3-1972

# Ariel - Volume 4 Number 6

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THOMAS JEFFERSON UNIVERSITY AND MEDICAL COLLEGE

# ariel

VOL. 4 NO. 6 MARCH, 1972

## *Kraatz Laughs Last*

by Rockey Weber

"What do you mean that wasn't funny ?"

Charles Parry Kraatz, Professor of pharmacology and wizard of the "one-liners," has decided to retire after 25 years of service to the Jefferson community. His departure will leave a gap in the core curriculum which even the Student Master Planning Committee will be hard pressed to fill.

It will not be easy to forget the name – Kraatz – which rhymes with "rots" as he so succinctly tells you on the first day of Pharmy. His perspicacity at injecting even the most mundane of pharmocology lectures with a small dose of wit goes unrivaled here at Jefferson. It is estimated that the 66-year-old New Yorker has put forth close to 7500 one liners and assorted poems, anecdotes, puns, and/ or jokes since his arrival at Jefferson in 1947. Some good, some fair, and some even rhyming with his last name.

Checking into Dr. Parry Kraatz's (he prefers Parry to Charles) educational background, we find it diverse. In 1926 he graduated with a B.A. in English from Berea College. He obtained a M.S. in Zoology at the University of Kentucky and followed that with a doctorate thesis on "The Physiology of Billy-Goat Anti-serum" at the University of Cincinnati. Presently at the age of retirement, we find that Dr. Kraatz's education is still expanding. He was married for the second time last time last July, 1971 to a pretty Czechoslovakian girl whom he met at a scientific meeting.

I asked Dr. Kraatz if, after a quarter century as an active administrator in the Jefferson Process, he would express his outlooks on two current topics: namely, curriculum change and students' attitudes.

Concerning curriculum changes, he muses:

"Everyone is aware of the mass rush to change the curriculum – no one is sure to what, but the impetus toward change of some sort is awesome. I have been unable to discern where the pressures are being generated, certainly not by recent graduates and probably not by the average medical student. I do have the feeling that somewhere are overwhelming desires to insert the clinical finger lower in the academic anatomy."

Referring to student attitudes:

"The change has been dramatic. From an almost masochistic pride in gobbling up everything put on the platter labeled 'Education' by the faculty, the present attitude seems to me almost to bespeak a fear of learning too much and perhaps too soon. The position has changed from medical education being the Number One thing in a man's life for four years, often to the exclusion of everything else, to the stance that many other interests may be as important or even more important than the academic."

On February 4, the day of his last lecture, the Class of 1974 presented Dr. Kraatz with a plaque to commemorate the occasion and to express their appreciation. The inscription was indeed a great tribute:

"To Dr. Charles P. Kraatz from the Class of 1974 of Jefferson Medical College:

"It has been said that the best teacher is not necessarily a friend. Rather it is his ability to stimulate and perpetuate the intellectual curiosity which is the basis of a sound education that

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## Counter Attack Enters Phase II

by Arnold J. Willis

Let me make one thing perfectly clear. The Venereal Disease Counter Attack program planned for April is gaining momentum and will proceed as planned. To many people who were initially interested in the drive and who did not maintain contact this seems somewhat of a surprise. However, Phase I has been nearly completed and with spectacular success.

To date, many Philadelphia high schools and even junior high schools have been entered by medical students who have taken over the hygiene classes and delivered the facts to the pupils. The feedback received from the administration, faculty and, most importantly from the public school students themselves, has been overwhelming. Yet, it is too early to slow down the attempt to educate the populace.

There are some schools which still need to be covered by student-lecturers, in addition to this there will be a necessity for many volunteers to aid in organizing, supervising and controlling both the door-to-door delivery of pamphlets by the younger students and the manning of V.D. screening stations which will be set up throughout the city. Much help will be needed to accomplish the huge goal planned.

The enemy can, and must be defeated and the timetable is set to begin in April.

Volunteers submit name, address and phone number to: Box #775, Jefferson Hall.

## Is Pass-Fail Grading Fad or Improvement ?

by Forrest West

For several years, the Student Curriculum Committee has advocated a change from the present numerical grading system to a system of honors/ pass/ fail or pass/ fail. Students would continue to be tested and subsequently shown the correct answers and the passing score in order to evaluate their performance. At the end of a course under the pass/ fail grading system, the department would tell the registrar whether the student had passed or failed. In addition, the registrar would receive a written evaluation of the student's performance.

**Self-Motivation**

The primary advantage of a pass/ fail grading system is that it would replace the external compulsion of grades with self-motivation. It would make knowledge of the subject more important and rewarding to the student than the achievement of a good grade. Since practicing doctors do not receive numerical grades for their performance, it would appear to be important to increase the student's level of self-motivation during medical school.

Without numerical grading and subsequent class ranking, a pass/ fail grading system would reduce the present competition between students for grades. The future doctor should cooperate with other students rather than compete against them (Funkenstein, 1968).

**Written Evaluations and Relevant Testing**

Besides the change in student attitudes, a pass/ fail system would place greater emphasis on the written evaluations on a student's official transcript. A written evaluation would give a more meaningful and accurate description of the student's performance in a course than a single numerical grade. Even if the numerical grade is accompanied by a reliability coefficient for that course in order to estimate the student's "true score," potential employers looking at a transcript would probably focus only on a single reported score and the class ranking which it produces.

A pass/ fail grading system would also encourage a change from the present norm-referenced testing (i.e., grading on a curve) to a criterion-referenced testing, in which a certain minimum amount of information would have to be mastered in order to pass a course. One medical school department which experimented with these minimum pass levels on examinations found that they "assisted the faculty in conceptualizing course objectives, helped clarify faculty expectation of student performance, improved the quality of department examinations, and improved the identification and counseling of nonpassing students. . .This seems to have resulted in examination questions germaine to the real issues of the course rather than questions related to the peripheral content" (Taylor et al., 1971). With Jefferson's present emphasis on a core curriculum, it would appear to be important to establish the core amount which a student is expected to learn, as well as the

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## Charles Kuralt Speaks at Jeff

by Bob Sklaroff

*I really wish you could have been along these last four years, just wandering around the country, sailing with the lobster fishermen in Maine, visiting a grist mill over in Maryland, touring a one-room schoolhouse in Louisiana, talking with Black men and women on the streets of Atlanta, Chinese-Americans in San Francisco, Mexican-Americans in Texas, and you know, sheep herders and what, farmers and steel workers and students --*

*Just hearing people talk in all the varied accents of America about their lives, their aspirations for themselves, and their families and their country. . .*

*Americans are proud of their country. They suffer wounds when she is wounded. . .They seek for leadership. . .*

*I really wish you could have been along. . .*

Is ours a sick society? Are we complacent? Alienated? Ignorant?

To answer these questions, suggests Charles Kuralt, "Listen to Americans tell their own story." Kuralt has done just that, for as a correspondent for CBS News he has taken TV viewers "On the Road" throughout the United States.

His features tell more than the story of a man with a dozen jobs, or the story of the construction of a park, or the story of the interactions of young with old. He paints a picture of an America which assumes that there exists a solution for every problem she faces.

**There is No "Silent Majority"**

Kuralt finds Americans searching for a new meaning for the old ideals of truth and justice. People are questioning, challenging, clamoring for attention. They are humane and share a public conscience.

The "little people" who run our country aren't "silent;" they are open, searching for a leader, eager to talk, decent, compassionate, unsullied by arrogance or hostility towards other people or delusions or superiority or motives of greed.

*I have found much to be comforted and reassured about. . .*

Kuralt painted an impressionist view of America for his Jefferson University Hour audience in February. A richly colorful, carefully styled, optimistic summary of our culture and where it is moving. He discussed six "concerns" he harbors for the future.

Judging from the applause at the end, Kuralt's speech seemed to captivate not only by its wit, organization, content, and insight, but also by it's constant reliance upon personal experiences to illustrate what could have been a boring sociology lecture.

