To serve as President of the Association is both an honor and a privilege. My most awesome duty has been this Presidential Address. I found it an even more lonely task than I had expected. Not until I shared my thoughts and ideals with some of my colleagues did it become a rewarding experience. On reviewing the pace of human progress and the many resulting problems, one becomes increasingly aware that the potentiality for future progress has never been so great. There is, however, a wide disparity between achievement and potential. It is this theme that I wish to develop.

We are living in an exciting period of great change and transition. Contemporary political, cultural, economic, and scientific upheaval is affecting every facet of human existence — and in no sphere, I submit, are these forces more complexly intertwined than in the science, or art, or profession of medicine in the world of today. Yes, the circumstances of daily life are changing more rapidly than they have ever changed before in man's experience. We must reckon with these many forces if we are to supply stability of purpose to our teaching hospitals. We must also be promptly and delicately responsive to changes in our environment, as well as to changes in objectives.

I should like, this morning, to discuss some of our difficulties may be unique to our times and the moment is at hand for forthright consideration of how best to address myself to some of the problems now facing the university teaching hospital and its department of medicine.

We must keep in mind the special role of the teaching hospital in contemporary medicine. Its function is a creative one. Here, new physicians are trained and graduated. Here, the character and content of medical practice are continuously reshaped as new researches are conducted and new ideas are conceived and tested. And here, last but not least, the patient is cared for in a manner that not only gives him the best that medicine has to offer, but also displays a standard and style of care that students and house staff may strive to emulate in the years beyond their training. This should be patient care in medicine's grand tradition, embodying humanity, wisdom, dignity, and compassion. But it is something more: It is razor-edged scientific analysis, probing, observing, recording, doubting, alert to every aberration — from the patient's demeanor to the enzymes in his serum. The teaching hospital does indeed have a special creative role, placing upon it responsibilities, both grave and inescapable. What we do and think in our teaching hospitals will influence the thought and practice of our colleagues everywhere, and, in turn, the health and happiness of our generation.

The great problem we now face is: How can we provide and maintain a properly balanced program of patient care, teaching, and research in the face of the torrential outpouring of new knowledge? Much of this knowledge has clear relevance for medicine, and more could have relevance if the right person were on hand to perceive and exploit its latent importance. Problems never come earmarked as problems. How, then, can we investigate an unknown in medicine if it has to be approached in biochemical terms by men who must both recognize a clinical problem and conceive a biochemical solution? If we are to promote meaningful and competent research at the more fundamental levels of biological organization, how can we simultaneously imbue our students with the chief humanistic aim of medicine — which is, that the patient's interest comes first and the investigator's second? How can we best integrate the new movement in scientific medicine with the work and thought of our experienced clinicians, who may be alienated by its esoteric techniques and minute concern with the capers of carbon atoms?

These are the questions to be answered and the problems to be faced. Few would denounce the major premise that a new scientific revolution is upon us. Starting soon after the second World War, there has occurred an incredible output of basic biological research in fields adjacent to or potentially adjacent to medicine. The factors inciting this revolution — the advent of radioactive isotopes, perfection of chromatographic procedures and methods of protein purification, increased financial support of research, etcetera — are beyond the scope of this discussion. Suffice it to say that many of our young physicians have participated in this development.

In 1958 slightly over one half million dollars were made available for 168 Specialists to visit 65 countries. For 24 Specialists to visit South America, $92,000 was allocated. Of this latter sum, $23,000 was allotted to various athletic activities and $5,914.57 was divided among three medical projects! About February 1, 1959, an official of the State Department invited me by telephone to serve as an American Specialist in South America for a period of seven weeks. The high point of my trip was to be attendance at the VIIIth Latin American Congress of Neurosurgery in Santiago, Chile. Before and after those dates I was to give lectures, attend conferences, and visit medical schools in other medical centers. At the last moment Haiti was added to my itinerary, but my experiences...
This leads to our second general premise—that integration must exist both among individuals and within individuals, particularly those key men who lead team efforts. Unless it does, the results may be disappointing.

Our Medical Service is composed of autonomous units, each covering one of the specialties of internal medicine. Thus, we have a Hematology Unit, a Gastroenterology Unit, a Cardiology Unit, and various others—twelve in all—covering most of the categories into which internal medicine has been divided.

In medicine, as in all of biology, we are primarily concerned with the details of structure and function. How can these specialties be organized so that they will enable us to preserve the unity of the whole of internal medicine? How can we mount this whirlwind and make it take us where we want to go? What is the composition of these specialty units, what responsibilities do they assume within the Department of Medicine, and how do their structures help them to attain their avowed goals?

Each unit is a group of variable but workable size, made up of full- and part-time physicians, clinical investigators, and, in some instances, basic scientists.

Each unit must serve as a miniature Department of Medicine, dedicated to total competence within its designated area of interest. The sweep of its activities must carry from basic laboratory research to the imaginative application of its discipline to the cure of the ill. This is no less than an injunction to these units to maintain a high standard of excellence in mastering the skills of their specialty areas, in applying these skills effectively, in the acquisition of new facts, and in the teaching of its discipline to other students of medicine.

Where can the harassed chief of a medical service find a physician to carry out all of these activities effectively within a service area? In American medicine—the answer comes back clearly—it is "nowhere". A specialty unit can no longer be the lengthening shadow of one gifted individual, miraculously adapted to the laboratory, the lecture hall, and the clinic. Basic laboratory research in all medical specialties obsessively demands the devotion of its members to the tasks required for maximal returns. Alternatively, seasoned clinical wisdom based on critical evaluation of experience, which is the hallmark of the excellent physician, cannot be acquired as a gratuitous by-product of laboratory research. Proficiency in clinical medicine is painfully acquired and must be constantly cultivated, or else degrade into the marketing of shopworn sophistries. Faced with this dilemma, we have accepted the fact that it is the unit, not the individual, which must responsibly insure the pursuit of medicine in its broadest sense as an area of both theoretical and applied biology.

How is this carried out in practice? One of our smallest units, for example, is composed of physicians who have had extensive training in organic or biological chemistry, physicians who have had experience in the physiological and metabolic techniques of classical clinical research, and clinicians in private practice who maintain an interest in this medical specialty. The weekly activities of this unit attempt to correlate these various approaches. There is a seminar at which the basic scientific foundations of the discipline are explored, led by either a member of the unit or by a guest speaker. The unit holds its own weekly "Grand Rounds" at which the clinical problems of one or two patients are explored in detail, attempting the most precise scientific analysis of the illness, its pathogenesis and treatment. Finally, there is a specialty clinic and a consultation rounds at which a large number of specific clinical problems are met in the daily evaluation and care of patients. All of these functions are attended by students and all members of the unit, irrespective of their primary interests. Each makes his major contribution within the area of his greatest competency, but serves further to challenge the accuracy and significance of observations and traditional teaching of the other areas of the discipline.

One of the larger groups, the Connective Tissue Unit, is comprised of a group of individuals representing a wide variety of backgrounds and disciplines, who share a common interest in the study of connective tissue, its components and its diseases. Senior members include practicing physicians, four clinical investigators, a biologist, a protein chemist and an organic chemist interested primarily in the carbohydrates. Together with a number of clinical researchers and fellows and students, these individuals share the responsibilities previously outlined, and, of course, conduct their own research.

The physician members of each unit also visit on the general medical wards and participate in the teaching of general internal medicine to second-, third-, and fourth-year students. Each of the senior investigators is responsible for determining the direction of, and conducting, his own research work. Collaborative research problems are undertaken when they spring from common interest.

To present one's work and ideas, either formally in a conference or informally over a cup of coffee, before this group of students and all functions of the unit, irrespective of their primary interests. Each makes his major contribution within the area of his greatest competency, but serves further to challenge the accuracy and significance of observations and traditional teaching of the other areas of the discipline.

