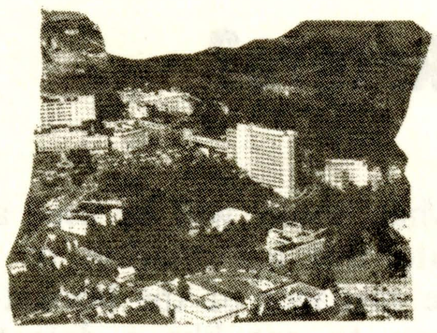


THE PULSE

Vol. 6, No. 2 November, 1969

THE MORATORIUM . . . .
A Question of Timing

The moratorium nationally, if not at the UOMS, was a great success. Thousands of young people across the nation put down whatever they were doing to participate in parades, listen to speakers, or distribute information. There was a feeling among the participants of pride in standing out on something in which they believed, of placing themselves openly in opposition to authority. This sort of participation, I think, cleared a lot of consciences. If the war is an evil thing, well, they had disavowed themselves from it. If the administration didn't listen, they had done their best. Not many will deny the personal satisfaction of these thoughts. But how many will wonder if the reasons for participation were to find this peace of mind rather than to find a means of *honest* expression of disagreement.

As I participated in the moratorium, a black band on my arm, I watched and talked with many people. Several questions kept coming to mind. Many of these stemmed from a very old question of the head versus the heart. Being in the medical field, we all know that the two are very different. The head deals with problems of intellect; the heart with emotion. Although the two are unrelated, people often use one to solve problems of the other. Admittedly, most problems deal with both of these aspects, but each should be analyzed in its own dimension.

The Vietnam war is largely a problem of intellect. It concerns problems of philosophy, politics, religion, and moral ethics in the broad sense. Yet most of us seem to attack the problem emotionally – for reasons unrelated to the problem. How many people, critical of the administration's stand on the war, are critical for the right reasons? How many are critical because it has now become the only socially acceptable way to act? Is there a difference between fad and flowers?

It is not difficult to see why this problem is being treated emotionally. There are an incredible number of factors involved. The information that we do get is highly edited; by observers in Vietnam reporting to the government, then by the government. Newspapers, authors, and friends all must edit what they see and feel in order to keep their reports of practical size. In doing this, it is inevitable that reports from our news media involve choices and exclusions. Thus, the opinions we hear depend on who we read and talk with. And we *are* influenced by these people. How else can one explain the geographical, occupational, and age differences in opinion? These different classes of people are reading and speaking with different types of people. The point of being this: our decisions and feelings on this subject are not always as objective as we believe. Peer pressure becomes a very influencial force. It is not easy to know what is right.

A second bothersome thing is the timing of this particular protest. It seems to come right at a time when the administration has been putting the greatest effort into getting out. (Witness the support and praise by Nixon's most natural opposition, Johnson and Humphrey.) During the moratorium at UOMS, there was much talk about what medical people were doing to promote peace. However, there was not talk about what we felt that the administration is doing. Do we feel that our government is doing nothing?

In this controversy, I offer the following thoughts. What will the consequences of our wishes be to others? It seems likely that there will be a blood bath in South Vietnam if we withdraw our protection immediately. Do we have some responsibility to the people of Vietnam whose dispute has been escalated into the major powers war? If what we are concerned about is humanity (a good thing for humans to be concerned about), then we should try to end this war better than it was begun.

This is not to say that the moratorium was a bad thing. It is good to see that so many people desire peace. It is good that concerned individuals are able to demonstrate this belief. Thus, as a means of showing the government the nature of our feelings, the moratorium was tremendous. However, I feel that many of us are too easily falling into the pit (that medical students in particular seem prone to fall into) of criticizing freely and ignorantly those in authority. I feel that as a device of putting pressure on those in authority, or as a means of threat, the moratorium was not well intentioned. Perhaps supporting the government and seeing if it is in fact sincere in its efforts will be more helpful to our common desires.

—James Allen, MS II

A Beginning

On October 15, thousands of Americans across the nation took part in what was probably the largest peaceful mass demonstration in the history of our republic. The goal – End the war in Vietnam. At UOMS, several hundred students, faculty, and staff attended a one hour program in the library auditorium. In retrospect, I think that our effort to participate in the national "moratorium" can be viewed both as a failure and as a success.

