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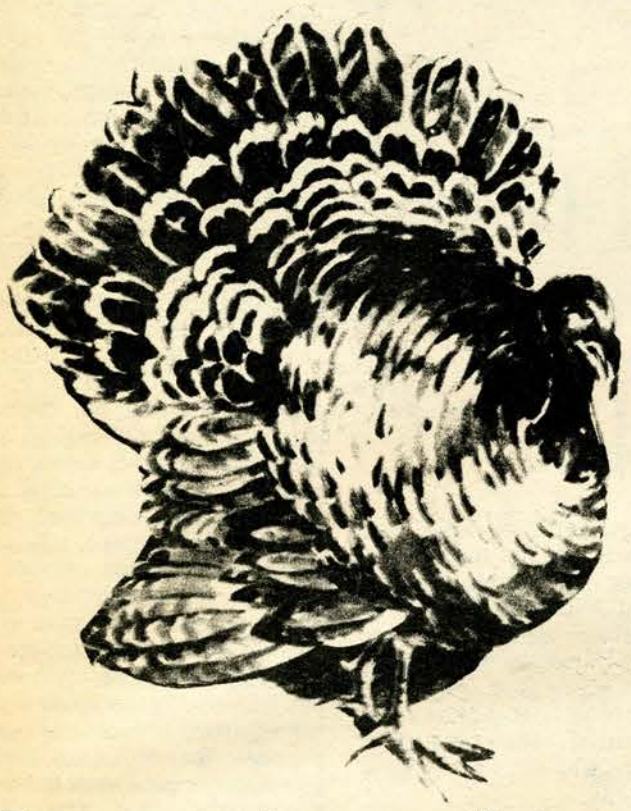

Community medicine What is it?

By Richard Bonanno

The term community medicine has cropped up often over the past few years, usually with regard to criticism for the lack of responsiveness of the contemporary health delivery system to the needs of the poor. It has come to mean a variety of things to different people and has become a focal point for both health care activists and "community people" themselves. I would like to investigate the meaning of the concept and the effects it has had and could have on the delivery of health care.

One might believe that the practice of community medicine would entail all medicine practiced outside the hospital setting–in the offices and clinics of the community. To most people, however, it is a term designating medicine for the poor and indigent–more specifically, government or privately staffed facilities in poverty areas where patients do not pay directly for services. For the people who live in these areas the issue of community control of the facilities has been a rallying point for the procurement of some power over their lives. Yet for the mainstream of American medicine, the impact of these centers–from the simple Black Panther Clinics to the multi-million dollar medical school clinics–has been relatively insignificant. For the highly specialized physicians of academe and medical center research, the medical problems are mundane, "anyone who would practice in a community clinic must be insecure about his competance as a physician." For the AMA private practicioner the thought of people not paying for services in the rugged old capitalistic fashion smacks of socialism, a curse of the highest magnitude.

These are generalities of course, but the concept of providing health care via a neighborhood health center without a fee for service structure is just an extension of charity medicine in the minds of most doctors uninvolved and uninformed about their workings. To a minority, however, the centers will hopefully be precursors to an organized system of health care delivery to which all people, rich and poor, could have access.

What exists now in Philadelphia as "community medicine" are a variety of different types of clinics which serve pover areas without direct charge to the patient. Some are what I would like to call "grass roots" clinics; these include the Gray's Ferry Clinic and the Black Panther center which provide limited services at limited hours, depending on when voluntary personnel is available.

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TJU plans to open new 500 bed clinical teaching facility

By Eugenia Miller

A new "Jefferson Hospital," rising from the area bounded by Tenth, Eleventh, Sansom and Chestnut Streets, will play a primary role in the life of TJU by 1976. Designated the Clinical Teaching Facility, the new hospital promises to be far more than a mere replacement of the old. Because the Clinical Teaching Facility represents the application of field-tested innovations, it will be able to meet the increased, changing, and sophisticated needs of the next decades.

The new 500 bed facility will occupy 950,000 total square feet of building space. Patient rooms, to be located peripherally, will have full access to fenestration and exterior lighting. The central portion of the building will be occupied by industrial type activities for support of the patient care areas. Space for at least 25 percent expansion of the CTF will be incorporated on the site or on adjacent land to be purchased at a later date. Parking facilities for more than 500 automobiles will be provided.

Plans for the CTF have been developed through consultation with E.D. Rosenfeld Associates, Incorporated, and Souder, Clark and Associates, Incorporated, and with the architectural advice of Harbeson, Hough, Livingston, and Larson Architects. A "steering committee for planning the CTF, recently appointed by the trustees under recommendation of the master planning committee of TJU, is chaired by Dr. Francis Sweeney, director of the hospital and has representation from all subdivisions of the university community. The two students nominated for committee membership are Jerry Grossman, from the Medical College and Catherine Weiczezynski, from the College of Allied Health Sciences.

Although Jefferson has not yet sought to commit any sources of funds for the building project, Jefferson plans to seet commitment from several of the following: 1) local sources; board of trustees, industry, business, alumni of the medical school, staff of the hospital and school, community; 2) Commonwealth of Pennsylvania; 3) United States Government.

The Clinical Teaching Facility incorporates solutions to a multitude of problems which currently plague hospitals in the attempt to deliver health care. No single hospital facility has yet incorporated all the innovative structures and techniques which the CTF will provide. However, both Temple and Cornell have laid plans for comprehensive structures similar to Jefferson's CTF, and certain aspects of the CTF approach have been successfully employed elsewhere.

Solutions to health care problems which the CTF will provide include: all-singie-room hospital; co-location of activities; decentralization of responsibility; intensifed use of physical facilities; strongly centralized logistical support; unit dose pharmacies; decentralized, convenient food service; structural adaptability to change.

Emergence of the all-single-room hospital is a natural sequelae to the gradual disappearance of "charity" patients a result of continually expanding government aid programs such as Medicare and Mediaid. The all-single-room hospital provides the advantage of decreased patient bed transfers and increased, more efficient utilization of beds.

Collocation of activities, decentralization of responsibility, and resource sharing provide for a series of "mini-hospitals" where equipment,

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Jeff Hall presents program on finance

By Brent Spears

As a medical student, I slowly became aware several years ago that I knew next to nothing about my future, financially speaking. Certain acquaintances, especially older persons, had spoken casually about life insurance, wills, financial management of a medical practice, and so on, but I did not understand the implications of any of these subjects, or how they might be related to form a total, balanced financial plan for a professional person.

By good fortune, I happened to meet a very affable and very competent fellow who happened to be an agent for a major life insurance company. My brain was then encumbered by the likes of pheochromocytoma and idiopathic thrombocytopenic purpura, as well as a diffuse and inarticulate dislike for big businesses (i.e., insurance companies), so I'm not certain that I responded at first to Trusts, Annuities, and Whole Life verusus Term Insurance, with much enthusiasm. However, this man was reasonable and understanding, as well as persistent. Eventually, we had a serious talk, and I bought my first life insurance policy.

My friend (for so he became) later left his company, but not before introducing me to another agent. My present counselor has been as genuinely helpful as was his predecessor: indeed, we have developed the dialogue beyond life insurance, to include the total picture of financial planning - a will, taxes, other accounting needs, trusts, and other elements as well. It has become apparent to me that regardless of a doctor's income, or interest in money, he has the choice of managing his resources foolishly or wisely. If he chooses the latter, good counsel should be sought and is available. It is never too soon to begin.

With this in mind, it occurred to me that a series of discussions on these subjects might be of interest to a number of people in the Jefferson community. Mr.

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Researcher predicts health regionalization

By Terry Burt

A recent article by physician-researcher, Charles F. Code, M.D., Ph.D, entitled **Determinants of Medical Care–A Plan for the Future**, in the September 24th issue of **The New England Journal of Medicine**, deserves some thought and comment from the Jefferson community. Dr. Code first examines the present system of health care delivery and analyses its defects; then he proceeds to mark certain trends and to carry them to their logical conclusion in a plan for future health care deliverv.

The Present Situation

People are increasingly demanding as a right, a ready access to the best medical care. Consequently, government participation in the delivery of health care is likewise growing. At the same time, a phenomenal explosion of medical knowledge has resulted in greater manpower shortages and changes in the mode of practice. Dr. Code reports a decline in solo and general practice and a trend toward specialization and group practice. He further comments, "I see no reason to fight this natural trend toward specialization.

