Mount Sinai

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Speakers:	George James, MD, Dean & President; Gustave Levy, Chairman of our Board of Trustees; S. David Pomrinse, MD, Director of The Mount Sinai Hospital; Bernard Wolf, MD, Chairman of Radiology and President of the Medical Board; Hans Popper, MD, PhD, Dean of Academic Affairs at Mount Sinai School of Medicine; Alexander Gutman, MD, Chairman Emeritus of Medicine and Chairman of the Research Committee; and Kurt Deuschle, MD, Chairman of the Dept. of Community Medicine at Mount Sinai

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Proceedings of a Round-Table Meeting
on 1971 Operations of Mount Sinai
Medical Center
February 7, 1972
Guggenheim Pavilion

A Round-Table Meeting on 1971 Operations of Mount Sinai, held in Guggenheim Pavilion on Monday evening, February 7, 1972, convened in the office of Dean George James of the Mount Sinai School of Medicine at seven-thirty o'clock. Mr. Beryl Reubens, Director of Public Relations, opened the meeting and made briefs remarks of introduction which were deemed to be off the record.

James: Well, two years ago we had a round-table discussion to review the highlights of the year and some of the plans that were in the offing. It seemed to be a very good, attractive, and effective way of reviewing our accomplishments, and we thought we would repeat it this year with an expanded cast.

Our task, of course, is to review the crucial issues that we faced during the year and cover some of our accomplishments in the field, first, of our general progress in development of our total program and its administration, and we have the Chairman of our Board of Trustees, Gustave Levy, to lead off in that, and then we have our accomplishments in the three major areas of patient care, and there we have the Director of the Hospital, Dr. [S. David] Pomrinse, and the Chairman of the Medical Board, Dr. [Bernard] Wolf, to lead off; then in the field of education, and we have Dr. [Hans] Popper, Dean of Academic Affairs, and myself, as Dean of the Medical School; and then in research, where we have Dr. Alexander Gutman, not only the Chairman Emeritus of our Department of Medicine, a distinguished scientist and editor, but also the Chairman - very active Chairman - of our Research Committee, who will review some of the major research accomplishments and trends during the year.

And then, finally, this year we thought we would expand a little bit and add a new dimension, which is the services which Mount Sinai Medical Center performs out into the community, the extension of our patient care, our education, and our research programs out into the community, and Dr. Kurt Deuschle, the Chairman of the Department of Community Medicine, is here to lead off in that area.

James: So I think that, gentlemen, this is the way we will do: We'll have a lead-off statement as to the highlights as the individual may see them, and then we will each of us, chip in and indicate some comments we may have in the same general area. No area belongs to anyone exclusively. We are here to represent the entire Medical Center; we're not here to represent only ourselves. And, therefore, if there are contributions that any of you can make, please feel free.

I'd like first to ask Mr. Levy to comment on what he might consider from his viewpoint to be some of the major accomplishments of the year--construction and fundraising, programs, or anything that he feels might be worthy of mentioning.

Levy: Well, 1971 was what I would term a pretty good year. On the highlights, certainly the building and the topping of the Annenberg building, and it was a thrilling affair, and we see it rising up there to its full majestic height. Hopefully - and we're pretty sure - it will be on target, so that the classes in the fall of 1973 will be housed in the building.

We had a pretty fair year of fundraising as well. We raised approximately $13,250,000, which was about two and one half times more than we raised in 1970, and the fund now totals $113,200,000. We're still some $40 million short of that necessary to not only fund the building but to fund an endowment sum which will go to help part of the hard core deficit which we expect.

Our donors were quite a few in number, and some of the older ones - the ones who had given before - came through again. For example, the Annenberg family, who originally pledged $8 million, have now pledged a total of $12 million, the bulk of which has already been paid.

Mrs. Moses, Lucy G. Moses, gave another million dollars for a cardiopulmonary center on the 8th floor, and we're very fortunate that Mr. Nathan Cummings pledged $5 million to name the Basic Sciences Building in the Plaza at 100th Street and Fifth Avenue. Mr. Cummings, I'm pleased to say, also became a Trustee.

Part of the Annenberg family gift was Mrs. Ames', [who] gave a million dollars of that $12 million to name the Herman G. Helpern Ambulatory Care Clinic. So, all in all, it was a great year for the building, and

Levy: things went well in the Hospital, but I don't want to talk all the while, and I'm sure I'll be heard from later on, so I'll stop.

James: I think on the sad side we have to recognize that several of our very cherished Trustees passed on, men who are going to be very sorely missed and have done a great deal for the institution: Mr. James Felt, who was Chairman of our Real Estate Committee; Mr. Philip Haberman, who was Chairman of our Law Committee; and Mr. George Lee, who was one of our Vice Presidents, a Vice Chairman of the Board, who has been on so many committees that it's hard to remember all of them.

Then, of course, you might want to say a word about some of our new Trustees.

Levy: Yes. Well, we were fortunate, as I said, that Mr. Nathan Cummings joined us, as did Representative Herman Badillo, who is making a great contribution, as is Mr. Louis Nunez, who is on the Board of Higher Education, as well as being the head of Aspira, and Mr. David Paul, who brings a great deal of effort and knowledge in the building and real estate field, and who will be a fine Trustee, as is the Reverend Dr. M. Moran Weston.

Also, Mr. Harry Mancher has come in as one of our Assistant Treasurers, and since Ira Schur is away a lot, Harry is doing a great job, and is functioning, really, as the Treasurer at the present time. Also, Mr. Jack Aron, who has a tremendous amount of hospital experience, being Chairman of the Board of the Tulane Medical Center, and prior to joining Mount Sinai he had been on the Board of the N.Y. Medical Center.

And we're also pleased to have with us Mrs. Seymour Klein, who is head of the Women's Board; and Chancellor Kibbee, who is now head of City University, is also welcomed to our Board.

James: And not to forget the Chairman of the Board of Higher Education, Luis Quero-Chiesa - I hope I'm pronouncing it right.

Levy: Well, he came on just -

James: He just came on. He has yet to attend his first meeting, right.

James: I think this is a very good review of our over-all administration during the year and some of the highlights of our total Medical Center activities. There are other things that we can touch on as we go along, but I think perhaps we ought to move on now to the patient care activities. Mount Sinai Hospital is just about at its 120th year. I have forgotten the exact date of its founding.

Pomrinse: 1852.

James: I know. I mean, remember the day of the month. I have forgotten.

Pomrinse: I'm afraid not. I wasn't there then.

[laughter]

James: I know that.

Levy: I think one of the great things about the patient care situation at Mount Sinai is that I'm a pessimist by nature, and I was sure that we would have tremendous disruption in both Klingenstein Pavilion and Klingenstein Clinical Center and Guggenheim and some of our other pavilions, because of the Annenberg building, but there was practically no disruption at all. The only suffering we did, really, was that we had to cut down a few beds to make way for the construction. But outside of losing some income and not being able to give the full service that we could by having those additional beds, there was no disruption. I was very pleased about it.

Pomrinse: There were some noise problems during the blasting, but that was over by the beginning of the year that we are speaking of.

I might point out what's been happening to the Hospital in the last five years. I have some numbers in front of me. As a result of the Annenberg preparation, and even more particularly in order to modernize the old wards, which used to house twenty-seven patients in one big room, we have replaced all those now with two-bed rooms and one bed rooms, so that throughout the Hospital there's nothing larger than a four-bed room.

This is a major step. Perhaps it might have been done earlier. But is has resulted in our losing some

Pomrinse: fifty-five beds compared to five years ago. The Hospital is that much smaller in available beds, in spite of the fact that our medical staff keeps getting larger. And the occupancy in all areas of the Hospital has stayed up, except in obstetrics, which reflects the over-all drop in birth rate, and we have converted twelve beds in that area already to gynecology, and we keep looking at others.

Another trend that's very interesting is that immediately after Medicare and Medicaid became law and became effective, the number of our clinic visits dropped for a couple of years, but in the last four years there has been a steady up-trend again, and we're now almost back to where we were before Medicare started. That trend is continuing in 1972, and I daresay we'll see a further development along that line.

Financial operations in the Hospital are getting to be an increasingly difficult thing, and 1971 was characteristically difficult. We ended the year with our expense budget almost precisely where we had forecast it, but we were able to balance the budget only because of a couple of special items which came in during the year, in terms of retroactive funds, and ended up with a budgeted deficit almost precisely where we had set it.

The Hospital lost Doris Siegel last year, who was probably the outstanding social work director of hospitals in the United States, and it was an enormous loss to us.

On the happier side, Dr. David Harris joined my staff as Associate Director of the Hospital, and has been working out very well.

James: You might say a word about our intensive care units, because we really have them much more effectively staffed and operating this year than we had before.

Pomrinse: Well, they were open the previous, at least, the Falk unit was open the previous year; but in terms of over-all staffing, we recruited 120 more nurses than we lost last year, so that by the end of the year we had 120 more nurses than we had in January of 1971.

We have done a number of other things in this area. One is that the former Mount Sinai Hospital

Pomrinse: School of Nursing is now operating fully as the Mount Sinai School of Nursing of the City College of New York, which is a baccalaureate program, and Mount Sinai Hospital continues to act as the clinical facility for that School.

