONCEPT IN PSYCHIATRIC RESIDENCY TRAINING FOR WOMEN OFFERS SOLUTION FOR OTHER FIELDS.

Three years ago, the Department of Psychiatry at the College introduced a new concept of graduate training—a residency program in Psychiatry for women doctors who have children. This unique modification in psychiatric residency training enabled qualified women physicians who are mothers to receive such training by working nine months per year with the summer months off while their children are on vacation.

The two prime goals of the program were to realize an increased number of women physicians entering graduate training in psychiatry and to eradicate, where possible, the automatic difficulties between the role of mother and the role of resident.

The training program was blueprinted to include the following innovations—four nine-month periods replaced the traditional three-year period; where necessary, supplementary educational programs were added; and complete cooperation from male residents was obtained. The continuing study of the graduate training of women indicates that the College’s program could be adapted to other fields of graduate medical education.

The long training and educational period required discourages many women from applying to medical school and the inflexibility of the program complicates the problem. It is necessary today to complete four years of college, four years of medical school, one year of internship and two to five years of residency. Most women received their M.D. at 26, an age when many are married and at the prime child-bearing period. In the average graduate situation, a woman can become a mother and still continue to study. Women physicians cannot do this.

The pattern of graduate medical training does not permit any interruption of the 48-month regimen for pregnancy and motherhood. And the alternatives are not very attractive—either postpone motherhood until completion of training at about 30 or have children and leave their upbringing to others. In medical training this separation is severe and its effect has yet to be properly evaluated. Last, a woman can withdraw from the field, hoping to resume her training when her children are older.

Such demands are obviously the prime difficulties in integrating women into medicine and keeping them active after they receive their degree. The loss of medical women-power in this country is of significant importance. The Department of Psychiatry’s current program is designed to reverse that loss and, although concentrated on our specialty, the program has potential applicability to other areas of graduate medical education.
Our department has a traditional, yet progressive, three and four year residency program. To qualify for general psychiatry, three years of full time training are necessary; for child psychiatry, two years of general and two years of child psychiatry are required. The residency program includes experience in: acute inpatient psychiatric services conducted on psychiatric wards at Metropolitan Hospital; intensive long-term psychotherapy with both adult and child outpatients; narcotics addiction; neurology and psychiatric consultations; experience with chronic psychotics through affiliation at a state hospital; community psychiatry; psychiatric walk-in clinic and emergency room; psychiatric teaching and education and psychiatric research and child psychiatry.

One day each week is spent in organized didactic seminar work which is taught by an eclectic psychiatric faculty. There is intensive individual supervision of all residents from two to five hours each week depending on the training level. All residents serve night and weekend duty varying again with their level. One part of the program is unlike any other in the country as qualified residents are able to attend our postgraduate psychoanalytic school without charge for tuition or supervision with only a small fee for personal psychoanalysis. This program, like other general psychiatric residencies was set up to be completed in 36 months—the period required by the American Board of Psychiatry and Neurology.

A mother-physician seeking to complete a residency in any specialty at an average hospital faces direct effects on her family life. She cannot have summers off to be with her children, a variable amount of night and weekend work is required, and fellow residents, usually males, resent it if a mother fails to carry her full load because such absences from the ward often increases the case-load for other residents. Hence, the woman physician with children who is in residency training is burdened with many more problems than male doctors.

Nevertheless the Department feels that women have made many important contributions to the field of psychiatry and should enter the field of specialty training. They already constitute an important percentage, 10%, of a specialty that is currently faced with a serious shortage. Women are specially well-suited emotionally for psychiatry which is uniquely appealing to them.

Specially-designed changes in the training program for mother residents lessen the friction which exists between the two roles, and they continue to meet the requirements defined by the American Board of Psychiatry and Neurology and the Council on Medical Education of the American Medical Association. High training standards not only have not been compromised but in certain ways, have been enriched.

Our modifications in the residency training program are:

1. Time Sequence Change: The usual psychiatric residency program starts on July 1 and runs through June 30. Since summer, Christmas, and Easter are times when pupils are home on vacation, mothers are allowed to start training September 1, and have summer, Easter, and Christmas off, but they all work a minimum of nine months per year. In order to complete the American Board of Psychiatry requirements,
one must study for 36 months; therefore, it takes a mother in this special program four calendar years to complete training. Certain mother-residents have elected to work for longer periods than nine months, and have been allowed this flexibility. It should be emphasized that the aforementioned is not a part-time but a modified-sequence residency. Mothers work from nine to five daily, in addition to night duty. Major innovation is in time-sequence flexibility. Since our major academic programs, like those at most other training centers, run from September to June, mother-residents actually complete three years of academic work in their first 27 months. Consequently, they are able to have an additional nine months of concentrated study during their last September-through-June period, a period which is not available to other residents. Mother-residents are paid on the same scale as their male counterparts, but are compensated only for periods actually worked.

We have been extremely cautious in modifying night and weekend duty, a period of stress for mothers. The concept that such duty is essential in the training of a physician and psychiatrist because from it he obtains experience with emergency cases, is on his own, and gains a sense of responsibility and self-confidence is consistent with all medical training. Although we have modestly diminished this experience for mothers, our main interest is in assuring sufficient experience for the purposes stated. On the other hand, such a duty should not be excessive or unnecessary, or dictated by needs other than education.

2. The Enrichments: mother-residents fulfill all training requirements of our usual residency program and, in addition, have the following enriching experiences:

RETIRED WOMEN DOCTORS ATTRACTED

Because of increased flexibility we have attracted women physicians who have been in retirement for periods from one to ten years. Many of them have been out of touch with current medicine. For these, we provide individual tutorial instruction, not only in psychiatry but in other areas.

We have decelerated the psychoanalytic training program so that mother-residents may receive the benefits of our concurrent psychoanalytic-psychiatric training program without having excessive demands made upon their evening time.

We conduct a special experience which approximates group therapy for mother-residents and they can share the experiences and problems of the dual life they lead. This experience is not only therapeutic; it is supportive, unifying, and instructive.

The climate of our residency program maximizes the training experience of mother-residents. Male residents and staff members recognize, understand, and tolerate their problems. This has minimized male resentment and has noticeably diminished guilt and anxiety of the mothers about special arrangements made for them.

This special program was started in September, 1962, with four residents. Four more were added in September, 1963, as a result of additional support from the Training Division of the National Institute of Mental Health. None of the mothers has dropped out. More were added in September, 1964. They make up 25% of the total psychiatric resident group in training in this institution.

All our residents take the National Board of Medical Examiners examination in psychiatry annually, and we therefore have an objective, comparable evaluation of their progress. Clinical and personal supervisors are continually requested to evaluate the progress of various residents. In all these areas, mother-residents’ performance has been generally on a par with that of male residents, and we are well satisfied with the progress of all the trainees.

PROGRAM HOLDS PROMISE

At this writing, it appears that this program is feasible, offering practical modifications of training that do not compromise quality but enable women physicians with children to progress readily with training. A number of implications for medicine in general may be derived from the program’s success.

It appears to offer a mechanism for increasing the number of psychiatric trainees without compromising quality.

It shortens or eliminates the premature forced retirement of many women physicians with children by enabling them to continue with their training while they still have small children at home.

It is a more humane approach to the training of this group of physicians; it causes them less anxiety and realistically allows them to gain more from their residency.

Such a program need not produce conflict with male house staff officers if it is properly handled, and if the hospital administration views the situation constructively and is frank with male residents about arrangements that are made.

