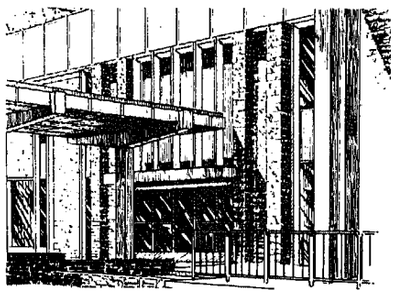

SHIFTING DULLNESS

DAVISON SOCIETY NEWSLETTER
DUKE UNIVERSITY SCHOOL OF MEDICINE

Box 2889, DUMC

November 2, 1976

Special-For Y'all

MEDICAL CENTER CABARET

Come to the Medical Center Cabaret, Saturday, November 13 at 7:00 and 10:00 pm, and Sunday, November 14 at 3:00 and 7:00 pm in Fred Theatre (West Union Building). Entertainment $1.75, beer - free!! Tickets go on sale November 1 outside the Hospital Cafeteria at lunchtime (12:00-1:00).

DAVISON COUNCIL MEETING

There will be a Davison Council meeting Tuesday, November 9 at 5:30 pm in Room 133, Davison Building.

CURRICULUM EVALUATION

The Medical School is undergoing a hopefully throrough and in-depth curriculum evaluation this year. To aid this endeavor, student task forces have been formed. If you are interested in working in any of these areas, please send your name and box number to the person who is listed as heading that task force:

1. Contact of Previous Duke Medical Grads; John Fath, Box 2735
   Who will be contacted? What questions should be asked? How will the information be used?
2. Guidance Counselling; Marilyn Prince, Box 2771, and Juan Batlle, Box 2716
   Introduction of students to 3rd and 4th years; evaluation of the 'panels', DPA's (Departmental Professional Advisors), Curriculum Fair
3. Alternative Approaches to our Medical Curriculum; Howard Eisenson, Box 2803, Gary Humphrey, Box 2748; Rich Olson, Box 2783
   Proplem-oriented approach; self-study; systems approach
4. Status quo Evaluation; Kathy Thompson, Box 2807, Allan Crimm, Box 2725
   Improvements of our present curriculum on a year-by-year basis, e.g. distinction between 'B' and 'C' courses; Christmas split of 1st year neuro;
5. How to Implement Curriculum Change; Bob Zeigler, Box 2894
   Role of curriculum committees, the Dean , the Dean of Students
6. How to evaluate a curriculum; Mike Magill, Box 2818
   What standards should be used - national board scores; quality of residency positions, number of grads going into academic medicine.

If there are any other suggested areas of interest which need task forces, contact Mike Magill, Jackie Rutledge, or Bob Zeigler, Box 2894.

USE OF THE DAVISON SOCIETY TV ROOM

There have been numerous complaints about unauthorized hospital personnel abusing the TV room on the 6th floor. If the door is locked or, if any non-medical student watches the tube while he/she is supposed to be on duty, call 684-2727 and the supervisor will come up and ameliorate the situation.

WHAT IN HEALTH IS PRIMARY CARE?

Those two words, Primary Care, have been appearing repeatedly in consumer based recommendations for change in the health system, such as the Task Force on Southern Rural Development, in Federal health legislation, such as the bill establishing Health Systems Agencies across the country, and in proposals for curriculum reform in this meeical school. One definition of Primary Care describes three characteristics: first contact with the patient; continuous, longitudinal care; and integration of health services. These three deceptively simple concepts have broad implications for the practice of medicine in the community, for the changing role of the physician in society, and for the education of medical students and residents. Dr. Terry Kane, Director of the Duke-Watts Family Medicine Program, will discuss the meaning and the impact of the philosophy of Primary Care in a seminar on Thursday, November 4, at 8:00 pm in room M-422. Dr. Kane will also outline his innovative goals for medical education at the student and residency levels. In a follow-up to this overview of Primary Care, Dr. Jim Kelly, Internist at Durham County General Hospital, Dr. Steve Gehlback, Pediatrician on the curriculum committee of the Family Medicine Program, and Dr. Greg Solovieff, Family Practitioner at Pickens Clinic, will participate in a round-table discussion comparing the roles of their specialties in community practice, and conveying their reasons for choosing their particular specialties, on Tuesday, November 16, 8:00 pm in M-422. For more information, contact Bill Griffin, Forum for Primary Care, Box 2760 DUMC.

