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University of Minnesota Hospitals
and
Minnesota Medical Foundation

Psychological Medicine in a General Medical Setting

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UNIVERSITY OF MINNESOTA HOSPITALS
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I. PSYCHOLOGICAL MEDICINE IN A GENERAL MEDICAL SETTING

Richard M. Magraw

One of the phenomena of contemporary medicine is the upsurge of psychiatry. Some doctors feel that psychiatry is, if anything, too popular, and few will doubt that the pendulum of opinion, at least with regard to some lay thinking, has swung past dead center in appraising the accomplishments and promises of psychiatry, and that time will see further shifts in this opinion.

In medical thinking, too, more time will pass before psychiatry's ultimate place as a medical specialty will have stabilized, and also before the contributions of psychiatry which are applicable to general medicine have been sorted and winnowed by experience and integrated into the general practice of medicine. In this second regard, psychiatry can be thought of not as a medical specialty, but almost as a basic science--a basic science which for want of another name might be called Psychological Medicine or the Human Approach.[19]

I am not going to be talking today about what psychiatry's niche as a medical specialty may ultimately be, but rather I would like to talk about this basic science aspect--about the question of how psychiatry can contribute to, and psychiatric information be integrated into general medical practice.

Much of what has been said on this question is speculative, since usually those physicians who are most conversant with psychiatry have had little opportunity to apply this in the practice of medicine, and to some extent, the converse is true.

I am going to use my experiences in the University Hospitals Medical Clinic during the past year as a basis for discussing this question. But there are obvious difficulties to drawing any very dogmatic conclusions on this basis. For one thing, a year is not a very long time. Moreover, an analysis of one's own work is apt to be rather subjective, and the fact that the factors we are analyzing are subtle doesn't make it any less so. Furthermore, while the Medical Clinic is the closest approach we have in this institution to the actual practice of medicine, it is really quite different from the practice of medicine as I knew it at least. For example, the case load there is heavily weighted by special problems referred to the University, such as cataracts, malignancies, and prostatism. Then, too, we don't, as a rule, know as much about our clinic patients as the family doctor does.

While I am talking about difficulties in presenting the subject, there are two other points that ought to be made. In this day of the popularization of psychiatry, of psychoanalytically tinged comic strips and movies, and when the term psychosomatic has become a household byword, we have all had to develop ideas (one might almost say convictions) about the role of emotions in the genesis of disease and about the psychological aspects of treatment. As far as I have been able to tell, everybody has developed a different philosoohy about this, and one of the difficulties in discussing the subject is that I am confronted by almost as many different points of view as there are people in this room.

To some of us, psychiatric pronouncements in this regard seem fantastic, bombastic, and slightly improper. Others are prone to rather uncritically accept psychiatric theorizing and are in this sense "more Royalist than the King". To most of us some of the psychiatric inferences drawn from behavior touch too close to our inner feelings for us to be entirely able to view the ideas objectively.

One other thing which makes a discussion of this subject difficult is the extent of the psychological dimension in practice. As Menninger said, discussing "emotional factors" in medicine "is comparable to a discussion of chemical factors" in medicine.

When I started working in Medical Clinic a year ago after a little better than two years in Psychiatry and Neurology, I had the usual misgivings about what I had forgotten in Medicine. I remember the near panic I experienced when I realized that I couldn't remember which lung had three lobes. However, I found, as others of you have with a similar experience, that what was forgotten quickly came back.

But these were not the only misgivings I had. There were in my own mind (and to an even greater extent in the minds of the people with whom I had discussed this departure from the beaten path) questions as to just how what I had learned in psychiatry would apply in general practice. I intend to discuss my subject today by restating those questions about whether what one can learn in psychiatry is applicable in medical practice and then giving the answers that have emerged in the Medical Clinic the past year. Before I do that, however, I think it would be wise to clarify a little what these things are that one can learn from psychiatry.

You are all familiar with some of the things which are learned in psychiatric training, such as the characteristics of behavior in the various psychoses, the procedures of insulin and electric shock. These things are associated with psychiatry as a specialty.

There are other skills and attitudes which psychiatry teaches for use in both its functions as a medical specialty and as a basic science, of which you are less apt to be aware.

