

THE

# PULSE

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UNIVERSITY OF OREGON MEDICAL SCHOOL

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## DO WE TRAIN THE PHYSICIAN BUT FAIL TO EDUCATE THE MAN?

by DANIEL H. LABBY, M.D.

I posed this question after identifying the theme of last November issue of PULSE as the need for more education in breadth for the physician. Jerrilynn Smith had noted that "diversion develops doctors with dimension," Dr. James Metcalfe that "man is only one of many proper objects of the doctor's study; all life is pertinent to the physician," and Dr. R. Durfee emphasized the need for developing physicians to meet the demands of social change. Editor Jim Levy, commenting overall, suggested that we must be more inquisitive of our environment in order to arrive at a better understanding of man and his problems. The need for additional breadth and flexibility in the physician emerges from these comments as an indictment of our system of medical education and suggests that the contemporary physician is narrow and has not been able to remain a man of extensive learning and commitment to broad scholarship.

Earlier in this century, a doctor was considered a highly educated man, trained in medical skills only after he had cultivated a broad liberal arts base in form of a classical education. Specie variation must have taken



DR. LABBY

place in the evolution of the doctor over the past thirty to forty years, possibly as an adaptation to changes in the medical curricular environment. An information explosion in the sciences has produced shock waves in the curriculum that have dislodged all but a glut of technical information.

physicians we can now boast that Americans are enjoying the best technical medical care in the world, though there may have been a commensurate loss in the willingness of the physician to give time and attention to understanding the more humane concerns of sick people. Most often the future medical student has been led to medicine as a career from a dominant interest in Science and he may have been further selected by admissions committees because his best grades were achieved in the sciences in undergraduate school even though premedical science requirements were modest enough to have permitted ample opportunity for cultivation of a taste for the Humanities.

Once caught up in an intensely scientific medical curriculum his vision must necessarily be narrowly scientific and focused

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## MARVA GRAHAM SCORES



MARVA GRAHAM

Marva doesn't mind being a freshman again, that is, a freshman legislator. As a newly-elected Oregon state legislator from Multnomah County she is looking forward, with some of the usual freshman fears and a great deal more than freshman ability, to her term of office. She is a poised, alert young woman, wife of University of Oregon Medical School senior, Doug Graham.

"Once in a while I have to pinch myself," she says, when she stops to think about her new role as a politician. Except for those sudden moments of self-reflection, however, Mrs. Graham is finely aware of the present

tense and her responsibilities as a legislator.

"She has a mind which quickly grasps significance," a high school teacher who worked with Marva in Lake Oswego said admiringly. "She puts facts into their social and historical perspectives. She has a special kind of intellect . . ." And she seems dedicated to putting it to use.

When I asked her why she decided to enter politics, she paused a moment and then said thoughtfully, "I don't want to look back on ten years of my life and wonder what I've done with it." As a secondary school teacher in history and political science Marva said she found herself trying to make the events and decisions and shaped history come alive for her students. Then she realized that what she wanted was to be an actor in, rather than a narrator of, those events and decisions. Marva looks back on the events of the campaign and reflects that there is a big difference between wanting to become an active part of public life and finally achieving election.

Except for her recent political success, Mrs. Graham says she is much like other medical students' wives. She enjoys getting together with other wives to talk over the frustrations and demands medical school makes on the "bread-winners." Most of all, she says, "I enjoy seeing Doug doing what he really wants to do." And I imagine Doug feels much the same way about Marva's venture into politics. It is surely not every medical student who has campaign headquarters in his home. And it is not every medical student's wife who is as able as is Marva Graham to make a state-wide contribution to government.

### The PULSE Presents

*Interest in the physician, his education and his seemingly inviolable position in American life is at its highest. Hours can be spent reading theories of medical practice, critiques discussing the ineptness of our educators and best sellers outlining the supposedly clumsy sorcery carried out by today's practitioner.*

*As medical students, we should be aware of these criticisms and certainly it is our obligation to make others aware of our insights as to how the educational process could be more effective and rewarding. However, we realize it is also our responsibility to stop and analyze our position in this learning endeavor; it is apparent that we are not capable of a totally objective evaluation of proposals for improving classroom practice.*

*Yet, we as students are uniquely able to outline what areas of the curriculum are stimulating, which lectures are redundant and the problems of grade emphasis as related to student intercommunication and well being. In order to benefit from our own intellectual enlightenment and to steer away from the dogma of downgrading, we students have tried to be fair and helpful in our criticism.*

*It is hoped that those individuals interested in student ideas and feelings will accept this issue of "The PULSE" as a sincere offering of thoughts which have been researched and discussed among a large population of the student body and faculty.—The Editor*

## CURRICULUM REVISITED . . . Again?

The need for periodic revision of the medical school curriculum is well recognized but is often a much more painful procedure than it need be. Some people see it as such a complicated project that they throw up their hands and others, having sincerely offered new proposals, retreat in frustration. And, of course, there are those who think we are living in "the best of possible worlds."

One of the main difficulties should be recognized at the outset. There are several groups pulling in different directions and making demands that coincide with their own interest.

