MEDICAL BULLETIN

UNIVERSITY OF MINNESOTA

MARCH-APRIL 1970

MEDICAL BULLETIN—UNIVERSITY OF MINNESOTA
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Published bi-monthly by the Minnesota Medical Foundation. Annual membership and subscription: $25.00. Second Class postage paid at Minneapolis, Minnesota. No advertising accepted. Editorial office: 5412 Powell Hall, University of Minnesota, Minneapolis, Minnesota 55455.

Vol. 41 No. 4

March-April, 1970

Published by the Minnesota Medical Foundation in behalf of the University of Minnesota Medical School, University Hospitals, Minnesota Medical Alumni Association, and the Minnesota Medical Foundation. Statements and opinions published herein are exclusively those of the authors themselves.

DEANS' CORNER

Your Medical School is caught up in the throes of renewal. The developments in this institutional renaissance range from the impending reorganization of the Health Sciences and the prospect of a redefinition of the missions of the School and of the other University health science units, to the new curriculum and the promise of a fresh approach to teaching and better insight about learning in medicine. These topics have been the subjects of essays in the Deans' Corner in previous issues. This month the focus is on the medical student.

A view of the medical student scene in 1970 finds the spirit of renewal very much in evidence. The student essays and extra-curricular accomplishments presented in this issue are important and time honored activities in which students show their ability to re new themselves by breaking out of the restraint of the ordinary curriculum. Another of the manifestations of renewal is much in evidence in the Dean's Office this month as 175 junior medical students plan and register for the completely elective senior year. The students are responsible for planning an educational program, with the help of an advisor. Last year, no two programs were completely alike! The students did a fine job in making the most of their educational opportunities.

In addition to assuming more personal responsibility for planning their education, students now want to learn more about social issues for which they feel an increasing and impending responsibility. They want to be involved more in programs which get them in the front line of medical practice and patient care, and they want to see more of the world of medicine. In several student initiated projects currently underway, they are working responsibly and acting and planning responsibly. In the Medicos Latinos project, from 6 to 8 students will work in the front line of delivery of health care in several deprived areas in South America. In a sophomore class project, supported by Dr. Jack Verby and the Department of Family Practice and Community Health, about 110 enthusiastic medical students have spent a portion of each week for one to two quarters working in the offices of more than 50 physicians in general practice. In the "buddy system" in Introduction to Clinical Medicine in Phase A of the new curriculum selected seniors and juniors act as mentors for the freshmen on a one to one basis. And, last year's sophomores worked out with Dr. Gaylord Anderson a plan to add several topics of intense student interest to the course in Public Health. These were presented at lectures and special discussions in conjunction with the course. How else are we to explain these activities if not as a manifestation of responsibility on the part of interested students?

The students' quest for renewal leads to various forms of involvement. Students are involved in planning for the new curriculum, serving as regular members of all major faculty groups which have worked to develop this new program. An especially busy group right now is the Academic Committee of the Medical School Council, which includes such stalwarts as Tom Cosgriff, Pat Lilja, Kathy Grant, and Henry Doerr. This committee is working jointly with the faculty group in planning a new course, Man in His Community. The presentations in this important segment of the new curriculum will be the apotheosis of a broad, interdisciplinary, relevant course of the future. Students are also involved nowadays as full voting members of all major school committees, including the Admissions Committee, the Scholastic Standing Committee and the ad hoc search committees for new department heads. Students bring their own special querulous, tenacious and often audacious "why not?" to the deliberations of these groups. They contribute greatly to the school through this involvement. There can be no doing without them in this capacity from now on!

Everywhere there are the outward trappings of change, and these deserve comment because they contrast so sharply with the past and confirm our suspicions that the world may, in fact, never again be quite the same. Time was when beards were removed by edict. Unthinkable today! Beards and all manner of hirsute faces and a variety of hair styles are just in step with modern trends. There is also considerable variety and color in dress which mirrors the modern world. The patients seem to accept these changes. For those very sick with little hope, their days are brightened by the colorful ties and clothes, to say nothing of the compassion and interest, of these modern young men and women.

Thus the 1970 student scene at Minnesota is one of activity and of struggle and change as the institution, its faculty and students work to discover themselves and move toward a better order of things in the decade ahead.

With best wishes,

Robert J McCollister

Robert J. McCollister, M.D.
Assistant Dean

"The Times They Are Indeed A-Changin'"

Gone are the days when Minnesota's medical students were passive, docile creatures who plowed through mountains of snow to class and simply would grin and bear the class or professor no matter what the appeal. The students of today look different, act different, feel different and react differently to social, political, environmental, educational and health care delivery problems.

Yet, for all the changes, there are emblems of the past which carry forward valued traditions. The seven fraternities still have large memberships ranging from over 80 members at Phi Rho Sigma to over 35 at Alpha Kappa Kappa. In each house, approximately one quarter of the members live in. The fraternities, their present locations on campus, and presidents for 1969-70 are as follows: Alpha Epsilon Iota (Women), 528 Ontario St., Susan Gardin; Alpha Kappa Kappa, 627 Ontario St., John Myhre; Nu Sigma Nu, 631 Oak St., S.E., David Giles; Phi Beta Pi, 632 Ontario St., Tom Vorpahl; Phi Chi, 325 Harvard St., S.E., Bill Bevan; Phi Delta Epsilon, 501 Ontario St., Frederic Nemer; Phi Rho Sigma, last of the nearby houses at 317 Union St., will soon be razed to make room for the building Expansion Program of the Health Science Center. Phi Rho owns three lots near the University, but it is doubtful that a new house will be ready for awhile, reports president Kent Molde. The medical fraternities keep alive the tradition of storing old exams, social hours, and inter-fraternity touch football rivalries.

In addition to the fraternities, student opinion and activity follow several distinct avenues. A dozen student leaders are active on the Student Council. This has been the traditional forum for student discussion and the formulation of plans to present the student voice to the Medical School administration. Student representatives are actually helping to shape the implementation of the new curriculum at the Medical School.

The **Student Health Organization** chapter commonly referred to as (SHO) did include a particularly vocal group of students who possessed a spirit more akin to activism. SHO had ambitious plans last year and formed a number of committees on such topics as Pollution and Radiation to the Disadvantaged Student Program. SHO is now in a state of limbo due chiefly to lack of finances and the absence of a communications network. The quotation from Pat Wolff, a sophomore medical student, appearing on pg. (2), sheds more light on SHO and its problems.

Students now have their own newspaper, **The Townmeeting Newsletter,** which appears occasionally, and presents views and information. Often its articles are sharply critical of the Medical School faculty and administrators. The Newsletter is currently under direction of editor, Carol Erwin and assistant editors, Jim Jaranson and Dave Lam. Carol, a sophomore, gives a general summation of the Newsletter's purposes on page (3).

Other students are involved in community projects and some like junior, Bill Rom, promote special projects. He has actively developed and supported **Medicos Latinos.** See his report on page (17) of this interesting international project for seniors during their free time.

In pages (2-4), a representative sampling of student opinion on both student affairs and social problems is presented. The students "tell it like it is" about the Student Health Organization (SHO), environment and pollution, and the tempo of student life at the Minnesota Medical School.

Alumni of the Medical School who wonder what it's like at Alma Mater today will find these student voices interesting and informative.

Today's U of M Medical Students Speak Their Mind

We sampled the opinion of the current medical students at the University of Minnesota concerning medical education and social issues.

They reveal their candid feelings and reactions in the following quotations.

Allan Solum — Senior
The senior class is definitely more attuned to social problems and issues. Many students are concerned about civil rights and a more equitable distribution of medicine to all classes of people. The medical students are like the rest of the University population . . . fairly rebellious!

Pat Wolff — Sophomore
Students have many ideas and are willing to work hard but a student simply cannot afford to spend 50% of his time making posters, telephoning, typing, and running around to five different offices. Getting information to Health Science students other than medical students was especially a problem. There are many health issues that involve all the health disciplines — disadvantaged student admissions, environmental health, updating of curricula, health care in the inner city and rural areas — to name just a few, but there must be a central place and person for coordination and communication.

Floyd Anderson — Freshman
My impression of the new curriculum is a reflection of the faculty and the administration as well: surprisingly flexible, invariably helpful, and encouragingly interested. Although many refinements are yet to be initiated, especially in Phase B, the freshmen are excited and confident of a still higher quality of education.

Carol Erwin — Sophomore
The Town Meeting Newsletter has a staff of five. We are interested in presenting the pros and cons of various controversial issues, student news, and a forum for student expression, dissent, and discussion on nearly any subject. Our goal is to try and balance the paper concerning shades of opinion and reactions so that we give representative coverage and not simply the lopsided view of a particularly vocal group.

Davitt Felder — Sophomore
The new curriculum is not doing half of what it is supposed to do. I was a member of SHO but we apparently weren't the kind of student organization that the administration wanted to sponsor financially. (At least this was my impression.)

Devron Char — Senior
The student body at Minnesota's Medical School is very conservative versus a more urbane, non-commuter campus. The new curriculum is great! The freshmen are much more enthusiastic about their education and have a chance to see the application of the basic sciences to clinical experiences.

Marshall Golden — Junior
I believe the class ranking system was ridiculous. The decision to drop it was a smart move. Either a person is acceptable as a doctor or is not. The grading system has served no good purpose and may have actually done harm to some individuals.