We have attempted to improve the quality of service as well as the quantity by programs such as "Sinai Stands for Service", which is a slogan which we introduced around the Hospital among the employee groups. We give an award to the person in various departments who is nominated for such an award by patients or by their boss or by their colleagues, to give them appropriate recognition in our publications.

Wolf: Dave, how many patients did we treat - take care of - last year?

Pomrinse: We have approximately 35,000 inpatients and 60,000 ambulatory care patients a year. These are different human beings. That's not visits.

Levy: I guess between the Emergency and the OPD, they come about five times, on the average, the two combined.

Pomrinse: Right.

Levy: We have got roughly 200,000 combined.

Pomrinse: Last year the figure was 271,000.

Wolf: Well, I asked the question because, obviously, what the medical staff is supposed to do is take care of people, and that's a very sizable number we're taking care of.

Levy: Don't say "supposed to"; it does do.

Pomrinse: It does brilliantly.

James: Dr. Wolf, on behalf of the Medical Board, which you have been serving now as Chairman for several years - and we're very happy that you have been reelected for another term, so you will continue your sterling leadership - perhaps you would say a few words about the medical staffing of the Hospital and the activities of the Medical Board.

Wolf: Fortuitously enough, last year amongst the professionals on the staff - the physicians - and their

Wolf: activities on the Medical Board, it was extraordinarily quiet, compared to the previous year. [laughter]

Gutman: Everything is relative.

Pomrinse: Go back to February of last year. It wasn't so quiet in February. [laughter]

Wolf: Maybe I don't have my months quite so straight.

Popper: Academic? [laughter]

Wolf: That was the end of all our difficulties. As an indication of that, I think the fact that I was reelected and the entire Executive Committee of the Medical Board was reelected unanimously, I guess, is some evidence that there is kind of a lull.

We had a big problem the year before last in bed allocations and so forth, and we came out of that, I think, surprisingly well. I think it's true, Dave, that all of our relocations that were planned were accomplished - finished - as of last year.

Pomrinse: Correct.

Wolf: [Continuing].... and that they are operating, in terms of the geographical relocations, surprisingly well.

That doesn't mean that we have straightened out all of our problems in the eventual goal, presumably, of having every patient, private and semi-private, Semi-Private Division, get the same kind of high quality medical care. We still have problems in terms of furnishing the same kind of care to all of these patients.

The Semi-Private Division patients, many of them, are referred still as direct referrals from the staff. In the past year, after a lot of work by a subcommittee of the Medical Board, guidelines for the relationships between the house staff, full-time staff, and referring physicians, the residents, were worked out and are being implemented on the individual services.

This did not specify exactly how each service was to operate, but indicated, as I say, some general guidelines, and we hope to keep in touch with this particular problem as the months go by and make changes, or suggest changes, which will improve the

Wolf: relationships between all of the professional people and all of the students and all of the residents that have the problem of taking care of patients.

Dave, you will have to check me out, but our negotiations with the Committee of Interns and Residents presumably took place in this past year.

Pomrinse: Right, during the summer.

Wolf: This is a kind of a new aspect of the relationships between the teachers and the students. However, there was a time that these negotiations got a little tender, because, I guess, their lawyer, representing them and representing the interns and residents of the City, came up with a series of requirements, or suggestions, for us, some of which we could not accept.

It is not clear exactly what will happen in the future, because the faculty, at any rate, feels that this is not really a professional way for interns and residents to act. At any rate, we do have a kind of working agreement with them now, and I suppose this will have to be examined and reexamined in the future.

As a result of that, I guess, we have added two of the house men to our Medical Board. So far they have been very quiet; I don't think they have said a word. But I guess this may not necessarily continue indefinitely.

James: They haven't said a discouraging word, anyway.

Wolf: I don't think that they have said a word.

The mix of effort involved in teaching medical students, the mix of full-time, geographical full-time, and part-time voluntary, and their roles in teaching not only medical students but residents, I think, still remains to be worked out in detail, at any rate. This has required a considerable amount of cooperation amongst these different types of professional people on our staff, and will continue to require this kind of cooperation, and I hope we can get it in the future to some better degree than has been evidenced in the past.

James: I think it's interesting that Mount Sinai Hospital [was on a] ten-best list of hospitals in the country, this one compiled among a group of physicians, and also it

James: had another good year of recruiting all top interns and residents for its services.

Wolf: I think the staff was very pleased by the functioning of the intensive care units. They were unhappy that there were times when apparently nursing shortage kept some of the beds empty. This has become a very vital part of the patient care in the Hospital, and I think the general opinion is that we need more of the same kind of intensive care and progressive care units.

Would you agree, Dave?

Pomrinse: Well, I think, in terms of what's used now, we are probably about where we are in surgery and surgical specialties. The problem is more one of geography than numbers of beds, I believe. Medicine would love to have one in its area, because it would be much more easy to move patients back and forth, and doctors back and forth; but I think we're about where the total number of ICU beds should be for the size for the Hospital.

Wolf: We have an extraordinarily busy voluntary staff of physicians. It's really amazing how busy they are. They are really turning away patients these days, and some of them are getting discouraged about the volume of work that they have. I just spoke to a couple this afternoon that are going to relocate in Miami, in an effort to cut down on the amount of work that they really have.

Pomrinse: You mean, in their offices?

Wolf: In their offices, and in taking care of private patients in the Hospital.

James: There are certain categories of patients in which this institution has an unusual leadership. One, of course, is the myasthenia gravis group, where we have one of the largest collections of patients in the country, perhaps in the world. Another is in the gastrointestinal diseases, particularly the one that was discovered here in Mount Sinai, regional ileitis, or Crohn's Disease, which is still one of the diseases of which we get much more than our share because of our particular expertise in it. And I'm sure there are many others.

Pomrinse: How about gout?

James: Yes, gout. With Dr. Gutman here, this has become the gout center of the area. I'm sure he's too shy to say anything about it, so I'll have to say it for him; but not only did he pioneer in the research activities, but in establishing a very successful treatment program for a large number of patients who remain intensely loyal to him and his staff for the fine services they have received.

Dr. Popper, you look at the Hospital from many different points of view. You see the end result in terms of pathology of the organs which are removed and studied, their content, and you have a picture of disease and patient care here that few others have.

Popper: Obviously, my statements will be biased by my loyalty to the institution.

What we are seeing in the end result is a quite unusual variety of different diseases, reflecting the tremendous breadth of the interests of the physicians in the institution. Obviously, we see the bad results, and have to assume that we have to multiply this with the good results in many areas.

I think one has to stress that in this institution unusually good results, hopefully not reflected at the autopsy table, have been obtained in hematological patients. I think we must emphasize that the hematologic service has really done a tremendous progress, and is probably leading in their therapeutic results.

What we are seeing is patients dying from these - who had originally these diseases - from unrelated complications. We see actual leukemias and lymphomas eradicated successfully here.

Something similar, probably, can be said about the results of cardiac surgery. Despite the large number of cardiac surgical operations which are done here, we see very few coming where we are able to examine them.

Good results apparently have been in the broad area of what has been described here by my predecessor as collagen diseases, now having become far more emphasized as immunologic disorders. In these, lupus erythematosus, which, in effect, also has been a systemic disease described here - we see a very large material as a result of, particularly, the renal

Popper: complications, and the treatment has been quite effective.

James: Let's not forget that you have made this place a liver disease center of the United States.

Popper: I share Dr. Gutman's feeling of modesty not to emphasize, except to stress that that's a disease where we have an unusually large material, but unfortunately also on the autopsy table, which means we really haven't come where we want to come.

And let me put the word in: Many of these diseases are curable. Many of the liver disease are simply curable, but for the fact that the physician keeps on drinking when he shouldn't drink. And we would hope ---

Levy: You mean the patient - the patient, not the physician. [laughter]

Popper: I'm sorry.

Pomrinse: At least, not many physicians. [laughter]

Popper: Unfortunately, we even have physicians falling in the group.

Levy: You see, we're listening, Hans.

Popper: This is a tragic reflection on our culture, that we still see a fairly large number of persons dying in their youth, relative youth, when they didn't have to, but were simply destroyed.

And as long as I talk about that, one disease is tremendously increasing, and that's an area where Dr. James is interested. We still see a very large number of carcinomas of the lung, and let me also point out that the Environmental group provides us with certain variants of these disease, and apparently it's entirely possible that it's not only the smoking, but also the combination with exposure to asbestos. And while this is more a research element, I would like to emphasize it that we have quite some proof of this today.

James: Yes, we have quite a good chest service here in many different respects. It's one of the centers for sarcoidosis as well as environmental lung disease.

Popper: The pathologist, obviously, doesn't see the cured diseases.

James: I think one of the interesting things about our medical care program in this Hospital is the fine way in which the physicians on the different services are working together. Our cardiac surgeons are working with our medical cardiologists. Our gastrointestinal surgeons are working very closely with our medical gastroenterologists. You work very closely in your liver disease studies with the Department of Medicine and with surgeons. So that the pooling of our resources - our intellectual as well as our scientific resources - on behalf of the patient has been very effective.

All right, I think we might move on now to the educational programs, although we can always come back - Yes, sir?

