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Ariel - Volume 5 Number 4

J.D. Kanofsky
Thomas Jefferson University

Bob Sklaroff
Thomas Jefferson University

Robert G. Lahita
Thomas Jefferson University

Ken Jaffe
Thomas Jefferson University

John Santartas
Thomas Jefferson University

See next page for additional authors

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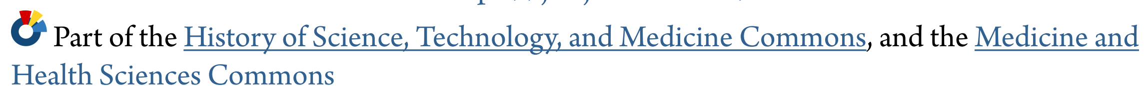
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Authors
J.D. Kanofsky, Bob Sklaroff, Robert G. Lahita, Ken Jaffe, John Santartas, Philip Nimoityn, Bruce Silver, Frank Chervenak, Gary Kaskey, Joe Conti, and Geoff Halleck

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THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE

ariel

VOL. 5 NO. 4 MONDAY, FEBRUARY 12, 1973

Opportunities For Education in Nutrition

by J.D. Kanofsky

Remember how it used to be in the good old college days? Where, if you would take a course like Square Dancing 405, you would find yourself faking a dosie – doe before an audience of would-be hoof-up-a-storm barn stompers just like yourself. I can still feel those pearls of perspiration drip from my skin as, weekly, I would introduce a new clod-hopper two step to the reportoire of previously sacrosanct variations most everyone else was doing. Yes, Square Dancing 405 brings back memories of the way things used to be.

At college it represented a course which had a reputation of being well worth your while to take academically or should I say gymnastically speaking. A popular course, it never failed to attract more females than males to its roll call of dabbling cross-your-culture curiosity seekers.

Courses like that are tough to find at a predominatly male school like Jefferson Medical College. However, **Ariel** is proud to announce that after much baited anticipation just such a course is in the offing. At the risk of sounding like a male chauvinist pig, we have been informed that the department of preventive medicine is currently sponsoring a course on clinical nutrition in conjunction with the department of nutrition at Drexel University.

There are now sixteen faithfully checked-out all-female student dieticians taking the course as a Wednesday afternoon elective. They sit side by side with four in-the-know male medical students as they count up calories and dispense One-A-Day Vitamin tablets.

Interested parties should contact Dr. Krehl if they wish to participate in a similar exercise during the upcoming spring quarter. Prerequisite for matriculation: Evidence of sufficient arithmetic skills to assure the attainment of a C plus average or better in any Advanced Multiple Digit Multiplication course of your choice.

—

What are we to make of the above announcement? I offer it as an example of the attitude most medical students have towards nutrition. Nutrition is to our medical school curriculum what square dancing was to our undergraduate curriculum. We might think it nice to know more about it but certainly it is not worth our while to indulge ourselves too long in the mastery of its mysteries.

Furthermore, it is something that only feather headed girls with a dearth of ambition would concern themselves with. How many male dieticians are there? Sparingly few. Irrational sexists that most of us are this cannot help but tinge our feelings towards the subject. We picture the dietician as a calorie counter or as one student put it "a glorified arithmatician."

All this and more has resulted in a generalized apathy among medical students to learn any more about this area. Fit for a smirk, always up for a dig, nutrition does not even rate a step child status as far as our medical education priorities are concerned.

Dr. Krehl, who is chairman of the Department of Community Health and Preventive Medicine here at Jefferson Medical College, is aware of the disrepute nutrition has among most medical students. Both on a clinical level and on a basic research level he thinks that we who will soon be doctors should acquaint ourselves more extensively with the life-giving properties present in our food.

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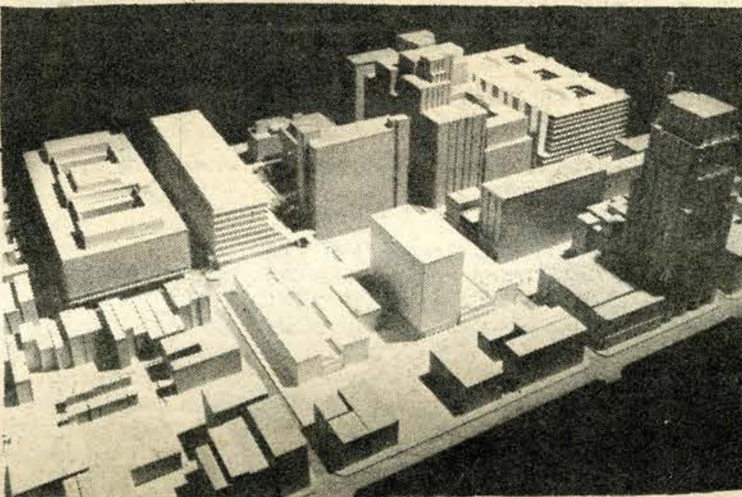
Jeff Sesquicentennial: New Hospital, Housing/Completion Date: 1976



Looking northwest here is a present and future look at Thomas Jefferson University's campus. The white buildings in the foreground represent the new student housing. White building directly behind this is an education facility not in the present planning. To the left of this, in grey, is the present Jefferson Alumni Hall at 10th and Locust Sts. The new hospital building is on the far right background in white. The 22-story Edison Building is the grey structure in the lower right. View from 8th St., looking west.

by Bob Sklaroff

Jefferson has initiated an $84 million expansion program, most of which is to be completed in the next four years, which involves the construction of a hospital, student housing complex, outpatient clinic, College of Allied Health Sciences, and three community health centers.

This effort to double the effective size of the center-city campus will be financed predominantly by self-supporting, long-term loans and private funds to be raised in a "Sesquicentennial Campaign." Philadelphia *Inquirer* reporter Donald Drake has quoted a University spokesman as stating that 10 percent of these funds have been raised.

"Unique, Innovative, Flexible"

The Clinical Teaching Facility (CTF), the "essential element" of the University, according to the January 7 press-release announcing the plan, is to be "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."

The eleven-story CTF will not only contain space for 400 patients, but will also completely replace most ancillary services, such as operating rooms, laboratories and radiology. Ambulatory facilities to accommodate at least 215,000 patient visits per year and office space for staff physicians will enable the CTF to "fulfill the health care needs of the community projected into the 21st Century."

It will replace the Main Building (1909) and the Thompson Annex (1924), two structures which have required $5 million in the last six years for renovation and restoration.

It will be located on a site bounded by 11th, Chestnut, 10th and Sansom Streets. The stated goal of this project is not to provide more hospital beds. It will, in fact, *reduce* the number of beds from 660 to 585. It is hoped that the CTF "will alleviate the most urgent need of the University – the replacement of obsolete hospital facilities."

Other features of the CTF include parking space and commercial space at street level facing 11th, Chestnut and 10th Streets; the latter has been planned to prevent serious depletion of tax income to the City. Tenants will pay City Mercentile Tax and Jefferson will pay the Property Tax.

Completion Date Unknown

The starting date for construction is contingent upon completion of financing and final receipt of approval from city and regional agencies. The Philadelphia *Inquirer* (1/7/73) reports:

"No date has been set for the hospital construction because approval must first be obtained from the Hospital Survey Committee, a quiasi-public agency that evaluates such construction city-wide.

"Without approval, it's virtually impossible to get funding and Blue Cross coverage is denied.

"State Insurance Commissioner Herbert S. Denenberg, who has frequently criticized Philadelphia institutions for costly and unnecessary construction, said he doesn't know if the construction was needed, adding that this would be for the committee to determine.

"Committee Vice President Richard Logan said plans haven't been evaluated yet and he can't say whether the proposal would be endorsed or not. He estimated *evaluation would take several months.*"

(Mr. George M. Norwood Jr., Vice-President for Planning, gives his estimate of the date of completion of the CTF in his *Ariel* interview. Read next month's *Ariel* for a detailed assessment of this ambitious project.)

Son of Orlowitz

Encircling the Stein Research Center between Walnut and Locust Streets on 10th will be constructed 312 student housing units. In the Fall of 1974 122 low-rise apartments will be available, the remaining to be constructed as a high-rise at a later date.

The University has noted a great need for additional housing demonstrated by the availability of Orlowitz Residence Hall since 1968.

Adjacent to the student housing will be a privately-constructed luxury apartment house, owned by the Monticello Corporation, which was formed in 1964 by a Jefferson Volunteer Faculty member, Nicholas R. Varano, M.D., a urologist.