(Anyone interested in listening to a tape-recording of Kuralt's comments may contact Professor Robert T. Lentz,

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## Brent Discusses Physcians Personal Problems

by Eugenia Miller

Will you become a dope addict, divorce your spouse, be a "lousy M.D.?" Dr. Robert L. Brent, Professor of Pediatrics and of Radiology, addressed these and other questions in a discussion of "Personal Problems of the Physician," at the University Hour February 9 and 16. The discussion ranged widely from finances, investments, and insurance, to self-education, to marriage, divorce and children.

At the opening of the first session, Brent developed what was perhaps the most meaningful concept of his whole discussion: the physician has an opportunity for personal growth and human understanding unmatched in any other profession. The physician is exposed to a broad cross-section of personalities. He sees them in some of the crises of their lives and confronts their basic drives and emotions. The physician with a capacity for self-development is not only an astute observer of behavior, but also one who is willing to involve himself and with his patients. "Why did I become so uneasy when John Jones told me his symptoms of ulcerative colitis? Am I as guarded and hostile as he when I must seek help from someone else?"

Brent's word on investments was: know your stock and know your personality. The M.D. who is a gambler at heart won't be bothered by moderate losses in risky stocks, whereas the doctor who worries about the dime he lost in the pay telephone will be functionally incapacitated by the loss. According to Brent, the library is the best source of information about stocks. A physician would not prescribe a drug for a patient without finding out about the effects of the drug through consulting the literature. Nevertheless, many fall into the

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# *The Making of A Doctor*

As is quite evident, Ariel has devoted much of this issue to the educational process at Jefferson–specifically the controversies over pass-fail grading and the significance of the National Board Exams. We will not comment on all the points made or take sides on the specific issues, but rather comment, with a somewhat broader perspective, on the four years at Jefferson.

It would seem that an institution which exists to provide our society with physicians should have some vision of what they would like to produce. This would then be followed by careful selection of individuals and would be exposed to an educational process constructed to fulfill the vision. We believe that Jefferson's vision is somewhat muddled. The medical profession exists to maintain the health of our people, and therefore the educational institution which trains them must have some idea about the health needs of our society and the type of people who can fulfill these needs. Yet the controllers of medical education are frequently divorced from the day to day provision of health services. Many of them are not physicians, others do not see patients on a regular basis, and the majority only see medicine from the University Hospital level. Their vision of health care is too often limited to the analysis and treatment of the chief complaint which walks into the office, and the consequent application in medical education is the provision of a storehouse of information to perform the analysis and cure the disease.

An example of the limitation of this view is provided by the currently fashionable criticism of medicine on the basis of infant mortality and life expectancy statistics which rate the U.S. inferior to many other countries. The medical profession has countered by stating that these deficiencies are not their fault, but are a consequence of the American life style and poor living conditions. They are, in effect, echoing the point that their responsibility basically ends when the person leaves the office or hospital. They are concerned with **medicine** as it was taught to them and not with **health** as it exists as a problem for everyone. But it is not difficult to guess who are the first to scream foul when non-physician attempts are made to control or change health policy. The point is that we as physicians cannot take a narrow view of our health responsibility, and yet expect to have major influence over a system which encompasses problems far beyond the disease orientation of our education.

We acknowledge that 4 years at Jefferson cannot provide all things to all people, and of necessity a certain emphasis on the scientific basis of medical practice is probably essential. Yet it must be geared to prepare physicians to see patients within the context of their total health needs. Jefferson must choose applicants and prepare physicians, in the acknowledged areas of **societal** need–primary care, psychiatry, orthopedics, etc. We must recognize that simply because one is knowledgeable in esoteric aspects of disease, it does not necessarily give one competance in managing everyday health problems which make up the vast majority of patient complaints to doctors. One must recognize that the facts one memorizes as a freshman are only as valuable as the self-discipline which is encouraged for learning completely different facts 20 years after graduation. Finally, the physicians that graduate from Jefferson must be aware of the limitations of their training, and be willing and prepared to work within a system which exists primarily for the benefit of the public–dealing with overall health rather than curing disease.

We realize that all these things have been said before, and many students and faculty may be tired of hearing them. But we repeat them because Jefferson seems far from prepared to evaluate them.

## *Letters To The Editor*: Teaching and Testing

Dear Sir:

For some time now, the possibility of a pass-fail examination grading system has been discussed at Jefferson. As a representative of I-am-not-sure-what, I have been conned by a local student (?) into expressing some views on this and the broader question of examinations and teaching in the medical school. This letter and its views should not be taken to represent anyone in particular, mostly because I've never been very representative. Unfortunately, for those that are looking for a spokesman for a cuase, I'm not a student (never was much of one). I'm not really very much like many faculty members and I don't practice medicine. Therefore, these will just have to be what they are - my thoughts.

First of all, let me say that I am basically in favor of a pass-fail system of grading. If the purpose of the medical school is to educate physicians, then we'd better decide what it takes to be a physician, who should evaluate applicants who pretend to have those qualifications, and then whoever is responsible should evaluate them and approve or disapprove their application (to become a physician) on the basis of that evaluation. In a sense the product should be passed as fit for consumption, but not marked as Grade A, B, etc. Since the consumer is being protected from other harmful products he also deserves to be protected from charlatans. Within this large framework I suppose it is necessary to preserve some gradations of evaluation in order to recommend people for specific positions, fellowships, internships, etc. Fallible as it is I would rather take that risk than having somebody know my uncle.

The basic idea here, I think, is to provide a final evaluation to screen the publics purveyors of health care. Below that final step, evaluation takes on a different tone. Evaluation of a students performance in any sense - clinical performance, oral stuttering or the calculated application of graphite to IBM sheet - should first and foremost be an aid to his learning to be a physician. The whole concept of evaluation has first to be founded on an appropriate idea of what the student has to learn to become a physician. Do you know that? I don't. And unfortunately it is my considered opinion that very few faculty members do either. That is not to say that they are either stupid or unwilling to listen or learn. But, it is to say that all of us are currently undergoing quite a change. All of medicine, and particularly medical school education, is painfully coming out of the master/apprentice stage. Because we're just coming out of that (particularly in clinical areas) most of us who are listed as teachers are only teachers because we are listed. No one taught us anything about teaching but because we are M.D.'s we are usually fat-headed enough to assume that we not only know everything about medicine but, we can teach it as well. Only a doctor would have such colossal gall! This, of course, also means that we frequently don't give much thought to what we should teach to make ordinary people into that wonderful entity - the M.D. We usually teach what we know (or assume we know), what the members of our department know, or what some famous person's textbook outline contains. Then we 'examine' the students to see if they learned what we thought we taught them. Perish the thought that this process should be related to larger goals.

My dim subconscious tells me that examinations are but one part of evaluation of a student. Evaluation should contain elements that make it a reliable entity, - that is if it tells you that a student did well in your evaluation system this should mean he is knowledgeable, not just an exams man. It should also contain an element of what is called validity, that is when your system tells you a student is good then he should be good at being a physician subsequently. If he consistently is not as good as you could predict you are evaluating the wrong things. This is making things a little simpler than they are perhaps, but the point is you can not assume that your evaluation system is reliable and valid, you have to look at it and continuously prove that it is!

Finally, I would say that evaluation should teach. An examination should teach both the student and the faculty. For the student, the exam should be able to tell him where he is not getting the hang of it; and it should be able to show him where he can really use his noggin. For the teacher (euphemism) the exam should tell him where he communicated something he did not intend to communicate, where he needs to reconsider his priorities, or where he can feel satisfied that he has placed a tool in the hands of someone who can use it.

