

MEDICAL BULLETIN

UNIVERSITY OF Minnesota



in this issue

- FAMILY PRACTICE
- PATIENT ISOLATION FACILITIES
- PSYCHOTHERAPY
- LIFE INSURANCE GIVING

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OUTLOOK

On February 1, 1967, the College of Medical Sciences gave approval to establishment of a Division of Family Practice and Community Health. Its purpose, according to Dean Robert B. Howard, is to develop a training program which would "concentrate on providing medical doctors to treat and understand the needs of patients searching for general medical help." (See MEDICAL BULLETIN, Feb., 1967, Vol. 38, No. 6)

The Division of Family Practice and Community Health is administratively attached to the Department of Medicine. During the past year the University of Minnesota appointed Dr. Benjamin F. Fuller, associate professor of medicine, as executive secretary of the planning subcommittee. Here is a report on the progress of this planning, written especially for the University of Minnesota MEDICAL BULLETIN:

The Division of Family Practice and Community Health

Benjamin F. Fuller, M.D.*

After several months of intense study, the Subcommittee on Family Practice and Community Health presented its recommendations to the Medical School's Executive Faculty on December 4, 1967. Since that date, the report has been presented to the central Administration of the University of Minnesota and to the Board of Regents. It was also presented to the House Interim Subcommittee on Educational Appropriations of the Minnesota State Legislature on February 16, 1968.

The Subcommittee report represents the initial planning effort toward developing a program for Family Practice and Community Health at the University of Minnesota. This Subcommittee began meeting on May 24, 1967 and continued to meet at weekly intervals through October of 1967. The Subcommittee consisted of members of the faculty of the Medical School and members of the practicing medical community. Faculty members of the Committee were as follows: *Dr. Richard V. Ebert, Chairman; Dr. Benjamin F. Fuller, Executive Secretary; Dr. Edward Defoe, Jr.; Dr. Donald Hastings; Dr. Glen Gullickson; Dr. Richard McGraw; Dr. Lyle French; and Dr. Robert McCollister.* *Mr. Peter Sammond* associate director of University Hospitals, was on the committee. *Dr. Edward Ciriacy of Ely, Minn. and Dr. Herman E. Drill of Hopkins, Minn.* represented the practicing medical community on the Subcommittee.

From the outset, it should be emphasized that a training program for Family Medicine and Community Health will stress different goals from those of the presently existing Medical School curriculum. We are really talking here about the *development of an effective health care delivery system* as it may be applied at the community level from point of view both of direct patient care and of health maintenance. The effectiveness of delivery will be directly proportional to the degree of expertise of the clinician in the traditional medical fields (i.e., care of the sick patient), as well as proper utilization of personnel in the allied health professions.



Benjamin Fuller

*Executive Secretary, Division of Family Practice and Community Health; Associate Professor, Department of Medicine, University of Minnesota

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There is little doubt that the responsibilities of the physician of the future will be quite different from the responsibilities of today's physician. This is brought out in all of the recent publications on the subject, but perhaps nowhere as emphatically as in the recent report of the National Advisory Commission on Health Manpower.¹ One of the most exciting things about the development of a new training program in medical education at Minnesota is that it may be possible, through this training program, to influence in a helpful way the manner in which the physician of tomorrow can be best utilized. The probability is great that, as medical practice changes, the physician will tend to delegate more and more of his present tasks to others. Personnel with whom he will work may vary from the traditional laboratory assistant to an operator of a highly sophisticated computer program. One of the great challenges in medical education today is to determine which kinds of tasks may best be delegated and which kinds of tasks are most appropriate for the peculiar training of the physician. The Division of Family Medicine and Community Health will lend itself well to a study of this question. In fact, the Subcommittee's first report represents an attempt to make an estimate of how it thought the future physician should best utilize his time.

MAJOR EMPHASIS

The Family Practice concept at Minnesota should be viewed as dynamic. The present report represents only a starting point and the program should and will change as experience is obtained. The emphasis will be on training for *health care delivery*. The major areas of research will be on studies of the effectiveness of the educational process and of effectiveness of the health care delivery process. *The Subcommittee felt that the basic body of knowledge of the family practitioner should be an integrated discipline emphasizing heavily the pertinent knowledge taken from psychiatry, pediatrics, internal medicine, and some of the behavioral sciences.* It will also incorporate knowledge of surgical principles so that the doctor can recognize indication for surgery and can perform pre- and post-operative care when necessary. He will also be trained to handle emergency situations. His obstetrical experience will stress pre- and post-natal care with considerable emphasis on the attitude of pregnant women, emotional acceptance of the unborn child, and the importance of the father in giving emotional nurturance and support. Normal individual development, patterns of family life, and individual reactions to stress and disease will also be emphasized.

1. Report of The National Advisory Commission on Health Manpower, Vol. T., Nov., 1967, U.S. Government Printing Office, Washington, D.C.

