3-1971

Ariel - Volume 3 Number 6

Eugenia Miller
Thomas Jefferson University

Michael Leo
Thomas Jefferson University

Richard Bonanno
Thomas Jefferson University

Ron Souder
Thomas Jefferson University

Peter Meissner
Thomas Jefferson University

Authors

Eugenia Miller; Michael Leo; Richard Bonanno; Ron Souder; Peter Meissner; Joseph S. Gonnella; Terry Burt; Robert L. Breckenridge, Jr.; and Rev. Vincent M. Walsh

Ariel

MARCH

VOL. 3 NO. 6 | Thomas Jefferson University And Medical College | Copyright 1971 ARIEL | MARCH, 1971

Gordon Discusses Relation of Race to Intelligence

By Eugenia Miller

Dr. Edmond Gordon of Teacher's College, Columbia University, discussed the interrelationship of "Ethnicity, Intelligence, and Education," with TJU's Sigma Xi Society and interested guests on February 3 at 4:00 in Solis Cohen Auditorium.

Gordon elucidated the flaws in the much debated studies by Dr. Arthur Jensen, a University of California psychologist. Jensen, in an extensive paper in the **Harvard Educational Review,** used statistical methods to prove that heredity is far more important than environment in determining differences in tested intelligence. He maintains on the basis of his studies, that heredity is the factor most responsible for the 15 point difference between average white and negro I.Q. scores. Gordon tore apart Jensen's theory on three major grounds.

First, such studies do not adequately consider the interaction of heredity and environment. According to Gordon, Jensen's concept of the interaction is too limited. Gordon proposed a very broad interpretation of the interaction. He maintained that phenotype itself is a manifestation of the interaction of genotype and environment. Gordon pointed out that medicine has intervened between genotype and phenotype in a wide variety of instances, such as in the treatment of children suffering from pheynlketonuria.

Second, current methods of scientific analysis cannot establish a conclusion such as Jensen's, because the factors determining intelligence are as yet inadequately defined, and there can be no adequate control

(Continued on Page 5)

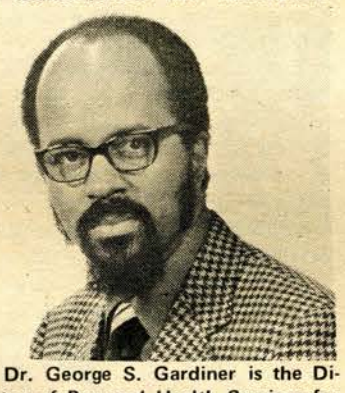
Can the Neighborhood Health Center Solve the U.S. Health Care Crisis?

It is important that the residents of the target area and the staff of the health center understand each other. One of the many activities aimed toward this goal was this recent seminar devoted to a discussion of the life and work of Dr. Martin Luther King.

By Michael Leo

Today our country is faced with a forbidding and in many ways a shameful health care crisis. The existing, or more accurately, non-existing, system is suffering from gross inefficiency, patient inaccessibility, and ever-increasing cost. The problems of delivery and minimum cost, high quality health care to all citizens, rich or poor, must be recognized and attacked with whatever innovative techniques we can devise. The accomplishments of such goals demands a complete restructuring of the current system and a redefinition of the role of the physician. A probable result is a system of multidisciplinary team practice in which the physician of the near-future must be willing to assume a less dominant hierarchical position. In so doing he recognizes his role and limitations as well as the roles and limitations of his medical, paramedical, and non-medical colleagues on the team. Such a system must be as concerned with health maintenance and disease prevention as it is with disease treatment. It must be both responsible and responsive to the people it serves.

How do we realistically go about structuring such a system? The Southeast Philadelphia Neighborhood Health Center (SEPNHC) may serve as a model to demonstrate the innovative approaches being pioneered at present. It deserves careful scrutiny by everyone associated with the health and allied health professions. (NOTE: Some debate and discussion of the above issues was given at a January student medical forum by Dr. George Gardiner (SEPNHC) and Mr. James Voiro (SEPCC), and Drs. Willard Krehl and Bernard Zamostein, and reported in an article by David Jacoby in last month's **ARIEL**)



Dr. George S. Gardiner is the Director of Personal Health Services for the Southeast Philadelphia neighborhood Health Center. (Photo-Robert S. Halvev)

The Neighborhood Health Center is devoted to delivery of **comprehensive** quality health care to each of the 30,000 residents in its geographic sphere. It is a full partnership between the Pennsylvania Hospital and the S.E. Philadelphia residents as represented by the Southeast Philadelphia Community Corporation (SEPCC). By virtue of such a relationship the Center is

(Continued on Page 4)

Is Multiphasic Health Screening A Key to Preventive Medicine ?

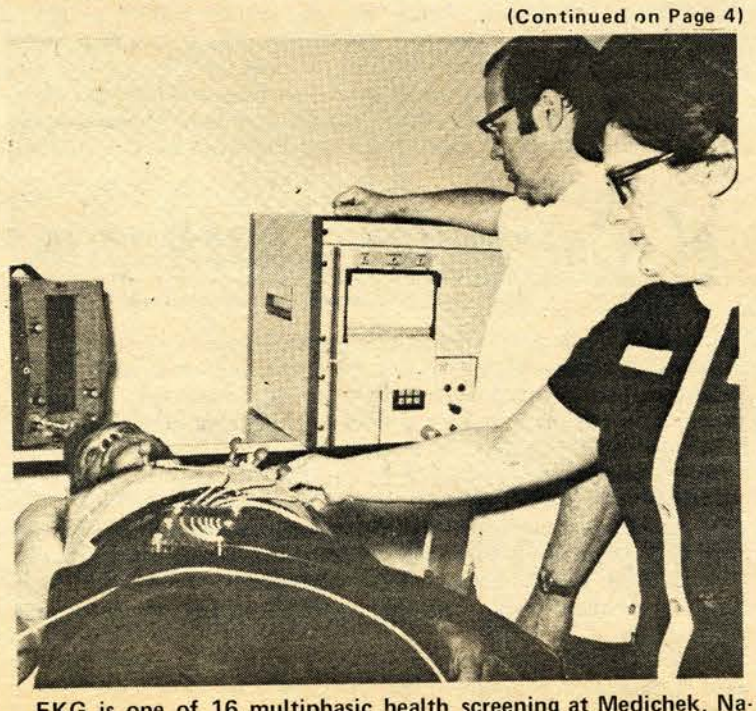
By Richard Bonanno

"Despite universal agreement as to its paramount importance, today's busy practitioners devote woefully few of their working hours to preventive medicine." This, according to Dr. Harry Gartzman, D.O., is why Medichek, Inc. in Cherry Hill, N.J. will grow in importance for both physicians and patients as a vital tool for practicing preventive medicine.

Medichek is just one of the numerous multiphasic health screening centers which has sprung up throughout the country in recent years to provide doctors with a large volume of information about their patients without expending a great deal of their time. Dr. Robert Breckenridge, associate professor of pathology at Jefferson, is president of Medichek, but although it is run as a private enterprise by physicians, doctors are not really required for its day to day operation. The 10 paramedical personnel now employed can handle 4 participants per hour–each participant's screening requiring less than 2 hours. The screening includes a computerized history, visual acuity, anthropometry, tonometry, pulmonary function studies, vital signs, chest X-ray, EKG, vascular evaluation, breast examination, audiometry, urinalysis, cervical cytology, hematologic and biochemical blood studies, and thyroid function tests. The total cost is $75 which is a fraction of what these tests would cost individually.

Medichek is used primarily to assist the private practitioner in the assessment of his patient's health so that preventive or early treatment for any significant abnormality can be instituted. There is an obvious advantage to keeping people healthy rather than treating them when they are sick, but there are those who don't really believe that a multiphasic screening system really prevents much illness in people who see a doctor regularly anyway. They further argue that to be truly effective, the screening would have to be extended to all people, and this would require expenditures of

(Continued on Page 4)



EKG is one of 16 multiphasic health screening at Medichek, Nation's first such center to be founded and operated by a group of physicians.

