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Medical Education Symposium-(Centerfold)

CHIASMA

VOL I, NO. 2 | Boston University School of Medicine | March 1970

Stone Declines B.U.S.M. Deanship

by Mike Siroky

On January 9th the Committee which had selected Dr. Daniel Stone to succeed Franklin G. Ebaugh as Medical School Dean met with approximately 35 students in Bldg. A., to explain the circumstances surrounding Dr. Stone's decision to decline the offer. Dr. Lewis Rohrbaugh, Chairman of the committee, said that, although Dr. Stone had expressed a number of concerns to the Search Committee, his letter of withdrawal came as a surprise to him.

Dr. Stone had met with the committee on December 4th to discuss these matters. At that time he expressed his concern that he receive a Professorship in Medicine with tenure. Other points were also brought up by Dr. Stone, such as the lack of real estate agents to help locate property in the Boston area, the question of licensure in Massachusetts, and the question of fringe benefits. Dr. Rohrbaugh stated that these points were settled at that meeting, apparently to everyone's sarisfaction. However, on Dec. 16, Mr. Everett Walters (from the main campus) received a letter from Dr. Stone stating that he would not be able to join us in Boston because Mr. Walters had a different conception of the dean's job than did the Search Committee.

Mr. Walters commented; "Dr. Stone thoroughly understood the lines of authority between the medical school, the medical center and the university. It was a shock when we received the letter from Dr. Stone." Dr. Stanley Robbins, another committee member, stated that a number of small irritants added up to an undesirable situation.

The students, however, were quite skeptical of this explanation. Many felt it was highly inconsistent for a man who had been selected after careful searching as the best candidate for the B.U.S.M. deanship to accept and then suddenly decline the post for ostensibly petty reasons. More likely the politics of personal power played a primary part, some thought.

Furthermore, many felt the fault lay not with Dr. Stone, but with the medical center power structure which grants very little influence to the office of dean.

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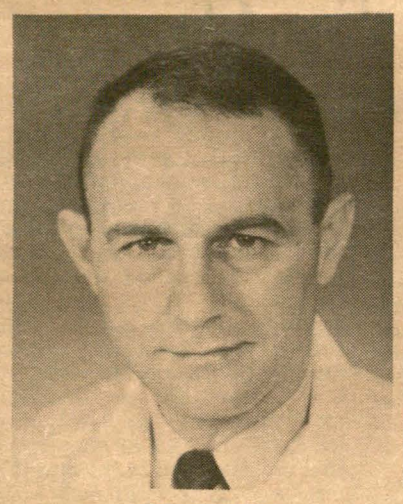
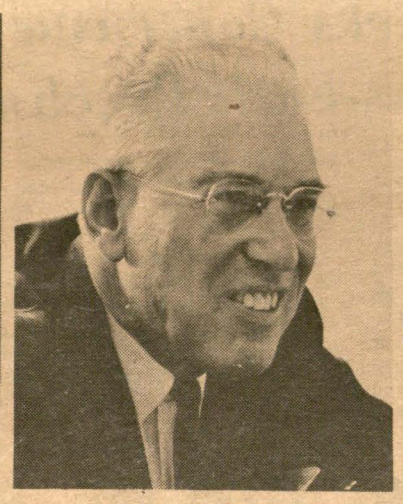
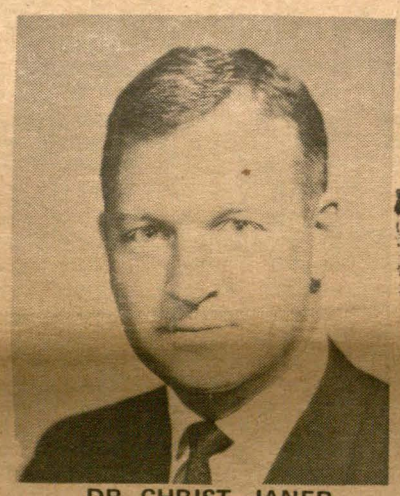


DR. STONE



DR. BANDLER



DR. CHRIST–JANER

MISS CHADWICK

IN...

DR. BAKST

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DEAN OF STUDENT AFFAIRS

Review Issues In Med Education At Student-Sponsored Symposium

by Russell Jaffee

The 2nd National Student Conferences on Medical Education sponsored by the Milbank and Sears Foundations, was held in Chicago February 5-8, 1970. The conference was entirely student planned and used the SAMA national office for coordination. Registration fees paid for a personalized notebook containing background information on three of the 17 topics discussed at the meeting, meeting areas, and a luncheon session.

The meeting opened with a social hour and wine tasting Thursday evening. Friday morning a live simulation of teaching experiences opened the formal program. Dr. Dan Funkenstein discussed "The Changing Medical Student"; and Dr. John Caughey discussed "Community Medicine and Medical Students" in the morning session. Friday afternoon and evening were entirely devoted to small group sessions with a student chairman and professional expert as "resource person". In a pre-conferrence questionaire, students indicated three areas of interest and were assigned to small groups on the basis of their preferences. Saturday morning was to be devoted to one-to-one discussions between teachers and students, but the issue of drug company support for the resource center was raised Friday morning and discussion of this topic ran into Saturday · morning. Saturday lunch included ån address by Dr. John Knowles on "The Rationalization of Health Care". (see page 10) Later in the afternoon the Student Health Organization, the Young Lords, and Young Patriots addressed the group on community health clinics. Later Saturday the small group reports were made.

A Resource Center was developed as an adjunct to the conference in order to provide data, material, and information on medical education. As an experiment the Resource Center was financially independent of the rest of the conference, i.e. it would exist only if it got its own money. Support came from a small group of pharmaceutical houses: Roche, Merck, Sharp & Dohme, Smith, Kline & French, Wyeth, and Squibb-Beech Nut. The Resource Center, in principle, was to present new approaches to medical education and to make published material on medical education available to participants. Delegates interested in particular areas could explore, study and be able to gain insight into these issues and thus be able to return to their schools able to constructively and actively improve their medical education environments. Many schools made changes attributable to information picked up at last year's med ed meeting.

The Resource Center was an untried idea and demanded use of the materials as well as involvement by the student delegates in order to make the Resource Center a meaningful contribution to the total conference experience. It was an active experiment initiated by students. Materials were available - it was up to the individual students to determine what was important and valuable to him.

The participants in the Resource Center - drug companies and Universities, by by and large-operated under certain restrictions. No commerical exhibits were allowed; only actual educational material and aids were to be displayed. No samples could be given out, nor was advertising of products permitted. This was the first time such restrictions were made upon a major meeting. Some drug companies could not understand this philosophy and did not choose to involve themselves.

It should be asked that the bulk of new approaches in medical education, especially

CONTINUED ON PAGE 3

Bakst Dean; New Position Is Announced

by Eric Honig

With the resignation of Dr. Daniel Stone from the deanship of the School of Medicine, the whole apparatus of selection of a new Dean has been put back into operation. At the same time, a number of other major posts throughout the school and university have become vacant, a number of familiar faces are departing, and a few gaps in the personnel roster have been filled.

Among the major outs are the following:

– Arland Christ-Janer, president of Boston University, who resigned his post after barely three years in office the last two marked by stormy relations with the undergraduate student body. Dr. Christ-Janer's resignation, effective July 1, is to enable him to assume the presidency of the College Entrance Examination Board. While the selection of his successor is primarily the concern of the B.U. Board of Trustees, student participation on the selection committee has been arranged. SCOMSA has declined participation in the process and BUSM will be represented by administrative personnel.

– Dr. Bernard Bandler, chairman of the Division of Psychiatry, who is retiring after a number of years in the post. Consideration of a successor has been actively underway for some months by a Psychiatry Search Committee which includes both student and faculty representatives. No definite decisions have as yet been reached by the group.

– Miss Edith Chadwick, officially the Recorder at BUSM and unofficially the den mother to a generation of BUSM students is retiring to Atlanta, Georgia.

– Dr. Daniel Stone, almost dean of BUSM, who, for reasons oultined elsewhere in this issue, chose to remain at the University of Iowa Medical School. Dr. Henry Bakst (see below) has assumed the deanship for what has been understood to be a limited time and the search apparatus has been reactivated. Some competition may be expected in this area as Harvard Medical School Dean Robert Ebert is reported to be leaving his post in the near future.

Among the ins are the following:

– Dr. Henry J. Bakst, Dean of BUSM, elevated to the post after the "Stone affair". Dr. Bakst, a thirty year veteran of the BUSM scene, has stated that he will remain in his post until June, 1971, by which time, hopefully, a new man will have been selected and groomed for the job.

– Dean of Student Affairs, a new position, has been created. Dr. Lester Dewis, who currently acts in this capacity, will devote more time to admissions. No announcements have been made as yet with respect to a definite choice to fill the new position.

CHIAMSA gratefully acknowledges the generous financial support of the BUSM Alumni Association, Boston University School of Medicine, and BUSM chapter of the Phi D.E. Medical Fraternity.

CHIASMA
70 E. Concord St.
Boston, Mass. 02118

Student-Faculty Committee: Progress Report

by Paul Kaywin

The Student-Faculty Committee, is a vehicle for communication between the four classes (through their elected representatives) and members of the faculty. Chaired by Dr. Dewis, it meets regularly once a month, but there is a considerable amount of flexibility in scheduling more frequent meetings.

The committee is relatively new, organized last year, and is in the process of defining its own role within the medical school. No specific functions have been relegated to it, so the door is open as far as areas which can be considered and goals to be achieved.

Some examples will better describe the activities which the committee is getting into. One meeting was held with the entire second year class in an open session, for the purpose of getting their complaints and impressions aired. Although the turn-out was less than desirable and the meeting rather short, the intent was there. A more effective meeting is being planned with the first year class, in coordination with the evaluations of the Student Symposium (centerfold), in an attempt to solve some of the problems of the first year.

The committee is planning to use the Symposium recommendations as a source from which topics of discussion can be selected.

The purpose is to get feedback from each of the classes. The emphasis of these discussions is on courses of action rather than theoretical palaver. The committee can then come up with realistic recommendations to be used by the Dean and other committees, such as Executive and Curriculum.

Along slighlty different lines, a very encouraging recommendation was brought before the committee in its session on January twenty-sixth by Dean Bakst. He proposed the idea of having one person available on a full-time basis for the sole function of student affairs. Acting as an ombudsman, he would advise individual students in personal matters (such as grades, leaves of absence, and draft problems) as well as deal with complaints and problems of the class as a whole.

The proposal was accepted quite favorably by the committee since it was generally recognized that students' problems ("like disease"., to quote Dean Bakst) do not crop up on a monthly basis, coinciding with committee meetings. The committee formally ratified the proposal which is now in the hands of the administration (specifically the Executive Committee). It is now a matter of finding the person and the money to fill this much needed job. The amount of resistance and red tape which the institution or such a position receives from the school's administrators will indicate their sentiments and willingness to work with and for the students of this medical school.

It is apparent from the recent meetings of the committee that the faculty wants to work with the students. It is of paramount importance that this is sincerely recognized by the students and not simply shrugged off as another feeble attempt. The Student-Faculty Committee is young, flexible, and has the means to better not only the quality of medical education at Boston University, but also the atmosphere in which this education is received. To stimulate and maintain the effectiveness of this committee, it is important that members of all four classes not only use their representatives, but speak directly to the faculty members; the committee is helpless without such communication. The faculty members who are all available for contact are: Dr. Dewis, Dr. Robbins, Dr. Williams, Dr. McNary, Dr. Kayne, Dr. Freed, Dr. Skinner, Dr. French, Dr. Lanzoni, Dean Bakst.

The student members are: Allar. Converse IV, Armen Kasparian IV, Michael Mullarkey IV, Sanford Kurtz III, Neal Sher III, Charles Welch II, Martin Keller II, Robert Meenan II, Henry White I, Paul Kaywin I.

EDS: The Student-Faculty Committee and the Curriculum Committee are the two formal committees of the medical school directly concerned with the problems of medical education. A third committee is in the process of formation (see **ad hoc** *committee below). In addition, members of the first and second year classes have independently evaluated the preclinical experience. Their preliminary report appears in the center fold.*

Curriculum Committee Seeks Consensus For Change: Plans Evaluation Of Pass-Fail, Preclinical Courses

by Robyn Karlstadt

The Curriculum Committee is a standing committee of the medical school. According to the by-laws, this committee has 3 major functions which are as follows;

1) To consider subject matters and correlation of the curriculum.

2) To set up subcommittees or ad-hoc committees to periodically evaluate the curriculum.

3) To make recommendations for changes to the executive committee which will present them to the faculty for approval.

The actual mechanics of the committee are not so limited. Dr. Lanzoni, who is ex-officio chairman, believes in a philosophy of unanimous consensus for the adoption of ideas. When ideas are presented to the committee, the members will discuss them considering pros and cons, until a blending of ideas is reached that is acceptable to all. The process or arriving at a decision is a slow one because of the desire to reach a compromise on the medical school issues. For this reason, few immediate or urgent decisions are reached.

This year, for the first time, student representatives are participating on this committee. Interested students submitted their names at an organizational meeting last May and were chosen by SCOMSA. The first year representative was elected by the class in December. The student representatives participated on the committee as full-time members. They aid in gathering information for various issues that are discussed at the monthly meetings, as well as now being voting members.

The committee has been successful in attaining some major achievements this past year. In previous years, a thesis by the fourth year students was required for graduating. The fourth year was seen as the culmination of an integrated program which would be summed up by a thesis in the area of interest to the student. The present fourth year class drew up a petition last year against this system. Scomsa supported the idea of making the thesis optional and, although the curriculum committee approved it, the executive committee vetoed it. Once students were put on the executive committee, the request was passed.

The curriculum committee has also supported the idea that each department have its own 'curriculum committee.' This new program entails each basic science course investigating its effectiveness during the term of the course. The faculty meets at various intervals of the course with the students to dicuss the lectures, labs, exams, grading system and anything else which warrants attention. Short-range improvements are made as well as far-reaching changes for the future. The aim of these "mini-curriculum committees" is to improve students-faculty relations as well as the quality of the course. Up to this point, neuroscience, physiology, and pathology have followed this program. Biochemistry has held a meeting with student representatives from the 1st year class at the end of the course.

The committee is currently investigating the pass-fail system. This investigation has been going on for a long time. Members of the committee are getting data from hospitals and other schools. The first two years of medical school are highly dependent on grades at this point. The faculty members feel that grading alone is not the biggest issue and much more research needs to be done before a decision can be reached. This is too important a change to be made immediately.

The committee is also investigating the electives. The desire here is to get student comment on all of them. Students or faculty with constructive ideas on these topics, or others concerning curriculum should present their idea to Dr. Lanzoni who is willing to set up individual appointments to discuss new issues. This committee can work best with student-faculty cooperation.

AD HOC COMMITTEE

An ad-hoc committee has been appointed by the dean to do two things:

1. Review the policy of BUSM regarding the basis for recommending to the faculty the awarding of the M.D. degree with honors. The feeling is that the present policy, which dates from 1951, should be revised.
2. Review and recommend a sound basis for student evaluation and grading.

People with ideas on these topics should contact the committee members listed below or Deans Bakst and Lanzoni.

The members are: Dr. Murray Freed, Chairman; Dr. Paul Kaufman, Dr. Herbert Kayne, Dr. Edward Pelikan, and Brian Murray, BUSM IV.

CHIASMA

CHIASMA is the official student-operated newspaper of Boston University School of Medicine conceived to facilitate communication between students, faculty, alumni, and administration. Contributions from members of the medical community are welcome, but must be signed. Articles should be submitted in double-spaced, typewritten form.

Current Staff: Tom Feeley, Harvey Gross, Judy Hogg, Eric Honig, Russ Jaffee, Robyn Karlstadt, Steve Marlowe, Gretchen Silverman, Harvey Silverman, Mike Siroky, Nancy Sprince.

Editorial positions for the coming academic year are open to interested medical and graduate students, faculty, and alumni. Since our budget is limited and we accept no advertising, monetary contributions of any size will be appreciated. This publication cannot continue without your literary and/or financial contributions.

Address all Correspondence to:

CHIASMA
Box 390
BUSM, 70 East Concord Street
Boston, Massachusetts, -02118.

Student Medics Cover Events: The Boston Garden Tradition

by Carl J. Heitz, Jr.

