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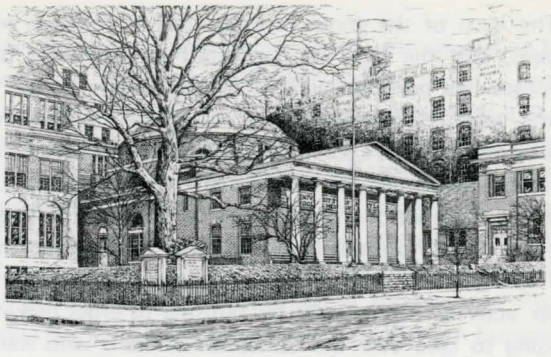
AESCLEPIAN

School of Medicine
University of Maryland



ALL YOU'LL EVER NEED TO KNOW ABOUT OSR

The Organization of Student Representatives (OSR) is a sub-council of the Association of American Medical Colleges (AAMC), made up of student delegates from each of the medical schools in the U.S. The purpose of this organization is to provide student input into the AAMC, which is the political representative of medical education in America. The OSR exists as the only medical student group that has *ongoing* and *direct* input into the governing bodies of medical education. These governing bodies of the AAMC include: the deans of all U.S. medical schools, the directors of specialty programs which provide our graduate medical education, and the administrators of teaching hospitals involved in medical education. Thus, the OSR is involved with a broad variety of activities that are of concern to medical students. These include such diverse areas as pre-medical education, the MCAT, the medical school admissions process, minority affairs including the unique problems facing women in medicine, medical school curricula and evaluation, certification of new medical schools and recertification of existing ones, stress in medical education and the National Intern and Resident Matching Program (NIRMP). The OSR also provides student input on issues of a more general nature, such as health manpower distribution, national health care policies and legislation, and the problems facing housestaff regarding working conditions and their dual status as students and employees.

Meeting twice yearly, (the Fall meeting coinciding with the annual AAMC general convention, and the Spring meeting coinciding with the Regional meetings of Deans of Student Affairs), the OSR discusses current developments in the aforementioned areas, and makes recommendations to the Council of Deans and to the AAMC general assembly. I would like to briefly relate some highlights from the recent annual AAMC general convention held at the beginning of November.

To begin with, it is noteworthy that the meetings this year were marked by a spirit of optimism and cooperation between the AAMC and the OSR that has not existed in recent years. Since the OSR represents student opinion, it is understandable that our views would often be in conflict with the "establishment" in medical education. However, in spite of the sometimes vast differences of opinion between the OSR and the rest of the AAMC, there was a good deal of common ground we shared that led to some productive discussions.

During the convention the OSR sponsored and led discussion groups on areas such as: Graduate Medical Education, National Health Policy Issues, NIRMP, Curriculum and Evaluation, Women in Medicine, Humanistic Medicine, and Homosexuality in Medicine. These were all well-attended and often had panels which included national experts in the field. The results of these discussion groups were a series of recommendations and resolutions which were brought before the OSR general assembly and voted upon.

The first resolution passed concerned OSR representation from AAMC member schools, urging them to "solicit, endorse, and adequately fund an OSR representative and an alternate representative to all national and regional OSR meetings." This was done to assure that no school would be unrepresented because of the inability of the representative to afford the expense of attending the meetings. It also guarantees that schools will establish a continuity of representation, by having an alternate representative who would attend the meetings and be able to fill in, should the official delegate be predisposed.

A resolution was passed that the OSR investigate the allegation that there are irregularities in the transfer process from one medical school to another, especially that involving the placement of students from a two-year medical school into the third year of a standard four-year medical school. Presently there are still about six U.S. medical schools that only teach the first two pre-clinical years. The students from these schools must then transfer to another medical school to complete their education.

The discussion group on Curriculum and Evaluation introduced a resolution requesting that all medical school send copies of their course evaluation forms and a description of how they evaluate their students to the national offices of the AAMC. This was done to enable schools to develop and improve their curricula and evaluation processes by being able to compare theirs with those of other schools in the country. Among the differences that exist between schools presently are that some schools require the passing of the National Boards part I for advancement to the third year, while other do not; some schools rely on the traditional A B C D F grading system while others are Pass/Fail; and some schools have voting student representatives on their curriculum committees, while other do not. Once the data are in, it is hoped that attempts will be made to improve and unify the approach to curriculum and evaluation among U.S. medical schools.

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The issue of the status of housestaff as students versus employees, and the right of housestaff to collective bargaining privileges has been an area of heated debate in the OSR for several years. Housestaff organizations are increasingly finding it necessary to resort to strikes and other job actions to secure improved conditions for their patients and themselves. The impact that these actions have on medical students rotating through these troubled hospitals is serious, and has involved threatened reprisals directed against students who supported the strikes either actively or passively by refusing to cross picket lines or refusing to take over the duties of residents who were out on strike. The OSR resolved at the last meeting to develop a special task force to examine and explore these allegations, and to formulate a statement of students rights and responsibilities in these very delicate situations.

