The Courier

OF THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

SPRING 1962

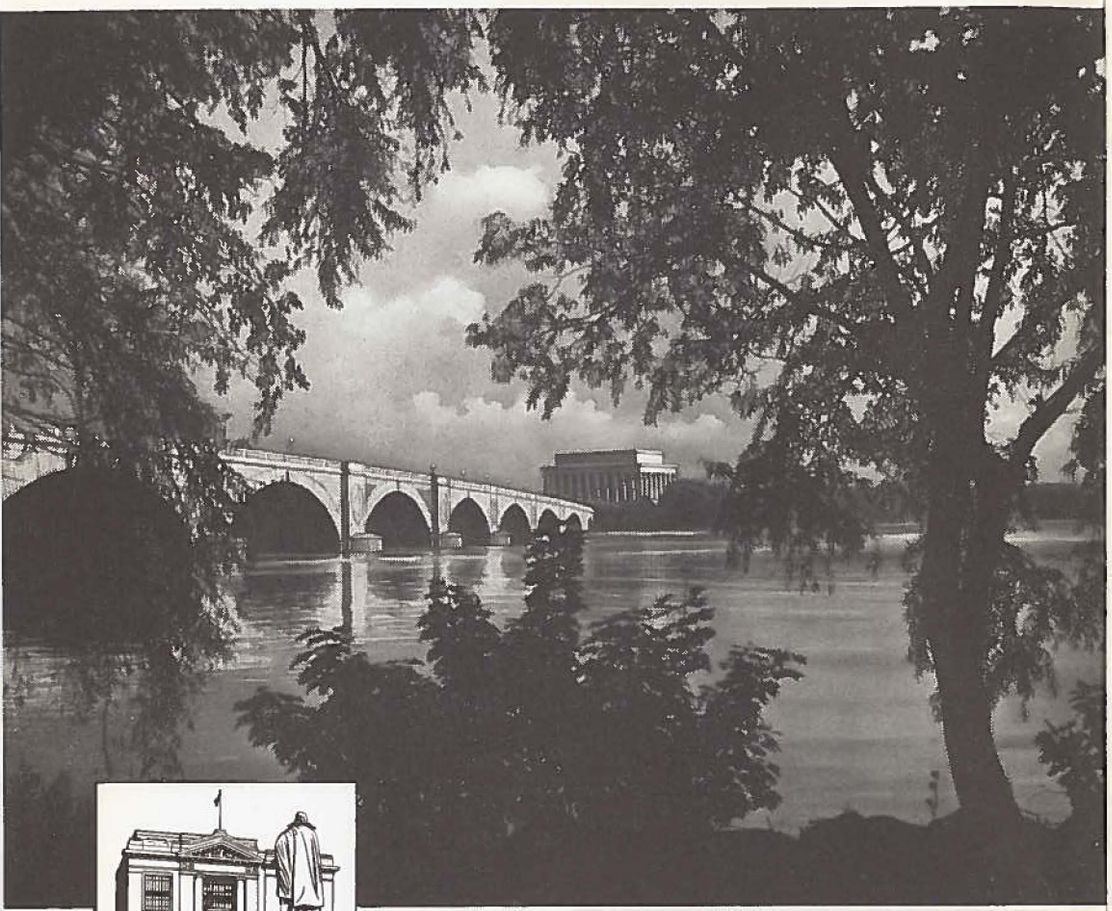
HOSPITALS FOR TOMORROW

DISASTER MEDICINE

Washington Portrait

The Lincoln Memorial and the Arlington Memorial Bridge—symbolic link between North and South

NO. 3 IN A SERIES OF COMPOSITE REPRODUCTIONS OF THE FACE OF THE NATION'S CAPITAL



The Courier OF
THE GEORGE WASHINGTON UNIVERSITY HOSPITAL
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SUBSCRIPTIONS

THE COURIER is published by the Women's Board of the Hospital to tell the story of medical programs of The George Washington University Persons may assist in this purpose as sustaining subscribers at $1.00 for one year and $2.75 for three years. Checks payable to The Courier should be mailed to the Board treasurer, Mrs. John M. Evans, 3303 Turner Lane, Chevy Chase, Maryland.

