

MEDICAL EDUCATION SECOND TIME ROUND. A DIARY

1967-1971

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PREFACE

Although I often had said that on retirement I was going to repeat the medical course, when faced with the reality, I hesitated for some time. Then one day when driving down Parnassus, I stopped and cornered Dr. Cullen with the question, " May I?" He said, " Sure, I think Dr. Carman would welcome it, he is revising the curriculum and you may be of some help." Later in the day Dr. Carman phoned me his OK and welcome.

My first round of medicine was at the University of Minnesota and my internship at Childrens Hospital in San Francisco. Then I joined Drs. E.C. Fleschener and E.B. Shaw in the practice of pediatrics.

This second round has been a unique experience. I am grateful to the administration, the faculty and my classmates. I have enjoyed it as much as my first round and learned as much from the extra-curricular observations as from the course itself. UCSF is as dear to me now as my first alma mater!

H.E.T.

Please overlook typing errors! My amateur attempt!!

MEDICAL EDUCATION SECOND TIME AROUND.

H.E. THELANDER, M.D.

Often during forty years of practice, I said that when I retired , I was going to repeat the Medical Course. This was partly nostalgia for I had thoroughly enjoyed my medical training, but also I was very interested in medical education. My membership in the World Medical Association added to my concern for both the unmet needs in health services in U.S.A. and in the world.

In the Fall of 1967 with the Dean's consent I entered the University of California as a freshman. It was fortuitous for me that curriculum revision was in progress, and incidentally, also, that entry coincided with the period of great student unrest, protestations and confrontations.

First impressions.

This was it, the first day as a freshman at UCSF. We were to meet, so I thought in Room 300, but when I arrived the room was dark and empty,- it did not occur to me that I was early! Next I was directed by a passer-by to another class room where some 25 or 30 students were gathered, mostly orientals. After a while I asked if this was the medical class and was told no, it was pharmacy. Why so many orientals in pharmacy? Is the Chinese interest in herbs inherited?

By the time I found my way back to room 300, the medical students had gathered,- several women, two or three blacks, an occasional oriental, the rest were white males, several bearded and with long hair. On the whole, however, they looked like a promising group and more square than hippies

Of course I thought all medical schools opened with a course in gross anatomy, but I learned that the first quarter was devoted to Biochemistry, Histology and Epidemiology. It seemed strange that Epidemiology should be given so early.

A few announcements were made by a faculty member followed by an interesting lecture on reproductive embryology, well illustrated and presented, which lasted until 10:30 followed by a study of slides which illustrated the lecture.

The afternoon lecture on Neurology lasted from 1 to 3 p.m. It was a hot room and hence even more fatiguing. Air cushions would have been a boon. The lecture, however, was very interesting. After trying for years to understand the origin and pathology of neurological diseases, it was rewarding to hear a lecture on the anatomy and histology of the brain, and especially to have it synchronized with Endocrinology.

With the slides of the reproductive system, it was mentioned that if anything went wrong in the early stages, pathological development of growth might occur. It would have been pertinent to have shown a picture of such a mal development. Turners Syndrome would tie this up with clinical medicine. Similarly, when the embryology of the nervous system was given and the effect of German measles mentioned, an illustrative case would not only make it stick but add interest.

FRIDAY, JAN. 5, 1968.

The first lecture to-day was a continuation of the male reproductive system. It was an excellent lecture with the material well presented and well illustrated. His dry humorous remarks were never offensive. He received a good hand at the end of the lecture. The next hour was a lecture on the physiology of the reproductive system with some mention again of syndromes. I wish he would present some illustrations!

The afternoon started with an introduction to Gross Anatomy and dissection. The lecturer was introduced and gave a brief history and illustrated his points with some very good references. The other members of the staff were introduced but were sitting at the back of the auditorium and we had to crane our necks to see them. I thought they should have been up front, been introduced a little more formally and perhaps their names written on the board so they would be remembered and their faces connected with the names. (I discovered later that the faculty members pictures and names were on the Bulletin Board on floor 13.) After the above presentation, instruction was given on how to approach the study of gross anatomy, mentioning some points of behavior in the laboratory which I felt were very pertinent.

SUMMARY OF THE FIRST TWO DAYS.

I felt as if I had been in class at least a week. I actually checked the calendar to be sure that only two days had elapsed. I was not tired but bewildered. If an old timer can be so affected, no wonder that the freshmen are confused!

The students have been very cordial. At the curriculum meeting that I had been invited to attend, it was suggested to the student member that I be introduced to the class. The president of the class approached me on this but by mutual decision we decided to await a more opportune time. I did not wish to be conspicuous but to sort of fall into place gradually. I was introduced to two or three class members standing near by. When some of the students seemed very tired on Friday morning, I said " Has it been a hard week?" the reply was "and this has been the worst day yet."