A resolution was also submitted to look into violations of the National Intern and Resident Matching Program (NIRMP) agreement that each senior medical student and each residency program director signs when participating in the matching process.

An important area that was dealt with extensively at the November meeting was the crisis developing in medical student financing. As many of us are becoming painfully aware, the availability of scholarships and low interest loans to medical students is rapidly drying up, and many of us are being forced to join the National Health Service Corps, Public Health Service, or a branch of the Armed Forces to finance our medical education. A task force is already looking into the matter, especially in light of the new "Health Professions Education Assistance Act of 1976" signed into law by President Ford in October.

The OSR and the Council of Deans jointly sponsored a program one evening dedicated to the problems of stress in medical education, and the need to include human dimensions into medical education. The program was well-attended by over 300 student representatives and medical school administrators. It pointed out many of the complaints, fears, apprehensions, and problems facing medical students as they grow and groan through four years of intensive education in preparation of becoming a physician.

Perhaps the most important aspect of these meetings is the opporunity for students to get together informally with each other and with medical school administrators to compare experiences at their respective institutions, and thus learn from each other how they can possibly improve the system.

This year we will be electing two new OSR representatives to serve for the '77-'78 year. In accordance with the new OSR resolution, one student will be elected as OSR voting representative, and the other will serve as alternate OSR representative, with the ability to assume the position of voting representative the following year. Anyone interested in the areas mentioned in this report, in learning more about OSR, and those interested in representing our local school may contact: Marc Bresler, MS IV, c/o Office of Student Affairs, Howard Hall Addition, Mezzanine.

A PLAGUE OF DOCTORS?

A REVIEW OF "MEDICAL NEMESIS", IVAN ILLICH, PANTHEON BOOKS, NEW YORK, N.Y., 1976. 295 PAGES. $8.95.

To the Greeks *nemesis* was the inevitable punishment for attempting to be a hero rather than human; god rather than man. She is seen as nature's response to *hubris*, the presumption of seeking to be god. The theme of "Medical Nemesis" is that our contemporary hygienic hubris has caused us to be visited by medical nemesis; we are suffering from a plague of doctors. For Ivan Illich, the damage done by physicians (iatrogenic injury) is of much broader scope than simply that of the doctor-related diseases; (of course the medical establishment can injure us with the drugs that it uses and the procedures that it employs) but it can also alter our social institutions in order to institutionalize health, and (most importantly in Illich's view) it can succeed in leaving us culturally less able to cope with the inevitability of suffering and death.

In "Medical Nemesis" it is Illich's thesis that the medical establishment, because of its enormous expansion during the present century, has itself become a major threat to health, and that thoughtful public discussion is the first necessity in correcting what he calls the iatrogenic pandemic. The cure is to be brought about by laymen who, unlike the physicians, have both the perspective and the power to stop the current waves of physician-induced diseases, and it is to the laymen, therefore, that "Medical Nemesis" is directed. Illich is providing the laymen with a sourcebook richly documenting the scope of iatrogenic injury (the book contains references to more than 1,000 authors, very many of whom are quoted from established medical journals) as well as a blueprint for political countermeasures.

The book is an important one that should be read by everyone interested in the impact of organized medicine upon society and upon the individual. Illich's is not a balanced work, rather it is a polemic argument for change, where the balance is loaded better to measure the good we do against the harm. By concentrating on the negative side of organized medicine, this book will enrage many U.S. physicians, as previous versions have enraged their colleagues in France, Canada and the United Kingdom. However, at a time when there is increasing public awareness of the fiscal limitations on health care systems this book deserves to have a major impact on our thinking about the future of the medical profession.

Ivan Illich was born to Jugoslav parents into the Vienna of 1926. After taking his initial training in crystallography at the University of Salzburg, he studied history, philosophy and theology at the Universities of Florence and Rome. At the age of 24 he came to New York where he served as a parish priest in a Puerto Rican community for five years. From 1955 to 1960 he lived and worked in San Juan, Puerto Rico, leaving to join Valentina Borremans in founding the CIDOC (Centro Intercultural de Documentacion) in Cuernavaca, Mexico. The Center served as a nucleus for scholars seeking to explore "the characteristics of a new society in which the expansion of industrial and professional agencies would be limited by political process." Besides medicine, the CIDOC group has examined the areas of schooling and adult education, communications and transportation, housing, agriculture, and energy-utilization. These studies

have been published as a series of more than 200 book-length monographs (the CIDOC Archives) which, together with their supporting documentation, are now housed in the library of the Colegio de Mexico. Two earlier versions of "Medical Nemesis" have been published in France (1975) and England (1974), but the present version is probably the last, for the CIDOC disolved after a final working meeting held in Cuernavaca, in January of 1976.

