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THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE

ariel

VOLUME 6 NO. 4 TUESDAY, MAY 21, 1974

Lawrence Weed Sprouts in the Jeff Jungle

by John Lammie

On March 26 a packed McClellan Hall resounded with the problem oriented gospel of Lawrence Weed, the zealous medical prophet from the University of Vermont. The engineer of the problem oriented medical system queried, "Is the system busy work or benefit?" – and answered.

People have not agreed on the goals, he replied. What should the goals encompass? The quality of medical care. But quality implies judgment: justice or injustice. And justice is fairness: you cannot judge people fairly if they didn't agree to the rules and goals.

Rules to doctors and nurses seem like dirty words. Grand rounds degenerate into adult show and tell! Medicine is unlike music or athletics where rules are defined and accepted. Teams play and win or lose according to rules, but in medical school, if a student flunks, he can rationalize that he didn't see the goals, or he didn't agree with them, and, besides, he really couldn't see how the subjects related to being an M.D.

Anyway, half the time, the professors are reluctant to fail a student during the first two years of medical school because they aren't sure of the relationship either!

Therefore, (1) a system is needed - a set of rules.

(2) Performance under the system must be audited. If the system is undefined, the audit can be unfair.

And (3), the system itself must be audited.

One of the fallacies of present medical care is that if the student or physician can just learn enough, he can handle an increased load. If he only knew more, ten patients could be examined instead of five in an evening.

But, given a reasonable load, what is your goal with this patient? The second fallacy, as the dumbest layman knows, is that the medulla, cerebrum, or peripheral nerve do not come in alone! There are patients attached.

Now basically there are two groups of patients: there are patients who come to the physician for truly episodic care; for example, a kid falls off his bicycle. Then there are patients who come to the doctor with a complaint, a presenting event, that represents only the tip of an iceberg of problems. Look at these underlying problems: the individual attached to them will keep tagging along with his backache whether you like it or not. The bulk of humanity is this iceberg type.

Yet we certainly do not want a country of Family Practitioners who love everyone in general but who can't help anyone in particular. Now people ask me if I want specialization or not? I say that physicians should look at all of the problems – all of the iceberg – and then I say that we do not want a country of generalists. People say "Make up your mind!" Well, the two extremes are the town family doctor who wakes up at age 45 as some old fuddy - duddy who only talks about sociology and the best cardiac surgeon in town who people call irrelevant.

The patient needs it all - both breadth and depth. Medicine is but a spectacle of fragments of invention, brilliant bits that never fit together. The faculty just rearranges all this confusion; that's what we do in curriculum committees. Buckminster Fuller observed that specialization at its best is triviality, and is at its worst extinction.

The medical record is the communication medium for the medical profession. Is it now leading to this comprehensive care? If it is, then we know what we are doing. The record is everyhing; Nixon has discovered this, and the same principle applies to medicine.

This care must be coordinated. This necessitates a complete record with a complete problem list with a defined data base. Never do anything without coupling the problem with the plan or the treatment. These problem lists and plans constitute medicine. The history and physical are not: we can teach housewives to do better physicals than one half of second year students.

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Anderson Injects TJU Heart Ideas With VitaminE & British Understatement

by J.D. Kanofsky

The subject of vitamin E and ischemic heart disease ostensibly smacks of quakery. How many times have we turned on the television only to be greeted by a Mennen E body deodorant advertisement. To some of us it might be comforting to know that a little vitamin E when applied to the skin once in the morning and once at night will assure us a scent comparable to that of the "all-outdoors". The wrench in the cogwheel or should I say stench in the quagmire is that scientific evidence is lacking to corroborate the claim or at least I know of no such evidence.

Another widely touted property that many vitamin E devotees never tire of testifying to is its alleged ability to enhance sexual potency. Listening to their oft-quoted tales of tittilation a person can come away amazed that vitamin E vending machines are not to be found in every brothel, motel lobby and men's room in the country. Once again medical *documentation is nil to nonexistant in support of the* claim.

The above examples are given to point out the confused, absurd, ludicrous and generally incomprehensible folk lore that surround vitamin E and which easily can be extended to include all vitamins and minerals. Unlike penicillin, digitalis or insulin, vitamins can be bought over the counter. This easy accessibility culminates in a myriad of unsubstantiated therapeutic claims. It is understandable and correct that physicians should put little store in them. Nevertheless, it is unfortunate that guilt by association inevitably taint those applications where they may be of value. For instance, should penicillin be discarded from the medical armamentarium merely because a sizable percentage of the lay public believes it can cure the common cold? This in no way detracts from its efficacy in treating pneumoccocal pneumonia and other types of infection. In years to come a similar statement may be made for vitamin E.

On May 1 Dr. T.W. Anderson MD, PhD. a Professor of Preventive medicine at the University of Toronto gave a lecture entitled "Vitamin E and Ischemic Heart Disease: Fact or Fancy." The lecture was sponsored by AOA and the Jefferson Department of Community Health and Preventive Medicine.

Dr. Anderson received his undergraduate and early medical training from Oxford University in England and the London Hospital. He is a man of many charms who out-Higgins Dr. Henry Higgins when it comes to speaking the Queen's English.

The subject of vitamin E and heart disease has been the topic of much controversy. Dr. Anderson in an August II, 1973 Lancet article suggested a provocative new perspective on this issue. In

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I.C.N. Loses Dr. Soentgen After Ten Years of Service

Nancy Redfern

"Medicine involves relieving the suffering of humanity and caring for the individual human life." Consistent with her philosophy, neonatologist Dr. Mary Lou Soentgen conceived and has successfully directed the Intensive Care Nursery here at the Thomas Jefferson University Hospital. After having been here almost 10 years, she is leaving Philadelphia in June to start another ICN in Johnstown, a city of 160,000 in western Pennsylvania.

Dr. Soentgen did her undergraduate work at Seton Hill College in Greensburg, Pennsylvania, where she majored in biology and minored in chemistry. With a sound pre-med background, she came to Philadelphia to attend Women's Medical College. After graduating from medical school, Dr. Soentgen did a residency in OB-GYN, then completed one in pediatrics. She stayed in northern Minnesota for three more years in a private pediatrics practice before coming to Jefferson in October of 1964.

What was just a small premature nursery ten years ago has been transformed, with generous financial aid from the Women's Board, into a full-fledged ICN. Its size has tripled in those ten years. it can now accommodate thirty babies, with an average population of twenty-two to twenty-four babies. So that every small hospital would not have to maintain the equipment, the expertise, and the facilities to be able to care for high-risk premature babies, the ICN was designated as a regional center in September of 1968. Dr. Soentgen had the full approval of the TJUH administration and the city to start this regionalization program in Philadelphia. As Dr. Soentgen explained, "The hospital administration has backed the nursery 100 per-cent right down the line ... the administration has been fabulous." The sixty-two hospitals that now transfer babies to Jefferson span a large radius, encorporating eastern Pennsylvania, southern New York, New Jersey, Maryland, and Delaware. Regionalization (i.e. having a fully-equipped, expertly run ICN in a large hospital rather than several mediocre ones in small hospitals) has noticeably increased the survival rate and decreased the neurological damage so often suffered by improperly cared-for premature babies. The helipad atop the Foerderer Pavilion, also financed largely by the Women's Board, has enabled these sixty-two hospitals to get their babies here as soon as possible.

With sixty-two hospitals transferring patients to Jeff's thirty bed ICN, one would think that space might create a problem once in a while. Dr. Soentgen can accommodate all. "We have turned down no baby." There is always room for one more in the ICN.

Hand in hand with the ICN's policy of not turning down any baby, Dr. Soentgen stated that the ability of the patient to pay is not a criterion in deciding whether that patient will be given or denied treatment.

If things here at Jeff seem to be going so smoothly, why leave? "I've been here ten years. This nursery is well-established. The favilities are excellent, and the nurses are well-trained. I'm going to Johnstown to set up a regional care center there."

Dr. Soentgen repeatedly stressed one aspect of her leaving: "No one is indispensable." She has no delusions of grandeur that this ICN that she started cannot be run by someone else.

Neonatology is a field which involves moral interpretations. Dr. Soentgen has not shirked this moral responsibility and has developed strong convictions. Although Dr. Soentgen does not consider herself "trained adequately or well enough to be able to play God," thereby deciding who will live and who will die; she stated with conviction: "I do not think that any treatment should be withheld from any baby." From this, an interesting analogy can be drawn. In her opinion, if medical personnel are willing to call a code blue for an elderly patient in cardiac arrest, "they should be willing to do anything to save a life that has just begun." Euthanasia, then, is out of the question, as is abortion. Dr. Soentgen stated emphatically, "I am anti-abortion. I can't create life; and I don't think I have the right to take it. To use abortion as a means of birth control is a sad commentary on our society's values of life. I think the unborn child does have rights. Who knows what you might be destroying?" But what if a therapeutic abortion is indicated? This is rare, according to Dr. Soentgen. "In very few cases is the mother's life 100 per-cent in danger. Treat the mother!"

When asked why she is in medicine, Dr. Soenten answered that medicine is "basically what I always wanted to do." Commenting on whether she thinks the quality of medical care has changed from what it was when she was in school, and what it is now, Dr. oentgen said that the dedication of physicians and medical staff members has not changed. What have changed are the facilities and availability of treatments which have been invented and discovered since then. Dr. Soentgen cited the case of the late President Kennedy's son Patrick, who died of hyaline membrane disease over ten years ago. She felt that that particular death could perhaps

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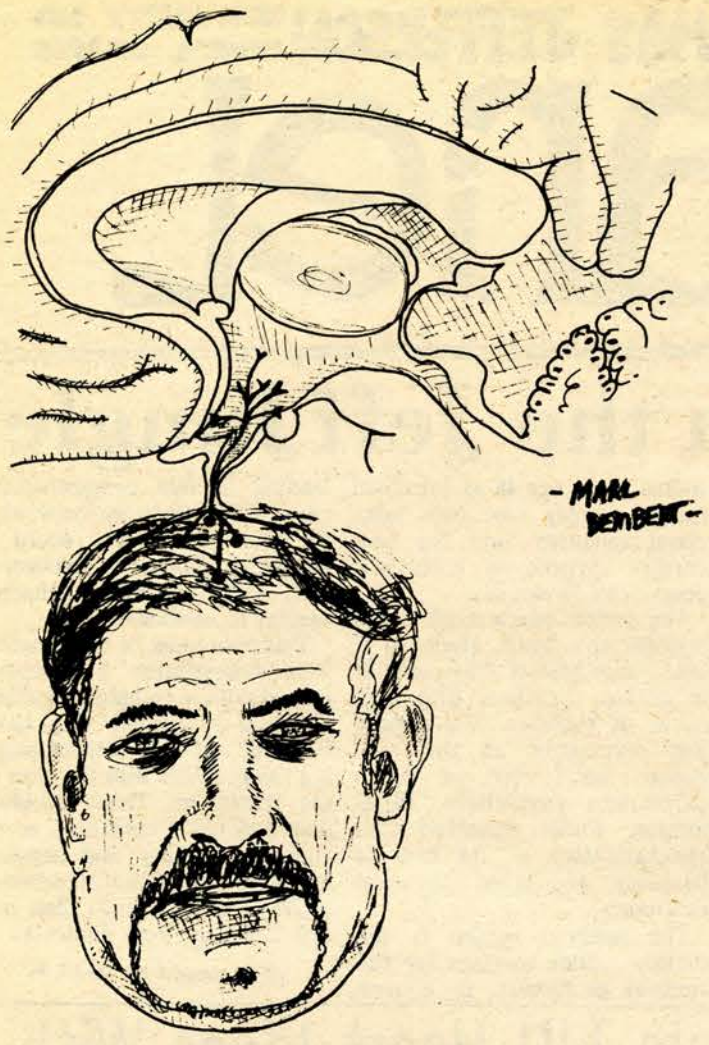

Latest Neuro-endocrine Discovery: Ruppophysial-hypothalamic Tract

Two Faces of Chinatown

Two Faces of Chinatown

Most sojourners to Philadelphia's Chinatown come and go, intrigued by the quaintness of the curio shops and grocery stores that line Race and 10th Streets. Few are aware of the life-style that the Chinese lead behind the closed doors and shabby red brick walls. For like most immigrant ghettos, Chinatown hides behind a mystique maintained by vast differences in language and custom. Its seclusion is often self-chosen. The ways of the **lo fan** (Caucasian) and **hak qui** (blacks) are too strange to follow.

Philadelphia's Chinese lead a much more fragmented existence than most other ethnic groups. Only 600 people are estimated to live there, yet they are crammed into four to five city blocks, locked in by the Vine Street Expressway, crumbling furniture storage houses and acres of parking lots. For those who have walked and explored Chinatown's street-alleys, the desolation brought on by the Highway Monster becomes an omnious sign of the area's physical disintegration.

Yet the immigrants continue to arrive from Hong Kong, not in as great numbers as in San Francisco or New York, but the flow is steady. They come seeking rumors of wealth and happiness. They find only drunks and whores who wander in and out of the bars, flop houses and porno shops that infiltrate their newfound home.

Most of these immigrants are single, young men destined to work 12 to 15 hours a day, six days a week as waiters in the booming restaurant business. A few will attend community college. Most speak English poorly: They are strangers in a strange land.

There are families there, too. They must raise their children on streets littered with soggy newspapers and broken glass – Chinatown's inheritance from the bums, Budweiser, Ripple and the **Inquirer.**

Scattered throughout the dwellings are 120 old men. Many live in dormitories where they can share their loneliness with others like themselves. Too many live alone in barren rooming houses with stairways fifty steps too high for their failing hearts and lungs. They have no families to care for them. Most came at the turn of the century: adventurous, tough young men but without wives, without relatives. They struggled as laundry men, waiters, porters. Most have changed their names long ago to become the false brother or uncle of a Chinese already in the U.S. – how else to evade the restrictive immigration laws of the 1900's?