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The tasks facing the Division in the immediate future are formidable. The areas of development which must be given careful consideration include the following:

1. Overall administration of the program which will include facilities planning and development, development of the staff, development of methods and procedures, coordination of the service aspects of the program with other hospital services, arrangement for and liaison with the patient population, and fiscal arrangements with the patient population.
2. Continuing educational program development, both for family practice and community health. These include such things as curriculum development and implementation, course and student time scheduling, coordination between the specialty areas involved in the program, and liaison with representatives of other community health organizations.
3. Continuing improvement of service and quality of care. This includes planning the coordination of professional and procedural aspects of patient care, integration of teaching programs into care patterns, and coordination of inter-service referral and consultation.
4. Continuing attention toward development of affiliated units. This includes making arrangements with the existing staff of such units, the provision of additional program related staff, and the development of physical facilities in the affiliated units.
5. Planning for research in patient care and educational techniques. This includes the development of quality and efficiency evaluation techniques, the development of educational evaluation measurements, and comparison of results of this program with those of similar programs.

This brief report has been an attempt to acquaint the readers of this publication with the present status of the Division of Family Practice and Community Health and with some of the kinds of projections that account for current decisions being made. Those of us who are vitally interested in this program recognize that the ultimate determining factor regarding success or failure will be its ability to attract students to choose Family Practice as a career. We feel that the success of this program will be determined by the quality of the educational process experienced by the trainees, and by the appropriateness of the information taught to them relative to their ultimate experience in medical practice. It is our hope that the formidable developmental problems can be successfully overcome so that the goal of excellent and appropriate teaching can be attained.

Environmental Health

A Laminar Flow Facility for Isolation of Low Resistance Hospital Patients*

Donald Vesley, M.S.[†]

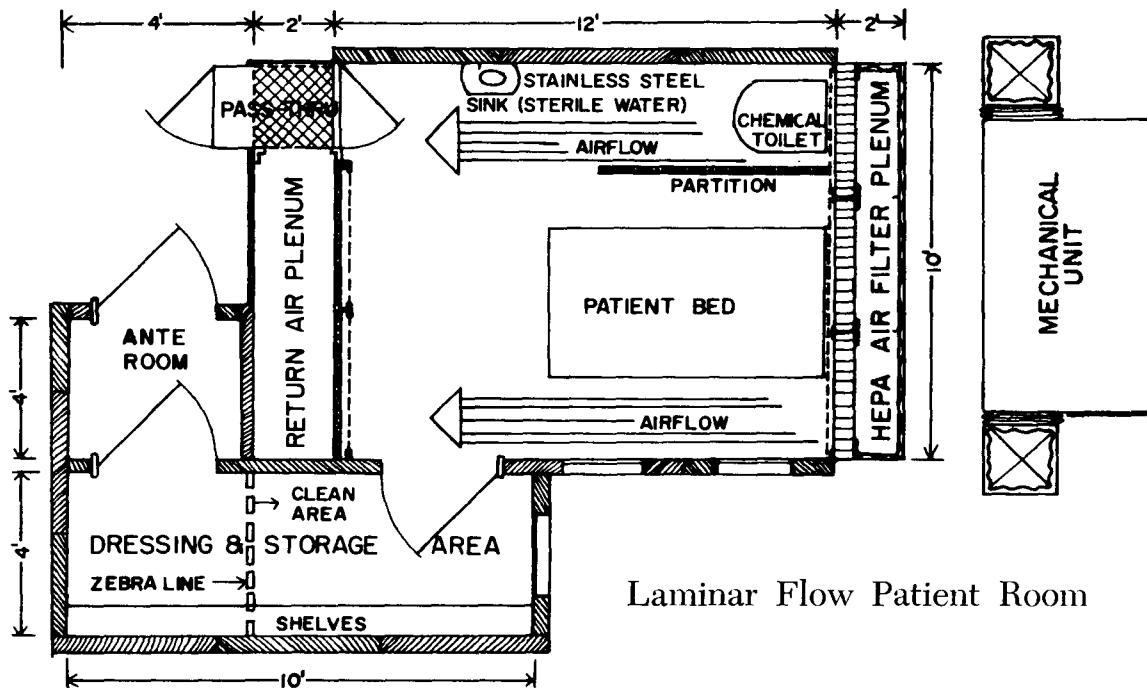
A prototype laminar flow isolation facility has been developed and evaluated at the University of Minnesota for proposed use in housing patients who are ultrasusceptible to infection. Used in conjunction with strict aseptic technique, such a facility can provide maximum protection for these patients against exogenous biocontaminants. Applications of this facility are being developed for patients undergoing leukemia chemotherapy; the principle is also applicable for organ transplant patients, burn patients, and in any other situation where the nature of the illness or the nature of the treatment has left the patient with a weakened natural immune defense.

Previous attempts to provide protection for low resistance patients have included conventional reverse isolation procedures and the use of plastic tent isolators placed over the patient's bed. The plastic tent isolators are effective in providing protection against extraneous contaminants, but they have several drawbacks. These include: 1) The difficulty of giving bed care to adult patients through restrictive glove ports and 2) The claustrophobic effect of the confining isolator on patients domiciled for long periods of time. The concept of using a full-size laminar flow room was formulated primarily to overcome these drawbacks.