The program itself was reasonably successful. The three speakers – Reverend Ira Blalock, Dr. George Saslow, and Dr. Morton Goodman – complemented each other and their remarks were informative and thought provoking. Following the speeches, the members of the audience were asked to participate by expressing their views on the Asian conflict and, after a slow start, a lively discussion took place. Despite these initial successes, the primary goals of the program were not accomplished. This can be attributed to a lack of publicity.

As originally planned, the program hoped to emphasize to the public that the medical profession is just as concerned about the course of American foreign policy as are the students and faculty of the nation's colleges and universities. It was hoped that our participation in the national protest and our concern over the death and destruction in Vietnam would, in some small way, help to influence public opinion against the war. But, although the press was repeatedly contacted, our effort received not one inch of copy. The people of Portland remain unaware of the fact that a concerned group within the medical profession participated in the activities of October 15. In this sense our effort may be viewed as a failure.

There was, however, an element of success in the program of October 15. It is significant that over 270 members of the medical community signed a statement condemning American participation in the Vietnamese conflict. It is significant that the convocation generated enough interest to draw a crowd which filled the main floor of the library auditorium. To me, these facts are indicative of a desire on the part of many students and faculty to take an active part in the resolution of social and political problems of a non-medical nature.

(Continued on page 5)

ATTENTION FACULTY:

A file of current overseas job opportunities for medical students is now being compiled by SAMA. This file, when completed, will be available to all interested medical students. If you are interested in this project and have any information or suggestions, please contact John Hoggard MS II through the campus mail.

Letters

Dear Editor:

I wish to congratulate your paper on publishing the excellent satire in your last issue. It was very well written and made some controversial points.

But, as in all good satire, two points must be remembered when reading it. First, satire makes its biggest impact by overstating the facts, and thus at times gives a distorted picture. This distortion is within literary license provided that the main point of the article is accurate.

Second, satire is not meant to please. Abe Lincoln said, "Be sure you are right, then go ahead." The purpose of satire is to get people thinking in order to make sure that they are right.

My last point deals with the way the article was published. While in a dictatorial country, it might be dangerous to sign one's name to inflammatory material, such precautions are not necessary in this country. To leave an editorial unsigned is a serious breach of Professional Journalism. I hope *The Pulse* will keep this in mind in the future.

—Bruce MacHaffie, MS III

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 position or which add additional information or ideas. To write an article, contact one of the editors or one of the editorial staff.

Editors: Diane Williams, Mike Herring

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

What About the Bookstore?

"That book won't be in for two more weeks." For those of us who use the medical school bookstore, this is a familiar and aggravating phrase. Once again the beginning of the new school year has demonstrated that the service provided by the bookstore is wholly inadequate to meet the needs of its customers.

A good example of the bookstore's incompetence is the shortage of books available for the third year students this year. The book list for third and fourth year students contains seventeen books, and two other books were required but not on the list. Total: nineteen. Of these nineteen books, at least nine were not available in the bookstore for all the students that needed them. Of these nine books that were not available, seven were required textbooks. Some of these books were not available because the publishers were late in delivering the orders; others were ordered in insufficient numbers; and others were ordered late or not at all.

A brief interview with Charles Davis, manager of the bookstore, revealed that there are many reasons for the bookstore's incompetence. Lack of physical space is one factor which prevents the bookstore from functioning adequately. There is insufficient room to store ninety or a hundred copies of every book on the recommended list. More room is needed for the display of books. There isn't enough space for people. Presently the bookstore is crowded with five or six customers.

Secondly, it is evident that the bookstore is not being managed efficiently. Too often books are not ordered until the last copy is sold, and too often they are ordered in insufficient quantities. An example of this is the required text *Outline of Orthopedics* by Adams. The text was not ordered until school began and then the initial order was sold out in one day. The unfortunate has to wait an extra five days for the next shipment. Closer inventory must be kept of the stock and the bookstore must be willing to overstock occasionally in order to be certain of always having an adequate supply of needed books.