Now they are old, alone and left battered by the hardships of their youth. Let me tell you a true story: Old Man Leong died last week at age 89. In February he had closed his laundry in the ghetto of North Philadelphia. A social worker had called us two weeks before he died, asking us to convince him to go to the hospital. We found him lying alone, soiled with his own wastes, emaciated and dehydrated and coughing up foul sputum. He was five feet, four inches tall and weighed 80 lbs. He had refused earlier to be admitted: one only goes to a hospital to die, he said.

Leong had worked there for 30 years running the laundry by himself, sleeping in the back room. He had been beaten and robbed a number of times in the past few years. That's all we knew about his past.

When we found him, he had only been bedridden for three days. A neighbor had stopped in once a day to check on him. Cockroaches feasted on stale crackers, rice and cookies. Dust and grime covered the desk which was littered with old letters, receipts, a cracked pair of glasses. An open gas flame heater burned brightly three feet away from his bed. Unclaimed packaged, heavy with gray dust, stood a silent vigil.

The three rooms where he lived and worked had no toilet. He had used a bucket to collect his body's wastes. In the past few months when he couldn't move well, he had resorted to emptying that bucket behind his laundry tub in the back room. In the same room he cooked his meals on a gas stove that sat precariously against a grease-spattered, rotting wood wall. The cold saved saved us from the stench of his back room sewer, but still the air smelled foul.

I sat for a long while with the others, waiting for the ambulance to arrive. *Most of the time we sat in silence. Each time* Leong tried to talk, he'd exhaust himself coughing. Anger and sadness, helplessness gripped us all. What kind of society could let this happen? Why hadn't we done something earlier – yet what could we have done? There are many more like Leong. We cannot nurse them all. Don't we have our own lives to lead?

What could we even do for him now – a daying man, long separated from his home village near Canton, China, who's lived alone nearly all his life. I wondered: what kind of happiness or joy had he stored in his heart to sustain him for this long? And how could we, strangers, bring him happiness now? Let me die, he said later; how could we force him to live and return to his cell?

But there are many more old men like Leong! Some groups are trying to help but there are many problems to overcome. That's another story in itself. But if you are interested in contributing some time and sweat, give a call to one of these people: Mike Rotman (MA 7-4539) or Brad Wong (MA 7-6796).

"Letters To The Editor"

To the Editors:

I am faced by many who feel frustrated and angry by the health care maze. There is a lack of emphasis on preventive medicine and adequate public health care. Instead our present system is crisis oriented in expensive hospital-based facilities where the poor and the rich have to wait hours to receive basic medical care. The present system is disease rather than health oriented. The priorities of profit, research and medical education seem to come before patient care. For the past two years I have seen the patient neglected. Perhaps, these priorities are misplaced since the patient is not the center of attention.

The nursing profession, too is responsible for this patient neglect. Being an overwhelming female profession, in a male dominated medical system, many talented nurses have been unable to give skilled independent nursing care. Morally, I will not perpetuate this system of patient neglect.

To place the patient and his needs as the primary focus may be difficult and time consuming but is necessary. Maslow's heirarchy of human needs, (Physiologic Functioning, Safety, Self Esteem, Love and Belongingness and Self Actualization,) is the theoretical basis of the Baccalaureate Nursing program at T. J. U. All patients need all of these factors for effective health care service. They need to know what is being done and why. It is not just as simple as a three-sentence explanation with a signature on a consent form. Place yourself in the patient's position and consider if you would like to be handled in this manner.

Change to a patient-oriented system must come from within. We are dealing with people - people not only with physical problems but also with psychological-emotional needs. There is much we could do to alleviate their frustration and anger with the health care system. Let's get started.

Deborah Boehm '74

Dear Editors:

Thank you for your invitation to contribute to Thomas Jefferson University and Medical College's newspaper "Ariel."

As requested, enclosed are my general comments about antibiotics and related issues in the area of quality health care. I hope this will prove of use to you and that your interest in the broader issues in health care will continue throughout your medical career.

—

Recently in the Journal of the American Medical Association, Dr. Stolley and I published data which indicate that antibiotic use is rapidly increasing in this country. Furthermore, there are a number of indications which suggest this increase is not entirely justified. The inappropriate use of certain antibiotics continues despite their limited indications and the publicity regarding the attendant hazards. Antibiotics are utilized prophylatically, although in most instances, information is lacking to justify such use. The hazards of superinfection and the selective pressure on the bacterial population producing resistant strains are less obvious but no less serious consequences of heavy antibiotic usage. Testimony at recent hearings before the Senate Health Subcommittee underscored the many problems in this area—problems which could, in certain areas, be causing more illness than is being corrected.

While the misuse of antibiotics is the major area of concern in professional drug prescribing, it is only one example of a fundamental and pervasive problem in the practice of medicine in the United States today: the lack of adequate study of diagnostic and therapeutic techniques to define the benefits versus the risks. For instance, the technique of gastric freezing for upper gastrointestinal bleeding gained moderate popularity in the Sixties before a carefully controlled study proved the procedure worthless. It has since faded from the repertoire of common treatments. Similarly, the use of estrogens to "protect" the coronary blood flow from the effects of atherosclerosis was popular until a randomized, clinical study by the National Heart and Lung Institute demonstrated greater morbidity and mortality for the experimental groups on two different dosages of conjugated estrogens than for a matched set of control groups on placebos. It is not clear that the practice of using such estrogens for this prupose has declined in use.

Unfortunately, a large proportion of clinical practice is still based on "experience" and tradition without the evidence which a carefully controlled study could provide. Those individuals charged with establishing health policy, whether in a National program or in other areas, cannot make the best judgments in the absence of such information. Without such information, we will have unnecessary procedures, treatments, operations, and hospital stays, with all the attendant risks to the individual patient and the more general "morbidity" of squandering resources.

Despite the reams of material published yearly, it is disturbing that there is not enough information which allows one to decide rationally about whether or not to implement various procedures. What evidence delineates the utility of coronary bypass surgery? Is it worthwhile for all people with coronary artery disease? If not all, then which symptoms and findings define the patients who should have the surgery? What are the indications for removing tonsils or uteruses? Why should the United States have a higher rate of tonsillectomies and hysterectomies than European countries of similar industrialization? These and many other appropriate questions face us and must be answered if we are to deliver "quality care."

The Professional Standards Review Organizations presently being established throughout the country will require the practicing physicians to examine the evidence to support a wide range of "accepted" diagnostic and therapeutic techniques in an attempt to establish rational standards of patient care. This process should help define on a broad base the scope and difficulty of this process and the problem in general.

My plea is for the medical profession to insist on careful, well-designed studies as evidence of the efficacy and efficiency of techniques and procedures before adopting them on a widespread basis. Without such information, the progress of medical science will be marked by periodic popularity of procedures and techniques which later prove to be worthless or even dangerous. At a time when resources of all types are scarce, it seems to me that we cannot afford the luxury of investing time and resources in practices which have not been proven effective.

Henry E. Simmons, M.D., M.P.H.
Deputy Assistant Secretary for Health.
Director, Office of Professional Standards Review.

Dear Mr. Chervenak,

If there is an analogy to be drawn between slave-holding and the abortion question, it is this:

Men as doctors, politicians, and theologians know what is best for women.

Men as slave-owners know what is best for slaves.

Sheryl Lederman Silfen

THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE ariel

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Psychiatry and the Matching Program

This year, a number of hospitals have violated the terms of the National Internship and Residency Matching Program (NIRMP) in regards to R-6 internships (emphasis inPsychiatry) and psychiatry residencies. These violations have placed those who have honored the contract, both students and hospitals, at a distict disadvantage. The student suffers because of a reduction in the number of desirable training program open to him; the hospital because of a reduction in the number of qualified applicants available.

According to the NIRMP Schedule of Dates for 1974-75 "October 1, 1973-Jan. 4, 1974 (is the) standard period for students to make application for internship-residency to hospitals...students are urged whenever possible to apply before Dec. 20, 1973."

Between the period of May 1, 1973 and Nov. 15, 1973 Gary Kaskey and I wrote to a total of 23 hospitals requesting applications for R-6 internships and-or psychiatry residency programs. Of these, ten replied in writing that they were no longer accepting applicants for their 1974 programs, or even more astounding, that they were now accepting only applicants for 1975.

A list of these hospitals who refused to accept applicants for their 1974 training programs although in every case petitioned in writing at least 6 weeks before the official NIRMP deadline for applications include:

1. Columbia-Presbyterian Medical Center (New York City).
2. University of Michigan Affiliated Hospitals (Ann Arbor).
3. Langley-Porter Neuropsychiatric Institute (San Francisco).
4. Massachusetts General Hospital (Boston).
5. The Cambridge Hospital (Boston).
6. Beth Israel Hospital (Boston).
7. Yale-New Haven Medical Center (New Haven).
8. University of Colorado Affiliated Hospitals (Denver).
9. Boston University Hospitals (Boston).
10. Stanford University Affiliated Hospitals (Stanford).

All of these institutions were listed as members of the NIRMP in the 1973-74 directory of approved internships and residencies which was distributed to all senior students at Jefferson. It should be stressed that this list includes only those institutions with which either Mr. Kaskey or myself have had personal correspondence. There are undoubtedly many other violators of the NIRMP contract in regard to R-6 internships and psychiatry residencies.

Apparently, both the American Psychiatric Association and the NIRMP are aware of these violations and plan to look into the problem. In the meantime though I would strongly urge any students finishing their junior year who are interested, even vaguely, in taking on R-6 internship or psychiatry residency to start applying to hospitals now.

Ken Jaffe

Senator Buckley Responds to Pro-Life Editorial

Dear Mr. Chervenak:

Your recent editorial, "Life: A Civil Right," was recently brought to my attention, and I wanted to congratulate you on the spirit and tone of the statement. I am particularly pleased by the fact that it appeared in a medical college publication, for I believe that in the long run the abortion controversy will be resolved for good or ill only by the informed participation in the discussion of medical professionals.

The central point of your editorial is especially worthy of note. I refer to the apt analogy between abortion and slavery. This was brought most forcefully to my attention shortly after the Supreme Court's ruling of January 22, 1973, by a petition for rehearing filed by the State of Connecticut (whose case was on appeal at the time the Court made its ruling involving the laws of Texas and Georgia). Among other things, Connecticut argued – and incidentally was joined by 17 other states as **amici curiae** – that it was not sufficient for the Court merely to say that the unborn child was not a "person" within the meaning of the 14th Amendment. For, the argument continued, the evidence was incontrovertible that the unborn child is a human being, and because he (or she) is a human being, Connecticut was not only free, but positively obligated, by its own constitution and laws to protect the unborn. And in support of that proposition, Connecticut cited a number of 19th Century cases sustaining prosecutions for criminal acts committed against slaves. It has conveniently escaped the modern memory that, although slaves were "non-persons" under the federal constitution prior to the ratification of the 14th Amendment, they were nonetheless considered (even in some of the slave states) to be human beings for purposes of the criminal law. The analogy between slavery and abortion is thus not only morally apt; it has a historical and legal application as well.

The central question in the abortion debate, it seems to me, is a very simple one, namely, what is "it" that is killed during an abortion? Medical professionals have an obligation – whatever their views on the merits of abortion itself – to see to it that this question is answered according to the best medical evidence available, and to beware of those who dissemble, misstate, or ignore medical evidence on behalf of a political or social cause. On this point, I would like to call to your readers' attention a passage from a succinct and forthright editorial published in September, 1970, in **California Medicine**, the official publication of the California Medical Society:

"....The process of eroding the old ethnic and substituting the new has already begun. It may be seen most clearly in changing attitudes toward human abortion. In defiance of the long held Western ethic of intrinsic and equal value for every human life regardless of its stage, condition or status, abortion is becoming accepted by society as moral, right and even necessary. It is worth noting that this shift in public attitude has affected the churches, the laws and public policy rather than the reverse. Since the old ethic has not yet been fully displaced it has been necessary to separate the idea of abortion from the idea of killing, which continues to be socially abhorrent. The result has been a curious avoidance of the scientific fact, which everyone really knows, that human life begins at conception and is continuous whether intra- or extra-uterine until death. The very considerable semantic gymnastics which are required to rationalize abortion as anything but taking a human life would be ludicrous if they were not often put forth under socially impeccable auspices. It is suggested that this schizophrenic sort of subterfuge is necessary because while a new ethic is being accepted the old one has not yet been rejected..."

I, of course, concur in these sentiments and would add only one further item for the thoughtful consideration of your readers. It is an eloquent statement being circulated throughout the world by a most prestigious and concerned group of European physicians. It reads as follows:

"At each instant of its development the product of conception is a living being, crucially distinct from the mother which receives and nourishes it.

From conception to senesence it is the same individual who develops, matures and dies.

As medicine remains at the service of life at its end, so it protects life from its beginning. The absolute respect owed to patients does not depend on their age, their disease or the condition which might afflict them.

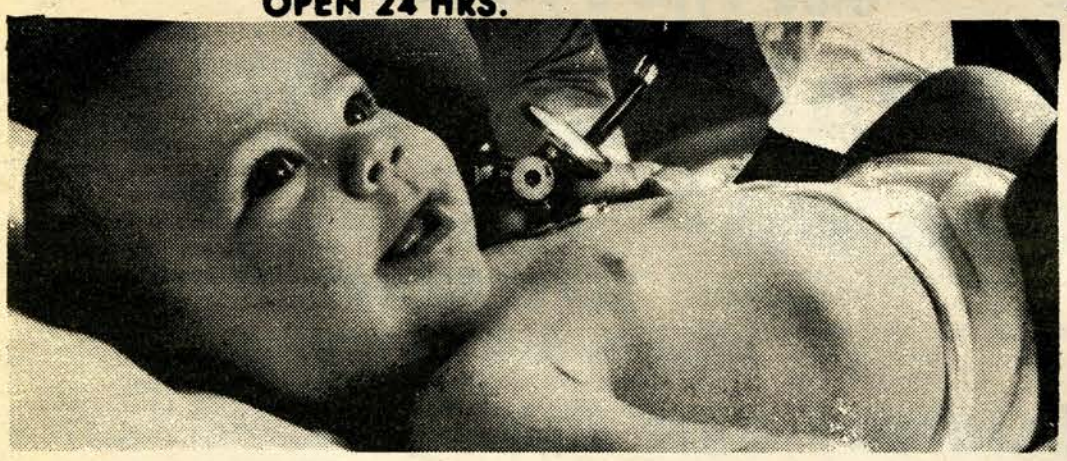
In face of the distresses which tragic circumstances may produce, the duty of the physician is to bring every aid to bear on helping both mother and child.