Laminar flow is a ventilation system which utilizes high efficiency filters over an entire ceiling (downflow) or an entire end wall (crossflow) to provide a curtain of air at a velocity of about 100 feet per minute for the room. The air moves in one direction through the room and is 95 percent recirculated. The major advantages of this system include the unidirectionality, which provides protection of a sterile field from any con-

*From a report to the Staff Meeting of University of Minnesota Hospitals on March 22, 1968. This project was supported by Contract PH 43-65-999 from the National Cancer Institute, National Institutes of Health.

†Instructor, School of Public Health, University of Minnesota



Laminar Flow Patient Room

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tamination disseminated "downstream," and a very high turnover, approaching 600 changes per hour, compared to conventional ventilation with a maximum of about 20 changes per hour.

The facility being tested at the University of Minnesota is the crossflow variety. It incorporates a small anteroom and a dressing and storage room to provide a buffer zone between the laminar flow room and the outside. Observation windows, a communication system, and a pass-through for entry and removal of supplies are also provided. Conventional hospital room furnishings, a stainless steel sink providing filtered hot and cold water, and a "bucket" type toilet facility behind a partition complete the setup.

The experimental approach was first to utilize presterilized department store-type mannequins to simulate the patient. Thus, contaminants detected following nursing and medical procedures were not confused with autogenous organisms which would be present from a live patient.

Later experiments utilizing healthy human volunteer subjects were carried out to help evaluate the logistics of providing care in such a facility, comfort factors and physiological responses associated with the laminar flow environment, and microbial contamination patterns in the room resulting from autogenous flora of the "patient."

Conclusions based on these experiments include the following:

- 1) Airborne contamination at the "upstream" end of the room can be virtually eliminated provided that the filter remains intact. This confirms the value of the unidirectionality in protecting the "sterile field."
- 2) Even at the "downstream" end of the room, if suitable protective garments are worn, airborne contamination levels can be kept approximately one order of magnitude below the best conventional system.
- 3) When protective garments are worn and rigid aseptic technique followed, contamination reaching the "sterile field" can be minimized even during extensive contact procedures such as bathing the "patient" or performing a physical examination.
- 4) When personnel gloves or other direct contact surfaces become contaminated, the contamination is quickly transferred to the "sterile field."
- 5) General comfort and reaction to noise levels and air

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motion is not a problem in healthy volunteer subjects but might still be a consideration for the seriously ill.

6) There is no adverse physiological reaction apparent in healthy individuals housed in the facility for 12 days.

7) Logistics of providing care, including presterilization of all items entering the facility, are manageable but require a large staff and constant diligence.

8) Flora from the patient readily contaminate room surfaces in proportion to the degree of shedding associated with the individual. Thus, the extent to which the patient can be "degermed" largely controls the degree of contamination in the facility and the frequency with which items have to be removed and resterilized.

We regard the laminar flow room as a promising approach to isolation of ultra low resistance hospital patients. Airborne contamination levels can be minimized well below any other system. However, contact contamination and autogenous contamination must be controlled by means entirely independent of the laminar flow ventilation.

"He that will not apply new remedies must expect new evils, for time is the greatest innovator; and, if time alters things to the worse, and wisdom and counsel shall not alter them for the better, what shall be the end?"

SIR FRANCIS BACON

Clinical Psychology

New Patterns in Psychotherapy*

Starke R. Hathaway, Ph.D.†

A review of the evolution of psychotherapy reveals much change in attitudes toward the patient and in the patient's self concept. Originally, the patient's family and friends and the patient himself regarded mental illness with such feelings of guilt and inferiority that it was even difficult to collect data on the epidemiology of mental illness. One would not subject the privacy of the doctor-patient treatment to observation or preserve accurate accounts of the nature of the treatment.

Due to a number of factors, psychotherapy was much slower than other medical areas to lose ostentatious mystique. Even while most medical specialties were becoming freer of dependency on jargon and ill-defined terms, the psychiatrist was still aware that a considerable part of his therapeutic power was exerted through the mystery and impressiveness of his even attempting to treat the mind.

A breakdown in traditional attitudes has been developing through which the psychotherapeutic processes and the mental patient are being opened for candid study. One important item causing this change has been our consistent failure to demonstrate experimentally that psychotherapy is effective.

When surveys of psychotherapy treatment outcome data began to show no demonstrable difference in benefit between patients from clinics with widely varying patterns of staff and treatment, and even from patients who had had no treatment, it released therapists from some of their need for secrecy. Finding that his peers were probably also aware that their techniques were not convincingly effective, the therapist was less on the defensive. Meanwhile, the failure to identify mental illness



Starke Hathaway

*From a report to the Staff Meeting of University Hospitals on March 15, 1968
†Professor and Director, Division of Clinical Psychology, University of Minnesota

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solidly with physiological causes on the one hand, or with consistent and convincing psychological causes on the other, left the patient and his friends more free from guilt and therefore, they too were ready to accept experiment and observation.

A natural result of study of the patient and his therapist has been a proliferation of publications that have described new techniques for psychotherapy. These new techniques unfortunately still depend too much upon timely psychological trends such as the current existential crisis, instead of upon any more acceptable basis such as evidence that their practitioners can produce more good outcomes.

