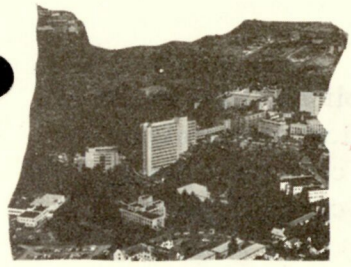


THE PULSE

Vol. 7, No. 1 SAMA Chapter, University of Oregon Medical School January 8, 1971

Study Indicates Prescription Price Decline. A report by the American Enterprise Institute, a Washington research organization, has reinforced a Department of Labor study that found that the price of prescription medicine has declined since 1960. The Institute study noted that average prescription prices, adjusted for the number of doses, have declined 5.8 percent; retail drug prices have dropped 9.2 percent since 1961; and wholesale drug prices have declined 7.7 percent. Postgraduate Med., Dec., 1970.

Vitamin C for the Common Cold? Dr. Linus Pauling, winner of Nobel Prizes for both chemistry and peace, has never been one to shrink from controversy.... Now the distinguished 69-year-old Stanford biochemist has found a new cause - one absolutely guaranteed to gain the attention of the average American. In a book coming out next month, Pauling advocates daily use of large doses of vitamin C to prevent and treat the common cold.

Newsweek, November 30, 1970

Effects of Pornography. Does pornography cause criminal or deviant behavior or adversely affect public or individual morality? The answer is no, according to the Federal Commission on Obscenity and Pornography. . . . On the basis of its own study and surveys of the literature the commission reported: "Extensive empirical investigation. . . . provides no evidence that exposure to or use of explicit sexual materials plays a significant role in the causation of social or individual harms such as crime, delinquency, sexual or nonsexual deviancy or severe emotional disturbances." Such exposure may indeed affect behavior, the report said: "Many persons become temporarily sexually aroused. . . and the frequency of their sexual activity may increase for short periods" - but only "the type of sexual activity already established as usual activity for the particular individual."

Scientific American
November, 1970

Vaccine for Pneumonia. Clinical trials of a pneumonia vaccine will begin by the end of the year. At a special briefing on progress in immunology held at the National Institutes of Health, officials stated that development of the vaccine has progressed significantly, and it should be on the market by 1973 if present programs are successful. Field testing could start as early as next summer, with large-scale testing beginning in 1972.

Postgraduate Medicine
December, 1970

HEALTH CARE DELIVERY IN THE 1970's

One year ago the Health Insurance Association of America published this report of their Subcommittee on Health Care Delivery of the Committee on Medical Economics. They compiled their report by interviewing experts in the field of health care throughout the entire country. They identified four major objectives for our health care delivery systems:

(1) Health care delivery systems should be responsive and relevant to the continuing health needs of people.

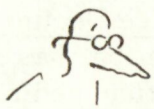
(2) Health care delivery systems should integrate and interact with other social and environmental systems.

(3) Health care delivery systems should be reflective of consumer and professional interests.

(4) Health care delivery systems should be adaptively structured and interrelated.

The report discusses in detail the Subcommittee's findings and recommendations related to the attainment of these objectives. It is a beautifully concise document and can be obtained from the SAMA national office.

FROM THE DATA BANK:



Medical students were asked to provide estimates of their expenses for the period from July 1, 1967 through June 30, 1968. Items of expense for which estimates were requested included: tuition and fees; books; equipment, supplies, etc.; lodging and maintenance of living quarters; board (food, beverages, and related items); and all other expenses (personal maintenance, car operation, transportation, medical care, etc.).

Some of the factors affecting these expense items are: control of medical school, marital status, medical school class, and living arrangements.

Average expenses have increased in each of these categories from 1963 to 1967, so that the average annual expense of medical students has increased from $3,577 to $4,394. The proportions of total annual expenses allocated in 1967 to school expenses (tuition, fees, books, equipment, supplies, etc.), board and lodging, and all other expenses were almost identical to those found in 1963.

For all medical students, the average for school expenses was $1,511. Expenses for lodging and maintenance of living quarters averaged $921, while board accounted for $809. Average expenses for the items combined in the "all other" category were $1,153.

See Graph on Next Page -

If you find a mistake in this publication please consider it put there for a purpose. We publish something for everyone, and some people are always looking for misstakes.