If young women contemplating medical training can be assured of flexibility in their training after medical school, this may be a major factor in increasing the number of women entering medicine.
ELECTRON MICROSCOPY: AN EXCITING FUTURE

BY JOHANNES RHODIN

Professor and Chairman of the Department of Anatomy at the College, Dr. Johannes A. G. Rhodin has had a distinguished career as a teacher and investigator at the Karolinska Institute in Stockholm, Sweden. He has been recognized internationally for his many significant contributions to the basis fund of medical knowledge in the various areas of cellular structure and function.

The electron microscope is just another tool by which one can magnify tissues and cells so much more than one ever could with a light microscope. This is something in the nature of oversimplification, perhaps, because the rapid growth of electron microscopy during recent years has provided something of a problem for most doctors and scientists who do not deal with the interpretation of histologic slides and photographs in their daily work.

Current medical illustrations are somewhat difficult to interpret not because of any doubt of their informational accuracy but simply because the magnifications used are ordinarily so high that they bear only a vague resemblance to the ordinary light microscopical illustrations in the histology courses of some 20 years ago.

To the layman who takes his first look through any microscope, a tissue, an organ or a cell looks completely different because of its high magnification. The same analogy holds true when a doctor or scientist, more accustomed to ordinary microscopical visions, sees the results of electron microscopy.

If the transition is gradual, it is quite easy for anyone to understand an electron micrograph which is a picture magnified 50,000 times via the electron microscope compared to the histologic picture of 200 times. The electron microscope of today can magnify up to 160,000 times compared to the light microscope maximum of 1,000 times, a striking difference which not only enables us to see cell details not known earlier but which has forced a re-evaluation of cellular ultrastructure not even envisioned years ago.

Applications of electron microscopy in biology and medicine are still so new that the normal appearance...
of the cells of the mammalian body are familiar. Though the first electron microscope was designed in 1932, little use was made of it for almost 18 years. Preparation of tissue specimens for analysis was the major obstacle.

Specimens have to be placed into the microscopical column at high vacuum because electrons travel in vacuum. Fixing, embedding and sectioning make it difficult to examine living cells successfully particularly because, to allow the electrons to pass through, sections must be from 2 to 3 thousandths of an inch thin. The short wave length of electrons enable them to penetrate between minute cellular structures. However, they lack the tremendous penetration of x-rays.

Although many electron microscopes were available, it was 1948 before adequate preparation techniques were devised. Thin enough sections were made on an ordinary microtome to enable electrons to penetrate and cast a shadow on the fluorescent screen. In two years, two special microtomes were designed and presently there are many highly reliable ultramicrotomes available.

The embedding medium problem came next and methacrylate was introduced in 1948. It could be cut into sections, did not have to be dissolved like paraffin and was immune to the high temperature of the electron beam. Various types of polyesters since developed have simplified the problem even further. Finally, buffered osmium tetroxide solution provided the correct fixative in 1952 and we then first put foot on the road to an enormous lode of information on cell ultrastructure.

In the decade preceding 1960, most of the normal ultrastructure was covered by electron microscopy. Yet today, botany, biology and zoology have countless structural problems yet to be solved. Electron microscopy has made only a comparatively minute penetration into the field of cellular pathology with experimental pathology the prime objective. Surgical pathology will soon use the electron microscope and needle biopsy can be used in conjunction with the electron microscope since the processing time thus can be reduced to 24 hours.

The horizons for the electron microscope are virtually endless and one of the most rewarding will be the integration of this steadily increasing amount of knowledge of cellular ultrastructure into the daily teaching of medical students. It is a natural consequence in assisting students to more easily understand the function of the cell, either normal or impaired. As an example, heretofore the student was taught that the intestinal cells were provided with a "cuticle" toward the lumen of the gut, but its function was difficult to understand.

Today's student now knows that the so-called cuticle actually consists of thousands of tiny finger-like processes which are all an aid in increasing the resorptive surface of the intestinal mucosa. Under certain pathologic conditions, these processes have gone with the subsequent loss of full resorptive ability. Medical students of the future, it is hoped, will learn to understand just as easily the function of the num-berless ultrastructural details that are now being charted for them. Full understanding of cellular function and malfunction in health and disease will be a great accomplishment.
A university typically comprises a college and one or more graduate or professional schools. Thus, most medical colleges are associated with universities combining arts colleges and colleges in various professional fields. A medical college without such affiliation becomes the nucleus for a medical university when the graduate school and technical colleges are added for the training of paramedical specialists.

The first such medical university is developing under the leadership of Dr. Ralph E. Snyder, President and Dean of New York Medical College. To the medical college, now over one hundred and five years old, have been added the Graduate School of Nursing and the Graduate School of Medical Sciences, leaving the various schools for training technologists in paramedical fields to be established subsequently.

The Place of the Graduate School of Medical Sciences in a Medical University

BY WARNER F. BOWERS

The role of the Graduate School of Medical Sciences is a varied one. The constantly expanding interest in graduate degrees in fields allied to medicine; in continuing education for medical practitioners; and in the still-developing areas of internship and residency training for clinical specialization require some formal organization to plan, develop, and control these activities. A Graduate School of Medical Sciences logically fills this need and supplies the directing force.

The basic medical sciences are fundamental to medical school education and with the rapid increase in new medical schools, the demand for trained men to teach and carry on research in these fields is far greater than the supply. In addition, industry and governmental agencies have an increasing need for men with advanced training and research degrees in the medical basic sciences. These compelling needs make the graduate degree programs in anatomy, biochemistry, microbiology, pharmacology and physiology the strongest and most important elements of graduate school activity.

The various specialty colleges such as the American College of Physicians, the American College of Surgeons and others, plus the many qualifying specialty boards would appear to make unnecessary any further qualifying hurdles in the clinical fields. However, none of these agencies takes into account the wide interest in research, both basic and clinical, directly related to clinical specialities. Many research men wish to have advanced research degrees in clinical fields to give the stamp of authenticity to their claims to be researchers and clinicians. The stigma of a "cheap" degree given routinely for completion of residency training plus the writing of a paper is avoided by requiring one to three years of full time research and basic science course work in addition to the residency program. The degrees of Master of Science with specialty designated or Doctor of Medical Sciences have real meaning and importance in such circumstances.

Residency training in clinical specialties culminating in eligibility for examination leading to certification by the various specialty boards is an elaborate, well-established system which is here to stay. Complexity of the problem has been increased by the tremendous numbers of foreign graduates who flock to the United States for such advanced training.

Problems of eligibility, suitability, school acceptability, language barriers and differences in approach to patients immeasurably complicate the situation. Furthermore, available training programs vastly exceed the volume of applicants from the United States medical schools. The management of attractive, accredited residency programs is a career in itself.

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Medical school curricula still tend to present the basic science material early, followed in later years by clinical experience. Thus, the student is deluged early with material, the importance of which he does not understand and with his own immaturity, he is not prepared to make the best of his opportunity. Furthermore, new developments appear so rapidly and clinical correlations appear so quickly that the new M.D. already is outmoded in his basic science knowledge by the time of graduation.

**POSTGRADUATE TRAINING IMPORTANT**

Most young doctors now take two or more years of specialty beyond the internship which puts them still further out of date in basic science material. Finally, the specialty boards include examination in basic fields in which the resident has become rusty. For these reasons, a continuing course in the new developments in basic sciences and their application is important for interns, residents and physicians reviewing for specialty board examinations. Such a course can fill a definite need if not allowed to degenerate into a certificate mill to fulfill paper requirements. Administering this type of Basic Science course is a graduate school function.