Mr. MacCloskey has pointed this out, poses some concrete questions which deserve attention. The students have recognized these problems but have not been invited to participate their solution. A step forward was taken last spring by the Student-Faculty Committee which appointed an ad hoc committee to make an ongoing study of student curriculum evaluation. This committee is headed by a student who will have access to the students' views. Wouldn't it be logical for this informed person to relate these views to the Faculty Curriculum Committee in a planned way by having him sit on this committee as a non-voting member?

Another perplexing situation arises when one considers the divergent views on what the curriculum should contain. Not only is there a ferment in medicine but a ferment in medical education. The Cogeshall report of the AAMC and the Millis Commission and ad hoc committee on Family Practice of the AMA have all pointed out the need for continuous, comprehensive medical care. If the medical community doesn't solve this problem, others will. One author in this issue calls for increased use of preceptorship programs as one way of alleviating this problem. He is supported by Dr. Morris Fishbein who, in a recent editorial in *Medical World News*, calls for preceptorships to be sponsored and controlled jointly by the medical societies and the schools as an initiation into family practice.

Education must be more than passive learning of past discoveries. The vast majority of medical students have the goal of practicing medicine. Many professors expect them to be academicians similar to themselves. Many students expect professors to teach courses which are devoid of minutiae, which present broad principles, and in which the student is shown its relevance to practical problems. Failure to fulfill these expectations results in frustration and hostile feelings which interfere with teaching and learning.

The experience of others should be evaluated as the "literature reviewed." For instance, guidelines for the development of the new curriculum at Harvard medical school was reported in the August 1966 issue of their Alumni Bulletin:

1. The amount of factual information in memorizing imposed upon students must be sharply reduced. Students must be allowed adequate free time to read, discuss and think in a graduate school atmosphere.
2. A core curriculum should provide the common information in the biological, behavioral and clinical sciences expected of all doctors of medicine. It should not be aimed at didactic coverage of everything and should be taught in a limited time, preferably as a coordinated, interdepartmental activity. There must be time in all years for elective courses, designed to explore subjects in depth and taught primarily on a departmental basis.
3. The motivation of the beginning student to help the sick, should be utilized by introducing him to the patient early in the curriculum. Such clinically oriented exercises should be designed to increase awareness of the emotional and socioeconomic aspects of illness as well as to illustrate the relevance of the pre-clinical sciences to the pathophysiology of disease.

These guidelines are presented for informational purposes. But wouldn't it be a valuable and exciting experience for a freshman to be assigned an expectant mother in prenatal clinic, follow the course of her gestation, attend the delivery, discover the development of the child in the well baby clinic and see the family on a regular basis throughout his four years in medical school?

Finally, curriculum revision could be simplified if better machinery were built now to facilitate changes in the future. Dr. Funkenstein states that, "Any changes in the curriculum should be flexible and have built-in devices for further change, based on society's needs, experience with students in medical school, and predicted future changes in premedical education."

Dr. Milton Eisenhower sums it up when he says, "Bright, eager students can be a joy to teach. Paradoxically, they are not *easy* to teach, for they place high demands upon their teachers, upon the institutions they attend, upon the very aims of higher education."

JOHN TYSELL, JR., *Chairman*  
*the Standing Committee on Medical Education of*  
*the Student American Medical Association*

## Grading System Questioned

I believe that the grading system as it is now used is the single greatest impediment to student growth and learning. Furthermore, well documented studies have shown that no positive correlation can be found between grades and career performance.<sup>1</sup>

Many students have expressed dissatisfaction to me and desire for change in grading practices. Most of them have suggested a "pass or fail" system to supplant the letter grades now used. I think this is not the ultimate solution but perhaps is a more sat-

isfactory one than we now have. In my own teaching experience I conducted experimental classes in which students graded themselves and each other. I concluded that students are far more aware of their own accomplishments and those of their classmates than their teachers are able to be. I think that successful performance in a field such as medicine, which is heavily dependent upon colleague trust, might well be predicted by peer evaluation.

Whatever solution is arrived at I believe new ways should be explored and that the student body should be consulted so that

## PRO AND CON . . . PRECEPTORSHIPS

by MERLE PENNINGTON, M.D.



PENNINGTON

Medicine was taught in the pre-Flexner era entirely by preceptorship. Formal training of good quality was limited to a few institutions, and most M.D.'s learned all the art and science of medicine by attending and observing an older practitioner of senior experience.

Four years ago, the Oregon Medical Association and the Oregon Academy of General Practice combined forces to offer preceptorships of two varieties. In one type of preceptorship, the student was exposed to private practice in the office of a general practitioner for a period of from one day to one week during Christmas or spring vacation week. The purpose of this was to show how a private office operates and to demonstrate the mechanics and economics of supplying private medical care. If some medicine was learned, or technical skills observed, this was a bonus. No stipend was involved.

With the other type of preceptorship, the student spent up to three months with a private general practitioner, both in the office and in the private hospital with his preceptor doctor. The purpose of such a preceptorship was to show the scope and variety of general practice; to let the student see medicine practiced in continuity, both of time and person or family, as well as the depth or variety of organic and functional disturbances; and to teach methods of handling the myriad medical, socio-economic, emotional and psychological problems brought to the private practitioner by his patients. A stipend of \$25 per month was paid the preceptee—a medical student who had completed his Junior year.

The first year's experience was very successful. The second year reaped problems sown by the first, i.e. difficulty in raising money and lagging enthusiasm on the Hill. The third year can only be described as a miserable flop.

