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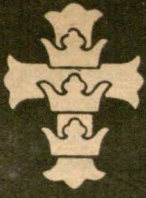
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CHIASMA

Volume III, No. 4

Boston University School of Medicine

April, 1972

Can MED and CLA Agree?

by Nancy Kuntz BUSM I
and Mitch Selinger BUSM II

Unknown to most members of the Boston University community, an important political struggle has been in progress for many months. A silent, but significant battle, fought with petitions, speeches, and influential personalities is being waged between the medical school administration and the leaders of the College of Liberal Arts. Unfortunately, the casualties of the skirmish are the very students that both sides claim to help.

The major issue involved is control over various aspects of the six-year medical program. Presently, the College of Liberal Arts independently administers the first two years and three summers of the joint AB-MD program. The medical school manages the last four years, with exception of that third summer in which six-year students return to the main campus.

It is control over this third summer, in particular, which has precipitated a power struggle between the Med School and the Main Campus. For this period of time appears to be essential for BUSM, if the types of medical curriculum changes, currently envisioned, are to be implemented.

The students most dramatically caught in this power squeeze are the first year medical students of the six-year program. The administrative responses from the medical school and the college of liberal

Arts have resulted in a tragedy of misunderstandings, apathy, and personal political considerations.

Efforts to modify parts of the six-year program is nothing new and had occupied much of the students' energies, prior to the current political fracas. The major gripe of the six-year students is the lack of opportunity, academic, financial, and even social. New regulations this year, as interpreted by Assistant Dean Tyler of the six-year program, require that all summer courses must be attended in residence at the main campus. In addition, as of last summer, six-year medical students were no longer eligible for research grants because they do not officially have an AB degree. In the past, six-year students had been able to take advantage of opportunities at universities all over the world, and had received summer grants in such fields as cancer research and cardiovascular disease.

The problems of the third summer requirement have plagued students for many years. Most are unhappy about returning to undergraduate school in the midst of a graduate medical education. They believe that a less rigid structure will allow them to better develop as human beings. In point of fact, the summer courses at BU cram sixteen credits into only twelve weeks. In addition, tuition is sixty-five dollars per credit, or \$1,040. BU has limited summer aid to \$300.

Last year, in the face of these impending changes, many efforts were directed by students to abolish or modify this third summer requirement. The sequence of events was a classic "Catch 22".

Initially, Assistant Dean Tyler of the six-year program was contacted. Apparently, as she explained the matter, her position was one of administration and enforcement. It was purely a CLA affair. The dean of student affairs at BU was contacted. It was an academic policy decision. Dr. Lanzoni was contacted. It was an affair for the special joint six-year CLA Med committee. Robert Smart, acting chairman of this committee was contacted. He was finally able to clarify the situation. The power to change the program rested with the initial committee which wrote the program charter over ten years ago. This was the place to go. Unfortunately, this committee has been defunct for over ten years! And as the summer approached, it was too late for more meetings, and everyone went to school.

This year, with additional restrictions, the freshman medical school class again attempted to be heard. In point of fact, the situation was somewhat altered. Dean Friedman, in anticipation of a new medical school curriculum, discovered that the new program could not be implemented. Since CLA, and not the medical school

controlled the third summer, six-year students could not continue at the medical school under this future change. As a result, the fighting started.

Students suddenly discovered that everyone was listening to them! Dr. Lanzoni proposed to the six year joint committee that CLA drop its requirements for the third summer. Perhaps, most agreed, the students were correct after all. Dean Tyler heartedly agreed. The committee overwhelmingly agreed. And so, a motion was to be drafted stating that the third summer term at BU was deleterious to the development of these future physicians. As officially voted on consideration of the proposed shortened curriculum was a minor part of the proposal.

In truth, the proposal that was finally drafted centered around the new curriculum change at the medical school. Dr. Patt, chairman of the joint six-year committee informed Dr. Lanzoni and members of the freshman class that the Academic Policy Committee at CLA was sure to approve the proposal. In actuality, the APC tabled the proposal because they did not exactly understand what was being said.

In response, freshman medical students contacted the APC directly, explaining their problems and needs. It was an informative session in which both sides realized that information was getting distorted from one committee to

the next. In addition, the students documented all their arguments and presented a petition to Deans Friedman, Lanzoni and McNary. Dean Friedman later revealed that although the students' points were well taken, they would not play a significant role in the struggle. His opinion was that pure politics of CLA vs the medical school were controlling the issues.

And so the petitions went on, and on . . .

Basically, the students never had a chance. The real question of modifying the third summer was never really a practical issue. The real issue was whether the medical school could gain control over this summer, or keep it firmly in the hands of CLA. Recent decisions from CLA have reaffirmed the requirements of the summer.

The political machinations of BU continue to persist to the limits of the absurd. To pacify the students, Dean Tyler has suggested a method of allowing students to individually petition. First, a petition is considered at the joint committee. It must then go to a special committee on petitions. Practically speaking, such parliamentary tactics could rule out any help for the students in time for the summer.

What does all this mean? In our opinion, real progress to improve the present six-year program under the present

(Continued on Page 2)

Crisis in America: Real or Imagined?

by Mary Kraft BUSM I

Is there a health care crisis in America? A panel of experts discussed this question at a recent meeting of the Sigma Delta Chi (New England Chapter, Society of Professional Journalists) held at BUSM. The participants included Dr. Gordon K. MacLeod, Director, Health Maintenance Organization Service, Department of Health,

Education, and Welfare; Boston University, Harvard, and Tufts Medical School Deans; doctors involved in community health, and Alice Rothchild (BUSM II). Lawrence Strum, Deputy Director of Communications, BUMC, moderated the panel.

While every panelist agreed that a health care crisis does exist, interpretations of what aspects of health care have reached crisis proportions varied.

Causes were suggested, although no definitive solutions were proposed.

Dr. MacLeod stated that the doctor shortage, overcrowding in hospital emergency rooms, specialization and solo practice, and the present insurance system have contributed to unacceptable levels of health care costs. "The net result has been overhospitalization, fragmentation and illness-oriented medical care. President Nixon . . . suggested a pluralistic approach to health care . . . Health Maintenance Organizations (HMO)." Although not viewing HMO as a panacea, Dr. MacLeod believes that by 1980, an HMO "should at least be able of assuring access and availability to whatever care its subscribers may need."

Dean Ephraim Friedman noted that the crisis has been

with us from "time immemorial." "Medicine has never been great or cheap. Too many people are not receiving adequate health care. Society is realizing that it needn't be this way.

"The HMO . . . may be too pluralistic. It is extremely difficult for the individual to know where to go.

"Medical schools have not been the cause nor will be the solution. I'm not sure that our experimentation with models has been successful. I'm skeptical as to whether medical schools can design the system or variety of systems that can solve the problem."

Dean Friedman added that the medical schools can challenge ideas and teach the responsibility the physician has to an individual. He feels that the schools have a responsibility



Photo by Arnold Baskies

"We are victims of our own success. . ." —Dean Ebert, Harvard. Dr. William Maloney, Tufts, looks on.

to the community, that the community has a right to expect delivery of care by schools and hospitals in the community.

Tufts Medical School Dean
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EDITORIALS

Impacted Curriculum

A new three-year medical curriculum is now being developed for BUSM. As presently planned, it provides for an eleven-month first year (September to August) and utilizes subsequent summers. The third year of the curriculum is similar to the present third year, but also includes the fourth-year requirements of psychiatry and community medicine. The fourth year will consist entirely of electives and will be optional. The curriculum is said to emphasize interdepartmental co-operation and clinical correlations.

What is the motivation behind the change? Was it the desire to produce more doctors to serve the people? This is the fashionable trend today: Shorten the training, get the doctor out to this patients sooner; a concession of supply to the demand. But what effect will this have on the doctor shortage? One year will graduate two classes, the last four-year class and the first three-year class. After that, we settle back to producing our quota of 100 to 125 new physicians a year.

What kind of new doctors will they be? Many serious doubts have been raised about the level of competence of physicians produced by core curricula as opposed to their more traditionally nurtured counterparts. Medical education is essentially a process of self-education. Skipping on instruction and whittling away at course time is not going to make this process of self-education any easier. In addition, cramming a medical education into three years will cut into the process of personal growth and development toward the maturity and responsibility necessary to be a good physician. The excellent doctor will still be produced, but now more in spite of his education than because of it.

One must wonder, then, whether the reason for such a change lies somewhere other than medical education or serving the people. The federal government, subscribing to the less-time-makes-more-doctors hypothesis is actively encouraging shortened curricula. Financial considerations are given to medical schools for each student graduated of a three-year curriculum. A New York medical school has recently developed a three-year curriculum and offers it as an alternative to the traditional four years. They are openly encouraging their students to opt for the three-year course. This is a school on the verge of bankruptcy and the federal monies are most welcome. While financial difficulties are both real and oppressive, let us hope this is not BUSM's prime consideration in changing its curriculum.

