5-1972

Ariel - Volume 4 Number 7

Ronald B. Levine
Thomas Jefferson University

David A. Jacoby
Thomas Jefferson University

Roy Cameron
Thomas Jefferson University

Joseph S. Gonnella
Thomas Jefferson University

J.D. Kanofsky
Thomas Jefferson University

THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE

ariel

VOL. 4 NO. 7 MAY, 1972

Health Research Group Reports Findings of Investigation

By Ronald B. Levine

This article is the second part of a series concerning national health care problems currently under investigation by Ralph Nader's Health Research Group. The first part, in the February issue of Ariel, described the nature and purpose of the HRG. Part two reveals some initial findings of an investigation of the pharmaceutical industry.

The spectacular growth of the pharmaceutical industry in the post-World-War II period has been founded upon a number of important medical advances and has been associated with some radical changes in the structural and behavioral characteristics of the industry. Prior to 1937 and the introduction of the early sulfa drugs, the industry was composed largely of long established firms producing relatively standardized commodities. With the introduction of penicillin and streptomycin during, and immediately following, World War II, the nature of the industry changed. As neither of these products was protected by patents, the rapid growth of demand resulting from their introduction was accompanied by the entry of many new suppliers and the development of active price competition. The price of a standard form of penicillin dropped from $20 per 100,000 units, in 1943, to 4.5 cents in 1950. Following this experience it was clear to the leading firms that their profits in the future would depend on reduced competition by the development of protected market positions to be achieved through (1) patent restriction (2) product differentiation and (3) mass advertising and promotion.

Testimony of Dr. William S. Comanor, Stanford University economist, before the Senate Subcommittee on Monopoly.

The patent system has granted pharmaceutical companies monopoly-status during the seventeen year life of a patent. This serves to foreclose, to a great extent, rivalry between identical chemical entities about which price competition might develop (as had evolved with the marketing of penicillin). This has resulted in a marked disparity between "brand name" (patented) drugs, with an average prescription cost of $4.11, and "generic" (non-patented or expired patent) drugs, which are subject to competition and average per prescription $2.02-a price less than ½ that of brand name drugs, yet still profitable for producers. While drug companies claim that patent restriction is necessary to recoup high research costs, most do so in a mere three years and reap excess profits for the duration of the patent.

An outgrowth of patent restrictions is product differentiation. This includes: "molecular manipulation," in which a company holding a patent on a chemical formula may alter it slightly, yielding a new entity, with often no therapeutic improvement, but which can be marketed as a "new" drug under the protection of the original patent; and "me-too drugs," which are subsances not significantly different from other drugs and represent little or no improvement in therapy, but which are sufficiently altered in chemical structure to win a new patent.

The pursuit of product differentiation has corrupted a primary activity of the drug companies- pharmaceutical research. Drug companies pride themselves in their extensive research activity-an expenditure averaging three times that of any other major industry-amounting to over $500 million a year (compared to only $100 million for government sponsored pharmaceutical research). But what has been the emphasis of their research? Between 1957 and 1968, 2,131 new prescription drug products were introduced. Of these, 1,440 were combinations of two or more older drugs; 380 were essentially duplicates or minor modifications of products already in use; only 15 per cent (311) of these products introduced onto the market were described as new chemical entities! Even among those few new chemical drugs, an average of only three per year represented significant technological progress in medical treatment. It can be observed that most research effort (85 per cent of new drug output) is wasted on replicative drugs to increase product lines (and, hence, to increase corporate profit) instead of original drugs to promote medical progress.

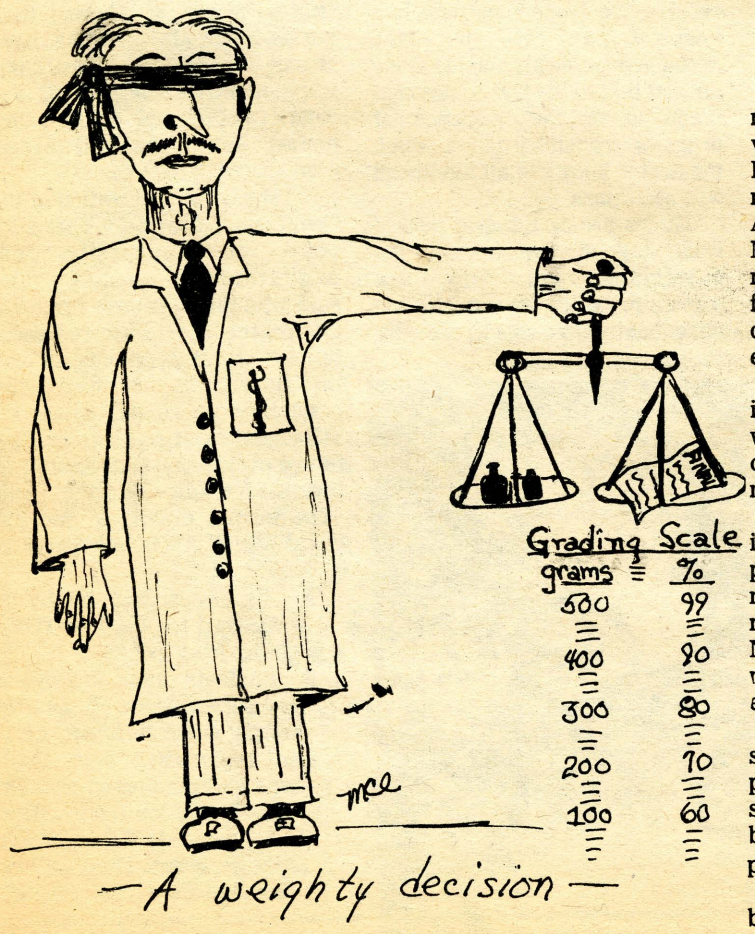
Indeed, the pharmaceutical industry's greatest success has been profit making-a study of 41 industries has shown that between 1956-and 1966, the drug industry never ranked lower than third on the basis of after-tax income as a percentage of net worth. In six of these year, it ranked in first place. The industry has defended its high profits on the necessity to offset "high risks" inherent in the drug industry. This justification is false, however; most companies market a large line of different drug products and thus their net risk is small.

The aggressiveness and extensiveness of advertising and promotion is both a causative and resultant factor of patent restraints, product differentiation, and profiteering. Dr. Comaner noted that in twenty industries, advertising was the most important source of product differentiation because consumers (in this case, physicians) are uniformed about the relative or absoulte merits of the many drugs continually introduced onto the market, and thus, the promotional activities of drug companies seek to this information gap.

The major "ethical" prescription) drug companies spend $900 million per year on advertising and promotion. This represents about $4,500 for every practicing physician-more than enough to send every medical student to school free!

The drug companies utilize various media for promotional activities. An important one is

(Continued on page 8)



—A weighty decision—

M&CO Students Learn About Health Care Delivery

We as future physicians are confronted with a crisis. This crisis centers in the delivery of health care. In the history of health care, there has not been as turbulent a period of questioning and scrutiny as there is today. At this time there are not less than a dozen bills being considered in Congress which address themselves to health care. There have been several plans, such as the Kaiser-Permanente Program, that attempt to establish a more effective and efficient model of health service in the community. I feel, however, that the needed improvement of our health services on all levels of care can only come with a reorientation and re-examination of the physician's own ideas on the system. But, in order to do this, one must gain a perspective of how this system works. I fear that this is very difficult for the practicing physician who is exposed to a limited sphere of this system. It is, therefore, very important that we, as students, gain this overall perspective in our medical education.