AVERAGE ANNUAL EXPENSES OF MEDICAL STUDENTS
FOR VARIOUS ITEMS, BY MEDICAL SCHOOL CLASS

EXPENSE ITEM	ALL CLASSES	MEDICAL SCHOOL CLASS			
		Freshman	Sophomore	Junior	Senior
Total Expenses	$4,394	$3,817	$4,291	$4,617	$4,954
School Expenses	1,511	1,578	1,492	1,405	1,342
Lodging and Maintenance of Living Quarters	921	752	924	1,063	1,157
Board	809	700	812	892	978
All other Expenses	1,153	787	1,063	1,257	1,483

From How Medical Students Finance Their Education
U. S. Department of HEW

From the Heights

I think it's fitting that the medical school

is on a hill.

Michael Danciger

Letters

To the Editor: January 4, 1971

The Clinical Center of the National Institutes of Health is offering electives for the year 1971-72 in the fields of endocrinology, hematology, immunology, and the biomedical uses of computers. Elective courses last 2 1/2 months, but students may arrange to work up to a total of 9 months with a particular research service or laboratory (the UOMS schedule will permit a maximum of 4 1/2 months). The electives begin October 4, 1971, January 3, 1972, and March 15, 1972. NIH will provide reimbursement for travel expenses to and from Bethesda.

Students who wish to pursue this further may examine the NIH catalog on clinical electives, available in the Registrar's Office.

Paul H. Blachly, M. D.
Professor of Psychiatry

THE PULSE - Office OPC 4352

Coordinating Editor: Bud Nicola
News Editor: Jim Tysell
Distribution: Glenn Morgan

Editorial Staff: Wayne Burton, Joe Rapp, Ken Ampel, Dan Thompson, Marilyn Rudin
Larry Zagata, Cline Hickok, Cody Wasner