Third, a big share of the blame for the bookstore's failure lies with the faculty. Their lack of communication with the bookstore results in many late orders or wrong orders being placed. There are a number of instances when the bookstore was told by a faculty member to order one book and the students were told by the same faculty member to purchase another.

There is no reason why the medical school bookstore cannot operate like any other university bookstore. That is, the bookstore orders only what the faculty members request it to order and what individual students request. This means that the faculty must take the initiative to decide early what books will be used and to communicate this information to the bookstore. The manager of the bookstore should not have to act like a detective attempting to discover the well kept secret of who is using what book at what time of the year for how many students.

The most appalling aspect of this problem is that it has been allowed to continue year after year. Neither faculty, nor administration, nor students have taken the initiative to force the bookstore out of this chaos. Unless somebody exerts pressure on the bookstore to improve its service, we will all be waiting two more weeks forever.

—Dennis Mayer, MS III

Tuesday Forum Slate Announced

The schedule of the Tuesday Forum for the next two months was recently announced by George Cameron MS II, and his committee. The Forum was initiated last year on a weekly basis and provided some useful and extremely interesting information for those who attended. The discussions regularly featured professors from the Medical School and other professional experts from Portland who challenged first and second year students with both sides of many issues. These are the problems of the practicing doctor and his family which are never discussed in the classroom. This year's Tuesday Forum is likely to draw as much enthusiasm as its predecessor did. The correct schedule is drawn up on an every-other-weekly basis with the discussions beginning at 1:00 p.m. The schedule which began on September 23 with "The Pros and Cons of the AMA" is as follows:

October 7. . . . "Medical School Admission and Minority Groups"
October 14. . . "General Practice in the Small Community"
October 28. . . "Medical and Legal Aspects of Abortion"
November 4 . . "Health Care for the Financially Deprived in Oregon"
November 11 . "Outside Clinic Proposal"
November 18 . "Drug Companies and Medicine"
December 2 . . "Prepaid Medical Care"

George and his committee emphasize that the topics discussed will not be as general as is suggested by the schedule. Why don't you come to the next Forum and make your lunch a little more flavorful?

—Mike Herring, MS

That Bright Fall Day

Twarn't a fit night out for man or beast as 'umble old medical sot warmed to his third beer in the Elephant's Castle near Washington.

"I 'member the bright fall day we entered the Clinical Years. It was the end of an arduous two year journey past the assaults of pathologists, the attacks of anatomists, the insult of physiology, fraught with the perils of Diagnostic Disease and buffeted by the hot winds of the Biochemical Desert. I 'member thinking we had it made, having crossed the National Board over the mythical River of Fear, with nary a suspicion of the chaos ahead.

"That bright fall day, as I was saying – another beer George, mah frien'll see ya square – marked our first encounter with the Patient Tribe. Oh, we weren't altogether strangers to their ways having seen specimens wheeled before us – a goodby distance away of course – resembling the deadly Cadaveric Tribe easily befriended by us in la Bore a Torie. Our brave Chief Lewis demonstrated what was expected of us as Medicals. Oh, those blows, deftly delivered with percussion hammer and phalanx, ringing through those hallowed halls! Those tympanic tones! Verily, they were transmitted through the ischial tuberosities to tickle the tentorium!"

A dreamy silence ensued.

"Excuse my reverie gents. Where was I? Oh yes, my BEER George! As I was saying. The Patients were housed in the tower on the hill, allowed to rest patiently in their cells and walk slowly in exercise lines, being let out only at night. A strange custom to be sure, but the way laid down in the manuals and upheld by tradition. In the other lands out there in the world called Real it was rumored the Tribe of Patients moved freely about without even identity cards – a frightening thought. Brrr! My blood runs cold at the thought that but for the fortress on the hill we would be among them!

"The battle lines were drawn. We Medicals grouped around our leader for stirring inspiration in the last minutes before encounter. Then each into his cell remembering the Lewis and Selling rules of combat: fist blows to the kidneys only as indicated, open handed direct blows to the clavicle and rarely the skull, blows to the chest and abdomen (only in dire circumstances to the scrotum) when the Patient is protected by pleximeter, needles used to elicit a feint, mallets only to test areas of reflex and tenderness – all with the drapes of modesty. Above all the mind, with great acumen, must be at all times in motion, unerringly directed at the problem.

