3-1986

Ariel - Volume () Number 1

Amy Colcher

H. M. Benshoff

Franny Lizerbram

Dave Cahn

Raj Sinha

See next page for additional authors

Authors
Amy Colcher, H. M. Benshoff, Franny Lizerbram, Dave Cahn, Raj Sinha, Anton Phibes, Bruce Watson, Palmar Norte, C. Hathaway, Diane Wonnell, Ron Berna, and Wasyl Szeremeta

Thomas Jefferson University

ARIEL

March 1986 Vol. No. 1

ARIEL RETURNS
By Amy Colcher

After a hiatus of over three years, ARIEL is back. ARIEL is the student run newspaper of the Medical College of Thomas Jefferson University. A group of ambitious students, with funding from the Student Council, have revived the newspaper. At the present time contributions to the paper have been largely from medical students, but it is hoped that the paper will eventually encompass the entire university. The function of a newspaper is to inform and express the views of the community that it serves, and that is what ARIEL will do. In order to successfully represent the university population, input from all schools, and from many sources is imperitive.

The name ARIEL is taken from Shakespeare's *The Tempest*, and is, when one considers the characterization of Ariel in the play, an appropriate name for a newspaper for medical professionals.

Ariel is a spirit. He is able to deceive both the sense of sight and that of hearing. Health care professionals are also able to decieve their patients' senses with drugs, with treatments, and with words. Ariel' sactions determine the course of the play, although they are directed, for the most part, by Prospero's commands. This parallels the determination of the recovery of the patient by the actions of the physician, nurse,or therapist.

Prospero is a symbol of knowledge; his magical powers were obtained through careful and long study. Thus Ariel's performance in response to Prospero's commands parallels a health care professional's performance as a result of long years of study.

Ariel, prior to the start of the play, had been imprisioned by an evil witch for refusing "To act her earthly and abhorred commands" (I.ii.331). How often in the treatment of illness do we refuse to accept the results of damage or the call of death? We too fight the natural responses of the body, these earthly commands, as if they were anathema.

Ariel describes himself as a "minister of Fate" (III.iii.80). He is not human. He does display human emotions, although he is reluctant to admit this. He wishes to alleviate the suffering of Prospero's enemies. He tells Prospero, "If you now beheld them, your affections /Would become tender . . ./Mine would, sir, were I human" (V.i.20-22). Here is illustrated the dual view of the health care professional: an impassive God-like healer, and an emotional human being. The patient wants to see the former; most of us would like to be the former, but we are fated to be the latter. Reluctant as Ariel is to admit that he has human feelings, so too will we be to admit we have human failings. Ariel perhaps is fighting against his human feelings because they may be too intense. Working with the ill on a daily basis one must fight against those empathetic human emotions that lead one to feel for every patient. If one felt for every patient one would go crazy.

The name ARIEL has a relation to the medical profession, although it is a subjective one. This newspaper too has a relation to our medical education, to us as medical professionals. It can be a means of education as well as a vehicle of expression. Let us all work together to help it better serve us.

BRIDGING THE GAP — IT'S ABOUT TIME!
By Dave Cahn

As medical students, do we wait until hospital rotations before developing techniques that involve initial interaction with patients? Of course not! We become familiar with taking a patient's history during our first year of medical school. Why then must a medical student wait until their mini-clerkship at the end of their second year of training before receiving exposure to even the most basic professional interactions with other contributors of the health care team?

The fall 1985 Organization of Student Representatives (OSR) report that was placed in the Jefferson Alumni Hall mailboxes of current medical students devoted its entire issue toward promotion amongst the professional health care team. The report emphasized three important aspects: (1) The need for physicians to recognize and respect the professionality of other health care team members. (2) The desire for constructive collaboration between team members. (3) The benefits obtained from an interdisciplinary education, one which maximizes the ability of each professionality.

Of the three points, interdisciplinary education is the most important. Offering such an opportunity of interaction early in our professional careers would not only provide a firm foundation for the development of the other two aspects, respect and constructive collaboration, but it would also allow everyone involved the chance to become comfortable associating with

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HOMOPHOBIA UNCOVERED AT JEFFERSON?
by H. M. Benshoff

A serious problem has been uncovered in the freshman year's curriculum. Currently, the freshman class is being taught issues in human sexuality by faculty members from the Department of Psychiatry. A heterosexist attitude has become apparent, culminating in one lecturer's statement that the AMA and clinical literature consider homosexuality a "deviant pathological state. Diagnosed homosexuality is a disease, and there is treatment for it" (transcribed lecture notes, Feb. 10). This is in direct contradiction to the published views of the American Psychiatric Association. Since 1973, the DSM (The Diagnostic and Statistical Manual of Mental Disorders, the compendium of mental illnesses compiled by the APA) has not considered homosexuality a psychopathology. The same lecturer discussed rape (considered an act of aggression and violence) along with homosexuality under the heading of "Two Special Perversions" (Transcribed Lecture Notes, Feb. 3). Not a body of people to remain complacent in the face of such gross misinformation, the first year class quickly organized a petition calling for the administration to investigate this matter. Over 80 signatures were garnered within four hours, and at the time of this writing (Feb. 24), several Deans were currently assessing the situation.

Whatever the outcome of their deliberations, this matter has uncovered a profound bias in the Psychiatry Department's presentation of homosexuality. Although the course coordinator defends the course coverage of this subject by maintaining his desire to present differing views on the topic, the definite psychoanalytical bent that the material has taken so far, and is scheduled to take must be questioned (not to mention the blatant disregard for the DSM). The lecturer mentioned above speaks from and teaches a Freudian analytical approach to issues of human sexuality. The recommended text on homosexuality was written by a psychoanalyst, and the one hour lecture devoted to the topic, scheduled for March 3, is also slated to be delivered by a psychoanalyst. The problem with this narrow and one-sided presentation is that the American Freudians have long been noted for their notoriously homophobic views. Although the American Psychiatric Association and the American Psychological Association have removed their pathology classifications for homosexuality, these Freudians never have, consequently flying in the face of the APA's ruling. And while Freud surely has a place in the curriculum, we must also keep in *mind this faction's adamant resistance to* change and new ideation. Today they cling to the disease model of homosexuality; yesterday they clung to their classification of women as passive, narcissistic, and masochistic by nature.

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HEALTH CARE PROFESSIONALS: A CONTINUUM OF INTERACTIONS
by Franny Lizerbram

There are a number of medical professional programs here at Thomas Jefferson University, many of which have mysterious or intimidating names. Included under the title "College of Allied Health Sciences" are Cytotechnology (Cytotech), Medical Technology (Med Tech), Radiologic Technology (Rad Tech), Occupational Therapy (O.T.), Physical Therapy (P.T.), and Nursing. Although medical students are grouped under the separate title of "Jefferson Medical College", prospective physicians should recognize the importance of working as a team in alliance with all health care professionals. Good communication between all facets of medical care will facilitate treatment of the patient as well as make the working environment more efficient and pleasant. It is important to understand and respect the roles of other health care professionals in order to interact productively with one another. To understand the relations we have with each other is to understand the potentials of cooperative health care.

The following are impressions extracted from interviews with students in the various health care programs at Thomas Jefferson University. Their comments are not meant to be an encyclopedic account of all of their responsibilities, but an account of their primary duties and professional contacts.

CYTOTECHNOLOGY

Carla Carbo: "The two-year program at Jeff readies one for diagnostic lab work. This involves staining specimens in the preparation of slides, looking at them under the microscope, and formulating a primary diagnosis. We work in conjunction with the pathologist. Occasionally, we also work with cytologists and histologists when we receive abnormal specimens from surgical pathology, such as those from gynecological procedures, lung cancer, or lumps in the breast."

MEDICAL TECHNOLOGY

Teresa Capobianco: "Medical Technology covers four divisions: (1) Hematology—blood smears, cerebral spinal fluid sampling; (2) Immunology—radioimmunoassays (RIA); (3) Microbiology; and (4) Clinical Chemistry—urinalysis. Most of the instrumentation is automated, but we learn manual techniques as well. One can be a specialist in an area such as blood-banking. Some medical technologists can do all four areas. They may work in the lab with the cytotechnologists. The physician is not in contact with us. He sends in the orders, and we send back computerized results. There is no personal contact in the large hospital. Sometimes the physician will call in, impatient to receive the

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other health care team members. Indeed, a personal communication presented in the OSR report from Robert A. Hoekelman, M.D., Chairperson, Department of Pediatrics, U. of Rochester Medical Center, stated that "programs designed to encourage positive attitudes of medical and nursing students towards each other as co-professionals are most successful if they occur early in the educational process and if the teaching method is small group interaction rather than lecture." Such small group interactions could even take place in an informal, nonhospital environment. Members of different health care professions could conduct joint seminars designed to enhance our knowledge, our respect, and our understanding of all health care professions.

