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Ariel - Volume 5 Number 5

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THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE

ariel

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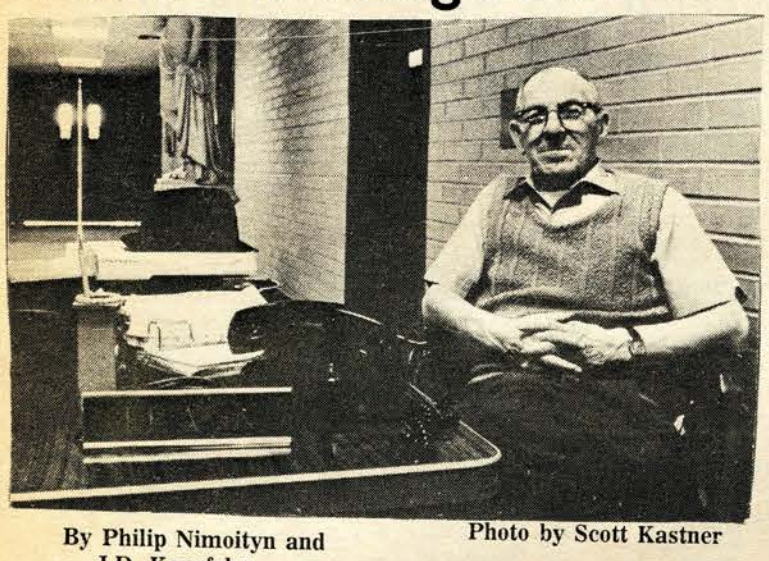
"Frank" Retiring From D.B.I.



By Philip Nimoityn and J.D. Kanofsky

Photo by Scott Kastner

Mr. Frank Lachman is retiring March 30 after working in Jefferson's Daniel Baugh Institute of Anatomy for 15 years. He began his association with Jefferson at the old D.B.I. building, located at 11th and Clinton streets, where he was the building superintendent.

Over the years he has given uncalled for, but much appreciated support to class after class of incoming freshmen. Student regard for him was demonstrated when over 200 students offered blood when he was in need of it.

Frank conducts many tours of the department for visitors on Parents Day and throughout the year. Many persons have written letters in response to the warm welcome they received from him.

The Department of Anatomy held a party for Frank on March 7. Dr. Andrew J. Ramsay, formerly Director of the Daniel Baugh Institute of Anatomy and Chairman of the Department of Anatomy, was present and reminsced about the great help that Frank was to the department and to him personally.

He will be missed.

The "Clinical Teaching Facility" - A Truly Modern Hospital

by Bob Sklaroff

"Hospitals aren't built like layer-cakes any longer. The standard design, embodied in the Foerderer Pavilion, of patient floors rising above those used for services (radiology, laboratory, surgery) is obsolete. The **functional organization** of the Clinical Teaching Facility (CTF) will employ the latest design innovations. You might well consider it the most modern hospital in the world."

Mr. George M. Norwood Jr. sees Jefferson's new hospital building in these terms. As Vice-President for Planning, he is employing proximity of services, interstitial space and the above principles in this virtual reconstruction of the clinical physical plant, to be completed in the Spring of 1977.

Some aspects of life in the Clinical Teaching Facility (CTF) may be projected:

Horizontality

You won't have to spend half of your time going from place to place, waiting for elevators, climbing steps. Lab facilities will be adjacent to hospital rooms, both one flight away from the physicians' offices and waiting-rooms.

Vertical movement of patients and doctors will be replaced by a horizontal clinical structure. For example, the cardiac catheterization lab, cardiac care unit, cardiac surgery operating rooms, pulmonary function lab, inhalation therapy unit, as well as all cardiopulmonary and vascular disease patients will **ALL** be on the same floor.

Programming Concepts

Services will be organized into four groups, those which usually refer to and consult with one another. The CTF will house patients, lab facilities and physican office-space respecting this division. Thusly:

Group A -- neurosurgery, neurology, orthopaedics, rheumatology, dermatology, trauma, physical medicine and rehabilitation, ophthamology

Group B--cardiopulmonary & vascular

Group C --GI, GU, oncology, ENT, Oral

Group D -- GI, GO, oncology, hematology, endocrinology, radiation therapy, nuclear medicine, communicable diseases.

Group C is primarily surgically-oriented and, therefore, will be located in close proximity to the operating rooms. Group D, medically-oriented, will be down the hall from the clinical laboratories. The other two service-groups will utilize both medical and surgical facilities.

The structure is to be integrated with the Foerderer Pavilion which will provide one of the three "towers" in this complex. Study of a cross-sectional diagram of the CTF will help you conceptualize the organization of services.

The University describes the CTF as "an exemplary setting for the interaction of superb patient care, the education of many kinds of professionals who must work together throughout their careers, and the clinical application of research results."

This is to be achieved by using distinctive architectural techniques.

Interstitial Space

The fourth, sixth and eighth floors of the CTF (cross-hatched in drawing) illustrate the concept of "interstitial space" in building design. It was used first in the construction of the Salk Institute Laboratories by Philadelphian Louis Kahn.

It permits flexibility in the layout of floorspace as well as cost savings. Because the structural-mechanical grid of the building is separated from the primary-use spaces, bidding and construction can begin before the primary-use spaces are programmed. Thus, construction is less affected by delays and rising prices.

In addition to this saving in initial construction costs, there are substantial savings in the operation of the completed building. Simplified maintenance and ease of repairs to mechanical systems are achieved because the entire support system is exposed in its own walk-in space.

Finally, proponents of the system say the interstitial space will lower the user's resistence to change; the very existence of high flexibility will provoke administrators to use the capability.

Hospitals being built with interstitial spaces includes: the Veterans Administration Hospital in San Diego, the Madera (Calif.) Community Hospital, and the Greenwich Hospital in London.

(Continued on page 6)

Rx For Schizophrenia: 8 g. Niacin; 4 g. Ascorbic Acid; 600 mg. Pyridoxine

by Morton A. Klein

Does Dr. Linus Pauling, the Nobel Laureate and Stanford University Professor who has published over 400 scientific papers and several books, need more honors and accolades bestowed upon him? With as many awards as Dr. Pauling has to his credit, any more praise is about as necessary as an acting lesson for Sir Laurence Olivier. Yet, Horizon House, a Jefferson-affiliated mental health rehabilitation Institute, has decided to, once again, laud this eminent scientist for his contributions to the fields of science, health, and peace. Pennsylvania's Governor Milton J. Shapp presented the "Horizon House Medal" during ceremonies at the University Museum, 33rd & Spruce St. on March 7, 1973.

After accepting the award, Dr. Pauling received a standing ovation from the overflowing crowd. He then wasted no time in making his views clear on how to improve our general health and more specifically our mental health. He first posed the question, "Why do some people escape the illnesses brought on by an epidemic, while others do not?" Pauling suggested that this is explained by more than merely genetic differences, but by our "molecular composition" which is influenced by our choice of foods, volume of ingestion of preservatives and additives, and by the air we breathe. Small changes in our molecular composition can lead to large behavioral changes, as evidenced by LSD.

Therefore we can readily understand how vitally important such relatively small components of our foods, namely vitamins and minerals, can be to our general and emotional well being, he added. Specifically he advocated massive dosages of niacin (Vitamin B-3), ascorbic acid (Vitamin C), and pyridoxine (Vitamin B-6) for victims of schizophrenia.

MANY STUDIES DONE

More than 20 years ago, he said, Drs. Hoffer and Osmond, both highly reputable psychiatrists, found that many schizophrenics showed remarkable improvement on a regimen of large quantities of vitamin B-3, and they later added vitamins C and B-6 to that schedule. The specific amounts to be used during this therapy, says Dr. Pauling, is 4 gms. of Vitamin C, 8 gms. of Vitamin B-3, and 400-800 Mgs.of Vitamin B-6. Dr. Pauling also said that 75%-80% of schizophrenics are hypoglycemic and should be immediately taken off white-sugar products such as candy, cake, cokes, etc. If diet is important for the health of the general population, then surely it must be even more important for the health of the mentally ill.