Such a state of affairs makes it difficult for the mental health professions to adopt a unified training and research program in psychotherapy. Concentration on particular techniques seems premature when there is such a flux of variety and so little basis for dogmatic specialization.

As a response to this status of the field of psychotherapy, we in the Department of Psychiatry have formulated characteristics that seem desirable for an inpatient service at University of Minnesota Hospitals designed to give maximal support to experimentation and training with a wide variety of psychotherapy techniques. To assure that such a service will be receptive to innovation and exploration of new ideas by students and staff, we have begun to develop an organization designed for freedom and toleration of innovations, while also assuring that the patient will receive the best treatment and respect. A new inpatient service is evolving that has encouraged a renaissance of interest in psychotherapy.

Recognizing that five to seven professional areas converge in contributing to the treatment of mentally ill patients, we have made the governing staff of this service representative of these fields. The psychiatrist, clinical psychologist, psychiatric nurse, social worker, occupational therapist, vocational counselor and hospital administrator all are involved. They participate in planning and directing psychotherapeutic teams and programs designed specifically for each patient and accommodating the techniques that any staff member or student may propose and defend. The service can provide for periods of concentrated therapeutic effort on a patient extending the traditional 50 minute hour to a 24 hour day. Such concentration of staff effort is made possible by economic evaluation of mental health resources to better utilize every available unit of time.

Highest priority is placed on communication and recording to assure coordination and to provide for the accumulation of descriptive information about every aspect of the treatment ex-

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perience. Thus there is a basis for retrospective research study against outcomes from hospitalization.

Details of the service are still evolving but we have been encouraged by the effects. Although not all patients have been successfully rehabilitated, they all have been greatly affected and the students and staff have become much more sophisticated both in knowledge about the factors of interpersonal treatment and the integration of the converging professional fields on the service. A most significant aspect has been the rapidly increasing contact of the inpatient staff with the patient after discharge. As the staff has become involved, it has developed concern that the benefits from the hospital stay may not be nullified when the patient returns to his outside world.

It is appropriate that the patients we are accepting on this service are not easy to treat. On the contrary, some of them have been failures from previous treatment. For others, the presenting symptom patterns promise long hospitalization if there is no intervention. We believe that such difficult patients are most appropriate for an intense training and research effort as well as being most promising for the largest return in an attack on the burden of social dependency.



Alumni Notes

American Cancer Society Honors Harold S. Diehl

The American Cancer Society recently paid tribute to one of its "elder statesmen," Harold S. Diehl, M.D., upon his retirement from the post of Deputy Executive Vice President for Research and Medical Affairs. Dr. Diehl was dean of the University of Minnesota Medical School from 1935 to 1958, at which time he joined A.C.S.

Dr. Diehl's retirement at age 77 years from full-time ACS activity comes after a decade spent as the Society's chief medical officer. This decade was a climax to his career as physician, medical educator, public health specialist, author, and medical administrator.

Highlight of the honor banquet sponsored by the Society on Jan. 18, 1968 in New York City was presentation of a "memory book"—a tooled leather volume of more than 100 letters written to Dr.

Diehl by those who have known both him and his work. The authors come from many walks of life, primarily the field of medicine.

Among them was a former pharmacist, and now Vice President of the United States, Hubert H. Humphrey, who wrote,

You have lived many wonderful lives . . . I am proud to be your friend and grateful for all that you have achieved for the cause of medicine, for medical education, and conquest of the disease enemies such as cancer which scourge mankind."

The largest single category of testimony bears the letterhead



Harold S. Diehl

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of various schools and departments of the University of Minnesota, from which Dr. Diehl received his M.D. in 1918. In 1921, he became director of the University's Student Health Service, as well as instructor in pathology and public health. In the field of student health, he is best remembered for the institution of regular tuberculosis testing for entering students, as well as other disease-control measures. These were extended to wider populations when Dr. Diehl became dean of the University's College of Medical Sciences in 1935—a post he held until his "first retirement" and transfer to the American Cancer Society in 1958.

Author of approximately 200 medical articles, Dr. Diehl wrote a pioneering health text for the general public, "**Healthful Living**" (1935), published by McGraw-Hill. He also achieved outstanding results in the University of Minnesota, helping to bring it to the first rank among schools with medical teaching facilities. Plans for a new medical-biological library, a Masonic Cancer Hospital, and a Clinical Cancer Research Institute were among the last fruits of Dr. Diehl's labors, immediately before joining the ACS. A visible reminder to students, faculty and alumni of the size of his accomplishment is Diehl Hall, housing these facilities and dedicated in 1959.

During his tenure with the American Cancer Society, Dr. Diehl was perhaps more responsible than any other single individual for the Society's intensified campaign to publicize the hazards of the cigarette. As part of this campaign, Dr. Diehl frequently served as a witness and ACS spokesman before investigational bodies and legislative committees in Washington.

The importance of his work has been reflected both in the Surgeon General's Report of Smoking and Health, published in January, 1964, and the legislation requiring a warning label on each package of cigarettes which followed in little more than a year.

