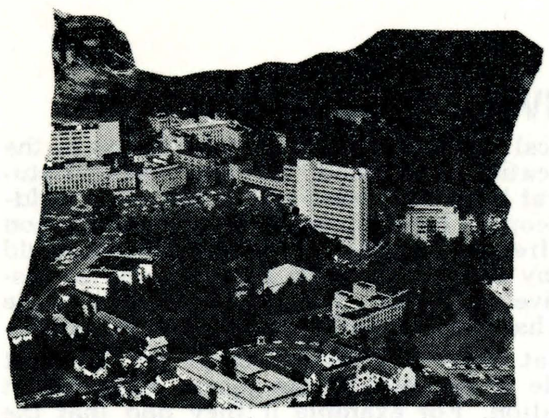


THE PULSE

Vol. 4, No. 1 University of Oregon Medical School—Portland, Oregon March, 1968

ABORTIONS, VIET NAM AMONG ISSUES OF SAMA REGION VII MEETING, MARCH 29-31

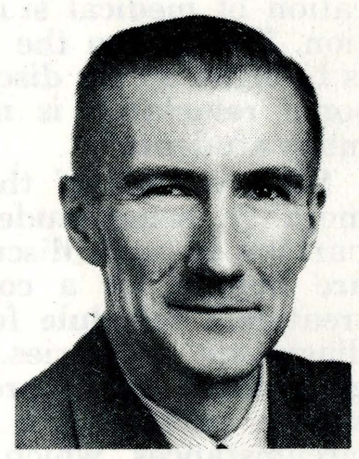
Medical students from all the far West states will soon be assembling in Portland for the Regional SAMA meeting, hosted this year by the Oregon Chapter of SAMA.

Delegates will be representing most of the medical schools of the West including the University of Washington, California College of Medicine, Loma Linda, UCLA, University of California at San Francisco, University of Southern California, Utah, and the newly formed Arizona Medical School.

This three day meeting will convene on March 29 on the University of Oregon Medical School's campus.

Following a welcome address by Charles N. Holman, M.D., the delegates will begin the official business meeting, which will include the main body of the session. This consists of introduction and discussion of proposed legislative issues and resolutions to be submitted to the national convention on April 19. The resolutions to be considered will be the products of the fertile imagination of attending student delegates and their colleagues, and will strike a wide variety of topics, including abortion laws, Viet Nam, Medicare, Medical School curriculum changes, community health projects and many others.

DR. PENNINGTON



DR. SMITH

Region VII is well known nationally for its progressive ideas, which have played an important role in determining policies and projects of SAMA in the past. This year promises to be no less fruitful.

Highlighting the convention will be a luncheon address by Merle Pennington, M.D., Chairman of the Oregon Medical Political Action Committee, and an after dinner address by Lendon Smith, M.D., the "Children's Doctor," a well known Portland pediatrician.

All Oregon medical students and faculty are welcomed and urged to take advantage of the intellectual stimulation afforded by this assemblage of medical students, and to attend as many of the sessions as possible.

Also participating in the conference as advisors or sponsors, and to whom the Oregon Chapter of SAMA is grateful, are the Oregon Medical Association, Multnomah County Medical Society, the Alumni Association, the Medical School faculty and staff, Minnesota Mutual Life Insurance Company, and Oregon Physicians' Service.

(Continued on page 4)

PROGNOSIS: IT'S UP TO YOU

Here we are in the midst of mankind—we sit with knowledge plastered to our brain, with the insight of time controlling our progeny and with the hope of the world begging for life and comfort at our feet. Yet we are so shallow as to ignore the minorities, as to perpetuate and prey on the poor, as to kill the innocent without so much as a whimper from our professional hearts. We attempt to educate and ignore in the same classroom; we preach concern and awareness while subverting compassion. And all too often, we treat disease, not people.

Is this true? Is there such a thing as police brutality? Is the hippie generation the savior of man? How do we justify killing? Where do we fail as parents? Are homosexuality and incest immoral? Do we need "THE PULSE" on our campus?