"We were spectacular that day, our uniforms resplendent under the fluorescents, our shoes a mirror hue, our bags creaking in their newness to deliver our armament readily to hand. The battle cries fell from our lips with practiced surety: Foley catheter! When did you first notice this! last completely well? orthopnea! P.N.D.! S.O.B.! vaginal speculum!

"Then at the apogee of conflict a quick retreat and conference with our leaders and back to administer the coup de grace – the diagnosis dignified with therapy and an honorable word of praise for the valor of the enemy.

"Later that day, around the café, were heard words of the seasoned veteran from the Medical who was a raw recruit not five hours before: 'she'd had an A and P resection, ...the differential was Dercum's disease or neuroma, ...signs compatible with the diagnosis psychoneurotic female, ...episodes of biventricular failure....'

"We may snicker at these new veterans now with many battles behind us and old scars of experience fattening our self, but that glorious first day is always with us. 'You forget the others, but you always remember the first.' A bordello queen once told me, and so it is with us."

The long, palpable silence broke only as the 'umble old medical sot called for another beer.

"Eay George another round. M'frien 'ere 'll see ya square."

—John Stoianoff, MS III

OMA Ombudsmen

The newest Oregon Medical Association committee is the Ombudsman Committee. Intended to serve as an intermediate between the establishment and the grass roots of the medical society, the committee solicits the comments of individual physicians and medical students. In this fashion it is hoped that feelings of the silent masses can be converted to new policy.

Presently the group is considering issues in a wide range of areas. The possibility of substituting National Board, Part I for the Oregon Basic Exam, an issue dear to the hearts of exam students, is under consideration as are political action committees and the use of public health facilities by private physicians. Student problems and concerns are solicited by the committee in hopes of obtaining a view of organized medicine from their vantage point.

If you have a concern or an opinion, or are seeking information about anything in the broad field of organized medicine and its relationship to society, the Ombudsmen want to hear from you.

Ombudsman Committee
2164 S. W. Park Place
Portland, Oregon 97205

—Mason Smith, MS III
—Bruce VanZee, MS IV

Junior Year Analysis

The transition from sophomore to junior medical student is somewhat like skiing. That is, you are sweeping down a long steep hill in good shape, lean away for a gentle turn and then discover that both bindings have come loose.

By the end of the sophomore year, the student has acquired a good bit of solid data about the science of medicine. After all, the study of Anatomy, Physiology, Histology and Biochemistry has prepared him for understanding the normal life processes. The disease processes were covered in Pathology. And during that sophomore year there was an introduction to the art of medicine: (Physical Diagnosis began to be concerned with the real life process of dealing with people.)

So armed, sophomore tests his data base with National Boards in the spring and then turns toward The Clinical Years.

The junior year is organized into blocks. There is something called Medicine, Surgery, Ob-Gyn, Pediatrics and Psychiatry. Some blocks are further called ward clerkships or out-patient clinics. There things look strange to the student who has recently completed at least five years of traditional college organized classes. But, the new junior is reassured by noting that each block begins with an orientation period. Orientation consists largely of directing each student to their appropriate starting block, and may include some indication as to who the new clerk is to report to and where. It lasts 10 minutes.

So armed with a new black bag and hopefully a copy of "The History and Physical Examination", the junior student enters the hospitals and clinics. A varying amount of time is then consumed finding the resident under which one is to work but with any luck at all by 10 a.m. of the first day of the junior year, the new student is told to "work up" the patient in room 15. This is where the free for all begins.

There are two concepts about the first clinical year that, in retrospect, appear fundamental. The first is "the complete history and physical examination". Most new juniors have never seen one done, but the pieces are there. This is really what the year is all about. Learning how to approach a patient and leave with every bit of possible information should be the major goal on each rotation. Perhaps it would be better to think in terms of blocks called the history and physical exam in Medicine, in Pediatrics, etc. Naturally it is very nice to be able to correlate the information gained with the data base one has acquired and continues to acquire daily; but this should be the second objective for the new clerk.