"The solo practitioner, like the one-room schoolhouse, is disappearing from the American scene–for many of the same reasons . . . One projection indicates that those in general practice will be reduced to inconsequential proportions in the 1980's."

A Plan for the Future

In the light of present trends and demands, Dr. Code then offers

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Hierarchies in medicine

By Paul Bialas and David Jocoby

Four Jefferson students have attended the last two meetings of the Philadelphia County Medical Society's committee on community health. From these encounters several points worthy of note have become evident regarding institutionalized medicine.

The first is that all doctors are men of goodwill. Unfortunately, those who are dominated by power, a desire for a turf of their own, can easily get it in medicine for the simple reason that those with the most goodwill are too busy **practicing** medicine to regularly attend meetings, especially if these meetings accomplish next to nothing.

The second, a corollary of the first, is that committees all too often serve no purpose but talk and artful delay–a diplomatic "no" to any and all suggestions. For instance, the committee on community medicine has been in existence for two years–yet it is neither sure of its purpose, its powers, or its influence. It listens to proposals and then, with varying levels of sophistication, shoots them down–either "Not well thought-out enough," "Too costly," "Counterrevolutionary–a stopgap measure that will only

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Master Planning: Everyone's Responsibility

Ariel has, in recent issues, spoken of the Jefferson Master Planning Committee which has been meeting for almost a year in order to map out the shot-and long-range goals of the University and how to achieve them. It seems a bit strange that so little information has been forthcoming about the Committee, since its mission should be of paramount concern to everyone at Jefferson or anyone interested in the future of the institution. We acknowledge the possible need for a small manageable group when tentative plans are being made, but the preliminary report is now due to be released. It is imperative therefore, that all elements of Jefferson be immediately involved in discussion and criticism of this preliminary report. The closed club stage of planning has ended and the Committee's work must be open to scrutiny.

The Student Council has, to date, been lax in involving students in this planning. Last year's Student Council president was somehow put on the Planning Committee with little or no notice to the student body. The Council has still not named any members for this year. Ariel would strongly like to urge that Student Council immediately organize a selection process for appointments to the Planning Committee–a process similar to that for selection of Student-Faculty Committees would be appropriate. We would also hope that junior faculty would press for more decision-making influence on the Planning Committee. There are too many indications that the task of plotting a course for Jefferson's future has been neglected for many years. If planning is to be effective now, new voices must be heard.

Community Health Project

As has often been reported in Ariel, Jefferson students have taken an active part in the Gray's Ferry medical clinic on Wednesday afternoons. The Clinic has been operating rather haltingly for about a year, but the persistance has helped the Jefferson and St. Agnes Hospital workers obtain funds for community organizing and nutrition. A health center proposal has been prepared in order that funding might be obtained in Washington. Jefferson's Department of Community Health has taken an interest in the program and it may be possible to obtain elective credit in the future. We would like to encourage all students who are interested, to participate in the Wednesday afternoon clinics at Gray's Ferry. Contact Delvyn Case at 627-1832 or Paul Fernhof at MA 7-3107.

A Little Help from Our Friends

One may have noticed that our October issue of Ariel was somewhat abridged and filled with advertising. As you might have ascertained, the problem is money. We pay our bills entirely from our advertising and whether it is the present inflationary trend or whatever, we are managing at a barely subsistance level this year. We are encouraged by the many members of the University who believe that we serve a vital function, and we are now asking your assistance. If anyone would like to submit a classified ad (50¢/ line) or knows any business or company which would like to advertise, contact us at Box 27, Jefferson Hall. If you can't help in this way, why don't you write a letter to the editor and tell us what you think of us.

Department of Community Health

It was stated in the article on Community Medicine that the concept of community medicine could be applied to all medicine practiced outside of the hospital. We feel that it is an important tenet to accept with regard to medical education, because the majority of medicine is practiced outside of the hospital, while nearly all clinical training occurs within the hospital setting. It has been estimated that only 5% of people who seek medical attention are candidates for a hospital and that about 80% of practicing physicians do not work primarily in hospitals. Yet our education is provided almost entirely by hospital-based specialists and researchers working on the 5% segment of the patient population. This does not even consider the people who receive no medical care in the early stages of disease where preventive efforts would be most useful.

With the above in mind, Ariel is pleased to note that Jefferson's Department of Preventive Medicine has changed to the Department of Community Health and Preventive Medicine, under the chairmanship of Dr. Willard Krehl. In a time when much commentary on medicine emphasizes the need for the primary physicians to see patients on a personal or family basis, Jefferson has been conspicuous in its lack of educational response to this need. Now however, we would like to heartily endorse the new program in Family Medicine initiated by the department of Community Health. It is a first step in what is hopefully a serious effort to make Jefferson's education consistent with a pressing societal need. We hope that students, faculty, and administration will work to support and expand these efforts.

Letters To The Editor

Abortions

To the Editor:

There is no difference between the killing of war and abortion; both are justified by their proponents as being for the long range good of society, and yet both are an active negation of life. Abortion is currently an "in" cause for those of liberal persuasion; it is a cause which has been accepted with too little thought.

The rich indeed can buy quick safe abortions while the poor cannot, but this has no more bearing on the basic issue–the sanctity of life–than the fact that the rich can squander the earth's non-renewable resources while the poor cannot. In the latter case most would agree that the solution is to prevent the squandering of our resources by the rich, rather than to let the poor squander them too.

In the middle ages a father had the right to sell or put to death his children as he so wished. He had the "right to control his family;" happily, as man has become more enlightened the right of the child, the right of the individual, has come to have weight equal to that of the household. Gradually infanticide, slavery, and child labor have come to be condemned in Western society.

Those who argue for the right of a woman to "control her own body," i.e., to have a socially approved abortion, take what is in historical perspective a reactionary view. Indeed, all women do have the right to control their own body; each woman has the right to decide whether or not to have intercourse with or without birth control devices with the man, or, if she is not married, the men of her choice. But a woman does not have the right to control (i.e., to end) the life of her child, a life which begins at the moment of fertilization. No one, neither the state nor the parents, has the right to take a human life merely for convenience. The tolerance of such actions, no matter how benign they may seem, is in the long run a precedent irrevocably antagonistic to the existence of a humanistic social order in which one can truly make love, not war.

Our powers to change social attitudes are remarkable, as evidenced by the phenomenal acceptance which abortion is winning among the young elite of our society. Would it not be better to channel this power into changing social attitudes towards unmarried mothers and their children–a glaring instance of societal deprivation of a woman's right to control her own body and to keep its fruit? Would it not be better to end the glaring injustice of societal retribution against the unmarried woman's very **legitimate**, although not **legal**, child? Indeed, in both cases it would be.

David A. Jacoby
Class of 1973

Editor's Reply

Let me make it clear from the outset that Ariel has not come out in favor of abortion, but only for the legalization of abortion for those who desire it.

Mr. Jacoby feels that a fetus from the day of conception is as human as an adult. The arguments against this view usually revolve around the complete dependency of fetus on the mother to the point that the fetus is considered part of the mother's body. The argument of when the human life starts is really unresolvable, but in Mr. Jacoby's mind, no argument exists. To him it is illegal for a person to believe that a fetus is part of the mother's body and therefore under her control. Everyone who believes this and wishes to exercise control over their body is verging on criminality.

Mr. Jacoby justifies his view historically by implying that abortion laws came into being due to some moral enlightenment of mankind, while, in fact, they were instituted to protect the mother in a time when abortions were far more dangerous than having a baby (it is estimated now that a woman is 8 times more likely to die in pregnancy than from abortion). Returning to history, the concept of a just conceived fetus being human is comparatively recent. The Catholic Church first set down this principle as law in 1869, up to that time the issue was nebulous. St. Augustine never took a position because he said he didn't know. Thomas Aquinas thought that life really began at the time the mother first felt movement. Like Mr. Jacoby, the Church stated that the other opinions were not legitimate, and morality henceforth was an issue in abortion. People are still aruging morality, rather than human rights.

Aside from the issue of legislating morality, Mr. Jacoby feels that the real issue is the sanctity of human life. As much as we would like the attitudes of many mother's to change as he suggests, how can we demand that a woman not neglect her child. The problem exists right now, and the prevalence of the unwanted, often neglected child seems to be a more infamous commentary on the regard we have for human life, than the unwanted fetus. One need only visit the mental institutions of this city and listen to some patient histories to see how much sanctity their lives held for their parents. The choice is not a pleasant one, but it must be made now, rather than after Mr. Jacoby educates all the mothers to love their children.

