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THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE
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Family Medicine at Jefferson: Three New Residency Programs Announced

The Residency Review Committee for Family Practice announced on December 18, 1973 that Thomas Jefferson University in cooperation with Thomas Jefferson University Hospital, Chestnut Hill Hospital, Philadelphia, Pennsylvania, and Latrobe Area Hospital, Latrobe, Pennsylvania has received approval for a new three year residency program in Family Practice starting July 1, 1974. The Review Committee is made up of representatives from the American Board of Family Practice, the American Academy of Family Practice, and the AMA Committee on Graduate Education.

Thomas Jefferson University Hospital has been approved for six residency positions, per year, Chestnut Hill Hospital and Latrobe Hospital each for three positions per year. All three of the programs have separate matching numbers and are included in the National Intern and Resident Matching Program.

The concept of Family Practice as an academic discipline has received great impetus over the past five years.

Initially, most Family Practice residency programs were established in community hospitals, but the concept has now spread to many medical schools wherein separate departments of Family Medicine and divisions of Family Medicine have been established. As of 1973, there are 173 Family Practice residency programs with approximately 1700 residency positions. 66 medical schools ir the United States now have Departments or Divisions of Family Practice.

Jefferson initially developed a Division of Family Practice in the Department of Community Health and Preventive Medicine. The chairman of that department, Dr. Willard Krehl, working hand-in-hand with the Pennsylvania Academy of Family Practice and Dr. Franklin Kelton, its representative, was instrumental in enlisting 25 volunteer board-certified family physicians to serve as clinical instructors in the Division of Family Practice. For the first time at Jefferson, elective precepteeships in Family Medicine were available to the medical student throughout a four year period.

In January 1973, a Department of Family Medicine was established both in the Jefferson Medical College and Hospital. Dr. Paul C. Brucker, a family physician who served as a clinical instructor in the Division of Family Practice, was named Chairman and arrived on campus full time in March 1973.

Jefferson's newly approved three year Family Medicine residency program will have a curriculum that will be largely in-patient based for the first year and a half and out-patient based for the last year and a half.

During the in-patient experience, the resident will have the opportunity to assume responsibility for patient care in internal medicine and its subspecialties, pediatrics and its sub-specialties, surgery, rehabilitation medicine, psychiatry, and the emergency room. In addition, depending on his interest or anticipated practice requirements, he will be given the opportunity to choose electives in obstetrics/ gynecology.

Signing the major affiliation agreement are: Kenneth D. Bowman, President of the Latrobe Area Hospital Board of Directors and Dr. Peter A. Herbut, President of Thomas Jefferson University. Witnessing the signing are: Dr. J. Robert Mazero, Latrobe Area Hospital Medical Director and Dr. Paul C. Brucker, Chairman, Department of Family Medicine, Jefferson Medical College.

The resident's out-patient training at Jefferson will take place in the newly constructed Model Family Practice Unit, located on the fifth floor of the recently purchased Allied Health Science Building (formerly the Edison Building of the Philadelphia Electric Company) at 9th and Sansom Streets. There, in a well-equipped setting, he will participate with Family Medicine Faculty, para-medical personnel, and medical students in a group practice for the delivery of primary care.

The Model Unit's facilities will include such traditional items as an adult and children's reception area, record room, insurance clerical section, nurse's station, medical offices and examining rooms for faculty, post-graduates and undergraduates, rooms for simple laboratory work, interviewing, minor surgical procedures and for testing vision, hearing and eye pressures. Certain features, such as video tapes, will be included in the educational program. X-ray facilities, a pharmacy, and a complete laboratory will be housed in the same building on other floors. These facilities will be supervised by the University staff and should provide an excellent resource for consultation and teaching.

The family-patient population will come from sources such as the faculty's private practice, from the non-urgent or non-emergency Emergency Room population, from the surrounding community and from some of the Clinic population.

An added educational benefit will be the availability and depth of the Jefferson faculty and specialists for consultation. All of the traditional departments in the Medical College and the University Hospital have been cooperative in accepting and supporting this program.

Elective opportunities will be available to the resident throughout his three year program. Such opportunities are designed to allow the resident additional experience in those fields of primary medicine in which he recognizes deficiencies or expresses an interest as related to future practice needs.

Chestnut Hill Hospital, an affiliate hospital in suburban Philadelphia, will have a similar program. Dr. Harry A. Kaplan, a practicing family physician, will move his private practice into a Model Family Practice Unit located on the Chestnut Hill Hospital campus. In addition to an individual Family Practice residency program, Chestnut Hill Hospital will have students assigned to the Family Practice facility during their junior and senior years.

Latrobe Hospital in Latrobe, a town located in southwestern Pennsylvania and approximately 250 miles from Jefferson, will have a similar affiliate program in Family Practice. The joint affiliation agreement enables a program which entails the

(Continued page 5)

Jefferson Launches New Breast Diagnostic Center

Hans Weltin

Professor John D. Wallace, Research Professor of Radiology at Thomas Jefferson University, is currently conducting a large scale Breast Cancer Screening Program under contract from the National Cancer Institute. The program will use and evaluate three Cancer detection modalities for their efficacy in detecting cancer significantly earlier than is presently done. These are:

1) **Thermography:** a technique which utilizes an infra-red sensitive camera to detect and display the heat patterns at the skin surface on a T.V. Monitor. These are then photographed and examined. A breast cancer may give off more heat than surrounding areas, or it may be associated with a vein which is not present on the other breast. Both of these findings would appear darker (hotter) on the film, than surrounding breast tissue.

2) **Mammography:** essentially an X-Ray of the breast done with a machine designed specifically for that purpose. The breast is supported on a small glass table and X-Rayed once from above and once from the side. The normal vasculature is visible and a breast cancer might show up as an area of minute calcification, or a small mass with a different density from that of the surrounding tissue.

3) **A clinical examination** of the breast is conducted in the normal fashion.

The purpose of the program is to determine which combination of these modalities, or which modality alone, if any, can be used as an effective cancer screening test which will alter the five year survival statistics for Breast Cancer.

Professor Wallace said that Breast Cancer five year survival statistics have not changed significantly since 1843 when they began to be recorded. This is primarily because by the time cancers are presently detected, the outcome is already predetermined. Ninety-five percent of breast cancers are presently discovered by patients themselves, and sixty percent of these cases have already spread to the axillary lymph nodes: a stage in which the five year survival is only forty to forty-five percent. On the contrary, when breast cancer is detected at an early stage, the proven methods of therapy are highly effective, giving eighty-five to ninety percent five year survival.

It is Professor Wallace's belief that this program can alter the five year survival rate of patients with Breast Cancer by detecting cancers much earlier than can presently be done. Professor Wallace anticipates detecting Cancers that are only milimeters in diameter, rather than centimeters. If the program is successful, then Professor Wallace will be able to recommend to the National Cancer Institute that a similar program be instituted on a Nationwide basis that would be as available then as a Pap smear is now.

The Breast examination which patients receive at the Breast Diagnostic Center is the most complete breast examination available anywhere. It far surpasses the exam a woman receives from her gynocologist, and the results are automatically sent to each patient's doctor. The entire Data collection process has been computerized: from the history which the patient gives, to the results of thermography, mammography and clinical exam. Each thermograph film and mammograph plate is read by two experts in the field who are unaware of each others' findings, or that of the clinical examiner. If there is any discrepancy in the readings, a third reading is done and a conference held to decide what the film or plate indicate. The clinical exam is conducted by only one Physician; however, if a biopsy of a lump in the breast is deemed necessary, another physician sees the patient to confirm the need for biopsy. (60-70% of biopsies are found not to be malignant.) The Breast Diagnostic Center is presently located in the College Basement at 1015 Walnut St., but it will move to the third floor of the Edison Building when that building is ready. Another Breast Diagnostic Center will be opening soon at the Bell Telephone Company Headquarters, 1 Parkway, Philadelphia.