Boston University School of Medicine, like most institutions of higher education in this country, has a number of longstanding traditions. Included among these traditions are such events as the annual Toy Dance and Class Day for graduating seniors. in recent years, however, another tradition has come upon the scene - that of "manning the first-aid station" during events

This year, as in years past, six seniors have shared the duties. What exactly is meant by "manning the first-aid station" is variable, but in essence it means being available to evaluate any medical problems that may arise during a Garden event. Thus far this year "problems" have ranged from major to minor - from an acute myocardial infraction to a mildly sprained ankle. An almost infinite variety of things may come up, and it is the job of the medical student on duty to assess the situation and send any major problems to the Mass. General (where else?!) for definitive care. It's an interesting experience from the standpoint of medical education - after all, it's not every day that one sees something like a man who has been kicked in the head by a horse. Common problems such as headaches, fainting spells, sprains, or "stomach-aches" are in reality, however, the order of the day.

From what has been said thus far, one could get the impression that the first-aid station at the Garden is much like the emergency room of a busy community hospital. On the contrary, the scene is hardly hectic, and it is a rare day when one has to see more than three people during any event. Herein lies the beauty of this BUSM tradition - while being a job which is interesting and pays fairly well, it affords ample time to enjoy whatever event may be going on at that time. This is especially attractive to avid Bruins' or Celtics' fans, since the man covering their games has a "ring-side" seat close to the action (and, in Bruins' games particularly, this can be quite a bit of action!). Since guests can be taken free of charge to most events, a further advantage is present for the married man or the single "mover" with a tight bank account. Professional wrestling, boxing matches, Roller Derby, track meets, the Ice Follies, and schoolboy sports are also on the card, so there is ample variety for the true sports' enthusiast. Putting it all together, the situation is in many ways ideal for the harried medical student, since he can earn money, learn, relax, and follow his favorite teams all at the same time.

For the sake of being complete, mention needs to be made of the fact that the job has its humorous moments. Recently during a hockey game the man on duty was asked to see a lady who had fainted. Upon entering the room, he was confronted by a rather buxom and hippy woman in her thirties with bleached blond hair, heavy eye make-up, and bright red lipstick. After questioning her, he was satisfied that this was a simple syncopal episode, but inquired as to whether she had been recently evaluated by a private physician.

"Oh no," she said, "I haven't been examined by a doctor for at least five years."

"You mean you haven't seen a doctor AT ALL for five years?" the student asked.

"Not exactly," she replied, "I see a doctor twice a year for my Hinton!"

Amen.

Eds.: Interested 3rd Year Students Contact Fred Kantrowitz BUSM IV

To Choose 100 Freshmen; The Admissions Process

by Carl Ingber

The Admissions Committee has the particularly difficult task of choosing the 100 best qualified students from among 2400 applicants to fill 60-70 seats. This task is made even more difficult when one realizes that hundreds of well-qualified applicants must be refused admission.

At BUSM, a committee composed of five faculty members (Drs. Chobanian, Friedman, Heimann, Jackson, and Schwartz), two students (Carl Ingber, BUSM II and Mike Siroky, BUSM IV) and Dean Dewis have met weekly since October in an attempt to select the best candidates for admission.

The procedure by which an applicant gains acceptance is as follows: after an initial screening (which primarily focuses on college grades, medical college admission test scores and personal evaluations), an interview is scheduled with one of the members of the committee. The student members may also participate in this process by giving supplementary interviews to candidates who have had, or will have, faculty interviews. The interviewer then relays his impressions to the committee where a decision is made to accept, reject, re-interview or review at a later date. This decision is based on a number of factors not least of which are the interviewers personal evaluation and the student's letters of recommendation.

The reliance on MCAT's and GPA's varies with each student as the committee tries to balance each candidate's strong and weak qualifications. Although remarkable achievements on MCAT's and GPA's merit attention, many students have been accepted with low scores while others have been turned down with high scores.

Minority Admissions has recently been discussed by SCOMSA and the Admissions Committee. The latter has agreed to follow a faculty resolution and accept a "significant number of underpriveleged students," each year. The committee ranks those applicants from underrepresented groups and accepts students in order, until a significant number have been selected.

The committee recognized the need to interview each student and will expand next year by adding two new members. Hopefully, more students will be interviewed while at the same time easing the load of each committee member.

In addition, the student role in admissions might also be expanded. The plan calls for four more students, in addition to the two presently on the committee, to serve as "associates" to the committee. Their primary function would be to organize and implement a schedule of tours of the medical center. A similar program was carried out last year by BUSM and was very successful.

ISSUES IN MEDICAL EDUCATION

First Year In Need Of Improvement: Phenomenological Approach To BUSM-I

by Ralph Rosenberg

There is no question in my mind that there have been significant improvements made in the quality of the first year education at BUSM in the past few years. I can also say with a great deal of confidence that many of the students in my class, myself included, found the first year to be somewhat less exciting, interesting, and rewarding than they had hoped it would be. I think it is not rash to say that we could have learned more, better, and less painfully had some things been different. On the basis of these observations, and because I have confidence in the teachers and students who make up the educational process, after completing the first year I think I can say that there will be further significant improvements to come.

What Are a Few of the Problems?

Implicit in any statement that there is something "wrong" with the first year are some assumptions as to what would be "right". These assumptions have to do with the goals of medical education as a whole, and the goals of the first year in specific. Even deeper, however, they involve the whole rationale behind modern medicine. These are some of the assumptions:

1. Knowledge of basic human biology and understanding of the methods for acquiring this knowledge is important for physicians, and these subjects deserve a considerable fraction of the medical school time.

2. Teaching may be rewarding or unrewarding as learning may be rewarding or unrewarding, depending on why, what, who, when and how.

3. Evaluation of the progress of the individual is necessary, and this is usually best accomplished by relatively formal written or oral examinations.

4. Medical education is a highly complex interaction involving a great many individuals, each of whom has a unique set of interests, abilities, deficiencies and desires.

5. Almost all of these individuals are sincerely interested in helping each other.

These assumptions have all been questioned and all of them merit attention and evaluation. They, and others, are the foundation upon which is built the structure of a medical school. They are the roots of the tree, and therefore, probably the most influential factors. Unfortunately, they are also the least discussed. My purpose at this point is not, however, to discuss them, valuable as that endeavor might be, but to try to show how some of the issues which are more out in the open may be related to these basic assumptions, and what some of the problems are that have arisen.

1. It is often the criticism of students in the first year, and of physicians in practice, that much of the material taught in the first year is of dubious value to the practicing physician. Whether or not this is so is of great importance. Since many of the students are concerned primarily with becoming practicing physicians, their attitudes towards these subjects may become, let us say, somewhat cynical. If a faculty member senses this lack of enthusiasm on the part of some of the students and interprets it as a symptom of a predisposition against the subject matter of basic human biology, in other words lack of interest, then he may (somewhat justifiably) adopt a similarly disinterested and/or cynical attitude towards his students. If this occurs often enough, in time what could have been an exciting exchange of thought and information may become a meaningless contest between students and teachers; the students trying to "get away with" as little work as possible and the faculty trying to "force" information into unreceptive minds. Obviously the quality of learning and of teaching must suffer. Neither "side" can win. The information that actually is conveyed will tend to be of a static, easily presented, easily memorized, easily tested, dull, and more or less useless form. The vicious cycle is reinforced.

2. There are a great many practical considerations which enter into the process of medical education. Faculty do not generally receive either grants or professional recognition on the basis of teaching. Similarly, medical success is probably not a direct function of facility with the basic sciences. How, then, can we make the first year rewarding for both students and faculty, without increasing the work load of either? In this light, we should concentrate along the lines of what could be taught/learned *differently*, rather than what could be taught/learned more or less. Remember that I have assumed that this part of our education is indeed worth while, and thus should not have less time devoted to it. (Just for the record, I might add that I strongly believe this to be true.)

3. The issue of evaluation has very profound significance in many areas. It is responsible for much anxiety, tension, and disgust. It is also, much as I hate to admit it, responsible for much learning. It is a vehicle for the faculty to receive feedback so that they may improve their teaching, as well as a useful guide for the student. It also may be of some importance in deciding such things as internship appointments, and is a means by which society can get some assurance that the "M.D." is not a meaningless symbol. Nevertheless, the bad features may often outweigh the good. I am convinced that fairly strict evaluation of students, and perhaps of teachers, too, can be a good thing, but I am equally convinced that most of the present methods aimed at these worthwhile goals are either attempting to evaluate the wrong things, or that the methods employed in the evaluation process are unsatisfactory. For a quick example, occasional numerically graded multiple choice tests may measure the ability to cram, rather than a more realistic index of accomplishment day by day. Also they tend to foster an uncritical attitude towards the material which is based on the "learn the notes" reaction instead of encouraging students' curiosity.

4. Diversity has advantages and disadvantages in the context of a medical school. It is the business of the medical school organization to take maximal advantage of an individual's capacities without either unfair restrictions on his time, or allowing his performance to fall below a certain baseline in any area. This applies, of course, to the faculty as well as to the students. Specialization should not produce narrow-mindedness. Neither should diversification inhibit productivity or usefulness. Freedom in choosing how one would like to spend one's time at school is freedom to maximize what one can accomplish.

5. Finally, here is the problem of what to do with all of the wasted good will that really exists in the community of a medical school. Basically, the students really do want to learn, and the teachers really do want to teach. Not only that, but the teachers want to learn and the students can often teach! Why doesn't all this come to the surface where it can be useful? Why, in spite of some efforts to encourage greater interaction, is there still a barrier that separates "students" and "teachers"?

What Can We As Students Do Now?

If you don't like a certain lab, course, lecture, exam, assignment, or anything, tell the teacher. Don't just trade complaints with your buddy. Try to figure out how to do it better, then discuss it. Get some information from other sources. Get some ideas on paper. Try asking a teacher if he would like to spend a half hour or so talking about some of them. Find out what he thinks. I have done this quite a few times and have never yet gotten anything but an enthusiastically positive response. I have never yet been disappointed with the results.

What Can the Faculty Do?

Make a special effort to contact the students. Invite them to your office every week or two to talk about the course, or anything else for that matter. Encourage students to assume a greater responsibility for their own educational progress by expansion of weekly elective time and greater freedom in choosing courses. De-emphasize grades and rote memory in favor of individual participation in problem-oriented small group discussions.

MED.-ED CONFERENCE

CONTINUED FROM PAGE 1

audio-visual aids, are being produced by or paid for by drug houses. The remainder of the educational developments are often done on shoe string budgets, and could not afford the cost of making themselves available at such meetings.

The Resource Center contained a cardiology teaching unit. (Merck), vidio-tapes and film cartridges in topics in medicine (Roche), programmed instruction devices (Wyeth), discussions in Medical Ethics (S.K. & F.), Computer Assisted Instruction: Problem Solving Approach (U. of Illinois); Computer Grading (Marquette U.), Core Library and MEDLARS (NLM), and a library of books and articles available for copying by individual delegates.

At the closing session on Sunday, the conferees were invited to participate in the upcoming A.M.A. Congress on Medical Education.

A SYMPOSIUM ON THE DRUG INDUSTRY

Brand Names vs. Generics
Drug Advertising and the Doctor

Speakers:
Dr. Edward Pelikan, Dept. of Pharmacology
Dr. Richard Pillard, Dept. of Psychiatry — Psychopharmacology Lab.
Dr. Robert Quinnell, Pharmaceutical Manufacturer's Ass'n.
Dr. Robert McCleery, Former Acting Director, Division of Drug Advertising, FDA. Now with Center for Study of Responsive Law (Ralph Nader's Group).
Dr. David French, Moderator

DATE: Wednesday, March 25
TIME: 10:45 A.M. — 1:00 P.M.
PLACE: Rm. 112 — Instructional Building

ALL INVITED

Facing The Problems Of Evaluation

by Brian Murray

A recent article in the Journal of Medical Education (44: 1076) reported the results of a poll of medical school deans and SAMA chapter presidents concerning attitudes toward grading. It noted that the majority of the deans and students responding preferred a "pass-fail" grading system regardless of the current system in use at their schools. Pass-fail grading in medical schools is now a major issue. Indeed, I feel certain that it is only a matter of time before such a system might be instituted here at BUSM.

Unfortunately, that solves very little. Indeed it may make the total assessment procedures even less meaningful than they have been in the past. Grades are just the end results of the more basic process of "evaluation". Interested parties should pay more attention to reform and revision of "evaluation" and less attention to the secondary issue of grades.

This kind of work is going forward at BUSM, in several places in several ways – albeit slowly. I would like to talk about my experiences in one such place and the subject of evaluation in general.

When one is teaching a basic science or a clinical science, it is not too difficult to reliably assess students' knowledge of a circumscribed body of information. Indeed, the science of constructing multiple choice examinations has become almost an art in some corners of BUSM A much more difficult and probably more important, yet less often talked about, task is that of the evaluation and assessment of students' clinical activities and the various departments' clinical programs. A comprehensive discussion of the clinical evaluation process in general, and at BUSM in particular, may be found in my senior "thesis". Another place to which I would refer the interested reader is to the book written by George Miller, the head of the Center for the Study of Medical Education at Illinois, entitled *Teaching and Learning in Medical School.* This work is probably the most outstanding general work in the field of medical education.

The best introduction to the consideration of evaluation that I have read appeared in the book by Miller, as follows:

> **Evaluation is a two part process. The firs. part is the determination of what is of value or, in simpler terms, the identification of the objectives or goals toward which the educational process is aimed. The second part of evaluation is the judgement of whether these goals are being achieved, or, more realistically, the extent to which they are being met ... Evaluation of medical education must begin with a clear, concise, meaningful definition of its objectives. A medical faculty cannot begin to judge the progress of its students or the efficacy of its educational program until it decides what the students should be striving for. Debating the relative worth of objectives and essay examinations is meaningless until the objectives of the program have been established.**
>
> **... After the institutional objectives of medical education have been defined, an equally difficult task remains: development of the criteria in terms of which the medical educator judges how well the objectives have been realized. When this step in evaluation is properly executed the selection or development of appropriate instruments is greatly simplified.**

Thus we can describe evaluation as a three-part process:

1. determining objectives
2. establishing criteria
3. developing assessment procedures

Elaborating the sordid details of the clinical evaluation process as it has existed at BUSM is depressing and unnecessary. Rather than discuss the old system which few people vigorously defend, I'd like to talk about some improvements and innovation now being enacted in a previous bastion of conservatism, the Division of Medicine of BUSM.

One of the results of the class of 1970's refusing to sign its third year final exams was the establishment of a committee in the Division of Medicine to advise the chairman about curriculum and evaluation, two things loudly criticized by the present senior class. The committee is chaired by Dr. Louis Sullivan, with eight or nine other faculty membership.

The initial meeting concerning the assessment of the third-year clinical clerks was a big disappointment. The prime concern semed to revolve around how the "grade" should be derived i.e. oral exam, written exam, house staff, visiting physician, which and how much. Little consideration was given to the objective of the third-year clerkship. As Miller has said, the definition of objectives comes before, and indeed leads into the development of assessment tools. The committee wasn't even starting with dicussion of the tools, but rather with the grade – the oversimplified method of communicating the results of evaluation.

It appears that in the chairman's original directive to the committee there is a statement of the general objectives of the Division of Medicine with respect to its medical students. These objectives are in line with the larger goals outlined by many departments and medical schools. Roughly paraphrased, the objectives are the development of professional or clinical competence. While lacking specific definition, these goals could serve as an easy starting point for any committee charged with improving the evaluation process.

The idea that the committee's question of oral or written exam could be answered by a consideration of the previously stated objectives has not yet been grasped by many of the committee members. But, it is beginning to be. Specifically, using the microcosm of the oral exam as an example, the committee at its last meeting considered the following.

1. What are the objectives of the oral exam?
2. What criteria can we use to see to what degree these objectives are being met?
3. What are the best tools by which we can reliably measure how a student measures up to these criteria?

The same thought-process can, and will be, applied to the appraisal of the student's three months on the wards.

This is a long, drawn out process and it has not been easy for the committee to arrive at this point. But, slowly, very slowly, progress through the "proper channels" is being made. I think all of us, students, faculty, administration, and alumni, can be proud of that fact. That such badly needed changes were so long in coming is something we all should be ashamed of.

Committee discussions and proposals for a rearrangement of the maze called medical school may not be enough unless the faculty and administration are willing to invest the time and money it will take to accomplish the fast of evaluation properly. Constant self-renewal in Gardner's terms is what this school needs, not paroxysms of change in the Flexner mold. This renewal will have to come from the faculty since they appear to be the only constant element at the school. In days when so many faculty members feel insecure as the research money dries up, student prodding for speedy change can be viewed as threatening. It is the students' job to do that prodding rationally, reasonably, and responsibly, but to do it nevertheless.

CORRESPONDENCE

To The Editor:

I have just received your first issue of the student newspaper, and I would like to commend you most heartily on your new venture.