The great problem of medical education is that there is little time given for the student to examine the present system of health care. In the first few years of his medical education he is concerned with the basic sciences. In his last years, he is on his clinical clerkships applying the basic principles he learned. With the start of his clinical years, the student is taking an active role in the health care system. He is, as result, too close to examine the method of health care delivery and can only get a restricted, if not distorted, viewpoint. Another obstacle to obtaining this overall view is that most medical schools, like Jefferson, are situated in the city. A student, even in his clinical education, rarely is exposed to small community or rural medicine. To fill this void in the student's education an experimental program was set up at the Illinois Masonic Medical Center in Chicago in the summer of 1968. It then was expanded by the Student American Medical Association with a Sears Roebuck Foundation grant to 18 states and the program was called the Medical Education Community Orientation Program (M.E.C.O.). Today this SAMA program is operating in forty states.

One may ask how does this solve the problem and what importance is this to the Jefferson student. The student in MECO is matched to a small community hospital where one of the family practitioners who works in the hospital is the student's preceptor. The student then will rotate under the primary guidance of his preceptor through the barious departments of the hospital. Stress, however, is not placed on clinical experience. Though the student is exposed to the clinical aspect through accompanying his preceptor on his rounds, the student also rotates through the administrative division of the hospital, as well as the preceptor's own practice with the emphasis being on **how** the health care is delivered to the patient and which personnel other than the physician, are involved in this service. Emphasis is also given to the specific community organizations involved in health care outside of the physician's office and the hospital. In

(Continued on page 7,

Bornemeier Discusses Health Insurance

by David A. Jacoby

Speaking to representatives of national heart, cancer, and other voluntary health organizations Dr. Walter C. Bornemeier, immediate past president of the AMA, discussed the shape which National Health Insurance is most likely to take and the influences which various candidates might have on it if elected.

That it will soon be here and include catastrophic coverage is without a doubt. How much basic coverage it will include is another matter.

Senator Kennedy's bill will include incentives for group practice and HMO's which are more extensive than the administration's; and as any bill of Nixon's must go through Kennedy's committee, Kennedy's effects will be strong indeed.

Neighborhood health centers serving populations of 20,000 and providing 24 hour emergency service–though not necessarily by physicians–are also likely to part of the bill.

Another key component of the bill will be Professional Standards Review Organization which will be applied to all doctors.

Financing remains a key unknown, possibilities including the AMA's Medicredit based on taxable property, Kennedy's proposal based on direct taxation, and the administration's proposal based on employer and employee payroll deductions.

The upcoming congressional elections will have a big effect on National Health Insurance's final outcome, for all but nine states have been redistricted and Congress has a new compulsory retirement law.

Bornemeier Speaks

Even the presidency seems to be up for grabs. Leaving out Wilbur Mills, Henry Jackson, and George Wallace, the other Democratic candidates differ very little. All would lean towards the proposals of Kennedy's Committee of 100.

In closing, Dr. Bornemeier noted that constructive political action is very important, **for politics is equal to government.**

Informed Procuning

Contrary to the religious dogma of the Christian Scientists, the physician is still the servant of the sick, rather than the other way around.

One of the physician's duties incolves purchasing services and supplies for the patient–on a carte blanche basis–in order that the patient may most speedily be restored to full health.

However, as neither the world's not the patient's resources are limitless, achieving this return to full health at lowest possible cost to the patient should be a consideration.

This is a job which can best be performed by the physician, but only if he has a knowledge of the **actual charges** for which his patient will be billed.

Yet if he operates on the basis of **relative** charges as they exist today, the hospitals and societ in general will suffer, for **charges** have no relation to **cost**.

Of course, for most patients **charges** (what is asked for on the bill) have no relation to the hospital's revenue (what is actually collected), for most third party payers pay **cost** for inpatient services and reimburse nothing, or next to it ($4.00 for all out patient services rendered to a medical assistance patient during a single visit).

The results are 1) the removal of the profit motive, 2) the encouragement of unecessary and expensive hospitalization, and 3) rising hospital costs as there is nor penalty for efficiency.

Can the situation be improved?

Most definitely–by making **charges** reflect **cost** in a directly proportional way, by applying charges uniformly based on cost for both inpatient and outpatient services, by reimbursing the medical providers equally on the basis of quality and quantity of service rendered rather than on whether they are solo, group, HMO, or hospital based and whether their services are inpatient or outpatient, and by letting physicians know in advance the costs of those services they so glibly order in order that they may procure for their patients the maximum benefits at least cost.

As already pointed out, for many **charges** are merely an exercise in bookkeeping, for the third party payers representing them pay only the **cost**. But for a significant number–the 11 % of hospital admissions nationwide who pay their own way and those hospital admissions only partially covered by private insurers other than Blue Cross--the charges are something which must be paid in full (although the hospital will occasionally give discounts) or their account will be turned over to a collection agency.

These are the people who at Jefferson must pay the full $51.40 **charges** for an SMA- 6 (incidentally, the **charges** for the individual components of the test are about $8.60**each**, although they are still **run** on the SMA-6)–while their Blue Cross covered friends pay the hospital the $3 to $4 **cost** (which includes the machine, materials,labor, overhead, and a 33% contribution for the subsidy of the rest of the hospital).

In their Robin Hood existence of old doctors charged the rich more and served the poor for what they could pay. Many still do.

Many hospitals used to also, but few still do, for as third party payers (Blue Cross and the state and federal governments) have taken over, they have denied the hospitals the right to hike the prices of those who can best pay.

As a result, due to government intervention, it is now not the rich, but the lower income wage earners as well as retired people not covered by medicare, who get charged more to pay for the destitute.

It is a strange system indeed. If the private sector has failed, it has been with a big shove from the state. The situation is bad, and as Dr. Bornemeier points out, National Health Insurance will come shortly.

Whether it will significantly increase health services, or only the costs, remains to be seen–but regardless of the system there are many things whech can and must be done **now** by hospitals and physicians alike if we are to deliver health care within the financial reach of this most wealthy of nations. As the procurement agents of the people, the responsibility starts with us.

Ariel Expands

Beginning with its next issue, **Ariel** will be expanding to a twelve-page format, providing even greater access for readers to share their ideas, comments, suggestions, and xomplaints with the entire Jefferson community. We sincerely hope that you will depart from the apathetic legions and become involved in effecting improvement in the community.

Abortion and Euthanasia, A Case for Medical Ethics

With advances in medical science and the price thereof, new ethical dilemmas confront the practicing phsician.

Our ability to say who shall live and who shall die without legal repercussion has expanded greatly. Should the doctor, or any man, play God?

Although some would say that the ethical thing to do is to let each doctor decide for himself, and that for one doctor to impose his views on another would be an unjust tyranny, I doubt it.

The perennial question, when removed from the medical model, is: "If each man has a right to act as he wishes, without constraints from others, what are his obligations when he sees one man about to kill another if, by his own actions, he can prevent that killing?"