New Jeff Clinic in Six Months

The Edison Building, a 22-story structure at 9th and Sansom Sts., will be purchased and renovated to serve two purposes: to replace Curtis Clinic and to house the College of Allied Health Sciences. This center for all outpatient, family (i.e., community) subspecialty, and laboratory

(Continued page 7)

"You might consider Jefferson the most modern hospital in the world!"
–George M. Norwood, Jr.
Jeff Master Planning

This is the evaluation of the new Clinical Teaching Facility, which is offered by one of its designers. In next month's *Ariel*, he will explain why this building fulfills his present criteria for the permanence of any structure. Mr. Norwood would like to see his plans for the CTF first published in the *Ariel*; and we plan to show how, for the first time, a hospital is to be build for the convenience of the patients. The program is almost "frozen." See next month's *Ariel* for the details of the projected functional organization and integration of the hospital of the future – the Clinical Teaching Facility.

Raft Debate 1973 -- Debacle of A Dubious Distinction

Robert G. Lahita

Once again the Hobart Amory Hare Medical Honor Society came through with their Annual Raft Debate last Wednesday evening, January 24. For those who could not attend, it was the second year for this great event. The Raft Debate is a scenario of three physicians who defend their worth in society while on a sinking ship. They are thwarted in their efforts by an appointed devil's advocate: usually someone with rhetorical talent who is also a physician. Just before the finale, the man that shows he is most worthy to live gets the raft to stay afloat. Seem confused? No matter. Th debate is the farthest thing from a debate, and the physicians are usually more akin to a warm-up crew of cheerleaders for a Mummer's parade. This year's debate is especially notable, for like a potato famine, it should never have been allowed (i.e., if you paid to get in, it would have been the biggest Rip-off since the last Giants-Eagles game), but as it was, it was another trip into the world of the "nutsy." Spruce Street on parade!

The whole debacle started off with Mr. Milton Packer, the senior student moderator and organizer of this year's debate. He nattily introduced this year's contestants in a voice which was a composite of Brooklynese, Sam Levinson, and upper respiratory infection; but it came off all right – albeit the loss of several Philippino exchange nurses from the last row. Milton's jokes were well placed and extremely subtle. First, he introduced Dr. Norman Lasker, who represented Medicine. Dr. Lasker arrived in bow tie and a long white coat looking like a real internist. Next came Dr. Russell Schaedler, who represented the basic sciences. Dr. Schaedler was admittedly more colorful in an outfit of dirty lab coat, oversized necktie, carrying a placard, and a new black physician's bag. Pretty characteristic of a basic scientist. Thirdly came Dr. Edgardo Alday representing Surgery. Dr. Alday arrived in a camouflaged Philippino guerilla outfit complete with sidearm and submachine gun, somewhat representative of the way in

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"High Priority For Prevention"

The two lead editorials of The American Medical Newsletter of 1972 stress the importance of preventive medicine. John Knowles, M.D. – Rockefeller Foundation President – is paraphrased as saying that "the next major advances in the nation's health will come from attention to an improved life style, rather than 'further high-cost technological development.' " Our own Senator Schweiker is in the vanguard of a movement dedicated to legislating more federal funds for this purpose.

According to the American Medical Newsletter, "The American Medical Association and many other groups have been actively pursuing health education programs for many years."

"These appeals for improved health practices become particularly pertinent when coupled with the well-known fact that in America today, about 75 percent of all deaths are caused by cardio-vascular disease, cancer and accidents. In all these areas, the public can do a great deal to protect itself. . ."

If all of this is indeed true, why is it that so few medical students are enthralled at the prospect of spending their life in the practice of preventive medicine?

I think this question can best be answered by drawing several analogies. Let us liken a doctor who specializes in preventive medicine to a high school teacher. On the opposite side of the coin, let us liken the doctor who specializes in crisis medicine to a salaried tutor.

Speaking from personal experience, after having spent a year teaching at Roxborough H.S. and having also devoted many, many hours to the task of working as a tutor, I can say that if I were given a choice between being a teacher or being a financially as well endowed tutor I would be strongly tempted to take on the job of tutor.

A teacher has to put up with a lot of back talk and phony excuses. For instance, a typical exchange between student and teacher might go, "Johnny, why didn't you do your homework today?" "I dunno, I suppose I just forgot." "Can you have it in by sometime next week?" "I guess so, that is if my amnesia doesn't get any worse." (Laughter is heard from the peanut gallery and class is resumed at its usual non-productive pace.)

Like it or not, the teacher is always the enemy. He is the one who is always telling you what to do just when you don't want to do it. He may be a heck of a nice guy and you may really like him but, Great Lord of the Flies, what a pain in the rear he can be. He never lays off telling you what is good for you. Who wants to put up with that sort of crud. As long as we feel O.K., we all know what is good for us and we don't need anyone else to tell us different.

On the other hand there is the kindly tutor who we come to in time of real need. He understands the seriousness of our situation and – although scolding at times – he reassures us that things are not going to be as bad as they seem. True, he is not always there when we need him but he is never too far away.

The point I am trying to make is that when people more or less desperately need your help they are a lot easier to deal with than when the contrary is the case. Therefore, the physician who practices crisis medicine will not be as frustrated as the physician who tries to persuade people to do something beforehand in order to avoid a tragedy. Also, there is an element of glamour involved in coming to the rescue of a patient when the chips are down.

It is similar to the excitement we feel when we watch an Arnold Palmer come from behind to take the lead in a golf tournament which has only one more hole for completion. Someone like Jack Nicklaus rarely generates that sort of tension because he is consistently out in front from start to finish. Are we to conclude then that Jack Nicklaus is any less a golfer than Arnold Palmer?

Similarly, a physician who consistently keeps his patients free from disease is no less of a doctor than the physician who takes care of them in times of crisis (not that there is any reason to believe that they have to be mutually exclusive).

This established, how then are we going to go about persuading patients to improve their life styles? A necessary beginning is to encourage them to come in for regular check-ups but where next to take it is very much up in the air. This is a problem that has no easy answer. Nevertheless, I have to go along with Dr. Knowles in believing that in the years to come its solution will take on an ever more increasing priority.

JDK

IN MEMORIAM

John H. Gibbon, Jr.
1903-1973

Caryl B. Heimer
1921-1973

"Kudos"

Ariel would like to commend Doctors O'Sullivan and Wallace of the Department of Surgery at Misericordia Hospital for the superb Wednesday afternoon elective in dog surgery which they offer.

Their enthusiasm, patience, and skill has made it one of the most valuable courses at Jefferson in terms of developing skills, knowledge, and confidence, while simultaneously stimulating interest in the subject.

Although expensive in terms of instructor time and dogs, per dollar spent it has been a bargain indeed. We would recommend it unconditionally to our fellow students and urge the administration to fund it and others like it adequately in order that we as students may perfect our skills on the patients whom we encounter on our clinical blocks rather than begin to start developing these skills through trial and error on human beings.

Correction

In December's **Ariel**, page two, the lines below in italics were inadvertently left out of the fifth paragraph of "Medical Ethics: The Right to Know."

"The physician must be a well-rounded man; he must indeed play the role of father-confessor, psychiatrist, and scientist, all the while leaving the patient **with at least some hope – but not to the extent of denying the patient** the results of that professional opinion which he has been hired to give."

A STUDY IN BLACK & BLUE :

Jefferson's $ $84 Million Dollar Birthday Party

By Bob Sklaroff, interviews of area residents by Ken Jaffe

They all came to learn of the new beast.

Administrators, businessmen, politicians, doctors, realtors, lawyers, private entrepreneurs, tenants and landlords studied the proposed black & blue elephant. They exchanged views...

***

"Jefferson's plans are necessary for us to implement programs of more readily accessible health care for all citizens, and medical education to meet tomorrow's demands," said William W. Bodine, Jr., chairman of the Board of Trustees of Thomas Jefferson University. Hospital Director Francis J. Sweeney, Jr., Vice-President for Planning George M. Norwood, Jr., and Mr. Bodine shared accolades.

State Health Commissioner Herbert Denenberg expressed doubts concerning the necessity of Bodine's Brazen Behemoth. Mr. Norwood answered, "This might soon be considered the most modern hospital in the world. A permanent structure, unlike our passable pavilion, which will, like our laudable library, be admired for decades to come as not only..."

"You said the same thing ten years ago," charged a neighborhood store-manager.

"But now we have the plans drawn and–"

"I read at that time in the **Inquirer** that you had even selected an architect and contractor."

"Yes, but now we have the financing to–"

"Sure, loans and handouts."

"And how do you expect to run a mini-hotel? You don't know anything about being a landlord," charged a neighborhood landlord.

"We've operated Orlowitz Residence Hall for a few years now quite effectively, and its existence has demonstrated the great need for–"

"You won't be able to administer security or maintenance efficiently without charging exhorbitant rentals. You can't cut into our business. We've been providing medical students a place to stay for many years–"

"How can you talk about money at a time like this? Jefferson has destroyed a community!" interjected lawyer Owen Lawrey, a representative of civic groups in the Washington Square West area for a number of years, and an opponent of Norwood's Nascent Nirvana.