The internship formerly was the only opportunity for the newly-hatched doctor to gain applicatory clinical experience but now he is squeezed between the clinical clerkship of medical school years and the lower rungs of the residency training ladder. Problems of one year versus two years, abandonment entirely versus amalgamation with first year residency, straight versus rotating or mixed service, a preparatory experience for further training versus definitive training for general practice—all remain to be solved.

Management of the internship program with this lack of guidelines and lack of unanimity as to goal is an important and difficult field which falls within the purview of the graduate school.

Accreditation of community hospitals and their internship and residency programs is essential to survival of the voluntary hospital system. Not only is accreditation necessary for attraction of acceptable personnel but without it, important sources of hospital revenue are lost.

More and more community hospitals are having difficulty in attaining or maintaining accreditation without medical school affiliation to furnish experienced advisors, ancillary skills, basic science teachers, special laboratory and other services and prestige demanded by patients. Such affiliation is a graduate school function which can become one of the most helpful, rewarding and important aspects of the program. Benefits include upgrading of the entire training program, raising the calibre and enthusiasm of the staff, improvement in patient care, contributions to clinical knowledge through research and last, satisfaction of increasingly stringent requirements for accreditation of the hospital and its programs.

Post graduate short courses for practicing physicians always have been important and popular but the need for keeping up is becoming so acute that postgraduate education on a continuing basis may well become a requirement for maintaining hospital privileges and licensure. The how-to-do-it courses, the lecture courses, the seminar-discussion method and other devices have their place in the program.

The problem of difficulty in finding time to attend may be solved in part by moving the continuation education courses out of the big centers into the affiliated community hospitals where under medical school supervision, courses can be presented on the home ground of the local physicians. This is an exciting new field for exploration.

In summary, the medical university is made up of a medical college with courses leading to the M.D. degree and a graduate school with advanced research degree programs in the basic and clinical fields, intern and residency training programs, basic science review and refresher courses, affiliation arrangements for community hospitals and provision for various types of continuing education for practicing physicians. These plus the professional colleges and schools for technologists in allied fields round out the concept of a medical university.
The dawn of renal surgery dates back to August 2, 1869, when Gustav Simon of Heidelberg removed by the lumbar method, the kidney of a woman who had an abdominal ureteral fistula resulting from an ovariotomy done one and one-half years before. Simon performed this operation despite the then prevalent universal belief that it was "madness to dream of extirpating a kidney in the human subject." Simon undoubtedly was aware of the experimental results of Prevost and Dumas "1823", of Claude Bernard, Rayer, Meissner and Schephard; all of whom established the fact that animals could live with only one kidney.

He compared the results of 15 hysterectomies with 15 nephrectomies performed on animals, and was satisfied that there was no more danger from the surgical point of view in the one operation than in the other. At the same time he convinced himself that the physiologic changes effected by the kidneys could be performed by the remaining kidney. Of course, it had been noted for a long time in the post-mortem remains that in the bodies of persons who had been left with one kidney, the other having been absent or atrophied, that life in itself had been maintained. But what was not known prior to Simon's classical operation was the assurance that one kidney could take over the work of both after the shock of so severe an operation as a nephrectomy in the mid-nineteenth century.

It is of further interest to note that in December 1870, Gilmore in America performed a successful nephrectomy for a painful, shrunken, fibrous kidney in a woman five months pregnant, and who recovered without a miscarriage. The second operation performed by Simon occurred in August, 1871, for a calculus pyelitis, but the patient died of "pyemia" on the twenty-first day. Again in 1872, two nephrectomies were performed, but unfortunately were fatal. One was for a painful kidney by Durham, and the other for calculus pyelitis by Peters, both of New York. In 1878 Martin was successful in four nephrectomies performed for painful floating kidneys. This confirmed Simon and Brants' belief that a quite healthy kidney might safely be removed.

One of the first nephrectomy incisions.

BY
LEONARD
PAUL
WERSHUB

Dr. Wershub, '27, Clinical Professor in the Department of Urology, also is curator of N.Y.M.C. Memorabilia.
In 1866, William Tod Helmuth who was then Professor of Surgery in our college, opened “Helmuth Hospital” at 465 Lexington Ave. This was a private hospital, staffed with competent nurses, and where he was assisted in his surgery by his son, William Todd Helmuth, Jr.

William Tod Helmuth was the Dean of New York Medical College, in addition to his surgical activities between 1893 and 1902. In 1887, he performed a nephrectomy and was assisted in this procedure by Dr. Knight and his son, William Tod Helmuth, Jr. It is of such historical significance that I am reporting this case verbatim as described in 1887.

"After having concluded in his mind that the kidney is to be removed, the surgeon must decide which method he will select in the performance of the operation. Of these there are two, the lumbar and the abdominal or ventral, both having strong advocates.

The lumbar is said to be the favorite with the general operator, while the abdominal has the support of those who have made laparotomy a specialty. In ninety-six cases where the site of the incision is recorded, forty-six were abdominal sections, of which twenty-three died; fifty were in the lumbar, of which nineteen died.

At a first glance, these figures would indicate that no question could arise as to which method should be preferred. In looking up each individual case, however, we find no comparison in their character, the abdominal section having been mostly adopted in those extreme cases in which the lumbar operation was impossible, and in others in which the operator, being unable to remove the kidney from the back, performed laparotomy as a last resource, the death being credited to opening the abdomen. It is said that Dr. J. Knowsley Thornton always, however, makes the lumbar incision, and if unable to remove the kidney by that method uses the wound as a means of drainage, as do Drs. Schuestler and Gross.

By the lumbar method, the operation is extra peritoneal, and thereby we can perhaps separate the adhesions behind the kidney with ease, but the great difficulty is the diagnosis of the condition of the other kidney. For this purpose many devices have been introduced. Glucke compressed the suspected ureter by forceps through a lumbar incision, and the opposite kidney was supposed to be sound, if iodide of soda or ferrocyanide of potassium administered to the patient was found in the urine. Sands recommends inserting the hand into the rectum and compressing the ureters by the fingers. Polk devised a clamp to compress the

THE CASE AND THE OPERATION

"Mrs. L., 28; married, with no children. Admitted into Helmuth House, February 27th, 1888. Previous to her admission she had suffered from a long array of symptoms, and had been treated for various diseases until she came under the supervision of Dr. B. G. Clark who diagnosed the case as that of pyonephrosis, and greatly relieved her general symptoms by judicious medication. On examination, she was found to be much emaciated, with a comparatively large semi-solid tumor in the left loin, immovable and very tender to the
...touch. No other physical signs were found by percusion.

While in the hospital, prior to the operation she suffered greatly with her stomach; vomiting often, and suffering from attacks of prostration, headache, constipation and nervousness. Her temperature ranged from 99 to 102. The urine when first passed was acid, containing pus in various quantities, the tumor diminishing in size to the purulent secretion found in the urine.

On March 3rd, the patient being in a comparatively good condition, she was given a warm bath in the morning, and the abdomen was carefully scrubbed, shaved, and an enema given. At 12:30, she complained of pain in the affected kidney, and in urinating passed a large quantity of pus, the tumor diminishing so much in size as to render it almost imperceptible. At 2 P.M., she received a hypodermic injection of atropine 1/100th and morphia 1/6th, and thirty minutes later was anaesthetized and carried into the operating room, which was heated to 80 F., to prevent shock from chilled intestines if exposed. The chest and limbs were wrapped in blankets, and the abdomen was again washed with a 1/1000 bichloride solution. The instruments were the same as those used in an ordinary laparotomy, with the exception of two very large retractors, covered with sterilized gauze, to hold back the intestines. No sponges were used, gauze pads being substituted which had been stored and sterilized in steam of a 1/2000 bichloride solution. These pads give excellent satisfaction, absorbing fully as much as sponges, and having the advantage of being sufficiently cheap to be thrown away after being once used.