This is the reason why the deliberate interruption of pregnancy for reasons of eugenics, for the resolution of moral, economic or social problems is not the action of a physician."

With best wishes,

Sincerely,

James L. Buckley



Hey, we won!

There's an old expression that goes something like, "When you've got it, flaunt it." Well, the **ARIEL'S** got it, and we'd like to flaunt it. What we've got is the 1973-74 "New Physician" Journalism Award; voted by a group of members of S.A.M.A. (including the New Physician staff), it is awarded to the best medical school periodical in the country. This year—in the first year that the award was given—it went to the **ARIEL**, out of forty-five entries.

We on the **ARIEL** staff are naturally quite elated and proud of this. But we'd like to share the award with you, the students and faculty of T.J.U. For you are the ones who gave us ideas and inspirations and encouragement by your participation—as well as many of our articles. So let's hear it for all of us: "Hip...Hip...Hooray!!"

Soentgen

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have been prevented today. She then added, "Yesterday's impossibilities are today's realities, and today's problems are tomorrow's challenges."

Despite the increasing number of women in medical schools, being a female physician still classifies one in a definite minority. Asked whether she thought she had ever been discriminated against here because of her sex, Dr. Soentgen replied, "If I have, I haven't noticed it. I really don't think my sex has been a detriment." Although not a staunch supporter of the Women's Liberation Movement ("I don't think I've ever been so chained down that I needed liberation"), Dr. Soentgen does agree specifically with two of the points Women's Lib avocates: equal rights for women and equal salaries for equal jobs. "If the woman is as well trained as the male, sex should not play a part as far as which one is picked for the job".

In keeping with her theory that "You can't run an ICN part-time," Dr. Soentgen maintains no outside practice. She is, however, a full-time faculty member of the JMC and lectures to medical students and interns on obstetrical problems and neonatology, the latter described by Dr. Soentgen as, "one of the most challenging fields that there is in medicine."

Where is it all going? Dr. Soentgen stated, "Medicine is never at a standstill," and she even went so far as to predict that an artificial uterus will someday take care of the premature baby who cannot function adequately out the aquatic lifestyle it was used to.

So while medicine is headed towards an artificial uterus, Dr. Soentgen is headed for Johnstown, where she hopes the building of the new ICN will be facilitated by the things learned from problems encountered while building TJUH's ICN. But what about the people who worked with her that are staying? How do they feel about her leaving? According to Mrs. Eva Geiger, Patient Ward Clerk on the 10th Floor Maternity Ward, the general consensus is that people "feeling terrible" that Dr. Soentgen is leaving. Dr. robert Brent, chairman of the Pediatrics Department, cited her tremendous contributions and stated, "Everybody in the department wishes her well and knows she will be the same success in Johnstown that she was at Jeff."

In conclusion, Dr. Soentgen's opinion that "no one is indispensable" reveals modesty when there is much to be proud of. She will be missed.

Weed

(Continued from page 1)

What is wrong with the present medical record? It places the human memory in the system - that isn't a good system, people. None will ever remember all. And you know that - you know that! The present record doesn't require plans and problems to be coupled. Sure, you know now why you ordered this treatment, but will other people? And will they know which problem you are acting on? And will you still remember next week, and later?

This same defect of memory is incorporated into education. It is epitomized by the "core" concept, for example, a core exam in OB-Gyn. This represents "the minimum to be credible" after a trimester of OB-Gyn. How do you justify putting in only common things or core on the exam? What if the patient comes in with an uncommon problem? And yet you are limited in the amount that can be taught - again, the memory and time. How is this material determined? Well, there is no god-given core of knowledge: it is a compromise from fatigue after many long hours of curriculum committee meetings. Why, even God is probably confused after a few curriculum committee meetings!

Even if the good student learns the uncommon details, the half life of knowledge places both the good and poor students at the same level after only a few years. "Core" is not patient care.

The medical record is patient care. It is all we know about medical care.

Physicians like to talk about the "art of medicine." Art implies discipline, style, structure, or form. Art is a long distance runner or good music: it is exact - there are certain things which you all must do! A musician in the Philadelphia Orchestra doesn't walk and tell Ormandy that he doesn't feel like playing the music the way it is scored! We debase the word art itself when we apply it to much of modern medicine.

It is equally laughable to call medicine science: the hallmark of science is the notebook, measurement, and feedback loops. Medicine is the only place in the world where coaches gather once a week and perform while the players sit on the bench; we call it grand rounds.

People, we will be audited. We will be checked for thoroughness and reliability. Confucius noted that a man who is not utterly reliable is utterly worthless. The written word is more reliable than spoken communication!

The progress notes will be evaluated, and so will the plans. Problem and plans should be stated at the level of understanding and sophistication. When the plans are audited, you must justify your analytic process. Prove to me it is sound and logical; and if you don't know something, get more information! Never, never again write down a plan or problem if you don't know about it. What? Look things up in the middle of the night? You know that's quite a revolution around some of these places!

Therefore, we should reorient education so that we aren't going to teach you a core of knowledge that you are going to forget so that you will act only on half-impressions and vague recollections. Instead, we're going to teach you a core of behavior. The way we teach basic science, we flood you with so many facts that you completely miss the behavior of the scientist. A good way to keep a mind from thinking is to keep it busy! Yet ruthless discipline will be maintained in a problem oriented system: you have an absolute responsibility to the patient. If you don't take time to look up problems that you don't understand, that tells me that you don't care about the patient, and I'll throw you out.

Now, since most patients are of the iceberg type, these diseases are not going to be cured; they are going to be managed. Thus efficiency will be required and will be audited. You have to pick up speed eventually; it comes with practice. You can do the most complete workup in the world on a patient, and it can meet the standards of thoroughness, reliability, and complete analysis, but if it took the entire day, you fail.

Usage always leads to knowledge. The problem oriented medical record provides the framework for behavior oriented medical education. It also solves the evaluation problem: the whole present examination structure is false. We justify courses and exams with statements of philosophy, but students aren't interested in philosophy: they are interested in what you are going to do to them at the end of the year. With the problem oriented system the record audit provides the evaluation.

Don't be afraid to make work your pleasure for awhile, to remain celebate, to hang around the library studying. These few years of effort and sweat will pay off later when your more "rounded" colleagues will be sweating over what they don't know and what they can't remember. Physicians are always too ready to run off from rounds to the opera or to read the latest best seller. Right on the ward is all the sociology and literature that you can handle. Education and schools emphasize second hand knowledge and "normals." Don't underestimate the capacity of school to intellectually castrate you.

"Normal" conditions will never occur on the ward. Medicine is like a chess game - relations among the pieces are infinite. Don't try to practice medicine without a chess board! Really, it is very intellectually challenging to play the game!

Congratulations to Dr. John Gartland, New President of the Alumni Association.

Paul Eckel, National Health Service Corps Representative will discuss the N.H.S.C. and the U.S. Public Health Service Scholarship Program Wednesday, May 29th; Solis-Cohen Aud. 1-2 p.m.

Flicks are For Fun.... and Fascination and Fear

By Bob Sklaroff **Film Review**

"How do you choose a movie?" Cocktail party conversationalists initially consider acting, photography, satire, popularity, philosophy and romanticism, and later debate soundtrack, realism and inventiveness. They generally disagree until the concensus settles upon that universal vague ideal—**Entertainment Value**—permitting an ego-sparing shift of topic (usually to a less controversial leisure activity, like sculling on the Schulykill, or squash, or sky-diving, upon which fewer people have developed hardened attitudes).

My recommendation to see **Don't Look Now** is based upon three particular criteria: **recovery-time, emotion-range** and **cinematic-flexibility.** It quite clearly eclipses **The Exorcist** for these and other reasons.

I was throughly scared by **Don't Look Now** (for the first time since I saw Boris Karloff in the Saturday matinee of **The Mummy.** From Cortex to Coccyx, I felt the impact and sensitivity of a duel between the irresistable force and the immovable object, waged in Cubism.

Some movies build momentum towards a climax which never materializes while others literally fade away. Consider, then, the structure of this film: To escape the memories of their daughter's accidental drowning death, Donald Sutherland and Julie Christie seek solace amid the canals of Venice.

They encounter two women (one, a blind seeress) who can not, until the movie's shock conclusion, identify that red-caped figure (they perceive as their daughter's ghost) darting about. Sutherland sights, relentlessly follows, and identifies this figure in a fifteen-minute eerie, anxiety-packed chase. One wonders whether a **deus ex machina** will be employed, as it seems that little else could challenge the force of the movie's accumulated tension.

The encounter with the immovable object is unexpected–a split-second of horror. The rapic denoument serves to enhance the impact as well as to coalesce the movie itself. The more one has observed throughout the two-hour experience, the more one feels the concluding kaleidoscope explosion of fantasy **and reality.**

A student of the cinema could best describe the intricate cross-cutting, imagery, texture, framing, special-effects, musical coordination and camera movement in **Don't Look Now.** One continually sensed the director's absolute control over what you saw. Crucial here is that such visual manipulation was goal-oriented and not a text of various editing techniques.

Moreover, a wide range of emotions was communicated: the most erotic lovemaking I have ever seen on film, the preoccupation with everyday matters, the ambivalence felt when faced with subtle (seemingly undeniable) evidence of parapsychology, the mourner's depression and strength. Each is pursued with unparalleled intensity. Missing only is the celebration of life.

One reviewer calls it an unforgettable movie "of burning intensity and disturbing eroticism; it grips the viewer long after the final frame!" (Kathleen Carroll, **NY Daily News**) My tachycardia & diaphoresis lingered for a half-hour before that phrase "It's only a movie," again made sense.

Is it unique? "A dark and frightening experience unlike anything ever filmed!" exclaims Paul D. Zimmerman **Newsweek.**

Is it entrancing? "Thrills and suspense! Director Nicolas Roeg and his stars will hold you in thrall!" cries a usually sedate Judith Crist **New York Magazine.**

Is it a classic to be studied not only for its tale, by Daphne Du Maurier, but for how it is told? Jay Cocks **Time** declares, "A brilliant film of deep terrors and troubling insights–one that works a spell of continual, mounting anxiety. Such a rich, complex and subtle experience that it demands more than one viewing!"

A cautionary note. I spent two months mulling over how to praise this movie without burying it. For as Andrew Sarris **Village Voice** has noted, "Movies are best enjoyed in a climate of minimal expectation. The curse of critics is that they inflict upon the movies they love most the onus of overpraise."

I decided to take the plunge, however—to class it with **Citizen Kane, Grand Illusion, O Lucky Man!,** and **On the Waterfront**—hoping you'll see it when it returns as a double-feature with **M.A.S.H.** or **Dr. Zhivago.**

A contrast with **The Exorcist** is appropriate. I schemed days in advance to see this film which has grossed $1 million in its first ten weeks in Philadelphia. (**The Godfather** took sixteen weeks). Days following its opening in Haddonfield, N.J. we grabbed a 5:30 cheese-steak dinner at Luna's before hopping the High-Speed Line and hiking to the Westmont. We viewed the movie with a responsive, youthful, middle-class, somewhat-tense, sold-out audience.

The following evening, the TLA audience for **Casablanca & Play it Again, Sam** was filled to capacity by the girl standing directly in front of me, so we drove to Bryn Mawr to see **Don't Look Now,** a last resort. All I knew were the stars, and the fact that one of my friends considered the movie a waste (except for the love-scene).

Maybe I expected too much, having read Blatty's book. The first fourteen minutes of archaeology in Iraq was somewhat interesting and the vomiting of bile was a jolt, but the rest of the film was absolute boredom.

One illustration should do. Music in **The Exorcist** was used to scare the audience. A man, deeply concentrating, works quietly at night, and the 'phone suddenly clangs shrilly. In **Don't Look Now,** auditory and visual sequences were intertwined. The music expressed a mood without being overbearing nor inappropriate.

And a final pertinent negative: **Don't Look Now did not** rely upon the occult for plot development. Rather, this provided the psychological suspense necessary to make the movie (in Sarris' words) "beautiful to look at but chilling to sit through."

What else could be more "entertaining"? You'll scream on screen cue, when you view **Don't Look Now.**

"They're Too Fit To Die!"

By Morton A. Klein

Man shall live for three score and ten years! The truth of that ancient biblical precept has lasted throughout time. Or has it? It has in American and among the civilized world; but ask the people in a valley in Ecuador, a hillside in Hunza (near Pakistan), of a strip of land in Caucasus, Russia. They'll give a hearty laugh from jowls that have been a hundred summers.

The evidence seems clear, says Dr. Alexander Leaf, chief of Medicine, Massachusetts General Hospital, that these people are living well past prime time. More importantly, they hover around the century mark while maintaining vigorous and robust health. Dr. Leaf made these remarks at a lecture, sponsored by the Hare Society, in the Soltis-Cohen Auditorium at Jefferson on May 3. In the Caucasus, Russia, Dr. Leaf points out, 43 per age of 100, while in the U.S.A., the rate is three per 100,000. Similar recordings of longevity were found in a certain area of Eduador and Hunza. Dr. Leaf has recently returned from a massive excursion observing these long-lived people in distant lands.

EXERCISE

Let's take a close look at the lifestyle Dr. Leaf believes accounts for their almost everlasting evasion of death. In all three cultures there is an enormous amount of physical activity. One of the primary reasons for this is, of course, that farming is the main form of work. The terrain tends to be quite hilly which increases the strenuousness of their activity. Not very surprisingly, the vast proportion of these elders are very agile and sprite, with excellent cardiac and pulmonary functiong. Dr. Leaf admitted he had a great deal of difficulty in keeping pace with these able-bodied people.