Life: A Civil Right

January 22 marked the first birthday of the Supreme Court's decision to legalize abortion. During the past year, the subject of abortion has faded from the general consciousness. Abortion has been accepted as an ethical procedure by lawyers, physicians, legislators, and most "enlightened" members of society. It is the purpose of this editorial to raise the question that perhaps we have made a mistake. To make this article as meaningful as possible, I have built around three contentions.

Slavery as an Unethical Practice

Each individual in our society has certain civil rights. Among these are life, liberty, and the pursuit of happiness. Man, by his aggressive nature will try to control other men and subordinate their rights to his. The purpose of law is to prevent this. The inscription above the entrance to the Supreme Court house says it well: "Equal Justice under Law." Every individual is to be protected, no matter how weak or defenseless.

In short, I do not think this first contention about the wrongness of slavery is that controversial. I feel that most, if not all, would agree that the steps taken by black men toward equality have been steps in a humanistic and progressive direction.

Abortion as a Form of Slavery

Abortion is a modern variation of the discrimination which occurred toward blacks 150 years ago. Let me support this contention by showing similarities in logic between the bigot and the abortionist.

ATTITUDES TOWARD SLAVERY	ATTITUDES TOWARD ABORTION
Although he may have a heart and a brain, and he may be a human life, a slave is not a legal person. The (7-2) Dred Scott decision by the U.S. Supreme Court has made that clear.	Although he may have a heart and a brain, and he may be a human life, an unborn baby is not a legal person. The (7-2) Roe vs. Wade decision by the U.S. Supreme Court has made that clear.
A black person only becomes a legal person when he or she is set free. Before that time, we should not concern ourselves about him because he has no legal rights.	A baby only becomes a legal person when he or she is born. Before that time, we should not concern ourselves about him because he has no legal rights.
A man has a right to do what he wants with his own property.	A woman has a right to do what she wants with her own body.
If you think that slavery is wrong, then nobody is forcing you to be a slave-owner. But do not impose your morality on someone else.	If you think that abortion is wrong, the nobody is forcing you to have one. But don't impose your morality on someone else.
Is not slavery really merciful? After all, every black has a right to be protected. Isn't it better never to be set free than to be sent unprepared, and ill-equipped, into a cruel world?	Is not abortion really something merciful? After all, every baby has a right to be wanted. Is not it better never to be born than to be sent alone and unloved into a cruel world.

The similarity can best be brought out by an honest answer to a question: "Which is a more arbitrary form of predjudice, respect for a seven month old fetus vs. no respect for a seven week old fetus; or respect for a white man vs. no respect for a black man?" Consider the possibility that the obstetrician is making the more esoteric and pedantic distinction.

The Need for Social Change

When society condones or promotes an unethical practice, it is the responsibility of each member of society to try and change that system toward a more humanitarian state. The reason that slavery stayed around for as long as it did was too few men and women were determined to improve society and lacked the social awareness to perceive the mistreatment of those around them.

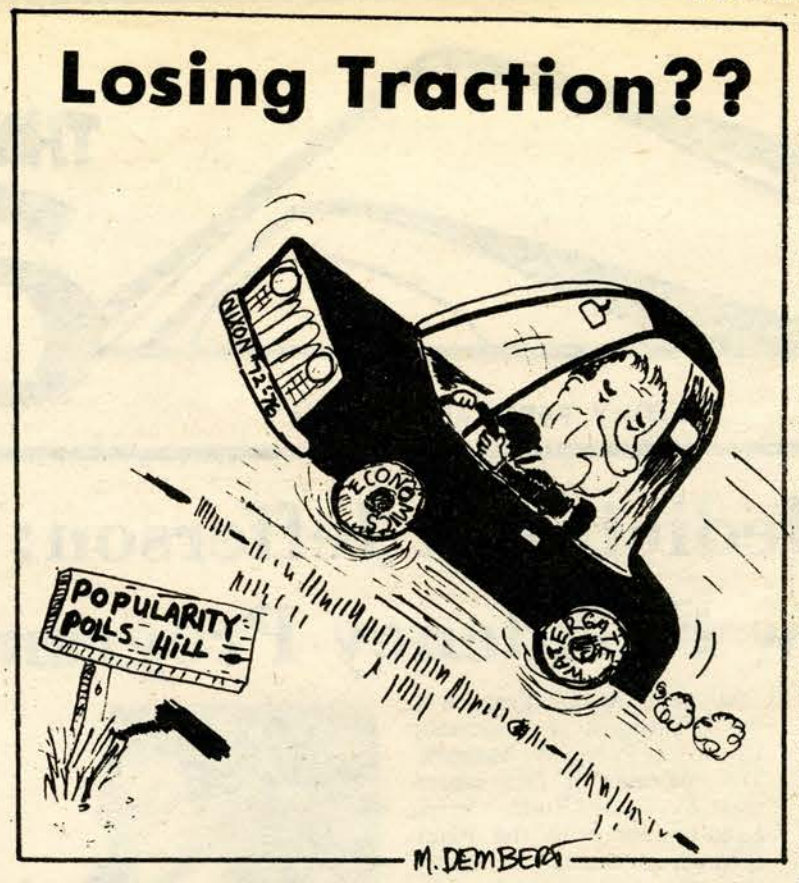
Today, social apathy is great. Vietnam and Watergate have seemed to deaden most social concern from most Americans. Nevertheless, there is a need to reaffirm EVERYONE'S civil right to life, black or white, man or woman, in utero. This is a challenge to unite all humanistic forces whether they go by the name of liberal or conservative. (The cooperation of Senators Buckley and Hatfield is exemplary of this cooperation.)

This effort to improve society should not be one sided. As we work to improve the quality of life for the unborn child, we should also work to improve the quality of life for the unwed mother. The social and legal discrimination which has been shown to her serves no constructive purpose and causes much pain.

Conclusion

In conclusion, the purpose of this article has not been to irritate or to insult anyone. Rather, I have tried to present a perspective which I feel society has lost. The individual human life is inviolable, and it is the function of our government to protect each individual. Be it slavery, abortion, or any other form of discrimination, they all attack this vital ideal of the intrinsic worth of all individuals. I hope that eventually our government will affirm each individual's worth through a Human Life amendment. In the meantime, I hope you realize the need for all to work toward this goal.

Frank Chervenak



The Inheritance

Quite a few years ago while staying in Atlantic City I woke up late at night. No matter how hard I tried I couldn't fall back to sleep. In desperation I decided to take a walk, hoping that I would return from my stroll sufficiently tired to induce a good night's rest.

As I was walking aimlessly up and down the streets I began to entertain myself by singing. My singing must have been louder than I thought because I heard an incoherent gutteral rumbling or rather a voice mouthing, "wha the ha ee a." The sound came from an alley. I turned around and saw a bum.

"What was that you said, sir?"

"What are you doing, bothering me? I ain' harmin' you."

"I'm sorry if I disturbed you, but I was singing in the dark, just singing in the dark. A peculiarity that I acquired from my father who does this all the time."

"Is tha' so? I heard of street walkers but I ain' ever heard of street singers before."

There I was looking for entertainment and gaiety – and what should I meet up with, none other than a fool! Wasn't that great? After all, how can a fool know that you are laughing at him; he's too dumb. Just treat with a little ridiculing respect, and he'll never suspect your devious intent.

"No, my good man, I am neither a street walker nor a street singer. I am a street sinner."

"Heben preserve me! The devil's got me!"

"No, no! You have me pegged all wrong. It is my holy duty to absorb the sins of all my unfortunate brothers and sisters and take them unto myself. The burden is heavy, but only the strong should wear sin. Have you any to give me?"

"Well, sir, you are just the man I've been lookin' for. I am glad to meet you. Now listen attentive-like; I want you to know what you are in for.

"When I was but twelve year of age, I slapped my mamma, can you take that?"

"Certainly, rest assured that I'll take it better than your mother did."