Mary Tierney — Senior
Last year SHO representatives played a strong part in supporting the Medical School's Committee for the Disadvantaged Students. Apparently the Medical School's Admissions Committee and the Committee for the Disadvantaged Students were in a deadlock concerning the admission of disadvantaged students. Eventually, we talked with both Dean Howard and President Moos. Today, there is a program for admitting disadvantaged students in Minnesota's Medical School.

IMPRESSIONS OF MEDICAL EDUCATION

A Sensitive Response to the New Curriculum and Life at the Medical School.

by James Jaranson, '73

For a freshman medical student to try to recall and record his impressions of and reactions to the first quarter of Medical School can present some difficulties. Personally, I feel that my senses have been so thoroughly bombarded with new experiences that I find quite a task trying to elucidate the events and people who have helped to formulate my ideas about medical school and, more specifically, about the University of Minnesota Medical School. Most certainly, in attempting to crystallize thoughts into a relatively short article, I cannot possibly and will not attempt to mention any but a small portion of the individuals who have influenced me during this quarter. At the other extreme, I may pursue tangents that would seem insignificant to other members of the freshman class. In the final analysis, I suppose I'll have to adopt the attitude of James Watson in his preface to *The Double Helix* and hope that in my situation as well as in his, "an incomplete version is better than none."

Excitement Over The New Curriculum

To be perfectly candid about my own situation, I must admit that I was somewhat apprehensive about what to expect at Medical School. Granted, I was excited by the prospect of a new curriculum and by the option of going through Medical School in three years rather than the conventional four. But I still didn't especially care for the idea of starting all over as a freshman again; in a way, this seemed almost humiliating after just having completed a four-year sequence to obtain a degree. And, after working hard for those four years to get into Medical School, the very thought of having to work just as hard, if not harder, when I got to Medical School was almost enough to defeat me before getting there. On the other hand, Medical School would in all probability be my last step in formal, structured education and, from this point of view, the most important one.

However, the orientation session served to alleviate, at least temporarily, some of the doubts that were plaguing me. After the initial drudgery of having pictures taken, filling out standardized forms, and taking psychological tests,

we were given more specifics on the nature of the new curriculum and on the changes in the evaluation of student work. Clinical work would be introduced during the first three quarters in the form of ten Saturday morning sessions on relevant topics and a more individualized tutorial and buddy system during free periods of the week. After the intensive basic science emphasis during the first three quarters, a major shift to a program of integrated core material related to organs, systems, or topics would last for five quarters. The remaining three or five academic quarters would consist of a largely elective "tract" in each student's major area of interest. Class rank had been dropped entirely, and the freshmen were to be given grades of outstanding, satisfactory, or incomplete in all courses. In fact, the changes seemed such an improvement over previous medical education that Dr. W. Albert Sullivan, Assistant Dean, felt he could no longer appropriately greet the freshman class with the inscription carved into the Stone Gate of Hell in Dante's *The Inferno*: "Abandon All Hope Ye Who Enter Here."

No Longer An A, B, C Grading System

Even the orientation session itself, we were told, had changed significantly over previous years. Rather than presenting us with a succession of lengthy speeches stretching out over the entire day, each of the deans gave a brief introduction. John Westerman, Director of the University Hospitals, entertained the staff at a meeting to which the freshman class was invited, and, in the afternoon, we split up into groups of twenty students, a faculty member, an upperclass medical student for discussion purposes. Dr. Shelley N. Chou, professor of neurosurgery, led my group into an informative clarification of the optional three-year program and of the rationale for the new student evaluation system. The option of completing Medical School in three years, we learned, would be open to all students who maintain satisfactory grades in their Medical School work. The new grading system was intended to de-emphasize the rather arbitrary A, B, C, distinctions and to concentrate on individual evaluation of each student. Faculty members were to write comments about each student as part of the official record. By eliminating the ranking system, the excessive weight which the quantitatively measured work in basic science courses had carried was substantially reduced. The emphasis had switched from research and the basic sciences to clinical work. In theory, the competition was reoriented from fighting for a class rank to a sort of self-competition.

My reaction to the very impressive theoretical superstructure manifested itself in a number of ways. I was thoroughly impressed with the thought and effort that had gone into the preparation of the curriculum. But I didn't want to try for outstanding grades for fear that I'd end up grabbing for the equivalent of the big "A" again. And we were told that, if we failed a course, provisions would be made for us to retake tests or to do additional work to obtain satisfactory completion of the course. Consequently, I felt rather secure in the situation.

Classes started, and I managed to weather the first anatomy lab without any adverse reaction to seeing and working with the cadaver. And, as the first week progressed, I attempted to adjust to the rather rigorous routine of a Medical School class schedule which included biochem, gross, histo, embryo, and psychology. After spending most of each day in class, I was exhausted enough to sleep for as much as two hours every night after coming back to the fraternity. To try to study after that, even with the additional rest, took a great deal of effort. In fact, it was much easier to talk to my roommate and other guys in the frat house than to read and digest fifteen pages of *Cunningham's Manual of Practical Anatomy.*

The Fast-Approaching Anatomy Exam

As the first anatomy test approached, however, I began to realize what a fantastically large volume of information was known about the upper extremities. I also began to realize that my volume of knowledge didn't begin to match that. And every time this realization would hit home, I'd run to the bookstore and buy a supplementary anatomy atlas or textbook.

Not only was this expensive, but now I had the added problem of trying to decide which book to study since I couldn't possibly study them all. To top it all off, I began to wonder just exactly what relevance knowing the detailed anatomy of the hand would have for anyone but a surgical specialist of the upper extremities. Consequently, I was extremely interested in attending the second introduction to clinical medicine session entitled, "Basic Science Relevance to Clinical Medicine and the Practicing Physician." As most of these sessions, I found this one particularly informative and very well planned and executed. The carefully selected array of speakers and the opportunity to question these practitioners provided many insights into the importance of the basic medical sciences. And I was convinced by the presentation of cases in which adequate knowledge of the basic sciences was essential to solve clinical examples that it would be worth every effort to learn as much basic science as possible during this initial coursework. Unfortunately, the first anatomy test was two days later.

Sessions with Faculty Tutors

Sessions with faculty tutors and upperclassmen served to ease adjustment to Medical School by putting the classwork into a clinical perspective. In an attempt to reduce the initial shock that upperclass medical students encounter when first exposed to patients, the freshman class was divided into groups of four students which met with a faculty clinician every other week for a period of three hours. On alternate weeks, groups of two students met with a junior or senior medical student who volunteered to act as a "buddy." Dr. Ben Fuller, Chairman of the Department of Family Practice and Community Health, provided my group with several insights into his own approach to patients as well as to the philosophy of the practicing physician and the factors influencing a doctor's ability to deal with his patients. With Dr. Fuller, we were not only exposed to a view of an actual doctor-patient situation, but were able to get some feeling for the doctor's role by placing ourselves in it. And, at least for me, wearing the white coat, using the stethoscope for the first time, and just talking to a patient meant a great deal. Dr. Russell V. Lucas, associate professor of pediatrics, showed my group how psychological factors can influence a patient's reaction to somatic illness, and illustrated these factors by interpreting a portrait of a family painted by Edgar Degas, the French impressionist. And, in a second clinical example, he showed us the relevance of anatomy and biochemistry in the understanding of pediatric cardiology. Thus, the importance of basic medical sciences was again reinforced and the coursework placed into a relevant framework. Within three weeks of the beginning of classes, all the freshman medical students had seen patients, a phenomenon previously deferred until the middle of the sophomore year.

A New Course in Psychology

In addition to the early clinical introduction, the actual coursework during the first three quarters had undergone revision. Most apparent was the addition of a course in behavioral science, consisting of one lecture and one discussion group per week during the first quarter and plans for two lectures and two discussion group periods during the second quarter. In this "Adult Psychology" course, Dr. John Brantner, associate professor of clinical psychology, beginning with the thesis that "heredity and constitution give the basis for man's behavior," lectured on topics ranging from the psychology of death and prolonged disability to the effects of clothing and tattoos on personality development. Following each lecture, the class split into groups of ten students and a faculty member for discussion purposes. Discussion topics ranged from amplification of lecture material to topics totally unrelated. Often my group leader, Dr. Reynold Jensen, former director of child psychiatry, brought in relevant material from his clinical background which added a great deal to my own understanding of the medical profession.

Somewhat similar to these psychology discussion groups were the seminars conducted by Dr. Pearl Rosenberg, clinical psychologist in the Department of Physical Medicine and Rehabilitation, for her studies of medical students.

These groups, involving a third of the freshman class, served mostly as a forum for airing grievances about Medical School and the life of a medical student. The group in which I participated tossed around ideas as varied as the financial problems of medical students, socialized medical care, the AMA, and homosexuality as well as the more conventional topics concerning courses, professors, the grading system, and the work load.

Student-Faculty Relationships

Although the changes in the curriculum seem dynamic, and indeed they are, this is not what has impressed me most about the University of Minnesota Medical School. After graduating from a small liberal arts college, I expected an institution as large as the University to have a very poor student-faculty relationship. But, quite the contrary, I have found the professors to be unusually willing to help students with academic difficulties or just with problems in general. I especially remember the times when Dr. Carl Heggestad, associate professor of anatomy, came to stress some aspect of dissection that had crucial clinical significance. Outside of class, faculty members seem to make great efforts to get to know students, and they are readily willing to talk about nearly anything. The coffee hours at Dean Cavert's home during the first week of classes provided an excellent means of communication, and faculty members are often invited to class parties.