My main reaction to this first experience was: the number of lecturers was confusing, they seemed to float in and out, and I could not help but think of another Mount Parnassus with the Gods coming down to impart wisdom to these embryonic doctors. The number of speakers, the lack of introductions or if given done so in a voice so low it was missed, left me not knowing who was addressing the audience, what his position was at the School etc. Again it seemed too impersonal. I wanted to know the name, how to spell it, what was the speakers degree and specialty. Maybe the faculty is overly modest or afraid of appearing pompous.

In one of the early lectures it was stated that there would be many people talking on the subject, guests from Berkeley, Stanford and from other departments locally, bringing the very latest material on each subject to the students. Theoretically, this sounds good and for refresher courses it is excellent. At this time in the students career, however, it seems to me it would be preferable to have one person give an overview of the subject and present most of it himself. Other members of the staff could participate in the laboratories and in Seminars. This would give the students and faculty a chance to know each other, to get accustomed to the manner of presentation. There would also be better continuity in presentation. There is plenty of time later to become interested in "continued learning". I felt that too much scattering at this time might actually discourage rather than encourage continued learning.

Almost every speaker gave his facts but added, "I won't have time to go into detail but look it up in your text book", then often added "You will be held responsible". In addition, often a list of references was given. This meant that at the end of 8 hours of planned work at capacity, the students in order to keep up must 1) consolidate the days notes on

lectures and laboratory, 2) prepare for the next day, 3) look up the references and consolidate that information. This becomes an impossible task. The student, therefore, resorts to selecting his material which is difficult for him to do as he does not know what is important and what is not. Some may try primarily to please the teacher and there by get by!

Although the lecturers may have had some training or preparation in teaching methods, this limited re-exposure prompts me to submit the following suggestions:

1. The material should be well organized and logically presented.
2. A typed outline of the lecture, with the name of the person giving the lecture. Illustrations inked in. This would permit the student to devote his attention to the speaker and supplement his handout with only a few pertinent notes. If in addition the sheets were perforated they could be inserted into the note book.

3. When speaking, even with a microphone, words should be clearly enunciated, the voice neither too high or too low, not too fast or too slow, and without too many ahs and ehs.

(Some one should teach the young instructors and especially the graduate students on how to give a lecture, organize the material, present it properly, and to write a scientific paper. If such instruction is not considered a part of medical education, help should be sought from a teachers college, - possibly as an evening course.)

4. When illustrations are put on the blackboard they should be in heavy enough lines to be seen at the back of the room. (Colored chalk on gray slate often can not be seen beyond the first few rows; reds and blues, particularly, are difficult to see at the back of the room.) In Canberra, Australia, Dr. Eccles had a plastic board that was milk white, and the colored crayons on it showed up very effectively.
5. The basic sciences could be linked to clinical medicine by the use of illustrative slides depicting the anomalies that may occur when organogenesis goes off the beam. Although actual cases are more dramatic, at this early phase, slides would serve a very good purpose.

Jan 18, 1968.

The first lecture this morning by a member of the Obstetrical Department was followed by a second one on the function of the ovary. Interestingly,

the students thought the lecture very good. I did not think so, probably because I was very familiar with the subject and thought some of the points were not very pertinent and others that should have been made were omitted. The laboratory session that followed had excellent material and the students worked hard and consulted the attendants frequently. There was good rapport.

I lunched with a couple of students to learn what had gone on the first quarter. They stated that biochemistry, except for one lecture, was poorly presented; it was disorganized, the speakers were poor, etc. However, I later discovered that the students who liked chemistry thought more highly of these lectures than those not interested in the subject. The same was true of other subjects. This undoubtedly is a normal variation. Epidemiology, for instance, had a great many statistics, and some of the students thought it repetitious others found it interesting.

The afternoon session opened with an exceedingly well presented lecture on the mammary gland, covering structure, function, disease, diagnosis and therapy. Even a great deal of history was inserted at appropriate times. Even so some of the students criticized it, - I guess it is impossible to please everybody - especially students in the year 1967!

Apropos the question of a special course in medical history, it seems to me that the type and amount of history given in this lecture is appropriate and sufficient at this stage of medical education. Those students who are particularly interested in history might get it later either in noon courses or special lectures.

The next morning led off with a lecture on ovarian histology followed by a second lecture on function. The afternoon was devoted to some pertinent physics and presented in an interesting manner by a lecturer who obviously was confident and at ease. He wasn't afraid to say "I don't know", or "I goofed". The students liked the presentation.