Illich's philosophical base is in the neo-Marxist economic theory of "specific counterproductivity." This sees all major institutional industries as inevitable producing side effects whose true cost must be paid by society at large if maximum profit is to be achieved by the industry. Furthermore, maximal profit can accrue only when the industry succeeds in removing itself from the specific purpose for which it is designed. Previous publications from CIDOC have applied this theory to the automobile, communications, housing and power industries, as well as to schooling and agriculture. Illich has previously published "Deschooling Society" and "Energy and Equity," now "Medical Nemesis" represents the culmination of the Center's efforts to apply this approach to the delivery of medical care.

What kind of injury is done by physicians? There are of course the injuries that a doctor may inflict on an individual patient (*clinical iatrogenesis*), but there are also the injurious societal changes that may be brought about by institutional medicine (*social iatrogenesis*), and the injurious effects that medicine may exert on our culture as a whole (*cultural iatrogenesis*).

Clinical iatrogenesis, where injury to the patient is inflicted by the doctor either by accident or by ignorance, is well known to physician and layman alike. Ineffective treatments, unwarranted treatments, side-effects of justifiable treatments, and accidental damage are part and parcel of the doctor-patient relationship, but are incomparably more common now that the physician has at his command a wealth of powerful drugs and surgical treatments that did not exist a generation or two ago. Perhaps the doctors could not do much good in the earlier ages – but they could not do much harm either. Public and physician alike are aware that all is not well, as the present wave of "malpractice" suits against doctors and their institutions bears witness.

Is clinical iatrogenesis an inevitable cost of medical progress"? Probably some amount of negligence, incompetence, and callousness is inevitable, and has been since the most ancient times. But the institutionalization of medicine and its scientification ("technification" might be a better word) has led to a degree of separation between doctor and patient where negligence may become "acceptable human error," incompetence may become "lack of specialized equipment," and callousness may become "scientific detachment." In Illich's view, "depersonalization of diagnosis and therapy has changed malpractice from an ethical to a technical problem" and this view is strongly presented with a wealth of references to the clinical literature. (Illich has apparently failed to read Roger Treadgold's "Patient-Centered Medicine." Treadgold terms the neglect of the patient the "Devil in the machine of modern medicine".) At the very least this part of the book, however prejudiced it may seem, should serve to even up the balance sheet presented in such glowing terms by the pharmaceutical industry's weekly magazines.

It is when he turns to social and cultural iatrogenesis, in the central section of the book, that Illich is most likely to anger the physician reader whose training has not encouraged him to think in either social or cultural terms about the impact of illness and doctoring. The physician is likely to ask "Why blame me for society's problems?" "Don't we give the patients what they want?" "Isn't cultural change an inevitable consequence of the passage of time (progress)?" Illich attempts to show, and indeed succeeds in showing, that the institution of 20th century organized medicine has had an enormous impact on Western European society, and by extension, on the rest of the world. In his view the societal costs of this expansion in many cases outweigh the societal benefits, for, like other rapidly-expanded modern industries, medicine "sponsors sickness by reinforcing a morbid society that encourages people to become consumers of curative, preventive, industrial and environmental medicine." It is this over-medicalization of life that gives Illich's book its subtitle "The Expropriation of Health."

Three examples of over-medicalization, from Illich's list of a dozen or so, will serve to illustrate social iatrogenesis. First, the medicalization of the budget. Illich's discussion of the escalating financial cost of health care will be well known to many physicians. During the last 20 years the cost of medical care has risen about 350% (while the general price index has increased only 75%). It is not physicians salaries (up two-fold since the mid-1960s) that are responsible, but rather it is the cost of building and equipment (now over $90,000 per bed), administrative costs (up 700%), and laboratory costs (up 500%). In 1975 the United States spent almost 8.5% of its Gross National Product on health care (up from 4.5% in 1962), and the average citizen is now spending the equivalent of about six weeks income each year on the purchase of medical goods and services. And it is not only in the United States that medicine has become a major industry: France and Germany are at the same high level of spending, Great Britain spends about 10% of its Gross National Product on health, and so does Colombia, a country where notoriously few have access to medical care. If there is real doubt if the United States can afford to spend more than about 10% of its national wealth on health care, is there any doubt at all about the less well developed nations' ability to do so?

Apart from budgetary costs, Illich holds organized medicine responsible for the social changes that have resulted from the removal of decision-paking about health from the community to the physician. Medicine, like law and religion, has always served to define what is normal, proper or desirable in the citizen. The physician made moral decisions as to who was sick and who was well, but he made them *within the context of his society*. (The patient "knew" he was sick and therefore summoned a physician). Today's physician, believing that his profession rests on a scientific foundation that is exempt from moral evaluation, will often define (create) sickness outside the context of the patient and his society. As the events of recent years have shown, such diagnoses can identify heterozygotes carrying a "deleterious" gene or exclude an individual from political life.