After some reflection on my first impressions of the Minnesota Medical School, I have virtually no regrets about coming to Medical School or to this particular Medical School. Granted, there have been problems for me and will undoubtedly always be problems for the freshman medical student to adjust. But I have found the favorable aspects of Medical School to greatly outweigh the disadvantages. The faculty is interested, students are aware, and the curriculum is exciting. And I know I can rest assured that I'm getting some of the best medical training available.

National Medical Honor Society Elects 28 U of M Medical Students

Alpha Omega Alpha, the national honor medical society, has elected 28 medical students at the University of Minnesota to membership.

Twenty seniors and eight juniors were cited in recognition of their academic achievements and personal qualification.

Senior class electees to Alpha (Minnesota) Chapter of AOA are:

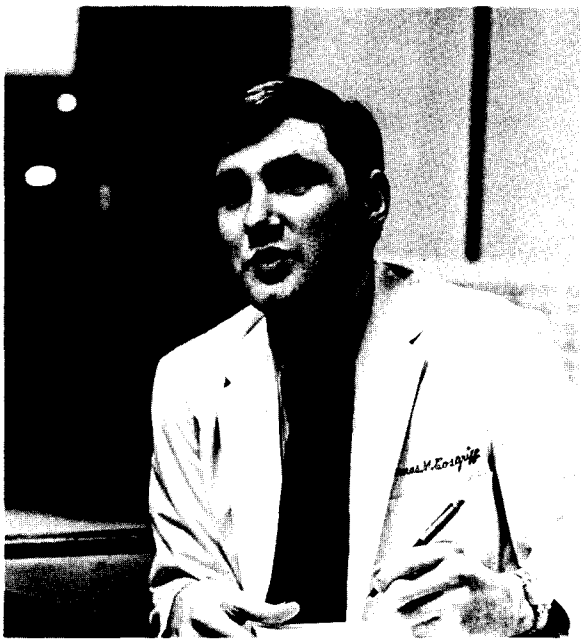
Richard C. Bailly, J. Paul Carlson
Dorr G. Dearborn, Noel K. Dysart, Jr.
James R. Eckman, Daniel H. Frenning
David L. Hanson, Frederick D. Hathaway
Wayne F. Moore, Gregory G. Nelson
Roger L. Nelson, Eugene W. Ollila
Nicholas F. Reuter, William S. Shimp
James C. Strom, Mr. Mary Falenzykowski Tanghe
Gordon J. Theneman, Paul T. Wicklund
John V. Wrigley

Junior class electees are:

Charles L. Beck, Darrell L. Carter
Roy J. Dunlap, II, Allen L. Horn,
Paul R. Julsrud, Robert W. Leland
Juris Priedkalns, Sandra J. Scobie

Dr. W. A. Sullivan, Jr., is faculty advisor to AOA at the Medical School.

The Rise of Idealism in the Medical School



by Thomas Cosgriff, '70

To speak of the rise of idealism is, at one and the same time, to pass judgment on whatever idealism already existed. Either the old idealism is a sham, or it has become irrelevant. Perhaps twenty-five per cent of America belong to an ocean of poverty. Like the levels of Dante's hell, the levels of deprivation vary. Michael Harrington called it the *other* America. It is also the forgotten America. The ocean of poverty is an ocean of disease. Serious illness is two to three times more common among the poor than among the population as a whole. Heart disease, hypertension, eye disease, dental disease, arthritis, and mental illness are all more common among the poor. Someone is seriously ill in twenty-five per cent of the families of poverty.

It is not an exaggeration to say that all the poor are sick. Malnutrition and inadequate housing combine with the conditions of crowding, inefficient or nonexistent sanitation, and low levels of literacy to produce a chronic malaise of mind and body. Poverty and disease in turn breed violence. As a final element of cruel absurdity, our culture sees poverty as a crime, not of the society as a whole, but of the victims. To live in the sea of poverty is to deserve to be poor.

The role of physician has always contained elements of idealism. The man who takes on the role is required to render service to others in a selfless manner, without thought of personal gain. He is expected to relate to persons as individuals, each relationship separate and special. His knowledge intimately relates to human welfare. His competence is to relieve suffering and to prolong life. A great deal of charisma attaches to his person. Selfless service to the individual, not nameless, but separate and special; the relief of pain and suffering; and the charisma of the healer all contribute to the idealistic image of the physician. He receives from society a degree of veneration that is only understandable so long as this idealistic image is sustained. In *Ecclesiasticus*, the people are told to, "honor the physician with the honor due to him."

The role of physician is exacting and individual men have always strained it in the performance. The real knight and the fable knight are not the same. Long before Christ, Plato worried that all physicians were not true physicians: "No physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of his own patient; for the true physician is also a ruler having the human body as a subject, and is not a mere money-maker."

In Defoe's account of the plague there is high praise for physicians who "ventured their lives so far as even to lose them in the service of mankind." But earlier chroniclers recorded the more ignoble fact that the physician was often the first to leave the city, the first to retreat to the country, and the last to return.

A long time ago, perhaps, it was enough for the physician to fix his attention on the narrow world of his face-to-face dealings with the few patients he treated. His world of intimate contact could define the scope of his responsibility. But now it is no longer enough. The responsibility of the physician is not to the few, but to the many. The individual can no longer be dissected out from his fellows and from the social situation.

In the fifty years of this century, the medical profession has ignored the social problems of the times. Its great concern for the individual man stands beside its seeming indifference to the great masses of impoverished human beings that can no longer be hidden behind the barriers of travel and communication. The old idealism exists apart from the concerns of the day. For this reason, it is no longer relevant. To see medicine in the 1970's is to see the slums.

If the spectre of poverty and disease, the spectre of the poor sick, is at the root of the new idealism in the medical school, the lack of relevance of the old idealism made it necessary. But it is important to know just what the new idealism is.

Like his counterpart in the Europe of the plague, the physician has left the city and the people of the city. Everywhere, it is the same: South Chicago, Harlem, Cleveland, Los Angeles, Detroit. He has retreated to the suburbs. He has retreated to a world where the problems are easier to grasp, where he can maintain some semblance of competence, where ugliness is less obvious and less intrusive. The new idealism wants to go back to the city, to the slums, to the ghettos, to the rural shacks of the poor whites and blacks of the South, to the burnt-out mining towns of Appalachia. It wants to go back to the arena.

The new idealism does not want to treat the patient and send him back to a sick environment where the only outcome is illness, again and again. It does not want to rip the person away from the setting where he lives and breathes, to treat him in a vacuum, to murmur admonitions that have no reality in his world. It does not want to treat rat-bite and do nothing to eradicate the rats, to treat pneumonia and do nothing about houses without windows or heat. It does not want to shout platitudes to desperate men. It has forgot how to explain away injustice and inequity. It has forgot how to look concerned from a distance. It has forgot the polite amenities that gloss over the quiet desperation of men's lives.

The new idealism does not want to become fatalistic about human suffering. It no longer wants to hear that nothing can be done, or that it must be done so slowly that the attrition of poverty and disease more than compensates for an illusive progress. It wants to know what ideas of liberalism and conservatism mean to children without food, to children who grow up surrounded by violence and crime. What they mean to the man whose life is an indignity because of bigotry and prejudice. What they mean to the nameless forgotten people whose whole life is a memory of the few times that they have not been lonely, or hungry, or in pain.

It is hard to believe that medical students all of a sudden appeared who expressed this idealism. It is hard to explain what prompted them to action. It is not enough to point to the philosophical basis for their appearance, to the spectre of the poor-sick, and the irrelevance of the old idealism. We are left with an inadequate explanation.

Perhaps the new student is a product of the more critical atmosphere of the last few years. Not only in the medical school, but in the universities and colleges, in institutions of higher learning in general, critical appraisal has become the modus operandi. If this has always been true, it is more so today. But where once such appraisal centered around the educator, it now centers around the student. The student has become the conscience of a disenchanted world.

Undoubtedly the present medical student has been affected by the revolution in communications. Attitudes and opinions that help shape his own constantly bombard him. Realities of life once only grasped by the mind are now available to the senses.

The decided trend away from the hedonistic orientation of the last generation has also had an effect. The values of the last generation were deeply scarred by memories of the depression. That generation could be aptly called the generation of acquisition.

The present generation has no such memories of a time like the depression. It does not see acquisition as a panacea. It is not afraid that putting an end to social injustice and inequity will destroy its style of life.

Apart from these few explanations, the student and his idealism must remain an enigma. But the important thing is not to reject what he says and does, because we are offended or afraid.

If this young man is at times too categorical in his judgments, if what he says to men who feel that they have tried as hard as one man can expect of another, is too unvarnished, too jagged, it is because he knows what terrible effort produces barely perceptible change. It is because he knows that all the passion of a life can be used up carrying sand to the sea, only to see it returned with every tide. Poverty and disease are working their crimes on man. They have looked man in the face and have told him that he cannot escape, that there is no reprieve, there is no exit. It will take a great effort to prove them wrong.

Long ago, Prometheus seized the fire of the gods. He stole it from heaven and gave it to man. For that, he was condemned to an eternity of pain. He was chained to a rock, where each day a vulture came and ate away his liver, and every night his liver reformed. And day after day, the terrible agony repeated itself. Each day, the agony grew worse, all the past pain adding to the pain of the moment.