More recently, researchers such as Vanderkamp in Grand Rapids, Michigan and Heryonic & Heryonic found that most schizophrenics needed from 20-110 gms. of vitamin C per day before any was excreted in the urine. In comparison, normal

(Continued on page 7

Family Medicine Department Begins under Brucker's Chairmanship

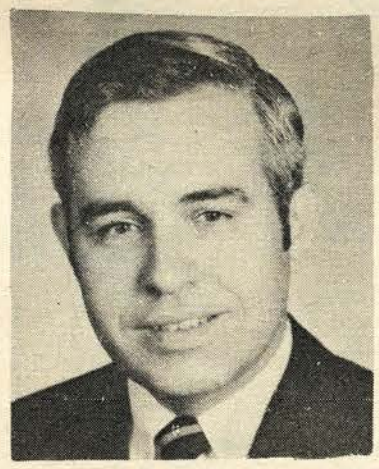
by David A. Jacoby

On March 1, 1973, Dr. Paul C. Brucker became Professor and Chairman of the newly created department of Family Medicine. A summa cum laude graduate of Muhlenberg College, he took his medical training at the University of Pennsylvania, his internship at Lankenau Hospital, a first year residency in Family Practice at Hunterton Medical Center, and a second year residency in Internal Medicine at Lankenau Hospital.

Since then he has spent thirteen years in family practice, acting as a preceptor for medical students from Jefferson, Penn, and Temple for ten of them and serving as an instructor in the Division of Family Medicine here at Jefferson for the past three years.

New Curriculum

He has high hopes for the new department and anticipates that six week clerkships in family practice will be a definite part of the class of 1976's junior curriculum, their clerkships taking place in the Model Family Practice Unit to be set up in Jefferson's newly acquired Edison Building, in upstate Pennsylvania rural affiliates, and at other affiliates in the city.



Its emphasis will be on primary outpatient care.

The senior year will be devoted to tracts in which further exposure to basic science and didactic teaching will complement the clinical exposure.

Family Practitioner's Role

Dr. Brucker sees the Family Practitioner's job as "meeting and taking care of people when they are sick; as he is the one who has first contact with them he must be equipped to give them continuing help or refer them to the proper source for aid. He should be a personal physician who affords a mechanism for readily available, continuous, comprehensive care. Such a mechanism should consider a team approach. The Family Physician, as coordinator, should be aware of health-care resources in a particular community.

Primary Care Shortage

"The government, which is theoretically made up of potential patients, is well aware of the fact that the percentage of primary physicians is rapidly decreasing. Not only is the number of general internists, general pediatricians, and family doctors decreasing, but also their distrubition is less uniform and more concentrated in attractive suburban areas. This results in an acute shortage of primary physicians in urban and rural areas.

"Legislative bodies, medical educators, medical societies, private enterprise and practicing physicians are concerned and wrestling with this problem. Hopefully, a solution is available which will be the result of a combined effort on the part of all concerned. I believe that the emphasis on basic research in the past decade or two has contributed to the decline in the number of primary physicians.

(Continued on page 7)

In Gratitude

ARIEL would like to take this editorial space to extend a very appreciative "Thank You!" to the Student Council. At a recent meeting, Student Council voted appropriations to enable **ARIEL** to substantially pay off debts incurred previous to this year, when it was self-sufficient financially, but unfortunately "in the red." Now, with Student Council's monetary vote of confidence, **ARIEL** can continue to serve the TJU community, as a catalyst for stimulating thought and response to the world both close to and far away from Jefferson.

Podiatry: Perspectives Re-emphasized

When you consider that millions of people in America visit a podiatrist each year, someone knows about podiatry. Unfortunately, among those who have little idea of the training and competence of a podiatrist is the physician.

Ask a medical resident, an orthopedic resident, or an orthopedic surgeon, "What do you think of podiatrists doing surgery on the foot?" and you may get any number of answers. One probable answer might be, "He's not allowed to do it." Another could be, "Why should anyone do surgery with only a couple years of education?"

Who is the podiatrist? What are his educational requirements and qualifications?

The podiatrist is not an M.D., though in many ways his manner of diagnosis and treatment is not unlike the M.D. In an article for the **New England Journal of Medicine** (Mar. 18, 1971 page 588), Richard N. Powell, M.D. wrote, "Although podiatrists do not hold M.D. degrees they share many of the characteristics of physicians, most important of which is the legal and effective right to make and act upon their independent medical judgement. Within the limitations of his specialty the podiatrist, in effect, practices medicine."

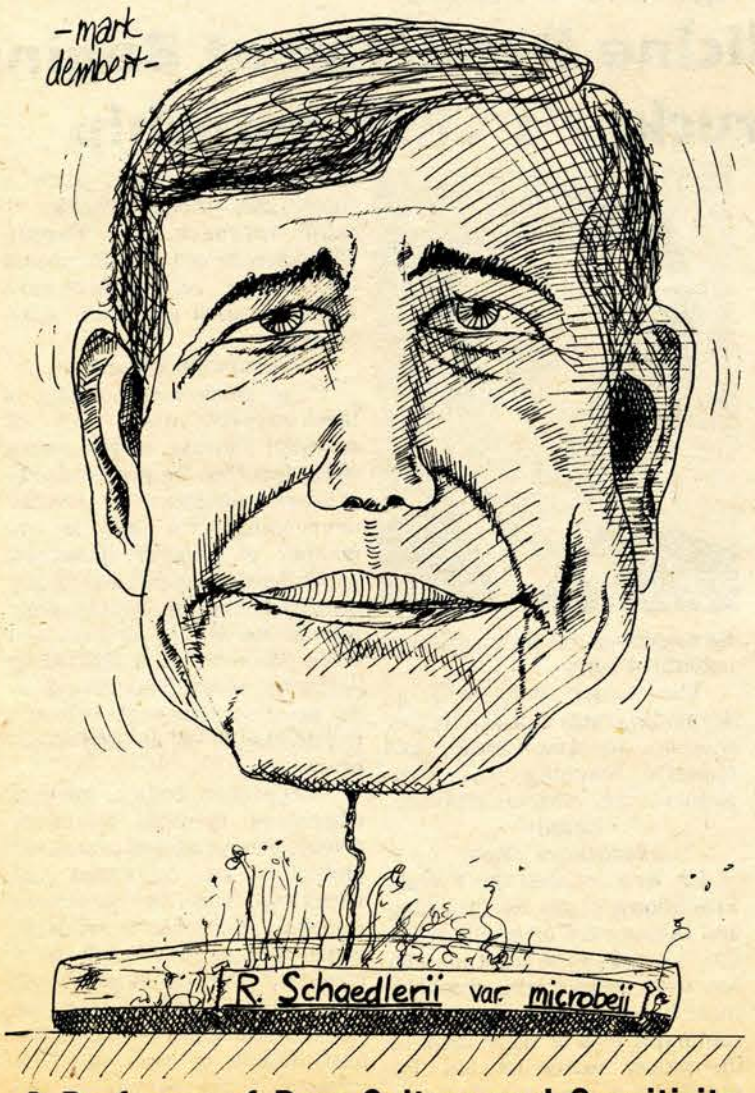
A student of podiatry must spend 4 years (after pre-requisite education) in one of five Podiatry Colleges in the United States. The first two years' curriculum is very similar to medical school. In the last 2 years, there are courses in PVD, surgery, general medicine, orthopedics-biomechanics, psychiatry, and community health programs. During the final year, students make ward rounds and visit clinics for dermatology, PVD, and orthopedics. To evaluate the scope of training of a podiatry student as compared with that of a medical student one has only to compare Part I of their respective National Boards.

Besides the scope of training, what is the scope of treatment? Podiatrists treat many conditions in the feet which include (besides corn-callous-toenail treatment): ulcers, fungal infections, cellulitis, sickle-cell disease, gout, rheumatoid arthritis, osteoarthritis, biomechanical foot problems, leg and hip deformities, congenital foot problems, neoplasms, psychiatric syndromes, venous incompetence, and edemas, including that of right-sided heart failure.

Podiatrists are trained to and do recognize the systemic implications of what they see in the foot as well as treat any and all lesions and diseases of the foot. On recognizing systemic implication, they are further trained to refer these patients to an appropriate physician for corroboration and care.

To physicians, the treatment of feet is unexciting, but to the podiatrist, it's a specialty.

By Elaine T. Carville



A Professor of Rare Culture and Sensitivity

"Letters To The Editor"

Discrepancies in Nurses' Training

Upon entering nursing school you receive a stack of rules: Residence Rules and Regulations, Code for Professional Nurses, and Class Room Policies.

If I had not specified that this article was about student nurses, these rules could be mistaken for nunery and reform school regulations:

.....

Curfews will be 12 midnight for all classes. Unlimited 2 o'clocks may be taken by all classes, except Sunday and Monday nights, beginning in March of Freshman year, provided there are no classes or clinical practice scheduled before 11 A.M.

Late cards must be filled out completely. This includes name, address, telephone number of destination, and date.

In order to spend an overnight at a girlfriend's home, parents must mail written permission to the Director of the School.

Study Hall will be observed until January 1st, from 8-10 P.M. Monday through Thursday night for all Freshmen

a) Students must remain on their own floors during this time, and quiet must be maintained

b) Students may sign out from 10 to 12 AM. midnight.