For example, psychiatric training should bring an understanding of the limitations of psychiatry and a recognition that one's goals may have to be fairly modest. It must have been a psychiatrist that first said, "You can't make a silk purse out of a sow's ear". The student must come to recognize that bilateral far advanced tuberculosis with cavitation of the psyche or carcinomatoses of the soul are far more frequent than their organic analogues, and he reluctantly comes to see that it is no more possible completely to remake the psyche than it is to remake the body.

Furthermore, the student should get an awareness of unconscious motivations and thinking. Psychiatric training can equip the trainee with a working knowledge of this domain wherein appears to lie that majority of our thought processes of which we ourselves are completely unaware.

From this awareness of unconscious feelings comes an understanding of symbolism in thought and symptom. It is hard to overestimate the importance of understanding unconscious feelings in understanding the "Language of Symptoms". In the few cases I am going to describe later I think the symbolic expression of unconscious feelings will be quite evident.

Another set of skills which are particularly difficult to explain, but which are especially pertinent to what we are talking about, are those which give the doctor clues as to what kind of a person the patient has been and what his present mental state is. This kind of skill has long been identified in medicine as "the Art of Medicine". All psychiatry has done here is to refine and bring up to a level of thought where we can talk about and study things which have been used intuitively for years.

It would be nice if the psychiatrist could carry with him a stethoscope especially designed for hearing emotional overtones. For one thing it might be easier for some of us to believe that he does hear the things he claims to. I am sure that I need not point out to you that the psychiatrists walk these halls unencumbered by such diagnostic appliances as stethoscopes, ophthalmoscopes, and without even (heretical thought) a percussion hammer.

In the absence of such mechanical aids in diagnosis, the doctor must rely on his own senses to get an understanding of the patient's feelings. He must "listen with the third ear"[16] and read be-

tween the lines to catch the shades of feeling which are his clinical facts. It is well to remember that when we are dealing with another person in any face to face situation, there are many kinds of communication involved other than the words spoken. We can see things in a patient's posture, demeanor, and expression which speak eloquent volumes about him. Thus we learn, for example, how he feels about us and conversely, he divines whether we like him.

Lumped together in a structure called an Interview, these subtle skills compose the tools a psychiatrist carries about in his side pocket. Further, this is the equipment he uses in treatment as well as in diagnosis.

Now these points we have been considering are what we ask about when we raise questions as to how or to what extent psychiatric skills and knowledge can be incorporated into general medical practice.

One of the questions which was brought up when I was going to start in Medical Clinic a year ago was the question of time. Would it be practicable, simply from the standpoint of time, to include in the usual medical workup more than an intuitive assessment of the patient's personality and of the background he comes from? Moreover, again from the standpoint of time, would it be possible in ordinary medical therapy to go further in the treatment of patients than just to say, "You're nervous," "It's your nerves," or "There's nothing organically wrong with you. Go home and forget it"? Experience in the Medical Clinic clearly indicates that the answer to these questions is "Yes".

It has been possible to practice this kind of medicine there and to carry a full clinic load without getting bogged down in any way. In fact in the Medical Clinic it has seemed to me that diagnosing and treating patients using the comprehensive approach is actually quicker than using other approaches. So what might at first glance be thought to be the long way around appears to be the short way through. This is what we might expect since in every phase of medicine the quickest way to complete things is to get at the core of the difficulty.

The saving of time is especially evident when we are dealing with patients with functional complaints. We have all experienced the time-consuming chase of "will-o' the wisp" complaints up one diagnostic by-way and down another only to wind up with nothing to show for our efforts but strained relationships with the patient. I am not suggesting that this comprehensive approach is going to obviate the "Diagnostic Impasse" we reach with such complaints, but it has been my experience that it has held the key to a surprising number of such situations. I would like to cite some recent cases to emphasize these points.

Case A

This patient, a 40-year old unmarried schoolteacher came in for a check-up complaining of tightness and drawing over the left precordium with radiation to the left shoulder and down the left arm to the hand. The pain was not clearly related to exertion and had been present intermittently for about two years. During this period the patient had not been working. Physical examination was normal except that the patient was manifestly depressed.