The last question is benign, it lacks little in the way of controversy. All of us profess the importance of a student paper; even the faculty have gone so far as to encourage us. (Quiet encouragement, of course—"don't rock the boat . . . not too hard . . . easy."

The value of this paper remains to be determined; but, even more important, the continuance of this paper depends on you—the students.

Presently this is a one man effort, one man who is biased, ignorant, amoral, egocentric, disillusioned and tired. This man should be replaced with someone who is selected by the student body, with the help and encouragement of the students and with the reassurance by the students that they are interested and concerned about their environment and their profession and their education.

Take note: **Fact #1:** Organized medicine is run by a few people; government is run by a few people. This small group of people are the ones who are making decisions important to your professional and personal lives. (e.g. Are you ready to go to Viet Nam, or to see medicine as a purely civil servant profession?)

Fact #2: As a physician we offer to people our help in preventing untimely, unnecessary or avoidable death; or at least to make death a bearable event. This goes far beyond the simple problem of thremodynamics.

Fact #3: This university, as all universities, has a responsibility to the student. If the system fails to meet the needs of the student, and the student fails to call for correction of those deficiencies, then he, the student, is being morally and intellectually negligent. From that point on he has sacrificed his rights, and he perpetuates his dishonesty when he complains about those problems which by his inactivity he ignores.

Is the lack of student concern a reflection of a lack of some of those abstract, complicated insights we are supposed to be offering the people who place their "lives" in our hands?

If you feel that "THE PULSE" has a place on "the hill" and if you wish to actively guarantee that it does continue as a student publication representing the students at U.O.M.S. then be present at Medical Science, 1162, March 27, at 5:00 p.m.—J. L.

This issue of THE PULSE is published by a non-representative body.

help!

(Continued from page 1)

SPRING REGIONAL CONVENTION

Region VII, SAMA, March 29-30-31, 1968

Portland, Oregon

FRIDAY, MARCH 29

8:30 a.m.—Registration, Library, University of Oregon Medical School. Coffee, juice and rolls.

9:00 a.m.—Region VII Business Session Convenes. Welcome, Charles N. Holman, M.D., Associate Dean University of Oregon Medical School; Max H. Parrott, M.D., AMA Board of Trustees, Portland; Glenn M. Gordon, M.D., President, OMA, Eugene. Report to Region VII, James D. Levy, Vice President, Region VII. Introductions of Resolutions.

12:00 noon—Luncheon: University of Oregon Medical School Hospital, hosted by University of Oregon Medical School. "Better Medicine—Better Government," Merle Pennington, Chairman, OMPAC, Sherwood.

2:00 p.m.—Business session reconvenes. Introduction of Resolutions.

6:00 p.m.—Social hour, hosted by the Oregon Medical Association Headquarters office, 2164 S.W. Park Place, Portland.

7:15—Dinner, Executive Suites, Benson Hotel, Portland. "The Fun of Medicine" or "Doctorship," Lendon H. Smith, M.D., Portland.

SATURDAY, MARCH 30

8:30 a.m.—Coffee, juice and rolls.

9:00 a.m.—General Business Session Convenes, University of Oregon Medical School.

11:00 a.m.—SAMA Delegates meet Oregon Physician and Student Hosts. Recommended: Review of local hospitals and medical facilities and other Portland highlights. Lunch with your hosts.

5:30 p.m.—Social hour on the Hill. Host: James Levy and Daniel Lewis, 3715 S.W. Marquam Hill Road, Portland. Dining at your pleasure.

SUNDAY, MARCH 31

8:30 a.m.—Final business session. Action on resolutions.

10:30 a.m.—Adjourn.

BIRDS ON THE HILL

by Steve Ebert, Ms IV

With the cold winds of winter not all remaining birds sit in the barn to keep themselves warm. A lot of them are at work here on the hill. A diligent bird watcher will find their antics in the lecture room fascinating and useful in helping pass the long hours spent in lecture.