"The incision was made in the linea semi-lunaris, and care was taken to catch all bleeding points until the peritoneum was reached. This was carefully divided and the intestines coming into view were pushed aside and held out of the way by the large retractors before mentioned. The condition of the other kidney was now ascertained by passing the hand into the abdominal cavity. Careful dissection followed, the fingers being used almost entirely to separate the meso-colon and adhesions which were found binding the diseased organ tightly to the surrounding structures. By slow and gentle teasing the ureter was at last brought into view, very much distended, and resembling a cyst the size of a pullet's egg, overlapping the artery and vein.

A large, blunt aneurism needle was threaded with ovariotomy silk and passed beneath the ureter close to the kidney; the needle was then withdrawn and the ligature securely tied. The tenaculum was again threaded and again passed beneath the ureter about an inch and a half from the first ligature. In tying, the distended and rotten ureter gave way, and a small quantity of fetid pus escaped, which was immediately absorbed with the sterilized pads, which had been packed around the intestines. The ureter was then divided between the ligatures. The artery and vein were tied in their turn, and for greater security, a second ligature was placed around the pedicle and the tumor removed."

"This was the method adopted in this case. Whether to ligate the artery and vein separately or together; stitch the ureter to the external wound; allow it to remain open; or unite them all together, are questions which the conditions of each case must determine. The entire wound was irrigated with hot water, a drainage tube carried to the bottom of the wound and the opening closed, catgut being used for the peritoneum and silver wire for the deep and superficial sutures. The whole wound was then dressed with great precaution.

Nothing unusual save that some vomiting occurred (which latter made it necessary to feed her with nutritive enemas) until the morning of the tenth day, when the temperature rose to 101 and a spot appeared on the bandage. Dr. Knight immediately undressed the wound and withdrew about four ounces of fetid pus. Again the whole cavity was washed with bichloride solution, 1 to 10,000, which process was repeated daily, save that unmedicated hot water was used. The sutures were removed on the twelfth day, and she left the hospital on March 28th. On May 22nd she came from her house in Harlem to No. 299 Madison Avenue with but little fatigue. A sinus, however, still remains, which discharges pus."

Dr. Charles McDowell wrote that "William Tod Helmuth was a handsome man and elegant in his personal appearance. He always appeared faultlessly attired with his hair and beard meticulously groomed. Even the diamonds he sported seemed natural and fitting. He was brilliant, aggressive, the idol of his students (considered our most interesting lecturer), full of enthusiasm, and made dramatic presentations with an easy spontaneous flow of humor, and, when the occasion demanded, with earnest convincing eloquence."

Today in the management of kidney tumors many advocate the transperitoneal approach, since in renal tumors the main renal veins or their tributaries were involved by tumor thrombus. It is therefore considered best to ligate the renal pedicle quickly, before any manipulation, to prevent dissemination of the tumor.

Such thinking gave rise to increasing emphasis on the trans-thoracic technique of nephrectomy for tumors of the renal parenchyma. Similar to the transperitoneal approach, this method permits ligation of the renal pedicle prior to the kidney manipulation and also allows for better exposure.
book review

ADVANCES IN DIAGNOSTIC UROLOGY

Edited by Joseph J. Kaufman, M.D., F.A.C.S., Associate Professor of Surgery/Urology at the University of California School of Medicine in Los Angeles

Little, Brown & Co., Boston, Mass.: 1964, Illustrated, $12.50

Detailed discussions of significant advances in diagnostic urology, particularly uroradiography, that have been made in the past few years, are presented by the fourteen contributing authors. The authors show when and how to use these procedures and point up the relative effectiveness of each. Many are the originators of these concepts and techniques.

Williard E. Goodwin, who wrote the chapter on anestra phyelography, devised this method for the diagnosis of upper urinary tract obstruction; Chester C. Winter, originator of the radioisotope renogram, shows how this widely used procedure has been perfected; and Charles M. Stewart describes the advances in the use of the cystogram, which he developed, for defining both pediatric and adult urologic problems.

As further aids to clinical use, the contributors have included discussions of the complications which may occur from many of these procedures. In describing the techniques of aortography, Joseph J. Kaufman also points out the vascular, neurologic and gastrointestinal complications which can result; and in the chapter on percutaneous needle biopsy of the kidney, Ralph Goldman included detailed discussions of the effect of renal biopsy on kidney function and the complications requiring operative intervention. Summarizing the degrees of risk involved in these techniques and outlining the precautions to be taken to minimize them are these and other chapters on diagnostic procedures in renovascular hypertension, prostatic carcinoma, and adrenal hyperfunction.

Practicing urologists and radiologists will find new, authoritative insights into the procedures they are now using, through details on their development and how they have been perfected today. Internists, surgeons and students will find that the straight-forward discussions of these methods provide a basis for improved medical and surgical treatment or urologic and related disorders.

L. P. W.

Last year saw alumni of New York Medical College, and their families come to the World’s Fair from every state and a number of foreign countries. Many came by the College to talk to old friends among the faculty, to make new ones, and to learn of our latest activities. More ideally, many planned their visits to the Fair to coincide with Alumni Day, with its clinical conferences held by department heads, a tour of the new Cohen Research Building, a luncheon, and the Annual Business meeting of the Alumni Association. In the evening, they went to the President’s Reception and Alumni Banquet, and some went to their own class reunions as well.

If you were one of those, we feel certain that you found it a marvelous way to renew your acquaintance with the College and your friends here—and to visit the Fair, too. If you were unable to come to New York, the Fair, and the College last year, this summer affords an ideal opportunity. First, it is the final year of the Fair, which in every way promises to be bigger and more exciting than last season (the long-awaited unusual Hall of Science will open). And second, for New York Medical College, each year in this decade heralds new developments in our progress toward a medical university. The 10-story Cohen Research Building is one of those milestones. It is an exciting place to visit, as it will afford you an opportunity to see research at its most advanced level, now possible with this new facility and fine equipment.

This spring will see the end of the first year of operations for the Research Building, and there are many more projects in full swing which you will be able to observe firsthand when you visit again—or see for the first time.

We extend to you a cordial invitation to participate in the festivities of the 1965 Alumni Day program and to visit the College. It will be held on June 1st, same as last year, and we tell you there is no better time to visit New York, weather-wise? The Fair is probably at its best then, too, for you will be able to wait on shorter lines (hopefully) for Ford’s Ride into the Future, General Motor’s Dinosaurland, or IBM’s hydraulic lift into cinemescopes computerland, and the marvelous “To Be Alive” documentary at Johnson’s Wax, without getting sunstoke—only a nice suntan!

As a final word from the wise to the wise, make certain you have reservations well in advance. There are many new motels and inns both in the city and the outskirts that you might want to consider instead of the big hotels which are usually overcrowded with conventions and tourists who got there earlier than you. If you stay in the city proper, you might consider garaging your car because it won’t be much use with all that traffic and no parking.

Although the subway is the fastest and cheapest route to the Fair (take it from experience), you can take your car. But be warned, parking is extra ($1.50) and the lots are far from the entrance gates. To make up for this, the Fair busies you free of charge to the gates, but if you are time-conscious, this takes up an extra ½ hour each way. The Long Island Railroad offers a less crowded ride to the fair for more (35¢) than the subway and just as fast; in rush hours it’s not a bad idea at all.

When you buy the official Tour Guide of the Fair, be sure to purchase also the large map of the Fair which shows all the exhibits in considerable architectural detail, making it plainly clear where you are, and showing you exactly how to get to where you want to go, sans confusion. Besides, it’s a beautiful map for all architectural schema enthusiasts.