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As a final example of social iatrogenesis one may cite what Illich calls the pharmaceutical invasion. Without the discouragement of the physician (Illich would say – with his encouragement) the pharmaceutical industry has invaded our society and fostered the notion of pharmacologic well-being. Whether an item is prescribed or over-the-counter, whether it is "free," sold, or stolen, indeed whether it is "drug" or "diet," there is no doubt that Western European society is over-medicalized, and little doubt that one of the major incentives has been the profit to be reaped by the pharmaceutical industry. Whether organized medicine will shoulder any of the responsibility for this pharmaceutical invasion remains to be seen.

Despite the difficulty that the reader is likely to experience in following the argument concerning social iatrogenesis, its understanding is important for a discussion of the notion that lies at the heart of Illich's complaint – that medicine is damaging the very fabric of western civilization, and, as a consequence, the rest of the world. For example, pharmaceutical invasion not only leads to the social changes that flow from the notion of pharmacologic well-being, but also interferes with our ability to cope with the realities of suffering and death. This is what Illich means by cultural iatrogenesis, and it is into this theological and anthropological field that the reader is likely to step most gingerly.

Illich eleborates on three aspects of cultural iatrogenesis; the invention and elimination of disease, the varied images of death, and the killing of pain. The first is a brief description of the history of modern medicine from its philosophical origins in the French Revolution. In particular it deals with the changing roles of the physician and the hospital in relation to society and its aspirations. The second leans heavily on the work of Phillipe Ariés whose "Western Attitudes Toward Death" serve as the classic work on the changing concepts of death that have occured since the Middle Ages. From joyous death, through the images of the Dance Macabre, of the deathbed scene, and of the physician holding back approaching death, we have come to our present image of hospitalized death. Like Ariés, Illich believes that our culture has paid a high price for the rise of organized medicine that has occured since the 19th century. The third section, on the killing of pain, lies at the very center of Illich's concern with cultural iatrogenesis. The many phenomena we describe by the single word "pain" (Illich tells us that thirteen distinct Hebrew words were translated into the single Greek word) are described as an inevitable part of reality with which the individual is normally able to cope. Illich traces the varied attitudes to suffering from ancient Greece to modern times to illustrate his thesis that while once pain could be suffered, alleviated and interpreted by the individual, now our cultural ideal seeks its elimination by priest, politician or physician. It is our neglect of the psychological and social factors that influence the appreciation of disease that John Platt has called the greatest failure of clinical science.

These then are Illich's perceptions of the injuries wrought by modern industrialized medicine. Injuries done to individual patients by ignorance or accident, injuries done to society by the increasing medicalization of life, and injuries done to the culture of western civilization so that we are less able to cope with the realities of suffering and death.

What of solutions? Illich would like to see medicine fitted into a modern culture in a way that would foster self-care and individual autonomy. It is his hope that concentration on public health, health education, and equal access to primary care will enhance the individual's ability to cope with disease without unleashing the destructive power of over-medicalization. As to how this is to be brought about, Illich devotes the final quarter of his book to the "The Politics of Health," and this is perhaps the most disappointing section. His remedies will be well-known to readers of "Small is Beautiful" and amount to a set of political reforms that are likely to affect primarily the injuries of clinical iatrogenesis. Thus Illich proposes that consumer lobbies and consumer control would "force doctors to improve their wares," that the nationalization of health care would control the financial biases of the clinic, that the combination of capitation payment and institutional licencing will "control doctors [in] the interest of patients," and that more resources devoted to public health ought to stretch the health dollar. (Illich also proposes that more public support should be given to competing sects to see what benefits they might offer). These remedies seem remarkably orthodox coming from one who holds that less medicine will lead to better health, and who believes that Oliver Wendell Holmes was speaking for our time as well as his own when he wrote (in 1883) "I firmly believe that if the whole *materia medica*, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind – and all the worse for the fishes." Indeed Illich himself recognizes that these measures are likely to reinforce the institutional nature of medicine and perhaps further increase counterproductivity. Perhaps the weakness of this final section is that it represents Illich's unfinished thought on changing the industrial society. As he says in the unedited manuscript of this book that was distributed at the final CIDOC conference (CIDOC Cuaderno No. 90), it will serve "as background material for further seminars organized by Valentina Borremans . . . [for] . . . the elaboration of a document on [medical] counterproductivity." Or perhaps Illich believes that a fundamental change in faith must precede any substantial change in society.