Several reasons for the decline of the preceptorship program can be found. The first of these is poor salesmanship. Time has dampened the enthusiasm of physicians working on this project, and since the 1963-64 academic year, no student has taken the responsibility for pushing the program. Secondly, a few *adverse* criticisms elicited on questionnaires and in personal communications from participating students contributed to the disappointment (the overwhelming majority, however, expressed satisfaction with the program).

Finally, the prospective buyer may have no need for the product. The University of Oregon medical student gets excellent training in most departments and has acquired a storehouse of scientific knowledge to the degree that he may be super-saturated.

But the student may be unaware that he  
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the system used is satisfactory to them.  
<sup>1</sup>"Measurement of Physician Performance," Price, P. B., et al, *Journal of Medical Education*, 39:203, 1964, Feb.

"Good Scholars Not Always Best," *Business Week*, February 24, 1962, pp. 77-78.

Lawrence Dean, Junior

# CONTINUING MEDICAL EDUCATION

by SAM EAST

A physician is only as good as his information and the way he uses it. There are many indications that the practicing physician lacks the means to "keep up with" current medical knowledge because of the lack of organization of information sources available to him and the inefficient means he uses to become acquainted with the information.

A 1966 review by Harris (1) indicates the extent of medical communication problems. There are more than 200,000 periodical articles in 21 languages published yearly and more than 1500 American biomedical journals published. A physician would have to read 148 articles daily just to keep up!

With the obvious limitations of physicians' time for learning, information evaluation must necessarily be an efficient process. However each physician develops a unique system of self-education usually in a haphazard way without direction or help. A better method might be that the medical school faculty provide help and suggestions in finding and assimilating medical progress.

How does the formal medical school curriculum prepare students to continuing their education after graduation? West (2) describes present medical school limitations: "1) Only a small portion of the current body of medical knowledge can be taught in four years. 2) Much of the knowledge which will be employed in the student's future career is not known today, and therefore cannot be taught. 3) Not all that is taught is learned. 4) A small part of what is taught is erroneous. 5) A portion of what is learned will soon be obsolete. 6) The physicians of the future (including family physicians) will be specialists. Thus some of what they learn will have limited relevance to their future careers. 7) Of that which is taught and learned and

The considerations indicate two changes in future medical education. First, relevant much is quickly forgotten."

The considerations indicate two changes in future medical education. First, students will be helped to develop greater abilities to gather and evaluate information in a problem-solving atmosphere. The student will take the *active* role in learning rather than the present passive one. Second, curriculums will consist of only the most basic concepts and facts so as graduates, students may revise and build as medical knowledge increases.

These change have scarcely begun at UOMS with student seminary emphasizing the active student role in learning in third year dermatology and hematology courses. But most of the burden of learning to learn actively lies with the individual students at present. A here and now question for each student might be posed—How long can you afford to postpone learning to learn on your own?

(1) Harris, Jerome T. Survey of Communication Sources Available for Continuing Physician Education. *J. Med. Educ.* 41: 737-755.

(2) West, Kelly W. The Case Against Teaching. *J. Med. Educ.* 41: 776-771.

## PRO AND CON... PRECEPTORSHIPS

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does not know the intricacies of private practice. There is certainly a lot of truth to the observation that the senior medical student is smarter than he will ever again be in his life. He has more usable (and unusable) information at the tips of his synapses than a whole gaggle of practicing general practitioners. However, not having seen medicine from the private side, he has no sonar to tell him the depth or shallowness of his knowledge in this direction.

By now, every student in medical school, from freshman to senior, is utterly convinced that medical education is an end unto itself. However, a little reflection should convince one that medical education and medicine, are but means to an end, albeit very powerful and important means. Perhaps four years of monasticism is a small enough price to pay for good quality medical care. However, many physicians never get over it, and continue to think of themselves as Jesus Christ instead of only John the Baptist.

With this brief introduction then, the pro's of preceptorship may well be self-evident: Preceptorships would demonstrate much more vividly than can be done in lecture form, the mechanisms and economics of private medical care. Preceptorships would teach a method of handling the weird mixture of physical, functional and psychological problems that patients present to their private physicians. And they would demonstrate the concept of family physician shared by many thousands of general practitioners and internists.

The con's usually cited are: a) that time limitations prohibit such additions to the curriculum, or b) that the student can learn these things when the immediate need arises, that is, when he has completed his schooling and begins private practice.

As for now, the Oregon Academy of General Practice, through its Medical Education Committee, will cooperate in every way possible to provide preceptorship opportunities on the following terms: namely, that a student ask for such an opportunity and that no stipend be involved. (The committee will attempt to secure employment for the portion of the summer not involved in actual preceptorship.

The Board of Oregon Academy of General Practice feels the above criteria must be met in order to assure awareness on the part of the student of the value of the program, and it believes that learning the art and science of medicine are but means to the end of a satisfying life.

There is no question in my mind but that the University of Oregon medical student obtains a full and practical education in the scientific aspects of medicine, and in those disease processes and syndromes which have names. It is also my belief that there is a serious deficiency in preparing the medical graduate for the many ill defined and unnamed situations which end up in the examining room of the private physician. It is to help prepare the student for these latter eventualities that the preceptorship program has been designed.