Looking forward to seeing you at the Fair and at NYMC!
Because the men and women who are members of the 400 Club of New York Medical College have volunteered to play a permanent role in perpetuating the planned progress of our Institution, they are unique in the annals of fund-raising.

Not limited as to members, the 400 Club is a singular group of persons whose annual support is significantly instrumental in implementing the College's plans for the future—to augment its faculty, enrich its teaching programs and expand its research.

Drawn from the College faculty, parents of the students, alumni and loyal friends of the school, each member has pledged to contribute a minimum of $250 to the College annually. The importance of such a “living” endowment is almost immeasurable since it provides basic resources of at least $100,000 annually and is the equivalent of a $2,000,000 gift in perpetuity.

Members of the 400 club receive no monumental reward except an inspiring alliance with medicine and its constantly exciting progress towards alleviating the ills that beset mankind.
Man's New Environment (Continued from page 6)

A variety of physiological parameters were evaluated during each Mercury flight. These measurements obtained by telemetry are under constant review by the control center for command decisions. The functions measured are based on clinical experiences and the limitations of equipment.

In general, we monitor the same functions as the Soviets. The Soviet Cosmonaut, however, is wired for “dynamic cardiography” by means of a “kinetocardiograph.” We feel that this is a form of ballistocardiography which by itself is of limited value. We are not at all sure that we are measuring what should be measured. With four astronauts aboard a MORL for 30 to 60 days, continuous monitoring from earth stations is not practical.

What is required will be an onboard monitor which will analyze the data and on command, telemeter such information to earth. A greater degree of telemetry-computer research is required along with the need for more precise definition of telemetry requirements. It may be necessary for a variety of tests to be performed by the astronauts on each other and the information recorded. Certain types of specimens will require storage of evaluation on earth.

Finally, the kinds of information necessary for military operations in space may demand a separate order of physiological telemetry.

I have mentioned only a few of the problems of life support and protection against the space environment. With the advent of Gemini, MORL, and Apollo, there are a number of potential psychological difficulties. The ability to make rational decisions while under the stress of a hazardous mission or the monotony of space is important. It is theoretically possible that prolonged weightlessness may diminish motor and sensory capabilities due to sensory deprivation. There may be morale problems created by alterations in normal biological functions, differences in diets and working relationships between crew members.

The Soviets have said there is no “Race to the Moon.” However, my personal knowledge of the Soviet effort leads me to believe that unless we can define, unify and direct our bioastronautics efforts with greater efficiency as a total national effort, Russian supremacy in space is assured.

NEW YORK MEDICAL COLLEGE ALUMNI DIRECTORY

Please send me a copy of the new 1965 alumni directory. My check for $2.50 payable to New York Medical College is enclosed.

(Please Print)
Name ....................................................... Class
Address ........................................................................................................

(Continued from page 6)
**notes**

1932

Gratifying is the note of Joseph Bloom of Silver Bay, Minnesota, a far-flung alumnus whose thoughts and feelings are certain many will echo and whose family accomplishments many will wish to emulate:

"I want you to know that I enjoyed the recent edition of the Chironian—in fact most alumni do. I don't have to tell you that it is with great pleasure that most alumni in far-off places read with great interest the news items of classmates and fellow students of former years. Their papers, research and continued in the school of our basic medical education help to keep alive the spark that our teachers implanted in us. This has been traditional as far back as I can remember, having been student, intern and resident surgeon at Flower. Those grand old men of former years have left for all eternity their imprint of mind and accomplishment and stimulation that all alumni are proud of.

"It might be of interest that I have one son, Harvey Bloom, who is now serving with the U.S. Air Force and who graduated from Flower with the class of '62 some thirty years after my own graduation; and I also have a son Stephen who is a sophomore this year and will I hope graduate with his class in '65."

Dr. Bloom also relates that he presented a paper on October 22nd, on 'Delayed Splenectomy for Traumatic Rupture of Spleen.'

1933

Various aspects of "Growing Up" will be explored in a mother-daughter class to be offered by the YWCA in Lorain, Ohio, conducted by Elsie Snell who has been running the course for six years. The class, open only to 5th and 6th grade girls with their mothers, provides an opportunity to strengthen understanding which is basic to home guidance and family discussion.

Lester Karlitz of Great Neck, New York has been elected to the presidency of the board of directors of a new private hospital in Queens, Deepdale General Hospital in Little Neck. Academically, Dr. Karlitz is Assistant Clinical Professor of Urology at the Albert Einstein Medical College.

William Kropf of the Bronx, New York, Chairman of the 31st Anniversary Reunion of his class sent us an enticing account of the affair:

"On Thursday evening, November 18, 1964, the Class of 1933 celebrated its 31st Anniversary at the Sheraton Motor Inn in New York City.

"As they arrived, thirty members of the class greeted each other in a warm spirit of friendship and loyalty which has grown and strengthened since graduation 31 years ago. After cocktails and conviviality at the bar, we adjourned to the beautiful Coronet Room for a private sumptuous dinner.

"Although most of those present came from the suburban and urban areas, Ted Krutky flew in from Akron, Ohio. Others came in from Connecticut, New Jersey and upper New York. Many of those unable to attend sent letters concerning their activities, professional and otherwise, also expressing good wishes for the health and success of all classmates.

"Al Robbins, unable to come up from Miami Beach, Florida, enclosed a check to be used for champagne at the dinner Befitting the occasion, during the dinner we all rose and drank champagne toasts to Al Robbins and to the wonderful class of '33.

"A moment of silent prayer was observed in memory of the seven departed members of the class. There are now 63 classmates actively engaged in the various specialties and practice of medicine. "Nine of our classmates have children studying medicine (or who have already received their M.D. degrees) at our alma mater. Two others have their children studying medicine at other institutions. Charlotte Yudell has three daughters following in her footsteps; two have already received their diplomas from our alma mater.

"The occasion was most enjoyable. The food, champagne and cigars were excellent, the speeches were humorous, nostalgic, and stimulating, as were the side remarks and interruptions.

"Three surprise door prizes were won by: Jack Fishman, a small leather utility case; Charles Popovits, a bottle of Canadian Club; and Nat Goldberg, an electric desk clock.

"As a final note it was unanimously decided that from now on a class reunion will be held annually."

Present were:

Jacob Bleiberg  Archie Harris
Maurice Berger  Samuel Horowitz
Frank Borrelli  Alan Kane
Emile Buscicchi  Meyer Kaplan
George Christman  Irvin Klein
Howard Day  William Kropf
Harry Feinberg  Theodore Krutky
Frank Fiero  Charles Popovits
Gerald Finelli  Paul Reiser
Joseph Fisher  Arthur Stern
Jack Fishman  George Stivala
Harry Fleischer  Exmate Terregrossa
Floyd Gindhart  Irving Weinberg
Nathan Goldberg  Morris Zeichner
Lester Greenberg  Herman Zurrrow

And a good time was obviously had by all!

1934

George R. Nagamatsu, Professor and Chairman of Urology at NYMC, has been elected to the Executive Committee, New York Society of the American Urological Association; named Assistant Representative to the Scientific Exhibit, Section of Urology, American Medical Association; appointed to the Advisory Committee, Section on Urology, New York Academy of Medicine; and elected Chairman, Urologic Surgery Section, International College of Surgeons.

1939

On August 1st, Frederick J. Dann moved his private offices to the Center Professional Building, 40 Union Avenue, Irvington, New Jersey.

1943

A very special Christmas greeting from George Green and family:

"Happiness is . . .