Reubens: While you're on the patient care, is there anything you want to say at all about psychiatry - the whole field?

James: Yes.

Reubens: You can say it later in the evening, too.

James: Let me back into it. Among the highlights in the educational programs has been the fact that we have a number of new department chairmen with us. Dr. Joseph Goldman retired this year,and was replaced with a very young and vigorous and effective Chairman of the Department of Otolaryngology in Dr. Hugh Biller, who was very proud to take over the fine department which Dr. Joseph Goldman has bequeathed to him.

Similarly, Dr. Marvin Stein has come to take over as Chairman of the Department of Psychiatry from Dr. Ralph Kaufman. Dr. Kaufman is our oldest department chairman in both service and age in this institution, and I believe he was the first full-time clinical chairman hired by the Mount Sinai Hospital. He finally retired because of age, but remains as a consultant to our Post-Graduate Program. Dr. Stein, in taking over, is instituting a number of innovations in the department in terms of expansion of community psychiatry and child psychiatry and developing other programs in relation to both the outpatient services and the bed programs.

James: Dr. Pomrinse mentioned that Dr. David Harris has come as Associate Director of the Hospital. Dr. Arthur Glick has been named Acting Chief of the Dermatology Department. Dr. Jack Hahn has come in to direct the new Laboratory of Computer Sciences, so that our educational programs can benefit from this new and rapidly expanding science and technology.

Dr. Barry Stimmel was named Associate Dean for Student Affairs, who is ably assisted by Dr. J. Michael Kehoe as Assistant Dean. And Dr. Carter Marshall has taken over in the Dean's Office as a liaison officer with City University.

We had our second commencement on May 26 of this year. Last year we had twenty-three students graduate. This year we had thirty-five. Next year we hope to have forty-eight.

The post-graduate education program continued in full blast, with some 1500 doctors coming here for courses ranging from one day to a week or more. We had 115 different courses, and a large faculty participating in them. We have cooperated very extensively with the many programs of the City University, in terms of their Allied Health Professional Baccalaureate program and their Master's Program in Medical Care Administration, which Dr. Pomrinse has worked with particularly. And we have even worked with two high school programs at Benjamin Franklin High School to get students interested in health careers, help them through the summer, and help them get through high school. And we have a program with a community college as well. And our Ph.D. program has been an integral part of City University's program.

I think, Dr. Popper, you might want to say a word about some of the problems and accomplishments in curriculum and other activities in the Medical School.

Popper: Discussing the Medical School, one unfortunately cannot provide clear statistics. We therefore have to make some general statements.

The key statement which I think I can make, and hope to be backed up by everybody, is that we actually have matured, and matured to an unbelievably high degree. We all know that developing schools run to about ten years of maturation period, and we have in

Popper: very short time come to this degree of maturity. Now, what do we mean by that?

We have a different student body than we started with. It's an articulate student body. They talk back to us very effectively, but constructively, and this is probably a change in our own development as well as probably reflecting some natural development. But the contrast between the unrest which our first student body in the beginning characterized and the security which our third class now presents is extremely refreshing for the teacher.

I don't know whether now is the time - it may be later on - that we discuss the question of the minority student.

James: I think you might go into that, because that's a very unusual program, and it's been very successful.

Popper: It was quite successful. It was troubled, we have to say, in all honesty. It entailed quite some difficulties; it entailed some ups and downs.

Under the leadership of the Dean's executive faculty and the Dean's Office - and I think the greatest credit has to be given to the people in your Office who saw the truth - this has pretty much been resolved. A remedial program has been unexpectedly successful, and the greatest success of a remedial program is always when it becomes useless, when you don't need it any more.

In my other hat as a teacher, I am deeply impressed in the laboratory about both the enthusiasm and the intelligence which these minority students now express, in contrast to only last year. I think we have to give a lot of credit to this program of upgrading the students without losing their pride, and coming even to a point that they feel that they don't need it any more. And once more, that's probably the greatest reflector of success.

James: I think it should be pointed out that our Admissions Committee, composed of thirty people, has the original jurisdiction in the admission of students. Nobody second guesses them in the selection of our student body, and they are delegated by the faculty and by the trustees with the task of admitting students who have

James: very high capacity - the highest possible capacity - to learn medicine, and also the greatest motivation.

Now, ordinarily, for normal, middle class America, this can be mirrored rather well - not entirely, but rather well - by grades in college and by the Medical College Aptitude Test scores and by recommendations which are received from members of the college faculty and by the interview which the student has when he comes to the School. But for some of the racial minority groups, the disadvantaged students, neither the grades nor the recommendations nor the Medical College Aptitude Tests, nor even the interview can be a suitable measure, and this was proved very definitely when we took a girl who was recommended to us by Aspira, the organization one of our Trustees is Chairman of, who was Puerto Rican, and who came to us with a straight C average and rather low scores in her Medical College Aptitude Test, but with enormous motivation. And this girl led her class at the first round of examinations.

Now, this is an unusual case, but it's an illustration of how the Admissions Committee, with the help of the remedial program that Dr. Popper has mentioned, was successful in finding a girl with both the capacity and the motivation, which was not reflected, as it might be considered to be in middle class America, through grades and normal recommendation procedures.

This program has been one in which we have invested a good deal. We have an individual with a faculty rank of associate who devotes his full time to it. He begins with the disadvantaged student in July of the year in which the student is admitted, works with each of them during the entire summer, and right on through their first two years of medical school.

He audits the classes with them. He gives them technical instructions in the material of the first two years. He is competent in basic science himself. He also has to teach them such things as how to study, how to separate important facts from nonimportant facts, how to take notes, and often has to coach them in the English language, in simple arithmetic, in some of the types of work that these students never really had an opportunity to learn.

Popper: If you want me to continue ----

James: Go ahead.

Popper: The faculty - on the faculty level, we obviously had distinguished faculty in the clinical sciences, but we had to develop - and again, it was a process of maturing - a faculty in the basic science. The faculty now is complete for the student body of forty-four students per class, which we will have still in the coming year, in 1972.

We all now are engaged in looking around: What kind of faculty we are going to have when 100 students will have to enter the student body? This entails difficulties which I don't think we want to discuss here; but the forty-four student faculty is now complete, and it is matured.

This is reflected in various national types of recognition. We didn't need this type of recognition for the clinical faculty. Sinai had this before. It is refreshing for us to notice that our basic scientists gradually are living up to the same degree of national recognition - international recognition - as the clinical faculty always has been.

James: They are away just about the same length of time now. [laughter]

Popper: That's off the record. [laughter]

There are very few criteria as objective as their being selected for the Study Section of the National Institutes of Health. Obviously, our clinical faculty has been strongly represented. I'm most happy to say that now quite a few of our basic science faculty has joined these ranks, and this is, for us scientists, probably the best type of recognition, the peer recognition which is the result of that.

Levy: Hans, as far as your basic science faculty is concerned, you have got the hard core now. It's a question --

Popper: For the forty-four students, yes.

Levy: Well, you have got the hard core for the 100 students in each class. What you have to do, you've got to challenge and follow the chief assistants, and what you have to do is to add additional scientists ---

Popper: Yes.

Levy: [continuing] ... in each field.

Popper: I have to slightly contradict you. We don't have, really, the hard core for any specialty type, let's say, in biochemistry. Biochemistry is just like internal medicine. It has variety, the same as microbiology - variety of areas. We are still covering to [a] small part by guest lectures, to a great part that men are covering areas in which they are not entirely competent.

It would be a great luxury if for a forty-four student class we would have the biochemists for any major area. I think it's the obligation of Dr. Katsoyannis, Dr. Kilbourne, Dr. Barka to fill that out. So, while it is a hard core, maybe, in rank, it is not a hard core in every field.

James: Well, you are both saying almost the same thing. We have the chairmen. We have the leadership. We now need some of the lower ranking people who are more specialized.

Popper: That's right.

James: We need another steroid chemist.

Popper: Yes.

James: And we need - we have a good protein chemist.

Popper: Yes. I could elaborate in any area you wish, that we need gastrointestinal physiology and what not, which aren't covered right now.

Let me, however, stress - and this is something of which we are very, very proud - that the clinical scientists are able to cover quite a few of the basic science areas with almost the same degree of competence as the basic scientists would do in other schools. And if you later on assume - and we will talk about curriculum - I think this will be one of our major progress in our thinking, to bring that to bear even more than now we have done.

Levy: I'd like to change the subject, if I could, a second. You know, we're one of the, I guess we're the second largest voluntary hospital in the city, and we have

Levy: been very proud in these 100+ years of the degree of excellence we have achieved, both in our inpatient and in our outpatient. We have been particularly striving in recent years - and certainly this year and last year - to upgrade our OPD and our Emergency, which still provides about 25 per cent of the inpatients.

Now, the bulk of these 275,000-odd visits that we have every year from 60,000 patients come from people in the East Harlem community, although quite a few of them come from all over the metropolitan area, which is widespread.

I'd like to ask Dr. Deuschle, if he would - because I consider it one of the most important functions the Hospital, and the Medical School, for that matter, has to do is to serve the community and to have excellent relations with the community. I'd like to hear from you what you are doing in that regard.