"When I was thirteen I kicked my papa down the stoop. When I was fourteen I stole my mama's and papa's jewelry and ran away from home. That's all. Just take these. Them will be plenty."

"Easily, a minute addition to my load. But, first, what will you pay me?"

"Thar ain' much I can give you, unless you want the shirt off my back."

"Good, good. That will do for a start, but certainly you don't think my services come so cheaply bought. Think, man, think. What do you hold most precious to you? Twenty dollars put away for a dry and sober day? Perhaps, some gidget or gadget you specifically swiped in order that you could prove to yourself that you have what it takes to be a lightfingered, shoplifting heavyweight when you want to be?"

"Must it be the most precious thing?"

"None else would do. Just think of the relief of knowing that your sins have been passed on to me."

"I'll give it then. I'll give it. Follow me."

He then came out of the alley; and, for the first time, I could distinctly see his features. Really there was not much to see. His hair was prematurely gray. His eyes were clouded up with some white film and naturally he was unshaven.

Let me add that I was not going to take anything from him that was just part of the joke. . .At least, I don't think I was going to take anything from him.

Where are we going, old boy."

"To my hole."

"Why aren't you there now?"

"I like the freedom of the night. No people stare at me. No children laugh at me. I hate them kids always laughin'. If I were thar parents I'd slug 'em. Thar plottin' against me."

"Pay them no mind."

"I try, I ain't no jerk. You hear, I ain' no jerk."

"I never said you were."

"Than don' think it."

I was being led up streets and through alleys. For awhile I wondered whether he could even find his way back home. Finally we stopped at the back of a filthy tenement. My friend took out a key and opened the door. Both of us were groping in the dark.

"I'll fin' this damn light. I always forget whar it is."

"Take your time, old boy. Time is but a measure for the living."

"Here, I found it. Now you'll get your payment. It's next to my bed."

"What priceless treasure have you there?"

He pulled out from his crusty night bureau an album. Much to my regret, I can still vividly recall his trusting eyes and upturned lips as he handed it over to me. How silly he seemed then; I really got a kick out of his idiotic adoration, but that was not to last for long.

"Say there, what have we here. Something good to sneak a peek at, I bet. Must be just what the doctor ordered, huh, yes, ha ha you son of a gun you." I began to gently poke him in his ribs.

I don't know why but I had jumped to the conclusion that he was bestowing unto me an inordinately lewd collection of third-hand pornographic pin-ups.

"This is the only thing my people left me after they died," he said.

"Oh, in that case we'll have to give it a thorough checking," I answered betraying a noticeable note of disappointment.

Upon opening the album I saw photographs of a little boy affectionately embracing a respectable, fondling female, a little boy who was joyously blowing out the candles on top of a cake while two delighted proud appearing parents cheered him on from the sidelines; a little boy wearing a catcher's mit facing a sturdy, smiling older man who was on the verge of tossing him a baseball.

"I don't understand, who is this cute little boy," I asked genuinely puzzled over who it might be.

"It's me," he mumbled in a broken voice.

Suddenly I was overcome by an overwhelming feeling of disgust. I flung the album onto a bed and fled from the apartment as quickly as my legs would carry me. However, my would-be-stooge was not going to let me get away so easily. He followed after me hollering at the top of his lungs, "Come back sinner man, we made a bargain, you can't go back on your deal. Redeem my soul and save me."

When, in time, I lost him I returned to where I was lodging. Though I was now more exhausted than I ever would have imagined I could have been, sleep did not come to comfort me.

J.D. Kanofsky

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Letters to the Editors

Dear Editors,

I read with interest your article of 12-19-73 "Orthomolecular Psychiatry; An Impression," and would like to comment on some of the issues raised.

I recently returned from a two month excursion which included six weeks of adolescent psychiatry at the Menninger Foundation and a half a dozen or so stops on the interview trail for R-6 internships and psychiatry residencies. In the course of my work and through talking with a number of psychiatrists and psychiatry residents throughout the country I came away with one firm conviction: as the editors suggest, American psychiatry is in the midst of an upheaval.

While psychoanalytic theory and practice remains a major force in American psychiatry it is far from the "be all and end all" that it approached a mere decade ago. Many large University affiliated residencies have broadened their programs over the last few years to include an increased emphasis on family therapy, systematic desensitization and other behavioral techniques, biofeedback, hypnosis, and psychopharmachology. In addition, there appears to be a heightened interest in biochemical and physiological research into psychiatric disorders which holds the promise of bridging some of the gap that has developed between psychiatry and the rest of medicine.

Some look upon this broadening of therapeutic modalities as an indication of lack of competence and general confusion within psychiatry. I disagree. I feel that this attitude is a reflection of a rather unfortunate yet surprisingly widespread notion that goes something like this: that once an emotionally disturbed individual has been designated as a member of a major psychiatric grouping (neurotic, psychotic, character disorder) all individuals within a given group can be treated pretty much the same way. This makes no more sense than saying that everyone with pneumonia should receive penicillin or everyone with diabetes insulin. With new options at its disposal psychiatry is in a better position today than ever before to tailor make a therapeutic program to satisfy the particular needs of each patient.

The upsurge of eclecticism and free thinking in psychiatry today is in the best tradition of one of the most important, yet often violated dictums of good medical practice – making the therapy fit the patient, not the patient fit the therapy.

Ken Jaffe

On January 1, 1974 the PSRO made its debut in Medicine. The PSRO - Professional Standar a Review Organization - is the direct result of Public Law 92-603 which sneaked through Congress under the tutelage of Senator Bennett of Utah and was signed into law by President Nixon on October 20, 1974. It's virtually unnoticed passage is in no way related to the bill's importance for it will lead to nothing less than a revolution in the way Medicine is practised in the U.S.

The local PSOR (and local assumes some significance as we'll discuss later) has specific duties under law. It must:

a) establish standards for diagnosis and treatment of the diseases found in its region,

b) establish lengths of stay for each patient commensurate with their disease and provide for review of the need for hospitalization and/ or continued stay of each patient,

c) provide for the public record a profile of each doctor, institution, and patient. This will be especially important in monitoring such things as drug usage, utilization of resources, etc.

Under the present law the sanctions will apply only to patients whose expenses are assumed in full or in part by the federal government under the Social Security Act. In present and practical terms this means Medicare, Medicaid, and some Welfare patients.

The law, as one may imagine has raised a storm of controversy. Several questions have been raised.

1. Who is the local PSRO and to whom will they be held accountable?

The Secretary of HEW will designate local areas presumably along geographical lines although it is expected that the university centers will have their own bailiwicks. Local groups can be formed by any collection of physicians and every doctor in the area must belong since as soon as 50% of the doctors in the area have signed up the rest are enrolled. Should the local practictioners fail to form a group (whether by active opposition or merely jurisdictional squabbles) the Secretary has the power to designate an agency and enroll the local practictioners by fiat.

2. How will standards be established?

This is a hornet's nest since even within one area differences in treatment between community and teaching hospitals will be apparent. The effect on research has yet to be assessed.

3. Who does the auditing?

This refers back to question #1 since the local group will have to audit its members - but then again in practical terms this means ownership of a computer and only a few groups (RMP's, institutions) are likely to have access. Conceivably, third party payers such as Blue Cross and state agencies will take up the slack.

The law was written with the idea of reducing costs for care. However, even the best analyses are uncertain if this will be achieved. Certainly doctors will have to become more cost conscious, particularly in the realms of hospital stay, drug prescribing, and laboratory tests. How much this will save is unknown. The cost of administering the program is placed by rather hazy estimates in the neighborhood of $500,000,000 for the nation. This will be borne by the federal government, but judging by the current debates between the Executive and the Congress over health spending this will no doubt be rich quarry for campaign rhetoric and posturing.

One would hope that the quality of medicine will improve under the lash of peer scrutiny. One by-product may be an increase in post-graduate education. Clearly comparisons of local statistics may lead to the discovery of areas where substandard medicine is practised and perhaps, eradication of the same.