...The Greens ... together at Christmas . . . wishing you Joy and Peace . . .

...Moving to a home of their own . . . a quiet street, a beautiful view, closets, eating in the dining room, unpacking everything this time, a shower, the warm welcome and friendly help of new neighbors . . .

...Watching Pat walk up and downstairs after months of casts and crutches following corrective knee surgery..."
knowing the love and loyalty of her true friends standing by... seeing her off to Beaver College in Glenside, Pa.... counting the hours until she's home for the holidays.... Seeing Garry pull into the driveway after an outing in the car... learning to slalom ski... shooting a duck... passing algebra... being almost six feet tall....

Looking for Connie as the Band marches by... trying out for Majorette and being a good sport when she didn't make it... being tapped for Jr. Honor Society... taking riding lessons and clearing a jump... wearing hose to school... making a speedy recovery from pneumonia... walking one of the dogs... being thirteen....

Packing Lyn off to camp... unpacking Lyn from camp... playing a real tune on the trombone... earning enough money for a ride... finishing piano practice... winning a game of tetherball... finding a lost piece of puzzle... playing a game with a friend who likes games....

Hearing the good news that George has passed his Boards in Nuclear Medicine after months of studying... enjoying his work... having time out for lectures and conventions... going deer hunting in the Adirondacks... discovering a year-round hunting and fishing camp nearby... taking the family for a boatride, picnic and swim on a Sunday afternoon... sneaking off for a nap....

Knowing that the animals have all been fed... that they've been out and back in... that you've finally convinced the kids that an old dog, a pup, and a crazy cat are enough....

Mom learning to park on a hill... finishing a dress... hitting a G... reading a letter from Pat... finding a good excuse for not water skiing... setting the table for six... getting this off to the printer... and knowing that Charles M. Schulz and "Peanuts" forgive her....

Thinking of each of you and sending our love....

THE GEORGE GREENS
474 Jefferson Street
Morgantown, W. Va. 26505
G. G. Green, M.D. '43

At the Annual Convention of the American College of Gastroenterology in October, Edward J. Nightingale was elected Chairman of the College’s Board of Governors.

1948
Raymond W. Lawrence of Franklin, New Hampshire successfully campaigned for the local School Board seat for a three-year term. Of his five children, three are at present in public school.

1949
To Edward H. and Katharine G. Ferguson, was born Douglas Hugh Ferguson on October 13. They also write that they saw Jack Minnis ('48) at the AMA meeting; he is now Chief of Surgery at St. Joseph's in Louisville, Kentucky.

William A. Whyland was initiated as a Fellow of the American College of Surgeons at the College's recent convocation in Chicago. Active on the surgical staffs of the Samaritan and St. Mary's Hospitals, in Troy, New York Dr. Whyland resides with his wife, Ann, and their three children in Troy and gives his current address as 275 Hoosick Street.

1951
From east to west--Thomas D. Armour, Jr. has moved his practice of General Surgery from New York City to 1005 South Third Street in Las Vegas, Nevada.

1953
From John W. Mills of Indiana, Pa. comes word that he and his wife had a pleasant visit with Dick Baugh and family in Rochester, New York; that John passed his Ob-gyn boards in May; that he has been named a Fellow of the American College of Surgeons in October; and last but not least, by any means, event "Number 4" is on the way! Proudly announcing his marriage to Eileen McArdle in Bogota, N. J. is John R. Doyle, who also informs us that he will continue his practice of pediatrics in Hackensack.

John E. Aiken, specializing in internal medicine, has joined the staff of the Frederick C. Smith Clinic in Marion, Ohio. He moved with his wife, Barbara, and three children from Long Island, where he was in charge of the Cardiovascular Laboratories in Nassau Hospital.

1956
A new Department of Hematology has been added to the medical facilities of North Shore Hospital in Manhasset, New York, and on July 1st, Thomas J. Degnan was appointed its fulltime Director of Hematology and Supervisor of...
the Hospital's Blood Bank operation. He will retain his teaching and research affiliation in Hematology with Mount Sinai Hospital, which he has held since 1962.

Board certified in General Surgery since April 1963, William F. Quigley formerly chief of General Surgery at the U.S. Army Hospital in Fort Ord, California, has been appointed Chief of Surgery and Chief of Professional Services at the U.S. Army Hospital, in Verdun, France.

1957

Detached from the Navy in July, writes Louis R. Gaudio, and practicing obstetrics and gynecology in West Nyack, Rockland County, New York. A son, John, 21 months lives with his parents at their new address: 100 Lawn Terrace, Mamaroneck, New York.

Guy A. Settipane, allergist, recently opened an office to practice his specialty at 183 Waterman Street, Providence, Rhode Island. Since leaving the service in 1962, he completed an additional two years' residency in allergy at Roosevelt Hospital in New York. With his wife, Margaret, and three children he now resides in Providence.

A fourth boy, William, fifth child for Tim Brewer and Norma. Tim successfully completed his Boards in Internal Medicine in April and recently became Associate Director of Clinical Research for Charles Pfizer & Company in Groton, Connecticut.

In the practice of General Surgery, Frank A. O'Boyle has opened a new office at Ford Professional Building, 16 Old Town Road North, Port Jefferson, New York.

1958

Edward V. Henry of Doylestown, Pa. has been appointed Assistant Director of Clinical Investigation in the Medical Division of McNeil Laboratories in Fort Washington.

His residency in General Surgery with the Cornell Division of Bellevue Hospital completed, Dr. Walter Pizzi has opened an office at 11 East 68th Street in New York. He has been appointed instructor in Surgery at Cornell University Medical College and Assistant Visiting Surgeon with the Cornell Division of Bellevue.

Howard J. Kline let us know that he received a Research grant from the NIH to study hemodynamic and metabolic alterations following myocardial infarction. He is conducting this work at Mount Sinai Hospital in New York City.

Announcing the opening of his office for the practice of psychiatry is Arnold J. Hodas of 35 East 85th Street in New York City.

And in a new office for the practice of Ophthalmology, after two years in the Air Force, is Donald S. Konicoff, who also tells us a third child is on the way.

1959

Paul A. Stavrolokas opened his new office for pediatrics at 20 Harbor Hills Drive, in Port Jefferson, New York.

Moving back to the New York area to practice pediatrics, after a two year military tour of duty in Bangor, Maine, Peter DeMarco has entered into an association in private practice in Suffern, New York, where he will live with his wife and growing family (two children).

Richard F. Gibbs notified us of his appointment to the faculty of the Harvard Medical School as an Assistant in Anesthesiology in the Department of Surgery, and clinically as an Associate Anesthesiologist at the Boston Lying-In Hospital (the Ob-gyn Division of the HMS).

Another joining the ranks of teaching Harvardians is David Miller, recently appointed a teaching fellow in Ophthalmology at the Harvard Medical School.

Entering private practice in St. Paul, Minnesota is Richard YaDeau who recently completed a surgical fellowship at the Mayo Clinic.

Not too long ago resettled in Reno, Nevada, John J. Stapleton has opened an office for his practice in Obstetrics, Gynecology, and Infertility.

William E. Reeves has moved, but not too far from Chestnut Hill, Massachusetts—his new office for Internal Medicine is located at 444 Angell Street in Providence, Rhode Island.

In the golfing capital of the country, as he puts it, Stuart Kase is not only getting his golf in good shape when he can, but after completing his Urology residency at Metropolitan Hospital, is in the U.S. Army, stationed at Fort Gordon in Augusta, Georgia, as Chief of the Urology Service. In November, he presented a paper at the Kimbrough Urology Seminar at Brooke Army Hospital in San Antonio.

