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UNIVERSITY OF MINNESOTA

# Medical Bulletin

OFFICIAL PUBLICATION OF THE  
UNIVERSITY OF MINNESOTA HOSPITALS  
THE MINNESOTA MEDICAL FOUNDATION  
AND THE MINNESOTA MEDICAL ALUMNI  
ASSOCIATION

IN THIS ISSUE:

*Blue Shield - Blue Cross  
Rehabilitation*

# University of Minnesota Medical Bulletin

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VOLUME XXVII

• November 15, 1955 •

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Published semi-monthly from October 15 to June 15 at Minneapolis, Minnesota.

# Staff Meeting Report

## Some Effects of Blue Shield and Blue Cross on Medical Practice

Edwin J. Simons, M.D.<sup>1</sup>

Blue Shield and Blue Cross pioneered prepayment health care which now is carried to some extent by two-thirds of the nation's population. Through the quarter of a century during which they have grown to their present impressive size, they have played a significant role in the changing order of medical practice.

In order to understand their role one must realize that they originated during the depths of perhaps the severest depression this country has known. Then, too, the period of their development has been a period of the most rapid medical progress in history. Statistics alone will not tell their story; one must know something of their history.

In 1933, at a time when few people could afford hospital care and many hospitals were faced with the possibility of having to close their doors, seven St. Paul hospitals adopted a plan whereby participants contributed regularly to a fund which was used to pay hospital bills for those subscribers requiring hospital care. By 1935 the success of this "Blue Cross" plan was evident and eight Minneapolis hospitals joined the plan, followed shortly by hospitals in Duluth and other areas in the state. Soon similar plans were developed in other states; today Blue Cross has organizations in all but two states.

Blue Shield was developed some years after the inception of Blue Cross as a means of helping people meet the cost of medical and surgical care. Although some financial difficulties were experienced at the outset in one or two areas, the Blue Shield plan, patterned in general after the Blue Cross program, soon proved its essential soundness. Today there are Blue Shield programs in 75 areas in 42 states, with residents of the remaining states served by plans in neighboring states.

What have been some of the results of the development of pre-

<sup>\*</sup>This is an abstract of a report given at the Staff Meeting of the University of Minnesota Hospitals on October 28, 1955.

<sup>1</sup>Medical Director, Minnesota Medical Service.

paid hospital and medical care plans which now cover such a large segment of our population? First, perhaps, is the fact that hospitalization has increased to the point where existing hospital facilities are inadequate in many areas. Many new hospitals have been built in an attempt to meet this need. Home care of patients has largely been replaced by hospital care except in chronic cases. With this change, home and country calls no longer require much of a doctor's time. Also, with coverage of some of the cost of medical care carried by so many people, doctors' services are sought earlier and in many instances more frequently.

With such a large proportion of the population carrying prepaid medical and hospital coverage, doctors' services are now being paid more promptly and rapidly. Furthermore, it is a generally recognized fact that doctors now receive payment for a greater percentage of their services and carry fewer uncollected accounts than before the advent of prepaid medical care coverage.

Blue Shield and Blue Cross, as the founders of voluntary prepaid medical and hospital care, have provided an effective substitute for some form of government controlled medicine, and in so doing have been an important factor in preserving the present American type and principles of medical practice.

# Staff Meeting Report

## Rehabilitation of the Elderly Patient

Glenn Gullickson, Jr., M.D.,<sup>1</sup> and  
Frederic J. Kottke, M.D.<sup>2</sup>

Among the most urgent medical needs of today is restoration of disabled old people to happy, purposeful lives. Although the span of life is steadily increasing, longevity is not associated with continued health, vigor, and usefulness. Most of the geriatric diseases are incurable, yet the majority can be alleviated to some extent. For example, about 90% of hemiplegics can be taught urinary and fecal continence, ambulation, and self-care.

In 1900, about 4% of the population in this country were 65 years of age or older. By 1950 the rate had doubled. In 1980, presumably 1 of 8 persons will be over 85.

In geriatric patients, the most frequent chronic diseases are degenerative, including various types of circulatory and metabolic disorders, malignant tumors, and arthritis. As computed in 1950, at least 5,600,000 of the 12,000,000 persons over 65 are physically or mentally impaired, and 2,100,000, or 17%, are disabled for three months or more per year.