"Jefferson's continuous expansion over the last decade has driven away most of the members of what used to be a cohesive Greek community."

"We don't exist just to serve Jefferson," remarked Samuel Gransback, area coordinator of the Philadelphia Redevelopment Authority. "We plan to develop housing for neighborhood senior citizens on the southeast corner of 9th & Locust Streets. This facility is to be constructed under the auspices of the St. George Orthodox Cathedral. Our goal is service to people within the realism of urban economics."

"That's easy for you to say, but I'm the one that has to move. I've been gypped!" exclaimed Mrs. Dascalakis, a 63-year-old widow who wants $45,000 for her property–$18,000 above her 1970 settlement price.

"I'm sorry you're so upset. Please call the relocation division of the redevelopment authority at WA 3-8530 anytime, and we'll try to help you. The 1970 Federal Uniform Relocation Act provides you with a number of benefits. As a property-owner, you may receive moving-expenses plus up to $15,000 towards the purchase of a new home. Tenants are provided a rent subsidy up to $4000 for 4 years i.e., to cover the rental-difference of comparable housing units before and after relocation) and our caseworkers..."

"I think you're missing our point!" cried Mrs. Edward R. Cortez. "We want comparable housing in this area which we can afford. My husband is a chronic asthmatic and is dependent upon the hospital for medical care. I think you should provide housing on the site of redevelopment for anyone who has lived in his residence for more than 5 years."

"We can't do that because the City has passed ordinances to prevent the construction of giant buildings without open-space. Disregarding the cost, we couldn't give the residents of a redeveloped area the top few stories of a high-rise, for example, because these laws prescribe a certain ratio of square-feet of total-building-floor space to square-feet of the parcel-of-land which may not be exceeded in any new construction.

"And we feel that the process of attrition is a fair one. Awareness of the ultimate disposition of this land has permitted most residents to seek alternate housing without the acute pressure of eviction, a process which nobody likes. Our greatest fear is uncertainty.

"We took title to your land (i.e., condemned it) in 1969 and posted vacate notices last March."

A local realtor was warning that the real story behind Sweeney's Sesquicentennial Scheme had yet to be told when two doctors approached, discussing a suggested addition to the plan.

"But if you were to build a private extended-care nursing home, Jeff's financial base for hospital operation would be undercut."

"You must admit that many patients would save money on the cost of their hospitalization. A nursing home certainly cannot be built by Jefferson itself. The University doesn't have the money to pay off the interest on present loans, let alone build still another building. Moreover, a 585-bed hospital couldn't supply it with enough patients. Why not use a floor of the new hospital as a nursing home?"

"Relax. We'll talk about this after we have read the next issue of **ARIEL**, in which the plans for the Clinical Teaching Facility are to be detailed. As well as publishing its contemplated layout, **ARIEL** plans a discussion of the significance of this building as well as a summary of other proposals for the design of a health-complex."

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Everyone agreed that the discussion had been worthwhile. Preparing a birthday celebration, it was noted, involves more than baking a cake; the ingredients must be chosen carefully. Even if its arrival is announced well in advance, there are few people who remain unaffected when a new elephant moves into town.

(NOTE: The above quotations, all of them, are accurate except for occasional minor embellishment. Only their proximity in time and space has been altered to facilitate the communication of these thoughts. Unlike the participants in the original elephant parable, these did not examine the strange beast while blindfolded.)

"LETTER TO THE EDITOR"

Supreme Court Protects Individual Rights??

The recent Supreme Court decision concerning abortion is the successful culmination to a concerted effort by many concerned citizens. The victory is complete – by a seven to two decision, the Supreme Court forbids states to proscribe abortion during the first three months of fetal life and allows states to permit abortions up to the moment of birth. This ruling will guarantee the mother's rights of privacy and self-determination. A large part of the Jefferson community takes great satisfaction in this long overdue proclamation. I feel the Supreme Court is making a mockery of the ideal it is trying to uphold.

Individual Rights

The overriding consideration in this decision is the protection of individual human rights. History must record this ruling as a bastardization of this very cause. This decision ranks with those condoning slavery and upholding segregation. In all these cases the court is certainly protecting the rights of certain individuals – but blatantly overlooking the rights of others.

If the Supreme Court believes it is wrong for the state to infringe on the rights of the individual, then the Supreme Court is indeed schizophrenic. The Court has rightfully promoted civil rights legislation – forbidding white restaurant owners the right to choose their patrons. The Court has rightfully promoted an end to discrimination toward women – forbidding men the right to employ whom they choose. Obviously, this is nothing wrong for the state to infringe on an individual's right, if this intervention will protect a more basic right of another individual.

Double Talk

In Judge Blackmun's words, "If the suggestion of personhood is established, the apellant's case, of course, collapses, for a fetus' right to life is guaranteed by the fourteenth amendment." In order for the Court to arrive at their decision, in spite of the above fact, they employed a cute maneuver. They avoided the central question of when human life begins." The Court is begging the question. By setting their arbitrary limits of three months and seven months, the court is indeed deciding when human life begins. Therefore, the Court is legislating an answer to a question which was not considered. This Court gave a lot of double talk. Their twisted logic insults some people; unfortunately, it is digested by many more.

Reasonable Doubt

There is a reasonable doubt that human life, entitled to legal protection, begins at conception. A sperm's level of existence is to be a sperm; an egg's level of existence is to be an egg. However, once sperm unites with egg there is an individual human. From the moment of conception, the individual is becoming – capable of developing his or her intrinsic potential into a self-meaningful being. This process of becoming and living is a continuous one; it is a process which does not end until death. Once this process is started, life has a basic intrinsic value, which must be protected by the state.

The Supreme Court may have thought that this argument, expressed and developed by men and women more capable than myself, sounded reasonable. However, they favored the notion that human life begins at birth. In the formulation of this decision, they overturned a cornerstone of American justice – the concept of reasonable doubt. No matter how overwhelming the convicting evidence, if there is a reasonable doubt that a suspect is innocent – then he is innocent, and he is entitled to protection by the state. The Court cannot deny the fact that there is a reasonable doubt that personhood begins at conception. They have to overlook and ignore this basic fact to arrive at their decision.

I find this disillusioning. I always realized that most Americans had minds which were selectively permeable to given information; yet I thought the Supreme Court would not think in a similar manner. I hoped they would judge all sides of an issue fairly, considering the individual rights of all of the individuals concerned.

Conclusion

In this letter, I have developed a point of view which our media does not develop. In the next issues, I will try to show how the pro-abortion American majority has developed so quickly. Just a few years ago, the decision would have met with strong national outrage. I feel there are basically three reasons: sincere concern for the mother, fear of overpopulation, and insensitivity to the needs of the unprotesting. I will also explore the future of the abortion issue and present a constructive alternative considering the needs of both mother and child.

Frank Chervenak

SAMA-MECO Unveils Job Spectrum

by John Santartas

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

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

One may ask how does this solve the problem and what importance is this to the Jefferson student. The student in MECO is matched to a small community hospital where one of the family practitioners who works in the hospital is the student's perceptor. The student then will rotate under the primary guidance of his preceptor through the various departments of the hospital. Stress, however, is not placed on clinical experience. Though the student is exposed to the clinical aspect through accompanying his preceptor on his rounds, the student also rotates through the administrative division of the hospital, as well as the preceptor's own practice with the emphasis being on how the health care is delivered to the patient and which personnel other than the physician, are involved in this service. Emphasis is also given to the specific community organizations involved in health care outside of the physician's office and the hospital. In essence, the student is exposed to how the physician, the hospital, and the community interact with each other to deliver care to the patient. Ideally, the student should observe each step of the process of health care including the administrative, the clinical, and the community orientated aspects in order to see how the patient gets the help he needs.

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

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

The American Indian Health Project.

The Community Health Orientation.

The Migrant Workers Community Health Project.

The Internship Evaluation Program.

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

Junior Fellow Program offers Early Exposure to Clinical Medicine

By Philip Nimoityn and Bruce Silver

Last year a group of sophomore students decided that they had not received enough exposure to clinical medicine in the early phases of their curriculum. Over 140 students signed a petition in favor of an optional program for freshmen, and a group of five students presented the proposal to the administration. The result of their efforts is the very successful "Junior Fellow Program," which offers freshman students the opportunity to see how medicine operates in a hospital setting.

The program is directed by Bruce Silver, a junior, who informed this year's freshman class about the program during orientation week in September 1972. He explained that over a hundred juniors and several seniors had volunteered to have freshmen accompany them in the hospital at mutually convenient times.

Almost 150 freshmen asked for junior fellows, some students asking to be mached with specific juniors that they knew. A list indicating each freshman's junior fellow was posted during registration. Each junior was asked to take the initiative in contacting the freshman matched with him. This was done so that the freshmen would not feel that they were imposing on the juniors by calling them.