During and following World War II, Dr. Diehl gave wide-ranging service to the government in the development of plans for the procurement and allocation of vitally needed medical manpower. Among the groups which he chaired or upon which he served were: the National Advisory Health Council; the Office of Emergency Management; the Health Resources Advisory Committee; and the Medical Advisory Committee of the Selective Service. He also played a prominent role in the reorganization of medical services of the Veterans Administration.

In spite of his long-standing association with Minnesota and its University, Dr. Diehl is by origin a native Pennsylvanian, born in 1891 in Nittany (Pa.). His father was a clergyman and

his early years were spent both at Nittany and Middleburg, where he attended the public schools. Dr. Diehl obtained a B.A. from Gettysburg College in 1912, and for two years thereafter served as teacher of mathematics and assistant principal in the Fulton (N.Y.) high school, before beginning the study of medicine at the University of Minnesota.

Throughout the years, his inseparable companion has been his wife, Julia, whom he married in 1921. Their two children, Annabelle and Dr. Antoni M. Diehl (Med. '47) have continued in medicine and allied professions, and have also presented the Diehls with 7 grandchildren.

The retirement of Dr. Diehl does not mark a cessation of his contributions to the American Cancer Society. He will continue as a special consultant, making available irreplaceable decades of experience, insight, and understanding. But there is likely to be more time available to spend on Star Island at Cass Lake, Minn., where the Diehls have enjoyed many cherished vacations.

◆ 1919

Hyman S. Lippman of St. Paul has retired as director of the *Amherst H. Wilder Foundation's Child Guidance Clinic*, a post he held for 36 years.

◆ 1925

Carl O. Rice, Minneapolis surgeon, was named winner of the 1968 *St. Barnabas Bowl*, an award recognizing professional and humanitarian achievement, sponsored by the Hennepin County Medical Society. He is on the clinical faculty of the Medical School, and has worked extensively in research and resident training programs at St. Barnabas hospital. Dr. Rice is editor-in-chief of *Minnesota Medicine*.

◆ 1932

George W. Clifford of Alexandria, Minn. retired from practice on January 1, 1968. He practiced in his home town, Osakis, Minn. from 1933 to 1939, and since then in Alexandria.

◆ 1934

Robert D. Thielen retired after 30 years of general practice at St. Michael, Minn. He is now living in New Brighton, Minn., at 153 Windsor La., and has been enjoying fishing, hunting, and golf.

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◆ 1946

Roger A. MacDonald, Grand Marais, Minn. was honored by the Minnesota Division, American Cancer Society, for cancer control work in Cook county, Minn.

◆ 1958

Frederick V. Featherstone was appointed assistant chief of the Kidney Disease Control Program at the U.S.P.H.S.'s National Center for Chronic Disease Control, Washington, D.C.

Dr. Peterson received the M.P.H. degree from Johns Hopkins University in 1947.

◆ 1960

Julian L. Berman was appointed assistant professor of pediatrics at the Chicago Medical School. He is head of genetics at Cook County Hospital division of pediatrics, and engaged in research at the Hektoen Institute.

Michael D. Levitt has been appointed an assistant professor of medicine at the University of Minnesota effective July 1, 1968. He is presently an instructor at Boston University Medical Center. Mike interned at University of Minnesota Hospitals and has been a resident in Boston hospitals. He will be assigned to the gastrointestinal unit at Minnesota, where he will continue his research. At Minnesota he joins his brother, John (Med. '58), and father, George (Med. '26) on the medical faculty. A brother, David, is a medical student in Minnesota's combined MD-PhD training program.

◆ 1961

James A. Kunz is practicing radiology in Rapid City, S.D. with a four-man group, and "*enjoying practicing and the Black Hills very much.*" His address is 5914 Timberline Trail.

Terence J. Scallen is an assistant professor of biochemistry at the new University of New Mexico School of Medicine, Albuquerque, New Mex. He is co-author of a recently published paper titled "Nuclear Magnetic Resonance and Infrared Spectra of Δ^{24} - and C-24 Saturated Steroids, published in the *Journal of Lipid Research*.

◆ 1963

Richard C. Siebert is a resident in neurosurgery at the Mayo Graduate School, Rochester, Minn.

◆ 1964

Lonnie L. Hammargren is a resident in neurosurgery at the Mayo Graduate School, Rochester, Minn.

Thomas P. Lake is a resident in radiology at the Mayo Graduate School, Rochester, Minn., which is his home town.

'66!

Neil I. Arnold's address is 6858 Lindbergh, Edwards, Calif.

Nancy B. Beecher is a "housewife and mother," living at 5712 Drexel Ave. S., Chicago, Ill. 60637. She writes: "James Arthur was born 6-24-67 on last day of internship here. Still recuperating. Husband Lee (Med '65) has one year left after this in psychiatry residency, Univ. of Chicago—then Navy for two years—then hopefully residency for me (Maybe another bambino before.) I miss so many faithful '66'ers and suggest a reunion before too long."