Comment: The days schedules are given out in a haphazard way. I have accumulated about six sheets on schedules, each one a little different. It is difficult often to know where the next lecture will be given, by whom, what on etc. The schedule for the quarter, or at least for the first half of the quarter, could contain all of the material which would be preferable to having each department or sub-department having a separate sheet.

DUPLICATION .

I think I have discovered what students mean by duplication and what it may mean to the faculty. During the past ten days, I have heard lectures on the breast and the function of the mammary glands by four different people. There was a great deal of overlapping (duplication) and some of the material was so advanced it will have to be presented again. If the mammary gland, as an example, is studied at this stage of the students training, he should be given the anatomy and some of the function. A little history is useful. But it should be obvious that the gland will have to be discussed again in surgery, lactation will be discussed in obstetrics and also in pediatrics, and some of the functions will undoubtedly also be covered in endocrinology. Three of the lecturers referred to the marsupials-- an interesting reference but not that important! There obviously is a lack of communication between lecturers.

The faculty members are most sincere and most anxious to give the students a good course. The students too, are hard working, very serious and anxious to learn. I don't know how communication between the two can be improved. I don't think the size of the class is the real problem, the ratio between faculty and students must be about the same as 40 years ago. It must be a part of the present generation gap.

One rather major eruption occurred when the students in anatomy felt that the amount of work assigned was overwhelming and a delegation took the issue to the head of the Department. The response to the students was very well handled. I don't know where my greatest sympathy lies, - with the faculty and their responsibility or the students who think they are overworked.

1/23/68. Secondary Impressions.

Comment: I think I am beginning to understand some of the reactions of the students. Yesterday a lecture on the respiratory system was very well given and well illustrated. In the gross anatomy laboratory, I asked a student how he liked the lecture. The reply was, "Sure it was good, but why do we have to hear it four times?" My question then was "What do you mean 'four times'?" He said "Well first we got it in the grades, then in High School, then in College and now in Medicine". The incident reminded me of another event some twenty years ago. A friend with his wife and boys were on a ride down El Camino Real one Sunday afternoon with the radio turned on. The comment was made "Isn't it wonderful to be riding in California and listening to the Boston Symphony"? One of the little boys said "What is wonderful about it daddy?" We are apt to forget that the children who have been reared during the scientific and industrial revolution have been exposed to experiences and knowledge that is as new to us as to them. There are many things, as a result, they grasp readily. In a film shown yesterday called "Frontiers of the Mind", a group of rats was given a very stimulating environment and the control group merely fed. Later the rats were tested for their ability to solve a maze problem. The rats from the stimulating atmosphere solved the problem far better than the control group.

It is difficult for ~~for~~ educators in the professions or any higher education to keep abreast of what is going on below, - even nursery schools and kindergartens are rather sophisticated now.

Another impression received this week, concerns the Clinical Sessions. I missed the first one on Wednesday but when I came back I found the students quite critical. They said it was a marathon of presentations, with little time for discussion; a few cases ~~were~~ given with more detail and time allowed for questions would have been a better learning experience. The comments are heard frequently, "You can read that" or "Why did he lecture on that, it is all in the book".

The clinical session yesterday following the lectures on the thyroid, was very well received by the students. Only two cases were presented, illustrating hypo and hyperthyroidism. The students asked many questions and even prolonged the session into the next hour.

Last week a presentation at the noon hour of a case of subarachnoid hemorrhage was well done, the patient present and the X-rays and angiography well demonstrated. It was followed by a relatively short film on Epilepsy made for the County Medical Society by local physicians. For an amateur film, it was good, but I can see how difficult it is to compete with TV presentations such as "Dr. Kildare". The film did not have much impact on the students.

I read with interest the article by Dr. Cullen in the Alumni-Faculty Bulletin. The medical profession should constitute a community of scholars, starting with the medical students and continuing through the faculty, the alumni, and the practitioners. It may be the nearest we can come to the old student-teacher relationship.

1/31/68.

Yesterday between lectures, I asked a faculty member, "Why not seminars instead of all these lectures?" He said there were not enough instructors to do it. When I mentioned that 4 to 6 instructors sat in on the lectures, he said seminars had been tried but the teaching was too varied, grading became impossible and the Administration did not like the results. It does seem like a waste of time to have several instructors spending two or more hours daily listening to lectures.

