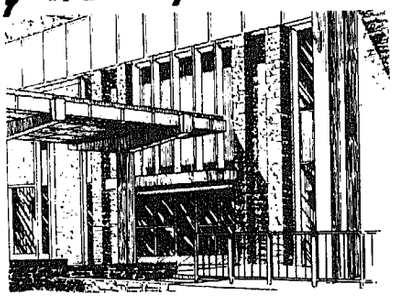
April 3-10, 1978



SHIFTING DULLNESS

DAVISON SOCIETY NEWSLETTER
DUKE UNIVERSITY SCHOOL OF MEDICINE
Box 2889 DUMC

Editors' note: This special issue of Shifting Dullness is devoted to the national convention of the American Medical Student Association.

The annual convention of the American Medical Student Association was held in Atlanta during the first five days of March. Due to the close proximity of this year's convention, our chapter was able to send a large delegation to the meeting.

The highlight of the meeting, as far as our chapter is concerned, was the election of Jackie Rutledge to the national presidency of AMSA. During the past year, Jack has served as national vice-president.

The harsh winter weather in the midwest and northeast prohibited some of the distinguished speakers from attending the meeting. Norman Cousins, the editor of Saturday Review, and Dr. Donald Kennedy, the Commissioner of the Fook and Drug Administration were able to appear.

The most valuable experiences for the convention participants were the numerous smaller sessions that were held during the meeting. Such diverse topics as acupuncture, health care for the elderly, humanistic medicine, and biofeedback were covered in more than 30 sessions. The body of this special edition of Shifting Dullness contains reports on a number of these meetings.

Since the birth of the Davison Society in the early 1970s, both the size and visibility of the Duke AMSA chapter have decreased markedly. Over the past year our chapter has undergone a moderate growth spurt. Our membership, however, is till only one fifth of the total student body. Apart from attending national conventions, individual activity has been limited. Over the past three years, a few of our members have been highly active in the national organization. Our chapter's primary goal for 1978 is to become more active on the local level, thereby bringing AMSA benefits to more people.

The first year seminar series "Issues in Health Care", which will continue next year, was started with seed money from a grant to national AMSA. We are hopeful that additional programs of this type will be spawned in the next year.

We encourage all members to attend our reorganization meeting which will be held within the next two weeks. At this meeting we will discuss the future directions of the chapter, and new officers will be elected.

One of the strengths of national AMSA is the sponsorship of numerous programs and projects in which students may participate during vacations or leaves of absence. Information regarding these alternative educational can be found in this report.

Membership in AMSA has complemented the medical education of many Duke students. We hope that with both the publication of this report, and the upcoming reorganization of our chapter, more Duke students will be able to take advantage of AMSA.

Additional information regarding membership can be obtained by contacting me at Box 2755.

Sid Gospe
Chapter President

HOUSE OF DELEGATES

The House of Delegates with representatives from almost every U.S. medical school meets annually at the AMSA convention to formulate new directions, principles, and goals for the organization. During the four day meeting in Atlanta just before spring vacation this year, resolutions reflectnng concern about national legislative issues, abortion, cost impact of individual physician decisions,humanistic and ethical questions in medicine, and curriculum matters were debated and passed.

MEDICAL SCHOOL CURRICULUM

--Urged the teaching of health care economics to increase student awareness of the cost of care they provide.

--Narrowly supported a measure to limit the on call duty for medical students and residents to 80 hours per week, with no more than 24 hours at a stretch. The resolution reflected concern that both medical care and medical education suffer when those providing it lack proper rest. Action is left up to students at each school.

--Established an AMSA Task Force on Aging composed of medical students to develop curriculum ideas, publish a newsletter, etc. Any student interested in becoming a local contact person for the Task Force should contact Allan Crimm.

HUMANISTIC AND ETHICAL QJESTIONS

--Adopted a 17-part Patient Bill of Rights with provisions calling for confidentiality in discussion of patient's medical problems; reasonable continuity of care; choice of health care provider; right of access to medical record, both during and after hospitalization; and right to see his medical bill, no matter what the source of payment.

--Supported the patient's right to refuse treatment when full informed of the consequences, even if this may result in death; also endorsed the patient's use of a Living Will to make known his wishes about not being kept alive by artificial means when there is no reasonable expectation of recovery.