Anyone interested? You may call me at 638-4051.

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## DO WE TRAIN THE MAN

and he will become highly trained within his field but not educated outside of it.

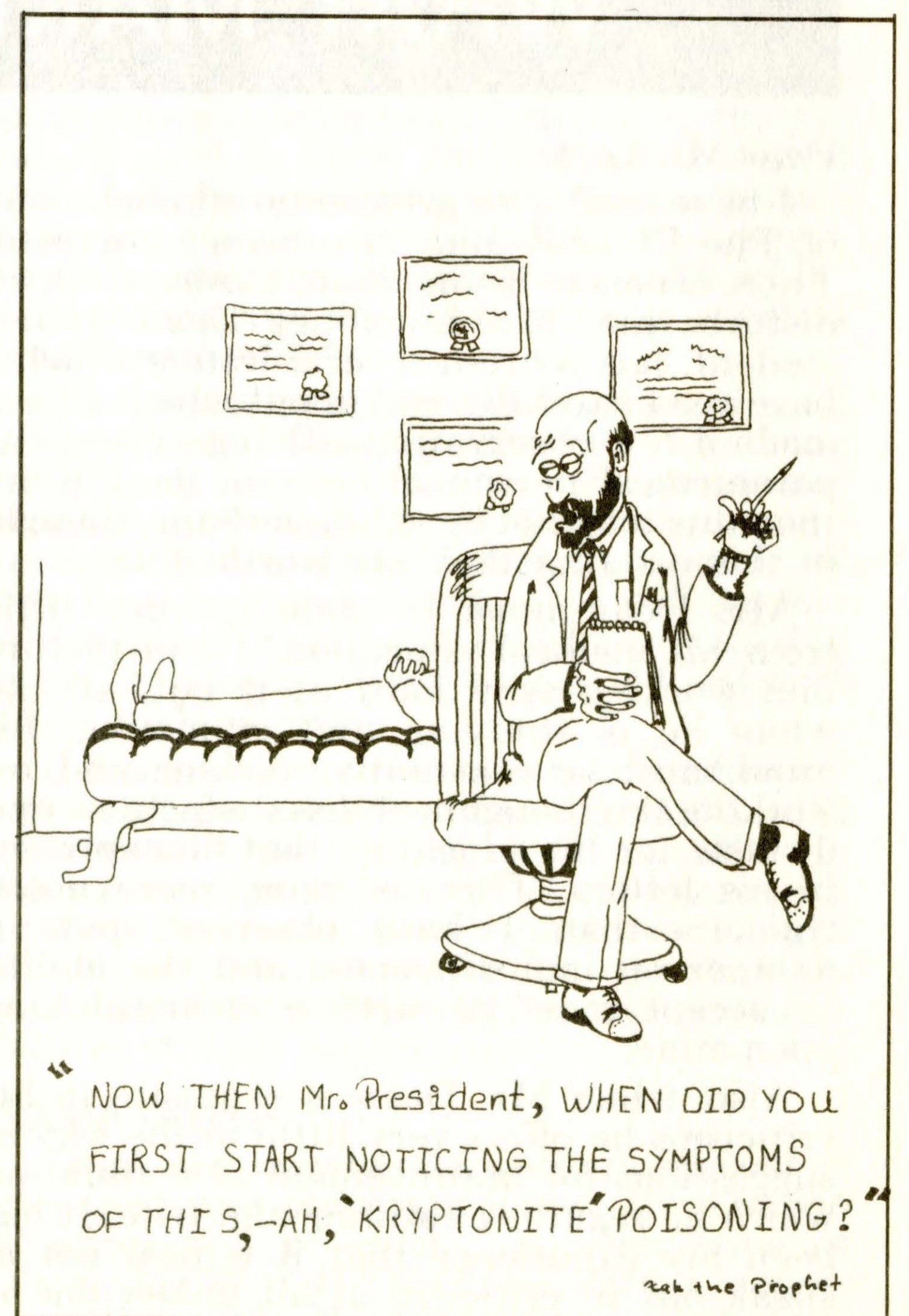
A recent article in Harpers stated "one of the things the average doctor doesn't have time to do is catch up with the things he didn't learn in school, and one of the things he didn't learn in school is the nature of human society, its purpose, its history and its needs. If medicine is necessarily a mystery to the average layman, nearly everything else is necessarily a mystery to the average doctor."

Humanitarian considerations have suffered in the competition for curricular time in medical schools since it is an unusual medical college that has been willing to extend the period of training beyond four years although many have already seized the interim summers. The unique and highly successful five-year program at the University of Oregon Medical School has enabled many a student to extend his training in breadth and somewhat in depth, though almost always in the area of technical proficiency.

Technical training and selection of specialty begin early in the medical student's life. This trend seems to be progressive and one might rightfully ask whether scientific interest which becomes the dominant force in attracting men to medicine will encourage the development of techniques and superspecialists. Some would hold that the fledgling physician is overtrained and correspondingly uneducated in breadth and understanding. The vocational drift in the past generation has worried medical educators as the rush to technical competence has displaced the true intent of the mission of answering to the broad human need of an individual in distress.