In a personal communication received on May 19, 1959, Dr. Dana M. Atchley wrote as follows: "I think we should speak of 'clinical scientist' and the 'basic scientist' because no clinician these days can be a good clinician if he is not a scientist in his attitudes and training."
erally in biochemistry, biophysics, or physiology. I have the very strong conviction that in the careful selection of unit heads lies the key to the success of this plan. By combining clinical medicine and basic science in their training, and by displaying superior competence in both fields, they represent a new breed of physician. Just as the biochemist once was a strange breed, trained in both chemistry and biology, he managed, nevertheless, to survive and flourish. Likewise, this new breed of physician, born of necessity, the product of modern medicine’s complexity, will also survive and flourish. They will flourish along with their conventionally-trained colleagues — in teaching hospitals where, we hope, their unique viewpoint will promote strong leadership and progress. They will respect the achievements of the clinicians and talk their language. Their scientific background and training should enable them to produce research of comparable quality to that of the non-clinically-trained scientist.

It is true that such men are hard to find and a chief of medicine who wishes to develop a unit system of this sort must take the time and make the effort to find them. I encourage this small but important group of young physicians who show promise of development in this direction. This may be one of his most important responsibilities. Equally important, he must also recruit the much-needed quota of able part-time physicians — clinicians who, because of previous training, wish to maintain an interest in a given medical specialty, as well as to participate in the teaching of students and house staff. He must also do everything in his power to attract top-flight scientists.

I believe that it is only through the efforts of such people that it will be possible to mount a team effort that will develop cohesion and direction. Each unit should be designed as a balanced one, with due attention paid to all levels of work. Each member should hold his own position on the spectrum, from pure science to clinical medicine, and should command respect for his abilities and accomplishments. We would like to believe that in such units, the whole may be greater than the sum of its parts. There should be little room in such units for suspicions and condescending attitudes so often marring the relationships between scientists and clinicians.

In this way, viewpoints can be shared, horizons broadened, and opportunities increased for individuality and self-development. By cooperative effort, members of a unit may take time off in sabbatical leaves or other changes of pace, so necessary for the maintenance of a fresh point of view. And a better appreciation of the many roads that lead to medical knowledge may be achieved. It is already becoming clear from our experience with this plan how exciting and fruitful the results of such team efforts can be when guided by the sort of men about whom I have been talking.

You may well ask how these units relate to one another and function as an integrated Department of Medicine. The Head of the Department meets with the Chiefs of Units at stated intervals. Here, problems are aired with candor and sometimes heat. This helps us not only in effecting unity of purpose in the care of patients and teaching, but also familiarizes each unit with the research interests and aims of the others. These and other regularly held exercises help to further our common objectives without encroaching upon individuality of expression or action.

Such a department of medicine has all the specialty subdivisions in medicine for purposes of investigation and teaching, yet the foundation of internal medicine is the general medical ward in which all of the various specialty members participate in the care of the sick, no matter whether or not the patients have the diseases in which they are well versed. It is the general medical ward that is the basic area of integration, both of the individual and of the discipline itself. I, personally, deplore the departments of medicine that have arthritis wards, gastroenterology wards, pulmonary disease wards, etcetera, and distribute patients on admission to these specialized services. In my opinion, medicine can’t be done that way in the last analysis. It can be and must be studied in the specialty areas, but the care of the patient in the final integration has to be done by an internist working in a general medical service. I emphasize this point because there is a trend in the other direction in this country and abroad.

We return, then, to our original question: How can a teaching hospital effectively carry out a program of medical care, teaching, and research? How does the integration achieved in the units help in the pursuit of these three goals? Let us consider them one by one.

As for teaching, the exposure to the unit teams provides superb opportunities for building into medical students and house staff a broad and deep foundation. We also have lost sight of the need that the under-graduate phase of medical education can no longer turn out physicians ready for the practice of medicine. It has to be satisfied with the building of general competence, leaving the acquisition of special knowledge and skills to the graduate training program — especially residency training. Much has been written in recent years about integrating the medical curriculum. Is it not reasonable to expect that this goal will be more closely approached if our teachers are better integrated? This must surely be a prerequisite for the success of an integrated curriculum, no matter how carefully it is planned.

Education is a simple process. It begins when two people of different life experiences meet and talk. It is this communication between those who are willing to learn from one another which is the essence of the educational experience. Obviously, we cannot teach our students all of medicine. What we can teach them, however, is the habit of being self-taught. As has recently been said, “It is our job as educators to see to it that our students, on graduation, be not rifle bullets, constantly decelerating, but self-propelled missiles.”

What about research — such an essential component of the modern university medical center? As physicians dedicated to the prevention and treatment of disease, we are vitally interested in furthering this goal. This we can attain by a better understanding of our patients, their diseases, the disturbed physiology, the biology of the involved tissue, and the chemistry and/or biology of potential etiological agents. Having assumed responsibility for teaching, we must imbue our students with an intellectual curiosity at all these levels. Finally, what better antidote for the dangers of cant and dogmatism than research? The unfounded statement, the unsupported conviction, or the traditional belief are not likely to survive long in the questioning attitude engendered by research.

To paraphrase an Elizabethan dramatist — research does make better doctors of us all.

I believe that most medical research can be carried out more effectively within a teaching hospital than in a research institute devoid of an association with medical care and teaching. This is obviously true for traditional experimental research of whatever variety. It is becoming increasingly evident that this is also true for the more basic scientific disciplines. In recognition of this fact, research institutes such as the Rockefeller Institute and the National Institutes of Health have seen fit to provide themselves with hospital facilities to further their research programs. In the hospital setting, the scientist is made constantly aware of the problems involved in medical care, while being stimulated by association with students and physicians concerned with the validity and applicability of medical knowledge. It is our hope that more scientists will do their research in hospitals. If they do, the unit system may become the means by which many scientists become aware of the unsolved problems of clinical medicine. We also hope that our units will attract scientists to them, for this would add as much to medicine as it would to science. We believe that fundamental research should be an integral part of the modern teaching hospital and can no longer be considered a luxury. The full-time scientist in the hospital must be regarded as the professional equal of the clinician and not his handmaiden. We trust that some of these important men will wish to remain permanently in the hospital research setting. We also hope that our units will attract scientists to them, for this would add as much to medicine as it would to science.

Finally, last to be mentioned but surely not least, we come to patient care — the goal and purpose of the whole complicated enterprise. This remains our primary concern. There are many opportunities in this area for self-delusion and cant. We must impress upon our students and house staff the importance of thinking of each patient as a whole human being, a whole that is the habit of being self-taught. As has recently been said, “It is our job as educators to see to it that our students, on graduation, be not rifle bullets, constantly decelerating, but self-propelled missiles.”

We believe that fundamentally research should be an integral part of the modern teaching hospital and can no longer be considered a luxury. The full-time scientist in the hospital must be regarded as the professional equal of the clinician and not his handmaiden. We trust that some of these important men will wish to remain permanently in the hospital research setting. Undoubtedly, some will return to other academic departments in medical schools and universities, carrying with them a new awareness of the applicability of their scientific disciplines to medicine.

Finally, last to be mentioned but surely not least, we come to patient care — the goal and purpose of the whole complicated enterprise. This remains our primary concern. There are many opportunities in this area for self-delusion and cant. We must impress upon our students and house staff the importance of thinking of each patient as a whole human being, a whole that is the product of modern medicine’s complexity, will also survive and flourish.
man or a woman of certain social and economic background, with hopes and fears and feelings of guilt and pride. Students so indoctrinated will be mindful of the fact that all the symptoms of a given patient are not necessarily due to a genetically determined enzyme deficiency, however crisply revealed before our eyes by the incontestable techniques of biochemistry. Unless our students are so trained, they will not bring to bear in future years the wisdom and vision needed in helping patients attain better health and more happiness.

I believe we must face this problem honestly. We must avoid the pitfalls of lip service and inconsistency. Here again is where I think the unit system can be of help. Beyond the scope of any single individual, it has the potential for demonstrating that no sharp boundaries can be drawn between the scientific analysis of disease and the compassionate care of the sick. We trust the unit chiefs will always keep clearly in mind that the primary concern of a teaching hospital is the care of the sick and that it is within this framework that the activities of the unit must be carried out. For the same reasons, they should be aware that the definition of good medical care is as elusive as good medical care itself. Whatever criteria we use must constantly be reviewed and rigorously judged from the standpoint of their effects on the patient rather than on the education or convenience of the physician. Good medical care, even in a scientific age, must still depend on the dedicated and well-trained physician. If we cultivate this attitude and create an environment in which it is commonplace, our medical students should learn that a good medical history is characterized as much by detailed knowledge of the personality of the patient as by an accurate analysis of the physical manifestations of his disease. If the interest focused on the individual, our goals must still be health and happiness. Each member of our house staff must still keep one thought uppermost as he approaches each new patient: How can I help this individual, and as I do so, what can I learn?