--Supported the establishment of a hospital ethics committee to make recommendations about treatment decisions. The Committee may be convened on request of either the patient or his physician.

NATIONAL ISSUES

--Urged the discontinuation of federal support of tobacco production and the Tobacco Support Program with those funds instead being used to finance a transition to production of other crops.

--This resolution is an addition to the earlier policy recommending an increase in federal cigarette taxes to fund research on cancer and atherosclerosis as well as disease prevention prevention programs.

--Supported the use of federal, state and local funds to provide voluntary abortions for indigent women. A resolution requiring that information about the "consequences of abortion" be provided to all patients desiring an abortion was narrowly defeated.

--Supported the inclusion of patient cost sharing requirements (e.g. deductibles and --co-insurance) up to a fixed percentage of family income to help achieve cost control under National Health Insurance.

--Also recommended that the present income tax deduction for health insurance premiums be abolished after NHI is passed so that the current incentives to buy supplemental insurance are reduced.

--Supported a proposal that physicians' office capital expenditures over $150,000 be subject to prior Certificate of Need Approval by Health Systems Agencies (HSA's). By law, this is now required only of hospitals and nursing homes.

--Opposed actions by state legislatures and courts to allow the use of drugs like Laetrile, not approved by the FDA for interstate use.

Fantastic! or Ridiculous? Anyone who would like to write a personal editorial for Shifting Dullness either in favor or opposing any of these proposals, please contact Allan Crimm, Box 2725 DUMC.

-Allan Crimm

THE NATIONAL HEALTH SERVICE ACT

The major controversy today concerning our health care system is not whether it is decreasingly cost effective--for most people believe it is--but how this problem can be corrected. The Committee for a National Health Service believes that growing numbers of Americans are realizing that the present health care system, based mainly on the private delivery of health care and financed on a fee-for-service basis, is unable to meet the health care needs of this country. The Committee also believes that no national health insurance system would guarantee that health care services are available to everyone, or will improve the quality of current services.

As an alternative, Congressman Ronald V. Dellums (Dem.-Calif.) has offered a National Health Service Act which will establish a health care system that provides comprehensive health services at no charge to all Americans and is accountable to those it serves. This will be a publicly-controlled and operated, tax-supported health service employing health workers who will directly serve the public. Supporters of the Act claim that any scheme short of this can, at best, only ameliorate the ailments of the present health care system. The political viability of the Health Service Act is currently under debate within the public health movement.

As Cong. Dellums himself puts it, "The USHS (United States Health Service) will provide comprehensive health care of the highest quality as a basic human right available to every person without charge and without discrimination." The USHS would supposedly ensure adequate numbers of health workers and facilities in every area of the country. Also, the Health Service would supposedly decrease health care costs by eliminating "the administrative costs of insurance and billing procedures, excessive fees and profits, and incentives for unnecessary treatments and hospitalizations encouraged by the fee-for-service medical practices." Supporters of the Act also say that the ingredients for the USHS already exist in hundreds of community health centers, neighborhood clinics, prepaid health plans, HMOs, and public hospitals. The Health Service Act prescribes a four-year transition process during which health boards made up of medical professionals and local citizens not in the health fields would be chosen, health workers hired, and the existing network of health facilities expanded and brought together into a coordinated national program. Physicians in the Health Service would be paid and treated much like those in the Public Health Service Corps are at present. At the moment the political feasibility of this legislation seems slight. However, there is growing sentiment within Congress to control health care costs, and this proposal is currently being considered by nine different committees in the House of Representatives along with the many national health instrance proposals.

-David Albert

AMSA FOUNDATION PROGRAMS NOW RECRUITING

Are you looking for something to fill an 8 week break? Would you be interested in working as a clinitian, or a health advisor, or a technical advisor in rural or underserved medical areas. If you are then the AMSA Foundation program offers numerous opportunities with pay and possibly academic credit in three areas:

1. Medical Education and Community Orientation (MECO)
2. Community Technical Assistance Project (CTAP)
3. Health Team Training Project

1. MECO is a clinical clerkship for preclinical (1st and 2nd year) medical students. These students participate in summer clerkships at community hospitals, group practices and individual physicians' offices. The 2 goals of the program are: 1)exposure to community health care activities; and 2)rotation through clinical and non-clinical areas under direct supervision of physicians and staff.
   Participating hospitals, physicians, clinics provide weekly salary for the

student plus room and board (or an additional stipend for such expenses if R & B are not provided). Due to different medical school schedules, programs may vary from 4 to 10 weeks. The usual format gives exposure to all the following areas: medicine, surgery, pediatrics, emergency room, laboratories, patient relations, physician's office, allied health, community health, and electives.