We appreciate attempts to integrate the departmental courses into a unified curriculum. Hopefully, greater co-operation among the departments and between clinical and basic science faculties will continue to grow. We also recognize the attempt to include certain subjects of importance which are not presently covered.

However, we are seriously concerned at the compression of an already close-cropped curriculum for reasons which do not appear to be primarily based on concerns of quality. One final comment: No matter how a schedule of courses is juggled, quality of education cannot improve unless quality of teaching improves.

Crises Are Commonplace

Boston, Mass. (API)—Rescue operations are still underway in Boston, attempting to locate 14 missing Boston University Medical Center employees and students. The victims have disappeared one by one after entering the medical center's Lot "C" parking facility. Rescue officials believe that the missing people were careless and drove their cars into one of the numerous pits in the lot. Many attempts have been made to locate them since the first disappearance during an early October rainstorm. The victims are believed to still be in their cars waving books of yellow parking tickets. Medical center rescue workers have

promised to continue their valiant efforts "until the last of the missing commuters surrenders his red BUMC parking sticker."



"Careless" motorists enter, perhaps never to return.

Mr. Herbert Klein "masterminds department moves or new construction with the ease of a skilled chess player," says Centerscope, BUMC's official publication. But the common opinion of many of the commuters who use the medical center's parking lot "C" is that he has played into a stalemate. The parkers cannot win, and Mr. Klein cannot lose. A number of evicted "freeloaders" (Mr. Klein's euphemism) no longer park in the mud lot on Albany Street for free, but now pay for the privilege of traversing a washboard, and parking in a lot, in the same repair as was the mud lot which is now the site of the new Mass. Mental Health building. For the opportunity to ruin their auto's steering mechanism and suspension, some 250 drivers pay \$.55 or \$.75 (soon to be increased) each day. A good portion of the southern side of the lot is completely impassable to all but a Sherman tank; the mud is a foot deep! In recent weeks, at least four cars have had to be pulled from the mud and holes by tow trucks. Of course, the drivers of these cars were responsible for the bills.

"He is terse with trivia, preferring to quickly sum a problem and produce a solution . . . His mind is quick with a 'get it done' attitude . . . Under his direction are the Center's physical planning and construction . . . and parking."

The condition of "C" Lot has steadily deteriorated for at least a year and a half! This winter's best maintenance effort lasted three days! The frustration of the parkers has been communicated to him many times. We suggest that parkers continue to direct their frustration at the administration and not at the security guards. (Quotes from Centerscope, January/February, 1972)

Letters to the Editor

Dear Editor:
In recent years, many health workers from the United States have visited Cuba to participate in teaching and research programs, and to exchange medical-technical information with Cuban scientists and physicians. A large group of us, joined by many sponsors, formed the U.S.-Cuba Health Exchange in order to organize and centralize these and other activities in an integrated, coordinated, and cooperative way.

During the last 18 months, U.S.-C.H.E. has carried out the following projects: held public meetings to discuss current health care and research in Cuba; gathered and/or purchased for shipment to Cuba current medical and scientific periodicals and books; specialized drugs, medical equipment and scientific apparatus. We have arranged visits to Cuba by U.S. Specialists for short term teaching or research projects. Unfortunately, during this period, a number of Cuban specialists have been refused permission to enter the U.S. to attend international scientific meetings, some of them after research papers had been accepted for presentation.

It is clear that the restoration of normal relations with the Cuban medical and scientific community would be mutually beneficial to both the U.S. and Cuban peoples. There are important and interesting

technical and social developments taking place in both countries. Furthermore, it is clear that scientific and cultural contact will serve to diminish tensions and hostilities that are created by the erection of political barriers between peoples of different countries.

We are, therefore, asking the academic community to join us in our efforts to restore and centralize these and other activities in an integrated, coordinated, and cooperative way. We are, therefore, asking the academic community to join us in our efforts to restore and centralize these and other activities in an integrated, coordinated, and cooperative way. We are, therefore, asking the academic community to join us in our efforts to restore and centralize these and other activities in an integrated, coordinated, and cooperative way.

U.S.-C.H.E. will be most interested in hearing about any activities that you plan and will be glad to help in any way we can. Lewis M. Fraud, M.D. William L. Nute, Jr., M.D. Co-Chairman Mailing Address: P.O. Box 469, Planetarium Station, New York, New York 10024

NEWS BRIEFS

At the general faculty meeting of April 5, the faculty reaffirmed Admissions Committee policy that "applicants are interviewed upon request of faculty and administration, and that members of the immediate family of alumni and faculty, if so identified, are granted interviews."

Internship matching day took place on April 14. Details of how BUSM students fared will appear in next month's issue.

On March 8, 1972, the BUSM general faculty approved the SCOMSA Constitution and the Honor Code. According to Dr. McNary, it is expected that all BUSM students familiarize themselves with the code and act in the spirit of the Honor Code. Copies of both documents are available in the library and in Dr. McNary's office.

Skit Night will be held on the evening of May 20 on the 14th floor. Medical and graduate students, faculty, alumni, and administration are welcome. Watch bulletin boards for further details.

Class meetings with the Dean and Faculty will continue to take place every Friday on the 14th floor. Next meeting: April 28, with the first-year class.

BUSM graduation will occur on May 21. Participation in University-wide exercises will commence at 11 o'clock in Nickerson Field, followed by the School of Medicine Hooding at 2:30 in the College of Basic Studies Auditorium.

BUSM's Annual Alumni Dinner will take place on the evening of May 6 in the Hiebert Lounge. The Class of 1972, of course, is welcome.

MED and CLA

(Continued from Page 1)

system of administration is not a reality. The position of Assistant Dean of CLA in charge of the six-year program must be held by someone who is willing to transcend political infighting in order to shed light on matters of conflict, and disseminate accurate information to all parties involved.

Finally, the present state of the program should be reviewed by an impartial group neither from the medical school nor from the College of Liberal Arts. The program has been significantly altered by political bickerings over the years with little regard to the changing needs of the students. A fresh look at this accelerated concept of medical education is certainly in order.

Our apologies to Dr. Thurm of the U.S. Public Health Service Hospital for the inaccuracies about the USPHS printed in our last issue, in an article mistakenly attributed to him. An accurate description of the USPHS will appear in our next issue. In the meantime information may be gained from Dr. Harvey Finkel at the USPHS Hospital, Boston.

Levinsky To Improve Teaching Programs

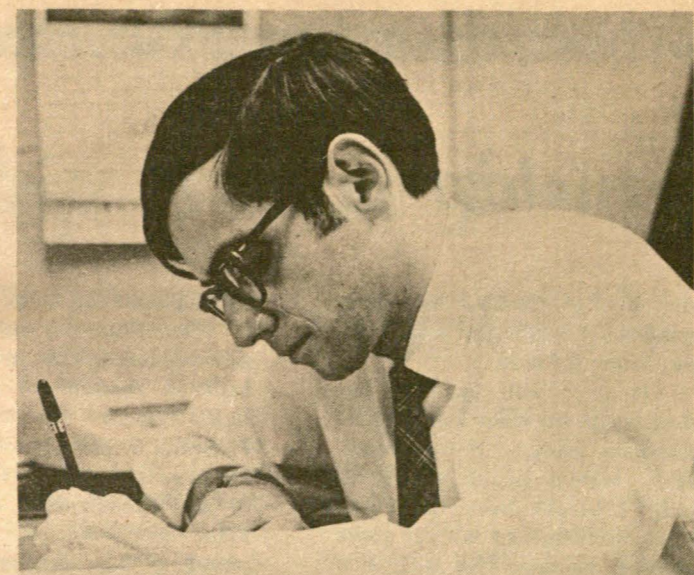
by Harvey Swan BUSM IV and Dan Dress BUSM II

Dr. Norman Levinsky, in a recent interview, delineated the directions in which he hopes to lead the Department of Medicine when he assumes the position of Chairman of the Department and Chief of Medical Services at University Hospital on July 1. Among his priorities is, first of all, the need to improve integration among BU's three affiliated teaching hospitals in medicine (UH, BCH, and VA), as well as to make more meaningful affiliations with the community hospitals. "In all candor," says Dr. Levinsky, "the major effort with regards to improvement and staffing would have to go to the VA Hospital." For if the school's students in medicine are to obtain the same quality education at the VA as they do at other hospitals, then a quality house staff is essential. The new Chief, therefore, plans several levels of activities: First, have the house staff from University and Boston City hospitals rotate through the VA. Secondly, all members of the faculty in Medicine should be available for making attending rounds at all three hospitals. Thirdly, increase the number of house officers at the VA, thereby decreasing patient load. These maneuvers, Dr. Levinsky hopes, would attract a greater number of quality candidates for post-graduate training at the VA.