Addendum: An attempt will be made to establish such seminars. If people respond enthusiastically, we could possibly have our first program this spring. If anyone is interested in sharing ideas and/or time towards such a project, please drop a note in mailbox #58 in the Jefferson Alumni Hall. Everyone is encouraged to become involved.

(HOMOPHOBIA — cont. from p. 1)

It is beginning to look as though the medical community is even more rife with homophobia than the larger community of lay people. This is doubly tragic because it is to physicians that the public must turn when seeking information on the topic. Woe be to our patients should we internalize the attitudes that are currently being put forth by the faculty. This problem is not just localized at Jefferson. Vicious homophobia is ever-present in our patriarchal culture, and unfortunately the scientific community has often been the fount of such misinformation. Books, from the enormously popular pseudo-scientific *Everything You Always Wanted to Know About Sex*, to textbooks such as Redlick and Freedman's *The Theory and Practice of Psychotherapy*, have presented biased and often fallacious "facts" of homosexuality. And, as Richard C. Pillard discovered of the matter, anti-intellectualism was seen in the faculty of many medical colleges: "Being as ignorant as possible is a common strategy to prove that one has not been infected by unorthodox and dangerous knowledge" (Pillard, 1982). Often these so-called professionals are called upon to justify anti-gay prejudice on "scientific grounds." What these people have failed to realize is that unless homosexuality in-and-of-itself is defined as a pathology, there is absolutely no reason to regard it as such. There has never been any proven correlation between homosexuality and psychopathology. In fact, "the proportion of disturbed individuals in homosexual and heterosexual populations is roughly equivalent" (Gonsiroek, 1982a). Does not the existence of openly gay, perfectly functiong professionals irrevocably discredit the disease model of homosexuality? (See Gonsiorek [1977] for a complete review of the literature.) On the biological front, there is some evidence that homosexuality may actually be a biologically normal, genetically adaptive trait (Weinrich, 1979).

Both American Freudians and behavioral therapists continue to "treat" homnosexuality with psychoanalysis and aversive conditioning, yet one such behaviorist says, "As a therapist who uses behavior therapy for homosexuality, I do not believe it is possible to alter a homosexual orientation" (McConaghy, 1981). Research has shown that behavioral conditioning for homosexuals who wish to convert to a heterosexual lifestyle is for the most part ineffective. As Pillard succinctly puts it, "My own evaluation of these estimates of the possibility of changing sexual orientation is that they constitute consumer fraud" (Pillard, 1982).

Where does the psychiatric community currently stand on the topic of homosexuality? DSM-III does list as a category the controversial label "ego-dystonic homosexuality," used to classify individuals who have a "desire to acquire or increase heterosexual arousal" (DSM-III, 1980). This label would never apply to individuals happy with their perceived sexuality, only those in conflict with it. As DSM-III continues, "The factors that predispose to Ego-Dystonic Homosexuality are those negative societal attitudes toward homosexuality that have been internalized" (DSM-III, 1980). Thus, basically, the category refers to a specific conflict within a given individual, a situation that arises when internalized homophobia conflicts with the individual's same-sex desires. However, this ego-dystonic label is problematic. What sort of treatment does this label imply? We already know that conversion from homosexuality to heterosexuality is very difficult to accomplish, if not impossible. If we follow the logic of the label's description, should there not also be an accompanying category of "ego-dystonic heterosexuality" for those individuals who have a desire to acquire or increase homosexual arousal? Many people in the field today consider the label to be both "nonsensicial" and "useless" (Gonsiorek, 1982b). Then how is the physician to treat an individual who is greatly disturbed by same-sex fantasies or desires? The label may be ludicrous, but the symptoms caused by the conflict between observed sexual predilection and internalized homophobia are most certainly real, often manifesting themselves in self-hatred, anxiety, and in what was once known as "homosexual panic." Imagine the conflict the adolescent might feel discovering same-sex feelings within him/herself after spending a childhood denigrating "fags" and "queers."

Fortunately, in the last ten to fifteen years, new therapies have been pioneered to help ego-dystonic individuals. Today, we discover that the focus in treatment has shifted from trying to eliminate the same-sex feelings and desires, to trying to help the individual accept these feelings and desires.

"Therapy now tries to enhance homosexual functioning rather than try to eliminate it" (Coleman, 1982a). This gay-affirmative psychotherapy is also beneficial to the homosexual client who may have true psychological problems. In gay-affirmative psychotherapy, unlike therapies of the past, the professional does not assume that the client's sexuality is at the core of the problem. As one such practicing therapist writes, "Gay-affirmative psychotherapy is not an independent system of psychotherapy. The goals of gay-affirmative psychotherpay are similar to most traditional approaches to psychological treatment and include conflict resoution and self-actualization. But while the traditional goal of psychotherapy with homosexual males has been conversion (to heterosexuality), gay-affirmative strategies regard fixed homoerotic predilections as sexual and affectioanal capacities which are to be valued and facilitated (Malyon, 1982). Clearly this represents a new appraoch to the treatment of homosexual clients. Because of these new structures, much research has been forthcoming in recent years on homosexual identity formation, the coming-out process, sexual dysfunction, the efficacy of treating gay clients with gay therapists, and stages and developments specific to gay couples. (See Coleman [1982b], Grace [1979], Reece [1982], Cass [1982], and McWhirter and Mattison [1984].)

By far the biggest benefit of recent research has been, as DSM-III makes explicit, the shift from considering homosexuality a personal disease state to that of considering internalized homophobia a societal pathology. This internalized homophobia lurks everywhere in our culture, even within gay men and women themselves. Anti-homosexual bias in our culture is highly correlated with the following variables: political conservatism, authoritarianism, religiosity, sexism, racism, sexual conservatism, sex guilt, cognitive rigidity, intolerance of ambiguity, belief in the sexual double standard for men and women, and traditional views on the role of family and women (Nevid, 1983). These facts are easily demonstrated simply by looking around oneself and noticing the characteristics of the most obvious homophobic individuals. Pillard (1982) lists three reasons for this irrational fear and loathing of homosexuality in our culture: (1) the lingering Puritan residue which abhors any expression of sexuality except for procreational purposes, (2) a fear of the crumbling of patriarchal authority patterns, which are to some degree founded upon covert homosexual feeling, should homosexuality suddenly become open, and (3) a perceived threat to straight identity. These two latter points imply that individual sexual identity is a rather shaky construct. Indeed, some researchers have concluded that the extremely homophobic individual is afraid of discovering that his/her perceived sexuality is not as concrete as he/she thinks.These people do "not fear homosexuals, but fear one's own homosexual tendencies" (Nevid, 1983). Famed sexologist A. C. Kinsey would perhaps agree, for his postulated six point scale of homosexuality/heterosexuality removes this "either/or" classification, substituting for that false dichotomy a sliding scale of human sexuality. This continuum model does away with the concept of "normality," and seems a viable non-judgemental approach to patient care.

What is to be done? Primarily, the teaching of human sexuality here at Jefferson must be upgraded to meet the high standards of educational excellence. All of the information presented above was readily part of many undergraduate programs; it is sad to see that Jefferson seems so far behind the times. To update our attitudes, the faculty, administration, and student body must all make an active and conscious effort to challenge the retrograde and homophobic notions that have caused so much discrimination for so long.

On a personal level, we must "detoxify" our impressions of gay people, realizing that gay people are not terrifying creatures from the id, but indeed friends, cousins, children, parents, teachers, students, doctors, and lawyers.

A future physician's lack of knowledge of the most current and useful facts concerning gay people demonstrates negligence and irresponsibility on the part of the physician. As physicians, we must be educators as well as healers. What we learn at Jefferson we will carry with us throughout our professional careers. Let us be sure that what we learn here is not tinged with prejudice, but is even-minded, up-to-date, and scientifically accurate. It is up to each of us, as thinking men and women, to provide this integration and understanding for ourselves, for our patients, and for all of those whom we meet.

Like the individual in gay-affirmative psychotherapy, our society needs to be told that it is OK to be gay, straight, or somewhere in between. By attacking homophobia and heterosexism wherever we find it, we are creating a better world—not just for homosexuals, but for everyone.

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results. This can be a problem. In a smaller hospital there can be direct contact with the patient in drawing blood and more contact with the physician."

Jacqueline Young: "Medical Technologists are involved in lab analysis. We perform any diagnostic test needed on body fluids—culturing, examining blood cells, urinalysis, etc. The Lab Manager is in direct contact with the physician, and we deal with the Lab Manager."

RADIOLOGIC TECHNOLOGY

Fritz Winderl: "Radiologic Technology deals with taking diagnostic X-rays and continual patient care. We may come into contact with the nurses when using portable X-ray machines on the floors, but otherwise we deal with the radiologist."

