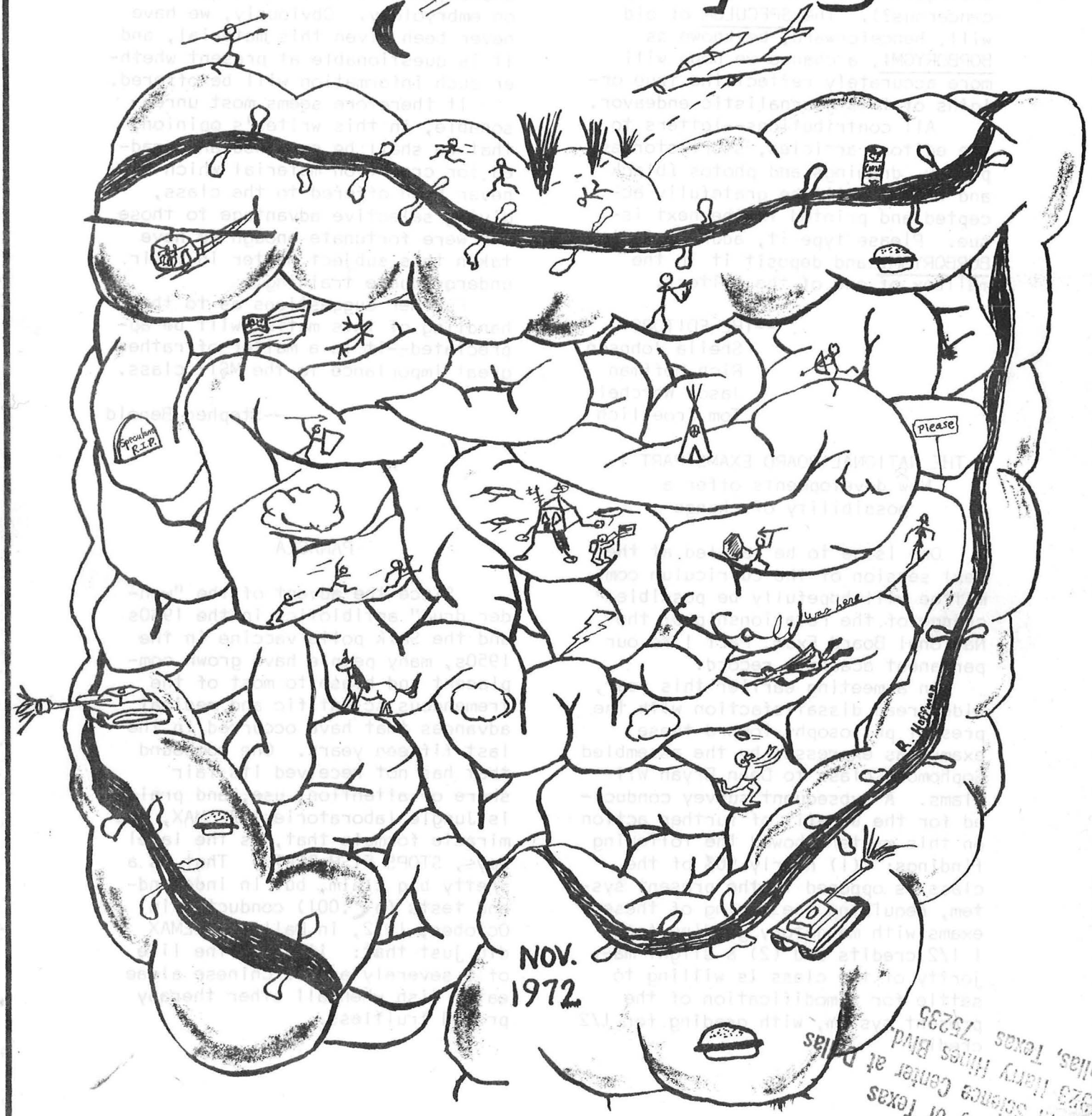
borborygmi

SAMA - UTSMS



EDITORS' NOTE

With a mandate from the people for "four more years" and our desire to respond to this auspicious demand the official SAMA scandal sheet has undergone a nominal metaplasia (precancerous?). The SPECULUM of old will, henceforward, be known as BORBORYGMI, a change we hope will more accurately reflect the true origins of this journalistic endeavor.