Rene Dubos has commented as follows, "There is no longer any thoughtful person who believes that the conversion of science into more power, more wealth, or more drugs necessarily adds to health and hap-

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Sub the Prophet

# OPEN LETTER TO THE CURRICULUM COMMITTEE

by CRAIG MACCLOSKEY  
Med Student III

Gentlemen:

Congratulations! First for being teachers, and secondly for being selected members of the curriculum committee. Your membership on the committee has tremendous potential importance to the local medical community, the future success of generations of medical students, and the enlightenment of the present crop of students. You have a unique opportunity to apply your considerable teaching talent to a larger population of students than you could hope to influence from podium, lab, or ward exposure.

American medicine is fast approaching a major juncture similar to the one it faced in 1910 following the Flexner report on medical education which led to the establishment of a unified curriculum in medical colleges. The citizens' committee on Graduate Medical Education set up by the AMA and the Goggeshell report to the American Association of Medical Colleges, both point out the need for adapting our medical curriculum to account for our "burgeoning science and evolving society" and "eliminate the fragmentation and flexibility in graduate medical education."

Psychiatrist Funkenstein of Harvard suggests that medical school basic science courses should form a continuum with the college courses, and at the same time should prepare students to meet their highly specialized goals. He further states that this cannot be accomplished by a one-design curriculum. Dean Ebert of Harvard Medical school amplifies this theme by the following suggestions:

1. There must be a recognition of individual aptitude and individual differences.
2. There must be a time in the medical curriculum to pursue knowledge in some area of particular interest, for this is how the student will learn in the future.

3. Responsibility must be given the student initially, for a significant part of his own education, and ultimately for the care of the patient; the latter responsibility must be graded according to the student's ability to assume it.

4. Rather than one curriculum, there should be several, responsive to the different interests and backgrounds of the students.

This huge order obviously cannot be filled by an eleven man committee alone. To fulfill the ideal, the committee needs the cooperation of the *entire faculty, administration, expert help and student involvement*, which brings us to some basic questions needing answers:

1. What is the way in which curriculum changes can be made at UOMS?
2. Who decides to incorporate these suggested changes?
3. Is there a faculty forum for discussion of curriculum?
4. Is there a student forum for curriculum discussion?
5. Where can we get expert experienced help in medical curriculum design?
6. Is there a "clearing house" where professors can find out *exactly* what students have been exposed to, and in what way?

Major revision of medical school curriculum is needed. But as we both know, major revision is slow, dangerous, costly and unbelievably hard to achieve. Any changes in curriculum should be flexible and have built in devices for further change. What then, in our opinion is the *least we can do now*.

I invite all interested persons to read and comment on the ultimate goal of a curriculum as outlined in David Funkenstein's article in May 1966 issue of *The Journal of Medical Education*.

We students feel that after 17-25 years of exposure to curricula, lectures and teachers, we have some knowledge of what constitutes the good presentation of subject matter. As

for the subject matter, we must rely on those who have had to apply the material they teach, and the information they felt was of instrumental value to them.

To me, the real beauty of medicine is that it is a *blend* of biochemistry, anatomy, physiology, bacteriology, pathology, pharmacology, psychiatry, observation, social grace, manual skill and common sense. These components separately have less beauty than when they are molded together, each interacting with the other. For example, why not have everyone who touches on diabetes meet together and decide *who* will teach what, when and how? This would end tedious repetition, emphasize difficult concepts and *correlate* structure, function, pathology and treatment. Some departments attempt this now on a limited basis. These departments are to be congratulated for their attempts, but not content with their initial effort. The rest of the departments can ill afford to miss the opportunity to correlate molecular, microscopic and gross structure with normal and pathological function.

Proven teaching methods must be adopted to enable students to better grasp with greater speed the avalanch of new useful material. Program learning, non-structured teaching, seminar approach, Harvard's non-compulsory lectures and New Mexico's system approach, are a few examples that must be explored.

Most students realize that they were not the ones who discovered the problems which exist. We further cannot be expected to have the maturity of judgment, nor the broad perspective and experience with the questions of educational goals, financial considerations and the human factors, all of which determine the decisions of academic government. But one has to admit, we are the only people at UOMS who know what the whole curriculum contains! We feel that dialogue on curriculum can only be to our mutual advantage.

## WHAT MAKES THE PULSE TICK?...LETTERS

Dear Mr. Levy:

I have read with great interest each issue of *The PULSE* and have been impressed. There seems to be one item, however, which disturbs me. Mr. Lawrence Dean, junior student, has written several letters which I have read carefully and about which I have made a few observations. Being among the paramedical personnel here on the hill my thoughts may not be valid; perhaps, though, in this instance they are worthwhile.

Mr. Dean must be gaining very little from his medical education. I can picture him working very hard at it but, all the while he is studying and cramming, his mind must be constantly working and reworking the thoughts of dissatisfactions and distaste for his educators that he expresses in his letters. This, as many more noted thinkers than I have observed, puts a damper on inquisitiveness and the ability to accept material with a clear-thinking open mind.

Also, while Mr. Dean is exquisite in his criticisms he offers very little in the way of suggestions for improvement of a situation which he regards as stifling and trite. It has been my experience that it is best not to speak out in criticism at all unless one is prepared to follow through to a logical and constructive conclusion.