Deuschle: Mr. Levy, as you know Community Medicine is a new Department, both in the Medical School and in the Hospital, and I think we have faced a severe challenge to begin to meet the quality standards and excellence that the institution established on a clinical patient care basis.

Our main mission was, really to define what community medicine would do in these problems. It was agreed, I think, that we should try to define the health problems more clearly, find out what the priority of these problems were, and to begin to find ways of developing solutions for these health problems, not only in concert with our colleagues here at the Medical School and the Hospital, but with our colleagues out in the community: other agencies, other hospitals, and the residents of the community.

I think 1971 has been very exciting, because we have begun to learn a great deal about what goes on in the community, and we have moved from the period in 1968, when we were anxious and talking about the problems, to where now, in 1971, we begin to get a real picture of what exists in the East Harlem community. I think some of the startling findings ought to be mentioned here. One is that the community isn't as large as we thought it was. We were estimating that it ran around 200,000 people, and what we have discovered with the 1970 census plus our own information on our

Deuschle: household survey, is that this population is shrinking. It's down to about 165,000.

Another thing we were startled by is that, in our household survey, about one third of the households are single person households, which I think has a big impact in terms of how we look at medical care in our community.

We know East Harlem - we often think of it - as a Spanish Harlem, and again we have confirmed the fact that the majority of people in East Harlem are Puerto Rican, or of Puerto Rican ancestry. But one of the things that particularly impressed me was that, from our findings, the Puerto Rican population here is much more sophisticated and acculturated, and aren't really as restrained in terms of their health practices as we thought they would be. For example, they do use physicians and hospitals when this is indicated.

Another thing: We have often thought of East Harlem as one of the most difficult inner city areas of New York City but from our findings we're beginning to see a picture that East Harlem isn't nearly as bad off as some of the other areas of the City, particularly Central Harlem. The health indices don't really look as bad as we initially thought that they might.

Another thing is that we had suspected that there would probably be pockets of people within East Harlem that were not reached by medical services. This is not true. There is almost no area in the East Harlem community that does not get medical services. What we see over and over again is that lack of coordination, the fact that we don't really have a system that makes effective and efficient use of all the services.

We veritably have a jungle of service in East Harlem, with two medical schools and four hospitals, and the Health Department, and many agencies, including HIP, with services available. So our problem is not to invent more health services, but to try to get more effective use out of those that exist.

We also are finding that quite a few of the people go outside of the East Harlem area for health services. They actually go to private practitioners. About 50 percent of health services in East Harlem are still obtained from private practitioners, but many of these are outside of the immediate East Harlem area.

Deuschle: We have also seen a major impact of Medicaid in the area, in that what's really happening is - it isn't that there are so many doctors' services, but that the expansion is in the area of podiatry, optometry, dental services - these other elective services, we could call them.

James: Just to break in, so that your talk isn't too long without an interruption, I'll interrupt to ask you if you would say a few special words about the Extension Service, because that program belongs almost entirely to 1971, particularly in its crucial period.

Deuschle: Well, as you know, it started in 1970 as an idea of one of our young faculty in Community Medicine. Dr. Richter had been Health Officer of East Harlem, and was so impressed with the problems of people living in rundown tenement buildings, and ascribed much of the illness he saw, or the aggravation of illness, to poor living conditions. When he began to look at this problem in a more scientific perspective, he found that 70 per cent of the buildings that were abandoned were abandoned because of lack of maintenance. He set forth the proposition that if you could train young men from the community to repair buildings and maintain them, perhaps there would be a better housing stock available for the people.

And with this idea, he was able to sell it to the local community and, really, every neighborhood in East Harlem joined with him in buying this as a solid idea for developing an improved housing situation.

Now, with this kind of backing - and not only did the neighborhood groups join in, but so did the landlords, and the unions actually thought this was a marvelous idea. So that, really, it was 1971, as you indicated, Dr. James, that this whole program came into fruition, and that, actually, the East Harlem extension Service was inaugurated.

Our Department played a role in providing health information and training for these men, but they got their vocational training at Manhattan Vocational High School.

Now, the local community set up its own corporation, and although initially the funding came from the rat control program in New York State, eventually, at the end of the year, the program had to

Deuschle: be funded out of sources from within the city and various private groups.

As we see it, this has been a splendid success. The local community supported it, and it's an example where an institution like Mount Sinai, in concert with the local community and with the agencies, developed a coalition that's been very powerful. And this year the crisis came when funding, just before the Christmas holidays, were really in great difficulty, and not only did Mount Sinai respond to a cry for help, but many other agencies in the City. We think that this corporation is going to go on and, in a sense, become self-sufficient in terms of maintenance of houses, although I think it will be dependent for a long time to come on getting extra sources of funding for the trainees.

James: In cooperation with our clinical services, and with Dr. Pomrinse, who has been working with HIP to develop some comprehensive medical care programs in the area - perhaps you would say a little bit about those.

Deuschle: Well, as you know, the latest federal slogan is HMO, and this means Health Maintenance Organization. What it comes down to is that it's really another label for prepaid health insurance, practice programs, such as Kaiser Permanente or HIP.

Pomrinse: If that's all it were, I would be in favor of it.

Deuschle: It's very hard, however, to get details on what the HMO is really all about. There's a bill in Congress, the Rogers bill, that spells it out, probably more specifically than any other.

But we have gotten a planning grant, with Dr. Pomrinse and HIP and Union 1199, to look at how we might jointly develop a population that can be enrolled in such a prepaid health insurance program. HIP would be the health plan, 1199 the initial core group of consumers, and Mount Sinai Hospital and physicians would be the backup institution and provide the professional input into the program.

We're all interested in trying out some new ideas, improving ways of keeping records, and delivering not only curative care but improved preventive services.

Pomrinse: I think another area one can point to in relations between the community and Mount Sinai that are working well is in the Ghetto Medicine Program in our clinics. This was a funding program to keep several hospitals from having to close their clinics several years ago, and part of the program requires the creation of an ambulatory care advisory committee which meets monthly with hospital staff. This has been a most amicable and constructive kind of board, and there has been one joint meeting with a committee of the Board of Trustees on ambulatory care.

The fact that it's working is demonstrated by the fact that two different public agencies, the City Health Department and the State Health Department, made separate inspections late in 1971 of our ambulatory care activities, and both of them gave us glowing reports. They pointed to a very sharp increase, primarily in the number of physician hours available for patient care in the clinics, as a result, in part at least, of the assignments of larger numbers both of house staff and senior attending staff to the clinics.

The operational details have also been much improved, and Dr. Robert London has done a magnificent job of organizing the whole thing, and we're very proud of it.

Levy: Dr. Deuschle, although there are quite a few other medical facilities in the East Harlem area - Flower-Fifth, Metropolitan, Joint Diseases, and so forth - are we the principal medical facility used by the East Harlem community?

Deuschle: No, we are not. Actually, if you take a count of all the bed services, Metropolitan would be giving more services, because it is a municipal hospital. It does provide care for those individuals living in this particular area of the city, so that they are qualified under city ordinances to use that particular facility.

Pomrinse: They have 950 beds, and almost all of them are used by people in this geographic area. We have about 15 to 20 per cent of our beds ---

Levy: How about our OPD facility?

Deuschle: The same would be true of the OPD. We run about 40 to 50 per cent of the OPD patients from East Harlem, and more than that in the Emergency Room.

Levy: And the last question I have here, which is a matter of judgement: How would you categorize our relations with the East Harlem community?

Deuschle: Mr. Levy, I would have to say at this point it's extraordinary. There is a rapport that has developed between Mount Sinai and the community that is really beautiful. We may get calls from the community asking for help, but we find that these calls come in a very, very mild way. There isn't a demanding kind of outcry. We find that we can sit down with people in the community and go over their problems and begin to look at possible solutions.

We have good rapport with every one of the neighborhood groups. We work very closely with the East Harlem Health Council. We feel very comfortable to be able to get their help, and they get ours. I think it's been a splendid relationship.

Levy: Well, that's great, and let's do everything we can to maintain that relationship on that "extraordinary"--I quote--level.

Pomrinse: I think Kurt is absolutely right about the medical and clinical services relationship. I wish it were equally true in the housing field, but there, unfortunately, we do tread on some toes, as we have to use space and areas that the community would like to use, or continue to use, for other purposes. We have been as gentle and careful and cooperative and consulting as we can be, but, unfortunately, the demands of the institution for expansion have caused some areas of difficulty.

James: In all fairness, I think we should say that there are many other organizations that are encroaching upon the housing of this area, and our encroachment has been minor, and, hopefully, will remain so, although the community has a tendency to group all of these together and react against all of them in toto.

There's no doubt that this part of New York needs additional housing, and that much of the slum housing should be replaced with a far better grade of housing. We have as an institution offered our cooperation. We don't have funds for this, but we would be very happy to sponsor jointly with them any projects that we can.

Deuschle: Dean James, I wanted to just recognize the increasing cooperation and collaboration we have from our own

Deuschle: clinical staff, who are joining us in the various programs and projects we have going on in the community. We have at least ten well-developed programs, and probably ten or more that are in the development stage. Whenever we have called on our colleagues here, whether it's in pediatrics or ENT or ophthalmology or ob/gyn, across the board we have had, really, tremendous cooperation.