The second concept involves the method of learning. Making the switch from the lecture hall to the bedside is not

(Continued next page)

Bottom of the Pile

One hears a great deal of talk about incorporating more clinical medicine into the first two years of medical school. Unfortunately, much of the talk expresses a negative reaction to such a proposal. The most common objections are: 1) the students are not "ready" for clinical medicine, 2) students do not have a sufficient background in the basic sciences to make clinical medicine meaningful to them.

I do not intend to argue with these objections. The objections may be correct if we are talking about the "clinical medicine" juniors and seniors experience. However, there is an obvious *need of certain students* that could be met by incorporating a course such as "suturing" or "sterile technique" in the early years of medical school.

The students I referred to above are those students on the tail end of the bell curve. Those students who, being admitted to medical school, have the potential of being fine physicians but are having trouble due to the lack of positive cues. The only people I've ever heard say "someone has to take a C or D", "someone has to be down there" are the people in the top 2/3 of the curve. They feel they are becoming fine physicians, are really doing well, because the system they grew with (grades) is still working for them. They may, in reality, be fooling themselves but as long as each maintains his grades he need not question his abilities or methods. The man in the lower 1/3 has a great deal of trouble in the system. He is used to being reinforced by grades. Now he is not. He looks around, tries to find other cues that say he *has* potential, he can become a good MD, and finds instead somebody saying, "It's been shown grades don't indicate whether you'll be a good physician or not." That is one hell of a poor positive cue.

I suggest that while traditional "clinical medicine" may not be necessary in the first two years, courses are needed which allow the low man on the totem pole to say, "I can suture pretty well; I really enjoy making these arm casts; maybe there are some reasons to go on." Needed, not because he needs to learn how to do these things early, although he will do that, but because these courses allow another way of looking at himself. Grades beat and frustrate a great number of people. In the first two years, that is the only basis for evaluation and comparison.

If the administration of this school really believes that the lower 1/3 *will* make good physicians, they should strongly support proposals for courses such as sterile technique, casting, psychological problems confronting practicing physicians, etc. in the first and second year of medical school. Such courses would not be bringing "clinical medicine" to unequipped freshmen and sophomores, but rather would offer a person a way to get off the downward merry-go-round of low grades → frustration → depression → rejection → lower grades → etc. Such courses allow the forgotten 1/3 a chance to see themselves as *someone* besides *somebody down there*.

—John Meyer, MS III

Med School Adopts 3 Grades

Editor's Note: The following article is a reprint from the "Minnesota Daily" University of Minnesota submitted by Doug Anderson, MS I.

Freshmen medical students at the University will be phased into a new grading system not offered to other University students. Grades given freshmen in the medical school this year will be "outstanding", "satisfactory" and "incomplete" according to Doctor Robert J. McCollister, Assistant Dean for Student Affairs in the medical school.

McCollister said the new evaluation system is not an experiment and will last for at least the four-year term of the present freshmen class. He said about a quarter of this country's medical schools have similar evaluation systems which have been successful.

The new evaluation system aims at the elimination of a "short-term approach to medical education," McCollister said. "What we are trying to do is foster a life-time of learning."

The sophomore and junior medical school classes have been given the option of evaluation by the new method and are now engaged in discussions prior to a vote on the matter.

"How the individual performs as a doctor doesn't necessarily relate to short-term learning in medical school. This system allows those who are so inclined to excel because they are rewarded with a grade of 'outstanding'," McCollister said.

The new system of evaluation has four main parts:

Grades are reported as "satisfactory," "outstanding" or "incomplete".

Successful completion of National Boards is a requirement for graduation.

Evaluation of performance and personal characteristics by medical school faculty will be improved.

Letters of recommendation for internships and other positions are to be detailed, but will give no class rank.

A medical student is virtually unable to fail school under the new system. Failing work will be given an incomplete grade and the student will be expected to make up the work satisfactorily and retake the tests he may have failed, McCollister said.

Examinations will probably be given number grades, although the procedure of grading individual tests may vary from instructor to instructor.

All exams are to be returned to the students because they are designed to tell the students what they do not know. Weaknesses will show up and contact with instructors will be encouraged, McCollister said. "We need to try to foster a dialogue between students and faculty, and we hope this is the way to do it."