By picking up and following out clues in the manner I described earlier the following story was brought out. The patient indicated that she had thought she might have cancer of the breast. Indeed the manner in which she said this suggested that she might welcome that diagnosis.

At the time of onset of the present complaints two years before, the patient's mother had died of breast cancer. (In explaining this the patient gestured toward her own left breast). At that time the patient had experienced a similar feeling of tightness in her left hand

and in fact her left hand had been clenched for two weeks then so that she could not voluntarily relax it, but had to pry her fingers open with her right hand.

In her second visit to the clinic this patient was able with a little help to express some of the deep anger she felt toward her mother with considerable subjective and objective improvement. She remembered that three years before her mother had died, at a time when she herself had been sick with pneumonia, she had had thoughts of violence toward her mother and a young nephew living with her mother at that time. For years she had supported her mother, had in fact purchased a home for the mother, only to see the mother devote her substance and efforts to the care of her sons who always came first.

The patient had been placed in an orphanage twice in her childhood for a period of about a year each time. The first time was as a very young child when her father abandoned the family and the second was at the age of twelve when her stepfather died. During the patient's hospital stay with pneumonia, she looked forward to convalescing at home under the care of her mother. As she said, she had been counting on "getting close to mother at last" only to find when she got home that the mother's interests were centered in the nephew.

She explained her unemployment in the past two years by saying that she guessed she had just become "tired of being the breadwinner for the family."

Case B

This patient, a 32-year old mother of three, was first seen on the same morning as case A. Her complaints were superficially similar to A's in that she also suffered pain in the left chest, shoulder, arm and hand. On physical examination there was tenderness in these areas most marked over the left humerus. This patient also was obviously depressed. It needed no questioning or indirection to elicit from her a concern that she might have a cancer of the breast.

Her complaints dated back eight weeks to about the time when she had decided to divorce her husband. About one year previously her husband had beaten her severely on the left side of the body as she lay in bed.

She was also seen on one other clinic visit after the initial examination. During the second visit the almost overwhelming self doubts and self accusations she felt over many things in her life and especially over the divorce came out. She felt that it was somehow all her fault and brought forth a good many rationalizations as to why she shouldn't go through with the divorce. I suggested that she was really being rather unrealistic in taking on all the blame for this and that apparently she didn't really have a very good opinion of herself. I suggested further that perhaps one of the reasons she found the idea of divorce so disturbing was that it only served to heighten her sense of failure and strengthen her inner convictions of her own unworthiness. Coincident with this discussion the patient's demeanor and expression changed. She became more relaxed and left saying she felt better already.

Part of the concern which was felt about whether this approach would require too much time came from the assumption that Psychological Medicine was something that had to be done in addition to and separate from the rest of the doctor's job rather than right along with it. In Medical Clinic I learned again that a thorough medical workup of history taking and physical examination is the best routine way of establishing rapport. Similarly I learned that the opportunities for quick evaluation of personality are better in this setting than any other I know of. Consequently it has been interesting and gratifying to find that this kind of handling of emotional problems can be done almost with the back of one's hand and with an overall saving of time to the physician. It can be done in an unobtrusive fashion wherein the

patient is not entirely aware of what is happening and hence the usual resistance to psychiatric treatment does not arise.

The question of how much time it is going to take to practice medicine in this way depends in part on how deeply one goes in treating emotional problems. What I have been saying is that there is a level of psychotherapy other than that of a thorough "vacuuming and dredging of compleses"[1] which experience has thus far shown to be particularly effective in a general medical setting, and to which medical practice is peculiarly adapted.

This has a different, but not necessarily inferior, goal to that long term, time consuming, expensive type of therapy which has come to represent to some the "sine qua non" of psychiatric treatment. This level of psychotherapy can be compared to incision and drainage of an abscess with evacuation of the collection of emotional pus as its goal. In this treatment the physician not only drains the abscess but may help the patient avoid similar future infections if the patient's own native powers of resistance do not appear adequate.

