SHIFTING DULLNESS

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DUKE UNIVERSITY SCHOOL OF MEDICINE

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Editor's note: This extra issue of Shifting Dullness is devoted to the American Medical Student Association Annual Meeting.

REPORT ON THE ANNUAL MEETING OF THE AMERICAN MEDICAL STUDENT ASSOCIATION

For the past 10 years, the AMSA chapter at Duke has been relatively inactive. Membership has ranged from between 10 to 15% of the student body. Many schools do not have an official student body organization such as the Davison Society that provides social and service projects, and therefore the AMSA chapter takes on this responsibility. Consequently, AMSA chapters at these schools have near 100% membership. Membership nationwide, however, is only 35%.

Membership in AMSA at Duke provides through the Association's journals a way for students to learn about national medical issues. Members may participate in one of the many AMSA Foundation projects during their years in medical school. They may also attend AMSA's annual meeting and Fall Workshop where they participate in diverse educational and political sessions. This year Jackie Rutledge was elected vice-president of National AMSA, and Mike Magill and Larry Wissow were both involved in organizing a portion of the annual meeting.

The Duke AMSA chapter intends to be more active in the near future. Our goals include the dissemination of information regarding AMSA's projects to all Duke students, the implementation of a prototype book coop, and the strengthening of our relationships with the other AMSA chapters in North Carolina and the Southeast.

A student may join AMSA by paying the one time only fee of $15. This covers membership costs for the student's entire enrollment in medical school (including enrollment in combined degree programs). There are no local dues. More information may be obtained by writing to me at Box 2755.

Sid Gospe
President, Duke AMSA Chapter

REPORT ON THE ANNUAL MEETING OF THE AMSA HOUSE OF DELEGATES

Delegate: Jackie Rutledge Alternates: Sid Gospe, Harry Severance

The House of Delegates met during the Annual AMSA Convention; The purpose of the House is to determine policy and establish directives for the Board of Trustees for for the subsequent year. As usual, AMSA had numerous 'hot issues' including National Health Insurance, Mandatory Service, and collective bargaining for residents. The House also considered the theoretical question of whether AMSA should address non-medical issues; In the past it has, but there was vocal concern about its future continuation. The HOD in a close vote reaffirmed its desire to continue to address such non-medical issues as aide to Southeast Asia and civil rights for gay people.

In specific legislation:

1) HOD supported comprehensive National Health Insurance financed through multi-source funding including a sales tax on tobacco and liquor.
2) HOD rejected a resolution supporting a mandatory quid pro quo arrangement of federal financing of medical expenses in return for mandatory service in a place of the government's choice.
3) HOD supported the recognition of interns and residents as employees under the National Labor Relation Act, thereby granting them the right to collective bargaining.

-Jackie Rutledge

THE AMSA NATIONAL BOOK CO-OP

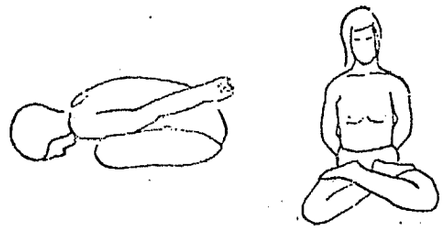
A session regarding the organization of a national book co-op was presented by the AMSA chapter at the University of Cincinnati. A prototype co-op is being set up for next Fall and Duke will be participating. A local co-op has been in operation

and stress. This last factor leads to the individual's association with the first three. Her medical histories are traditional but also include a detailed history of personal stress and diet.

Many Yoga postures were performed for the audience and their anatomical and physiological aspects were presented.

More information on Dr. McLanahan's clinic can be obtained by writing to Integral Health Services, Inc., 245 School Street, Putnam, Connecticut 06260.