2. CTAP is the newest of the AMSA programs and provides the most individual approach to community health services. Medical, dental, nursing, allied health, etc. students are matched individually to project situations. These 'situations' are usually communities which have a recognised need, or lack of some, many, or all existing health services. Students are matched according to background, skills, and interests. The job consists of developing health care systems using available resources in the project community. Activities are usually of the following sorts: providing clinical services, grant writing, health education, provider recruitment, data collection, health needs assessment, developing cooperative health systems, organization of community efforts, etc. There are currently 30 active sites in 10 states including such diverse areas as Honolulu, Hawaii, Chicago, Illinois and Jackson, Mississippi. Students receive travel pay, $80/week, and $30 living expenses. Many sites provide room and board. Programs run in 8 week cycles throughout the year.

3. Health Team Training Project is substantially like the CTAP project above except the student is a member of a health team of 3 to 5 students placed in a community of recognised need. Project groups work in these areas in an ongoing basis to organize and provide health delivery services in underserved areas. Most sites are small southeastern towns that have incomplete health services. Project efforts in these areas can cover different aspects of health service from directly providing health care to coordination and developing the needed health care systems from existing resources. Stipend and travel allowences are the same as for the CTAP project.

The above are very brief thumbnail sketches of the service projects which the AMSA Foundation operates. I have much more inclusive information including applications and I would be glad to meet with any person or group interested in learning more details concerning any or all of these programs. One can also receive applications to any of these programs by writing to the following addresses: for MECO or CTAP, write AMSA Foundation, 1171 Tower Road, Schaumberg, Ill. 60195. For Health Team Training Project, write AMSA Foundation, University of Tennessee, HPER Building, 1914 Andy Holt Ave., Knoxville, Tennessee 37916

-Harry Severance

MINORITY PARTICIPATION IN MEDICAL SCHOOL

An early Saturday morning meeting focused its attention on some aspects of minority participation in medical school. The most informative and interesting presentation was by Dr. Paul Elliot, PhD from Florida State University, whose most salient comments addressed the issue of admission policies. The presentation was refreshing because his data and recommendations contained socioeconomic, demographic, racial and cultural considerations.

In these "Bakkian" times much discussion has centered on admission policies for minority students, which appear to sidestep regular admissions criteria. Objective criteria such as MCAT scores and college grades have predictive value for success in the first two years of a regular medical school program. Dr. Elliot pointed out however, that they are only predictive for white upper-middle class suburban males, not for females, other racial and economic groups or rural and urban inhabitants. In fact there is no proof even if they are essential to becoming a good physician (NEJM 297:554-556, 1977). If an admissions committee should not use objective data alone, what kind of subjective

information will be the most useful? Seven subjective criteria which can be measured in the interview process, were outlined.

1. a positive self concept
2. positive racism (a realistic view of racism based on personal feelings and experience)
3. realistic self-appraisals (especially important in a non-reinforcing society)
4. preferred long range goals
5. availability of a strong support system
6. successful leadership and community experiences (taking differenc cultural reference points into account)
7. an expressed medical interest

These criteria may appear trivial, obvious and unremarkable but this is probably due to your cultural perspective. I think they are very acceptable and will provide that supplemental information needed to complete an admissions package as well as provide predictive value for success by groups traditionally under-represented in medical schools. Qualifications for becoming a competent, skilled physician should not place undo weight on academic cultural, racial or economic considerations. Other non-cognitive factors such as motivation, judgement and interactive skills should also be considered. The above criteria can provide for an open, fair admissions process for everybody that will meet private, public and societal needs.

-Verna C. Gibbs

PRISON HEALTH CARE SEMINAR

Presented by Lambert N. King, M.D., PhD., Department of Medicine, Cook County Hospital, Clinical Assistant, Department of Preventive Medicine and Community Health, University of Illinois, Chicago, Illinois.

Health care for prison inmates in the U.S. is, on the whole, quite inadequate. No money is available from the federal government under such programs as medicaid or medicare and prisoners don't qualify for Blue Cross and Blue Shield. The stand taken by the federal legislators so far has been "If the law-abiding constituents can't even get good health care, then why should the prisoners?" So money must come from state and local sources.