Campused as punishment, the student is restricted to the resident with the following exceptions: hospital, library, class, and church.

No phone calls after 8 P.M.

No callers except parents.

No permission for overnights or late passes.

Curfew is 8 P.M.

Rooms are periodically checked by housemothers. Fines will be set by Judiciary Council for dirty rooms on room check.

Attire: Leotards or panty hose should be worn with short skirts or dresses when attending class. Slacks may be worn at student's discretion except in the hospital or clinical area. Absolutely no jeans. Shoes must be worn in the first floor lounge and when entering or leaving the residence. Properly fitting Bermuda shorts may be worn during the summer months, no short shorts or coulottes may be worn.

The student uniform may be worn only to the following places–the hospital, residence, clinic, library, and Jefferson Hall for classes.

Consumption, possession or being under the influence of alcoholic beverages in the residence, school, hospital property or at social functions attended as a student is prohibited.

.....

Isn't it ironic that a profession as highly regarded as nursing should be so restricting upon the personality of the individual. In my mind, if our personality must be so strictly molded to fit the role of the nurse–maybe we wouldn't make good nurses. Surely the girl who is really dedicated will have her own morales, some maturity, and some discipline. And if she doesn't, why force it.

The true question is "responsibility;" the serious responsibility toward the patient in comparison to the non-permitted self-responsibility. On one hand you may have just completed (successfully) cardio-pulmonary resuscitation only to return to the residence, after signing in, find a note in your mail box summoning you to Judiciary Board. Why? To decide your punishment for being five minutes late after your twelve midnight curfew.

As we progress through nursing school our intellect is molded through a strict, concentrated medical course. The first year is concentrated with: Anatomy, Physiology, Microbiology, Pharmacology, Psychology, Sociology, Nursing Fundaments, Cardio-Pulmonary Nursing, Gastro-Intestinal Nursing, Normal Nutrition, Therapeutic Nutrition, Chemistry, plus working in the hospital.

This first year is the worst year. The major concern is to make it through.

Test questions are a game of semantics and obscure detail. Instructors ride you constantly. The main emphasis is on the procedure and theory, not on the complete patient care. The important thing is that each piece of equipment is properly placed for the procedure. We are not taught patient communication until the end of freshman year. So there is no preparation of the patient just the equipment.

We had mandatory study hours, the head housemother made her rounds to see that we were really studying. Heaven forbid if you had finished studying for you still had to stay in the dorm. I ask you, why can't we be trusted to develop our ownself discipline to study when we please?

I wonder if it wouldn't be easier to weed out the future nurses by allowing them the responsibility to study and make their own personal decisions. If they don't study enough–they obviously fail. It should be our own decision if we truly want to succeed. It is very confusing to be allowed to make such life threatening decisions during the day in the hospital and then return to the dorm where we have housemothers to reinforce and interpret all these rules.

I believe that if we were allowed these personal privileges of self-discipline we would be able to become more mature, organized, and professional nurses.

We are taught to be professional, in quotes. Every misbehavior that doesn't have a specific written rule falls under this category of being "unprofessional." This can be interpreted to mean anything, to every instructor. This can apply to having your hair touch your collar, laughing in the nurses station, or leaning on a patient's bed as you talk to them.

It gets to the point that you are so busy being professional that you can't relate or offer anything to your patient.

Professionalism is nice and safe to hide behind so that you don't have to relate sincerely. You can easily mouth the common nursing platitudes.

There is nothing so sickening as having a nurse say 'Everything will be all right.'

By the second and third year we are going through our specialties rotations: Orthopedics, Rehabilitation, Psychiatric, Gynecology, Urology, Neurology, and ENT.

Third year: Pediatrics, Maternity, Intensive Care Nursery and Intenisve Care Unit, Cardiac Care Unit, Emergency Room, Clinic, Operating Room, and finally Team Leading.

These are really crash-cram courses. Eventually in nursing you reach a saturation point when everything you think, talk, or study is nursing. I find myself bored. It is a real effort to remain open-minded. At times I feel as though I have on blinders. Very few girls even read a newspaper or watch the news. At parties nurses hide behind their profession. Their conversation is medical, they never move beyond that safe ground since we, or they, know very little about anything else.

You might say well, why do you allow yourself to become narrow-minded? It creeps up on you as professionalism, but is professionalism really narrow-mindedness? I should think professionals would be just the opposite.

I believe that if we were taught on a more dynamic level, still practically, we would be more stimulated to expand our own knowledge. This not an argument for the B.S. nursing program, just an improvement for this, our diploma program.

For we have all come in contact with a degree nurse. I was appalled at the lack of practical experience they receive. I sometimes .wonder what they would do with a "code," stand and theorize about the possibility of arrhythma versus heart block, instead of actually starting cardio-pulmonary massage.

In summary, Jefferson nurses are very good nurses. There could really be a lot less hassle in our training and I am sure we would still develop into just as good nurses. At times numerous rules harbor rebellion, which is wasted energy. Much time is spent bitching (complaining) rather than expanding our knowledge.

I think we have learned tolerance, patience, how to manipulate around the rules, and especially how to hold our tongues.

Anonymous

VOLUNTEERS WANTED

Volunteers are needed to staff a Jefferson drive to send medical aid to North and South Vietnam.

The drive is sponsored by the American Friends Service Committee.

If interested contact:

D. Kanofsky	WA 5-5626
J. Amsterdam	PE 5-7462
C. Cummings	WA 5-0742
L. Cutler	PE 5-3205

"LETTERS TO THE EDITOR"

The Merger

To the Editor of Ariel:

The Boards of Trustees of Thomas Jefferson University and Pennsylvania Hospital have issued a joint statement about the possibility of developing a very close working relationship between their institutions. President Herbut announced the plans at a General Faculty Meeting on March 5, 1973.

If the talents, energies and resources of both institutions are combined, there is no question in my mind that this association will produce one of the best medical centers in the United States. As with any association there are both advantages and disadvantages to both institutions. The two groups who will benefit the most will be the patients and the students. Coordinated, efficient clinical services could be provided to patients in our community and to those patients referred to staff physicians from far and near. The students would have a larger number of model inpatient and outpatient programs within walking distances of their residences and the medical center.

In the next few months the negotiations will begin and the various groups will make their voices heard. I urge the student body to examine the facts, to examine the positive and negative aspects of the merger and to examine the accuracy of the information being disseminated. In my opinion this is the most important opportunity in the entire histories of both institutions. I urge you to get the facts, find out what people are saying and detail it accurately in the newspaper. Interviews with faculty, staff and employees might clarify any misconceptions about this association. If the students do not communicate their considered opinions about this matter through official channels to the officers of Jefferson, then you will have missed an opportunity to influence the history of Jefferson that will probably not recur in our lifetime.

Sincerely,
Robert L. Brent, M.D., Ph.D.

Bored??

Then rap about

Future Commons Programs, 6:30 P.M. Jefferson Hall M-25.

S.F.S. Parties, Tuesday, April 3rd.

Spring Picnic, Tuesday, May 1st.

Commons Program Budget. Tuesday April 24th.

Summer Program Tuesday, May 15th.

Dr. Szasz Replies

To the Editors:

I appreciate your kind invitation to present a brief summary of my views on the myth of mental illness to the readers of **ARIEL.** Such a statement appears in the revised edition of **The Myth of Mental Illness,** published by Paladin (Granada Publishing Limited, London) in 1972. I hope you will find this satisfactory for your purposes. Part I of the text below is excerpted from the "Preface to the Paladin Edition," and Part II is the full text of the "Summary for the Paladin Edition."

***

The problems to which I address myself in this book are easy to state but, because of the powerful cultural and economic pressures that define the 'correct' answers to them, are difficult to clarify. They have to do with such questions as: What is disease? What are the ostensible and actual tasks of the physician? What is mental illness? Who defines what constitutes illness, diagnosis, treatment? Who controls the vocabulary of medicine and psychiatry, and the powers of physician-psychiatrist and citizen-patient? Has a person the right to call himself sick? Has a physician the right to call a person mentally sick? What is the difference between a person complaining of pain and calling himself sick? Or between a physician complaining of a person's misbehavior and calling him a mentally sick patient? Without attempting to answer these questions or trying to anticipate the contents of this book, let me show briefly the sort of reasoning I bring to it.

When a person claims to be ill, he usually means, firstly, that he suffers, or believes he suffers, from an abnormality or malfunctioning of his body; and secondly, that he wants, or is at least willing to accept, medical help for it. If the first of these conditions is absent, we do not consider the person to be physically ill; if the second is absent, we do not consider him to be a medical patient. For the practice of modern Western medicine rests on the scientific premise that the physician's task is to diagnose and treat disorders of the human body, and on the ethical premise that he can carry out these services only with the consent of his patient.