PLAN	GOALS	COVERAGE	FINANCING	IMPLEMENTATION	IMPACT ON PHYSICIANS	ESTIMATED COST	COMMENTS
The Insurance Assistance Act of 1970 (Medicredit) (HR 1856)	1. To financially help Americans buy health-care coverage by a deduction from their federal income tax equal to a portion of the premium paid and federal certificates to persons below poverty level. 2. To establish Peer Review system to control utilization, changes, quality of care.	To be eligible for tax deduction policy must include: (1) 60 days hospital care with $50. deductable and 20% co-insurance of first $500. (2) Physicians fees with 20% co-insurance of first $500.	Credit system computed on individuals net taxable income. Ability to pay concept. Family paying less than $300. tax would get 100% of health insurance cost.	Voluntary on part of consumer. Must purchase Qualified Policy, then takes credit on tax return.	Very light impact. Would leave current financing and delivery arrangements intact. Minimal governmental involvement.	Varied: range from 8 billion to 15 billion.	1) Members of the Commission and the Panel in Peer Review would be doctors. These people are responsible for maintaining the cost and quality checks. Some what akin it seems to me to asking wolves to guard sheep. 2) There are no incentives for reorientation of the health delivery system to become more efficient, accountable and acceptable to consumers.
The JAVITS BILL (Medicare Expansion) (S. 3711)	1. To establish NHI by gradually extending Medicare coverage to entire population. 2. To provide Federal assistance to develop local Comprehensive health service systems.	Basically the same as Medicare. Drug co-payment and dental care after 1974.	Through Health Insurance Tax with base moved from $7,800 to maximum of $15,000 and increase in tax rates to 3.3%. Employers and Employees contributions equal 2/3rds and government equals 1/3rd. Exclusion from tax if employer has health plan option which meets criteria.	Through a Health Benefits Commission. It requires Employers to maintain health programs covering needs of Employees. Phasing in of additional benefits over 4 years.	Probably small but potentially large. Group practice promoted. The wording "approximate and reasonable fees" could mean control. Drug list promoted.	First year 10.5 billion to 68.1 billion in the fifth. Federal share from 3.5 billion in first year to 22.7 billion in fifth.	1) There is no assurance that an expansion of Medicare to cover everybody would provide the delivery arrangements that the subsequent demand would call for. 2) Federally set standards for licensure, continuing medical education in addition to the probably extension of the detailed type of governmental regulation of health professions and institutions now emerging under Medicare is unappealing. 3) The encouragement for further study in comprehensive health delivery and then encouraging use of those techniques is a definite positive in this bill.
The Health Security Program (The Reuther Plan) (S. 4297) (Kennedy)	1. To provide National Health Insurance to all. 2. To restructure the delivery of care and control costs and quality.	(1) All necessary physician services, (2) Unlimited in and out-patient care, (3) 120 days nursing home care, (4) Approved drugs, (5) dental care to age 15, (6) limited psychiatric.	40% General Revenue (Fed.) 35% tax on Payrolls by Employers 25% tax on earning up to $15,000.	Contractual arrangement through Regional Board responsible to National Health Security Board composed of 5 members appointed by the president	Extremely heavy. An anual budget for each geographical area would be established. Preference would go to pre-paid groups, then M.D.'s on per/capita, then salaried Doctors. Fee for services divy up what is left. Fee schedules imposed on fee-for-service M.D.'s.	Varies with whose estimating. Range is 40-65 billion dollars.	1) This proposal is better described as a national health system rather than a national health insurance. 2) This is not a self-regulating system proposed but rather a governmental regulated system. 3) This is a direct avoidance of established consititutional limitations and delegation of power levy bypassing state governments. (4) The bill imposes consumer domination. (5) Acceptance of this program would mean acceptance of the concept that health care is a civil right - this poses a definite obligation on the national government.
The Griffiths Bill (AFL-CIO) (HR 17806)	Government universal health insurance program through national system of prepayment plans.	(1) Unlimited and physicians. $2.00 per visit after 1st visit. (2) Drugs. List not mentioned. (3) Eye care (4) dental care under 16.	1. 4% Payroll tax 1% by employee 3% by employer 3/4 of aggregate amount matched by Federal government. 2. Tax base: 1971 $9,000 1972-73 $12,600. 1974-75 $75,000.	Contact arrangement between regional Federal Boards and groups, medical societies, hospitals, etc. Payment on per/capita or salery for Physicians. Payments on budget or per/capita for hospitals.	Heavy. Physicians have option of being in or out of plan but the economics would gradually force them into group prepayment plans. Per/capita rates established at national level.	Minimum of 35 billion if it would have been enacted in 1969.	1) It seems that with the proposed method of allocation of funds, accountability will be difficult. 2) This bill and Kennedy Bill do not have within them a phasing-in of benefits. I fear the stress on the system would be overwhelming. 3) While consumers have a role in this plan they do not carry the power that they do in the Kennedy Proposal.

National Health Insurance: Part III, Conclusions

This is the last of three articles on National Health Insurance. In this article I have tried to compare the four proposals which will be before hearings next Congress. As you will see, the proposals span the complete spectrum of governments role in medicine.

There are several gross deficiences in the current proposals.

1) They either contemplate little or no change in delivery arrangements or they substitute an equally inflexible system.
2) They either want to maintain the present physician monopolized system or put in its place a Federal Government monopolized system.

I believe major modifications are necessary in all the proposals if our people are going to get the advantages a National Health Insurance could produce.

As a final sobering note: If a vote were to be taken today on NHI, The Reuther Plan would have the very best prospects of winning.

John Meyer, MS IV

The American Academy of General Practice gives:

ESSENTIALS OF A PRECEPTORSHIP

AIMS: The purposes of these preceptorships are outlined as follows.

(a) To give insight into a medical way of life of a family practitioner in private practice in a community and to demonstrate what family practice is like, the scope of the family physician's work and the problems encountered.

1. To clarify for the student the physician's place in society, his social and and civic obligations and his responsibilities to his patients.
2. To help the student grasp more fully the individual nature of private practice and the need for and the possibility of understanding each patient in relationship to his family, his job and his total environment.

(b) The preceptorship will provide a brief period away from the medical school during which time the students can develop some mature ideas concerning their own values and goals. This is a time when the students can contemplate the physician's place in society, as well as his social and civic responsibilities, and his responsibilities to his profession. The preceptorship permits each student to participate almost totally in a "medical way of life" with a dedicated physician carefully selected by the school.

ESSENTIALS OF A PROGRAM - A preceptorship program should include the following essentials:

(a) Ideally the program should be an integral part of the medical school curriculum.