My answer, and that of most who believe in individual freedom, is that one must do one's best to prevent that killing, that one must do one's best to the free man being unjustly attacked, lest that man one day be he.

Thus, I would hold that we have an obligation to all we can to end war as an instrument of national policy.

But we as physicians must not work just in these areas where our individual contributon is small and our likelihood of success is low; we must also address ourselves to those areas of medical ethics where our influence is large, and consider not just the immediate benefits of a given expedient act, but also its long range effects on the morality and ethics of society (a schizophrenic one, to be sure) as a whole.

There are several areas where debate is heated--abortion, euthanasia, the right to refuse the herioc efforts of doctors to prolong one's life, and care of the "retarded" individual to name a few.

Without a doubt the world suffers from overpopulation, war and inadequate food, housing, education, and job opportunities, but is the solution one of changing our very definition of life or humanity in order that we may kill unborn children with clear conscience? One need only read the "letters to the editor" column of the **Evening Bulletin** to realize that many in all sincerity know that a human fetus is not alive!

If one removes the sanctity of the unborn baby's life, then the unintended result which is bound to follow is that one removes the sanctity of all human life, for there is no variable other than being born of human parents which will allow one to separate human beings from the rest.

Surely it is not knowledge–or one must deny the humanness of those denied an adequate education (for instance, many of the residents of North Philadelphia and of Central and South America). Surely it is not intelligence, for there are many of low intelligence who nevertheless embody those noble traits by which some would define humanity; surely it is not the opposable thumb–for there are many who through traumatic injuries or congenital malformations have none, and yet they are human; surely it is (ought not) be one's age at either extreme, for there are many alive today who were born so prematurely that they could have been legally aborted in New York up to their time of delivery and also many older people–Piccasso for example– whose contrbutions and human genius continue in spite of their age.

In the past other criteria of humanness have been tried and used--the German experience with health, race, and religion being a notable example–with disastrous results.

As a student at Jefferson I have been asked (but not required) to aid the "team" when abortions are being performed for no reason but the mother's convenience; I have been told that the best thing to do for a woman bleeding from metastatic ovarian carcinoma (site of bleeding already known) is to let her bleed to death; and that several children with growth and/ or mental retardation problems should be allowed to die of their next infection or bout of heart failure.

Medicine is a profession which can easily deaden one's sensibilities, especially when one recognizes the sheer number of sick people with whom one must deal. This illness is a problem both for the patient and for the society which is increasingly assuming the responsibility for paying the bills of many of its members. In this situation many, overwhelmed, are starting to view the "illness" as the sick patient who must be eliminated through either a speedy recovery or a quick death. It is a view which we must reject.

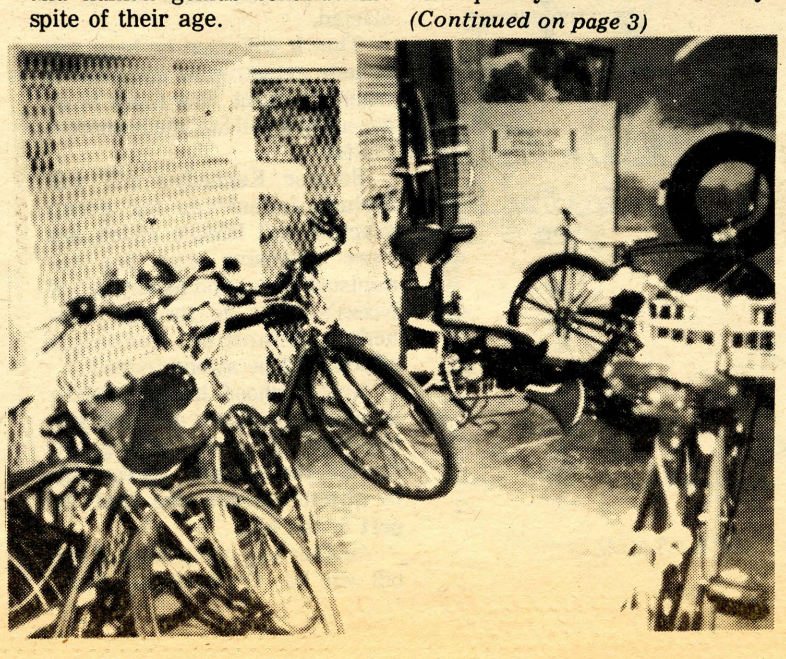
Regarding euthanasia, if we accept a person's worth as determined by the amount of his future income or the extent to which he is wanted by easily identifiable others (i.e., immediate family), then we are by extension denying that the lives of those on welfare mean anything and once again encouraging large families as a form of life and health insurance.

Certainly a person has a right to be wanted, but this surely does not mean that if not wanted he has no right to live. Many of mankind's greatest thinkers were not wanted, but happily they lived in spite of this lack of appreciation, their appreciation coming after their death.

On the other hand, a person most certainly has the right to refuse heroic treatment and yet receive the basic care which a hospital can offer--but this decision must be his and his alone and not that of his family nor that made under the influence of drugs or transitory pains which the doctor knows in all likelihood will soon pass.

Ethics are an integral part of each day of our training as physicians, yet they are something which we consider too infrequently. In cases where only

(Continued on page 3)



We Need Bicycle Racks

The bicycle is without a doubt the speediest method of commuting in center city. As numerous Jeffersonians have found out, it is also fun, good exercise, and cheap–until one starts to consider the cost of stolen bicycles.

A bicycle rack in a location visible to the library, Orlowitz, or Jefferson Hall security guards is sorely needed, for right now there is not adequate safe parking space available for the number of bicycles owned by Jeffersonians.

Currently a car can be kept in the city with relative safety at great expense to both the owner and the residents who must breath its pollution. A bicycle, on the other hand, is neither costly nor poluting– yet no provisions are offered for its safe parking.

We have heard that one estimate for such a rack ran to $5000--which is indeed a ridiculous price, for all that is needed is a bar or a series oposts around which padlocked chains to secure the bicycles can be easily attached.

Therefore, we hope that new bids will shortly be taken on a **simple** rack, bar, or what-have-you and a safe place to store bicycles provided.

If visible to already present guards, such a facility would be well worth its cost.

Letters To The Editor:

The Future of TGIF

Due to increasing conduct problems experienced at recent TGIF parties in Jefferson Hall, the *Commons Program Committee* decided to cancel the March social event and reevaluate all aspects of the TGIF parties. Their original intent in sponsoring these parties was to provide an event where Jefferson students, faculty, and employees could relax and socialize together. As the parties became more popular, greater numbers of non Jefferson people attended...to the present situation where outsiders probably outnumber our own people and have little or no regard for the welfare of our students or facilities. Discouragement in the form of admission charges ($1.00, then $1.50, then $2.00) had no effect in decreasing the number of non Jefferson people in attendance. Attempts at limiting admission to only Jefferson people and their guests failed also because many of our own people will willingly bring in large numbers of outsiders (as their guests) that they neither know, nor will accept responsibility for.