To understand psychiatry, we must also understand the concept of mental illness, which arises in part from the fact that it is possible for a person to act as if he were sick without actually having a bodily illness. How should be deal with such a person? Should we treat him as if he were not ill, or as if he were? Today, it is considered shamefully uncivilized and naively unscientific to treat him as if he were not, everyone regarding such a person as obviously sick, that is, as 'mentally sick'. I believe this is a serious error. I hold that mental illness is a metaphorical disease; that, in other words, bodily illness stands in the same relation to mental illness as a defective television receiver stands to an objectionable television programme. To be sure, the word 'sick' is often used metaphorically. We call jokes 'sick', economies 'sick', sometimes even the whole world 'sick' – but only when we call minds 'sick' do we systematically mistake metaphor for fact; and send for the doctor to 'cure' the 'illness.' It's as if a television viewer were to send for a TV repairman because he disapproves of the programme he is watching.

Furthermore, just as it is possible for a person to define himself as sick without having a bodily illness, so it is also possible for a physician to define as 'sick' a person who feels perfectly well and wants no medical help, and then act as if he were a therapist trying to cure his 'patient's' disease. How should we react to such a physician? Should we treat him as if he were a malevolent meddler or a benevolent healer? Today, it is considered quite unscientific and uncivilized to adopt the former posture, everyone (except the victim, and sometimes even he, himself) regarding such a physician as obviously a therapist, that is, a psychiatric therapist. I believe this is a serious error. I hold that psychiatric interventions are directed at moral, not medical, problems; in other words, that psychiatric help sought by the client stands in the same relation to psychiatric intervention imposed on him as religious beliefs voluntarily professed stand to such beliefs imposed by force.

It is widely believed that mental illness is a type of disease, and that psychiatry is a branch of medicine; and yet, whereas people readily think of an call themselves 'sick', they rarely think of and call themselves 'mentally sick'. The reason for this, as I shall try to show, is really quite simple: a person might feel sad or elated, insignificant or gradiose, suicidal or homicidal, and so forth; he is, however, not likely to categorize himself as mentally ill or insane; that he is, is more likely to be suggested by someone else. This, then, is why bodily diseases are characteristically treated with the consent of the patient, while mental diseases are characteristically treated without his consent. (Individuals who nowadays seek private psychoanalytic or psychotherapeutic help do not, as a rule, consider themselves either 'sick' or 'mentally sick', but rather view their difficulties as problems in living and the help they receive as a type of counselling). In short, while medical diagnoses are the names of genuine diseases, psychiatric diagnoses are stigmatizing labels.

Such considerations generate two diametrically opposite points of view about mental illness and psychiatry; according to the one, mental illness is like any other illness, and psychiatric treatment, whether voluntary or not, is like any other treatment; according to the other, mental illness is a myth, psychiatric intervention is a type of social action, and involuntary psychiatric therapy is not treatment but torture. This book attempts to demonstrate the fallacy of the former view, and the validity of the latter.

The principal arguments advanced in this book and their implications may be briefly summarized as follows:

1. Strictly speaking, disease or illness can affect only the body; hence, there can be no mental illness.

2. 'Mental illness' is a metaphor. Minds can be 'sick' only in the sense that jokes are 'sick' or economies are 'sick'.

3. Psychiatric diagnoses are stignatizing labels, phrased to resemble diagnoses, and applied to persons whose behavior annoys or offends others.

4. Those who suffer from and complain of their own behaviour are usually classified as 'neurotic'; those whose behaviour makes others suffer, and about whom others complain, are usually classified as "psychotic".

5. 'Mental illness' is not something a person has, but is something he does or is.

6. If there is no 'mental illness', there can be no 'hospitalization', 'treatment', or 'cure' for it. Of course, people may change their behaviour or personality, with or without psychiatric intervention. Such intervention is nowadays called 'treatment', and the change, if it proceeds in a direction approved by society, 'recovery', or 'cure'.

7. The introduction of psychiatric considerations into the administration of the criminal law – for example, the insanity plea and verdict, diagnoses of mental incompetence to stand trial, and so forth – corrupt the law and victimize the subject on whose behalf they are ostensibly employed.

8. Personal conduct is always rule-following, strategic, and meaningful. Patterns of interpersonal and social relations may be regarded and analyzed as if they were games, the behaviour of the players being governed by explicit or tacit game rules.

9. In most types of voluntary psychotherapy, the therapist tries to elucidate the inexplicit game rules by which the client conducts himself; and to help the client scrutinize the goals and values of the life games he plays.

10. There is no medical, moral, or legal justification for involuntary psychiatric interventions, such as 'diagnosis', 'hospitalization', or 'treatment'. They are crimes against humanity.

Thomas Szasz, M. D.

SAMA Job Service: Summer

Jobs Available at Jefferson

Department of Hematology:

4-6 positions open.

10-week Fellowships for $700 or elective credit.

Contact Dr. Erslev, 1015 Sansom St., or extension 7780.

Department of Pediatrics:

N.I.H. Training Program in Reproductive Biology for $700 per quarter Under Dr. Hensh and Dr. Brent. Contact Dr. Brent, 1 Stein, extension 7800; or 706 College, extension 6520.

Division of Nephrology:

A job is presently open for a second year student involving a study on a new antibiotic for patients with renal failure. It involves blood and urine sampling. It could be worked into the student's time so it would not interfere with his other responsibilities. The stipend is $700 per study. Contact: Dr. Norman Lasker, extension 6550 or 6950.

Department of Pathology:

The department sponsors students under a Cancer Training Grant for a 10 week period, at Jefferson and at approved affiliated hospitals. Contact: Dr. S.M. Sabesin, 236 Jefferson Hall, extension 6437. Openings in the affiliated hospitals will be checked by SAMA.

Department of Rehabilitation Medicine:

Dr. Ditunno informs us that his department usually offers a 12 week block for $900. However, this year the department is still waiting for funds. Information for summer jobs should be available in April.

Division of Oncology:

25-30 positions open.

A 10 week fellowship is available for Freshman and Sophomores provided by a Clinical Cancer Training Grant. It includes a series of didactic introductory lectures on the general field of cancer, various conferences and rounds, library research on a subject of the student's choice in the field of Oncology, an oral presentation of this report to the group and individual assignments to specific faculty members for a more detailed experience in the field of Oncology. The stipend is $800.

Contact:
Dr. Chester Southam, Div. of Oncology
1014 College, extension 8874

Dr. Harry Goldsmith, Dept. of Surgery
605 B College, extension 6923
or Dr. Simon Kramer, Dept. of Radiation Therapy
1st Floor Main, extension 6702

Clinical Laboratories:

Dr. Heinz Schwartz, Associate Director of Clinical Laboratories, informs SAMA that there will be limited number of positions open in the Jeff Labs. The exact number will not be known until the Spring. Contact Dr. Schwartz at 323 A Foerderer and at Extension 6374.

Dept. of Pathology – The Cooper Hospital, Camden, N.J.

Dr. Burrows, Chief of Pathology, says there are no summer openings. He DOES stress, however, that there maybe openings in a year-round night coverage schedule. This entails a short training program fellowed by emergency laboratory coverage one night each week and one weekend (Saturday and Sunday nights) in six. Two medical students work together so each can get sleep during the night. The work pays $31 for each night covered.

Contact: Dr. Stanley Burrows or Miss Joyce Portnoy at 609-964-6600, extension 401 or 402.

Dept of Genetics

Number of positions 3-6 (if funds are available). There are available through the Clinical Cancer Training Program.

Contact: Dr. Sabesin, 236 Jefferson Hall, Extension 6437 (To check if there are available funds.) Dr. Laird Jackson, 710 B College Extensions 6834, 6955.

Dr. Jackson also suggests that NIH student summer fellowships are available in the Pediatrics Dept., Obs/ Gync. Dept., and the Dept. of Medicine.

Contact: Dept. of Obs./ Gync., 300 College, Extension 6507; Dept. of Medicine, 801 College, Extension 6946.

Dept. of Psychiatry

Dr. Gottheil says that positions for summer jobs are severely limited due to the scarsity of funds from NIH. In previous years, the financing for the program has come late (Last year the money came in the month of May). Because of the uncertainty of the funding, as well as, the hard-core research that is planned in the program, he urges only those students seriously interested in psychiatry to apply and take their chances on the funding of the program. (There are 16 positions open in May last year and 11 were filled.)

Contact: Dr. Edward Gottheil, Rm. 305, 1127 Walnut St., Extension 6105.