SAMA Offers Hospital Projects This Summer

By Ron Souder

This summer the Student American Medical Association (SAMA) is sponsoring a new program designed to expose students to a community oriented health-care system. The program is called MECO and stands for Medical Education and Community Orientation. The MECO project had its beginnings in the state of Illinois but has now spread to many other states including Pennsylvania. The purpose of the program is to match students with community-oriented, non-afiliated hospitals in order for them to gain insight into the problems of health-care delivery in a rural or semi-rural setting. Each student will be assigned to a primary care physician who will act as his preceptor and aid him in planning his program for the summer. The student will spend time not only in the hospital but also in the office of the primary care physician in order to get a better appreciation of the total health-care system. In addition, the student will hopefully study the community as a whole to try to determine the ways in which it meets the health-care needs of its people.

Students from Jefferson accepted into the MECO project will be matched with hospitals in Pennsylvania east of the Alleghenies. Each student is guaranteed a stipend of $600, plus room and board, for the summer program which runs for eight weeks from June 28 to August 20. Those wishing to apply should contact Ron Souder (WA 2-2491), Student Mailbox #638, for further information. The official deadline for applications is March 15; however, special circumstance permit filing applications until April 1.

Drug Ed. Work to Begin Here

By Peter Meissner

In the last issue of the **Ariel,** I proposed that anyone interested in working in the area of drug abuse education contact me to set up a time for a meeting. Very few replies were sent in, possibly due to the unstructured nature of this program. In keeping the nature of the meeting undefined, I am not being devious – I hope the participants will develop their own definitions of how they can work in the drug education, i.e., what each individual has to contribute is what I want. There will be a meeting on March 15, at 12:00 noon in Jefferson Hall (Room M-23). If you are interested in working along these guidelines, please come.

The War Goes On

It seems almost absurd to again editorialize against the war in Southeast Asia, even following our latest folly–the invasion of Laos. Whatever the rationale given for this escapade, the problem remains of believing what we are told about Southeast Asia when the words of our government have been so incongruous with our behavior there over the past 17 years. Are we really expected to accept the self-righteous indignation of our leaders over Communist assassinations or mistreatment of POW's while we bomb thousands of civilians into oblivion and maintain our POW's in "tiger cages."

It is popular to attribute the lack of public outcry after the Laotian "incursion" to the decreasing American casualties and the withholding of American ground forces. This may be true for some, but it is incredibly naive for the administration or anyone else to believe that the true anti-war spirit in this country fluctuates with American body counts. The killing continues on a massive scale with little hope of remission, even if it is true that Americans are dying less frequently. The government persists in its attempt to assure militarily a pro-American government's existence in Saigon, irrespective of the political realities in Southeast Asia. Little has really changed.

There is less outcry against the war recently, but we do not believe it is due to confidence in the President's intentions or handling of the war. Rather it is to many of us the frustrated realization that the men running our government harbor attitudes about Southeast Asia which are so mired in political cliches and American egotism, that our views are beyond their comprehension.

Mr. Nixon's National Health Strategy

John Veneman, Under Secretary for Health in HEW recently stated that "health is going to be the major political issue of the next couple of years." Over the past year the proposals and debates in Congress on National Health Insurance (NHI) have consumed increasing amounts of time, and President Nixon's address on February 18, outlining his health proposals has made Mr. Veneman's statement a real possibility. **Ariel** certainly cannot explore all the issues involved in NHI or all the proposals of Mr. Nixon, but we will attempt to open discussion in some areas in future articles. We would encourage everyone to use our pages to voice their view on national health policy. The times are ripe for new initiatives in health, and exploration of all avenues of change are a necessity.

A few comments are in order about Mr. Nixon's message. In general the goals he has put forth are impressive. Initially Mr. Nixon should be commended for recommending a health strategy–direction for our system has been almost totally lacking. His aims of 1) assuring equal access 2) balancing supply and demand 3) organizing for efficiency 4) emphasizing health maintenance 5) preserving cost consciousness and 6) building on strengths, are all laudable. The only major area he does not mention which we believe to be of paramount importance is citizen participation and power in the running of health care facilities. No health maintenance program can succeed if the public is not deeply involved with solving the social, political, and environmental problems which affect their health.

The general strategy is fine, but the doubts regrettably remain with regard to action. The stated goals have been acknowledged as important by many people for years, so we must see more than lip service from Mr. Nizon. In addition, it is significant that the influence in the health field has been in the hands of organized medicine in the form of the A.MA. and more recently the medical-industrial complex of medical schools and health related industries. It is on record where Mr. Nixon stands with regard to the AMA; his 1968 campaign received an estimated $2-1/ 2 million directly from the AMA political action committee. The AMA successfully blocked the appointment of Dr. John Knowles, a far from radical appointment to the country's top health post. Although organized medicine has successfully weathered recent changes (and often turned them to their advantage), if Mr. Nixon's proposals are to be fully implemented the President will have to sacrifice some past allegiences. As we have emphasized many times in the past, the best interests of the public, not the traditions of the medical profession, must be of first priority.

We would hope that Mr. Veneman is correct about the rise in priority for health as a political issue. We would hope that everyone will welcome the challenge of implementing a national health strategy in the best interests of all of us. Why not join in the debate and the action?

Curriculum Committee Approves Family Practice Preceptorships

Ariel is happy to report that family practice preceptorships will be available this summer–as a six or twelve week elective for sophomores–and as a Wednesday afternoon elective, **starting this Spring,** for freshmen.

In addition, the Curriculum Committee has lent support to the Department of Community Health and Preventive Medicine regarding the establishment of preceptorships for credit with practitioners in rural Pennsylvania. For further information, contact Dr. Willard Krehl, chairman of the department.

We wish to commend all those responsible for the establishment of these preceptorships–they will make a welcome addition to the Jefferson curriculum.

Headway on Curriculum

In one of our December editorials a deadline for developing a new curriculum was called for. Although no deadline has been set, there is a recent proposal before the Faculty Curriculum Committee which appears to make much headway in medical curriculum overhaul at Jefferson.

The proposal itself is general and still needs much attention. But it has some interesting features. All basic science and clinical instruction, it is proposed, is to be completed by the end of three years, the third year remaining clinical clerkships. The fourth year will be devoted entirely to clinical electives, with the intent to prepare a student to enter his specialty residency training directly from medical school. The proposal also includes some systems teaching (taking one organ system at a time and teaching all medical aspects of it) the first two years, the proportion of which remains to be worked out.

Hopefully input from students, especially the students who sit on the Faculty Curriculum Committee, and faculty will be sought to develop the specifics of the new curriculum. The Committee should study curricula of other medical schools so that Jefferson's Curriculum can adopt their best aspects. Students and faculty eagerly await the adoption of a new curriculum that may well be based on this commendable proposal now before the Faculty Curriculum Committee.

Guest Comment.. Process of Curricular Construction

By Joseph S. Gonnella, Associate Dean

I have been asked by the Editors of **Ariel** to summarize the recent accomplishments of the Curriculum Committee. The official report of the Committee for the 1969-70 academic year is to be found in the Annual Report of the College. The following statement is my personal summary of what has been accomplished.

A curriculum is not merely a collection of courses but is a series of educational experiences that should facilitate learning and should lead to the fulfillment of clearly defined educational objectives. These should be obtainable and related to the needs of the students, to the capacity of the faculty, to the available physical facilities and to the financial resources of the university and its medical school.

A new Curriculum Committee consisting of students and faculty was constituted at the beginning of the 1969-70 academic year. The Committee had to accept the past, evaluate the present and plan for the future. The task was not an easy one.

As with any new committee much discussion took place regarding the charge. The issues discussed were:

1) What should the objective of the curriculum be? Should they be stated by the Committee or should the entire College be involved?

The Committee chose to involve the entire Faculty even though it realized that this would necessarily slow the Committee's progress. Since ultimately the Faculty will have to implement the program the Committee believed that the Faculty should be involved from the start.

2) Another issue was what should the structure be? i.e. The Departmental vs. the System Approach. Again the Committee agreed that while structure is important, one needs to know first what one plans to build. The same applies to the instructional systems. All have been found effective when used appropriately and both are being used successfully at Jefferson.