And what about the mother who has been told of all the right attitudes but simply will not have the child. She is most often relegated to a quack or to her own means. Approximately 350,000 women go to hospital clinics yearly for abortion complications; 500 of them die. Provision must be made for these women immediately. It is not enough to say that we don't approve and that they should change the way they act or think. They exist, they are pregnant, and they know that they will not regard the future child's life with the sanctity that it deserves. We must cease to ignore them.

Pass-Fail

Dear Editor:

No evaluations are completely accurate; in fact they all too often measure skills other than those which they claim to measure. Medical school tests have a circular validation. Success on one correlates with success on others, and as a result both are then claimed to be valid tests of medical knowledge. In reality both primarily measure one's ability to study for and take objective tests.

However, the more parameters there are available to judge a person, the better things are. To discard grades (used to compute approximate class standing) plus written evaluation in favor of written evaluation alone is a regressive insanity.

First of all, written evaluations are even more inaccurate than grades. Although one can quickly form a distinct impression of another person, this impression need have no basis in reality. Further, when this impression is transferred onto paper and read by still a third party, that third party's evaluation of the first party is more frequently based on the style of the recommender's expository prose than on the merits of the person being recommended.

Secondly, the pass-fail system as presented by the Committee on Student Evaluations is

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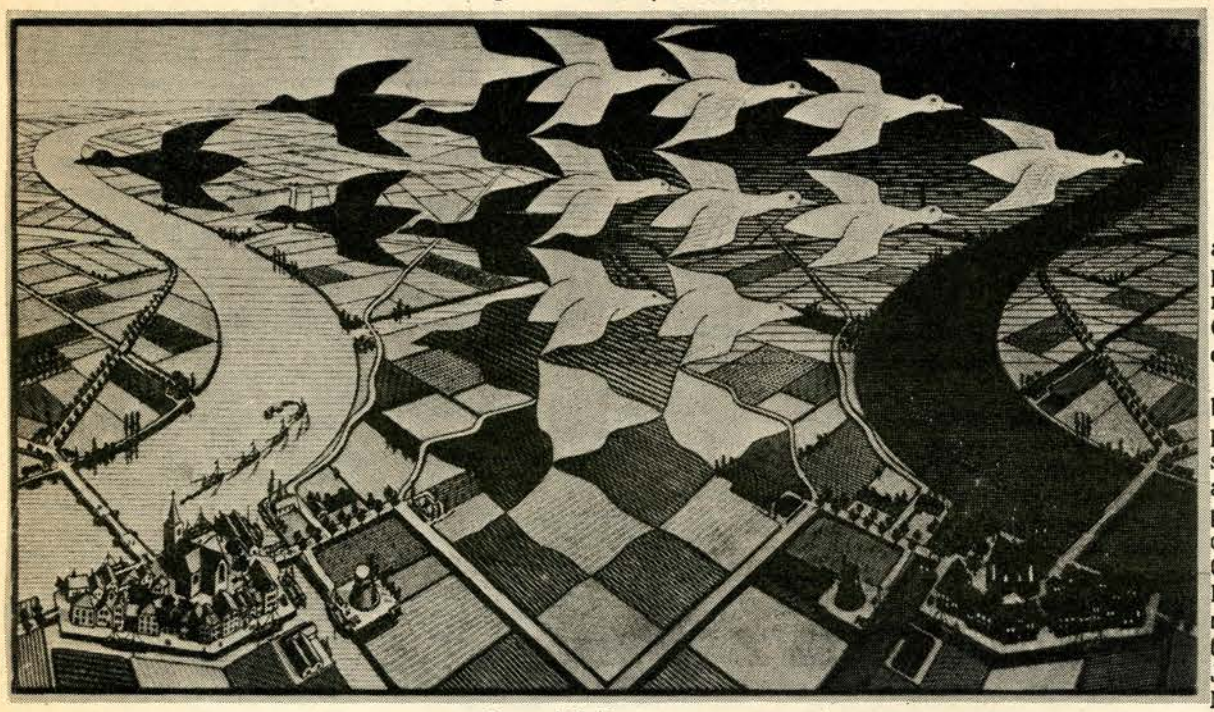
The work of Dutch artist M.C. Escher is catching, no matter how you look at it.



Day and Night
Are these fields formed by white birds against a black sky or black birds created out of white fields and sky? In 1970, nearly 40,000 readers -- mostly college students -- pondered problems like this as presented by THE GRAPHIC WORK OF M.C. ESCHER (Hawthorn Books, Inc., $9.95).

Personal Finance

(Continued from page 1)

Grebos, the Jefferson Hall Program Director, was quite enthusiastic. We have arranged for the following informal sessions to take place:

Wednesday, November 11, 12:30, Jefferson Hall, **Estate and General Financial Planning,** Mr. Jerome Verlin, LLB.

Wednesday, November 18, 12:30, Jefferson Hall, **The Role of Life Insurance,** Mr. Jeff White, MBA, CLU.

Wednesday, December 2, 12:30, Jefferson Hall, **The Physician and the Federal Income Tax,** Mr. James Turtle, CPA.

Wednesday, December 16, 12:30, Jefferson Hall, **Trusts,** Mr. Theodore Kling, Vice-President, Continental Bank.

All these men are very well qualified in their fields. Brief presentations will be followed, we hope, by stimulating and informative discussion. No sales talk, of course, although each speaker would be happy to give counsel on personal questions during the meetings or afterwards. The intent is to develop a balanced picture of personal finance, in the course of four midday sessions.

So, why not have a bite to eat, and then join us at Jefferson Hall on Wednesdays? Announcements and room numbers will be posted. See you there!

Commentary

Appalachia

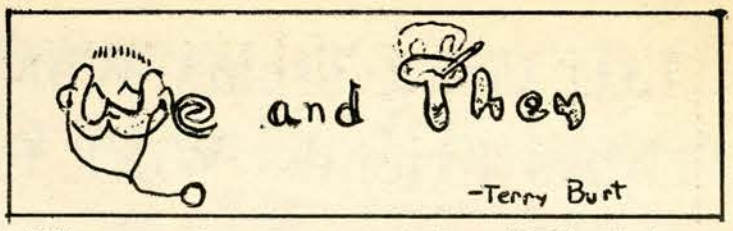
By Richard Bonanno

I would like to take this opportunity, without the encumbrances of editorship, to make some rather personal observations about the SAMA Appalachia project which Paul Bialas has described in the last two issues of Ariel.

This type of project, where medical students spend several months working with the disadvantaged, has received wide acclaim from the "liberal medical establishment," but to me the project is an anachronism. Although organizers and participants are obviously idealistic and well-meaning, the project seems to be only an extension of the colonialistic charity medicine which has been practiced on the poor for many years. In 1968 I spent a summer working with the Student Health Organization--a group of health science students which was, on occasion, labeled the medical student SDS. The participants worked on inner city health and welfare projects for 10 weeks, and it was definitely a significant learning experience for me, but little was accomplished by way of alleviating the problems of the people we worked for. Just like the private physician spending his afternoon in the city clinic, we soothed our consciences and "learned off" the misery of the poor, but we did little to improve their lot.

I presently feel that I will devote my life to improving the health of the disadvantaged, and I would hope that others would also seek to educate themselves by seeing first hand the problems that the poor face; a summer project is not the best way, however. I spent the past summer again working in the city, but this time in an already established community clinic which is actually providing medical services to people who receive little care elsewhere. I worked alongside the fulltime staff, doing whatever my competance allowed. The patients benefitted to some degree from my work and I learned a tremendous amount, yet more importantly, I knew the work would go on when I left, and the people would not be wondering why the "do-gooder" had come and gone so quickly.

I believe that SAMA should recognize the distinction I'm trying to make. They should spend their million dollars on a permanent health project with a fulltime staff which could be complemented by health science students. Elective credit could be arranged so that students could aid the staff all year around. In this way the charity medicine label, which leaves only hate when the "missionaries" leave, can be abolished for the good of all concerned.



"Who are we becoming? I asked last month. Two thought-provoking answers are offered by notable sources. Dr. Charles F. Code in the **New England Journal of Medicine** (see synopsis on page 1) reports that we will end up being specialists in group practice in regional health units, since the general practitioner is an anachronism and is disappearing from the scene. On the other hand, Dr. Willard A. Krehl, Chairman of the Department of Preventive Medicine has announced to the freshman class the initiation of a new program at Jefferson, a course in Family Medicine, since, as he points out, today's need is for more primary physicians who will provide "competent, comprehensive, and continuing care."