James: You have many of your people with joint appointments, in surgery, dentistry, obstetrics, pediatrics, medicine--in many different fields.

Deuschle: I might say that dentistry has been one of our closest collaborators. There is a great need in the community for more dental care.

James: Well, I think we'll come back to some of these activities later. I think they are very exciting.

We should remember that Mount Sinai has had an unusual reputation for medical research throughout the century, and as short a time ago as 1962, some years before we had a medical school, we were 28th among the institutions of the nation in those receiving large federal grants for research. And since at that time there were 86 medical schools, you can see very readily that we outranked most of the medical schools in this country in the performance of high quality research.

No one in this institution represents research to us more than Dr. Gutman, not only for his sterling activities in the field of gout and related work that he himself has performed with his team, but as Editor of the American Journal of Medicine he has had to review critically and accept for publication some of the best clinical and medical research activities that have gone on all over the entire country. He has served us recently as Chairman of our Research Committee. It would be very nice, Al, if you would tell us a little bit about some of the highlights of our research program for the year.

Gutman: Well, as you say, Mount Sinai has had a long and distinguished tradition in research. I would like to add that with the advent of the Medical School, research effort has increased, not only in number but also very considerably in quality. It has had a very important impact on the clinical research in the Hospital, and I think also that the clinical research

Gutman: has had a favorable effect on the basic research being conducted by the basic scientists. So all this has been to the good.

Research is, of course, the leaven, the yeast, for the clinical activities and the teaching activities. It's what keep the staff on its toes and intrigues students, and it's a kind of activity which gives the staff and the students an outlet for their creative abilities - a healthy outlet - which is very desirable, quite apart from what practical achievements may ensue.

1971 was a rather difficult year for research, not only at Mount Sinai but throughout the country, because of the restricted availability of government funds, which, as you know, were reduced rather drastically, which made it difficult to get supporting funds. With a reduction in funds, the competition for available funds became even keener. So it was really tough going.

Nevertheless, here at Mount Sinai we did maintain a very active and prolific and productive program for the year July 1, 1970 through June 30, 1971. We had 360 active research projects, involving practically every department in the Hospital. Some departments, of course, are more research-oriented than others, but throughout, clinical as well as basic scientists, there is a very healthy appreciation of the need for looking ahead and pushing ahead, finding new ways of doing things and new ways of treating disease.

All together, approximately 400 professional staff were engaged in research, most of them, of course, part-time, some of them full-time, and approximately 500 personnel - assistants, technicians, and so on - were employed in carrying out the research.

Now, with regard to the support of this large research program, which is most varied - I can't give you details because there just isn't time to detail the substance of 360 projects, but suffice it to say that it was more diverse, covered all fields of disease and all normal physiology and biochemistry. The funding was for the most part by governmental agencies, notable the NIH. We were successful, in other words, in competing with other institutions. Approximately $8.9 million was available from government sources in support of research, and about half of the 360 active projects were supported by these governmental agencies.

Gutman: About 124 projects were supported by private philanthropies, showing how important even in this day and age private philanthropy is in the support of research. Our total research expenditure for that year was approximately $13 million, a fairly substantial segment of the over-all funding.

Reubens: When you say "that year," do you mean the year ending -

Gutman: July 1, 1970, through June 30, which is the last time we have figures for.

James: Our figures for research are on the academic year.

Reubens: Thank you.

Gutman: Of course, the research that's going on in this place is, as I say, very varied. Now, much of it doesn't deal with animals or human beings at all. It deals with enzymes and other compounds, all in the laboratory. It deals with cells, with bacteria, viruses. All of this has no direct impact on the patient studies. Much of it deals with intact animals--dogs, rabbits, rats--and we have to maintain a large and rather expensive animal facility to take care of these animals. We also have a farm on which the animals are bred and cared for. This is a rather large operation that you wouldn't know about unless you we engaged in these activities.

And then, of course, a substantial part of the work deals with sick patients, and here we have to exert extraordinary care to protect the rights of the human subjects involved in research. All research is conducted only with the consent of the patient, to whom the project is very carefully explained, so that he knows exactly what he is getting into. Most of the research with human subjects is in the way of treatment. Much of it - for example, when the conventional methods of treatment fail in a very sick patient under the threat of death, you have to resort to newer methods, newer chemicals, newer radiotherapeutic programs. In other words, the program of treatment becomes more or less experimental, and when you are in a desperate situation like that, the patients, as well as the physicians, agree that this becomes necessary.

At any rate, we make every effort to protect the rights of the patients who are participating in the

Gutman: research. This is done by review by the departmental chairman first, then review by the Research Committee, which is a professional committee, then review by Dr. Kupfer's administrative office, which is in charge of all the research projects. Then it is reviewed by a Research Administrative Committee, which is a joint professional and lay Trustee committee, so that we can get the viewpoint of the nonprofessional - that is, the lay person. This committee is headed by our Dean.

Every research project involving human subjects is reviewed four times a year for adverse reactions, so that in case something is going wrong we are made aware of the difficulties soon and can make the necessary inquiries and, if necessary, stop the research.

The number of adverse reactions, because of the great care and supervision, is really quite remarkably small. When there are fatalities we find that the patient has leukemia, for example, and is moribund, and some new chemical is ineffective. The patient dies not because of the treatment, but because of his underlying disease.

In general, research can be divided into two large categories. There is what is known as basic research, and what is known as applied research. Now, basic research in an institution such as ours is conducted mostly by the basic scientist and amounts to study of normal organisms, including man, the structure, the function, operation, enzymes, integration of the various systems. We have to know how normal man works before we can understand how these normal systems become dislocated in disease.

There's a feeling, I think, in the country and, I suppose here too, that basic research is something of a luxury, and much of it not relevant to current social and other problems. Well, those of us who are engaged in clinical research appreciate that this is not so. We must have the basic, primary information before we can go on to the subtleties of disease, and it's from the basic scientists that we get most of our methods that we then apply to our patients and the study of our patients.

So we don't consider it a luxury. We consider basic research a necessity. And moreover, there is so much overlap between basic research and applied research that often you can't tell where the one ends

Gutman: and the other begins. I'll give you an example from some of the things going on in this hospital.

In the Department of Microbiology a large and intensive effort was made in the study of the influenza virus. This has been going on for several years. This would be basic research. Now, as a result of these efforts it was possible to develop a vaccine which is promising, as the result of a rather ingenious mosaicism of induced genetic strains, which took a lot of ingenuity and a lot of work. It was possible to develop a vaccine.

Now, of course, with epidemics of influenza coming on, the development of a vaccine that would be effective not for one single strain but for a number of strains, which is exactly what is being done here, would be of enormous benefit to populations far beyond the confines of our Hospital.

In the Department of Pharmacology there is a study going on on the effect of narcotics, mostly heroin, in rats and other animals. Of course, this relates directly and importantly to the large narcotics program, the heroin control program that is going on in this Hospital.

I could go on to many other examples in which you begin with very basic problems that don't seem to be related to relevant medical problems, but sooner or later some relationship is worked out. And the reverse is also true. People begin with a study of disease, and they soon discover that there are certain facts about normal man that they have to know in order to understand their disease. The next thing you know, they find themselves doing basic research. Then when they get the information that they need, they go back to the study of the disease. There is a constant interplay here between so-called basic research and so-called applied research.

Much of the applied research in this Hospital is really directly concerned with disease. Dr. James mentioned the well-known clinical programs that we have in the Hospital: myasthenia gravis, diabetes --

James: Regional ileitis --

Gutman: Regional ileitis --

James: Gout --

Gutman: Gout, hepatitis, and such things. The design of these experiments is usually to collect a large number of patients, make a very careful study of them as clinical problems, so that you begin to understand the clinical problems, from which you go on to the physiological and biochemical problems.

So it's impossible to draw a sharp line here between clinical care and research. The two merge one into the other.

James: As somebody said, 'The treatment of every leukemia patient is research.'

Gutman: It's research. When you get right down to it, even in the care of a leukemia or other patient, the physician begins with a conventional dosage of a conventional drug. If that works, fine. But often the patient proves to be resistant or refractory. Or a particular surgical operation discloses an unexpected complication. Or radiotherapy, or chemotherapy.

Well, once you leave the conventional, you are on your own. You have to do research on that patient. So even in common, everyday clinical care, every physician is obliged sooner or later, when he is confronted with a difficult clinical problem, to engage in organized research.

I'm trying to make the point that research is part and parcel of the clinical care activities of any great hospital. And, of course, the same applies to education. Research and education are almost synonymous terms. You learn by exploring new things. So far as teaching house staff is concerned, the instructor soon finds that the student is well aware of what's in the books and in the publications. What he wants is new information, which the instructor can provide usually only if he himself has done research.

The whole thing makes a whole. You just can't separate one from the other. And the fact that --

Pomrinse: But I must interject, Al, that we have to, because the reimbursement people insist that we do. And what you are pointing to is the key reason, I think, that

Pomrinse: teaching hospitals' costs are so significantly above those of community hospitals --

Gutman: That's right.

Pomrinse: [Continuing] ... where teaching and research are not significant parts of the total.