Walter Bauer, M.D.,
Chief of Medical Services

Miss Ruth Sleeper, R.N., Director of our School of Nursing and Nursing Service, was one of three American nurses who were awarded Florence Nightingale medals by the International Committee of the Red Cross last May.

The Nightingale medals, awarded biennially, are given in recognition of "exceptional devotion in the care of the wounded and sick during dangerous and difficult situations in time of war and public disasters."

The Hotel Lincolnshire, 20 Charles Street, was sold to the Massachusetts General Hospital last May. It will be used as a residence for our student nurses. Some of the larger rooms may be used for classrooms and library.

MEDICINE IN LATIN AMERICA
(Continued from page 1)

in that country will not be included in this report.

Although the State Department made it quite clear that the American Specialists were to render "a specific service to the United States rather than to work on a project of their own choosing", there seemed to be no bar to recording independent observations. I was greatly interested in trying to learn as much as possible about the general level of attainment in medicine in Latin America, which I was to visit. Also, I wished to discover whether medicine and the medical profession were or could be an important cultural and political force in Latin America.

Although my tour included visits to eight cities in the countries of Colombia, Peru, Chile, and Uruguay, the Neurosurgical Congress gave me an opportunity to speak also with physicians from Venezuela, Argentina, and Brazil. In all, about one thousand doctors were spoken to and I feel that it was possible to formally and frankly exchange views with over one hundred. The opinions of this latter group, together with the remarks of citizens engaged in politics, law, teaching, and business and, finally, my own observations, form the basis for my conclusions. A typical "working day" was seventeen hours in length, including the time necessary to record my impressions on a Gray Audograph dictating machine.

The hospitality and kindness shown to me by every South American with whom I dealt is one of the very happy memories of this trip. This was equally true of the Indians and Mestizos in Central Peru and the well-born descendants of the original Spanish grandes in Chile. Although my friends would discuss frankly the presence of anti-American sentiment, it always seemed to be another group of people who were guilty of it! Of course, I did not live in Lima, but in La Paz. All of the women and children of the American Embassy in La Paz were evacuated to Lima because it was felt that their lives were in danger. There seemed to be incontrovertible evidence at the time that the anti-United States actions in La Paz, as well as the April riots in Buenos Aires, were the direct result of communist propaganda and finance.

It was, of course, possible to sample only a small proportion of the cultural aspects of a continent measuring six million eight hundred thousand square miles and having a diverse population of over one hundred twenty million people, but I did gain certain broad general impressions. First, it seemed that the social structure, in most if not all of these countries, is one of a small aristocracy dominating a large, mostly illiterate class. Mining and farming are the most important economic pursuits, and an individual's social status is determined primarily by wealth and lineage, and, to a much lesser extent, by education. Attendance at the universities was until recently the prerogative of the well-to-do and for this reason had not tended to augment the numbers of the middle or upper classes. However, the present younger generation has recognized the advantages accruing to a higher education and is increasingly crowding the doors of the few universities in South America, even though many of the students must live on the verge of starvation.

That portion of the population which lacks economic advantages is becoming increasingly restless. The average South American, through his reading, his radio, and the many examples of material wealth which he sees on the street (most of it has been imported from North America), is awakening to the fact that a more abundant life is somehow possible. The desire for automobiles, radios, electric kitchens, etc. has led to dollar buying which, coupled with the economic shambles characteristic of the aftermath of dictatorships, has been a tremendous inflationary factor. Furthermore, in many South American countries the population is rising faster than economic productivity, leading to a still lower standard of living. The disparity in living standards and income, which is so apparent among the various social groups, is a prime factor in causing current political unrest, since from the desire for a better life comes the urge for immediate radical social changes and the attraction of the communist line of propaganda.

The Latin American physician apparently plays an important cultural role in this special situation. As in other societies old and new, he is held in some respect simply because he is a physician. He is essentially an upper middle-class citizen who, to a very large extent, has his origin from the lower middle-class and is thus a factor in broadening the base of the social structure. As an educated member of society he is often a leader in fields outside of medicine. His outlook (as seems to be the case with most physicians in all countries) is likely to be a conservative one. His medical contacts, if he is at all prominent in his field, are apt to broaden his understanding of problems of international significance.

Another important cultural consideration is the fact that the majority of the leaders in medicine have had some foreign education and in most instances they identify themselves with the medical and social cultures of the country in which they were trained. Frequently, for many reasons they tend to deprecate the level of medical attainment and the cultural attributes of the countries other than their own and the one in which their training was received.

For example, an outstanding medical figure in South America was trained in Europe and since his return (about twenty years ago) has sent his own pupils to various South American cities. This man and his students have been not only prominent in Europe but, unfortunately, anti-United States in their medical thinking; and this point of view has inevitably entered into their political thinking as well.

Again, at the university in Arequipa I met a young medical instructor who had
been trained in Paris. He spoke good French but no English, and was going to school at night to learn German. It seems reasonable to deduce that this young doctor feels that English-speaking countries have little to offer him medically, culturally, or politically. It is probable that his viewpoints on all of these matters will in some measure be communicated to his students.

At this point we might consider the political implications of certain medical activities. If this aspect of the healing art seems strange, remember that our Congress is currently deciding how much of your tax dollar shall go for health purposes and that recently the Massachusetts Legislature carried out an investigation of the cost of private health insurance.

In all of the South American countries which I visited, the governments are deeply involved in education, health, and welfare. Most of the medical schools, virtually all of the hospitals, and all of the practicing physicians are dependent upon the State for all or part of their income. When these governments face a financial crisis (which is a practically continuous situation), the health and teaching budgets are the first to suffer. The medical schools and the hospitals are then poorly financed and the physicians feel underpaid for their services. The populace, which looks to the State for good doctors and good hospitals, becomes unhappy when these are not provided. The medical students are unhappy because adequate teaching facilities are not available. The teachers feel insecure and the practicing physicians are apt to neglect the patient for whom the State pays the bill, in order to care for the individual who can afford to pay a private fee.

So — medical teaching and medical care become political issues; and medical research, which is thought by the State to be an expendable item, virtually disappears.

The physicians, whether teachers, investigators, or practitioners, have for these reasons a vital interest in politics. Many of them become influential in the political parties and a surprising number attain high government positions. In Brazil, for example, the President and two of his cabinet ministers, as well as the Mayor of São Paulo, are physicians. In Haiti, the President is a general practitioner and his foreign minister a psychiatrist. In all Latin American countries, the Minister of Health is usually a physician.

Whether the mixture of politics and medicine is a good thing is a matter of opinion but it is a fact of which we should be cognizant. Furthermore, if my thesis that the foreign-educated physician is loyal to the country that provided that education is valid, then this national problem of the physician as a politician takes on international significance.

The South American university, of which the medical school is a part, plays a very important role on the political scene. For this reason, I should like to comment briefly concerning this problem which is an inextricable combination of culture and politics.

With perhaps three exceptions, all South American universities look either to the State or the Church for their support. The faculties, such as medicine, law, engineering, and teaching are virtually independent one from the other. A student enters one of these faculties at about the age of seventeen and may in six years receive a degree. If, at the end of two years of instruction he decides that medicine is not for him and that he would be happier as an engineer, he finds that he must repeat his first two years in the university, as there is no mechanism for crossing over from one school to the other. This leads to the production of men trained for special careers who, in many instances, are unfit and unhappy in their specialty and thus turn to other pursuits.

Since university education is virtually free, the universities are overcrowded, and in many of them there is no provision for forcing a student to leave if his work is unsatisfactory. There are a number of individuals who have been students for ten, twelve, and fourteen years. These "professionals" are usually more interested in politics than in education, are usually leftists and communist trained, with great influence within the students' unions which they use as forums. These students' unions are international in organization, and almost all university students are members.

The political activity within the universities is well illustrated by the situation in Peru, where the students, through their union, have demanded "co-gobierno" — that is, a voice in administrative affairs. They have taken the third representation on the university and faculty councils, which means that expenditures of funds, election of deans and professors, even the choice of courses offered to the students would be voted upon by their representatives.