THE GREY DUFFER . . . This bird has been around for a long time. A long, long time. This bird is recognized by his shuffling gait as if he were hypnotized by the tops of his shoes. His shoulders are warped by years of pearing over the tops of speekers podiums and his eyes or sort of squintish from peeping longingly down the shaft of a brass microscope.

The grey hair of the Duffer usually lets the shine peak through in a spot or two and his mustache bears evidence of having strained hundreds of gallons of cafeteria coffee. The tweed coat of the Duffer has probably seen more medicine than most hospitals' admitting desks and treasures deep in its maze of bagging pockets one of the finest collections of broken and chewed through pipes in the history of smoking. These pipes are in a state of constant motion during Duffer lectures. Sort of a shell-game of being filled, tamped, lit and then absent-mindedly being stowed in a secluded pocket only to have another pipe take its place. The students watch this Smokey-the-Bear roulette with a mad fascination as all are convinced that the Duffer will burst into flames with the first good cross draft.

The call of the Duffer is a sound to remember. His mouth closes only about half as many times as his teeth and this imparts a certain musical quality to his lectures. Its rather as if the background music were supplied by a Brazillian rhythm band.

THE SILVER CRESTED OMNIPOTENT . . . This is another bird which has withstood the test of time with a variable degree of success. It takes little time your first day on the ward to learn that this bird has the authority of the Pope as she greets you with a list of thou-shalt-nots that sounds like the minutes from a runaway Ecuminical Council Meeting. Her general appearance is that of Rosie the Riviter and on inspection of all the little gold buttons that decorate her breast one wonders if she was with Roosevelt at San Juan.

As she speaks to you her voice has that certain quality which assures you that on her list you rank right between mumps and menopause. When she comes on the ward in the morning the nurses' desk gets busier than the Green Bay Packers' backfield as she greets all noxious stimuli in the same manner . . . an icey start that would stop a bus. She once resorted to violence . . . she hit the cardex so hard that the clock down the hall came out of hibernation and has kept perfect time ever since.

OREGON TO LAUNCH COMPREHENSIVE HEALTH PLANNING

by David Sack IV

Though health care in Oregon is generally good, there are problems in this area which need to be corrected.

In November, 1966 Congress passed the Comprehensive Health Planning Act which encourages states to set up committees to "plan health" in a comprehensive manner. As a result of this act, a Governor's Committee on Comprehensive Health Planning was formed.

This committee held a conference on January 8 and 9 with about 200 Oregon citizens from various backgrounds, including this writer, to begin considering its task of "planning." The people involved were not just doctors; in fact, a majority are health "consumers" rather than "producers." Included at the conference were welfare recipients, housewives, lawyers, businessmen, laborers, as well as doctors, nurses and hospital adminitrators.

In considering comprehensive health planning, it became clear that the discussion could not be limited to traditional medical areas such as hospitals or germ control. Formerly, tuberculosis, typhoid, and other infectious diseases were most important; now these are nearly controlled. In their place have come drug abuse, suicide, alcoholism, heart disease, cancer. New patterns of diagnosis and treatment are required for disorders of the physical environment, of oppressive economics, of family structure, or of community services. Health planning is now obliged to look at man in the total environment, a truly comprehensive task.

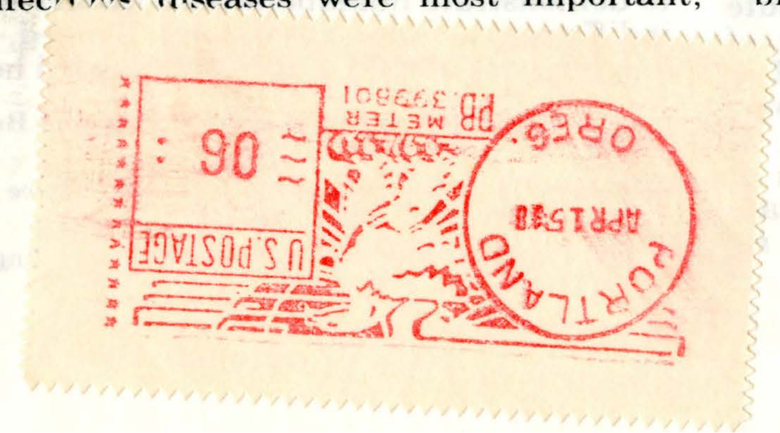
Some specific problems which were examined at the conference were the problems of nursing shortage, nursing faculty shortage, paramedical personal shortage, the high cost of illness, and the distribution of health services throughout the state. Illustrating the effects of the poor distribution of medical services is the fact that among certain segments of the lower socio-economic groups in Oregon, the infant mortality doubles the average infant mortality for the general population.