When evaluation ceases to place its priorities on numbers and places them on teaching, and on proper evaluation of student progress, for our mutual benefit not for a ranking, then the balloon of grading deflates. Puncturing it is not as simple as changing the rules on paper. The paper rules reflect some deeply ingrained concepts. Both sides are responsible for these concepts. The faculty has classically held to the ranking of students for a variety of reasons. But students, too, cling to the system. Maybe it is primarily our pressure on them from early life that has molded the form, but it is there. A case in point is the class of 1975. Despite assurances to the contrary, many who vocalized questions about an exam prior to it, were obviously concerned about its accent on a grade. After the exam many voiced the opinion that to be asked to solve a problem was mildly unfair since no example of such problems had been openly demonstrated to them. The fact is that the exam and the subsequent display of the solutions demonstrated the problems. Some who were able to logically utilize what they knew did so and solved the problems, they perhaps discovered that knowledge can be used and not just regurgitated. Others either didn't have the knowledge, or failed to use it logically. In either case they should have been reminded of an area where they might brush up. Was the exam reliable? In spots yes. Was it valid? I am not at all sure but I intend to try to find out. Should I have been more specific and open in my assurances that I was not using it primarily to assign a grade? I do not know. Some would tell me that then the students would flush genetics and cram for biochemistry - okay, if that is the only motivation they get then somebody is not holding up their end. Who is going to force them to learn' from old Mrs. Smith in the clinic or after they have graduated? No thanks - I believe that medical school teachers should be able to motivate with out threat (God knows they have enough interesting material) and that medical school students should be adults who want to learn to reach a goal - a continuing one. In that context evaluation is a mutually introspective look telling each of us how we are doing in our progress towards our goals. In that context the accent on numbers quietly slides away and the accent is focused on learning.

Sincerely,

Laird G. Jackson, M.D.
Director, Division of
Medical Genetics

## The Jefferson Community
## The Alumni Association

Joe Sassani

During the past 14 years the 6,000 Jefferson Medical College (J.M.C.) Alumni have raised over $3,000,000 for the College. This year's goal is $500,000. In order to get some feeling for the point of view of the J.M.C. Alumni Association, I interviewed Dr. Herbert A. Luscombe, Chairman of the Dept. of Dermatology of J.M.C. and outgoing President of the J.M.C. Alumni Association.

My first question to Dr. Luscombe was, "What does the Alumni Association do for the medical students?" He responded that the Association tries to help students directly whenever possible e.g. by the financial aid guide which is being prepared and through the attempts to have the mail room open to students in the evening. However he prefers not to think of relationships in the college as, "What do you do for me or what do I do for you, but rather what can we both do to maintain and improve the quality of J.M.C. clinicians." In the latter regard the Alumni Association directs the major part of its time and all of its annual giving funds into the improvement of the teaching facilities of the medical college.

To Dr. Luscombe and the Alumni Association the reputation of Jefferson is based on the quality of the practicing physicians it teaches. Therefore, as long as the quality of this physician is maintained there is no danger of the Medical College being lost in a growing medical University just as, "the quality of the Harvard Medical School preserves its identity in a vast University." For this reason Dr. Luscombe was gratified to note that the clinical experience has been introduced into the first year of medical school.

While emphasizing Jefferson's tradition as a teacher of clinicians, Dr. Luscombe recognizes that in order to meet this goal the other aspects of a medical University, "research, publishing of findings, and all that this entails," must not be neglected. In this way the quality of the non-clinical instruction and the general academic reputation of Jefferson is maintained.

In discussing problem areas at Jefferson, Dr. Luscombe said, "The one big problem at Jefferson, if one can be singled out, is that often I see a lack of communication." To correct this he recommended that, "everything be above board and frank in the various committees and representative bodies in the college." Specifically, students could be of service by "speaking up and expressing whatever they feel needs to be expressed." Frankness is especially needed in the student representatives to the alumni Association.

Concerning the student body Dr. Luscombe said, "The more I know younger people the more I realize that they are very sensible and willing to work for the common good. And although we may be separated in age by 'several' years our basic points of view are often not very different.

The President of the Alumni Association also cited the **Ariel** as an appropriate organ of communication and recommended that it might be beneficial for representatives of the Dean's office and of the Alumni Association to write informative articles in the **Ariel** from time to time. He was also enthusiastic about the possibility of a member of the Alumni Association attending the Student Council Meetings, provided of course that this would not prove a "stifling influence on our discussions."

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# PASS-FAIL

## The Case for Pass-Fail

To the editors:

It's about time that Jefferson take its place among the ranks of those in the forefront of the graduate professional schools of this nation. The fact that Jefferson still uses numerical grades as a measure of a student's knowledge is indicative of just how far behind we are! Even a non-astute observer soon realizes that the overwhelming majority of Jeff students are not the prototype of the searching scientist with burning ambitions and high ideals, but instead, resemble vessels phlegmatically waiting to be filled with knowledge. Thriving on faculty-force-fed pearls of wisdom in anticipation of the portentous National Boards, the student is unfortunately often oblivious to the role he plays.

After the completion of one and one-half years of medical school, we have personally encountered and have heard stories of many examples of the absurdities of a numerical system of grading. Two recent examples shall be mentioned. In one sophomore course, we have seen two extremely similar exam papers, marked by the same person, one having a grade twenty points higher than the other. Also the fact that this particular course was worth three credits, whereas Pathology, which was covered in the same quarter, was worth only nine credits, seems to point out to us the worthlessness of our system of credit distribution. In another course of last quarter, the finals exams, that were returned graded, seemed to many of us not to have been read at all (deduced on the basis of the lack of comments, marks, or creases of any kind). The grading seems to have been done on the basis of builk; the more one wrote, the higher one's grade. Taking into account that this was a test that could not have had anything that really could have been considered a "wrong" answer, we were flabbergasted to find out that eight of our classmates failed the exam. Will it relieve the anxieties of those who received the failing grades to be reminded that this course was worth only one credit?

However, the above examples point out only some of the minor inadequacies of our present evaluation system, showing that numerical grading is far from infallible. We feel that the major fault of a numerical grading system is the effect it has on the motivation of the students involved. Instead of being reinforced to study for the sake of knowledge and understanding of a subject, too often the Jeff student, feeling pressured, studies for and concerns himself only with the grade. Unfortunately this practice is reinforced by the numerical grading system. For example, just recently we were speaking with a classmate who was concerned with the fact that our class was presented with nearly as much about certain fairly rare and exotic diseases, as was presented about certain very common diseases. On being asked why he had not read a textbook to supplement his knowledge on the common diseases in question, as had been recommended, he replied, "Who's got the time? I mean, the material on the tests comes only from the handouts and the lectures. I've got to study that."

How much longer must we put up with a system that pays only lip service (if even that) to the idea of studying for the sake of knowledge; that reinforces the student who studies for the grade and thus condones such a practice; and that has faculty members stating that they really don't want to give numerical grades, but since they must...; and everyone is left feeling unsatisfied? When is Jefferson going to start treating its students as mature adults?

What has the administration done? There has been one very long, nebulous questionnaire the results of which have not yet been disclosed. And there is the Pass-Fail sub-committee of the Promotions Committee that has been meeting and discussing the problem in secrecy. Their final report is due to come out soon. This abominable situation must be corrected now, before more minds are turned off from the study of medicine. Therefore, we now call for the immediate institution of Pass-Fail at Jefferson. We ask the entire student body to support this endeavor.

The Student Curriculum Committee has started the ball rolling. Their multi-proned strategy for dealing with this situation includes a survey of the Freshman and Sophomore classes. A source high in the administration has indicated that in order for such a survey to bear weight, at least 80% of each class must respond. So please, when you get your questionnaire, fill it out immediately and turn it in.

**Joseph R. Berger '74**
**Albert L. Blumberg '74**

## Pass-Fail: Better or Easier?

**by J. S. AGNELLO, JR.**

The question of pass-fail versus numerical grading has been the center of heated discussion at institutions of higher learning for several years. Many schools have adopted the former system while the majority have elected to remain with numerical grades. Still another group has found it possible to integrate the two systems in varying degrees. Inevitably, medical schools became involved in this controversy with similar results. Those which chose to operate under a complete pass-fail system, would seem not to have suffered from any loss in the quality of education or retention of material on the part of their students. Why then, shouldn't all medical schools switch to pass-fail?