At the recommendation of the Commons Governing Board (a body of University administrators, faculty and students) the Commons Program Committee met with representatives of all segments of the institution to explore the possibility of reinstatement of TGIF parties. It was agreed that future events **must** be limited to the Jefferson family and

The format drawn up for the "trial basis" April 14th party is as follows:

A. Admission will be by a Jefferson I.D. card or TGIF "Guest Pass" only.

B. Students and employees may obtain Guest Passes by showing their Jefferson I.D. and registering both their name and the names of their guests in the Commons Office (M-63) before 1:00 P.M. on the day of the event. There will be no charge for Guest Passes.

(Continued on page 3)

Abortion

(Continued from page 2)

an adult patient is involved, mutually acceptable solutions can be worked out by he and his physician; but where a third party is involved--an ailing family member, a legally incompetent person, or an unborn baby with no one to represent his interests--no other person has the moral right to end that third person's life, for our role must be that of preserving, not destroying, life with the awareness that a human being is free to do with his or body what he or she wishes, so long as it does not infringe on the rights of another human being. Until proven otherwise unborn babies, retarded children, and those who in all likelihood will not contribute anything to society arestill human beings and must be protected as such.

—David A. Jacoby

Letters (cont'd)

C. Guests must be accompanied by their host.

D. Student monitors will be hired to patrol side doors and fire exits to hopefully eliminate illegal entry through those means.

E. Because of increased costs (hired student monitors) and reduced income (eliminated admisision charge) refreshment prices will be raised to $.20 each-six for $1.00.

The future of the social program is at stake and only the full cooperation of everyone to see that TGIF parties are orderly social events solely for Thomas Jefferson University will assure its continuance.

—David Grebos

The Right of Life

I thought with all the controversy of late concerning the "dying patient" that a few words from a more controversial philosopher might do some good-therefore, I quote from Nietszche, a man who saw through quite a few things:

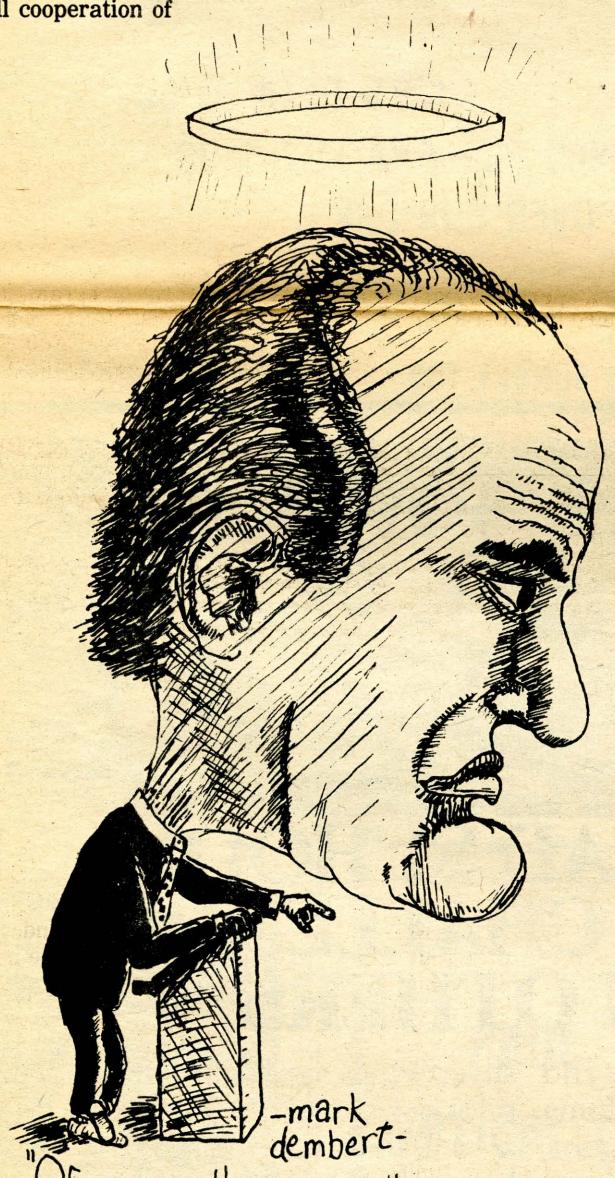
"A moral code for physicians-

The invalid is a parasite on society. In a certain state, it is indecent to go on living. To vegetate on in cowardly dependence on physicians andf-medications after the meaning of life, the right to life, has been lost ought to entail the profound contempt of society. Physicians in their turn ought to be communications of this contempt-not prescriptions, but everyday a fresh dose of disgust with their patients....To create a new responsibility, that of the physician, in all cases in which the highest interest of life, of ascending life, demands the most ruthless suppression and sequestration of degenerating life-for example, in determining the right to reproduce, the right to be born, the right to live proudly. Death of one's own free choice, death at the proper time, with a clear head and joyfulness, consummated in the midst of children and witnesses: so that an actual taking of leave is possible while he who is living is still there, likewise an actual evaluation of what has been desired and what achieved in life, an adding-up of life...one ought to desire to die...freely, consciously, not accidentally, not suddenly overtaken.

Finally, a piece of advice for the pessimists and other decadents. We have no power to prevent ourselves being born; but we can rectify this error-for it is sometimes an error. When one does away with oneself, one does the most estimable thing possible; one thereby almost deserves to live... Society-what am I saying! Life itself derives more advantage from that than any sort of 'Life' spent in Renunciation, green sickness, and other virtues-one has freed others from having to endure one's right, one has removed an objection from life-"

As far as I can see, this is an excellent argument for man taking control of man's destiny, of man's willing; it should seem one has the right, even more the duty, in an attempt to make life work-of suicide, abortions, euthanasia, to restore to nature via man, the correction of nature's errors.

Sincerely,
Roy Cameron



-mark dembert-

"Of course, there are those among you who believe I am all-knowing just in Pathology. I think rather it is a case of mistaken identity."

EVALUATION

I have been asked by the Editors of Ariel to summarize briefly my views on evaluation. It should be understood that this article reflects my views and not necessarily those of the Office of the Dean and/ or the Committee on Student Promotions.

I believe that medical school should foster the growth of its students in four areas. These are the areas which play a role in the physician's competence: knowledge; data gathereing; clinical judgment; and attitudes. It is obvious that no single system of evalustion could assess student performance in these different areas. Of course, the easiest area to evaluate is knowledge: we often concentrate all of our efforts on improving our measurements of knowledge while we should focus on the other areas as well. The latter may actually be of greater importance once a certain level of knowledge has been achieved.

I will describe first my views as they pertain to the evaluation of knowledge. I believe that it is the obligation of the faculty to set the standards for the minimal passing level of the student rather than having the students set their own passing level, as is implied in the use of distribution curves. If a student has achieved a minimal passong level this may be recorded as pass, by a grade of C, or by use of a number such as 70. I prefer the use of numbers.

