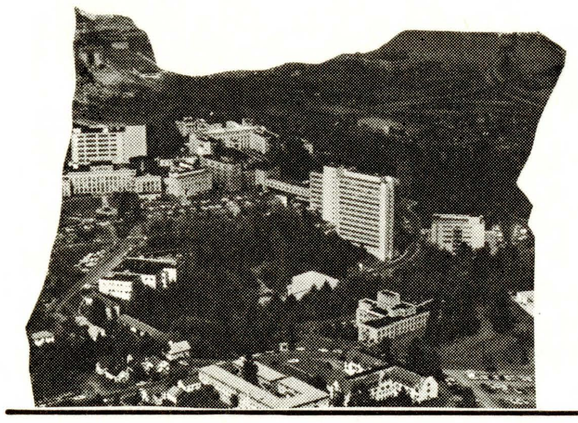

THE PULSE

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"Problem Solving and Decision-Making"

FACULTY-STUDENT INTERCHANGE IMPRESSIVE

The impact of the student-organized conference *"Problem Solving and Decision Making"* is still very apparent some two-weeks later. A rational organized approach to medical problems and decision making is what we would like to have for everyday patient care, but no single system has been devised for use by all physicians under all circumstances. Problem solving and decision making based on a sound foundation is what we're all working toward but we do not necessarily need names, analyses and categorizations of each step in our approach to function as a rational physician; must we all take a given route to arrive at the same solution? However, the necessity and benefits of a structured approach to our problems and of data recording along the way are apparent to most.

Emotions of students and faculty aroused by the conference were not all well-directed or necessarily well-contained, however they were welcome for the flare exhibited by the group indicated that passiveness was not the tone of this conference as is the case with many and that past thoughts about teaching, learning and patient care and their interaction may be redirected in the future.

Faculty-student interaction before, during and after the conference was one of the highlights of the conference. That faculty and students can plan and work together for the mutual educational benefit of both, points out that a rational adult approach to education is still possible with faculty-student interchange.

— Daniel L. Dennis, M.D.

"Problem Solving and Decision-Making"

Symposium Must Not Become U.O.M.S. Monday Morning

So much was said that Saturday and Sunday; a common bond was begun and the excitement seemed to penetrate our people and school in such a way that it could never be the same again. Students and faculty working together with compassion and thought which might truly offer our patients the care they deserve.

And then, Monday morning and it was so easy to return to the ways of old, the habits and the thoughts with which we are so uncomfortable and insecure. The enthusiasm wanes and change is not as easy as the wisemen seemed to imply. We remember, "medicine has done a pretty good job", and forget, "how do you know". We believe, "the care is not as bad as the records indicate", and ignore, "how do you know"? Will we remain committed to a non-system which has a flaw so basic that we cannot evaluate the quality of care much less determine the success or failure of a therapeutic regimen. How can we accept such a system of chaos which is so apparent that *Time* magazine, no pinnacle of perceptive insight, describes a picture of mismanagement which axiomatically results in defective medical care.?

Can we continue to ignore the role that we, as students, must play in our own education; must we await a dictum from the hierarchy of the administration and faculty before accepting the responsibility that is ours. The students, with the help of the faculty, will have to begin the needed changes at U.O.M.S. We will have to demand of ourselves the discipline of thouroughness and thought which is the only way we can establish the rational and effective foundation which Dr. S. Feinstein, Smith and Weed spoke of. As students we can:

1. implement a program of problem solving;
2. begin the development of a medical terminology which will describe the patient accurately and allow a rational development of therapy and prognosis; and
3. organize our workup and progress notes so that we can be evaluated and evaluate ourselves effectively and with rigor. Yet, we cannot do it alone; we need the guidance and wisdom of the faculty coupled with the mutual respect found in the give and take of open critique and discussion.

What might we anticipate, if history is repetitive. Nothing will change. Certainly there will be the token "improvements" which are easily administrated and implemented. But, in the final analysis we will all sit back and wait for change via that lengthy yet wise process of evolution; how convenient, easy and sometimes tardy mother nature is.