PROSPECTS IN MEDICINE III

DR. JACK KLEH, Medical Director of the Department of Welfare, the District of Columbia, and Assistant Clinical Professor of Medicine, writes on health needs and hospitals, and what some changes mean . . .

HOSPITALS FOR TOMORROW

An extended life expectancy and a changing pattern of disease have created a need for changes in our way of providing medical and nursing care. Control of infectious disease and improved anesthesia and surgical techniques have created an ever expanding group of patients who, while no longer requiring the extensive facilities and services of the general hospital cannot be cared for adequately in their own homes. Many of these do remain in hospitals but the rising costs which accompany medical progress have made this level of care impractical for prolonged periods. Changing social structures and practices also have compounded the problem by decreasing ability for home care of marginal patients.

There is need for some intermediate facility which would provide less extensive care and bridge the gap between the general acute-disease hospital and the home. As a matter of fact, there is need for a whole constellation of facilities and services with unimpeded interchange of patients, if adequate care is to be provided at a reasonable cost for a range of patients.

At the present time most communities have good general hospitals, but few have even a semblance of an extended care program. There are many church and fraternal institutions with some medical services, and an assortment of proprietary nursing and personal care homes. There is little custodial or supervised housing except for those isolated of necessity because of communicable disease or mental incompetency. As a result most general hospitals must continue to house patients who do not require general hospital care.

Each community must develop facilities and services according to this changing picture in order to provide extended care commensurate with need, without compromising a high level of care.

Of course, this is still in the planning stage. There is insufficient data available to permit a definite blueprint but we hope that research in the next few years will fill the gaps in our knowledge. However, there is a faint distant image of a health center that may evolve somewhat as follows—

We see three basic facilities for patient care: the *first* essentially our general hospital of today; the *second,* an intermediate care building; the *third,* a facility for protective housing. These would be connected to each other in triangular arrangement so that there would be easy communication and transfer.

The program of the *general unit* would be geared to special diagnostic and therapeutic efforts, as well as short term medical and psychiatric care. It would cover surgical and related services, as well as obstetrics and pediatrics. This facility would house complete X-ray, laboratory, physical medicine and other related services.

When a patient no longer requires these services—but needs continuing care—he may well be transferred to the adjacent *intermediate care building,* where adequate management can be provided for much less cost than in the general hospital. Nursing care would be largely by practical rather than graduate nurses, although under the latter's supervision. Here the patient would receive a service unique to this facility: inter-disciplinary staffing. A team consisting of physicians, nurses, social workers and other specialized persons would evaluate and define the *functional status of the patient* and provide a plan for maximum restoration and prevention of further degeneration. This plan would include social, economic and even recreational aspects, as well as those levels involved in medical care.

Patients in this intermediate facility do require nursing care. When they reach the point of relative independence, they may well be transferred to the *third* main building; one that provides custodial and protective housing. Here they would receive around-the-clock supervision and perhaps some assistance in activities of daily living, in addition to meals and lodging. This could be provided at considerable savings compared to the intermediate program. There may be many aged persons who have such frequent need for medical care that they cannot be kept at home and would require this type of program.

The final phase in this proposed plan would be return of the patient to his home and independent living. Further, while we have traced a patient from the general hospital through intermediate care

and protective housing and back to home—in practice he could have been admitted to *any* of these three facilities and transferred about as necessary.

Around this core of three buildings providing patient care would be other units of the health center. There may be a school of nursing, a medical school and other buildings for professional education, research and technical training.

The importance of providing purposeful activity is being recognized as an adjunct to the medical management of patients requiring long term care, and recreational facilities would be a must. An open park area, which may be quite small in size, a theatre and even perhaps limited sport facilities.

There would be a circle of professional office buildings and varied stores and shops surrounding this center, for not only would there be need for medical and related supplies, but also for clothing, furniture, gifts and beauty and personal services. Professional offices would house the practicing physicians providing office or out-patient care. Their proximity to the three patient buildings would facilitate in-patient care, medical education and research.