Any system of measurement should be reliable and valid. Validity presupposes reliability and, therefore, the latter should be discussed first. It is relatively easy to determine the reliability of a multiple choice examination. Once this has been derived a standard error of measurement of the examination can be determined. The grade which is given to a student should also reflect this standard error of measurement. For example, a student would receive a grad of 75 & 3; the plus or minus 3 would reflect the error of measurement. This leads me to discuss the possibility of using a measurement to test knowledge not only to separate those students who do not have the minimal passing level from those who do have it, but also to differentiate within the group of students who have achieved the minimal passing level on the basis of their range of knowledge. Using the example given previously, a student who recieves a numerical grade of 75 & 3 will differ in the amount of his knowledge from a student who has a numerical grade of 90 & 3. It may be argued that giving this information will lead to an increase of competitiveness and/ or anxiety among students. I disagree. The causes of anxiety are many and complicated. One becomes anxious when one does not know what is expected of him, and if he does not understand how he will be evaluated. Anxiety will not result from the reporting system of evaluation alone. All of us have strengths and limitations and it would be wise for us to realize what these are. While it is important for us to know that we have passed a test in Internal Medicine, It would also be very useful to know how well we have performed. A practicing physician would not be too happy if the hematology laboratory were to tell him that an examination of his patient's blood revealed a low hemoglobin but no values would be given to him. The management of a patient with anemia with a hemoglobin of 9gms/ 100 ml is quite different from that of a patient with a 2.0 gms/ 100 ml of hemoglobin. I agree that to give numbers which are unreliable is misleading, but if it is possible to give numbers which differentiate levels of knowledge as assessed by a paper and pencil examination, this should be done. Healthy competition is not a destructive process. In addition, knowing that in certain areas one has a great deal of knowledge might allow the individual to devote more attention to other areas in which his knowledge is only minimal. It is often argued that if instead of giving numbers the school would give just a pass or fail symbol, the faculty would allow the student to learn better or use his time in learning other material which he might feel to be relevant. These hypotheses when tested in a controlled environment have not been upheld by the data.

It is difficult to evaluate the abilities of a student in the collection of clinical data, in the area of clinical judgment, and in the type of attitudes which he has towards his work, his patients and his colleagues. The tools which have been used have not been found to be highly reliable and valid. I believe that we need to explore different ways to assess medical students in these areas since they are highly crucial in the evaluation of competence. At present I feel that the use of such techniques as patient management problems (PMP), which are simulated clinical situations using a paper and pencil or a computer, should be explored. In additon, the faculty should collect descriptive information which reflects the perfomance of the students in these areas. This is necessitated by the fact that the situation is rarely standardized for different students. Therefore, I would not give numbers to summarize level of achievement in these areas, but rather have descriptive information available that would reflect the student's behavior. For transcript purpose, I would use such terminology as pass or fail and possibly include honors. The academic record of the student would contain a file of descriptions of his behavior as observed by the faculty. If letters of recommendation were to be written, descriptive information relating to his ability to collect clinical data, his clincal judgment, and his attitudes, would be stressed.

Conclusion

I would like to restate my position that in my opinion no single evaluation technique is adequate to describe achievement in the four areas which a medical school curriculum should cover. For the assessment of knowledge, I prefer a numerical system which requires a minimal passing level to be determined by the faculty prior to the examination; the grade should include a standard error of measurement. In addition to this, I would also require on the part of the faculty descriptive information about the behavior of the students in the laboratory and at the bedside. This evaluation is necessary in order to let the students as well as the faculty know how successful the teaching-learning process is. It is mandatory in my opinion that the teacher inform the student of his progress and share with the student his impression of the student's performance. This should be a teaching function, not an administrative one. I realize that what I ask is difficult, since it is not easy eith to give or to take criticism no matter how constructive it is. However, we must learn to do this if we are to correct our deficiencies. If the medical school faculty and the students were to be more successful in giving and receiving criticism, the problem of Peer Review and performance after one leaves the formal educational process might be easier to solve.

In order to continue to attract highly qualified students, I believe that the faculty must continue to be more specific in their definition of the objectives

(Continued on page 4)

Ealuation

(Continued from page 3)

of the curriculum and in their definition of how the assessment of the students will be conducted. I realize that the issue of Pass-Fail is a popular one among the students, but I believe that it is the obligation of the faculty to set standards which are fair ones. The faculty should not fall pey to the temptation to be popular for the sake of popularity alone. Hopefully, popularity would follow fairness. The student body should be involved in the formulation of principles for evaluation, and both the faculty and the student body should let data be the deciding factor rather than unsubstantiated opinion.

I have been pleased with the discussion regarding evaluation which has occurred on campus for the past two or three years. The discussion has allowed the faculty and the student body to explore the complicated issues which are involved in a system of evaluation. A Subcommittee of the Committee on Student Promotion has collected a great deal of data as to the feelings of the students and the faculty regarding evaluation, and in the near future the report should be available to our community.

Joseph S. Gonnella, M.D.
Associate Dean
Director of Academic Programs

VOTE
Tuesday
April 25

Gongho Gongyo

by J.D. Kanofsky

On a lazy evening late in June of the summer of '68 I was engaged in taking my usual daily constituitional. As I was lost in my thoughts I dimly recall passing two middle aged women. Perhaps. I smiled at them, perhaps, I didn't. Whatever my response may have been it certainly was not intended to have been any more provacative than a casual greeting. Try to imagine my surprise then when these two very same females materialized before me and obstructed my path. My meditation interupted, there was nothing left for me to do but to stare into their laughing eyes. One of them was an oriental, the other - as I was to find out later - was born and raised in Germany.

Formality was not their forte. Without much more ado than that which I have related to you, they suggested the following excursion. "You very lucky we find you,hurry now, you come with us we make you happy." I ask you who could resist an offer like that? Undoubtedly, I should have been suspicious but there was such a tone of simple goodness in their voice that I could not help but hope for the best. Suffice it to say that there was no turning away from these twentieth century sirens.

Very few words were exchanged as I followed them to their destination. However, if my mind is not playing tricks with me, I could swear that the oriental lady made known to me in an exquisitely matter-of-fact fashion exactly what they had in store for me. "Oh yes, very lucky boy, we shall shakibuki you and you shall never be the same." Only much later on did Ilearn that "to shakibuki" is the English equivalent of "to break and subdue" but by then the disarming deed had already been done and only a time machine could undo it.

Upon entering a simple row home on Conly Street my temptresses indicated that I should take my shoes off. I was ushered into the dining room and asked to sit on the floor. The smell of incense pervaded the air. Situated in the center of the room was a girl in her middle twenties blessed with uncommonly good looks. What her real name was I cannot recall but I shall always remember her as my Lotus Flower. She was bowing down to a cabinet that contained a holy sacred scroll which had inscribed on it. "Nam-myo-ho-ren-gye-kee-yo". Over and over again she kept repeating the chant, soon my saintly seducers joined her on the floor and accompanied her in a three part harmony, "Nam-myo-ho-ren-gye-kee-yo-, Nam-myo-ho-ren-gye-kee-yo, Nam-myo-ho-ren-gye-kee-yo-". It fell like a torrent of virtue upon a heathen's head. All thought of any hanky-panky went out the window. Yet despite the realization that lechery was not he intent of the evening, the charm of the chant captivated me and would not let me leave.

It was not long before more people crowded into the small dining room, each taking their turn in paying homage to the Gohonzon (which is what the holy sacred scroll is called). For almost an hour I sat bewildered in that room wondering what would come next. More than twenty people had assembled in the dining room. Eventually, the chanting came to a stand still. At last I would fine out what this was all about.