On the other hand, the whole principle of confidentiality is likely to be called into question. As hospital records and doctor profiles become public records the doctor-patient relationship will become increasingly put into a precarious position. Where will psychiatric work-ups go? Will physicians who over-prescribe or waste resources be identified? And to whom?

Finally, where will the power to control and/ or to change medicine reside? To the local hospitals and practictioners who will establish the statistics and practise medicine; to possible third part payer-auditors; or to the government who will be footing the bill?

In conclusion, all of this is in the formative stage now. It is well to remember that local areas will no doubt provide local answers to all of these questions. And as of now only a small percentage of patients are involved in the system. However...

The day that national health insurance comes- and it is coming- **everyone** will be involved. And despite AMA foot-dragging (at the last meeting in *Anaheim a resolution was passed* asking for repeal of PL 92-603) it appears that the wave of the future is breaking on our shore now.

Robert B. Baker

A few weeks ago, ballet came to Jefferson. Teachers from the Pennsylvania Civic Ballet agreed to hold classes here as part of the Commons recreation program. The response was surprising – about 65 people paid a deposit of $15, refundable on completion of 6 out of 10 sessions. These people were divided into three classes, two of which meet on Tuesdays, and one of which meets on Thursdays. The practice room is McClellan Hall, chosen because of its wooden floors and movable chairs which serve as bars. The sessions open with exercise at the bar, and include basic ballet steps and turns. Some of the steps are basically for male dancers, although there are only a few men in the class.

When asked why so few men attend, Ken Levin commented that there are lots of programs offered by the Commons that few people take advantage of. Myron Schwartz said that most guys would just rather play basketball when they take time out from studying. Ken contends that he is enjoying himself, finding dance an outlet for his tensions. Myron, on the other hand, is mainly interested in refining his technique and developing his skills and plans to continue studying dance even after the Commons lessons are over. Myron feels discriminated against because the teacher refers to the class as "girls" and only the girls get to wear a leotard. In addition, due to the large sizes of the classes, Myron feels not enough attention is paid to individual improvement. But all this doesn't detract from his generally positive outlook, nor does it distract him from his goal of touching his nose to the floor when seated with his legs outstretched.

I asked Iren Alvarez, the teacher (who has been with the Pennsylvania Civic Ballet for 23 years and who is performing with the troupe on February 18 and 19, and again in April) what her goals for the class were. She hopes she can just get the students to enjoy the work, since once they enjoy it they will want to perfect it. She is concentrating on the basics so the students will have a foundation for either continuing ballet, or experimenting with modern dance. She herself lives ballet – she speaks in the language of dance and moves that way, too. Every motion is totally controlled. She believes the physical training is the best aspect of the classes. When she begs, "Stand up straight -- that's even more important than the steps," it makes one wonder if maybe this isn't the answer for all those slumping students stumbling through the Commons!

Sno White

Faculty Perspective III

Eight Degrees of Charity: 100% for the 150th?

by Robert L. Brent , MD

My mother had a neighborhood hat store in Rochester, New York, in a section of town inhabited primarily by an immigrant and first generation population of Polish and Italian extraction. It seemed as if a day didn't go by without someone entering her store with a cardboard container collecting for one charity or another. If it wasn't coins, then it was merchandise for the bingo contest or a raffle at the local church. Although I was too young to realize that we were in the midst of the "Great Depression," I was not too young to observe that she enjoyed giving.

In retrospect I am thankful for the example that she set; for giving is just another expression of affection for people Yet Maimonides, the twelfth century Hebrew scholar, would not have rated these episodes very high. It's true that on a pass/fail system she would have made the grade, but numerically she was a 70. Maimonides described eight degrees of charity. The eighth degree is "when one gives grudgingly." The highest degree is to provide a means whereby the recipient will become self-sufficient and in turn be able to contribute to society. Although my mother gave cheerfully, those gifts had little impact, except to provide short-lived cheer to the beneficiary.

In all likelihood Maimonides could not have foreseen the plight of the private university in the last half of the twentieth century – but there is no doubt that he would have considered university support the highest, most mature level of philanthropy.

Yet when students leave a university not all feel an obligation to support the university in its role to educate individuals who will contribute to the common society.

At Jefferson this is less true since a higher percentage of alumni contribute to their alma mater than at most schools in the country. This has pleased me from the day I joined the faculty at Jefferson because it meant that the alumni had a relatively high esprit de corps, but I am still not certain why; except to comment that most of the alumni donors probably also give to their undergraduate schools and to many local and national charities.

I would rather concentrate on the individuals who never contribute a penny to their alma maters from the day they obtain their diploma. Do you think you can stereotype non-givers? Do you think any of them who have paid full tuition would conclude that they paid their own way through medical school? Certainly every medical student knows that tuition covers only 15% to 20% of the cost of a medical education. In essence, everyone who goes through medical school has at least an 80% scholarship. And that 80% is paid for by endowment income, the public and former alumni. There are no self-made doctors – not any!

I once participated in a telethon in the Philadelphia area for my alma mater (not Jefferson). I made about forty phone calls to alumni in Pennsylvania for an annual alumni giving campaign.

One physician who had a 28 acre farm, five horses and five cars told me that his expenses were very high and he couldn't afford to participate. Another physician was in the middle of his second divorce. He was very angry -- mad at everybody including his former school. A husband and wife, physician team, refused to give because they had both worked their way through school and "no one had helped **them.**"

Because of the high incidence of angry responses it is easy to utilize a psychological explanation to unfairly stereotype all nonpersist in projecting their conflicts on parental substitutes for the rest of their lives. This includes the law, government, the boss, the administration and even the alma mater. It might be true that this explanation could account for the lack of response in the less mature and more neurotic graduates. But one would doubt that the projection of anger and the existence of unresolved conflicts could explain the fact that 30%-60% of alumni never support their university – there may be a better explanation, at least a more appealing one. . .one phone call I had during that telethon was very enlightening. The man on the other end of the line was very pleasant. He said with some chagrin that he had never contributed. I said, "I know, I have your donor card in front of me." I didn't say another word and he began to talk. . .

"I wish I had sent a dollar in the year after I graduated, my internship year. It would have been so easy to start on the right foot. But I had such a valid excuse. You know how little you earn as an intern." Then he said, "That excuse was just as good the next year, and before I knew it, five years had gone by and it was then very easy to throw the annual-giving-card into the waste basket." It was his eleventh year past graduation and the next words he uttered startled me. "If I donate $150, will you credit me with $50 this year and $10 for each of my previous years?"

I said that I was sure that could be arranged. As he hung up, he said, "You know, if I had just given a few dollars each year I wouldn't have gone broke. . ."

In looking up "the eight degrees of charity," I noted that Maimonides also said, "No one ever becomes impoverished by giving charity."

If any fourth year students have any doubt that I'm talking to you – dispel that doubt. I would like to see this class aim for 100% participation in the alumni annual giving, from the internship year on. Wouldn't it be great if the class graduating from Jefferson in its 150th year started a new precedent for the rest to follow?

Remember, "No one ever becomes impoverished by giving charity." In fact, I guarantee you that the gratification and joy of sustaining an institution of education will become a very rewarding part of your life.

Free Jewish University Offers Variety of Courses

The Spring 1974 bulletin of classes for the Jewish Free University of Philadelphia has just arrived at its distribution points. The bulletin lists 66 courses, all offered at no charge at locations throughout the city and in surrounding areas, an increase over the offering of this past Fall 1973, which was also a record high. The continued growth of JFU reflects the interest in and success of this approach to reach college age Jews, particularly those with marginal affiliation, with mature lectures and discussions of Jewish interest. Questionnaire responses have indicated that over 2/ 3 of those attending JFU classes are between the ages of 18 and 26 and have almost no other contact with the Jewish community.