DIET

How do their diets compare with our own regimen? The most striking differences are their ver low caloric intake (1300 calories vs. avg. U.S. diet of 3300 calories) and that their foods are mostly of vegetable origin. They ingest very little animal fat and limited protein. (I would also estimate that their chemical additives and preservations range from zero to none). The Hunza diet is particularly unique in that they endure a short period of semi-starvation each year. (Dr. Clive McCay of Cornell has shown that he could extend the lifespan of rats by 20 percent to 40 percent simply by lowering their caloric intake and totally withholding food intermittently).

The dietary regime of those in Caucasus, Russia is somewhat more abundant. They do have more cheese, butter, and dairy products. Nevertheless, their intake of animal fat and protein remains very small. However, the shepherds, a small subgroup here, live almost exclusively on Goat's milk, other dairy products, and corn meal. This diet may be thought of as atherogenic by our standards, yet here there exists little incapacitating heart disease. Some may believe that this hearty physical fitness may have a genetic basis. However, Dr. Leaf explains that in this section of Russia there is a diversity of people and cultures. Among them are Turks Armenians, Jews, and Russians. The genetic rationale simply does not seem to hold true.

SOCIO-PSYCHOLOGICAL CLIMATE

The last longevity-producing factor, besides the spectacularly clean, refreshing air and water these people are blessed with, is the Socio-Psychological climate. Dr. Leaf found these peoples to be exhilirating, full of gaiety, and good-will. It also seems that with increasing age grows increased respect and esteem. The Elders act as patriarchs whose word is accepted as law. They constantly feel useful, needed, and wanted; in sharp contrast to their aged *counterparts in our own country. There is really no retirement,* only a gradual slowing down.

Dr. Leaf asked them what was most meaningful in their life? They generally replied, "The continuity of the family." They live in an extended family group, seeing their children, grandchildren, and great-grandchildren, mature from in fancy to adulthood and beyond. They certainly don't suffer from the strains and anguish of mobility that we in America endure.

One certainly has to marvel over these hale, hearty, and happy people, who are able to esape the ravages of disease. Their generally slender physique's, sinewy limbs, and zestful movements, explain in a glance why and how they go on living and living. they're simply "Too Fit To Die."

Jefferson Students V.D. Offensive

We in medical school are taught to worry about rheumatic fever, scarlet fever and the other infectious diseases. Yet, we somehow seem to gloss over the history of symptomatic venereal disease, the number one communicable disease in the United States. Even worse is the public's treatment of the subject – ignore it and the problem will go away.

What can you do about it? If you are a bored freshman or sophomore asking yourself if this is really medical school, you can help greatly. Medical students have volunteered to enter the Philadelphia public high schools and lecture students on venereal disease.

The important aspect of this program is that it is organized and run by Jefferson students with the backing of the Philadelphia Boards of Health and Education. However, students are needed to coordinate, run and supply manpower for this endeavor.

Do you feel run-down? Is medical school a drag? Do you wonder if you'll ever really study and learn **medicine?** If you would like to begin learning, and even contribute to other people's well-being, join us. After all, how else could you combine medical school, preventive medicine, the feeling of satisfaction and even fun so easily? Let's make Spring and love even more enjoyable.

Contact: Arnold J. Willis, Box #775, Jeff Hall, if interested. For V.D. info for yourself call: Operation Venus.

George Could Never Lie And Neither Do We

Photo by Jay Amsterdam

Join ARIEL and Keep Us Honest

Forum Brings The University Together And Reign of the Medical College Ends

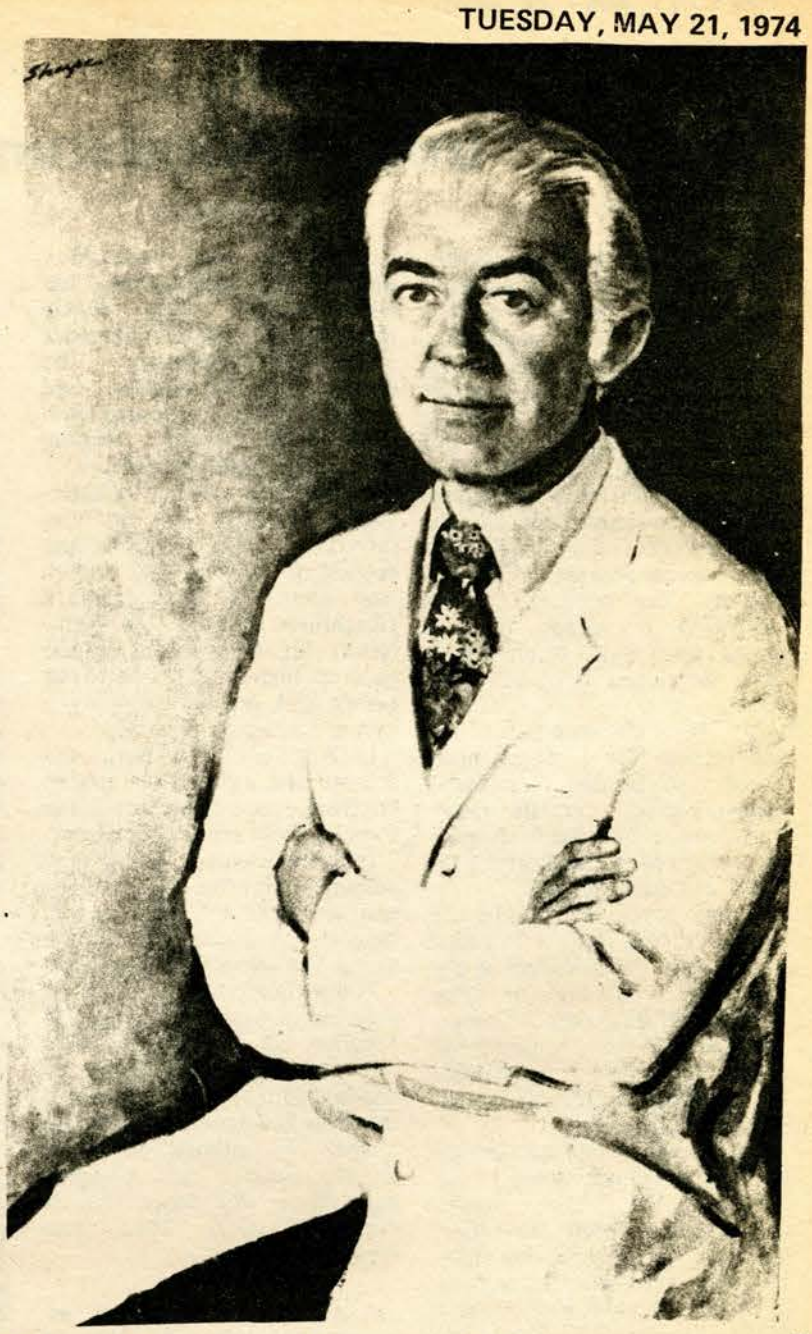
by Bob Sataloff

On July 1, 1969, Jefferson Medical College became The Thomas Jefferson University. In so doing, the Jefferson community committed itself to a new and broader philosophy of education.

For 145 years, Jefferson Medical College provided the dominant – essentially, the only – perspective in our educational community. However, while its charge was executed with distinction, any intellectual environment can be improved through contact with diverse, well articulated differences in approach. Therefore, Jefferson chose to support around itself the growth of the College of Graduate Studies and the College of Allied Health Sciences, and to combine with them, to expand its horizons and to meaningfully share its experience. Ideally, this symbiosis should provide each of the colleges with support, fresh ideas and the challenge of another point of view.

From the student's vantage point, this ideal has been approaching slowly in the university's first few years, but steadily. Despite difficulties in establishing routes of communication and forums of interaction, more and more activities and organizations have attracted students from all schools of the university. The University Commons, **ARIEL**, Choir, Ethical Society, Dance Club and many other groups have brought students together in both social and academic discourse. Refreshingly, some of the academics have even been within the realm of the "liberal arts." Most of us feel the atmosphere is noticeably richer.

In order to further this cooperation, the establishment of a university-wide student government organization has been proposed. It is suggested that it be called the University Forum. The constitution for the University Forum has been written. As printed, it has already been adopted by the Student Council of Jefferson Medical College, the Student Affairs Committee of the Faculty of Jefferson Medical College and the Student Council of the School of Diploma Nursing of the College of Allied Health Sciences. Support has been expressed in all colleges of the university, and it is hoped that the first meeting of the University Forum will take place before the end of this academic year.



Poetry Review: From The Calaveras County Courier

by Aesculapius Brown

Good contemporary American poetry is remarkable by its absence. McKuen, Ginsberg, and the faceless ones of "The New Yorker crowd" stand in a corner of the void left by the passing of Frost, Williams, and Cummings. The public and the poets aren't alone to be blamed for this situation. The poetry critics are also culpable.

There is a conspiracy among poetry critics and the poets that they laud. It is called, the allusion. Among the most highly regarded poets are the ones with the most numerous and most obscure allusions. A poet can score many points by referring to other literary works. This is how the game is played. In order to allow people who aren't graduate students in literature to adequately fathom the depths of obscurity that the proper poet can attain, poems should be cross-indexed. This would enhance an appreciation of the "great works" of our English literature.

The allusion or reference to another piece of literature is an egregious error and an affront to the reader. The error that I speak of is the error of second nature. Even though literature is a part of man's world, it is only the natural world seen through the lens of the artist and refashioned by his fingers of words. Thus, to refer to another literary work instead of going to the source of life itself is an error of second nature. A return in the direction of the omphalosceptic poets may by in order at this time.

Ginsberg and his compatriots are a new force in American poetry. Refreshingly, they started down the path toward naked omphaloscepticism; but, got hopelessly lost. Invariably they wind up a few inches below the **omphalos.** For want of a better name it seems quite **a propos** to call this group the Scheiss (pronounced "shice") School of American Poetry. Their basic idea is to use words like "shit" and "fuck" in order to have people come to grips with reality. As for the quality of creative genius, well, one can see better lines on the walls of comfort stations. Fornication and defecation are very much a part of life and should be accepted as much as sleeping and eating. Therefore, to continually harp on sex and anal activities seems quite imbalanced and can get boring.

To uneducated youth, these modern writers are heroes who blaze a trail in the quest for truth and sanity. Using gutter language is not very original. Ginsberg can not rise above Reverend Edward Taylor, a card-carrying member of the establishment. This early American Puritan poet used lines such as, "A petrid pot of putrid excrement."

The balance of life is lost in the lines of the Scheiss school. Some lives may be lived in the gutter with the filth and sewage; but, even in these instances in our country, the sun shines above and one can feel inner warmth. For most people, a good part of their lives is spent in the bathroom and-or in pursuit of sexual stimulation; but, this is dwarfed by the rest of life's activities. It sometimes is hard to reconcile the fact that about one-third of one's lifespan is spent asleep. Of the remaining period awake, about ⅛ of one's time is spent eating. If this progressive school really wants to pull down the clothes of life and streak, they better get with it.

Rod McKuen has stayed closer to the omphalosceptic model. His popularity is largely due to the sophisticated teen-romance readers of yesteryear and grown-up Annette Funicello fans. This isn't to imply that Mr. McKuen's works aren't so unsalvageable that he is beyond poetic rehabilitation. In fact, McKuen's use of simplicity and transportational phrases are quite masterful. The use of simple words to communicate can be a powerful style. Thankfully, he has little use for allusion to other literary works. Many a critic in search of sophistication forgets that the art involved lies in the communication. McKuen's use of words and images are transportational because he takes the reader onto the beach, sweating in the sun; to his solitary room wrapped in sweaters of loneliness; and along on a love affair with his cat.

The flaws I find in the works of Rdo McKuen concern the following: paucity of theme, lack of depth, and insincerity. His themes continually center around love, losing love, lamenting lost love, and loneliness lamenting lost love. This "1"-thematic obsession detracts from the quality of his collections. Harping on the music of love detracts from its pureness of tone. Lack of depth is noticed when one tries to reread his poems. There is nothing there after the first impression, nothing to contemplate, no new or multiple insights to ponder, no "multilevels" to discover or fresh feeling to sense. Rod McKuen gives us some light, enjoyable reading. He certainly doesn't have the stature of a Robert Frost or a William Carlos Williams. Popularity doesn't make a good poet, only a wealthy one.

I reserve very few words for the poetry of the faceless ones of "The New Yorker crowd" who publish in journals and magazines that uphold the poetry establishment. **The New Yorker** typifies these magazines. It is a good magazine for looking at cartoons; but, if you are interested in poetry, it is a defoliated jungle of words. Uninspiring is about as mild a description as one could make. Their poetry is mostly unvaried and executed in a boorishly sophisticated style. Errors of second nature are the rule in these works. Their insipid poetry sticks to the tongue like unpalatable store-blught white bread.

I haven't denigrated the character of our contemporary American poets, only the character of their poetry. Hopefully, more new voices will be heard. From my vantage point in Calaverous County, the best poetry that comes to the ear is from our celebrated jumping frogs, especially the bull variety.

Dr. Dowling Honored

Dr. John J. Dowling has received the highest possible honor for a faculty member at Jefferson Medical College of Thomas Jefferson University.

On Wednesday, May 8, a portrait of the outstanding professor was presented to the College by the senior class at a 3:30 p.m. ceremony in McClellan Hall. The honor is regarded with the greatest esteem because the selection is made freely by the students themselves in order to exalt their most respected teacher.

Dr. Dowling, Professor of Orthopedic Surgery, received the coveted Christian R. and Mary F. Lindback Award for Distinguished Teaching in 1971. In 1973 he was also honored for distinguished teaching by the medical fraternity Phi Alpha Sigma.

Earlier this year, the Main Line Junior Chamber of Commerce awarded him a community service citation for his work at St. Edmond's Home for Cripplied Children in Rosemont---an institution he has served since 1961.

A resident of Gladwyne, Pennsylvania, Dr. Dowling has been directly associated with Thomas Jefferson University Hospital since 1947, when he served his internship. He was later a resident in general surgery and then in orthopedic surgery at the same institution. Upon completion of his residency, he became active at the State Hospital for Crippled Children, Elizabethtown, Pennsylvania.