Gutman: There is an added cost, and you get the benefits of that added cost in improved clinical care.

Pomrinse: And somebody has got to pay for it.

Gutman: And somebody has got to pay for it. There's no question about that.

James: Thank you very much, Al.

Let me try to give a few overviews, and I hope each of you will make either written or mental notes of points as I go along that you would like to comment on further.

In the research field we have been successful again in competing for support for our Clinical Research Center. This is a program started by Dr. Gutman some years ago, with the able assistance of our Associate Dean, Dr. Sherman Kupfer, in which we can hospitalize patients for research purposes. These are sick people generally, but because their disease is so important to study, they are hospitalized at no cost to them, supported by the federal government, on a particular research program.

Practically every department in this entire institution has had patients in there. We're very happy that, although the competition is getting keener and keener for the support of these, we have received very excellent support for another several years.

Levy: What have we got? Twelve beds?

James: We have twelve beds in this project.

Gutman: Nine are supported.

James: Nine are supported. We support twelve for nine months, which amounts to the same thing as nine for twelve months, because during the summer it's harder to get patients to come.

James: In addition, we're getting ready, as Dr. Gutman has mentioned, to make major inroads into the field of cancer research, in which the government is now very much interested. Dr. Gutman is chairman of a planning committee. We hope soon to apply for a planning grant, so that we can narrow down the activities and plan them the way we would like to do them, identify the principal investigators who will work on different projects, and start a major, across-the-board operation in cancer, all the way from the epidemiological studies that Dr. Deuschle's department would do, on the one hand, to the chemotherapy, radiotherapy, surgical treatment, case finding--the whole field of cancer control.

And then we're at the threshold also of a major advancement of a program in genetics. Genetics in this medical school and the Medical Center is part of the Department of Pediatrics. In Dr. Kurt Hirschhorn we have a very splendid geneticist who has already made very wonderful contributions. We have the rudiments here for a major Medical Center-wide approach to this problem under his leadership and that of Dr. Hodes in Pediatrics.

Similarly, in hypertension, which has recently received a good deal of attention, it has been shown that if you can find the early hypertensive, even before he has symptoms, and treat his hypertension, lower his blood pressure, you may prevent his getting serious strokes or other vascular conditions. We have a very good group of hypertension specialists here who are attempting to expand these activities.

And then, of course, Dr. Gutman has mentioned narcotics control, which is going on very actively here, both as a treatment program and as a research program.

For the Medical School, I think the overview is that we are getting ready for a very large, expanded class, when the Annenberg building is finished. We're trying to move toward it, as Dr. Popper has mentioned. We are increasing the size of our first year class by a nominal 10 percent, and we are increasing the size of our third year class up to 56 or maybe even a few more, so that we will get used to having the larger classes.

We're also working very actively with our other affiliated hospitals - Beth Israel, Hospital for Joint

James: Disease, which eventually will move to our campus. Beth Israel, of course, being some distance away, but will be worked into our teaching programs. The Veterans Hospital in the Bronx has been brought in very closely, as has the Elmhurst Hospital.

The Medical School also has just completed a three-year study to revise its governance, to make it far more democratic, giving the faculty and the students a far greater role in the decision making as to what goes on in curriculum and the day-to-day operation of the Medical School. This package, which has come through this committee after much study, is going to be voted on early in 1972. We have every indication that it will be approved by a referendum; whereupon we will pass it over to the Board of Trustees for their action.

In the patient care field, I think the advent of the expanded intensive care units, the checkerboards which we must play with the beds, which are working out, the narcotic methadone program, the improvement of comprehensive care, and looking forward to the improved operating rooms, x-ray departments, and clinics in the Annenberg building, are going to take up a good deal of planning.

We have some new special surgery. Our cardiac surgeons are now doing more and more of the cardiac shunt operations, which seem to be effective. We don't know what the long-term outlook is, but we have avoided doing the cardiac transplants, because we have not felt that they have been adequately shown to be effective. I think that has been borne out quite clearly by the results. But the cardiac shunt operations, the redevelopment of a new blood supply for the heart by means of taking a piece of vein from the leg and connecting it to the large artery of the body, the aorta, and then into the coronary arteries, has been effective, and we hope it is so borne out.

In community medicine, I think the large number of projects which the staff have undertaken have always been undertaken with the full cooperation of the community. I would say, as an overview picture, that the most striking feature of these programs has been that the Department has given solid professional leadership. They have given it with the warm support

James: of the community, which means that it has not been a filtering from the top down arrangement. It has been a joint working with the community, which has accepted the professional judgement and leadership of the Department, but pointed out their problems, and have been quick to point out when the proposed solutions of the Department haven't answered the problems.

And self-help has been emphasized, so that the community can work - and work hard - itself, like in the Extension Service, to develop these programs. And the Department has been willing, with the cooperation of our clinical departments -- medicine and pediatrics particularly - to expand its programs out into the community.

And then, finally, by the way of an overview, I think all of us in this institution must pay great tribute to our Trustees. You all recall that when the Liaison Committee of the American Medical Association and the Association of American Medical Colleges made the accreditation visit here, they pointed out that there were many new medical schools, but there were none that they knew of that had made as rapid progress as we did. Although they gave us all great credit for being fine doctors and teachers and scientists, they quickly pointed out that in their opinion, that factor that made the difference was our Trustees, who had always demanded the highest in the way of scholarship and quality from us, have found us the resources even when it's been unusually painful and difficult, and have been responsible for working with us on many committees, very often the tedious ones.

Dr. Gutman mentioned their fine work on the Research Committee, where they review all human experimentation and help us as laymen and as attorneys and as businessmen, give us their recommendations as to how they feel this research is related to the individual human dignity and the rights of people. And they have helped us on our Planning Committees, our Building Committees, and our Personnel Committees, our programs to develop a Medical Service Plan for the future, in many different ways too numerous to even begin to enumerate.

Levy: Well, on behalf of the Trustees, George, thank you very much. We certainly have a lot of fun working with the institution and seeing it grow and maintaining the excellence of the Hospital. And certainly we feel that

Levy: the birth of the Medical School was a great thing, and we are pleased that we had quite a lot to do with it.

But, you know, a lot has been said about the research that's been done in the Hospital, and a lot of it has been done by our full-time men, but also a lot of it has been done by our volunteer staff. One of the things that the American Medical Association and the Association of American Medical Colleges commended us for and, really, gave us our temporary first charter to run a medical school, was because of the excellence of the voluntary staff. They do enormous work. They not only fill our beds - 1100-odd beds every day, or pretty near every day - but they also do a yeoman's job in the clinics and teaching and all the things that go to create the excellence of the School.

Now, as well as the voluntary staff, we have our voluntary lay people - literally hundreds of them - who work around the hospital every day; and certainly without the Women's Auxiliary and their Board, this institution wouldn't be the kind of institution that it is.

You know, it's hard to believe - we get mundane - what a huge financial burden - or not a burden, but what a huge financial structure this organization has developed into. It's got an income and outgo, unfortunately, a little larger of over $100 million per year, when you consider the Medical School and the Hospital and the auxiliary institutions. And the problem of the budget has been modest every year, but it's still substantial. Fortunately we have been blessed by some generous people who leave us money in their wills, so that our General Fund throughout these past few years has been able to be maintained at somewhere between $4-1/2 and $5-1/2 million.

But nonetheless, it is scary when you set down a budget of over $100 million every year and don't know, really, where it's coming from. Particularly in this year and last year, with the Medicaid freeze in New York State and with costs built in by the result of our negotiations with the labor unions, and this year with the wage-price Phase II in effect now, and knowing that we are going to have a union negotiation coming up that will start pretty soon, because the contract terminates on June 30. We might be faced with a huge deficit next

Levy: year if the union demands come anywhere near the guidelines - which they certainly will, and probably will exceed them - and we're frozen on our cost structure.

So we're keeping our hands towards heaven in prayer that we can work it out on a satisfactory basis, because otherwise, we can envision a deficit not at the $400,000 or $500,000 level that we have been able to bear these past few years, but at the $2, $3, $4 million level. And, hopefully, that won't occur; but it could.

But I must say that I want to pay great tribute to the volunteers, both professional and lay, and the women particularly, for the magnificent job they are doing for the institution.

One of the things that bother me - and I've talked to Dave Pomrinse about it - is the steadily ascending cost of a patient day. It not only applies to us, but to every hospital in the metropolitan area, and not only in the metropolitan area, but throughout the country. It bothers me in the sense that we know that Blue Cross and related agencies are getting tougher, and we don't know how long the public will stand paying, in effect, $160 a day - I think is the cost now. Is that about right, Dave?

Pomrinse: It was $150 in 1971.

Levy: $150 in 1971, and it goes up at the rate of about 12 percent a year. But I don't know how long people will stand this kind of cost. It seems to me that some organization, whether it's the American Hospital Association, Blue Cross, or someone has to sit down and make a study of how, without taking away needed services, costs can be brought under control.

Pomrinse: Well, I know it's no comfort to you, because the numbers are so large, I can say that since 1967 the rate of escalation has been coming down about 2 percent a year. In teaching hospitals in New York City, the average increase in 1967 was over 21 percent, and in 1971 it was 13.5 percent.