Paul D. Bandt announces arrival of a son, Douglas, born 6-20-67. Paul is a U.S.P.H.S. Research Fellow in Nuclear Medicine. His address is 174 20th Ave., San Francisco, Calif. In July he expects to be relocated in Las Vegas, Nev.

Arlen Brodin is a resident in pathology at Mt. Sinai Hospital, N.Y., and lives at 56 W. 65th St.

Paul E. Carlson is a battalion surgeon with the U.S. Marines north of Da Nang, South Vietnam. He has been there since last July. In July '68 he will be rotated to the U.S. for a final year's duty with Navy. His present address is BAS Hdg. Co., 7th Eng. Bn., 1st Mar. Div., FPO, San Francisco, Calif. 96602.

Robert D. Christensen is attached to the U.S.A.F. Hospital, Carswell AFB, Ft. Worth, Tex. He writes "Am a flight medical officer, learning to fly privately, child No. 3 on the way (June), and I'm thinking about orthopedics for the future."

James Daniel is a resident in Medicine at Minneapolis V.A. Hospital, and expects to enter the Army next July.

Richard M. Duff was married recently and is serving in the Air Force. He's stationed at Jacksonville, Ark.

John R. Goetz is a medical officer aboard the *USS Halsey*, a destroyer operating off North Vietnam. His wife, Marsha, is living at 3127 Ronald Ct., Spring Valley, Calif. 92077

James Gordon is a research associate, Immunology section, Biology branch, National Cancer Institute, and lives at 10500 Rockville Pike, Rockville, Md.

Stephen L. Hanson is a medical officer at the Ft. Jackson, S.C. Army Induction Center. The Hansons have an 18 mos. old son, are expecting again in April. Steve expects to return to Minneapolis to general practice after service.

Douglas V. Jewson is a resident in Internal Medicine at the W. Va. Univ. Medical Center, Morgantown, W. Va., under the Berry Plan B.

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Robert D. Kreiser is taking an anesthesiology residency at Providence Hospital, Seattle, Wash. "I spent six weeks in Africa last summer on safari, getting lion, leopard, elephant, cape buffalo, and other great trophies!"

David Lamusga is in general practice in Mora, Minn.

Benjamin Leadholm is an Air Force flight medical officer at the Grand Forks, N.D. Air Force Base.

Roger D. Lillemoen is on Navy duty in Long Beach, Calif., serving aboard minesweepers. He will be in the Navy until July, 1969. His address is 1068 Temple Ave.

Capt. George Lowell is taking an ophthalmology residency at Ft. Sam Houston, Tex. He went scuba diving in Yucatan recently, and will spend the summer on temporary duty in Waterville, Maine.

Richard E. Lund is in a year's training program in anesthesiology at the U.S. Naval Hospital, Newport, R.I.

Marguerite McKay Uphoff and her husband, Norman Uphoff, are parents of their first child, Elisabeth Kathleen, born November 3, 1967. They are headed for Accra, Ghana, where Norman will continue his political science studies and Marguerite will probably practice pediatrics. Mail will reach them if sent via Gerald McKay, 2349 Carter Ave., St. Paul, Minn.

Thomas O. McNamara is spending this year as a first year resident in radiology at the University of California Medical Center, where he interned. Tom expects to enter the Navy for two years next summer. The McNamaras were "expecting their first son" this winter. They also have a daughter. Tom was "very impressed" with the quality of his internship, and "heartily recommends it."

Margaret Nelson is a resident in Medicine at the University of Wisconsin, and is living at 2239 Woodview Ct., Madison.

Robert D. Ostrow is a general medical officer at Westover Air Force Base, Mass., with part time psychiatry practice.

Avrin M. Overbach was married Feb. 18, 1968 to Ronald B. Cohen of New Orleans, La. They are living at 25 W. Rue Maison, Apt. E., Birmingham, Ala., where Avvy is continuing a pediatrics residency.

Capt. Hugo Paulson is a flight medical officer in the U.S. Air Force, stationed in Thailand. His address is 432 USAF Disp. Box 12 APO San Francisco 96237.

Paul R. Pedersen reports birth of a daughter on Feb. 4, 1968. Paul is in the Army at Ft. Clayton, Canal Zone, and expects to start a residency in Medicine at Walter Reed Hospital this Fall.

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Walter J. Peet is a U.S.P.H.S. medical officer, working in tuberculosis control, in San Francisco, Calif. His address is 2460 Larkin St.

Jerome D. Poland is on duty with the Navy as a flight surgeon at Pensacola, Fla. His address is 34 Srant Drive.

Gaylan L. Rockswold is a first year resident in general surgery at the U.S.P.H.S. Hospital, Baltimore, M.D.

Tony Rayer is stationed with the Army at Ft. Rucker, Ala. His address is 18 Hartell Way.

Jan C. Sarnecki is a flight medical officer with the U.S. Air Force at Richards-Gebaur AFB, Missouri, 64030.

James Shanks is a first year resident in Medicine at the University of California; he will transfer in July 1968 to continue training at University of Minnesota Hospitals.

Kenneth W. Shunk is a general medical officer at the U.S. Air Force Base, Riverside, Calif.