Justin Howland has completed his Orthopedic Surgery residency at Fitzsimons General Hospital in Fort Sam Houston, Texas. His next assignment effective this January will be Verdun, France. Going with him are his wife and rapidly growing family, now up to five (children) the newest addition a daughter named Tracy Anne—and in his words, "after 4 boys a welcome change!"

1960

In private practice in internal medicine and hematology is W. T. Minogue in Westfield, New Jersey. He reports that he is on the staff at St. Vincent's Hospital in New York and Overlook Hospital in Summit, New Jersey. On February 24, he presented a paper before the American College of Cardiology in Boston on the subject of cardiac resuscitation. In the area of family expansion, a 3rd child was born to the Minouges on July 14.

Stanley Ostern is serving "Uncle Sam" at Castle Air Force Base in Merced, California, and he hopes to go into private practice after his 2 year tour of duty is completed. His address for those who wish to know: 219 Castle Drive, Atwater, California.

Colorado Springs, Colorado has gained from San Francisco a practitioner in internal medicine, Harry R. Locke, who has opened a private office at 1819 North Circle Drive, North Circle Medical Arts Building.

John D. O'Brien in the private practice of ophthalmology has joined in association with a group of physicians at the Medical Arts Building, 375 East Main Street, Bay Shore, New York.

After completing a 3-year residency in ophthalmology, with his last year as Chief Resident at Wills Eye Hospital in Philadelphia, Raymond Adams reports that, by way of the Berry Plan, he is in the Air Force for two years and is presently stationed in Chanute AFB as base ophthalmologist.

Ronald Hartman has associated with another ophthalmologist in Lakewood, California, and is so happily located that he tells us he hopes to remain there. His growing family includes two sons, Carl, 4 and Bruce, 1.

Appointed in July as Chief Resident in Surgery at New York University-Bellevue Medical Center was Floyd J. K. Donahue whose home is in Westfield, New Jersey. Roxbury, Connecticut has acquired its first resident physician in 24 years—

Robert Lee McDonald, who has opened an office in his home for general practice on Roxbury Falls Road. He spent the last three years in service at the U.S. Naval Construction Battalion Center in Davisville, Rhode Island as senior medical officer, and has two children, Thomas, 3, and Robert, 1.
Harvey Hammer is currently in the Department of Child Psychiatry at the Johns Hopkins Hospital, and April saw a welcome arrival—a son and first child, Mark Corey.

Notes from Frederick E. Siefert:
"More than a year ago I received a most welcome letter from Wilmot Draper (my apologies for not relaying the news long before this) which brought me up to date on his activities through December 1963... following internship he spent a year with the Marines in the Far East, then returned home by taking a trip around the world courtesy of US Air Force "space available" rides... then into a dermatology residency at the US Naval Hospital in San Diego, Calif., where I assume Wil still is as of January 1965, when this is being written. "From Ed Gordon several communications since December 1963, for which I am most grateful... Ed is now practicing psychiatry in association with L. Clovis Hirning, M.D. in Katonah, New York... he and Marty (and family) are living at RD White Hill Road, Yorktown Heights, New York. In his 12/63 note Ed reported that Frank Baldwin is married and in an orthopedic residency at Metropolitan Hospital. Also from Ed were details on the activities of Ike Lissauer... these were soon followed by a letter from Ike, himself. He did his internship and one year of medical residency at Chicago's Michael Reese Hospital... then an additional year of medicine at Mount Sinai in New York (where he met his wife, Ruth, an Israeli nurse)... then work as a Fellow in Cardiology with Charles K. Friedberg at Mount Sinai. Currently Ike, Ruth and their daughter are at 965 Washington Street, Denver, Colorado... not sure just what they're doing there.

Another bit of late news: from Herb Joseph in January 1964, word that he and Laurie had a girl, Stephanie Lynn, joining their two-year-old Michael... Herb is a resident in orthopedics at Hospital for Joint Diseases (New York)... he plans to finish there July 1965, when he goes into the Public Health Service for two years.

"From Sheila and John Russell... continued pleasure at being out of the 'land of ice and snow'... they're in general practice in Gulfport, Mississippi and things are going well for them and daughters Dawn and Terri.

"From Ted Figlock a note in March 1964... he wrote from the Medical Field Service School, Fort Sam Houston, Texas... said he was attending the 'Associate Career Officer Course'... that his next assignment would be at DeWitt Army Hospital, Fort Belvoir, Virginia, for one year of pre-specialty surgical training and then to Walter Reed Hospital for an Ob-Gyn residency.

"In April 1964, Barbara Kowalewski was married to Robert Q. Reynolds, M.D. ... Barbara at that time was senior resident in pediatrics at FFAH.

"Fran and Andy Peters are settled in Rockville Centre, Long Island, New York... Andy finished his medical residency at Meadowbrook Hospital and is now in practice.

"From Herb Kasnetz in April 1964... he and Heath had their first child, Andrew Blair, last March. In July 1964, Herb rotated to Veterans Hospital as chief ENT resident... this represented the start of his 4th year of ENT residency at Bellevue (N.Y.) Herb reported news of fellow classmates... all in New York: that Dick Giery and Whitey Hays were going into their 4th year of surgical residency at FFAH; Walt Taub was finishing his medical residency at Bronx Hospital; Jim Rubin finishing medicine at Beth Israel; Floyd Donahue at Bellevue going into 4th year of surgery; Roger Hinkson at Long Island College in Ob-Gyn after two years in Turkey with the Air Force; and John Elkas in pediatrics at Seton Hall (New Jersey) after two years in the Army. Herb saw Gene Sweeney and John O'Brien at 1964 Ground Hog Day but no comments from him on their current work.

"An announcement arrived September 1964... that Harry R. Locke and Burrell D. Stripling opened an office to practice internal medicine in Colorado Springs, Colorado.

"In September 1964, a letter from Carl Marchetti... his current address is c/o Martin Army Hospital, Fort Benning, Georgia. Carl completed his Ob-Gyn residency at Fitzkin Hospital, Neptune, New Jersey and is now a Captain in the Army Medical Corps. He sent a newspaper clipping from the local paper covering the accomplishments of his wife, Janice, according to the article she finished nursing school and received a perfect score in the pediatrics section of her State Board of Nursing examination, the highest score ever received by a graduate of the school since its inception 60 years ago, and she received top scores in other courses... all this while carrying out chores as a housewife and mother of two children, Michael and Laurie... congratulations!

"1964 Christmas greetings from Mary and Jack Tobin living at 42 Oak Street, Wakefield, Mass., and Dottie and Bob McDonald who are in general practice somewhere in Connecticut.

"And our news from Greenwich... Lora and I have finally settled down in our own home located at 70 Meadow Road, Riverside, Conn. It's a large one and we therefore increased the family to two boys: Robb K. arrived Friday, November the 13th... (what a day to have a baby) and brother Gregg, age 4, is delighted to have an ally. What free time general practice permits is devoted to our German Shepherd named Eton... we're grooming as a show dog... we've done well in the few shows he's appeared but this year's competition may prove too tough for 'Tuffy' (Tufts of Cosalta) to earn any points toward his championship.

Happy 1965! Fred
70 Meadow Road
Riverside, Connecticut

1961

Judith and John G. Ketterer announce the arrival of John G. Ketterer III on July 26th at St. Luke's, where Judith is on the attending staff in the Department of Pediatrics and John is in the Ob-gyn program at Woman's Hospital. A third child, Jessica Ann was born in January 1964 to Malcolm E. Drenez, Howard J. Alfandre is presently stationed at the School of Submarine Medicine at the U.S. Naval Submarine Medical Center in New London, Connecticut. He writes that his wife Geri is kept very occupied with their two daughters, Rachel, 3 and Elyse, 10 months old.