Despite its weaknesses, "Medical Nemesis" is an important book. Although not easy reading, Illich's closely reasoned argument is worth following, and the questions that he raises will be raised in one form or another by those who, as the cost of health-care keeps rising, will increasingly be calling the tune. The debate should begin because sometime soon we will have to make choices as to the kind of medicine that we want. Although Ivan Illich has made a major contribution to that debate, only time will decide whether he is, in the words of a well-known Canadian physician "The Pope of Anti-Medicine" or, as his pupils believe, "The Seer of Cuernavaca."

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University of Maryland School of Medicine
Baltimore, Maryland 21201

STUDENT COUNCIL MEETING – NOVEMBER 30, 1976

[Reproduced as submitted]

Members present:

Blase Harris . . . . . Pres. Student Council
David Otto. . . . . MS I Representative
Bill Dunlap. . . . . .MS II Representative
Jan S. Elliot . . . . . MS III Representative
Frank George . . . . . MS IV Representative
Bill Martin . . . . . .MS IV Past Pres.
Mike Pratt . . . . . .MS I Pres.
Amy Davis. . . . . Sr. PT
Jill Gruner . . . . . Secretary
Jim Davis. . . . . Sr. PT

Ads for Yearbook:

This year ads will be collected to lower the cost of producing the yearbook. Letters are being sent to potentials advertisers and they will be followed up. Further discussion regarding the yearbook will take place at the next council meeting.

AMSA:

AMSA requested $300 for its annual convention to Chicago in March. This request was approved. The meeting is worth attending for students take part in the Student Business Session and discusses many important issues for future student happenings in the educational area.

NEW OFFICES FOR SC

The new offices now ready in Howard Hall are for Student Activities (Student Council and Yearbook and Aesclepian). One office will be for the President of the Student Council and the other office will be shared between the Aesclepian and Yearbook.

FILMS:

The experimental film series will begin in January. Input will be requested from all UMAB schools by means of a questionairre.

PARTY–JR. CLASS:

The Junior Medical Class is sponsoring a Party–dance to be held at the Lord Baltimore Hotel on December 17 from 9 p.m. to 1 p.m. Tickets will be $2 single and $3 per couple. There will be a cash bar. Tickets will be sold by students and may be picked up at the Office of Student Affairs (Sally Miller). The class has the verbal support of the SC to back any financial difficulties should they arise. Non were oppeses to this.

The Physical Therapy Classes will be holding their open house on December 11 from 8–12 a.m.

The next meeting of the SC will be Wednesday, December 9, 1976

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STUDENT COUNCIL MEETING – JANUARY 18, 1977

[Reproduced as submitted]

Members present:

Blase Harris . . . . . .President SGA
Calvin Chatlos. . . . . Vice President SGA
Jim Davis. . . . . PT representative
Joel Lahn. . . . . .MT representative
Russ Wright . . . . . AMSA and MSII Representative
Jim Ruppel . . . . . Jim Rupel MS I Film Representative
Garry Ruben . . . . . .MS IV President
Bill Dunlap. . . . . .MS II Representative
Jill Gruner . . . . . .Secretary SGA

Garry Ruben reported that the Yearbook ads were coming along slowly. There were alot of promises but only about $400 has been collected. He also reported that the band for the banquet will cost $50 more than originally planned. The $50 difference will be taken from the flower money?

A representative from an organization called 3HO (Healthy, Happy, Holy Foundation) came to request the council support to organize Yoga classes to be held on the UMAB campus. He spoke to Dr. Cappleman who told him that unless sponsored by the Council, any course given on the campus as part of the evening program must be taught by a student or faculty member. Blase or Calvin will meet with Dr. Cappleman and back up sponsorship. If permission is granted, the classes will be organized.

The movies series to be held at UMAB will begin this Friday, January 21. "Women In Love" will be shown in the Freshman lecture hall. Posters are found in all buildings of UMAB to confirm the time? Other films to be shown are "Horse Feathers" and "Casablanca". Jim Ruppel came and requested the money for "Casablanca"/ Any losses will be backed by the Office of Student Affairs.

A letter stating the purpose of the Student Council and also one to inform Medical students who to complain to about their rotations will be published in the next issue of the Aesclepian.

PT representatives requested information as how to go about getting action regarding departmental problems.

The next Student Council meeting will be Tuesday, February 1 in Howard Hall. Topics to be discussed will include: Problems with the Aesclepian, Gary Ruben's letter for Alan Gaby regarding the note-taking service, discussion of future movies and further word about the Yoga and TM courses that may be given on campus.

A SHORT GUIDE TO DOCTORS

by John J. Secondi, M.D.

Dr. Secondi is a New York City health physician and a medical documentary writer-producer. He is also the author of a book on the venereal diseases entitled, "For People Who Make Love: A Guide to Sexual Health."