The opportunity is present – should the students fail to become actively involved in the learning process then the medical care at U.O.M.S. will continue to go undefined and unimproved, no matter how good or bad. Certainly we must accept that precept of problem solution; first, define the problem.

That definition is left to the student. It took the students to establish the symposium and it will take the students to bring it to fruition. Or will it be another Monday morning at U.O.M.S.?

— James Levy, M.S. IV

How-to "Weed" Your Medical Records

This article summarizes the technique of medical record keeping advocated by Lawrence L. Weed, M.D. The material is taken from his article "Medical Records that Guide and Teach" in *New England Journal of Med.*, March 14, 1968.

Purpose: To provide better patient care by the complete formulation of all problems in a specific case and by the disciplined following of each problem. The physician is then able to cope with the multiple problems in a clinical situation in a rigorous and systematic fashion.

Technique: (1) "Write a complete list of all the patient's problems, including both clearly established diagnoses, and all other unexplained findings that are not yet clear manifestations of a specific diagnosis. When the data warrant, these findings can be crystallized into a specific diagnosis. The "problems list" then is not static in its composition but is a dynamic "table of contents" of the patient's chart, which can be updated at any time.

(2) "All subsequent orders, plans, progress notes and numerical data or physical findings can be recorded under the numbered and titled problem to which they are specifically related. Inherent to this approach is the *necessity for completeness in the formulation of the problem list and careful analysis and follow-through on each problem as revealed in the titled progress notes, requiring that the proper data be collected and that the conclusions drawn from this data are logical and relevant.* The precision of titled, problem-oriented progress notes and conclusions is directly related to the precision and integrity with which the problems are initially defined.

(3) "For certain problems a narrative progress note is not adequate for relating multiple variables. Data involving physical findings, vital signs, laboratory values, medications, intakes and outputs can lead to sound interpretations only if they are organized (by means of a FLOW SHEET) to reveal clearly temporal relations. The time required initially in setting up a proper flow sheet is small compared to that wasted unraveling and reassembling disorganized and misplaced data."

THE PULSE

If you have a comment or criticism, please drop a 50-150 word letter into the P-Q box in the mailroom. The PULSE will print all letters which disagree with its positions or which add additional information or ideas. To write an article, contact one of the editors or one of the editorial staff.

Editors: Paul Pennington, Peter Peruzzo, John Stoianoff, Diane Williams.

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Cartoons: Bill Hosack

Contributors: All Medical Students, Graduate Students, Faculty Members, Administrators, and Oregon Physicians.

PROBLEM LIST

6/17 # 1 Rheumatic heart disease
- a. Mitral insufficiency
- b. Atrial fibrillation
- c. Compensated conjestive failure TTB
- d. Cardiac catheterization

2 Presumed SBE
3 Repeated pulmonary embolism
4 Allergic dermatitis
9/3 # 5 Arthralgia
9/8 # 6 Family problems

8/5 – CARDIOLOGY
TEMP – 36.5 WEIGHT – 73.6 kg

 # 1 RHD:

Sx – excellent exercise tolerance – does housework, taking walks, etc. no SOB.

Obj. – wt. up 4 lbs. P 100 reg. with rare P/C BP 150/90 chest – few rales at (L) base that do not clear with cough; cor. unchanged.

Rx – unchanged – see flow sheet.

Plans – in view of excellent clinical response and exercise tolerance I am not concerned about rales but will continue to watch.
- a. Quinidine o/200 q2h # 300 – continue other meds.

9/8

 # Arthralgias – see EW not 9-3-66

Sx – continues at about same intensity but more concentrated in (R) arm.

Obj – ASO neg. RH factor – not significantly up. Repeat sed. rate – films of shoulders, elbows, wrists.

Rx – symptoms **exascerbated** by ASA – some relief by heat.

Plan –
- a. uric acid, serum glob, LE prep.
- b. observe.