In function, the crux of this concept lies in the matching of services to needs, and it follows logically that there would be clear delineation of function between the general hospital, the intermediate care facility and protective housing. In order to facilitate flow—and this would be three directional—there would be a common method of financing, to cover intermediate care and protective housing as well as that in the general hospital.

There would be control through regulation and accreditation, training and education programs would exist in all areas, and there would be research into disease and into improving administrative methods, use of space and services, and care programs.

This image of the future has intentionally been called a *health center* rather than a medical or treatment center or by some other title. To date we have been largely concerned with the diagnosis and treatment of diseases; too little thought has been given to functional capacity of the patient. Social and economic factors have been considered only when they have presented a pressing problem. The health center concept enlarges our scope to include both evaluation of the functional ability of the patient and social and economic planning. It promotes the concept of health maintenance, which implies utilization of all restorative services as well as preventive measures to keep functional health. It attempts to provide adequate medical and nursing care at minimal cost by matching the services to the needs of the patient.

PART II of Marriage and The Physician; a summary discussion of marital counseling for the family physician, taken from tape-recorded sessions between members of the Department of Psychiatry and an audience of general medical practitioners at The George Washington University Hospital.

DR. PAUL CHODOFF
Assistant Clinical Professor of Psychiatry

The Role of the General Practitioner

Usually the first occasion for the medical practitioner to be helpful to his patients in a marriage situation is during the interview which accompanies pre-marital examination. Such interviews should be held with the man and the woman individually, because together they will inhibit one another.

The physician will find most of the questions will concern sex in marriage, its anatomy and function. Though he may be surprised at how misinformed many adults are about sex, the physician must not seem bothered or amused by the nature nor the level of the questions. He should avoid having a set speech for these occasions, and instead be guided by the kind of questions asked.

If he is alert, he will find that many patients, seeming to want straight medical information, are actually seeking something more, and by listening beyond the exact questions themselves, the physician may be able to sense what his patient needs and how he can be of help. There may be anxiety about sex or deeper doubt about marriage which he can help bring to the surface and perhaps allay. The patient may feel guilt about his or her pre-marital conduct and sex experiences, asking the physician in effect to pass judgement. The physician should avoid doing this, and instead should try, in a non-judgemental manner, to help the patient explore his feelings about his behaviour.

Sometimes a patient will experience so much premarital anxiety and nervousness, that actual physical symptoms are present. If the physician has seen this patient before and knows him (or her) to be a stable personality, then a reassuring conversation may be all that is needed. But if the patient is not known and the symptoms are severe, then psychiatric counseling may be in order to learn why the prospect of marriage is so devastating.

One final opportunity for the physician to help early in a marriage may occur after the honeymoon. Weddings are emotionally exhausting, and wedding trips can be even more so, especially if the

couple has built up Hollywood fantasies about what they expect. Here, all that may be needed is reassurance and support, by letting the newly-weds know that their frustration is not uncommon, and that a little patience will solve their problems.

Problems in the marriage itself will be different and often more serious. Patients may not let the physician know on the first visit that their marriage is in trouble; they may not have admitted it to themselves. A patient may present herself (or himself) with physical symptoms of an obscure nature for which no organic cause can be found. The physician, knowing that marriages do get into trouble and that physical symptoms can have emotional origins, should consider the possibility of a marital problem just as he seeks an organic cause. A high index of suspicion on the part of the doctor along with indirect questions worked into the history-taking can produce leads worth following, whereas, direct inquiry, at this early stage, may fail, because the patient is ashamed or defensive and evasive.

As mentioned before, the physician whose patient has a marital problem must avoid giving declarative judgement as from on high, even though the patient may wish this and may even try to force it. The physician should avoid taking sides in a marital controversy, nor should he allow himself to be drawn into the role of referee, but should rather try to catalyze a process of mutual self-appraisal by both parties in the marriage. This will be difficult and perhaps tiresome, but is a legitimate and necessary medical function. However, the physician should be aware of the extent of his own interests and skills as a marriage counsellor, and should not undertake the management of marital conflicts which are out of his scope.