The program is directed entirely by students and will be continued next year under the leadership of one of this year's sophomore class officers.

Questions, comments, complaints, suggestions, and requests for junior fellows should be directed to Bruce Silver, Box 746, Jefferson Alumni Hall Mail Room.

THOMAS JEFFERSON UNIVERSITY UNIVERSITY HOUR SCHEDULE

WINTER TERM 1972-73

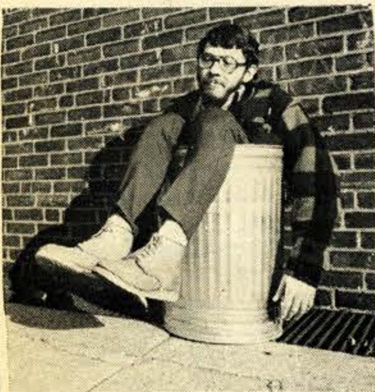
Solis-Cohen Auditorium
Jefferson Alumni Hall
Wednesday 1:00-2:00 P.M.

Feb. 7--Student fashions presented by the Celeste Agency with the Sally Shops.

Feb. 14--Pan Am public relations director will discuss skyjacking and methods of prevention.

Feb. 21--Thacher Longstreth, Esq., Philadelphia Chamber of Commerce. Topic: "What's In Philadelphia's future?"

Down in the Dumps?



Join ARIEL and Let Us Keep You Company

Friday Parties to be Continued

On January 10, 1973 the Commons Governing Board voted unanimously to reinstate the Friday SFS Parties. Previous cancellations of these events were due to the increasing number of non-Jefferson people in attendance and apparent lack of concern from our own students in preserving these parties as Jefferson events. After polling a cross section of the institution, the Commons Governing Board determined that a significant number of Jefferson people desired the continuation of these parties. The following format was unanimously agreed upon by the Commons Governing Board as being necessary for the welfare of Commons' programs and facilities:

1. The next party will occur on Friday, February 16, 1973 from 4:00 to 9:00 P.M.

2. Admission will be by a Jefferson I.D. Card or SFS Guest Pass only.

3. Students and employees may get a Guest Pass by showing their own Jefferson I.D. and registering both their name and the name of their guest in the Commons Office before 1:00 P.M. on the day of the event.

4. There will be not charge for a Guest Pass but will be limited to one per host.

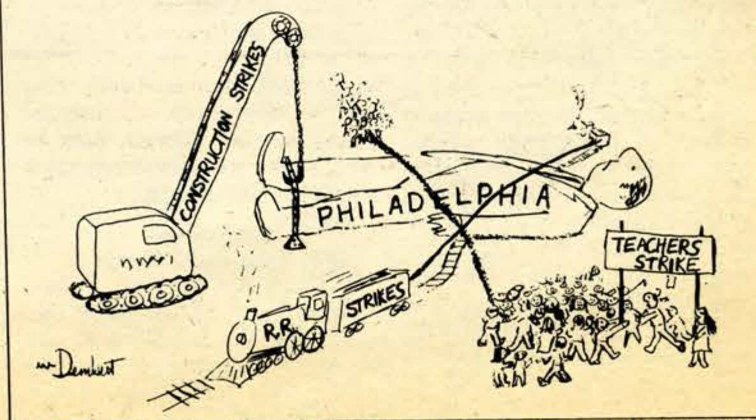
5. A guest must be accompanied by his or her host.

The success of this party and any future parties depends entirely on the cooperation and commitment of Jefferson people to see that these events are solely for Thomas Jefferson University.

Classified Ads in Ariel

Got something to say? Sell? Do it in ARIEL. 50 cents/ ad. With 5000 circulation, someone is BOUND to reply. So, send ads to ARIEL, Box 27, Jeff. Hall.

"A Modern-Day Gulliver"



SpeakOut Articles Of The Month

"To Commit or Not To Commit"

New England Journal of Medicine, August 10, 1972,

Voluntary Mental Hospitalization An Unacknowledged Practice of Medical Fraud

Thomas S. Szasz, M.D.

Abstract: Regardless of the method of admission to a mental hospital, the patient in such an institution does not, as a rule, have an unqualified right to leave. I suggest, therefore, that, although involuntary mental hospitalization is indeed involuntary, so-called voluntary mental hospitalization is often actually a covert form of involuntary mental hospitalization. Typically, this is the case when a person agrees to hospitalization under the threat of commitment. A 1971 decision of the Supreme Court of Utah, in which the Court held "...that a voluntary patient at the (mental) hospital is as much 'confined' and has as little freedom as a mentally alert trusty in a jail or prison," supports this view.

There are, so our language and laws tell us, two types of mental hospitalization: voluntary and involuntary. This terminology would lead us to believe that voluntary mental hospitalization occurs when a person defines himself as a mental patient and seeks admission to a mental hospital, which he is free to leave when he wishes, and that involuntary mental hospitalization occurs when someone is defined as a mental patient by others and is confined in a mental hospital against his will until such time as those in charge of him release him.

Actually, only one-half of the foregoing statement is correct: involuntary mental hospitalization is just that – hospitalization in opposition to the will of the so-called patient. The other half is incorrect: voluntary mental hospitalization is often actually a type of involuntary psychiatric confinement.

Constraints on Voluntary Mental Patients

In the majority of the states (in 44 out of 55, according to Lindman and McIntyre), a voluntary mental patient may, despite his desire to leave and his written request for it, be held in the institution for periods ranging from 48 hours to 30 days. This period is intended to provide sufficient time for those interested in committing the patient to make appropriate judicial arrangements for hospitalizing him involuntarily.

Furthermore, "Four states and the Draft Act (write Lindman and McIntyre) specify that hospitalization proceedings cannot be initiated against a voluntary patient unless he has requested his release." Although this provision is a clear admission that voluntary mental patients are actually, or at least potentially, prisoners – their incarceration remaining tacit so long as they do not challenge it.

This brief review of the laws governing voluntary psychiatric hospitalization makes it unmistakably clear that what is called "voluntary mental hospitalization" is often actually a type of involuntary mental hospitalization. Typically, this is the case when a person is forced to sign himself in as a voluntary patient under the threat of commitment, and when, having been admitted to the hospital as an ostensibly voluntary patient, he is not unqualifiedly free to leave when he wishes.

A recent court decision offers further support for the foregoing critical interpretation of the true nature of voluntary mental hospitalization.

Court Interpretation

A woman who admitted herself as a voluntary patient to the Utah State Hospital died. Her heirs sued the hospital for her "wrongful death." The hospital claimed immunity under the Governmental Immunity Act and was upheld by the Supreme Court of Utah. The Court's decision was based on what it regarded as the fundamental similarities between jail and mental hospital:

> We are of the opinion that in reading the whole section (of the Utah Governmental Immunity Act), the words "other place of confinement" obviously referred to something other than a "jail" or "state prison," including a hospital where one cannot be released without some kind of permission...There was no request here for a release, but even so, counsel's urgence that there was or is no involuntary confinement or restraint under the act cannot stand the test of the statue cited...
>
> It is true that a patient may demand his release forthwith – except that he cannot obtain it if the superintendent, within 48 hours of such a demand or request, goes to court to prevent it, which action, if pursued successfully may result in no release at all, and may result in "confinement" or "incarceration" for the patient's lifetime. Hence, it is obvious that the patient is "confined" against his will for whatever period of time he has been at the hospital, up to the time he demands his release, and even then he is confined for another 48 hours waiting for the superintendent to act...We think the legislature had no intention of waiving sovereign immunity in the case where a hospital attendant or guard is involved any more than it did where a nurse in a prison or a jailer is involved, and in logic and sense it seems that to treat the two differently would reflect a departure from legislative intent, simply by playing upon the adjectives "voluntary" and "involuntary," when it is obvious that there was a "confinement" at the time of the injury...
>
> We might suggest that a voluntary patient at the hospital is as much "confined" and has as little freedom as a mentally alert trusty in a jail or prison.

In short, there is no such thing as voluntary mental hospitalization, nor can there be so long as there is involuntary mental hospitalization.

Implications For Voluntary Patients

Although this decision of the Supreme Court of Utah leaves no doubt about the actual status of the so-called voluntary mental patient, its implications – especially for law and psychiatry – invite two comments.

In the first place, if it is generally true that voluntary mental patients are in effect prisoners (the Court compared them to "trusties" in jail), present legal and psychiatric practices regarding voluntary mental hospitalization are nothing but strategies of entrapment: to avoid the inconvenience of involuntary hospitalization, increasing numbers of Americans are seduced or coerced into assuming the status of involuntary mental patient "voluntarily."

Secondly, if mental-hospital patients – even voluntary mental patients – "have as little freedom as a mentally alert trusty in a jail," it follows that psychiatrists who confine such persons in mental hospitals behave like jailers, not like doctors. This confronts university administrators and medical and psychiatric educators with a moral dilemma: Are medical schools and psychiatric residency programs the appropriate institutions in our society for the training of jailers and wardens?