3) The process of learning was another topic which evoked a great deal of discussion. All agreed that the student ought to learn how to solve problems, assume responsibility for his learning and receive feedback. However, this cannot be done in a vacuum and, therefore, clearly defined objectives are a necessity.

4) The Committee also agreed that change must be evaluated. And evaluation cannot be done unless the objectives are well defined.

Unfortunately the writing of objectives is difficult and laborious. It is much more popular and dramatic to talk about the structure and process of learning. Therefore, there is the constant temptation to bypass the writing of objectives and go to the next phase - the design of learning experiences. In my opinion the Committee has resisted this temptation and has persisted in its attempt to have the Departments and System Committees specify the concepts, skills and attitudes which the student should acquire prior to the next phase of his education.

With the above in mind progress has been made. The most important outcomes have been the involvement and interaction between the Faculty and the Student Body. While a consensus has not been reached on all issues, discussions between the various segments of the College have opened lines of communication - a necessary ingredient for success.

In addition, as deficiencies have been found measures have been taken to correct them. For instance, new courses have been introduced in the curriculum for the 1970-71 academic year. The Spring Quarter of the Sophomore Year will be devoted completely to system teaching - a major innovation at Jefferson.

I would like to add that the Committee recognizes that it cannot succeed unless it is willing to make mistakes. Therefore, the Committee has agreed that changes introduced in the curriculum must be evaluated. Unfortunately some mistakes are bound to be made but hopefully, the Committee will correct them when they are recognized. Finally, the Committee has been pleased with the contribution made by the students and hopes that constructive criticism will continue.

I would like to conclude my adding a personal note. Since my coming to Jefferson, I have enjoyed my association with the students, and I have been very proud of their accomplishments not only on internal but also on external evaluations such as performance on National Boards and most importantly performance during the post-graduate years. These accomplishments were achieved under a system which we have been trying to change for the better. While no one would deny that there is room for many improvements, failing to recognize the strengths of the present system and stressing only its weaknesses will lead to an inferiority complex which would be self-defeating. I believe that we can be proud of Jefferson, and in our work for improvement we should recognize that we deal from strength rather than from weakness.

Joseph S. Gonnella, M.D.
Associate Dean

Task Force On Youth Reports

(A summary of the conclusions and findings of a study of YOUTH AND THE ESTABLISHMENT conducted for john d. rockefeller 3rd and THE TASK FORCE ON YOUTH by Daniel Yankelovich, Inc.)

About the Study and Its Sponsor

The Task Force on Youth was established in the Spring of 1970 by John D. Rockefeller, 3rd to investigate the posssibilities of building collaborative efforts by youth and Establishment leaders to effect constructive social change. Its mission is threefold:

1. To determine through a formal research program whether a sound basis exists for building a working relationship between youth and the country's older leadership groups, particularly the business leadership.

2. If so, to develop guidelines for bringing it into being.

3. To formulate one or more specific projects to put the collaboration into effect.

The study was undertaken as the first of the three steps listed above.

Method

The two main research methods used in the study were survey research and in-depth psychological studies. The research made full use of both structured surveys and free-form depth interviews in which students, business executives and Establishment leaders from other fields were able to discuss freely and fully what was on their minds. These interviews often required two to three hours to complete. The in-depth interviews with students were conducted by specially trained young interviewers, assuring good rapport. Depth interviews with corporate leaders were conducted by executives and senior staff members of the Daniel Yankelovich, Inc. organization.

Sample

The research was conducted in two phases, in the course of which a total of 872 students and 403 business executives and other Establishment leaders were interviewed. The students were selected from a representative cross-section of 35 universities and colleges in all parts of the country, including both public and private, large and small institutions. The business sample, while representative of all of the major corporations which normally would have provided both the leadership and involvement required by the type of collaborative effort being studied. Interviews were conducted with chief executive officers and decision-makers.

Summary of Conclusions

1. There is a broad agreement among students and Establishment leaders on the pressing areas of domestic need that warrant attention.

2. Beneath their anger, Establishment leaders are keenly interested in working with the students, sympathetic to their goals, and even their feelings.

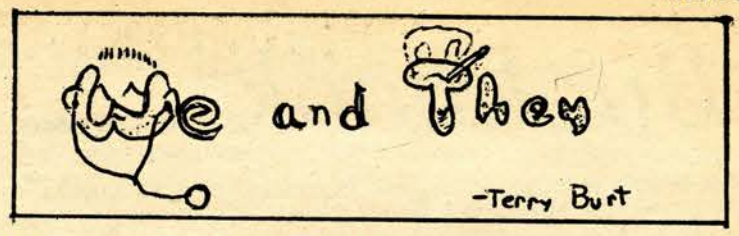
3. Beneath their mistrust of the Establishment, the majority of students wants to work with the Establishment leaders.

4. The emphasis of the media to the contrary, the overwhelming majority of the student body is moderate, antiviolent, and desirous of working within the system.

5. Millions of students, especially the Forerunner* group, are willing and even eager to devote time and effort at minimal compensation and at the cost of postponing their individual career paths to working toward the solution of pressing social problems.

* The Forerunners are, in general, students who have adopted "new values." They take for granted their education, their ability to make a living, to be successful and their opportunity, if desired, to enjoy a secure niche in our society. They emphasize other goals in life, such as the importance of the individual, the reappraisal of our society, and the desirability of social change. They represent 44 percent of students. In contrast, the larger Career Minded segment of students (56 percent) holds as its goals earning money, having a more interesting career and

(Continued on Page 6)



We and the Dying

"Because I do not hope to turn again
Because I do not hope
Because I do not hope to turn
Desiring this man's gift and that man's scope
I no longer strive to strive towards such things
(Why should the aged eagle stretch its wings?)
Why should I mourn
The vanished power of the usual reign?
–from "Ash Wednesday" by T.S. Eliot

My Ash Wednesday mood came early this year. The book which I talk about in the Booknook was not the cause of this morbidness, but only a consequence. The cause was simply the fact that more people seem to die in January than in June. (I wonder if this is statistically true?) Anyway, this January and February several patients had died, and I was beginning to wish I made my living in a less traumatic profession than nursing.

Now that I have already revealed my egocentric concern with my own psychological trauma while other people are dying, I might as well open myself to more criticism by confessing to more of my nurse's attitudes and complaints about doctors. I remain open to argument and comment, however. Since one day I too hope to assume the M.D., I am willing to be converted to M.D.-attitudes when they are defensible.

My first heretical idea is that nurses have a harder job than doctors, when it comes to taking care of the terminal patient. The nurse has to stay. The nurse has to be there. The nurse cannot stop going into that room. The nurse has to wrap for the morgue the body to whom she had been talking an hour beforehand. The nurse has to decide about a Code Blue call. After a certain point, the doctor's only order is "Call me when he is gone." After a certain point, the doctor's only concern is "I hope we can get a 'post'."

My overwhelming question was and is what can we do when we can no longer hope to cure the patient? Is our job over then? Is there no reason to visit that patient? Does our responsibility stop with physical care?

Dr. Ross's book gaveme some help with these questions, but I still think that many doctors resign responsibility too soon and underestimate the importance of the psychological support they could give with a little time. Or can we really excuse ourselves by saying we don't have time to waste on the dying when the living need us? Do doctors really think that way? I hope not. But perhaps for the male mind this attitude is more tenable than the admission that I avoid that room because I feel bad in there. I never can be sure whether my conflicts are merely professional, that is, nurse vs. doctor, or more basic, female vs. male.

I think there should be time in medical school for exploration of our own attitudes towards serious matters like this one. Isn't this at least as important in our preparation as studying "Biostatistics"? Our whole medical education directs our attention outward to the study of the disease process, the therapy, the basic sciences. Shouldn't there also be attention directed inward to preparation of me for medical practice? Shouldn't we sit down and think about and talk about how we shall feel and what we shall do when we have to cope with death?

When I first read about Dr. Ross' seminars on the dying, I felt that every medical student should have the opportunity to take part in such a learning experience. Isn't such a seminar possible at Jefferson? Does anyone else agree it would be useful?