All contributions--letters to the editor, articles, short stories, poetry, drawings and photos (black and white)--will be gratefully accepted and printed in the next issue. Please type it, address it to BORBORYGMI and deposit it in the mailbox of one of the editors.

--THE EDITORS
Sheila Johnson
Rich Hoffman
Jason Worchel
Tom Froehlich

THE NATIONAL BOARD EXAMS PART I
New developments offer a possibility of change

One issue to be tackled at the next session of the curriculum committee will hopefully be possible change of the relationship of the National Board Exam, Part I to our permanent academic record.

In a meeting earlier this year, widespread dissatisfaction with the present philosophy toward these exams was expressed by the assembled Sophomore class to Dean Bryan Williams. A subsequent survey conducted for the benefit of further action on this matter showed the following findings: (1) nearly 90% of the class is opposed to the present system, requiring the taking of these exams with mandatory grading for 1 1/2 credits and (2) a slight majority of the class is willing to settle for a modification of the present system, with grading for 1/2 credit.

Now new developments have come to light. This next June, the National Board Exams will have a separate exam on the behavioral sciences. Also, as in past years, the anatomy exam will include questions on embryology. Obviously, we have never been given this material, and it is questionable at present whether such information will be offered.

It therefore seems most unreasonable, in this writer's opinion, that we shall be examined and graded for credit on material which has never been offered to the class, giving selective advantage to those who were fortunate enough to have taken this subject matter in their undergraduate training.

Further suggestions as to the handling of this matter will be appreciated--it is a matter of rather great importance to the MSII class.

--Stephen Benold

PANACEA

Since the advent of the "wonder drug" antibiotics in the 1940s and the Salk polio vaccine in the 1950s, many people have grown complacent and blase to most of the tremendous scientific and medical advances that have occurred in the last fifteen years. One compound that has not received its fair share of attention, use, and praise is Jungle laboratories' ZEEMAX, the miracle formula that, as the label says, STOPS FISH DEATH. That is a pretty big claim, but in independend tests ($p < .001$) conducted in October, 1972, in Dallas, ZEEMAX did just that: it saved the life of a severely anoxic Chinese algae eater fish when all other therapy proved fruitless.

Before describing this exciting experiment, an introduction and chemical analysis of ZEEMAX would be enlightening. The Jungle laboratories corporation of Sanford, Florida, manufactures and packages ZEEMAX in two ounce containers and suggests dissolving one teaspoon in five gallons of water. This will condition the water for thin fish and revive fish that die "without visible reason" without increasing the temperature of the system. The compound consists of NaCl, Na sulfathiazole, Na lauryl sulphate, K dichromate, and lactose in unspecified amounts. The mechanism of action of ZEEMAX is unknown, but it produces its therapeutic effect without a latent period.

The conclusive experiment was performed on one Chinese algae eater (Otocinclus species), the hardiest fish of the experimental aquarium community. The fish jumped from its water source and lay without oxygen on the laboratory carpet for at least fifteen minutes. At the end of this period, no signs of life were observed, and the fish was placed back in the community tank. As it lay motionless on its side, slight branchial movement was noted, but when ZEEMAX, the miracle formula that STOPS FISH DEATH, was poured in large doses into the aquarium and onto the subject, the fish sprang to life and swam away. As a control, when this very fish was seen lying on its side, motionless, in respiratory distress the next day, no ZEEMAX was administered and the fish died. Legal consent for autopsy was not obtained.

We may ask, if, as clearly demonstrated, ZEEMAX can STOP FISH DEATH, then might not it have, with slight adjustment, great value for all mankind, being marketed in the 1980s as ZEEMAX: stops human death and conditions polluted air without raising temperature.

--Richard Hoffman

IN DEFENSE OF THE ACADEMY: A MODEST PROPOSAL

Disturbing evidence of weakness in our posture of academic excellence has recently leaked out from the previously impervious seams of our Department of Medicine. Once staunch and vociferous defenders of our pristine position now betray us with dangerously radical suggestions. A nationally prominent journal recently published an editorial by one of our faculty defending Community Medicine. He stated: "Knowledge of molecular biology is needed and acquisition of the skills needed in the care of the critically ill patient is essential."

Sober reflection will prevent our being deluded by what will follow this: deletion of the word critically, a subterfuge to pretend that, indeed, any area of patient care can be important enough to deserve equation with molecular biology. But the writer went even further: "Exposure to community medicine should begin early in a student's career. First-year students, fresh from the strikes, protests, and confrontations on college campuses, are sharply attuned toward society's problems. Before they are "turned off", they should be given guidance and direction, hopefully to maintain an interest and concern in these issues throughout their medical careers."