The scheduling of classes still seems erratic. Even the daily work posted on the Bulletin Board is unreliable; the rooms are changed, the lecturers changed, the hours modified, and the students sort of follow the herd. I asked one of the instructors about this and was told that this was a difficult year, the curriculum was being revised, the system was changed from semester to the quarter system and "Integration" in teaching structure, function and clinical application was being tested. He did not seem very enthusiastic about integrated teaching. Neither am I ! I am told that Northwestern is shifting back to the traditional method. I am still concerned about repetition of subject matter already learned at lower levels of schooling. At the graduate level-- and medical students are college graduates-- the students should be given every opportunity to move as rapidly as possible. It is rumored that Harvard has divided the freshman class into two groups according to previous training, especially in the basic sciences.

2/1/68

The morning lecture was followed by a section meeting, at which time medical articles pertinent to the current studies were reviewed with two students assigned to each paper. One student presented the background

and the other briefly criticized the paper. The moderator brought out a great deal of pertinent information on medical writing and also gave the students an opportunity to do a little "lecturing" on their own, with criticism from contemporaries and the moderator. Incidentally, the moderator who had not performed too well as a lecturer did a superb job in the seminar.

The noon hour was another unique experience,-- I shall dub it "The Gripe Hour". The students and some staff members met together to give and take criticism, and ^{it} was the finest opportunity for emotional catharsis that I have seen anywhere. The main gripes were:

1. Too much material.
2. Why histology and neurology at the same time, both very heavy courses?
3. Biochemistry of the hormones and enzymes was too much material and too early in the course to be properly evaluated and assimilated. They had not yet seen the glands in gross anatomy and ~~and~~ had no knowledge of their function.

The faculty members brought out some good points too:

1. Lectures were voluntary for the students.
2. The material was heavy, but the faculty did not have much choice as they were limited to four years in which to present it.
3. Grades were questioned and the psychologist pointed out that as students they had been "conditioned" to be concerned about grades because of competition to get in to the medical school. Though this pressure was now removed there was still a hangover of the conditioning. This should have relieved the students who seemed on the verge of a neurosis over the possibility of failure. Each student learns best in his own peculiar way: some like to hear it, some to read it and some want it illustrated. The students vary in background, some have had more science than others. It is rather hard for a faculty to satisfy 130 students.

The main problem of the students, seemed to be to get a definition of "hard core" so they could pick and choose the rest. They seemed to feel that the profs were so afraid of "spoon feeding" that they deliberately did not organize the material presented leaving too much for the students.

When I was chief of Pediatrics at Childrens Hospital, I was accused of "spoon feeding" because I organized the two years of residency training to cover all aspects of Pediatric practice. We even had a course in

"Childhood Ecology" a term then almost unknown. When I was in the Marine Corp I found many of the officers ambivalent regarding handling of the men below them. Did you make the men "soft" by feeding them well? was the old "chow" method good discipline? Etc.

One of my concerns, dating back to my teaching days, has been the health of the students. In an institution designed to teach Health, they seem to ignore practicing it. The students are under terrific stress, they lack sleep and rest, they eat improperly and they have very little opportunity for recreation. They probably are well designed individuals and hence can take it. There ought to be provided some time for fun and for creativity so they could look back on the medical course as a pleasurable even if strenuous experience.

Feb. 6 1968.

I have puzzled ~~even~~ the attitude of the students and even of some practicing physicians toward the study of anatomy. How can the study of anatomy be non-relevant to medicine? The doctor is the authority on the human body. How can one practice medicine without knowing the body? Its structure, function and pathology? The mechanic is expected to know his car, the Veteranarian his animal, is man alone to be without an authority? Doctors including Psychiatrists must know anatomy, physiology, pathology, histology, embryology and biochemistry, the basic sciences, the core curriculum!

Teaching methods ^{may} need to be improved. Maybe we are not up to date on teaching techniques. A recent visit to the National Geographic Museum in Washington, D.C. was enlightening. The main floor had exhibits of the explorations and by picking up a receiver you could listen to the story of the adventure. Why not equip the library and the study room on

the third floor with life size anatomical charts, transparencies, models, stereos etc. Doctors Leake and Saunders should be experts at planning such an exhibit and there may be others talented in this type of teaching technique. These should supplement, not replace dissection. As one student said, " There is no substitute for finding it in the body yourself".

The sessions on surface anatomy were excellent! There should be more of these. The practising physician, after a little experience, makes many diagnoses by looking at the patient, and before he has had time to examine him or run any of the laboratory tests. He usually verifies the diagnosis by more extensive studies even after it is made. One morning several pediatricians were standing at the Nurses station when an infant in a cubicle nearby raised his foot into view; promptly one of the doctors said, " A Turners Syndrome"? It was. Many clues to disease can be picked up by simple inspection. Much emphasis should be placed on inspection,- learning to observe and be sensitive to stigmata.