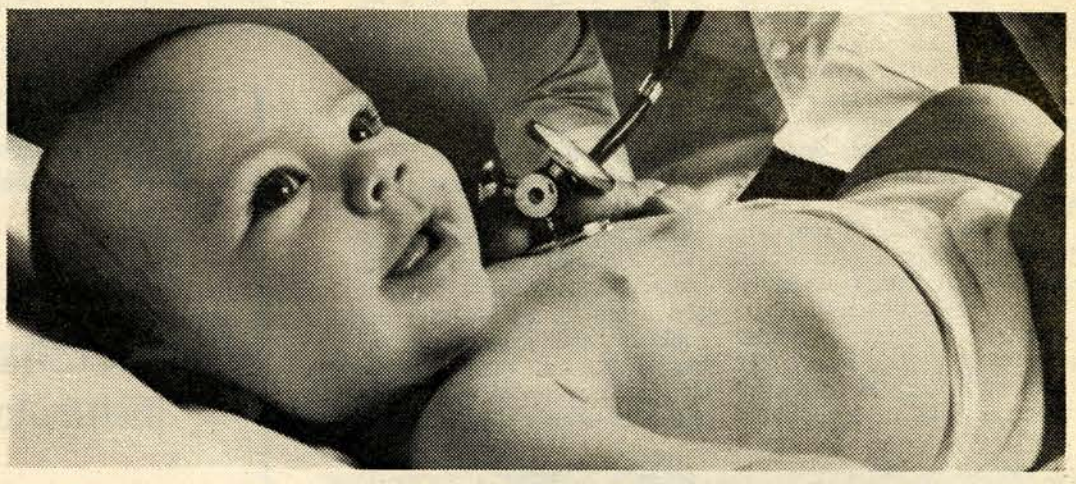
The wide range of topics covered by the course listing is indicated by the following few titles from the new Spring schedule: THE PSYCHOLOGISTS VIEW OF JUDAISM, THE SOCIOLOGY OF AMERICAN JEWRY, RECONSTRUCTIONISM: A JEWISH WAY OF LIFE, NEW FORMS OF ANTISEMITISM, THE STRUCTURES OF MIDDLE EAST POLITICS, THE FICTION OF ISAAC BASHEVIS SINGER, MIDRASH: LEGENDS OF THE BIBLE, YIDDISH & JEWISH LIFE, LEGAL STATUS OF THE AMERICAN JEWISH COMMUNITY, BEGINNERS & INTERMEDIATE HEBREW, MYTH, MAGIC & THE SUPERNATURAL IN JUDAISM, JEWS IN THE UNITED STATES, PROBLEMS OF KIBBUTZ EDDUCATION, JEWISH ACTIVISM, JUDAISM & MEDICAL ETHICS.

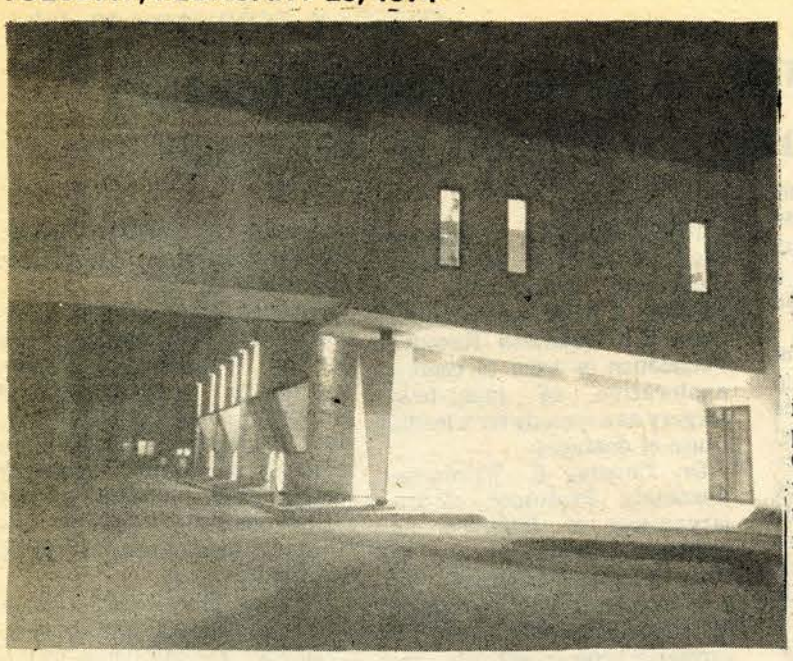
The Jewish Free University has no single location and no fixed schedule; its classes are held wherever it is convenient for teacher and students to gather. Most JFU classes will begin the week of February 18, but many will not have a first meeting until March or April. This is particularly true of some JFU mini-courses in which the instructor attempts to encompass a topic in three to five lectures.

To constantly update its catalog, as well as to register students and as a contact point for those wishing to obtain more information, the JFU maintains 24 hour phone service at LO 8-6261.

Free Breast Cancer Screening

A free breast-cancer screening examination is being offered to all women between the ages of 45 and 64 at Thomas Jefferson University. Women who have no previous history of breast cancer can receive a thorough physical examination of the breasts, an evaluation by X-ray, and a new test, called thermography. To obtain this free, preventive service, call Jefferson's Breast Diagnostic Center at 829-8350.





Latrobe Area Hospital Ambulatory Care Center where Jefferson Medical College junior and senior student physicians will rotate to complete clinical studies in Family Medicine.

Residencies

(Continued from page 1)

educational expertise of the Jefferson Medical College guiding the Latrobe Area Hospital in physician training on both a pre-graduate and post-graduate basis. On the pre-graduate level, the Hospital will be receiving both junior and senior year medical students rotating through the Hospital's new Ambulatory Care Center. Two students have already arrived in the Latrobe area.

During their junior year in medical school, the students will be expected to spend approximately six weeks at the Latrobe Area Hospital in a Family Practice "Clerkship." In their senior year, those students interested in concentrating in Family Practice Medicine will spend approximately three months at Latrobe. They will spend the majority of their time in the new Ambulatory Care Center under the direction of Drs. Robert S. Gordon and Joseph R. Govi. Drs. Gordon and Govi will continue to maintain an office in nearby Pleasant Unity, Pa.

In addition, Jefferson will be supplying the Hospital with first, second and third year resident physicians. The resident physicians will have the elective opportunity to assist local general practitioners in their office facilities in such surrounding communities as Ligonier, Blairsville, Derry, and the Avonmore-Saltsburg area in addition to Latrobe. These external activities will be done in conjunction with the physicians already in those areas. Preliminary inquiries have indicated a very wholesome and receptive atmosphere created by the practicing physicians for such involvement.

The complete program will be monitored by a full time director of the Family Practice Unit, the co-directors being Drs. Gordon and Govi. Overall supervision of the program in Latrobe will come from Dr. J.R. Mazero, Medical Director of the Latrobe Area Hospital. Supplementing these efforts will be the input from the faculty of the Jefferson Medical College, which will be accomplished by monthly on-site visits.

The program to train resident physicians for Family Medicine beginning in July, 1974, was recently approved by the American Medical Association's Committee on Graduate Education. Although some students have already rotated through the Hospital, the program is not expected to be fully operational until the summer of 1974. The students will be housed in a nearby apartment building which the Hospital has under agreement to acquire.

Problem Oriented Medical Education (POME): *Philosophies, Approach*

Halley S. Faust

[This is the third in a series of articles describing the Problem-Oriented Medical Education [POME].

Toward what are we educating? That is, what is the physician's role in health care? Only until this role is defined can we describe the mode of education necessary to help the medical student to reach his goal.

The physician is a link in the health care system. His position is becoming more narrowly defined. There are technicians, nurses, paramedics and computers who/which can gather data, store data, regurgitate that data in an organized form, and perform detailed therapy. There is a systems prototype approach to record-keeping in Dr. Weed's problem-oriented medical record. Where does the physician relate? Essentially, he is the problem solver. He defines the problem as he assimilates the date, prescribes a detailed management plan for each of the problems of the patient, and then supervises the performance of that prescription.