That the problems have to be solved in a comprehensive manner is of great importance. An example is that of the doctor shortage. One solution to this shortage is to graduate more M.D.'s. A second approach might be to improve the safety of automobiles, thus reducing the time doctors spend treating accident victims.

Another example of comprehensive planning is found in Watts district. There, a trip to the outpatient clinic meant a two-day excursion because of poor transportation facilities. What was needed in Watts was not a new clinic in the neighborhood, but rather better transportation to the existing clinic.

Those planning for health also considered some basic questions in medical practice. For example should the role of the nurse change so that she could "practice" medicine in certain circumstances such as acute emergencies or in very routine cases? Should the nurse of the future be able to sew up simple lacerations, thus freeing doctors for other tasks? Obviously changes like this would involve changes in the education of the nurse, alterations in the public attitude, as well as changes in laws governing medical practice.

The conference on comprehensive health planning was only a start in gaining an overall plan for health care in Oregon. Many problems are yet to be defined, and even more solutions must be found. I would welcome any ideas on medical planning you may have, either problems or solutions.



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THE PROVIDENCE OF THE PHYSICIAN

by James Metcalfe, M.D.

A definition of the classical responsibilities of the physician in Western culture would include: (1) care of the sick, (2) teaching of "the art," and (3) increasing knowledge (and control) of health and disease. Great as these responsibilities are, the definition is incomplete, and dangerously so. I want to discuss one aspect of its incompleteness, an area of responsibility which our profession is neglecting.

In August, 1966, a national meeting of the American Institute of Planners was held in Portland. Despite a nationwide airlines strike, nearly 1000 people attended the opening session. The theme of the conference was "The Optimum Environment—With Man As the Measure"—and three days of carefully organized discussion were devoted to the theory and specifics of planning man's environment. Many of the participants were urban planners, and many of these hold responsible (and powerful) positions as advisors to government. Only a handful of the thousand conferees were biologists (by any definition of the term) and, to the best of my knowledge, I was the only physician present at any session.

Rene Dubos, Professor of Pathology at Rockefeller University, gave the keynote address of the conference. In it (as in his writings[1]) he stressed the interdependence of health and environment. According to his concept (for which he does not claim original authorship) health can be defensibly defined as the harmonious interaction between an organism and its environment and, as a corollary, disease can be considered a failure of harmony, a dissonance between the organism and the surrounding world. This definition increases the responsibility of those of us who are professionally concerned with human health and disease. We must, it seems, understand man's environment and its effects upon the individual and we must accept a professional role in planning man's environment for maximum human health. Nor can we limit our interest in the environment to such well-accepted (and emotionally neutral) subjects as air pollution, radioactive fallout or bacterial pollution. With the earth's exploding human population, other men become increasingly dominant as a part of each man' world. Human health (even human survival!) is threatened more by the intraspecific aggression of man[2] than by the success of such other species as the tubercle or plague baccilli. Medicine must do more than extend its scientific base to encompass "human biology," although that step is essential. The physician must be prepared to act on his knowledge. Where once he spoke for mass vaccination he must now speak for population control[3]. Where once his research dealt with the physiology of organ interactions, he must now extend his interest to the effects of human interaction upon health.

There are, of course, objections to this point of view. It can be said that others (psychologists, ecologists) are already pursuing such work. Indeed they are, and their results are full of implications for human health. But whose job is it to be concerned with human health?

Another objection (which would apparently win government approval at this time) is that medicine already has enough to do—let us only apply our present knowledge to cure the sick. Indeed, we have never lacked for work, but neither have we shirked our responsibility. Who speaks for man's health?