SpeakOut ArticleOf The Month

Must We Precipitate a Crisis in Medical Education to Solve the Crisis in Health Care???

GEORGE L. ENGEL, M.D.,
Rochester, New York

Annals of Internal Medicine 76;487-490 (1972)

I am writing of my concerns about changes that are being made or proposed in respect to both undergraduate and graduate medical education, the consequences of which I fear will be deleterious to the professional competence of future physicians. Limitation of time precludes adequate documentation here of my claims, but since we all share a common objective - namely, to assure that physicians obtain the highest degree of professional competence – I trust they will serve nonetheless to generate a healthy discussion among us. A fuller discussion appears elsewhere (1, 2).

I am not a member of the American College of Physicians, nor am I a spokesman for any group or society. My concern is as a medical educator who for more than 30 years has been dedicated to imparing to medical students and house officers the clinical approach to the patient. I am the product of an old-fashioned 2 1/ 2- year rotating internship of the late 1930s and never had formal residency training in either medicine or psychiatry. I spent a year as a Fellow in Medicine at the Peter Bent Brigham Hospital, and there I was first introduced to the psychological perspectives of medicine by John Romano. Since that time my central interest in education has been teaching what I call the elementals of medicine - - those aspects of medicine that are virtually timeless and unchanging. I refer to the nature of the human encounter between patient and physician, an indispensible ingredient of the physician's task; to clinical observation, the skills a physician uses to elicit the information from and about the patient necessary for him to make judgments and decisions; to clinical reasoning, the mental operations whereby the physician translates the primary data obtained from clinical observation and diagnostic procedures into the conceptual frameworks of biochemistry, pathophysiology, morbid anatomy, or psychopathology; and to the processes of rlinical judgment and decision-making, whereby the program of care and treatment of the patient is evolved. These are skills and functions requisite for all physicians regardless of their specialty. At Rochester we begin the teaching of these basic elements of medicine in the first year and continue emphasis on this aspect throughout the 4 years. I am personally heavily committed to this endeavor, and I consider it important for our students that I demonstrate by my own example that these are basic clinical skills applicable to all patients, regardless of their formal classification. This I do by conducting teaching exercises with patients from every service: from medicine, from surgery, from pediatrics, from psychiatry, from obstetrics-gynecology, from neurology. I demonstrate the approach with patients who speak no English or who are aphasic or comatose; patients who are desperately sick, in pain, dyspneic; patients who are anxious, depressed, or angry; or patients who are psychotic. The central issue is for the students to learn what constitutes the essential modalities common to every physician's task.

With this preamble I now will make a series of charges that I trust will provoke thoughtful discussion as well as controversy.

1. The teaching of the elementals of the clinical approach to the patient as I have just defined it is seriously neglected in the educational programs of most medical schools in this country today. Students are being graduated who are deficient in skills in interviewing and physical examination. They are disease-oriented, insensitive to patients as human beings, and excessively dependent on the laboratory as the basis for diagnostic decisions and clinical judgements.

2. Medical educators, especially those with a primary laboratory orientation who have not been involved with or who are not particularly interested in patient care, have been slow to recognize these deficiencies. Many have not even familiarized themselves adequately with the nature of the physician's task, for which they presumably are preparing their students. That the American Board of Internal Medicine should have to require candidates for certification to demonstrate their ability to do an adequate interview and physical examination is in itself an acknowledgment of this failure; in my view this should be a minimum requirement for the granting of the M.D. degree, not for certification as a specialist in internal medicine!

3. Agencies external to the medical schools are making recommendations and decisions that may not only preclude the necessary reforms in undergraduate education but may even render present programs less adequate. I refer here particularly to the AMA, the specialty Boards, and the Carnegie Commission, not to mention state and federal legislative bodies. For the most part their proposals are defended as providing the most economical way of increasing medical manpower and thereby improving the delivery of medical care. But you may question whether the changes may not in the long run prove more, rather than less, costly for society if they do not assure sound preparation of the physician in the elementals and basics of his profession. Let me cite some of these recommendations and what seem to me to be some of the more serious consequences for the quality of education.

A. It is being urged that the undergraduate period be cut to 3 years. Among the problems this brings up are the following: (1) basic science teaching may become too condensed and abstract to provide the students with the vocabulary and language necessary for their clinical work; (2) students may be deprived of sufficient opportunity to work with patients in all the major clinical disciplines for periods long enough to gain the breadth of clinical experience so necessary before concentrating in a special area; (3) overcrowding of the schedule will reduce elective time and eliminate free time, so important for the student's growth and maturation – the breathing space he needs to fit the pieces together; (4) the most critical deficiency in existing programs, the limited attention now devoted to supervised acquisition of clinical skills and mastery of clinical reasoning, would be difficult if not impossible to correct because of lack of time; (5) and the quality of teaching may decline, at least in some areas where faculty does not have the time to reanimate and redesign their courses before having to repeat them with a new class, which was a serious problem during the accelerated schedules of World War II.

B. Some recommend a track system whereby students are encouraged to choose specialty preferences earlier and to arrange programs in their undergraduate years to prepare them for that specialty. This may have merit for a few exceptional students, but for most the dangers are narrow parochialism for those who make the right choice and career dissatisfaction for those who make the wrong choice.

c. Increase in the size of the student body and reduction in teacher-student ratios are urged. At the preclinical level I am particularly concerned with the decrement for the student in his opportunity to learn firsthand about the structure of the human body in gross anatomy and gross pathology because there may be neither adequate time, material, nor supervision for appropriate laboratory experience, a typical situation in some schools in Latin America and Europe. The problem can be even more serious at the clinical level if patients are too few and if supervision for clinical learning is insufficient and inadequate. Even now most students are being graduated without ever having been supervised in an interview or physical examination.

D. The abolition of the internship seems virtually decreed. Especially when taken in conjunction with the changes in undergraduate education just noted, this is probably the most short-sighted, ill-conceived, and unfortunate proposal of all. Sponsored primarily by the specialty Boards, with the blessings of the AMA, even the threat of implementation of the proposal is having profoundly disturbing consequences, Psychiatrists, neurologists, radiologists, pathologists, opthalmologists, and others are being hurried into their specialties without having experienced broad clinical responsibilities for patents in other areas. It is my observation that some of the more enthusiastic supporters of this development are the heads of weak programs who have had difficulty attracting residents. It is easier to seduce and flatter the insecure fourth-year student into entering a program when his experience and judgment about such matters are still slight. Departments of psychiatry adhering to the internship requirement have noted a decided drop in number of applicants for the residency this year. Yet a survey last week of the psychiatric residents at Rochester showed unanimous agreement that the internship year was an invaluable preparation for their work as psychiatric residents, although several acknowledged that if they had had the option as fourth-year students, they probably would have elected to omit the internship. Only in retrospect has its great value become evident, especially as they discover that on a representative day more than 50% of the patients hospitalized on the inpatient psychiatric service prove to have significant medical or surgical disease over and above the psychiatric problem for which they were admitted (3).

Departments of medicine are being irresponsible and hypocritical in their response to this issue of the internship. On the one hand, they lay claim, and rightly so, to being the most important clinical department in the medical school; yet, on the other, they refuse to face their responsibility to provide a year of training, open to the best applicants regardless of their ultimate career goals. Internists have only to gain by providing good internship opportunities to the specialists who in the future will be the consultants for their patients. You need only to think how satisfying it is to have a consultation from a radiologist, neurologist, or psychiatrist whom you know to have been one of the good interns on your service. But by integrating the internship into the residency, these programs will become closed, for departments of medicine will have no choice but to give preference to those who will remain in medicine. The expectation that departments of psychiatry, radiology, neurology, and so forth will be able, by themselves, to arrange for adequate medical experience for their residents is illusory. Simple arithmetic will demonstrate that no department of medicine could take the flood of residents from other services for whom they are now expected to provide this experience. Nor will they want to be burdened with residents not of their own choosing. Consequently, these house officers will be treated as second-class citizens and will be shunted to second-class appointments, most probably in understaffed community hospitals without adequate resident or attending staff. What logic dictates that the outstanding future pathologist, radiologist, or psychiatrist should not get the best possible training in internal medicine that his ability justifies simply because his ultimate career choice is other than internal medicine? That crucial period, the fourth year of medical school and the internship, during which most physicians have the experiences that enable them to reach some kind of a rational judgment as to the area of medicine for which they are best suited, now is threatened. This is short-sighted and fool-hardy to an extreme, for it is in his formative period of youth that the physician should enjoy the greatest options and freedom to make career decisions. Unhappy or unwise career choices can have profoundly unfortunate consequences for patients, not to mention the physician himself.