Now, this is still an enormous amount of inflation, but what happened, in part at least, was the fact that for several years following the enactment of Medicare and Medicaid, there was open-ended

Pomrinse: reimbursement, and those whom the hospital pays recognized this - knew it as well as the managers of the hospitals did - and demanded their share of the available funds. Hospital workers used to be the most poorly paid people in town, and now for equivalent work, they are the best paid people in town. In comparison to other service industries in New York, our employees are now about the very top.

This reflects itself immediately in the per-patient per-day costs, since 75 percent of our costs are people: salaries and fringe benefits. The other variable, of course, is the number of employees, and that relates directly to the sort of things that all of you have been talking about tonight, and it has to do with the quality of care. The more intensive care units you have, the more personnel you have. The more sophisticated laboratories you have, the more technicians you have. The more house officers are being trained, the more costs go up, not only because they get paid - and they are paid much better these days - but because they in turn order a lot more on their patients.

Dr. Wolf's department, for instance, showed an increase in numbers of x-rays last year of 17 percent over the previous year. The five-year history has been an increase of 13 or 14 percent each year in laboratory tests per patient day and x-rays per patient day.

James: And new procedures discovered in x-ray.

Pomrinse: So the only way we are going to slow down the rise in costs is either to have people accept less in the way of wage increases or less in the way of the benefits of technology. One or the other has got to give - or both - and I don't anticipate either one of them happening very quickly.

James: I think we have to be cost conscious all the way through and try to give the highest quality of care we can, as you say, saving all the money we can.

One of the ways, of course, that we hope to save money eventually in medical care is through research. When we had a poliomyelitis vaccine, it made it infinitely cheaper to take care of poliomyelitis by preventing it. If we can develop drugs to prevent coronary heart disease, to control hypertension, we can reduce these diseases.

James: It's interesting that fifty years after the discovery of insulin, diabetes is still the eighth leading cause of death in this country. We still have to do much more research in diabetes in order to control that disease. Even though we have a sure cure for syphilis and gonorrhea in penicillin, we still have epidemics. We have to develop a vaccine for these.

Research is one way of attempting to reduce the cost, and investment in research is an investment in our future ability to really control these diseases. But as Dr. Pomrinse says, in the meantime... In fact, [as] Mr. Levy said, we have got to figure out ways to work more efficiently and reduce costs to the greatest degree without hurting quality.

Wolf: How do you determine what these things should cost?

Levy: You can't. There's no way. But there's one figure that stands out that bothers me to some extent, and that is that through the years - our qualities [?] are not a Hospital Fund figure for New York - the number of people [employees] per bed has not gone down. As a matter of fact, it's risen slightly. Now in any industry that's efficiently run - and I'm not saying that this is possible in a hospital - the productivity of people has risen, and that should be shown by a decrease in the number of people per bed.

Now, I don't know if that's a viable figure in an institution such as ours or not, but it seems to me in that area - because certainly I agree with Dave that we are not going to reduce the quality of care, No. 1, and you can't reduce the relative wages of the employees, because once they have smelled heaven you are never going to change that, and we don't want to change it, furthermore. They are entitled to a fair and decent living wage, particularly in New York City.

So the only way you can do it is to get greater productivity, by some manner, out of these individuals. Now, how that's done I'm not smart enough to know, but somebody is going to have to learn.

Pomrinse: Industry does it by substituting machinery for people wherever possible, and we do this. But, unfortunately, the areas that lend themselves to substitution of equipment for people are very limited in a hospital. We can do it in areas such as the laundry, and we do,

Pomrinse: and we have the cheapest laundry in New York, I think, per pound, per patient day, or any way you want to look at it.

James: We have one of the cheapest restaurants in New York. They give room service, too.

Levy: Don't say "cheapest." Less expensive.

James: High quality; less expensive.

Pomrinse: Our over-all hotel costs, when compared with a commercial hotel, are about 50 percent of what a similar quality, if you like, hotel would cost. The costs are not in the areas that lend themselves to comparison with the commercial world, but are in the professional and semi-professional activities which permeate the place. Every time we use a new drug because the patient's become resistant to an old one, the cost is sharply increased. Whenever Dr. Wolf comes up with some new diagnostic technique, you can be certain that it's going to take expensive machinery and more technicians.

James: How much angiography do you do in the coronary tree and in the brain now, and carotids?

Wolf: On the brain we do about six a day; and coronaries, we're averaging four or five a week.

James: You know, these were practically unknown five years ago.

Wolf: The point I was trying to make is that if you try to judge what this should cost, how do you throw these things in?

Pomrinse: It should cost what people are willing to pay for it. At the point they say they're not willing to pay any more, the advance in technology will stop, and the availability of salary increases for employees will cease. At that point there is rigid confrontation, and this has already happened in New York State. The rate of decrease that I have mentioned is not true through the rest of the country. New York State is the only state in the country that has a cost control law, in which we are told in advance how much money we will have for the year, and must live with it. Other states don't have this, and the hospitals get back what they

Pomrinse: spend; so that they have not shown this downward trend in the rate of inflation.

Wolf: Then the professional side is really caught in the middle.

Pomrinse: Exactly.

Wolf: Because you insist on better and more high quality care be furnished by the professional people, by the laboratory people, and so forth.

Pomrinse: We're doing precisely what the State has mandated we do, which is "to increase the efficiency of production of hospital service"--in quotation marks.

Wolf: If you want to get into that area, though - and I assume this is going to be edited - one of my problems is motivation and incentives. To increase productivity, at least when I took elementary economics, incentives were important.

Levy: I think the whole reimbursement system is lousy.

Wolf: I can stand on my head, apparently, in my department before I can figure out some way of motivating some of the people. For example, transport is our biggest problem in x-ray, to get a good day's work out of them. How do you motivate them? Because presumably, your arrangements with 1199 are such that seniority is the only thing that counts, essentially, when it comes to increments.

Levy: Well, you better get together with Dr. Stein. [laughter] Maybe he can find a psychological means of motivating these people.

But one of the things that bothers me is - I remember reading very assiduously a report which I thought was tremendous, by the fellow - what's his name? - up in Rochester who used to be -

Wolf: Folsom?

Levy: [Continuing] ... the Folsom Report. And one of the things that stand out in my memory about Dr. Folsom's - Marion Folsom's report - was that hospitals really weren't being used for the acute diseases in which they were supposed to be, but because of the reimbursement of Blue Cross, and so forth and so on, doctors put

Levy: their people in for tests when they should be ambulatory for those kinds of tests, and that would make available a lot of beds, and therefore not necessitate building of new hospitals, et cetera, and that kind of thing.

People read it, and they applaud it, and then they get beautiful editorials in the New York Times, and nobody does a damn thing about it. And that's one of the things that sort of disturbs me.

Pomrinse: There's a good reason for that, Gus. If Blue Cross were to do that, their needs for additional premiums from the people would be even greater, and there's no question: The total cost to the community would go down, but -

Levy: Well, isn't that the important thing?

Pomrinse: I would agree fully. The problem is finding a lever to make it happen.

James: You see, being a teaching hospital to a medical school, we need a cardiac surgical service. Our cardiac surgical service is about fifty operations a year below what it should be to be running at peak efficiency. Now, you could say that we ought to close and let all our patients go - this isn't going to be in the final version.

Pomrinse: I hope not.

James: ...we should close and let all our patients go to Columbia --

Levy: We can do the reverse, and induce the other patients to come to us.

James: Have all the patients go here - right.

Pomrinse: We're working on that.

James: But these are part of the problems.

Wolf: As soon as you do that, you know, that means 200 more coronary angiograms a year.

James: Right.

Pomrinse: And another operating room.

James: That's expensive. That's difficult.

Wolf: And at Stanford, apparently, they are doing five a day - coronary angiograms.

Reubens: I think we have, maybe, about twenty minutes left on the tape, and by nine-thirty I think we should all be through.

There are two areas which, if you'd like to go over and talk about, would make writing easier for me, and more attractive, perhaps, reading. So if you could hear these two and then think whether it's worth the time ---

James: If we can help you, we will. Go ahead.

Reubens: Thank you.

(1) From the very decision that the Trustees made to build a medical school, and then methadone, and then drug abuse - adolescent drug abuse - and unwed mothers - these are ways that show Mount Sinai's steady responsiveness to changing needs in the society and in the city around. If we talk to that point, that makes awfully good reading, instant ways - not "instant", but steady ways that Mount Sinai responds to these innovations - that's one area.

The second area came from Jan. Are we discovering - or what are we discovering as to patient care benefits from having a medical school? Have we been finding things in which patient care itself benefits?

James: Well, Dr. Gutman has mentioned that. Let's ask Dr. Popper, who has been around here a while and lived through the development of the Medical School and the thinking that went into why we needed one, and also knows something about the other programs that you mentioned.

Popper: Yes. I wanted to stress this point before, in response to Mr. Levy's statement.

The research which is going on is directed - is partly biological research and partly, more and more, research in patient care delivery, and this hasn't been really stressed.

Popper: Now, research in biologic areas will have the part in the future - the beneficial effect - to reduce patient costs, if we will have a drug for hypertension, or if we will have an effective therapy for cancer. But this is the future. In the meantime, the costs will go up for patient care, because, simply, more methods are developed. Methods cost more money.