In addition to his teaching capacity at Jefferson, Dr. Dowling is Chief of the Department of Orthopedic Surgery at Lankenau Hospital, Overbrook, where he is also on the Medical Advisory Committee, and is Consulting Orthopedist at Misericordia Hospital, Philadelphia.

Delaware State Med School Plans on Shelf

by Wally Judd

The proposal for a medical school in Delaware has been mothballed for at least one year if not for considerably longer.

The specific reasons given for not pressing forward with the plan are a lack of funds and a need to recruit more faculty at the university in health sciences.

However, some medical sources say a subtle force working to cloud the climate for the establishment of a medical school is the close relationship between the community's philanthropists and the Wilmington Medical Center.

The medical center has traditionally urged the university to proceed with the school with caution because of the large capital costs involved. And, the medical center's doctors, in a recent survey, said they liked the current cooperative educational program with Jefferson Medical College of Philadelphia.

Yesterday, Dr. William V. Whitehorn, director of the university's division of health sciences and special assistant to the president for medical affairs, said he had asked the president of the Faculty Senate to withhold from active consideration the program he proposed last April which would establish a six-year medical school by 1975 and which would cost about one-tenth as much as a previous proposal.

"At the present time, it is not practical or feasible to do so," said Whitehorn.

Whitehorn has recently resigned his position, effective at the end of the school year, to take a medical job in the federal government.

Dr. L. Leon Campbell, provost and vice president for academic affairs, said it was no secret that Whitehorn would "probably be happier with a much faster rate of progress on the program."

Whitehorn said the marginal state budget makes it unrealistic to expect public funding necessary to start the school. Federal funds are drying up because the Nixon administration believes medical education should be the responsibility of the state and the student.

Campbell cited the need for more faculty.

"We don't want to do the program if it is not first class," he said.

Delaware has no medical school.

The establishment of a medical school in Delaware has been a controversy in the medical community since the early 1960s.

Currently, 20 Delaware students a year begin a four-year cooperative education between the Wilmington Medical Center and Jefferson Medical College of Philadelphia. The program is primarily financed by the state-funded Delaware Institute for Medical Education and Research (DIMER).

Campbell said the program would not revived until a replacement for Whitehorn was found and he had a chance to become accustomed to his job. Campbell said he expected it would take about a year to find a replacement.

"As far as a timetable for the program, I just don't want to make any guesses," Campbell said.

Traditionally, community philanthropists have contributed much to the medical center. With the center's cool reception to the university's plans, the philanthropists prefer to continue giving to a center as compared to a new proposed medical school, the medical sources say.

They urge that those pushing for a medical school will have to break this close tie. This could happen in three ways.

First, the General Assembly could take the initiative and say the Wilmington Medical Center could not receive its DIMER funds (about $1.4 million) unless a Delaware medical school were established.

Also, the Pennsylvania legislature could pass a law which has already been approved by the Senate twice, that all students who attended a state-financed medical school must practice a set amount of years in Pennsylvania after graduation.

Also, some Pennsylvanian legislators have expressed concern about Delaware students going to a Pennsylvania school when some Pennsylvania candidates can't get into medical school.

Or, friction could develop between the Wilmington Medical Center and Jefferson, especially as the medical center grows.

(Reprinted from EVENING JOURNAL, Wilmington, Del., April 20, 1974)

Reflections on a Sabbatical

Irving Olshin, M.D.

As is the case with all human endeavors, several motives were involved in my selecting the Marriage Council as my sabbatical enterprise. Certainly the most obvious was the omnipresent evidence of dysfunctional marriages. Beyond this was an overgrowing curiosity about human behavior in general and the modes available for changing it when it became hurtful and destructive. Despite twenty years of clinical experience and competence in the diagnosis and treatment of physical illness, I was not at all certain that I possessed to a sufficient degree the insights into behavior and the necessary skills to help people learn to cope with either physical illness or the problems of daily living. I fully anticipated that a sabbatical spent at Marriage Council would promptly remedy all of these deficiencies and that after six months, I would be able to practice a medicine at once more comprehensive and compassionate.

How close to this fantasy I shall in fact reach must be left to the judgement of my patients. What I can now write about with a much greater degree of certainty concerns my reactions to being a student again after a lapse from that condition of almost two decades. Indeed I now feel that perhaps one of the greatest benefits which I shall take away with me from this experience is a much greater degree of empathy with students than I had when I left in February. While it may be that my patients will not immediately profit from my still unperfected skills, I am hopeful that my students will gain from this serendipitous aspect of my sabbatical.

My sabbatical taught me above all else what it feels like to deal with uncertainty. Not only did I have to cope with limited knowledge and skill in the initial stages of seeing patients, but even after I had acquired these to some degree, there were yet other uncertainties to be dealt with. Problems involving human feelings and behavior, I found, do not lend themselves to simple diagnostic labels. Nor is the physician able to prognosticate with the same degree of assurance as he can with well defined organic syndromes. I discovered that behavioral modification techniques were not always successful and that what on initial evaluation appeared to be a problem amenable to such therapy, on further scrutiny involved more complex intrapsychic processes. These processes had to be examined – and undestood by both me and the client before some of the techniques of Masters and Johnston could be used. There was also the realization, often after much resistance on my part, that some patients could not be helped with their problem for a variety of reasons. Some were, for instance, not yet sufficiently motivated to change or had enormous resistance to examining their current modes of behavior and changing them. With some couples and individuals, I had to accept the sad but inescapable fact that their marriages were unsalvagable and that they could not change destructive patterns of behavior. In a word, I had to abandon feelings of omniscience and omnipotence which are burdensome and dangerous babbage for a physician to carry. With an increasing appreciation of the complexities of human behavior, I had also to be honest and realistic enough to see that some of the improvement which patients were showing may or may not have been associated with the therapy which I was providing. The aphorism of Pare, the surgeon, often came to mind: "I dressed his wounds but God healed him.

Presenting my patients to my fellow traninees and a supervisor evoked all those, uncomfortable feelings which I had experienced when, as a medical student, I had had to present a case. What had I missed? What had I failed to do? What catastrophic consequences might follow from my errors? From this aspect of my training, I have tried to learn to take criticism without defensiveness and hostility and to recognize and live comfortably with my limitations. Students of all ages and with all degrees of sophistication must accept less than complete mastery of their fields and thereby be open to continued learning, for not from books and journal articles but from colleagues, students, and patients.

Perhaps the most valuable skill which I acquired as a result of my sabbatical experience was that of learning to be a more attentive and skillful listener and observer. These are talents which we assume most physicians have somehow acquired during their training, but the degree to which they can be refined and their usefulness in the therapeutic relationship was made much more explicit during my training. The meanings behind words, gestures, and broken appointments assumed new significance as I was directed to re-examine more critically what had in fact transpired however subliminally between me and a client.

All of these experiences have led me to a renewed appreciation of what it is like to be a medical student. Armed with experience and professional status, I nonetheless felt discomfort and unease. How much more threatened must the junior student feel seeing his first patients when he is uncertain about his skills, overwhelmed by his feelings, and plagued by uncertainties with which clinical medicine abounds. It is with a new awareness of these difficulties and, I hope, a greater empathy with the students' plight that I shall return to teaching.

IFC: A More Active Role Needed

Curt Cummings

The Interfraternity Council has made a definitely strong comeback from the doldrums of five years ago, but has not asserted its power where needed. As evidence, I've heard some complaints.

The bitching and moaning reaching this writer's desk have grown in volume and intensity over the year, at times becoming even comical. Naturally the slant that I hear from where I sit runs in certain biased directions. Yet, I've learned a lesson here at Jefferson: when a group does complain, something somewhere will be found to be wrong.

The object of all the sounding-off is our Intramural Sports, presently booming in participation and competition. Personally, I have enjoyed playing IM sports, am pleased with the progress they have made around here, and am satisfied in general with the way they were conceived and set up. IM's greatly increase the fun, recreation, and competition that can be produced solely from a physical plant even as good as ours. No pickup volleyball game could match the excitement or skill of the IM finals, nor could swimming 44 lonely laps beat the fun of the free-for-all meet.

A nasty observation is, however, to be made. The intramural system here needs an overhaul. With the competition as serious as it is, for better or worse, IFC must control it more closely. Also, while it has the clout, IFC should extend itself where it can in Jefferson's social system.

Gary McNulty is not to be faulted for his stellar role in re-establishing Jefferson's sports scene and helping to set it on the upswing. However, now there is an IFC trophy, which can only be won by a frat, but there are numerous independent entries, some of whom compete for points. There are ringers brought in by the frats for most sports, legally under the rules – but discouraging when a friendly frat blasts yours off the field with players you don't recognize. And the team seedings for each tournament have been the subject of controversy that is not worth examining.

Present control over this scene is exercised by a four-man IM committee chaired by McNulty, upon which only two of five frats are represented. IFC's first step must be to divide authority properly between itself and a reformed committee, then set intelligent eligibility and point-scoring rules, and take whatever further steps are needed to prevent IM's from progressing further into a competitive brawl. They are already ceasing to be fun.

What else can IFC do? Quite a lot. Outside of the TGIF parties, the IFC holds a monopoly on Jefferson's big social events and could do much to plan a social calendar with McNulty and Dave Grebos. Since applications to live at frat houses and-or participate in frat life are booming, steps could be taken to take advantage of it – particularly by bringing more people to more events, and perhaps by resurrecting Theta Kappa Psi, which cannot bounce back on its own. Finally, IFC has rarely stepped in to correct small abuses such as two-fraternity monopoly of Kappa Beta Phi, or one house undercutting another's parties in spite, rather than showing good fellowship. One more big thing – its voice is worth hearing in Student Council.

In short, IFC should make itself the great peacemaking force, while it can.

Fired Professor Reinstated

By Bob Sklaroff

A Jefferson ophthamology instructor was fired by the department head because of his advocacy of a bill in the Pennsylvania Legislature favoring optometrists. He was reinstated, however, by the executive coundil.

Dr. Joseph C. Toland was dismissed from his faculty position by Dr. Thomas D. Duane because he went to Harrisburg in February n order to garner support for this bill among state representatives. Both men confirmed that the only rational for Dr. Duane's action was this specific political activity.

Dean William F. Kellow stated that the dispute "resolved into whether or not the difference of opinion was an adequate basis for non-reappointment."

The bill (which has since become law) permits optometrists to use certain drugs for diagnostic purposes. Dr. Toland explains that only mydriatics, miotics and anesthetics are covered in this law, which exists in a number of other states including New Jersey. He states further that the optometrist may still not prescribe such drugs for therapeutic purposes, but may only use them for the clinical examination of the eye.

Dr. Duane feels this bill will give the patient a "false impression that he has had a complete ophthalmologic evaluation." He maintains that optometrists are not adequately trained to treat complications of use of these drugs.

Dr. Toland, an optometrist as well as an ophthamologist, feels that optometrists are quite capable of handling such rare problems (e.g., glaucoma, diarrhea). Because there are 1500 optometrists and only 350 ophthamologists in Pennsylvania, most of the latter concentrated in large cities, he feels that better health care will be provided to the public with expansion of the duties of the optometrist.

The dismissal was explained in a letter from Dr. Duane to Dr. Toland:

"Your activities as a faculty member in the Pennsylvania School of Optometry and your advocacy of optometry in the state Legislature are diametrically opposed to our philosophy and in my opinion represents a major step backwards in the care of patients with eye disease."

Another explanation was offered to Paul Critchlow, a reporter for the Philadelphia **Inquirer**, by a hospital spokesman representing Dr. Duane:

"Dr. Toland's association with Jefferson has not been renewed.... This is not the result of a difference in opinion, but differences in basic philosophies concerning patient care."

Dr. Duane illustrates his viewpoint rhetorically: "Do you think a chiropractor should be permitted on the Jefferson staff, interacting with students, preaching his brand of quackery?"

The letter dismissal was apparently given to Rep. Patrick McGinnis, who distributed it to all members of the House; McGinnis called the firing a "violation of Toland's First Amendment rights to free speech," according to the **Inquirer**.

Dr. Duane stated that his action had been under consideration for a period of time and that its coincidence with Dr. Toland's Harrisburg trip was just that–coincidental. He also predicted that the new law granting optometrists the right to use drugs for diagnostic purposes might soon be tested in the courts.

In lauding the reinstatement, the Philadelphia **Inquirer** editorialized:

"For the fundamental issue was whether one of this city's great medical teaching institutions would abide censorship of the expression of philosophical differences. Subtle though it might seem to some, we believe such censorship could have set a tone of intellectual tyranny which would have been stultifying to those within the institution and contemptible to reasonable people outside it."

Pakistani Prof Visits U.S. Med Schools

H.S. Faust

How do the problems of American medical education compare with those of Pakistan? This question is the basis of the World Health Organization sponsored tour of eight American medical schools by Dr. Muhammad Saleh Memon, former Dean of the Hyderabad Medical School and now Professor of Medicine of the Dow Medical college in Karachi.

In addition to the week of March 4th that he spent at Jefferson, Dr. Memon plans to spend one week each at Johns Hopkins, Ohio State, Indiana, Chicago, Buffalo, Rochester, and Harvard Medical Schools. His hope is to leave the U.S. with some concrete solutions to very disturbing problems in Pakistani medical education. These include inadequate spaces for all those applying to Pakistan medical schools (only fifty percent who apply are admitted); difficulty in enlisting basic sciences faculty, who have been M.D.s who are required to forego all medical practice when under teaching contract (they are compensated by a salary increase of 20 per-cent over clinical faculty members who may practice); and decreasing student and faculty satisfaction with the curricular structure. The curriculum requires seven years, delineated as two years of pre-med physics, biology, chemistry, and language — English the medium of instruction and Urdu the official Pakistani language, two years pre-clinical including only anatomy, physiology, and biochemistry, and three years clinical with preventive medicine, pharmacology, microbiology, pathology, medical jurisprudence, and traditional clerkships of medicine, surgery, OB-GYN, ENT, and ophthalmology.