When and how should gross anatomy be introduced? Is it preferable to start with the gross and give histology later or is it more logical to start with the cell and proceed to the gross? It has always seemed more logical to me to start with the familiar,- the total individual and master this information first and then proceed to the microscopic. The human body can be compared to a machine,- or probably the machine was patterned after the body. The brain is an inefficient computer with input through vision, hearing, smell, taste and sensation. The digestive tract provides the energy to function, supplemented by the glandular secretions. The lungs are ventilators; The kidneys, the filters; the heart and vessels the distributors; the skeleton supports; the muscles take care of motion and the skin wraps it all up. Microscopically the detail of cells with DNA, RNA, Mitochondria and so on is so fantastic

how can any one be bored studying it?

Learning is not a one shot process. The conditioning by first exposure, recall, and supplementation are all a part of the process. When working with superior minds, as with medical students, there should also be added stimulation of motivation, creativity, discrimination and judgement. The lecture to-day on the 8th nerve was an excellent example of first presentation, not cluttered with too much detail or speculation. It was explained that this was the first basic information to which subsequent courses would add. The lecture on diagnosis was presented in a similar manner, i.e., history, physical examination, laboratory information, diagnosis and treatment. A clinical session on valve replacement was also very well presented.

Comment. Fatigue is a distinct deterrent to learning. Four hours of lecture is fatiguing and by the end of such a period, the students are not learning optimally. When I spent two years in the Marine Corp where Sick Bay meant 8 hours a day in one room, I was more tired at the end of those 8 hours than at the end of a 12 or sometimes 16 hour day in private practice. A change of activity is restful, - some home calls, hospital rounds, office hours, a lecture now and then and grand rounds or ward rounds with students breaks up the day and this is restful.

We need some courses on "How to Teach" especially for the younger faculty members, - it may be too late to teach "the old dogs new tricks". Emphasis on "new discoveries" is often over done at the expense of basic knowledge which is necessary for continued growth. When new knowledge clarifies a subject, much of the old material can be deleted.

Trisomy 21 explains Mongolism and eliminates much theory and speculation. Some instructors find it difficult to modify lectures when a disease has been controlled, like diphtheria or poliomyelitis. Since World War II, emphasis has been placed on research and both teaching and service have suffered as a consequence. This trend seems to be reversing, and particularly so at this institution. When I asked a student the other day, why he chose this school, he replied, "because it has the reputation of emphasizing patient care."

(I tested a $3\frac{1}{2}$ year old girl's knowledge of anatomy in my office while examining her baby sister. I asked her " What am I listening to?" and she replied " her chest". "What is inside her chest that I am listening to?". She thought for a minute and then said, " Her valentine." It was February!) Kids are smart these days!

The premedical preparation of students apparently varies considerably. One student told me she had had no courses in chemistry or physics and her only biology course was in High School; another student had had no chemistry or physics prior to entering Medical school. Emphasis on the social sciences and the humanities has resulted in the admission of more students without much previous training in the sciences. One student said she was planning to take psychiatry and was not interested in anatomy! Too many patients have been seen at autopsy with brain tumors or other brain pathology whose symptoms had been treated by psychiatrists for long periods of time, for me to subscribe to such a view.

If the time is properly utilized during the three or four years prior to entry in the medical school, the sciences as well as the humanities can be covered. A physician needs to have a comfortable knowledge of the social sciences but it is relatively simple and probably renders a better service to the patient if social problems are delegated to the

proper paramedical personnel; it is impossible for a physician to be an authority in all fields. The social worker, the visiting nurse, the psychologist can extend the hand of the physician into the home and the community. Midwives, health educators and now doctors assistants are being advocated but it is not necessary to create a second class M.D. in an attempt to expand the services.

The Generation Gap

In a conversation with students the other day I was asked if the faculty was as hostile toward the students when I attended the medical school as now. This startled me as during the months I have attended classes, I have seen no evidence of hostility, on the contrary it seemed that most of the faculty members have tried very hard to show interest and concern for the students. The question, however, recalled a query from one of the children in my neighborhood when I first moved in, who asked : "you like us kids dont you?"- the implication being that adults do not like children. I wonder if we have not unwittingly alienated our children and that hostility is actually the younger generations resentment projected onto the elders? If many children are growing up with the feeling, right or wrong, that they are not loved or wanted by their elders this would explain the hostility toward the "Establishment".