For a long time, medical schools and their affiliated hospitals have trained physicians to deprive patients, under the guise of mental illness and treatment of their liberty. Neither medical schools nor any other institutions of learning have trained progressionals to help mental-hospital patients regain their liberty. This is as if law schools trained their students only to serve as prosecutors, and as if there were no academic or professional recognition of a legitimate need for defense lawyers -- district attorneys being defined and socially accredited as the protectors of the "best interests" of the accused.

I believe that we can evade the moral and political character of mental hospitalization no longer. The Supreme Court of one of the states has now ruled that even a voluntary mental patient is "confined" and has as little freedom as a mentally alert trusty in jail or prison." The time has come for university administrators, and for medical and legal educators, to reexamine their responsibility for supporting the present principles and practices of psychiatric hospitalization.

CONDITIONAL VOLUNTARY MENTAL-HOSPITAL ADMISSION

A. Louis McGarry, M.D. and Milton Greenblatt, M.D.

Abstract The continuation of the practice of voluntary mental-hospital admission under certain contractual conditions is a desirable alternative to court-mediated involuntary commitment. Total abolition of involuntary civil commitment of the mentally ill, however, is likely to be regressive, leading to an increased use of the criminal-justice system in the management of the mentally ill, with destructive consequences. There will probably always be some citizens who require conditional voluntary or involuntary commitment status in mental-health facilities.

No more troubling responsibility exists for judges and physicians than their involvement in the involuntary commitment of the mentally ill. The desirability of voluntary admission as an alternative even under conditional circumstances (such as notice in writing in advance of intention to leave) has therefore been little questioned. Authorities in the field have accordingly given support to the practice of so-called "conditional voluntary" admission to mental hospitals.

Although Dr. Szasz challenges the practice of conditional voluntary mental-hospital admission, his main attack is on the social policy that authorizes involuntary mental-hospital admissions, and he favors its total abolition. Many people of goodwill and good intentions are being misled by this simplistic approach to public policy.

A major flaw in the abolitionist position concerning involuntary mental-hospital commitment is that it is dated. This idea had much more relevance 20 years ago than today. Not taken into account are the extraordinary improvements in the care and management of the mentally ill in recent decades. In the last 10 years, the doors of most mental hospitals have been opened. If a mental patient, whether on voluntary or involuntary status, wants to go home, for the most part, he has only to put one foot before the other. Thus, at Boston State Hospital in fiscal 1972, 2492 patients who received residential care and treatment on 1367 occasions left the hospital on their own decision. In only 165 cases did the hospital designate the departure as an "escape" – i.e., seriously dangerous to the patient or others; hardly the characteristics of a jail, or of jailers. It would be a curious jail, indeed that permitted unilateral withdrawal by its prisoners many hundreds of times a year.

A second fact is that there has been great progress in recent years in public mental hospitals in terms of shorter hospital stays and accelerated rates of discharge. Although more patients are being treated in such institutions each year, the census has dropped successively for the past 15 years. Thus, in 1956 the census of public mental hospitals in America was 559,000. By 1970 the figure had dropped to 339,000– and it is still falling. Much of this phenomenon can be ascribed to psychotropic medication, but much also is attributable to the community focus of new programs throughout the country.

If civil commitment of the mentally ill were to be abolished altogether, what would be the consequences? Since mental-health facilities must assume responsibility for suicidal, homicidal and gravely disabled mental patients, occasions do arise when the uncontrolled exercise of freedom would result in disaster. Although, as we have indicated, the doors tc facilities are for the most part open today, psychiatrists do have to manage patients who are assaultive or actively suicidal. Is it wrong to try to prevent the personal, social, and familial tragedies of unbridled assaultive and self-destructive behavior?

Dr. Szasz has written elsewhere that it is his conviction that people have a right to kill themselves. Not everyone would agree. Patients who have recovered from severe depression during which they were actively suicidal would not agree. Regarding psychotic antisocial conduct dangerous to others, Dr Szasz here, too, appears tc eschew preventive persuasion; he advocates instead that such behavior should be subject to criminal prosecution, after the antisocial act is committed. Then, such a patient would be committed to what Dr. Szasz calls "Prison Hospitals."

It is essential to consider all the consequences in human terms of the abolition of involuntary mental hospitalization. Many who need treatment would not get it. This would be particularly tragic in an era, again unlike 20 years ago, when successful treatment modalities for large classes of mental illness are available, especially in the form of psychotropic medication. The human cost to such people, their families and their communities, if treatment were denied, would be incalculable.

Another predictable consequence of the abolition of civil commitment would be the sharp increase of the number of mentally ill persons who would be processed by the criminal-justice system. In California, with the recent adoption of very strict and rigid criteria for involuntary civil commitment, there has been a sharp increase in the use of criminal commitment procedures for the mentallt ill. In effect this criminalizes the management of many mentally ill persons. We have seen how destructive and antitherapeutic such management can be.

Dr. Szasz's contention is largely correct that voluntary mental-hospital procedures in this country do have involuntary provisions that may be petitioned for by hospital authorities. However, his contention that voluntary admission "...does not exist" is not accurate. Dr. Szasz cites the 1961 edition of The Mentally Disabled and the Law, but the second edition, published in 1971, lists eight states that provide by statute for unconditional voluntary, or "informal," admission as it is also called. Under "informal" admission procedures the patient is totally free to leave the hospital at any time. The book cited calls this "a new development". No statistics are given to indicate how frequently these procedures are used, however, Massachusetts "de facto" has had informal admission since 1959, when Dr. Walter Barton established it at Boston State Hospital.

As officials in a state department of mental health, we can report that the greatest pressures on us come from family members and the community to admit and retain the mentally ill and retarded. Our sharpest and angriest critics among practicing legal and medical professionals and the citizenry are those who are convinced that we deny admission too frequently, that we discharge patients too soon and that we do not pursue patients who leave our hospitals without authorization.

The abolition of involuntary mental hospitalization would have destructive and regressive consequences. Its practical effect would bring about a situation in which misdemeanor charges such as "disturbing the peace" or "disorderly conduct" would increasingly be leveled against the mentally ill for disturbed behavior, and commitment would be accomplished under criminal procedures. Abolition would be a large step backward on the long road that we have traversed since the mentally ill and the criminal were lumped together and their isolation from society enforced by high walls, locked doors and neglect.

Mythos of Causality

Gary Kaskey, Epistamologist

Myths are principles which guide the behavior of individuals in a culture and are usually below the level of consciousness. Only allegorical stories of these principles are available for examination and when these start to be closely examined for conscious guides to behavior they are on the way out as functioning myths. A common misconception is to call something a myth means that it does not really exist–nothing can be further from the truth. "Primitive" societies had animistic myths involving a close relationship with nature. The Judeo-Christian myth is that of a universal God. The myth of democracy is that of human freedom, that of communism is human altruism. It must be emphasized that all these myths are real to those who operate within them, and to all others fairly ludicrous. The main myth of medical practice which all responsible doctors should be obliged to consider is that of causality.

The twentieth century world is a world of mechanical descriptions. An apple falls to earth. When one questions why, one is told that the force of gravity pulls it down; and, if one researches even further, he'll even find that gravitational forces has been described as equaling 6.67 x 10-8 dyne/ cm2–gm2–M1M2/ r2. But what exactly is the force of gravity? The answer is simple–no one really knows. In other words, skillful manipulation of unknown, say occult occurances have gotten us to the moon. Powerful sorcery.

Sir Russel Brain pointed out that a neurologist must assume spatial relations are constant and only accuracy of the reporting of those constant relations varies to study "inaccurately functioning" human brains. But in the world of Einstein which is the best model of our world currently available, no two people can share the same space time continuum. Although in the everyday world, description of objects offered by separate individuals should not differ significantly, we, if we are to believe in our current mathematical concepts, must accept the fact that **perfect objectivity must be impossible**. The Heisenberg uncertainty principle is yet another rational example of how a subject can only be viewed in relationship to a viewer. Things **cannot** be described as things in themselves; they are always things in relationship to the describer. A similarly revolutionary concept exists in sub atomic physics, that is the parton which is a field of influence in four dimensions. In other words science now holds as true that the future **must** influence the past. Admittedly this is hard for us to grasp, for our language and our way of thought is Newtonian having such separate concepts as time and space or future and past wherein "reality" no such black and white distinctions occur. Furthermore, we can easily see that Newtonian mechanics is a myth of our culture by comparing our culture with mythopoetical societies. In those societies life is seen as a collection of almost totally unrelated moments (some Indian tribes don't even have a word for time) and any attempt to influence a future is just not comprehensible to those beings who do not recognize a future. So it is easily observable that, even by working within our own rationality, mechanistic causality can be recognized for what it is–a myth and one that is on the way out.