The real problem with prison health care is the quality. Outdated equipment and methodology are the norm. This archaic care obviously needs updating.

Prisoners are a unique group of people in atypical environments and thus have special health needs. Overcrowding has its adverse effects, one of which is to increase the incidence of communicable diseases such as TB. Because of the unfavorable environments from which many inmates come, they have more problems with such things as hepatitis, dental disease, VD, and interestingly enough - epilepsy. Compliance is a serious problem with prisoners, many of whom would rather have the money they can get by selling their medications.

To compound the problem, prison facilities typically (but not exclusively) attract those physicians who cannot compete in the free market.

Prison health, then obviously leaves a lot to be desired. But the problems are not going totally unnoticed, and many states are now under litigation for inadequate facilities. What is needed, according to Dr. King, is favorable new public policy which recognizes the special needs of the prison health care system. Toward that end, the National Health Service Corps has set up criterion for prison health programs to be included in their overall program and hope to have a number of such projects operating within a year. National Health Service Corps scholarship recipients choosing to fulfill their obligation through such a project would have a tremendous amount of flexibility in choosing a location since there are virtually no such programs in operation.

Total resolution of the prison health care problem is, to a large degree, up to the politicians. But it certainly will never be accomplished unless competent, empathetic medical personnel are willing to get involved.

-Frank J. Spence, Jr.

WHOLISTIC HEALTH - A REALISTIC ALTERNATIVE

Wholistic health -- sounds organic! The expression wholistic health seems to have become a catch-all for all types of health care service that cater to "the individual", that mentally, emotionally, and spiritually unique organism. Not until I heard a lecture by Dr. Donald Tubesing did I realize this ideal concept could become a practical reality.

Dr. Tubesing has set up two successful wholistic health centers in Illinois. The main philosophy behind the centers is to treat the whole person. Beyond that core idea, widely applicable concepts like placing responsibility on the patient for his own well-being, and promoting a program of care involving different resources in the community are stressed.

The centers are church-based family practice facilities. The full-time interdisciplinary team includes a physician, nurse, pastoral counselor, and psychologist with a board of directors drawn from the community. Each new patient goes through a special write-up. It begins with a standard minimal physical exam. This is followed by an initial health planning conference attended by the health care team and the patient's private physician if he was referred to the center.

Before this conference, the patient filled out a questionnaire on the physical symptoms concerning him, personal events and changes in general, in his marital relationship, in his household, at work, and in his finances, emotions concerning goals toward which he'd like to begin moving, his strong points in moving towards the goals, and the help he needs in moving towards them. The purpose of the conference is to tie in physical problems with changes in his life or emotions. With all the disciplines present, recommendations cover medical treatment, counseling, and even changes in lifestyle. The initial goal is to help the patient redefine his problems and then choose his own treatment plan. The fee for the conference is $20, beyond which the patient pays for what he wants done. After the conference and treatment, there are patient feedback evenings and newsletters.

The center has enjoyed a tremendous compliance rate of 66% for all suggestions and 15% for some suggestions. This is understandable since the treatment plan is molded by the patient himself. What impressed me most was the realistic stand Dr. Tubesing takes on the position of a wholistic health center in a community. First, he realizes that a center would probably not be as successful in a disadvantaged community where people may be less verbal about their problems, have fewer resources, and in general are unable to manipulate their environment. Second, he sees the center as an adjunct to the pre-existent medical community - one to which patients can be referred if standard medical care was inadequate. And finally, he feels the center should be well integrated in the community and actively involved in its preventive health.

If anyone is interested in the wholistic health concept or this particular center, I know Dr. Tubesing would be more than willing to send you information. His address is Dr. Donald Tubesing, 3806 E. 3rd street, Duluth, Minnesota 55804

-Gwen Arens

THE FURTHER REACHES OF HUMANISTIC MEDICINE

This seminar was presented by Dr. Dale C. Garell, who serves as the Medical Director of the Institute for the Study of Humanistic Medicine in San Francisco, California. He began the presentation by giving some background information on the Institute and its basic beliefs. This organization was founded in 1972 in reaction to the depersonalization/dehmunanization in health care that many people perceived to be a growing problem for our society. It was decided that, in order to minimize such dehumanization, the Institute should attempt to:

1) Incorporate humanistic endeavors, such as anthropology, Western and Eastern civilization, psychology, sociology, religion, etc., into modern health care delivery.
2) Promote an "aspirational view" of humanity into medicine; i.e., human vision, sense of meaning, and aspiration, was an essential part of what medical care could be.
3) Profess a "confluent approach" to health care - one in which the cognitive component of medicine was equally mixed with a component of feelings, experience, values, spirituality, and meaning.