Some experiences in private practice support this view. A wealthy family with an English governess for their two children scarcely knew their own children. When after 5 or 6 years, the governess had to return to England, she expressed her concern for the children, as she put it:-

" They do not know their parents; I am their mother substitute, I dress them in the mornings and send them in to see their parents, they get a pat on the head and come back to the nursery." The children are dressed beautifully, they have spacious rooms and every conceivable toy,

were given dancing lessons and anything that money could buy, but very little parental love and understanding. After the governess left, the parents decided to take a vacation in Europe and asked if I could recommend another governess. I suggested that they take the children with them, using the opportunity to get to really know and enjoy them. The mother seemed very receptive to the idea, but later I learned that the children were left behind,- the father felt the holiday would be spoiled if the children accompanied them!

This type of child rearing is not limited to the very rich. A young mother when discussing child rearing practices, said she had never really known her father,- he left for work before she was up and came home late. She and her brother were given their meals by the maid before he came home, so as not to disturb the parents' cocktail hour and dinner. Her memory of her mother was that of an elegant lady, dressed in beautiful gowns, or sitting in bed in the mornings talking in the telephone either arranging for a party or ordering the groceries.

Families have been and are stratified by age groups. If a party is given for 6 years olds, the 4 and 8 year olds are sent off to do something else. There are few if any family parties with the attendance of every one from one year to 80.

At Thursdays gripe session grades were again discussed,- why not have the "pass/ fail" system. Two staff members attended and the discussion was friendly. These two staff members have been "accepted" by the students, probably because they have made a great effort to listen and understand the basis for the discontent. Several times some one said words to the effect that they did not wish to embarrass these teachers or put them at odds with the administration.

The course in Neuroanatomy is excellent,- fine lecturers, excellent demonstrations and adequate help in the laboratory.

The gross Anatomy course suffers from lack of time but the aids to learning are available. The winter schedule this year was very heavy!

The "Noon Topics" and the "Noon Films" are delightful diversions.

March 6, 1968.

Yesterday two neurological cases were presented, apparently designed to supplement the courses in neuroanatomy and neurophysiology. The presentation illustrated the Specialists narrow view of a major and multifaceted problem. The first presentation, a man 43 years of age, entered with the symptoms of headache and a hemiplegia. Angiograms and ventriculograms had been performed and a diagnosis of brain tumor made. At surgery a biopsy was taken of an inoperable tumor on the ridge of the Sphenoid. The only pertinent past history was that as a child the patient had had petit mal seizures. Questions from the students indicated that he had also had grand mal seizures starting during adolescence, and he was "a queer guy",- (this was said after the patient left the room.)

The students have had neuro-anatomy, neurophysiology and biochemistry. They have had excellent lectures on the inter-relationship of the endocrine glands and the nervous system, including the role of enzymes on function. This was an opportunity to tie all of this information into the symptoms and findings in this case. It was not done! The tumor was slow growing, had it been present since childhood; the patient was obese, he had epilepsy, he was queer yet there was no detailed history of his childhood, of the time of onset of his petit mal, of his performance in school, of the family history etc; did the tumor by pressure or enzyme

secretion upset the endocrine system? Did it cause a disturbance of brain physiology which might account for the epilepsy and behavior problems? How early could the pathology have been detected? This lack of concern or interest in the antecedents to disease is as appalling as the lack of concern of what happens to the patient when he leaves the hospital. On this campus are several Health Sciences. How are they utilized? Will a visiting nurse see the patient when he goes home? Will he return for rehabilitation? Was he seen by a psychiatrist?

Comment. Medical education has been disease-oriented far too long, it is no longer enough. Medical education must become patient-oriented. This is not difficult and it is very rewarding. It is the ideal the students have when they enter. It should be retained. I have this reaction frequently at rounds. There is such concentration on the disease entity that the whole patient, his family and environment is forgotten.

Fortunately, the next clinical session was very different and helped greatly to soothe my ruffled nerves! Two patients were presented; one had multiple sclerosis and the second Apraxia. The clinician stated in advance of the last patient's entry that the class was to keep a poker face if the patient said queer things as this was part of her symptomatology and he did not wish to embarrass her. The students were asked to identify the muscles as he checked them, they were asked to identify the possible location of the lesion as revealed by the clinical history and findings. It was a good exercise and got a good response from the students.

March 11, 1968.

Another "Gripe" session with a continuation of the discussion of the grading system. A petition opposing the present and favoring Pass-Fail had been circulated among the students for signatures. At the time less than half had signed it and only 25 or 30 students attended the meeting.

The leaders of the movement, obviously were disappointed. The apathy of the class was deplored. One student, however, spoke up and said it was not fair to the absent members to label them apathetic, maybe they did not believe in the Pass-fail method. One student was over¹heard to say he hated to be a freshman again. The unrest and discontent probably stems from many causes. A great effort should be made to get to the bottom of it. The students enter with high ideals, they are graduate students and an attempt should be made to bring them into the medical fraternity at a more professional level,- like apprentices and with greater social contact.