In large part as a result of his experiences with the Boston City Hospital, the new Chairman feels a second priority would be for the Department of Medicine as a whole to become involved to an increasingly meaningful extent with the surrounding community. This responsibility, he feels, may be served by further increasing the clinical services at the BCH out-reach clinic, by greater integration between UH and BCH in this effort, or by University Hospital, itself, setting up an improved method for serving the community. In addition, Dr. Levinsky feels, it is important to improve staffing at the UH medical out-patient clinic. In any event, he maintains that University Hospital should exhibit greater participation in the area of community responsibility.

Dr. Levinsky points out that the Department of Medicine cannot accomplish this alone, but must attempt to interact with the other departments in order to improve the services to the South End residents. One alternative the Chairman is currently considering is the possibility of converting the UH out-patient department into an HMO-type group practice. Such a facility could offer comprehensive medical care to its constituents: Medical Center students, employees, their families, as well as area residents who wish to participate.

Dr. Levinsky feels very strongly about a third priority in his new role: re-evaluating the training programs affecting students at the School of Medicine. He flatly states, "The single most important deficit in the education of our students in



"If one has to pick one thing that is most important, it is teaching."—Norman Levinsky, M.D..

medicine is the total focus upon the in-patient service." Dr. Levinsky candidly confesses that he currently has no immediate solutions for this problem, but re-emphasizes that, "this focus on the acute crisis to the exclusion of the natural history of the patient, both well and sick, is something that has to be changed."

In addition, the new Chairman believes that the Department of Medicine should assume a large role in the teaching of the medical basic sciences. "From the point of view of the training of students, we ought to use the talent where it exists," states Dr. Levinsky. If it lies in the Department of Physiology, or of Biochemistry, or of Obstetrics, that's fine. "I don't think that we should compartmentalize teaching, so that for example only a PhD in Pharmacology can teach that subject, when there exists an outstanding clinical pharmacologist," Dr. Levinsky maintains.

At the same time however, Dr. Levinsky realizes that an involvement of the Department of Medicine in all four years of medical education is imposing

increasing burdens upon the limited department staff. The Chairman maintains that teaching ability will be a principal criterion for appointment and promotion of department members.

A fourth priority for Dr. Levinsky will be to strengthen certain subspecialties within the Department of Medicine, such as Immunology, Clinical Pharmacology, and Oncology.

Finally, Dr. Levinsky stated that, "nobody is going to walk onto the wards of our hospitals or into our clinics, who does not think it is a crucial responsibility to take good care of sick people. As Chief of the Medical Services at University Hospital, I consider it a very personal day-to-day responsibility to be aware of all the details of patient care on the Medical Service. I want to know what goes on in terms of interaction of house officers with nurses; I want to know how well house officers follow their patients, by reviewing the patients with them; and in general, I want to have a day-to-day and minute-to-minute understanding of what goes on."

Inflation Hits BUSM

by Lynn Curtis BUSM II

Earlier this year, students at BUSM were officially informed concerning the increase in tuition from a level of \$2640 to \$2900. Each student received a personally signed letter from Dean Friedman, (see below) describing this recent encroachment upon student economies. (It is noteworthy that the Dean, after only six months in office, accepts "some responsibility" for this situation.)

It is reported that the medical school operated in the red this past fiscal year. Along with this, the University's deficit budget (which contributes to the medical school) have had a share in causing a general increase in tuition throughout the University. President Silber became cognizant of the fact that the University has been operating on capital not originally earmarked for operating funds, thus depleting reserve capital. In order to protest these invested funds the colleges of the University are

re-evaluating their budgets in light of President Silber's tightened fiscal policy.

Questions arise as to whether BUSM students might see relief in sight from the "per-capita" federal law passed recently as aid to the medical schools. This law funds schools which are increasing their size (which BUSM has done). However, through possible loss of other federal funds BUSM might face no significant net gain in operating funds. Along with this fact was the prediction two years ago that inflationary costs would drive tuition up by 10 percent in the subsequent few years. Finally, with the expansion of new buildings (hockey rink, recreation center) at the Main Campus and a relatively new Instructional Building, maintenance costs are increased.

The BUSM administration is keeping a closer watch on expenditures, reflecting inflationary times and recent federal involvement in medical school finances. Dean McNary

predicts that within a few years the administration will have immediate recall as to specific costs in educating medical students.

As yet B.U. cannot state whether more increases are in the future or not. Present indications are that our medical school administration is becoming vigilant with respect to its own fiscal policy, yet remains subject to the financial situation of the University, and ever-changing Federal policies. Following is Dean Friedman's letter, sent to each student on January 12:

Although the messenger who brings bad news is sometimes wrongfully blamed for the content of his message, this particular messenger bears some responsibility for his tidings. I write to inform you that tuition at Boston University School of Medicine will increase once again July 1st, 1972.

After careful consideration of anticipated Medical School (Continued on Page 8)

New Pill Is Born At BUSM

by Stephanie Larouche BUSM III
"Using small animals such as rats, rabbits, and hamsters, we have now shown that one can completely inhibit reproduction in these animals by injecting or feeding estriol, following mating. Thus, estriol acts as a post-coital pill, or what is often referred to as the 'Morning-after Pill.'" Dr. Herbert Wotiz and his research group have been testing the contraceptive effect of estriol on small animals for three years in the Biochemistry Department at BUSM. Having found their method 100% effective on animals, Dr. Wotiz plans to begin human testing in conjunction with Drs. Joel Rankin and David Charles of the Ob-Gyn department.

The estriol pill is being developed in the hope of providing a new contraceptive that will retain the efficacy of the present estradiol-containing contraceptives but avoid some of their potential hazards.

Estriol is a metabolic derivative of the potent ovarian hormone estradiol.

Though possessing mild estrogenic effects on uterus and vagina, estriol has previously been shown to act in opposition to estradiol. Dr. Wotiz explained, "We have concentrated on utilizing our earlier studies on the mechanism by which estriol competes with estradiol for receptor molecules in hormone-responsive organs, such as the uterus and the breast . . . thus preventing a significant amount of estradiol from getting to the genetic material thereby controlling cell replication, i.e. tissue growth."

An example of the opposing effects of estriol and estradiol is the fact that the enzyme histaminase, closely associated with implantation, is greatly increased in tissue concentration after injection of estradiol but decreased after injection of estriol.

The reasoning behind the studies of estriol as a contraceptive is that in the post-ovulatory proliferation of

endometrium (which requires the effect of estradiol) preparation for implantation might be inhibited. Thus estriol would not prevent ovulation, as does the estradiol pill, but implantation of the fertilized ovum.

The presumption of greater safety in using an estriol rather than estradiol pill is based on a possible protective effect against breast cancer and thromboembolism, and the maintenance of the more physiologic state of ovulatory menstrual cycles.

An inverse relationship between levels of estriol and incidence of breast cancer has been noted in several situations:

1) Decreased estriol in women with breast cancer.
2) Increased estriol and decreased breast cancer in Asian women.

3) Increased estriol in pregnancy and decreased breast cancer in multiparous women as well as decreased breast cancer in women pregnant at an early age.

4) Increased estriol in the post-ovulatory period and increased breast cancer in non-ovulating women.

Dr. Wotiz adds, "In preliminary experiments we have now shown that when small amounts of estradiol are leaked from a silastic tube into an animal treated with a cancer-producing chemical (DMBA), more tumors are formed than in controls. On the other hand, if estriol is leaked from such a silastic tubing over a period of weeks in similarly treated animals, very few tumors



Proud father of morning-after pill, Dr. Herbert Wotiz.

appear and there is a decrease of about 80% in the number of animals which develop any tumors."

Though there is no empirical evidence for an increased incidence of cancer in women taking oral contraceptives, Dr. Wotiz explained, "Since the present popular estradiol-containing pill inhibits ovulation, and since many rather young women take the pill, the possibility of an increased breast cancer situation perhaps as long as twenty-five and thirty years after the initial administration of the pill must be considered. Our own interests in developing contraceptives, therefore have led away from any attempts to interfere with ovulation, since we consider the latter to be a beneficial event."

In regards to thromboembolism, Dr. Wotiz stated, "Although it is not possible at this time to pinpoint (Continued on Page 7)

The Grapevine in Black and White: Electives and Internship

Residency Without Internship

by Carl Brotman, M.D.
BUSM 1971

The following article was solicited to address the question of whether or not to take an internship when it is not required.