(REPRINTED WITH PERMISSION FROM THE AUTHOR)

Medicine, like every other field these days, is so overspecialized that even a card-carrying doctor like me has trouble telling who's who. The layman, I imagine, is almost helpless to distingish the forest from the tree surgeons. I have noticed, however, that my colleagues have a tendency to run to type. So, in an effort to clear up the confusion, I have compiled a little list so simple that the most naive patient can spot at a glance which doctor is which.

The General Practitioner: These gentlemen used to be the ones you saw most often, when you lived back in Nebraska and watched the cars go by from your front porch for entertainment. Now they are nearly extinct, like the buffalo and the stork, although there are a few left in a preserve in Iowa. Most of them looked like a cross between Charlie Ruggles and Colonel Sanders; they were warm, wonderful, and always had time for you, even if they slept only three hours a night. They knew you inside and out from the moment they delivered you until their ink dried on your death certificate, and they were always there to help you push your car out of the mud. If anybody knows where there's one of these left, please drop me a note. I could use a good doctor myself.

The Internist: This is a general practitioner with more diplomas on the walls and without house calls. (He also has money in the bank.) By the age of thirty at the latest he becomes obese, sallow, and emphysematous. Usually bald, he is always found sitting and smoking a pipe. (The pipe is a deliberate attempt to evoke the Delphic Oracle, which also simmered and steamed with ideas. The internist is nothing if not oracular.) As opposed to the surgeon, who carries no equipment at all except the keys to his Rolls-Royce, the internist can be seen with a stethoscope protruding from one of thousands of pockets in his clothing. Really big stethoscopes are worn to give the impression of expertise in heart disease.

In his desk the internist stocks lifetime supplies of sample drugs; when you are in his office he may pick one or two at random and give them to you with alarming liberality. But don't worry; he won't let you know what they are. The internist is really happy only when deciding how to cope with some chronic incurable disease, preferably in a case some colleague has botched. The longer the name of the disease, the happier he is; and if it's in Latin he's ecstatic. An internist is required by law to have his phone ring twice an hour at least while he is at home, and he can never vacation. No internist's children ever become doctors.

The General Surgeon: These are the prima donnas of the trade. Today's surgeon is descended from the barbers of the Middle Ages, but washes more often. He may be fat or slim, but he is always loud, noticed, and in a hurry. He dashes dramatically in and out of rooms (whether patient, operating, or bath) and never lets you finish a sentence. To probing questions he nods wisely, smiles enigmatically, and runs off. (Never say "Now cut that out" to a surgeon.) He generally visits patients cloaked in green from head to toe to give the impression of being fresh from an operation, when probably (unless he is over fifty) he has been idling in his office all day waiting for someone – anyone – to call. After he does a surgical scrub, he raises his arms, which drip from the elbows. This posture serves both as a gesture to God for the usual assistance, and as a method to keep the bacteria flowing away from the surgeon – towards the patient.

Surgeons are taught early to rip off bandages as quickly as possible, pulling as much hair as they can get out with one clean tear. They have a distinctive jargon: For instance, they speak of healing by "primary intention" (which is to make lots of money), or by "secondary intention" (which means the wound got infected). If anything goes wrong during operations, surgeons are unanimous in blaming it on the anesthesiologists. Surgeons are the only doctors left who haven't cut out smoking, because they are confident they can cut out cancer. If this description still doesn't make a surgeon flash in your mind, recall James Coburn in *Candy*. Absolutely accurate.

The Gastroenterologist: Gastrointestinal doctors, or "GI men," have had oral fixations since childhood. This means they are always talking a mile a minute, and at mealtimes they ingest like Electroluxes. They're usually roly-poly, literary, and very pleasant to gossip with, as a consequence. The unsavoriness of their work is grossly exaggerated; nevertheless, they do receive a lot of cologne for Christmas. As kids they were the ones whose parents always had to bang on the bathroom door to get them out. If Alexander Woollcott had become a doctor, he would surely have been a gastroenterologist.

The Obstetrician-Gynecologist: The real wise guy in medicine. Sitting on their high stools day after day with their patients in that absurd saddle, these comedians see the funny side of life. They have to have a good sense of humor because otherwise they would be so nauseated by some of the things that come along they would swear off sex forever. Always ready with a wisecrack or a foul story (depending on whether you are a patient or another doctor), they are universally popular, except with pediatricians. Child doctors blame every childhood disease from thumb-sucking to Mongoloid idiocy on the anesthesia the obstetrician used. It is not true that all obstetrics is done at three o'clock in the morning. I personally recall one case in 1968 that was done at six in the morning, and others may have had similar experiences. Many Ob–Gyn men are now getting crash courses in abortion, which was never part of the medical curriculum before. These are the ones with the sterile coathangers.