SUBJECTS WANTED

The Health Services Consortium Inc. is interested in contacting students to serve as a testing population for the purposes of evaluating self-instructional programs. Students will be paid $4.00 for achievement above the 90% and $2.00 for achievement below 90% on each program tested. The average reimbursement for a student's time is in the area of $6.00-$8.00 an hour. Interested students in Medicine, Nursing, Pharmacy, etc. should contact Jerry Haynes, Coordinator, Education Systems, Health Services Consortium, Inc. 200 Eastowne Drive, Suite 213, Chapel Hill, NC 27514. 914-942-8731.

GUIDES FOR APPRAISAL & SELECTION OF HOUSE STAFF TRAINING PROGRAMS

The AMSA student guide to the appraisal and selection of house staff training programs is available to all 3rd&4th yr. students in Dr. Bradford's office.

contests

The American College of Legal Medicine is now accepting applications for the 1977 Schwartz Award, presented annually to the outstanding paper on legal medicine written by a medical student in an accredited program in the U.S. or Canada. Deadline for receipt of papers is January 31, 1977. Awards for the winning papers range from $250. and an invitation to the 1977 International Conference on Legal Medicine, to $150. Further information is available from Dr. Shirley Osterhout.

The American Association of Poison Control Centers announces its 1976-77 student research fellowships. A brief outline of the proposed project is due by November 15 All students in recognized schools of medicine or graduate schools of health science are eligible to apply for support for small, clinically oriented research projects relevant to the epidemiology, prevention or treatment of poisoning, particularly accidental poisoning of childhood. Further information is available from Dr. Shirley Osterhout.

Externships, etc.

Yale University School of Medicine has medicine clerkships (electives) available from January 24- July 10,1977, six weeks in length. Applications are available from Marilyn, Room 136 Davison.

Student preceptorships in anesthesiology ponsored by American Society of Anesthesiologists for med students finished with basic science courses (NOTE: Duke 1st year students are eligible.) are available in 39 states. Award of $800 for 8 weeks or $600 for 6 weeks. For details of eligibility, location, time and for application, contact Dr. J.H.J. Brown 684-6841. Deadline for applications - January 7, 1977. Appointments will be announced March 1, 1977.

MED JOCKS

TENNIS TOURNAMENT RESULTS

Paul Auerbach, MSIV/William Lieppe, Cardiology fellow,defeated Stan Appel, Neurology/Rich Jelousek, OB-Gyn. Many thanks to Dr. William G. Anlyan for the most successful tennis party following the tournament.

SOCCER TEAM CREAMS OPPONENTS

The Europeans continued their unbeaten string with two impressive victories last week. Led by Matt Stern, Hal Bible, and Dan DeShannon, with several goals apiece, the offense racked up 12 goals on the way to a 12-0 victory. Ken Trofatter, Jeff Symonds, and Jim Avent played integral roles in the Med School's drubbing of the Medical Administration students. The defense, led by Al Cooper, Kim Boekelheide, and Tom Shelburne completely shot down the Med Ad offense. Goalie Kurt Newman touched the ball once; by mistake. Star forward Phil Butera was overheard to say, "That will teach those business men who really runs things around here."

In the second game, the Europeans were so impressive that the Law School was afraid to show up. The warm-up featuring Steve McCoy and Okefor Lekwuwa was just too much for those Law wimps. The high point of the beautiful fall afternoon was a spectacular midair collision putting Al Cooper and Kurt Newman in the ER.

Come out next Friday at 3:30 on East Campus for some real stardom and possible suturing practice.

-Kurt Newman

THE POLICY MAKERS

HEALTH CARE IN THE 1976 ELECTION: NOBODY'S RIGHT BUT MOST ARE LEFT

III. What is to be done?

This third and final article is being written before the presidential election, but will be read after that event, the outcome of which is becoming less clear as the day of decision draws near. In keeping with the theses of the two preceding discussions, it is thus unclear whether the appearance of this article will find our profession in a desperate situation, in the event of a Carter victory, or a difficult one, should Mr. Ford win. In any event, the fundamental issues of our national life generally and our health care problems particularly will be with us still, and will be all the more pressing and difficult for the paucity of serious thought and reasoned discourse which must sooner or later be dealt with, and which will not be resolved with smiles and demagoguery, nor with a path of least resistance.