In short, I ask one question. Is it possible Mr. Dean himself is at least partly responsible for the stifling of his education? I should think his time could be better spent in constructing a better mental attitude, leaving him more receptive to the many fine educators at the school and more tolerant of those not so fine. He could then possibly feel the satisfaction and respect displayed by so many of his classmates and look upon his duration here as a valuable and enriching experience as well as an education.

Eleanor Cooper, Secretary  
Department of Pathology

Dear Editor Levy:

I quite agree with Larry Dean's letter in the recent edition of *PULSE*. Larry is quite right when he points out that fear as a primary motivator in medical school, certainly is teaching by archaic methods, and if research means anything, it certainly has been well proven by research in the past that people are motivated to learn much more positively and much better by factors other than fear.

It is indeed fascinating that a collection of scientists, who are also teachers, would accept without question, time-worn educational principles which perpetuate submis-

sive followers. This perpetuation starts even before medical school in the selection of people by the admissions committee.

I suppose though that occasionally there is some merit in dealing with the people that one has to deal with through medical school. This probably gets one accustomed to dealing with these individuals, for of course they are everywhere in life, and if one doesn't deal with them in school, probably one won't learn how to deal with them later on either.

Probably the finest thing that happens to a medical student happens subliminally, that is students in the process of medical education learn to be extraordinarily responsible people towards their patients in the sense of personal awareness and great dedication seems to be instilled in medical students, and this is missing in other professional schools, such as in the training of clinical psychologists.

It might be well if the faculty would cease overlooking the most useful journal in medical school. *The Journal of Medical Education* and it might also be well if somehow, required reading for the faculty could be *Teaching and Learning in Medical School*, by George Miller, M.D.

Robert Mighell, M.D.

# SEPTEMBER DREAMS

by MIKE GILBERT

*"How could the sweetness of my  
September dreams*

*Have so quickly soured into this  
nightmare of supression"*

"I came to this institution well-meaning, eager and excited. Now I stand stripped of these motivants and open to apathy. I stand not alone. I stand with most of eighty and the eighty before and before. The Institute asked amelioration of the student. It asked him to merge within the white coat and anonymously fit into the role of another freshman class. It asked, if you will, a communism of his consciousness.

The Institution allows no outlet for the subjective. It allows no means whereby the student can see himself (his ideas) reflected in his work. Rather, it demands he suppress his initiatives and submit to the prescribed pattern, that he do not his lab but the lab of his instructor's mind. All this functions to make Medical School most unrewarding. In fact, amidst the aura of our age (Freudian Revolution, Modern Art's Expressionist Movement), which is telling the young man to believe in himself and that he does well to seek expression of his feeling and thought, these demands on the student make him reproach himself. Indeed, what sort of creature does not respond with some sort of self-rebuke when circumstance makes him abandon what he believes. And I submit gentlemen, one does not mix self-debasement with academic curiosity. Why cannot the Institution meet the student's enthusiasm with a structure that would nurture it rather than frustrate it?

The curriculum demands the student sit—receptive and passive and THEN learn. There is no manner in which the student may express himself. No way for him to say, "I think." It is observed that the medical curriculum does a commendable job of applying many of psychology's technological discoveries about the nature of learning. That is, the proper labs follow promptly the proper lecture, the material is reinforced with good timing and so forth. But I think it does a poor job of considering how their mode of applying these discoveries may affect the student. That is:

Why does the curriculum demand anonymity?

Why does it demand the student be a reactor instead of an actor?

Why does it demand suppression and humiliation of the student?

Why does it not foster excitement and curiosity?

Why does the first year student lose his reverence for medical knowledge and the medical profession?

The preceding comments are fragments from a paper of protest written as a freshman last year during a night of exasperation. I quote them not for their profundity, but in hope that their emotional coloring, which makes them now appear somewhat ludicrous even to me, may testify to the intensity of the feeling. And further, that they may serve as subjective data of how one medical student responded to medical school. This response is a fact. A fact, I think, neither limited to my own experience last year, nor to the class of last year, but can be found equally applicable for the preceding classes.

Now I know that dissatisfaction is not a novel phenomenon among medical students. In fact, it may be said to border being a syndrome. However, I do not think it should be dismissed as that. Neither should it be dismissed as adolescent demands for freedom, nor as the protests of the immature

student unable to accept the demands of the profession. No, I feel it asks basically one very legitimate question—"Why does the situation have to be like this?" Surely in 1966 with our modern body of knowledge a presentation of the medical school curriculum can be synthesized which stimulates the student rather than stultifies him.

Whereas it used to be considered noble and virtuous to completely lose yourself in your work, forgetting self and repressing feelings, today, such an ideal appears mundane, and, a bit perverted. There has been a revolution against this ideal as evidenced in modern drama, poetry, the Existentialist movement in Philosophy, the change in modern morals, and as mentioned before Expressionism in Art and the Freudian revolution. Could I not also cite the adoption of shorter medical school texts and the appearance of the married medical student as tangible evidence of the incorporation of this revolution into everyday affairs? The modern medical student has been caught up right in the middle of this revolution as a part of the youth of this century. As a result not only has he learned that he does not have to be deaf to his feelings, but of all things, it is not good to be deaf then.