"Turned off"? By the excitements that lie in wait for them in molecular biology? In what arid academic arena could such a Freudian slip have been nurtured?

But even more distressing is the suggestion that we foment the disruptive elements brought from the strife-ridden campuses of such leftist citadels as SMU, Texas Tech, or UT Arlington. So now we face attack from within even more insidious than that without.

Prevention of further attrition of ivory from our tower can be accomplished only by immediate adop-

tion of the following proposals: (1) In order that teaching and research maintain their properly primary role, only those individuals free of illness be admitted to our wards. Otherwise, for moral reasons, patient care will ineluctably take precedence over every other activity. (2) Licensing and registration of all orderlies and aides; since theirs is the only primary moral interaction with the inmates, they should be legally culpable for their misdeeds. (3) Greater emphasis on student exposure in the outpatient clinic and emergency room, where seeing patients and having moral obligations are so clearly divorced. (4) Finally, there should be a firmer stance by the faculty on maintaining an academic arena. Pussy-footing around with mild statements like: "The price for community service requirements may be the inexorable erosion of academic activity."

"May" is too wishy-washy when we're faced with inexorable erosion.

In 1837 Emerson depicted the "American Scholar" and his relationship to society: "In the right state he is Man Thinking. In the degenerate state, when the victim of society, he tends to become a mere thinker, or still worse, the parrot of other men's thinking."

Heaven grant us even more mere thinkers, for only in that direction can we escape activism. Thucydides said of the Greeks that they possessed the power of thinking before they acted, and of acting too. And look what happened to their academies.

--Erewhon

ADVICE FOR FRESHMEN

In the last edition of the Speculum in March, 1972, the adventures and study methods of Eli Drontin, medical student, were reported to the community at large. The night before a major exam, Drontin discovered that by chopping his textbook into tiny pieces, liquefying them in a Waring blender, and self-injecting this homogeneous mixture IV one hour before his quiz, he could gain instant knowledge of the subject matter with perfect recall. Indeed, Drontin made 100 on his test the next day.

Soon after the publication of that issue of the Speculum, freshman Mike Irwin coincidentally made a perfect 100 on a neuroanatomy exam. In a special statement to the editors of Borborygmi, Irwin, now a sophomore, reveals how he made his 100 and offers some simple advice to this year's freshmen class: "Well, it was like this. The neuroanatomy practical exam was coming up the next day, and I had only been to three lectures, two of which I slept through, so I decided I needed drastic study help. Seizing on Drontins idea, I ate all of Truex and Carpenter, our textbook, made my 100 easily, and was asked by Drs. Ashworth and Sprague to join the neuroanatomy faculty the next day. But of course I refused. As for this year's freshmen, we are now at work on a suppository for Shearer's anatomy textbook and you should be able to shove it up your ass by January."

--Richard Hoffman

THE NEED FOR TEACHING EVALUATION

It would appear that a goal of the staff at Southwestern Medical School is achievement of teaching excellence. Unquestionably, another is to maintain a center of active research, rectifying misconceptions and advancing new ideas. But unless accumulated knowledge can be adequately disseminated among students, the school becomes little more than a living encyclopedia. We already know the school is a great reservoir of information; we are faced with the need to evaluate its effective transmittal.

Professors interested in achieving teaching excellence are aware of the need for some kind of feedback mechanism to ascertain the success of their efforts. One source of such information is testing. The prevailing attitude is that exams show both student and professor what material has been conveyed. Whether or not a high score correlates more closely with the student's learning ability or the professor's teaching ability is uncertain--perhaps even irrelevant--since "essential" information has been transmitted. In any case, both parties claim credit. A low score, however, exposes more underlying deficiencies of both, often in terms of obscene charges and countercharges. As a compromise both sides accuse and convict "the test" and nothing changes except for an increase in the prevailing hostility between students and faculty. In many instances the test is justly critized for inadequately reflecting what was transmitted--for reflecting a myriad of other parameters such as psychological states, rote memory ability, cramming techniques. However, the Dean of Students explained to the sophomore class that high scores on national exams have a unique value--enhancing this schools image and prestige and making it more attractive to "better" professors and applicants. The rhetorical question is whether those who use this as a major criteria for coming are attractive to the school.