Advocates of the pass-fail system have used a variety of arguments the most prominent of which, I have chosen to present. First of all, it is claimed that grades do not give an accurate assessment of the working knowledge which a person has accumulated. In other words, if one student has an 85 and another has a 75, this does not mean that the higher man has learned 10% more information; especially since examinations place more emphasis on minutia rather than upon the core of information which it is assumed all students have absorbed. Secondly, with the tremendous emphasis placed on testing and the attainment of high grades, intellectual curiosity is stifled leaving only a test-oriented study environment. Students are forced to study that material which they know will be tested on and do not have the opportunity to read for their own interest. Lastly, a system of numerical grading perpetuates and intensifies the fierce competition which originated in the undergraduate world of the pre-med. Certainly, this is an undesirable and unhealthy atmosphere for the development of future doctors.

Although these are compelling agruments against numerical grading, under careful scrutiny, each can be disproven. Analysis is carried out on each examination given at Jefferson in order to assess the validity of the numerical grades. Results have shown that some courses consistently achieve a high degree of accuracy in their numerical categorization of student ability while others have been severely lacking. It can be shown that a student has consistently earned an 85 average with a variance factor of plus3 (in a given course). That is, that on any given day, this individual would score between 82% and 88%. Studies such as these, not only give the student a fair assessment of what he has learned, but they provide department heads with information on teaching and testing effectiveness. Those departments which show high variance factors (Need I list the offenders?) are thus given concrete evidence of their ineffectiveness, regardless of the source, and advised to change their methods. Secondly, it is said that with a pass-fail system, students are not trapped into studying solely for exams and feel more freedom to explore areas of personal interest. This is an idealization which does not hold up since most students are achievement oriented and will put out their best effort only when they have something tangible to show for it. It is no great strain for the average medical student to score a 70 on a test. Why, therefore, should he force himself to work harder when both the 70 and the 85 will appear on his record as a simple "P." This is not meant as a reflection on the student's capabilities; only, that by removing one of his greatest personal motivating factors, one also encourages a lax attitude. Lastly, the heated competition which is often blamed upon the grading system is created and perpetuated by the students themselves. The medical student is no longer competing with his neighbor for an ultimate goal since he has entered a field in which he will always be in demand. Competition, then, has become a personal factor which is only as intense as the student makes it for himself. The first man in the class and the last will both be called "Doctor"—if each is personally satisfied with his performance, that is all that matters.

In conclusion, changing to a pass-fail system would do nothing to improve those departments which show a high variance factor in their grading effectiveness and would probably hide such deficiencies. Numerical grading is still the best means of assessing knowledge in the pre-clinical years of medical school—a time during which little else can be evaluated about the student's ability as a future physician. The intangibles—those factors such as bedside manner, ability to relate to people, and clinical judgement which are a part of the "Art" of medicine—are much less amenable to objective testing and become matters of great importance in the last two years of medical education. Although I will not discuss it at this time, a pass-fail system would most likely find its best application in the Junior and Senior years where numerical grades have often proved inaccurate and inconsistent from one affiliated hospital to the next; but, this is part of a separate argument entirely.

## *Grades ?*

**by Thomas J.A. Lehman**

Grades! Here we are graduate professional school students. We are all mature individuals, soon to be doctors, and they are giving us grades, just like in high school. Isn't it time they stopped treating us like children? Mandatory classroom attendance and enforced deportment are all things we left behind in high school; shouldn't grades have been left behind too?

I wish the above were true. However, after almost two years at Jefferson, I cannot agree. "Classroom deportment" was indeed left behind. In four years of college, I never sat through a lecture where the audience was as noisy, rude, or otherwise immature, as our class has been on many occasions. While some will say that the fault lies with poor lecturers, this in no way excuses the poor behavior and shouted insults. At best, it excuses poor attendance. Now our class objects to being treated as "immature individuals." Perhaps one should remember that lectures are the only time professors see our class as a whole.

Even if one ignores all of the above, a number of basic reasons remain to support the argument that grades should be given. At the same time, many people have pointed out valid drawbacks to receiving grades. Many people have told me, "Grades distract me from learning what I really will need to know;...Grades keep me from doing reading on medical subjects which interest me more;...Grades are aren't truly reflective of my abilities–look at the poorly written tests we are given." All of these statements are true, but my answer to all of them is the same. If you are really mature enough to be thinking in those terms, then you are mature enough to

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# Pass-Fail: Pro and Con

**Some Thoughts about Pass-Fail**

**by Philip C. Hoffman**

For several years, I was a staunch opponent of a pass-fail system at Jefferson. My attitude was based on two important objections to it, but recently my opinion about one of them has changed. I still maintain opposition to a total pass-fail system based on the second objection. I will initially deal with the first.

One opposition to a pass-fail system has centered around the question of internship. Proponents of the traditional grading system have argued that a pass-fail system makes it close to impossible for hospitals to pick internship applicants wisely. They are forced to rely on letters of recommendation, and **anyone** can get **someone** to write a letter stating that he is the most valuable item in the medical profession since penicillin. At a recent visit to a leading university medical center, a group of intern candidates were told by a rather antagonistic director of medical education that because they (a majority of medical schools) had elected to eliminate grading systems and therefore declined to provide information about themselves, it would be difficult to choose an intern with confidence. Despite the apparent advantage an attitude like this provides for a student with grades, I no longer subscribe to this view.

I sincerely believe that a good intern group can be chosen without a set of grades. The primary reason for this belief is that it is being done; with few exceptions, the best university internships have excellent housestaff, most of whom are graduates of pass-fail schools. Moreover, letters of recommendation can be quite significant, depending on who writes them and how well known he is to the selection committee. Any influential person, too, is discriminating about whom he describes as the next William Osler, since if he wrote everyone a sparkling letter, his opinions would lose all credence. Another reason, although tenuous, is that students who lack sterling credentials would be less likely to apply to the most competitive internships. So much for changes of opinion.

My primary objection to a total pass-fail system is the lack of incentive inherent in it. After all, if one can pass an exam with 20 hours of study, why put in twice the effort if the reward remains the same? This statement is not so ridiculous as it may sound. I have heard from housestaff at several hospitals where the medical students on service are from pass-fail schools that a not significant number of students take advantage of the system and function quite poorly. This is even more true of schools that not only have eliminated grades, but have also eliminated exams. Feedback is the very stuff of education; it reinforces the learning process and points out weaknesses. It may be argued, not unjustifably, that by the time a person reaches medical school, he presumably has his goals defined and needs no further incentive than his own desire to excel. This is a beautiful ideal not always borne out in fact. Perhaps unfortunately, but probably not, many students need the pressure of upcoming challenges and anticipation of feedback in order to work most effectively. This pressure is not to be confused with competition– it is an inner pressure. With rare exceptions, Jefferson students will agree that there are no after-exam sessions of "How many did you get wrong?" and "What did you get?" Post mortem review sessions are usually for clarification of material, not for comparison of results. Also, since Jefferson's attitude is that virtually everyone should pass, those students to whom it makes little difference whether they get an 80 or an 85 will be satisfied, while those who need the drive of grades will also be satisfied. In other words, if a student is pro pass-fail, he can think pass-fail in either system, while the student who prefers a grading system requires a grading system. The common denominator is a grading system. I hasten to add that a system which has as its possibilities fail, low pass, pass, high pass and honors is not a pass-fail system by any stretch of the imagination.

I do not suggest that the grading system should be applied to all aspects of our medical education. It should not be applied to electives, since presumably the student chose the particular course because he had the interest and incentive. It should not be applied to one-and two-credit core courses that are intended more for exposure to an area rather than for in-depth coverage. It is especially suited for the basic science core curriculum, where on many occasions, students are not aware of the need to learn particular material (i.e., clinical application) and the grading system feedback becomes important. Its suitability to the clinical core is difficult to assess. The reason for learning is much more obvious and most people need no other motivation or pressure. Perhaps the answer is to have a grading system for basic science core, pass-fail for electives and short courses, and some mixed system for clinical core (e.g., a grade in an exam covering principles that all students should know, and pass-fail for the student's day-to-day performance on the block), since evaluations on clinical blocks are frequently not subject to comparison with those of other students.

Thus, although my reasons are fewer than in the past, I remain an opponent of a total pass-fail system at Jefferson.