Thus, the youth of today requires more expression of himself in life, not I assert out of adolescence or immaturity but because he has been taught that this is a good thing. This demand for expression manifests itself today in the Peace Corps, Civil Rights Movement, Revolt of Red Guard, Psychedelic experiences, student newspapers at UOMS Medical School and to me the most blatant (and perhaps the most significant), modern dancing.

The youth of today has come to expect an opportunity for self-expression in life and if this opportunity is denied then he looks upon himself and his life as inadequate, unfulfilled and unworthy. It is the denial of much of this opportunity that makes the medical student a little bit ashamed of his submission to the archaic demands of medical school and gives him his anger which dissolves all the initial well-meaning.

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## DO WE TRAIN THE MAN

piness or improves the human condition. Indeed, haphazard scientific technology pursued without regard for its relevance to the meaning of human life will spell the end of civilization."

Is it possible we are not educating men to take a vital individual interest in people? As another commentator has noted, "what we are asking in the nature of humanistic concern is no more than should be asked of any individual in the type of society in which we would desire to live."

The cultivator of proper attitudes in future physicians should be given special concern as well as time and space in contemporary and future medical curricula. Attitudes come along to medical school with the student out of his family background and personal experience and are partially set prior to admission to medical school. The writer would point out however, that a medical student body is a heterogenous group of highly intelligent and educable individuals, that their many channels are still wide open and that in the course of being educated to become physicians they are capable not only of imitating the best they encounter in their exposure to the faculty but will depend on the faculty for being educated to what is important.

Now that new appointments have been made to our Curriculum Committee it is to be hoped that time and attention will be given to counter balancing the weight of sci-

entific and technical material with a reasonable and appropriate weight of concern for general topics of more liberalizing scholarship in the field of human behavior. This is as important a base to the practice of medicine as is biochemistry to the understanding of physical disease. Such matters should probably be introduced early in the curriculum as advanced preparation for the shock that occurs when the medical student at last finds himself alone in an examining room with his first patient.

There has been discussion of attempts to stake out "core or kernel information" as an educational base for the medical curriculum and hopefully to offer opportunities for students to pursue knowledge in areas of particular interest. It is to be hoped that broad elective choice will be offered in addition to the required courses.

Alan Gregg has said "responsibility teaches." Medical students must be considered adult postgraduate students and given responsibility for a significant part of their education. Our faculty is large enough to offer a wide diversity of talent and interest to the curriculum. The education of a physician is for a variety of careers; our curriculum must reflect this diversity and the student must be free to elect some choice. At present our curriculum needs loosening, updating and elective freedoms. Election to the study of the broad emotional study of the patient should be available.

One large area of humanistic concern is now beginning to receive modest attention as an elective offering to the senior class: that of premarital and marital counselling particularly in the area of sex education. As an area of trouble and doubt to doctor and patient, it probably has no equal in medical practice. It usually finds a modern physician out of date with rapid social change, totally unprepared, unskilled, and frequently confused and even embarrassed. In addition a new elective opportunity will soon be offered the sophomore class in the form of a perspective survey of literature dealing with the scientific method, the history of science and its relation to other forms of thought and the position of the scientist in contemporary society.

Additional opportunities should be provided to assist the medical student in establishing his moral position with regard to such ethical problems of practice as the patient's right to know the truth, the care of the aged and the dying, euthanasia, human experimentation, drug testing, contraception and abortion, sterilization, artificial insemination, and the large area of medical legal responsibility.

The tutorial program and student directed conferences of the Department of Medicine have been important initial efforts toward this but they should be permitted to expand broadly. Perhaps the University facilities of our Eugene campus and other college faculties in our community could be enlisted to bring a broader view to our educational effort in Medicine.

If discussion in areas of ethical and moral concern can be developed concurrently with rich vocational training and exposure to the extraordinary benefits of contemporary medical research, it can only result in a more complete education for our students and better preparedness for the responsibilities of total health care.

## SAMA NOTE

Freshman membership—Sixty percent of the freshman class has joined the Oregon Chapter and received their first issue of THE NEW PHYSICIAN. Their representatives are Paul McConnel and Dan Morris. Any questions you may have about SAMA can be brought to them.

# "LIVE BY THE PHAGE, DIE BY THE PHAGE"

The first step in the chain of events which led to the catastrophe began when Denny Dipton, sophomore med student, strolled into Bacti lab one afternoon carrying a butterscotch ripple ice cream cone. As he casually made his way through the milieu of other students, he was spotted by Dr. Bleazy, one of the lady staffers who kept a constant lookout for such arrants.

Dr. Bleazy rushed over, notifying Denny of his violation of departmental regulations, and asked him to take his cone out into the hall. However, this precaution was too late, for inadvertently Denny let drop a small glob of his butterscotch ripple onto the floor. It went unnoticed as it melted and oozed into a crevice beneath one of the desks.

The second incident which occurred that day was when Bob Douchi bopped down the same aisle carrying a tube full of highly pathogenic contagious *M. snarfossa*, bumped into a chair, and dropped the insidious innoculum on the floor—in the same place when Denny Dipton had spilled some of his ice cream. Over ran Dr. Bleazy and her cohort, Dr. Snoginsi, "Out, out damned spot!" they cried as they poured twenty gallons of Lysol, detergents and other disinfectants on the area. Such a calamity had not occurred in years . . . it was quite an

uproar! But with a little straightening up and a short twenty-five minute lecture on the proper way to carry a test tube, the day finally ended and everyone went home.