Given these functions, what does the physician require in order to fully perform his duties? The first, and most obvious though least taught in Jefferson's basic sciences, is a problem-solving ability. Indeed, this is what the POME is based upon. The necessities of understanding problems and resolving their etiologies are the foremost tasks of any student in medicine. Developing the mode of function related to a problem is the vital key to more successful diagnosis and better understanding of disease. Instead of a student's studying the disease and its manifestations in pathology, he should study the underlying etiologies of disease as presented by manifestations. Very rarely will a patient present with chief complaint of "COLD"; perhaps instead he claims that he gets "short of breath while walking up steps." It is not "atrial tachycardia" with which a physician is initially confronted, but "pounding in my chest," as the distressed patient accounts.

Primarily, then, a student need be taught problem-solving techniques working directly in the medical field. He learns the techniques of problem-solving in order to become the artist of science just as the aspiring musician must first learn harmonics to develop his art of composing. The medical student needs to deal with a problem, its significances, its attempts at removal, and its effects on the patient's physical and mental world.

What does one require in order o be an adequate problem-solver? The very last requisite is a "core of knowledge." Facts are of little value if they are improperly utilized or have no significance to the individual. This is an unfortunate emphasis in the present system of basic sciences learning. The needs of an adequate problem-solver include the abilities to a) recognize and define the problem, b) place in perspective the problem in relation to the individual and his environment, c) develop a rational approach toward attempting to alleviate the problem, and d) evaluate the first three criteria by some systematic form of self-audit.

For example, the student is told a patient presents to the physician with complaint of a GI disturbance such as diarrhea. The student can then build from his knowledge of diarrhea by a logical sequence which may be expressed as one of the following: Neither is absolute, nor is either complete. But, as an example, on a first or second year medical student basis each reveals a logical procession of understanding of the disorder called diarrhea. These problems can be delved into further as more practical skills, knowledge and attitudes are obtained. In addition, better comprehension of interrelationships of problems and knowledge could result. And the student's learning, though medical-system guided, would be student initiated and motivated. The student would have a much greater capacity for feeling greater capcity for feeling self-fulfilled due to his discoveries and imagination and creativity utilization. The stifling of students' intellectual curiosity is a result of eliminating the imaginative and creative aspects of learning as is now the case in the conventional medical training programs.

The second study trend of the student would be to develop a good communicative ability with those with whom he works – not only the patient, but the nurse, technician, administrator, etc. This includes attempting to understand, trust, and empathize with the individual's social, moral, emotional, and intellectual problems. As noted in the first and second part of this series of articles on the POME, no person is simply a physical problem with which to deal. Medicine and Society has told us this, but one can hardly consider the idea seriously taught when the body (physical problem) is emphasized for 85% or more of our class hours and the other four crucial dimensions of the Homel/Evual Total Person Concept is considered for at the most 15% (for a more thorough discussion of the Total Person Concept see **Pediatric Clinics of North America**, 16(2): 379-393 (1969). Why cannot true feelings, social pressures, rationalizations, and religious experience be correlated with ulcer, anxiety, SLE, pneumonia, etc.? What does ballet offer the physician other than biomechanics? Why is there no integration of humanism with medicine?

The unfortunate fact that basic medicine is taught as basic sciences manifests the absurdity that medicine incorporates none of the humanities in its devices. This system assumes one method, one discipline (pure science), one product. Yet no one would admit that physicians are of one method, one discipline – one automaton-aid nature. Who sees the worth of history in medicine? Who sees the values of art, literature, anthropology, economics, government, education, and their interrelationships of solving the problems of medicine? Many would agree that they exist. As it cannot be assumed all medical students do have the basic knowledge of medicine, neither must we assume that all students have a basic knowledge of men. Why is history of medicine not even offered at a school that prides itself on its own history? What valuable hints are not offered to students in solving problems because the students have no perspective of self-discovery? of the self-discovery of those in history who have developed our heritage of medicine?

Sir William Osler in his **Aequanimitas** quotes Marion Crawford that "Passion rules the world, and rules alone. And passion is neither of the head nor of the hand, but of the heart. Love, hate, ambition, anger, avarice, either make a slave of intelligence to save their impulses, or bread down its impotent opposition with the unanswerable argument of brute force, and tear it to pieces with iron hands." How can we adequately rule the medical world if we cannot evoke from, grasp, and communicate to the patient his "passion" or if we do not have a knowledge of men?

As opposed to the current system, the POME would not lose sight of the fact that the core of the curriculum is the student and his capabilities. It would not destroy its goals by implementation of absurd mandates imposed on students. Students would emerge as problem-solvers, communicators, managers of individual health care. The student would be expected to operate on his current level of understanding, a level which everyday would rise toward successful cognitive, manipulative, and attitudinal skills required by a physician. The teacher as guide would have the capacity to help the student to assess his own progress.

One should not fret that fewer facts would be learned. Instead, variations of, or the same facts as are learned today, would be understood in their context of the medical world. The facts could be quickly found in references or deduced with the proper basic understanding of human biology and disease. Journals could add facts and ideas to a system already organized by and for the student.

Dr. Lawrence Weed is right when he proclaims "The only protection a student gets against the misconceptions of the faculty is reality, and you must create teaching situations where students always deal with the real problem, whose solution depends upon the student's ingenuity and drive and not on his memory. We must teach a core of behavior, not a core of knowledge." (Hurst, JW, Walker, HK (eds.): **The Problem-Oriented System.** New York, Medcom, 1972, p. 81). For a physician to best fit into his link in the health care system, he must be allowed to develop these skills as primary devices for proper medical management.

Extending a Green Hand: a Munificent Student Council Seeks Broader Support

Jim Burke

Unlike many organizations operating during these inflationary times, Jefferson's Student Council does not suffer from a lack of funds. The Council is allocated two dollars per medical student by the administration in addition to a surplus balance from previous years. Despite this financial security, the Council lacks student support in many areas. The members of the Council feel that the student body often fails to take advantage of the Council's resources.

One such resource is the money available for the initiation and continuation of student projects. The Medical College is presently attempting to establish a "University Forum," which would seat representatives from each branch of the Jefferson campus. This organization would coordinate projects and activities involving different Jefferson groups. For example, through this "University Forum" the nursing students could consult with medical student representatives as to the most suitable time and place for a social function involving both student groups. This new organization would not supersede the Student Council but rather be a branch of it to provide better communication with other non-medical student groups at Jefferson. New student organizations are being encouraged by the Council as well as greater input into present ones. The newest officially sanctioned organization at Jefferson is the "1961 Society." The Council expects more involvement from students when they realize that funds are available for the pursuit of their interests. Mike Flacco and Alan Neff, two board members, said that the Council is considering the possibility of sponsoring a rock concert at which Jefferson students would have first priority in obtaining tickets.

Besides funds for student activities, the Student Council also possesses another strong asset available to the students but often unused. The Council has rapport with the faculty including direct access to the Dean and his associates. Student problems and objections can be handled most efficiently and expeditiously with the Student Council acting as a liaison between students and faculty.

Dave Mayer, the President of the Student Council, sums it up well, "What we basically want is for the students to realize and then, more importantly, to take advantage of the opportunities which the Student Council offers." The meetings are held on the third Wednesday of each month at 5:30 in room M-28. All students are encouraged to attend whether to propose new programs and activities or to just listen to the Council's present work.

Manning St. to Present "The Orphan"

The Manning Street Actors' Theatre proudly announces that it will produce and present a new version of David Rabe's drama, **The Orphan.** This will be only the second professional production in Philadelphia of a work by the nationally acclaimed Drexel Hill playwright. (**The Basic Training of Pavlo Hummel** was presented in the spring of 1972 at the Locust Theatre.) The Manning Street production is to be done in association with Joseph Papp and The New York Shakespeare Festival.