Why, then, do not more physicians participate in planning the human environment? Largely, I think, because this is not within the traditional role of the physician and tradition is important in medicine and its teaching. But there are other reasons. Perhaps, although we are prepared to deal with microorganisms or tumors or heart valves, we have too much humility to deal with man. Perhaps the humaneness of the physician prevents him from "political" activity which governs the interactions of human beings. Perhaps so—but decisions about man's future are being made, by others or by default, and often with bone-chilling arrogance or indifference or ignorance. It is in the best tradition of the physician to demonstrate humaneness and never to be indifferent to human problems. Indeed, the humaneness of the physician is needed here.

1. Dubose, R.: Mirage of Health. Harper and Brothers, New York, 1959.
2. Lorenz, K.: On Aggression. Harcourt, Brace and World, Inc., New York, 1966.
3. Birth control: the medical mandate. New Eng. J. Med. *274*: 1503-1504, 1966.

SENIORS BANQUET, DEAN BAIRD SALUTE BY O.M.A.

David W. E. Baird, M.D., Dean of the UOMS for the past 25 years was honored by the Oregon Medical Association for his "imaginative and capable leadership" at the annual Senior Banquet sponsored by O.M.A. Presenting Dean Baird with a plaque and citing him for his contribution to medical education were O.M.A. President Glenn M. Gordon, M.D., Eugene, and Herman A. Dickel, M.D., Portland, member of O.M.A. Council on Medical Education and master of ceremonies. Class President David A. Durfee responded for the graduating class.

IS THERE STILL AN M.S.-M.D. OR A PH.D.-M.D. PROGRAM?

by John M. Brookhart, Ph.D.
Chairman, Graduate Council

The number and the quality of questions raised by students in recent months concerning the programs of combined graduate and medical education warrants a brief description of the current situation at our institution. The broad question above breaks down into two main subquestions and a large number of more detailed ones. The two main questions might be phrased: Do we have the necessary approval of programs leading to combined degrees? Do we have the resources to activate these programs?

With regard to the first question, the program leading to the M.S.-M.D. combination has been in operation for quite a number of years. It is still available and active. In addition, the Graduate Council proposed last year that the institution should recognize the limitations of the M.S.-M.D. program in the context of modern medical science and offer carefully selected students the opportunity to prepare themselves more rigorously for careers as physician-scientists. A structured but flexible program leading to the fulfillment of requirements for both the Ph.D. and the M.D. degrees over a total time span of six to seven years was therefore proposed. This has been given administrative approval. Thus, the Ph.D.-M.D. program is in existence from the administrative point of view and is available to qualified medical students.

The second question, concerning resources, is harder to deal with. The resources of particular relevance are qualified students, qualified faculty and, finally, money. The first two of these elements give us no problem. The third one generates a problem which is always with us. For many years, money to furnish stipends and supplies for M.S.-M.D. students was derived primarily from research grants and from a small number of teaching assistantships. Over the past five years, the M.S.-M.D. program was supported from a training grant obtained from the National Institutes of Health. The proposal for renewal of this grant, coupled with an increase in its scope to include the Ph.D.-M.D. combination, was unsuccessful. Therefore, training grant funds for this program will no longer be available on an institutional basis for the support of these programs after May 31, 1968.

The programs themselves are still in existence. The necessary funds to support them must be derived currently from research grants to the faculty member with whom the student chooses to work, or from other sources such as fellowships for specific students. The possibility of re-allocating some funds within the institution is under active consideration. The Graduate Council is currently exploring other possible sources for grants from external sources to support these programs. Our medical school looks upon these programs as an important facet of its total educational effort and will continue to exert serious effort to maintain this activity.

Most students seem to be attracted to this program through interest in a particular field of biomedical science or through rapport of some sort which springs up between the student and a faculty member. Personal contact between a student and the appropriate faculty member is still the best route for a student to adopt for exploration of possibilities offered by these programs. If a personal contact with a potential mentor does not seem appropriate for a student, he or she is advised to speak to Dr. Bacon or Dr. Oginsky, the two members of the Graduate Council who have accepted special responsibility for this sort of activity.