# Pass - Fail: Fad?

*(Continued from page 1)*

core amount which he is taught.

**Internships?**

Most of the opposition to a pass/ fail grading system has been concerned with the possible negative results of such a system at Jefferson. Many students fear that pass/ fail grading will hurt their chances of getting the internships or residencies of their choice. Even though there are many more internships and residencies offered than students to fill them, there is still intense competition for positions in certain hospitals. If one assumes that a written evaluation is a more accurate indication of a student's performance than a numerical grade, then the major fear appears to be that internship and residency committees will discriminate against a student graded by a pass/ fail system rather than a numerical one. For the few undergraduate colleges which have pass/ fail grading systems this fear appears to be well-founded in regard to placing their students in graduate school (Warren, 1971). However, this is not the case in medical schools where, as of June 1970, 46 % of all medical schools had a pass/ fail grading system for all four years, while 34% had letter or number grading, and 18% had a mixed grading system (Abrams and Byrd, 1971). Among those schools which have all pass/ fail grading are Penn, Harvard, Rochester, Stanford, and Case Western Reserve.

**Partial Pass/ Fail?**

Many faculty members have been opposed to a pass/ fail system because they think that students will lose motivation and study less, resulting in poorer performance. Several studies have shown that if a student takes pass/ fail and graded courses concurrently, he will tend to spend less time on the pass/ fail courses (Warren, 1971; Phi Beta Kappa report). However, where complete pass/ fail grading has been instituted, no evidence of a decline in student effort has been found (Warren, 1971). These studies show that it is important that all courses be pass/ fail, and not just the smaller ones such as genetics and preventive medicine.

Some medical educators have stated that student anxiety is likely to increase under a pass/ fail grading system (Zeleznik, 1970). However, studies have shown that this anxiety is due to a lack of self-evaluative tests and not from the lack of grades (Warren, 1971).

Some have objected that changing the present numerical grading to pass/ fail grading would be replacing a continuous grading system with a discontinuous, less accurate one. The present system, however, is itself discontinuous: 70 is set as passing. If one assumes that a certain amount of information must be learned in order for a doctor to be competent, then this should be a dividing line between those have mastered the information and those who have not – in other words, pass/ fail.

**Possible Drawbacks**

There appear to be two drawbacks to pass/ fail grading. The first is that faculty members will have to spend more time writing student evaluations. It obviously take more time to write an accurate evaluation of a student's performance than simply to compute an average of his test scores. (However, since written evaluation of students is already required for all courses at Jefferson, this increase in time should not be too great.) In addition, evaluations would be more cumbersome in selection and administrative processes involving large numbers of students (Warren, 1971). It would be unfortunate, however, if the many benefits of pass/ fail grading were ignored because of these administrative problems.

**Just A Fad?**

One way of measuring the benefits of pass/ fail is the satisfaction of medical colleges with their present grading systems. In a recent study, 32% of the schools with letter or number grading systems were "generally satisfied" while 29% were contemplating a change toward pass/ fail. In contrast, 66% of schools with pass/ fail grading

*(Continued on page 5)*

# Grades ?

*(Continued from page 3)*

ignore the number grade you receive and consider yourself a pass-fail student. The system doesn't need to change; only your outlook needs change.

Please remember, we all have an obligation to our future patients. It is one thing to accept a 71 if you are studying something else; it is another thing if you simply want to take off for Florida.

If on the other hand, you advocate pass-fail because you are afraid a low grade in an "irrelevant" course will keep you from getting the internship you want, reflect on how Jefferson's converting to pass-fail will help you.

The hospitals will be forced to put more weight on the National Boards, which the same people claim are "over-emphasized." Perhaps in addition, more hospitals will begin giving exams when you come for an interview. If these two alternatives strike you as more fair, please explain. Remember too that the hospital

*(Continued on page 5)*

# Pass - Fail: Fad?

(Continued from page 4)

were "generally satisfied" while only 2% (one school) were contemplating a change back to a letter or numerical grading system (Abrams and Byrd, 1971). It appears that pass/ fail is not just a fad sweeping the medical schools but a superior system of grading.

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A complete bibliography is available from the author, Jefferson Hall, Box 804.

# Grades ?

(Continued from page 4)

committee selecting interns will have its own ideas of which courses are relevant; and if their ideas don't match yours, that is probably not where you want to intern.

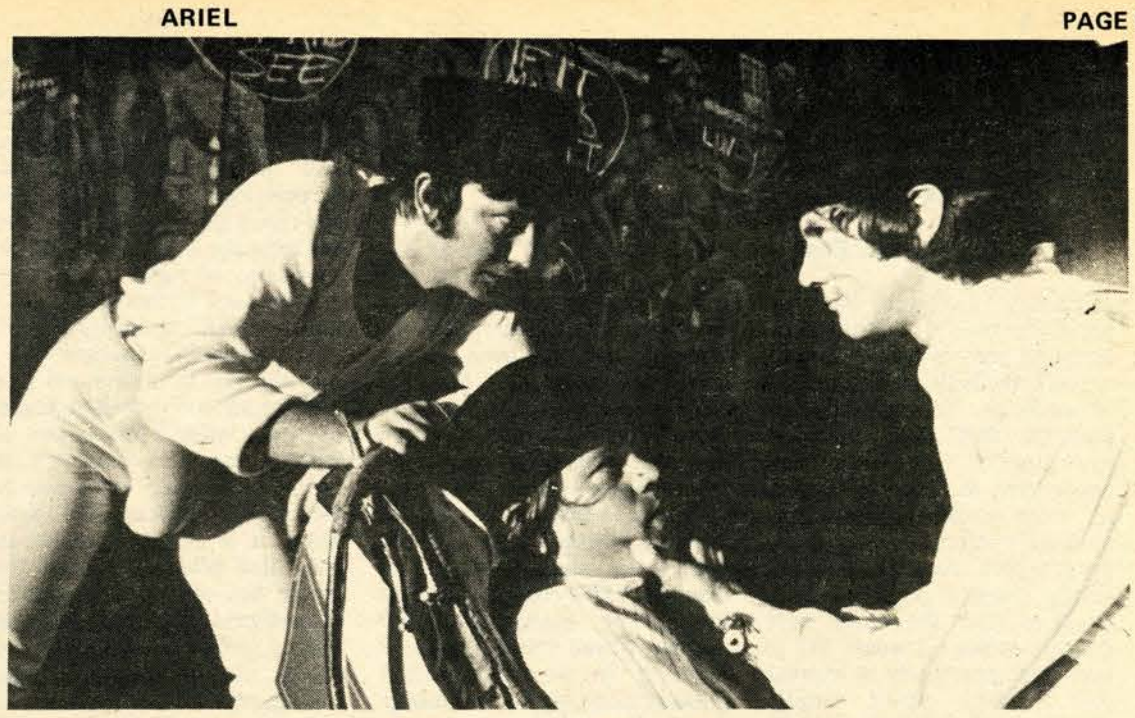
The hospitals must have a way of distinguishing applicants. If anyone advocates pass-fail with a letter of evaluation from the professor, think what will happen to the students who ignore labs as "senseless" and stay home and read the note-taking service instead of coming to lecture. Everyone has trouble with one or another type of exam, but at least the machine-graded multiple choice tests protect us from the personal vagaries of subjective evaluation.

Hospitals are aware of the drawbacks to numerical grades. An article in this month's Journal of Medical Education points out that no significant difference existed on an I.Q. test given to the top ten and bottom ten students at a large number of medical schools. While a single grade may be far off in one direction or another, it is the overall pattern which will be evaluated. It is not completely fair, but if you are smart enough to realize this, so are they. The alternatives are less fair. Unless you are willing to be accepted by a hospital as a blanket Jefferson student without further differentiation for you or against you, you must have grades to show them. Otherwise you will have only your National Board Scores.









# The New Ultra Violence

by Robert Breckenridge Jr.