Several professors were asked what criteria they used for evaluating their teaching ability. The following standards were most frequently cited: the number of students either absent or asleep; the incipient noise level; graffitti on blackboards and toilet stalls; overheard comments; the number of petitions circulating which call for their resignation; and ESP. While these may say something about a professor's overall teaching ability, they fail to indicate specific areas in which improvements can be made. For instance, a professor might gaze out into the masses and notice 40% of the class asleep--10% above normal. Differential diagnosis of such epidemic narcolepsy should include such phenomena as: it's too early in the morning; the coffee-maker is broken; dim lights and "Oh shit" slides; monotone voice; the class being subjected to the same information presented five times in three different courses in two days. The existing abyss between most faculty and students discourages any physical examination of the afflicted class, and lab findings are unavailable since no lab exists. Therefore definitive treatment is either absent or, at best, haphazard.

In view of the deficiencies in the present feedback mechanism, it would be advantageous to institute a formal teaching evaluation to augment the existing quasi-established system. The new system should be designed to provide the professor weekly feedback and a final analysis after his allotted lectures have been completed. Concurrent analyses could be implemented through weekly meetings between class-elected representatives and individual profes-

sors. In addition to eliminating tedious paperwork, this would give the professor an on-going analysis of content presentation and it would help promote student-faculty communication. Furthermore, this procedure might help reduce the current unintentional duplication of information presented by different departments. A final written analysis taken by the entire class and sponsered by each department would give complete and detailed information not obtainable from weekly conferences. Faculty teaching, tests, laboratories, visual aids, exams, relative time apportionment, and inner/intra departmental curricula coordination could be evaluated and departmental chairmen could better design teaching programs for the following year.

Last year, when it became evident that no formal teaching evaluation would be initiated, a small group of freshman students approached Drs. Ron Esterbrook and Art Babbock for assistance in designing a biochemistry evaluation form. Even though both were too late and lengthy, the resulting benefits greatly outweighed the faults. We were dismayed, however, to find that the Physiology Department chairman had not instituted such an analysis because he had "expected" the students to initiate it. Who benefits most from a post-mortem examination of a department's teaching performance? Surely not the class that has just finished the course and will probably not be exposed to those professors again, but the individuals of that department's faculty who wish to improve their teaching ability and the coming students who thereby benefit from the resulting educational excellence. For these reasons, it is the ardent hope that while it is still early in the academic year, the administration and department chairmen will begin developing a formal teaching evaluation.

--Jason Worchel

HMO AND THE SOVIET POLYCLINIC

The proposed evolution of Health Maintenance Organizations (HMO) in the United States has brought criticism and praise from various quarters of the medical world: it is the pariah of medical societies and well-to-do physicians in private practice; it is the salve of the socially-minded physicians who worry about how they are going to effectively give to all strata of society good medical care; it is the perplexity of planners and coordinators as to how, where and how well such a program can be applied given the American medical "non-system" as it now exists. So far, the critics have won out--HMO is dead for another year, having been "tabled" by congress until next year. This gives us time to think further about the idea.

Briefly, and in general, Health Maintenance Organization is an institution of primary medical care

which serves a defined and enrolled group of people who partake in a pre-paid payment plan of some sort. A great many permutations upon this basic theme have been proposed, but all fit under the general definition. The idea behind HMO is not a new one. It has its precedents in several of the more or less socialized countries in the world, with varied devices, efficacy, and results. It would be very useful to look at all of these implementations but for now one very prominent one will suffice--the Soviet health system offers us a working model of such an organization in its polyclinic.