 # Family Problems

pt. has been upset lately by husband's constant admonitions not to over-do herself and his general over-protective attitude. Today was very upset, depressed and crying – it is not obvious that more fundamental conflicts exist in this marriage. Husband drinks, is jealous of attention she gives to children, etc.

Plan — have asked her to have husband call me and will get a greater feel for the situation starting with the part of the conflict revolving around her medical condition.

FLOW SHEET

Date / Time	BP	P / R	T / VP	HCT / BUN	CO_2 / Cl	Etc.
5 / 27 6 PM	170 / 120	112 / 36	/ >30	62 / 32	27.5 /	
6:30	180 / 90	108 /				
7:00			360 / 21			
8:00	116 / 76	104 / 9 Set	/ 21			
9:00	120 / 70	96 / 9		50 /		
etc.						

. . . On Poaching Oranges

COOKING, as an art form, is best practiced by men. Don't misunderstand me, women are more than competent to perform the drudgery of preparing the daily fare that warms your stomach, some even achieve an elan that warms your heart, but culinary feats that affect centers higher than the viscera – soul food – is best prepared by men. This recipe – a variant of a party dessert published in *Gourmet* magazine – delights the eye as well as the palate of friends, wives, children (a remarkable tranquilizer) and even dogs who relish any morsel you might, in your zeal, drop on the floor.

You must begin sometime during the morning of the day of the occasion, by selecting 6 oranges. Beware! Fruit companies know oranges should be orange – so they dye them – many taste like wooden grapefruit. The end of the season, just after Christmas, is the best time for oranges. They begin to look as though they were floated around the Horn on rafts. Pick one with a moist appearing peel of a dirty orange color – scars and small green or yellow spots are of no consequence – squeeze it *gently*. It should feel spongy and soft. Ideally they should be of baseball size or smaller with thin peels. The grocer will eye you suspiciously – ignore him. He thinks you are mauling his produce like the housewife hoardes he confronts every day looking for the ad-man's orange.

If you can't find 6, go to another store – the effort is worth it. While you're there pick up a can of mace – not the aerosol variety, but the spice. Next stop by the liquor store for a good brandy or Grand Mariner orange liqueur. I prefer a good brandy because 1) it is less expensive, 2) the taste is almost indistinguishable in the finished product, and 3) brandy tastes better while you are cooking.

At home open the bottle of brandy and mix yourself a drink (brandy & 1 squeezed lemon wedge & ice & a soupcon of water is delightful and wards off the possible ravages of scurvy in the morning) which you can enjoy while you leisurely peel the oranges, carefully removing as much of the white membrane as possible without becoming obsessive about it. Next, shave for the evening's festivities if you must; to attempt shaving later could result in a trip to the emergency room. Pour yourself another drink, and select a pan large enough to contain all the oranges with room between. Add 1½ cups sugar and 3/4 cup water, ½-1 teaspoon mace, and a small handful of orange rind which you have finely slivered after removing most of the white membrane.

Stir while heating to boiling and let simmer undisturbed 7-8 minutes while you finish your drink and separate into sections all but perhaps one of the oranges to be used as a centerpiece. Mix another drink and add all the oranges to the gently simmering syrup. Spoon the syrup over the oranges and continue this basting for 8-10 minutes until the oranges are warm but still firm. Remove from the heat, add 2-3 ounces of the brandy and spoon the mixture over the oranges again. Allow to cool, basting periodically and place in the coldest portion of your refrigerator for 3-4 hours until they are *very* cold, basting often.

You are now free until company arrives to do whatever you wish save for occasionally making a trip to the refrigerator to baste the oranges and perhaps to make another drink or two.

I've never tasted the finished product sober, but friends say it's delicious eaten from fingers, toothpicks or in a bowl.

Oh yes. It's called POACHED ORANGES if you must have a name, but don't let that keep you out of the kitchen.

– John Stoianoff, M.S. II

MEDICAL LITURGY

And lo, ye shall find that as thy premed days, so shall thy post-premed days be.

Thou and thy colleagues shall understand from observing the sham diligence of they elders.