According to one of my Peruvian colleagues, this agitation for co-gobierno grew out of the complaint of the students that the professors were in large measure neglecting their teaching duties. This situation is apparently due to the fact that professorships, particularly in the State-dominated universities, are prestige appointments, often given for political reasons and carrying no salary. Many professors are, therefore, forced to earn their living in ways other than teaching, and they are therefore less interested in the latter regard which are indeed often neglected. Unfortunately, the students have attempted to remedy one bad situation by creating another.

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The political activity within the universities is well illustrated by the situation in Peru, where the students, through their union, have demanded "co-gobierno" — that is, a voice in administrative affairs. They have taken the third representation on the university and faculty councils, which means that expenditures of funds, election of deans and professors, even the choice of courses offered to the students would be voted upon by their representatives.

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American, were ever really interested in issues or events outside their specialty!

The great charitable foundations such as Rockefeller and Kellogg, on the other hand, appear to have been much more effective. In Colombia, the town of Cali has a modern, well-equipped teaching hospital supported by one of these foundations. Its young chief of medicine was trained at the Presbyterian Hospital in New York. Many of his staff are also graduates of teaching centers in the United States, thanks to fellowships from Rockefeller and Kellogg. The faculty of the medical school and the staff of the hospital are organized in the best tradition of American medicine. The teachers in the basic sciences devote themselves full time to instruction and research because their salary scale is adequate. Not only are the hospital and medical school an example of good medical practice to the community, but their students, interns, residents, and the graduates of its nursing school provide the means of bringing to all Colombians an ever-increasing amount of some of the best products of American culture. Furthermore, the medical faculty will inevitably strengthen the university because of its belief in academic independence and the dignity and value of a teaching career.

Our foundations and the government, through Fulbright scholars, have been most helpful in exporting for various periods of time medical teachers from the United States to Latin America. The importance of such a teacher, if he is wisely chosen, goes far beyond the technical aspects of his specialty. In his out-of-classroom conversations with students he can often correct misconceptions about the American way of life. With the faculty he is frequently helpful as an advisor on problems of curriculum and administration. In the community he is an example of the fact that the United States is not wholly oblivious of the importance of the scholar. At the same time he is never in economic or professional competition with his colleagues. It is unfortunate, however, that the foundations and the government not only have no coordinated program, but that there is not even an effective exchange of information about their current activities.

My visit to South America has convinced me that a vigorous extension of our efforts, governmental and otherwise, into the international field of medical teaching and research must be considered a foremost policy objective of the United States. These efforts should be equally a matter of export and import of students and teachers, but this must be done with the full realization that there is a cultural and political point of view to be considered. Senator Lister Hill has recently introduced into the Senate a resolution calling for the establishment of fifty million dollars annually for an international medical research program. In presenting his bill Senator Hill said in part, "The interesting thing is how the doctors and scientists, themselves, emphasize not only the importance of this legislation to the cause of scientific advance against disease and disability but its importance to the cause of peace." I would fully agree with this but would add that, as a governmental activity, promotion of the cause of peace is a major responsibility of our State Department. It seems rather ironic, therefore, to read recently that the Health and Welfare Committee, when considering the Hill bill, had rejected the idea that this program be directly under the President. It preferred to assign the funds and authority to the National Institutes of Health in order to keep the effort from being "mixed up with cold war politics". If the International Medical Research Program comes into being, it will inevitably influence the cold war either way which we wish it or not. In my opinion it is an obligation of our government to see that the activities of this program work efficiently for us in promoting peace, good will, and understanding on the international level.

Whether or not international medical activities become a function of the National Institutes of Health, it would seem advisable to have in the Department of State a high-ranking official, perhaps an Assistant Secretary of State, for medical affairs. He and his staff would have the task of directing, guiding, and advising on the cultural and political aspects of our efforts in the international medical field.

We should have North American medical investigators and teachers in every major teaching center in Latin America. The State Department should know who these men are and should perhaps have a voice in their selection, since they must be chosen as much for their understanding and sympathy for the country in which they work as for professional competence. They should have a grasp of the political situation and the problems of the Latin American university, and whenever possible they should be chosen for their ability to speak Spanish. More young Latin Americans should be studying in our hospitals and medical research laboratories, and the State Department must be made aware that whether these students come on government grants, foundation grants, or on their own resources they will be an asset or a liability to our cultural and political program depending on our treatment of them.

In this respect we, as private citizens, can make a valuable contribution. Recall for a moment the actions of the Dean of Medicine of the University of the Philippines who, when Marcos the man who stands like a rock against the wave of co-gobierno and the domination of the University by the students. I am certain that his present stand is in part due to the fact that he was once at the Harvard Medical School. Yet he almost left Boston a homesick, lonely, and embittered young man. The understanding, sympathy, and encouragement of fifty of his teachers kept this man here until he had finished his training and made of him a true friend of the United States. All of us can, if we make the effort, create an opportunity for a foreigner to feel a little more at home in the United States, a little more friendly toward us and our institutions. Furthermore, we should seek out and bring to the United States for "eye-opening" purposes those key Latin American students who seem anti-American. Again it will be the function of the State Department to identify these students and make it clear that they are worth-while material and then make it possible for them to visit here. Most of the time the prejudice that they have stems from the influence of communist propaganda, and a short tour in this country will do wonders to set the record straight. We should not concentrate exclusively upon individuals whose loyalty to the United States is unquestioned.

It should also be possible for the Latin American professor of medicine to come to the United States to see our work and our institutions. In 1961 a World Congress of Neurosurgery will be held in Washington. Our State Department should, even now, be offering its services in order to be certain that visitors from foreign lands get a good impression of the United States. It is not to my knowledge, doing so; and it seems to lack the machinery to be effective, as well as the realization that medicine can be important as a cultural and political force. Finally, once the United States has trained a foreign physician, every effort should be made to keep in contact with him and his country of origin. Time and again I heard of young men who became discouraged and bitter when they found themselves unable for various reasons to practice medicine or carry on research as they were accustomed to do in the United States. Many of them were in competition with men trained in other countries whose teachers had contact with their pupils. Our trainees, feeling forgotten by their teachers and friends and unable to achieve professional satisfaction, became bitter toward this country, which had opened the golden door and then slammed it shut. Here again, the State Department can be of immeasurable assistance through its Cultural Affairs Officers. If we are to choose from a cultural and political point of view the right policies for gaining and maintaining the good will of the Latin American physician, we need the help of our State Department and it needs the staff and funds to give that help.

In conclusion, I would like to speak of the incredible feeling which I had of being welcome and wanted in South America. The people in these countries seem to be searching for a culture — a way of life. As one of my Latin American friends phrased it, "The majority of the citizens of my country are just now emerging from the jungle." It seemed that we had an opportunity (although perhaps a fleeting one) to influence the peoples of this great continent to the south of us. Whether in the end they adopt the cult of the citizen enslaved by the State or turn to our philosophy of the State serving the citizen will greatly depend, I am sure, upon our efforts. In the medical field a unique
opportunity exists. By increasing our aid, both public and private, to medical schools and teaching hospitals in Latin America, we can transplant a segment of our culture. An increased exchange of professors and students will continually strengthen that tie. Inevitably, then, will we reap the political benefits.

H. Thomas Ballantine, Jr., M.D.,
Associate Visiting Neurosurgeon

Dr. Churchill was awarded the honorary degree of Doctor of Science by the University of Alabama on May 31. The citation which accompanied the award reads:

EDWARD DELOS CHURCHILL — World-renowned surgeon. Born in Illinois. Bachelor of Arts and Master of Arts of Northwestern University and Doctor of Medicine, cum laude, of Harvard University. Now Professor of Surgery of the Harvard Medical School and Chief of Surgical Services at Massachusetts General Hospital. He has held many positions and has been highly honored by many personal and professional organizations and decorations, in peace and in war — at home and abroad, for great professional knowledge and skill, and for large international service. A dedicated, patriotic and eminent citizen who is truly an adornment to the medical profession of the world.