Before beginning a discussion of what this year has been like without an internship, let me say that I am not surprised that this inquiry has come repeatedly from people at B.U.S.M., more than from any other group. As a senior medical student I found myself constantly discussing this issue as I took my medical and psychiatric rotations. At the time, I felt that my decision was opposed by almost everyone on the faculty. Arguments varied; people told me I needed more training in internal medicine to be a good psychiatrist; an internship would teach responsibility; I would take care of sick patients; I would confront death with my patients; I would be more mature; when I found out what psychiatry was like, I might want to get back into medicine; "It was the year I learned what I know now"; "You won't be a doctor without it." In fact, only

Dr. Egdahl was in favor of my decision. He was convinced after my third snagging while trying to cut sutures during an adrenalectomy.

One can therefore imagine the volume of fear I held just before my Residency began. Not since my toilet training had I done something which was so universally disapproved.

As Residency began, the first mention I heard about internships was a comment by another resident to the effect that it was hard for him to learn how to use information from psychiatric nurses and attendants because interning had been such a one-man show. (I remember how infrequently the blood pressures that nurses diligently plotted q.i.d. at University Hospital were checked.)

The next comment came from my chief Resident who said he was flatly against the idea of dropping the internship. That proved to be the last time the issue cropped up for a 6 month period. No one talked about it, and for 6 months I worked under the impression that I was the same as the other residents. When it resurfaced 2 months ago, my chief admitted

that he had changed his mind; missing an internship wasn't an impediment for me.

It may well be that the decision to do what I did would not have made sense for others. Mass. Mental Health Center is only 2 blocks from the Peter Bent Brigham and we get good medical backup. I've treated a number of simple medical problems, but I can get medical consultants whenever I need them. I do not entertain any fantasies about doing a little internal medicine on the side of my psychiatric practice.

From the maze of arguments in favor of an internship presented to me as an undergraduate, only one emerges which identifies something I wanted for myself and did not get by skipping the internship. There is an intellectual sense of satisfaction one gets from integration of some of the fragments that courses in medical school present. I would have derived pleasure from handling complicated medical diagnostic and management problems; I would have gained a sense of completion of medical school, but not necessarily a preparation for psychiatric residency.

by Stephanie Larouche BUSM III

The following information was obtained at a meeting between students of the third and fourth years held in January. The meeting was intended to enhance the efficacy of the Grapevine in conveying vital information regarding arranging for careers beyond medical school. The meeting was taped, the tape edited and printed here for those who could not attend. A dash will be used when necessary to indicate change of speaker. When not otherwise indicated, the speaker is one of the following members of BUSM IV: Valerie Buysse, Carl Ingber, Drew Kelts, Jim Brasic, Tom Weiss, and Libby Anderson. We are grateful to these students and to Dr. McNary for their time and advice.

Electives, General Information

--- The main thing that came across to me in talking to 3rd year students is the feeling of being too late to schedule good electives. I want to bring up this point: I and many other people didn't arrange the electives they took half the time until a month or two before. There are ten times the number of electives

out there that you want. It just takes looking to find them.

--- It is really too early now to commit yourself because many schools don't require their 3rd year students to plan their 4th year until sometime in the spring. They may not take students from other schools until after their own students have decided. Also, you hear about some things later in the year that you might want to take.

--- (BUSM III) Can I ask a question? They want the forms filled out and given to Mrs. Keefer by mid-March so how do you go about waiting until a month or two before to schedule?

--- It's a good idea to fill out the form with tentative electives now. You can always change later. But whatever you do, be sure to let people know in advance if your plans change. I've heard some bad feedback about some people in our class who changed their electives without notifying the people concerned. This makes things bad for you because people offering electives get turned off to B.U. students. Just let them know and they'll undo whatever arrangements they've made for you.

--- If it's a competitive elective or any of the electives you have to sign up early for, I don't think you should be able to change. There has been a lot of elective swapping in my class which I think is really bad. It's not fair to the other people in the class.

To get information on particular electives that are good, one of the best sources of information is the students in the 4th year. There are some elective evaluations in Mrs. Keefer's office from people who have been through these electives.

If you have an idea of what kind of elective you want to take, go to the head of the department in that field and ask advice on where there is a good elective in it. Usually you will get a very good response.

In regards to electives at Harvard, you can get a list of their electives available. Their stated policy is that you must go through their Registrar's Office to get electives. That's not true. All the Harvard electives I've taken I've gotten directly through the person concerned. Talk to the heads of the department and ask how many students they usually get, whether the elective is filled with their own students, and what time he wants to apply. At Tufts the situation is similar. Your best bet is to talk to the students there.

Finally the details of how NIRMP works will be given to you in plenty of time to figure them out for yourself. Just plan to sit down sometime in Sept. or early Oct. with DAIR, make out a list of internships that seem desirable to you, bring it to Dr. McNary for comment, and send off for applications. The rest will fall into place.

Away Electives

--- You can take an elective almost anywhere you want. If

Elective and Internship Advice from BUSM IV

you are interested in a particular city, you can look in the green book, the directory of internships and hospitals (available in the library) and look at the hospitals available. You can get a pretty good idea of which are the major teaching hospitals. In general these have good quality teaching.

If you're a poor student and can't afford to set yourself up in a distant city, you might try some of the hospitals with limited affiliations. Often these are the hospitals that are interested in improving their public relations and will give you room and board.

If you are interested in a particular hospital for internship, I'd take an elective there to make sure.

--- If you can determine in the 3rd year that you want to go to a certain city or hospital for internship, it's certainly going to help your chances of getting in if you take an elective there. They know what they're dealing with; they know they can work with you. That doesn't mean that you have to take electives at every one of your places of interest. If there are a couple of places you want to look at you could take electives at those places and on your way back stop and look at other programs. That would be less expensive than making several trips out from Boston.

--- I tried a series of one month electives. Now I would warn against trying to cover the waterfront. There is no way to be prepared in all areas prior to internship. Rather, I would suggest taking a long period of time in one area that you're interested in. You're more likely to come away knowing something in depth, having a basis for further expertise. Not as much time is wasted adjusting to new situations and disciplines and jargons. It won't be as easy later to go into depth.

Interest in one area of specialty ought to suggest spending time during fourth year in other disciplines. For example, someone interested in pediatrics would do well to spend time in adult medicine, i.e., renal, respiratory, hematology, or in surgical specialties that bear on pediatrics, like ENT. Then, taking a straight internship doesn't mean such a loss of breadth. It's easier to organize a variety of electives around an interest in family practice.

Most people shied away from clinical or ward electives because the hours were longer and there were nights on. They didn't want a repeat of third year experiences. However, learning from patients is one of the best ways to learn. There can be more responsibility for the fourth year student.

Outlying Hospitals

--- If you want to look at all

the electives listed in the book, there are a lot of good electives which are so-called "sleepers." For example, I took a Cardiology elective over at the Shattuck which is primarily associated with Tufts. In this elective you get good basic Cardiology, a lot of EKG experience and if you want to do some research, you can even get it published if you spend 1 or 2 months out there.

--- I had a similar experience. I took a Hematology elective with Drs. Coco and Adner at Framingham Union Hospital. It was a really good elective.

--- (BUSM III) It's not a sleeper anymore, it's already full.

--- Cardiology is a good elective with Dr. Evans at Framingham. I'm looking forward to that next month.

--- I've had that elective. In terms of Cardiology, you get to read a great number of EKG's, and you get to see Dr. Evans all the time.

--- In regards to outlying hospitals there are a lot of fine programs tucked away. Carney Hospital is getting more involved with Pediatrics and has a jumping accident floor if you want that kind of experience that you may not get at City. It's a smaller accident floor but very busy. It sees a lot of ambulatory care kinds of things and good orthopedics.

--- I'll give a plug for an outlying hospital that you might be turned off with because it's a military hospital. Chelsea Naval has been a fantastic experience for me. I took surgery there last year and was impressed with two things: anesthesia and the ICU. I haven't had anesthesia yet but everyone who has, has enjoyed it. You get more responsibility because it is a military hospital and also because people there are really up on teaching and letting you do things.

--- Some of the programs of the outlying hospitals are not as described in the catalogs. For example, at the Providence VA Hospital, the Pulmonary elective is actually an elective in tuberculosis and the renal elective is actually an elective in chronic dialysis.

--- Something else which varies and which no one can predict is the people you are working with are residents - fellows who frequently change during the year. They can be the make it or break it of an elective. That's why anything that's said about a given elective depends on who is there that given month.

--- One thing that small hospitals avoid is the variability of house officers. In addition, you get to work with the person who is head of the department who is usually a much better teacher. A cardiologist at Mt. Auburn may not be as well

known as a cardiologist at Peter Bent Brigham but you'll get to work with him every day.