The consequence of this can be better discussed after a brief aside. Kierkegaard in **Fear and Trembling** wrote of the philosophic development of man. This begins with just personal sensory involvement with the outside world progressing to symbolic involvement, speech, symbolic thought and in rare instances culminates with "the leap of faith." The leap of faith involves knowledge of both sensory and symbolic levels and faithfully accepts the absurd conflicts between levels. This is the closest to the way things are. For example, it is absurd to view Christ as a man and as the Son of God at the same time. Yet one with faith can accept both levels at once. Buddism deals in a similar method with levels: there is the level of non-existence where life is viewed as Being or just a collection of internal moments with no past or future, the level of existence, Becoming, like our mechanistic view of life, and the level of Enlightment where both lower levels are seen for what they are–incomplete descriptions, and the world is seen for what it is–both at once, absurd as that may seem, that is the Middle Road. What I am trying to bring forth is that knowledge is behavior based on full realization of all the levels implied.

A simpler, more practical, less cosmic way of saying the above is that the physician must act with proper perspective that is based on both medical science and aesthetic art. I am not saying we should throw away medical knowledge and return to witch doctors, for that would be only using the primitive level. But just as false as the non rationalists who preach a complete return to nature are the so called rational men of the twentieth century who are afraid to recognize the influence of 60 million years of primalism on our everyday behavior.

Just ask any good clinician which he trusts more, a machine's test result or his "feel" of the patient. But our primitively rational causality leads us to err seeking one "cause" to a disease while ignoring the totality of the patient. Arteriosclerosis is the number one precipitating factor in deaths in the United States, yet what is the treatment–an ill defined, **ex post facto** regime culminating in the major trauma of coronary bypass and perhaps in the future cerebral artery bypass. This symptomatic treatment ignoring the whole patient's mode of living (obesity, stress, and poor nutrition are symbolic cultural indicators) is really negligent practice. The clean cut failures at causal cure attempt of the symptoms of drug addiction and alcoholism further show that medicine must stand as socially responsible if it is to be medically responsible.

Objective causality again leads to the mistake of the doctor thinking his feelings are divorced from objectivity. How many times have well meaning M.D.'s tranquilized a family grieving in hospital corridors, never realizing the need for grief in times of loss, doctors will give treatments to the parent for the sake of the doctor and not the patient.

Simply said the quality of the moment is as important as the number of moments. The wizened old G.P. knew all this without having to look into any such epistamology. Medical education and medical super-specialists so well trained in the science of causal practice will have to relearn the G.P.'s art of dealing with the person. Doctors now should be at the point where they can look on their knowledge as useful but based on myth and as just an adjunct to increase the power of their sorcery.

With a Hotel, Rent is $1,000

by Joe Conti

Most people have played the Parker Bros. game, Monopoly, at some time in their life. A salient aspect of the game is the hustle that arises once all the properties have been sold, commensurate with the wheeling and dealing between players. A person who can hustle his properties the best stands an excellent chance of winning the game. However, it is just a game, isn't it?

The movie, **King of Marvin Gardens**, united the directing talents of Bob Rafelson and the excellent acting of Jack Nicholson for the second time (The first was for the masterpiece, **Five Easy Pieces**), concerns itself with the real and unreal aspects of Monopoly as it applies to two brothers, both of whom are closing in on middle age.

The game analogy is crucial to the movie because the plot is not as well developed as one would like. There are certain relationships that are not delineated very clearly. Yet what makes the movie interesting and ultimately saves it from being a failure are the characterizations of the brothers by Jack Nicholson and Bruce Dorn. The interplay between them explores the various facets of fraternal relationships drawing on their past and present and relating to their future plans. The brothers present two approaches to the fantasy dreams of Monopoly – like fame and fortune.

Jack Nicholson plays a Philadelphia radio monologist, a professional prevaricator who uses a laconic delivery for his stories. The opening scene illustrates Nicholson's technique. There is a close-up of his face as he delivers a childhood story that is false, but is obviously entertaining to his audience. He is a true hustler of form. This scene is followed by one of Nicholson eating alone in a Horn & Hardarts late at night with a group of deaf mutes eating at a table in the background. There is a subtle irony present since Nicholson is eating alone, not communicating, in spite of his profession, and the deaf mutes are engaged in a conversation in spite of their handicap by means of sign-language. The only fault with this scene is that it is used as a backdrop for the film credits and consequently is not as clear as possible.

The scene changes shortly to a burnt-out deteriorating Atlantic City (also the basis for names in Monopoly) where Nicholson's character's brother, played by Dern, is chasing a pipe-dream. He is a runner-messenger boy for a black syndicate in A.C. – in reality, a dice-roller for the people playing monopoly for real stakes (big business). Of course, he aspires to a decision-making position and devises a plan to achieve this end – a resort in the Pacific – complete with a hotel (another aspect of the Monopoly game). He calls his brother to come down to Atlantic City and help him in his plan. What results is a series of scenes in which Nicholson's inability to communicate and Dern's inability to hustle successfully are revealed.

In perhaps the major scene of the movie, Dern demonstrates his hustling technique to his brother only to have it fail at the last minute. Undaunted, he exlaims to his brother that he loves the hustle that is Atlantic City. Both are interested in a form devoid of any content. Dern is hustling his brother, a middle-aged woman and her daughter as sexual partners. Nicholson is hustling his listeners.

However, just as Atlantic City has passed its days of millionaire dreams and is now a faded, dilapidated testimony to the glory of the 30's and 40's, the two brothers are symbols of unrealized childhood dreams. Dern's dreams are played out to a tragic end that ultimately produces a catharsis for Nicholson that enables him to communicate a true feeling, even if it is a tragic one.

In conclusion, the illusionary title, **King of Marvin Gardens**, is a vacuous dream that proves unattainable for people in real life, a title devoid of content, a tragic display of human style.

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NUTRITION

In anticipation of future student interest in this field. Dr. Krehl was happy to let us know that there now exists an affiliation between Jefferson and the Department of Nutrition at Drexel University. The upshot of all of this is that Jefferson has acquired the services of Drexel's basic research laboratories. In return, Drexel can now send their student dieticians to the Jefferson clinics where they will receive on-the-spot training which otherwise would not have been available to them.

In our conversation with Dr. Krehl we discussed some recent breakthroughs in the field of nutrition. Dr. Krehl felt that all of these breakthroughs deserved further investigation.

FACT: One-third of the caloric intake of the average American diet is made up of refined foods which in general are of little nutritional value (for instance, the average American consumes 100 pounds of supplementally added white table sugar per year).

The consequences of such an enormous preference in our diet for refined foods are the following.

1) Peter Kuo of Penn has shown that massive carbohydrate intake compatible with that which the average American is exposed to daily will increase blood triglyceride levels. Blood triglycerides are universally accepted as playing a prominent role in the formation of atherosclerotic plaques. Kuo claims that a reduction in the carbohydrate intake of our diet will significantly deter the progression of the atherosclerotic process.

2) Franz Goldstein -- a professor of Medicine here at Jefferson Medical College -- summarized the findings of "Diet and Colonic Disease" in an article written for the June '72 issue of the Journal of the American Dietetic Association. In this article mention is made of how little bulk is contained in most refined foods. There are strong indications that too little bulk in our diet will dramatically enhance the chance of our succombing to irratable bowel syndrome, diverticulosis and worst of all colonic carcinoma.

3) By filling ourselves up with empty calories we do not supply ourselves with foods that are more nutritious. Hence, many of us may be suffering from "latent nutrient deficiencies." As in latent diabetes, trouble may only flare up when the individual is overwhelmed by a stressful situation. Dr. Krehl felt that this area is still rather vaguely delineated but that in the future a great deal more work will be directed to its further elucidation.

4) The notion of "biochemical individuality" espoused by Roger Williams at the University of Texas suggests that a sufficient quantity of nutrient for one individual may be an insufficient quantity for another individual. (For instance, most guinea pigs can avoid scurvy by ingesting a total of 5 mgs. of vitamin C per day. However, some guinea pigs can survive on only 2 mgs. of vitamin C per day whereas others will require more than 20 mgs. per day.) This too is a field that has only been lightly touched upon to date.

5) Very much in the domain of conjecture are the findings of Henry Schroeder, who is a professor at Dartmouth Medical College. His argument starts out by stating that refined foods are stipped of trace minerals. He then presents evidence to support his belief that a deficiency of trace minerals – particularly the trace mineral chromium – may be considerably responsible for the high incidence of cardiovascular disease found in our culture.