The Urologist: Urologists do for men what gynecologists do for women -- more or less. They are drawn to their specialty irresistibly by its identification with the masses of tight curly hair they all have. Many urologists are now growing beards and mutton-chops so you can spot then more easily than ever. Walking around weighted down by their waterproof rubber aprons and all those whiskers they resemble Noah before the flood. At home they putter around a lot with the kitchen sink to keep in

practice. Like other plumbers they work good hours and make a good living.

The Anesthesiologist: Anesthesiology is the Tower of Babel of Medicine. There are a total of four English-speaking anesthesiologists in America: two on the East Coast, one in Chicago, and the other in L.A. All the others communicate with frenzied nasal accents or sign language. They are short, shy, retiring types who hide behind the sterile barrier during surgery and squeeze contentedly on their little black respiration bags. You will recall the bags from the 1930's movies because when Lionel Barrymore came too late they quit moving and you knew the patient had died.

The night before your next surgery an anesthesiologist may mince into your room, unheralded and uninvited. He will never show up after five o'clock, however. Without bothering to identify himself or even to ask for an interpreter, he will quiz you on all the allergies you may have. This is done to choose exactly the right toxin to put you to sleep with the next day; for God's sake, don't forget anything that might be relevant. Then he will bow graciously and back out of the room, and you'll never see him again. (Whether you'll see anyone alse again is another question.) If you wake up from surgery, you may have a sore throat, even after an abdominal operation. This complication occurs because the anesthesiologist routinely puts the rubber airway down your esophagus six times before he finds the right hole. Anesthesiologists fear surgeons the way helpless children fear angry fathers. They are very sensitive and feel left-out enough, so be kind to them.

The Pediatrician: All pedi-pods, as they are called on the wards, act and look like Peter Pan. They wear saddle-shoes and bow ties, have cherubic faces, and wear crew cuts or pageboys, depending on whether they are over thirty. They are shorter than most other doctors, although they can be told from anesthesiologists because pediatricians are slightly taller, speak English, and have horizontally placed eyes. They never use words longer than two syllables or sentences of more than four words. Generally they sound as if they are doing Jonathan Winters imitations. Many have a lilting gate, and a few skip during clinic. About the age of forty they lose patience with all those frantic mothers and either commit suicide, go into research, or start child labor camps.

The Ophthalmologist: (This is the real "eye doctor" and is not to be confused with optometrists or opticians, who aren't M.D.'s at all.) Ophthalmologists, despite being constantly misspelled and mispronounced, are the happiest men in medicine. They work laughably few hours, make extravagant fees, and are adored by their patients, who understandably value their sight above all else. Thus ophthalmologists are always well-tanned and talk knowingly of Tahiti and the Riviera. They also play a great deal of golf. Curiously, they are uniformly tall, slim, and vaguely ethereal. A good example would be Pope Pius XII with a suntan. They use jargon so technical and so infinitesimally detailed they cannot even make small-talk over drinks with other doctors.

The Otolaryngologist: When you've been to an ear, nose, and throat man you'll never forget it. These are the true sadists in medicine. Children despise them; they're the only doctors who make you feel worse than when you came in. What with the nausea produced by cocaine sprayed in the nose, and all those tiny little probes poking God-knows-where back in your sinuses, and all that blood swallowed after a tonsillectomy, going to an ENT man is like being used for an experiment by Edgar Allen Poe. The only common physical characteristic by which these gentlemen can be spotted is that they all still have their own tonsils.

The Plastic Surgeon: Immediately identifiable. They all wear handtailored clothing of vast expense and have sculptured features worthy of a Phidias or a Michelangelo. Gorgeous from every angle, they look years younger than they are, and boy do they know it. They were the big face men of college fraternities, the ones who were put strategically at the front door during rush week and in the first row in the yearbook picture. They are very rich because there are a lot of jealous women who will pay *anything* to look as good as the plastic surgeon. They have a tendency to get very snotty when you ask them what kind of plastic they're going to put in, and lecture you on the origin of the word "plastikos" in the traditions of Greek sculpture. Nevertheless, they have terrific guilt complexes about spending all their time on frivolous surgery, so they occasionally take on a burn victim to soothe their consciences. The patron saint of plastic surgery is Narcissus.

The Psychiatrist: Spotting a psychiatrist on the street is easy enough, but as he wanders on the wards of a state hospital he may need a nametag. Psychiatrists either avert their eyes from you or stare right through you, whichever makes you more uncomfortable. If they sense you're going to ask a question, they slip one in first. They never use complete sentences, only clauses and long words. I know a psychiatrist who begins every sentence with the word "that" and ends it with an exact quotation of Plato. The main object a shrink has in mind when he sees a patient is not to rescue the patient's sanity but to prove his. After all, how many surgeons do you know who have five years of operations on themselves before they can practice?