Rehabilitation may be limited by (1) senility; (2) medical complications such as intracranial bleeding, acute heart failure, cancer, malignant hypertension, and severe renal disease; (3) inability to remember instructions — an almost hopeless obstacle; (4) psychosis; and (5) lack of motivation.

The impetus to activity must either arise from within or be inspired from outside. Rather than concentrating on disability, the invalid must learn to appreciate assets such as remaining undamaged musculature, mental powers, and personal relationships. To aid the philosophic shift, the physician, family, and others must have understanding, tact, and perseverance.

<sup>1</sup>This is an abstract of a report given at the Staff Meeting of the University of Minnesota Hospitals on November 4, 1955. A copy of the complete report, including references, may be obtained by writing to the Editor, UNIVERSITY OF MINNESOTA MEDICAL BULLETIN, 1342 Mayo Memorial, Minneapolis 14.

<sup>2</sup>Instructor, Department of Physical Medicine and Rehabilitation.

<sup>3</sup>Professor and Head, Department of Physical Medicine and Rehabilitation.

Rehabilitation is adjusted to capacities of each patient. Self-sufficiency is ranked arbitrarily in 6 grades, ranging from normal performance of all daily tasks to only a few self-care activities.

Common problems and methods of training are illustrated in 2 classes of patients, those with hemiplegia and those with degenerative joint disease.

Hemiplegics now number about 1,250,000 in the United States, a large proportion being in the older age group. Physical capacity and emotional attitude are determined as soon as possible, especially learning ability and motivation.

The hemiplegic will be able to walk if he can perform two simple prognostic tests: moving the affected arm, since the leg is nearly always less involved; and lifting the paralyzed leg one inch off the bed, which demonstrates sufficient quadriceps strength.

Physical rehabilitation aims to prevent or correct deformities, restore movements of ambulation and elevation, teach procedures of daily living and work with the sound arm and hand, retrain the weak arm and hand as far as possible, and improve faulty speech.

Precautions are taken to avoid deformity in the acute stage of illness. A position representing good posture while standing erect should be maintained in bed. A foot board or posterior splint prevents foot drop. To keep the trunk from sagging, a bed board is used and no pillows are allowed under the knees. External rotation of the leg is averted by sandbags and shoulder adduction by a pillow in the axilla. A wrist drop splint or a roll in the hand prevents wrist and finger flexion.

Twice a day, the invalid or an assistant passively carries each joint of the involved limbs through the full range of motion. The patient moves the good extremities through full scope five to ten times every hour.

For early contractures, heat is applied and the joints are passively stretched until full motion is regained. Severe deformity may require operative correction.

As soon as possible, the patient is encouraged to sit up alone, first on the side of the bed, then in a chair. He learns to go from bed to chair and back. Meanwhile, resistance exercises are done to strengthen muscles weakened by paralysis or disuse.

The spastic hemiplegic can generally extend the hip and knee but usually holds the foot in equinus and supinated and is afraid to bear weight on the leg. In about one-half of the cases, a drop foot

brace is needed, such as a double-bar brace with Klenzak joint and outside T strap.

Practically all hemiplegics can learn to walk and should start early for the great psychologic benefits. Balancing and weight shifting are done in the standing position between parallel bars or two kitchen chairs. Next, heel-toe gait is practiced with bars or a chair, then with a cane. Reciprocal leg motion is learned rather easily, but reciprocal arm motion is difficult and often impossible.

Independent activities like eating, dressing, writing, opening or closing doors, and shaving or other toilet procedures are learned with the good arm, since the paralyzed limb will not function for a long time, if ever. Self-help devices are commonly needed.

The arm with spastic paralysis is moved by the functioning arm, beginning with flexion at the shoulder. The elbow is flexed and extended, and the fingers are opened and closed. Exercises are repeated five times an hour. Flaccid paralysis requires muscle re-education, sometimes with electric stimulation.

Aphasia is hard to manage, but the patient and his family may be assured that loss of speech does not necessarily mean loss of intellect. Dysfunction may be expressive, with inability to speak or write words; receptive, with failure to understand oral or graphic symbols; or expressive and receptive in equal degrees.

The patient is evaluated, and a speech therapist teaches necessary skills, including ability to read street signs, indicate directions, write one's name and address, and make telephone calls.