In Pakistan, where the major health issues are not acute, curative issues such as in the U.S. but preventive care in the fields of nutrition and infectious diseases, both of which account for more than 90 per-cent of practicing medicine, the medical school aims to produce the general practitioner available for rural areas. Specialties are not emphasized with only 20 per-cent of graduating M.B.s (Bachelor of Medicine, again the British system) specializing. The prestige lies with the G.P. In fact, recently in Karachi, based on the Australian model, a College of Family Medicine was founded to aid in medical student impetus and contacts needed for better understanding of primary care.

Dr. Memon sees the American medical system as the best in the world, but claims that "the program is too ambitious and too much for a student. It should not be sor crowded as to have a student miss so much should he be laid out sick with a cold. It should be a much more flexible system." He feels the U.S. system needs a greater perspective of balance between the specialties and the primary care areas.

As to student problems in medical education everywhere, Dr. Memon states, "There should be an integrated teaching so the student can get interest and maintain that interest. Now he gets suffocated with basic sciences. Coming into the first year the student should feel he is going to treat disease, not just move from the biology of frog dissection to that of human dissection. with no feeling of purpose."

A gracious man with former students all over the world (currently two are residents at Jefferson), Dr. Memon left Jefferson with wishes that he could have stayed longer and feeling he gained much from his visit.

Dukes to Play in Jeff Village

The Dukes of Chance, Jefferson's resident Dixieland Band, performed most recently last Saturday night, May 18, at Phi Alpha Sigma's Senior Farewell Party. They will appear again on the evening of June 12 in the courtyard of Jefferson Village on South Alder Street. This end-of-the-year party, an IFC affair, commemorates the end of the sophomore Boards, and was last year acclaimed "Jefferson's best party."

This year The Dukes have played for two parties at Phi Alpha Sigma, their home fraternity, and also in concert at Jeff Hall on February 13. They have taken a genuine step up from the 1971 beginnings as an outgrowth of Phi Alph's now-dormant Jug Band. The quorum for a concert now numbers eight, and the repertoire has expanded beyond mainstays "Bill Bailey" and "Carolina in the Morning". They now feature danceband music, including "In the Mood," "Alley Cat," "Hokey Pokey" and gay nineties music.

Present membership includes those pictured above—from left Curt Cummings, Leroy Borkowski, Dave Brent, Fred Vasta, Tom Nasca, Hal Wighton, and Lee Denlinger, plus new faces Bob Bonner, Harry Knowles, and Paul Rodberg. The word from Phi Alph is this—any instrument players at Jefferson are welcome to come by!

First B.S. Nurses Graduate

The Baccalaureate Nursing Department of the College of Allied Health Sciences is graduating its first class on June 7, 1974, in the Academy of Music. Forty students will be graduating with a Bachelor of Science degree in Nursing, with hopes of passing State Board Examinations this summer to earn their R.N. certifications.

Dr. Charlotte E. Voss, chairman of the Department of Baccalaureate Nursing, wishes "Hearty congratulations" to the following forty members of the first graduating class:

Deborah H. Boehm, Linda Bucher, Jane L. Buckman, Nancy M. Calabrese, Josephine A. Catanzaro, Kathleen G. Comeaux, Ruth B. Conlon, Dolores A. Coyle, Betsy A. Davis, Janice G. DeBaun, Mary Ann Erthal, Ellen A. Gellar, Carol I. Gordon, Merle S. Gottheim, Patricia O. Haggerty, Jane A. Hummel, Lorraine M. Hwozdek, Stuart A. Lazar, Judith A. Lynch, Patricia A. Maguire, Elaine C. Mannherz, Nancy L. Mattera, Carolyn J. McCormick, Michael J. McLane, Robyn G. Midouhas, Lynda G. Mintz, Donna M. Nicolo, Theresa M. O'Connor, Elizabeth Oliver, Adele B. O'Neill, Mary E. Payne, Leigh A. Pierson, Marianne Previti, Judith A. Sedmak, Sherry L. Taylor, Ann V. Timmons, Valerie Walter, Gail E. Weiant, Linda P. Weisberg, and Rosemary A. Wozny.

Jefferson Professor Named "Outstanding Educator in America"

–Dr. Ronald P. Jensh, Assistant Professor of Anatomy and Assistant Professor of Radiology at Thomas Jefferson University, has been named an "Outstanding Educator in America."

This annual awards program honors distinguished men and women for their exceptional service, achievements, and leadership in the field of education.

Dr. Jensh, a faculty member of both Jefferson Medical College (JMC) and the College of Graduate Studies, was graduated from Bucknell University in 1960, and received his master of arts degree there in 1962. He has been teaching at Thomas Jefferson University since 1966, when he received a doctor of philosophy degree in anatomy from JMC.

He will be featured in the national awards volume, 1974-75 edition, of "Outstanding Educators in America."

Dr. Robert C. Baldridge, Dean of Jefferson's College of Graduate Studies, nominated Dr. Jensh for the award, noting that, "He was honored with the 1973 Lindback Award, which is presented by the senior students themselves. As one of the highest honors any member of the Jefferson faculty can receive, that alone speaks for his proficiency. But Dr. Jensh is also known in faculty circles as a talented and resourceful educator."

Nomination guidelines include an educator's talents in the classroom, contributions to research, administrative abilities, civic service and professional recognition.

Anderson

(Continued from page 1)

recent weeks the Canadian College of Family Physician's has agreed to sponsor a large scale double blind clinical trial that will test the validity of his hypothesis. But more of this later. His argument goes as follows:

Is there a modern epidemic of ischemic heart disease?

An editorial in the March 9, 1974 Lancet mentioned that today's common run of the mill heart attack was not even clinically described on paper until the year 1913. Dr. Anderson would take issue with this statement. He, personally, has read clinical descriptions that date back to the early 1890's. Nevertheless, it is generally accepted as true that heart attack was a rare cause for death in the English speaking western world up until shortly after World War I.

Is there any evidence in humans to substantiate these claims?

In a letter to the October 20, 1973 Lancet, Malcolm Silvers (a pathologist at the University of Toronto), Anderson et. al. demonstrate that animals who die of nutritional muscular dystrophy displayed widespread small foci of fibrosis in the myocardium. A similar histologic pattern was observed post mortem for ten out of ten patients who died of myocardial infarction. In a control group of male accident victims between the ages of 45 and 59, only two out of the ten myocardiums examined showed similar lesions.

Curiously, Schwartz and Mitchell (3) explored 75 autopsied male hearts and found no positive correlation between the degree of coronary occlusion and the appearance of small focal fibrosis in the myocardium. This would negate the role of atherosclerosis and the subsequent hypoxia in producing them.

Is this increased incidence of heart attack coincident with an increased incidence of atheroma or thrombosis?

If atherosclerotic vascular degeneration is more prevalent now than it was in the early 1900's we would expect to find an increased incidence of cerebral vascular accidents. Anderson has demonstrated (I, 2) that when differences in terminology (cerebral apoplexy, stroke, cerebral thrombosis, etc.) are taken into account the incidence of CVA's has remained approximately constant in the province of Ontario from 1900 to 1961. Since Ontario is pretty much representative of the rest of the English speaking western world, Dr. Anderson feels that he cannot be too far afield when he assumes that similar patterns are to be found in the U.S. and England.

Supporting evidence that atherosclerosis is not the all encompassing villain that it is made out to be comes from J.N. Morris at the London Hospital in England. In a Lancet Jan. 5, 1951 article Morris was unable to find any evidence of an increase in the prevalence of coronary atherosclerosis in necropsy material at the London Hospital between 1907 and 1949.

In regard to coronary thrombosis, many recent articles have commented that thrombosis is not the cause but rather is the result of myocardial infarction. Theory has it that muscle infarction leads to blood stagnation which culminates in thrombosis. The most convincing article to demonstrate this was a study conducted by a Swedish group that was reported in the Feb. 24, 1973 Lancet. By injecting radioactive fibrinogen into the veins of recently infarcted patients, it was discovered that the coronary thrombi of those patients who died contained the radioactive fibrinogen at their core. This indicates thrombus formation occurred after the injection of the fibrinogen and hence after the initial infarction.

What factor then has resulted in the modern epidemic?

Anderson in his August II, 1973 Lancet article dates the rising incidence of myocardial infarction in the U.S., England, Wales and Canada to roughly the year

THE LANCET, AUGUST 11, 1973

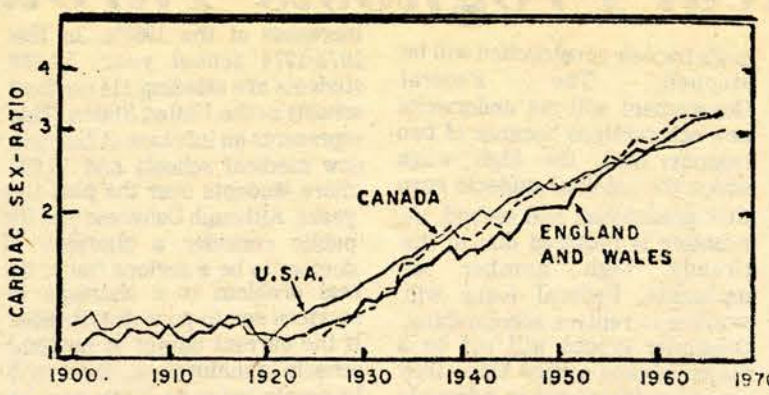


Fig. 1—Trends in the sex ratio of heart-disease death-rates in England and Wales, Canada, and the United States.

Age-group 45–64, deaths ascribed to any form of heart-disease. (Canadian data were not available before 1926.)

1920. At this time a new way of processing bread was introduced in all four countries to make white bread whiter. Unfortunately, this process also destroys nearly all the vitamin E or d-alpha tocopherol in the bread (interestingly in the Lancet article, Dr. Anderson never calls vitamin E "vitamin E" but instead refers to it by its generic name for fear of provoking a needless stop-up-the-ear kneed jerk response that often accompanies the mere mention of its popular name).

Other countries do not take 1920 as the take off point for their modern epidemic. In the case of Italy, 1947 marks the beginning of their epidemic and it may be more than coincidental that shortly after 1945 Italian flour makers adopted the American and English method for processing grain.

Other environmental and dietary factors such as butter-fat, meat, and sugar consumption as well as motor vehicle sales do not fit so neatly into the evolving picture.

How can a deficit of vitamin E cause heart disease? Is there a relation?

One of the purposes of vitamin E in the body is to act as an antioxidant. That is it protects unsaturated fatty acids from combining with oxygen. To quote Dr. Anderson, "Nutritional muscular dystrophy is a disease that develops in a number of animal species when dietary unsaturated fatty acids are inadequately protected by antioxidants. Under these circumstances highly reactive lipid peroxides are formed that affect both skeletal muscle and the myocardium, and the animal is liable to die suddenly of a 'heart-attack', especially when stressed. It is suggested that a subclinical form of this disease may have developed in man (especially males) during the past few decades, and that by increasing the vulerability of the myocardium to atherosclerotic ischemia, it has increased the incidence of myocardial infarction."

Note that Dr. Anderson does not exclude "atherosclerotic ischemia" as a factor in the pathogenesis of a myocardial infarction. He merely points out that a vitamin E deficit may produce a vulnerable myocardium that could be the deciding factor that tils the scales in favor of infarction over non-infarction.

What will the future bring?

Dr. Anderson has recently persuaded the Canadian College of Family Physicians to sponsor a project that would test the efficacy of vitamin E in treating angina pectoris. Three or four hundred subjects will be recruited to participate in a double blind trial that will be carried on over a two year period.

It is surprising that previous to Dr. Anderson's arrival on the scene, despite all the controversy surrounding it, only one double blind study ever tried to prove or disprove a link between heart disease and vitamin E. This was a small study on Angina conducted by Rinzler et. al. (4) The results were partially – though not impressively – positive.

To close on a somewhat tangential note, Dr. Anderson was asked in private what encouraged him to pursue his present line of reasoning in light of the fact that so many authorities would take issue with his hypothesis. He replied that his contact with Knut Haeger, the Swedish surgeon encouraged him to keep plugging away at his research. Haeger has supervised double blind clinical trials that were intended to determine whether vitamin E is of value in the treatment of intermittent elaudication (which loosely can be thought of as an angina of the legs). Haeger's experience has been that vitamin E can be of great benefit for this condition (5). Numerous other clinical trials have resulted in a similar confirmation of benefits (6, 7, 8, 9).

Admittedly, barrels and barrels of balderdash do not even come close to estimating the amount of nonsense that has been written about vitamin E. Nevertheless, the time has come to follow up on Dr. Anderson's lead by putting our prejudices and reiterations of hearsay behind us so that we may get on with the job of submitting this controversial vitamin to the scrutiny of objective scientific investigation.

Where there is so much smoke there might be some fire.

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Author's Note: Physician's who have worked with vitamin E caution against its use in certain conditions. This article is not intended to encourage the layman to experiment with the vitamin on his own. Consult your family physician if you have any questions on the matter.

J. D. Kanofsky

Medical Prognosis Through The 1980's

Jim Burke

A possible overproduction of doctors without further increases in medical school enrollment . . . biomedical researchers working at large complexes with no teaching obligations . . . more medical schools located on college campuses . . . These are some of the forecasts which Dr. Robert Ebert, Dean of Harvard Medical School and President of Harvard Medical Center, revealed in his keynote address as part of Jefferson's Sesquicentennial Celebration.

These changes in medical schools of the future will be primarily due to funding adjustments. The Federal Government has been and will continue to be the most important subsidizer of medical schools. There will be no cuts in Federal funds, just no further increases. The Federal increases in the 1960's resulted mainly in increased medical school enrollment. By 1975, Federal funds for new construction will be stopped. The Federal Government will not underwrite new scholarships because of two reasons: first, the high wage which the medical students earn after graduation, and second, no incentive is required due to the already high number of applicants. Federal loans will continue to replace scholarships. Consumer groups will not be a major income source since they are more interested in adequate health insurance than in increasing costs of medical education. Contributions from large foundations, corporate industry, and the private sector will also not become anymore numerous due to their greater interest in social medicine and national health. State funding will be confined mainly to state medical schools. Contributions to medicine in the future will be diverted somewhat from medical schools to other areas, such as voluntary health services, in which the results of the contributions are more obvious and immediate. This stabilization of medical school funding will result in reallocations within the frmework of the institution and also increased tuition as a more significant source of income.