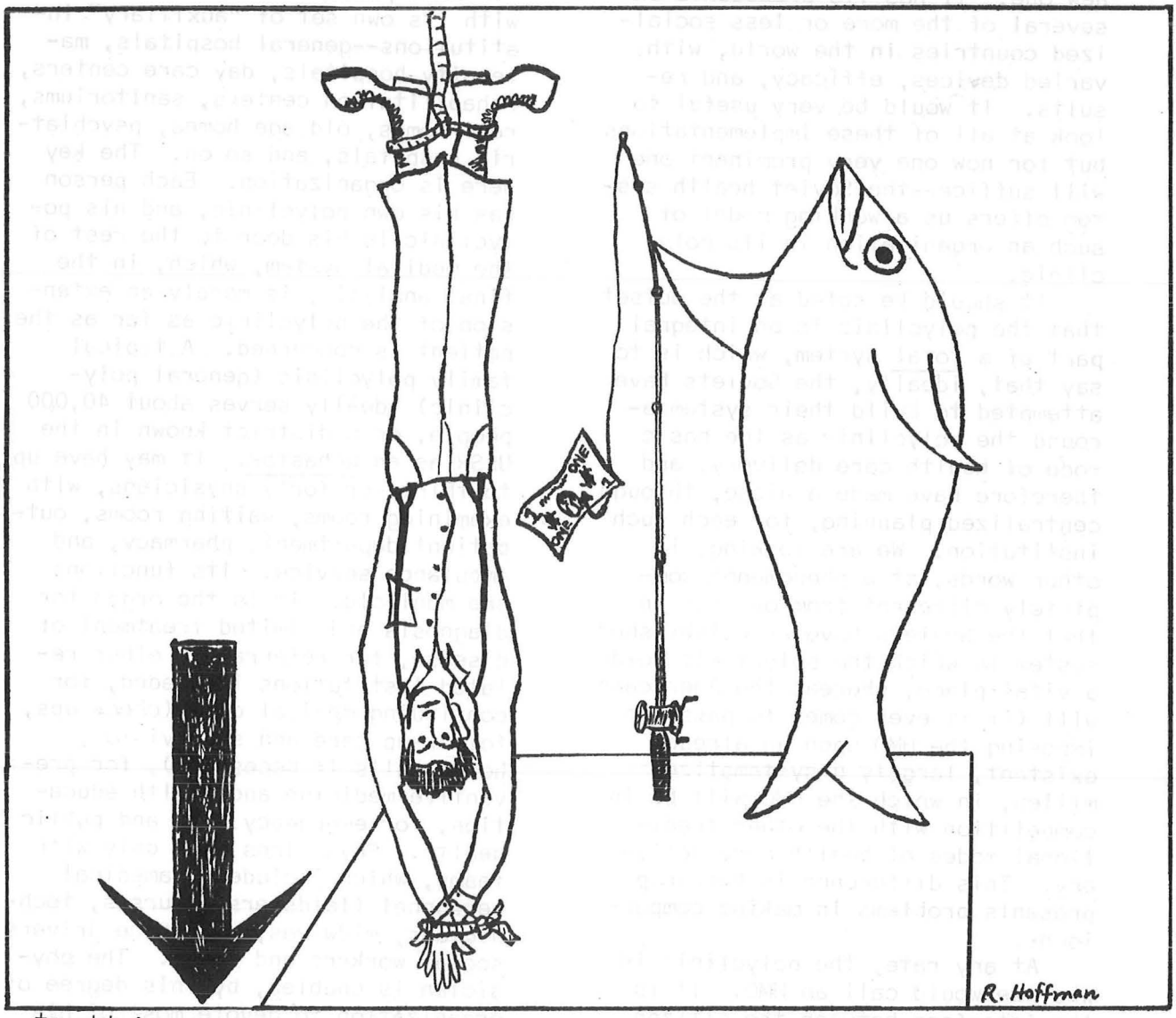
It should be noted at the outset that the polyclinic is an integral part of a total system, which is to say that, ideally, the Soviets have attempted to build their system around the polyclinic as the basic mode of health care delivery, and therefore have made a niche, through centralized planning, for each such institution. We are looking, in other words, at a phenomenon completely different from our own in that the Soviets have an established system in which the polyclinic holds a vital place, whereas the Americans will (if it ever comes to pass) be imposing the HMO upon an already existent, largely unsystematized milieu, in which the HMO will be in competition with the other traditional modes of health care delivery. This difference in backdrop presents problems in making comparisons.

At any rate, the polyclinic is what we would call an HMO. It is the interface between the citizen and the medical system in Russian medicine. Consisting of a group of specialists all under the same roof, it serves the medical needs of a defined population. Care and treatment are free--that is, paid for by the government through the taxes of the people; likewise, the physicians are salaried by the government. There are several different types of polyclinic in the urban setting, depending on the population that it serves, including family, pediatric, psychiatric, factory, and variously other designated polyclinics.