PERHAPS INTEGRITY IS NEEDED

by Ira Pauly, M.D.
Assistant Professor of Psychiatry

A rather new challenge faces the young physician today. As always, he is asked to acquire the ever increasing body of knowledge which is the foundation of medicine. But, in addition, he is being challenged to communicate with his patients more openly and directly than ever before.

No longer is it acceptable to a patient to be kept in the dark with reference to his diagnosis or prognosis. Fewer physicians will be able to hide behind the protective cover of their white coats and avoid demands for closer communication.

Young people, especially, are seeking out the physician as a person from whom they expect open and direct advice on a number of important issues. Particularly, this is true in the sexual sphere. Many have commented on this as the age of the sexual revolution.

Recently, Kirkendall has commented in a lecture given in the elective on Counseling of Sexual Problems, that the significant thing about youngsters today is their willingness to discuss sex openly and their expectations that others reciprocate this openness. They turn logically to the physician, whose opinion they respect because of the training and experience they attribute to his background.

Yet, the physician quite often has not had the necessary training and exposure to deal adequately or comfortably with this topic. Attempts are being made at the present time to overcome this deficit in the education of medical students at this institution. Even when the available information is brought up for discussion, a certain personal reluctance is noted on the part of many students.

Still, victims of their past and a rigid morality, some students feel awkward to partake in such discussions. Rather, they are hoping for a cookbook, ready made treatment schedule for clearly formulated diagnostic categories. If anything can be generalized about problems in the sexual sphere, perhaps it is the highly individual circumstances which contribute to such problems and the need to avoid judgemental, pre-determined attitudes.

No longer is it possible to "cop out" by mouthing legal or institutional interpretations of such questions as abortions, sterilization, birth control, etc. Even the laws and the institutional attitudes are changing and reflect even greater flux in the attitudes of society generally.

Too frequently do I hear medical students disqualify themselves from having opinions on social issues which are part of their patient's problems. Perhaps we on the faculty have contributed to students' self-depreciation by not allowing the students to collaborate more in their own education and become more active participants rather than passive recipients of factual information.

Postgraduate education generally, and medical school in particular, prolongs the adolescent stage of dependency and delays the process of identification through which we achieve a sense of self-esteem. Unfortunately, the premedical competition continues, and the lower classmen emulate the seniors, and the seniors look up to the housestaff, and they to the faculty. In this never ending search for the ideal father-figure, the son seems too willing to minimize his own value.

I say give up this "born yesterday" attitude which permits too easily the evasion of responsibility for decisions. You were capable, competent people before you entered this institution, or you would not be here. Whereas you may have been ignorant of some medical knowledge and experience, it is doubtful that you will ever be satisfied with how much you do know.

Control the anxiety which prompts you to search for omniscience (and the omnipotence which goes with it). Begin participating today and take your individual stand. Have the courage to question, to disagree, to state your own views. Distinguish fact from opinion and beware of the dogmatist.

Above all, give value to your own opinion, trust your instincts, make your own mistakes, and learn from them.

The really meaningful encounters I have had with students have come when the participation was equally active at both the student and teacher level. I know there is the temptation to remain anonymous in the hope you can get through medical school without attracting enough attention to be singled out for fear of exposing your ignorance. If the price of that is to sit passively by without exercising your own capabilities, then this price is too high.

Oh yes, I know you will say that when you're finished with your training and you have the necessary degrees and credentials, you will resume your identity and become your own boss. But are you sure, or will the atrophy of disuse have become irreversible, and relegated you to a permanently passive position.

The time is now. Stand and be heard . . . perhaps integrity is needed.

SURVIVING IN MED SCHOOL?

Many medical students have valid objections to the way their education is handled. However medical students in general have impressed me as the most yielding group of people I have known. If the dissatisfaction which I have frequently noted in my classmates could be found in any other population it might well be dissipated in active opposition. It may be that this docile characteristic has survival value in medical school.