- Sid Gospe



"KNOW THYSELF" -The Constructive Use of Differences: An Introduction to Physiological Type and Career Selection

This conference dealt with the Meyers Brigg Type Indicator Test as applied to medical students. Isabell Briggs opened the session by giving an overview of how she became interested in "type" and the development of the test itself which was initially evaluated on a population of medical students in the early 1950's. The test grew out of C.G.Jung's Personality Theory which is founded on the belief that a person's behavior reflects consistent choices based on the individual's perception and judgement. It is a 30-45 minute forced-choice exam which ranks the individual along four scales or "functions": introvert vs. extrovert; sensory vs. intuition; thinking vs. feeling; judging vs. perception. As a result, each person is categorized as one of 16 possible types and given a detailed explanation of each personality type.

Following the historical background of the test, Mary McCaulley, PhD (AMSA Director of the Foundation Center for the Application of Psychological Type) discussed various statistics which compared and evaluated different "types" with respect to medical school admissions,basic science grades, clinical performance and specialty selection. Students who had taken the test were provided with a table correlating each type with different specialties. The table was derived by Ms. Briggs's follow-up of the ultimate career choice of the 5350 medical students tested in the 1950's as well as more recent studies. It is hoped that by taking the test the student will become more aware of his preferred functions as expressed in his "type" and will use this information to help select a career or specialty which has demands and activities compatable with his "type".

-Karen Long

EXPLORING DEATH AND DYING

This session was an excellent seminar on the medical ethical, legal and emotional issues involved in the care of the terminally ill with special emphasis on euthinasia. The panel included a member of the Euthinasia Educational Council, a volunteer counselor for patients and families facing terminal illness, a past chairman of the Committee on Civil Rights, a moral theologan and a Professor of Medicine from Columbia.

California's "Living Will", whereby a person may sign a legally binding statement instructing his/her physician not to artificially prolong his/her life, was discussed at length along with the rights of the dying patient. Both support and opposition to this idea were presented. Criticism of the medical profession was also given with respect to the lack of patient involvement in life and death decisions - i.e. the decision to label a patient as a code or no-code, a decision sometimes now made instantaneously on the whim of the housestaff. Other issues discussed included the quality vs. the quantity of life, civil rights of thepatients and a frank discussion of the attitudes and practices of physicians in terminally ill situations.

A movie was then shown depicting a young man recently rendered quadraplegic who wished to be discharged to die and his enormous struggle with the medical staff who labelled him insane, etc. Small group discussions followed where personal opinions and experiences were voiced. Overall, it was a very educational and worthwhile experience with a subject seldom touched in medical education.

-Karen Long

THE AMSA PREVENTIVE MEDICINE PROJECT

AMSA's Preventive Medicine Project, funded by the Department of Health, Education, and Welfare through the CDC, serves as financial and spiritual back-up for self-education and community out-reach programs at several schools around the country, including Duke. Representatives of the various projects met in Chicago to discuss continuing present efforts, adding new schools to the program, and disseminating information and skills gained thus far. Duke currently has a "Peer Education Project" that runs an optional week night seminar series on the "soft" subjects of medicine, for first year students. The PEP seminars are planned to continue for next year's entering class. Chances seem good that Duke will also get funding for our outreach project involving preventive medicine and self care principles. One possibility for such a project is to establish some sort of adolescent services center in a nearby rural county with the cooperation of local organizers and the state office of health education. Such a project could involve medical and allied health students at many levels, dealing perhaps with mental health, nutrition, and sex counselling. Out reach projects at other schools include a state-wide venereal disease education project in West Virginia and a chronic disease screening and patient education project at Stanford. The Duke AMSA chapter now has information about these projects as well as bibliographic materials on preventive medicine.

-Larry Wissow

REFUSING TREATMENT: Considering the Interface of Medicine and Ethics

This panel discussion was the last in a series on Death and Dying related topics. And though it promised to be extremely interesting turned out to be much less than it could have been. The panel was led by Ronald Carson,PhD,Chief of the Division of Social Services and Humanities at the University of Florida College of Medicine, Gainesville, and Albert Moraczewski O.P. PhD, President, Pope John XXIII Medical Moral Research and Education Center in St. Louis, Missouri.

"The seminar conducted by Dr. Carson featured a video taped interview of a 27 year old man who was blinded and severely maimed in an explosion ten months prior to the video tape. The interview provides an excellent stimulus to discussion of a wide variety of ethical issues surrounding the right to refuse treatment, the meaning of medical competancy and the value of life."