Course instructors are to be held responsible for informing students of work which is of marginal quality. This will be done to alert students of poor performance and help them avoid an incomplete.

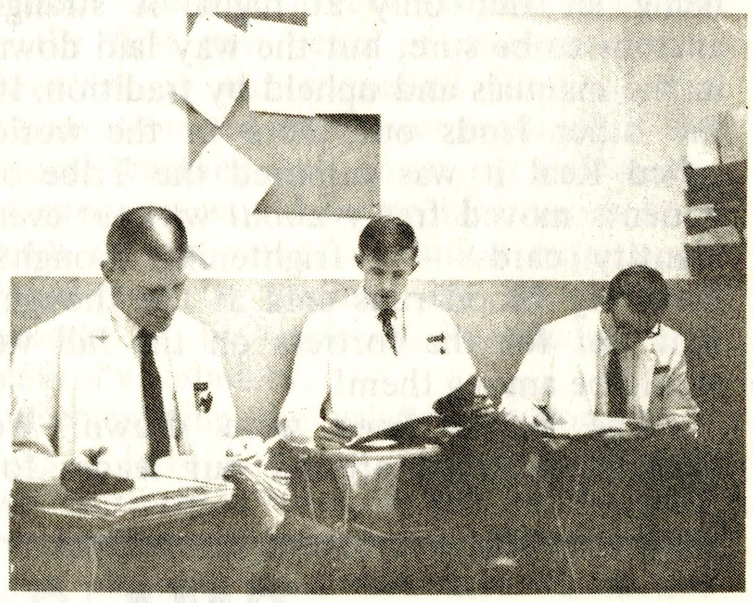
No class rank in any form will be compiled. McCollister said this has been a matter of discussion among faculty members; some favor ranking a student by thirds of the class, that is, whether a student is in the top, middle, or lower third of his class.

Since this evaluation system has only come into use in September, there has been no appraisal of it, either by students or faculty. The executive faculty of the medical school voted the system into use.

Would this type of evaluation system benefit areas other than medical education? McCollister said, "If personal and intellectual characteristics of a student could be told in a better way, in terms of his future life's work, I think it could be very valuable."

Junior Year Analysis

(Continued from previous page)



difficult for most students; the motivation is there. But there is a tendency to feel lost and undirected for awhile. Before this year very few students have had the opportunity to learn by practice. To learn by practicing is fundamental in the junior year. To return to the textbooks to find new material and correlate old is, of course, necessary. However, it should come as an outgrowth of the observations made and techniques practiced by the student.

And that brings us to the essence of the junior year. To read the book and say, "Yes, that's just the way it is in my experience"!

—Phylis Brown, MS IV

Salishan Conference . . . A Report

It was not the hot line, but it was perhaps as momentous and communicative – The Oregon Conference on Family Practice held October 24-26 at Salishan, Gleneden Beach, Oregon. Sixty-five concerned physicians were present, one group from the medical school, the others from private practices throughout the state.

The participants were general practitioners, pediatricians, and internists who as a group are considered primary physicians. These are the physicians whom patients usually seek first. Included in the medical school entourage were three medical students – Jack Loverin, Ed Cadman, and Francis Kenyon – who added spice where spice was needed.

Four guest physicians were present to contribute resource information: Lynn P. Carmichael, M.D. (Director, Division of Family Practice, University of Miami School of Medicine); S. Spence Meighan, M.D. (Director of Medical Education, Good Samaritan Hospital); August Swanson, M.D. (Acting Dean, University of Washington Medical School); and Charles C. Strong, M.D. (Member of Education Commission, American Academy of General Practice).

The goals of the Conference were to discuss the pending problem of the primary physician shortage and the ever-increasing need for primary physicians in Oregon, and to determine how to alleviate this shortage.

The primary physicians accused the Ivory Tower of brainwashing the young knights in shining armor not to become primary physicians. The kings of the Ivory Tower accused the primary physicians of overemphasizing the need for more help. In the beginning there was no light, just lots of heat.