I believe that medical students accept the fact that they have little or no voice in the course and conduct of their education. For example if they find that the rigid adherence to the lecture system is destructive to motivation or that stress and negative feedback keep them in a continual state of insecurity and frustration they often seek mental escape rather than express their resentment. However as highly informed citizens, in intimate contact with these problems, they hold unique position for such expression and bear partial responsibility for the unquestioned perpetuation of the customary way of conducting the medical education enterprise.

Indeed the offspring of medical education appear dynamic and aggressive. However I believe the scope of their aggression is narrow and as I observe the weak offensive which the medical profession as a whole has taken against the major health issues of our day, e.g. auto safety, birth control, air and water pollution, integration and juvenile delinquency, I wonder if perhaps this is only a carry over from the acceptance of "the way things are" which they learned so well for survival in medical school.

Respectfully submitted,
LAWRENCE DEAN, MS III

Editor's note: Mr. Dean dropped out of school in his junior year, however, his remarks may have continued relevance.—J.L.

FRESH APPROACH TO SEX EDUCATION

by Frank H. Webster, MS II

It says something of curricula in our medical schools and of society when a grant is required to get people together to discuss sex.

Early this past summer representatives of 33 medical schools gathered in Seattle under the auspices of Josiah Macy, Jr., Foundation to discuss sex. The objective—to outline a program for establishing an effective medical school curriculum in "Population Dynamics, Sex Education and Family Planning." The representatives from the University of Oregon Medical School were Doctors Raphael B. Durfee and Daniel H. Labby, and medical student Frank H. Webster.

A series of workshops entitled Family Planning, Marriage Counseling, Sex Education, and Demographic Considerations were conducted by the 100 plus representatives. From these workshops a wealth of information was taped and, after editing, will be made available by the conference director, Dr. Ronald J. Pion, University of Washington Medical School, Department OB-Gyn.

Some of the symposium's suggestions are hopefully reproduced here. It was generally agreed sex education should be carried out at the family level; unfortunately this is not often done. The physicians may see this omission as a contributing factor in broken homes, bad marriages, poor family planning and the teenager "in trouble."

If the physician recognizes sex education as an important aspect of health, he should be as well instructed in this area as in Biochemistry, Anatomy and Pathology.

What is the best way to inform the medical student? (and the community as well as the patient). Should not clergy, attorneys, marriage counselors and other advisors of youth be asked to bring their points of view to medical students together with faculty in matters of contraception, abortion, homosexuality and divorce?

The symposium's answers to these challenges can be summed up as follows: That medical schools institute an integrated interdepartmental course in sex education, for example, OB-Gyn, Internal medicine, Pediatrics and Psychiatry contributing to a discussion of family planning. Presenting some of the material in small "group therapy" sessions would allow discovery of personal bias and the opportunity to expand life experiences neglected because of academic involvement.

With this self-knowledge the student would be able to understand and counsel patients in sexual matters. Professionals representing law, religion and counseling should be included for a broader foundation and closer relations between these fields and medicine. This is especially important since such specialists are called on to solve family problems in practice. Witness "the pill" as it concerns the clergy, the attorney, the physician and the unwed teenager and one is no longer in doubt as to the value of the interprofessional approach. Ideally this course would be taught early in medical training. This allows the first year student involvement in something humanistic before his zeal can turn to cynicism.

It would also be instructive to send interested students with their knowledge of Anatomy and Physiology strengthened by their newly gained sex education to the community and school health classes. This is now being done at the University of Washington Medical School, and on a small scale at the University of Oregon Medical School.

The foregoing represents only a few of the suggestions and viewpoints heard at this symposium.

Here at Oregon, Doctors Labby and Durfee conduct an elective course for seniors in which moral and medical aspects of "the pill," abortion and the law, sexual adjustment, the sexual history, family planning, homosexuality, premarital and marital counseling are some of the topics. This course is well received and indicative of a new interest and approach to sex education in medical school curricula generally. These two Doctors are to be complimented for their fresh approach to sex education.