Each polyclinic is associated with its own set of "auxiliary" institutions--general hospitals, maternity hospitals, day care centers, rehabilitation centers, sanitoriums, rest homes, old age homes, psychiatric hospitals, and so on. The key here is organization. Each person has his own polyclinic, and his polyclinic is his door to the rest of the medical system, which, in the final analysis, is merely an extension of the polyclinic as far as the patient is concerned. A typical family polyclinic (general polyclinic) ideally serves about 40,000 people, or a district known in the USSR as an uchastok. It may have up to thirty or forty physicians, with examining rooms, waiting rooms, outpatient department, pharmacy, and ambulance service. Its functions are manifold: it is the organ for diagnosis and limited treatment of disease, for referral to other related institutions if needed, for continuing medical care (check-ups, follow-up care and supervision, house calls if necessary), for preventive medicine and health education, for emergency care and public health. Physicians work only with teams, which include paramedical personnel (feldshers), nurses, technicians, midwives, ambulance drivers, social workers and so on. The physician is enabled, by this degree of organization to devote most of his time to his patients without wasting his time on preliminary processing or work-up procedures, which are taken care of by people under him. He is also able to obtain consultations easily and make house calls. His office hours are defined by the office hours of the polyclinic. It

is evident that the physician-patient rapport is enhanced in such a situation.

The polyclinic is so located that it is readily accessible to its "target" population. This in itself accomplishes several things. It gives the patient the opportunity to obtain preventive medical care through regular physical examinations, innoculations, prophylactic medicine and care for incipient conditions, and information. In the same vein, the polyclinic personnel are acquainted with their constituents and are able to deliver continuing medical care on an individualized basis. Dissemination of information to this defined population is simple, and emergency care is available and prompt when a situation calling for it arises. In general, the organization is much more comprehensive when the patient and the source of his care are in such close proximity. This organization is evident at all levels, as shown in the fact that there are, as we have mentioned, various types of polyclinic. The factory polyclinics have as their defined population the workers in a particular factory, and is located in or near the factory, making it very conven-



ient for the workers to receive medical care. Pediatric and psychiatric polyclinics are specialized subsets of the overall polyclinic idea, and have complete facilities for their defined populations--children and people with psychological problems.

If it is evident from all of this, that many good things flow out of the polyclinic approach to the delivery of primary medical care, it can also be argued (and has been) that there are several problems with it. Aside from the theoretical problems which we are primarily concerned with, the main problem is that the polyclinic, as has been described, does not by any means universally exist in the USSR. It should be realized that the description is ideal in that as far as is known, only a few of the established institutions have succeeded in fulfilling all the dimensions we have mentioned. However, enormous gains have been made in the direction of fleshing out the system, whose groundwork has been well-laid; the ideal exists in some cases, and in others, is actively pursued. One of the main areas of failure in the polyclinic approach has been the universal problem of delivering adequate health care to rural areas. As has been said, the polyclinic is primarily an urban phenomenon.

The theoretical problems with the polyclinic are complex. To start, it seems that the family-care concept has suffered. While everyone in the family gets good care, they don't get it in the same place: father gets it at the factory polyclinic, mother at the family polyclinic, and the baby at the pediatric polyclinic. For a one or no-car family, this presents problems. It has been said also that often times a dissatisfied patient will not be able to switch doctors, or for that matter, polyclinics, which means that although he is receiving good care in most situations, he is not allowed the freedom of choice as to where and from whom he receives his care. There has been talk recently that a class structure exists in the Soviet health system in that the "more important" citizens receive better care from better polyclinics. However this may be, it does not detract from the fact that medical attention does exist for everyone: "better" or "worse" are only a matter of degree. There are, indeed, many levels of criticism of the Soviet system as a whole--the lack of physicians' incentives, the general low level of the quality of care and technology, the overall poor level of health, all of which are certainly debatable, but not cogent to this essay--we are concerned with the mechanism of the polyclinic as a primary care establishment, and this has been described.

The American concept of HMO is not so well developed as the Soviet concept of polyclinic. At any rate, it is not so far reaching in terms of centering all health services--personal, public, and community--at the local level, as does the polyclinic in its ideal form. In their present level of definition, our HMO's will be private institutions which would offer personal medical care to an enrolled population on a pre-paid basis (either through Medicare, Medicaid, or some sort of private, group, or company insurance), and that, basically, is all that they will do. They will, as has been said, be in competition with private practitioners, municipal hospitals, group practices, and so on. In effect, they will be just another part of the American kaleidoscope as it now exists.