Oftentimes it is surprisingly easy to do this kind of psychotherapy. However, before I cite additional cases, I would like to digress a moment to emphasize that in handling emotional problems, as in other problems in medicine, we expect different patients to achieve varying therapeutic goals. One cannot expect a perfect or even satisfactory result in many cases here just as one cannot expect to restore certain cardiac cases to anything like full activity. Consequently, there is a lot of room in the handling of emotional problems for therapeutic conservatism and the light touch. It is well to avoid the error that Rogerson described as "unwise therapeutic pushfullness."

I would like to use additional cases for illustration. These cases I am using are samples rather than selections or exceptions since a good portion of the patients coming to the Medical Clinic for their initial examinations present this kind of problem.

Case C

This patient was a middle aged woman who in addition to slight anorexia complained of a constant right upper quadrant abdominal pain which was not related to food intake but tended to be accentuated by activity (in her case, usually housework). In response to a question about what the pain made her think about she said that once years ago she had been kicked in that area by an adolescent daughter. The daughter had been a thorn in her side from her earliest years because of a convulsive disorder and as a behavior problem. The patient then indicated that she was waiting the daughter's return from the Cambridge Epileptic Colony where she had been treated for several years. Further it developed that on the day her abdominal pain started she had received a letter from this institution stating that her daughter was to be discharged to her home as it was felt that she could now make some sort of an adjustment outside of the institution.

Case D

This patient was a 44-year old married woman, mother of ten children, who complained of palpitation and of numbness and stiffness of her hands and fingers. She first developed these symptoms in the summer of 1949. They came on one night when she was in bed nursing her two months old baby. At that time she became faint and felt as though she was losing consciousness. She suffered palpitation and her hands became numb and stiff. She described and demonstrated this to me by saying she felt she "couldn't close them together". Her husband was not living at home at the time except for weekends as he had taken a job in Minneapolis. Shortly before this episode the patient had learned of his affair with a woman in Minneapolis and had felt a burning resentment about it which she had largely been unable to express to him. While we don't really know

the answer, the things I have told you and the rest of the evidence available indicated that this symptom portrayed this conscientious mother's horrified repression of vengeful thoughts about her husband and/or their youngest child.

I have pointed out that uncovering and treating the psychological factors in these cases did not require any extra part of the doctor's time in Medical Clinic. I think it is important to explain that this conserving of time in the Medical Clinic was not done at the expense of added work for the specialty clinics or for the laboratory. In fact, I think the opposite was true. It has been my impression that using a comprehensive approach in Medical Clinic resulted in considerable economy in laboratory and x-ray procedures and in hospitalization.

I do not mean to imply that such economies are the reason for applying Psychological Medicine for I think the improvement in medical care inherent in its use is obvious. However, I do feel that such economies are an inevitable result and a welcome result, too, in this day when the rising cost of care is one of medicine's major problems.

Similarly, the use of this approach seemed to necessitate fewer of the "rule out disease" variety of referrals to the specialty clinics. I felt that fewer patients needed to be started off on the clinic merry-go-round in the hope that they would come back labeled. Fewer, too, wound up as "floaters", drifting vaguely through the clinics. Those who have worked in any of the outpatient specialty clinics know what a burdensome and frustrating load this kind of patient makes.

Some of you may be wondering whether I didn't find it necessary to get what might be regarded as unnecessary consultations and laboratory tests anyway in order to establish rapport and convince the patient. I have become convinced that while it is sometimes necessary to use these stratagems in this way, in general, they do not work as well as we like to think they do. Perhaps this is a good time to point out that when we order a plethora of laboratory and x-ray procedures ostensibly to convince the patient, more often than not we are ordering these procedures to bolster our own confidence in our diagnoses. When we have facts such as are apparent in the case histories given, we need less of such reassurance. With regard to using a profusion of laboratory tests to impress the patient with the thoroughness of the examination and thus establish rapport I can only say that there are easier ways of establishing better rapport inherent in psychological medicine.

This brings us to a consideration of the second question that came up in regard to integrating psychological medicine into medical practice. That question was asked in various ways. "Is this factual?" "How accurate are these guesses about patients' feelings?" "How much can we rely on our impressions of emotional aspects of cases in proceeding in treatment?" "Is this information exact enough so that we can really bank on it and be safe in not pushing our diagnostic armamentarium to the utmost?"