The graying of hair and expanding of waistline tends to make me an "old grad", and I can look back at many of the problems I encountered as a student at BU. In the short twelve years since my own graduation, I have seen many upheavals in medical education and in the concept of what it takes to be a good physician. I am not sure whether either of us, your generation or mine, has the right answer. We tended to be more docile, more amenable to whatever the Faculty would say and, I think, turned out a relatively more placid generation of physicians. Whether we were better or not only time will tell. I do feel that there is a great need for more interest on the part of physicians in what goes on outside of the clinic and outside of the hospital, and in the world in which we live than has ever been exhibited by physicians in the past.

I commend the entire new student body on their ability to talk both with the Faculty and the Administration of the Medical School in an attempt to change the school. Much needs to be done to increase and reorganize medical education. I think that the boycott of the Class of 1970 of their third year exams, while proving their point, was to a certain degree somewhat immature. The fact was that this was a futile gesture as the entire curriculum, I see, has been changed. While examinations never judged the true worth of an individual, some objective evaluation must be made. I feel that clinical judgment must be made by the instructor, not by any sterile written exam, and that after the first years of clinical sciences grading is of little value. I feel that physicians are judged not only by their ability to absorb factual material, but more so by their ability to use this material and by their ability to deal with individuals as patients and as human beings. This is nothing that can be transmitted across an examination, but can only be tested and learned through constant repetitive exposure.

I feel that there is a need of communication between the present student generation and the generation of the faculty, but at the same time I think it is necessary for the student generation to understand that there is a bilateral generation gap that as much as you feel that we do not understand you, I feel you do not understand us or our needs and our frustrations. I do not want to act like many of my professors whose only comments on change were, "if it was good enough for me it is good enough for you". This is a stodgey dull unimaginative approach, and I am glad to see there is a renaissance of new thinking, of new commitment on the part of the students to the Faculty.

I again commend you most highly on your venture, and offer you my most heartiest solicitations.

Sincerely,
David A. Lee, M.D.
Class 1957
Northridge, California

To The Editor:

Congratulations on the publication of your first issue of *Chiasma!* Enjoyed it tremendously!

Also - congratulations to you for having the initiative and courage to urge changes so desperately needed.

Sincerely yours,
Helen A. Papaivarori '53
Detroit, Michigan

Chiasma
70 E. Concord St.
Boston, Mass. 02118

To the Editors

Your paper is well named. Possibly it is a betrayal of your basic, although subconscious, motivations and a splitting and branching of members of the faculty and also of the student body. Hopefully, there wont be a destruction at any point proximal to, at, or distal to the Chiasma. The unilateral blindness or the hemianopsia won't achieve a thing.

I am very surprised at the present student attitude. Possibly, I was very fortunate in having the finest of classmates. We were highly competitive. The very spice of study was to out-do a class-mate in a quiz or examination. There were the geniuses that no one could out-do. They had the unfair advantage of being extremely intelligent. The thought never dawned on us that we, the less intelligent, should organize and refuse to sign our examination. If any one of us less intelligent ever proposed such a plot, our individual antennae would receive the signal that he was trying to out-do us by such a maneuver or he was hopelessly behind in his studies and would inevitably flunk if he didn't try this maneuver. It would not have worked in the years 1943-1947. We didn't have such a desire to conform, a spirit Geist. Each of us were solely concerned with our own achievement, as humble as it may have been.

The members of the faculty in this era were magnificent and for the most part did a masterful job in presenting their lectures. Their relationships with the students was(sic) a variable thing depending on their degree of gregariousnes.(sic). None of popular with the students, although a gregarious person does become popular. This didn't mean that a less gregarious teacher was considered a lesser type person. My contemporaries know members of our faculty that constantly worked a minimum of a 14 hour day. Such a day's work reduces gregarious proclivities.

Could it be that the present faculty members who support the apparently inordinate student demands are trying to win a popularity contest? If they are, you students are being used.

With regards (sic) to the alledged racial prejudices certain things should be becoming apparent. The first thing is that for every black student that is not allowed to enter BUSM for the lack of meeting minimal standards there are probably just as many whites who don't meet the standards. It is just as logical to say that BUSM is anti-white but even more logical to say that BUSM is anti-human race. This is nonsense. BUSM must maintain standards regardless of race.

Of course the blacks were slaves of whites but just as many whites were slaves of whites and, even more relevant, there are blacks that are slaves of blacks at this time on the continent of Africa.

Incidentally, the vast majority of Americans today are sons of immigrants that weren't in this country at the time of slavery. Even if they were, guilt is not genetically determined. The whole thing is stupid.

Were I a black I would resent special privileges (sic) because this would imply inherent inferiority. But, maybe if I were black I wouldn't or couldn't think such a thought and this is evidence of something.

Sincerely,
Dr. F.X. MacAulay BUSM 1947
Dillon, S.C.

To The Editor:

We in the Mental Health Unit of the Boston University Student Health Service send you our warmest congratulations on the publication of Chiasma. It's terrific!

We thought you would like to know that the students of the six year medical program, while on the undergraduate campus, have a new facility of full psychiactric services available to them.

The Mental Health Unit has provided them with their own psychiatrist, Dr. Bertrand Shaffer, (trained in psychiatry at Boston University) who sees them immediately and for as long as they need to be seen at no charge. These services are supported by the six year program and are being utilized enthusiastically.

Again, our good wishes.

Alan S. Katz, M.D.
Chief Psychiatrist
Mental Health Unit.

To The Editor:

In the first issue of *CHIASMA*, John Dundas, writing on the question of Black Admissions, stated, "I have heard *no one* suggest, directly or indirectly, that minimal medical school admission requirements be made a carte blanche, or that anyone be guaranteed an M.D. when he is admitted."

Mr. Dundas is apparently unaware of demands made of the State University of New York at Buffalo School of Medicine. These demands included:

1. "Open admissions for all 'Third World' (minority group) students from Buffalo and the surrounding area.

2. Formation of a board composed of Third World students, Black physicians, and representatives of the community to 'control all aspects of the Third World students' administrative activity."

3. No dismissal of a Black or Third world student without approval of this special board." (Am. Med. News, 12/8/69). Since Mr. Dundas is now aware of such suggestions, one wonders if he can explain by what perverted logic one might support such morally obscene demands.

In the minutes of the SCOMSA meeting dated January 8, 1970, is the outline of a proposal by Mr. Dundas that suggests that BUSM "establish a minimum quota" for minority group students. He goes on to suggest that "BUSM rank all applicants from such ethnic groups together (excluding *only* those who clearly would be unable to successfully complete the academic course of this medical school), accept the quota, and when some of these decline B.U., accept the next names on the list, etc., until the quota is filled, or the list exhausted."(italics mine)

Presumably, if the medical school is to possibly accept all minority group students except those *clearly* unable to complete the course, minimal medical school admission requirements may indeed be a "carte blanche".

If Mr. Dundas has still heard no one suggest *"directly or indirectly"* (italics mine) that "minimal medical school admission requirements be made a carte blanche", he apparently does not listen to himself, a luxury which, attractive as it is, cannot be afforded when such inconsistent, depraved proposals are being made.

Harvey Silverman
BUSM IV

□□□□□□□□□□□

Pagophagia, the eating of ice has been correlated with iron deficiency anemia. According to a study, of 38 consecutive patients with iron deficiency anemia 23 ingested at least 2 glasses of ice each day. Pagophagia disappeared in 22 of 23 as the iron deficiency anemia was improved.

(Ref: Annals of Int. Med. 69:435, 1968 - Harvey Silverman)

BEGG SOCIETY

On February 25th, members and faculty and their guests attended the Begg Society's annual banquet, held this year at Anthony's Pier 4. After settling down to capon, baked alaska and a generous supply of two carbon fragments, the audience listened to Dr. Vincent Lanzoni, the recipient of this year's Begg Society teaching award.

Dr. Lanzoni addressed the audience on the subject of medical education. Beginning by relating one of Aesop's fables, "Doctor Vince" concluded that multiple etiologies worked against the interests of the medical student and contributed to his plight. Factors such as interdepartmental autonomy, lack of communication and conflicts of interest between various power groups were all important. Likewise, intrastudent interest groups, students and faculty, faculty and administration, administration and the community – all must put individual interests aside and co-exist with one common overall goal (the education and growth of the medical student) in order to avoid conflicts which become immediately detrimental to the student who is attempting to be nurtured within such a delicate pot-pourri. Indeed, it was for focusing the light on this melage of problems with such sensitivity and intelligence as much as for his work in developing the Biology of Disease course per se that Dr. Lanzoni received this year's Begg Society award.

Hot questions from the faculty and students in the audience were then handled adrioitly by Dr. Lanzoni. Issues discussed were the faculty's need for feedback from the students, and the question of students feeling that they might be "marked" by the administration if they spoke out too freely or too often. Whether students should

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Phi D E

Does the fraternity movement still have a signicant place at the graduate level in a medical school? In an era when there is an emphasis on individualism and personal identity does fraternalism have any meaning for us? Perhaps some, and even most, students would answer that fraternities are dying and should be laid to rest.

As a student who strongly believes in a fraternity let me try to respond to some of the questions. When a student first enters medical school he feels confused by the mass of work with which he is confronted. In addition, he is usually new to the city and is unfamiliar with most of his classmates. Thus, the student is seeking direction both academically and socially.

There are often many directions open to the student. He soon becomes familiar with several classmates and established close friendships. Classes are small and such relationships are not difficult to make. He has probably acquired little knowledge of the true workings of a fraternity as an undergrad since he has spent a great deal of his time trying to make good grades. What familiarity he does have with fraternities is a "sour" taste for boisterous party-making. Thus the student tries to work within his own small realm in an attempt to get along. Often he is quite successful.

The fraternity is only one of the ways a student can establish his social and academic contacts. Perhaps it is not the best way, but it offers the student an organized way to find a place at the medical school. If nothing more, the student makes contacts with upper classmen who are more than willing to advise him. Since the frat works in close conjunction with the graduate club, there are many opportunities for close friendships with community physicians. The relevance of this opportunity is not often realized by the student.

The frat offers other valuable programs including interest-free loans and scholarship awards. Socially, the frat has conducted four parties this year. Up to this point the frat has opened the parties to all students while it is attempting to rebuild a strong and coherent group of brothers. Once this goal is established the frat will concentrate on conducting more sophisticated affairs such as dinner and theater parties for the brothers only. However, the frat recognizes its obligation to hold functions for the entire school, since the medical school provides very little social outlet for the student.

One important and informative event which Phi D.E., sponsors is the Aaron Brown Lectureship program which presented, on March 9, Dr. Norman Geschwind, James Jackson Putnam Professor of Neurology at Harvard Medical School. His topic was "A New Frontier in Medicine – The Neurology of Behavior". The frat is able to present events such as the Aaron Brown Lectureship because we are given large allowances from the National Treasury for social and educational events.

Later in March, the frat is planning to sponsor a mixer. If you are interested in helping to plan the programs and are eager to get involved in an established organization, do consider becoming a Phi D.E. Brother.

The fraternity is attempting to grow and build a strong organization. If you have any questions or wish to join contact Harold C. Leeds, Box 262.

– Harold Leeds

Eight members of the first year class have demonstrated the social and physiological significance of Bernoulli's Law. That is, their total energy is not spent under the pressure of medical school, but is sublimated to other areas of kinetic energy. For the past four months they have been participating in the B.U. Intramural Basketball League. Coached by Joe McEvoy, the team has lost only one game and is looking forward to the playoffs in March. The mid-season acquisition of Bernard Cooke added to the team's scoring ability. Together with the fine backcourt play of Rob Sandberg and Frank Miraglia, the team is well-coordinated. The recent knee injury of Paul Kaywin has been compensated by the extra effort of the other players; up front, the rebounding of Tod Hunter, Wade Hamilton and John Gillespie has been one of the team's major assets. Whatever the outcome of this season, the team will be playing for the next three years as a representative of the medical school in the intramural competiton.

– Rob Sandberg and Paul Kaywin

AOA

Alpha Omega Alpha, the National Honorary Medical Fraternity, had its annual winter lecture and dinner on March 3, 1970. Dr. Louis Weinstein, Professor of Medicine at Tufts University School of Medicine was the guest speaker. At the dinner, the new members were inducted. They are: John Daly, Gene Grindlinger, David Hartmann, William Kasdon, Armen Kasparian, Michael Mullarkey, David Poplack, and David Teele.

Within the next month, the present members will meet to elect the first four students from the Class of 1971, who will be inducted in the Spring.

– Robert Vigersky

Medical Center Director Lewis Rohrbaugh

Old Deans, New Deans, Power, And Communication

By Mike Siroky and Steven Marlowe

CHIASMA: As you know, Dr. Rohrbaugh, many people in the Medical Center have been disturbed and confused by the events which led up to Dr. Stone's decision not to accept the office of Dean at this Medical school. Would you discuss the factors which provoked Dr. Stone's decision?

Dr. Rohrbaugh: I wonder whether putting more material into print isn't beating a dead horse because most of the reasons that I know that Dr. Stone decided to withdraw, in a sense, reflect on him. So why stir it up; I mean, why not be affirmative because we've got to get a new dean for a year from this June.

Well, let's see what Mr. Walters and I said and the committee said. He went away from here in August on his last interview where he **was enthusiastic about us** and then a lot of things began to crop up. For instance, he agreed to the salary and everything else. He asked for a salary increase; he was given it. This is over and above the one he had accepted. Then he asked for another one and he was not given that. Mr. Christ-Janer handled these matters. These are really piddly things. He thought that he had been promised - this, I think, was perhaps the most important thing - he thought he had been promised a professorship and tenure - a professorship in medicine and tenure in medicine and Dr. Walters (he was the one involved here) had not promised him these. He called me at one point after he had talked to a lot of people and I said: Well, we don't give tenure to a new arrival and anyway we're hiring you as dean and I told him I was sure, if after he arrived here his credentials were such that he could warrant an appointment as professor, this could probably be done. You see, the way the medical school handles this is by a special **ad hoc** committee (this is referring to professorships). Even for somebody being here awhile, a special **ad hoc** committee is appointed and makes its recommendation after looking thoroughly into the thing. For instance, Dean Ebaugh was not a professor. He was either an associate or an assistant professor. This was because the people in medicine, having nothing to do with his abilities as dean, felt that he didn't walk in tandem with the senior professors in medicine.

Well, I think Dr. Stone was pretty **disturbed** by this matter. For instance, the matter of tenure - well, you can't give anybody tenure coming in as professor. Of course, he was coming in as dean, but even if he were coming in as a professor, he wouldn't be given tenure when he came in - nobody gets that; they have to wait a year or more. So, I think that this was one of his chief concerns. We decided (Mr. Christ-Janer, Mr. Walters and I met) that we ought to have him in here (this was about a Wednesday in early December) and find out what it was that was troubling him. So we did. Mr. Christ-Janer didn't meet with us but Mr. Walters and I met with Dr. Stone and we talked these things out. We wondered, for instance, was he confused about his relationship in the medical center. He said "no, not at all". He understood that he reported to the medical center and we didn't spend very much time on it. But, he asked us then to hear him out and we did on some things, particularly what I have mentioned on tenureship. Then we said: "Well, look, are you really interested in this post, because we offered it, you accepted it and we want you." And he said "Yes, definitely." It was about ten days after that he sent the letter to Dr. Walters saying that he was withdrawing. So, these were some of the problems.

CHIASMA: Some of the students have felt that on the one hand, after searching for over a year, the search committee unanimously, as you mentioned, liked this man and chose him to be dean; on the other hand, it seems that there were many small, petty things on the basis of which he decided not to come here. There seems to be some sort of inconsistency. How can you reconcile this?

Dr. Rohrbaugh: Well, some of the things were very small; the tenure and the appointment as professor of medicine were not, of course, but I wasn't then on the search committee as you know. I would think this would have been thoroughly talked out with the proper University people before, so that they wouldn't have cropped up later. It's too bad, because the search committee sent a great number of letters, saying, "Would you be interested in being considered as dean?". They got a large number of affirmative replies with **curriculae vitae** and so on. Then they had 3 men who came. One of them, his name escapes me for the moment, later became dean at Tulane. The other was the head of the Psychiatry division at Duke. Everybody involved, I think, thought that for all of the needs now, Stone was best suited. He met with a lot of us. He met with me a couple of times; he met with our trustees; he met with students; he met with a lot of people. So it's hard for me - he felt that Mr. Walters had committed him tenure and a professorship and Mr. Walters said (I've seen the correspondence) he didn't and he wrote that he didn't.