Rehabilitation of the osteoarthritic cripple is directed mainly toward relief of symptoms and prevention of further joint damage, since anatomic cure is not expected. The chief symptoms are pain, weakness, and restricted range of motion. Any mechanical disalignment should be corrected and obesity reduced.

Pain is lessened by salicylates or other analgesic drugs or by heat applied for twenty to thirty minutes at a time. Moist hot packs, soaks in hot water or melted paraffin, electric pads, infra-red rays, or short-wave diathermy may be used. Massage is given to diminish muscle spasm and subcutaneous fibrosis.

Most important is therapeutic exercise, prescribed to increase joint motion and to strengthen muscles. Success depends on closely supervised active stretching of tight structures and progressive resistance exercises.

Accessory devices, such as arch supports, shoe corrections, cor-

sets or braces for lumbar spinal involvement, crutches, or canes, may be indicated. For the cervical spine, a Sayre head sling is helpful. Traction may be applied in the sitting position for two to three minutes with a tension of 30 to 50 lb.

Most people with degenerative joint disease must continue the physical regimen at home, under careful guidance.

With hemiplegia, osteoarthritis, or other chronic disease, occupational therapy is indispensable. As with physical therapy, the desired function must be carried out by the parts involved. Interesting constructive work is most effective, and short periods of activity should alternate with periods of rest.

Useful home crafts are jigsaw puzzles, weaving, crocheting, knitting, simple woodwork, gardening, typewriting, using a treadle sewing machine, washing dishes, piano playing, riding a stationary bicycle, or any other simple activity that improves a particular function.

More than physical training is required. Early in the course, the invalid is told about his chronic disease and warned of probable exacerbations and limitations of activity. The hopeful outlook for a longer life is stressed. He should be impressed with the fact that he must be largely responsible for his own comfort.

When all possible function is regained, the patient is encouraged to forget self-pity. He learns to side-step remaining infirmities and make the most of his aptitude for a useful, cheerful life.

## Editorials

### The Clinical Pathologist and Medical Practice

In an earlier but not too distant day the surgeon and the internist grew into their specialties in an informal way. This produced many good practitioners, but it is no longer feasible in most instances. The need for formal specialty training programs is widely recognized. Developments in various fields have proceeded in different ways and at different paces. Training in the specialty of clinical laboratory has yet to mature.

Circumstances, largely economic and organizational, dictated that the pathologist of traditional training assume charge of hospital laboratories, and although many fine laboratories have so evolved, the demands of modern hospitals and medical care require an altered approach to this need.

It might, perhaps, have been logical for the internist to assume direction of the clinical laboratories, since his specialty is so closely dependent upon the laboratory. The provision of a hospital chemist or bacteriologist, although highly desirable, is limited to larger centers. Even there, unless those individuals have medical training, additional medical liaison is required. Regardless of what might have been, the pattern of control has been set with the clinical pathologist. The American Society of Clinical Pathologists has been active in reacting to this need. Examinations have been considerably altered and specialty board requirements changed to permit qualification through fields other than morphology and to give encouragement to a plan of training divided between morphology and the other basic sciences employed in the clinical laboratory.

Some of the consequences of this have been unfavorable: few pathologists in the future will have as complete a morphologic training as has been the case; fixing responsibility for multiple basic disciplines with a single individual, although not unique to this field of medicine, is not ideal. Training programs are needed, and if superfluity is to be avoided, universities must aid in finding the answer to the problem.

Encouraged by fellowships provided by the National Institutes of Health, the University of Minnesota Hospital Laboratories have begun a program with eight fellows in a two-year plan of training. Besides providing for direct practical experience in the laboratory,

its management and the application of its results to the patient, emphasis is given by courses, seminars, and assignments to basic considerations. In the latter respect it is obvious that the time is too short, but the matter has been resolved in favor of depth of consideration as against extent of coverage. It is hoped to continue the program for a trial period of five years. Thoughtful criticism is invited.

The firm foundations of medicine were laid without many of the services provided by today's clinical laboratory, but the superstructure of advance is and will continue to be dependent upon it. Unless the organization of hospital practice changes, the clinical pathologist will be asked to respond to ever increasing requirements.