The first session presented several general practitioners who gave the audience an idea of what a general practitioner actually does, and what a family practitioner might be expected to do in the future. Doctor Carmichael chronicled the conception, birth and development of the Family Practice Department in Miami. Doctor Meighan discussed the present distributions of physicians in Oregon. The first session concluded with small organized group discussions concerning the topics: "What is the Problem?" and "What are the Causes?"

Possible alternative solution to the identified need of primary physicians was the subject of the second session. Doctor Swanson presented the four pathway curriculum of the University of Washington – Family Practice, Medical-Surgical, Behavorial Specialist and Medical Scientist. Doctor Strong presented the philosophy of creating a new Board Certification Residency Program in Family Practice. He discussed its advantages and deficits as a means of alleviating the identified physician need.

"Solutions Involving Medical School" was then discussed in small groups. The overall conclusion was that medical schools bear a large portion of the burden in closing the ever increasing gap between the need for physicians and their physical numbers.

Proposals of the UOMS Curriculum Committee relative to family practice were presented by Doctor Krippaehne, Head of the Curriculum Committee. The following discussions revolved around the possibility of involving primary physicians with the medical students education, both as a volunteer preceptor and during an organized elective to be offered during the academic calendar.

All in all, the primary physicians found out that the Ivory Tower is made of brick and had no kings, save perhaps one and he was a Dean. What was thought to be knights in shining armor were reflections of themselves imprinted in their minds by time. No one was washing any ones brain. The hill people were doing some finding too: the need for physicians in primary care is great and getting greater unless measures are taken to supply this need; the pressure for correction may become governmental.

So, in the end there was light, and a lot less heat.

–Ed Cadman, MS III

A Beginning

(Continued from page 1)

I have always felt that the members of the medical profession – and particularly medical students – could be tremendously influential by involving themselves in peaceful political activism. It is true that the main concern of a medical student should be directed toward his chosen profession. At the same time, however, it would be wasteful for a student with an active interest in social and political problems to let himself be limited by the rote learning of his freshman year to the extent that his outside interests are stifled – perhaps permanently.

A physician is able to render an invaluable service to society as a result of his years of extensive training – a training in which we, as students, are currently involved. Yet, the medical student has a great deal to contribute to society long before he is able to offer his professional services. The interest and participation generated by the moratorium program serves to strengthen my conviction that there are many students here who are anxious to make this contribution.

Viewed in this light, the October 15 convocation was, indeed, a success. This is the view I prefer to take, but let's not stop now. Instead, let us use this beginning as a point of departure for a growing student involvement in social and political activism. Although we can't practice medicine for a number of years, we can still do our part to help improve society by not losing sight of the fact that a medical degree is not required in order to perform meaningful social services.

–John A. Kitzhaber, MS I

A Cry for Clinic

Recently a symposium was held at which some aspects of the medical education here at UOMS were discussed. One topic discussed centered around that fact that there is little exposure to clinical medicine for the first or second year student.

It was pointed out that more patient contact could be a very valuable addition to the first two years of our education. However, it was suggested that: 1) the organization and manpower required of the clinical teaching staff to set up a meaningful program would be prohibitive; and 2) much of the value of clinical experience would not be realized by the student because of his lack of knowledge and medical vocabulary.

Recognizing the validity of both positions, I have a suggestion. I propose that two mornings a week be left unscheduled for the first and second year students. With some planning these two days would not coincide for both classes, thus, preventing the clinics from being swamped on any one day. Students of either class would have adequate time to visit the clinics, attend rounds, observe surgery, passively participate at autopsies, or interview patients. Using this available time the student could get some feeling for clinical experience without burdening the clinical teaching staff. In this way, the first and second year student could learn a great deal from the third and fourth year students, interns, residents, or staff physicians and thus ground much material that would be otherwise forgotten.

–Keith W. Harless, MS II

A Brief Review of Loans Available to Medical Students

There are basically three types of long-term loans available for medical students. They are summarized below.

1. Federal Loans: These are loans directly from the Federal Government under the Health Education Act. The maximum allowable is $2,500 per year, $10,000 total. No payments are due until one year after graduation from medical school, and they can be deferred for residencies. Three per cent simple interest per year is charged when repayment is begun. A couple of features of these loans are worth extra consideration.