It all started with **Night of the Living Dead.** After that I saw **Straw Dogs** followed closely revivals of Sam Peckinpah's **Wild Bunch** and **The Ballad of Cable Hogue** and I became strongly aware of a strange mood of violence in the "new movies." **A Clockwork Orange** confirmed my suspicions. Today's moviegoers are being fed a lot of pop statements on morality and accepting them apparently without question.

**A Clockwork Orange,** based on Burgess' novel, is Kubrick's vision of a society so mechanized and programmed that man is incapable of making a choice – all men, except Alex, who is made out to be the only human with a soul in the picture, despite the fact that he is a vicious prankster. Played by the excellent actor, Malcolm MacDowell (who played Travers in Anderson's **IF**), Alex can sing as he mugs an old man or listen to "Ludwig van" with feeling while surrounded by people who have no more life than a clockwork orange. It's all stacked very nicely against the straight society: Kubrick accompanies Alex's muggings with "Singin' in the Rain" and "The Thieving Magpie" and as he sensitized us to the violence, he also makes us feel sorry for the suffering Alex as the scientists use the same type of conditioning on Alex, forcing him to "vidie" the old violent movies. In **2001** Kubrick used the non-actor Keir Dullea so that his robot acting would make HAL seem more human (I assume Kubrick's taste isn't **that** bad.) In **Orange** he estranges us from the victims by using crummy actors who ham it up so that we don't mind it at all when they are killed by a plastic phallus.

Another way he plays up to the audience, especially the youth audience that the hype is aimed at, is with his peek-a-boo porny shots. It's certainly for the audience's benefit when he keeps the camera on the fleering nude girl with the gargantuan breasts rather than focusing the attention on the confrontation between Alex's and Billie-Boy's gangs. And then he throws out lines like "Goodness must come from within. When a man ceases to choose, he is no longer a man." The whole point of the film seems to be that in this mechanized society the maintenance of freedom and individuality is preferable to plastic people. My question: is ultra-violence preferable to plastic people?

If **Orange** is a call to freedom, then Peckinpah's **Straw Dogs** is a call to fascism. **Dogs** is more devious than **Orange,** is a better piece of film, and yet the point he makes is more loathesome.

The whole movie is a gradual set up for the inevitable confrontation and forces the audience into accepting Peckinpah's point of view. David (Dustin Hoffman) is a mathematics intellectual who has gone to Cornwall to escape the violence of America. We are given the improbable situation of David being married to a fickle, cookie cut-out wife (Susan George). They live in a solid stone house and are surrounded by the most crude, despicable thugs imaginable. Finally, David has to defend his wife and an imbecile he accidentally injured from the advances of these louses. Peckinpah places him in the situation where he must choose either the life of an innocent man and the sanctity of his wife or the lives of these louses. It reminds me of the situations people pose when questioning a conscientious objector: "What would you do if someone tried to rape and kill your mother and you had a gun in your hand?" Peckinpah balances the scales against us with a barely credible situation. David uses his wit to kill one thug after another until the last one is in a struggle to death with David, and as his wife hesitates with the rifle, the whole audience screams inwardly "Pull the trigger." It's an inevitable response that he gets out of us and that we later feel the necessity to defend. The only difference is that David felt good at the feat of having killed **all** of them whereas I think most people would have felt disgust and a little less human for having killed so many people.

Moreover, when Suan George gives Dustin Hoffman that admiring look at the end, we know he has finally won her over. The implication is that the act of violence was necessary for him to become a man.

Disregarding the violence, the two movies do have more to say, say it well and are worth seeing. However, we must be careful to examine all the implications fully.

**At TLA**

From Feb. 28 thru March 1 TLA Cinema (3rd & South) showed two of the finest propaganda films of recent years: **Z** and **The Battle of Algiers.** I highly recommend both films, especially **Algiers.** It's an amazingly well done reconstruction of the Algierian revolution which contains absolutely no documentary footage.

Finishing up the program, from March 16-19 they will be showing Truffaut's **Wild Child** which I have discussed previously and De Broca's **King of Hearts,** a beautiful film which explores the differences between sanity and insanity. You probably won't know the difference yourself by the end of the film.



# Kraatz Laughs

(Continued from page 1)

sets the best apart from the crowd. To have done this, as well as be a friend, is indeed a rare achievement."

Well, no article about C.P. Kraatz would be complete without a few of his finest. Dr. Kraatz assured me that the following were some of his real "biggies!"

Biggie Number One: Two hogs were watching a girl eating a ham sandwich. "That's Henry she's eating," said one. "Yes, I guess so," said the other. "He was a gentleman to the very end --always giving his seat to a lady."

Biggie Number Two: "What's yellow and lies on its back?" "A tired school bus."

Biggie Number Three: "What's blue and goes ding dong?" "An Avon lady at the North Pole."

Biggie Number Four: "An Australian returned to his London Club after many years and found only an elderly and prim-looking man in the lounge. Said the Aussie, "Excuse me, Sir. I'm a stranger and lonely and I wonder would you have a drink with me?" "No,thanks," said the Old Boy, "tried it once and didn't like it." The Aussie tried again. "Well, would you smoke a cigar with me?" "No, thanks," repeated the old man, "tried it once and didn't like it." The Aussie, not discouraged, suggested billiards. "Sorry, don't play," said the Old Boy, "tried it once and didn't like it. But my son will be along soon. He will enjoy a game, I'm sure." The Australian: "Your only child, I'm sure, Sir!"

# Common Diseases Are Common , Rare Diseases Are Rare

by Gregory J. Edinger

Family medicine offers a physician one of the most interesting and rewarding lifelong careers available in the practice of medicine. It is with much pleasure that I observe the evolution of family practice residencies. At Jefferson, as well as most medical schools and medical centers, there is the progressive recognition that family practice programs have much to offer the health care delivery system. I would like to take this opportunity to express my feelings about family medicine and to take issue with certain criticisms leveled against family practice residencies.

It is true that medicine is progressing into a highly technical, mechanized, super-specialized profression; but in terms of health care, common diseases are common and rare diseases are rare. One often hears that a general practice would be uninteresting and without a feeling of accomplishment because of any or all of the following: (1) inability to adequately treat a serious illness, (2) lack of follow-up of a referred patient, (3) a predominance of psychoneurotic patients, (4) an overabundance of colds and diarrhea, (5) a multitude of well baby visits and routine physical exams. Another common criticism is that a general practice would lead to incompetency because of the problem of keeping up with current advances in both internal medicine and pediatrics. Furthermore there is the discouraging concept that a family practitioner is always an overworked, undercompensated doctor who is without any leisure time for himself and his family. All of these criticisms have essentially been corrected by the emergence of a Family Practice specialty with its related programs and the development of group practice.

Most residencies in Family Practice emphasize internal medicine and pediatrics but also make available the opportunity to receive training in out-patient gynecology, office surgery, and out-patient psychiatry. The three year residency in Family Practice, which incorporates the internship, offers excellent and adequate training in all of the above mentioned medical disciplines. Medical principles and practices are relatively the same whether treating an adult or a child. The uniqueness of each specialty is not in the general medical care but in the frontiers of knowledge for each specialty. A Family Practice residency trains a physician to handle the bulk of medical problems and to properly use specialty consultation. As a physician matures medically, he is able to work-up, diagnose, and treat all but the very complex or exotic medical problems.

A resident in Family Practice receives intensive training in the management of common medical problems of infants, children and adults; and at the same time learns to consider all of the possibilities in a complete differential diagnosis. Because the Family Practitioner is a primary care physician he has to be trained to properly evaluate subtle subjective and objective signs and symptoms in order to pick up a physical or mental disorder before it progresses to a serious health hazard. Out-patient medicine requires the development of good medical judgement and thorough knowledge of the particular illness and its complications in order to properly manage the patient. The trend in medicine is quite clear -- more diagnostic work-ups and medical treatments should be done on an ambulatory out-patient basis.