It seems that with foresight, the HMO could be a much more basic vehicle for the delivery of comprehensive care at a local level to the population which is stated to par-

take in its services. The Soviet system offers some clues as to how this is possible. If we look there we can see that not only can the presently acknowledged benefits of the HMO be realized, such as efficiency of the team-medicine approach including the peer review concept, the rationalization of the use of medical manpower, the availability and accessibility of quality care to a defined population at a reasonable cost, but we can also work on incorporating other important benefits, such as emphasizing preventive medicine and continuing health care, attempting through proper management to consolidate all existing health services at the local level and maximizing their impact on the target population, and perhaps raising the general level of health education.

Finally, we would hope also to incorporate some of the traditional and quickly dying assets of American medicine, in particular the "family doctor" idea. Indeed, it seems that although the HMO is functionally a collection of specialists, it could include an element of the old-time American family practitioner who has personal contact with and knowledge of a particular family, its situation and its problems. This might be a specialist with enough general medicine under his belt to be able to be a "family physician" in that he would be the personal physician and the first contact of the members of a family under his care with the rest of the staff of the HMO, and hence the rest of the medical system. This does not mean that he will devolve into a generalist (a general practitioner), but means, rather, that he is precisely a "family physician" who handles small matters, and knowledgeably refers the larger ones that are not in his field. Hence, it seems that an appropriate adjunct to the development of this new vehicle of health care delivery, HMO, might be the designation of a new class of physicians, who would function efficiently and humanly within the framework of this vehicle, which holds so much potential.

--Steve Moser

LITERATURE

In ordered columns march on
Down the tunnel to Babylon
In a monotone sing a dirge
About beauty and life's worth

Media strings minds obey
Of puppeteers far away
Buying new necessities
To live in glass societies

Left, the will to exist
Knowing neither despair nor bliss
These zombies ooze into space
Thriving on the Masters' waste

Trading freedom for slavery
Passion for depravity
There exist no extremes
To be the norm is their dream

Somber forrests laid to rest
Birds poisoned in their nests
The cradle chemically stilled
Nature's life, once wild, killed

Listen to the sirens shriek
See the panic flood the streets
The final decision made
To the end forfeit bade.

--Jason Worchel

TO JERALD

Outside the clinic door
(Shining white and, on the outside, clean)
Stands a windowless truck
Darkness
Prevents one from seeing inside, but
Brilliant sunshine
Blinds the men in white overalls who step out
Bewildered
And wrist bound
Brothers, black and white

Floating faces of the clinic,
Sea of sickness,
Ebb aside to let them pass.
Fish cannot have expression
They do not see their own agony,
And cannot agonize over
The deputy's sleeve which
Bulges with the stars and stripes
Old glory
Unfurled by muscle.

The men in white coveralls
Swim through,
Shuffling in shoes without laces,
Have patient looks,
But their smiles betray them.
They are not fish.

And long to say as they surge
"Move aside motherfuckers!
You have freedom.
Look what you've done with it."

--Emil Sea

BAND-AID

I workin' hard, mighty busy
Man come up, ask what's the time
I blow my top, mad at him
Then I stop, say it's two twenty-nine.

Yeah how's your dog, how's your sister
You can't be callous, you gotta be a blister.

I in a hurry, makin' a plane
Blind ole man holds out a cup
I mad at him, I's feelin' kinda good
Then I stop, and help him up.

Yeah how's your poodle, how's your sister
You can't be callous, you gotta be a blister.

I watchin' the news, on TV
Man come on, says war is near
I flip the channel, gonna watch a movie
Then I stop, drink all of my beer.

Yeah how's your afghan, how's your sister
You can't be callous, you gotta be a blister.

AC on, I's tryin' to sleep
Knock on the door, askin' for a fan
I got one to lend, but he woke me up
Then I stop, glad that I can

Yeah how's your tootsie, how's your sister
You can't be callous, you gotta be a blister.

--Richard Hoffman

Stop! I surrender. Shackle me to time.
I never wanted to commit this crime
I ate the alphabet with rhythm and rhyme
Then shit on the faces of the stupid and blind

The professor spoke with an open fly
And lost his mind when he couldn't cry
Didn't eat ice cream when the truck went by
But invited me in to wine and die

Fuck softly, the children are already dead
One more orgasm in your mind made bed
Then you, me, and Jesus shall all be wed
Guilty! the salt and pepper people said

It was a mirror that gave them such a fright
They saw me pedal her home at night
But forget just where to park my bike
And moths are still addicted to street light

Of rats and men with cinnamon spice
And halls and balls on little green lice
All lost in the toss of plastic dice
No, reality will never suffice!

--Jason Worchel