The answer that I have found is that these facts can be used with the same confidence that we use any other facts gathered in our medical workup. However, just as the radiologist can see facts on a film that the uninitiated have not learned to see, so skills such as we described earlier enable one to gather from a patient psychological facts which may not be evident to someone less sensitive in this regard. It is easier for doctors to see the radiologist's "facts" derived from the film than to see psychological facts derived from equally good evidence because of our almost exclusively materialistic background. It is hard for us to make confident use of clinical information obtained through skills in interpersonal dealing. We have all seen carefully correct medical workups which omit nearly all of the really relevant information for this reason. Thus we might see duly recorded in a history of a patient with gynecological complaints, for example, the fact that the patient had measles at age four but find no mention of the fact that living her early

years with a brutal, indifferent father had colored all her subsequent feelings about and reactions to sex.

The question here, then, is not so much "Is this material factual?" as it is "How can doctors overcome their own blind spots and mental sets so as to be able to accept this material as factual and act on it?" A doctor's ability to recognize and integrate these facts into medical practice is a measure of his working understanding of the total organism point of view that we all pay lip service to these days.

Given a set of facts such as in the case of the woman whose daughter had kicked her long ago, the question is no longer whether we are justified in not working ourselves, our diagnostic instruments, our special departments, and the patient, to the limit in an attempt to pin something organic on the patient, but rather whether we are justified in doing so.

There is still a third question. "Does becoming interested in Psychological Medicine make one more likely to miss organic disease?" I think it is evident that an exaggerated development or interest might have the same effect as a distorted interest in any special part of medicine, including the usual extra interest in organic disorders with which medical training has endowed most of us.

As I have indicated earlier an awareness of emotional factors does not exclude an awareness of organic factors. There is no more excuse for slighting organic factors while paying attention to emotional factors than for neglecting to examine the patient's heart irrespective of the demonstration of pathology during examination of his lungs.

I think the question has been well answered by Weiss in the quotation, "Somebody usually reminds me that in becoming interested in psychosomatic medicine one may overlook organic disease, not mentioning that an exclusive organic orientation leads to equally serious consequences in overlooking neurotic illness. Of course, as long as we are human, we are going to make mistakes. But if we plant one foot firmly in tissue pathology and the other foot firmly in psychopathology, then I think we have the correct balance for this approach."

These are the main questions which came up before I started on Medical Clinic regarding the feasibility of integrating psychiatry into medical practice, and these, too, are the observations I made in Medical Clinic in answer to them.

While in the Clinic I have learned some other things about this kind of practice which I would like to talk about briefly before I conclude.

I was surprised to learn how frequently depressions occurred as the primary difficulty in patients consulting a doctor in a general medical practice. At first I thought this might be peculiar to the University Hospitals, but I learned that other doctors in practice have had the same experience. It was interesting to see how few of these patients expressed depression in psychological terms. Almost all were disguised by physical complaints. Out of the last 150 new patients I saw in Medical Clinic prior to January 1, 1950, depression was the sole or major problem in 18. It was impressive to observe that among the patients seen, persons who developed symptoms of peptic ulcer for the first time during middle age were all in a depression at the time they had their symptoms.

One very pleasant thing discovered about this kind of practice was that the practice of medicine was more satisfying than it had ever been before. You all know how we tend to get the major part of our pleasure in medicine out of making a difficult organic diagnosis and competing in the diagnostic game, the kind of satisfaction that makes us push hard and stretch points to diagnose a *rara avis* condition such as Cushing's Syndrome, etc. Whitehorn called attention to the fact that because of this attitude "the neurotic runs the considerable risk of being

reacted against emotionally as if he or she were cheating in the diagnostic game." It seems to me now that almost every case has the potentialities of enthusiastic interest which I used to reserve for diagnosing multiple myeloma, ectopic pregnancy, and the like. No longer are neurotic complaints merely unavoidable chaff to be waded through to get at the organic nuggets mixed in. Incidentally, I think this new frame of mind makes it easier to treat the kind of problems that make up the bulk of practice since an ability to feel friendly interest in the patient, is the cornerstone of therapy.