Celebration

An encounter idea for students and others

Celebration was first organized by several graduate students last April at Temple University. Its purpose is to promote encounters by serving as an intermediate social structure through which people with things in common can get together to meet and talk.

Cool any uptights. **Celebration** is not a sex or lonely hearts club, nor is it a computerized mating center or a Mickey Mouse dating game. It has been created as one response to John Lennon's statement, in a noteworthy interview on the David Frost show, that society conditions us to hide from one another, and that we must learn to break down the

(Continued on Page 8)

Contrapuntal Wailes

Whanne that Azerinsky with epigrammes shorte
The mysterie of nerves hath perced to the roote
Thanne beginneth freshemen to wende their ways
And make pilgrimage at ende of days
To fourthe floor altars of learning
True wisdome and test answers yearning
to possess.
Thanne proceedeth Doctor Kalf slowlie
To expounde to studentes lowlie
The secrete of synthesis of purines
And steppe by steppe struktures of pyrimidines.
Inke is flowing, pages turning,
Answers to these questiones burning,
Are alle too soone erased.

--Terry Burt

Booknook

by Terry Burt

On Death and Dying by Elisabeth Kubler-Ross, M.D. (The Macmillan Company, 1969. Paperback available, 277pp.)

"What can I do for a dying patient? What can I say?" When I asked a friend these questions, he gave me this book. If you have ever experienced similar feelings of anxious futility in the presence of the terminal patient, perhaps you too will find this book informative and interesting. My opinion is that it should be required reading for anyone in a hospital-related profession.

Dr. Ross wrote this book after two and a half years of working with dying patients at the University of Chicago Billings Hospital. She describes how a small research project with four students developed into an ongoing interdisciplinary seminar in the hospital, which came to include any interested staff members, from therapists and technicians and students to the nursing and medical staff. The book is actually a report of the results of this seminar.

The most enlightening part of the book were the transcripts of interviews with terminal patients. "Terminal" included patients whose death was imminent, and also patients with cancer who still had many months or even years to live. In the course of the interviews, Doctor Ross would explore and reveal the patient's attitudes towards his disease and also his feelings about the care he was receiving and how he felt care could be improved. The whole emphasis of the seminar was on the fact that the patient had much to teach the hospital staff; that we had much to learn from **them**; that **they**, the patients, could help us to be more helpful and understand better what the seriously ill patient most wanted and needed from us.

Without reading the book, your first reaction to such a project might be, as mine was, "How ghoulish! How insensitive to do research on" these poor people at such a time and to pry into their most private feelings and experiences, and "to use them" for teaching! But one of the surprising revelations of the book was the eagerness of most of the patients approached to be useful in this way and at this time, and their eagerness to share their feelings with students and staff in order to help. Also the book reveals the tact and sensitivity of Dr. Ross, who never seemed invasive, but on the contrary, always was most aware of how far the patient wanted to go, and when he wanted to talk.

Since Dr. Ross is also a psychiatrist, she does not stop with merely reporting interviews. She also uses the material gathered during the seminar to analyze the psychological stages through which all the patients must work, before they can die peacefully. This analysis is extremely helpful for anyone trying to understand and cope with the behavior of the seriously ill. The stages she lists are the following: denial and isolation, anger, bargaining, depression, acceptance. An understanding of this necessary progression is essential for anyone who wants to know what to say and how to help the dying.

No one book or theory can answer these questions completely. But this book is the first one I found which even tried to answer them. It is a book to read more than once. It is even available in Jefferson's bookstore. A must for all.

Narcissus and Goldmund by Hermann Hesse, trans. by Ursule Molinaro. (Farrar, Straus and Giroux, 1968) 315 pp.

Hesse still has my vote for Favorite Author, even though **Time** says that he is now out of fashion with the young, whatever that means. But I wonder whether I would have understood **Narcissus and Goldmund** if I hadn't read **Siddharta** and **The Glass Bead Game** first. In fact, there is even a short story about Han Fook in which Hesse explores a similar theme. Someone once said that an author only has one tale to tell in his life and even if he writes many books he continues to play the same theme in different ways. This seems especially true with Hesse.

It is not a criticism when I say he plays one theme. Each book and story is a work of art in itself, and on the level of story-telling, and character delineation, and scene-setting, and sensuous description the novels are all different and each has its own perfection. I guess it is a matter of clarifying what I mean when I ask what a book is about. I do not ask for a blow by blow description: "There was this skinny dark kid who was a scholar who became an ascetic and an abbot and there was his friend, a little blond kid who . . ." When I ask, I want to know why the author wrote the book.

When Hesse writes, to me it seems that he is always posing a question: What is the perfect life? His principle characters always seem torn by the dichotomy in life between the spiritual and the sensual. Does a choice have to be made? Is synthesis of the two impossible? Only through art and music do his characters approach such a synthesis. And only through an asceticism and solitariness does the artist come to the heart of his art and achieves both the sensitivity to perceive the meaning of life and the mastery of his art form to express this mystery. But how in one life does one man manage both to experience life fully and also to be ascetic and solitary enough not to lose sensitivity? Or, in terms more meaningful to us, how does the ascetic scholar retain contact with and comprehension of life as it is lived by the 99% while he is absorbed with his test-tube "knowledge" of it?

ABORTION COUNSELING, INFORMATION AND REFERRAL SERVICES

Abortions up to 24 weeks of pregnancy are now legal in New York State. There are no residency restrictions at cooperating hospitals. Only the consent of the patient and the performing physician is required.

If you think you are pregnant, consult your doctor. Don't delay. If you choose to have an abortion, early abortions are simpler and safer.

Abortions should be performed by Board certified obstetricians and gynecologists, with Board certified anesthesiologists attending, in fully licensed and accredited general hospitals. You should not have to pay exorbitant charges for any of these services.

If you need information or professional assistance, including immediate registration into available hospitals, telephone The Abortion Information Agency, (212-873-6650), which has helped counsel and place more than 22,000 women for safe, legal hospital abortions.

The total costs at good facilities range as follows (in-patient hospital service, except as noted):

For D & C: Pregnancy up to 9 weeks, $285-$310 (out-patient hospital service); up to 12 weeks, $385-$410; up to 14 weeks, $560. For Saline Inductions: 16-24 weeks, $560-$585.

THE ABORTION INFORMATION AGENCY, INC.

160 West 86th St., N.Y., N.Y. 10024

212-873-6650

8 AM to 10 PM Seven Days a Week

Multiphasic Screening

(Continued from page 1)

huge sums of money for a program of questionable effectiveness.

As with many recent attempts at innovation in medical care, the roots of multiphasic screening come from the Kaiser Foundation Health Plan in California, which instituted a rudimentary program in 1951. By 1964 they had automated and computerized their facility. Since that time over 60 other multiphasic centers have been initiated, many of them with the impetus of the federal government. They are being used for screening of hospital patients before admission, for pre- and postemployment physicals in some industries, for admission to prepaid group practice plans, or simply for private physician use.

The implications of this trend go beyond the simple possibilities of picking up disease signs earlier. Many physicians believe that they spend large amounts of time with patients doing things which could be routinely done in a screening center. To relieve the doctor of much of this time consuming work and allow him to use his talents more efficiently would help to alleviate the doctor shortage in the opinion of some. The most far reaching use of multiphasic screening is proposed by Sidney Garfield of the Kaiser Foundation. He believes that pre-paid practices like Kaiser are best able to utilize preventive medicine techniques. His reasoning is that the fee-for-service system inhibits people from seeking medical attention early in illness where prevention and treatment are most effective. However, he states that if the system is completely open to entrance of the patient, people seek aid for trivial reasons and doctor time is misused. Since Kaiser prides itself on efficiency, they have used the multiphasic screening to control the flow of patients into their medical facilities. In this way, only those who reveal a truly medical problem after screening are seen by doctors, and therefore the doctor's time is used in areas where his skills are most necessary.

Undoubtedly enterprises like Medichek will continue to grow and they will be of great benefit to physician and patient individually. Yet it remains to be seen whether the concepts can be economically applied on a broad scale which encompasses a large portion of our population.