Dr. Varastad H. Kazanjian was presented with a plaque on May 15, in recognition of his many contributions to plastic surgery and his many years of leadership in the field. The award was made by the American Association of Plastic Surgeons, during their three-day annual meeting. Dr. Kazanjian was a pioneer in the development of plastic surgery in the United States. He was Chief Dental Officer of the Harvard Unit, which served with the British Expeditionary Unit in World War I. King George V awarded him high honors at that time for his treatment of facial wounds.

The Board of Trustees, at their meetings during May, June, and July, voted:

To accept the resignation of Dr. Porter H. Smith from the position of Assistant Anesthesiologist, beginning July 1;

To change the appointment of Dr. George Chalpin from Clinical Assistant in Psychiatry to Assistant Atteniding Psychiatrist at McLean Hospital, effective May 15;

To change the appointment of Dr. John G. Clark, Jr. from Clinical Assistant in Psychiatry to Assistant Psychiatrist at McLean Hospital, effective July 1;

To change the appointment of Dr. Jacqueline Gauthier from Assistant in Psychiatry to Clinical Fellow in Psychiatry at McLean Hospital, effective July 1;

That the appointment of Dr. Harold L. May as First Assistant Resident in Surgery be retroactive to October 1, 1958 rather than beginning April 1, 1959;

That the title of Dr. Renée Bennett O'Sullivan be changed from Intern to that of Second Assistant Resident on the Children's Medical Service for surgical service, July 1, 1956 through June 30, 1957;

To appoint Drs. Daniel S. Ellis and Howard Ullfelder as members on the General Executive Committee for one year, beginning July 1;

That the Children's Medical Service be granted one additional Assistant Resident, that is, a total of six Assistant Residents, with the understanding that one such Assistant Resident will always be assigned to the Pediatric Unit of the Massachusetts Mental Health Center;

That the invitation extended to Professor Theodore Gilman to give a Richardson Lecture at the Hospital on April 28 be approved;

That Professor R. J. Turner Warwick, Hunterian Professor of the Royal College of Surgeons of England, be invited to give a Richardson Lecture at the Hospital on June 10.

To promote:

Dr. Myron Lotz to the position of Assistant Resident in Medicine for one year, beginning July 1;

Dr. William T. McCoy to the position of First Assistant Resident in Radiology, beginning July 1;

Dr. Farrokh Saidi as First Assistant Resident in Surgery.

To appoint:

Miss Phyllis Ackman as Assistant Psychologist at McLean Hospital, beginning September 1;

Dr. Elroy. E. Anderson as Assistant Resident on the Children's Medical Service for one year, beginning July 1;

Dr. Homer L. Ash as Intern on the Dental Service for one year, beginning July 1;

Mr. William Caudill as Associate Social Anthropologist and Acting Chief of the Department of Social Sciences at McLean Hospital, beginning September 1;

Dr. Virginia L. Clower as Assistant Attending Psychiatrist at McLean Hospital, beginning August 1;

Dr. Pierre M. Dreyfus as Assistant Neuropathologist in the Research Department and Assistant Neurologist at McLean Hospital, beginning June 26;

Dr. Nathan H. Feiner as Assistant to the Children's Medical Service for one year, beginning July 1;

Dr. Edward L. Ferguson as Clinical Associate in Surgery, beginning May 1;

Dr. Thomas B. Firepitt as Chief of the Dermatology Service, beginning July 1;

Dr. George A. Glines as Assistant to the Children's Medical Service, beginning July 1;

Dr. Henry U. Grunebaum as Resident in Psychiatry at McLean Hospital, beginning September 1;

Dr. Andrew D. Guthrie, Jr. as Assistant to the Children's Medical Service, beginning July 1;

Dr. Floy C. Helwig as Exchange Assistant Resident on the Children's Medical Service, for the period July 1 through August 30, 1956;

Dr. Kenneth E. Jones as Assistant in Medicine for one year, beginning July 1;

Dr. Martin Kantor as Assistant Resident in Psychiatry for one year, beginning July 1;

Dr. Melvin K. Kaye as Assistant in Psychiatry, beginning July 1;

Dr. William S. Low as Intern, beginning April 23;

Dr. Padmakar P. Lele as Assistant in Neurophology in the Department of Neurosurgery, for the period of one year, beginning September 1;

Dr. Edward Lowenstein as Assistant Resident in Anesthesia, beginning July 1, 1956;

Dr. Alexander S. MacDonald, Jr. as Clinical Associate in Children's Medicine, beginning May 1;

Dr. Edward F. McGrath as Clinical Associate in Children's Medicine, beginning May 1;

Dr. Edwin J. Madden as Assistant Resident in Orthopedic Surgery for one year, beginning July 1;

Dr. Jack H. Mendelson as Assistant in Psychiatry, beginning July 1;

Dr. Eugene J. Morrissey as Assistant Resident in Orthopedic Surgery for one year, beginning July 1;

Dr. Barbara Gurd Mueller as Clinical Fellow in Psychiatry at McLean Hospital, beginning July 17;

Dr. Charles W. Neville, Jr. as Clinical Fellow in Psychiatry at McLean Hospital, beginning July 17;

Dr. George M. Perrin as Clinical and Research Fellow in Psychiatry, to act as Resident for one year, beginning July 1;

Dr. Juma A. Povall as Clinical Fellow in Psychiatry at McLean Hospital, beginning August 1;

Dr. John T. Pollard, Jr. as Assistant in Radiology, beginning January 1, 1960;

Dr. Robert N. Rapoport as Consultant in Social Science at McLean Hospital, beginning September 1;

Dr. Earl H. Rosenberg as Resident on the Dental Service for one year, beginning July 1;

Dr. Mahmoud Sadrieh, Chief of Surgery at Saadi Hospital, Shiraz, Iran, as Consultant in Surgery pro tempore for one year, beginning July 1;

Dr. Richard E. Senghas as Assistant Resident in Orthopedic Surgery for one year, beginning July 1;

Dr. William R. Shelton as Assistant in Psychiatry, beginning July 1;

Dr. Herbert C. Wimberger as Clinical Fellow in Psychiatry at McLean Hospital, beginning August 1;

Dr.orey Wosnitzer as Assistant Resident in Urology for one year, beginning July 1.

At their meetings on April 29, during May, June, and July, and on August 5 and 19, the General Executive Committee voted:

To reinstate Dr. Geza F. P. Kaplan de Kaplan-yaza as Clinical Fellow in Anesthesia, effective as of June 7;

To change the title of Dr. Arthur D. McGowan to that of Clinical and Research Fellow in Dermatology, effective as of July 17;

To rescind the appointment of James W. Mayer, Ph.D. as Research Fellow in Physics (Medicine), as Dr. Mayer decided not to accept the appointment;

To accept the resignation of Dr. Claus W. Reichle from the position of Clinical Fellow in Anesthesia, effective June 30;

To rescind the appointment of Dr. Victor J. Rosen as Clinical Fellow in Pathology, as of July 1;

To change the title of Dr. Giles D. Toll from that of Assistant Resident in Pathology to that of Clinical Fellow in Pathology and Acting Assistant Resident in Pathology for one year, beginning July 1.

To promote:

Dr. Luis L. de Mota to the position of First Assistant Resident in Pathology for one year, beginning July 1;

Dr. James H. Duxbury to the position of Assistant Resident in Urology for one year, beginning July 1;

Dr. Charles S. Kevil, Jr. to the position of Clinical Assistant in Medicine for one year, beginning July 1;

Dr. Bernard F. Mach to the position of Assistant Resident in Medicine for one year, beginning July 1;
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Dr. Stuart E. Price, Jr. to the position of Senior Assistant Resident in Urology, beginning July 1; Dr. Steven J. Schatzki to the position of Resident in Radiology, beginning July 1; Mary L. Stephenson, Ph.D. to the position of Assistant Biochemist (Medicine), beginning July 1; Dr. Donald W. Sutherland to the position of Resident in Medicine for one year, beginning January 1, 1960.