The above quote was from the prospectus for the seminar and though the video tape was as promised, the discussion was lacking. However the main points the discussion seemed to stress were the following:

1) Does the mentally competent patient have the right to refuse treatment, refusal of which will cause death?
2) What is mental competence?
3) What is the quality of life that the person is presently experiencing or will expect to experience?
4) How strong is the person's resolve to reguse treatment?

The answer to the first question legally seems to be yes. But precedent also leans toward an intimation that anyone in a position of stress caused by severe sickness or disease is at least suspect of mental incompetence in deciding matters relating to therapy and life or death decision. In most prior cases the wishes of such a patient have been overruled and the hospital acts'in the best interest of the patient.'

The answer to the third question in final analysis is <u>probably</u>. Totally subjective experience of the patient is in question, and can only be indirectly determined by dis-

cussion with the patient.

The fourth question in the discussion was presented as the health team's responsibility to the patient who wants to suspend therapy: to try to determine how firm in his resolve the patient is. This was presented in the context that many patients in compromised situations are oppressed more by total dependancy than any other factor. Therefore they attempt to exert control in the few areas they have left, one of which is refusal for therapy.

At this point the meeting broke up, to my disatisfaction without any suggestion of how a health team should attempt to determine resolve, or without any firm look at the question of patient competency.

Harry Severance

ALTERNATIVE CONSIDERATIONS IN THE ECONOMICS OF PREVENTION AND HEALTH

Professor Victor Fuchs from the Center for Economic Analysis of Human Behavior and Social Institutions at Stanford spoke first about the scapegoats used to explain the lack of preventive medicine in our society. The first was ignorance, but the speaker held that people know that smoking and drinking are harmful, and that the 55 mph limit has saved lives, but everyone still smokes and drinks, and there are now pressures to remove the 55 mph limit. The next scapegoat is big business and advertising, but the speaker pointed out that residents in the Soviet Union smoke and drink without the benefit of Madison Avenue advertising. The last major scapegoat is fee-for-service medical care which presumably would not foster preventive care; However Professor Fuchs then noted that dental care in the U.S. is also fee-for-service, but dentists practice excellent prevention.

The speaker then discussed obstacles to preventive care which include time-value depreciation (people don't see immediate results; therefore, the results are worth less) and the problems of dealing with probabilities and risks which cannot be translated to individual cases.

Finally, Professor Fuchs touched on solutions which include re-orientation of medical training toward health and the non-hospitalized patient, and incentives for "health" such as taxes on alcohol and tobacco to support the additional burden that consumers will place on National Health Insurance resources.

The second speaker, Dr. Morris F. Collen from Kaiser Permanente in California, a pre-paid health plan, discussed data from their studies which demonstrate less hospital days per patient than other health plans and several other impressive results . He also mentioned the educational resources Kaiser offers with many ancillary personnel participating.

-Jo Gordon

HOW TO DO A BETTER PELVIC

This session was an informal discussion led by two representatives of the Chicago Women's Health Center. It did not deal with interactions between a physician and pat patient for this group strongly disapproves of pelvics performed in the traditional medical setting, especially those done by male physicians. Instead, they advocate a self-help program whereby the woman actively participates in the exam by inserting the speculum herself, inspecting her cervix, viewing all lab proceedures, etc. The remainder of the exam is performed by health team workers and checked if necessary by a female physician. Much emphasis is placed on the equality of all health team workers and the patient. No white coats are worn, no titles used with all workers rotating through each role of receptionist, history-taker, lab worker, examiner, etc. Through this approach they hope to greatly enhance the women's experience in "well-woman" care above and beyond the often dehumanizing experience of a typical medical clinic with its long waits, harried workers, non-explanation of proceedures and over-paternalistic doctors. This traditional setting is viewed as a controller/controlled situation with many women viewing the exam as a

"little rape" experience.

They feel their approach causes each woman less discomfort because of her understanding and self-control of the situation. There is a breakdown in the distance between the lay person and the M.D. in a shared relationship which they feel a male MD cannot relate to. They hope to increase each woman's knowledge of her body and its functions in a pleasant environment while taking care of her "well-woman" needs.