GERALD T. EVANS, M.D.  
Professor and Director  
Clinical Laboratory Medicine

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### The House Officer Speaks

The workaday language of the medical house officer is always picturesque, not infrequently astonishing. A few weeks ago we heard an intern, in making a case presentation, state that his patient had been "anticoagulated." We immediately envisioned some sort of ray gun in the hands of a Space Patrol villain which would, when aimed and fired at the victim, result in paralysis of the clotting mechanism. Ultimately, of course, we realized that the patient had been treated with heparin and dicumarol. We are often told today that our patient has been "diuresed" or "chloruresed," that Mr. A. has been "surgerized," or that Mrs. B. has "infarcted her spleen."

At the risk of appearing unduly pedantic, we deplore the use of these bastard expressions. They assail our ears and suggest to us the possibility that those who use them regularly think as loosely as they speak. Lest, however, we become too self-righteous, we must remind ourselves that earlier generations of physicians have been no less guilty. Such expressions as "the lesion was biopsied," "the patient was proctoscoped," and "the body was autopsied," having now gained a status of semi-legitimacy that they do not deserve, are to be found from time to time in the most respected medical journals. Finally we must point to the verb "digitalized," analogous certainly to "anticoagulate" which time and Noah Webster have legitimized. It is a pity that the proctologist did not claim it, in a somewhat different connotation, before the cardiologist. At least we have refrained from "insulating" our patients with diabetes mellitus.

# Minnesota Medical Foundation

## In Memoriam

The passing of a close friend, relative, or an immediate member of a family often finds those left behind desirous of perpetuating the memory of the absent one in some manner that will benefit mankind. If the individual has succumbed to a disease such as cancer, diabetes, or hypertension, there may be the desire to make a financial contribution to a research project under way in some institution or group that is investigating such diseases. Or the memorial may be expressed by furthering the scientific education of a talented young man or woman by means of a scholarship. The basis of all creative and progressive medical research is an individual with ability and ideas.

The Minnesota Medical Foundation has frequently served as the recipient of memorial funds, channelling such contributions into appropriate areas within the University of Minnesota Medical School. If a family or a group of friends desires to support research in a chosen field, the Foundation will gladly receive such funds and place them in an appropriate memorial within the University. If the donors desire to inaugurate a memorial medical scholarship, the Foundation will see that this end is accomplished. Physicians are often asked by members of the family and by friends about such contributions, and the growth of the Foundation's activities has been aided by the doctor suggesting that memorial funds should be channelled into specified areas by the Minnesota Medical Foundation. In some cases, unrestricted contributions have been made, and the officers of the Foundation have designated in what manner such a memorial fund should be applied within the Medical School.

No more worthy memorial could be perpetuated in the name of any person than an undergraduate medical scholarship for a talented and needy student of medical sciences. These awards have usually amounted to \$500 a year. An endowed fund of \$20,000 to \$25,000 could yield sufficient return to permit an annual scholarship. This would be a most fitting living memorial to the memory of a loved one. Such contributions should be made payable to the Minnesota Medical Foundation and forwarded to Dr. Robert B. Howard, Secretary-Treasurer, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14. Further information can also be secured by communicating with officers of the Foundation.

WESLEY W. SPINK, President,  
Minnesota Medical Foundation

# Alumni Association

## Homecoming

The Minnesota Medical Alumni Association is pleased to be able to report another successful Homecoming program. Quite a few alumni attended the special University Hospital Staff Meeting on Friday, October 28, to hear DR. EDWIN J. SIMONS discuss "Some Effects of Blue Shield and Blue Cross on Medical Practice." Principal Homecoming event was the Dinner-Dance which was held that same evening in the Radisson Hotel. DR. V. J. P. LUNDQUIST, '42, was in charge of the general arrangements and once again turned in a fine job. More than 125 alumni and wives attended, and all were agreed that it was a most enjoyable occasion. DR. CHARLES C. COOPER, '34, was master of ceremonies for the short program and proved to be in his usual good form in this role. Brief messages were given by DRs. CARL O. RICE, '25, and WILLIAM C. BERNSTEIN, '27, *Medical Alumni Association President*. Election of officers was held, and the following slate was adopted unanimously: *President*, DR. BYRON B. COCHRANE, '37; *First Vice-President*, DR. V. J. P. LUNDQUIST, '42; *Second Vice-President*, DR. SHELDON M. LAGAARD, '43; *Secretary*, DR. LEONARD A. BOROWICZ, '38; and *Treasurer*, DR. JAMES C. MANKEY, '43. DOCTORS ELMER T. CEDER, '29, KRISTOFER HAGEN, '42, and NEIL M. PALM, '50, were elected to the *Board of Directors*.