I am a little afraid that what I have been saying might leave you with the impression that Psychological Medicine is something to be applied only in dealing with functional complaints. Actually, it is a universally useful instrument in our relationships with all patients.

ACKNOWLEDGMENT

I would like to express my thanks to Doctors Donald W. Hastings and Cecil J. Watson for arranging this period of training in the Medical Clinic. I also wish to thank the staff of the Medical Clinic and Dr. C. Knight Aldrich for their support in this. I would particularly like to express my indebtedness to Dr. Robert D. Mooney with whom I share an interest in this aspect of medicine. He and I have discussed this so extensively that it is impossible for me to tell where my ideas leave off and his begin.

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II. MEDICAL SCHOOL NEWS

Coming Events

March 27-29 - Continuation Course in Dermatology for General Physicians.

April 10-12 - Continuation Course in Pediatrics for Specialists.

April 17-19 - Continuation Course in Gynecology for General Physicians.

April 20-22 - Continuation Course in Cardiovascular Diseases for General Physicians.

April 20 - Phi Delta Epsilon Lectureship - "Regional Ileitis" - Dr. Burrill B. Crohn of Columbia University; 8:00 p.m., Museum of Natural History.

* * *

Faculty News

Dr. Roger W. Howell, Associate Professor of Psychiatry at the University of Minnesota, has begun a series of weekly radio broadcasts over the University station, KUOM. Dr. Howell's broadcast, which is heard for a quarter hour beginning at 5:15 p.m., Monday, is devoted to a presentation of mental health topics. Dr. Howell is followed by Dr. Robert N. Barr, Deputy Executive Officer of the Minnesota Department of Health. Dr. Barr speaks on other health problems. The entire half hour broadcast is entitled, "An Invitation to Health."

Dr. Wallace D. Armstrong, Professor and Head of the Department of Physiological Chemistry, has been awarded a special fellowship by the Rockefeller Foundation. The award will enable Dr. Armstrong to pursue further study in the field of radio-active isotopes in Stockholm and Copenhagen. Dr. Armstrong will leave for the Scandinavian research centers in June and will return to our campus in September.

The University of Minnesota Medical School has had the pleasure this past week of having as guests on our campus Dr. Jean A. Curran, President, and Dr. Jefferson E. Browder, Professor of Surgery at the Long Island Medical School. These distinguished guests are visiting various medical schools throughout the country before embarking on a reorganization at their own institution. During their week here they have conferred with many of our department heads about problems of mutual interest.

* * *

Dr. Good Receives Markle Foundation Award

Dr. Robert A. Good, a graduate of the University of Minnesota, was announced as one of 20 medical scientists to receive the John and Mary R. Markle Foundation award for 1950. Dr. Good is now on leave of absence from the University and is spending the present academic year in research at the Rockefeller Institute.

A grant of $25,000 will be awarded to the medical school to be spent at the rate of $5,000 a year for five years to enable Dr. Good to pursue his research in rheumatic fever in our department of pediatrics.

These awards have been offered by the Markle Foundation to enable promising young medical scientists to continue a career of medical teaching and research. Dr. Good is the second University of Minnesota graduate and faculty member to be so honored. Dr. George A. Moore of the department of Surgery received such an award in 1949.

III. UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS

March 19 - March 25, 1950

No. 281

Sunday, March 19

9:00 - 10:00 Surgery Grand Rounds; Station 22, U. H.

10:30 - 11:00 Surgical Conference; Rm. M-109, U. H.

Monday, March 20

9:00 - 9:50 Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff; Todd Amphitheater, U. H.

9:00 - 10:50 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; M-109, U. H.

10:00 - 12:00 Neurology Rounds; A. B. Baker and Staff; Station 50, U. H.

11:00 - Pediatric Rounds; Erling Platou; Sta. I, General Hospital.

11:00 - 11:50 Roentgenology-Medicine Conference; Veterans Hospital.

11:00 - 12:00 Cancer Clinic; K. Stenstrom and A. Kremen; Eustis Amphitheater, U. H.

12:15 - 1:20 Obstetrics and Gynecology Journal Club; Staff Dining Room, U. H.