In psychiatry, marital conflict is considered as an inter-action between two personalities, with the presenting problem itself being perhaps not too important. Every marriage has difficulties of much the same kind: sex; children; finances, the family life, but in the troubled marriage the partners cannot resolve these difficulties, and everything becomes an issue, a power struggle. In marriage counselling, one approach is for the physician first to see the complaining partner, the one with symptoms. After establishing that these symptoms are the product of a troubled marriage, the physician then should talk separately with the other partner. In these first two, separate interviews, each partner will want to criticize the other, and he should be allowed to do so while the physician listens.

Then, still in separate interviews, the focus is shifted to suggest that every marriage is a two-way street and that the partner being interviewed may himself be contributing to the problem. If this is admitted, the point should be pressed by asking the husband what he thinks is his wife's view of him (and vice versa). The patient's

ability to do this in a reasonable manner will give the physician a good idea as to whether the patient will be able to use this kind of psychotherapy. A perceptive and tactful physician working with a cooperative patient can often develop a pattern in the marriage which the patient can then identify and consider objectively.

Finally the marriage partners, each with this more realistic view of the marriage arrived at independently, can be brought together for a joint session, when the physician can summarize what each has brought out, showing how the neurotic interaction between them causes their difficulties.

With cooperative patients who want their marriages to work, the general medical practitioner will not infrequently be able to bring about desirable changes in a marriage and render a real service to his patients.

DR. NORMAN C. RINTZ
Associate in Psychiatry

Chronic Illness, Marriage and the Family

Chronic illness, physical or mental, in a family group, will of necessity produce social, psychological and economic problems for everyone concerned. The anxiety of the patient and the resulting anxiety and concern of the other members make it necessary for the family physician to assume a responsibility which he may not wish to take or will surely at times feel that he is ill equipped to deal with successfully. At times he may treat the patient and try to ignore the effects upon the other members, often out of the anxiety which could develop when becoming involved with their interpersonal problems.

Chronic illness invariably restricts the healthy independent function of the individual. It is impossible to predict how any individual will react to this stress. The patient's reaction will depend in part upon the intensity of the stress and his previous experiences, which will have given him the strength to react to it, and to adjust and live with the change involved. Sometimes the stress may be too

severe for the individual to handle without catastrophic psychological effect. In such a situation, a psychiatric emergency may result, which will necessitate expert help.

In any event, the physician must do all that he can to explain and at times even educate the patient and his family insofar as his illness is concerned. The reality of the family, the goals, the future of the whole family frequently have to be changed. Hopefully, in his contacts wtih them and the patient, he will be able to help the patient and family accept and live with this change in their reality.

In a neurotic marriage, the neuroses will become intensified and the physician may find it difficult or even impossible to do anything except to treat the patient. Even in a healthy marriage, chronic illness will often intensify the weaknesses in the marriage. In any event, the reverberating effects will result in demands upon him. He may or may not listen, may or may not take action, but whatever he does will be motivated by his own life experience and his feelings about the patient and the illness involved.

Chronic illness, physical or mental, makes the individual much more dependent than he would ordinarily like to be. One person may take a severe stress as a challenge and fight to preserve his own independent existence. The better he is able to accept his limitations and continue to maintain a reasonable identity, the less will be the stress upon other members of the family. Another individual may react to stress by using it as an excuse to give up his independent struggle and regress to a more-or-less helpless dependent state. Such a reaction will usually occur in a person who has never really been able to establish a healthy independent existence and has been overly dependent during his life.

Increased dependency and the results can be well illustrated by the mental illness of a spouse or child or by chronic alcoholism in a spouse. Mental illness of a spouse puts the other under very severe stress. This calls for expert help. At times the expert may try to help him maintain his job and his existence without hospitalization. This maintenancy of independence is important to the patient, for hospitalization and separation from his loved ones may be the last straw, with the result that while in the hospital he may regress and it may be a long time before he is able to resume his former life in society. During outpatient treatment, the spouse and also the children must be supported and helped to understand his condition.