And with this understanding thou shalt be blessed.

For, in thy learning of the pitfalls of thy elders, thou shalt hopefully be instilled with the prophylaxis for thy own future good.

Ye shall see that man cannot be trusted for what he shall emphasize with regards to thy studying for thy exams.

Nor can he be relied upon for academic sincerity, ye shall learn that with attainment of professional success cometh the inability to admit one's guilt or ignorance of any subject.

Thou shalt see with thy own eyes, that as thou hast paid him to teach thee of that which he knowest, he shall, in truth, be absent on the day appointed.

Thou art therefore of utmost unimportance to him as thou rankest below his research or his non-academic interests.

Yea, verily, in his lectures thou shalt not find those virtues of him who is well prepared, of him who can delivery well, or of him who can stimulate thy and thy colleagues' minds.

Thou and thy colleagues shall discern that elder-apprentice communication is of, in truth, little avail.

For, in truth, tenure differs but in two letters from manure.

Verily, except one learn from the error of another, he cannot, in all faith, be of the new breed to come.

–Chap. 3

The Book According to St. Disgust

1966 CLINIC STUDY SUMMARIZED

This issue of the PULSE attempts to present some student and consumer evaluations of the clinics. However, these cannot match in thoroughness or in value the "Evaluation of the Pediatric Outpatient Clinic" which was completed in June 1966. This study was done by Patria Asher, MD and Walter A. Goss, MD; and involved many other individuals in the Department of Pediatrics.

For those interested in improving the service to the patient – either as an individual student or clinician or as an administrator – this study is required reading. Almost three years have passed since the completion of this phase of the ongoing project. Perhaps it would be valuable to review the conclusions of the study, and to compare these with the current state of our clinics.

This Clinic serves primarily the Portland area with a population of 750,000 and to a lesser extent the state of Oregon. The Clinic is geographically located poorly in relation to the low socioeconomic areas it serves. Probably over half of the eligible patients do not use the Clinic. Transportation and parking problems significantly deter full utilization of clinic facilities. The clinic premises are small and cramped, but construction of a new clinic has begun.

The standard of medical care and of teaching are exceptionally high. Noteworthy deficiencies are as follows: long patient waiting time, a large number of appointments are not kept, inadequate communication with referring physicians and agencies, excessive use of the Emergency Clinic, delay in X-Ray and Laboratory reports, imperfect doctor-patient relationships, no dental facilities, inadequate drug formulary, and no coding of clinic diagnoses.

Noteworthy recommendations are as follows: establish satellite clinics in low socioeconomic areas, include a dental facility in the Clinic, increase medical reports, code clinic diagnoses, expand the drug formulary, improve the appointment system, and increase use of Public Health Nurses.

Recommendations for future research are the following: a study of the medically indigent who are not currently using the Clinic should be undertaken, further study of patient waiting time, study of reasons for failed appointments, further study of patient's attitudes toward the Clinic, study of doctor-patient relationships, study of the Emergency Clinic and a continuing program to evaluate current changes and problems arising in the future.

In 1969, what other clinics can claim this record?

The Pediatric Clinic is the only Outpatient Clinic at the Medical School which has a full-time Director. It is also unique in the following important respects; it provides continued and total care for its patients, accepts walk-ins, is open on Saturday mornings, accepts telephone inquiries which are handled by a doctor or nurse, spreads appointments through the day, reviews charts of patients seen in the Emergency Department and asks for student critiques of the service. In these and other ways attempts are made to make the service more complete, more efficient and more readily available to its patients.

Which of these recommendations have been instituted? Which are still necessary?