I, poor freshman, easily confused, am in a quandary. At present, my own inclination is toward family practice, general practice. Am I like the men who invested in a harness shop right before Henry Ford came down the road? If I must plan to invest eight years in preparation for my career, I would like some reassurance that the role will still exist in eight years. Is there a prophet in the house?

How can these two forecasts about the future be reconciled? As Dr. Krehl pointed out, even in an age of specialization there remains a need for the primary physician" who will be at the portal of entry to the system and who will also assume the responsibility for comprehensive, continuing care. But realistically, can this role still be handled by a single man? Perhaps we must readjust our thinking and transfer this responsibility to a group, which might be the initial small unit in Dr. Code's scheme. But does a group ever do anything but fragment and dissolve responsibility? I have an Ayn Randian mistrust of committees.

And would this "primary physician" necessarily be a doctor? Dr. Code speaks of the logjam at the portal of entry. What will computers be like in eight years? What will nurses be like in eight years? (I just returned from two years in the Peace Corps in rural Thailand where I worked as an unlicensed "primary physician"--public health nurse). If we cannot train enough doctors, then as Dr. Code states, we must learn to use less trained people to help with parts of the traditional doctor's role.

How will the Family Physician product of Jefferson's envisioned program function? Will he be in solo practice? What will be the essence of his role? Diagnosis? Preventive medicine? Will he still be able to function without a battery of laboratory tests and X-rays, or must he stay in an area where all this is available? How general will his practice be? Or will he be basically an internist, though holding on to the old tag of "family physician" for sentimental reasons?

And if group practice is the only answer to providing continuous, competent, comprehensive care, how soon will Dr. Code's Utopia of organized, regionalized, efficient health units, assuring health care for everyone, come into being? (And by what means will medicine suddenly get so organized?) I am pessimistic about the chances of all this coming about within a decade. Meanwhile, what happens to the people in the hamlet (and the ghettoes) who do not yet have ready access to any physician or health group? Can they wait for 1980 or 1990? Meanwhile, maybe one doctor is better than none. Meanwhile, until laboratory and X-ray facilities become readily accessible geographically and economically to all, maybe that

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Meeting Announcements

Willing to enter contests? Interested in fabulous prizes? Then for just a quarter you can attend the Don's Program Game Night on Friday Evening, November 20, from 7-9:30 P.M., in Jefferson Hall.

Ariel Meeting Monday November 21, 11, 7 P.M. Rm. 139 of Jefferson Hall, Everyone Welcome.

TJU Grad Treats War Casualties Urges Friends: Work for Peace

Editor's Note:
The following is a letter written home by a Jefferson graduate.

Dear Skip & Susan,

When the "Meanest, Ugliest, Heaviest Father-Stabber of Them All" isn't sitting on the "Group W" bench, he works for the post office as a cookie crusher. The cookies arrived in fair shape despite the unending effort of the U.S. Mail to reduce all cookies to a pile of crumbs, and we're enjoying them. All being the other three doctors who live in our Hootch, V.N. for house. I thank you for your prompt reply on the dean's full name and the unexpected, thoughtful bonus. As you can imagine, mail-call is perhaps the most important time of the day & I've been very fortunate to receive a plethora of mail and many unexpected packages.

Like more people, you're interested in my reactions and feelings on the war. It is important in listening to anyone's experiences to understand his feelings before coming and the type of experience he's having. You have some understanding of my viewpoint on the entire situation and I'll give you a little description of our activities before rendering any opinions and feelings. It's much like the classic Japanese Film, Roshomon, where one simple event is seen-and described by four different people involved, and even the uninvolved observer's story is suspect because he is found to have stolen the pearl-handled murder weapon. I don't know if one gains any further insight into the "big picture" by being here, but I'll proceed after these words of explanation.

I'm assigned to an Artillery Batallion as their batallion surgeon, a position which has been made totally obsolete by the advent of the helicopter ambulances "Dust-offs." Fortunately, there's a clearing station on the same post, and this is where I spend my time. There are three other doctors assigned here and we live in relative luxury for this close to the real bush. We live in one large room but it's really not too crowded, and we do have air-conditioning. Our work consists of the usually horendous but sometimes interesting sick-call where we see much V.D., malaria and a few more, and running the A&D (The Army equivalent of an emergency room). We function as a resuscitation facility for the casualties before shipping them on by helicopter for more definitive care. There's very little enemy contact in this area; however, the only land which is secure are the scattered fire-support bases. My Lai is a few miles from here, and this is the Northern Highlands where the V.C. & M.V.A. are still almost fully in control. It's the land of the ubiquitous mine and booby trap ranging from the toe-popper made from a M-16 round to mines made from 500 lb. bombs, which didn't detonate in our air strikes. If you want to get a good picture of what the grunts (foot soldiers) have to face & what really happened at My Lai, read "Anatomy of a Massacre" in the July "Playboy." My mood fluctuates with the level of casualties we see and fortunately it's been rather low recently. It's easier to understand my feelings by a few examples.

It's said that "nothing's too good for the man in the field, & that's exactly what he gets." You rapidly develop a tremendous sympathy for the young men in the field who generally don't know why we're here & don't want to be here. We see heat casualties frequently because they don't have enough helicopters for resupply, but the Generals ride around in spit-polished helicopters. Eighty eight percent of all infantry soldiers are draftees and the "REMF" are not "Rear Eschelon Mine Finders" as written in the Playboy article, but rather "Rear Eschelon Mother Fuckers." The lifters sit in the rear and collect unearned metals and promotions.

I was leaving our emergency room last week at about nine P.M. after spending all day treating casualties from one mass casualty situation after another and almost vomitted when seeing the headline of the propoganda sheet "Stars & Stripes."

"AGNEW SAYS WAR NEWS OPTOMISTIC"

These kids are literally blown apart and the only thing they want to know is not how bad their wounds are but, how far back toward home their wounds will take them. The only way to save lives and secure their safety is to bring them home.

How about the often heard comment about the high morale of our finest fighting men? Our suicide rate is sometimes higher than our KIA (Killed In Action). Not to mention the countless number of people who are so screwed up mentally that they aren't sane enough to consider suicide as a way out. Drug use is almost universal and the Army still says it's not a major problem. How about the lives that are ruined mentally not physically. A close friend who was a C.O. & volunteered as a medic saw so many of his fellow medics killed & rot in front of him from the intense heat that his only reaction to his commander's death was uncontrolled laughter. You don't hear this viewpoint from the Nixon-Agnew cover-up machine.

If the Vietnamese would stop playing aggressor in Cambodia; they could replace all the U.S. forces in our area, which is the most active in all of Viet Nam. Despite our long presence here in Viet Nam and the continuous efforts to win the hearts & minds of the people, after you've blown away their village and their family, little children run up to the Med Cap (Medical - Civic Action Program) visits and drop little presents in the jeeps, i.e. sachel explosives or hand grenades. Another comment on Med-Cap before leaving this subject is in order. Our Lt. wants more Med-Caps because he needs a higher "body-count" – the same term used for "enemy killed" – to give his superior. One batallion surgeon said he saw 465 people in one afternoon to please his commander, but he had never left his aid station that day & hadn't seen a Vietnamese patient in weeks. At each level, the ass-kissing factor is added to – by the time it reaches the top, I'm sure we're supposedly seeing each person in Viet Nam.

It's impossible to make a diagnosis in the field unless it's so obvious that any dude could tell what was wrong, and then after you've made a rare diagnosis, there's nothing you can do for the people. Most of the medicine you give them reaches the V.C. almost instantly & if you don't give them candy & cigarettes all the children, who were all peace signs of "hellos" on your arrival, serendade your departure with a chorus of "FUCK YOU!" I feel like a good-humor medicine man riding around the country side passing out candy pills for one and all. I will soon be transferred to the clearing station eliminating any need for Med-Caps. We see V.N. patients here gladly & have minimal lab or X-ray facilities to do some good & a small ward of their own in our hospital.