All the congregants were members of the True Buddhist Church. This is an eastern religion that very recently has taken a strong foothold here in America. I do not profess to be an authority on True Buddhism, therefore, I do not want to venture deeply into what True Buddhists believe. But I suppose a superficial going over is called for.

True Buddhists believe that there were three buddhas or wise men. A buddha way back in the past that I had never heard of, the buddha we all know and if not love at least respect, and a third buddha who lived in Japan during the 13th century. The first two buddhas propagate teachings that were suitable for their age but their knowledge was an incomplete knowledge. It was left for the third buddha to clear matters up and put everything together from his labor came the absolute and eternal teaching. According to True Buddhism there will be no fourth coming. World peace and personal salvation is now at hand if only all of us take advantage of the teaching of the final buddha.

The source of all sagacity is to found in the recitatio of daimoko. Daimolo is the incantation inscribed on the Gohonzon. Roughly translated it means, "Adoration to the Lotus of the Wonderful Law." By chanting the siimoko throughout the day supposedly many benefits will come to you.

The religion does not demand that you place any restrictions on your life style. The attainment of inner contentment can be reached by many paths.

The intellectuals of the sect delve into the teaching of the third buddha and accept the Lotus Sutra of his predecessor the second buddha as sacred and worthy of intense study. However, True Buddhism recognizes that not all people were meant to be mental giants and therefore, it places most of its emphasis on persuading the convert to practice Gongyo twice a day and chant daimoko as often as possible.

To do Gongyone kneels before Gohonzon and recites in Japanese the Lotus Sutra along with a few other prayers. All of this takes anywhere from twenty minutes to an hour dependent on how skilled you are at mimicing Japanese.

At meetings members stand up and tell the benefits they have received due to their chanting. Some true believers will report the purchase of a new hat, suit or car that would ordinarily be out of their reach financially but thanks to some surprising and often mysterious stroke of good fortune is now theirs. Another member might cite the acquisition of new found health. A third enthusiast will give the Gohonzon credit for putting the smap-crackle-and-pop back into his relationship with his wife. No matter how small or how great you wish Gohonzon will get it for you. "As you treat Gohonzon, so Gohonzon treat you."

There is no denying that the followers of True Buddhism are sincere in their beliefs. They are pleasant companions and approach life optimistically. Many of them admit up to having been former down-and-outers until they too made rendez-vous with a pair of Gohonzon-charged angels of mercy and were unexpectedly shakibukied (which is to break and subdue an individuals will so that he will go with you to meeting). Having once been shown the light they stead-fastly cling to the bosom of Buddhism. Listening to what they were like before and looking at them now I can understand why many of them feel so strongly towards their adopted religion. However, all of this can be explained not directly in terms of the power of the Gohonzon but more simply as yet another example of the power of positive thinking Asmitedly, some of the stories you hear at meetings are mighty weird but no doubt the teller has unconciously erased from his own mind some detail that would make everything come out perfectly plausible.

For many years this was my attitude towards the religion. Occasionally, I would spend a day or two trying out daimoko but no immediate results would materialize and eventually my interest waned.

Then late last winter word got out that quite a few members of the Jefferson community were attending meetings at the new True Buddhist shibu on Delancey Street. I had not gone to a meeting for quite awhile but the interest generated at Jefferson induced me to trek on down to Delancey Street in the company of few friends and see what was happening there.

Business went on as usual except that there were a few more familiar faces among the preoslytes. Just before leaving I retired to the john. While doing what comes naturally I overhear a conversation between one of the group leaders and a black man in his late twenties.

"Please, hold it a second brother, something is bothering me. I mean I've been chanting just like everyone says I should and I ain't shot up for a month and that's the truth. Look I ain't a fresh mark anywhere on me. But I don't know, I just don't know, you tell me now. Should I stop sniffin' too? Now hold it there don't get me wrong I don't sniff much but sometimes you know.... I mean I can't say no. What should I do, you tell me."

"I can't tell you what is right for you. But there is no reason to be upset. I can assure you that if you chant long enough you will find out for yourself what is right for you."

There was a pause followed by, "You're right, that ain't no bullshit. Thank you, thank you."

Both conversants left, I was left alone with my thoughts. It was at that instant that I decided to give Gohonzon another chance. This time I would go out of my way to give it a real test.

Late on Friday night of that week, just before midnight I began to burn incest. Rarely, if ever had I practiced gongyo in private. I never found it to be something to look forward to. Your throat gets so dry after mouthing all that Japanese and being down on one's knees is not exactly the most comfortable position for a muscle tight westerner to assume. But this was going to be it. For once and for all I would prove Gohonzon to be a misfit of an anachronism, a vestige from the dark ages when incantations were anong the stock and trade of every marketplace shaman.

What it all boiled down to was that I was sick and tired of the nagging uncertainty that maybe I was passing up a good thing. If anything or anybody or anyoneness is obliging enough to hand out great jobs of good fortune to anyone who is willing to accept it, rest assured, Koholovski is going to be there to get his fair share and then some.

What could I lose. The worst that could happen would be that I would not get my wish in which case that too would be a benefit. Never again would I be tempted by the power of the Gohonzon. No longer would dreams of gratis grown greed intrude on me.

By eleven thirty that night all preparation was completed. With knees bent in compliance to custom, I humbled myself before the Gohonzon that layed hanging from a wall in my bedroom. Gongyo was about to begin. Slowly at first I began to recite the ageless wisdom entrusted to us via the contents of the Lotus Sutra. With time I picked up speed such that by midnight just as the clock struck the hour I had finished my prayers. Happy that my timing had worked out so well, I looked up at the sacred scroll and made an eternal covenant with it.

The terms of our agreement were as follow. I went out of my way to make them as specific as possible so that there would be no misunderstanding betweenst us.

1) I will dutifully do gongyo twice a day
2) I will maintain the holy shrine is strict accordance with the dictates of the ancien law.
3) Daimoko will always be on the tip of my tongue and will never leave the seat of my soul
4) In return. Gohonzon will deliver unto me within one week one female love Goddess whose likeness will be in the spitting image of Raquel Welch
5) This aforementioned love Goddess will fall in love with me and needless to say I will fall in love with her

Six days went by. Each day I did gongyo once in the morning and once in the evening, catered to the needs of the holy shrine and never let an instant go by when daimoko was not on the tip of my tongue or firmly quartered to the seat of my soul. But I did not receive anything in return. Finally, I decided to help Gohonzon along by lightening its burden. I would provide it with ample opportunity to satisfy its part of the bargin.

At ten thirty P.M. on Friday-only an hour and a half before the agreed upon week would be up-I swagered into the Chances Are which at that time was a popular singles bar at Broad and Lombard. As usual the place was packed with Aphrodites of all sizes and shapes. If Gohonzon could not do its thing here it could not do it anywhere.

Content to let destiny work its will on me. I walked up to the second floor and strategically situated myself in a position that would assure me the best overview of what was going on. From my lookout point I extablished A-OK facial contact with all incoming troops. None of the new recruits measured up to that level of toughness to which I aspired to under the given set of circumstances. A half hour went by then an hour but conditions remained the same. The countdown proceeded smoothly until about ten of twelve. At that point I edged towards the bar in anticipation of a toast to celebrate my liberation from Gohonzon. No longer would I lose a half hour of sleep in the morning to do gongyo., no longer would I suffer from housewive's knee. From now on till forever more that oriental Godsend would be lucky if it could hang-on as an oreiental ornament.