Initially, the Institute started by forming discussion groups of various health professionals who met in an attempt to decide how the various humanistic endeavors could be successfully incorporated into health care. The ideas that evolved from the group sessions were then put into practical application in the members' own medical practice. A number of monographs resulted from these studies, and these reports can be obtained from the address given at the end of this article. The Institute then initiated training programs in humanistic medicine which provided instruction for practicing physicians, nurses, and clergy, and for students in their respective fields.

In the latter part of his discussion, Dr. Garell elaborated on what he perceived humanistic medicine to be and identified ten movements which, in his opinion, fell "under the rubric" of humanistic medicine. Basically, he sees humanistic medicine as being a horizontally wholistic approach to health care which considers the patient from the perspectives of body, family, community, education, spirituality, and so forth. The ten humanistic movements which he identified were: the Behavioral Science Movement, Behavioral Science Techniques (primarily Rogerian), Bioethics Movement, Lifecycle Movement, Alternative Therapies Movement, Humane Letters Movement, Health Team Movement, Consumer Movement, Wellness Clinic Movement, and Physicians' Wellbeing Movement.

His final contention was that each of the medical professions must identify and strive to develop those unique characteristics within itself which make it humanistic. For further information on the Institute, write to the following address:

Institute for the Study of Humanistic Medicine, 1017 Dolores Street, San Francisco, California 94110

-Bob Parkerson

AMSA PREVENTIVE MEDICINE PROGRAM

The Preventive Medicine and Health Education project began in 1975 and continues to operate through May 31, 1978, with support from the Bureau of Health Education of the Center for Disease Control. The project explores alternative and needed approaches to education and service which will help meet contemporary health problems. The goals have been to communicate to students the importance of preventive medicine and health education in their medical school curricula and to provide opportunities for students interested in working in these areas.

The program can be subdivided into three separate projects. Community Outreach and Patient Education (COPE) projects include activities typically outside the hospital in community settings such as occupational health screening, teaching students health education skills for management of chronic illnesses, and developing health education materials for primary care clinics and community residents. Peer Education in Prevention (PEP) projects combine peer support with peer education. These are directed toward supporting and encouraging students at various institutions in the development of educational experiences for medical students in the broad areas of social and preventive medicine. Some PEP accomplishments have been the development of elective credit and non-credit seminars, workshops, support groups and "rounds" in preventive medicine. One

of the newest projects, the third subdivision, is a pilot course at N.Y.U. designed to expose first year medical students to field work, clinical case studies and patient simulation. The emphasis is on problem-based learning and the integration of preventive medicine and health education with clinical and community problems at an early point in medical school.

Selective projects were represented at the National Convention in Atlanta this year. The NYU program updated its efforts and reported on plans to integrate the course permanently into the curriculum. The Stanford COPE project stepped up its plans for teaching volunteers to counsel the chronically ill in the self-management and control of their illnesses. The West Virginia University COPE project in V.D. education has grown into a multimedia campaign which spans the entire state. Duke was represented with a report on its PEP program which consists of an optional noncredit seminar series organized by students, moderated by faculty and delivered primarily by speakers from the Duke and UNC legal and medical communities. Approximately 35 seminars have been conducted over the past two years through the efforts of this activity.

Despite cessation of funding from CDC in May, the national office and local chapters are taking steps to encourage continuation and formation of similar activities in the future. The continuation of these and various other PEP and COPE activities beyond the period of funding and the integration of many of these programs into curricula speaks to the success of the Preventive Medicine Program.