12:30 - 1:30 Surgery Problem Case Conference; A. A. Zierold, C. Dennis and Staff; Small Classroom, Minneapolis General Hospital.

1:30 - 2:30 Surgery Grand Rounds; A. A. Zierold, C. Dennis and Staff; Minneapolis General Hospital.

1:30 - 2:30 Pediatric-Neurological Rounds; R. Jensen, A. B. Baker and Staff; U. H.

4:00 - Public Health Seminar; Subject to be announced; 113 Medical Sciences.

4:00 - Pediatric Seminar; Thrombo-cytopenic Purpura; Antoni Diehl; 6th Floor West, Child Psychiatry, U. H.

5:00 - 5:50 Clinical Medical Pathologic Conference; Todd Amphitheater, U. H.

5:00 - 6:00 Urology-Roentgenology Conference; D. Creevy, O. J. Baggenstoss and Staffs; M-109, U. H.

Tuesday, March 21

7:30 - 9:00 Fracture Rounds; General Hospital.

8:00 - 9:00 Fracture Conference; Auditorium, Archer Hospital.

8:15 - 9:00 Roentgenology-Surgical-Pathological Conference; L. C. Thomas and L. G. Rigler; M-109, U. H.

Tuesday, March 21 (Cont.)

8:30 - 10:20 Surgery Seminar; Small Conference Room, Bldg. I, Veterans Hospital.

9:00 - 9:50 Roentgenology Pediatric Conference; L. G. Rigler, I. McQuarrie and Staffs; Todd Amphitheater, U. H.

10:30 - 11:50 Surgical Pathological Conference; Lyle Hay and E. T. Bell; Veterans Hospital.

11:00 - Contagion Rounds; Forrest Adams; Sta. L, General Hospital.

12:30 - Pediatric-Surgery Rounds; Drs. Stoesser, Wyatt, Chisholm, McNelson and Dennis; Sta. I, Minneapolis General Hospital.

12:30 - 1:20 Pathology Conference; Autopsies; J. R. Dawson and Staff; 102 I. A.

1:30 - 2:30 Pediatric Psychiatry Conference; R. A. Jensen and Staff; 6th Floor, West Wing, U. H.

1:00 - 2:30 X-ray Surgery Conference; Auditorium, Ancker Hospital.

2:00 - 2:50 Dermatology and Syphilology Conference; H. E. Michelson and Staff; Bldg. III, Veterans Hospital.

3:15 - 4:20 Gynecology Chart Conference; J. L. McKelvey and Staff; Station 54, U. H.

3:30 - 4:20 Clinical Pathological Conference; Staff; Veterans Hospital.

4:00 - 5:00 Pediatric Rounds on Wards; I. McQuarrie and Staff; U. H.

5:00 - 6:00 Porphyrin Seminar; C. J. Watson, Samuel Schwartz, et al; Powell Hall Amphitheater.

5:00 - 6:00 X-ray Conference; Presentation of Cases by Veterans Hospital Staff; Drs. Lipschultz and Mosser; Todd Amphitheater, U. H.

8:00 - Minnesota Pathological Society; Cerebral Lesions in Porphyria; Ian A. Brown & Samuel Schwartz; Centers for Control of Respiration and Circulation in Man; A. B. Baker and Howard Matzke; Medical Science Amphi.

Wednesday, March 22

8:00 - 8:50 Surgery Journal Club; O. H. Wangensteen and Staff; M-109, U. H.

8:30 - 9:30 Clinico-Pathological Conference; Auditorium, Ancker Hospital.

8:30 - 10:00 Orthopedic-Roentgenologic Conference; Edward T. Evans and Bernard O'Loughlin; Room 1AW, Veterans Hospital.

8:30 - 12:00 Neurology Rehabilitation and Case Conference; A. B. Baker; Veterans Hospital.

11:00 - Pediatric Rounds; Erling Platou; Sta. I, General Hospital.

11:00 - 12:00 Pathology-Medicine-Surgery Conference; Surgery Case; O. H. Wangensteen, C. J. Watson and Staffs; Todd Amphitheater, U. H.

12:00 - 1:00 Radio-Isotope Seminar; Use of N15 in Study of Porphyrin Pigment Metabolism; Robert A. Aldrich; 113 Medical Sciences.