As a result of the preceding findings the following recommendations are made for consideration:

a) Establish satellite clinics near or within low income areas.
b) Improve parking facilities. (A new parking structure is under construction.
c) Build a new Pediatric Outpatient Clinic with adequate accomodation. Construction of a new Pediatric Outpatient Clinic has begun.
d) Establish dental facilities as part of the new Pediatric Clinic.

e) Consider including a laboratory within the Pediatric Clinic in the new facilities.
f) Use Public Health Nurses more for follow-up care and home penicillin injections.
g) Increase medical reports so they are sent to physicians or agencies not only upon request, but when referral is in writing or when information is needed by referring source for follow-up management and treatment. Written medical reports should be written by physicians.
h) Make every effort to have patients return to the same doctor.
i) Bring drug formulary up to date (this is being discussed).
j) Improve patient appointment system so as to shorten patient waiting time.
k) Add more telephone lines.
l) Keep readily available patients' current addresses and phone numbers.
m) Establish Outpatient diagnosis code so that research projects can be planned in the future.
n) Stress punctuality to Medical Staff working in the Clinic.
o) Continue evaluation of Clinic – several agencies and many parents told us the clinics services had improved recently. The very fact this study was undertaken seems to mean that something was being done. This momentum should not be lost and continued evaluation is the best way to maintain efficiency.
p) Circularize this report to all personnel having any part in the functioning of the Pediatric Clinic, to all related departments and to the administrators of the University of Oregon Medical School and Clinics.

Which student criticisms are still valid?

There were far more compliments than complaints. Almost all the students praised the service highly, most stating it was the best clinic they had experienced in their teaching thus far. They complimented several of the staff men, particularly the Director, whom they felt were outstanding teachers. Several felt the first week of orientation conducted by the Director was excellent. Many felt they were treated with courtesy and respect by all personnel and were particularly complimentary to the nurses on duty.

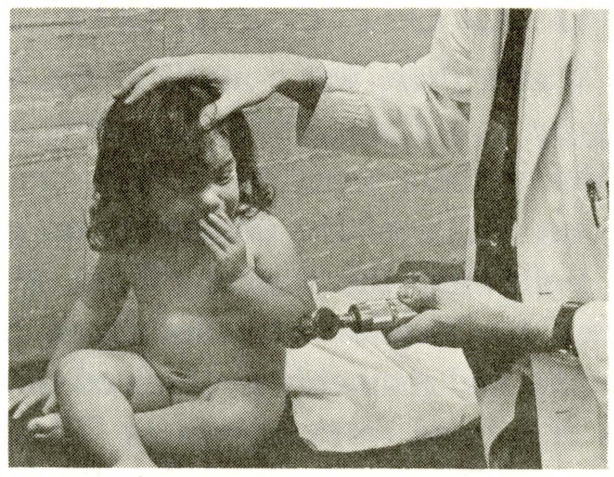
The General Pediatric Clinic

Criticisms and suggestions of the General Pediatric Clinic with frequency mentioned as follows:

Too much time spent waiting to present case to staff man	15
Patients not put in examining rooms orderly or promptly	5
Not enough opportunity to see interesting cases	4
Complete work-up of all patients unnecessary	2
Student "Patient-Diagnosis" list a bother and not worthwhile	2

The most common complaint was regarding the time wasted waiting to present their case to a staff man. Some felt more staff men should be available, others mentioned that some of them arrived late or left early.

The Clinic, A Student's Evaluation



A casual glance at Oregon reveals scurried if somewhat concealed activity directed at improving the medical clinics. The mammoth task is unrewarding and slow for those involved, but will eventually result in a better educational program for the senior student, more satisfactory working arrangements for the volunteer staff, and perhaps better medical care for the people we call patients.

Identification of existing problems has been the easiest task for the committee appointed by Dr. Lewis to improve the outpatient program. Dr. Kassebaum, the chairman, recently aired many current problems with senior students on medicine rotation. What follows is an enumeration of the problems thus far identified.

An immediately apparent difficulty is recruiting a sufficient number of volunteer staff to adequately care for a large number of patients and to teach a large number of students. *Overworked physicians have little time to instruct* or explain difficult diagnostic or therapuetic problems as they arise. Moreover, the student fourth in line to present a patient hardly desires that each of his earlier colleagues receive a lengthy dissertation on their respective cases. A large student to staff ratio obviously hinders whatever learning experience is to be derived from the clinic.