The Class of 1930 had its own reunion the same evening on the 25th anniversary of its graduation from the Medical School. Arrangements for this dinner were made by DR. PAUL N. LARSON, and more than 50 members of this class were on hand. Members of the class donated a total of \$3,035 to the Minnesota Medical Foundation as a Class Memorial Gift.

The Alumni Association is, indeed, pleased at the increased interest with which its activities have been met in the past few years. We are sure that this interest will continue to grow and that a closer association between alumni and faculty members, mutually beneficial, will result.

# Medical School Activities

## Dr. Bell Honored

On Tuesday, October 18, members of the Minnesota Pathological Society and a host of members of the Medical School Faculty paid honor to DR. E. T. BELL, *Emeritus Professor of Pathology*. The Society has established an annual E. T. Bell Lecture named in honor of this beloved physician, teacher, and investigator. The first Bell Lecture was given that evening by DR. C. J. WATSON, *Professor and Head, Department of Medicine*, whose address, "The Pyrrol Pigments in Relation to Hemoglobin Catabolism," was received enthusiastically by a large audience.

At a dinner in the Campus Club before the lecture, a portrait of Dr. Bell was presented to the Medical School by the Minnesota Pathological Society. The presentation was made by DR. S. MARX WHITE, *Emeritus Professor of Medicine*, also an outstanding leader of the medical profession and a long-time friend of Dr. Bell. Dr. White's words were so fitting that we chose to reprint them here:

Here to honor our friend, we are faced with the complexities and contradictions of the modern world. This era may become notorious for the lack of devotion to the highest ideals of human relationship and lack of respect for the past. Modern man is too busy with his probing science by new methods, his development of means of transportation and communication, of gadgets and his inflations, depressions and wars. And yet despite all this, man in the past one-hundred years has become more historically-minded than in any previous age. The amount of source material he has with which to work grows with unprecedented rapidity. Philosophers will differ as to whether historic events make the men or certain men make the events historic. Some stand out because of their relationship to events, some are great because of service to their time. President Morrill at the Wangenstein dinner said that "a great teacher affects eternity." Thus we think of Moses the lawgiver, Hippocrates the Father of Medicine. Nearly two millenia have passed since the Great Physician linked soul and body in healing and laid the basis for the civilizations and cultures of the lands west of the Jordan River. Most men can occupy only a niche in the wall separating aspiration, knowledge, light and progress from indifference, ignorance, darkness and decadence.

We often hear it said that an institution is but the elongated shadow of a man or sometimes of many men. The Medical School of the University of Minnesota has been blessed and is now blessed with some great leaders. Millard Hall bears the name of one. Dr. MacEachern of Kentucky, who was familiar with medical practice the nation over, at a period before and after 1900, stated repeatedly the country over, and I heard him say it here, in Boston and in New Orleans, that the general level of medical practice in Minnesota was the best to his knowledge in the United States. Frank Fairchild Wesbrook laid the physical foundation which has put the Medical School in the forefront of development in the University. He abolished sectarianism in the Medical School in 1908. He initiated a movement for a medical campus just south of the old line of the Great Western Railroad. The movement was taken up by the Greater Alumni Association and became the movement for the Greater Campus. He agitated for University Hospital development, and a medical and a surgical pavilion were opened in old residences on Washington Avenue. Then came the initial hospital bequest, the Elliott Memorial. He secured the interest of William J. Mayo in the Medical School and the University. Dr. Wesbrook left in 1913 to become President of the University of British Columbia. He died at Vancouver in 1918. Elias P. Lyon assumed the chair of

## THE MEDICAL BULLETIN

Physiology and the Deanship of the Medical School in 1913. He built strongly and well, developed clinical departments into whole-time services and consolidated the affiliation with the Mayo Foundation. Dr. Mayo became a member of the Board of Regents in 1907 and died while still a member on July 28th, 1939. In the environment sketched above, a young anatomist from the University of Missouri came in 1910, and transferred to the Department of Pathology in 1911. Richard E. Scammon replaced him in anatomy. Clarence M. Jackson was brought in 1913 to head that department. Jackson and Scammon promptly began to raise our sights in the field of research.