I must first, however, correct an error and rebut an alleged response. The error, which appeared through my mistakes in last week's article, was a lamentable transposi-

tion of "former" and "latter" in the peroration, whereby Mr. Carter became the eventually dangerous anaconda and Mr. Ford the immediately deadly cobra, thereby conferring upon the peanut-peddling populist an advantage to which has increasingly feverish and desperate irresponsibility in the closing days of the campaign has shown him to be not in the least entitled. Clearly, Mr. Carter should have been the cobra and Mr. Ford the anaconda, but the options open to the medical profession remain immediate envenomation with the poison of cheap imitation socialism or gradual strangulation in the Federal embrace, and we had better figure out something to do about that. The alleged response appeared in these pages last week, and purported to rebut the points made about the Carter threat in the initial article of this series; in reality, however, it might best be described in Carterisms as a vicious attach on me, my family, and my fatuout and irrelevant humor. Aside from the general argument that humor is perhaps the best way to deal with the toothsome pomposity whereby Mr. Carter has managed to shift the campaign just ended from the important issues of the day to his home ground of goodness and light versus evil and darkness, the major problem with this thoughtful and well-considered critique is that it does not address the questions raised in the article to which it seeks to respond. Rather, it attacks the straw man of negative, ostrich-like conservatism, and neatly suggests that the writer of those articles is wrong because the author of that one is right. While I do not believe I have stuck my head in the sand and bared my tail plumage to the inexorable winds of social change, I am afraid I am still too obtuse to see why it is specious to suggest that the failure of large, limited Federal health care programs strongly argues against huge, unlimited Federal health care programs. What is truly specious is the suggestion that dragging the medical profession "kicking and screaming into the twenty-first century", the Social Security Administration, the Kremlin, or the cold and deadly waters of Nantucket Sound, will do physicians and patients lasting good rather than serious harm, and that enslaving the medical profession will bring hope to the newly shackled unfortunates.

"What is to be done?", asked Lenin at the crossroads of the Russian Revolution. With this question, and the pamphlet so entitled, the evil genius of Communism crystallized the issues and solutions facing has party and his nation; at the time his situation and that of his faction seemed hopeless, but with clear thinking and forthright action they were able to master an unfavorable situation, all the while still encumbered by a philosophy of violence, repression, and denial to all their countrymen of security in their property and persons. Those of us who believe in the right of all to live and work in freedom from governmental interference, who desire both the equality of opportunity which is the bulwark of republican government and the inequality of result which justly favors personal achievement and productive labor, and who seek the right and the privilege to pursue a learned profession according to our judgement, our training, and our concern for human welfare as expressed in the Hippocratic oath, can do at least as much by adopting a similar clear and realistic outlook and uncompromising devotion to our principles. "What is to be done?", is the fundamental question which all health care professionals must ask if they are to remain responsible for the lives entrusted to their care.

We must first consider that the important decisions regarding the delivery and financing of health care are likely to be made in an environment that is not favorable to the medical profession and through a process that is not responsive to medical considerations. It is unlikely that anything will change the present alignment of party and ideology that favors the Democratic party and allows its liberal wing to preponderate, short of a major economic or social cataclysm such as that which fundamentally altered American politics between 1929 add 1932; Therefore, our destiny in general and health care questions in particular are likely to remain largely in the hands of a party which is institutionally committed to comprehensive, mandatory, nationalized health care. The response to these articles that was printed last week suggests that the medical profession can do little but go along with the process of nationalization and

contribute "input" - in other words, pour gasoline on the fire with which we are to be burned at the stake. We should instead take an ever more active role in the political process, as individuals and as professionals, to oppose developments and politicians prejudicial to the freedom and quality of American medicine, and we must be prepared to stop deleterious nationalization and bureaucratization by withdrawing our services from such a scheme if that is necessary, a decision which the British and Swedish medical communities have not been prepared to take, to their great cost and the detriment of their patients. Medical care is indeed a great national resource, but trained and dedicated professionals are not and cannot be resources themselves, to be "budgeted" as governments see fit.