In anatomy today, an orthopedic resident explained the shoulder joint. This was a good exercise for both the resident and the students. a certain amount of teaching is done better by recent graduates, it is a review for the performer and it makes the students more aware of the relevance of the subject than when given by a professor. Also the older you get the more you take for granted as common knowledge and hence are apt to omit it. I found this to be true when teaching the house staff at Childrens Hospital. The minutae of routine on the wards was better taught by the resident than by the chief, but the interns and students wanted the chief available to discuss diagnosis and treatment. This gradation of teaching and learning should be recognized and utilized fully. It is particularly appropriate in the study of anatomy. It is very difficult for the entering student to learn anatomy only from books and dissection and even if he does, there is so much new material he cannot possibly remember it all; when he has reached his specialty training stage he needs a review, and teaching the entering class gives him this opportunity. The student is bound to be impressed by the eagerness and interest shown by his slightly senior colleague.

The students are asking for feed-backs from their exams. They are still asking for what is relevant . It would help to answer these questions if , at the beginning of a new subject, the chief of the Department or his delegated representative would give an outline of the entire course, the texts to be used and the approximate time allotted to each major division. The faculty members who would be teaching the course might be introduced at this time and their subjects stated. Hopefully such preliminaries would eliminate some of the present vagueness.

At the National Health Forum held in Los Angeles March 15-17, 1968 the topic for discussion was " The Quality of Health Care and the Delivery of Health Services"

Quality. Licensing of health personnel, per se, does not necessarily produce high quality. It is simply a minimal standard imposed by the State or other licensing body. High quality of care is the result of action taken by the members of the professional group themselves, such as certification, accreditation, formation of tissue review committees, tumor boards, hospital rounds, continuing education etc.

Criticisms raised in smaller group discussions were: a) Frequent lack of concern for the patient (consumer), his time and comfort, particularly long waiting lines in clinics where patients may have to wait for hours even though they have problems at home needing attention, such as limited baby-sitting time, children coming home from school, transportation etc. b) Even in private practice, it was noted that a routine health check may mean weeks of scattered appointments with different specialists and tests at a variety of laboratories. For busy people, this is time consuming and inefficient administration of health care. c) The very short contact with the physician was also mentioned. In many instances an appointment is made weeks in advance with a series of laboratory procedures then intervening before real contact is made with the

doctor. Remedies suggested were: 1) Group practice. 2) Centralization of services. 3) Better utilization of paramedical services. Some one suggested a " Super market" type of health center. (On my way to Long Beach after leaving the meeting, I passed through Watts where a Center housing all the Medical Services has been built.)

Delivery of Health Services. California may not be typical of the States, as we have a fairly high ratio of MDs per population. Considerable discussion centered around the topic of " Team approach",- an "IN" subject now. Several types of teams were mentioned, e.i., cardiac surgery, kidney transplants, kidney dialysis, etc. The para-medical personnel involved in a team approach are nurses, Social Workers, nutritionists, audiologists, psychologists, educators etc. The head of the team should be a physician. In rare circumstances another member of the team may assume the leadership. In developing countries, it has been found ^{an} advantages sometimes to have a nurse screen the patients and handle many of the minor problems.

Comment. (Personally, I am afraid of too far extension of such a method. Screening is not a simple process,- some serious conditions are almost sure to be missed.) Another facet of the problem discussed was the role of poverty, poor housing, lack of education, etc. in health protection.

How to Teach the Above in the Medical Schools. Not much time was devoted to this part of the program except to mention that it is learned best by seeing and participating.

April 8, 1968.

The joint discussion by faculty members and students, hopefully will lead to a better relationship between the two groups. The seniors (Faculty) listened and were finally successful in eliciting the real basic cause of discontent. It was put in these words by one student, " We want to talk to you. We want to be accepted". It was like the mute wail of neglected children.

I hope that action will be taken jointly by the faculty, administration and students to try to eliminate or at least reduce this gap in the future. The adjustment to the medical school is difficult but possibly it can be made easier with a little more effort on the part of every one.

This quarter is much lighter than the winter one. Many of the students have so much time they don't know what to do with it. Hopefully, the curriculum will be better balanced next year.

Dr. Crede's introductory lecture in Community Medicine was excellent. Practising pediatricians are ahead of the internists, surgeons and obstetricians in their knowledge and concern for the community. Dr. Neal, in a lecture on Friday in Continuing Education, described the role of the General Practitioner in a small community as very similar to that of the pediatrician. -- Pediatricians, of course, are General Practitioners for an age group.