OCCUPATIONAL THERAPY

Michele Broad: "We rehabilitate patients with disabilities. The physical therapist builds up the muscles and gets the patient back on his feet The Occupational Therapist works on incorporating the gained muscular strength into daily activities. We receive the chart from the physician with the physical or mental disability and set the goals for the patient."

Charles Nelson: "The Occupational Therapist utilizes activities beyond exercise in facilitating the healing of the patient. We aid them in the functional use of themselves in everyday activities. This may involve the use of adaptive equipment for better use of bodily capabilities such as splints, zipper strings, etc. The P.T. and O.T. departments may be side by side under the title of REHABILITIVE SERVICES. Our work can also extend to the mental health care area."

Rachel Nazareth: "We work in three areas: work, self-care, and play. Occupational Therapy is a means of rehabilitation through purposeful, goal-oriented activities. Our aim is to render people as independent as possible. Work contacts vary by setting. We take the team approach."

PHYSICAL THERAPY

Michele Sigman: "Physical Therapy is the evaluation and treatment of the musculo-nervous system without drugs. The physician can refer to the physical therapist who in turn refers to the occupational therapist for refining skills of daily living. But it is not a linear process—all steps are interrelated and intercommunicating."

Mark Armstrong: "Physical Therapy is the evaluation of the function on the musculo-skeletal system and treatment to this system. It is a non-invasive way of increasing the patient's capabilities, and one which makes a lasting impression without medications. It encompasses all of medicine. We can be involved with

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physicians, occupational therapists, speech therapists, and nurses."

NURSING

Judy Rappaport: "A nurse deals with wellness and the psychological issues such as stress and its affects on illness. The main difference is that they deal with the whole person, the family and not just disease and treatment. After getting my R.N. degree, I want to get a Masters in midwifery. I'll be involved in family therapy and the birthing process" (labor, delivery, and neonatal care).

Susan Livesay: "The responsibilities of a nurse differ depending on the area of the hospital in which he works. The units differ from the floor, which differs from the emergency room. Basic care occurs on the floor, while there is more autonomy in the emergency room. Nurses help with activities of daily living and watch for changes related to drugs or treatment. Teaching is an important part of nursing. It includes explaining to the patient and family about medications, disease, and clarifying the physician's orders. Nursing takes a biopsychosocial approach — that is, how illness impacts on all of life, its biological as well as emotional and social aspects. Nurses primarily deal with other nurses — teamwork is first. They work with social workers in homebound plans. Contacts with the physician depend on the nurse's position, because there is a nursing hierarchy." (Susan is currently a medical student.)

Denise Hoffman: "On the floor, patient care involves all of the basic needs. In the emergency room, the nurse works closely with the physician. Here, there is more diagnosing and use of medical knowledge. Examples include knowledge of Advanced Cardiac Life Support andd EKG rhythms. There needs to be a nice working relationship between the physicians and nurses, and an overall respect for each other." (Denise also is currently a medical student.)

Some of the responsibilities of the various medical professions have been elucidated, with the underlying theme that none of these professionals work in isolation. Beginning at the student level one must develop respect and awareness of all health-care careerists because communication on a daily basis is vitally important.

AMSA AND ETHICAL SOCIETY MAKE FRESH START
by Raj Sinha

It seems that apathy at Jefferson hit new heights in the past couple of years as several organizations and societies faded into oblivion. Fortunately, the Class of 1989 has taken matters into its own hands and is attempting to reverse those trends.

Along with the revival of ARIEL, the student newspaper, the month of February witnessed the rebirth of the Jefferson chapter of the American Medical Student Association and that of the Ethical Society at Jefferson.

Under the direction of Dr. Ronald Jensh, Tamara Guion, Martha Carlough and James Monath orchestrated the successful return of the Ethical Society as an active organization on February 20, 1986. The topic of discussion at this first meeting was the "Ethics of Drug Testing" and as the keynote speaker, the organizers chose a popular and dynamic speaker, Dr. Wolfgang Vogel, Professor of Pharmacology.

Dr. Vogel, speaking to an audience of over 70 in the Art Gallery, addressed the topic with his usual flair and eloquence. He dealt with the nature of the controversy by proving that there does indeed exist the need for drug testing, and that drugs for humans need to be tested on humans.

Pointing out the problems with obtaining a truly representative sample, he boldly proposed two new procedures to choose test subjects. The first of these proposed that prisoners on death row be used for drug studies. Vogel argued that rather than waste human lives, why not use them for something constructive that could be applied to the remainder of the population.

Secondly, Dr. Vogel proposed that everybody should be required to participate in a drug study, in much the same manner that each citizen is required to serve jury duty. He suggested that the health of each person be taken into account, so that if a particular drug were deemed too dangerous for that person, he would be assigned to another study. Nevertheless, everybody would be required to participate.

Considering the discussions that Dr. Vogel's presentation provoked, the first meeting of the Ethical Society seems to have succeeded in providing a forum for intelligent discussion regarding ethical issues that face the medical community today.

Surely, the Jefferson community will look forward to the next meeting an March 20 with Dr. Laird Jackson.

With the help pf sophomores Kenn Ashley, Laurie Karl and Gerard DelGrippo, a group of industrious freshman have undertaken the task of making AMSA an active organization once again.

At the first organizational meeting in February, new officers were elected. These students are Herbert Conaway, President; Charles Hummer and Jeffrey Paffrath, co-Vice Presidents; Raj Sinha, Treasurer; and Sheldon Lin, Secretary. Since the first meeting there have been two more meetings at which wheels were set in motion.

Delegates were chosen for the AMSA National Convention from March 5-9 in Crystal City, Va. The convention should provide a great deal of exchange with other AMSA chapters and thus give Jefferson members more ideas for future activities.

Among those already planned are the revival of the patient visitation program at the hospital and any of a number of volunteer programs with the United Way. The patient visitation program allows students to follow the progress of an assigned patient by spending a certain number of hours with that patient. Reports would be filed with a faculty advisor who would thus keep track of the student's development. The United Way programs range from organizing blood pressure clinics to speaking with high school students about contraception and STD's. For either program, interested students need only contact AMSA for more information.

As other activities are arranged, further information will be made available. Also, keep an eye out for AMSA convention highlights in the next issue of ARIEL.

ARIEL congratulates the newly elected Student Council Representatives for the coming year.

Class of 1988:
Evie Alessandrini
Kevin Ashley
Paul Kaiser
Tom Londergan
Mike Schaeffer
Paul Kotalik (Alternate)

Class of 1989:
David Cohen
Julie McCann
Barbara Shotwell
Raj Sinha
Wasyl Szeremeta
Chip Hummer (Alternate)

FILM NOTES
by dr anton phibes

[Dr. Phibes, long a resident of Maldine Square, has graciously agreed to supply ARIEL on a regular basis with critical reviews of current cinematic achievements. Professor Phibes, who holds doctorates in theology, philosophy, and music, as well as medicine, embodies a deep passion for all forms of visual and auditory stylization and makes it his personal duty to experience as much of it as his busy schedule allows. When not involved in writing this column, Dr. Phibes enjoys composing at his pipe organ, conducting his orchestra of clockwork musicians, and motoring around the neighboring countryside in his sleek, gray Hispano Suiza.]

RAN, director Akira Kurosawa's meditation on *King Lear*, is certainly one of the most impressive films playing in Philadelphia this season. Indeed, the first half of **RAN** ranks among the very best of this director's work, for here Kurosawa is working with material that can sustain his visual style with its own emotional and thematic richness. Unfortunately, the latter half of the film becomes somewhat unfocused and meandering to sustain the supremity of the former. The film begins with the aged Lord Ichimonji (Tatsuya Nakadai) dividing his kingdom between three sons. The plot then approaches the Lear mythos with the first half of the film climaxing in a fiery siege upon the old Lord and his castle. Kurosawa films most of the battle silently using only a lush musical score to hauntingly counterpoint the carnage on the screen. Stylistically, these scenes are the work's greatest achievement. The apocalyptic imagery is presented in an expressionist manner that recalls the golden age of German cinema during the 20's. (Indeed, throughout the film Tatsuya Nakadai easily suggests Emil Jannings, one of the silent cinema's greatest expressionist actors.) Yet nothing in the remainder of the film could live up to this beautifully executed sequence. Perhaps the problems are less Kurosawa's and more Shakespeare's, for the story of Lear always becomes rather meandering (dare I say dithering?) once the great man has played his mad scene. The view of humanity depicted by the mythos, as Shakespearean scholars would note, is a harsh and unchanging one. In this light, the film's closing image of the Gloucester surrogate perched on a decaying castle wall, having lost his symbol of faith and now facing the abyss of man-made destruction, works quite well. The machinations of the plot and its dreary world view, however, are not enough to sustain the dwindling emotional investment in Lear himself. Kurosawa cannily creates the character of Lady Kaede (Mieko Harada), a femme fatale to make all others blush, to bolster the film's latter half. Unfortunately, the inevitable battle scenes that make for the film's climax seem slightly overblown, hearkening one back to the excessive longeurs of Kurosawa's earlier film, THE SEVEN SAMURAI (1954). Nonetheless, for beautiful visual design, powerful imagery and sequencing, and a strong, tight narrative (especially in the film's first half), Kurosawa's RAN is definitely worth experiencing. It surpasses any other screen adaptation of *King Lear*.