The story is told that Prometheus had a choice, and like his punishment it stood for eternity. He could give back the fire, and he would be freed. His agony would stop. Or he could refuse, and his torture would go on, the passing days bringing it no nearer to its end.

But Prometheus knew that with the fire came the light and to give up the fire was to lose the light. To be free from pain would be to live in darkness. And so he decided that light is worth the price of pain. For the light, no pain is too much to bear.

MEDICINE IN MADAGASCAR

Experiences with a People and a Culture

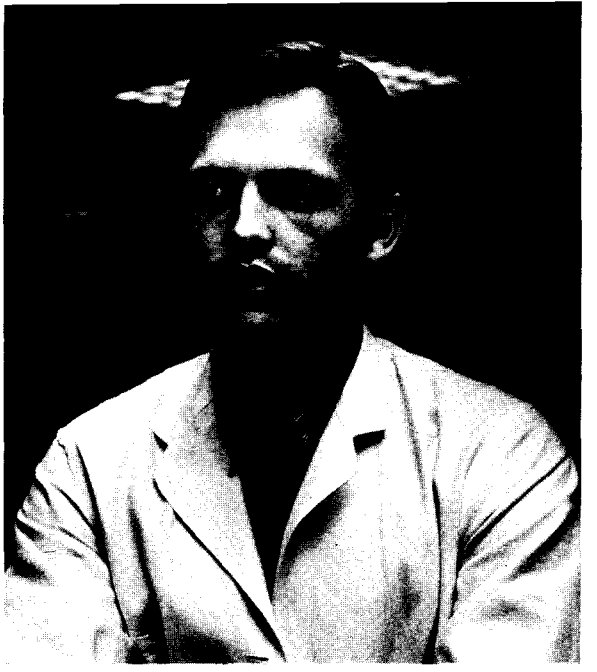
by Gordon Rockswold, '70

"It is hard to absorb another man's way of life in a radically different setting in a period of ten weeks.

One thing for sure. You can not understand a Tandroy's way of life by reading about it. You must do it, experience it, go to Ejeda yourself. To say his society is without pressure is ridiculous, just as saying people are the same the world over. They're not. There are profound differences in perspective, in custom, in orientation, belief and expectation. But the impulses are the same, and there is humanness wherever you are able to open your eyes . . ."

The opportunity to live and work within the framework of a society far different from one's own is a rare privilege; when the expenses for such an experience are paid, it is rarer still. Such a privilege was granted to me for the summer of 1969 by the Smith, Kline and French Drug Company. My summer fellowship consisted of ten weeks of clinic and hospital work at two Lutheran Mission Hospitals in Southern Madagascar. Undoubtedly the name, Madagascar, conjures up a lot of set images in your mind. I invite you to forget them for the moment; for to try to understand another people, the stereotypes which imprison them in our minds must first be broken.

It was June 26th, 1969 when I left Johannesberg, South Africa. In a plane all too similar to the "Spirit of St. Louis," we headed out over the choppy waters of the channel of Mozambique which separates the continent from the world's fourth largest island. Automatically I reviewed my bookish, sterile knowledge of Madagascar: a land mass of nearly 225,000 square miles, a population of almost seven million with multiple ethnic origins; the early prehistoric movement from Indonesia, the second from Africa and finally a third from Islam. Of course, Captain Kidd and other pirates had made it their renegade domain in the 1800's and in 1885 it became a French colony. It was under the Vichy government during most of World War II but was retaken by the Allies in 1944. In 1958 it became a republic and nine years ago (1960) achieved full independence.



Tisranana, the only president, has held power since 1960; there is no major opposition. Political gatherings must be approved in advance by the government. There is a Cabinet of ten high ministers, a popularly elected biannual legislature and a High Court of Justice. The country is divided into eighteen Prefectures just as there are eighteen major tribes with considerable linguistic and cultural differences.

It's capital, Tannanarive, a startlingly modern city of 400,000 located a mile above the sea in the northern central mountains, is the home of a fine University and the Pasteur Institute. It is truly the city of Madagascar; the cultural, economical, commercial, political, educational, recreational and entertainment center of the island.

About 90% of the people of Madagascar are farmers and the guaranteed minimum wage is 127 odd francs (51¢). But many people do not receive even that. Most people raise vegetables, fruits and cattle for their own consumption.

Somehow all of this seemed a little bookish and quite ridiculous — like something a computer might regurgitate at you. Real insight comes only in experiencing, in doing yourself. You can read about another man's way of life, of course. But only when you have eaten his food, traveled over his dusty roads, felt the blazing heat of his sun, attended him when he was sweating with malaria, enjoyed yourself with him and witnessed a death and funeral for one of his family can you develop something more closely akin to empathy and understanding.

My assignment was to work at the Twin Lutheran Mission Hospital at Manambaro and Ejeda, each a town of around 800, both located in the southern part of the island. Between them they serve an area with a total potential patient population of nearly two million people.

Manambaro and her people, the Tanosy, are, I think, typical of the Malagasy up-country: poor, friendly, dirty, generous, diseased, illiterate, uncomplicated, and stoic towards pain and death. Yet, they still are very much able to enjoy a good time and despite some suspicions that the American doctors are making a lot of money, basically thankful. (A Malagasy can get a hospital room with all costs included for 50¢ a day; major surgery for $4.00. The hospitals have taken the policy of making everybody pay something for what they get according to their ability to pay. Otherwise the natives tend to waste or throw away their medicine. The French and other whites who come are charged something closed to U.S. prices.

The Lutheran Mission clinics and hospitals in Manambaro and Ejeda mark themselves as perhaps the leading medical centers in Madagascar outside of the French-oriented institution in Tannanarve. Even from there, many referral cases are sent especially for surgery or difficult medical problems. They can rightly be said to be the Mayo Clinic of Madagascar. There is also an affiliated nursing school at the hospitals which trains around 40 native students, mostly men! As Malagasy go, they are educated, relatively wealthy (or will be) and surprisingly competent.

Boto, a boy of 17, is diseased weighing only 55 pounds.

Here, Boto is healthy again after extensive medical care.

One Malagasy nurse, Berthiene, even does normal deliveries and spinal taps besides cut-downs and circumcision with practiced ease. Currently she is learning to be an anesthetist.

Two American doctors, B. E. Lloyd and Paul Larsen, and a medical missionary head the Manambaro group. In addition, there is a full-time laboratory technician and two American nurses at each hospital. The temporary staff for the summer rotated between the hospitals and included John Platt, a surgeon from New York who was something close to a tutor for me, John and Floyd Miesner, two dentists from Minneapolis, Marvin Hurah, an anesthesiologist from California, two other medical students, Craig Stein and Paul Buhr, and myself. Dr. Curtis Stolee and Noel Rakotomavo (a native M.D.), work at Ejeda.

It was through Noel, through his educated, perceptive, humble eyes that I really came to appreciate Madagascar and its people. I lived and ate with him my entire stay on the island. Noel promptly dispels most of the myths of Negroid inferiority. He is bright, not dull; nineteen years of education have seen to that through primary and secondary school, college and then Medical School. Also, he was honored as the only Malagasy of his class to represent his country at the Paris Medical Conference in 1957. He speaks four languages fluently, is generous to a fault and, as near as I can tell, practices rather intelligent medicine. As a fun-loving relatively well-to-do bachelor, he is also one of the prime feminine targets in the Fort Dauphin area. After living with him a summer, I quietly accept the fact of knowing a dark-skinned person who excels me in any or all phases of living.

A pathologist would go wild at Manambaro or Ejeda, live in ecstasy and never finish his work. Follow me into the first hospital room where I made rounds in the morning:

10-E *Boto*—This boy of seventeen came in so weak and emaciated he was unable to talk, eat or adequately ventilate. Six feet tall and 55 pounds in weight. His original stool culture was loaded with Schistosomi, his urine specific gravity was 1.010 plus evidence of urinary tract infection. No sooner put in bed than he developed decubiti over his sacrum and right posterior iliac spine. The very first night in the hospital he had an episode of acute pulmonary edema (IV overload—(my error) with marginal cardiovascular response) and needed oxygen and tourniquets and aminophyllin and morphine. The next night it was hypocalcemie tetany and I had to give IV calcium gluconate. After two days in the hospital, he started spilling 3+ sugar in the urine and displayed the metabolism of a diabetic, showed an NPN of 60, came

down with a tremendous case of diarrhea. Even through the worst of it, we did not give up hope. We tried everything: Insulin, Hydrocortisone, Sodium bicarbonate, magnesium sulfate, a small army of antibiotics, Vitamin K, B-complexes, C, D, *b*, salt and sugar water, protein concentrates and eventually Metrecal. And, miraculously enough, he improved enough to become an active young boy again. He was/is a walking laboratory of medical therapeutics. A doctor treats a patient like him maybe once in a lifetime. I am glad I had my chance.

10-A—A forty-five year old male with severe elephantiasis of his right leg with a large open ulcer over the area of the tibialis anterior. He also had an elephantiasis of his scrotum with two stony-hard testicles. We were at that time trying to talk him into an amputation. He has been walking on that leg for 15 years.

10-B—Old Mr. Scott, an emphysematic with an obstructing enlarged prostate, urinary caluli, incredibly bad teeth (average in Madagascar), arthritis, borderline congestive heart failure and a very kind grin.

10-C—A normal patient with the usual run of worm, malaria, T.B. and gonorrhea.