CHIASMA: How will some "mess-up", as this was, be prevented in the future? Is the search committee going to be instructed more closely as to the role of the dean?

Dr. Rohrbaugh: Well, the search committee knew exactly what the role of the dean is. You remember that day we had a meeting of the faculty and later with the students to discuss Dr. Stone's withdrawal and our future plans. The search committee was reconstituted and I thought this was a good idea because we had to be sort of experts. By that time, Mr. Walters and Mr. Christ-Janer had asked me to serve as co-chairman of it, but otherwise we reconstituted the committee exactly the same. They met and as you know, recommended that Dr. Bakst be Dean until June 30, 1971.

CHIASMA: Do you think the publicity associated with this will adversely affect our chances of getting as competent a man as Dr. Stone perhaps was?

Dr. Rohrbaugh: I don't think so. I am sure that anybody who comes in will say "Look what happend to Dr. Stone" because the fraternity is sort of a small fraternity, but I don't think it will handicap our getting a decent fellow because we have so much to offer.

CHIASMA: What are the things that you are looking for in a dean of the future?

Dr. Rohrbaugh: Well, obviously, he has to have experience and strong views on medical education and I would hope that he would have had been or be willing to be an innovator because of many things about the curriculum, that still remain to be done. Clearly he will have to be an effective administrator. Clearly, he will have to be able to work well with people because you can't have a dean who doesn't work well with students, faculty and his colleagues. There are a lot of smaller things, but these are the principal ones. Of course, he needs a familiarity, if at all possible, with what's happening to the whole spectrum of health services in the United States and have his ideas about the alternatives for health care, research, medical education, and, broader than medical education, health education because we have a lot of health education down here and we're going to have more.

CHIASMA: Do you view the role of the dean as primarily concerned with medical students or do you think he has some wider role in the medical center, in relation to your office and to hospital administraters?

Dr. Rohrbaugh: Well, he has a very close relationship with this office, the graduate school, the hospital, and the dental school. He has to work very closely with the University Council on the other campus, which is in effect a board of deans which acts with regard to matters that are common to all schools. I think his chief office is in producing M.D.'s, but does he have a relationship to house officers? Well, the house officers are under University Hospital and a lot of the education of the medical students is related to that unit and the house officers. He certainly would have a role there. He has an important role in the affiliates of the medical center, and a most important role, of course, is at City Hospital where he works with the deans of the other two schools and the commissioner and staff. We do at least one half of our medical student teaching there and we have about 60-65% of the beds at City Hospital under our auspices.

CHIASMA: You've helped us a lot in understanding some of the problems in searching for a dean and some of the functions of a dean. We'd like to ask some questions slightly off that topic. Some students feel that the heirarchy or the so-called power structure of the medical center is something about which they know very little and would like, perhaps, to become involved or at least informed of some of the decision making processes. Would it be desirable to get students involved? If so, how could they do this?

Dr. Rohrbaugh: You know that there are students on, I think, every committee in the medical school. Maybe not on the tenure committee, but on practically every other committee. I've been meeting with three medical school deans and with, what we loosely call, the leaders of the medical schools. Do you know of these meetings?

CHIASMA: No.

Dr. Rohrbaugh: We've had either two or three of these meetings and in addition we've met with the student-faculty committee. The Deans and I have been meeting with that committee as well and we hope that this will lead to a meeting with each class as a whole so they can express their concern and contribute. I think much of the concern that you speak of is probably a lack of information internally. At one of these meetings with the, let us say, medical school leaders, they asked about participation in the decision making process, and they got from me copies of the medical center agreement. It spells out pretty much the way things operate (it can always be amended). They asked me about having some students on the medical center advisory board, which is a group of about ten people that are appointed each year. I am going to discuss that with that group this noon. They also asked about a voice in the process of selecting a new University President...I was glad to find out as we went along that the medical students weren't concerned necessarily that it be a medical student. As far as they were concerned, it could be a dental student, but what they wanted was some younger generation person there. I said that I would be glad to pass this along to Mr. Estin and I did at once. There are to be, I think, three undergraduates and two graduates, the graduates being chosen by the graduate students association...

CHIASMA: You say you have meetings with students called student leaders. Are these meetings publicized? Are they open meetings? Are they meetings by invitation?

Dr. Rohrbaugh: I think the students themselves picked these leaders. I just am not sure...I would guess that they are probably the leaders of SCOMSA, of SAMA and perhaps the class officers - I don't know.

CHIASMA: It seems that a connection with a small handful of people is needed in order to attend these meetings. Yet there are a lot of students who have very good suggestions and objections, but they are not able to express them because they don't know the fourth year students that are involved. It would seem that if you publicized these meetings, you would get the more interested students to attend instead of the power elite of the students, so to speak. They have power problems, too.

Dr. Rohrbaugh: Oh, I know they do...We certainly, I certainly, didn't mean to pick any elite and I don't know how they were picked. I think they were just picked...

CHIASMA: Well, it seems obvious there is not enough free flow of information in this medical center, not only with regard to meetings such as we've been discussing, but with regard to any topic of general interest. It seems that we need some communication vehicle that would reach everyone in the medical center. Do you think that would be a worthwhile project?

Dr. Rohrbaugh: You know the two vehicles that we have, **Front & Center**, which is by, for and about the people here, and then we have **Scope**.

CHIASMA: But something like the meeting which we have discussed would not be announced in either of those publications. Furthermore, they don't come out frequently enough to keep up with developments as they happen.

Dr. Rohrbaugh: Well, what you mean is some sort of calendar.

CHIASMA: A calender or anything that would inform people. We need something geared to the professional staff in the medical center. It seems that **Front & Center** is geared to employees and other people rather than physicians and medical students; **Scope** seems to be geared more to parents. It's not of great interest to students.

Dr. Rohrbaugh: There ought to be a free flow of information between you and the faculty in the school of medicine. That's where you ought to go for information, and the dean is there.

CHIASMA: The administration in the medical school was not organized with respect to transmitting information. An example is the registration deadline for next semester. The old system was that Miss Chadwick would put a note in everyone's mailbox, and if you didn't check it, you were late for registration. Another example is deadlines for scholarships and financial aid. If you're around the medical school, you may find out. People are very angry right now about the tuition increase. There was a little notice down by the mailboxes. There was no explanantion, no discussion, no rationale given. This gives students a feeling of bad will, a feeling that the administration doesn't really care. It's deadly as far as alumni contributions and alumni participation in the school.

Dr. Rohrbaugh: Your concern is primarily for things that are timed. I think that if you spoke to Dean Bakst about this, you would find him very sympathetic. One of the problems that all of us realize is that we need a full time dean of students or an assistant dean for student affairs. Dr. Dewis does a splendid job, but because he is only working half-time, he has to spend most of this time coping with applications. It's true we need someone to make sure that notices are put up and the reasons behind them given and someone to whom the students could go, although I am sure you can go, when you can get to him, to Dr. Dewis and Dr. Lanzoni.

CHIASMA: Are there any plans for increasing the availability of services to students as you described?

Dr. Rohrbaugh: Yes, by next year we plan to have a person in the role that I described.

CHIASMA: What will Dean Dewis's role be then?

Dr. Rohrbaugh: I would guess that Dean Dewis would continue to handle applications. You build up a lot of expertise in that kind of thing. It is a tremendous job. We had 2300 applications for 58 vacancies this year, plus the relationship of the six year program. I think this new office would go far towards alleviating some of the lack of information you speak of. This fellow might not have it, but he could make sure it was gotten out.

CHIASMA: What are your impressions of the new students who are interested, students who get on your back every once in a while and annoy you about details of how the medical center works?

Dr. Rohrbaugh: I think myself it's a good thing. It's a good sign. Some of them may have some individual axes to grind, or their interest may be down one alley rather than across the board, but as far as I'm concerned, it's all to the good. Some of us were not too different years ago.

CHIASMA: Do you have any suggestions or complaints to bring back to the medical students?

Dr. Rohrbaugh: Well, I don't know how much the students use their membership on say, the faculty committee. It often happens that once students get a place, they don't make use of it.

The Student Symposium On Medical Education In The Preclinical Years At BUSM

CHIASMA

This issue of CHIASMA deals with a problem of utmost importance to the future of medicine – medical education. The fact that no major changes in medical education have been instituted since the early part of this century is disheartening to many would-be innovators. However a unique situation exists at this point in time – namely a few key administrators and faculty are willing to work with students to effect meaningful changes by evaluating basic educational concepts. To the administrators and faculty members who remain as roadblocks, the future is clear: "get out of the road if you can't lend a hand."

Steven Marlowe

If medicine has achieved success, medical education is notably less successful. Medical education happens. The Med Ed symposium led by Ralph Rosenberg attests to this. Medical education is rarely planned. The artificial division of basic medical science into Anatomy, Biochemstry, Physiology, etc. is an example. This makes a neat division of power. Communication between disciplines is necessarily impaired. One effect is that certain phenomena will be repetitiously labored, e.g. inborn errors of metabilism and porphyrin metabolism, while others are neglected, e.g., bio-medical electronics and variability or limitations of clinical chemistry tests. If the present structure is to be retained, there must be integrated planning of what each department will teach and how other departments can assist. This, of course, presumes that *teaching* will be considered rather than mere *lecturing.*

It has been demonstrated at Yale and Western Reserve that elimination of some lectures can lead to high levels of academic and clinical achievement. The Biology of Disease course indicates that planning can markedly raise the mean-quality-of-lectures. Changes, then, can be successful.

There is a lack of correlation between academic performance in the first two and last two years of medical school, and, more striking, lack of correlation between medical school performance and ultimate achievement in medicine. This further indicates the need for re-examination of priorities and methods in medical education.

With rising expectations for care and greater public awareness of what good care can be; with the "privatization of medicine" come other reasons for re-examining medical education. With over 60% of physicians treating less than 40% of the population, an explosive situation exists. The pressure is going to build for education of more medical students. We lack the manpower to adequately educate the rather homogeneous (compared to society) group of present medical students. And, for the first time, students are beginning to speak out. President Nixon initially expected an immediate increase of 4000 students due to local initiative and government help. He is now "hoping" for 500 "at some point".

At the National Student Conference on Medical Education, a Resource Center was established. New approaches to medical education, particularly audio-visual aids, were available for students to view, learn from, evaluate, and compare. The scope was broad. The premise of the conference was student activation. The conference provided materials and experts but the students had to seek the specific experience which would satisfy their needs. Article by Paul Kaywin (BUSM I) and Mark Rapaport (BUSM IV) present some impressions of our representatives to the meeting.

The Resource Center tried to show that individualized instruction can be effective through audio-visual aids. They could have the advantage of focusing national talent on well planned and field tested, standardized, up-datable programs.

Most of the aids at the Resource Center (as are over 80% of the new developments in Medical Education) were financed by Drug Companies. *(editors note: The next issue of CHIASMA will examine the drug industry. Contributions of articles (original or published) and suggestions are eagerly sought.)* Some of the conference members felt the medical profession, led by students, should divorce the drug industry in any and all its forms.

Were the drug industry to be abruptly disengaged by medicine, progress already made in improving medical education could easily be halted. Within a few years, alternative sources of funds, Federal and private foundations, can be cultivated. The seed money provided by drug companies will yield pilot projects to justify larger sources of funds. Abrupt cut off of these projects will not only stop these but indicate to private and government administrators that such projects are of questionable value. In fact, they are essential to any dramatic increase in the number of medical students and to a broadening of their background.

Is it really valuable to have extra-medical school projects? After all each school has its committees and each department tries to improve it curriculum. The efforts of a department are limited by its member and physical limitations. It's hard to step back and examine the principles of what medical students should learn and systematically analyze need. The in-politics of our and other schools make unbiased evaluation difficult. Also, on a national level, a broader spectrum o talent can be mustered. It is often asserted that generalized program do not take into account the needs of an individual school. The sam comment was made about the usefulness of National Boards. Th acceptance of a well tested, useful piece of equipment also attests t the virtue and acceptability of a valuable improvement. The sam reasoning applied to good education – let's develop some good an effective teaching aids . . . then lets see if they fit in. If it works, I think it will be accepted. Students will demand it. To educate more students from a broader background (especially minority groups), mor effectively we need to make our limited, real talent available.

(1) Knowles, John, Address before 2nd National Student Conferenc on Medical Education, Chicago, February 7, 1970.

Russell Jaffe

During the last three months a group of thirty first and second year students have been meeting in order to formulate a critique of the pre-clinical years at BUSM. The organizer of this effort was Ralph Rosenberg, a second year student and a member of the curriculum committee. Mr. Rosenberg arranged for an initial meeting of eight students who then drew up a list of five general categories of experience at BUSM which could be examined. These categories were as follows:

1. *Teaching - techniques, motivational aspects, lectures, labs.*
2. *Personality development - changes which occur and those which should be sought, the relationship between the personality of a successful medical student and a successful physician.*
3. *Communication - student-student, student-faculty, faculty-faculty, interdepartmental.*
4. *Guidance and orientation - tutorials, advisors, students who fail.*
5. *Limits and goals of courses - time available and amount of material covered.*

In the next meeting, the thirty students who ultimately participated in this study divided into groups, with each group studying one of the above topics.

The purpose of this critique is threefold. First, it is meant to serve as an integrated criticism of life at BUSM. Many efforts have been made in the past which examined only one facet of medical school life. Hopefully this report will go beyond that limited goal. A study of the grading system, for exampke, is futile without a parallel study of our system of examinations, which in turn is not the whole story unless the question of student guidance is examined. A second goal of the report is to offer solutions to the problems which are found. However, since many such solutions are complex and require knowledge and information not held by the participating students, the complete resolution of this goal was not fulfilled. Finally, the third goal of this study is to involve more students more actively in molding the educationl process in which we participate. This goal is diffuse, but ultimately it may turn out to be the most important of the three.

– David Thanhauser

The following is the penultimate draft of the report from the BUSM Student Symposium on Medical Education in the First Year and a Half. It is presented here and now in order to stimulate comments and criticism which may be incorporated in the final form. Any comments may be made in writing (to Ralph Rosenberg BUSM II) or in person at an open meeting to which all faculty members, students from all classes, alumnae and other interested people are invited. The meeting will be held sometime next month and will be publicized.

INTRODUCTION

The first year and a half at BUSM is what is usually called the Basic Science section of medical education. It is during this period that we are given our first exposure to the vast amount of information that we must eventually be able to use as physicians to care for our patients. This first experience, rather than being a stimulating one, is, for most of us, an exercise in frustration. It is essential that our time be more effectively utilized in working toward the goal of becoming technically competent as well as socially responsible and sensitive physicians.

In spite of the transiency of our stay and our limited perspective, we as students are unique in that no one is in such a good position to react to the experience of medical school as a whole. We are the integrators. We are obligated to act as a source of feedback, a stimulus for change. We hope that the report will provoke further discussion. of the goals, means, and effectiveness of medical education. We ask that the report be used by individual faculty members as well as the standing committees and departmental committees in their efforts to improve the curriculum. We believe that we have taken a significant step towards correcting a needless deficiency in communication between students and faculty. Just as we have tried to state explicitly what our thoughts are, we hope that the faculty will respond in kind. We would like to stress the point that for dialogue between students and faculty to be most effective it must be a continuous process. Finally we think it is important to see medical education as a totality. This means that people must get together and coordinate much more effectively than is done presently.

AIMS AND OBJECTS

The goal of the teaching in the pre-clinical years should be to give students a basic framework of knowledge for solving medical problems. Within such a framework, of course, a great deal of factual material must be learned. The present emphasis is to teach this material out of the medical context, in the first year and a half. However, much of the detail that appears to be trivial minutia in the first year suddenly becomes of great importance later, in the second year, when presented in the proper context. Our feeling is that the first year should be devoted to teaching a more skeletal set of vocabulary and information, and that Biology of Disease should be expanded to occupy the entire second year. Much of what is now learned but quickly forgotten in the basic science courses, because it appears irrelevant there, can be more effectively taught as a functional and indispensable part of a system in B.O.D.

The courses that now occupy the first year and a half should be synthesized into a one-year coordinated curriculum.

The courses that now occupy the first year and a half should be synthesized into a one-year coordinated curriculum. This does not mean compressing fourteen months of trauma into nine months of agonv. Rather. it requres elimination of the huge amounts of non-productive time that presently exist in the schedule. It also requires careful removal of items from the first-year curriculum and their insertion into the second-year scheme. We are willing to work with the teaching staff to do this in a way that avoids loss of important items in the shuffle.

We believe that intradepartmental committees should include students who are taking the courses offered by the department, as well as students who have completed those courses. These committees could serve as a focus for interaction and as a valuable source of information both for the residents and the faculty.