Health Centers

(Continued from Page 1)

both responsible and responsive to the community residents it serves. The Center's goals and policies are prescribed by the Community Corporation and are effected by Pennsylvania Hospital in terms of high quality, dignified health care services.

It is important to emphasize the role of neighborhood residents at all levels of the structure. As already mentioned, residents sit on the board of the Corporation as direct administrative overseers. In addition, a Community Health Action group, responsible to the Corporation, evaluates services and receives community feedback. Further, community residents are directly employed at the Center, all receiving on the job training. For example, the Family Health worker is a community resident trained to assist the visiting family nurse, and serves as the most direct link between the family and the Center. Such integrating mechanisms make for a viable and sensitive organization.

The Family Health team is the nucleus for delivery of personalized health care to the entire family. Each team includes a group of medical specialists (internist, pediatrician, obstetrician, gynocologist, psychiatrist, dentist, dental hygenists and assistants), social workers, clerical workers, and a public health nurse, who coordinates a team of family nurses and family health workers. Furthermore, other special services are available through the team in such areas as home economics, nutrition, environmental health, general counseling and rehabilitation. The full services of the Pennsylvania Hospital are available when needed. The patient is always seen by the same team members (more than one team exists) whether at the Center, the home, or the hospital.

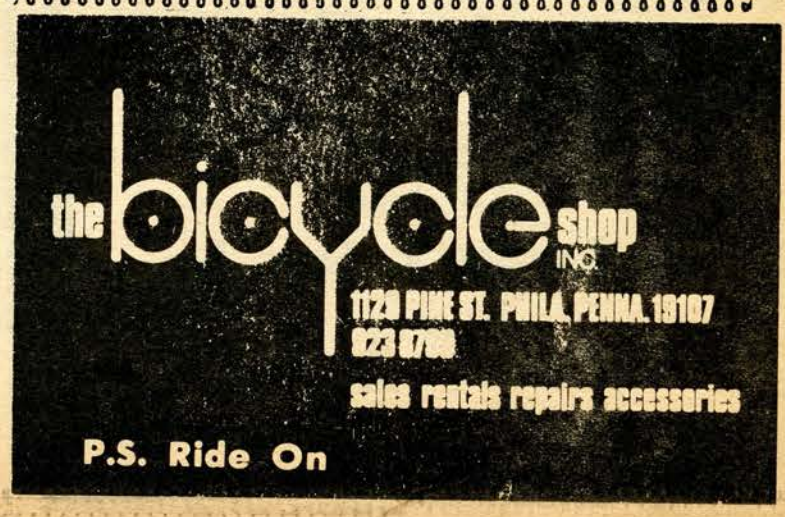
Since its opening in July, 1969, the Health Center has progressed with stability, and planning is now underway for a new and greatly expanded facility to meet increasing demands. To date financing of the project has been through federal funds with the Community Corporation gradually assuming full responsibility for allocation. Eventually the Center will charge fees for service to the residents based on a graded scale according to family financial status.

Mr. James Vioro, a Southeast Philadelphia resident who serves as Administrative Assistant of the Southeast Philadelphia Community Corporation. (Photo-Robert S. Halvey).

Although still in its earliest formative stage, this system of comprehensive health care offers much as a foundation and functional approach toward development of a national health care plan. An outstanding feature is its apparent adaptability for utilization of forthcoming innovations from areas such as advanced record keeping systems to education of a broad spectrum of "paramedical specialists" to serve health teams. These promise to expand its effectiveness and efficiency–to meet urgent present and foreseeable future demands.

It is incumbent upon the professional medical community to critically re-evaluate its position and responsibility in the face of urgent national needs and impending changes, and to then plan and expedite in conjunction with the federal government the formation of the most effective system of health care delivery possible.

The present health center is located at the corner of ninth and South Street. (Photo - MCL.)



Gordon Discusses

(Continued from page 1)

of extraneous variables operating upon persons involved in such studies. Jensen attempted to measure learning ability. Gordon believes that learning ability is not a function of genetics and that therefore, its measurement has no relevance to genetically determined intelligence. According to Gordon, learning ability differences reflect differences in degrees of fit between learner, teacher, material, and manner of presentation. Furthermore Jensen's distinction between racial groups was on the basis of skin color, a social distinction, not on the basis of a specified set of tested genetic coordinates a scientific distinction.

Third, Jensen's theory reflects and its adoption would potentiate, a narrow projective, rather than broad interactive view of the educational process. Jensen's theory reflects the projective educational approach. The projectionists believe the factors intrinsic to the individual will determine his interaction with the environment. Gordon sides with the opposing educational theory, the interactionist theory, that each interaction of the individual and his environment determines subsequent interactions. The particular educational theory a society develops, Gordon emphasized, determines the goals, designs, and management of the educational system.

According to Dr. Gordon, a man's self concept and sense of control over his destiny can be as important as genetics or environment in determining his intellectual development and behavior. Whereas genetics provide potential for behavior, and the environment provides the elements for molding the behavior, a man's self concept and sense of control of his destiny are the elements responsible for calling forth the behavior.

The question and answer period following the presentation focused Gordon's somewhat philosophical arguments upon current problems at Jefferson.

Dr. Hyman Menduke, Coordinator of research at Jefferson and President of the Jefferson chapter of Sigma Xi, asked Dr. Gordon if he believed the MCATs to be an effective criteria for evaluating black applicants to TJU. Gordon replied "Yes, if you want to choose students who will fit into the Jefferson educational system as it presently exists." Gordon went on to say, however, that an educational institution should be geared, not merely to maintain those who have developed skills to learn under any teaching program, but rather to develop those who have not acquired such skills. In order to do the latter, the teaching system must be directed to become more effective, relevant, inspiring and flexible to individual needs.

A black medical student asked Dr. Gordon in light of his comments about self concept, how he would counsel a black at TJU who knew he head not been chosen by the same MACT criteria as his white classmates? Dr. Gordon replied that such a black student must evaluate what the difference between his scores and those of others really means. Does the difference represent a difference in experience or a difference in characteristics? If it does represent a difference in characteristics are those characteristics of real value? Gordon further pointed out that men are developing beings and therefore their existence at one plane of ability and achievement in life at a given moment does not preclude their movement from that plane.

A Hitch in Time Saves the Mind

By Robert L. Breckenridge, Jr.

With movies such as **Love Story, Song of Norway,** and **Alex in Wonderland,** one has difficulty finding the courage to view, much less review, the current cinema. The only two films in town at this writing that I can stomach are **Trash** and **Gimmie Shelter,** but these films have enjoyed so much notoriety that anything more would be superfluous. When hard times such as these strike, one is grateful for revivals of film classics such as the Commons' Hitchcock Festival at the end of March.

Alfred Hitchcock and Orson Welles are undeniably the only great American directors alive, and yet it seems Hitchcock is often overlooked in current comprehensive film criticisms. Perhaps this may be the result of Hitchcock's pure cinematic vision which may pass unnoticed in retrospect or because his films may seem to be shallow melodramas. Yet, upon careful examination, his films reveal a distinct personal style combined with creative genius and technical skill.

Hitchcock's art was never fully appreciated until the French New Wave directors (notably Truffaut and Chabrol) began to review his works in **Cahiers du Cinima.** They found a consistent rigorous morality coupled with black humor in his works that would, to this day, be ignored by many Anglo-American critics. Hitchcock takes a situation of normality, however dull it may appear, to emphasize the evil abnormality that lurks beneath the surface. One cannot have a gang of Hell's Angels commit a murder in a dark alley and make a meaningful statement to the audience. It simply makes the audience feel an apartness from the action on the screen. However, when murder is committed in a sanitary motel bathroom during a shower when we are maximally exposed, the incursion of evil into our well-cleansed existence becomes intolerable (I never have felt comfortable showering in a motel since seeing **Psycho**). Unlike Stanley Kubrick, Hitchcock does not espouse that brand of humanism that insists that people are good, and only systems evil, as if the systems themselves were not functions of human experience. He insists, almost intolerably, upon a moral reckoning for his characters and for his audience.