HANNAH AND HER SISTERS is the new Woody Allen film in town, and as one has come to expect from Mr. Allen, the film is an intelligent, witty, and sane-eyed look at modern love, life, and death. Hannah and her siblings, beautifully played by Mia Farrow, Barbara Hershey, and Diane Wiest, are the daughters of a retired song and dance team, touchingly played by Maureen O'Sullivan (Mia Farrow's real life mom) and, in his last performance, Lloyd Nolan (a staple of Hollywood melodrama since the forties). The crux of the plot, if one can use that word in a work that tries so hard to maintain a realistic perspective on the anti-narrative continuum of life, concerns Hannah's husband (Michael Caine) who finds himself to be madly in love with his wife's sister (the Barbara Hershey figure). In addition to paying homage to Ingmar Bergman, the film is packed with Mr. Allen's stylized visual motifs and humor. HANNAH . . . includes a full canon of Woody Allen's smart and successful New Yorkers with Allen himself taking the liberty to express a full range of responses to the modern world. From Max Von Sydow's role as the bitterly pessimistic artist, who regards daily life as a subtle Holocaust, to the slightly neurotic and hypochondriachal writer played by Woody Allen, the script brings into focus the dilemma of man's eternal existential crisis and search for meaning. After hilarious bouts with Catholocism and Krishna, Allen's character discovers that there are no real answers to these questions. He concludes that nothing is absolute or static. Life, rather, is an ongoing event from one being and experience to the next. Mr. Allen beautifully visualizes this theme using repeated shots of wooden dock supports swaying in the oceanside. **HANNAH AND HER SISTERS** may not be Woody Allen's best or most original film (who can forget **ZELIG**/1983?), but it is a "Woody Allen" film. Given the supreme artisty of this individual and the relative dearth of interesting cinema currently being produced, one can easily recommend this film.

BRAZIL is another candidate for the most unique film of the decade. Starring Katherine Helmond, Jonathan Pryce, Robert DeNiro, Michael Palin, and directed by Monty Python alumnus Terry Gilliam, **BRAZIL** has been described in its press releases as an "Orwellian satire." It, too, raises existential questions like Woody Allen's new film, only in a more excessive and rarified way. Chief among these questions is what is a sane man to do in the face of an insane world? The setting of **BRAZIL** is peopled with pewling bureaucrats, obnoxious society ladies, and incompetent public servicemen, and is haunted by the ever-present spectre of Fascism. Sam, the film's "everyman" figure, is a pewling bureaucrat who dreams of flight and of someday finding the woman of his dreams. Yet his waking world is altogether another reality, and it is experiencing Gilliam's visual realization of this modern technohell that makes for most of the entertainment of **BRAZIL**. As Sam searches for the real-life counterpart to his fantasy female, one outlandish situation or character follows another, and this seemingly never-ending parade of nightmarish visions allows the set, costume, and make-up designers to go wild. Unfortunately, though, this film falls into the same pitfalls as last year's film, "1985." Without emotional interaction between the characters and their environment, the horror of the world depicted becomes merely an exercise in set design and not the cathartic experience for which the filmmakers could have striven. What's so funny about Fascism, anyway? Gilliam's climactic revelation that the face of Fascism is identical to that of Sam — i.e. that the villainous problem is not somewhere out there, but rather inside each and every one of us — seems to be the "take home message" of the film. Yet Gilliam throws away this moment far too quickly. As the protagonists inevitably fall to the fascist state, we are reminded of RAN. Both films are clothed in exciting and intriguing visual imagery, yet both films share similar fatalistic outlooks. These films explore the horror of existence without offering much hope for positive change. **HANNAH AND HER SISTERS** also looks into this void. Yet with love, logic, an appreciation of continuum, and a bit of complacency, Woody Allen lets his characters learn to live with the horrors of self-confrontation and self-realization concerning our meaningless existence. The critic's advice: put your money on Woody.

ADDENDUM: While on the subjects of religion, existence, and fascism, let's add an angry note concerning the protesting of Jean Luc Godard's **HAIL MARY**. When the film played in Philadelphia, outraged groups of Roman Catholics and lesser cults picketed the screenings. Yet none of the protesters this critic spoke with had even seen the film. Religion is a social structure that supplies ready-made answers to some of the questions the aforementioned films raise. One is terrified by the possible consequences born of individuals unthinkingly following any doctrine, including religion. Blind faith, coupled with perverse leadership, can misguide us to a fascist state. We must never forget that independent thought and creativity is the greatest capacity our species possesses. Let us exercise and praise it. As for the film, it is a typical "Godard" work, an art film nonpareil replete with impressionistic collages of ideas and images. Those who do not like Godard (dr phibes included) probably will not enjoy the film. Others will find it intriguing and provocative. Whether or not the film is "blasphemous" is irrelevant. If you think the film will offend you, then simply avoid it. But don't ask this author to understand or in any way condone such an uninformed attempt to silence an artistic event.

VIDEO PICK OF THE MONTH:
CREEPSHOW

Master of the gothic genre, George Romero's 1982 outing seeks to recreate the look and feel of the old DC horror comics. It succeeds brilliantly using intensely stylized lighting, editing, and a ghoulishly exciting screenplay penned by none other than Stephen King. Five tales of terror, plus a frame story, make for delightfully creepy entertainment with no deeper meanings other than the realization that perhaps nasty people really do get what they deserve. With Hal Holbrook, E.G. Marshall, Adrienne Barbeau, Leslie Nielsen, and Stephen King himself.

A READERS' GUIDE TO ROACHES
by Bruce Watson
Palmar Norte

(taken from La Cadena/ Feb. '86 — a Central American Peace Corps publication)

In the best selling novel *Hawaii*, James Michener traces the history of the islands from their geological beginnings to the present day. In doing so, he offers a vivid portrait of the early settlers, explorers and adventurers, but more importantly, his verbose style makes *Hawaii* an outstanding tome for the killing of cockroaches.

Speaking from a literary standpoint, not just any book will do when the average, erudite Peace Corps volunteer wants to kill a roach. And yet, paradoxically, when a roach is scurrying across the table, one has precious few moments in which to choose the deadly weapon from the shelf. For this reason, students of both etymology and entomology have found it wise to have several books in mind before turning on the light.

Literary critics from Edmund Wilson to John Updike have discussed this all important field but have yet to arrive at a concensus. Some, like Updike, favor the classics, while in others a reverence for the masterpieces precludes their use in the shedding of cockroach blood. Nevertheless, a few basic criteria can help the not-so-gentle reader choose the literary work best suited for crunching the world's most pernicious pest.

Among the criteria one must consider in choosing a roach killer is literary style. A light, airy mystery by Agatha Christie often lacks the punch needed to destroy the larger cockroaches. More deadly are the densely written, psychological character studies of a Henry James or the self-important ravings of a Norman Mailer. Even the largest of cockroaches has seen to quicken his step in the face of James' *Portrait of a Lady*, and several cockroaches in this reviewer's room wept one night when confronted with Mailer's *Ancient Evenings*.

In choosing a book, one must also consider the genre. When is it correct to kill a bicho with fiction, and when is non-fiction more apropos? This, of course, has long been the central question in the critical debate among literate cockroach killers. No one has the answer, but as John Leonard of the "New York Times" wrote in his classic study, "From Roaches to Rilke," the ultimate decision should be left to the reader, not to critical fashion. Most readers have found fiction to be a better slayer of the young and more easily influenced cockroaches. For baby roaches no bigger than ants, a simple pop-psychology work, or perhaps *Jonathan Livingston Seagull* will suffice. But again, it's a matter of personal taste. In choosing

Here's an outdated medical approach.

a book, fiction or non-fiction, classic or page-turner, the reader would do as well to ask himself a simple question: What kind of statement do I want to make to this bicho in his final moments of life? If the answer is a weighty one, if the reader wants to convey to the target roach and all others watching from the cracks that he is fed up with this invasion and is about to take decisive action, then it is best to turn to the masterpieces of world literature. Reverence for the classics may be fine for professors and critics, but the average reader has to be more realistic. The fact is that few roaches are going to fret much if their numbers are being reduced by an ordinary Ken Follett thriller or some meaningless cat book. But not even the most illiterate of cockroaches can ignore the message when a reader lifts Proust in the air and brings all seven volumes of *Rememberance of Things Past* to bear on the carapace of a crumb-nibbling member of the Blatidae family. A carefully planned murder like this can do more to rid a room of roaches than the best insecticide.