To extend the appointments of:

Dr. Fernando A. Cardenal as Clinical Fellow in Internal Medicine, beginning from September 1 through December 31; Dr. Jacques E. Dumont as Clinical and Research Fellow in Medicine to November 30; Dr. Ira A. Ferguson, Jr. for one month, through July 31; Dr. William H. Harris as Senior Resident on the General Service, during the period May 1 through May 15: during the period May 1 through May 15 he will be granted the privilege of assisting in the care of Dr. Otto E. Auerbach's private patients; Thomas Nussbaumer, Ph.D. as Research Fellow in Medicine to September 30; Dr. H. Jurard as Clinical Fellow in Orthopedic Surgery for an additional six months, through December 31; Dr. Jenich as Clinical Fellow in Anesthesia, from June 1 through August 31; Kathleen Stratton, Ph.D. as Research Fellow in Physics (Medicine) through September 30.

To reappoint:

Dr. Khalil Abi-Torbey as Clinical and Research Fellow in Urology for one year, beginning July 1; James E. Anliker, Ph.D. as Research Fellow in Anesthesia for one year, beginning July 1; Bronius Baskys, Ph.D. as Research Fellow in Dermatology for one year, beginning July 1; Dr. William H. Batchelor as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. John F. Bertles as Assistant Resident in Surgery for one year, beginning July 1; Dr. Paul H. Black as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Robert J. Bragg as Clinical and Research Fellow in Psychiatry for one year, beginning July 1; Dr. Willi Burgi as Research Fellow in Medicine for one year, beginning September 1; Dr. A. Cavanaugh as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Burtz as Clinical Fellow in Medicine for one year, beginning July 1; Dr. Frederick J. Duhl as Clinical and Research Fellow in Psychiatry for one year, beginning July 1; Edwin H. Eyar, Ph.D. as Research Fellow in Medicine for one year, beginning September 1; Dr. Daniel D. Federman as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Howard S. Frazier as Clinical and Research Fellow in Medicine for one year, beginning September 1; Dr. Alan H. Goldberg as Assistant Resident in Anesthesiology for one year, beginning July 1; Dr. Richard M. Hays as Clinical and Research Fellow in Medicine for one year, beginning September 1; Dr. Alan J. Huggett as Clinical Fellow in Surgery for one year, beginning July 1; Dr. Robert L. Johnson as Second Assistant Resident in Surgery for one year, beginning July 1; Dr. Myron B. Laver as Clinical Fellow in Anesthesiology for one year, beginning July 1; Dr. Ortin Lederman as Clinical and Research Fellow in Surgery for one year, beginning July 1; Dr. Federico G. Lopez, with a change of title from Fellow in Neuropathology to that of Clinical and Research Fellow in Neurology, for one year, beginning September 1; Dr. Jesus N. Villaplana as Clinical and Research Fellow in Neurosurgery for one year, beginning July 1; Dr. Pierre A. Maurice as Clinical and Research Fellow in Urology, beginning September 1; Dr. Hans Nevinny-Stickel as Clinical Fellow in Medicine for one year, beginning July 1; Mr. Emery Ross as Assistant Physician (Medicine) for one year, beginning August 5; Dr. Richard C. Packert as Clinical Fellow in Radiology, beginning July 1; Charles I. PCR as Clinical Research Fellow in Medicine for one year, beginning September 1; Dr. Howard E. Plumer as Clinical and Research Fellow in Medicine for one year, beginning year 1959; Dr. Alberto Salama as Clinical and Research Fellow in Medicine, assigned to Cardiology, for one year, beginning July 1; Dr. Elhmu A. Schimmel as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Nathan T. Sidley as Clinical and Research Fellow in Anesthesiology for one year, beginning September 1; Dr. Norman T. Smith as Assistant Resident in Anesthesiology for one year, beginning July 1; Leon J. Spector, Ph.D. as Assistant Biochemist (Medicine), beginning July 1; Dr. Robert G. Spiro as Research Fellow in Medicine for one year, beginning July 1; Anne M. Stoffyn, Ph.D. as Research Fellow in Medicine for one year, beginning May 13; Pierre J. J. Stoffyn, Ph.D. as Research Fellow in Medicine for one year, beginning September 1; Zofia Tarasejska, Ph.D. as Research Fellow in Medicine for one year, beginning September 1; Lloyd B. Tepper as Clinical Fellow in Medicine, assigned to Occupational Medicine for one year, beginning July 1; Dr. Robert G. Willocx as Clinical Fellow in Medicine for one year, beginning September 1; Dr. Anthony A. Zarimpanoglou as Clinical and Research Fellow in Orthopedic Surgery, for the period July 1 through September 30; Dr. John A. McDow as Clinical and Research Fellow in Psychiatry for one year, beginning October 1; Dr. Marcel Bellemare as Graduate Student Assistant in Surgery for one year, beginning July 1; Dr. Bernard Bharti as Clinical Fellow in Neurology, to act as Assistant Resident in Neurology, for one year, beginning July 1; Dr. John A. Bolzan as Clinical Fellow in Medicine, assigned to Surgery, beginning July 1; Dr. Laurids K. Christensen as Clinical and Research Fellow in Medicine for one year, beginning September 1; Dr. George E. Dorey as Clinical and Research Fellow in Neurology for one year, beginning July 1; Dr. Adolfo G. Cousirot as Clinical Fellow in Anesthesiology, beginning June 25; Dr. William L. Garven as Clinical and Research Fellow in Dermatology for one year, beginning July 1; Dr. Alvin Essig as Clinical and Research Fellow in Medicine, beginning July 1; Dr. William I. Falem as Clinical Fellow in Pathology, beginning July 1; Dr. Dorothy E. Ford as Clinical Fellow in Physical Medicine for one year, beginning July 1, 1960; Dr. Joseph E. Geary as Clinical and Research Fellow in Surgery for one year, beginning July 1; Dr. Giovanni Giuliano as Clinical and Research Fellow in Medicine, beginning December 1; Dr. John Hedley Whyte as Clinical Fellow in Anesthesiology, acting as Resident, beginning July 1, 1960; Dr. Rauno J. Heinikheiman as Research Fellow in Anesthesiology for the period May 1 through August 31; Dr. Manuel Hernandez as Clinical and Research Fellow in Psychiatry for one year, beginning July 1; Dr. Thomas F. Hewes as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Peter R. Holt as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Tony L. Hwang as Graduate Student Assistant in Surgery, for the periods July 1 through October 1 and from December 1, 1959 through June 30, 1960; Dr. Sophus H. Johansen as Clinical Fellow in Anesthesiology for one year, beginning August 1959.

Dr. Earl F. Jordan as Clinical and Research Fellow in Neurosurgery, for the period July 1, 1959 through August 31, 1960; Dr. Bogdan Kajewski as Clinical Fellow in Anesthesiology, beginning December 1; Dr. Edmund Klein as Clinical and Research Fellow in Dermatology, beginning September 1; E. M. Christine Kris, Ph.D. as Research Fellow in Physics (Medicine), for a period of four months, beginning July 1; Dr. Robert S. McCarger, M.A. as Research Fellow in Sociology in the Department of Psychiatry for one year, beginning August 1; Kosac Maryum, D.Sc. as Research Fellow in Medicine for one year, beginning September 1; Dr. Oscar E. Masetto as Graduate Student Assistant in Surgery, for a period of nine months, beginning August 4; Dr. Marion C. Mather as Clinical Fellow in Anesthesiology for one year, beginning August 1960; Dr. Ian P. C. Murray as Research Fellow in Surgery for one year, beginning July 1; Dr. Teruo Okuma as Clinical and Research Fellow in Psychiatry for one year, beginning July 1; Dr. Turuhi Naito as Research Fellow in Pathology for one year, beginning July 20; B. S. Narasinga Rao, Ph.D. as Research Fellow in Physics (Medicine) for one year, beginning November 1; Dr. Paul F. J. New as Clinical Fellow in Radiology, beginning June 15; Dr. Isidoro N. Nova as Clinical Fellow on the Children's Medical Service, to work in the Out-Patient Department, for a period of six months, beginning July 1; Dr. Teruo Okuma as Clinical and Research Fellow in Psychiatry for one year, beginning July 1; Dr. Juan L. Pimentel as Graduate Student Assistant in Orthopedic Surgery, for a period of three months, beginning July 22; Dr. David B. Riefkohl as Research Fellow in Neurosurgery, for the period July 1, 1959 through August 31, 1960; Dr. Henry L. Schwepppe, Jr. as Clinical and Research Fellow in Medicine for one year, beginning July 1; Dr. Dagoberto Sosa as Clinical Assistant in Neurosurgery, for a period of eight months, beginning May 1, this appointment to run concurrently with his Residency in Neurosurgery; Harish C. Srivastava, Ph.D. as Research Fellow in Medicine for one year, beginning...
January 1, 1960; Dr. Oscar E. Starobin as Clinical Fellow in Medicine, assigned to Cardiology, beginning July 1; Dr. Willem Storm van Leeuwen as Research Fellow in Neurology, assigned to Neurophtalmology, for a period of three months, beginning May 1; John B. K. Sur, M.S. as Research Fellow in Biomechanics on the Orthopedic Service, for the period June 15 through August 14; Dr. Afonso Z. Tohen as Graduate Student Assistant on the Orthopedic Service, for the period June 8 through August 31; Dr. Barbara E. Waud as Clinical Fellow in Anesthesia, beginning July 1; Dr. Alfred L. Weber as Clinical Fellow in Radiology, beginning July 1; Dr. Alfred D. Weiss as Clinical and Research Fellow, Neurology for one year, beginning July 1; Dr. Louis Wener as Clinical Fellow in Radiology, beginning January 1, 1961; Dr. George F. Wilgram as Research Associate in Dermatology, beginning June 1; Dr. Ralph C. Williams, Jr. as Clinical and Research Fellow in Medicine, for the period October 1 through December 31; Dr. Ralph C. Wright as Clinical and Research Fellow in Neurology, for the period August 1 through December 31.