Probably another reason that his works seem to be ignored by many Anglo-American critics is that he gives so much pleasure to his audiences--more pleasure than is permissible for serious cinema. Discovering his cameo appearances are always challenging to the audience and they point to the irony of the situation where the most important man involved with the film plays the most insignificant role. Hitchcock departs from the Eisenstein style of montage of varied shots and favors the intricate editing of objects and glances within a scene. Examples of this are the focus on the incriminating cigarette lighter in **Strangers on a Train** and the falling bicycle in **I Confess.** Even his dialogue provides pleasure for the audience. My favorite sequence in **The Birds** occurs when a family is eating fried chicken in a restaurant under attack by the birds and one frightened child asks, "Mommy, are the birds going to eat us?"

Hitchcock's method of creating a film is unique and is essential to properly communicate his art. He usually begins with a novel or story he has heard that appeals to him, but instead of trying to adapt it to a screenplay, he constructs the entire film on a storyboard. He sketches every shot to appear in the film and includes every necessary detail. This enables him to plan each sequence with precision so as to create suspense and fully manipulate his audience's emotions. Then too, it is a simple matter to shoot the film in a minimum amount of time at a minimum cost. Unfortunately, this also prevents the utilization of any spontaneous ideas on location, but this is of small importance in the suspense genre.

The "Mac Guffin" is another characteristic of Hitchcock's films. This is a device with which he begins every film to lead the audience into the plot. He makes it seem as if it is of vital importance, yet at the end of the film it is of no importance to the plot at all. For example, in **Psycho** Janet Leigh steals a large sum of money and it appears that the movie will revolve around this theft. However, she is soon murdered, and the emphasis shifts to the psychopathic murderer. In an interview with Hitchcock, Truffaut explains, "all of this clearly shows that you're always fully aware of your intentions, and that everything you do is carefully thought out. And yet, these pictures, hinged around a Mac Guffin, are the very ones that some of the critics have in mind when they claim that 'Hitchcock's got nothing to say.' The only answer to that is that a film-maker isn't supposed to say things; his job is to **show** them."

Jefferson Commons will be showing **Stage Fright, Strangers on a Train, I Confess,** and **The Wrong Man,** all Warner Bros. pictures from the early fifties. They are worth seeing if you can spare 25¢ and need a break from studying for the Physiology exam.

The Bandbox in Germantown is also showing a number of film classics by Ray, Bunuel, Truffaut, Kurosava, Resnais, Visconti, and other international directors. A fifteen minute/ 40¢ ride on the Reading Railroad and a $2.50 admission price lets you see a double feature of some of the best films ever made. If you just collected your pay check or welfare check you can buy an economy pass: 10 shows/ $15. The management will even remit the 10¢ you paid for the newspaper listings if you prove you didn't read any of the news.

Priest Presents Catholic Point of View on Abortion

By Rev. Vincent M. Walsh

(Editor's Note: In accordance with out continuing discussion of the subject of abortion, Reverend Vincent M. Walsh, the Catholic Chaplain for Jefferson has submitted the following article in response to Ariel's support for legalization of abortion.)

Many thanks to the editors of **Ariel** for this opportunity to expound the Catholic Church's teaching on abortion. The issue is so complex that I fear some will read this article and say, "Well, he didn't convince me" or "He didn't face the real questions." Nevertheless, the opportunity has been given and although the medium of a newspaper article does not allow for the give and take of dialogue, I certainly welcome the invitation. The parts of the article are: 1) The central but unanswered question; 2) The Catholic Church and this question; 3) The State and this question; 4) What medical evidence has to say on this central question; 5) The State and the medical evidence; 6) After abortion, what then, and 7) Related problems.

Central but Unanswered (even unasked) Question

At the heart of this abortion controversy lies the central question which those seeking abortion on demand do not answer, in fact, do not even want to ask.

In common language the central question, "When does the fetus become human?" or "When a pregnant woman comes to a doctor, is he treating one patient or two?" Pro-abortion literature does not even ask this question (Read it sometimes and try to find that question treated). They would like to consider all the other date – the family situation, that the mother does not want the child, the inconvenience of this pregnancy to the other children and to the parents, etc.

The Catholic Church and This Question

Contrary to popular opinion the Catholic Church has never defined just when human life begins. While not defining this ceientific and rational event, on the moral level the Church has always taught that interference with this process is sinful.

Although the Old Testament condemned murder, it also seemed to justify war and permit abortion. Under the influence of Jesus' attitude that all men were brothers, Christians condemned abortion and restricted severely the exceptions to homicide. In the Didache, the first Christian writing after the scriptures, is found: "You shall not slay the child by abortion. You shall not kill what is generated." This condemnation of abortion has been a continuous tradition ever since. (A lot of strange information concerning the Church's teaching crops up in debates on abortion. One I have heard frequently is, "The Church never condemned abortion until 1869." I get the idea that somebody said that once and it has been misquoted by everybody speaking for the abortion movement ever since.)

As an aside, I was amazed that all references to abortion were deleted from the Hippocratic Oath when administered to Jefferson's 1970 graduating class.

The Church's basic attitude is respect for life (sometimes caricatured by an exclusive interest in large numbers). However, it does not equate "quality of life" necessarily with material goods or with a trillion dollar gross national product. "Quality of life" is measured more by how much a nation cares and by how sensitive we are to others. It is difficult to see how wide open widespread abortion, justified by the mere wish of the mother can make us, as a nation, more sensitive to life.

The State and This Question

Basically, the state has a duty to protect the rights of individuals. Our constitution claims these rights are inalienable, not granted to the individual by the state or by law or even by the parents. An individual has rights because he is a human being.

Once again, we have returned to the central question, "When does the fetus become human?" The state, unless it is hypocritical, has to answer that question. If it does not, then in effect, the state says that certain individuals are not worthy of legal protection – as was done by Germany toward the Jews.

Medical Evidence and This Question

I do not if abortion is still debated here at Jefferson. I kind of guess that the question has been decided functionally (that is, by having abortions performed). But if it still is debated, I would consider this article worthwhile if this central question is at least talked about, "Is the fetus human?" or to put it another way, "Are human beings being aborted at Jefferson Hospital?"

I asked one doctor performing abortions here at Jefferson on what medical basis he decided that the fetus was not human. He answered that the question of whether or not the fetus was human had no place in an abortion discussion.

This beginning of human life is a scientific and rational question which should consider all date supplied by embryology and fetalogy and should be decided after the study of this data. The conclusion would be that "it seems like here human life had begun."

All the date indicates that the fetus belongs to the human race. I do not have recount for medical students what the fetus can do at different stages. I do not have to recall the findings of genetics. I do not have to state that at eight weeks the EEG shows a distinctly individual pattern. Even viability itself has become elastic and no one can predict what future medical procedures will be. One doctor has stated, "Birth is seeen now as merely a statement about where the child is." Doctor S. Cherry, fetalogist at Mt. Sinai Hospital, New York, has put this way, "Fetalogy has humanized the fetus."

Perhaps a quote from a biophysicist at the University of California would sum things up. **"The fetus is not an apendage or organ of the mother, but rather a separate organism. It can be identified as belonging biologically to the human race. It contains all the genetic information that, during development, will interact with its environment to produce the complete human organism. There is no point in its development where the biological form and function of the body are suddenly added."**

The State and Medical Evidence

Whenever the state is presented with medical evidence, it has to make laws to protect the individual. The most recent example is the medical evidence connecting smoking with cancer, causing the state to ban TV advertising.

The paradox in the abortion controversy is that, while the medical evidence piles up saying that the fetus belongs to the human race, the states are removing legal protection. For example, the New York law is not based on medical evidence. I have read entirely the Abortion Commission's Report to Governor Rockefeller. Medical evidence is scant and hard-to-believe analogies are employed to justify abortion. For example, the fetus is likened to the blueprints drawn up by an architect. Since an architect can destroy blueprints because he might want a different type building, so a woman can destroy the fetus.

After Abortion, What Then?

If anti-abortion laws are removed, what legal changes come next? The very next step seems to be euthanasia. Legislative initiatives have already been begun in Britain. Legislation, which was just defeated in the Florida legislature, but will be reintroduced next year, states that a person has "the right to die with dignity." This means not only that a person can ask a doctor to

(Continued on Page 7)

Who?