Community Health Electives

--- So far we've talked about clinical electives. I've had the opportunity to take several non-clinical electives in community health. I lived with a doctor and his family for 2 months in Appalachia which was a fantastic experience. I did some clinical work in less than half my time. The rest of the time was a community type of experience - going out and surveying the needs of the people in the town I was in. Usually in these situations you work not only with medical students but with nursing, pharmacy and dental student as well, taking an interdisciplinary look at the needs of the community. Most of the students were able to set up meaningful programs like bringing in occupational-physical therapy for post-stroke patients.

The other program I was in was the AAMC fellowship to Israel which was the biggest bust I've ever seen. They perpetuated the illusion that we were going there to do a public health elective. When we got there, they had a big list of things they wanted us to do. They wanted me to do steroid metabolism. I told them I didn't come 3,000 miles to do that; I could do it in Wotiz's lab with more money and better equipment. I knew Dr. Brandt was going to kill me and put me on home medicine if I didn't do something in public health, so I was able to get hold of a professor in family medicine. He set up a fantastic elective for me in community health. I was able to travel all over the country and get an idea of what their health care delivery system was like and do an epidemiologic study at the same time. If anybody is planning to enroll in that program be sure that you know what you are going to do before you go there. Be sure to work with the community medicine department here in setting up what you plan to do and finding out about the materials you need so you won't get stuck in a laboratory when you get there.

--- Make sure it's not his vacation either.

Letters of Recommendation
--- In regards to the political approach to getting an internship, if you get a letter of recommendation from someone well known in the field, that will swing weight like you've never seen. And, from what I've heard, letters of recommendation are one of the most important things.
--- Interviews are not very important. Grades aren't extremely important either since so many people come from pass-fail systems. Letters of recommendation do seem to be important.
--- This is something you should be careful of too. Some people by reputation are hard to get a good letter from. So, if you've decided to take an elective with someone big for the sake of recommendation, ask people who have tried it before what kind of letter he writes.
--- This is an important thing to think about because when you ask for a letter, you want to know what kind of letter he's going to send. Do this tactfully, of course, but don't just ask someone if he can write you a

letter; ask him if he can write you a good letter. If he's sending that letter to the program that is your first choice, it can be a very critical letter. I know someone who was nailed to the wall by a letter that wasn't too good. This sounds like playing a lot of politics, but this kind of thing is going to matter when you get into the 4th year.

--- You can also feel out through the fellows what kind of letter you might get from a particular elective.
--- Most places only require 2 or 3 letters but they won't refuse to read extra letters. So, if you can get more people to say you're wonderful, very little bit helps.
--- Another point I want to make is be nice to secretaries. Some doctors' secretaries really have a lot of pull. When you're handing her the list of programs to send the letter to, I think it's a nice thing to give her addressed stamped envelopes. She's got a hundred letters to type up individually and doesn't get paid any extra to do it.

Arranging for Electives
--- When you are arranging for electives, one way to avoid a lot of the hassle which doesn't take very much time, is to take a few more minutes to see the person himself rather than his secretary. Find out if he's going to be there that month and find out his conference schedule. Another thing you can do is to go see the secretary again two months before you start the elective and make sure they know you are coming.
--- Another point on arranging interviews and away electives: it's cheaper to write letters if you have the time, but it's helpful to arrange your interviews by phone. You save a lot of time and sometimes you get to a place and find they haven't received your letter. Speak to the secretary of the head of the program. She can handle all the arrangements.

Tuition for Electives
--- Make sure you know what you're getting into. There is a friend of mine who I think went to Duke and found out later that he was going to be charged \$250 tuition for that elective. This was in the information he was provided but he neglected to read it very carefully.
--- Denver charges too, but there is a way to get around it that they will tell you. If they have to send a formal grade, which we don't use anymore, they will have to charge you the tuition for that month which is \$200. If they can send just a letter back, you can get by without paying the tuition. It's an important thing to check on. Timing
--- Take electives for recommendation before
(Continued on Page 7)

How To Approach An Internship

by John Dundas, M.D.
BUSM 1971

reprinted from Chiasma 1971

Before I proceed with internships, a word about those medical specialties which no longer require any internship before residency. Neurology, Obstetrics, Gynecology, Ophthalmology, and Psychiatry are the four I know of; there may be others. (Some specific residencies in these specialties, however, continue to require internship before entrance.) If you plan to forego internship be sure to arrange your fourth year schedule to have your clerkships or electives in the pertinent specialties EARLY in the fourth year so your residency applications can have the benefit of appropriate recommendations.

Most straight and many rotating internships imply automatic acceptance into that hospital's residency training program, so if you have decided on a specialty you may not really be looking for an internship but for a full course of specialty training. Further, some specialties require an internship in their field, so if you take one type of internship and half-way through it decide to switch fields, you may have to take another year of internship.

The hardest questions to

answer about internships are how to pick them and how to rank them, particularly how to pick and rank hospitals that most nearly approximate your competitive range. The AMA "Directory of Approved Internships and Residencies" (DAIR) lists every internship and residency in the country by state, city, hospital and type; it tells who to write to for applications, and it gives more details on the various types of internships.

The DAIR's "Consolidated List of Hospitals" will give you your first indications of the competitiveness of the internships. First it will tell you whether each hospital is affiliated with a medical school, and the relative nature of that affiliation. Second, it will tell you which hospitals "fill" their available positions - an indication that last year's applicants judged them favorably. Finally, it will tell you the ratio of American medical school grads to foreign medical school grads in each internship. By and large, the more Americans the more competitive the internship, because most hospitals give preference to the native product, so if a hospital has few Americans one can infer that few of last year's applicants judged it favorably. The DAIR is published rather irregularly but Dr. McNary's office will have

some old copies.

After all this talk of "competitiveness" of internships, be advised: competitiveness and quality are not always synonymous. But while establishing the relative competitiveness of an internship is relatively easy, ascertaining its quality can be difficult. To help there, Dr. McNary has an extensive list of parameters by which to judge an internship. Take it with you when you go out for interviews, and give each hospital a thorough going over. The list is in the form of a questionnaire; try to answer as many questions as possible, both to inform yourself and, when you return it to him (as he hopes you will) to give next year's class a head start.

Also helpful here should be SAMA's "Intern Evaluation Reports" in two volumes, which covers over 1000 internships and which will soon be in the library. Finally, utilize Dr. McNary and his new advisory committee on internship to the fullest extent. They will tell you about previous year's experiences, letters of recommendation, what to do in interviews, and a host of other tactical details.

Since the National Intern and Resident Matching Program (NIRMP) clearly dominates the internship application process, a few words of encouragement and advice: First, you can't lose

by using it and you can't gain by not using it. Second, sometime before you send your final ranking in to the NIRMP, discuss with your advisor and the Dean's office the consequences of not matching, with the following question in mind: How badly do you have to dislike a prospective internship before you should risk not matching rather than risk going there? Not matching, is usually not nearly as catastrophic as it first sounds. Each year a number of good internships go unfilled due to the vagaries of applicant preferences. Unmatched students therefore are usually offered internships as good as or even better than those they originally applied to. (There is usually not much choice as to location of internship, however.) So if you decide you really do not want a specific internship "X" it, don't "rank" it. On the other hand, it is certainly more secure if you avoid the risk of not matching, by applying to a judicious range of internships.

Finally the details of how NIRMP works will be given to you in plenty of time to figure them out for yourself. Just plan to sit down sometime in Sept. or early Oct. with DAIR, make out a list of internships that seem desirable to you, bring it to Dr. McNary for comment, and send off for applications. The rest will fall into place.

Med Frat Fights To Live

by Lew Green BUSM II

A medical fraternity may seem an anachronism to some of you, something that should go the way of the old family doctor. Well, those of us active in the ODE Medical Fraternity agree in part.

The old general practitioner served an important function in his time, a function that still must be fulfilled today. But today, the requirements to fill these needs are much higher, and the old general practitioner had to adopt to the changing times. The Doctor of Family Medicine is the developing adaptation of the medical profession to the needs of today.

Likewise, the medical fraternity is composed of medical professionals attempting to adapt to the changing times. To this end, we seek your help, suggestions, and active participation in keeping the medical fraternity a viable organization, responsive to the times and the needs of the medical community and the community at large.

With this end in mind, the ODE Medical Fraternity is making a concerted effort to revitalize the local organizations, expand and improve its unique contributions, and seek new ways to serve. As an example of its recognition of the changing

times and its desire to expand its base and ability to serve, the fraternity earlier this year changed its charter to allow and welcome women medical students into its membership.