A new workshop for directors of hospital volunteers, sponsored by the Committee of Directors of Hospital Volunteers of Metropolitan Boston, will be conducted at Boston University. The course will be given on Tuesdays, from 4 to 6 P.M., October 6 through December 8.

This, the first workshop of its kind in the New England area, has been developed after considerable research and study by a committee under the direction of Miss Mary Ruth Wolf, Director of our Volunteer Service, and Professor Carol Hills of Boston University, Coordinator for the course.

The workshop is designed to provide the professional director of hospital volunteers, the chairmen of volunteers, and other participants in hospital services with a better understanding of their place in community and public relations.

Titles of the latest publications by members of the Massachusetts General Hospital and the Massachusetts Eye and Ear Infirmary staffs, as received in the office of Dr. John B. K. Sur, M.S., as Research Fellow in Biomechanics on the Orthopedic Service, for the period June 15 through August 14; Dr. Afonso Z. Tohen as Graduate Student Assistant on the Orthopedic Service, for the period June 8 through August 31; Dr. Barbara E. Waud as Clinical Fellow in Anesthesia, beginning July 1; Dr. Alfred L. Weber as Clinical Fellow in Radiology, beginning July 1; Dr. Alfred D. Weiss as Clinical and Research Fellow, Neurology for one year, beginning July 1; Dr. Louis Wener as Clinical Fellow in Radiology, beginning January 1, 1961; Dr. George F. Wilgram as Research Associate in Dermatology, beginning June 1; Dr. Ralph C. Williams, Jr. as Clinical and Research Fellow in Medicine, for the period October 1 through December 31; Dr. Ralph C. Wright as Clinical and Research Fellow in Neurology, for the period August 1 through December 31.

New titles have been received:

### Allergy & Immunology

Waksman, B. H.
Allergic encephalomyelitis in rats and rabbits pretreated with nervous tissue.

### Anesthesia

Becher, H. K.
Measurement of subjective states.

### Biochemistry

Gergely, J., Kaldor, G., and Briggs, F. N.
Participation of a dialyzable cofactor in the relaxing factor system of muscle. I. Studies with single glycinated fibers.
Biochim. et Biophys. Acta 34:211.

Gergely, J., Kaldor, G., and Briggs, F. N.
Participation of a dialyzable cofactor in the relaxing factor system of muscle. II. Studies with myofibrillar ATP-ase.
Biochim. et Biophys. Acta 34:218.

Gergely, J., Martonosi, A., and Gouvea, M. A.
The role of SH groups in the interaction of myosin with phosphate compound and with actin.
Biochim. et Biophys. Acta 34:283.

Kaldor, G., and Gergely, J.
The effect of pyridoxal phosphate and its inhibition by carnosine on the ATPase activity and synergism of myosin.
Biochim. et Biophys. Acta 34:283.

Kaldor, G., Gergely, J., and Briggs, F. N.
Participation of a dialyzable cofactor in the relaxing factor system of muscle. III. Substitution of pyridoxal phosphate for the cofactor.

### Biological Chemistry

Fekete, L. L., Lever, W. F., and Klein, E.
Characteristics of cobalt-induced hyperlipemia in rabbits.
Federation Proc. 18:358.

Klein, E., Lever, W. F., and Fekete, L. L.
Inhibition of pancreatic lipase by serum of hyperlipemic & hypercholesteremic patients & by extracts of human tissues.
Federation Proc. 18:82.

### Cardiology

Graybiel, A., Malt, R. A., Colehour, J. K., Barlow, G., and Spudich, G.
Comparison of the cardiovascular dynamics and the size and fat content of the heart in lean and fat dogs.
Am. J. Cardiol. 18:847.

Morgan, W. L., and Bland, E. F.
Bacterial endocarditis in the antibiotic era, with special reference to the later complications.
Circulation 19:152.

Thurbeck, W. M., and Currens, J. H.
The aortic arch syndrome (pulless disease): A report of ten cases with three autopsies.
Circulation 19:499.

### Dermatology

Mazt, M. H., and Blank, I. H.
Contact dermatitis from 4-tertiary butyl catechol in Thermo-Fax paper: Report of a case.

### Endoscopy

Benedict, E. B.
Diagnosis of diseases of the stomach by gastroscopy and gastroscopic biopsy.
J. A.M.A. 170:284.

### General Medicine

Bauer, W., and Bartter, F. C.
Diseases of the bone.
In Diseases of metabolism, ed. 4, Garfield G. Dunas, Editor, Philadelphia, W. B. Saunders Company, p. 1588.

Isbell, K. J.
Galactose metabolism and galactosaemia.

### General Surgery

Garconel, G. G.
Sarcoma gland tumors: Management and results.
A.M.A. Arch. Surg. 78:12.

### Hospital Hygiene

Allen, H. F.
Air hygiene for hospitals. I. Arrestment of airborne and dustborne staphylococci by a hospital vacuum cleaner.
J.A.M.A. 169:553.

### Laboratory Science

Waksman, B. H.
A histologic study of the auto-allergic testis lesion in the guinea pig.

### Neurophysiology

Brazier, M. A. B.
The historical development of neurophysiology.

### Orthopedic Surgery

Aulfric, O. E., and Sweet, E. B.
Study of patients with hip arthroplasty at Massachusetts General Hospital.
J.A.M.A. 170:507.

### Cardiology

Hirsch, O., in cooperation with Hannibal Hamilton.

### Orthopedic Surgery

Aulfric, O. E., and Sweet, E. B.
Study of patients with hip arthroplasty at Massachusetts General Hospital.
J.A.M.A. 170:507.

Otolaryngology


Pediatrics


Psychiatry


Radiology


Surgical Research


Miscellaneous


Books


BOOKS RECENTLY ADDED TO TREADWELL LIBRARY

The library call number is given, within parentheses, for each item.


(23Q) Skoog, T. (Editor) Transactions of the International Society of Plastic Surgeons, First Congress, Stockholm


(2A) Strunk, W., Jr. The elements of style.


(1AD) Symposium on fundamental cancer research. Radiation biology and cancer.

Austen, Tex., University of Texas, 1959.

(1SV) Taylor, J. (Editor) Selected writings of John Hughlings Jackson 2 vols.


(19A) Tocantins, L. M. (Editor) The physiology of the newborn infant, ed. 3. 2 vols.


(13V) Vickery, B. C. Classification and indexing in science.


(1C) Vygodchikov, G. V. (Editor) Clinical pathology.


(25K) Wallerstein, R. S. Pathogenesis and immunology of tumours.


(14B) Vander Eycken, H. M. Haemorrhagic nephroso-nephritis.