We are in a period in which it is increasingly acknowledged that adequate health care is a right and not a privilege. We are going to have to do a good deal of rethinking about the job of the physician and the educational system that will best quality him for that job. But, whatever changes may take place, two things are immutable. One is that the physician must be qualified to use the scientific method in his work with patients, and the other is that he must be effective and skillful in eliciting clinical data and applying his knowledge for the benefit of the individual who presents himself as a patient. It is deeply disturbing to me that, at a time that calls for flexibility in design of educational programs to meet these newly recognized needs, so many pressures are being exerted that threaten to produce more narrow and highly specialized programs turning out physicians less able to meet these challenges. And let us not forget that a major argument advanced in support of these various changes is that they constitute the most economical way of increasing physician manpower within a relatively short time. But we might well heed the 1967 report of the National Advisory Committee on Health Manpower (4): "There is a crisis in American health care . . . the crisis however is not simply one of numbers . . . if additional personnel are employed in the present manner and within the present patterns and systems of care they will not avert or even perhaps alleviate the crisis unless we improve the system through which health care is provided. Care will continue to be less satisfactory, even though there are massive increases in cost and numbers of health personnel." I, for one, believe the proposals now being implemented are educationally unsound; apparently others feel that they may be economically unsound as well. Before it is too late we had better pause and consider whether we may not be compounding the crisis in health care with a crisis in medical education as well. Most particularly do I believe that we must take a strong and unequivocal stand against the edict that abolishes the internship, for this is a change that affects everyone - students, faculty, hospitals, patients - and one that, once implemented, cannot with ease be reversed. Its implications are enormous. It would be tragic for American Medicine if this change were to be made without first making a full-dress study of these implications. In my conversations and correspondence with physicians, medical educators, and students across the country I find virtually no support for this proposal, although all too many, I regret to say, assume the matter to be no longer open to debate. I refuse to accept this. Indeed, I urge you as responsible physicians and citizens to demand that the powers that be reexamine and reconsider this decision before it is too late. We owe this to our patients, who, in the final analysis, will be the unwitting victims of this folly.

References

1. Engel GL: The implications of changes in medical education. Hosp Pract 6:109-116, 1971.

2. Stetten D: Projected changes in medical school curriculum. Are three years really better than four? Science 174:1303 - 1306, 1971.

3. Romano J: Elimination of the internship - an action of regression. Am J Psychiatry 126:1565 - 1576, 1970.

4. National Advisory Committee on Health Manpower: Report. Washington, D.C., Superintendent of Documents, U.S. Government Printing Office, 1967.

National Boreds? Broads? Boards?

(Dedicated to those fearless sophomores and seniors!!!)

Testing Spoof
Spoof by H.S.F.

With every segment ot the Thomas Jefferson University anxious as to standing in National Board examinations, I offer the following examination format that will more fairly prepare one for the examination of examinations: the National Boards.

MAIN DIRECTIONS

1. Place your name, social security number, place of birth, date of birth, age, parents' profession, checking account number, telephone number, course, and HPI on the answer sheet. **Do this now,** and block in the appropriate space under each letter on the answer sheet.

2. There are 473 pages. Count them **now** (total 15,360 questions).

3. Make your choice to each question by blackening the corresponding space on the "score" sheet. Use only a #2 pencil as our computer contains only #2 pencilase and develops lead intoxication with any other graphite.

4. If one extra dot is found on this "score" sheet the results will be invalid. Live in mortal fear of stray or extra marks appearing on the answer sheet.

5. Not more than one mark will be accepted for each answer. Only answers on the "score" sheet will be accepted. Correct answers will paper the walls of the fourth and fifth floors.

6. Unless a statement is made specifically to the contrary, the structure and/ or function should be considered under "normal" pathological conditions.

7. IMPORTANT: Where you think that there may be more than one answer possible, give the answer which is more equivocable, or describes the condition most inaccurately.

NOTE: If time remains continue.

PART I

Directions: Each of the questions, incomplete statements, inadequate statements, or impotent statements below is followed by several suggested (but not necessarily recognized) answers or completions. Select the **one** that is **best** in each case and blacken the appropriate space on the answer sheet. Remember, the **best** answer is the one we want, not necessarily the **correct** one.

PART II

Directions: Below is a set of lettered headings followed by a list of coded words or phrases. For each numbered word or phrase select:

PART II

A. If the item is associated with A only
B. If the item is associated with B only
C. If the item is associated with both A and B
D. If the item is associated with A or B
E. If the item is associated with A, B, or C
F. If the item is associated with a party other than the recognized arm of the two party system

PART III

Directions: For each five sets of even numbered letters below there are 14 sets of differently ordered mixtures of the five sets with 72 possible answers. Match number 31 with any four blue marbles designated with an asterisk. Be sure to circle your answer on the "score" sheet if the associated question has any clinical significance, however, also be sure that main direction #4 is not violated.

PART IV

A. If only 1,2, and 3 are correct
B. If only 1 and 3 are correct
C. If only 2 and 4 are correct
D. If only 4 is correct
E. If only 3 is correct
F. If only 2 is correct
G. If only 1 is correct
H. If only D, E, and F are correct
I. If only A and B are correct
J. If none are correct
K. If all of the above are correct
L. If all but one are correct
M. If some are correct and others are not
N. If some are correct
O. If M and N are correct
P. If M and J are correct
Q. If only C is correct
R. If only R is correct
S. If some other combination is possibly correct.
T. If you don't want to reveal the answer as it might compromise national security
U. If you don't know about A through J inclusive
V. If you think you know about A through J inclusive and S and wish to receive 0.346 x 1 credit
W. If you want to be a doctor
X. If "it's all bullshit, man"
Y. If only Z is correct

PART IV

Directions: For each of the incomplete statements below, **one** or **more** of the completions given is probably correct. On your answer sheet blacken the space under:

This exam will be gone over for your benefit on Wednesday, December 31 at 10:30 P.M. in the Solis-Cohen Auditorium. Please defer any discussion until that time. No other acceptable answers will be considered except during that time.

CTF (Continued from page 1)

Note that interstitial floors between patient bed floors may be used for "M.D. offices and Support." This is planned in one CFT tower and is possible because far less "support" space is needed for such facilities, than is necessary for the services (lab, radiology, surgery) in the middle tower. (see sketch)

Other CTF Features

Through the replacement of the Main Building (1909) and the Thompson Annex (1924), the CTF will reduce the number of hospital beds from 660 to 585, excluding those associated with the Wills Eye Hospital. Each room will be a single.

The entire first floor of the Foerderer Pavilion will be renovated into an Emergency Ward, increasing the net square feet devoted to this end from 7000 to 9000. An economic feasibility study has prompted the University not to construct parking space under the CTF as originally projected. The basement of the CTF remains unassigned, inasmuch as Radiation Therapy will probably not be moved from its recently renovated site under the Main and Thompson Buildings.

Roadblocks

The three major "political" considerations are land acquisition, an alterred Jefferson "community," and approval of the above plans by the doctors who will use the product.

The Executive Council has voted approval of the CTF and the plan was presented on March 14, 1973, to the staff physicians.

Because a merger of Pennsylvania Hospital (8th & Spruce Sts.) and Jefferson is under consideration by both boards of directors, any programming for the CTF although detailed in hundreds of pages of published reports, must be considered tentative. Such an action, wrote David M. Cleary in the Evening **Bulletin** of Tuesday, March 13, would benefit both hospitals.