The concept that is currently present in the minds of many medical school faculty and practicing specialists is that the best way to train for a general medical practice is by a three year internal medicine residency. This concept is slowly fading for many practical reasons. Three years of intense training in acute inpatient medical management eventually leads to the physician who is truly 'a jack of all inpatient trades and a master of none.' An internal medicine residency without a specialty fellowship results in a doctor who after a few years of general medical practice realizes the increasing difficulty of handling acutely ill, hospitalized patients who could best be served by an appropriate specialist. The general internist has to rely more and more on the specialist physician and at the same time because of inadequate training finds difficulty in properly treating his office patients, who in addition to their chief complaint, present with associated emotional problems, minor gynecologic disorders, specific pediatric or adolescent medical and psychologic problems, dermatologic diseases, etc. The end result is a practice that does not solve the problems in urban, suburban, or rural health care delivery, and further perpetuates the wasteful 'specialty clinic' type approach to patient care. One also has to understand that 'tacking on' one year of pediatric residency after a few years of internal medicine residency is far from desirable. To be able to understand children and their needs, it is best to train in an integrated schedule so that the doctor has continuous exposure to pediatric medicine and its related problems such as school phobia, obesity, toilet training, feeding problems, etc. To be in general medical practice, one should be especially trained in general medical practice and instructed how to efficiently and adequately handle a wide spectrum of health problems.

The pleasure and reward of family practice is summarized in a recent Ariel article by Richard Bonanno. He states, "the family doctor is not only a diagnostician and therapist, but a counselor and educator in areas which influence the patient's health." One only has to spend one week in the office of a Family Practitioner to see the extremely varied medical problems that present which require careful evaluation. By far one of the strongest points in favor of Family Practice is that it allows a doctor to establish a relationship with a family. Well-baby visits allow the physician to informally follow up physical and emotional problems of his other patients. Friendship and trust develops between doctor and family which permits better therapy and the implementation of preventive medicine.

With the development of group practice, a family doctor can work a forty hour week and be assured of night coverage and ample recreational and educational time. The American Academy of Family Physicians has goals of keeping its members up to date by requiring a minimum of education credits per year and periodic peer group evaluation, which is long overdue in the medical profession. A family practitioner by being able to perform a bone marrow aspiration, sigmoidoscopy, pelvic exam, mirror laryngoscopy, lumbar puncture, thoracentesis, and many other routine procedures can adequately service his patients. In Family Practice a physician can develop skills in diagnosing and treating both acute and chronic emotional problems. Another important role is the management and education of parents and relatives of patients who have physical or mental disorders. Family Practice allows the physician to truly enjoy the art of preventing and curing disease by serving directly and indirectly all of the health needs of a family.

# Kuralt Speaks

*(Continued from page 1)*

Librarian and organizer of the University Hour Lecture Secires, or Associate Librarian Samuel A. Davis.)

**Americans Tell Their Story**

"Are we complacent? Well, then you'll have to explain to me, Pat Baker." This (Caucasian) nurse was deeply disturbed by the death of the Rev. Martin Luther King. So she mobilized her Reno, Nevada community to donate its time, energy and resources to transform a vacant lot into a public park. Kuralt was there the weekend the part was built. A Black man said this was the only good thing that had ever happened to him. He didn't mean the park. He meant **building** the park.

"Are we materialistic? Then you'll have to explain Joe and Muriel Quintiss to me." He is a Texas medical student and she was a VISTA Volunteer. Although she is Catholic, she is the Planned Parenthood director in her community "because somebody has to be." She's also secretary of the Methodist church and runs the Girl Scout troop. As well as commuting 60 miles to med school, he teaches American Citizenship classes, runs a high school for dropouts and donates time to the "Neighborhood Center." The water system is rotting out and the city won't fix it, so now he's planning to run for water commissioner.

"Are we ignorant? Then you'll have to explain Patty Nelson to me." Kuralt described how young and old interact in Santa Cruz, California, a college town and retirement village.

"If you think about it, you know people like I'm describing."

**Youth Are Patriotic**

Kuralt contrasted today's college students with those of his time (16 years ago). "We were a silent generation. . .This was the silence of self-interest and of self-indulgence. . .The shadow of McCarthyism was still upon the land. . .There was a war abroad. . .We took no risks. . .We did nothing.

*That's how a culture decays. Silently.*

Youth today are interested in the quality of life, not in the quantity of personal possessions. "They are **more** patriotic than we were."

Kuralt maintains that the nation's young people have the whole-hearted support of their elders. "No president can be elected this fall without the support of the committed young."

**National Debate Is Revitalizing**

Vice-President Spiro Agnew is **wrong**, says Kuralt, when he accuses the press of elevating protesters to national attention. He's afraid they'll destroy America. "I think that what we have to fear is the **suppression** of such voices." Citizens must be encouraged to consider the problems of the environment, women's lib, racism, politics, bureaucracy and consumer ethics.

*We are grappling more seriously than before with fundamental problems in our lives.*

Having dispelled the notion that a massive "Silent Majority" exists in the United States, Kuralt nevertheless refused to ignore our problems.

**Kuralt's Concerns**

He is worried about six characteristics of American life.

(1) Casual Inhumanity. The taxi-driver who yells "Nigger" to any Black, and "Redneck" to any Mexican blocking his path.

(2) Numeralization and computerization to the point of dehumanization. "I need a number to put down here." Hotel clerks demand a driver's license before allowing anyone to check-in. A name simply won't do.

(3) Government accumulation of information on private citizens. "A debasement of the Constitution!" This process is accelerating, and the blame rests with the military, FBI and Attorney General.

*1984 is twelve short years away!*

(4) Overpopulation and the Environment. "The standing-room-only day is coming." Dallas freeways are choking. The land is littered. The water is contaminated. The forests are stripped. "The hillsides are skinned and raped by strip miners and terraced by unscrupulous land developers. National monuments are destroyed. . despoiled for private gain."

(5) Malnutrition. "An offense to God." Nothing much has changed since the broadcast of his acclaimed "Hunger in America" television program, a number of years ago. Doctors have a special responsibility to try to bring health care to the many areas in which **none** is available.

(6) "Melanoma of the spirit." People feel powerless to effect change because of the affliction of an unresponsive and insensitive government.

**Federal Leadership**

Kuralt claims that Congress could solve many of the problems facing America in 30 days. "We're the richest country in the world, but Congress is blocked by "insensitivity to human need, greed, power, politics, fear, and conservatism."

*Washington attacks the universities while the real problems are racism, powerlessness, pollution, poverty, racism, ugliness, and war.*

**Q & A**

When asked to comment on the "crisis of leadership" we now face, Kuralt was speechless for a few seconds, and then concurred. "I don't think the very best people have been thrown on top of the political heap in the last few years. . .Americans get tired of searching for rainbows."

*Every once in a while, leaders are elected who can be counted upon to give us a rest.*

The last few questions concerned the media and Kuralt's work. He was asked whether his view of America was weighted disproportionately in the direction of the rural populace.

In lieu of a direct reply, he discussed the city-dweller. "People in the midwest think of New York as a Gomorrah, where you can be shot dead if you walk down the street. This isn't true, and urban private life is just as rich and rewarding as that of anyone else."

Why is the news so depressing? Disclaiming any responsibility for its existence, Kuralt stated flatly that it has to be covered. "Maybe this, too, is part of the American Malaise. . .Sometimes I like to turn off the news and go outside and contemplate the sunset. I see Harper's and the New York Times sitting on my coffee table and I throw them all out. . .It's refreshing for the soul."

Can any political campaign be effective without reliance upon television? Yes. Kuralt cited the organizational skill of one of his ex-classmates, Allard Loewenstein of New York, to whom many give the responsibility of having "dumped Johnson."

*It doesn't take too many years for people to see through the slick Madison Avenue campaigns and I see evidence that this has already occurred in this country.*

How does he get ideas for his "On the Road" reports? Half from letters, and the rest he "runs into" while traveling or he "steals indiscriminately" from other media sources.

# Sports Shorts

**Drexel Dragons Defeat Jefferson Swimmers**

Coach Gary McNulty of Jefferson's Swimming team helped to get the first "away" meet off to a good start at the University of Pennsylvania's 25 yard pool by sending a strong delegation of Jefferson freshman against a veteran Drexel swim team. The younger collegians won by a score of 54 to 36. The Dragons weren't the only standouts in the meet, 'natch, as the Jeffersonions swept both the 400 yard medley relay and the 200 yard freestyle relay behind the combined talents of Dick Jackson, Pat Coughlan, Crawford Smith, Jack Hocutt, John MacSween, Gary Clark and John Van Summern.