Wednesday, March 22 (Cont.)

12:15 - Staff Meeting; Main Classroom, General Hospital.

3:00 - Pediatric Rounds; C. J. Huenekens; Sta. I, General Hospital.

3:30 - 4:30 Journal Club; Surgery Office, Ancker Hospital.

5:00 - 5:50 Urology-Pathological Conference; C. D. Creevy and Staff; E-101, U. H.

Thursday, March 23

8:30 - 10:20 Surgery Grand Rounds; Lyle Hay and Staff; Veterans Hospital.

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; M-109, U. H.

10:00 - 11:50 Medicine Ward Rounds; C J. Watson and Staff; E-221, U. H.

10:30 - 11:50 Surgery-Radiology Conference; Daniel Fink and Lyle Hay; Veterans Hospital.

11:00 - 12:00 Cancer Clinic; K. Stenstrom and A. Kremen; Todd Amphitheater, U. H.

11:30 - Pathology Conference Clinic; Main Classroom; General Hospital.

11:30 - 12:30 Clinical Pathology Conference; Steven Barron, C. Dennis, George Fahr, A. V. Stoesser and Staffs; Large Classroom, Minneapolis General Hosp.

1:00 - 1:50 Fracture Conference; A. A. Zierold and Staff; Minneapolis General Hosp.

4:30 - 5:20 Ophthalmology Ward Rounds; Erling W. Hansen and Staff; E-534, U. H.

7:30 - 9:30 Pediatrics Cardiology Conference and Journal Club; Review of Current Literature 1st hour and Review of Patients 2nd hour; 206 Temporary West Hospital.

Friday, March 24

8:30 - 10:00 Neurology Grand Rounds; A. B. Baker and Staff; Station 50, U. H.

9:00 - 9:50 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U. H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.

10:30 - 11:20 Medicine Grand Rounds; Veterans Hospital.

10:30 - 11:50 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Department, U. H.

11:00 - Pediatric Rounds; Erling Platou; Sta. I, General Hospital.

11:00 - 12:00 Surgery-Pediatric Conference; C. Dennis, O. S. Wyatt, A. V. Stoesser, and Staffs; Minneapolis General Hospital.

12:00 - 1:00 Surgery Clinical Pathological Conference; A. A. Zierold, Clarence Dennis and Staff; Large Classroom, Minneapolis General Hospital.

1:00 - 1:50 Dermatology and Syphilology Conference; Presentation of Selected Cases of the Week; H. E. Michelson and Staff; W-312, U. H.

Friday, March 24 (Cont.)

1:00 - 3:00 Pathology-Surgery Conference; Auditorium, Ancker Hospital.

1:00 - 2:50 Neurosurgery-Roentgenology Conference; W. T. Peyton, Harold O. Peterson and Staff; Todd Amphitheater, U. H.

3:00 - 4:00 Neuropathology Conference; F. Tichy; Todd Amphitheater, U. H.

3:00 - 6:00 Demonstrations in Cardiovascular Physiology; M. B. Visscher et al; 301 M. H.

4:00 - 5:00 Clinical Pathological Conference; A. B. Baker; Todd Amphitheater, U.H.

Saturday, March 25

7:45 - 8:50 Orthopedics Conference; Wallace H. Cole and Staff; M-109, U. H.

8:30 - 9:30 Surgery Conference; Auditorium, Ancker Hospital.

9:00 - 11:30 Neurology Conference; Pain; Powell Hall Amphitheater, U. H.

9:00 - 9:50 Medicine Case Presentation; C J. Watson and Staff; E-221, U. H.

9:00 - 10:30 Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater, U. H.

9:15 - 10:00 Surgery-Roentgenology Conference; F. Ruzicka, O. H. Wangensteen and Staff; Todd Amphitheater, U. H.

10:00 - 11:30 Surgery Conference; O. H. Wangensteen and Staff; Todd Amphitheater, U. H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.

10:00 - 12:50 Obstetrics and Gynecology Grand Rounds; J. L. McKelvey and Staff; Station 44, U. H.

11:00 - Contagion Rounds; Forrest Adams; Sta. L., General Hospital.