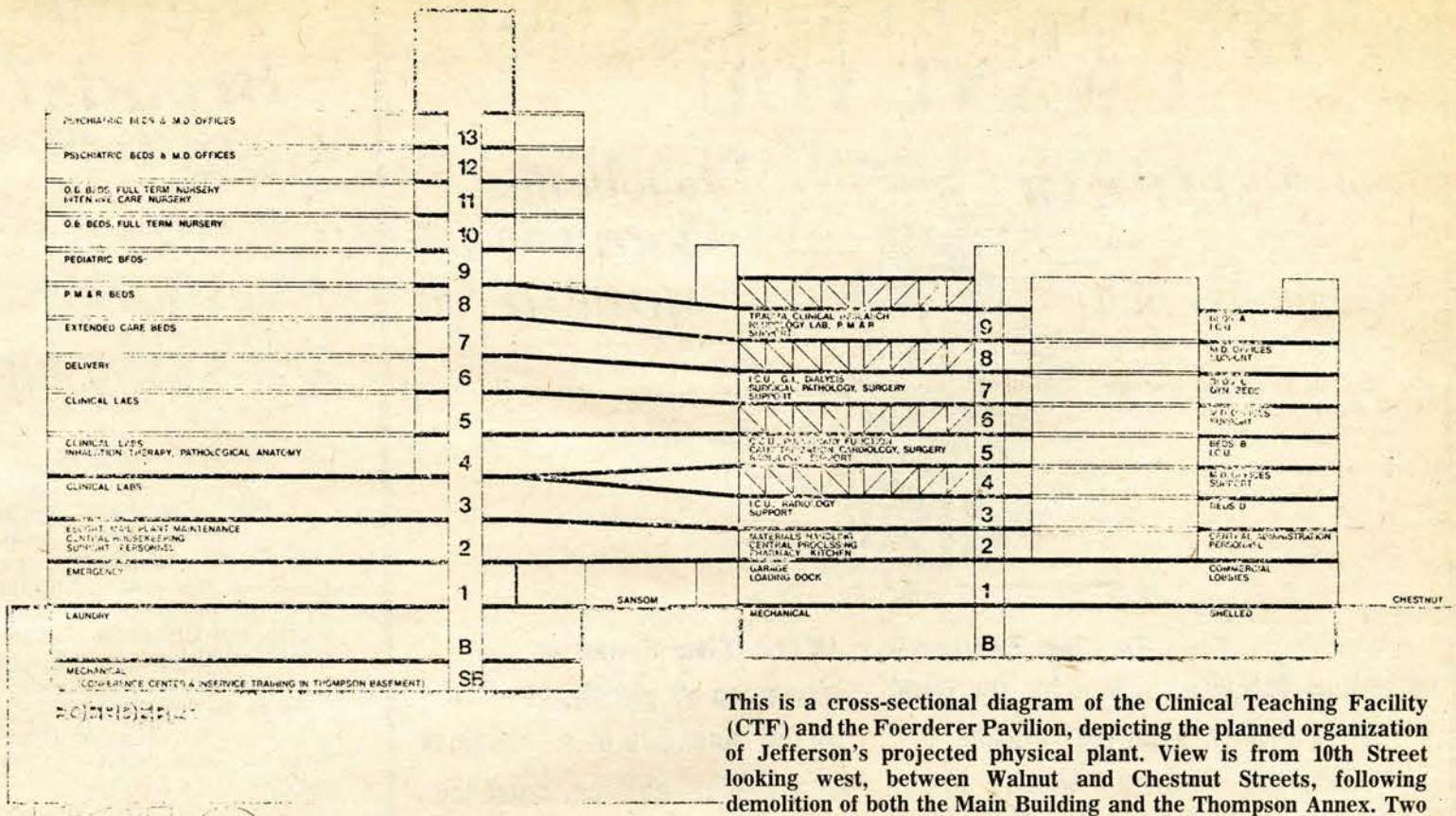
"For Jefferson, the psychiatric facilities of Pennsylvania Hospital would be a welcome addition. They include the Institute at 49th and Market Sts. and the Hall-Mercer Clinic at 8th and Locust Sts., expressly designed to function as an outpatient mental hospital...

"Pennsylvania Hospital also stands to improve its pediatric services by a merger. Jefferson's department of pediatrics is a referral center for high risk infants born in 25 Greater Philadelphia hospitals, while the pediatric service at Pa. is small, existing as a branch of the department of obstetrics and gynecology."

According to Mr. Norwood, there are 6 outstanding properties on the site of the CTF. "We are negotiating with the City to secure their cooperation to put together completion of the land parcel."

The Clinic

The "two-door system" of medical care is on the decline, and as a result, there will be no distinction made between the "clinic" and the "private" patient.



This is a cross-sectional diagram of the Clinical Teaching Facility (CTF) and the Foerderer Pavilion, depicting the planned organization of Jefferson's projected physical plant. View is from 10th Street looking west, between Walnut and Chestnut Streets, following demolition of both the Main Building and the Thompson Annex. Two additional floors will be constructed atop the CTF to house the Wills Eye Hospital (not appearing in this sketch). Wills Eye Hospital will be considered a separate unit of the hospital with its own elevator banks and operating rooms, while utilizing many CTF services.

Nurses Eye B-ball Crown

by Janet Welsh

The Thomas Jefferson University student nurses basketball team finished their 1972-73 season with 5 wins, 1 loss, and a sure spot in the quarter-final games for the championship. Our wins all were by a margin of at least 10 points. Championship games will be played during March at Memorial Hall in Fairmount Park. With the fine coaching of Mr. Sol Kaubin, we hope to keep our first-place title for the second consecutive year. *(Continued on page 8)*

Kaskey's Tips on Platters and Places to Go.

WHAT IS GOOD

by Gary Kaskey

The Tower Theatre: Reminiscent of the old Fillmore East with it's morocco opulence, the Tower stands a block away from another opulent structure, the 69th St. Market Street subway station. The crowd is friendly, the acoustics are super. **Good God** and **Captain Beefheart and the Majic Band,** appeared recently. About **Good God**--well, the acoustics were good. Unfortunately. they have their own genre--space muzak. The Captain seemed to be laying back a good deal. But Zoot, Rocket, and the rest of the Majic Band wove an enchanted web of cajun rythms. A good show at a good theatre.

The Bijou Cafe: Unlike the Tower, the Bijou is an intimate setting. Located at 15th and Lombard, its acoustics are also fine. The drinks are fairly expensive, so it's better to maintain an already obtained high than to start from scratch. I had the very real pleasure of seeing **Dough Sahm and Band** perform there. From the age of 7 as Lil' Doug to his Sir Douglas Quintet days, Sahm has remained true to his Texas route. Performing **Rain, She's About a Mover, Wodvestern Mountain, Ban Antone,** Doug showed a remarkable combination of technical skill, musical ability and a rough good humor. I don't know why he hasn't played the East since Atlantic City Pop in '69, but it has been our loss.

The Academy of Music--Perhaps the one institution Philadelphia can be proud of. Bonnie, Ryiatt and Taj Mahal had the place reelin'. Bonnie was a little nervous and very high. Taj was just as smooth and natural and beautiful as is possible for a person to be. Like most concerts, you were either there or you missed it. Stay tuned for Doc Watson at the Academy April 1 with John Hartford and David Bromberg.

The Kinks--Existing in a foggy fantasy world peopled with all sorts of other nymphs, fairies, trolls, Ray Davies minstrels through this world showing startling empathy with the problems of everyman. Everyman whose problems are his car, his kids, and his varicose veins, who wants to be like a motion picture star but has to turn off the living room light to make it with his ugly lover. At best Mr. Davies can spin surrealistic tales where people must take pictures of each other to show that they really exist. For those who would the Kinks at their best, **Kink Kronikles** and **the Village Green Preservation Society** are the albums of choice. There is more to be said, but the inside of **Kinks Kronikles** says it so much better. I suggest that those who would like **Kinks,** do.

The Beachboys--Anyone still so far out as to think of the **Beachboys** as a hot car, big wave group is in for a bit of wonder. Their new release **Holland** continues the **Surf's Up** style of melodious tunes enhanced by vocals so light they make you want to cry. Especially tasty are "Trader," "Bunky Pretty," and "California." If you like relaxing to gently flowing music, then this is what the doctor ordered. Coming to the Spectrum soon.

Schizophrenia

(Continued from page 1)

people needed a dose of only 4 gm. or less to elicit detection in the urine. Drs. Robinson and Pauling at Stanford University conducted similar studies verifying this. This suggests that schizophrenics needed and were using up the large quantities ingested. Similar findings were found for both niacin and pyrodoxine loading.

No one understands why this is so, but it indicates a relationship between vitamin metabolism and schizophrenia, explained Dr. Pauling who won the Nobel Prize for chemistry in 1954 and the Nobel Peace Prize in 1962. There is also an abnormality in the vitamin metabolism of alcoholics and drug addicts. There is strong reason to believe that they would also benefit from the non-toxic therapy of large doses of vitamins. In fact, the amount of mental illness in general could be diminished by the use of nutrition and nutritional therapy. Yet, he said, the psychiatric community in this country has not investigated as thoroughly as it should the benefits accruing from mega--vitamin therapy. (Since vitamins are not prescription drugs, even psychologists could use vitamin therapy if they so desired).

DAILY VITAMIN REQUIREMENTS TOO LOW?

Despite the substantial evidence which continues to accumulate of beneficial effects of vitamins, the minimum daily requirement (MDR) for vitamins set by the Food & Drug Administration (FDA) remains at its prehistoric levels. Dr. Pauling adamantly asserts that the minimum daily requirements set by the FDA are ridiculously low. He explains that the present MDR are enough to prevent scurvy, pellagra, and the like, but are far from the amount needed for the body to operate at peak efficiency. In addition, Pauling pointed out Dr. Roger Williams' (University of Texas) study of individual differences. Dr. Williams has shown that even in-grown strains of guinea pigs have heterogeneous needs in terms of vitamin requirements. Human beings are also very heterogeneous, meaning different people may need different amounts of vitamins.