Just as I was about to order a glass of Champagne, a voice-as if from the wilderness-called out, "Danny, Danny is that really you?" I turned around and who should I see? None other than Ravishing Rita Bratight the closest thing to an incarnation of Raquel Welch this side of Myra Breckinridge. I was absolutely flabbergasted. The last time I had seen Rita was at Temple more than two years ago. Everyone knew her as Raunchy Ricky's girlfriend. If you put any value on your life, you were well advised to not mess with her. Ricky had a reputation for being one of the last of the Wild Ones. He would come to class dressed in dungarees and black leather jacket with a Transylvanian skull-and-crossbone medallion hanging from his neck to accentuate the time-chiseled charm of his combat scarred face. "Dressed to kill" was not meant to be an exageration in Ricky's case.

"Why Rita, fancy meeting you here, where's my good buddy Ricky, not including the bouncer into another one of his funloving 'Fry-a-Bar Bum fruit-fly-fricasees,? Don't worry I'll bring him back to you. But just in case we get lost in the crowd I want you to know its been nice seeing you again Rita. Ta Ta."

"Oh Danny, please don't go., you're the only boy I know in this place. Ricky broke up with me two weeks ago and ever since then I don't know what to do. None of the boys seem to want to have anything, to do with me. Some of my girlfriends suggested that I go with them down here. Oh God, it's been horrible, I feel like a piece of meat in a marketplace. Why did Ricky have to leave me? I feel so very, very sad."

With that she began to sob on my shoulders, I tried to cheer he up and miraculously it did not take long before we were both gigling over a mug of beer. Soon, though Rita had to leave. Her girl friends wanted to go home and-my luck-Rita was the one who had driven them down. I told her that I would call her sometime

(Continued on page 6)

Anatomy Evaluation Proceeds

Ad Hoc Student Committee on Freshman Course Evaluation

From Thursday, March 9, through Monday, March 13, the Freshman Class of TJU Medical School completed a series of four questionaires, designed to evaluate the student response to individual lecturers, course material, and exams. The questionaire was produced by the **ad hoc** Student Committee on Freshman Course Evaluation of the Student Curiculum Committee. The Evaluation Committee was composed of members of the freshman clas. The actual form was written, refined, and printed by these same people, with consultation of the Student Curiculum Committee. Included in the scope of the endeavor, were the four major first year courses, Neuroanatomy, Gross Anatomy, Histology, and Embryology, each of which were evaluated separately.

The questions were designed to be as objectiveandconstructive as possible. The Committee recognizes that there are flaws in the format and wordings of some of the questions, but it is hoped that valuable insights will be derived from the results. In addition the Committee expressed the belief that the present project will be worthwhile with respect to future course evaluations.

Two modes of response were encompassed by the questionaire. The objective portion requested responses evaluated on a one to five scale, with one indicating a strongly negative response, three a neutral opinion, and five a strongly positive response. The subjective portion requested written comments.

The collating of the data is now in progress, and should be completed in several weeks. The Committee is confident that the results will provide an effective channel for constructive feedback to the various departments by students

Disaster Foretold--

Freshman Class

Play coming!

Gongho Gougyo

(Continued from page 5)

next week. Just before she left she gave me a kiss on the cheek that quickly progressed into a warm, lingering, softer-than-springtime hug.

Shizam, I'll be darned if Gohonzon did not come through for me. "As you treat Gohonzon, so Gohonzon treat you." How true, how true. There wasn't anything too good for it. To show my gratitude, I spent all day Saturday in search of a store that could sell me a gift wrapped box of caviar scented incense.

Nonetheless, one minor detail bothered me. What would Ricky do if he found out that I was taking out his ex-girlfriend behind his back. There was only one thing left for me to do. I would have to call him up and ask his permission.

On Sunday, two days after my meeting with Rita I gathered up enough courage to give him a ring. It went well, it really did. I could not detect any sign of displeasure in his voice. I did notice that he seemed to have been grunting more often than he normally does but that might just have been the echo of my heart my imagination. At the end of our conversation he mumbled his consent which is more than I had hoped for. Now there was not anything that stood between me and the actualization of my dreams.

The following evening I self confidently dialed Rita's number. The line was busy. Not put off I dialed again an hour later. Again the line was busy. Finally, at ten o'clock I reached her. No sooner had I opened my mouth then Rita greeted me with a great gale of laughter. I don't think there was ever anyone who was more delighted to hear from me. Even my own mother when she heard my first scream as I cried fresh from her womb could not have been any more ecstatic than Rita was that night. Whatever I said,- no matter how mundane the matter-Rita was reduced to a state of tears. After a lengthy dose of ego-uplifting, side-splitting chit, Rita interupted me.

"Danny, you silly goose, we don't have to carry on this charade any longer. There is no reason for me to play a game and hide from you that which must already be obvious. I love you Danny. I will always love you always, always, always. My guardian angel must have been working overtime when he had us meet that fateful night at the Chances Are. What else could explain it? When Ricky and I return from our honeymoon you'll be the very first guest of honor to be invited to our little love nest. I don't know what you said to Ricky on the phone last night but as I guess you already know he'll be coming over tomorrow with thering to make it official. I'm so very, very happy. Bless you, Danny, bless you."

There was nothing much else for us to say to one another. But man till the end that I was. I considerately abstained from any mention of suicide and shaky upper lip notwithstanding wished Rita the very, very best of everything.

Gohonzon had done an impeccable job. Rita was in love with me and I was in love with Rita. But that was not quite what I had in mind.

Both Gohonzon and I satisfied to the letter our respective parts of the agreement. Yet, something was missing.

"As you treat Gohonzon, so Gohonzon treat you."

How true, how true.

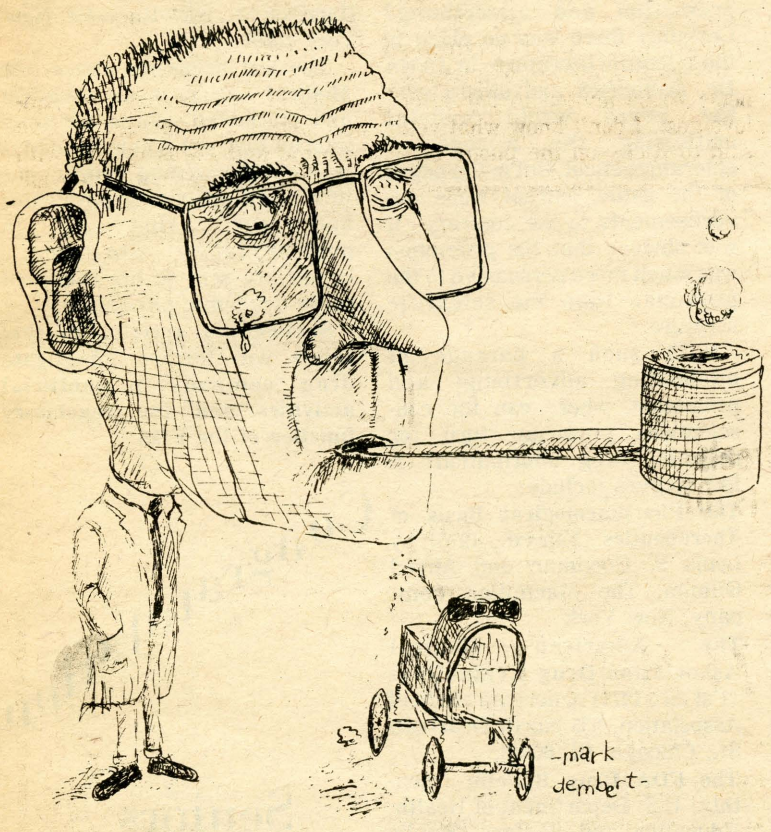
Black and
Blue Ball-
April 29, 1972

PLEASE ADDRESS ALL
CORRESPONDENCE TO :
Ariel
Box 27
Jefferson Hall
10th & Locust Streets
Philadelphia Pa. 19107
829-7925