Today's psychiatric resident may have elbow-length hair, wear rings in one ear, and go to work in purple satin capes. This kind of psychiatrist has not hit Park Avenue yet, but it's only a matter of time. Incidentally, the reason there are so many Jewish psychiatrists is that they are basically yentas with M.D.'s.

The Radiologist: Radiologists hide in dark places and never come out, like other rodents. They make creepy-crawly gestures and rub their noses frequently. Their world is one of shadows and they detest the light of day. They hole up in leadened tunnels and, though they tell you that X-rays are harmless, they generally have their offspring as early as possible. (By the time they reach fifty irradiation has given their skins the texture of refried beans). Like Whistler, they view everyone as a study in black, white and gray. The thought of being responsible for a live human being is abhorent to them. Yet they give off smiles of delicious perverse pleasure as they make patients swallow thick white slime and poke around in their bowels so their guts will show on film. Peter Lorre would have played a perfect radiologist.

I would like to complete the list, but I just got a frantic phone call from A.M.A. headquarters, and I have to run. Something about an emergency protest march against socialized medicine.

IF

" If I had my life to live over, I'd try to make more mistakes next time. I would relax. I would limber up. I would be sillier than I have been this trip. I know of very few things I would take seriously. I would be crazier. I would be less hygenic. I would take more chances. I would take more trips. I would climb more mountains, swim more rivers, and watch more sunsets. I would burn more gasoline. I would eat more ice cream and fewer beans. I would have more actual troubles and fewer imaginary ones.

" You see, I am one of those people who live prophylactically and sensibly and sanely, hour after hour, day after day. Oh, I have had my moments, and, if I had it to do over again I'd have more of them. In fact, I'd try to have nothing else. Just moments, one after another, instead of living so many years ahead of each day.

" I have been one of those people who never go anywhere without a thermometer, a hot water bottle, a gargle, a raincoat, and a parachute. If I had to do it over again, I would go places and do things and travel lighter than I have. If I had my life to live over, I would start barefooted earlier in the spring, and stay that way later in the fall. I would play hooky more. I wouldn't make such good grades except by accident. I would ride more merry-go-rounds. I'd pick more daisies. "

CHILDHOOD RADIATION/THYROID CANCER LINK

Baltimore, MD, January 17 – Recent studies confirm a link between thyroid cancer and childhood radiation of the head and neck.

The Medical and Chirurgical Faculty of the State of Maryland (the Maryland State Medical Society) formed an Ad Hoc Committee on Thyroid Cancer with representation from the Maryland Hospital Association to study the situation and to recommend a course of action to the physicians of Maryland.

Thyroid cancer is a rare form of tumor which can be successfully treated. Death from thyroid cancer is a rare occurence. An independent mass screening program has not been recommended for Maryland.

James P. G. Flynn, M.D., Chairman of the Committee on Thyroid Cancer, states, "Anyone suspecting they may have this problem should contact their physician or regular source of medical care. Physicians in Maryland are being alerted to the most recent information available on the treatment and management of thyroid cancer."

State and county medical societies maintain a list of board certified internists, endocrinologists and surgeons available both to physicians and to the public. Persons without a source of primary care may call the Medical and Chirurgical Faculty office at 539-0872, Baltimore City or one of the County Medical Societies for the name of a physician to contact in their area.

THIS IS THE WAY IT WAS . . . and is

The name of Dr. D. Carleton Gajdusek may not be a community watchword, but the name "kuru" should mean something to most of us here at University Hospital. Dr. Gajdusek lectures to each sophmore microbiology class about this slow virus degenerative neurological disease in New Guinea; what some of us may not remember is that Dr. Gajdusek helped initiate the studies of kuru, which in turn led to research in prevention and control of several other degenerative disorders.

Dr. Gajdusek graduated from Harvard Medical School in 1946 (he's a mere youngster!). He eventually became a staff member of the Walter Reed Army Institute of Research and worked at the National Institutes of Health. From 1953 until 1955 he was Instructor in Experimental Medicine at University of Maryland School of Medicine. During this period he demonstrated the preventive efficacy of immune serum for rabies.

In 1956 Dr. Gajdusek began field studies which led to publication in 1957 of an article in the *New England Journal of Medicine*, "Degenerative disease of the central nervous system in New Guinea. The endemic occurence of 'kuru' in the native population." Sound dry and uninteresting? It may to some, but this article was the beginning of extensive studies which ended in the identification of slow viruses as causes of brain disorders. Dr. Gajdusek was awarded the Nobel Prize in 1976 for this work; next year's sophmore class will be taught by a Nobel Laureate in Medicine.

(Thanks to Dr. Theodore Woodward for materials from which these articles are written, and for his new publication, "Two Hundred Years of Medicine in Baltimore.")

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