Our anatomo-pathologist grew apace, attained full professorship in 1920 and headed the Department of Pathology until he became Emeritus in 1949. The name—Elexious T. Bell—known to all as Tommie.

The task of outlining Dr. Bell's contributions presents difficulties because they are many and varied. He has been eminent over many years in his contributions to the teaching and organization in the Medical School and in the Graduate School. On the thousands of potential doctors passing under his watchful eye, his excellent teaching, careful appraisals and thoughtful helpfulness have exercised a profound influence. For the graduate student his keen judgment and unremitting industry have been a great stimulus. The number of pathologists he has trained testifies to the place of the Bell school of pathology. His "Textbook of Pathology" has gone through eight editions and "a reliable source near the White House" tells me he is working on the ninth. His experimental work on kidney diseases led to many important contributions. His many careful and detailed histologic studies of the kidney in various types of disease, including hypertension, have brought him recognition as one of the world's authorities in this field. His fine book on renal diseases has brought together the results of his researches over many years and has been translated into Spanish and Italian. In diabetes his studies of the islands of Langerhans, the significance of hyalinization and its frequency in relation to diabetes and in relation to the specific staining of the beta granules has been a contribution of genuine value in this field. He has made important studies of the Kimmelstiel-Wilson renal lesion in diabetes.

Dr. Bell the scientist may not realize to the full the value of the service of which I wish next to speak. Before he assumed the chair in Pathology permission for autopsy was often hard to get in this community. Certain racial and religious groups opposed the procedure and many morticians encouraged this opposition. Dr. Bell, by patient indoctrination, often attending meetings of various groups, especially the morticians, helped to change drastically this attitude. Now our record for percentage of autopsy to death is among the best. Physicians have a deep sense of gratitude for this educational program.

Deep in the knowledge of medicine and of his particular subject, broad in his culture, his scholarship and his sympathies, high in the councils of the Medical School, the Graduate School and the community—we salute the man. May the portrait which means so much to us mean also much to future generations.

### Faculty News

DR. HAROLD S. DIEHL, *Dean of the College of Medical Sciences*, has been appointed Honorary Civilian Consultant to the Surgeon General of the United States Navy. His term will be three to four years.

DR. LEWIS W. WANNAMAKER, *Associate Professor of Pediatrics*, is on a year's leave of absence. During this time he will be a Visiting Investigator at the Rockefeller Institute for Medical Research in New York City.

DR. ERLING W. HANSEN, *Clinical Professor and Head of the Department of Ophthalmology*, was named President-Elect of the American Academy of Ophthalmology and Otolaryngology at the annual meeting of that organization held in Chicago in early October. He will succeed DR. A. C. FURSTENBERG, *Dean of the University of Michigan Medical School*, current president.

## IN MEMORIAM

Within the past month death has claimed three physicians who have contributed much to medicine in Minnesota and to the Medical School.

DR. ANDREW T. RASMUSSEN, *Emeritus Professor of Anatomy*, died on October 15 in La Canada, California. Dr. Rasmussen, a graduate of the University of Chicago, and Cornell University (Ph.D.), served as a member of our faculty for 36 years until his retirement in 1952. Long a favorite of students, he was respected not only as a teacher but as an investigator. His course in neuroanatomy was unexcelled for organization and thoroughness. Author of several books and a host of scientific articles, his "Principal Nervous Pathways" in particular will be remembered by a generation of his former medical students. Dr. Rasmussen is survived by his wife and three sons.

DR. ALBERT J. CHESLEY, *Secretary and Executive Officer of the Minnesota Department of Health*, died on October 17 in Rochester, Minnesota. Long recognized as a leader in the public health field, Dr. Chesley was held in high esteem not only by those in his own field but by the entire medical profession. He graduated from the University of Minnesota Medical School in 1907 and became executive officer of our state health department in 1921, remaining active until shortly before his death. During this time he received almost every honor that exists in the public health field. He is survived by his wife and a daughter.