Ultimately, the choice is up to reader. When the light goes on and six roaches the size of video cassettes scurry for cover, one needs to have thought well in advance in order to do more than scramble for the nearest *Newsweek* and make an ineffectual killing of the weakest and slowest. Those who take their roach hunting as seriously as their reading will have a well-chosen book beside the light switch and ready for action.

Editors' note:

Although health-field related texts and note packets would certainly kill the pest, the bulkiness of these "literary works" precludes a swift, effective response. We suggest the classics.

WHO KNOWS THE BEST BEST?

by C. Hathaway

The difference between music critics and normal people is that music critics do not have to pay for albums. They get sent hundreds of new records every couple of months from the recording companies and therefore get exposed to more music and more styles of music than the average listener could ever dream of encountering. About half of these new records get a listening of a minute or less. The critics are paid to judge the music as music, and judge they will.

The general public also makes judgement. Yet we common folk end up judging fairly only what we deem worthy of a purchase, and this decision is based in part on what we already feel we like. What we like we buy, and what we buy becomes successful in the eyes of the music industry.

Every year the "Village Voice" asks music critics to list their favorites. The result is the annual Pazz and Jop Critics Poll ("Village Voice," 18 Feb., 1986). Likewise, the National Academy of Recording Arts and Sciences (whatever that is) presents its annual Grammy Awards. This year over two hundred critics representing the "Voice" selected their favorites yielding lists of the top 40 albums, 25 singles, 10 EP's, and 10 videos. The "Grammys" had 71 categories ranging from "Song of the Year" (to be distinguished from "Record of the Year"; i.e. best 45) to best "Polka Recording." It's interesting to compare some of their choices on their common ground which seems to be limited to rhythm and blues and rock.

Record and song of the year at the Grammys was "We Are the World" (USA for Africa) which came in as single #17 on the "Voice's" poll. Similarly, the "Voice's"

One of this year's best

select critics chose as the best "Sun City" (Artists United Against Apartheid — Year of the Benefits). Phil Collins (No Jacket Required) got Grammys for best album and pop solo male vocalist. He was ignored entirely in the "Voice's" poll where the experts chose as top albums Little Creatures/Talking Heads, Tim/The Replacements, Scarecrow/John Cougar Mellencamp, and Rain Dogs/Tom Waits (in that order). John Fogerty ("Old Man Down the Road" and "Rock and Roll Girls") received the highest rating for male vocalist with the third and thirteenth best singles. The two sides agreed on Don Henley ("The Boys of Summer" from Building the Perfect Beat) who was awarded top rock solo male vocalist by the Grammys and single #6 and album #29 on the "Voice's" critics' list.

Top pop female vocalist Grammys went to Whitney Houston ("Saving All My Love for You") and Tina Turner ("One of the Living"). Both were absent from the "Voice's" selections. Aretha Franklin ("Freeway of Love"), though, was grammied as the top R&B solo female of the year and ranked highly in the pazz and jopists poll with the #2 single and #9 album (Who's Zoomin Who). Sade, recognized as the best "new" Artist in Los Angeles, was voted fourteenth best album (Diamond Life) and twenty-fifth single ("Smooth Operator") in the "Village Voice."

Dire Straits (Brothers in Arms) received votes for twentieth on the critics' album tally and second in the videos ("Money for Nothing"). They received Grammys for top rock vocals for the single and best engineering for the album. The Commodores took twenty-third with the critics for their single "Nightshift," which also earned a Grammy for best R&B vocals.

That's it for the overlaps which are the exceptions when one views side by side these two very different approaches toward recognizing musical recordings. The critics' view is expectedly eclectic but still confined to Pazz and Jop. Whatever Pazz and Jop is, it is not for everyone. The Grammys consider all styles of music that are defined and recognized, yet this itself constitutes bias. So country/western fans get no satisfaction from the "Village Voice," and a band like the Butthole Surfers are out of the running for those little gold record players. To be fair and complete in this accounting, here's mention of some of the mentioning unmentioned by both: Grammys — Rosanne Cash and the Judds (country), David Sanborn and Wynton Marsalis (jazz), Amy Grant and Larnelle Harris (gospel), and Chicago Pro Musica and Yo-Yo Ma (classical).

The Voice's poll: Hüsker Dü had two albums in the top eight thus showing that hardcore can and will surface. Fables of the Reconstruction/R.E.M. was a favorite on college campuses in '85 and took number seven. Albums by the Velvet Underground, Bob Dylan, Kate Bush, Sting, The Mekons, Luther Vandross, Run-D.M.C., and Suzanne Vega also made the top 40 album list with The Ramones, Doug E. Fresh, The Smiths, Madonna, and Prince included in the top 20 singles.

CALENDAR OF EVENTS

March 17 — **Professional Sporting Events**
Single Phillies game tickets and Sixers Playoff tickets go on sale

March 26 — Lunchtime Entertainment with **Stephen Coffey** — piano and vocal selections

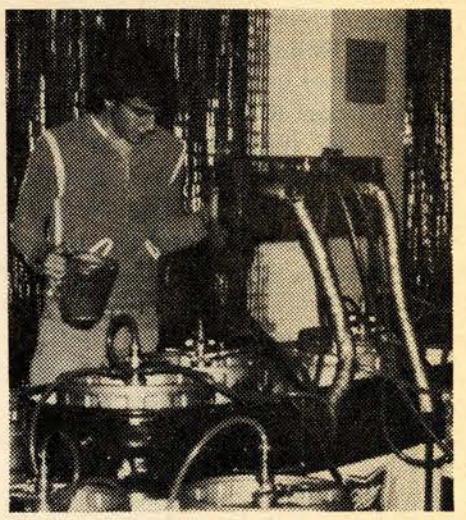
March 28 — **MY ONE AND ONLY**
Starring Tommy Tune and Luci Arnez
20 Orchestra seats available at $36.00 each
20 Lower Balcony seats available at $26.00 each

April 9 — **FANTASY DAY AT JEFFERSON**
See the performing talents of Jefferson Students and Employees

April 10 — **CASINO TRIP**
The Activities Department is sponsoring a trip to the Tropicana Hotel and Casino to see Nell Carter in performance. Cost is $14.00 per person which includeds tickets to the show plus $10.00 in coins. Bus will leave 5:30 and return by 1:30

The **Series on the Plaza** begins the last week in April and will last until May 23. The series is entitled "Freedom of Expression" and will feature jazz, pop, fifties & sixties, and folk music. Concerts are from 12-1 and admission is free.

For further information on these and any other events sponsored by the Activities Department of Thomas Jefferson University, please call (215) 928-7743.



Department of Anesthesiology

ANNOUNCEMENTS

Phi Delta Epsilon is sponsoring their annual Aaron Brown lecture this Spring. This year's speaker is Ali Z. Hameli M.D., Chief Medical Examiner for the state of Delaware. The topic of the lecture will be the "Identification of Josef Mengele".

* * * * *

The five fraternities of Jefferson Medical College wish to announce The First Annual Interfraternity Dance Marathon to support The Philadelphia Center for Older People (PCOP). May is National Older People Month, and in keeping with the spirit of this time of year, the Dance will take place from 12 noon to 12 midnight Saturday May 10, in Jefferson Alumni Hall.

What is PCOP anyway? PCOP is a multi-purpose senior center, one of the largest and oldest in the country, which provides a myriad of support for over 8,000

(cont. on p. 6)

(ANNOUNCEMENTS — cont. from p. 5)

of the Philadelphia older population. The Center provides hot lunches five days a week at the Main Center (Broad and Lombard), Northern Branch and at four community saatellites, one being the Coffee Cup at 247 S. Tenth St. right next to Jefferson Alumni Hall.

The Center offers more than just good meals. On any given weekday, there are over 150 classes, workshops and other activities taking place. A partial list includes the Studio Arts Program, chorus, glee club, drama group, opera appreciaation, country dance, sewing, macrame, guitar, ballet presentations, and holiday dances. Freshmen Kip Dolphin and Jerry Kline, as well as sophomores Dave Horton, Mike Munin, and Robert Gailliot of Phi Chi recently attended the Main Center's Valentine's Day Dance. We had a ball! Workshops on legal rights, health education, and financial planning are well attended. The list goes on and on.

The Center counsels 900 homebound people each year, helping with health, financial, and emergency care. At the Center, another 900 people receive help with housing, fuel, emergency needs, and information about benefits and entitlements, or referrals for further help. The Post-Hospital Program, a pilot project with our own Jefferson Hospital, provides care for frail people immediately after hospital discharge.

PCOP receives United Way funds, corporate, and private donations. The Center has seen cuts this year and is expecting more cuts in the future. The monies raised in conjunction with the Dance Marathon will go toward some of the harder hit programs, which include the aforementioned classes and workshops.