Recent developments in Great Britain have shown the fundamental fallacy and inherent weakness of a national health care system. In order to be universal, it must be uniform; in order to be uniform, it must be either uniformly expensive or uniformly within whatever limits the state must obey as to funding and expenditure; as it cannot long be uniformly expensive, it must uniformly comply with financial exigencies, and therefore it cannot uniformly meet the health-care needs of a large and diverse population, and must provide unnecessary or superfluous services to some and insufficient services to others. There is, of course, a theoretical remedy for this problem in the preservation of a private medical system, but the burden of universal support for a national system must inevitably impair the ability of those who are unsatisfied by that national system to seek health care outside it. The coexistence of private medical care must inevitably create dissatisfaction among those whose needs are not met by the uniform health-care system, but who must underwrite it anyway, and must also draw patients, professionals, and resources out of the uniform system. The resultant economic and political stresses will thus require that a universal and uniform system be a complusory one as well, that the freedom of choice which works to the disadvantage of that system be curtailed for users and purveyors of medical care alike. Freedom of choice is of course curtailed already by economic forces and the judgement of medical professionals. This is the major problem which confronts us in any consideration of the delivery and financing of health care, but me must not lose sight of the fact that this curtailment is fundamentally different from the curtailment imposed by a prospectively-determined appropriation which must meet all health care costs, and which by its very nature has a profoundly inflationary effect on the very costs which it is designed to meet. The curtailment imposed by economic conditions is essentially remediable, and can be redressed by alternation of those same economic conditions, which the curtailment imposed by politically-determined appropriation is not responsive to economic developments or medical judgements.

The need to remove economic impediments to free access to preventive and restorative medical care is very great, but these impediments do not exist in isolation; rather, the costs of medical care, and whatever difficulties they may impose, reflect the influences of many complex factors -the imbalance between spending in the public and private sectors, the inflationary forces engendered by that imbalance, the contributions of increasing malpractice premiums and judgements and of militant unionization and expensive regulation in health care facilities. Neither aspect of the problem can be anything but exacerbated by a national health care system which seeks only to meet health costs and to distribute services at their present cost level; such enonomic impediments as exist must be removed and significant changes must be made in the power of labor unions and regulatory agencies within the health care field, and in the relationships between government and citizen. This must be done through the strengthening of the free individual, the private producer and consumer, if any lasting effect is to be achieved.

These, then, are the goals for which we must strive and the imperatives under which we must operate, in our own interest and that of our patients. The election which takes

place between the time these lines are written and the time they are read will help determine whether America's long binge of socialism is at an end, or whether this nation will insist on "one for the road", one more slug of the intoxicating nectar of something for nothing; the issue will remain alive for some time to come, however, and the illustrious heritage of the medical profession demand of us that we do nothing less than fight for freedom-our freedom and the freedom of a vigorous free enterprise system and an unparalleled apparatus for the control of disease and the preservation of health to strive ever onward toward a good life, a long life, and a health life for each and every one of us.

-Miles Edward Drake, MSIV

Legislative Review: THE HEALTH MANPOWER ACT

The President has just recently signed into law the Health Manpower Act. Although the original versions of this bill created quite a rumble from the academic medical arena, the final form is a more acceptable bill with most of the troublesome portions deleted.

(A) The bill provides for Guaranteed Student Loans for medical students. Up to 50% of the student body may receive these loans. The maximum amount annually is $10,000 with a total limit being $50,000. But the interest is 10% and must be repaid starting as soon as you get the loan, i.e. all the way through medical school and residency.

(B) Secondly, the bill provides also for National Health Service Corps Scholarships consisting of tuition, fees, and $400 per month (for 12 months). One year of service is required with the NHSC for each year the scholarship is received. This service may be deferred for only 3 years after medical school (if a residency is longer than 3 years, you must serve with the NHSC, and then return to the residency).
If someone does not serve with the NHSC, he must pay triple the amount of the loan plus interest!!

(C) Medical Schools participating (Duke will) can receive up to $2,000 capitation per student; the school is assured of at least $1,500.

(D) All U.S. citizens in foreign medical schools who pass Part I of the National Boards will be assigned to the different U.S medical schools. This only applies to U.S. citizens currently enrolled in foreign schools of medicine as of the date of the signing of the bill (October 12, 1976). The severest part of this is that schools can not use any other academic criteria for admission of these students other than their passing Part I of the National Boards.

This has been designed to be merely a superficial, informative report. Any questions, see Jackie Rutledge.