As have all of Rabe's plays, from **Sticks and Bones** to **Boom Boom Room, The Orphan** originated at the Villanova University Theatre Department. It was produced in New York by Joseph Papp in April of 1973, and then in November at the North Carolina School of the Arts under the direction of Barnet Kellman. Mr. Kellman, who has directed numerous off-off-Broadway shows, will also direct the Manning Street production.

The upcoming production is not a revival but a reconstructed version of the drama which, the playwright feels, more closely resembles his initial intention. In **The Orphan** Rabe has transformed the myth of Orestes into an examination of contemporary violence and guilt. What happens in the House of Atreus happens in America. It is a devastatingly powerful – but in its way very funny – work. The play opens March 12th and runs Tuesdays through Saturdays through April 6th.

Jeff Makes the Radio Scene: "You and your Health"

Susan Shapiro

First broadcast on November 13, 1972, the series, "You and Your Health," has been selected as the best project in electronic communications by the American College Public Relations Association.

The series airs on KYW Radio each weekday at 9:23 a.m. and 7:28 p.m. This will be cut to once daily in the near future. The program is an ask-the-doctor type of format, whereby listeners write in questions covering any medical or psychological topic and receive an answer, on the air, by a Jefferson specialist.

Several physicians are "regulars" on the program. Dr. Mario A. Castallo, Honorary Clinical Professor of Obstetrics and Gynecology; Dr. Paul C. Brucker, Chairman of the Department of Family Medicine; and Dr. Martin B. Wingate, Professor of Obstetrics and Gynecology

Listeners with questions on any health topic are asked to write "You and Your Health," Public Relations Department, Thomas Jefferson University. All questions are answered, either on the air, or by letter. The actual names of listeners are never used in the 2% minute medical advice program.

Laser - Beam Research Funded at Jefferson

PHILADELPHIA – Jefferson Medical College of Thomas Jefferson University has received a $6500 one-year grant from the Deafness Research Foundation in order to continue exploration of laser-beam surgery as a remedy for a leading cause of deafness.

Dr. Chester R. Wilpizeski, Associate Professor of Otolaryngology at Jefferson, and principal investigator for the study, said the use of lasers could hold promise in the correction of otosclerosis-a condition whereby excessive bone growth interferes with the transmission of sound.

An experimental technique under study at Jefferson uses a bright pinpoint of blue laser light, directed through a microscope for only a fraction of a second, to break through the bone barrier. Successful trials with animals indicate the new method could allow access to the deepest and most difficult to reach areas of the fragile inner ear, Dr. Wilpizeski said.

The grant was announced in New York City by Mrs. Edward McSweeney, DRF Chairman. The award is one of 33, totaling $302,000, which the organization has made for medical investigations throughout the United States and Canada.

Founded in 1958 as the first, national, voluntary health agency devoted to furthering research into the causes, treatment and prevention of deafness, DRF has, since its inception, directed more than $4.8 million to ear research and related objectives. The Foundation's 1974 grants are going to 26 institutions in 14 states and Canada.

The New York-based agency carries the endorsement of such leading professional bodies as the American Otological Society; The American Laryngological, Rhinological and Otological Society; American Academy of Ophthalmology and Otolaryngology; and Section on Laryngology, Otology and Rhinology of the American Medical Association.

In addition, it has the support of individual members of the medical professon through the participation of otolaryngologists on its board and committees, and through the Centurion Club of ear, nose and throat doctors, whose annual dues defray the Foundation's operating costs.

NBC's Levine Pledges More Inflation; Calls Oil Shortage Real

NBC News correspondent Irving R. Levine relaxed before the February 20 University Hour audience and quipped that it was nice to be out of Washington these days, even if it wasn't very far. "Also," he observed in a glance at the podium, "it's pleasant to be in a room with a microphone you can see."

Levine kicked off a renwal of the Potter Memorial Lectures supported by the legacy of William Potter, Jefferson Medical College Chairman of the Board at the turn of the century and leader of Jefferson's first big building campaign; the Main building of the hospital complex is the only survivor of his efforts.

As first speaker in the new series, Lwvine was chosen for his renown in radio, television, and books and cosmopolitan reporting experience of ten years in Rome, four years in Moscow, two years in Tokyo, and one in London.

Levine centered his remarks on inflation and the energy crisis.

As a result of the energy problem, more industries will follow the examples of the auto and airline industries with shutdowns, Levine predicted.

"Inflation is worse than ever," he emphasized. "The controls have failed because the individuals in charge had no faith in them." He compared the wage-price control administration to putting Pope Paul heading a birth control program or John Mitchell a Justice Department.

Levine claimed that Nixon instituted the controls only because Congress threatened to legislate them first. John Connelly was the only administration official in favor of the controls, and the relatively tight Phase II controls in his charge were fairly effctive, Levine noted. But when Connolly retired at the end of Phase II, businessmen hiked their prices for fear of being unable to raise them under later controls, and in a form of self-fulfilling prophecy resulting inflation forced further ill-considered controls.

Levine pointed to a lack of effective enforcement as being the major flaw in the price control programs. He discovered that although Internal Revenue Service reprisals were threatened against companies violating the price guidelines, that the threat was a paper tiger and the administration wanted to avoid enforcement in order to prevent the growth of a new bureaucracy.

Levine - University Hour

"It is impossible to have adequate controls," said Levine, "without adequate control measures. Such a sham inevitably takes a toll in public confidence."

"The Nixon administration is throwing in the towel," he summarized. The controls which lack plan and enforcement have created as many problems as they have solved. The White House will not renew the controls when they expire in April.

Citing Agnew's integrity, Kahoutek's fizzle, and the Soapbox Derby's scandal, Levine thought that it was a sumptom of our times that people ask "Is there really an oil shortage?"

"Unquestionably there is a general shortage," he replied. He identified the Arab oil cutoff and declining domestic production of oil since 1970 as precipitating causes. Persons to blame sit in the oil companies, in the administration, in congress, and in environmental groups. In spite of the good intentions of environmentalists, he claimed, if oil were now flowing from Alaska, the oil shortage would only have been one half as great.

"And unquestionably the oil companies are making big profits," he continued. But last year the farmers were the profiteering scapegoats; in an economy such as ours, he analyzed, a shortage of a commodity leads to profits for the producer. "That is simply the way it is in our society; we may lament it, but we cannot change it."

Levine identified Henry Kissinger as the ultimate solution to the oil embargo. Nixon has been handicapped by Watergate, even abroad, but Kissinger is in a uniquely influential position as chief architect of the Mid'east peace. Arbas know, Levine said, that Israel will not return captured territory without US pressure.

More important than the oil itself is the cost, Levine commented. Effectively wealth is being transfered from the industrial nations to the oil producing countries. Oil price rises have destoyed the faorable balance of payments for the US. Attempts to establish a stable world currency system have been derailed in the turmoil.

A "Sleeper" of a Film

Gary Emmett

Woody Allen's new movie, **Sleeper**, is an expensive looking Hollywood movie as were **Play It Again Sam** and **Everything You Wanted to Know About Sex But Were Afraid to Ask**, but this picture is a return to the older style of his shoestring budgeted films like **Bananas** or **Take the Money and Run. Play It Again Sam** was a hilarious film full of the loser humor of Allen, but it was a conventional movie that opened up the stage play to film (which is something a goodly number of directors fail to do), but did not have the spontaneity of a typical Allen picture (or even a typical Allen **New Yorker** piece). Everything was a picture of great highs (the parody of "2001" as an orgasm) and emetic lows (the "What's Your Perversion"), but it was too spontaneous and was not held together enough.

The common denominator of **Sam** and **Everything** was their glossiness. By the time that **Play It Again Sam** came along, Woody Allen was box office and he was being sponsored directly by a big studio instead of having to raise his own funds for these two films but also forced Allen to work within restriction other than budget. **Sam**, his first big studio film, had to be conventional in aspects, except the humor which was uniquely Allen's, so the studio filmed Allen's on Broadway success. If a Broadway success isn't convention, what is? Then Allen was forced to work out an expensive title without any idea at all in **Everything**, and the forced nature of the work showed in the movie's unevenness.