ON THE LEARNING PROCESS

It is regrettable that, in spite of modern advances, word of mouth is still the principle means of conveying information in our courses. The lecture system ties up the student's time and energy for most of the day, but it is not learning, it is stenography. It is prone to inaccuracies, on the part of both the speaker and the copyist. It also limits the amount of information conveyed to the amount one can write in an hour's time, which rarely does the subject justice.

The use of handouts should be increased.

Movies do not solve these problems. They have the further disadvantages of putting people to sleep, and being difficult to use as references sources.

On the other hand, the existing texts are not used to full advantage. Many lectures are merely a rendition, sometimes an inferior one, of Robbins, Goth, Ganong, Davis, et.

Our main recommendation is that the use of handouts should be increased. They should be not merely outlines of subject headings, but instead a full presentation of the material. They should be distributed several days befoe the lecture, and the lecturer should *not* reiterate them mechanically in class, but should instead discuss problems of understanding, or ask the class challenging questions to make them think about the material. If the lecturer has to spend much time reciting information, it merely reflects an error of omission, and the handout is to some degree a failure.

Examples of good handouts are Dr. Broitman's on fungal infections, the Virology handouts (although some are sketchy), and Dr. MacDonald's in Pathology. Dr. Levine's handout on diuretics was superb.

Inadequate handouts are typically lists of unconnected nouns that tell the student nothing about the material.

The advantages of a good handout system are:

– Easier for students.

– More accurate transfer of information

– Frees the lecturer from the task of dictation and lets him devote his energy in handling conceptual problems, showing slides, and challenging the class's intelligence.

– Since less time would be required for the lecture system, students would have more free time.

As it is, the lecture system often subverts our learning efforts by draining our time and energy in a non-educational exercise, and it is imperative that the system be changed.

There is no lack of alternative methods. Students are very good at absorbing information on their own if they have a good text, but the present schedule restricts this process to the evening, when most people are exhausted. If the schedule can't be filled with intensive learning, it should be left open for students to study on their own.

The use of dialogue is neglected except in Pharmacology and Biology of Disease. It can take many forms, such as programned learning, the CPC problem sheets or case discussions, but the important point is to help the student learn by asking him challenging questions. this is known to be an effective method for all kinds of reading and it should be used to great advantage in every course.

Exams chiefly are used to pass judgement on the student. It would be preferable if they were also used as an educational aid, to tell him where his strengths and weaknesses are. Indeed, the principle purpose of exams is to maintain standards of expertise, and this is best done by finding out a student's deficiency and correcting it. That this is not at present the faculty's attitude is clear from the fact that exams are never reviewed, and many are not handed back at all. Students do have the maturity to learn from quizzes and exams, and it is a real defect of B.U. that they are not allowed to do so.

Perhaps one reason for this situation is that not all exams address the important material of the course.

"Time is wasted in the preclinical courses."

We will not deal with the question of pass-fail in this report since the Curriculum Committee is presently studying its effects at other medical schools. However, it follows from the above that grades are not objectionable if they are used as educational aids, and they may even be necessary for the maintenance of educational standards. Their drawback consists in their abuse as instruments of threat.

Huge amounts of time are spent at the medical school in non-learning experiences. Granted, these exercises are well-intentioned on the faculty's part, and they involve a big investment of time by the teaching staff, but they are just not worthwhile. Dissection is not learning, it is manual labor. Biochem. lab is not learning, it is confusion on wheels. Parts of Histology and Micro labs could fairly be described as "needle in a haystack" or "hurry up and wait". And in the face of this flagrant abuse of our time we are told that there's no way to give us a free afternoon a week.

What we need is at least a day per week of elective time, so that some students can do dissection, some do physiology research, others do projects in community medicine, and so forth. The way things are, nobody is learning enough about what interests him, but everybody is hard pressed for time. We do not want free time so we can go home and goof off, we want it so we can learn more medicine.

Our main concern is that a great deal of everybody's time is wasted in the pre-clinical courses, especially in the first year. We have tried to specify what should be deleted and what should be rearranged. We have also given our subjective opinions on the teaching methods we've experienced, in the hopes that they will be changed. We intend to discuss and research these points further, and will work at length with any faculty members interested in solving these problems.

ON GUIDANCE

Orientation should not be limited to the first day, or week, or even the first year. It should be part of a continuous process whose goals are both in the area of communication of relatively technical information (eg. what texts are useful, where to buy microscopes, etc.) and in much more personalized guidance. Well meant leaflets, lectures, or other mass procedures are often taken less seriously than their substantive content deserves because, being presented before rather than during the time when advice is needed, they are often neglected. At present, most students have very little contact with students from other classes, and personal, non-academic contact with faculty and/or physicians is limited to tutorials and a few social functions.

The problems of guidance and orientation fall into broad categories such as:

1. Personal Guidance – study habits, dealing with medical school problems and pressures.

2. Orientation towards the school – many students know little about the various committees, procedures, activities, resources and programs which are available, or are hesitant to make use of them

3. Orientation toward the medical profession – This includes career planning, medical ethics, medical education, history of medicine, etc.

Since much of the information of the above sorts now comes to students either through tutorial or through hearsay via a small number of students who do have personal contact with faculty and/or upperclassmen, it would be worthwhile to expand the areas where such contact might take place. Individual faculty advisors and upperclassman buddies are logical extensions of the tutorial program. It is, of course, important that the design of any such program recognize the need for active participation on the part of the advisor/buddy.

We feel that a congenial atmosphere, conducive to personal interchange among students at various levels and faculty is the basic requirement for an adequate program of guidance and orientation. Students often note the lack of communication with faculty even though the means may exist on paper. For example, students are included in the membership of many faculty committees.

... exchange between students and BUSM alumni ...

Individual members of the faculty often urge students to speak their minds; but whether they don't feel the courage of their convictions, the possibility of being heard and understood, or whether they are influenced by traditional ideas of the unapproachability of faculty, students don't often take advantage of available channels.

In order to facilitate more interaction, time, personnel and facilities must be specifically and actively employed for these purposes. Some preliminary suggestions include individual faculty advisors (from the clinical and preclinical departments, not arbitrarily assigned), a buddy system, pairing volunteer upperclassmen with incoming freshmen, coordinated lunch breaks and other time off for the first and second year classes, encourage wider participation in student-faculty social activities.

Concerning the tutorial program, we feel that it is very worthwhile, but suffers from trying to cover too broad a range of needs. We hope that as more specific programs come into being for purposes of personal guidance, tutorial will be able to concentrate its efforts towards the most appropriate, and more well defined objectives. For instance, tutorial would be a fine place for group discussion of medical ethics and other non-academic issues relating to medicine. Tutorial leaders might, in addition. invite upperclassmen and alumni to attend.

Between these groups as between other groups in the school, much could be gained from more communication. Clearly, there is more that upperclassmen could do to make things easier for the succeeding classes. It's easy enough to fill out course evaluations in a few minutes, and that is worthwhile; but it takes time and effort to work through the political processes to initiate substantial change or to orient succeeding classes. When one course or semester or year is over, students are so immediately involved in their new tasks that the old complaints no longer seem so pressing.

Even though the upperclassmen are the ones in a position to appreciate what might

Students often note a lack of communication with the faculty.

be gained from an interaction with freshmen, they find themselves too busy to go out of their way to seek it.

There would be comparable gain from exchange between students and BUSM alumni. Active involvement, especially of the younger alumni, in the early educational process would enable the students to benefit directly from the experiences and perspective of previous BUSM students.

The medical educational process must be a period of emotional as well as intellectual growth if it is to implement our goal of the best care of the patient. The total environment needs to allow for the development of the student's humanity as well as his acquisition of knowledge. Such an environment must include understanding of the student as a mature individual with individual needs and aspirations, strengths and weaknesses. Some of the issues which are raised in a consideration of the emotional growth of a medical student are these: the image that the student has of himself as a person and as a future physician and the challenges to that image which he faces when entering medical school; the anxiety that is a virtually universal phenomenon among medical students; the need for a system to help the failing student; the need for the student to be equipped emotionally and intellectually to deal with the ethical questions raised around him increasingly as he assumes the role of a physician.

One way that the entering student sees himself is as a person with an inquiring mind, with special interests he would like to pursue. The student thinks of himself as capable, creative, and highly motivated to learn medicine. But as he enters the first year, he is not treated like a mature adult capable of initiative and decision-making. The medical school curriculum, especially in the first two years, is highly structured and predecided for the student. Everyone takes the same courses, with the same people at the same time and place. Even students who are repeating the year must follow the prescribed curriculum (including repeating courses which they had passed). Such standarization discourages creativity and may decrease motivation.

The faculty's lack of respect for the student as a fellow inquirer is further manifest in the edict: "Learn your notes and you will pass the exam." Such an attitude stands in the way of creative thinking and of the overall understanding of an area of study. Rote memorization and regurgitation of facts are the efforts which are rewarded. Competition seems to be condoned, reducing the willingness of students to work and question together.

The student's image of himself includes his life outside of the medical school and the work that it asks of him. It is unfortunate that pressures engendered by course work force a student to give up his hobbies or other activities unrelated to his studies. Many a student feels that he should spend all available time studying with the result that leisure-time activities are often accompanied by guilt or anxiety. These demands on free time are as often imagined as actual, but this makes the guilt of anxiety no less real. Nonmedical, creative outlets are often important for the maintenance of a student's emotional equilibrium. No matter whether the source is internal or external, unreasonable demands on a student's life will decrease his ability to learn the material and may inhibit his motivation to become a physician.

Students arrive at medical school with different preconceptions of a physician. Some think most doctors should be highly trained specialists, and others think doctors should be social activists; still others think doctors should be teachers and researchers. Clearly, all of these descriptions are correct. But, because of little interchange between students concerning their preconceptions, the future heart specialists may fail to understand the motivations of the future community psychiatrists, and vice versa. The result is that some students come to mistrust each other or themselves. More exposure to the whole spectrum of practicing physicians and more dialogue seem to be indicated.

THE MEDICAL STUDENT ANGST

The anxiety that the medical student experiences occurs for several reasons. The first anxiety is that of failure; this is augmented by seeing and listening to those people repeating the year. The professors seem to project the attitude that the student must prove himself, even though he has been proving himself since high school that he could make it into medical school. There is also fear of the comments made by the faculty that will enter the student's *permanent file,* possibly affecting his chances for an internship. The anxiety of overt competition and fear of being in the bottom of the class curve may hinder an effective medical education. There is also anxiety concerning the absurdity of the dual standard at B.U.: pass the course, fail the year. The medical student may constantly ask himself these questions: do I really belong here? will I make a good physician? do my grades really project my potential as a good physician?

The Fears: failure, competition, Boards, uncertainty.

There is also anxiety created by the lack of information about such future concerns as passing National Boards or getting internships.

This anxiety comes from not knowing what is expected (especially during the first year) because the students are never told as a group about the mechanics of National Boards, internships. licensure and even more critically about the school itself (the grading system, what is really passing, the file with recommendations and the like).

Anxiety also arises, as mentioned above, from the choice that the student feels he must make between school and "outside life."

The fear of failing is especially poignant when one becomes aware of the school's attitude towards failure.

THE FAILING STUDENT

It is ironic that a school that teaches "identify, cure and prevent the disease" has not applied this approach to the failing student. His problem is a simple one, that he needs to know more, but we do not always face this problem squarely and deal with it efficiently. The following steps have been followed at some times by some people, but if they were standard policy in the future, failure would result in more of a pick-up and less of a put-down for the student involved.

The question of ethics is grossly neglected.

1. The department Chairman should meet immediately with any student who fails an exam to assess his weaknesses in knowledge and study approach, and to assign him a tutor (a graduate student or instructor). The goal is prompt corrective action.

2. After remedial work, the student should be able to take a make-up examination to raise his grade to 75. The date and form of the exam should be left up to the chairman. If the student passes, he has rectified his status, but, more important, his educational weakness has been corrected in the most efficient way possible.

3. The student's grade should not be submitted to the recorder until after the make-up exam.

4. In the event that a student has an overall average below 75 or a failure in a course after a make-up exam, he should meet in person with the Promotions Committee, and the Committee should explain his position to him precisely. The student's educational plans should be discussed and decided upon. The point is to let the student have an active part in the decision instead of being told what to do. His options should include summer work under a tutor, summer school, independent study, and National Boards.

5. If the student fails to achieve the goals of the initially decided upon plan, then the Promotions Committee alone should decide between repeat and expulsion.

6. No student should be prevented from taking the National Boards. A student who is "flunking out" might still pass them, and this would improve his chances of staying on the tracks at this or another medical school.

We think that this method of dealing with the failing student will alleviate the fear of failure and its sometimes obscure consequences. Furthermore, the student will have an active part in his educational plans, and the school will have the satisfaction of knowing they did everything they could to help him earn his degree.

SOCIAL SERVICE IN MED. ED.

It is clear that, in a few years, we students will play a major role in making the decisions that will determine the structure of health care in America. At the same time, we will be faced with daily decisions concerning patient treatment and care. In both cases there are ethical and social, as well as medical, parameters to be considered.

There are many issues confronting physicians today which pose as many ethical questions as scientific. These include the Pill, transplants, care of the poor, prescription drugs, pollution, abortion, euthanasia, care of the elderly, and the role of doctors in the military. By the time we are physicians, this list is likely to enlarge. If we are going to be able to deal intelligently and sensitively with such issues. we need to have some preparation. At present, however, the question of ethics in medicine is grossly neglected in our training, and the development of a student's ethical sense is left more or less up to chance. This omission seems even more serious when we consider that the physician's role in social planning and educating the consumer is increasing, and that with the increasing shortage of physicians, even the decision of how and where we will devote our skills may present ethical questions.

If this aspect of medical training continues to be neglected, physicians trained at BUSM will be deficient in dealing with complex socio-medical issues and will be unable to assume leadership or play active roles in these areas.

We recognize that this area of medicine is dealt with to some extent in Community Medicine and the Freshman Tutorial Program. Nevertheless, we feel that some formalized presentation of ethical issues should be instituted in the curriculum, most practicably by expansion of the Community Medicine Department's consideration of such topics. Students need information on the issues mentioned above as well as the opportunity to understand their own feelings and prejudices through discussion.

Two Views

Second SAMA Conference On Medical Education:

by Mark Rapoport

The conference lent itself to varying impressions by its very organization, and additional, unexpected factors furthered this trend. A pre-conference questionnaire to participants indicated a preference for small sessions, and these constituted the bulk of the workings of the conference. Participants spent a good part of their time at one or more topical workshops with approximately twelve members in each group. Before I describe my particular topic, a few words on the other portions of the conference might be due.

A registration session, accompanied by the classical SAMA wine-tasting Bacchanal, opened the proceedings. The first real activity was a session featuring a decidedly unenlightening speech by the dean of Western Reserve concerning authority figures. Dr. Dan Funkenstein, a SAMA stalwart, said much more on "Personal Development in Medical Education". Dr. John Caughey compared current systems to "prisons and kindergartens" and criticized the dehumanizing experience of medical school. In a free-swinging foray before a partisan hometown crowd, he criticized the isolation of the profession from society, the undue emphasis on rating the young professional for the institution at the next rung of the ladder, and the educationally and spiritually regressive effects of undue anxiety-forming devices. He seemed to shed his years as he sympathized with the students' efforts to create a relevance heretofore lacking in the medical education process, i.e. eliminate all evaluations to substitute a cooperative experience for a competitive one and cut unrealistic work loads and basic sciences taught as if to train Ph.D.'s. Certain key thoughts stand alone as "pearls", if you will, as follows:

"Nothing is so inhumane as incompetence."

"It is time to change med. ed. from a manufacturing process, stamping out identical images, to an agrarian process, nurturing students as growing plants."

A final speech, late in the conference agenda, was given by Dr. John Knowles of the Massachusetts General Hospital. In a departure from his prepared text, he delivered a sharp rebuke to the government and medical establishment for its gross failures to devise even initial means for controlling the continuing health needs of the country. He flayed everything from AMPAC to Spiro Agnew.

Following Dr. Knowles' speech a handful of memebers of the Young Patriots and Young Lords asked for and received permission to speak to the group. These ex-street gangs, one white and one Puerto Rican, have set up independent clinics to serve their own communities in a way that the Chicago hospitals could not. Their articulate analysis of the community clinic concept was very well received, as was that of a Howard University student who requested aid in furthering his school's effort to set up clinics for the indigent in Mississippi in face of the now classic patterns of Southern hostility to outside agitators.