The most frustrating part is that the American Public has swallowed Nixon's "Just & Honorable Peace" and taken their usual apathetic attitude that allows them to absolve itself of personal guilt; or they've taken the "I'm only one person & can't change things" attitude: or "he's the only one who knows all the information and must be making the right decisions" – that's exactly what the administration wants an ignorant, unquestioning, unthinking public – or t2222"the Vietnamization is working & we'll soon be out of the whole mess" – what about the thousands more to die before we leave? – What about the whole English grammar, which I've totally destroyed with that last thing that was supposed to be a sentence?

Well, Sue & Skip, I've gone on much too long, but perhaps you could pass my letter or comments around & start a few more people not only thinking about but doing something for PEACE.

If you know anything about

(Continued P. 7)

Pathology *Debate Continues*

By Paul Bialas and David Jacoby

A few weeks ago, the sophomore class held its first official meeting for the new school year. The turnout was disappointing to say the least. Twenty students were present, and this included three juniors who sat in on the action.

Though a few select topics of discussion were tossed about, most disturbing was the proverbial issue of Dr. Aponte's pathology course. Once again, an undercurrent of dissent is present among the sophomores, but one would have to greatly stretch his imagination to believe that this feeling is shared by a majority of the class.

It was quite evident that nearly all of those present were grinding their personal academic axe with the course in pathology. In addition, three students of the curriculum committee were present and pushing to keep Dr. Aponte's efforts confined to the proper guidelines (whatever they may be) as set forth by that committee.

When one considers that all this was topped off by an emotional junior who apparently was still trying to settle a score from last year, and considered himself to be quite a valid resource, it is easy to see how an atmsophere of "crucify pathology" was generated.

At any rate, we do not believe that the attitudes of this handful of students reflects the overall feeling of the sophomore class.

Specifically, the discussion concerned the unfairness of too many pathology pictures, of being tested on upcoming winter quarter handouts, indeed, of having any "extra" material to learn at all! Voices were raised to attempt a curriculum committee move to coerce Dr. Aponte into trimming his obese course to a leaner, core-like size.

Student members of the curriculum committee, along with most of the class officers, appeared to wholeheartedly support these ideas. The moment any voice was raised in support of the path course as it now exists, that voice was sneered or shouted down by the more all-knowing of the group or by that one poor junior who had such trouble keeping his emotions under control.

It should be noted that some very good points were raised on behalf of changing the pathology course. One of these includes the debate over the validity of a term paper that is customarily due in the spring and mandatory for a passing grade in the course.

These points cannot be denied; however, they should not be lumped all together and taken as the opinion of the majority, to be hastily acted upon by class officers or student curriculum committee representatives.

It would be a sad thing, indeed, if Dr. Aponte were to drop a bomb on the class in some manner, as a result of any hasty action or misconceptions on the part of our student representatives.

Certainly, the sophomores would scream dissatisfaction and say that they knew nothing of the situation. Of course not! They are tooth apathetic to care unless someone suddenly steals the candy from their mouth and stuffs a rotten apple in its place.

It is pointed out that many students appreciate an enjoy the extensive efforts of Dr. Aponte to provide as complete a course in pathology as is possible. If these students wish to protect their interests, they can only do so by attending class meetings and making their opinions known. Class officers cannot be blamed for acting on the vote of a few, if those few are all that care enough to get involved.

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Debate

(Continued from P. 4)

Finally, we wish to extend a vote of confidence to Dr. Aponte and his excellent teaching efforts. While we do not necessarily agree 100% with his manner of teaching, we feel that it is certainly the best that we have received to date, and we would like to point out that minor dissatisfactions do not necessitate drastic change.

Furthermore, we cannot endorse those students whose efforts at changing curriculum stem from their desire to get by with a bare academic minimum. It would be truly unfortunate if such immaturity is permitted to determine the destiny of any academic pursuit.

The Booknook

By Terry Burt

How many medical students are aware that the Mercantile branch of the Free Public Library is only a block from Jefferson--on Chestnut Street between 10th and 11th? And how many know that anyone who lives, works, or attends school in Philadelphia can get a free library card? Finally, how many care? If not, then, let your wives and siblings, parents, uncles, aunts, and cousins read The Booknik. This section is rated (P) for People.

The Booknik is not a book reviewer. He is not even a reincarnated English major, but only an amateur reader without expertise, who simply likes to share books he has enjoyed. He isn't even up on best sellers, which cost money, much less classics, which usually are uninteresting re-bound volumes on the library itself. His system of selecting books is a non-system which sometimes amounts to nothing more than judging a book by its cover. He goes on author jags, or nationality jags, or period jags, or type jags.

The Booknook is open to anyone who wants to talk about a book. Even textbooks will be tolerated.

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The Glass Bead Game – By Herman Hesse
(translated by Richard and Clara Winston. Holt, Rinehart and Winston, Inc. (1969)

I was tricked into reading this book by a change in title and an interesting book jacket design. I had heard of **Magister Ludi** before, but I never felt inclined to read about a teacher named Ludi, so I bypassed this Hesse book even though I had been impressed with **Siddhartha, Demian,** and **Steppenwolf.** I figured that **Magister Ludi** must have an early book of Hesse's before he learned how to pick a title. But the mistake was mine. "Magister Ludi" turns out to be Joseph Knecht, master of the Glass Bead Game, and the book turns out to be another of Hesse's fascinating explorations of human nature and institutions.

The setting is in the remote future to gain perspective on the present and past. The Glass Bead Game device seems to be a symbol of the perennial striving of human genius to attain a synthesis of all knowledge.

Joseph Knecht is educated from early youth in a scholar's paradise, the Province of Castalia. In this world-to-come, promising scholars are spared the trials and distractions of coping with supporting themselves, and are subsidized by the rest of the population. They live a rarified existence in Castalia while the rest of the world goes its own way. Joseph Knecht rises effortlessly through the ranks to become Magister. He is the perfect Castalian. But eventually one day he decides to renounce his position and leaves Castalia. Why? That is the question Hesse explores in this long novel.

The question involves analysis of what constitutes the ideal human life. There is the general contrast between the practical world and the intellectual Castalian life. But also many life styles are demonstrated and examined in the various characters. Elder Brother's life decision is to go his own solitary perfect way and let the rest of the world take care of itself. Fritz Tegularius is an erractic, emotionally unstable genius, whose disruptive behavior is only tolerated by the group because of his intellectual contributions. Then there is the majority the "good" group members, well socialized, who follow the rules without scruple or doubt and never rock the boat. There is Plinio Designori who tries unsuccessfully to stand between the two worlds and lives in an unhappy private limbo as a result. And above all, there is Joseph Knecht who lives aware, never ceasing to re-examine his **raison d'etre** and retaining to the end the courage to act on his own convictions.

We also live a rather rarified intellectualized existence here at Jefferson. Hesse makes us wonder with Joseph if we are losing contact and even ability to communicate with the other world. The question of social responsibility is central.

(Continued on P. 8)

Movie Reviews

Trufaut's Children

By Robert Breckenridge, Jr.

Francois Truffaut's eighth feature film, **Mississippi Mermaid,** has just left Philadelphia after an unsuccessful week at the box office, which is the typical fate of almost any good movie that makes it to Philadelphia. His ninth feature, **The Wild Child,** opened up this year's New York Film Festival and should open in Philly within the next few months.

To appreciate **The Wild Child** fully one must be aware of Truffaut's background. He was born in Paris in 1932 and experienced a childhood plagued with parental neglect and incarceration in reformatory school. He started working at the age of 15 at various jobs, never holding one for very long since he spent most of his time in the cinema. Finally, after a dishonorable discharge from the French military, he was taken under the wing of Andre Bazin and joined the staff of **Les Cahiers du Cinema,** the now-famous international film journal.

Truffaut, along with two other critics from Cahiers, Jean-Luc Godard and Claude Chabrol, began to formulate a new theory of film criticism known as the **politique des auteurs.** They would constantly view the films of Hitchcock, Ford, Hawks, and other Hollywood directors, as well as the early French directors Jean Renoir and Jean Vigo several times. The films of the latter two had a profound influence on Truffaut, especially Vigo's **Zero for Conduct** which served as the basis for Lindsay Anderson's **If** and Francois Truffaut's first feature film, **The Four Hundred Blows.**

This film marked the beginning of 'the new wave' of French film directors when it opened the 1959 Cannes Film Festival and won the grand prize for direction. It is largely an auto-biographical film of the childhoods of both Truffaut and Jean-Pierre Leaud, the star of the film, who has since become the principal actor used by the new wave film directors. Leaud is constantly in and out of trouble. He plays hookey from school for days and days so that he can go to the movies. When he finally returns to class, he tells the teacher his mother died only to have her show up later. Finally, after a number of such incidents, his parents commit him to a reformatory. He is locked up in reform school for a few weeks and eventually manages to escape. The last sequence is a long tracking shot of Leaud running along the beach towards the water. He finally glances towards the freedom of the sea as the camera freezes on his haunting and immobile face.