What does the fraternity have to offer? First of all, it has a well-established, easily accessible, multi-level channel of communication and comradeship amongst your fellow medical professionals

throughout your lifetime, that cuts across the arbitrary limitations of geography, discipline, and bureaucratic red tape. It offers substantial financial aid in the forms of scholarships, loans, and group insurance programs. A wide ranging education program covers matters in both professional and personal areas. Assistance in finding the right clinical clerkships, internships,

residencies, and practices is also available on a national scale. Its social activities are almost limitless and its representative voice is on a nation-wide level. All these services are valuable and relevant, and some are unique to the fraternity, but for some reasons there are not enough to attract the active participation of the majority of medical students.

WHY? This is the big question we seek to answer. What turns you on or off about a medical fraternity? What would you like the fraternity to offer you, the medical community, and the community at large? What can you bring to

specialists that are needed. I'm not sanguine about the solution."

Dr. David M. French, Chairman of the Community Medicine Department at BUSM said that it is most important for the university medical center to reorient its thinking to more appropriately do what "we're about." "The medical schools should be involved in a community sense and should respond to the people who receive care."

Surgeon-in-Chief of Boston City Hospital John J. Byrne feels that there is a crisis in terms of the availability of physicians. The cost factor is another matter, as Dr. Byrne notes that ancillary services are expensive, physicians' fees representing only 8 to 10% of the total cost.

Alice Rothchild, BUSM II, asked if the health care crisis was going to continue. "Who

controls the quality of an HMO? Unless the consumers have a say, there will be no improvement."

She thinks that these organizations have been reorganized on the basis of financing rather than quality. "Who controls the cost? Will there be consumer control, not just the consumer in an advisory role?"

Dr. MacLeod answered that there would be consumer control in HMO, and with the application of pluralism, a priority would be consumer involvement in planning and carrying out the HMO.

Also on the panel were Dr. Floyd Wolff, a Quincy internist; Mrs. Thelma Moore, a nursing administrator at BCH; Dr. Vincent Hennessey, Chief Surgical Resident at BCH; and Mr. John S. Gracey, Deputy Director of Administration, BUMC.

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Crisis in America

(Continued from Page 1)

William F. Maloney suggested that the crisis is not so much a decrease in services but that there would be an increase in the use of available knowledge. "The availability of medical care at higher quality, lower in cost is a 'crisis' in terms of perception ... of what the country needs."

"The second reason is that we have accepted a national commitment that reasonable health care ought to be available to all people. "Training has been for the individual instead of the community. We have a system that encourages the use of the most expensive care, namely hospitals. We have no incentives for economy or increased productivity, and no system for allocating the number of

of Harvard Medical School, thinks that there exists a crisis for two reasons. "To a degree we are victims of our own success. In the last two or three decades specific therapy has led to the specialization of medicine. The problem is that the system has not been modified to respond to these revolutionary changes."

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Elective and Internship Advice from BUSMIV

(Continued from Page 5)

November because letters are due on December 15th and they'll need time to get them in. --- If you're thinking of applying to a lot of internships and you'll need time, I suggest you schedule your vacation or an elective in which you won't disturb people by taking off time to go visit these programs. Remember that the Deans and Directors of Medical Education are not generally around on weekends so you'll need to take time off during the week to see these programs.

--- There are various theories on when to go for an internship interview. Most people go in November so at this time you may not get the interview scheduled at a time when you want it. Even if you do get the time you request, you may be interviewed with 4 or 5 other students so you won't get the personal attention. It may be more advantageous to go earlier.

--- And yet you can't go too early, July or August, since the interns have not been there long enough and can't view their internship objectively. I think September and October are good months to go. I think the most important thing about going for interviews is talking to the house officers. By November, they really get tired of talking to internship applicants and answering the same questions day after day.

Internship Interviews

--- I've been to 19 interviews and they usually aren't high-pressed.

--- Well, that varies. A class-mate went to Mass. General today and the first question he

was asked was, "Give me the differential diagnosis of hemobilia."

--- His response? --- "You're not interested in me and I'm not interested in you."

--- Remember there's a lot of good medicine west of Route 128.

--- The one thing they all ask is, "What do you plan to do after medical school." They want to take someone who will stay in the specialty. The only medical question I've been asked is, "Present an interesting case."

Other things they might ask are questions on how socially involved you are in medicine, questions about National Health Insurance for example. Mostly they want to find out that you don't have three eyes. The questions you can usually handle.

--- Allow yourself at least a half a day in a place. The one day you spend at that hospital is the best information you're going to have about it. If you want to get adequate information about a program you have to work at it. Talk to at least 3 house officers and see how they like it. It takes time to ask them a lot of questions. This is very draining and it's hard to visit more than one place a day.

--- Remember that the house officer who takes you on a tour is not going to be someone who dislikes the place. Sit in on a conference, make rounds, see what kinds of patients they have on the wards. Nights are important too; see what goes on at night on the wards.

--- After you've visited a number of hospitals you'll

develop your own set of routine questions which will help you find out about a program. One of the most useful questions I ask is whether it's an intern's hospital. Who writes the orders on private patients? How approachable are the staff members of the various subspecialties?

--- It's to your advantage to go to a lot of internship interviews because only that way can you narrow down exactly what type of internship you want. It may cost a lot of money now but it's a very good investment. It's the only way you can be sure you'll be happy at the program you end up at. --- Read the brochure the programs send so you'll be primed to ask appropriate questions when you get there. If you send out your letters now you can get elective information and internship applications at the same time.

National Boards Part II

--- Regarding taking Part II in 3rd year, take them! Part I is set with a failure rate of about 12% and Part II with a failure rate of about 2%. You can take the Boards as a noncandidate for \$15.00 then after you've passed you can proclaim yourself a candidate for \$25.00 more. If you're a candidate a hospital can call the National Boards to get a report but not if you're a non-candidate. But, usually they don't even ask. Your Boards results are included in your Dean's letter only if you have done remarkably well. The purpose of taking Boards Part II is for licensure so you don't have to take state boards. To change from non-candidate to candidate

status you have until you sign up for Part III six weeks before taking Part III.

Selecting an Internship

--- Be wary of a place that pays too much or has too many foreign medical graduates on the house staff. Choose from the Green Book by geographic locations. Send away for information and compare details of the programs.

--- Don't count out a program just because it doesn't have a major medical school affiliation. Because of my wife's career plans, I looked into a program in Columbus, Ohio, and found the happiest group of interns and the most ideal program for me - and in the most unlikely place, Columbus, Ohio.

--- Look in the places you want to live in but don't be afraid to consider places you never thought of living in. Most of us from up North have a prejudice against places south of the Mason-Dixon Line, but there are lots of good programs down South. Chapel Hill, Atlanta, Tennessee - all these have good programs.

Matching

--- If you really don't think you will like a program, don't put down a preference for it. It's better not to be matched to a program you're not going to enjoy. Come Matching Day, there are going to be a lot of good programs not matched. If you're a good student you can call up and match up with them. You're almost bound by contract to go to a place if you put down a preference for it.

Dean's Letter (Dr. McNary) Last year the

average student applied to about 12 places. This year the average student applied to well over 19. I had one student with more than 30 letters. We have rented form IBM an automatic typewriter. Your letter is written in a specific way which I think is paying off. One thing is that it is written so that we can fill in information as it comes in. If you want a letter in July, I send that letter out and maintain it on a tape so that if you want a letter in November, I can add on your electives to that date.

Secondly, if we can get your letter on tape early, it's easy to modify it and send it out again very rapidly. So what I would suggest is that you make a selection early, ask for your Dean's letter early. It will be written, and kept on a card or tape so if you come in on the 14th of December asking for a letter, I can throw the card into the machine and your letter will be out on the 14th of December, that means the letter has to be dictated, put on tape, the letters have to be written and all your transcripts copied. That letter won't go out for at least probably 15 days. About this time of year (January) I'll start getting telephone calls from all over the country from internship selection committees asking if there is any change or further information on an individual. Today I had 12 phone calls. So they do follow up on these letters. --- That's also true of letters of recommendation. If they know the person who wrote the letter, they'll call to talk with him personally.

(Mac's words of Wisdom continued.) On electives to sell (Continued on Page 7)

POETRY

Alone

Black, bleak, barren street,
One dark figure walking, walking.
Cold, oppressive, biting wind
Numbing, haunting, stinging, stalking.

Moonless, starless, friendless night
Enshrouding tree and earth and life.
One dark figure wonders, ponders
Smear'd with love and hate and strife.

Bolted doors and shuttered windows
Blinded eyes and hearts repeat.
One sad figure crying, dying
On the black, bleak, barren street.

-Joe Cuzzo

Cadmus

The efforts of a thousand years
Cannot achieve the unthought note.
While Hope alone surmounts these fears,
The death-wish looms but now remote.

-James Brasic

Dimensions of Oblivion

I am dead.
My mind has fled my body.
I feel life no more.
As memories return,
The cosmos destroys their magic.
Eternity merges with nothingness
And there is no death.
This is the dimension of oblivion
Where time cannot enter.
I am losing identity.
I am a child
I am dying
I am d. . .