MECO Students

(Continued from page 1)

essence, the student is exposed to how the physician, the hospital, and the community interact with each other to deliver care to the patient. Ideally, the student should observe each step of the process of health care including the administrative, the clinical, and the community orientated aspects in order to see how the patient gets the help he needs.



-mark dembert-

For once.... speechless

In summary, as outlined by SAMA guidelines, the specific experiences and knowledge the Student should obtain from MECO are:

in the Community:

1. Function of the health related agencies and institutions in the community and the mechanisms by which patients are referred to them and by them.
2. Availability and quality of care as seen by the patient.
3. Politics, economics, and culture in the community and how each affects health care.
4. Life style of the primary care physician.
5. Patients' image of the physician and the doctor-patient relationship
6. Function and roles of local medical associations.
7. Health education programs.

B. In the Physician's Office

1. Exposure to solo and group practives and to specialty and family practice.
2. Introduction to the care of ambulatory patients and the differences between these patients and hospitalized patients.
3. Role of each person employed by the physician, with discussion of the training required for each position.
4. Administrative role of the physician in his office.
5. Office record-keeping, billing, and financing mechanisms.
6. Clinical medicine and the scope of primary care.

C. In the Hospital

1. Function and operation of each department both clinical and non-clinical in the hospital and its relationship to the physicians and to patient care.
2. Role of the physician and his responsibilities in the hospital, including rounds, emergency room, operating and delivery rooms, medical staff meetings and conferences, and peer review.
3. Activities undertaken by the hospital in regard to comprehensive health care in the community.
4. Past present and future role of the community hospital in relation to the community and to other health care institutions, especially regional and university medical centers.
5. Role of the hospital administrator, and his relationship to the medical staff and to patient care.
6. Legal responsibilities of the hospital and physicians to patients.

In reference to the Jefferson student in particular, he will be able to gain insight into how the care system works as a whole and not be restricted to the clinical experience he gains as a Junior and Senior which is onlv a part of the whole picture. Since the program is geared for Freshmen and Sophmore students, it serves as a preparation for the student to play an active role in health care delivery beginning in his clinical years, as will as, an experience in small community health care which he will not obtain in his clinical years. Above all, in the tradition of Jefferson Medical College there will be some individuals who will become lenders in the medical field. Hopefully, their participation in the SAMA -MECO program will lead them to make the right decisions in overcoming the crisis we face today.

Since many did not know about SAMA-MECO, I would also like to stress that the Student American Medical Association, the largest independent student organization in the world is also involved in many other programs and services such as:

The American Indian Health Project

The Community Health Orientation

The Migrant Workers Community Health Project,

The Internship Evaluation Program

Aid is given to any individual with initiative to set up his own health project in thelocal community. If anyone has any questions or ideas about SAMA, Please contact the author.

Health Research

(Continued from page 1)

advertising in scientific journals. The American Medical Association receives an annual income of over $15 million from advertising in its journals. The AMA admits that 43 per cent of its total income comes from advertising compared to only 33 per cent from membership dues. A typical specialty association, the American Psychiatric Association, receives approximately one third of its income from its publications through subscriptions and two thirds from advertising.

A journal cannot maintain scientific indifference to the products that are responsible for supporting its very existence. Credence to this assertion was provided by two notorious cases of the recent past: In 1957 Dr. Harry Dowling published a now-classic article as a Report to the Council on Drugs in the **Journal of the American Medical Association** denouncing the use of fixed-combination antibiotic drugs. Since that time a legion of fixed-combination antibiotics entered the market, with sales reaching $200 million a year. Not one scientific article published in a well-known journal supported the use of these preparations as promoted by drug companies. Why did physicians use them? Where was the physician's source of information? It had to be the advertising and promotion drug companies. Advertising in **JAMA** and elsewhere proselytized the use of combination drugs contrary to the editorial and scientific positions of the journals' themselves. The journals thus, in compromising their integrity to their sponsers, were an accomplice to drug companies in promoting massive malpractice.

The hypocrisy of journal advertising policy reached its tragic culmination with the infamous chloramphenicol case. Ads of chloramphenicol ran for months depicting a bronchoscope and just a simple heading: "Chloramphenicol, when it counts." It was not indicated for any upper respiratory illnesses but the implication was obvious. The **JAMA** accepted the ad, as did many others. Dr. Dameshek, of the Mount Sinai Hospital, estimated that 94 per cent of patients were prescribed chloramphenicol for non-indicated uses. Over 3.5 million people were needlessly exposed to the drug. Then, catastrophe struck- 406 cases of chloramphenicol-induced aplastic anemia were reported, half of whom died; only 6 per cent were given the drug for indicated uses and 12 per cent were given the dangerous drug for the **common cold!** Where did the physicians who prescribed it get their information about the use of choloramphenicol except from promotion and advertising? Certainly there was no place in the scientific literature. In **JAMA** Dr. Dameshek and others over the years wrote articles criticising the misuse of chloramphenicol. But in the pages of the same journal were advertisements to the contrary. It was obvious that the promotion was much more persuasive to the physician than the scientific litrature.

With such a barrage of misleading advertising and promotion, where can the conscientious physician turn for objective drug information? A few sources include:

The Pharmacological Basis of Therapeutics (5'th ed., 1970) by Louis S. Goodman and Alfred Gilman, The Macmillan Company, New York.

The American Medical Association Drug Evaluations (1'st ed., 1971) American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

The FDA Drug Bulletin (monthly) U.S. Department of Health, Education and Welfare, Public Health Service, Food and Drug Administration, 5600 Fishers Lane, Rockville, Md. 20852.

Clin-Alert (published as information is received) Science Editors Incorporated, 142 Chenoweth Lane, Louisville, Kentucky 40207.

The Medical Letter on Drugs and Therapeutics (fortnightly) The Medical Letter, Incorporated, 56 Harrison St., New Rochelle, New York 10801.

The last reference above, the **Medical Letter**, is an excellent and oft-quoted source for drug information, yet its circulation is only 40,000-reaching barely one fifth of all practicing physicians and even this is an overestimation, since many copies are sent to libraries and serve academic physicians.

Succeeding articles in this series will further investigate drug company promotional activities and the regulatory function of the FDA.

Congratulations Seniors