QUESTIONING THE SAFETY OF SUGAR

Pauling stated that white sugar (sucrose) is a major cause of heart disease and arteriosclerosis. He cited the work of Dr. John Yudkin in London, England, who compared those who consumed 150 lbs. and 120 lbs. of white sugar a year with those who consumed 60 lbs. a year. (The average American consumes 120 lbs. of sugar a year). The probability of heart disease was 6 times as great in the 120 lb. group and 20 times as great in the 150 lb. group when compared to the 60 lb. group.

Dr. Pauling then reemphasized that both the general population and the mentally ill should drastically reduce their intake of white sugar and dramatically increase their intake of vitamins and nutritious foods. This will greatly enhance their possibilities for good and excellent health.

In a closing note Dr. Pauling challenged more psychiatrists to try his treatment, saying that the vitamins can do no harm, and can very likely do much good.

Why not give it a chance, Dr. Pauling persists in asking. Indeed, why not?

(Editor's Note: Megavitamin therapy for schizophrenia is a hotly debated issue. A look through the literature will reveal ardent advocates for both sides of the dispute.)

The following journal articles are recommended as an introduction to the controversy:

1. Osmond, H. and Hoffer, A.: Lancet 1: 316-319 (1962).
2. Saarma, J. and Vasar, H.: Current Therap. Res. 12 (11): 729-733 (1970).
3. Ban, T.A.: Canad. Psych. Assoc. Journal, October, 413-431 (1971).
4. Greenbau G.H.C.: Amer. J. Psychiat. 127 (1): 89-92 (1970).

In the Limelight

Samuel B. Eckhardt, of Holland, Pa., has been named Business Manager and Assistant to the Vice President for Health Services at Thomas Jefferson University. .....

Congratulations go to the following who passed the Senior Life-Saving Course recently given at Jeff Hall: Walter Graves; Mary Ann Roddy; Elaine Pepper; Maureen Kelly; Patricia Jones; Mike Weinberg; Mark Gottlieb.

Brucker

(Continued from page 1)

Necessary sub-specialties with their rigorous training requirements have occupied the spotlight in the medical school curriculum. Hopefully, the establishment of a new Department of Family Medicine at Jefferson will allow interested students the opportunity to identify with another discipline -- a family medicine discipline in which a specialty board has been established and which in turn demands additional post-graduate training.

Family Practice Can Be Fun

"Family Practice can be fun. It offers a continuous stream of problems related to a family unit. It offers the practitioner the opportunity to deal with the aspects of preventive medicine, of episodic and chronic illness.

"Perhaps the Family Physician has done a poor job in the field of preventive medicine. Part of this stems from the fact that he has had inadequate training, and that it is not nearly as ego-satisfying as resolving a dramatic, episodic illness. Patient education, which is a large part of preventive medicine, frequently takes considerable time and effort. The busy physician can ill afford this."

Patient Responsibility

Regarding peer review, Dr. Brucker welcomes it but feels that "an important part of patient care evaluation has not been considered, namely, that of patient responsibility. Without patient cooperation the delivery of any type of care in any setting can be poor. The family physician must attempt to stress patient responsibility as being a very important ingredient in the delivery of care. By the same token, the patient's responsibility, or lack of it, should be a factor considered in an audit of any patient care."

Spring Film Festival

FRIDAY AND SATURDAY, APRIL 13th-14th

"Five Easy Pices" starring Jack Nicholson, Karen Black, Susan au Spach. Award-winning movie nominated for best picture. ALSO: "Nite at the Opera" starring the Marx Brothers. Most successful film. 50¢.

FRIDAY AND SATURDAY, APRIL 27-28th

"Bogart Festival"--"Big Sleep" and "Dead End."

B-ball

Continued from page 6)

This season's starting line-up included: Denise Boyd, Betsy Dalton, * Patti Jones, Donna Raneri, Cecelia Ridgeway, * and Cheryl Steimer.* On the bench were: Debbie Boyle, Cathy Callaghan, Chris Coleman,* Loretta DiNardo, Kathy Glavey, Jane Husband,Chris Gilmore, Ruth Keers, Peggy Malone,* Mary McGillin,* Janet Welsh,* and Mary Woltemate.* Connie Laboda* and Barb Willey* were this season's managers.

The third annual Greater Philadelphia Student Nurses' Basketball Tournament was held in the Commons' gym on February 14, 15, and 22. Bryn Mawr, H.U.P., Lankenau, P.G.H., Presby., and T.J.U. teams vied for three trophies. In the final standings, T.J.U. was number one with Lankenau second and Bryn Mawr third. T.J.U. beat Lankenau 45-19 for first place and Bryn Mawr beat H.U.P. for third.

Our coach of 5 years, Mr. Sol Kaubin, is the same man this season but with a different name since his July, '72 marriage to the former Miss Brenda Kauffman. Kaubin is derived from the first three letters of each of the couple's former surnames--Binik and Kauffman. This boost (?) for womens' liberation may have been a "first" in this area--at any rate, the change was legalized and deemed important enough by Philadelphia reporters to merit articles in the newspapers! Coach, will you be sending us a Ms. Kaubin for our team someday?

Jazz Comes to Jeff

by Steve Glinka

The Charlie Byrd Trio performed in the Jefferson Commons on Tuesday evening, February 27th to an audience of about 300. Since a large percentage of the audience consisted of members of the Classical Guitar Society, apparently not many Jeffersonians were willing to spend 1-1/ 2 hours nor $1.00 to discover a great entertainer.

Byrd was born in 1925 in Virginia and probably is best known as a jazz guitarist. However, he is more than a jazz guitarist for his versatility has carried him into many other fields of music. In 1947 he became seriously interested in classical guitar, and after an audition with Andres Segovia, Byrd was invited by that master to study with him in Italy. Around 1956 Byrd became interested in adapting the classical finger style to playing jazz on unamplified guitar. After Byrd's return from a tour of South America in 1961 he became the first and among the foremost North American exponents of "bossa nova."

Last Tuesday, the 1973 Charlie Byrd demonstrated his unique brand of versatility, moving smoothly from bossa nova ("One Note Samba," "Meditation") to some of the latest rock releases ("Evil Ways," "Killing Me Softly With His Song.") Byrd ended his first of two sets with several classical guitar pieces on unamplified guitar. And, of course, there was jazz – Charlie Byrd style – a rare treat for Philadelphia.

Students Needed

Attention Sophomores, Seniors and Residents: A limited number of slots are available for you to participate in the CBX (Computer Based Examination) project. This project involves utilizing a computer terminal attached via telephone to a computer facility at the Massachusetts General Hospital. Medical diagnostic problems are given. Additionally, participants will take a set of mental abilities tests designed to give insights relative to what intellectual skills are associated with performance on the diagnostic tests. For additional information, please contact Miss Candy Baldwin, 829-8907 or 829-6669, Office of Medical Education, Room 131, College Building.

THE SCORN OF A LINGERING MIRAGE

Namque tu solebas
Meas esse aliquid
Putare nugas. . .
(Catullus)

(Lauding GS - 1972 and all the many others)

She, whose flamboyant eerie
squirk as the unhelping flight,
Could tear anon the agile mind
unsucceedingly right,
As her's, so inagile, trudged to doom;
I thought last I broke her pride
Once her falcon's reach
Tipp'd the brimming pitcher...!

The downstate eaglet strumm'd
black and blue shackles
And local airs to Jeffersonians
She would deride yet hum;
Who really tore the Promethean glare
Than she the nimbled digit
Clipp'd as glib Herculean hand
Must rest in her daunted doom!

Kodwo J. Abaidoo (GS-72)

UNIVERSITY HOUR SCHEDULE
Spring Term 1973
Solis-Cohen Auditorium
Jefferson Alumni Hall
Wednesdays 1:00-2:00 P.M.

April 4--John Glenn--Merves Distinguished Lecture on the Humanities in Medicine. Topic--America: Daring to meet the future.
April 11--Dover Baroque Ensemble. Presenting a program of Renaissance, Baroque and contemporary music.
April 18--Peter Levin, Assisstant District Attorney with Criminal Justice and Drug Abuse Unit. Tropic: Legal and Medical Aspects of Drug Abuse Problems in Philadelphia.
April 25--Arthur B. Tarrow, M.D. Professor of Anesthesiology Jefferson Medical College. Formerly Chief of Anesthesia U.S.A.F. Topic: Medical Aspects of Skylab and space flight.