-Mike Rocco

SPORTS PODIATRY

Richard O. Schuster, D.P.M., Prof. of Orthopedic Biomechanics, New York College of Podiatric Medicine, speaking on Sports Podiatry, in particular the prevention and treatment of running injuries, emphasized that there is little place in the treatment of these problems for injections and medications. Dr. Schuster's approach is the Biomechanical treatment which stresses the establishment of structural balance and architectural integrity of the body, especially the feet. Running is an OVERUSE of the body and as a result, structural imbalances which are insignificant in walking can cause serious difficulties in the runner. In reviewing the types of problems runners frequently present, a differentiation must be made between injuries relating to biomechanical problems and intrinsic injuries (stress fractures, "shin splints", torn ligaments, etc.). Biomechanical injuries seldom become symptomatic when the runner first begins daily run, but rather after the run he will begin to notice symptoms. Intrinsic injuries, on the other hand, are evident immediately as the runner sets out Injuries related to biomechanical problems are cumulative and become symptomatic with accumulated mileage. In other words, the runner with such a problem will have a "brick wall" - a certain mileage where the injury invariably becomes symptomatic. Below this mileage there are usually no problems. Intrinsic injuries are present at the outset and only worsen as the runner proceeds. Another clue that one is dealing with a biomechanical problem is when a runner takes off a number of weeks from running to help an injury, starts back running again, and notices symptoms of the "old" unjury at the same "brick wall". The structural imbalance has persisted and the time off has not corrected the problem.

Dr. Schuster also spoke on the mentality of the runner and with great insight cautioned: NEVER TELL A RUNNER TO STOP RUNNING!! (except in the case of a stress fracture). The runner's compliance with such orders from physicians is notoriously low!

-Pamela Bowe

HEALTH CARE FOR THE ELDERLY: Strategies for Change

How can new physicians be trained to meet the health care needs of an aging population? This was the central issue addressed by a panel of both health care professionals and consumers. Patricia L. Blanchette, of the John A. Burns School of Medicine, U. of Hawaii, opened by pointing out the misconceptions about the elderly fostered by the present system of medical education. Although only 5% of all Americans over the age of 65 are institutionalized, the medical student rarely sees the other 95%. Hence, "old" is equated with "weak" and "sick". Organic brain syndromes with reversible causes such as drug toxicity or malnutrition are often misdiagnosed as untreatable "senility". In addition, since illness is seen as the natural condition of the elderly, geriatric medicine is assumed to be the most depressing of specialties. In reality, Blanchette argues, the challenge of dealing with complex problems and the opportunity to fill a great need make working with the elderly most rewarding.

Margaret Kuhn was involved several years ago in the founding of Gray Panthers, a group that works against all forms of ageism. Doctors have often faced the elderly in an adversary position, she argues, occasioned by physicians inability to deal with their own humanity and finitude. Thus, the sign she carried, while picketing an AMA convention in New Jersey read, "Touch me--wrinkles are not contagious." Medicine fails both young and old, she thinks, by neglecting to look at the situation in which a person lives. Thus the Gray Panthers, in conjunction with members of the clergy, are developing a "Good Health Center" in Berkley to provide holistic health care. She also proposed the use of retired persons are "patient advocates" in existing health centers.

Dr. Robert N. Buckley, author of "Why Survive? Growing Old in America", and head of the National Institute on Aging, NIH, discussed current research on the causes of senility. Of 100 cases of senility, 50 are due to progressive, idiopathic dementia. 20-25% result from multiple infarcts, and 20-30% have reversible causes--malnutrition, depression, etc. Research continues into the etiology of dementia, especially into possible autoimmune phenomena and slow virus infections.

The quality of medical care for most nursing home patients is abysmal, according to Dr. Stephen Smith, Assistant Professor of Family Medicine at U. of Commecticut. Few nursing homes have fulltime physicians; the RN/patient ratio is low, and few F.P.'s or internists continue to see an elderly patient who enters a nursing home. Thus serious conditions like Parkinsonism go untreated, immunizations lapse; drugs are haphazardly prescribed, frequently over the telephone; and often drugs, especially sedatives, are prescribed for the convenience of the nursing home rather than the patient.

Does there need to be a separate specialty of geriatric medicine? Medicine already is too fragmented, answered Dr. William Reischel, Chairman of Family Medicine at Franklin Square Hospital in Baltimore. He discussed alternative approaches, such as electives in geriatrics for medical students, postresidency fellowships for physicians with a special interest in geriatrics and the establishment of interdisciplinary centers on aging within medical schools to promote research and training in geriatrics.

AMSA is setting up a Task Force on aging. Interested persons should write to the American Medical Student Association, 1171 Tower Road, Schaumburg, Ill. 60172.

-Gloria Ashland