A. If you practice in an area designated by the State Board of Health as being acutely short of doctors, up to 58 per cent of the loan can be cancelled, at ten per cent per year of practice.

B. If, in addition to the above, the area is designated as a low income area by the Federal Government, the total loan may be cancelled at 15 per cent per year of practice. The Federal loans offer the best terms, but the catch is that only 42 per cent of the total funds requested were appropriated this year; therefore, these loans are very hard to get.

2. Oregon State Scholarship Commission: Guaranteed loans. These are loans from local banks, at seven per cent per year simple interest. The OSSC pays the interest until ten months after graduation. At that time, the borrower begins payments of not less than $30 per month, and assumes interest charges. Ten years are allowed for total repayment. However, if the loan applicant's parents have an adjusted gross income greater than $15,000 per year, and the student has:

A. Resided with his parents within the last 12 months;

B. Accepted more than $600 worth of aid from his parents in the last six months;

C. And/or been claimed as an exemption on his parent's last income tax return;

the student must pay seven per cent simple interest per year. This interest is usually due each year on the anniversary of the loan. Repayment of the principal is the same as above. The maximum loan under the OSSC program varies from $1,000 to $4,500 per year, and $5,000 to $7,500 maximum, depending on the bank carrying the loan. As a point of interest, the Linn County Medical Society has deposited $5,000 with the Citizens Bank of Albany as further guarantee on this type of loan. This should make OSSC loans more easily obtainable there.

3. American Medical Association Loans: Up to present, these loans were more or less restricted to residents and interns, as they are not eligible for the loans described above. With the scarcity of Federal Funds, however, these loans are now also available to medical students. These loans are made up to $1,500 per year, with a maximum of $15,000 total of *all* educational loans outstanding. The seven per cent simple interest per year is to be paid by December 31 of each year. Payments on the principal may be deferred through residency.

Loan applications and further information are available in the Business Office through Mr. Leonard E. Shapland, Student Financial Aid Officer.

Reflections From A MS-I

Arriving at medical school is analogous, to any novel academic adventure, eg. that very first day of first grade class. One brings a fear of new unknowns only slightly "buffered" by rumors and stories from experienced elders. One brings an anticipation of new fellowships, possibly members of one's kindergarten class. There is the expectation and reality of new teachers and new books and new knowledge – not only will Miss Jones expect you to learn, but to remember! Nonetheless, excitement overshadows anxiety, and one is encouraged to believe that with previous knowledge in hand the task is not insurmountable.

One member of the Class of 1973, in search of a remedy to THE GREAT PROBLEM has used the administration building bulletin board.

WANTED: ONE WEALTHY MISTRESS
Preferably
Good looking
Good cooking
Willing to pay poor medical student's expenses

The response was overwhelming! What was the appropriate reply to a soft, young voice on the other end of the phone . . . "Hello, are you the MS I who is looking for a young wealthy mistress? My husband is overseas for a year. Would I need to be interviewed. I could be of service for only this one year. Would that be acceptable?"

Our poor MS I decided that his lark has real value. Alas, ready and willing to consumate the legal papers, he finds his Senior-Big-Brother has set this whole scene up. ALAS, all is for naught!

At this writing we find our hero without mistress or applicants. Tune in next week, same time, same channel. Available mistresses: check your local bulletin boards for job opportunities!

—Fred Filament, MS I

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T H E P U L S E

November 19, 1969

Dear faculty and Oregon physicians:

The Pulse has attempted in the last couple of years to provide an outlet of opinion for students, faculty and outside physicians. At present there is no other form of written communication at UOMS which solicits information, opinion, humor, criticism and suggestions from these three sources. As the new curriculum is instituted next year, there will be an even greater need to maintain this avenue of communication.

The Pulse has been able to function from your contributions made two years ago and by the help of the OMA. As of this issue, we will be out of funds and are again appealing for your financial support. If you consider our endeavors worthwhile, we would appreciate any contribution. Please address checks to The Pulse via the campus mail.

Thank you very much.

Sincerely yours,

Diane C. Williams

Diane C. Williams
Coordinating Editor