Two men stand in a little girl's nose

(Bright lights,
Sharp steel,
Green gowns)

Who will she be?

(Sculpting,
Shaping,
Moulding,
Making)

Yes, I know she'll be beautiful,

But
Who will she be?

–S. Ager
Clinical Clerk
Surgery IV

MCHR Course Begins

An organizational meeting was held on February 23. Discussion centered on the philosophy and purpose of medical presence, with some advocating a neutral, service role, and others favoring open support of political groups in their actions. MCHR's stance is that neutrality is no longer feasible or desirable – while we will, as a matter of principle, provide care to anyone injured, our presence at demonstrations is seen by most MCHR members and by police forces as denoting support for the demonstrators. We will take into account political sympathies in our organization of emergency teams, so that no one is pressured into attending an action whose aims he does not support. Also, we will probably also have to establish contact with the police for the purpose of getting into cordoned-off areas, etc.

Schedule of Meetings

Wednesday, March 17: 7:30, Christian Association. Topics: Emergency treatment in violent situations - a) Tear gas: identification, treatment, decontamination; b) Legal first aid for demonstrators and medical personnel.

Thursday, March 25, place to be announced. Topic: Emergency care in large, peaceful groups, e.g. rock festivals, peoples' conventions, etc. - a) drug problems and psychiatric first aid; b) heat prostration, exposure, other common medical problems. Concluding discussion: establishment of telephone chain, decisions about future goals.

NOTE: All are welcome to any and all of these discussions. Our main intention is to establish tightly-knit teams which can function as units in any emergency situation. The course is primarily for people with prior medical training (although more detailed sessions may be held for non-medical people). Most areas of the course are not covered in conventional medical training. Other areas will be useful as refreshers. Also, supplies of any sort are welcome. Call if you have, or know of, any.

For more information, call or write Medical Committee for Human Rights, 410 S. 8th St., Phila., 19147, WA 3-6350. Call anytime.

Priest's Point of View

(Continued from Page 6)

kill him, but even that a relative can make such a decision for the person if he is not capable.

Abortion on demand is just the beginning toward a "totally controlled" world. There will be other problems. If the question of the human existence of the fetus is never settled and the state removes legal protection from the unborn merely on the functional reason of unwated pregnancy, what about the unwated, deformed infant? What is a woman sought an abortion and was denied it to lack of hospital facilities? Who could prosecute her if she committed infanticide, when she has a constitutional right to an abortion? These latter are only conjectures but in the years 2000 I do not want to say, "I told you so thirty years ago."

Two other issues should be appended to this article: 1) the connection between contraception and abortion, and 2) the obvious social problems which do exist.

The Church's Teaching on Contraception and Abortion

Many people feel that the Church's teaching on abortion is just an extension of its teaching on contraception. Please let me distinguish these two issues.

During the 1930's. within the Catholic Church raged a moral debate over the right of parents to limit children and to introduce reason into planning the numger of conceptions. Since then, the Church has taught the right of couples to limit their conceptions. Concerning the number of offspring, the recent Vatican Council stated, "The parents themselves should ultimately make this judgment in the sight of God." Although admittedly, the Church is still trying to sort out means which it feels are moral, the radical commitment is that the couples, before conceiving, have the right to exercise a choice. Once conception takes place, however, the Church would say that there is no choice left.

Although there exists a valid distinction in the Church's teaching between contraception and abortion, I must admit that to some degree these two teachings are connected. So sacred and untouchable is the fruit of the act of marriage, that this sacredness reflects backward onto the act itself.

On the other hand, the pro-abortion movement certainly links the two. Carl Rowan in his syndicated column asking for abortion on demand called abortion "a convenient tool in population control." I am unalterably opposed to any vision of man which sees the unborn merely as a "tool." The unborn child does not exist for the convenience of the born, just as children do not exist merely to fulfill emotional needs of parents.

Abortion and Social Problems

Proponents of abortion on demand have sought vast legal changes, have gained some and are still seeking others. They claim to seed these changes because of social problems like backroom abortionists, overpopulation, illegimacy, etc.

Some questions, however, should be posed.

To what problems are the proposed changes in law actually addressed? What is the exact size of that problem? Are the proposed changes necessary to achieve a solution, and will they solve the problem? Or, will the changes bring about more problems than they solve.

The research done by the pro-abortionists is shoddy at best, if not outright dishonest. Take, for example, their most widepublicized statistic – that over a million illegal abortions occur every year. Their "real" figure they say is anywhere from 200,000 to 1,200,00 which everyone admits is not even a guess, let alone statistic.

Where does the 1,200,000 statistic come from? The source is a 1934 book by M.E. Kopp, which stated there was one abortion for every 3.55 births. This figure was based in histories of 10,000 women who attended a birth control clinic between 1925 and 1929.

Since there were over four million births in 1970, the pro-abortionists claim 1,200,000 illegal abortions.

Or consider the so-called "death statistic" of 10,000 annual maternal deaths due to illegal abortions. Kennedy Conference on Abortion 1967) placed the real figure as not more annually throughout the country.

Yet these statistics are used (the pro-abortionists in California in a brief for the State Supreme Court claimed 5,000 maternal deaths in that State alone from illegal abortions) and everyone is supposed to believe that deep research has been done in a social program, when really very poor research is being put forth. Besides this, serious liberalization of abortion regulations does not reduce illegal abortions anyway. (Cf. Swedish statistics).

What frequently happens is that abortion on demand begets a population of women who are abortion prone. There, then, begins the phenomena of widespread, multiple abortions. The results of these practices can be seen in a recent survey taken by the Prime Minister of Health in Japan. Especially significant was psychic damager (51percent of Japanese women who had four abortions claimed severe emotional problems directly related). This entire survey should be read well, since its statistics deal with the medical and psychological aspects of abortion over a long term.

Certainly, this article has not touched on many aspects of the abortion question. I am willing to answer any questions at all on this matter. Individuals should feel free to submit questions tharough the **Ariel** editor for answers in future issues.

Once Upon a Time

Mothers were sitting at water springs,
dancing, singing,
gently caressing their children,
guiding them into the currents of Life. . .
Ocean waves gently rushed
at beaches of a peaceful world. . .
Men and women drank the joy of Living
from the movements of their limbs
and their melodies into the eternities.
Children's laughter sounded in exuberance of voices
filled with gaiety and delight.
Joyful glances in young men's eyes,
regleamed in smiling faces
of maidens gay with love
and drunk with youth
in tender bodies.
Suddenly. . .a howling. . .
What a jowling!
Never heard nad never felt before,
uninvited, perpetrated. . .
It was the plague that penetrated:
Stiffened faces,
Falsehoods grinning,
Tired arms and deadened loins,
Weeping cheeks and dulled-out gazing,
Hardened backs, polite in bowing;
Bodies bare of love,
Wanting bare of will,
Longing bare of sensing,
Fighting bare of victories,
Martyrdom of marriage torture,
Moaning, Groaning,
Children's screaming, agonies. . .
Murder, misery and crooked thinking. . .
Cowards' gallows and parades,
Marching, medals, rotting corpses:
What a scrambling idiocy,
hunting, tripping, nightmare fooling. . .
Woe to Men
a million fold. . .

— — Wilhelm Reich

President Nixon Proposes A National Health Strategy

The following is a part of the text of President Nixon's message on health delivered on February 18. It deals with his proposals for a National Health Strategy which we discuss in our second editorial.

BUILDING A NATIONAL HEALTH STRATEGY

Things do not have to be this way. We can change these conditions–indeed, we must change them if we are to fulfill our promise as a nation. Good health care should be readily available to all of our citizens.

It will not be easy for our nation to achieve this goal. It will be impossible to achieve it without a new sense of purpose and a new spirit of discipline. That is why I am calling today not only for new programs and not merely for more money but for something more–for a new approach which is equal to the complexity of our challenges. I am calling today for a new national health strategy that will marshal a variety of forces in a coordinated assault on a variety of problems.

This new strategy should be built on four basic principles.