Terry A. Sorom is an Air Force captain and chief of professional services for the Air Force's Southern Command. His address is Box 424, Albrook AFB, Panama, Canal Zone.

Lewis E. Struthers is in solo general practice in Parkers Prairie, Minn., and is "looking for a partner."

Thomas R. Swanson is "doing two years with the Air Force" and is currently stationed at Clinton-Sherman AFB, Oklahoma 73632.

David F. Sweet is serving a general medical officer at Minot, N.D. Air Force Base, "*coldest in the United States.*"

Richard Thompson is in general practice in Garden Grove, Calif., waiting to go into the Army, probably July 1, 1968. His address is 9755 Bixby Ave.

James A. Tremann has begun a five year residency in urology at the University of Washington, sponsored by the U.S.P.H.S. "We're spending spare time skiing and hiking in the mountains," he writes. His address is 1404 NE 166th Pl., Bellevue, Wash.

Rachel Trockman and her husband, Mitchell, are parents of Mark Alan, born Sept. 30, 1967. They live at 8026 Plymouth Ave. N., Minneapolis 27, while Rachel pursues a pediatrics residency at U Hospitals.

David L. Trudeau is getting a "surprisingly interesting experience" caring for military dependents at the Ellsworth Air Force Base, South Dakota.

Gary Underhill is serving with the Air Force in Izmir, Turkey. His address is TUSLOG Det. 119, Box 2889, APO New York 09224.

Jon E. Wallestad writes from Pensacola, Fla.: "I will finish six months in aerospace medicine and become a Navy flight surgeon in April. I've volunteered for duty with the Marines and will be sent to California and to Vietnam sometime next fall . . . hope to eventually return to Minnesota for a residency in orthopedics."

Murray Warmath, Jr. is assigned at the U.S. Air Force Dispensary, San Antonio, Tex. In July he begins a radiology residency with the Air Force in that city.

David M. Weston is a resident in internal medicine at the Minneapolis V.A. Hospital, and "thoroughly enjoying it."

Marshall Zamansky is a resident in surgery at New York University Hospital, and is living at 247 E. 33rd St., New York 10016.

Medical Foundation News

How to Benefit from Planned Philanthropy

The experience of most charitable institutions, including the Minnesota Medical Foundation, shows that tax rewards alone are not sufficient to motivate meaningful gifts to Alma Mater. The average alumnus does not first decide he must do something to lower his taxes and then, upon looking around, hit upon a gift to education as the way to obtain relief. A wish to contribute to the Foundation, or to help young people further their education in medicine, must come first. To help our medical alumni, the MEDICAL BULLETIN continues its discussion of deferred giving. This article will emphasize four basic areas:

- Basic Tax Considerations
- Timed Giving — During Life or at Death
- Examples of Giving Through Life Insurance
- The Foundation's "Special Gift Policy"

BASIC TAX CONSIDERATIONS

The basic tax considerations in the area of gifts and bequests to charity are as follows:

1. *Lifetime gifts*, including cash, securities, real estate and the value found in lump sums or cash value of existing life insurance policies, are deductible by the donor in calculating his net taxable income for the year.

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2. *Gifts by Will*, or through a trust arrangement, are deductible for estate tax purposes.

3. *The Foundation receives gifts and bequests free of all taxes*, including any income earned on property or securities which might be donated to the Foundation.

Although simply stated, these tax considerations have tremendous significance when used as guideposts in connection with estate planning and charitable giving. When lifetime gifts are made from capital, the inherent complexity of our tax laws comes into play and may produce additional benefits. This "complexity" makes the average person mostly unaware of the advantages which can be realized through a charitable giving program. This includes the person with an overriding interest in his own security and that of his family.

TIMING CONTRIBUTIONS — DURING LIFE OR AT DEATH

The advantages of making gifts during life can produce financially-attractive results. So much so that experienced tax counsel are sometimes appalled at the waste incurred when donors utilize only the procedure of making gifts by Will, since they lose the advantage of reducing their income tax at the time the gift is made. The Life Insurance Giving Program has been conceived to make lifetime gifts even more attractive.

For example, an out-of-town physician, with a well-established practice involving two partners, has requested assistance in updating his life insurance program. Preliminary review indicates it is feasible for him to donate one or two small life insurance policies to the Foundation as part of simplifying his insurance portfolio. In doing so, the doctor can deduct the existing cash value from current income as well as any future premiums at the time they are paid.

Many of our alumni and friends have expressed a desire to make a gift to the Foundation but have held back for fear of cutting into capital that will be left for their families. Several small life insurance policies have already been donated to the Foundation by friends who wanted the satisfaction of making a larger gift during their lifetime.

MECHANICS OF CONTRIBUTION THROUGH NEW LIFE INSURANCE PROGRAM

Sufficient interest has been shown to justify a specially designed *Insured Bequest Plan* with minimum overhead and underwriting rules to permit guaranteed issue without evidence of good health. North American Life and Casualty Company of Minneapolis, Minn. is sharing the added risk to make this unique

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plan available to friends of the Foundation. A policy may be obtained merely by completing one form and without a physical examination (except for substantial amounts).