Dr. Ebert foresees an increase in the quality of health care and the availability of physicians. This will be brought about by a proper redistribution of doctors, particularly those added to the pofession during the enrollment increases of the 1960's. In this 1973-1974 school year, 50,000 students are atteding 114 medical schools in the United States. This represents an increase of thirteen new medical schools and 13.000 more students over the past five years. Although Congress and the public consider a shortage of doctors to be a serious issue, the real problem is a shortage of services due to poor distribution. If the current output of medical schools is maintained, there will be nearly twice as many doctors by 1985. Thus far, medicine has been successful at providing more physicians, but unsuccessful at providing better, more available, and less expensive health are. Further funding for increased enrollment is now being seriously questioned and seems rather unlikely because of its minimal impact. The effort should now be transferred into a better distribution of the already adequate supply of doctors to avoid an overconcentration in a limited area. Future emphasis will concern improving the primary care of Americans. One aspect of this emphasis may result in an increase in medical students from disadvantaged areas. Increased education costs and funding shortages may also result in a shortening of the pphysician's education, probably by cutting the four years for the college degree to just three.

The curriculum of medical school will become more conservative and less subject to constant revisions that have become fashionable over the past few years. Dr. Ebert described the system, block-type teaching as being an inflexible, expensive method offering little satisfaction to the professors. The trend toward this method will probably be reversed except in pathophysiology, where it seems to have been successful. The curriculum will become more structured with less electives and a greater concentration on basic science and clinical medicine. The interest in general practice will increase most significantly over the next few years, while fewer students will enter psychiatry. Medical students will continue to have little say in determining their curriculum due to their diversified attitudes and lack of unity behind a common interest. Apparently the students' views on curriculum change abruptly over the years with no set trend.

Dr. Ebert also had much to offer on the future of biomedical research. Large centers will be the focal point of the future for such research. This is based on the belief that a scientist's work is unlikely to fluorish unless there is an interchange of ideas with other scientists. These large centers will present an environment of shared ideas and technology for the researchers more than a team or group effort of research. This clustering of research into large centers will often be devoid of any accompanying teaching obligations. Competition for grants will be among centers, not individuals. In fact, the isolated scientist will find it difficult to compete with these large centers for grants. The grants will be concentrated into broad categories like cancer and heart disease. Such grants will result in less money for basic medical science. The fulltime medical faculty will decrease, while much of the full-time clinical faculty will e diverted into clinical service due to greater interest in health care. Unlike previously, medical schools in financial difficulty will be closing. The Federal Government will no longer come to the aid of such schools due to its awareness of the futility of increased supply of physicians without good distribution of health care.

Biological research is no longer confined to medical schools but is also found in many universities. Molecular biology, first a spearhead in conceptual problems, is now being applied to complicated, more practical problems. Thus biomedical research has expanded in the universities into numerous fields including virology, neurobiology, and microbiology. The university has the advantage of better facilities. This is especially true since the large number of premed students has led to more science courses and professors. Large grants will be awarded to such universities. This trend may very well lead to university-based medical schools, in which the medical faculty is preserved, but is also part of the undergraduate faculty. As a final word, Dr. Ebert cautions that these are not predictions which he makes, but rather extrapolations of present-day, self-evident trends that are likely to continue.

On March 11, Dr. John Paul spoke about his interesting work *on hemoglobin. Following this, an* informative lecture about the regulation of steroid hormone synthesis was given by Dr. Bert O'Malley to complete this phase of Jefferson's Sesquicentennial celebration.

Faculty, Perspective IV: The 'Acceptable' Addiction

Robert Brent, M.D.

No discussion of the smoking problem can be confined to the medical effects, if a fair and accurate picture of all aspects of this addiction is to emerge. Every civilization or culture develops defense mechanisms in order to engage in activities which are pleasurable but hazardous. An outsider immediately recognizes these mechanisms to be pathologic and often hypocritical. A missionary once asked the chief of a cannibal tribe if it were true that "they killed people and ate them." The chief thought a minute and then asked the missionary if it were true (in the civilized world) that "they killed people and did not eat them."

The human mind is capable of unbelieveable deception. At a site visit by staff members from the National Cancer Institute were four faculty members presenting their ideas for a clinical cancer training program. All four faculty members were chain smokers. The scene would have made an excellent cartoon with the right caption.

It is not surprising that many physicians and police officers, when addressing school audiences about the "drug" problem confine their remarks to heroin, amphetamines, LSD, and marijuana. Alcohol and tobacco addiction are acceptable drug problems in our culture. And only a small portion of our youth considers this protection for imbibers and tobacco addicts hypocritical, though they are quick to accuse the nation of being hypocritical in other areas. The fact is that no large group in our population can accuse another group of hypocrisy without itself being hypocritical.

The older generation or establishment agonizes over marijuana smoking and LSD use but condones the use of alcohol and tobacco, not only because the tobacco industry has legitimate ties to the government but because a large percentage of the population is not about to give up its addictions. On the other hand, the young and liberated who smoke marijuana completely ignore the fact that some of the money they spend on these pleasures goes to support organized crime. Furthermore, they indirectly contribute financial support to the distribution of heroin, which brings death and despair to many in the ghetto.

Let us now examine some of the medical problems of the youthful smoker. There is very little information on the short-term effects of smoking on children and teenagers but little doubt that the earlier one starts smoking the greater the chances of developing one of the late effects; but this is not our present concern. There are data that indicate that teenage smokers have physical symptoms associated with their habit—more respiratory symptoms such as cough, phlegm, breathlessness, wheezing and colds than nonsmokers.

There are other clinical symptoms and personality traits that are more common in teenage smokers. These may have a coincidental relationship or simply reflect personality factors that predispose to smoking. For example, teenage boys have a higher incidence of traumatic injuries and teenage girls a higher incidence or urinary infections than do their nonsmoking associates. Furthermore, the teenage smokers have lower grades in school, are more often truant, and are more likely to have a car available to them. It is extremely important that this type of information not be misued; the basis of these relationships is not understood and any explanation must be considered to be hypothetical. It is obvious that well-designed studies should be initiated to document the incidence and cause of respiratory or other symptoms and to further our understanding of the personality traits and needs of teenagers who adopt the smoking habit.

As pediatricians, we are concerned about the rights of the child. Not infrequently we intercede on behalf of a child whose parents may be acting irresponsibly, whether it be by preventing child abuse or by performing surgery when the parents refuse permission. Similarly, the child has little control over his immediate environment and is in no position to ask his parents to stop smoking in spite of the fact that a reasonable percentage of the nonsmoking population has an "intolerance" to smoke. The symptoms of eye irritation, rhinitis, headache, cough, wheezing, sore throat, hoarseness, dizziness, and nausea are commonly reported by nonsmokers when they are around smokers. Certain pathologic findings, such as spirals of mucous (although seen commonly in smokers), will also be found in nonsmokers who work in a "smoking" environment.

A recent report from Wayne State University indicated that children from homes where parents smoked had a higher incidence of clinical respiratory disease than did the children of nonsmokers. It is obvious that this is in an area where more data are vitally needed. Are the intolerances of adult nonsmokers primarily due to bias against the smoker or are they really due to physical symptoms induced by the chemicals in smoke? Does smoking parents affect the health of the children at home?

As physicians, we should be most concerned about prevention. It is less expensive and more efficient to direct our efforts at preventing nonsmokers from smoking—and children are the largest group of nonsmokers. Thus, antismoking campaigns should be primarily directed toward nonsmoking children and adults. The techniques involved in antismoking campaigns should recognize the importance of identification in the adoption of the smoking habit, since it is known that children are likely to smoke if their parents or older siblings do. Even teachers who smoke can influence the smoking habits of their pupils. A teenager who starts smoking at age 15, who has a smoking parent or sibling, and who feels that he will continue to smoke will, in all likelihood, become a highly addicted, inveterate smoker. Present advertising appeals to the smoking parent to give up smoking in order to decrease the chance that his children will take up smoking. As with any addiction, little help can be expected from the addicted since, if they will not stop smoking to protect their own health, it is less likely that they will stop smoking to protect their children's health.

Besides preventing the nonsmokers from adopting the habit, it is important to encourage them to become active in educating the smoker. The mental attitude and elaborate defense mechanisms of the smoker present a formidable barrier to any group attempting to reduce the incidence of smoking.

What appeal can be made to the nonsmoker? First, he can be educated to his rights of comfort and freedom from smoke. A recent editorial in Science described the high levels of carbon monoxide in the smoking cars of some trains and the abuse that the nonsmoker suffers from traveling in carriers that do not provide "separate but equal" facilities. The question of infringing on the rights of others is even more important when considering children, since they wield little influence over their environment. Those of you who have attempted to stop an inveterate smoker, either parent or doctor, on an inpatient pediatric service can realize the magnitude of the addiction. Thus, an effective campaign could inform the nonsmoking public that it has to take a more active part in preventing individuals from smoking by letting the smoker know that he is infringing on the rights of others by littering public places, polluting the air, and causing discomfort to some nonsmokers. Nonsmokers are paying millions of dollars each year for extra cleaning services in public places and common carriers. Clever advertisements depicting the average smoker in situations that are annoying to the nonsmoker, in airplane, theater, or train, could be very provocative. It may even be possible for the nonsmoking public to limit, by appropriate legal means, the areas and circumstances in which smoking is currently permitted.

Despite the fact that teenagers and college students have rejected many aspects of society, they have accepted the older generation's smoking habit. The fact is that teenagers could eliminate society's smoking addiction without revolution and without new legislation, since they hold the key to this health problem. They smoke! If they smoke, their children will smoke. Here is one national problem they could eliminate almost by themselves.

Promises, Promises! The Housing and Parking Cometh

BY John Lammie

As the cleared lots across from Orlowitz residence hall suggest, additional building on the Jefferson campus is imminent: at last more student and staff housing will be constructed, after several years of promises.

About twelve people are still living in the remaining old structures in the 900 block of Walnut Street. They will be relocated soon — this has been the cause of part of the delay — and demolition should be completed in June. The city Redevelopment Authority will then turn the block over to Jefferson, and construction will begin with a targeted completion date in the spring of 1976.

Plans have changed since last - another cause of delay - when 122 apartment units and a 200 car parking garage were proposed, Vice President for planning, George Norwood reports. A parking facility has been designed for the site of Jefferson's present parking lot, and it has been expanded to absorb this parking load. The energy crisis helped underscore that one 400 car garage between 10th and 11th streets seemed wiser than smaller ones on both sides of 10th street.

As a result, designs for the space surrounding the Stein Research building have been revised also: now about 140 apartment units will be built. They will be grouped in an L-shaped building that will have the elbow at the corner of 10th and Walnut. The main entrance and lobby will be here. Exteriorly this building will bear little resemblance to Orlowitz because, first, it will be faced with the dark brick of the Scott Building instead of rather abundant Jefferson orange variety. It will be ten stories high at the corner of 10th and Walnut, and it will be stepped down-like-stairs along the arms of the building. First floor frontage on Walnut Street and possibly some on 10th will be stores and will be leased to help subsidize apartment rentals and to retain some of the commercial flavor among the aseptic medical atmosphere of Jefferson's blocks. A large courtyard framed by the building and Stein will be attractively landscaped.

Beneath this imaginative exterior lie the guts of Orlowitz: the apartments themselves will probably be nearly indistinguishable from the present units, although some changes may be adopted as a result of questionnaries Orlowitz residents have completed.

The revised parking garage is equally creative: it will encompass the entire area of the present lot, but most of its 400 car capacity hides in two underground levels. Above ground structures have been painstakingly disguised to integrate with the rest of the campus: two 18 foot high brick veneered towers - each covering one quarter to one third of the present lot - will frame a central landscaped plaza that will provide a true "center of campus" and an open walkway between the Scott Building and Alumni Hall. The towers may be used as bases for future growth sometime in the unplanned future.

More immediately, demolition for the Clinical Teaching Facility in the 1000 block between Chestnut and Sansom should begin within thirty days, and the last tenant on the block should be relocated by January 15, 1975. The Cardeza Research Foundation should be completely moved into the Curtis Clinic building by the end of this year.

DR. SAUNDERS

Tay-Sachs Program Tests 10,000 Persons

By Philip Nimoityn

In the Fall of 1972, a program was started at Jefferson to prevent Tay-Sachs disease, a recessive genetic disease that primarily affects children of Eastern European Jewish ancestry. The disease, which results from an enzyme deficiency, causes mental retardation, blindness, and death in afflicted children by about the age of four.

Over ten thousand persons have been tested in community screenings to determine if they are carriers of the gene that causes this disease. Sixteen couples have been found in which both husband and wife are carriers. These couples, which have a one-in-four chance of producing a Tay-Sachs child, are offered prenatal diagnosis by amniocentesis. If the child will be afflicted with Tay-Sachs disease, the parents can choose to terminate the pregnancy.

Dr. Saunders: Care Of The Dying Patient

by Sno White

On March 27, Jefferson hosted a meeting of Ars Moriendi, an organization formed in 1971 by the Health and Human Values Task Force to provide a forum for the discussion and improvement of care for the dying patient. Members of Ars Moriendi represent 60 medical hospitals, schools, and organizations and include social workers, doctors, morticians, nurses and lay people.

The speaker at this meeting was Cicely Saunders, a British physician who has two additional degrees in nursing and social work. In 1967 she was able to realize one of her lifelong dreams by opening St. Christopher's Hospice in London, a hospital financed entirely by donations, built to provide for the dying patient. Of it she said, "It is planned as something between a hospital and a home, combining the skills of one with the warmth and welcome, the time available, and beds without invisible parking meters beside them that belong to the other."