Assuring Equal Access: Although the Federal Government should be viewed as only one of several partners in this reforming effort, it does bear a special responsibility to help all citizens achieve equal access to our health care system. Just as our national Government has moved to provide equal opportunity in areas such as education, employment and voting, so we must now work to expand the opportunity for all citizens to obtain a decent standard of medical care. We must do all we can to remove any racial, economic, social or geographic barriers which now prevent any of our citizens from obtaining adequate health protection. For without good health, no man can fully utilize his other opportunities.

Balancing Supply and Demand: It does little good, however, to increase the demand for care unless we also increase the supply. Helping more people pay for more care does little good unless more care is available. This axiom was ignored when Medicaid and Medicare were created–and the nation paid a high price for that error. The expectations of many beneficiaries were not met and a severe inflation in medical costs was compounded.

Rising demand should not be a source of anxiety in our country. It is, after all, a sign of our success in achieving equal opportunity, a measure of our effectiveness in reducing the barriers. It also has a responsibility for what happens after they are reduced. We must see to it that our approach to health problems is a balanced approach. We must be sure that our health care system is ready and able to welcome its new clients.

Organizing for Efficiency: As we move toward these goals, we must recognize that we cannot simply buy our way to better medicine. We have already been trying that too long. We have been persuaded, too often, that the plan that costs the most will help the most and too often we have been disappointed.

The toughest question we face, then, is not how much we should spend but how we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one.

There are two particularly useful ways of doing this:

EMphasizing Health Maintenance: In most cases our present medical system operates episodically – people come to it in moments of distress, when they require its most expensive services. Yet both the system and those it serves would be better off if less expensive services could be delivered on a more regular basis.

If more of our resources were invested in preventing sickness and accidents, fewer would have to be spent on costly cures. If we gave more attention to treating illness in its early stages, then we would be less troubled by acute disease. In short, we should build a true "health" system–and not a "sickness" system alone.

Preserving cost consciousness: As we determine just who should bear the various costs of health care, we should remember that only as people are aware of those costs will they be motivated to reduce them. When consumers pay virtually nothing for services know that all their costs will also be met, then neither the consumer nor the provider has an incentive to use the system efficiently.

Building on Strengths: While it would be wrong to ignore any weakness in our present system, it would be equally wrong to sacrifice its strengths.

One of those strengths is the diversity of our system–and the range of choice it therefore provides to doctors and patients alike. I believe the public will always be better served by a pluralistic system than by a monolithic one by a system which creates many effective centers of responsibility–both public and private–rather than one that concentrates authority in a single governmental source.

This does not mean that we must allow each part of the system to go its own independent way, with no sense of common purpose. We must encourage greater cooperation and build better coordination–but not by fostering uniformity and eliminating choice. One effective way of influencing the system is by structuring incentives which reward people for helping to achieve national goals without forcing their decisions or dictating the way they are carried out.

Task Force

(Continued from Page 3)

enjoying a better position in society.

In general, the study cites four areas of need that are most promising for youth/ Establishment cooperative effort: (1) poverty, (2) pollution, (3) social justice and (4) reform of party politics. For any collaborative effort to be successful, the study points out, it is necessary to meet head-on the emotional obstacles separating the two groups.

To create a meaningful working alliance between students and business leaders, the study contends, student participants will have to come to believe that (1) more than a dialogue is involved and concrete results can be achieved, (2) Establishment participants have no ulterior motive such as appeasing them or distracting them from getting work done, (3) they are equal partners in the undertaking and (4) Establishment participants will not "cop out" when their own parochial interests are at risk. At the same time, business leaders will have to come to feel that (1) students are serious and constructive, (2) students are prepared for a partnership based on mutual concerns arrived at through discussion and analysis, (3) students are willing to accept some of the experience and know-how of the business leaders and not just their financial support for projects with which business may or may not be sympathetic and (4) students are not unduly impatient or unrealistic in the kinds of results they anticipate.

The study also suggests that four project concepts proposed by the Task Force on Youth should not be treated as short-range stand-alone programs, but rather as points of entry.

In interpreting the findings, the study notes that "the student rebellion is not a transient phonomenon – a product of the Vietnam war or the generation gap or the failings of our universities as institutions of high learning. Rather, it is a movement of enduring significance, transcending any one specific event and signaling vast changes in the American life style. The public mind today is one of impatience with rebellious college students – their mode of dress, their style of life, their rejection of traditional values and their sanctioning of violence. The mood is punitive. Politicians who suggest repression win points with large masses of people. The public is angry and the students have, many of them, drawn in on themselves in resentment and bitterness. The tone of the debate on campus protest has become decidedly harsh and emotional.

That strong feelings should exist is not surprising. All of the ingredients that make for conflict divisiveness and instability are present. The students are strongly against the war in Vietnam; large segments of the public fear national defeat and humiliation. The students challenge established authority; the public sees the challenge as a threat to the stability of our institutions at a time of deep hunger for law and order. The student-inspired "counter-culture" threatens deeply felt traditional values: patriotism, hard work, religion, respect for authority, sexual morality, material well-being, neatness and cleanliness.

In explaining how changes in attitudes will occur and "new institutions will emerge more responsive to the needs of the Forerunners," the study states: "Small groups of students take extreme positions on the 'new values,' larger groups take more moderate positions. Gradually, the 'new values' work their way from the Frontrunner college group to the Career Minded majority of college students, and then to other young people, and then to upper middle class older people in urban settings, and then to the mass of population. At each stage in the process the 'new values' become attenuated, modified and assimilated to older more traditional ways. By this catch-as-catch-can process, a synthesis of the old and the new is finally reached, although the process may take decades and perhaps generations to complete and may be sidetracked in the process."

In describing the students who comprise the Forerunner group, the study notes that they "resemble their peers and parents in most respects. But their needs, values and motivations have a different economy.

Among the conditions for building a working alliance between youth and the Establishment, two stand out as most relevant. The first is the need to take at face value what each side states to be its most worrisome reservation, however trivial, irrelevant or irrational it may appear to the other side. The second key condition is that structured opportunities be created to permit the strong emotions on both sides to be "worked through." Well-established principles of group dynamics can be brought to bear to create opportunities for participants to give vent to irrational feelings, to overreact, to backslide even after agreements have been reached, to voice anxieties and hidden fears, and to undergo all the other well-known sequence of experiences involved in reaching conflict resolution.

Celebration

(Continued from Page 3)

walls around ourselves, and become truly open and share our experiences. Increased human encounter – exchange of experience – is the central value and point of the growing **Celebration** idea. Its focus is to increase, within the impersonal atmosphere of large city life, likely human meetings.

After the good response last spring at Temple, **Celebration expanded over the summer and fall to nearly 20 Philadelphia area schools. More schools will be added during the spring semester 1971 distribution of our forms. So Celebration** should afford the meeting of people with comparable values and interests in many Philadelphia schools, beyond the limited range of one's own college group. A number of intercollege encounters over a semester, otherwise impossible given a student's limited time, should prove for anyone a most interesting part of their school-in-Philadelphia experience.

To participate: respond to the questions on form. They should afford a common field of experience with those whom you meet. Then mail form with three dollars or check to **Celebration, P.O. Box 5102, Phila., Pa. 19141.** We are human, but the coins just do cover advertising, printing, distribution, and – accurate, scrupulous, and responsible – processing costs, so help us Ralph Nader. If you honestly have no money but real interest, circle this sentence or otherwise tell us so and we will include you.

An alternate way to apply is by arranging to meet a member of our staff at Penn or one of several other locations just to rap for a while with them. Call CA 4-8935 on Sundays to work out a time.

Ideally with three days to three weeks after you apply, you'll receive two to seven names and phone numbers -- the average is three or four. You can then call each other and arrange an informal meeting somewhere -- over tea, cokes, tequila, Kool Aid, or whatever your drink happens to be. Regardless of whether your relationship extends beyond this, you should at least have an interesting talk, a human exchange – and that would be a good thing.

If you would like a complete account of the **Celebration** structure, plans and ideas, send us your name and address. This inclusive additional information should be especially helpful to college newspapers interested in stories (since we operate at cost, we most appreciate any PR), but is available to anyone requesting it. Inquiries about other matters can be made at WA 4-7160 after 6 or Sundays.