Life Insurance gifts are **created out of current income** in the sense that the participant sets aside, periodically and out of current earnings, an amount for the gift to the Minnesota Medical Foundation. Creation of bequests does not mean depletion of the participant's existing capital. Instead, the benefaction is created out of earnings and the concept enables every man to make a good, sizable gift.

This is How it Works:

If the Donor Lives—The Foundation owns the accumulating cash values.

If the Donor Dies—The Foundation receives the entire amount he intended to give. There are no problems of transfer or legal complications.

If Donations are Discontinued—The Foundation retains a paid up bequest based upon the accumulated value of the annual gifts to date.

Tax Deductible—As a convenience to participants, an annual notice is supplied for tax records.

AN OUTLINE OF A SPECIAL PLAN OF INSURANCE AVAILABLE FOR THE MINNESOTA MEDICAL FOUNDATION

Issue Age	Minimum Annual Premium	Maximum Annual Premium	Approximate Policy Size Range
25	\$ 35	\$100	\$2,000 - \$6,850
35	45	100	1,890 - 5,000
45	60	125	1,800 - 4,140
55	80	150	1,710 - 3,270
60	100	150	1,700 - 2,650

The Foundation will soon send a special letter to its friends in this regard. You are invited to direct any inquiries to Variable Income Plans, Inc., 5615 Olson Highway, Minneapolis, Minn.

—HAROLD VAN EVERY, C.L.U., *Trustee*

Dr. Morse J. Shapiro Memorial Established

A memorial fund for Dr. Morse J. Shapiro, former Minneapolis physician who died February 11, 1968 in Los Angeles, California, has been established by the Minnesota Medical Foundation. The Foundation announced the memorial would be used for support of research in pediatric cardiology at the Variety Club Heart Hospital.

Dr. Shapiro, 74, was among the founders of the Heart Hospital, and served on the University of Minnesota's clinical Faculty in Medicine and Pediatrics. He was a 1917 graduate of the Medical School.

The family requests that gifts to the memorial be directed to the Dr. Morse J. Shapiro Memorial Fund, c/o Minnesota Medical Foundation, Box 193, University Hospitals, Minneapolis, Minnesota 55455.

Alumni Deaths

◆ 1919

Dr. Herbert H. Busher, St. Paul, Minn. Died January 26, 1968. He was 75 years of age, and practiced surgery for many years. He is survived by his widow, Helen, two sons and one daughter.

Dr. William G. Crandall, Denver, Colo. Died November 18, 1967 of a heart attack. He was 75 years old, and a veteran of World War II.

◆ 1920

Dr. Raymond M. Eppard, Cloquet, Minn. Died January 1, 1968 at the age of 73 years.

◆ 1946

Dr. Morris H. Sherman, Minneapolis, Minn. Died February 10, 1968 of a heart attack at age 44. He was a staff member of Mt. Sinai Hospital and lived at 3201 Cavell La., St. Louis Park. Dr. Sherman had practiced internal medicine for over ten years in Minneapolis, and was formerly a staff physician at the V.A. Hospital, Iowa City, Ia. Survivors include his widow, Lorraine, two sons, and one daughter.

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◆ 1948

Dr. William E. Taylor, Minneapolis, Minn. Died February 24, 1968 of cancer. He was 43 years old. Dr. Taylor had practised OB-GYN in Minneapolis since 1954, and had been active on school board work and politics. Survivors include his widow, Doris; three sons and three daughters. The family residence is 85 Hampshire Av. N., Golden Valley, Minn.

M E M O R I A L G I F T S

The Minnesota Medical Foundation acknowledges with gratitude recent contributions made in memory of:

Alice Adler	John T. McNulty
Ursula K. Causewitz	Leopold Pistner
Dr. George C. Kelso	Dr. Morse J. Shapiro
Laura S. Landers	Albert R. Shiely
Joseph Lejchar	Dr. W. E. Taylor

Memorial gifts are a thoughtful means of honoring the memory of a relative, friend, or colleague. Gifts may be designated for specific purposes. The Minnesota Medical Foundation acknowledge all gifts to both donor and next of kin.

"Nothing will ever be attempted if all possible objections must first be overcome."

—DR. SAMUEL JOHNSON

COMING EVENTS

University of Minnesota Medical School
CONTINUATION COURSES FOR PHYSICIANS

1968

April 15 - 19	Proctology
April 20	Trauma
April 29 - May 1	Ophthalmology
May 23 - 25	Surgery
May 23 - 25	Anesthesiology
Oct. 16 - 18	Dermatology
Oct. 21 - 25	Radiology

You and Your Will

Alumni and friends of the Medical School are urged to name the Minnesota Medical Foundation as a beneficiary in their will. The following form is suggested:

"I give to the Minnesota Medical Foundation the sum of _____ dollars, to be used in its work by direction of its Board of Trustees for the benefit of the University of Minnesota Medical School."

Funds may be bequeathed for specific purposes. For further information, contact the Executive Director, Minnesota Medical Foundation, 1342 Mayo Bldg., University of Minnesota, Minneapolis, Minn. 55455. Telephone: (A.C. 612) 373-8023.

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Editor

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