In a similar vein, there is *no uniform pattern regarding student presentation, staff instruction or teaching,* criticism on a job poorly done or commendation on a well-handled situation. An attempt to regiment these variables would perforce be an attempt to remove some of the spontaneity and joy of practicing medicine; but perhaps a few guidlines could be established without strangling anyone's ego.

There is probably *too little student responsibility in Medicine Clinic.* Not with regard to patients per se, but concerning seminars, conferences, reading assignments, and consultations. Possibly this feeling stems from suddenly having a large amount of free time with no explicit directive. This disorients many students.

Some of the randomness might be removed from the process of putting patient 'A' into Room 'B'. When a student walks into his room and says, "Hello, Mrs. Jones", he may or may not be aware of the ritual that has inexplicably bestowed Mrs. Jones on him. Into room 'B' may stream a steady procession of congestive failures, or ulcers, or headaches. After a few weeks of steady processions, the return appointment list begins to fill, and the system is safely perpetuated for 12 weeks. Although admittedly difficult and time-consuming, *some device to provide a greater variety of case material is desirable.*

The *reliability, availability, and desirability of grades* must also be discussed. A provisional grading system has been temporarily rescinded, but may offer a partial answer. Student acceptance ranged from prickly to passive, but after group discussion wholehearted approval was generated by most.

Having solved all the foregoing with some magic wand, there is laid evident a most curious morsel, heretofore hidden by bustling clinic coats – the patient. He requires our attention and new insight in developing a more efficient system of delivering medical care. This aspect of the "Clinic Problem" is covered in another article in this issue of the PULSE.

A brief allusion to a complex and varied problem will not assist the struggle for improvement. Historians, who prefer a calming collection of mold to have settled on the present before attempting to pry loose it's secrets, would be aghast at any effort to accurately portray an ongoing event. The shortcomings of such an attempt are recognized at the outset, however, and the noblest of our intentions is to interject a note of optimism and visions of a rosier future.

Dan Lewis, M.S. IV

The Clinics From The Patients' Viewpoint

The following article is submitted as a composite of several interviews on experiences and insights of the patients into their care at the clinics. It should be emphasized at the onset that the greatest problem is economic, and therefore, chiefly out of control of those directly involved and in the hands of the State Legislature.

It became obvious that over half the patient's complaints could be attributed to the lack of adequate staff and facilities to handle the overload of patients. The month-long appointment waits (if you are lucky), the long lines seen serpentining the halls, and the iritated response of an overworked receptionist fall into this category. The emergency room pile-up, where patients congregate with obvious noncritical conditions, mirrors their frustration at the backlog and appointment waits. Likewise, the physicians are faced with the impossible task of seeing "emergency" patients in a never-ending stream.

However, amid the many indignant complaints, two areas could be singled out which have the possibility of direct improvement. The first involves honest communication – both to the patients and between specialty clinics. Patients are told to keep a 12:30 appointment at a clinic where the doctors notoriously don't arrive until 2:00 p.m. due to scheduled classes and other responsibilities. Patients are also shuffled from specialty to specialty with the "Sorry, we can't help you here, try dermatology or neurology", or "Wait one more month and then arrange another trip to the hill".

These long waits between visits and the doctor's consequent reliance on outdated written histories without immediate inter-specialty consultation can be improved. Added red tape of registrations and records has its effect on efficiency and the patient's cooperation too.

The second area of generalized complaint concerned the doctor's apparent unawareness of the patient's social, economic, and psychological problems. True, the clinics were not meant to include a hand-holding or Dear-Abby-problem session, but perhaps a realistic assessment based on a more extensive social history would aid in the patient's total care. One patient told of her physical and economic inability to make repeated trips to the clinic; another, the stress at home making it impossible to carry through with the treatment prescribed; another, the dilema of a sick child and a house without heat. Welfare patients commented on the degrading, judgmental attitudes they faced as charity cases from individuals of upper middle class backgrounds. Or the pompous comment "why can't they rise above this, or at least take a bath?" Certainly the complexities of the patient-doctor relationship aren't concealing an easy answer, but this is a problem which the patients recognize, and which *we* can begin to solve.