Under such a regime, the patient may recover and the integrity of the family preserved. However, the patient may also not recover, and in such an event, he should be hospitalized to spare the spouse and the children the increased damage which will inevitably result from further living with the psychotic.

Dr. Overholser Portrait

Dr. Winfred Overholser, Professor Emeritus of Psychiatry, was honored at ceremonies February 22 with the presentation of his portrait by the University to the Department of Psychiatry which he directed. Here Dr. Overholser (at left) is congratulated by Dr. John Parks, Dean of the School of Medicine, who made the presentation on behalf of the University in recognition of Dr. Overholser's twenty-four years of service on the medical faculty. At center is Dr. Leon Yochelson, Professor and Chairman of the Department of Psychiatry. The portrait will hang in the Department's conference room.

Medical Alumni Meet June 2

Saturday, June 2, is the date for the Medical Alumni Association program at the George Washington University. There will be a morning scientific session at the University Hospital and the evening banquet at the Statler Hotel. The 10th, 25th and 50th year Classes will be honored at this banquet.

GW Authors in New Text

Three members of the University's medical faculty and staff are authors of specialty sections in the new 800 page "Modern Concepts Hospital Administration," a text and reference book published this month by Saunders Company. Dr. Thomas E. Reichelderfer, Associate Clinical Professor of Pediatrics, wrote the chapter on pediatrics; Dr. Edward L. Rea, Associate in Medicine, the chapter on outpatient department; and Richard C. Thompson, Director of Medical Public Relations, the chapter on hospital public relations.

It is intended that The George Washington University, as a public service, prepare a television series for presentation on WTOP-TV beginning April 16 on Medical Self-Help. The fourteen half-hour programs, each treating some aspect of medical emergencies, will be prepared by members of the University's medical faculty and by public health and other specialists in the District of Columbia. Recorded on video tape and on film, these programs can be used elsewhere in a variety of ways over a long period of time.

A national program to teach disaster medicine to one person in each family in the United States is scheduled to begin sometime this summer and continue over the next two years. This is the little-publicized project of Medical Self-Help, a course of illustrated lectures and demonstrations to train some 60 million persons in family survival medicine.

The project assumes that normal medical skills and facilities—nurses, physicians, hospitals and clinics—will be largely unavailable or useless to much of the population following a nuclear attack. It assumes that most people surviving the attack will be confined to fallout shelters for days or even weeks. In such isolation, these people, probably family units, will be on their own for a considerable time. It assumes that both the usual and the unusual medical emergencies can be expected to occur in these shelter situations, and that medical help will be self-help, from ordinary illness to delivering a baby.

The project includes but is not limited to first-aid. This is because first-aid is "what to do until the doctor comes," but Medical Self-Help is "what to do because the doctor cannot get there."

The Medical Self-Help project has been some two years in the making. It has been prepared by the American Medical Association, the United States Public Health Service and the Office of Civil Defense. The national program will be introduced into each state by the medical society of that state and first taught through the medical, nursing and health professions, then through civic, social and service clubs and organizations.

Developing the national program depends on the distribution of training kits and manuals and some further evaluation of the lessons by the medical profession. Because the Medical Self-Help program will be handled by the states, there have been three meetings in different parts of the country attended by state medical society representatives, state civil defense, health and other special interests. At these meetings the program has been outlined and discussed, and some training kits distributed to the representatives.

Dr. Howard C. Pierpont, Associate Professor of Surgery, was designated to represent the District of Columbia Medical Society in this program. He attended the first of these three national meetings, and he has since demonstrated the training kit and its contents before those groups who will be first asked to participate, including the medical staff of the University Hospital.

"We will begin our training courses in Medical Self-Help in the District later this spring, after some trial runs and evaluation by the local medical profession. A full supply of training kits and manuals will also be available then," said Dr. Pierpont. "This is too good a program and too well worked-out for anyone to hurry into it before it is ready. I know that when it is started, Medical Self-Help will pick up a momentum which we must be prepared to maintain. Its effectiveness will multiply quickly, in an 'each one teach one' fashion.