However, it has not been stressed that there is an answer to Mr. Levy's problem, and I think the Medical School is charged with this, and we'll do it. This is research in the delivery of medical care, and I think there are ways to improve financially the delivery of medical care.

It is constantly stated that medicine, in many ways, is still a cottage industry. I know that's a cliche, but we still are a haphazard affair. With the help of Community Medicine, with the help of Administrative Medicine, the necessary improvement will come in the utilization of physicians' time, which nobody really has studied yet, and which is a great obligation for the Medical School to do. We will at the same time probably, hopefully, reduce the cost. I know it's utopian, but there are studies going on all over the country, and Sinai is joining them, and I think this is a major obligation, not only to improve Sinai's response to the general need which you have mentioned, but also to reduce the cost of medical care.

And to me this is the only answer, Mr. Levy, to your question. Anything else is utopian - impossible - but this is possible. We know that there are countries in this world in which medical care is just as good as here, and the costs relatively much lower, like Scandinavian countries. It doesn't mean that we will accept their system, but it means that we can learn from them something.

Pomrinse: Sweden has the highest rate of hospital cost inflation in the world.

Popper: It still is cheaper, much cheaper than here.

Pomrinse: Their wage rates are low, and so on.

Gutman: I would like to say something about your question: What is the Medical School contributing to patient care?

Gutman: Well, what we had added in constructing the Medical School is not the clinical; we had those all the time. We added on the first two years of basic scientists.

Now, it is not the objective of basic scientists to treat patients, and you mustn't expect them to do this. Indirectly, they do help, but what they are doing is turning out more physicians. Now, unless you have physicians, you will have no medical care whatsoever. So the answer to your question is that the Medical School is training more physicians in a country that needs more physicians, and this is our contribution.

Levy: Well, furthermore, I'm blessed with a good memory, and the principal reason that I was sold a bill of goods on being chairman of a committee to investigate a medical school and come up with the answer that we ought to have one, was that I was convinced by Dr. Popper, and you, Al, and Dr. Wolf, and the other associates here, that in order to maintain the quality of physicians in the institution, we needed the interplay of a medical school, so that we would attract the same kind of physicians today that we used to ten years ago. And I think that is still the most valid reason, at least from my end of the thing, as well as the training of additional physicians, which, as you say, are sorely needed.

James: I think Dr. Gutman was trying to come up with a very simple answer, and I don't think it's quite that simple. There are two immediate spillovers into patient care that come to my mind immediately; one is a relatively minor one, and one is a very major one.

The minor one is the use of the turkey diet in the treatment of psoriasis. Now, it's a nasty disease when people have it. I'm sure the research could have been done - and much of it was done - when we were a hospital and not a medical school. But the stimulation of research that can be plowed back into patient care has been stepped up. Now that we have a medical school, we can expect more of it.

The major one, of course - one in which we made a major contribution - was the large-scale proof that followed the small-scale proof that Dr. Cotzias did that L-DOPA is truly effective in the treatment of Parkinsonism. Here's a disease - an extremely crippling disease, a degenerative disease - which in

James: previous days was extremely difficult to treat, extremely costly to society, a terrible problem to have in your own household. And here, with a new drug and a major therapeutic trial, we were able to help literally hundreds of patients with this disease.

Pomrinse: We were one of several centers that were doing this.

James: Yes. I mean, I won't say we were the only one, but we quantitatively proved in large numbers what had already been demonstrated by one of our colleagues.

Wolf: Because you have a medical school? The L-DOPA program was essentially a clinical program.

James: It was a clinical program, but the fact of having a medical school intensified the research effort. Much research effort went on when we had a hospital, and much good research was done when we had a hospital.

Gutman: L-DOPA was developed at Brookhaven, which is not a hospital, by basic scientists.

Wolf: I think we have to admit what Mr. Levy said. In fact, I think this is the first time it's been put on the table so bluntly. We would have been kind of sad, actually, if we didn't have the medical school.

Popper: I'd like to add one more point to that.

Wolf: I think Dr. Popper and Dr. Pomrinse were right. It's hard to make this good reading, to say that without the Medical School this would have been a pretty pedestrian hospital and community hospital - excuse the expression - by this time. I don't think there's any doubt that what has been achieved since the start of the Medical School is because we have the Medical School.

James: Well, I hear this in relation to the point that Mr. Reubens made, that Mount Sinai has remained great because it has remained flexible and adapted to the challenges of the era. The challenge of the 1960's was to have a medical school if you wanted to maintain your quality of research and patient care.

Wolf: We have maintained it, and done somewhat better. It must be compared to what might have happened to us.

James: Right, and for the late 1960's, and moving into the 1970's, priorities look like they are going to be in

James: the area of community medicine, genetics, cancer research, maybe hypertension control, maybe alcoholism, and drug addiction. So Mount Sinai is active in each of these.

Popper: I want to add a point which has not been stressed as yet.

I'm not quite sure, but I believe strongly, that only teamwork - multidisciplinary teamwork - [unintelligible] and this is what has to be done for the future. Whether it's alcoholism, whether it's drug addiction - whatever it is, we are speaking about a multidisciplinary team. The reality of the situation is that the Hospital individual department would never have had the teams which we have now. I believe one of the strongest contributions of the Medical School to the community is the creation of the teams which deal with methadone, with alcohol, which hasn't been stressed yet, where we are moving in rather rapidly, as well as any of the areas which Dr. Deuschle has made reference to.

Deuschle: And the child health activities.

Popper: The enthusiasm and motivation would not have existed without the Medical School. It means we meet the challenge better with the School than with the Hospital.

Deuschle: Dr. James, there was a spectacular success that Mount Sinai can take credit for with the Medical School, and that's Dr. Selikoff's work with asbestosis, in which the basic research, the clinical research, and the epidemiologic research has resulted in information that has allowed us to begin to control the problem of asbestosis.

Popper: And again, what is it?

Deuschle: Right, it's a multidisciplinary --

Popper: Multidisciplinary.

James: It think on a purely social realm, it's also of interest that it's the first time that a research program has been supported equally by a labor union and its industry. The labor union and the industry might meet over the bargaining table and fight bitterly over salaries and wages and fringe benefits, but each group

James: is contributing equally to the support of Dr. Selikoff's research. I think the laborers are donating a penny a day from their wages, as part of the union dues, and the industry is making a like contribution.

Gutman: We ought to get one word on the record, and that's air pollution. This is what Dr. Selikoff is working on. So again the activities of the School are relevant to the social problems of the day.

Pomrinse: Before we quit, there's one other area that hasn't been mentioned in which we have also been aware of need and filled it in the last ten years, and this is the affiliation program with Elmhurst. We have the largest contract of the sixteen contracts - I mean, affiliates of the City - to staff the Corporation, under the New York City Health and Hospitals Corporation, from the School. And the Corporation headquarters, whenever they have a distinguished visitor that they want to take to a showplace, always take them to Elmhurst. It's recognized as easily the best of the group.

During the past summer we spent an enormous amount of time negotiating a new contract format, in which we were able to be responsive to the Corporation's need to increase accountability to the public, at the same time assuring that we would maintain professional control of activities at Elmhurst.

Levy: Well, I think, before we wind it up, talking again about the affiliation program, our affiliation program with Beth Israel and Joint Disease is working equally well. With Joint Diseases we're entering into a venture with them in which we have made an application to the State under Section 28(b) to build a 780-bed facility, of which 500 would be additional beds at Mount Sinai and 280 would be orthopedic beds to be operated jointly by Mount Sinai and the Hospital for Joint Diseases under a dual-chief program.

We have met with the Southern District - what do they call it, Dave?

Pomrinse: The Southern New York Regional Health and Hospital Review and Planning Council. It's the longest name in Christendom.

Levy: And we expect that they will approve it, and subject to State approval we hope to begin building under that program some time next year.

Levy: This will do two things: (1) it will ensure a joint, first-class orthopedic service; and it will additionally give our voluntary staff, which is the largest voluntary staff of any of the voluntary hospitals in the metropolitan area, more beds to bring their patients, so that they won't have to distribute them among twenty or thirty profit hospitals and other types of institutions around the city.

We're very pleased, and we are hopeful that this project will be underway next year.

James: Very good.

Well, thank you very much, Mr. Levy and gentlemen. I think that all of us realize that there are thirty department chairmen and active people on our Administrative Council and personnel and public relations and development and finance who will be heard from, and whose reports will appear in other sections of our Annual Report. We know that each of them has contributed greatly to the activities of Mount Sinai.

I think, in summary, the point we have been trying to emphasize is that this has been a great institution for 120 years because it's been flexible, because it's had fine leadership in its Trustees and medical staff, and the medical staff run the gamut from the department chairmen to the practicing physicians, and all of the technical help and nursing help and people working with patients and working with research and education, community service, and all of our fine volunteers and Trustees, and we intend fully to remain equally relevant to problems as they come in the future.

We know that times are difficult, and money is scarce, but we haven't sacrificed quality in 120 years, and we intend to do our best to maintain this high standard in the future. Thank you very much.

[The meeting adjourned at nine twenty-five o'clock.]