After rounds we usually had several surgical cases to perform. First, I assisted on a wide variety of major surgical procedures ranging from splenectomies to C-sections to radical groin dissections to A & P resections. We used mostly spinal anesthesia. Our infection rate was startlingly low; I saw only one all summer. I also performed normal deliveries and epesiotomies, biopsies, incision and drainage procedures, spinal punctures with anesthetic, D & C procedures, circumcisions, cutdowns, two herniorrhaphies, and three tubal ligations. The typical internship pales in comparison.

The afternoons were taken mainly with outpatient Clinics. Here, language was a severe problem especially when the patient started ask-questions in rapid staccato. With some language study and help from an interpreter, I was able to make a go of it. Most of the patients who came in were sick. You might walk into a room and see disseminated Hodgkin's disease in a lady whose neck is so swollen she can't move her head. You might see a man with an ugly infected fulminating cancer of the gland penis. You might see a patient with liver failure and horrendous ascites. But mostly you see malaria and worms (especially Schistosomi Mansoni) and gonorrhea.

Patients are unbelievably stoic towards pain and death. To complain or cry out or even grimace is chided and laughed at by fellow Malagasy. Death, after all, is the really big event in a Malagasy's life. It is then that the party is given; the cattle are butchered, and the family gets together to dance and sing.

One time we were desperately trying to save an old man's life, who was terribly weak and febrile. We asked the family for blood in case of a transfusion. Then, the senior spokesman became a bit irate and pealed out in solemn Malagasy: "You need no blood. The old man is already dead inside, and we shall soon celebrate his end." Even with these words, I saw the old man's eyes blink in pain and acknowledgment. But we cheated them out of their fete. We drained the old man's liver abscesses that night under local anesthesia at the insistence of Dr. Larsen who had made the correct diagnosis in the first place. Miraculously, the old man lived, and today he walks. The most amazing dead man I ever saw.

Oddly enough, there are some hypochondriacs who came regularly to the afternoon clinic, easily identified by their never-ending multitudinous complaints, their obsessional delight with their own physical ailments and their response (even if temporary) to medication like meprobmate.

We treated all patients routinely for malaria. As soon as they walked in the door, we biopsied their rectums for Schistosomi and obtained stool cultures for worms and did a Mantoux skin test for T.B. Also, we started them all on vitamins and Fe because the mythical "average" Malagasy has a hemoglobin of 8 or 9, is chronically undernourished, especially in terms of protein and certain vitamins, and is probably currently infected either with Schistosomi or worms or both. He also has probably had malaria many times, and gonorrhea, and suffers from indescribably poor teeth. He does not

drink or smoke since these forms of self-dissipation are beyond his economic grasp. He lives with his family of eight or so in a little wooden shack, the floor lined with dirt and kids. He urinates and defecates in the area close around his house, drinks from a contaminated water supply and feeds uncooked garbage to his animals. He comes to the hospital with something of a magic-seeking attitude. He is regrettably obsequious in this manner. Even though he is treated at the white man's hospital, he usually goes to the witch doctor just to "make sure."

Once the mayor's wife was treated at the hospital for a severe infection. A week or so later I sneaked into an all-Malagasy *Belo* which is a celebration where the sick person dances until he either falls exhausted and dies or is "cured"; the center attraction: you guessed, the mayor's wife! And they are some of the more enlightened people in the area! The witch doctor bit goes to extreme lengths at times. After every circumcision I performed, it was necessary to give the foreskin to the family so the father could eat it.

Malagasy woman carrying wood.

The "average Malagasy" is somewhat stranded between the old and the new, the rational and animistic, the way of the white man and the way of the ancestor.

His word for one million means literally "the numbers have given out." But he is remarkably generous and happy and thankful. If there aren't many virgins on his island, there is not even a word in his vocabulary for homosexual. If the roads over which he must travel are full of bumps and dust, he would not think of refusing you a meal or lodging for the night. And if he doesn't live in beautiful houses row on row in the suburbs, he has no orphans and few delinquents to inhabit them. And even though you walk the night streets of his largest city as a white Vazaha (stranger, foreigner), you still feel safer than walking the streets of any city back home. And if he does suffer from malaria and worms and taboos, he never gets peptic ulcers or heart attacks or mental breakdowns or neurotic behavior that is so common in the modern world. And if he does seem to worship death, he seems to enjoy life and feels far less ashamed at being "only human" than the great Vazaha.

One thing for sure; I will never pity him in the childish way I did before living in his world. And I will pity myself and my society in ways I never did before.

Modern medicine is one of the most readily conferred and easily understood blessings that one people can share with another. The needs of the Malagasy are stupendous in this respect; their gratitude is overwhelming. One does not have to be an Albert Schweitzer to appreciate them or their response.

The ultimate solution to their health problems will not come from the Vazaha but rather, and more appropriately, from the Malagasy themselves, and from people like Noel and Berthiene. This day will not come easily or swiftly, but it will come. Their potential is exciting if largely unacknowledged by many. Only when we greet them as brothers, do we aid in their fulfillment as persons. Only when we are willing to learn, can we expect to be their teachers. Ours is a temporary service, and our aim must be to eventually work ourselves out of a job. Of this I am convinced. For their acceptance and instruction and inspiration as well as that of the American doctors and other people at Manambaro and Ejeda, I am indebted. It was a mind-expanding summer for me. Never before have I been quite so content that I have chosen to become a doctor.

MEDICOS LATINOS

Ambitious Plans for Student Work in Latin America

by William Rom, '71

With a rising concern for the less-privileged, a dozen members of the Class of 1971 have enacted a program, "Medicos Latinos," to carry their medical knowledge southward to help the Latin American deprived. During their senior year free period, the students are voyaging to Peru, Colombia, and Mexico, countries near enough to lower travel costs, but with vast and challenging medical problems.

In Peru, five medical students will be working with the Peace Corps and bilingual preceptors. Cuzco, the ancient Inca capital, is the center for several students who will be working in a nutrition center for the Quechua Indian children beneath the towering Inca ruins of fortress Sacsayhuaman. Nearby are the famed lost city of the Incas, Machu Pichu, nestled atop a thousand-foot precipice, and crystal clear, cold Lake Titicaca straddling the Peruvian-Bolivian frontier.

The Colombian Association of Medical Schools has arranged bilingual preceptorships for six students in cities of their choice, from Cartagena on the shimmering Caribbean to Cali high in the Andes. The Mexican project is coordinated through the University of Yucatan Medical School Merida. Two students will be staying near the Mayan Jungles next winter. The three areas in Peru, Colombia, and Mexico were chosen with an eye to a richness of culture, warmth away from the Minnesota winters, and the opportunity to learn about and help solve Latin American problems.

Financial objectives have been designed to defray transportation costs and to have the preceptors provide board and room. The Shakopee Rotary Club has taken us under wing in helping to present the program to area Rotaries. The response has been exciting. Over $2000 has been pledged through pancake breakfasts and other fund raising activities and help is being sought through the Minnesota Medical Foundation.

A crash program in Spanish has been started with all participating students meeting every week. Dr. Ferando Torres, a native Colombian and member of the U. of M. neurology staff, is our faculty advisor assisting us with the linguistic and red tape barriers. Two students involved in the planning are the financial procuror, Steve Nelson and executive secretary, Sue Gardin.

The Medicos Latinos Program portrays the attitude of a new breed of medical students who feel that medicine should be a vanguard in solving the social and organic ills engulfing two-thirds of the world's population. It is an opportunity for medical students to acquire a first-hand appraisal of the vast and multifarious problems encompassing Latin America, our pitifully neglected and vitally important neighbor.

High in the Andes, these descendents of the Incas still cook outdoors. One of the Medicos Latinos students is scheduled to work here next year in the Cuzco, Peru area.

Dr. Robert B. Howard

Leaving the Deanship

In a surprising move on February 10, 1970, Robert B. Howard announced he was concluding his career as Dean of the College of Medical Sciences at the end of this academic year. Dr. Howard said he would not be a candidate for any other administrative post within the Health Sciences Center at the University, which is presently undergoing major reorganization, concurrent with a huge expansion program.

"My decision to terminate my administrative responsibilities at the University of Minnesota on July 31, 1970, is founded on the conviction that people shouldn't remain in a top post indefinitely," remarked Howard. He believes that "change in management," at reasonable intervals, is healthy for any institution. The University is currently reorganizing its Health Sciences administrative structure, and the College of Medical Sciences as a unit apparently will cease to exist on University charts. The Medical School will remain intact, however.

Howard's tenure as dean spans thirteen years, including an interim period as acting dean in 1957-58. He succeeded Harold S. Diehl. In an interview, Howard was asked: "What do you consider the landmarks of your administration?" He prefaced his reply with frank praise of both the faculty for their support of many projects, particularly the new curriculum and the efforts of the administrators and faculty members involved in the Expansion Program for the Health Sciences Center. He said he perceived his role in Medical School undertakings not always as a direct one, but rather "trying to preserve a climate where necessary changes could take place." Howard views with pride the Health Sciences Expansion Program just getting underway. "As one of the people who was deeply involved in the planning effort for the Expansion Program, I was very glad to help shape it," comments Howard.

Denying the theory that "everything bad that happens in the Medical School is the dean's fault," Dr. Howard observed that the strong growth of the Minnesota Medical Foundation paralleled his own period of service. The Foundation has grown from a $90,000 organization to nearly a $6,000,000 asset capable of major financial support for the Medical School.