(12N) 

VOLUNTEER GROUPS

DISTAFF CLUB

The first official meeting of the Club was held on September 9 in the Penthouse, with Dr. Clark as the guest speaker. He welcomed the old and new members to the MGH family, gave a brief history of the Hospital, and answered questions from the wives about M.G.H. and its routines.

Before Dr. Clark spoke, Mrs. Soma Weiss took us on a tour of the Hospital. Officers for the coming year are: Mrs. George M. Williams, President; Mrs. Robert G. Ojemann, Vice-President; Mrs. Willard M. Daggett, Jr., Secretary; Mrs. Melton S. Grossman, Treasurer.

Brief bits:-

Dr. Henry F. Allen was elected Secretary of the Section on Ophthalmology of the American Medical Association, for a three-year term, at their June meeting in Atlantic City.

Dr. Mark D. Altschule, Director of Internal Medicine, Department of Pathology and Laboratory Medicine at McLean Hospital, has been appointed Editor of Medical science.

Irwin H. Schie, Ph.D. was given the Special Award for 1958 only May, by the Society of Cosmetic Chemists, "in recognition of his fundamental research and writing on factors controlling suppleness and flexibility of skin."

Dr. Bradford Cannon acted as Chairman of the Committee on Local Arrangements, which was host to the American Association of Plastic Surgeons, at their meetings in Boston, May 15-19.

Dr. Edwin E. Cave was elected President of the American Orthopaedic Association, at their meeting held in Lake Placid, N. Y., June 14-18.

Dr. Jack R. Dreyfuss presented a paper on "Infra-pulmonary pleural effusion", at the Hammersmith Hospital in London on May 20.

Dr. John W. Irwin, Director of the Microradiologi cal Laboratory, has been made Chair­man-elect for the 1960 Microradiological Conference.

Dr. Fred G. Johnson (Dr. 1943) is now teaching in the Biology Department at the University of California, Berkeley. He completed his graduate studies in the Public Health Department, Yale Medical School, and received his M.D. in June 1958.

Dr. Benson R. Roe (F. S. W. 1943) was appointed Chief of Cardiac Surgery at the University of California Medical Center in May 1958. Full-time University appointment became effective Dec. 1, 1958, with the temporary rank of Assistant Professor. His Associate Professorship became effective on July 1.

Dr. Paul M. St. Augin has rejoined the staff of the Department of Radiology. Dr. St. Aubin has spent two years as Radiologist-in-Chief of the Atomic Bomb Casualty Commission in Hiroshima and Nagasaki.

Dr. Milton S. Thompson (Dr. 1934) has been appointed Professor of Forensic Orthopedics at the University of Texas.

Dr. W. T. Taliatferro Thompson (a.r.p. 1941) has been appointed Professor and Chairman of the Department of Medicine at the Medi cal College of Virginia, Richmond, Va.

New addresses:-

Dr. H. Clarke Anderson (Path. 1959), Dept. of Pathology, University of Louisville School of Medicine, 101 N. Chestnut St., Louisville, Ky.

Dr. Richard H. Ater (M. 1958), National Institute of Arthritis and Metabolic Diseases.

Dr. Frank K. Austin (M. 1955), c/o Dr. John Humphrey, Div. of Immunology, National Institute for Medical Research, The Ridge way, Mill Hill, London N.W. 7, England.

Dr. George P. Baker, Jr. (M. 1958), Metabol­ic Unit, Grace-New Haven Community Hos­pital, New Haven, Conn.

Dr. Ruth B. Beuschler (a. attend, psychiat.), 168 Homer St., Newton Centre 59, Mass.

Dr. Peter J. Gomolattes (r.p. 1959), Students' Residence Hall, Rockefeller Institute, New York 21, N. Y.

Dr. Mehran Gouljian (a.r.p. 1959), Yale Uni­versity School of Medicine, 335 Cedar St., New Haven, Conn.

Dr. John W. Grover (S. 1957), Strangeways Laboratory, Wott's Causeway, Cambridge, England.

Dr. H. David Hall (Dr. 1958), Dept. of Oral Surgery, University of Alabama Medical Cen­ter, Birmingham, Ala.

Dr. William H. Harris (s. r.s. Or. 1959), Royal National Orthopaedic Hospital, Great Portland St., London, England.


Dr. John D. Hildberg (S. 1956), 10302 Brunswick Ave., Silver Spring, Md.

Dr. Joan Kazanjian Hied (r.p. C.M. 1959), 1004 Hudson Drive, Altus, Okla.


Dr. Wallace A. Jones (a.r.p. Path., 1959), Dept. of Pathology, Cincinnati General Hospital, Cincinnati, Ohio.

Dr. John W. Josse (M. 1957), 814 Sayconme Drive, Palo Alto, Calif.

Dr. Charles S. Kevyl (M. 1956), Concord Medical Center, Concord, Mass.

Dr. George Keleman (res. assoc. Otol., Massachusetts Eye and Ear Infirmary, 243 Charles St., Boston 14, Mass.

Dr. Kazuo K. Kimura (C.M. 1955), 9 Stuart Terrace, Worthington Heights, Bel Air, Md.

Capt. Howard S. Kaufman (a.r.p. C.M. 1959), USAF Hospital, APO 653, New York, N. Y.

Dr. Richard M. Kuzniawski (S. 1952), 207 Medical Center, Spokane, Wash.

Dr. Robert G. Knapf, Jr. (Dr. 1956), 258 Genesee St., Utica, N. Y.

Dr. John T. Loubser (M. 1942), 768 Park Ave., New York, N. Y.
Nix Professional Bldg., San Antonio S, Tex.  
Dr. William H. Tinger, Jr. (Dr. 1959), 115 E 4000 South St., Murray, Utah.  
Dr. David Van Buskirk (M. 1958), Massachusetts Mental Health Center, Boston, Mass.  
Dr. James L. Vanderven (c.c. Av. 1955), Massachusetts Memorial Hospital, 750 Harrison Ave., Boston, Mass.  
Dr. Arie C. van Ravenswaay (Path. 1934), 700 N. Country Club Tr., Tucson, Ariz.  
Dr. Frederick H. Veroeff (cons. c. Opht.), 61 Monmouth St., Brookline 46, Mass.  
Dr. Ludo von Meyenburg (C.M. 1912 & IF.M. 1918), 123 New Haven Ave., Melbourne, Fla.  
Dr. Jerome K. Walker (Dr. 1954), 42 W. Brook St., Manchester, N. H.  
Dr. Ralph C. Williams, Jr. (M. 1955), Massachusetts General Hospital, Boston 14, Mass.  
Dr. Herbert C. Wimberger (c.p. Psychiat. (M.L.) 1959), Massachusetts General Hospital, Boston 14, Mass.  
Dr. Herbert Welt (a.r.p. 1959), Columbia-Presbyterian Medical Center, 622 W. 168th St., New York, N. Y.  
Dr. Stanley M. Wyman (j.r. R. 1942), Cambridge Medical Bldg., 775 Mount Auburn St., Cambridge 38, Mass.  

Mrs. Helen H. Cushing, for many years the courteous and genial hostess at Baker Memorial and more recently hostess in the Warren Building Lobby, was honored by a tea-and-coffee party on June 12. The occasion was Mrs. Cushing’s retirement from active duty at the Hospital, and her many friends came to express to her their appreciation of her long years of service at M.G.H. and to wish her well for the future.

Dr. and Mrs. Dean A. Clark and the Distaff Club gave a party for members of the House Staff and their wives in the Warren Building Lobby on the afternoon of August 6. The party provided a very pleasant opportunity for many invited guests to meet the new members of the House Staff.

Delicious and attractive refreshments were served.

Dr. Arnold M. Katz, Assistant Resident in Medicine on our House Staff, has contributed a unique and most valuable item for our Archives collection.

During his recent travels in the Near East, Dr. Katz visited Cos, one of the islands in the archipelago off the coast of Asia Minor, where Hippocrates was born and practised medicine round 300 B.C. From the plane tree, under which Hippocrates is said to have carried on his teaching, Dr. Katz carefully selected and removed a very small dead twig. This, along with a piece of pure white marble which he picked up near by, he had enclosed within a little plastic box.

We have all seen, in the Warren Building Lobby, the results of the seedlings from this same tree which Dr. Wilder G. Penfield of Canada sent to the Hospital. But...