Sleeper, though it is glossy in camera work and technical aspects, is Woody Allen's own idea of film. Although the movie is full of Allen's one liners (of Nixon: the Secret Service checks the silverware every time he leaves the White House; of Norman Mailer: he willed his ego to Harvard Med School), the movie itself is sight-gag oriented with Allen as a robot, or fighting a vicious chocolate pudding, or stealing a nose. **Sleeper** returns to the utter nonsense (based on a reality that we have all seen) of the loser finally winning, maybe.

The plot of **Sleeper** is an old one that was used by Wells in the **Man Who Owned the World** and has been used at least three times in the past three years for television movies. A person, for some reason or another, is put into the state of suspended animation and wakes up hundreds or thousands of years later to discover that his presence is vitally important to the world of the future. But **Sleeper**, like a good deal of science fiction or fantasy, only uses the future to comment on the foibles of today.

The most exciting aspect of **Sleeper** is its return to utter nonsense that is also social comment as in **Bananas** and **Take the Money**. The studios are finally letting Allen do his own thing (he wrote, produced, directed, and composed the music for this film) and his thing is very, very good.

Jefferson Names New Director of Student / Employee Health

DR. J. WOODROW SAVACOOL

Dr. J. Woodrow Savacool has been appointed Director of the Student/ Employee Health Service at Thomas Jefferson University Hospital according to Dr. Francis J. Sweeney, Jr., the University's Vice President for Health Services.

Dr. Savacool has been with Jefferson since 1942, first as an Assistant Demonstrator in Medicine and most recently as Clinical Associate Professor of Medicine. A graduate of Muhlenberg College in 1933, he is a 1938 alumnus of Jefferson Medical College

From 1941 to 1972 he served the Philadelphia Department of Health's Section on Tuberculosis, first as Clinical Chief and later as Consultant. For 9 years he directed the Health Maintenance Clinic of the Department of Preventive Medicine at Jefferson.

Dr. Savacool is a representative of the Pennsylvania Thoracic Society to the American Thoracic Society. He is a member of the American College of Physicians, the College of Physicians of Philadelphia and a member and past president of the Pennsylvania Chapter of the American College of Chest Physicians.

Sports Medicine --- A Sub-Profession

by Curt Cummings

The Orthopedics Lecture of the Biggon Surgical Society's bill of monthly lectures was a change of pace, and not because it was the only orothopedica lecture of the year. The topic was Sports Medicine Forum, it was held on February 6th, and in essence it brought to light an entire subspecialty of medicine.

Previous Gibbon Society lectures have included excellent technical and theoretical talks by some of the top surgeons in the area. For instance, the January lecture was on the evolution of pediatric surgery by Dr. C. Everett Koop, one of the nation's first and foremost.

The Sports Medicine Forum featured two men the public has often heard mentioned--Dr. James Nixon of the Eagles and Dr. Phil Marone of the Phillies. Many an injury has gone under their knives, and they spoke of the two best known of their sports--the knee injury in football and the pitcher's elbow of baseball.

Dr. Nixon, who has had 10 years of experience with the Eagles, spoke in both technical and colorful words about the various types of knee injury he encounters and fixes. Though his talk was based on operative technic, he also stressed the patient management aspect of his job, since the injury involves an athlete, his livelihood, and his personal idiosyncrasies. Dr. Marone talked in less technical terms, portraying the problem as one of ballistics with the strain of repeated pitching stressing muscles in certain unnatural motions. He spoke of the damage that pitching can do to an adolescent or pre-adolescent elbow because of the strain upon epiphyses and medial epicondyle, and drew parallels to tennis elbow, occurring on the lateral side.

Dr. Nixon especially stressed his role as a team physician, not as an orthopedic surgeon, in this particular type of job. As students we have heard a dozen times how our only goal is the well-being of the patient. This point is what makes sports medicine almost a complete subspecialty, for you are more of a general practicioner than a surgeon here, and part psychiatrist. Your own ethics must stay intact, for the worst thing you can do is accede to management as in the Charlie Finley-Mike Andrews incident of the World Series. Yet, your beliefs about "what's best medically" must be modified, for if a player has an injury he can aggravate easily but can still run upon, you cannot keep him out of next week's Super Bowl.

COMMONS EVENTS

Jeff Cafeteria -- Free

Tues., March 26- 8:00 P.M. - Coffee House, Featuring Michael Bacon, Jeff Cafeteria -- Free

SPECIAL EVENTS

Fri., March 8- 7:00 P.M. - Student, Faculty, Staff Party,

AKK Wins I.m. Swim Meet

by Curt Cummings

The intramural swim meet is the most unusual event on McNulty's Intramural Calendar, and also the most fun.

Never mind the fact that the day's victory will be carried by some All-American come to Jefferson, and that Joe Average Student will likely be blasted out of the water. The spirit of the meet has made it into a frolicking free-for-all that is entered by all types of unexpected folks, women included. There's even a big crowd of spectators attracted, up on the observation deck.

Of course, "a strong spirit and a lot of heart" never made up for raw muscle. As usual the Big Berthas did carry the day, and it was only a question of who would recruit enough ringers and use proper strategy.

Around here, a ringer is defined as one who belongs to no fraternity but has not competed for points for any frat or independents. AKK pulled off the biggest, perfectly legal coup by obtaining Jack Piatt and Jeff Adam. Added to the already reckonable strength of teammates Bob Lawlor, Dave Eisner, and Dick Jackson, AKK's combination won the meet with 41 points.

Their strategy was simple and effective--enter only events in which they could take a lot of points, abandon the weakest ones, and concentrate where needed. Entering only seven of 12 events, they took no lower than second place in any of them.

Phi Chi was almost as strong on paper, featuring Alex and Bill Bodenstab, Pat Coghlan, Mark Generd, and Jack Hocutt. However, they spread thin in too many events, went overboard with their three strongest men in breaststroke, and failed to win either relay. They finished second with 31.

Phi Alpha Sigma was third, mostly on the streng of Bob Atkinson, with 27 points. Atkinson was unbeatable in his events, but other than the opening relay, only Steve Ross and the women gained any additional points.

The women were permitted to score team points this year, and their spirited participation was one of the high points of the meet. Big gun Patty Jones had to work, so the torch was carried by Sally Plumly and Ruth Keers, who finished one-two in backstroke and swam well in some men's events. Becky Paul and Laurie Burke grabbed eight valuable points for Phi Alpha in the freestyle, and Karen Lutz won an uncontested breaststroke for Phi Chi.

SWIM MEET RESULTS

40 yard backstroke, men - Atkinson, Phi Alph; Lawlor AKK; Hocurt, Phi Chi.

40 yard backstroke, women - Plumly, nurses; Keers, nurses; Burke, Phi Alph.

80 yard breaststroke, men - A. Bodenstab, Phi Chi; W. Bodenstab, Phi Chi; Ross, Phi Alph.

80 yard breaststroke, women - Lutz, Phi Chi; H. Smith, nurses.

80 yard butterfly - Piatt, AKK; Jackson, AKK; Smith, Phi Chi.

80 yard backstroke - Adam, AKK; Lawlor, AKK; Olson, AKK.

320 yard freestyle relay - AKK, 2:28.0

320 yard medley relay - Phi Alph, 3:38.0.

200 yard freestyle - Atkinson, Phi Alph; Adam, AKK; DeLone, Phi Chi.

40 yard butterfly - Piatt, AKK; Eisner, AKK; Smith, Phi Chi.

40 yard freestyle, men - Generd, Phi Chi; Lawlor, AKK, Doll, Phi Chi.

40 yard freestyle, women - Paul, Ph Alph; Keers, nurses; Burke, Phi Alph.

40 yard breaststroke - A. Bodenstab, Phi Chi; W. Bodenstab, Phi Chi; McNulty, Employees.