The Medical Liberation Front, a group of activist students led by a strong New York University contingent, with the conference only ten minutes old, walked forward, took over the microphone, and demanded the expulsion of the drug company exhibits held in conjunction with, but not a part of, the conference. The discussion at this and two subsequent meetings on the topic were long and rambling. I will summarize. Everyone agreed that these particular drug company exhibits were not *per se* bad. According to SAMA's wishes, only pure educational material devoid of product samples were present. The radicals felt that the other activities and policies of the drug industry were so bad that no connection whatsoever with them was tolerable. Specific complaints centered on excessive profits, the establishment of a compromising relationship to physicians, reprehensible advertising techniques and the insufficiently controlled experimentation on the poor.

There seemed little disagreement on the validity of these claims among the students. The drug people finally agreed to have a spokesman present their position. Mr. Robert Liversidge of Smith, Kline & French indicated willingness by drug companies to discuss any issue, any time, and that a committee had already been set up to do this. There was disagreement, however, on two points. The first was a total condemnation of a drug industry based on the profit motive, which the radical proponents of expulsion viewed as intrinsically inimicable to the public welfare. The second concerned the most effective way of bringing about drug industry reform, either maintaining a dialogue for change or making the firmest stand possible to make the point clear.

In the end, both radical proposals were defeated. Two factors behind this vote were the hurried importation of SAMA president Ed Martin for a spirited defense and some rather unpleasant maneuvering by SAMA heavy Mark Berger. SAMA's vested interest was clear since approximately 20% of their $1 million plus budget comes from the drug companies.

My personal position changed radically in the course of the discussions. Whereas I spoke out initially against expulsion, I later reversed my stand. The abuses by the drug industry are incontrovertible. Anyone desiring documentation might consult the recent Nelson Senate Subcommittee report. The issue was initially blurred by the "good dollars" that we are vigorously shown, for educational aids and dinners and black bags to the starving neophyte physicians. The choker is simply this – regardless of its ultimate use, the money originated in the frequently exorbitant mark-ups on drugs that people have no choice but to buy – on doctor's orders. If we are to be advocates for our patients, how close can we be to the drug companies? I think very far away indeed. Their profits (the highest of any major industry in America) and their expenses for advertising and gifts to the profession, and research costs all come from the patient population, and we are not justified in taking any of it.

To avoid a confrontation over these fundamental issues, the drug firms try to buy a good name by association with SAMA, *et al.* Their motives are obvious – stave off the necessity for basic policy changes that might compromise profits. This is something to which we can not allow ourselves to be a party. It is for this reason that I voted for their expulsion. The issue, although undecided at present, is up for consideration at the next national SAMA convention.

A compilation of some of the materials from the conference including reprints, surveys, and speeches, are available for reference in the Library. Also, a report on the proceedings of the workshop on "Strategy and Tactics for Change" is in preparation and will soon be available.

COMPUTER ASSISTED Instruction in action . . . a more efficient and effective method of learning through problem solving?

by Paul Kaywin

I was one of three students who represented our medical school in Chicago at the SAMA convention on medical education. One of the first things that I learned was that SAMA has quite a different image at the various medical schools. I was a bit skeptical as to the usefulness of a convention sponsored by SAMA. since here at BU the organization has little contact with the students other than their yearly wine tasting. However at other schools the opposite situation exists and SAMA is the only organized body of student representation.

As for the convention itself, of all the scheduled items on the planned agenda only the small group sessions held on Friday were of any value. As a representative on the Student-Faculty committee here at BU I chose to attend the group session on student-faculty relations. For an entire afternoon and evening I met with six other medical students and two assistant deans in a very stimulating discussion. The overall notion which I have taken from this session is that curriculum changes are fine and necessary but at the same time as criticising and evaluating the faculty, the medical student should actively aim at establishing a better rapport with his instructors. It was generally recognized by both the students and faculty at this meeting that the atmosphere in which you spend four years of your life will undoubtedly affect your future attitudes as a doctor. Furthermore it was concluded that it is up to the student to create the type of conditions in which he desires to receive his medical education. I came back from Chicago with a number of concrete ideas which are being tried by the first year class. For example, in the near future interested students will be inviting faculty members and their spouses over to their homes for dinner.

Aside from this small group session the majority of scheduled functions at the convention were rather worthless. The introductory speeches were typically platitudinous and a good part of Saturday afternoon was wasted on inaudible summaries of the small group meetings. Dr. Knowles gave a speech which he prefaced by the remark that no new ideas on medical education had been proposed since the 1930's. He then went on to talk about the necessity of medical students having a solid background in the social sciences; a concept which I had gotten from my high school guidance counsellor, who was born way before 1930.

A number of unscheduled activities took place which helped to compensate for the poorer scheduled ones. A major issue focused on the presence of certain drug companies at the convention. The opinions of the students ranged widely. Some felt that since the companies had been invited by SAMA for the sole purpose of demonstrating materials directly related to medical education they should be allowed to stay. Others said that the unethical practices of the drug companies did not justify their presence at the convention or their affiliation with SAMA (20% of SAMA's budget is suppled by money from drug companies.). Personally I found the displays of the companies to be of no use as far as giving me information about developments in medical education. Their absence from the convention would not have been missed.

A group of Young Lords from the Chicago area were allowed to address the convention. They described a free clinic which they had established in one of the local communities. To hear about their practices of health care delivery on Saturday and then listen to speeches given at the AMA convention on medical education on Sunday was an enlightening experience. I questioned one of the speakers at the AMA convention who had talked about a family health center in Ohio. I asked about programs they were using or developing for the prevention of disease. He answered in a rather wry tone that the way medicine is now practiced most of the prevention comes from the Churches. Whether this attitude is representative is questionable, it nevertheless was a striking contrast to the Young Lords of the previous day.

On the whole, those few worthwhile experiences which I have described made the convention a positive undertaking. It was especially good in that it gave me the opportunity to talk to other medical students and gain a sense of perspective about BUSM. My hope is that in the future conventions more time will be given to the small group meetings rather than the useless large sessions.

A VIDEO TAPE library allowed comparison of different approaches to med ed across the country.

Surgeons Meet On Curriculum

A curriculum committee meeting of the Division of Surgery includng all the Departmen Heads, (Drs. Austen – Urology, Vanderveen – Anesthesia, Friedman – Ophthalmoloty, Spatz – Neurosurgery, Strong – Otolaryngology, Coppel – Orthopedics) and in addition, Drs. Byrne, Howe, Mannick and Nabseth was held in my office on February 2, 1970. A quite complete discussion was carried out concerning the role of the Division of Surgery in the entire undergraduate surgical curriculum. It was agreed that the Division is happy with a first year role in the basic sciences consisting of clinical correlation sessions and that we would welcome the opportunity to expand this role if it were offered to us by any of the basic sciences. Particularly effective have been Dr. Moyer's clinical correlation sessions and the freshman medicine clinical sessions organized by Dr. Melby have been thought to be effective, as well. It was suggested by several Department Chairmen that the basic science chairmen be informed that the Surgical Departments and individuals would like to be considered for utilization in the in-depth period of the basic science, if at all possible.

It was suggested by several individuals that Dr. Lanzoni be informed of the feeling by the Division of Surgery that Wednesday afternoon time in the first year should be left free according to the original terms of the curriculum committee recommendation. It is reported that this time is being scheduled for other purposes, and if Wednesday afternoon time is available for curriculum assignment, various members of the Division of Surgery would like to be considered for an active role. It was thought far better by the group that this time be left totally free and activities not scheduled by any department.

The group felt that the Biology of Disease course in the second year has been remarkably effective and should be both continued and expanded. Every effort should be made by those organizing segments of the Biology of Disease course to include surgeons from various departments who are knowledgeable and good teachers in that portion of the curriculum. It was felt that representation as surgeons per se was not necessary if appropriate contact time with the students based on special interests and capabilities was made available.

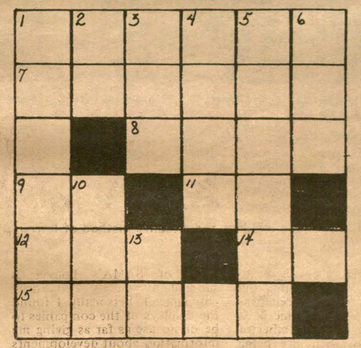
It was agreed that the 3 months that the Division of Surgery has in the third year would be best spent by having the students spent two months on a general surgical clerkship and one month on the "surgical specialties." It would be up to Dr. Friedman to coordinate the month on surgical specialties into block periods for those surgical specialty chairmen who wish a period of time. It is up to the chiefs of surgery at each of the three base hospitals (University, City and Boston V.A.) to work their third year students into their affiliated teaching hospital which in the case of University Hospital is Carney; in the case of the City Hospital is Framingham Union; and in the case of the Boston V.A. is the Public Health Services Hospital. The strong suggestion was that at least one or two students be assigned at all times to the affiliated hospitals in order to keep up the teaching momentum at those hospitals and continually improve the educational milieu (for future class expansion). Affiliated hospitals are not developed as teaching hospitals overnight and concentration on undergraduate, graduate and postgraduate education is necessary in concert in order to be able to achieve this objective.

It was concluded by all that this group should meet with Dr. Lanzoni within the next few months to discuss these subjects and get his viewpoints on the role of surgery in the curriculum. The group was in agreement that this has to do with understanding principles in the diagnosis and treatment of the critically ill and traumatized patient, and also is concerned with all aspects of pre and postoperative care. The group was agreed that details of operative therapy and emphasis on large amounts of operating room time were not appropriate in a modern undergraduate curriculum. All Departments of the Division are interested in having modest numbers of students participate in electives in the various surgical areas of interest and will endeavor to work hard to make these electives of high quality.

Considerable interest was expressed by several members of the group in the evaluation process whereby the Surgical faculty assesses the impact of the surgical curriculum, especially the clerkship, (and changes in it) on student learning. Future discussions will focus on the evaluation process and our current methods will be subjected to critical appraisal by several consultants both from within and outside our Medical Center.

–*R.H. Edgahl, M.D.*

Eds.: Dr. Egdahl promised that students would be invited to participate in the next Surgery Curriculum Committee meeting.



ACROSS

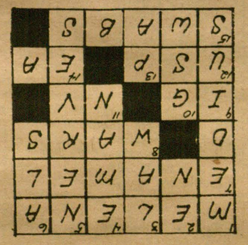
1. the passage of dark, blood-containing stools
7. substantia adamantina
8. conflicts (n.)
9. immune globulin (abv.)
11. naked vision (abv.)
12. compilation of drugs (abv.)
14. earliest diety associated with the art of healing
15. used in bacteriological studies

DOWN

3. intermediate
2. in (prefix)
3. constant principle
4. 10-10 curie
5. impulse conductors within the body
6. neurological disease (abv.)
10. gun shot wound (abv.)
13. a megaloblastic anemia (abv.)

In Our Next Issue:

CHIASMA LOOKS AT PROBLEMS IN HEALTH CARE DELIVERY ALSO THE DRUG COMPANIES AND THE DOCTOR



FINANCIAL AID

Scholarship Money Comes From Many Sources

For many students at BUSM financial aid is an important, although ancillary, part of their medical education. Information on loans and scholarships, which are based on good academic standing and financial need, is available from Miss Whitehead in the Admissions Office. The medical school administers scholarships based on accrued interest on various funds as well as Health Professions scholarships funded by the federal government.

The major source of loans through Boston University is the Health Professions loan program. Application forms for these scholarships and loans must be filed with Miss Whitehead, as well as a parents' confidential financial statement for students under 25, married or single. The deadline for applications for the academic year 1970-71 is March 15, 1970. A meeting of the financial aid committee to determine awards is planned for early April.

In addition to aid available directly from the medical school, students should be aware of numerous sources of outside aid that are readily available. One example of this type of aid is the Massachusetts higher education scholarship program which offers assistance to needy students in good academic standing who have lived in Massachusetts for four years prior to accepting an award. Most states have similar programs offering bank loans at low interest rates and extended repayment terms. Third and fourth year students in Boston medical schools are eligible for loans from the Franklin Foundation at low interest rates and a long repayment agreement. The Edwards Scholarship Fund, for Boston residents only, may be contacted at 75 Federal Street, Boston (tel. 426-4434) for further information about awards available. During the December holiday special scholarship awards may be made, but the donors specify certain qualifications at that time.

Although the vast majority of awards are granted prior to the start of each academic year, Miss Whitehead is available at any time during the year to discuss any financial difficulty an individual student may be experiencing, and to offer suggestions. Further information on most scholarship and loan programs mentioned may also be readily obtained upon request from her office.

Dr. Jacob Schwartz, President-elect of the B.U.S.M. Alumni Association, considers the primary goal of the Alumni to be service-to-students oriented. Yet many students have neutral or negative feelings about the Association because they don't know what the Alumni realldy do. This information gap will be narrowed in the next issue of CHIASMA.

Culture For Free

At 280 The Fenway is located the Isabella Stewart Gardner Museum. Mrs. Gardner was twice blessed. She inherited fortunes from both her father and her husband. With freedom and money Mrs. Gardner set about amassing a mansionful of paintings, statues, and *objets d'art.* A refreshing afternoon can be spent by a book-weary medical student at her home which is open to the public for free on Tuesdays, Thursdays, and Fridays, from 10 until 4, and on Sundays from 2 to 7. The center of the museum is occupied by a garden with Greek statues. Through the skylight four stories above, the sun illuminates the horticultural magnificence below. Particularly pleasing is to hear musical phrases faintly, but distinctly, come from an upper room. Indeed, on each afternoon the museum is open, local professional musicians give free concerts at the museum from three until three-thirty. This Sunday leave your travail as a healer of mankind; for an afternoon let the pursuit of the muses be your *raison d'etre.* You cannot but be a better physician as a result of it.

James Brasic

Social Awareness Underemphasized In Med Ed, Maintains Mass. General Director, Dr. Knowles

by John H. Knowles, M.D.

No one can seriously challenge the many virtues of the contemporary system of medical education and all would heed the caveat to make change slowly and carefully. However, many educators and the public at large are dissatisfied with the lack of change since the Flexner report. This is a rising tide of feeling that medical education in all its phases is *not* keeping pace with the wants and needs of the population it strives to serve. Rising expectations; rising costs; maldistribution of services; inefficient organization and utilization of facilities, institutions and personnel; the seemingly endless expansion of time required for education and training in the health field; increasingly critical shortage of manpower; the uncertain state of quality controls in medical services; the continued production of experts and specialists and the dearth of generalists and medical administrators; the increasing participation of governmental agencies, professional organizations, third party payers, and other groups with special interests in the life of the Doctor and the institutions he uses; the counter-cultural and intransigent posture of "organized medicine"; the overwhelming need for and the rational uses of medical technology – these and many other problems demand a more effective articulation of the work of medicine with the needs of the people. I shall assume that one way of achieving or at least enhancing this desirable state is through the system that educates the student and trains the doctor.

Medical education can be divided into four distinct phases: 1) the pre-medical period of undergraduate work in the college; 2) the graduate period in the medical school; 3) the post-graduate work, most of which is carried out in the *teaching hospital; and 4) the life-long, continuing educational needs of the practicing physician.* We should examine all these phases as we ultimately consider the rationalization of health services.

Pre-Medical Education

The formal years of education have been called a rehearsal for life, a preparation for the purposes of living. The individual should emerge as Lionel Trilling has said, "at home in, and in control of the modern world." The aims of all forms of education are three-fold: the development of the intellect; the acquisition of skills; and the passing on of the culture, its values and morals.

Undergratuate education in the university becomes differentiated into the special interests of natural and physical science, and mathematics once the individual has declared himself a pre-medical student. There are at present no social science requirements for admission to medical school. There are two opposing views of this, expressed by well-intentioned educators, looking for the best balance between depth and breadth in college education. One viewholds that breadth is particularly necessary for the would-be doctor and that the humanities and social sciences must receive their full measure of attention along with the biological and physical sciences. The other view holds that the steadily increasing period of medical education must be reduced and this can be accomplished by more intensive work in the "medical" sciences in college, which therefore will not be repeated in the first year or two of medical school. There is merit here but the intellectual acceleration and constriction of the students' interests may not be desirable. In this view, the humanities and social sciences become embroidery to the physical and biological sciences and mathematics.

The fact is that the undergraduate has little choice today if he wishes to leave little to chance on applying for admission to the medical school. As the Assistant Dean for Admissions of the Faculty of Medicine of the Harvard Medical School stated in answer to the question of how best to gain entry – "... the humanist dedicated to working with people but fearing mathematics, who hopes that science will be a minor part of this medical education, stands little chance of being accepted to medical school."