– Diane Williams, M.S. II

The Beatles: Life's A Gas So Don't Spoil It.

If ever there was a myth of the Intellectual Beatles (and judging by two disappointed reviewers in *Saturday Review* and *High Fidelity* there must have been one) it was shattered with the recent release of *The Beatles* (in the plain, white cover).

Following the release of *Sgt. Pepper's Lonely Hearts Club Band* the Beatles were acclaimed by many of those who previously had staunchly maintained that the only "good" music was an ill-defined form known as "Classical" as the originators of a new Art Form. For them *Sgt. Pepper* went beyond the attempts of Milhaud and Gershwin and others to synthesize jazz and classical music; it was a kind of idiomatic, secular cantata, a thematically tight statement on the quality of life in the post-industrial Western World.

In the light of this warm-and unexpected—acceptance of "rock" by the entrenched it is hard to understand the disappointment of those like Ellen Sander in *Saturday Review* who find that in the new album "The spirit lags in most of the songs that try to be deep, and the album suffer badly," unless she and the others are missing the whole point of what the Beatles have said: simply that life's a gas and mustn't be spoiled by always thinking deep thoughts, and being dour and untrusting and unwondering of everything.

Despite all that was written about *Sgt. Pepper* it was not a consciously intellectual essay which required a deep critical insight to penetrate, and by the same token, *The Beatles* bears no burdensome message. It is, rather, simply a vision of the present which is necessarily influenced by the biases of the artists, but which has no other hidden meaning—and it is a serious mistake to look for one.

The Beatles lacks the structural integrity of *Sgt. Pepper*—it is more a shotgun blast of satire, a free-wheeling parody of popular music and the cliches that underlie much of it—but it maintains that sense of delight in just being alive that characterized their music. These four, very much involved in the world, are thumbing their noses at anyone who takes himself too seriously—including The Beatles sometimes.

The record opens ("Back in the U.S.S.R.") by dismissing the emptyheaded commercialism represented by the Beach Boys, with a beat even they would envy, and a set of perhaps the most inane lyrics ever set to music. Twenty-nine cuts follow, ranging from a gentle mockery of the Bob Dylan twang ("Rockey Raccoon") to a playful poke at the jerks of the world ("Ob-La-Di, Ob-La-Da) to horror at the relentless de-humanization of man ("Piggies") to a beautiful love song "'Julia"). There is a look backward to the beginnings of "popular" music in the present sense of the word ("Honey Pie"), and a prospective view to possible new directions ("Revolution 9").

In the end, one is left with the feeling that in some way the album is a kind of summary of the state of the art: this is where we are, and this is how we got there, and these are some of the ridiculous things that happened on the way. But perhaps even that is imputing too much purpose to an album which is best remembered for its rollicking fun-making and total lack of the bitter cynicism so characteristic of much of contemporary music.

— Tom Duncan, M.S. II

Philosophy

Competition motivates the everyday pursuits of medical students. The "determined" student often resorts to whatever means necessary to assure total development of the massive knowledge required of a top-notch physician. He sometimes employs an approach which clearly ignores the ethics of behavior which he might expect of others: belligerent impatience with "incompetent" instructors is not uncommon.

If success were to be measured in terms of status and respect achieved for one's prowess in the accumulation of knowledge, such an individual would attain it. However, the term "success" should more deservingly be accorded those individuals who give of themselves and their knowledge to foster progress in the entire field of medicine, rather than to those who greedily horde everything essential to build or to preserve an image of superiority over their colleagues.

The maintenance of competition to achieve self-recognition breeds not only anxiety but also dissatisfaction with life. How can a doctor who dwells on his own misfortunes feel he is contributing to humanity by prolonging the life and thus, the anxiety and dissatisfaction with life, of a patient who may be suffering from greather unhappiness than his own?

— Howard Henjyoji, M.S. II