Dr. Howard described the approval of a new Constitution and By-Laws in March, 1966, as a necessary prelude to curricular changes. "Before this time, there were no clear cut mechanisms for dealing with educational revisions," he said. Momentum for curriculum change was generated in the mid '60s. Because of the new Constitution and By-Laws, the Educational Policy Committee was formed and empowered to act on proposals concerning educational reform. "The new curriculum implemented in 1969 was the outgrowth of this newly designed system and very much a faculty undertaking," says Dr. Howard.

In the area of civil rights and social action, there has been considerable concern on the part of Medical School officials. An important start has been made toward improving the Medical School's public image through the Program for Disadvantaged Students. Dr. Howard commends the work of the Committee For Disadvantaged Students under the leadership of Dr. Charles McKhann, professor of surgery, who spearheaded the organization of the program. Faculty donations and pledges of financial support enabled two black students to enroll in 1969. The prospects for 1970 are even brighter, said the dean, for the Medical School expects to admit 10 disadvantaged students.

In the final analysis, the strength of the Medical School lies in the quality of its faculty and department heads, said Dr. Howard. He is confident that the new department heads attracted during the '60s will render outstanding services in the years ahead. He has a special fondness for the Medical School "Adytum," an important addition providing a place for exclusive use by medical students. Dr. Howard spurred support of this venture through the Minnesota Medical Alumni Association and is credited with dubbing this medical student center, the "Adytum."

As for his personal plans, Dr. Howard will take a leave of absence for a year to travel and sharpen his clinical skills. After this, he expects to return to Minnesota's Department of Medicine as a professor, a faculty rank he holds concurrent with the deanship. Dr. Howard obtained the Ph.D. in Internal Medicine from the University of Minnesota in June, 1952.

Minnesota Medical Foundation Support For Medical School Increasing in '70s

Nearly half a million dollars awarded for research projects during past 18 months

Nineteen Seventy! The '70s were ushered in by a major policy change, approval of 10 research grants, launching of an innovative fund raising program, and support of two programs for the Disadvantaged by the Minnesota Medical Foundation. At the Foundation's Board of Trustees meeting, January 7, 1970, the Trustees voted major policy decisions and approved medical research grants totalling $63,718 from the Stone Memorial Fund for heart and cancer projects. Recipients, representing six different departments of the Medical School, included:

Dr. Richard Moore, Associate Professor, Department of Laboratory Medicine — $3,500.00
Studies of Erythrocyte Permeability

Dr. Frank Ungar, Professor, Department of Biochemistry — $6,118.00
Steroid Hormone Secretion in Neoplastic Diseases

Dr. Demetre M. Nicoloff, Assistant Professor, Department of Surgery — $17,500.00
Development of an Artificial Heart

Dr. Charles Blomquist, Assistant Professor, Department of OB-GYN and Biochemistry — $4,000.00
Studies on Ovarian Tumors

Dr. Andreas Rosenberg, Associate Professor, Department of Laboratory Medicine — $7,600.00
Myosin-cation Interaction in Heart and Skeletal Muscle

Dr. Maurice B. Visscher, Professor, Department of Physiology — $5,000.00
Cardiovascular Research

Dr. David M. Brown, Assistant Professor, Department of Pediatrics and Laboratory Medicine — $8,500.00
Connective Tissue Disorders

Dr. Henry Buchwald, Assistant Professor, Department of Surgery — $5,000.00
Surgical Treatment of Hypercholesterolemia

Dr. Marvin B. Bacaner, Associate Professor, Department of Physiology — $4,500.00
Cardiac Arrhythmias and Their Controls

Dr. Arnold S. Leonard, Associate Professor, Department of Surgery — $2,000.00
Computer Monitoring of Shock Patients

The awards were the latest allocations for medical research underwritten by the Foundation. A total of $403,000 was allocated by the Foundation during the period July 1, 1968, to January 31, 1970, according to a recent report by Eivind O. Hoff, executive director. Support of medical research, Hoff pointed out, is now a major function of the Minnesota Medical Foundation.

Career Opportunities in the Health Sciences

The Foundation approved a request by Drs. Ernest Gray, associate professor of pediatrics, and Ronald Edstrom, assistant professor of biochemistry, for increased support for the *Career Opportunities in the Health Sciences* program initiated last summer. The Foundation granted $3,000 in 1969 and has allocated $6,780 in 1970, so that this successful program for minority high school students could be expanded.

Drs. Gray and Edstrom were co-directors of C.O.H.S. last summer. Six black high school students from disadvantaged backgrounds in the Twin Cities were given jobs in research labs at the University Hospitals. The program is designed to acquaint talented youths from minority groups with the opportunities in the health sciences and to encourage them to pursue a science discipline during college. These students are given a $500 scholarship for their summer's work and an opportunity to observe and assist in a wide range of laboratory and research activities. Each student is assigned to a faculty advisor. Observers and participants alike judged last summer's program a success.

The larger grant will help underwrite a program approximately triple in size, involving 18 students. The 1970 program will include Indian students as well as black students. The program received the enthusiastic backing of Minnesota Medical Foundation president M. E. Herz, who urged that the Foundation expand its role in preparing talented youths for careers in the health fields.

Disadvantaged Student Program

Dr. H. Mead Cavert, chief executive officer of the Medical School, reported the needs of the fledgling Disadvantaged Student Program. The Medical School faculty has supported this program with donations and pledges exceeding $15,000. Yet, in order to sustain it and build for an increased program, Dr. Charles McKahnn, faculty director, is seeking avenues to all forms of public and private support. He is plugging for the program before anyone who will listen. The Medical School expects to enroll 10 disadvantaged students in the Fall of 1970.

Since the program's financial status is still uncertain, the Foundation has guaranteed a commitment of $25,000 to the program in 1970-71. The Board's decision to ensure this program's immediate future suggests foresight and intelligent planning for a major social and medical dilemma confronting the Medical School.

Major Policy Change

The Foundation's Board, viewing the need for unearmarked funds to meet Medical School needs, enacted an historic decision relating to the financing of organizational overhead costs.

Hereafter, administrative costs of the Foundation will be borne by income from investments of the Foundation. Previously, such costs were borne by unrestricted income, which is generated primarily by membership dues income, plus unrestricted gifts.

The policy change means all unrestricted income of the Foundation will be available for timely allocation to the most pressing needs of the Medical School.

ALUMNI NOTES

1922

Helen Brenton (Pryor) has had a fruitful career in medical practice and as an author. Recently, her book entitled *Lou Henry Hoover, Gallant First Lady* was published by Dodd, Mead and Co. After graduation, Helen spent five years in China, one at Rockefeller Foundation Hospital, Peking, and four at Nanking University Hospital. Her husband, Roy Pryor, was head of a Middle School for boys in Nanking before the Communist invasion interrupted their stay. For many years, Dr. Pryor was Director of the Women Students Health Service at Stanford University where she did research and taught. She worked closely with Lou Henry in planning pioneer health activities and related careers for the young women under her guidance. She has been an officer in many professional societies as well as health and welfare agencies. Dr. Pryor is author also of *As the Child Grows* and co-author of six books in the American Health Series. She lives at 659 Middlefield Road, Palo Alto, California, 94301.

1928

Milton Rosekrans and his wife, Sarah, a 1927 graduate of the Medical School, were recently honored by the people of Neillsville, Wisconsin, for 40 years of medical practice there. They received gifts and testimonials from nearly every local club and were lauded for establishing the first local hospital.

1930

The Navy's Surgeon General Awarded **Capt. James R. Kingston** the *Meritorious Service Medal* for outstanding service to the Bureau of Medicine and Surgery. Capt. Kingston and his wife, Irma, live at 5602 Brite Drive, Bethesda, Maryland, 20034.

1931

Corrin H. Hodgson is medical director of 3-M Co. in St. Paul. He spent many years on the staff of the Mayo Clinic as an internist.

1932

Tucson Medical Center, Arizona, renamed its Cardiopulmonary Laboratory in honor of **O. J. Farness** in recognition of his part in the development of the laboratory. Dr. Farness, a specialist in internal medicine, joined the medical staff at TMC in 1936 and became chief in 1951. He identified Valley Fever, a lung disease common to the southwest, in 1936.

1936

Lawrence Hilger has been elected president of the St. Paul Surgical Society.

1937

Theodore Drachman has recently written a book, *Reason for Madness*, published by Abelard-Schuman. The book is billed as a mystery with a medico-legal, psychiatric background. Ted lives now in Philmont, N.Y.

1938

Harold G. Ravits has been elected Chief of Staff of St. Paul-Ramsey Hospital for 1970.

1939

John J. Beer, immediate past Chief of Staff of St. Joseph's Hospital, has been named *Physician of the Year* at the annual awards luncheon of the St. Paul Area Council on Employment of the Handicapped.

William I. Davis was named medical director of the Moose Lake State Hospital in a recent announcement by Gov. Harold LeVander. Bill has been acting chief of the medical staff there since 1968.

Milton M. Hurwitz was presented with a plaque by Dr. D. R. Gillespie, president of the Minnesota State Medical Association, at a meeting of the Committee on Heart Disease. Dr. Hurwitz was given a Certificate of Service for years of devoted service on the Heart Committee of M.S.M.A.