Other highlights of the meet saw Jefferson (1-1) grab a silver medal in the 200 individual medley as Dick Jackson bested his personal record.

Gary Clark won the 500 yard freestyle in a rather slow 7:35; Gary and Crawford Smith were double winners. Jack Hocutt took third in two events, the 50 and 100 yard freestyle while Crawford Smith took a third in the 100 yard butterfly.

The girls half of the meet saw Ilene Dickson (a Nurse) gather a third in the Springboard Diving event. Alice Potter and Jay Silvester (students) finished out of the money in their events, springboard diving.

The last meet was held February 23rd. Presently, the Jefferson Squad is composed entirely of freshman (8) and depth is a problem. Any new candidates are welcome either from the student body or the faculty.

**Billiards, Ping Pong**

Congratulations to Mark Zager ('75) who finished seventh in reaching in the semi-finals of the regional billiards tournament held at Riders College. Mark competed against 65 other colleges and universities.

Mitchell Factor '75) also reached the semi-finals in the regional Ping-pong tournament. Teammate Dave Karasick advanced into the semi-finals of the consolation round of the Table Tennis tournament. One-hundred and twenty-five (125) competed in the regional ping-pong tournament.

Mitchel Factor and Mark Zager have been selected to represent TJU in the ping-pong and billiard tournaments at the AUCI regionals in Trenton, New Jersey.

# Alumni

*(Continued from page 2)*

To Dr. Luscombe it is more important that a member of the J.M.C. faculty be interested in advancing the clinical reputation of the medical college than that he be an alumnus of J.M.C. And in the same spirit when asked of he thought Alumni representatives might be helpful on the various faculty committees, he replied, "Yes, it might be very helpful, if alumni were on such committees but not just a representative of the wishes of the Alumni Association but rather to seek the good of J.M.C. as a whole."

# Is Service Denied?

*TO:*
*Clinic Chiefs, Curtis Clinic*
*FROM:*
*Max Goodman, Manager*
*Outpatient Services*

*In an effort to improve the financial posture of the Curtis Clinic, Hospital Administration has instructed me to implement the following procedure with regard to Ancillary Services:*

When ancillary services requested appear to be excessive (as a general rule more than a total of $20.00) for self-paying clinic patients who cannot pay cash for at least 50% of the charges or who have delinquent accounts, the Registrar has been directed to call the physician ordering the tests(s) to deterine if the tests(s) can be delayed until the patient is able to make satisfactory arrangements for payment.

*The cooperation of the Clinic Chiefs and personnel authorized to order ancillary services is essential in order to facilitate this program.*

**To:**
**ARIEL**
**From:**
Max Goodman, Manager
Outpatient Services

Reference is made to the article by Richard Blutstein in your February issue.

To set the record straight it was not the intent of the directive to reduce any essential service. It is inconceivable to me that clinic doctors could be "intimidated to the point of rendering substandard service" by cooperating with the contents of the memorandum. At no time is a necessary service denied a patient at Jefferson because of inability to pay. The need for any procedure is a professional determination and resides ultimately with the clinic physician. Although I don't feel that this article should be headed "Curtis Clinic **Increases** Its Service to the Poor," it would certainly be nearer the truth in view of the fact that there were .47 ancillary services provided each clinic patient in December, 1971 as compared to .40 in November, 1971, an increase of 20%.

The quotation from the memorandum, though accurate, is taken out of context in that the preceding paragraph in the memorandum did explain the reason for the procedural change and the concluding paragraph, none of which were quoted, solicited the cooperation of involved personnel. The headline to the article is a good eye catcher in that it draws the attention to its content. However, it is totally inconsistent with Mr. Blutstein's conclusions that services to the poor are being reduced.

**Author's Reply:**

Perhaps the intent of the directive was not to reduce services to the poor; however, if the memorandum is fully enforced, it will have the effect of reducing services while not improving the financial situation.

Most of the expenses involved in delivering ancillary services are the amortized costs of maintaining the clinic and staff and do not rise or fall appreciably with a changing patient load. Reducing patient services will not bring about a corresponding reduction in costs.

If clinic doctors are badgered by chronic calls from the registrar concerning the financial status of their patients, physicians might be induced to err on the side of so-called financial wisdom and in the process render substandard service to that patient.

The quoted statistics are irrelevant to the question at hand. The relevant statistics are the number of times doctors have been called by the registrar and the number of patients who have been refused service. If the patients who are refused service miraculously come up with the money, then the directive is having the desired effect. More likely, however, the patients are either not getting the tests or are going to Pennsylvania Hospital or to the inadequate Philadelphia General Hospital.

To allay any fears of being misrepresented out of context, the entire memorandum is reprinted below, with the previously omitted portions in italics.

We are sympathetic to the financial crisis which Curtis Clinic and the entire health care delivery system is undergoing. We also recognize the fact that Curtis Clinic pro-rates its charges on ability to pay and accepts DPA patients at only $4 per visit.

However, any policy of harassing either physicians or patients is unlikely to solve Jefferson's financial problems.

**Richard Blutstein**

# Brent Discusses

*(Continued from page 1)*

trap of investing money in stock without firsthand information. A word to the wise: don't always trust your stock broker.

Brent's discussion of self-education was a discussion of self-discipline. According to Brent, most M.D.s have developed the self-discipline they will employ the rest of their lives by the time they reach medical school. This self-discipline enables the doctor to spend nights in the library learning about his patient's illness when he might rather spend the evening relaxing at home. Brent warns against buying too many journals. "You won't read them and you won't be able to find the articles you want to read."

How will you finance your practice? In order to make a living, if you charge $4 per visit (Curtis Clinic rate), you will either have to see more patients than you adequately can care for, or give too many appointments. Perhaps instead you will give B12 injections, become an obesity specialist, or give up entirely and, as did one Jefferson graduate, hypnotize your patients to perform immoral sexual acts with you. Many deficiencies exist in the current medical payment system. Such deficiencies encourage development of bad doctors who become even less adequate as they expend their psychic energy attempting to justify their actions. Brent emphasized that systems for health care delivery and payment must be changed, that changes are not likely to come from the existing medical power structures, that ideas, criticism, and pressure change must be exerted from outside the established medical profession, by students and by community groups.

Though many might question Brent's belief that the purpose of marriage is protection of children, few would question his belief that self-giving and mutual respect must be the basis of a lasting marriage. Brent focused his discussion of marriage on those aspects which produce special conflict for the M.D. He discussed how a physician might "outgrow" his wife. The wife at home taking care of the children does not have the opportunity for self-growth and development that the husband has in dealing each day with patients and fellow physicians and in attending seminars and conferences. Brent did not, however, point out that the wife could just as easily "outgrow" the husband. If working, she may grow through contacts in her own work or profession. If her interests are not confined to a limited field but her husband's are or if she has more "free time" than he, she may develop far beyond him. She might grow, for instance, through joining the League of Women Voters, the Americans for Democratic Action, or Common Cause. She might become engaged in developing a day care center.

Unfortunately, Brent did not discuss or even acknowledge the existence of problems a physician might have with her husband or problems physicians might have as husband and wife.

With regard to children, Brent stressed the need for discipline, not discipline of the Victorian authoritarian variety, but reasonable, predictable discipline. Brent stressed the significance of parent example. Children are preceptive and will learn from what their parents do whether it contradicts or confirms what they say.

In discussing "Personal Problems of the Physician" in two hours, Brent necessarily presented only the highlights of the more significant problems. Much of what he talked about was based on personal experience, personal opinion, and personal moral standards, but such is the nature of personal problems. Though Brent's discussion might be criticized for such incompleteness or bias, it must nevertheless be highly commended because it tackled those issues which are seldom discussed in a medical school, but which, by influencing a physician's life and style, very definitely influence the life and health of his patients.