At the end ot our session Dr. Krehl invited medical students and graduate students to contact him if they are interested in taking advantage of the research facilities open to them at Drexel University. However, if your interests in nutrition are more clinically oriented there is no need to look elsewhere. Dr. Krehl is highly qualified to give instruction and advice in both the basic research and clinical aspects of nutrition. He holds a Ph.D. degree in biochemistry (with an emphasis on nutrition) from the University of Wisconsin. After completing his Ph.D. requirements at Wisconsin he entered Yale Medical School and presently holds down a dual professorship at Jefferson in both Preventive Medicine and Internal Medicine. Therefore, whatever your interests may be in the field of nutrition, counseling can be sought from his office.

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"The Whole Idea of A Hospital Is To Serve The Patient!!"

(An interview with George M. Norwood, Jr., Jefferson Master Planner, by Bob Sklaroff, in which a sketch of the future begins to unfold. These issues will be examined in depth in next month's Ariel.

Ariel: Where is Wills Eye Hospital to be built on campus?

Norwood: As you may know, Jeff and Wills have agreed this past July to become associated institutions. We tentatively plan the top to floors of the eleven-story CTF to house this hospital. It will have separate elevators, separate entrances. Its association with Jeff, however, will be more than physical.

Ariel: Speaking of Elevators, how do you plan to avoid a repetition of the mistake made with the other hospital buildings at Jeff: not enough elevators?

Norwood: More elevators and less need for them. We plan to double the number of elevators in Foerderer (which will renovated and retained). With the intended design of the new structure, the patients will not have to be moved as frequently from floor to floor for various services (e.g., radiology, surgery).

Ariel: When is this CTF to be completed?

Norwood: That is a difficult question. This much I do know: The building will require 3 years for construction. Our target date for the initiation of this construction is April 1, 1974. Since demolition takes 90 days, we hope to have acquired the six remaining unpurchased properties, as well as clearance for the project, by the end of December of this year. Therefore, we hope to open the building in the Spring of 1977.

Ariel: Do you think you will meet this timetable?

Norwood: Yes, but I am very pessimistic that the schedule for construction of the new student housing complex will be met.

Ariel: What is that timetable?

Norwood: Demolition here also requires 90 days; Construction, 18 months. We hope to move in some students in September 1974. That means that we will have to begin within the next few months.

Ariel: What's holding you up?

Norwood: Law suits and land acquisition.

Ariel: How many people still live on the lot on which you plan to build the housing?

Norwood: The last census, taken last summer, set the figure at about 30. Some may have moved away, so I have requested a new census from the Redevelopment Authority.

Ariel: What will you do with the Main and Annex buildings?

Norwood: I would prefer to leave that up to my successors. That's what this job is all about: leaving flexibility for your successors--a luxury which would be welcome today.

Ariel: The Redevelopment Authority has districted the southwest corner of 11th and Walnut Streets, where Smalls is located, as land to be developed by the University in the future. Any projection?

Norwood: No. That property along with the parking lot along Locust St. may be used for any number of projects–none funded as of yet.

Ariel: What is planned?

Norwood: We are studying the possibility of opening a Dental College. We may use the space for the Basic Sciences. An audiovisual aids complex may be build there, to include a large auditorium. Finally, parking for 200 cars, 40 more than the present capacity, would be provided.

Ariel: Does the existence of the Stein Center affect your plans for the student housing complex?

Norwood: As you can see from the map, Stein is right in the middle of the project. But we planned it in such a way that the only facility which is "inconvenienced" is the parking garage; ramps will be constructed to avoid the building, creating many cul de sacs.

Sometime in the future, Stein may be moved to a less-cramped area, but for now, it's welcome where it is, and our plans attempt to integrate it with the surrounding housing.

Ariel: Is it true that the Edison Building is to be used solely for paramedicals?

Norwood: True. It is to be used for the newly-developed undergraduate curricula. "Paramedical" is a degrading term, I think, because it is possible that undergraduate programs will be developed eventually which are not now considered "paramedical"–for example, health care administrators.

Ariel: You mention three Community Health Clinics. Where are they to be located?

Norwood: The first will be in the Edison Building, then transferred to the CTF. The second is to be in "deep" South Philadelphia. The third site is yet to be programmed. It may be placed at Broad & Fitzwater Sts. in the Children & Youth Program Building.

Sesquicentennial

services will begin to function by July 1, 1973.

Jefferson faculty members are being actively encouraged to move their offices to this new building, Mr. Norwood states that the administration hopes to have the new program of "community ambulatory health-center care established on a fully comprehensive basis in the Edison Building so that it may be transferred in its entirety to the CTF upon completion." (This process of moving all facilities into the CTF would take an estimated six months.) The new clinic system will be described in next month's *Ariel*

Some professors are reluctant to move to the Edison building, only to have to move again in a few years. They express contentment with having their offices closer to the hospital. (The University has found it impossible to construct a tunnel from the Edison Bldg. to the rest of the campus.)

The University has discouraged any capital improvement of the College Bldg. and Curtis Clinic. For example, plans to renovate individual clinics put forward by various departments are vetoed by the University, but more forceful efforts to move the physicians to the Edison Bldg. are denied.

When the College of Allied Health Sciences is moved into the Edison Building, there will be space for expansion of this division of the University which educates undergraduate health professionals. As well as offering degrees in nursing, radiologic technology, and medical technology, additional programs for physical therapy, occupational therapy, physicians' assistants and radiologic technology are projected.

The Curtis Clinic, which currently serves as Jefferson's outpatient facility (at 10th & Walnut Sts.), will be used as a Medical College academic and research facility – for example, expansion space for the Cardeza or Stein Research Centers.

Two other community clinics will be opened in South Philadelphia (in cooperation with South Phila. Health Action, Inc.).

Additional Funds for Education

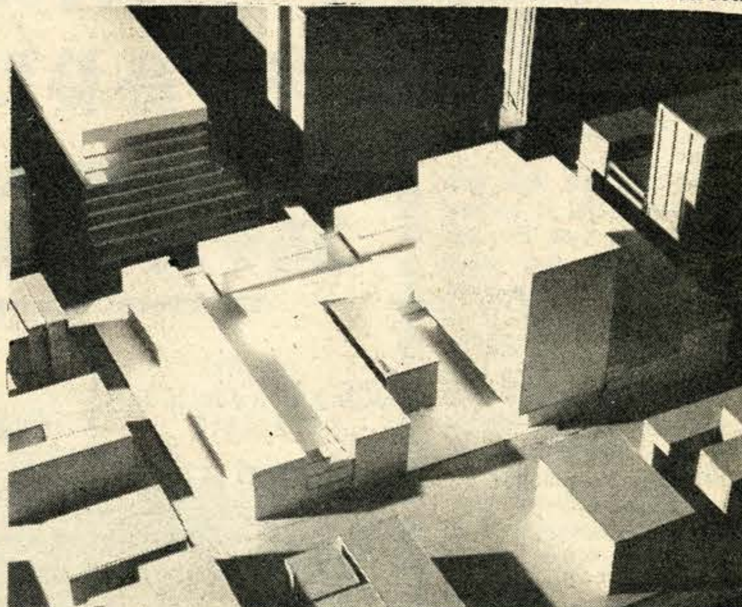
The rest of the money raised in the Sesquicentennial Campaign will be invested in the development of varied educational programs. $1 million will be allocated to the coordination of instruction at the 15 affiliated hospitals.

University Fellowships and Faculty-Fund Distinguished Professorships are expected to further the complenentary ends of attracting able instructors and underwriting substantial research. Faculty-Fund Honor Fellowships will draw gifted scientists to Jefferson who might ordinarily pursue a private practice or be attracted to other institutions. Additional funds will be made available for student-aid loans and scholarships.

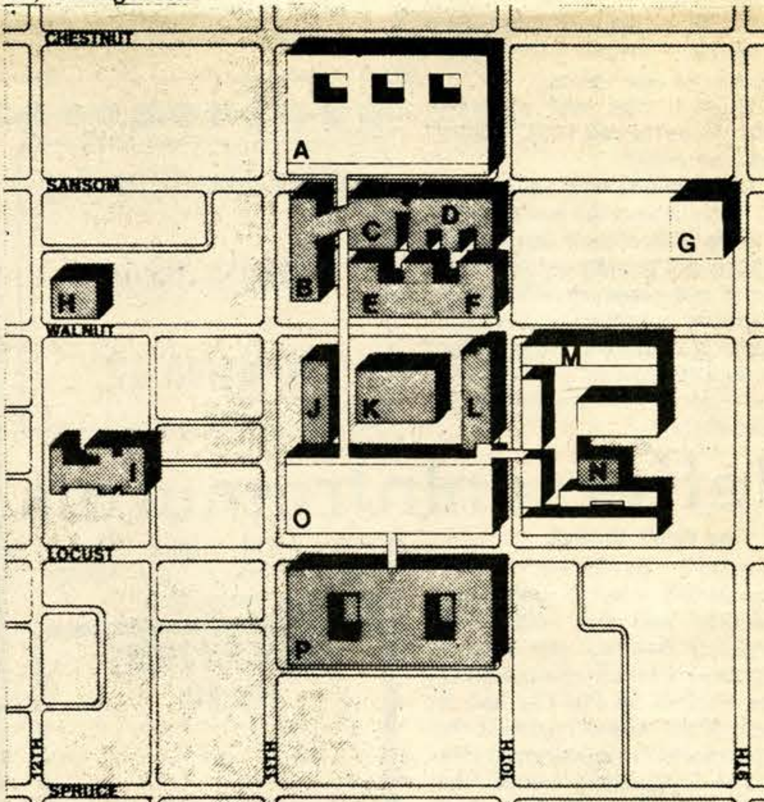
This is a model of the present 22-story Philadelphia Electric Company Edison Building at 9th and Sansom. Thomas Jefferson University has acquired the property to be remodeled into an ambulatory care facility. Later it will house the University's College of Allied Health Sciences. View is from 8th St., looking west.