Carl L. Larson is director of the Stella Duncan Memorial Institute at the University of Montana. He has developed special expertise in the study of chemical and biological warfare and has participated in several forums around the country on this subject.

Osler L. Peterson was appointed acting head of the Department of Preventive Medicine at Harvard. He is a professor there and associate director of studies of the Medical Care Education Foundation, Inc., in Boston.

1940

John W. LaBree, clinical professor in the Department of Medicine at the U. of M., has been named director of medical education at St. Mary's Hospital.

1943

A former professor in the Department of Psychiatry and Neurology and Internal Medicine at the University of Minnesota, **Richard M. Magraw,** was appointed associate dean and director of program planning and development in the College of Medicine at the University of Illinois Medical Center Campus, Chicago. At the U. of M., Dr. Magraw was also director of Minnesota's Comprehensive Clinic Program.

1949

Donald F. Holm is in a group radiology practice at 2001 Blaisdell Ave., Minneapolis. He and his wife Phyllis have two children.

Julius Stone has been a solo dermatologist and teaches at Wayne State University. He and his wife Marilynn have three children and reside at 36712 Chathum Center, Fraser, Michigan, 48026.

N. L. "Neal" Gault

1950

Associate dean and former director of the University of Hawaii's medical education program in Okinawa, **N. L. "Neal" Gault,** was honored with the highest award of the Japanese Medical Association, the *"Supreme Japanese Medical Association Award."* The award, rarely given to an American, cited Dr. Gault for his development of "an unparalleled two year postgraduate curriculum for training young doctors from mainland Japan and Okinawa." The Gaults are now at the University of Hawaii in Honolulu.

1951

John Anderson of Blue Earth, Minn., received an award for the quality of his paper delivered to the Southern Minnesota Medical Association on *"Coronary Care in the Very Small Hospital—a Year's Experience."*

1954

William F. Feller has a full-time appointment on the Georgetown University Medical School faculty as an associate professor of surgery. He writes: "Our research team may have isolated the virus conceivably related to the development of human breast cancer."

Oleg Jardetzky has joined the staff at Stanford University of Medicine as a professor of pharmacology. Previously, he was the executive director at the Merck Institute of Therapeutic Research in Rahway, New Jersey. Most of Dr. Jardetzky's research has been in the biological application of nuclear magnetic resonance, a method which permits detailed study of interactions between drugs and receptors.

Emery A. Johnson, career USPHS officer, has been named director of the Indian Health Services and mental health administration. His new post carries the rank of associate surgeon general. Dr. Johnson will administer federal health services for 410,000 American Indians, Eskimos, and Aleuts in 23 federal reservations and Alaska.

Edward O. Jorgensen has been appointed a consultant in obstetrics and gynecology at the Mayo Clinic and will be working with Dr. D. G. Decker and associates. He interned at St. Luke's Hospital, Duluth, served in the United States Air Force from 1957-1963 and was a resident in the Mayo Graduate School before receiving his M.S. in OB-GYN from the University of Minnesota in June 1966.

1955

Alvin S. Zelickson was elected as a director of the American Academy of Dermatology. He is an associate professor at the U. of M.

1957

Lucy Balian Rorke was appointed chief of the Department of Anatomical Pathology at the Philadelphia General Hospital. Previously, she was head of the neuropathology division.

1958

Eric O. Feigl, an associate professor of physiology at the University of Washington, was awarded the American Heart Association's First Basic Science Research Prize. His paper on control of blood flow to the heart was one of 23 entered in the national competition.

1959

Wilfred A. Corson, an internist, joined the St. Louis Park Minnesota Medical Center in 1968. His leisure time interests are skiing, camping, and playing tennis. He is also clinical instructor at the U. of M.

After residency at the University of Michigan (1962) and Hennepin County General Hospital (1963 and 64), **Thomas F. Mulrooney** is now director of the pulmonary disease section at Hennepin County General Hospital and associate professor of medicine at the U. of M.

Roger K. Nelson specializes in pediatrics at the Cleveland Ohio Clinic. He was a flight surgeon for four years in the U.S. Navy. He and his wife, Rose Marie, have three children and live at 2900 Chadbourne, Shaker Heights, Ohio, 44120.

Roger K. Nelson

Duane Orn reports he is in general practice, including obstetrics-gynecology and surgery, in suburban Minneapolis. He is president of Brooklyn Center Chamber of Commerce and enjoys fishing, hunting, and skiing.

"I hope to pursue a career in international medicine," writes **James J. Plorde.** He is on leave from the University of Washington, where he is an assistant professor of medicine and preventive medicine, to be in Ethiopia as an associate professor at Haile Selassie I University Medical School. Jim and his wife, Diane, have three children and can be reached at U.S. Naval Medical Research, Unit #3, Field Facility, Ethiopia, APO 09319, New York, N.Y.

Darline D. Smith

After completing a residency in internal medicine at the Highland General and V.A. Hospital in Oakland, California, **Darline D. Smith** remained on the staff at the V.A. Hospital there for five years. She is now completing a second year of cardiology training at St. Michael's Hospital, Newark, N.J. and says, "although I am enjoying my sojourn in the East, I truly hope to return to the Bay Area. It is a most wonderful place to call 'home.'"

Byron A. Teska completed his ophthalmology residency at the U. of M. in 1964 and joined the partnership of Drs. Walter & Robert Fink. He is now in solo practice at 1721 Medical Arts Building, Minneapolis, Minnesota. He and his wife, Marie, have three children.

1960

Vincent Hunt closed his Red Lake Falls, Minnesota Clinic, to join the new Department of Family Practice and Community Health at the U. of M.

Jerry L. Schottler joined Stanley Goldberg in Minneapolis, specialist in colon and rectal surgery.

1961

The United States Public Health Service awarded **H. Stanley Thompson** the *Research Career Development Award*. He is an assistant professor of ophthalmology at the University of Iowa. Dr. Thompson's special interest is visual difficulties resulting from strokes and brain tumors and abnormal eye movements.

1965

Yossef Aelony was reassigned to the American Embassy in Bonn, West Germany, for his last year in the service as a general medical officer. He says, "the responsibilities and hours are in sharp contrast with past Army experiences, but the excitement of working with an older, sophisticated population in a cosmopolitan community more than makes up for this. We may find ourselves taking histories in French, German, or Spanish in a given day." The Aelonys plan to return to the United States in 1971 and settle in California.

Dale Von Ruden is a Peace Corps physician. His address is Peace Corps, American Embassy, Tegucigalpa, Honduras.

Several graduates from the classes of 1965 and 1966 are pursuing graduate work at the Mayo Graduate School, Rochester, Minn. **Paul S. Etzell** ('65) is in internal medicine while **Robert D. Christensen** ('66) and **John R. Krohn, Jr.** ('66) are in surgery. **Gary E. Gran** ('66) is in pediatrics.

1966

Ernest L. Bade is completing his fourth year of military service. He is looking for a position in practice in Minnesota, but would prefer a group practice and will be available in July, 1970. He is presently in Honolulu, Hawaii.

George G. Lowell is chief resident in ophthalmology at Brooke General Hospital. His address is 128 Foulais, Fort Sam Houston, Texas, 78234.

Local residents of Parkers Prairie, Minn., refer to **Lewis E. Struthers** as their "kid on a bike" because of his habit of riding a bicycle on his medical rounds in town. He and the town are hopeful of finding a second doctor for the community. (Ernest Bade, please note.)

1968

John H. Berg, Jr. has joined the staff of the Family Medical Clinic in Montgomery, Minnesota.

"I'm a GMO in the enlisted sick call and am becoming a pro in treating more weak knees, sore elbows, and low back pain than one can believe!" reports **John Bergman.** He is stationed at El Toro Marine Corps Air Station. He and his wife are living at 1341 San Juan Street, Apt. C-2, Tristin, California, 92680.

David R. Brown was married last year to Jeanenne Sue DeMesy. He completed an internship at the University of Michigan Hospital and is now a resident in pediatrics there.

Tom Cairns is in the Congo as a medical missionary.

Mark V. Dahl is presently doing research at the University Hospital in Copenhagen. He will be finished with this research in March or April and would like to find a temporary job as physician to a hospital, clinic, or town from April to July 1, 1970 after which time he will be inducted in the Army.

John Gambill is "enjoying his residency" with the Department of Psychiatry at Massachusetts General Hospital which he finds "a very intellectually stimulating experience."

Joseph Keenan has joined Dr. Olaf Lukk in Prior Lake, Minnesota. He interned at Santa Clara County Hospital. His wife, Peggy, has two years of Medical School left at the U. of M.

Jerry T. Reese married Lea Rae Mork. He formerly practiced at the Mound, Minn. Medical Center. The Reeses will be living in San Antonio, Texas where Jerry is stationed with the Air Force.

David Sorley has joined the staff of the Doctors' Clinic in Forest Lake, Minn.

After an internship in Orange, California, **Jon Talsness** has joined Drs. Crow and Walter in practice at International Falls, Minn.

Marvin Timm has joined the Community Clinic in Wabasha, Minn.

1969

Eugene Elvecrog was recently married to Paula Urban. He and his wife live in Oakland, California where Gene interns at Highland Alameda General Hospital.

Frederic P. Nelson married a fellow intern, Diane W. Furst, at Vermont Medical Center, Burlington, Vt.

DEATH NOTICES

Samuel M. Rosen—1904

Died August 8, 1969, age 88, of coronary artery thrombosis in Los Angeles.