Dr. Saunders believes that it is important for patients to say goodbye but also to continue to be themselves. Patients are maintained at home as long as possible before they are brought to the hospice where the median stay is two weeks. When the patients enter the hospital, every effort is made to make them feel that they are still part of the world. St. Christopher's is practically panelled in glass, and patient beds are often rolled out onto patios so their occupants can be reunited with nature. The staff also tries to reunite the patients with their families. Often fear of the ominous spectre of impending death causes families to treat loved ones as strangers. Hence much time is spent counseling the families as well as the patients on the acceptance of death. When relatives and friends come to visit, it is suggested that they participate in ordinary activities, such as knitting, or reading the newspapers. This prevents the strained museum-piece atmosphere which evolves when visitors come to "see" the patient, who feels obligated to try to be entertaining rather than to simply "be with" the patient, quietly present to share his ordeal. Patients are made to feel comfortably at home by having them bring many of their familiar belongings with them to the hospital and by having them engage in meaningful activities such as writing down their own story. With both family and patient at ease, the parting farewells can be beautiful rather than traumatic and the final days spent together peacefully memorable.

Visiting is an essential part of the care given the dying at this hospice. Visiting is permitted all day, six days a week. After a patient dies, his visitors often continue to visit other patients they met during the stay of their deceased friend. No patient goes without visitors since doctors and nurses return after they make their rounds to visit with the patients, to sit down and LISTEN. Dr. Saunders advised that it is "better to sit for two minutes than to stand poised for flight for ten."

At St. Christopher's death is accepted as an eventuality but not an end. Death is not a force to be struggled with, but a natural event for which one can prepare. One does not prepare by denying it. There are no respirators or any other life-prolonging machines in this hospice. There are no tents and tubes to isolate the patient from the world, forcing him to face his passage with fear and loneliness. The hospital stay is neither a frantic futile battle with the grim reaper nor a dismal wait for him. Rather the stay is filled with quiet joy–a joy because the time is spent coping with something real, an integral part of life itself. Dr. Saunders said, "They (the patients) are going THROUGH the hard thing, the dark thing, to the other side." The hospice sends cards of resurrection to the family on the first anniversary of the patient's death. St. Christopher's Hospice is simply a stopover on the road of life.

Dr. Saunders expressed all these philosophies by means of a warm humanistic movie and then focused on a specific case which was presented in the form of a filmed interview with a patient five days before her death. This particular patient, Sadie, explained what she had gained from her stay.

Sadie entered the hospice in a state of depression and self-pity. She had closed herself off from the world and no longer had any interests in the problems of anyone else, even her own daughter. During her stay she used her time she said, "to put my life into perspective, thinking about what I am in relation to people, life, God...There is something bigger behind us all—the world is just a little thing." Sadie did a lot of thinking and reached a state of mind that allowed her to express herself and reach out to the world. She even became reconciled with her daughter.

Sadie's suggestion to the medical profession was that doctors should stop trying to shield patients from their fate. She said that when the family knows but the patient hasn't been told, a great gap opens. Honest communication can't transpire. The family feels stilted, and the patient who Sadie contended is fully aware that he is indeed dying, feels lonely in his prohibited knowledge. Perhaps the greatest relief the patient can gain comes from telling his physician what it is that he intuitively knows. The doctor should be receptive to the outpourings of the patient's feelings, and instead of shunning death as a taboo subject he should help the patient go through the psycholoical stages that precede acceptance.

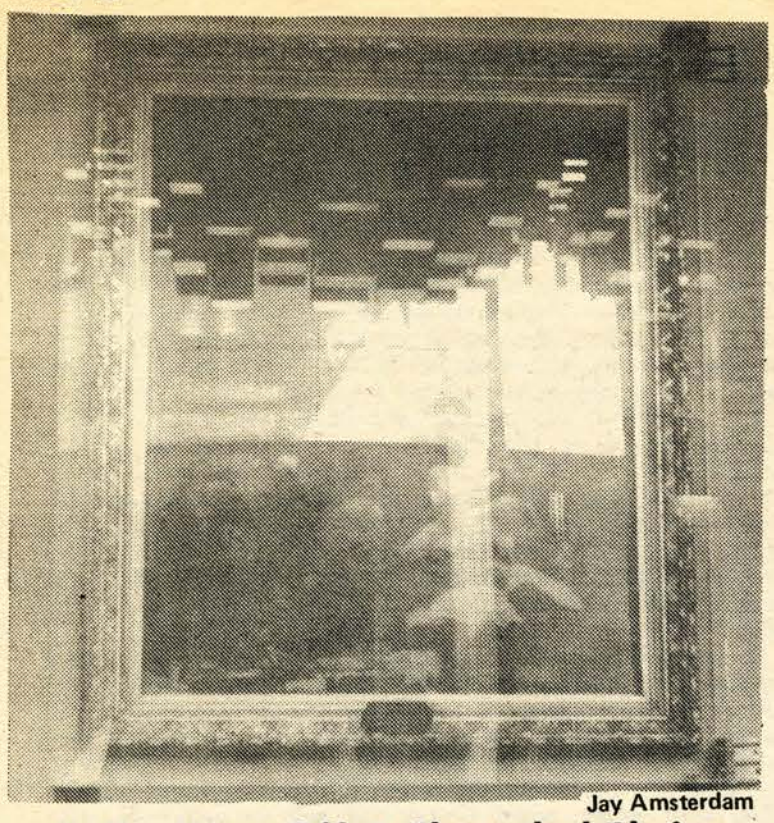
After this film was made Sadie developed pneumonia. No antibiotics were administered, but she was made comfortable with agents to relieve her congestion and distress. She died with dignity.

Dr. Saunders believes, "There is always something basic and practical you can do instead of just walking away." We have walked away from the problems and fears of dying patients too long. It's high time we recognize that much of our avoidance is due to our own inability to cope with death. It is the urgent responsibility of physicians and all those of us who deal with the dying to reconcile ourselves with the concept of death as a natural event. Terminal patients need understanding to relieve their tension, anxiety, and fear more than they need painkillers. We must cease neglecting their needs.

One of the best ways to start preparing ourselves for facing death and managing dying patients is to read Elizabeth Kubler Ross's books, **On Death and Dying**, and **Questions and Answers on Death and Dying.** In addition, Ars Moriendi is making it possible for us to actually meet Elizabeth Kubler Ross at their next meeting to be held at 8:00, May 29 in Naval Hospital auditorium. Tickets ($2.00) will be available at the door, but you can get them by sending a check to:

Health Care and Human Values Task Force, 3601 Locust Walk, Philadelphia, Pa. 19104.

If you are interested in the activities of Ars Moriendi, send a card to the above address requesting their free newsletter.



Jay Amsterdam

Reflections Off A Shrouded Shrine

A new perspective...

The electric eye on Thomas Eakins' **Gross Clinic** has been given glasses. The trouble is, the new security cover on the famed painting hanging in Jeff Hall covers it with glare as well.

Samuel Gross will continue to view the world through his $2500 window. A new spotlighting system is being considered in order to clear our respective fields of vision.

R.B.S.

Rugby is Played with Leather Balls

by R. Wing

After reading the "Sports" issue of the T.J.U. Alumni magazine, one is left with the impression that rugby is a rapidly dying sport here at Jeff. "Not so," says Mike Griffin and Crawford Smith, co-captains of the Jefferson Medical Rugby Club, and after a couple of weekend "outings" with the team, this reporter has to agree.

I journeyed with the team to the Bryn Mawr Polo Fields for an East Coast Rugby Union Tournament. Fifteen daring souls in Black and Blue took the field against a similar force from Dickinson University. Early in the game it looked bad for Jefferson as the Dickinson Scrum appeared stronger, but as the half wore on, it became apparent that they lacked speed, both in the scrum and in the backfield. So, backfield captain Dave Kamsler decided to take advantage of the speed of his "Wings," Mike Steel and Tom Nasca, by bringing the weak-sided wing across the field on plays near the goal line. The result was two quick "tries" (not touchdowns) for "T-Bird" Nasca, and the game was beyond reach.

As the afternoon progressed, the Jefferson fifteen took the field in the second round against Moravian College. Playing with the same fifteen men (Jefferson's "B" Team was busy playing Villanova Law School), the Black and Blue started out strong with two quick tries by Nasca on the same play, but tired by the half. Moravian came on strong in the second half, but another quick score and a field goal by Bill "the Toe" Mirenda put the game on ice for Jeff.

The tattered and torn Black and Blue took the field against Philadelphia College of Osteopathy in the final game of the tournament. However, Jeff could not come home with the trophy. It began to snow and rain, and the wet field neutralized Jefferson's speed. This, coupled with the fact that P.C.O. had brought enough players to have seven of their fifteen men fresh (Jeff came with only fifteen), was enough to keep the Black and Blue from victory. However, we were to have the last word as Jeff defeated P.C.O. later in the spring.

Impressed, but not thoroughly convinced that Jefferson Rugby was really on the way back, I journeyed with the team to watch the rematch with the rough and often dirty Blackthorn team. Blackthorn had defeated Jeff in the fall with a try late in the second half of that rather rough game, and this was considered a "must win" by the team.

Jefferson consistently moved the ball down the field early in the first half, but was unable to score. Finally, Mike Griffin picked up a loose ball on the one yard line and dove in for the score.

Jeff continued to control the ball with excellent running and kicking "inside" by Dave Kamsler and Pat Coughlin, but misplays near the goal line prevented another score. Blackthorn kicked the ball downfield and out-of-bounds, and it appeared as though the momentum might change. But Dave Kamsler forced a misplay and Coughlin lateraled to Nasca moving down the wing. A few broken tackles and 60 yards later, Jeff was on top, 10-0 and continued to roll, as scores by Pat Coughlin and Alex Bodenstab boosted the score even further. Jim Nocon, an OB resident and the only team member from the days when Jeff was one of the best teams in the area, urged the team on and second-half scoring on fine runs by scrum half Derf Hensal and others ran the score up to 23-0.

After the fine showing last Saturday at Blackthorn, I am inclined to say that rugby is a viable sport at THU. Enthusiasm for the sport is sufficiently great to field two teams, and the record and performances this spring indicate that the team is capable of competing with and of beating formidable rivals.

Nurses B-Ball -- Third Place

Just about the way a dramatic novelist would write it, a mini-dynasty at Jefferson came to an end, not with a bang, but with a few tired tears. And – to end the dramatics in the first paragraph -- as the emotion-charged second half saw the big rally fall short, the Nursing School Basketball Team lost a heartbreaker to Helene Fuld, 26-22, in the Philadelphia Area Playoff semi-finals. The loss ended a three-year string of league championships for the Jefferson Nurses, but they rebounded to edge HUP, 21-20 in overtime, for third pace.

The first paragraph read like a high school newspaper, but credit should be given where it is due, for a lot of good publicity has come Jefferson's way through this team's exploits. This season, despite "only" a 9-3 won-lost record, the student nurses brought home another trophy for wnning the Jefferson Tournament, plus news clips in Philly papers; a 20-18 win over PGH at the Spectrum; and television shows for two team members. Yes, national TV, for Patty Jones and Donna Ranieri made it to the national finals of the Bulova Women's Freethrow Competition. The Jefferson Tournament final, 32-24 victory over the same PGH team, was a spiritedly rough game, almost a rumle, and the best spectator show of the year.

The there was the 31-19 blasting of Cooper to make the playoffs, where the girls defied the law of averages by beating PGH a third straight time, 21-16. Finally, the aforementioned heartthrobs in the close loss to Helene Fuld, and squeaker victory over HUP. Third place notwithstanding, Sinatra might say, "It was a very good year!"

Coach Sol Kaubin's system was certainly hurt this year by the switch-over from six-man women's rules to the men's system. Jefferson's talent and his style of coaching were well-suited to the former, as only two highly mobile players are really required, and since he leans heavily on his seniors, the players could learn their fixed positions very well after three years. Five-man play requires far more mobility and skill, the big adjustment being on defense and on rebounds. Kaubin used mostly six players – Patty Jones at center, Chris Gilmore and Jane Husband at forwards, and Donna Ranieri and Denise Boyd at guards, with Keers coming off the bench. Boyd was an excellent outside shooter and team high-scorer, averaging eight points, and Jones was over half of the team's hustle, rebounds, and flying elbows. Gilmore and Husband were defensive forwards and occasional scorers. Ranieri and Keers provided much of the action – Ranieri as the ball-handler and playmaker, and Keers with her running, often shaking up the opposition defense.

The prognosis for next year? Unknown, as Ranieri, Husband, and Keers return but must be joined by untested help from the bench.

–Curt Cummings

Volleyball - - A Spectacular Competition

It was obvious to the major antagonists at the start of the double-elimination volleyball tournament that this sport might well decide the victor of the IFC trophy this year. Anything could have happened in this tournament, and the result probably should not have been so surprising as it was. Anyhow, Phi Chi A upset Phi Alph B to win the volleyball title. Never was there a more beautifully played set of games around here, and that is why volleyball is the big news in IM sports.

The story of the tourney is an interesting one, and points up what has been happening all year in intramurals —— with a concerted effort when it was needed most, Phi Chi has picked itself up off the floor to land a knockout punch, while power-house Phi Alpha Sigma teams have done a dying swan in the thick of the playoffs.

Knocking off its first two opponents in straight games, Phi Chi nonetheless did not appear a good shot to beat any of many strongly loaded teams, including Phi Alph B and C, AKK A, and the independent 'Nads. But after losing to Phi Alph B, Phi Chi in one marathon night overcame Phi Alph C and the 'Nads, then destroyed AKK the next night. Their manpower was not dependent on spikers or height, although Rich de Andino and Harry Bade became the team's main point-scorers. Having to beat Phi Alph B, the defending champs, twice on different nights, Phi Chi was able to pull it off *on strength of good old-*fashioned teamwork.

With the volleyball victory, at this writing, Phi Chi has 20 cup points, AKK is next with 16, and Phi Alph third with 13. One-on-one basketball and softball remain to be decided.

——Curt Cummings