How can one become involved and lend support? You will be receiving specific information in the near future through the Note Service, IFC Bulletin Board, etc. There will be plenty of opportunities for involvement, from soliciting community businesses for donations, to volunteering your time and expertise down at the Center, to obtaining sponsorship and dancing in the Interfraternity Dance Marathon Saturday, May 10.

If you have questions or suggestions, please contact Robert V. Gailliot, President of IFC (923-3083), or any other fraternity brother. (Some information derived from *PCOP Annual Report 1984.*)

ANNOUNCEMENTS

The Kappa Beta Phi Fraternity of Jefferson Medical College will be sponsoring the fifty second annual Black and Blue Ball on Friday, May 2, 1986 at the College of Physicians. This black-tie event will begin at 7 o'clock with a cocktail hour, followed by a formal dinner and dancing. "Harriet Fay Music" will entertain with a wide variety of selections. An open bar will be provided until 1 a.m. This year's guest of honor will be the chairman of T.J.U.'s Department of Surgery, Dr. Francis E. Rosato, the Samuel D. Gross Professor of Surgery.

Kappa Beta Phi was founded in 1924 during Prohibition as a secret drinking society It is Jefferson's only honorary social fraternity. Following the repeal of prohibition, Kappa Beta Phi came above ground and its annual dinner-dance, the Black and Blue Ball, became Jefferson's only formal dance for medical students, faculty, alumni, and friends. In 1940, under the direction of Dr. Eli Saleeby, the accumulated profits of the preceeding dances were turned over to the board of trustees of the college and administered as the Kappa Beta Phi Loan Fund. The fund provides loans to junior and senior students and the proceeds from the 1986 ball will be used to continue this tradition.

This year's Black and Blue Ball promises to be a truly enjoyable and memorable evening, we look forward to seeing you all there.

CONSPICUOUS ONLY IN ITS ABSCENCE
by Dave Cahn

Question: What does love mean to you?

Love? In 1986? I'm from New York. We hate everyone.
Claudia Chemas
1st year student,JMC

Confusion.
Michele Sigman
Junior P.T., CAHS

Love is when everything you do is for the betterment of the relationship between you and your partner; And you know it's right. It's a purpose for living!
Robert Guilday
1st year student, JMC

To me, it's poetry. It's hard to define.
Harry Ryan
Security Personnel

Mom and Dad.
Alexandra Simkivich
3rd year student, JMC

Sensitivity, caring, and sharing.
Dave Cahn
1st year student, JMC

(Last answer placed in forum at request of those to whom I had asked the original question.)

Personals

* * * * *

FRIENDSHIP DESIRED BY INCARCERATE

It is my fondest wish that through this brief message I'll be able to establish a mutually beneficial rapport with Staff and/or students. I seek genuine friendship devoid of the nonsensical games too often allowed to hinder relationships. Any rapport built upon a solid foundation of truth and honesty will be unshakable. If you respond, I can guarantee you'll never regret doing so. If not (God forbid!), at least you'll know I exist. One is truly a very lonely number! Letters would help fill the void, and champion the monotony of institution life. Any photo accompanying a letter would be considered an additional pleasure. Be gentle with yourself.

Peace Profound,

Mayo W. Turner, Jr.
#N-20832
P.O. Box 4002
Danville, IL 61834-4002

And a special note:

The Staff of ARIEL would like to extend a special thanks to The Typesetting Company for helping us pull through with this, our first issue.

ARIEL STAFF

Editors:
Amy Colcher
Harry Kahn

Business Manager:
Raj Sinha

Sports:
Wasyl Szeremeta

Typists:
Harry Benshoff
Amy Colcher
Harry Kahn
Julie McCann
Kathy Palmer
Raj Sinha
Wasyl Szeremeta

Advertising:
Bruce Ackerman
Ed Kim
Chris Siegel

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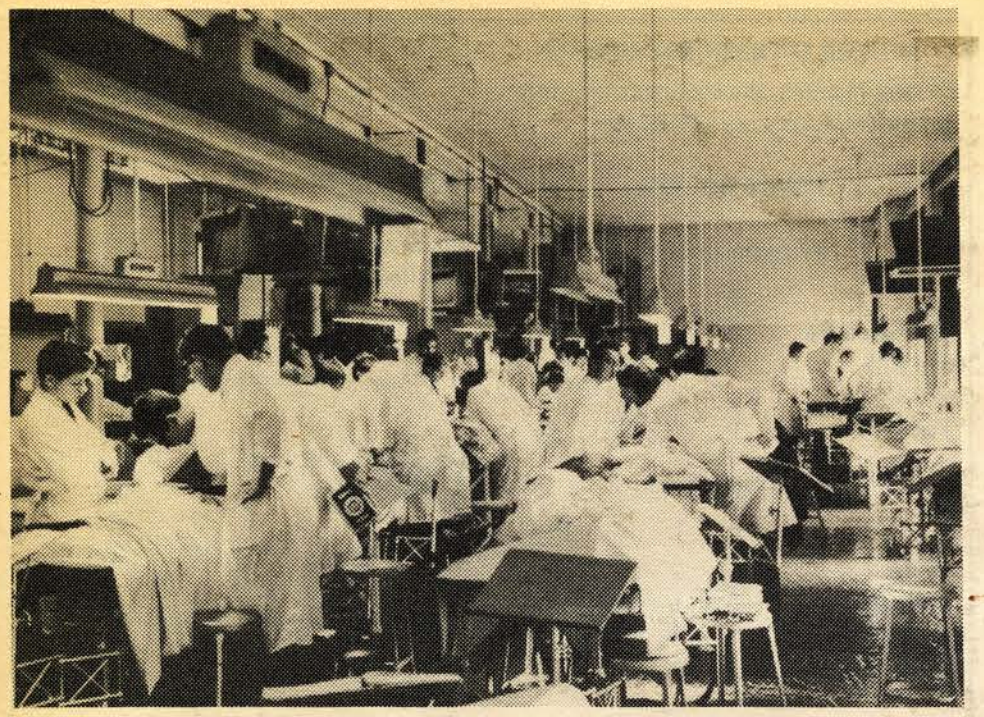

In the days before Jefferson went co-ed . . .
Jefferson was one of the last medical schools in the country to enroll women.

SEXISM IN MEDICAL SCHOOL
by Diane Wonnell

A subtle form of sexism exists within the curriculum of Thomas Jefferson University's medical school. Bassed upon an assumption of maleness, women are often treated second to men in many of the textbooks, lectures, and medical values sponsored by the college. Such sexism can have profound effects upon the attitudes and actions of medical students.

This year's anatomy text, *Anatomy as a Basis for Clinical medicine*, perpetuates this form of sexism. It is a representative outgrowth of a social phenomenon characterized by Simone de Beauvoir, author of the foremost women's history *The Second Sex*. Man, she argues, is regarded as the norm, while woman is regarded as the "Other". Pervasive as this bias has been, progress has been made regarding women's rights. The study of anatomy, like any element of a socially conscious and responsible curriculum, must reflect changes in societal views. It should not continue to purport an outdated, biased regard.

One can find many examples of this subtle sexism. In the aforementioned text, the description of the inguinal region presents a good example of the assumption of maleness. The section begins, "It is through the lower part of the anterior abdominal wall that the testis passes in its descent into the scrotum" (p.252). The premise here is that the prototypic human is male. In addition, there is disparity between the sexes simply in terms of the amount of space allotted to the male inguinal region versus the female inguinal region. The prototypic male receives approximately eight pages while the female receives only one paragraph.

Another example of the sexual bias found in Hall-Cragg's text is the discussion of the perineum. The male perineum receives an eight page description, the female perineum half that number. Indeed, the author prefaces the pages on the female with, "Using the male as a model, a pattern for the anatomy of the urogenital triangle has been established" (p.383). De Beauvoir speaks to the significance of just such a bias: "Thus, humanity is male and man defines woman not in herself but as relative to him . . ." (*The Second Sex*, p. xvi). Again one sees the male used to illustrate human anatomy with the female discussed relative to him.

A legitimate argument perhaps could be made as to why the male pelvis and perineum are emphasized in the text. For example, the male structures, being larger and external, are easier to study. Or maybe more attention is given to male anatomy because the male pelvic area is prone to complications and injury. Even if these arguments are sound, sexism still exists in the text's presentation. If such an unbalanced treatment of the sexes is warranted, it should be fully noted in the material. To do less is to condone conventional practices which have been based on the sexist "Woman as Other" ideology. Even those who agree with the above arguments cannot deny that the assumption of maleness exists in the text and **is** sexist.