Truffaut's latest film, **The Wild Child,** shares and is a continuation of the themes in **The Four Hundred Blows.** He based this movie on the true story of an eleven year old boy found in the woods of France in 1789. Apparently, the boy had been abandoned by his parents when he was three years old and had lived in the woods for eight or nine years without any clothing, shelter or human communication. The film opens with the capture of the boy by a group of hunters and dogs. After a short stay in a deaf and dumb institution, they find that the boy is able to hear and he is taken to Paris and placed under the care of Dr. Itard, played by Francois Truffaut. Itard begins the slow difficult process of teaching Victor (the name given to the boy) to communicate and consequently adopt the manners and traditions of eighteenth century Paris. Using pre-Skinner methods of operant conditioning, Itard rewards the correct performances of the boy with a glass of cool water which he drinks by the window because the cool water, fresh air and countryside remind him of his lost freedom. Dr. Itard purposely exposes the boy to excessive cold so he will learn to wear clothes because "what he loses in strength he gains in sensitivity." By the end of the film Itard admits that he is sorry the men had ever taken him from his happy life because of their sterile curiosity.

In these films Truffaut portrays beautifully the manner in which society's use of authority stifles the blossoming individuality and freedom of children. They are celebrations of children's health, independence, and freedom striving to overcome the slavery of adult's compulsion for formula and protocol. Truffaut is the true inheritor of the art of Jean Renoir (son of the painter, Auguste Renoir) in his ability to celebrate the life and spirit of the character who forms the drama. The stunning black and white photography of Nestor Almendros is reminiscent of Renoir's best works of the 30's such as **Boudu Saved from Drowning** which shares much in common in both theme and spirit with **The Wild Child.** Make sure you see the film the first week it comes to Philadelphia. There may never be a second.

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Bandbox (Germantown):

After **Fellini Satyricon** leaves, there will be a number of films starring Humphrey Bogart, James Cagney, and Errol Flynn. **The Big Sleep** (Wed., Nov. 18) is the best.

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Eric II:

The Passion (of Anna) - Ingmar Bergman's newest film to date. The best film in Philadelphia this month.

***

Midtown:

Catch-22 - A good attempt by Mike Nichols **(The Graduate, Who's Afraid of Virginia Woofl?).** Alan Arkin and Orson Welles save the film.

***

Arcadia:

Joe - A cheap, exploitative, immoral movie. Judith Crist calls it a triumph.

***

Trans Lux:

Little Fauss and Big Halsey - Robert Redford, motorcycles, and naked broads. Put 'em together and what have you got?

Letters

(Continued from page 2)

misleading, for it gives students a false sense of security. When the time comes to write evaluations the grades on file in the department office need not be mentioned–but if the grades are at all exceptional the candidate's approximate class standing in that department most likely will be reported. If the student is in danger of failing, the "confidential" department grade records will be consulted. Presumably, if the student has done well in courses prior to this academic crisis he will pass; if he has not done well he will fail. The differences between this and the present system are illusory–and very misleading to those who may sometime during their next four years at Jefferson find themselves unexpectedly in danger of failing.

Thirdly, the replacement of a continum of grades by the binary choice of pass or fail is completely wrong, for pass or fail draws an absolute borderline at a point where there should be none. A desirable modification of the current system would be to have the scores reported and recorded accompanied by the standard error of the test–a numerical reminder of the fact that the difference between any two scores, say an 83 and 89 or a 65 and a 71, is not significant. But, to pretend that the difference between a 95 and a 75 is meaningless, while the borderline between 69 and 70 is not meaningless, is not a desirable modification.

Currently, for all intents and purposes, Jefferson is on a graded pass system. It should be kept this way and improved. As outlined in the Committee on Student Evaluation's report, students should be informed of their written evaluations at the end of each year, or **before** if the evaluation is likely to be unfavorable.

Merely changing the evaluation system will not significantly affect the pathological competition that so infests the medical profession. A mature realization that the enemy which we fight is disease and the conditions which spawn it, not our fellow professionals, can.

David Jacoby

Editor's Reply

The last statement in Mr. Jacoby's letter addressed to October's pass-fail editorial is best answered first. He states, "A mature realization that the enemy which we fight is disease and the conditions which spawn it, not our fellow professionals, can affect the pathological competition that so infects the medical profession." This is, in fact, the primary reason for instituting a pass-fail system of evaluation, rather than a defense of the present system. The "mature realization of disease and the conditions which spawn it" is the very basis for abolishing strict grades. It is our contention that the psychological principle of removing the stimulus of competitive grades that brings about the "disease" of intense competition, should be utilized. This stimulus can readily be removed; it does not have to be present. And the need for removing the stimulus is greater than the need for maintaining the more precise method of evaluation that numerical grades establish over written evaluations. The best evidence of the need for removal is student opinion.

Considering the first objection in the letter, it may be true that abolishing a permanent record of numerical grades will cause less precise evaluation. But why is such a precise evaluation of the medical student's performance necessary? Only about one half of all available internships are filled each year, so there should be no nagging fear of not being placed in an internship. The few students competing for highly regarded internships, who just happen to be unfairly judged by written evaluations, do not balance the grief that the recording of numerical grades seems to bring to many students.

The second point, perhaps not yet dealt with on paper, is remedied here. A student need not be in the dark about by how much he is passing. Examinations should be returned to student so that each student can correct his mistakes. However, the only indication of performance given out with the examination by each department could be the passing numerical grade. Thus, the student would know by how much he passed, and would not be caught unexpectedly in the hole should he fail a future course.

As for the third argument, a correction of reasoning is needed. No one thinks that the difference between a 75 and a 95 is meaningless, just that it is not particularly necessary to record officially. With regards to the absolute borderline where pass becomes fail, we disagree. There actually should be a point at which doctors fail to qualify to practice medicine. Any number of methods could be used to determine this pass level, probably the least desirable of which would be a rigid numerical grade. As it stands now in a number of courses for freshmen, great leeway is given students who flunk courses, because they are permitted to make them up during the summer.

One last idea is important to bring out. Pass-fail evaluation should not negatively and coldly be balanced against the merits of numerical grading as many of its opponents do. The potential for helping students to dig into their studies responsibly with feeling forced to do so should be kept in mind. This potential is what can make all the difference for the rest of a physician's life. And many can attest witness to the fact that doctors need something to inject joy into the drudgery of keeping up their education.

We and They

continued from p. 3

one doctor will have to make diagnosis at times without all of the 1970 helps. Maybe he will be criticized for practicing a primitive type of medicine. Dr. Tom Dooley was criticized for the type of medicine he was practicing in Laos. They said it wasn't modern! Is it preferable always to provide the best, even if only to a few, than to spread the icing a little thin while trying to give something to the multitude?

The multitude is still there. What is our answer?

Teaching Facility

(Continued from page 5)

patients, and staff are organized on a systems basis. The physician need not travel continually from site for diagnosis to sites for therapy, to the patient's bedside. Similarly, the patient need not be transported from one area of the hospital to another for tests and procedures which could be performed just as easily at the bedside. Although policy-making administration would be centralized, work and responsibility within that policy would be decentralized. Resource sharing by departments rather than specific allocation of similar facilities to each department and to each of its subdivisions eliminates wastage of material, personnel, and funds without sacrifice of adequate, competent service.

With strongly centralized logistical support, the provision of linen, food, drugs, and supplies will be from a central industrial plant with an automated mechanism of distribution.

Unit dose pharmacies where pharmacists monitor prescription and administration of medication have been shown to significantly reduce medication errors. Modern techniques for preparation and distribution of foods, techniques now used in commercial restaurants, will allow for wider menu selection, more flexible feeding schedules, and a decrease in dietary staff, work day, and costs.

Whereas techniques of therapy and diagnosis are subject to rapid change, patient quarters are not. The CTF will be designed to allow for continued growth and expansion of the former.

Innovative structures and techniques will not be limited to acute patient care within the hospital. The CTF will establish new patterns for ambulatory patient care. Main patient and emergency entrances will be located close to one another. Trained personnel will screen incoming patients, separating non-emergency patients, and will help the latter to set up appointments in hospital clinics or with private physicians whose offices will be located within the hospital structure.