There are two problems here. One is concerned with the too-early acquisition of specialism and expertise, the other with the almost universally accepted notion that knowledge of the physical and biological sciences and mathematics (to the inevitable exclusion of competitive down-playing of the humanities and the social sciences) represents the best preparation for medical school and therefore one's life in medicine.

Can the medical intellect function only or best on a foundation of natural science? Certainly it is true for those who plan a career in medical research, but is mathematics necessary to the successful practice of medicine? Can intellectual development suitable for a doctor be developed other than through the study of the physical and biological sciences? Why did Virchow say that medicine is a social science and politics was nothing but medicine on a large scale? Why did L.J. Henderson refer to the practice of medicine as "applied sociology"? Could it be that man is, indeed, a social as well as biological animal? Is there *social*, as well as biological ease and disease? And can dis-ease in one system give rise to dis-ease in the other? The answers are obvious. The methods and content of scientific thought are vital disciplines for all educated men, but where does that leave the remainder of the liberal and general education? Is there anything in the humanities and social sciences which relates to medicine or more importantly to the well-educated man which we want our doctor to be?

My view is very simple; pre-medical education should be horizontal without steeples, broad without depth in any of the three areas, for I believe that medicine is a social as well as a physical and biological science, and that it needs the humanities and social sciences and the effects of their study as never before in the history of man. Pre-medical requirements should include all three areas, and not, as at present, just the physical and biological sciences. Let the differentiation occur in medical school and beyond but *educate* the man in college.

Medical School Education

Science prevades all for the first two years in medical school, that is biological and physical science. The last chance to treat of at least some of the aspects of medicine with the disciplines of the social sciences is taken only in several of the present medical schools of this country. Why this exclusion? Not enough time in an already overcrowded curriculum? The "non-scientific" nature of their results? Pehaps it is all these reasons but just as important has been the complete segregation of Schools of Public Health from the mainstream of medicine. Such schools do utilize the social sciences when considering the subjects of medical administration and the formulation, organization and implementation of public health programs. Quite clearly, human attitudes, beliefs and values play a determining role in the utilization of health services by the recipient public as well as in the implementation of programs by the purveying members of the health profession. Sociological research in medical care has given us invaluable information in many spheres. A brief listing of such studies would include the analysis of health wants and needs of communities; the influence of prepaid insurance programs on the utilization of health services; the dynamics of solo versus the group practice of medicine; role expectations amongst the various categories of health workers including doctors, nurses, social workers, dieticians, and medical scientists; the influence of social and economic class on the receipt and utilization of services; the evaluation of types of organizations designed to give comprehensive, continuing medical care in ambulatory clinics; the internal organization of the hospital with its paradoxical arrangements of authority and responsibility; the public's attitude towards the general hospital, the mental institution, the public health unit and so on; the assessment of medical care programs for special population groups such as the medically indigent, dependents of military personnel, the chronic and mentally ill; the effect of cultural determinants on the utilization of health services; and the recruitment, development, organization and retention of health personnel.

Clearly, the results of such studies have tremendous implications for all of us interested in the health of our communities, whether we be the professional purveyors or the non-expert recipients of medical care. The rational organization, distribution and utilization of limited and costly health resources is of central importance. The rationalization of the behavior of doctors, nurses, administrators, patients and so on should facilitate the goal of high quality medical care for all the people.

I am perplexed and fascinated with the problem – or phenomenon – of why such intellectual activity is *not* an integral part of the medical school's program of teaching and research. The medical school curriculum accelerates the constricting effect of pre-medical education by its complete emphasis on a foundation of biological science in the first two years of medical school. The opportunity still exists to study medicine from the viewpoint of the social sciences but is not seized. The history of medicine, its people, its institutions and its social setting is neglected, as are the political science, the cultural anthropology and the economics of medicine. The student is relentlessly forced to focus on the individual doctor-patient relation and the science of disease as objects, and his own subjective self-understanding and his understanding of the world around him flags. At the end of four years he is a highly individualistic person cloaked with the charismatic robes of the profession, trained to take immediate action with the individual patient and to expect immediate rewards, with his knowledge firmly grounded in science. The primary purpose of medical education – that is, to understand disease and to be able to comprehend and manage the problems of sick people from the perspective of biological science, has been fulfilled. But the broader issues of the physician's (as well as the patient's) place and problems in the world at large has been neglected. The world of the health profession and its institutions – the givers and the receivers of care – has been left undescribed and unstudied (and therefore will remain undisturbed by the profession). The social environment surrounding the sick person and its effects on the causation and/or course of disease is virtually unknown.

Why has this happened? Is the launching pad already too overcrowded with the physical and biological sciences to permit room for the social sciences? Is the inherently utilitarian nature of the social sciences incompatible with truly scientific nature of present day medical education? Do the social sciences really qualify as science, ie., hard factual knowledge concerning predictable and reproducible natural phenomena?

JOHN KNOWLES, Professor of Medicine and Director Massachusetts General Hospital.

If the health profession understands as much of its history, economy, political science, social psychology, cultural anthropology and behavioural psychology as is available, at least part of the behaviour of doctors, patients, politicians and so on can be understood and rational choices for action or inaction can be taken on the basis of understanding through knowledge. Perhaps short-term, vested interest can be overcome more often by long-range decisions (or ideas, which ultimately are more powerful than vested interests) in the public, or over-all interest through the moral suasion of knowledge. I am convinced that "the local descriptions and statistics found in sociology, economics, anthropology, and psychology" are central to the work of medicine and should be part of the intellectual development of the doctor. The fact that it is no "science" and will not result necessarily in better behaviour disturbs me not one whit. I do believe that better understanding of this body of knowledge *will* help improve health services. I also believe (to paraphrase Brandeis and Santayana) that one page of history is worth a volume of logic and that he who knows no history is doomed to relive it. I also tend to agree with Keynes who is quoted by Paul Samuelson in his textbook of economics that:

"The ideas of economists and political philosophers, both when they are right and when they ae wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men, who believe themselves to be quite exempt from any intellectual influence, are usually the slaves of some defunct economist."

Can anyone argue that today the health profession and its various institutions is not being ruled by the ideas of economists and political philosophers? Is it not possible that the medical profession could play a larger, more constructive role in its future if it at least understood the issues and arguments?

Perhaps the crux of the situation is the necessity to bring the medical school and medical education back into the university, where the other university disciplines, and particularly the social sciences, can be used as powerful research tools in medicine and will be available to the intellectual development of the medical student. These needs for the social sciences are not peculiar to medical education. The graduate schools of business, law, education, and theology are also recognizing the need for a more complete approach to their highly specialized and vocational pursuits. They recognize the need for knowledge of human behaviour and the social sciences for two reasons: 1) to increase the understanding of one's self and the professional socio-economic system in which one works, and 2) to understand better the objects of one's professional work, be they patients, clients, employees or students. More truly university work will further the aims of a true university education and the social science disciplines can add much to the perspective of the student and to the development of knowledge in specialized areas. I am also of the firm opinion that relevant disciplines in schools of public health should be a central part of the medical school curriculum.

Graduate Medical Education

Upon graduation from medical school the student embarks upon his graduate education in the hospital. Again he is fored to differentiate and specialize, as he must choose in particularly all internship programs in the major teaching hospitals of this country amongst medicine, surgery, pediatrics and obstetrics. The degree of responsibility for patients is directly proportional to the value of his educational training experience. This is the main determinant of the degree of success of his acquisition of skill and mature judgment, provided, of course, that he is properly supervised by mature and skilled preceptors. There are many problems in this period of training but three main areas of interest stand out: 1) the indentured apprentice phenomenon, 2) the effects of syndicalism, and 3) the hazards of specialism.

The indentured apprentice phenomenon is a carry-over from the 18th and 19th centuries when the medical student and medical school graduate attached himself to successful practitioners for the purposes of training. A fee was paid the preceptor by the indentured apprentice. Today the apprentice attaches himself to a hospital (and its staff) which pays him barely living wages in return for a tremendous amount of medical work involving both the indigent as well as the affluent sick. He is, in effect, an indentured apprentice, still paying for his training. If either the hospital or the practicing staff, or the patients had to pay the going rates for such work, the amount would far exceed the meager salaries paid.

But there is even a more important aspect of the indentured apprentice system of graduate education in hospital, and that is, the lack of corporate responsibility for the educational program. The Surgical house staff is indentured to the Chief of Surgery, the Medical to the Chief of Medicine and so on. At the moment there is no joint responsibility for the on-going scrutiny, evaluation, and reformulation of graduate programs of education. Thus, there is no regular meeting and no Committee identified in the hospital which carries on this work. Therefore there is no truly University type of Faculty responsibility for the details and evolution of the curriculum and of course, no ultimate corporate authority or responsibility, ie., that which is vested in the Board of Trustees of the hospital, such as exists in the University's Board of Trustees or Overseers for the articulation of the University's curricular program with the wants and needs of society. The Chiefs of Service maintain their respective house staff members as their own and there is no discussion or debate which would relate the parts of the teaching program to the whole, or the whole to the community *or* the university. It is quite obvious that this is a defect which both hospital trustees and university overseers should correct.

This discussion leads naturally into a second dilelemma in graduate education, namely, the defects of *syndicalism and vested interest*. I refer specifically to the Council on Medical Education and Hospitals of the A.M.A. and to the various Specialty Boards in medicine and surgery. These organizations have done much to standardize training and the requirements for specialist certification at really high levels. Thus they have worked diligently and successfully in the public interest. Paradoxically, however, these agencies have the control and power of decision over the programs of graduate education and their structure and development in hospitals, where the University and the hospital have virtually none and have let it all go by default. This is done through the setting of requirements for ultimate certification as a specialist in one of the many sub-specialties of medicine or surgery. The A.M.A.'s Council on Medical Education accredits and sanctions the various types of residency programs in the teaching hospitals of this country. The specialty boards set the ultimate requirements for certification, both in content and length. No one would deny the virtues of such a system in terms of standardization, particularly for non-university affiliated, teaching hospitals, and the guarantee that certain minimum requirements have been met in terms of actual experience and formal educational exercises. In this instance the public interest is served well by the A.M.A. and the specialty groups.

There are, however, certain distinct hazards. If requirements for entry to the specialty profession are set by the profession itself, then the profession can set the numbers which are allowed to enter. Granted the public is protected from excessive competition by being able to limit the numbers allowed to enter. The public must have the guarantee of well-trained doctors, but the public needs more doctors. If numbers can be limited and a shortage exists, then there is more demand for the specialist, and his services become more precious, i.e., expensive. Furthermore it is a well-known sociological fact that the status of a group is enhanced by extended educational requirements. There is some evidence that the A.M.A. purposely attempted to limit the number of doctors for these very reasons during the 1930's and 40's. At any rate, no specialty board or the A.M.A. has ever *reduced* the period of time necessary for specialist qualification, and there are no current attempts to do so. Nor, to my knowledge, are there any attempts to rationize and sub-divide the work of the doctor so that other workers can assume more responsibility and free the doctor for work that only he can do. The public interest demands well-trained doctors *and* more doctors. The profession now controls their production and their educational programs, and not the teaching hospital or the University, a paradaoxical and, I believe, basically unhealthy state of affairs. There is built-in all the defects of conflict of interest, in this case, the self versus the public.

The manpower shortage is too important to be left to the medical profession alone, and manpower is very definitely controlled by the length and requirements of graduate education. Graduate education exceeds the time for medical school education in some instances. Its control and development is properly a university function. It should ultimately be articulated with the needs and wants of society-at-large by the non-vested, neutral view of the University and the teaching hospital Board of Trustees. It should not be left to the authority of the American Medical Association, which is controlled by non-educators and practicing, professional interests.

We have spoken of the hazards of too early differentation in the educational process and the defects of *specialism*. Perhaps the greatest defect of specialism is that it creates experts who are able to function without moral commitment outside their own area of expertise. There are two hazards here: 1) the patient is forced to make his own diagnosis and then try to pick the right specialist, thereby frequently delaying appropriate medical care; and 2) the expert "sees" only his area of expertise and avoids or neglects all else, leading the patient to believe that everything else is all right. The eye surgeon may remove the cataract without detecting occult, underlying diabetes. This is not good medical care.

If only we could say that there are only two cultures, but alas in the health profession, there are more than 50, and they are increasing exponentially! The patient's body and soul is subdivided by all these experts and the thread of continuing care for the whole human being is sometimes hard to find. Manpower is short and the shortage will become even more acute. Only furtive attempts are made to subdivide the work rationally so that scarce manpower can be utilized optimally. No attempts are made to shorten the educational period which would help recruitment. Here again such work is properly that of the teaching hospital and University. The public's interests are protected here by their representatives – the Boards of Trustees. If this is not done, then the public will turn to their other representatives, i.e., their elected political officials, and a complete system of Government medicine will come into being. I, for one, believe this development undesirable.

Continuing Education

The contemporary social scene should be sketched so that we can place the practicing physician and his problems of continuing education in the proper perspective. At one end of the scene we have the individual leaving the "gown" - the medical school and its large urban teaching hospital – and travelling out to the "town", where lies the community hospital and no medical school, no large university hospital, no academy and leaves the rigors of the university environment with its rich intellectual rewards to enter the demanding world of the community with its rich emotional and financial rewards. Very soon his capacity to stay abreast of advances in medical science and medical care diminishes. His attendance at Staff meetings flags. Trips for an occasional post-graduate educational program become socially acceptable excuses for a sojourn with the wife and a comfortable rest from the demands of his patients while *passively* listening and relaxing through lectures on "Advances in the Treatment of Hypertension", or "Hazards of Antibiotics" and so on. This Arcadian delight can not provide the positive rigors of learning that exist in the university hospitals. What is provided is too frequently a dull, passive, vocation-laden exercise on "what to avoid", "how to do it" and "how much to give and when".

As the practicing physicians grows more successful and busier with his expanding number of dependent patients, he finds it increasingly difficult to capture the time to share in education programs, either as the recipient or as the teacher of the house staff in the community hospital. The "detail man" from the drug house becomes his chief tutor and medical mentor. Slowly but surely, he begins to feel estranged from his in-town medical school colleagues; and the same professors he used to admire and even hero-worship now become the objects of slowly growing hostility, resentment and even suspicion. He feels that the ivory-tower, "gown" boys "don't know the facts of life," too often criticise him and his fellow community physicians, are usually left of center and willing to see the central government take over medicine and hospitals because "they are on salary so what do they care!", and generally lead "the soft life" in the upland pastures of the academic microcosm. It is almost incredible that there should be this split between gown and town when both originated from the same place, both at one time shared identical educational programs, and certainly both have or *should* have similar goals. The estrangement is peculiar to the profession of medicine.

The Journal of Medical Education in its issue of June 1963 neatly lays out the complexities of the "town-gown" problem and medical education. The struggle for status, patients and hospital beds, in short the securing of the economic life-line and the all-important ego-gratification, constantly gnaws at the vitals of medicine and distracts it increasingly from effecting adaptive change. Simultaneously it explains at least some of the suspicion and inability of the two worlds of medicine to effect coordinated change in its education system. Value-judgements concerning the medical school and university hospital held by many practicing medical alumni are listed: the medical school and its hospital are teaching too much science and not enough art, producing too many specialists and too few general practitioners, doing too much research and not enough training, establishing a "corporate practice of medicine" and neglecting the individual, and successfully competing to fill an ever-increasing number of house staff berths and thereby depriving the community hospital of its full complement of interns and residents. Also carefully reviewed is the fear of the community physician alumnus, that two strong forces may eventually prove disastrous to him by pulling the distribution of medicine from the periphery to the central, university-affiliated hospital: 1) the centripetal force of modern medical technology and 2) the changing needs and demands of the patient.

The town-gown battle interferes with the process of continuing education. Recently, several developments have given cause for hope in the continuing education of the physician. One is the increasing interchange of house staff between teaching hsopitals and community hospitals; another is the creation of a new group of "Directors of Medical Education" in community hospitals. In the first instance joint programs with a two-way flow of house staff can benefit both community and university hospital *and* also help materially in the recruitment of house staff for the community hospital. The environment thus created gives much to the Staff in terms of this continuing education. A third development has been the Heart Disease, Cancer and Stroke legislation which will stimulate regionalization of medical activities, including educational programs.

To hold the Director of Medical Education – a latter day Plato! – university hospitals should be ready, willing and able to form house staff and staff sharing plans – for this is one of the best ways to seed new knowledge in the community hospital – and should be willing to share educational material and methods by joint conferences, television, slides and so on. The Heart Disease, Cancer and Stroke legislation will provide support for such activities. The University hospital must extend itself outside its walls and not be accused of ulterior, competitive and financial motives when it does so.