DR. RAYMOND C. HEDIN died on October 21 in Red Wing. Dr. Hedin, a graduate of the University of Minnesota Medical School in 1930, served his internship at the University Hospitals and took his surgical training in various Chicago institutions following which he began practice in Red Wing. Long recognized as a leader in Minnesota medicine, Dr. Hedin was in addition a continuing friend of the Medical School. From 1952 to his death he served faithfully and effectively as a member of the Board of Trustees of the Minnesota Medical Foundation. He is survived by his wife, a daughter, three sons, and his mother.

To members of the families of these outstanding men the Editors of the BULLETIN and the entire Faculty of the Medical School wish to extend most sincere sympathy.

## Postgraduate Education

### **Gastroenterology for General Physicians**

A continuation course in Gastroenterology for General Physicians will be held at the Center for Continuation Study from December 1 to 3, 1955. DR. HENRY L. BOCKUS, *Professor of Medicine and Chairman, Department of Medicine, University of Pennsylvania Graduate School of Medicine, Philadelphia*, renowned gastroenterologist, will be guest speaker and will also deliver the annual Journal-Lancet Lecture on Thursday evening, December 1. The course, which will stress the management of the more commonly seen gastrointestinal disorders, will be presented under the direction of DR. C. J. WATSON, *Professor and Head, Department of Medicine*.

### **Obstetrics for General Physicians**

The University of Minnesota will present a continuation course in Obstetrics for General Physicians at the Center for Continuation Study from January 5 to 7, 1956. The course will be presented under the direction of DR. JOHN L. MCKELVEY, *Professor and Head, Department of Obstetrics and Gynecology*.

### **Course for Nurses**

The University of Minnesota School of Nursing will present a continuation course in Selection and Use of Teaching Methods in Nursing Education, December 15-16, 1955, at the Center for Continuation Study. Faculty members planning the program are RUTH HARRINGTON, *Professor*, SYBIL NORRIS, *Assistant Professor*, and FRANCES DUNNING, *Instructor in Nursing Education*. Registration will be limited.

### **Notice**

All continuation courses presented by the University of Minnesota are approved for formal postgraduate credit by the AMERICAN ACADEMY OF GENERAL PRACTICE. Attendance certificates will be furnished on request.

Further information concerning the above programs or others to be presented may be obtained by writing to Dr. Robert B. Howard, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14.

## Coming Events

- November 21-23 . . . Continuation Course in Fractures for General Physicians
- December 1 . . . . JOURNAL-LANCET LECTURE: "Mechanism of Abdominal Pain"; *Dr. H. L. Bockus*, Professor and Chairman, Department of Medicine, University of Pennsylvania Graduate School of Medicine, Philadelphia; Mayo Memorial Auditorium; 8:15 P.M.
- December 1-3 . . . Continuation Course in Gastroenterology for General Physicians
- January 5-7 . . . . Continuation Course in Obstetrics for General Physicians
- January 30-  
February 1 . . . . Continuation Course in Emergency Surgery for General Physicians
- February 2-4 . . . Continuation Course in Mental Deficiency for General Physicians, Pediatricians, Obstetricians, and Child Psychiatrists

## WEEKLY CONFERENCES OF GENERAL INTEREST

### *Physicians Welcome*

- Monday, 9:00 to 10:50 A.M. OBSTETRICS AND GYNECOLOGY  
Old Nursery, Station 57  
University Hospitals
- 4:00 to 6:00 P.M. ANESTHESIOLOGY  
Todd Amphitheater,  
University Hospitals
- Tuesday, 12:30 to 1:20 P.M. PATHOLOGY  
104 Jackson Hall
- Thursday, 12:00 to 1:00 P.M. PHYSIOLOGY  
214 Millard Hall
- Friday, 8:00 to 10:00 A.M. NEUROLOGY  
Station 50, University Hospitals
- 9:00 to 10:00 A.M. MEDICINE  
Todd Amphitheater,  
University Hospitals
- 1:30 to 2:30 P.M. DERMATOLOGY  
Eustis Amphitheater,  
University Hospitals
- Saturday, 7:45 to 9:00 A.M. ORTHOPEDICS  
Powell Hall Amphitheater
- 9:15 to 11:30 A.M. SURGERY  
Todd Amphitheater,  
University Hospitals

For detailed information concerning all conferences, seminars and ward rounds at University Hospitals, Ancker Hospital, Minneapolis General Hospital and the Minneapolis Veterans Administration Hospital, write to the Editor of the BULLETIN, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14.