Conference, class, and consultation rooms will be distributed throughout areas of patient care, diagnosis, and therapy. Clinical research facilities, as well as clinical facility offices, will be located between hospital and medical school or dispersed within the hospital complex as space allows.

The CTF is designed to meet teaching needs, but will not eliminate THU's dependence on affiliated hospitals as teaching sites. This continued dependence is partially related to continued expansion in size of entering medical classes.

Despite the changes introduced by the CTF, its goals remain the same as those of TJU as a whole and those of the hospital it replaces: 1) education of medical, nursing, paramedical, and other allied health personnel; 2) continuing education of practicing health care professionals; 3) maintenance of environment for research; 4) and, as an inseparable part of 1, 2, and 3, community education and care service that improves both personal and community health and well-being.

Hierarchies

(Continued from page 1)

delay the coming of socialized medicine in the next five years," or "Not enough." The one common denominator in them all is talk–and "No!" The one concrete proposal submitted to the county society for approval during the past two years–the allocation of 5% of the society's annual income for approved Philadelphia community health projects–was flatly refused with the argument that the budget would not permit such expenditures.

The meeting of October 26 involved presentation of a program, funded by $200,000 per year of federal money, probably to be renewed for the next five years, merely to set up the concept, but not the details of a pre-paid practice for the Hahenmann area with development of an ambulatory health service center at Hahnemann itself. The bill for this preliminary planning is $1,000,000, yet the city can't even supply enough money for an adequate lead-poisoning control program in North Philadelphia. Why? Simple because planning and the setting up of models threaten no one and step on no one's toes.

Currently, there exists in Congress the Yarborough-Rooney bill to provide money to train family practitioners and allied health personnel. It is for $500,000,000. Everyone, even the AMA is for it, with the exception of President Nixon and the Association of American Medical Colleges. Why? The AAMC is against it mainly because they want no strings attached in order to divert the money for their own, nearly bankrupt, specialty programs for which the populace as a whole has not need. The bill passed in the Senate 64:1. It is likely to be vetoed by President Nixon.

Professional jealousies are real. Institutional jealousies are viscious. But yet they are allowed to persist because those interested in treating people are too busy doing just that–70 hours a week–while those with a desire for prestige alone are free to spend their time, and our money, establishing their self-fulfilling, ego-building, "turfs."

How may this be stopped? As a first step by getting involved and staying involved, by resisting hints from the "powers that be" that as a doctor you (but not they) should be busy with patients all the time. The one all too valid assumption under which they work is that reformers will quickly lose interest with the interminable talkfests and drop out, leaving them to go their merry self-fulfilling way. Do not give them this satisfaction. Persist, and by your own action, shame them into action.

JJU Grad

(Continued from P. 4)

the senior student I used to date, include it in your next letter. I haven't heard anything from her for many months, but still think about her often.

In closing let me say this, "Yes, Virginia" there is a war going on & it stinks!" Do what you can to work for PEACE, NOW!" I saw a beautiful brace of doves in a bamboo thicket recently even after the visit of SUPER-HAWK" s"Spiro Agnew." There aren't many doves left in Washington, but perhaps it was a good omen for the Fall elections.

Hope you can read my scrawl. Take care & work for peace.

PEACE & LOVE,
Bill

A Reflection: Isolated Man Seeks Meaningful Encounter

By Joseph S. Agnello, Jr.

Something within mankind cries out. What is it that he seeks? A warm touch, a glance, a word of comfort, a sign of interest and concern: or simply, a bit of humanity? Perhaps all he wants is some evidence of a "we" in this world of "i's."

People are trapped by a false concept of ego. Why must the word "I" preclude the existence of a "we?" Why must self-sufficiency and independence lead to a removal of all meaningful ties with the external world? The "I" can provide much support, but by no means can it hope to complete this task. Men are a community of interdependent, each one requiring a different degree of interaction with their fellows. No man, however, can function free of this contact. Without it, he becomes an island in a sea of non-existence. Experience flows around him like so many waves breaking upon a barren shore.

The etiology of man's apparent isolationism is his refusal or inability to understand himself and the people about him. This understanding can only come from one's experience of another and an attempt to experience that individual's experience of oneself. And so on, in an ever-increasing reciprocal spiral. Then, and only then, can man approach the concept of "we."

The "I" that is man huddles within the womb that is his body. It is warm and, yes, safer, to remain witnin the recesses of one's mind. To venture out or, worse still, to allow another in would be a risk. It is an invitation for perplexity, suffering, and humiliation. And yet, to forego such an opportunity is a refusal to grow, to learn, to experience. There is certainly the possibility that the problems and frustrations of one "I" may become those of another. Rejection may also occur. But there is always the possibility that a meaningful exchange and synthesis will result -- understanding, respect, admiration, love or all shades in between.

Man must learn to shed his feelings of insecurity and fear of the "we." His desire to remain sequestered and invulnerable must be suppressed. To reach out is a risk, but not to do so is to miss his fellow beings. Once the barriers of the mind have been broken, all that is left is to experience others. And then, if the "I's" meet, the joy of beginning. And if they don't, the hurt. But, after all, what else is life about?

Researcher

(Continued from page 1)

a plan for more efficient delivery of health services. He remarks that modern transportation and communication have altered the geographical requirements of medical care delivery systems. "In the past, some people living in rural areas felt insecure if a doctor was not available within 10 miles. Today, these people can be better served by an adequate health-care unit within a radius of 100 miles or more . . . Today, having a doctor in every hamlet is wasteful." He concludes, therefore, that in planning an improved system "the basic principle is integration; the basic ingredients are regionalization, health care units of integrated practice in the region and a health care center integrated in practice, education, and research with the units of the region."

Finally, Dr. Code points out that the logjam in the delivery of health care today lies at the portal of entry-the doctor's office. As a remedy for this situation, he recommends further delegation of some aspects of the physician's traditional role to auxiliary personnel. He states: that "Doctors need much help, and yet it is so hard to give it to them, for their security seems threatened when

others perform their traditional tasks and the public loses the assurance of their presence. But unless doctors assign some of these tasks, they will not have time to acquire new skills or to deliver enough care to enough people to satisfy the health needs of the nation."

In spite of these problems, however, Dr. Code remains optimistic that a good system of health care will be developed in America within the next decade.

Community Medicine

(Continued from page 1)

I consider these to be not primary care centers, but only bases of organization upon which people can begin to build more comprehensive facilities and gain sophistication in how much and what kind of health services they need. In fact, two of the comprehensive neighborhood health centers now in operation in Philadelphia began as grass roots operations, and after several years of struggling have obtained the necessary funds to significantly broaden services. Most of the larger neighborhood health centers in Philadelphia grew from Titles XVIII and XIX of Social Security Amendments passed in the 1965 and 1966 Comprehensive Area Wide Health Planning Act. Each of the 5 medical schools operates a Children & Youth Center, the goal of which is to provide comprehensive care to those under 18 who live in a specific catchment area. The 2 largest centers in the city which are attempting to provide the full range of family services for all ages are run by Temple University and funded by O.E.O. There are several other centers which are in the planning stages. All of them were funded as pilot programs and although final results of successes and failures have not been submitted, many things have been learned. I will not attempt to discuss all the problems and issues related to the centers, but I would like to make some observations.

When the clinic administrators speak of comprehensive care they are referring to maintenance of the total physical and mental well-being of the individual within the context of his family and community environment. The traditional private office, emergency room, and hospital clinic modes of delivery cannot begin to cope with health problems on this scale, nor can the physician alone be expected to take the responsibility for this full spectrum of health. What is needed from the neighborhood health center is a deep community involvement in order to identify problems and educate on the most effective ways of dealing with them. The center must provide medical and social service specialists who can eliminate the specific pathology which requires their expertise, and encourage the preventive medicine and self-help programs. All the centers in the city attempt, with varrying success, to meet these necessities with two basic mechanisms. Community participation is developed by organizing community boards (or better yet, working with already existing indigenous community groups) with decision making power, while hiring and training as much of the personnel as possible from the immediate area. Secondly, they attempt to provide services on the basis of a family team of medical and social service components, in order that particular problems will be referred to the appropriate team member. In addition, referral to other sources of assistance is facilitated by the combined knowledge of the team members.