Sexism also is present in the lecture hall. This fall there were instances where offensive, sexually provocative slides of women were shown, not so much for medical instruction as for "amusement". This tactic, meant to appeal to the male section of the class, is another example of assumption of maleness. Assuredly, there is nothing objectionable to jocularity during lectures; however, when the jokes demean and exclude a section of the class, they are no longer a laughing matter.

Assumption of maleness and exclusion of women also are evident in the predominant use of male values in the presentation of various health-related parameters. This bias, one that seems to pervade medicine, is illustrated in some of our textual material. For example, the Upjohn Nutrition text that the first year medical students were given lists tables which include data on males only (see pp. 17, 64, and 76). *Respiratory Physiology*, by Allan H. Mines, presents data on pages 8, 10, and 63 that is based upon male values. Parameters for females are not presented. Likewise, the material discussed in lecture often is based upon male systemic levels exclusive of female values (see p. 183 of Physiology handout taken from Comroe). If there is no legitimate reason for the majoral use of male values, then this sexual bias must be investigated and irradicated. Female parameters must be included for equality and completeness.

These examples of sexism are significant for a number of reasons. First, the sexual bias presented in the text has a great effect upon both students and faculty, because lecture material and laboratory study are often based closely upon the text. Second, the existing presentation has a tendency to make students more knowledgeable of, and therefore more comfortable with, male anatomical structures and systemic values. Third, it easily is conceivable that this inequality may affect a physician's attitudes toward his or her patients. The importance of searching our everyday existence for examples of sexism is that we may then begin to eradicate biases in society, leading towards equality for all. This is not a leap in judgment when one considers the profound effect that subtle conventions have upon our attitudes and actions.

A sensible restructuring of the subject's presentation would reduce the inequality which now exists. Non-sexist texts should be written. Such books should stress equally the male and female structures and should present the female figure as often as the male when referring to human anatomy. Clarification of sex, rather than assumption of maleness, would comprise the format of these textbooks. Efforts also should be made to include female as well as male medical parameters, or simply human systemic values if applicable. Furthermore, lectures here at the university should be more carefully worded to avoid a sexual bias. Finally, students and faculty alike should be more conscientious about clarifying sex.

Not only would these simple changes reduce the sexism that is present in texts and lectures, but they would also make the study of certain subject matters less confusing. In the present anatomy texts, one cannot be sure whether a structure described for "the general human" also occurs in the female. In addition, when the female structures are included at the end of a chapter, almost as an afterthought (see text p. 269), the student is left confused about the relationship between these structures and those described earlier for the prototypic human form. Similarly, it is difficult to ascertain female medical values, because often they are neither given nor even discussed.

The sexism which exists in medicine, and in medical school, is a reflection of an outdated sexual bias which unfortunately lingers on. Obviously, medicine is not immune to larger social opinions and reform. Physicians, medical school faculty, and students must respond to a growing awareness of the subtlety and pervasiveness of sexism by recognizing problems where they exist, and by making any and all attempts to change them. As society grows less sexist, medicine and its study must follow suit.

OF HUMAN BONDAGE
OR THE CYCLICAL NATURE OF A MEDICAL STUDENT'S EXISTANCE
By Ron Berna

It has become painfully apparent that the life of a medical student is not governed by the gravitational forces which control the earth, but by the cycle of tests to which the poor wretch is subjected. This cycle is a rather bizzarre one. Let's start at its beginning, where all good circles have their origin, and trace the path of this rather strange behavior pattern.

The commencement of a new school block brings enthusiastic freshmen to medical school who are excited about the interesting things they are about to learn. What the poor fools do not realize is that, while a little knowledge may be a dangerous thing, a lot is life threatening.

At this point our medical student is congenial and happy. He/she still has time to devote to interests other than academic ones which gives him/her a false sense of sanity.

Sometime during the second week our industrious scholar vows to catch up and remain caught up, but unfortunately our poor wretch has underestimated just how far behind he/she has become. With this realization begins the stressful part of the cycle.

During the third week our protagonist is once again confronted with new trials. There is one thing that makes our hero very nervous at this time, the "hang your lab partners" syndrome. This strange malady affects medical students when they realize how hopelessly behind in lab they are. At first the syndrome produces nervousness, but it progesses producing terror at its worst stages. The terror sets in when lab partners are heard discussing structures in the cadaver which are totally foreign to the listener. It is as though the listener were transported to some strange planet to eavesdrop on the conversation of some moon creatures. The listener is left feeling desperate, without a clue. The terror increases when the listener realizes that he/she read the chapter in which the structures being discussed had been presented, the previous night; the listener realizes he/she has retained nothing.

The end of the third week brings pseudo-relief. The medical student lives a paradox. She/he attempts to keep up in school by doing as little as possible, every medical student's dream.

Unfortunately, all too soon the dreaded fourth week arrives. Terror turns to horror. Somehow, somewhere, there has got to be a better life than the one our poor scholar lives the week before the exams. Not just one, not even two, but three exams all at once. This is a formidable taks indeed, even for our humble scholar. This is the week and weekend of the living nightmare.

At this time the medical student's most precious commodities are in diametric oppostion to one another. While one of these is sleep, the other is anything to keep one from sleep. Sleep now exhibits the qualities of the sirens of Greek mythology. Just as the sirens signaled doom to sailors, sleep is our medicl student's most dangerous adversary. If our hero gives in to Sleep's call, she/he will be forsaking her/his studies and the pursuit of knowledge for thhe comfort of a bed; all hope for a solid evening of work will be lost.

The last week passes too rapidly, and the big day finally arrives. The student is tired, downtrodden, and depressed. He/she just wants to get the tests overwith. Nothing else can be done. Our medical student suddenly becomes very religious.

Ten fifteen rolls around and one is down. Twelve o'clock and our medical student is ready to drown his/her sorrows in massive quantities of liquid depressant, but he/she has got to hold out. There is still the practical to get through, and our hero does not start until four o'clock. He/she must wait until five to have a drink. He/she has stamina though. He/she was built for endurance, otherwise he/she would not be in medical school in the first place. Our student takes the practical. It is really bizarre. He/she could have gotten a 20 or a 90, but does not care which. His/her entire being is pervaded with a feeling of relief. She/he feels either extremely smart for being able to swallow all the material thrown at her/him or extremely stupid for being in medical school in the first place. Nothing else really matters now; it is time to party.

If we brought in an impartial psychologist she/he would be astounded. Undoubtedly, she/he would make the parallel between post exam behavior and the behavior of wild beasts freed from a cage after many years of brutal bondage. Nothing is sacred to these restless fiends. Just as before when they were solely directed to their one pursuit of studying, now they seek every hedonistic pleasure known to man with equal intensity.

When the partying has concluded, three days later, the student finally experiences some calm relief from the stresses placed upon him/her. What possible harm could come from being a stalk of broccoli for three days after a test? What could possibly happen in three days? Nine lectures and three anatomy labs, our poor wretch realizes can occur in the span of three short days. Once again our dedicated scholar starts behind.

However, this time he/she vows that things will be different. He/she will not allow him/herself to get behind, and if by chance he/she does, he/she will work harder on the weekends to catch up. What a lovely fantasty. Unfortunately, that is exactly what it is, a fantasy.

EDITOR'S NOTE

We welcome any comments or opinions regarding the contents of this paper or any other issue. Submit letters and other writings to Box 88 JAH or Box 1503 Orlowitz.

MY CRYSTAL BASEBALL
by Wasyl Szeremeta

Predictions. I love 'em. As sure as every spring marks the end of Anatomy & Physiology for the Freshmen, while Sophomore's start thinking clinical rotations and National Boards, the sports writers in this country get their own mad fever. It has been clinically shown that this illness is caused by a small bacterium called *Baseballus Predictalus*. The only known cure is for the afflicted writer to sit down at his typewriter and to generate his prediction list as to who will be in the baseball playoffs come the fall. Well fans, I am ill, and must take this opportunity to cure myself, although after you see my predictions, you may doubt if I have recovered.

American League West

I'm sorry, but this is the sorriest division in baseball. Little League is more interesting. At least if a Little League game gets boring, you can get your jollies by watching Little League parents make perfect fools of themselves. I'm picking the Royals to win this division again, because they are the only team with a little talent. After all, they did win the World Series last year, but that was because they went to that stupid 7-game format which cost the Toronto Blue Jays the division crown, and because the St. Louis Cardinals were enjoying "coke" over Pepsi. I'll let you figure it out.

American League East

The winner here is going to be the Boston Red Sox. My reasoning?? It's simple: 1. Toronto won't win, because baseball is an American sport, and therefore a Canadian team will be eliminated just for being Canadian. 2. I had a good reason for not picking Milwaukee to win, but I forgot it; the Brewers must not have been very important to begin with. 3. As for Baltimore, any city who first, can't keep track of its NFL football team, letting it escape to Indianapolis, and second, gets a championship football team, albeit a USFL one, and won't give them the respect they deserve as champions, doesn't deserve a championship baseball team. 4. Cleveland?? The Mistake on the Lake? Be serious!!! 5. It's not Detroit's year. 6. I hate the Yankees.