"Medical Self-Help is a parallel program to fallout shelters and it has at least as great a potential. By whatever name it is called—shelter medicine, disaster medicine, survival medicine—it is likely to become one of the more ambitious programs in civil defense yet developed for this nation."

There are twelve lessons in all, to be given in prescribed sequence. Each instructor will work from a portable training kit, using prepared lectures with matched filmstrips in color (a projector and screen are in each kit) and two manuals for each student. At the completion of the course, students will receive certificates which qualify them in turn to teach others, again working from the training kits. The entire course of twelve lectures, plus orientation and review, could take about sixteen hours, as given to classes of perhaps twenty-five students. The lessons have been prepared and tested for use with persons age fourteen and older.

Space Medicine Lecture

A discussion of space medicine by a prime authority was offered February 10 at the School of Medicine by the School's Smith-Reed-Russell Society. Brigadier General Don S. Wenger, Chief, Consultants Division, Office of the Surgeon General, U.S. Air Force, presented a summary of the United States space program, with emphasis on the medical aspects and illustrated with color movies of launchings and the Shepherd ballistic flight. Dr. Wenger is Associate Clinical Professor of Surgery on the University's medical faculty. Much of his lecture was given over to questions from the audience of medical students concerning the Astronaut program whose seven participants are, in a sense, patients of Dr. Wenger's. Shown here, left to right, are Dr. John Parks, Dean of the School of Medicine; Lowell M. Weiss, President of the Smith-Reed-Russell Society; Dr. Wenger and Dr. Brian Blades, Professor and Chairman of the Department of Surgery.

New Medical Alumni Office

The new Medical Alumni Office has been set up in the School of Medicine building at 1335 H Street Northwest. Renovation of the room has been completed and the new office furniture has been installed. It is planned that a one-day open-house be held so that alumni and faculty can stop by, to see the place from which their Association will be operating.

The room was made available by the School of Medicine, with the Association underwriting the costs of furnishing and staffing. Mrs. Ruth Jackson, a former secretarial employee in the School of Medicine, has been employed as office secretary to set up and maintain alumni files and handle correspondence and other Association business.

Establishing such an office was approved by the Medical Alumni Council as necessary to developing an effective national organization.

Redecorated Lobby

The Hospital's public lobby has been strikingly redecorated and refurnished, with new lighting fixtures, dark red chairs and deep blue carpeting. The University seal is used in blue and white on draperies and on one wall to complete the colorful effect.

Multiple Sclerosis Grant

The University Hospital has recently received $1100 from the Multiple Sclerosis Association of Greater Washington, representing final payment of Association Grant Number One for the support of a therapy program in the Hospital.

Hospital Methods Institute

Frederick Menk, Associate Director of the University Hospital, presided at a three-day Methods Improvement Institute sponsored in late January by the Maryland-D.C.-Delaware Hospital Association. Mr. Menk is Chairman of the Council on Association Development. The Institute program included a discussion of 'Formalized Methods Improvement in U. S. Hospital' by Frederick H. Gibbs, Professor of Hospital Administration at The George Washington University.

Dr. Feffer in Saigon

Dr. Henry L. Feffer (center) and Mrs. Feffer are shown as guests-of-honor at a farewell party at the Cho Ray Hospital in Saigon; at left is Dr. Pham Phu Khai, Hospital Director. Dr. Feffer, Associate Clinical Professor of Orthopedic Surgery, spent three months in Saigon last fall on behalf of MEDICO. He set up an orthopedic program at the Hospital.

THE COURIER: Spring 1962; sources and credits:

PROSPECTS IN MEDICINE III—*A continuing series on varied medical topics.*

MARRIAGE AND THE PHYSICIAN—*Lecture summaries by Richard C. Thompson.*

DISASTER MEDICINE—*Text by Richard C. Thompson; illustration is filmstrip 5 from the Medical Self-Help training kit.*

News Section photographs by Reni.

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