-Joe Cuzzo

Friedman Replies To Kozol

Following is a statement released to the press by Dr. Ephraim Friedman, Dean of BUSM:

Boston City Hospital and Boston University School of Medicine have been proud partners for over forty years in delivering better medical care for the patients of the hospital and in providing exemplary teaching for the students of the school.

"The future of this joint venture lies not only in improving the quality of the services already offered, but in the future development of innovative programs which will allow us to serve even more of the citizens of Boston.

"In his testimony this week before an ad hoc committee of the U.S. Senate, Jonathan Kozol was quoted in the press as condemning the care of children at Boston City Hospital, as well as indicting the obstetrical care there.

"Mr. Kozol's statements do not reflect, however, the current situation at the hospital. Under the vigorous leadership of Dr.

David Charles, chief of the Department of Obstetrics and Gynecology, a totally renovated and modern Ob-Gyn building is in its final stages of completion, and the maternity care afforded there compared very favorably with that of any major teaching hospital.

"The care of children at Boston City Hospital continues to be exemplary. Not only is the inpatient service outstanding, but the Department of Pediatrics is pioneering in its efforts to develop effective ambulatory programs. The department has developed what is acknowledged to be one of the model lead-poisoning testing programs in the country.

"Boston University School of Medicine is quite proud of the heritage of Boston City Hospital and welcomes the constructive cooperation of crusaders such as Mr. Kozol in the effort to improve the capability of the hospital to deliver first-rate medical care to the citizens of Boston."

A Roadmap Through No-Fault

by Ed Coyle
Oblivion, Russell & Co.

The following article is the first of a series designed to provide general information and guidelines on financial, legal, and other matters of general concern to members of the local medical community. We welcome and encourage any comments and suggestions on past or future articles. Please direct all correspondence to: Lewis E. Green, BUSM, Box 247.

On January 1, 1972 Massachusetts Compulsory Automobile Insurance became effective which required all automobiles registered in the State of Massachusetts to carry liability insurance. The purpose of the law was to enable the motoring public, in case of an accident, to collect compensation if injured and also to obtain legal counsel for the right to sue for pain and suffering.

However, in recent years the cost of Mass. automobile insurance had increased substantially, mainly as a result of ever increasing claims and cost per claim. As the motoring public became increasingly alarmed with ever-rising premiums, the Massachusetts Legislature decided that a whole new approach to automobile insurance was needed which led

to the passage of the first no-fault automobile liability insurance in the United States which became effective January 1, 1971.

The No-Fault Bodily Injury Insurance will pay up to a total of \$2,000 to every person injured while occupying an insured vehicle or a pedestrian struck by such a car for his medical, hospital and funeral expenses. The coverage will provide this benefit regardless of whether the person has other insurance. The insurance also provides coverage for 75% of the insured's loss of salary; however, this benefit would be in conjunction with any other insurance the claimant may have. In other words, if the person has other insurance which provides him 50% of his salary, his auto insurance would pay the remaining 25%. If a claimant's medical expenses exceed \$500.00 or results in death, loss of limb, loss of sight or hearing, or a fracture, he can obtain legal counsel and sue for pain and suffering. Basically, the \$2,000 limit is broken down between \$500 medical and \$1,500 loss of wages; either benefit exceeding these amounts the claimant can sue the party at fault. Many times the question arises, if my benefit is \$2,000 why should I carry higher limits

and the basic answer to this question is if the person causing the accident is, in fact, at fault he is subject to suit. As was pointed out earlier, in cases of death, loss of limb, etc., the pain and suffering law prevails and many rather substantial judgments have been awarded through the Courts. Basically, the no-fault law has eliminated the over-payment of claims since out-of-pocket losses have to be substantiated by medical bills and statements from employers that such persons were, in fact, out of work.

The insured also has an option to purchase deductibles in amounts of \$250, \$500, \$1,000, or \$2,000 however, the small savings realized are not worth the loss in benefits. On an average medical claim such as a visit to the doctor and x-ray probably would not total more than \$50, hence no coverage at all with the deductible. The insured is wiser to avoid any deductible on the Bodily Injury Coverage.

No-Fault Property Damage

Effective January 1, 1972 Massachusetts will have no-fault Property Damage protection. This coverage will enable the insured to collect for damages to his car regardless of fault generally. This coverage will now be compulsory for at least a \$5,000 limit. Basically, the Property Damage Insurance is set up with three options:

1) Collision Coverage—payments will be made for actual loss to insured's vehicle. In cases of total loss, actual cash value of the vehicle would be paid. This option should be elected in cases where the insured had both property damage and collision coverages.

2) Restricted Collision Coverage—choosing this option means your company will pay for damage to your vehicle, less the deductible the insured chooses, when involved in an accident in which the other party was at fault. This option should be elected in cases where the insured was carrying property damage only.

3) No coverages for own car— with this option the insured cannot collect for damages done to his vehicle regardless of fault if involved with another Massachusetts vehicle. If an out-of-state vehicle is involved and was at fault the insured would be able to collect for damages to his vehicle less deductible. This option could be elected in cases where the insured has an older car and cost of repairs would almost equal the actual cash value of the vehicle.

semen. Estriol appears in this situation to have both a systemic and topical effect on the uterus. No loss of libido was noted in the male animals, and the destructive effect of estadiol on sperm was not found. This opens the possibility of a male contraceptive and also of administration of contraceptive by tampon.

When asked of his future plans in regards to this issue, Dr. Wotiz replied that after the clinical testing now being planned, he intends to return to his basic biochemical research and his graduate students. "We plan to continue looking for molecules which have very little growth-promoting activity but which prevent estradiol from acting on the uterus, with the hope of developing even better post-coital contraceptive agents. Thus it is hoped that one may be able to develop successful post-coital contraceptives with anti-cancer activity which may not cause blood clotting."

Advice

(Continued from Page 6)

yourself - I don't like the idea of this, but it does pay to be known. This is especially true of the West and Southwest. Some people have actually said that they won't even look at a candidate no matter whether he's AOA if he hasn't been here and we know him. So if you're interested in a particular hospital for internship or residency, it pays to be known.

My philosophy on internships is the best internship is the one that gives you what you want. I don't care if it's the top one in the country or the bottom one, if it gives you what you want, it's the best.

On options one and two, a standard deductible of \$100 would apply for damage to insured's vehicle.

Regardless of options chosen, damage to property of others such as hitting a fence or building is covered.

Since No-Fault Insurance is a relatively new concept in Automobile Insurance, this article is intended to serve as a guide in helping people understand the basic provisions of the coverages and should not be interpreted as answering all the questions that may arise concerning an individual's rights under Massachusetts Motor Vehicle Insurance Laws.

Recognizing that the moral and ethical practices in medicine are in large part dependent on the personal responsibility and integrity of the individual physician, the students at BUSM have sought an Honor Code which would encourage and promote the development of these attributes. The Honor Code, therefore, had to meet the following criteria: Its foundation had to be laid on the acknowledgement of the basic sense of responsibility and integrity of the individual student; its structure designed to further refine these attributes. It had to be flexible to adapt to the changing demands of the varying circumstances and the needs of the individuals involved. It had to be effective across the board on a broad scale from eliminating the rare willful, chronic abuser to salvaging the one-time offender caught in a moment of weakness under excessive stress, and everything in between. And, lastly, it had to be non-intimidating and preserving the individual rights and personal dignity of those involved, uncomplicated, in order to encourage its utilization when the situation arose, while helping to eliminate such

BUSM Honor Code: A Brief Review

by Lew Green
BUSM II

situations. Dedicated work by John Dundas (BUSM 71), Martin Bress (BUSM 71), and Bob Meenan (BUSM 72) spearheaded a cooperative effort amongst BUSM students, faculty, and administration and the B.U. School of Law culminating this spring in the initiation of the new BUSM Honor Code.

The aims of the new Honor Code are as stated above, but the mechanics might bear further brief review and explanation, without an attempt to repeat all the technical details. The step-wise order of events is initiated by direct confrontation of the accused by the witness. It is hoped that in most instances this will be sufficient to get the accused back on the right track. If it is not sufficient or if the incident itself warrants further action, then the Dean of

Students or the Chairman of SCOMSA is to be notified in writing with complete details of the incident in question. A committee of five students will then be formed to hear the case. The accused may challenge any member of the committee or choose not to go before the committee at all. If the committee hears the case, it may call forth any witnesses or records pertinent to the discussion at hand, to include past offenses by the accused. The committee may find the accused innocent or guilty, that there is insufficient evidence and dismiss the case, or that the incident requires hearing by a higher body. A finding of guilt or innocence by this committee is binding on the student body, faculty, and administration of BUSM. On a finding of innocent,

all records of the incident will be destroyed. On a finding of guilty, the committee may take remedial action requiring no further involvement of faculty or administration or recommend that further action be taken. Such recommendations are not binding on the faculty and administration, but may allow entrance of reports of the incident into the intramural and/or extramural records of the accused.