-Karen Long

CHART AUDITING AND MEDICAL CARE ASSESSMENT: A MEDICAL STUDENT APPROACH

There is no doubt that in the near future we will witness a marked increase in the implementation of quality assurance programs (peer review). With this in mind, a modicum of American medical schools have included into their required and/or elective curriculum actual experiences in peer review. The University of Illinois at Rockford has one of the most active programs. At Rockford, all students spend at least two afternoons a week for three years in one of many rural primary care clinics where they serve as the primary deliverer of health care to their own group of patients. The peer review system operates around a narrow medical topic e.g. the initial diagnosis of a moderately hypertensive patient. After this subject has been defined, a grand rounds session is presented where students are taught all of the current facts concerning the topic.

A committee then establishes a list of criteria which they feel must be included on the chart of all patients who are diagnosed with the topic problem. In order for a student's work-up to be considered exceptional, most of the criteria must be met. Examples of criteria for the above topic include: a) the inclusion of a complete family history concerning the presence or absence of high blood pressure, MI, and CVA; b) a good description of the funduscopic exam; and c) recording of blood pressure in both arms in the supine and standing positions.

Charts from the primary care clinics are then reviewed by secretaries who look for the inclusion of the criteria and then numerically score each chart. Baseline scores are determined by looking at the point totals from charts written before the grand rounds were presented. After the charts have been scored, they are critically reviewed by committees of medical students. The committee then decides via these quantitative and critical reviews of the student's charts whether he has handled this one problem in the "correct" manner. Students are then notified of the committee's opinion by letter.

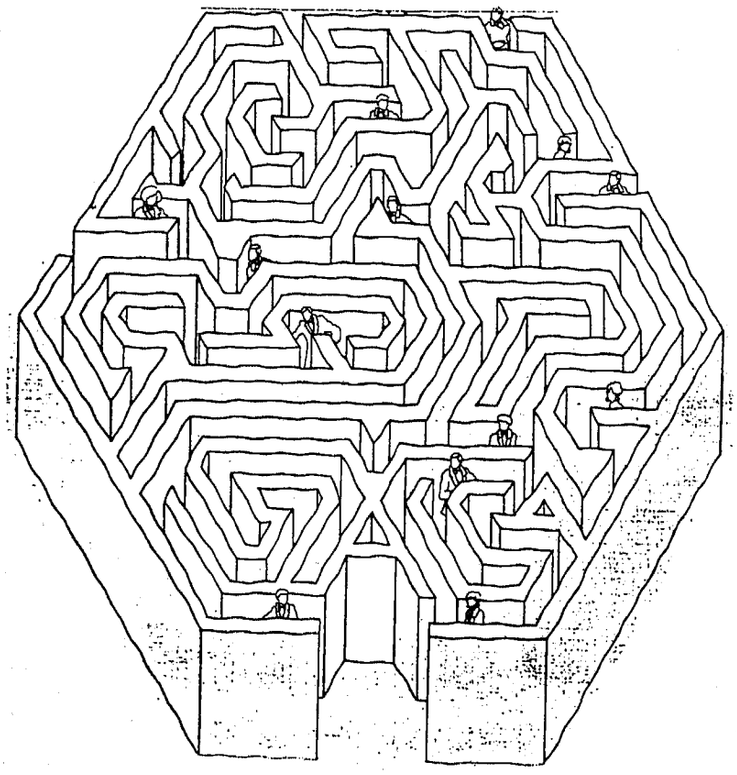
A more complete account of the Rockford Quality Assurance Program as well as other programs can be found in J. Med Ed 51,362 (1976).

-Sid Gospe

CANCER EDUCATION SERVICE

The Southern Medical Association operates a free Cancer Education Service via the toll free 800 area code. Anyone may use the service by dialing the number and asking to hear one of over 100 5-10 minute tapes concerning various topics in the field of oncology. A limited number of copies of the Cancer Education Service guides are available in Marilyn's office.

-Side Gospe



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alternative roles in health . . . a new definition of medicine