National League West

The only two teams that make this league interesting are the Dodgers and the Reds. My money's on Pete Rose and the Cincinnati Reds. Rose is still the little boy that never grew up, and still plays the game for its enjoyment, although I'm sure the paycheck doesn't hurt either. The Dodgers won't win this year, because at every crisis point manager Tommy Lasorda is going to think about pitching to Jack Clark last year during the playoffs and losing bigtime.

National League East

This division is easier to do by eliminating teams first, and then seeing who remains to win the title. 1. Montreal won't win for the same reason Toronto won't win. 2. Chicago can't win or we will see the end of civilization as we know it. Imagine what that city would be like if both the Bears and the Cubs won their respective sport's championships? It would not be pretty. Anyway, the Refrigerator can't play shortstop. Also, we've got their secret to victory already working in Philadelphia for another team. 3. It's not St. Louis's year either. 4. Pittsburgh fans want to sell their team. With friends like that they don't need enemies. No, scratch the Pirates for this year. That leaves the Mets and the Phillies; I like both of them, but I think the Phillies are going to edge out the Mets. They better because I'm a season ticket holder, and I want to be a satisfied customer.

The World Series you ask?? Well, even if you didn't, I'm picking the Phillies over the Red Sox in 6 games. Everyone knows the Sox choke when the weather gets cold. Well, there you have it. I feel much better now, although I wouldn't advise you plunking down your life's savings and betting with my picks. But remember, you read it here first.

WINTER INTRAMURAL UPDATE

As of March 5, the standings for winter intramural sports are as follows:

MEN'S HOCKEY

Franklin Division

	W	L	T	Pts.
Nu Sigma Nu	5	1	0	10
Phi Chi	4	4	0	8
Our Gang	1	3	1	3
Puck U	0	6	1	1

Washington Division

	W	L	T	Pts.
Fever	6	2	0	12
Alotta Lous	5	1	0	10
Green Leafs	4	4	0	8
Skarry Keeds	2	4	0	4

Semi-Finals — March 22 — 11:30
March 23 — 6:00

Championship — March 29, March 30, April 5 (if necessary) (best 2 out of 3)

MEN'S BASKETBALL

JEFFERSON LEAGUE

Div. 1 — Keith Byers Division

	W	L	Pct.	GB
The Assasins	5	0	1.000	—
The Work Force	3	1	.750	1.5
The Family	2	4	.333	3.5

Div. 2 — Dale Murphy Division

	W	L	Pct.	GB
Sudden Impact	5	1	.833	—
The First Cut	4	2	.667	1
The Leuktrienes	1	3	.250	3
Joga Brothers	0	7	.000	5.5

HAMILTON LEAGUE

Div. 3 — Lawrence Taylor Division

	W	L	Pct.	GB
Wrecking Crew	6	0	1.000	—
The Bricklayers	4	1	.800	1.5
Sixers	3	3	.500	3
Fleas	3	4	.429	3.5

Div. 4 — Charles Barkley Division

	W	L	Pct.	GB
Backrow	3	2	.600	—
Shih Bops	3	3	.500	0.5
TBA's	1	4	.200	2.0
Red Palace	0	6	.000	3.5

Semi-Final — April 16, April 17 8:00 & 9:00

Finals — April 22 8:00 & 9:00

Championship — April 23, April 28, April 30 8:00 (best 2 out of three)

All Star Game — May 5 8:00

SOPHOMORES CAPTURE INTRAMURAL FOOTBALL CROWN
by Wasyl Szeremeta

On Sunday, January 12, while most of the football world was watching the Chicago Bears demolish the LA Rams, the real football championship was being decided on Barringer Field, where The Team, after playing to a 6-6 halftime score, put up two second half touchdowns to defeat the Mooners, a group of third year medical students, 18-6.

This was a rematch of last year's championship, which the Mooners won, and it seemed that the Mooners were to begin where they left off last year. The Mooners took the opening kickoff and began moving the ball quite well. However, an errant pass by Mooners quarterback and captain, Michael Zaragoza, was picked off by The Team's Greg Narzikul. However, The Team was unable to do much with its possesion, and was forced to punt the ball away.

The Mooners began on their own 20, and promptly turned the ball over again. The Team's Brian Pelczar picked off Zaragoza's second interception of the afternoon and returned it to the Mooners' 10 yard line. The Team's quarterback and captain, Bill Prebola, chose to immediately take advantage of this turnover, and called his own number on a sweep to the left, resulting in the game's first score. The conversion attempt failed, and The Team held an early 6-0 lead.

However, that lead did not last long. After the ensuing kickoff, Zaragoza found wide receiver Brad Auffarth deep, down the right side for a 45 yard completion. After two incomplete passes, Zaragoza hooked up with Paul Schwartzkopf with a 10 yard touchdown pass over the middle. Their conversion attempt failed as well, and the half ended with the score tied at 6-6.

The Team returned the opening kickoff of the second half to their own 15 yard line. Prebola then orchestrated a good mixture of runs and passes that seemed to confuse the Mooners' defense. Seven minutes later, Prebola hit a cutting Pelczar with a pass from the Mooners' 30 yard line, which Pelczar ran in for a touchdown. Again the PAT was no good, and The Team led 12-6.

The following kickoff was returned to the 25 by Schwartzkopf, and it looked like the Mooners were ready to drive again. Instead, they ran out of gas. The Team's defense sacked Zaragazo for a loss to the 2 yard line. Unable to pass out of this deep hole, the Mooners were forced to punt. The Team could not muster much of a drive and had to punt the ball. At this point the Mooners made a critical mistake, which may have sealed their fate. Instead of taking a touchback, the Mooners' return man decided to try to bring the ball out after receiving it on the goal line, and only made it out to his own 5 yard line. Again, The Team's defense shut the Mooners down, forcing them to punt with only 4 minutes left in the game. The punt was returned by The Team to the Mooners' 25 yard line. Quarterback Prebola immediately connected with Pelczar on a down and out to the left side with a touchdown pass that Pelczar hauled in as he was sliding out of the end zone. The conversion failed, but The Team now held a commanding 18-6 lead, which would be good enough to win the championship.

It was a day where The Team stole a page out of the Chicago Bears' defensive playbook, and ended up by doing what the Bears did all season: winning. Buddy Ryan would be proud.

MOBOLIZERS CAPTURE JEFFERSON INTRAMURAL VOLLEYBALL CHAMPIONSHIP

On Wednesday, December 18, the Mobolizers defeated Our Gang 3-0 to capture the Jefferson Volleyball Championship for 1985. The scores of the individual matches were 15-13, 15-11, and 15-12.

Despite winning the championship in three straight matches, the Mobilizers found their victory anything but easy. Our Gang displayed tenacity throughout the match. But the team of sophomores kept falling victim to mental lapses on the court. The Mobilizers, a team composed of mainly Allied Health students, capitalized during these moments of confusion to frustrate their opponents, and ultimately to win the match.

In the first game it appeared that Our Gang was going to have an easy time with the Mobilizers. On the strength of John Catalano's serving, Our Gang quickly opened up an 11-2 lead, and seemed to have the first game won. But the Mobilizers' Dolly Fisher began serving flat, hard serves to the near corner, and before long, the score was knotted at 11. Ferocious net play by Jeff Ostrowski helped the Mobilizers increase their lead to 14-11. Our Gang survived three game points, before succumbing to the serve of Dolly Fisher and the Mobilizers in the first game 15-13.

The second game saw much more balanced scoring. Our Gang's early lead of 4-0 was quickly wiped out by 6 unanswered points by the Mobilizers. The next several points developed into a war between Our Gang's Peter Nowotorski and the Mobilizers' Jeff Ostrowski and team captain Jeff Hepler. Furious setting, spiking and well-timed dinks were the rule as some players had to quickly move to avoid the whistling volleyball. Nowotorski's strong front-line play gave Our Gang a tenuous 10-7 lead. But Ostrowski's serve together with the front line play of Joe Ruhl gave the Mobilizers a 14-11 advantage. Denise Kendrick administered the final service point, and the Mobilizers were only one game away from the championship.

Kendrick began the serving for the Mobilizers in the third game and quickly gave the Mobilizers a 6-0 lead. But Our Gang was not ready to quit just yet. Tim Cole began to play an inspired front line spiking points right and left while Catalano confuse the Mobilizers with his serve. The score was 12-9 in favor of Our Gang, and it seemed that the sophomore team had finally found its rhythm. But no sooner had they found the rhythm, than confusion began to rule again. Fisher served 6 straight points for the Mobilizers with Joe Ruhl administering the final spike from the left-front corner, giving then a 15-12 victory, and the championship.