Col. George F. Lull, Jr. (left), Hospital Commander, presents the "Fort McClellan Certificate of Achievement" to Captain Neil A. Kurtzman for his outstanding performance as Assistant Chief of Medical Service, Noble Army Hospital, at an award presentation ceremony and dinner held in his honor at Remington Hall, Fort McClellan, Alabama.

1962

In William E. Tesauro's own words, he attended Dave Scott's wedding and it was a "real blast"; he met there Cy Shore, Gene Senal and John De Cicco.
“A very special trick and treat arrived this Halloween” in Brighton, Massachusetts to Anthony F. Milano and wife Betty—their new daughter, Susan Elizabeth, who has a sister, 15 months old, Marie Ann.

Robert C. Lieberman and wife Susan have a new “edition”—their son, Aaron Daniel, who arrived in June.

Born to Alan Krupp and Judy, living in Albany, Susan Natalie on October 26, who completes a happy troika with Peter, 3 and Larry, 22 months. Al spent the summer on a 2-month elective at Georgetown Hospital on renal diseases with Dr. Schreiner, and is now back as a second year medical resident at Albany Medical Center. The Krupps write that while in Washington they saw the Antonellies (he is in service at Indian Head, Maryland), and the Moses (Don is also in service).

John J. Bucchiere, Jr., now Captain, MC, in the U.S. Air Force writes that he is presently stationed in Valdosta, Georgia at the Moody Air Force Base:

“Never having been this far South before, to date it has been quite an experience. Imagine, the middle of October and we had the airconditioning turned on today (84°). It seems as if it were only yesterday that I was a Freshman at Flower, and now it is over two years since graduation. With my year of Surgical Residency under my belt, I volunteered for the Air Force. Presently, I am the Base Surgeon, and it is a pretty good deal—rank of Captain, $800 a month. My wife and I rented a house, have pecan and orange trees in the backyard, azalea bushes in the front yard, $9,000 in bills, but, what the hell, you only live once!

“I heard from Ken Cass recently. He seems to be doing quite well. I think his rank is Major now. Julie and I fully expect him to be a General before he leaves the Army! Don’t laugh—he’s just the one to do it. My new address is 807 West Alden Avenue, Valdosta, Georgia, it should stay that way until July 1966 (I hope)! Never know when Uncle Sam will play musical doctors and ship you to Alaska!”

Wedded in New York on October 21st were Howard T. Bellin and Christina O. Paolozzi, in the setting of St. James Episcopal Church, with the rector, the Rev. Dr. Arthur Lee Kinsolving performing the ceremony. Howard is now a resident in surgery at Metropolitan Hospital.

Arthur L. McGovern and his wife proudly announce the birth of Scott Michael, their second son, on June 29th in Cambridge, Massachusetts. Arthur is currently in his second year of residency in Obstetrics at Cahn House, Cambridge City Hospital.

1963

Now an ophthalmology resident at Metropolitan Hospital is Dr. Robert A. Held after completing an internship at Brooklyn Jewish Hospital.

Presentation to President by Alumni

The Alumni Association of the College formally presented a bust of Dr. Ralph E. Snyder, President and Dean, at a testimonial presentation in his honor at the Harvard Club in New York, on December 18, 1964.

The bust, the Association’s commemorative gift honoring Dr. Snyder’s ten years in office, was originally presented in replica at the June, 1964 dinner honoring the President and Dean at the Waldorf-Astoria. Upon its completion, the Association—on behalf of its membership—decided on a personal presentation affair at the Harvard Club. It was attended by Officers and Governors of the Association, Department heads of the College and Mrs. Ella Scher, President of the Parents’ Council. Guests were Frederic W. Lincoln, former Chairman of the Board of Trustees, and Jackson E. Spears, new Chairman of the Board.

TO THE EDITORS, NYMC CHIRONIAN

This space is for your news and views. Fill it in and mail it to us right away.

_________ (New office, appointments, honors, children, activities, moved, etc.)
Notice

to the Honored Alumni of New York Medical College

the Officers and Governors of the Alumni Association
cordially invite you to attend the

President's Reception

and

Annual Alumni Banquet

on the First of June, Nineteen Sixty-five

in the Waldorf Astoria Hotel

President's Reception in the Gold Room

Banquet in the Starlight Ballroom

(invitation will be mailed in early April)
This is what the Christmas tree in the entrance looked like...

New York Medical College has played a role of constantly increasing importance in the American miracle of public and private health which has seen the taming of countless diseases and a determined move upon many others.

The framework that encompasses such accomplishments is the traditional dedication of our College to the preparation of physicians of professional competence and social responsibility and the alleviation of human ills through zealous research in medicine and related fields.

But deep as our dedication may be, noble and lofty as our purposes may be, all are based on the harsh realities of financial need. You are one of the hundreds of alumni of the College who are practicing in almost every state in the Union and the cherished M.D. degree that you received at Commencement was obtained by diligent effort on your part and constantly increasing costs on the College's part.

The 1965 Annual Fund is underway. It is a potent weapon in our campaign to eclipse future problems with financial solutions today. Financial support of a magnitude never before conceived is needed from our Alumni now. You are our endowment. Send your contribution to the Annual Fund today.
A special meeting of the Board of Governors of the Alumni Association of New York Medical College, Flower and Fifth Avenue Hospitals, Inc., was held on Friday, March 26, 1965 at 12:00 noon in the Halsey Room.

PRESENT were: Drs. Andronaco, Borrelli, Fierro, Leis (by proxy), Lombardi, Mersheimer, Michele, Nagamatsu, Shiner (by proxy), Snyder, Stone, Thom (by proxy), Wattiker (by proxy) and Paul F. Scheffels.

ABSENT were: Drs. Blankfein, Byron, Donnenfeld, Halkin, Hayner, Slobody, Wershub.

A quorum being declared present, Dr. Fierro opened the meeting at 12:10 p.m. Purpose of the meeting was nomination of a new slate of Officers and Directors of the Association.

Dr. Mersheimer, as head of the Nominations Committee which included Drs. Borrelli and Nagamatsu, presented the following slate of officers for a one-year term beginning the day following Alumni Day 1965 through Alumni Day 1966.

President ......................Bernard J. Wattiker
1st Vice President ............Henry P. Leis, Jr.
2nd Vice President .............Martin L. Stone
Secretary ............................Joseph M. Andronaco
Treasurer ..........................Cyrille R. Halkin
Archivist .............................Herbert M. Eskwitt

Directors:
Saul A. Schwartz '65
Jules Blankfein '52
Irving S. Shiner '65
Leon Root '65
Joseph F. Dursi '65
Allan B. Weingold '65

Automatic members of the Board are Drs. Ralph E. Snyder and Alfonso M. Lombardi.

Alumni Trustees of the College, according to the Constitution, who are automatically members of the Board are Drs. McNulty and Thom.

Also, the following Chairmen of Departments of the College, are automatically members of the Board: Drs. Borrelli, Fierro, Mersheimer, Michele, Nagamatsu, and Slobody. Dr. Fierro will also be a member of the Board with vote as the immediate past president.

The following past-presidents of the Association, with the exception of the immediate past President, shall be members of the Board of Governors Ex-Officio, without vote: Drs. Hayner, Wershub and Wilson.

Dr. Mersheimer requested from those present names of any other candidates. None being suggested, a motion to accept the nominations was seconded by Dr. Nagamatsu and put to a vote. The unanimous vote was "Aye".

The meeting was adjourned at 12:26 p.m.