It was that night, though, that the critical accident took place. Hidden in a nick beneath a desk corner lay a single *M. snarfossa* which had escaped the scourge of chemicals, and was now nourishing upon a drop of butterscotch ripple ice cream. It was then that one of those mutations of nature occurred bringing about an alteration in the DNA strands of the bacteria. Instead of dividing as normal *snarfossa* do, this one grew; its endoplasmic reticulum and mitochondria multiplied a billion-billion times over. The organism surged out of its crevice, its cell wall pulsating, and frothing at the pores. Reaching out with its flagella, it devoured plates and tubes of cultures plus a large vat of agar. Once satiated, the monster lay quiescent—a huge balloon-like mass with undulating tenacles that almost filled entire room.

Meanwhile, back at his residence, Dr. Floyd Frick, head of the Bacti department, became restless wondering if his culture of pet phages were doing okay in their incubator at the lab. By ten o'clock Dr. Frick was in his darkened office hunched over a microscope watching his phages frolic in a

sea of ooze he had specially prepared for them . . . so engrossed that he didn't notice a giant tenacle writhe into his office and then suddenly wrap around his leg. Terrified beyond utterance, Dr. Frick could do nothing as he was pulled across the floor toward the monster. His last gasp before being engulfed was "Oh . . . Zinzzzer, Zinzzzer!" Whereupon he was converted into molecules of purines, ATP and some debré.

Let it suffice to briefly mention the sequel of happenings which occurred after the monster's discovery: The Nation watched aghast as CBS covered the National Guard operation that attacked the creature, while outside a group of beards from Reed College stood protesting. Later Mark Hatfield arrived to deliver a speech, and lastly—of course—legislation was initiated in Washington to outlaw the use of pathogenic bacteria in teaching laboratories.

Oh . . . it took a while, but like most things the whole affair became only a passing topic with an occasional rumor hinting at the intrigue; and in addition a plaque was hung on the fourth floor hall in honor of Dr. Frick, upon it, his favorite saying . . .

"Live by the phage, die by the phage."

J. E. Lyneh, Jr., Med. Student II

## COMMUNICATION KEY TO MEDICAL EDUCATION

Interest in medical education has been growing all over the country the past several years. This is no less true at this institution than anywhere else. The student faculty committee has recognized the interest on our campus and has formed a subcommittee on Medical Education.

Last year some dissatisfaction with the student evaluation questionnaires arose from both student and faculty viewpoints.

The students felt that some of their criticisms were not being received in the way intended or were not being seen by the people for whom they were intended. Faculty members felt that the questionnaires could have been more valuable with some change in their design which would allow other information of interest to them to be obtained as well as that asked by the questionnaire.

Both groups felt that in general the system of communication had value but needed improvement. As a result of the above exchanged viewpoints in student faculty com-

mittee meetings, an interim committee was set up to establish a policy, look into methods of obtaining student opinion and improving questionnaire. This committee was established at the meeting of May 4, 1966 and made the following report which was accepted by the Student Faculty Committee on November 16.

The committee felt that improvement in communication between faculty and students in the area of medical education was possible and desirable. It was thought that the formation of a Student Faculty Committee on medical education could be of assistance in promoting communication.

The committee might accomplish this by:

1. Approaching faculty personnel in order to determine areas where student viewpoints would be of interest or assistance.

2. Development of questionnaires, polls or other methods which would accurately gather the information desired.

3. Make the information gathered available to those requesting it and the parent committee.

4. Provide a forum where student and faculty ideas on present or future programs could be informally exchanged.

5. Promote a cooperative attitude between student and faculty groups by improving mutual understanding.

6. Increase the awareness of students and faculty groups that mutual interest exists in the field of medical education.

The subcommittee, composed of four student representatives (George Douglass, John Lindgren, Dennis Ellison and Gary Ellibee) and four faculty representatives (Dr. Bacon, Dr. Meehan, Dr. Meyer and Dr. Weinzirl) hopes that it can serve as a constructive and instructive link by gathering opinions from both students and faculty as described in the interim committee report. Student and faculty ideas are welcomed.

## THE PULSE

The PULSE, official publication of University of Oregon Medical Students, published periodically throughout the school year by an Editorial Board which is solely responsible for its contents. The views expressed are those of the authors and do not necessarily represent those of the board or the school.

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## THE PULSE

University of Oregon Medical School  
Portland, Oregon

Dear Doctor:

As you know, earlier this year we began a campaign to support the school paper in a manner which would allow us to publish without formal school or organizational assistance. All in all the response has been most rewarding and this is the third issue of the 1966-67 school year.

The first three issues have been distributed to nearly all the physicians in the Tri-county area and, of course, to the faculty members on the hill. This was done in hopes that those individuals who might have been skeptical about our purposes would be able to see the publication first hand. Due to costs and time this will be the last issue so handled. On the back of this letter is a list of those individuals who have so kindly contributed to the paper. We would sincerely like to thank them for their interest and support. These people will continue to receive The Pulse. Should you desire to be on our permanent mailing list, a note to THE PULSE, UOMS, will be sufficient. In addition, your contribution will help maintain a healthy "PULSE".

Yours truly,

Jim Levy  
Editor-in-chief

Bill Disher  
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