A major stumbling block to the implementation of the above approach is finding specialized personnel to fit the new roles of the clinic. Doctors and nurses are presently trained to fit comparatively well-defined positions, consequently major conflict and inefficiency may develop because a doctor refuses to trust a nurse's history or a nurse bridles at having a community trained aide draw blood. These role conflicts exist at all centers to a varying degree.

Though the difficulties described in this brief summary are not insignificant there is reason for optimism if one observes centers which have been in operation for 2 or 3 years compared to those just starting. Many of the problems seem to have been solved successfully. For the future, economics and community participation looms as major unresolved dilemmas. For instance, the cost per patient at some of the larger centers is as much as $50/ patient visit. Efficiency in provision of services should cut this in half but it will take time and no one knows for sure about future vagaries of government funding. It is also worth noting that at the larger more sophisticated centers appointment keeping rate may be in the 40-50% range while at a center which is rather crude medically but has a large degree of community support, the rate is above 70%. There are other ticklish issues which could be raised, but hopefully as more centers develop and report, a more clearcut view of problems and solutions will be forthcoming.

One may ask what the "big deal" is, why are these centers needed? Do they only serve as an extravagant expenditures used to pacify the anger of the poor? Most of the people committed to the neighborhood health center concept see it as far more than charity medicine; to them it will help to abolish the ghetto, not simply serve it. As mentioned previously the centers are envisioned as basis for a universally better health care delivery system–a socialized system if you wish–but more to the point, a system where health care is a right of all people, not something bought and sold on the open market.

Without going into all the pros and cons about the present modes of delivery, a few points are key to understanding why the neighborhood centers are advocated as a basis for revamping the existing system. Theoretically, the most important branch of medicine is preventive medicine, consequently the primary goal of any system would be to promote and preserve health rather than curing illness. Preventive medicine depends on good health education and early diagnosis. Health education has not been a high priority item for a medical establishment which has been enamored with medical technology in specialized areas rather than with the mundane chores of day to day prevention. Early diagnosis has clearly been stifled by the fee-for-service system, the aloof reputation of the medical profession, and the crudeness of many hospital outpatient services. If one does not seek help until it is an emergency because of either an inability to pay or fear of medical institutions, prevention of chronic disease or death becomes an impossible goal to implement. The system may work for the upper-middle class who have good health insurance coverage, but below that getting sick can be a financial disaster. The system for the poor has been "propped up" by Medicaid, but the middle and lower-middle class have no place to turn if they have no health insurance and will probably be unable to afford frequent visits to the doctor to cut down on possibilities of serious illness. It has become increasingly difficult to get any medical services in the inner city because there are so few physicians. The doctors who do remain are overburdened and often barely have time to take a brief history much less provide comprehensive care. The story can go on, but it has been told many times before. Many expect the financial burdens to reach nearly all people soon, particularly with hospital costs skyrocketing as they are, and this is why it is felt to be essential to keep people from needing hospital care if at all possible. Although the above analysis is admittedly superficial, I believe it conveys the belief of many people that initiation of some form of comprehensive health delivery is necessary to halt the so-called health care crisis. Nearly every other western country has some form of centralized delivery system.

The problem in implementation is primarily the medical establishments reluctance to have any government intervention which will infringe upon the entrepreneurial system. They have been fighting the battle since the 1930's and the piecemeal changes they have allowed to occur only exacerbate the dilemma. Government intervention is equated with socialism and no where is socialism a dirtier word than in AMA chambers. I will never forget the discussion several students were having with a Jefferson department head and mention of socialized medicine was made. He immediately began lecturing us on how dull and dreary it was in the Soviet Union. Having not been inculcated with the values of the Joseph McCarthy era, it is difficult for me to comprehend the paranoia about socialism which shrouds the American mind. What I fail to see is how planning and implementation of a medical care system which covers all Americans has anything to do with Moscow. We deem education a right so we have public education. If health care is a right what is the danger of public medicine if it serves the needs of the people better than the existing system?

Obviously we will someday have a comprehensive care system (I would personally advocate a decentralized system with community control of neighborhood health centers). National Health Insurance is only about 5-10 years in the future, but the delivery system emphasizing the principles of community medicine must be initiated if health care is going to be distributed in an efficient and human manner.

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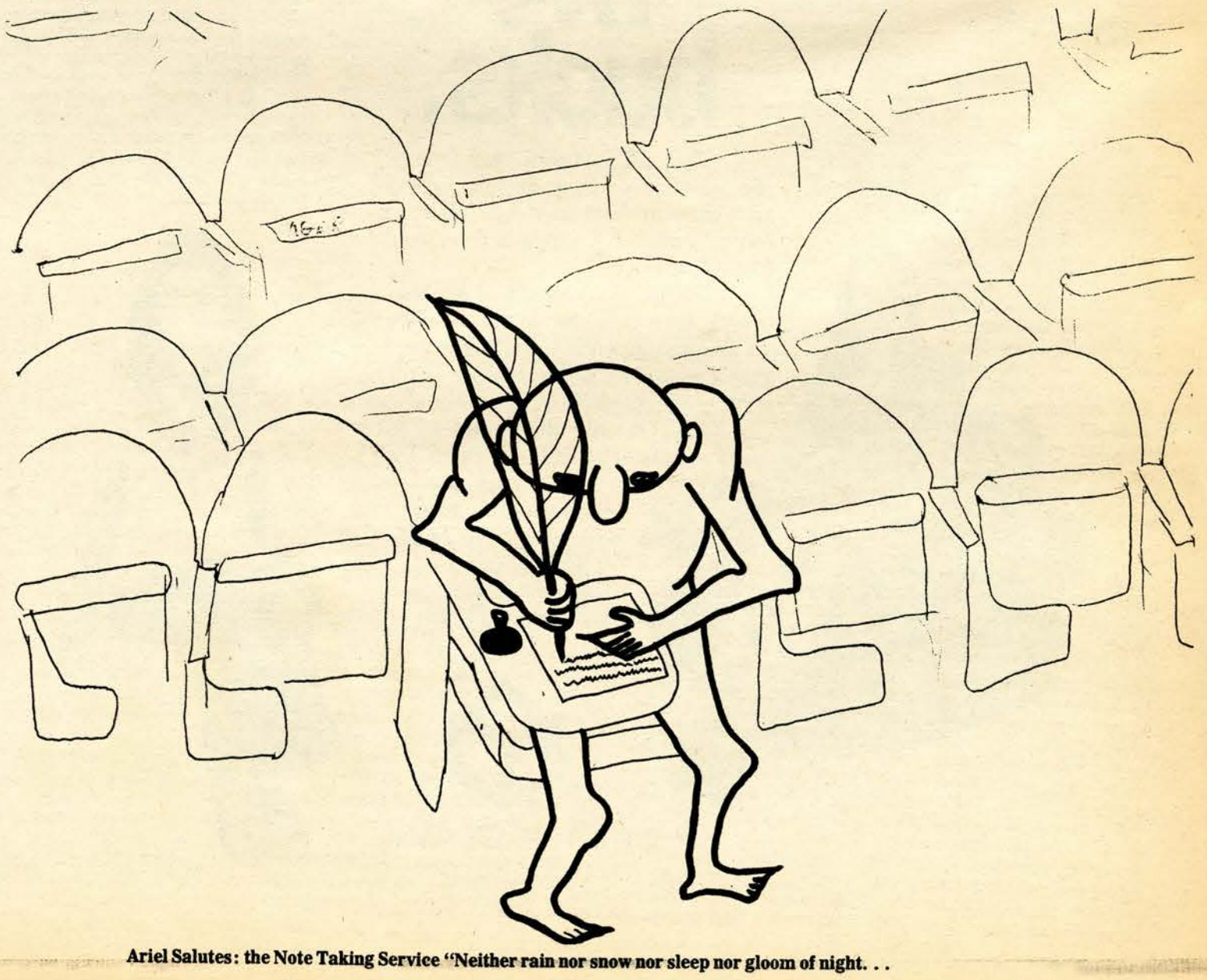
(Continued from P. 5)

("**Knecht**" in German means "servant.") What does the individual owe the group? What does he owe himself? How far can he go in self-donation before sacrificing his own integrity and ability to contribute anything? What constitutes human freedom? human perfection? Surely relevant questions for doctors and doctors-to-be.



Ariel Salutes: the Note Taking Service "Neither rain nor snow nor sleep nor gloom of night. . .