(b) The administration of the program should be under the family practice department or a preceptorship committee of the faculty. At least one of the members of the committee should be a preceptor.

(c) The location of the preceptorship and the preceptors should be selected by the family practice department or the committee. The preceptors should receive faculty appointments.

(d) The preceptorship period should be long enough for the student to adequately perceive the role of the family physician. The preceptorship should be required early enough in the curriculum to enable the student to perceive the role of the family physician prior to his medical career choice.

Although office visitation programs can be an effective area of student contact, it is understood that the preceptorship experience must be long enough to provide the student with in-depth insight to the role of the family physician. Usually this requires at least two weeks.

(e) Preceptors should be required to evaluate the preceptee similar to other faculty members.

(f) The student should be required to submit a written report on his experience during the preceptorship.

(g) The preceptor should, where applicable, provide maintenance for the student but no other remuneration. This does not preclude the possibility of financial support from other sources.

- To Be Continued Next Issue -

December 31, 1970

Dear Readers,

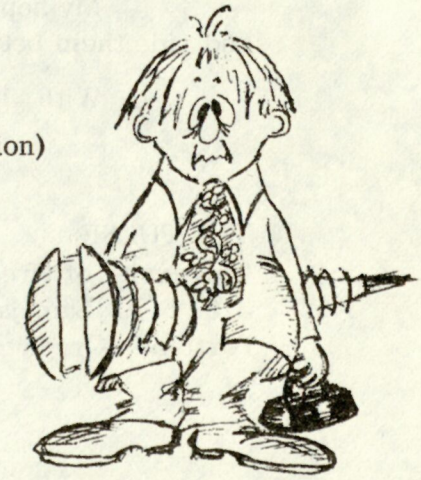
Once again the staff of The Pulse is attempting to explicate the multi-functional potentialities and raison d' etre for this bimonthly SAMA newsletter at the University of Oregon Medical School (i.e., this is the time for our annual fund drive).

During this past year we have been operating by means of monies gathered from you, the subscriber. Our goals, as stated one year ago, are directed toward the facilitation of communication between students and doctors (practicing physicians and faculty members). There is a sharing on both sides: the sage advice of those experienced in the ways of medicine to physician-hopefuls in an academic ivory tower; the articulations of tomorrow's M.D. coming to the realization that his responsibilities are just beginning and wondering where he can make his contribution.

The past year has taken us a little closer to the fulfillment of the above objectives. We have been delighted with the contributions of students and doctors in the past year: vociferous letters and articles; reports from conferences, conventions; data from student and physician polls and studies; the first-page headlines; the poetry; the humor; the cartoons (those infamous little figures). We're sorry if you missed all this - Now is your chance to subscribe and to help ensure this enterprise for another year.

To those of you who have been with us this past year, our grateful thanks. We hope to bring another year of issues to you.

The Editors and Staff



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To the editors:

I happily receive the copies of your media - "THE PULSE." I have been a participant financially in your efforts because of my membership in the Oregon Medical Association.

It is a joy to witness these efforts being expended by the young men and women in our medical school. Soon they will replace us in our efforts to provide medical care for the citizens of these our United States and to the non-citizens who are residing within our borders.

There is no question in the minds of your elders that vulgarity and common cuss words are good attention arousers. In general we feel the use of such vocabulary is a sign of inability to use more acceptable terminology because of ignorance of language and tongue and, in particular, we feel it is not in good taste. Taste does not necessarily equate with conformity.

I was pleased to find that in the issue of Pulse, Volume 6, Number 14, on page two, that you included a full paragraph relative to student participation in volunteer health clinics.

May I suggest that your interests be continued and that you consult with the older generation of volunteers in our medical school as to the background, growth and development of our own outpatient clinic facilities. You will find that in its continuum that it started initially with just such just a small beginning and became known as the People's Free Dispensary. It occupied a storeroom space across the street from our lovely Portland City Hall. This was long before our City Hall was scathed by a bomb placed within the replica of our liberty bell.

I am very positive that our mutual interests in the improvement of outpatient clinics is no different that that of the Dean of our Medical School relative to our medical school facility.

My hope is that your young men and women will continue to ride your horses and ride them better and better.

With kindest personal regards and good wishes.

John F. Abele, M. D.
Portland, Oregon

THE PULSE
University of Oregon Medical School
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97201