William W. Will—1905

Died July 11, 1969, age 90, in Erskine, Minn. He practiced for many years in Bertha, Minn.

Edwin H. Schneider—1910

Died June 3, 1969, age 83, of cardiac failure and arteriosclerotic heart disease in Los Angeles.

Gustaf T. Nordin—1917

Died November 7, 1969, age 80. He was a member of the Hennepin County Medical Society for nearly 50 years.

Walter H. Fink—1920

Died December 5, 1969, age 74. He had been a life member of the Hennepin County Medical Society.

Harrison B. Wilson—1926

Died September 23, 1969, age 77, of myocardial infarction and arteriosclerosis in Sarasota, Fla. He was an obstetrician-gynecologist who delivered 3,243 babies in Bergen County, New Jersey. He practiced for 40 years and was director of the Hackensack Hospital's department of OB-GYN since 1933. Dr. Wilson was well known in the area as a philosopher and humanitarian who delighted friends and patients with an endless string of anecdotes.

Alfred J. Elkins—1927

Died October 11, 1969, in Cincinnati, Ohio.

John S. Milton—1927

Died recently, age 69. He is survived by his wife, Una and daughter Mrs. John (Joanne) Kendal and five grandchildren.

Edward R. Addy—1931

Died July 9, 1969, age 59, of hepatoma. He was affiliated with the Eveleth Fitzgerald Community Hosp. in Eveleth and Virginia Municipal Hospital in Virginia, Minn.

Hugo C. Andre—1931

Died September 27, 1969, age 61, of coronary artery disease. For many years, he was on the faculty of the State University of South Dakota School of Medicine in Vermillion. Also, he was a veteran of World War II and on the staff of the V.A. Hospital.

Wellington William "Duke" Rieke—1932

Died unexpectedly on December 7, 1969, age 63. He was a founding member and former president of the Hennepin County Chapter of the Academy of General Practice. He belonged to Abbott Hosp. staff and was chief of staff there in 1950. He had been past president of the Rotary club and served as chairman of the March of Dimes and Metropolitan area Salk Vaccine program. He practiced for 36 years in Wayzata, Minn., as a family doctor.

John T. Lund—1933

Died in Fergus Falls, Minn., on October 16, 1969, age 64. For many years, he was county coroner and on the staff of the Lake Region Hosp.

John H. Aldes—1938

Died October 17, 1969, age 63, of coronary artery thrombosis and arteriosclerotic heart disease in Los Angeles. He was certified by the American Board of Orthopedic Surgery and had been director of the Ben R. Meyer Rehabilitation Center of the Cedars of Lebanon Hosp. Division.

Charles W. Fogarty—1938

Died November 20, 1969, age 54. He practiced in St. Paul, specializing in internal medicine. He was a veteran of World War II.

John R. Butter—1940

Died September 5, age 52, of heart failure in St. Petersburg, Fla. He was on the staff of the Palms of Pasadena and St. Anthony Hospitals.

David S. Thorsen—1943

Died July 4, 1969, age 52, of a lymphoma. He was certified by the American Board of Psychiatry and Neurology, and a resident of St. Paul, Minn.

William R. Heilig—1946

Died November 16, 1969. He was an outstanding pediatrician, chief of the Children's Seizure Clinic in the St. Paul Outpatient Medical Center, and a clinical assistant professor at the U. of M. He was on the staffs of various area hospitals and a member of the Scottish Rite.

William R. Watson—1953

Died October 1, 1969, age 44, in Pueblo, Colo.

Eugene L. Acuff—1960

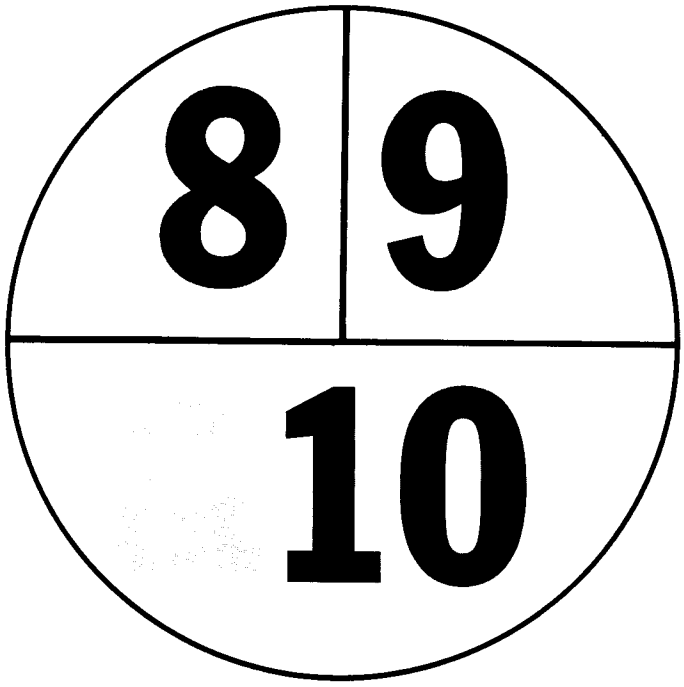
Died August 12, 1969, age 34, of a coronary artery occlusion. He was a veteran of the Korean Conflict and served in Vietnam also.

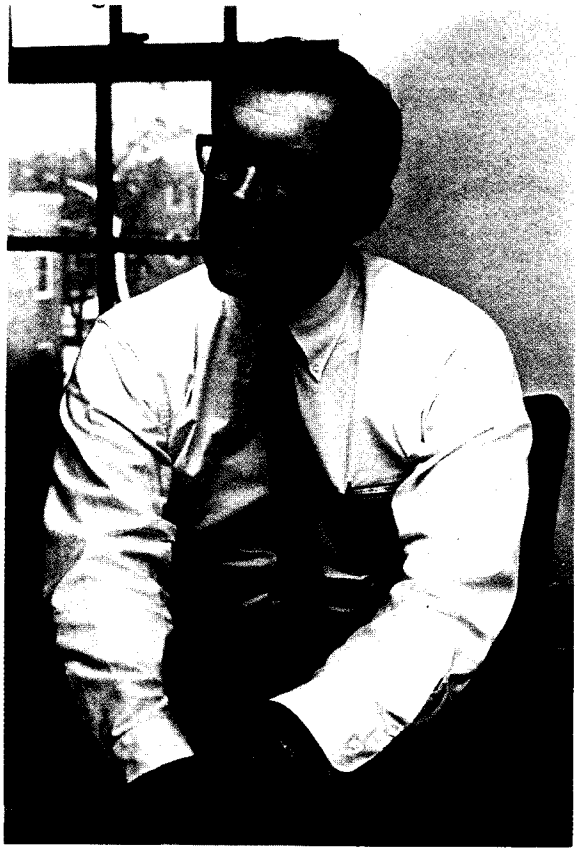
MEMORIALS:

Gifts have been received recently by the Minnesota Medical Foundation in memory of the following:

Dr. E. Covell Bayley
Mrs. Taba Bearman
Catherine Anderson Boyd
Mrs. George Castner
George Devitt
Mary Louis Caley Dunn
Ed Goedhart
Mrs. Phyllis Goff
Mrs. M. Gorsky
Mary Briggs Graham
Mr. Art Hayes
Dan Hedwick
Mrs. Edith Kari
Walter B. Kenyon
Lawrence W. Klopp
Mrs. Beatrice Kohl
Mrs. Ruby H. McDow
Douglas C. Moore
Karen Murphy
Richard Nagel
Mrs. Harvey Otterson
Emma V. Pennington
Dr. W. W. Rieke
Rufus R. Rosell
Art Skon
Mr. George Owen Steiner

Memorial gifts are a thoughtful means of honoring the memory of a relative, friend, or colleague. Gifts may be designated for specific purposes. The Minnesota Medical Foundation acknowledges all gifts to both donor and next of kin.





We can think of 7 reasons and possibly 8 or 9 or 10 why your gift to the Minnesota Medical Foundation is needed this year: scholarships, loans, research, alumni Medical Bulletin, the Stone Research Laboratories, disadvantaged student programs, and faculty teaching awards.

These 7 programs are administered by the Foundation . . . reason enough for many alumni to send their gift checks already this year. For those of you who have forgotten or still need convincing consider:

(8) 227 freshman medical students will enroll at the University of Minnesota in September, 1970 (65 more students than admitted in last year's freshman class).

(9) While the Medical School is opening its doors to more students, it is ironic that federal appropriations for student aid have been reduced this year. Medical students are depending on your support of the Foundation for more scholarship aid and a new, special supplementary loan service.

(10) You'll be happy to know that through a recent Foundation policy change all gifts and membership dues will be part of an unrestricted fund, unless otherwise specified, to be applied to the most urgent needs of the University of Minnesota Medical School in 1970-71. Administrative costs of the Foundation will be borne by income from investments of the Foundation. Previously, such costs were borne by unrestricted income, which was generated primarily by membership dues, plus unrestricted gifts.

Aren't these 10 reasons . . . reason enough for you too! Send a generous gift check today while you're feeling so reasonable. The Minnesota Medical Foundation needs your help.

Sincerely,

Eivind Hoff

Eivind Hoff
Executive Director

Dean Robert B. Howard recently announced that he was concluding his career as dean of the College of Medical Sciences and would not be a candidate for any other administrative post within the Health Sciences. This decision will bring to an end Dr. Howard's thirteen year career as dean. See p. 18.

Features