Recently Dryer has published an excellent review of "Life-time Learning for Physicians." The study calls for a nation-wide "university without walls" - a national program of continuing medical education for practicing physicians. This is a well-written document and well-conceived plan. For those community hospitals and physicians within striking distance of the medical school or university-hospital – the experiment in continuing education can start now! The academy and its academic ideal can develop in the community, separate from the university if proper cooperation can be established and positive attitude maintained. In this way, the gap between scientific knowledge and its application at the bed-side can be narrowed, our patients will receive better care, and the profession will show positive evidence of their continuing concern for what makes the profession great – its humanitarian motive and its special, ever-increasing body of knowledge, accumulated and passed on for the benefit of mankind.

The Rationalization of Health Services

Granted certain weaknesses in the process of medical education – from the intellectual constriction of the pre-medical student, to the treatment of medicine and man solely in terms of physical and biological science, to the production of experts through an indentured apprentice system governed by the profession and not shared by the hospital and university, to the intellectual isolation of the practicing profession with drastic, unmet needs for continuing education – what has all this to do with the rationalization of health services? Will the doctor recognize new responsibilities? Will the patient receive better care? Will high quality care be more readily available to all the people?

My answer is "yes", without implying a philanthropic or even a vocational purpose to study of the social sciences. The need for breadth in college education is obvious. Why should the physician be deprived of an education because of unrealistic and constricting pre-medical requirements? Equally obvious is the fact that medicine is a social as well as physical and biological science and needs the application of the social sciences in medical school, both for a complete understanding of illness in individual and groups as well as self-understanding in the members of the health profession, their organizations and institutions. The indenturers and the experts of various special interests are the only ones who will complain when a corporate teaching hospital and university responsibility assumes its share of control of graduate education, and helps to rationalize its content, scope and length as only a non-vested, neutral interest can. I believe this can be accomplished through hoint action of the A.M.A., the specialty boards, the hospitals and the medical schools, with the majority control in the hands of the university and the teaching hospital (Faculty and Trustee).

But why should this improve the medical "system"? If the humanities are given a larger share of attention, *will* their study produce in our doctors "enlivened imagination, increased responsiveness, broadened interest, clarified purpose and in the end also, quickened ethical sense"? Will exposure to the social sciences improve the doctor's social behavior by knowledge of its laws? And will it improve the care of patient and community if our doctors have been at least exposed to the social and economic issues that surround medical care? Will knowledge of man as a social as well as a biological organism lead, through increased understanding, to better organization, distribution and utilization of health services by both doctor and patient?

Again my answer is both "yes" and "no". Perhaps our problems are "due in part to the willfulness, stupidity, greed and fears of men; in part also to the presence in life of real choices and hence of ineducable conflicts!" But, I do firmly believe that "real choices" should be made, wherever possible in the full knowledge of human behavior and the consequences of the choice. A studied awareness of contemporary man in the contemporary social system can lead only to greater self-understanding on the part of the doctor and in turn to greater understanding of, and effectiveness with, the problem of his patients. Understanding leads to a certain degree of moral suasion in all men. Morals aside, knowledge of political and economic systems will allow the physician to participate more fully in his own future and that of his hosptials and his patients.

The three great revolutions since the turn of the century which have affected medicine and will continue to shape its future are: 1) The Flexner report in 1910 which established medical education in the university, 2) the advent of third party, pre-payment medical services with the Blue Cross in 1929 and the Social Security Act of 1935; and finally 3) the 1965 Amendments to the Social Security Act known popularly as Medicare. In each case, change has been forced on the profession at large from without and not from within and as a consequence, the profession has played little part in the shaping of such change, except in the form of resistance and rear-guard action. Medicine must assume its responsibility for adaptive change to match an ever-changing set of social, political and economic problems or surely it will lose more and more of its precious freedom to central bureaucracy.

Federalism can be creative only if local action by responsible citizens shapes the content and course of programs and guides the use of money appropriately. A balance of public and private interests must be struck to achieve what a fully governmental and a completely private system of medical care has been and is presently unable or unwilling to do by itself. New organizational arrangements are needed to articulate these combined interests with the wants and needs of society at large. Understanding of political, social and economic systems as they relate to Government as well as to medicine's institutions such as hospitals is needed by physicians and their organizations if they are to be allowed to have a hand in shaping their own future.

Medicine today is a house divided against itself. The final test of the private practice of medicine and the voluntary system of hospitals has begun. Will the profession continue to fight with itself? Are the three major enemies of organized medicine as described recently by a high official of the A.M.A. – the hospitals, the medical schools, and the Government – really the enemies or has the profession met itself?

It is not too late for the profession to acquire a broader view based on certain changes in its educational process and thereby to assume new responsibilities. The question remains, will it?

SHO Regional Conference On Medical Systems: "Servant Or Oppressor Of The People?"

The Non-Competitive Drug Industry

Recently, the New England Student Health Organization held a regional conference to discuss some current problems concerning the health care delivery system. One of the major areas of discussion centered on the drug industry and its relationship with the medical profession. Some pertinent points which we, as medical students, should be aware of are as follows:

The drug industry is a highly concentrated, non-competitive enterprise. Despite the fact that no company controls more than 7% of U. S. prescription drug sales, drug markets are separate and non-competing. That is, the sale of tranquilizers does not cut into the market for antibiotics; and the sale of these do not cut into the market for anti-inflammatory agents. There is no price competition between drug companies in general, but rather, between companies producing a particular chemical entity.

The number of firms producing and/or selling a drug is limited primarily by patents and licensing practices. Patent protection of drugs provides exclusive rights to produce the drug or grant licenses to other companies. The patent gives the producer the option of "charging what the traffic will bear" and to sustain the monopoly for a period of 17 years. The monopoly can be extended by proper spacing of improvement patent applications or by making slight changes in the drug's molecular structure, to supposedly increase its potency, efficacy, or safety. The combination drug is the mechanism by which drug companies extend their patents and price monopolies.

The backbone of the drug marketing system is the brand (trade) name. Once the brand name wins acceptance by the physician, it is difficult to erase from prescriptions in favor of a generic product. The overwhelming proportion of drugs sold today, are such that even a prescription for generic drugs stands a 50-50 chance of being filled with name brand products. 44 or the 50 states have antisubstitution laws making it illegal to fill a prescription for a particular brand with any other. Generic prescriptiions, however, may be filled with any brand. The high cost of brand name drugs has virtually nothing to do with production costs and other expenses but rather is based upon the maximum the public in its medical need can be induced to pay. For example, Prednisone, a well known steroid in common usage today, under the brand name of Meticorten (Schering's name brand) sells for $102.57/1000 while Wolins (a large wholesaler of generic drugs) sells Prednisone U.S.P. for $4.40/1000. That is a price differential of $98 for the same drug sold under different names!

The industry's campaign for its name brands begins early. With medical students, the strategy of names takes on great importance. We have been taught in our pharmacology course by Dr. Pelikan both generic and trade name drugs. How often do we remember generic names? Brand names stick very easily in our minds when we are constantly exposed to them on the wards, in drug advertisements, and through "detail men." This campaign of indoctrination to name brands is carried on in many fronts. Marketing expenses absorb anywhere from 15% to 35% of the industry's sales. To the tune of $3000 – $5000 per physician per year throughout the U.S., the industry can treat each M.D. to: 1) brochures and journal advertisements 2) free product samples 3) displays and hospitality at conventions 4) grants for research, professors salaries and academic courses 5) detail men 6) "gifts" to medical students and doctors.

Another area of interest concerns those men who decide medical center policies. Interlocking directorships have emerged on boards of trustees of various medical centers and hospitals all across the country. Dr. Philip Lee of H.E.W. has pointed out that through grants, contracts, fellowships, guest lectureships, and unrestricted support many people in academic medicine have developed very close ties to the drug makers which amount to millions of dollars each year. Power structure analysis has elucidated the fact, for example, that an overseer of Albert Einstein College of Medicine is also chairman of the executive committee and director of Warner-Lambert, the fourth largest drug company in America. The same man is also president and director of a large Foundation which grants a quarter of a million dollars a year to various medical investigators. When it was disclosed that dean Ebert of Harvard Medical School was on the board of directors of E. R. Squibb & Co., student protest forced him to resign. A well-known trustee of Tufts University and a member of the board of Tufts-New England Medical Center is also a director of Merck, Shart, & Dohme., Inc. (the fifth largest drug company in the U. S.). In addition, he is president of Merck, Sharp, & Dohme Research Laboratories Division, and a trustee of the Merck Co. Foundation which every year grants nearly a million dollars to medical education, hospitals, loans for interns and residents, and fellowships in clinical pharmacology. No one can be sure when and if conflict of interest exists but it certainly is food for thought.

Another of our treasured legends has gone the way of the unicorn and the hippogriff, explained away by the wonders of modern science. It seems, according to a lecture delivered here by Dr. Stephen Robinson, that the werewolf may merely have been a poor sufferer from congenital photosensitive prophyria. The prominent dermatitis, brought on by exposure to the sun, and the resulting facial disfigurement are thought to have been sufficient to force porphyria victims away from personal contacts and to limit their wanderings to the night hours when the moonlight was less likely to produce dermatologic distress. The incidental symptom of erythrodontia (red teeth), while not necessarily a problem to the prophyria victim, did not contribute to his social mobility.

It is not hard to imagine what the superstitious would make of a shaggy-faced, red-toothed wraith seen rambling about by the light of the full moon. One just did not think of checking his (its?) urinary prophyrins at times like this.

Of course, we all know better now. Thesis buffs interested in confirming this vital medical concept are advised to hie to the moors of Massachusetts with their Watson-Schwartz kits at the next full moon, March 22.

Just in case Dr. Robinson is in error, however, an adequate supply of wolfbone might be advisable.

– Eric Honig

The Cuban Health Crisis

The weekend of February 13th saw the first annual regional SHO (Student Health Organization) workshop in health care problems. This conference, intended for concerned health-care students and professionals, welcomed students from Philadelphia, New York and lands as distant as Toronto, Canada. Issues to be discussed included: the drug industry and the public, hospital organization, and ecology. The conference began with a discussion of the Cuban health care system. Three men and two women who are or were Boston area medical students gave a slide show-discussion about a trip they made last year to view first hand the way health care is handled by the Castro government.

Their first step was to obtain visas from the Cuban government. Once accomplished, they flew from Mexico to Jose Marti airport (which you would recognize if you've ever been on a hyjacked plane to Havana). As they stepped from the plane, our guests of the Cuban government noted the inevitable posters of Che and Van Troi (a young North Vietnamese who tried to assinate Robert McNamara and was executed in the streets of Saigon - now a Cuban and North Vietnamese hero.) The visitors were put up in the Hotel Havana Libre (formerly Havana Hilton), a luxury accommodation designed for Cuban workers, North Vietnamese and honeymooners. The tours they were to take were organized by the Ministry of Health. They talked with the Minister of Public Health who was also Professor of Preventative Medicine at Havana Medical School (professors frequently have dual roles as administrators and acadamicians) and he described how the 8 million Cuban people receive health care – as the system works on paper:

The smallest unit of health care delivery is the *sector*, made up of a sanitation worker and public health nurse who are responsible for 3000-5000 people. Five to eight sectors are served by each *polyclinic* (caring for 25,000 - 35,000 people). Each of these facilities has an internist, pediatrician and obstetrician-gynecologist. At the clinic vaccinations and preventive health measures are practiced. The next level is the *regional hospital* where surgery and diagnostic techniques can be carried out. Several regions are grouped under a *provincial center* where specialized problems such as neurosurgery can be handled. At the very top are the *university medical centers* where the most difficult diagnostic and management cases are handled.

Playing a strong role in handling health needs of the Cuban people is the Committee for Defense of the Revolution (CDR). This organization began in 1960 for the purpose of preventing "counter-revolution". Since then, with more national stability, CDR members have devoted more of their energies to a public health function. On the local lebel the CDR takes the form of political clubs and assist in dissemination of health care. Recently it was decided that all children should be vaccinated and this, we are told, was accomplished in half a day because children in each area were brought to their local CDR center and vaccinated.

Medical school education is said to be available to anyone wanting it and students eliminate themselves only by not being able to keep up with the pace. At least 50% of MD's are women as are the majority of dentists. The Cubans feel a common bond with the VietNamese and despite overcrowding of medical schools, training is given to Viet Namese wanting to become doctors. None of the graduates of medical school since the revolution have gone into private practice. However, the "old boys" –MD's practicing before the revolution – can still see old patients and charge fees. The government feels that this form of "non-revolutionary" practice will simply fade away in time.

Problems of health care are far from solved in Cuba, our visitors realized. Children still suffer greatly from viral gastroenteritis and parasites, though perhaps a more concerted effort is being made now to control these problems. The tap water in Havana must be boiled before use because faulty and inadequate plumbing contaminate the water supply. Drug addiction, prostitution and alcoholism were not problems our visitors were told. This, however, was not what they observed. They soon learned that certain topics were just not discussed. The full 10 million tons of sugar cane would be cut this year, they were told without qualification.

The Cubans are not at this time concerned with a population explosion, and so they frown on birth control. It is available, primarily in the form of IUD's but suggested for married women with more than five children. Abortion is available but not encouraged.

Paul Haydu

Begg Society,

CONTINUED FROM PAGE 4

be exposed to patients in the first year, the problem of students seeing the relevance of material that they're asked to learn and the definitions of a "core curriculum' were also discussed.

The lecture as an effective teaching tool seems to be on the way out, but whether this will help medical education become more dynamic or "come alive', was not resolved. The problem of too-much-in-too-little-time will remain and most people agree the enthusiastic, interested, dynamic professor is as important in the presentation of material as the mechanism used itself.

In sum, the mechanism of educating the medical student was discussed from various angles and the evening was worthwhile more for the enthusiasm and genuine interest in solving these problems engendered by the faculty and students than for any concrete proposals adopted.

Dr. Cohen appropriately closed the evening by noting that behind every successful man stands a woman, and Dr. Phoebe Lanzoni (a BUSM graduate also and involved in research with Dr. Cohen) should be recognized as Dr. Lanzoni's connective tissue.

– Al Converse

CALENDAR

CONTINUING EVENTS

Mon. - Fr.	4PM	Pediatric Conference Children's 9 Conf. Rm., BCH
Tues.	1PM	Neurology Grand Rounds E3-109, Boston VA Hospital
Wed.	12Noon	Combined Services Medical Grand Rounds Dowling Amphitheatre, BCH
	4:30PM	Surgical Grand Rounds Rm. 112, Instructional Bldg.
Thurs.	11:25AM	Medical Grand Rounds Evans 8 Amphitheatre, University Hosp.
Sat.	10:30AM	Topics in Medicine Cheever Amphitheatre, BCH

SPECIAL EVENTS

March 18

Surgical Grand Rounds – "Multiple Trauma" Robert L. Berger and Lester Williams.

March 19

Medical Grand Rounds, UH – "Pathophysiology of Cholesterol Metabolism", Dr. John M. Dietschy, Assoc. Prof. of Medicine, Univ. of Texas Southwestern Medical School

Psychology Colloquium, 4PM, Student Lounge, Inst. Bldg. "Experimental Studies of Intergroup Conflict", Leonard Solomon, Ph.D., Assoc. Prof. of Psychology, Boston University

Boston Society of Psychiatry and Neurology, 8PM, 5th Floor, Countway Library. Details of program may be obtained from Dr. Feldman's office.

March 21

Topics in Medicine – Topic TBA, Eugene D. Robin, Prof. of Medicine, Univ. of Pittsburgh School of Medicine.

March 25

Seminars in Gastroenterology, 5PM, Sherman Aud., Beth Israel Hospital – "Studies in the Intestinal Transport of Digitalis Glycosides", Norman J. Greenberger, M.D., Assoc. Prof. of Medicine, Ohio State University

March 26

Medical Grand Rounds, UH – "Sjogren's Syndrome", Dr. Kurt Block, Asst. Prof. of Medicine, Harvard Medical School

March 27

Boston Student Neurological Society, 5 PM, Rm. 1003, Inst. Bldg. – "Nerve Growth Factor", Roger Luria, Dept. of Microbiology, BUSM.

March 28

Topics in Medicine – "Chondrodystrophies – Fact and Fiction", Dr. David L. Rimoin, Asst. Prof. of Medicine in Pediatrics, Director, Division of Medical Genetics, Washington University, St. Louis

April 10

Boston Student Neurological Society, 6:30PM, Evans 8, UH – "Retinal Processing of Visual Images", Dr. Charles R. Michael, Asst. Prof. of Physiology, Yale Univ. School of Medicine

Send notice of future events to:
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