The next step is a hearing by the Dean's office, which may be initiated by the accused himself, recommendation by the SCOMSA committee, or the character of the incident itself. At this level and higher action may be punitive and binding, and reports may become permanent entries into the records of the accused. The

accused, therefore, may be represented by legal counsel. Recommendations for probation, suspension, or dismissal require final decision by the Executive Committee of the Faculty. Any incident requiring action beyond the resources of the school will be handled accordingly.

At every level of action within the school the individual rights and dignity of the accused will be protected with speed of action, utmost confidentiality, and minimum required corrective action, aimed where possible towards rehabilitation and prevention rather than punishment. The accused will have ready access to appeal through the established means both at BUSM and the Boston University Judiciary System.

All active and entering students at BUSM will be expected to become familiar with the new Honor Code, accept in principle its underlying premises, and pledge to abide by and actively participate in its implementation when necessary. It is hoped by us all that the new Honor Code will uniquely and significantly contribute to the overall effort of BUSM to produce "good" doctors.

Herb Wakabayashi,

Where Are You?



Pictured here after a recent loss are (l. to r.) John Love, George Parker, Ed Brown, Mike Corbett, Bill Garvin, Mike Boyars, Joel Schulman, Pete Willard, and Eric Honig.

by Eric Honig

"We ran out of booze," was Coach Bill (Snooks) Garvin's excuse for the absence of a celebration after the BUSM hockey team's first victory, on April Fools Day, a 5-3 decision over Harvard Medical School at BU's Brown Rink.

"We've been having wakes after every game all season," said Garvin, "but I just got kinda tired of all those defeat parties, so I didn't buy for this one." After eleven straight defeats, Snooks' boys won their first, and had to do without a celebration.

It had been a long season for the team, finishing dead last in the BU intramural league, the only team without a victory, or tie for that matter. Added to that were two losses to Harvard. The most recent was dropped 11-2. Far behind in all of their games, the Med School led only once in one game all season. They took a 1-0 lead in that contest, a lead which lasted 30 seconds before falling on the way to a 6-2 defeat.

Snooks, whose previous claim to fame had been skating with BC hockey captain Vin Shanley, won his first victory with finesse, on the ice and off. After offering the Harvard boys the use of his regular goalie Larry (Red Light) Opoliner, he succeeded in decking Opoliner out of the net, and set up Bob Chamberlain for a 50-footer on an open goal. That sent the Med School on its way. Although Chamberlain later succeeded in scoring on his own net, star

defense by Pete Willard, Chet Zarnoch and checking by Turkey Line of Mike Boyars, Joel Schulman, Eric Honig, and Steve Goldberger held the Harvards at bay. The key factor, however, was the absence of Harvard's George McManama, one time teammate of Oliver Barrett and a Crimson star in his own right.

Most of the season's scoring output (average 1.5 goals a game) was accounted for by the Ace Line of Mike Corbett, Ted Herlihy, and Garvin. Varsity letters were won by Garvin, Herlihy, Willard, Opoliner, Corbett, and John Love. The Purple Heart went to Joel Schulman for a cracked rib received in the line of duty against the Light Blue and the DeWitt Querles Memorial Award for most lumps taken while never getting the puck out of their own end of the ice went to the Turkey Line. Friends of BU Med School Hockey Awards went to George Mitchell, Hackie Reitman, and Arnie Oppenheim for showing up. The first annual Sieve Award went to Larry Opoliner, whose comment was, as it had been all season as the Red Light shone behind him, "Why me?"

Opoliner, next year's coach and captain, promised a brighter future for med school hockey fans, pointing out that the "never daunted and never scoring seniors" would be graduating and new players coming in "could only be an improvement."

We shall see.

Cancer, Cyclic AMP, and BUSM

by Hackie Reitman BUSM II

Exciting research in the field of cancer is taking place at BUSM. On the fifth floor of the research building, a group of dedicated investigators challenge the mystery of cyclic AMP and its relationship to cancer.

Under the leadership of Dr. Alexander Rutenburg of the Department of Surgery, the research program has taken the

view that perhaps the cyclic AMP system, one of the most basic of the body's regulatory mechanisms, holds practical applications to medicine's most complicated problems. Cyclic AMP is a key regulator of most cellular function and, as a "second messenger", mediates the actions of most hormones.

Other important functions of cyclic AMP include synthesis and release of certain hormones such as cortisone and of many enzymes, proteins, synthesis, and regulation of cellular growth. Cyclic AMP also participates in the cellular immune response and certain aspects of pyrimidine synthesis. Defective cyclic AMP system functions may result in uncontrolled cellular transformations or depression. A study of these functions may provide new leads for studying the role of this key biochemical mechanism in cancer.

Right now, the Research Group which includes Dr. Rutenburg, Dr. Polgar and Dr. Rao, are investigating various segments of use of cyclic AMP system in clinical and experimental cancer. These include the various leukemias, mononucleosis, Burkitt's lymphoma, and solid tumors,

such as breast cancer and cancer of the colon. Patients' material is examined before and during treatment. This research has led to valuable insights.

Glimpsing into the future, this reporter envisions one particular line of inquiry in Dr. Rutenburg's lab as hitting a jackpot of sorts. This involves peripheral leukocyte mobilization in secondary response to trauma, with the innovation of the Perillie Cup in research. Simply, the cups are affixed to the patient's arm, which is very slightly abraded and the responding leukocytes are collected over a period of time (Note: the experiments are carried out with the utmost care for the welfare of the patients, who volunteer for these experiments and are not "gently pushed" into them, even though there is essentially no discomfort involved). The cells are then studied from the cyclic AMP standpoint and from other aspects. In this way, the group hopes to uncover essential differences in the overall immunological response among healthy individuals, "normal" patients, and cancer patients.

Preliminary results of the cyclic AMP have been exciting and encourage further research.

Inflation

(Continued from Page 3)

income and expenses and diligent examination of our alternatives, we regret that tuition must inevitably be increased to \$2,900 per year, a rise of about 10%. Increases in funding from the federal government in the immediate future are expected to be marginal and, at best, highly unpredictable.

I anticipate that financial aid for individual students through loan and scholarship programs will increase and be sufficient to prevent this tuition rise from forcing any student to cut short his medical education. Although the other medical schools in the city have yet to announce their tuition rates for 1972-1973, I fully expect our tuition to be in line with the total of their tuition and fees. (Student fees have been incorporated into our tuition since July, 1971).

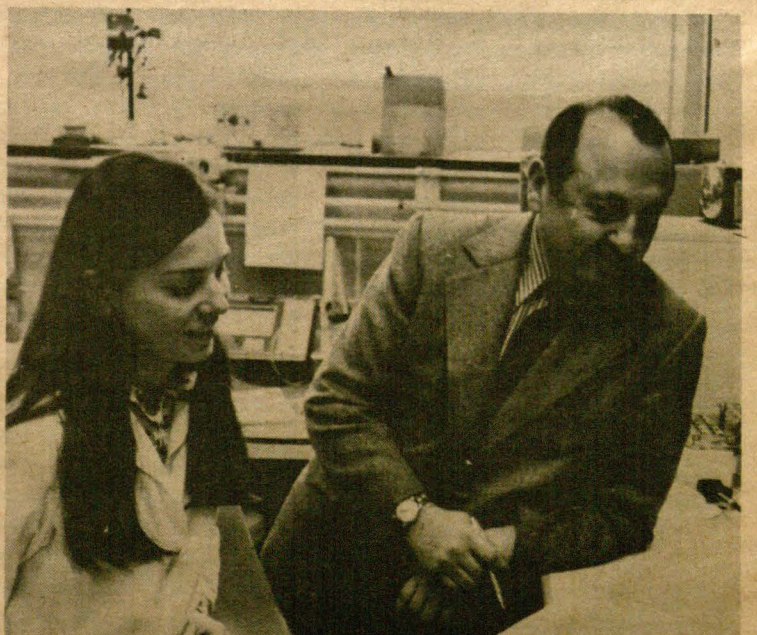
I deeply regret the necessity for yet another increase in the School's tuition. As I explained, however, to your SCOMSA representatives at their December 2nd meeting, this is the only way we can maintain academic standards in a financially responsible manner.

Thank you for your cooperation and understanding.

Sincerely

Ephraim Friedman, M.D.

Dean



Dr. Rutenberg and Mrs. Williams map out research strategy.