Photos of architects' models. courtesy of TJU Public Relations Department. Photos of present city by Scott Kastner.

The present block bordered by 9th, 10th, Walnut, and Locust Streets.



Here is a model of the new 312-unit Thomas Jefferson University student housing complex to be located between Walnut and Locust Sts., east of 10th. It will be available in the fall of 1974. View is from 8th St., looking west.



THOMAS JEFFERSON UNIVERSITY CAMPUS PLAN

KEY

A - CLINICAL TEACHING FACILITY
B - FOERDERER
C - THOMPSON
D - MAIN
E - COLLEGE
F - CURTIS
G - EDISON
H - COMMUNITY MENTAL HEALTH
I - WHITE
J - MARTIN
K - SCOTT
L - ORLOWITZ
M - HOUSING
N - STEIN
O - ACADEMIC BUILDING
P - JEFFERSON HALL

NORTH

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The Jefferson Sesquicentennial Program

Expenditures	
Clinical Teaching Facility	$53,725,000
Student Housing	6,000,000
Edison Building	5,920,000
Curtis Clinic Renovations	1,500,000
Community Health Centers	900,000
Affiliated Hospitals	1,000,000
College of Allied Health Sciences	2,000,000
University Fellowships	3,800,000
Faculty-Fund Distinguished and Honor Professorships	8,000,000
Student-Aid Loans and Scholarships	1,500,000
	$84,045,000
Sources of Funds	
Self-Supporting, Long-Term Loans	$57,545,000
Private Funds/ Sesquicentennial Campaign	25,000,000
Miscellaneous Sources	1,500,000
	$84,045,000

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Raft Debate

which surgeons dress in New York City. These were the contestants. The devil's advocate, a pediatrician by the name of Dr. Arturo Hervada, came attired anticlimactically in normal street clothes.

The show started off with Lasker doffing his white coat to reveal a tuxedo, at which time he intermittantly drank urine and played the fiddle. Schaedler, during this opener, produced beer for all on stage while expounding on fermantation, microbes, Aureomycin, and marching back and forth with a placard advertising a choir recital – as if he were having a slow cerebral bleed that all but he were aware of. Not to be outdone, Alday in broken English spoke of his trips to N.Y.C., talent with karate, and proficiency with the opposite sez, to a big finish by lifting his submachine gun and playing "la palomes" on the grand piano. If it all seems overwhelming, dear reader – you had to be there!

Dr. Hervada had little with which to work, and it became apparent that he was the only sane person on the stage (relatively speaking), except for Packer who was oblivious to all but his can of Schmidts. Dissecting each panelist, Hervada was not without his own flare, early proclaiming that he did not trust internists, never used Aueromycin, and had not seen a surgeon since his birth (proud of being incircumcized, no less). Well! This was enough to send a barge of Arabs to a floating Bar Mitzvah! Devoid of continuity and time limits, this display lasted two whole hours. We went from musical virtuosity to discussing the merits of being alone on a raft with Marlene Dietrich; from electrolyte balance to cow manure.

When it was over we were glad. "Give the raft to anybody!" someone yelled.

Dr. Hervada won the raft in the end, allowing the motley crew of three to meet their demise. He left the hall proudly extolling the joys of being Spanish, while autographing souvenir Xeroxed copies of a Gerber formula for crushed enchiladas. I left the hall glad that I was graduating in June. Oy!

From the Jefferson Commons

Jefferson Scuba Provides Training Which Qualifies Novices For Skin & Scuba Diving.

The Commons has for the past 18 months offered a basic Scuba course which will qualify any member as card-carrying official PADI (Professional Association of Diving Instructors) members.

According to Harvey Small club-president, enlistees for this course take three weeks of basic training in skindiving followed by seven weeks of advanced individual training in Scuba diving.

Instructor Don Kenley is assisted by Jerry Miller and Bill Richards. The Philadelphia Depthchargers as the club is more publicly known is the older club in Philadelphia (in their nineteenth year).

Anyone interested in such sport should inquire on Friday night at poolside 8:00 P.M.!!! New members are welcome! The program is free to all Commons Members.

Future courses will be offered beginning: March 30th and September 14th.

Further information may be gotten through Harvey Small at OR 6-8400.

***

Jefferson Outing Club has formed. New members are welcome! Contact John Marsh– Box 484

The Thomas Jefferson University Choir will entertain for the third year at the Employee Recognition Banquet on Wednesday, February 28.

Happy Birthday, Kathy Cunius!

Jeff Hall Commons Spring Film Festival

FRIDAY, SATURDAY, SUNDAY, FEBRUARY 24th, 25th, 26th
"AIRPORT" starring Burt Lancaster, Dean Martin, Jean Seberg, Jacqueline Bisset, George Kennedy and Helen Hayes.

This powerful drama takes place at night during a seven hour period while an international airport is plagued by a crippling blizzard, a mired airplane that blocks a vital runway, and a second jetliner trying to limp back home after surviving a midair bomb blast. ALSO: Cartoon. $.50.

FRIDAY AND SATURDAY, MARCH 9th-10th
"THERE'S A GIRL IN MY SOUP" starring Goldie Hawn, Peter Sellers.

A debonair T.V. personality, Robert Danvers sets out to seduce a girl in his bachelor bedroom and suddenly finds himself falling in love. $.25.

HAPPY VALENTINE'S DAY!!!

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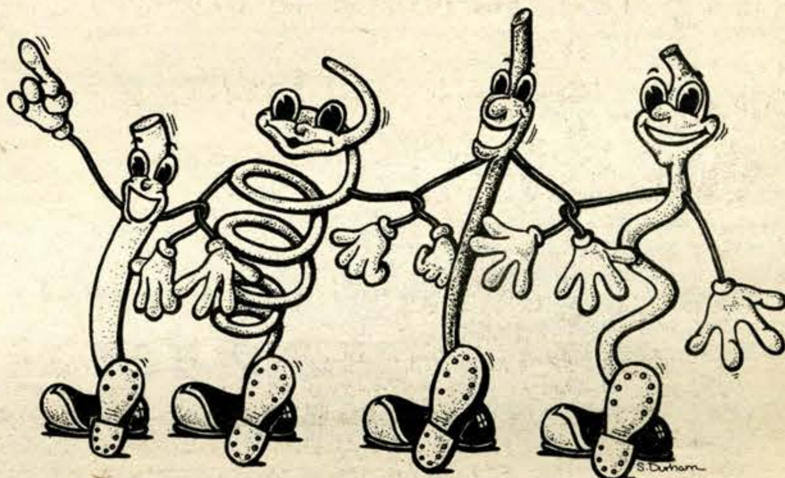

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Letter Deadline For March Issue Is March 12

Jefferson Intramurals

by Geoff Halleck

After numerous postponements due to inclement weather and the impending threat of snowfall, the 1972 intramural football championship was decided as Phi Chi had to come from behind to defeat the Sophomores (Independents) 19-4.

The Sophomores scored first on a 60 yard bomb from Tom Ellenberger to Mark Weisman, and led 7-6 at halftime. Phi Chi, led by quarterback Steve Baez, then scored 2 quick touchdowns and thereafter held their own except for a deflected pass that bounded up and cross-field into the hands of Dave Weiss. Weiss then took it 50 yard for the final score of the game.

Phi Alpha Sigma finished third in the standings, losing only to Phi Chi and the Sophomores.

FINAL FOOTBALL STANDINGS

	W	L	PCT.
Phi Chi	4	0	1.000
Sophomores	4	2	.667
Phi Alpha Sigma	1	2	.333
Alpha Kappa Kappa	1	2	.333
Independents	1	2	.333
Nu Sigma Nu	1	2	.333
Phi Delta Epsilon	0	2	.000

Intramural Handball

J. Tibone, Nu Sigma Nu defeated M. Steel, Phi Alpha Sigma to win the 1972 intramural handball championship. Alan Hoover, Phi Alpha Sigma, finished third in the double elimination tournament.

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