The clinicians, with a few exceptions, do not present their illustrative cases to the Freshmen very effectively. (This has been mentioned before). Some have opened the session by saying, " This is really not my case-- I don't know much about him" or words to that effect which immediately turns the audience OFF. It lowers the students opinion of the physician. Really the clinician has no assignment more important than that of presenting a case to the first year class! " Where are all our Heroes Gone?"

April 11, 1968.

In this Thursdays gripe session, there was less talk about grades and more on morale and Esprit de Corp. Again only 30 of the class attended and mostly the same ones as at previous meetings. The president of the class read a list of suggestions drawn up by a committee of students and these were then posted on the Bulletin Board. Briefly they were: that Community

Medicine be given the first quarter and if necessary be extended into the winter quarter; that Histology be given in the first quarter; that Epidemiology either be dropped entirely or given at a later date in the course; (The chief complaint centered around statistics.) that endocrinology occupy 11 weeks; and that Anatomy be more evenly distributed through out the year, or at least through two quarters.

The afternoon lecture by Dr. McIlroy was well received. He was very much at ease. Some lecturers are afraid of the students or at least they seem to be. But then the present generation of students are a rather hostile group!

April 12, 1968.

The second session of Community Medicine was devoted to transplants and the medical, moral, ethical and legal problems involved. Three physicians spoke, a surgeon, a psychiatrist and a philosopher. The donor and the recipient of the transplant were present. It was an interesting and a most unusual session.

At the group discussion after the session, the leader failed to get much discussion. One student made the remark that transplants, dialysis and some similar problems posed problems and decisions that were new to doctors. I felt obliged to break in at that time to say this was not true, that physicians had always been faced with questions and decisions involving life and death choices; and cited the case of the first respirator in this community with two patients needing it simultaneously. The attitude is fairly common among the students, that things happening now are unique and the past is not very relevant. They are much more concerned with social issues,- poverty, the war, racism etc.

What has been wrong with this first year of medicine for the class of 1971?

Many of the students obviously are unhappy, some are depressed and some seem disillusioned; this is tragic and should be taken seriously by the faculty and the administration. Every effort should be made to get at the basic causes in order to prevent a recurrence yearly.

What might be done to change it? A modification of the curriculum may help, but this is not the main cause; nor is it likely that the grading system is at the basis of it. There must be something more basically wrong, something that affects the moral and the esprit de corp of the school. Possibly a joint effort by sympathetic faculty and interested members of this class could plan an orientation week for the next years Freshmen to try to prevent the development of this type of atmosphere.

Some of the things that might be tried are:

I. Devote the first week or at least a few days to orient the new students to the school as for instance:

- 1) The class might be divided into sections of 10 or 12 students with a faculty member as escort who could take his group on a tour of the campus, including wards, research, administration, library, recreation etc.
- 2) A few short and interesting talks to the entire class by the best and most enthusiastic speakers might be given on such subjects as :

A brief history of the School.
Some vignettes on medical history.
Medical ethics.
Attitude toward patients.

- 3) An introduction and some brief comments from members of the paramedical staff;

Nurses.
Social service.
Rehabilitation.

- 4) A knock out social hour with the chiefs of the departments in attendance.

II. Change in curriculum:

- 1) Start the year with Community Medicine and let the sessions continue into the second quarter if necessary.
- 2) Omit Epidemiology and Biostatistics, and or give it in a modified form later when its relevance is more apparent.
- 3) Revise the course in Biochemistry. (Both the students and some of the faculty were unhappy with it.)
- 4) As an alternative, gross anatomy might be introduced in the Fall quarter and continue through the winter quarter. Considerable time should be devoted to surface anatomy, radiology and help from residents in the surgical specialties.

III. Premedical training. The premedical preparation varies markedly;

there should be greater flexibility the first year with opportunity for students to proceed accordingly. The summer quarter might be used to make up subjects in which they are deficient.

April 26, 1968.

This quarter is much lighter than the previous one. The students have relaxed; they are more attentive and there is less confusion. This is partly due to less heavy courses, but also in part to the meetings that have been held with the Student Welfare Committee and the Thursday Gripe sessions.

The material presented on the heart was well received, it is so evident that this knowledge is pertinent. There are complaints still about overlapping, the last being over repetition of the anatomy of the genito-urinary system. It has now been given at least three times. The first year faculty should review this.

Dr. Henrik Bloom spoke on the Social Responsibility of the Physician in Community Medicine. I thought it was needlessly overstated. The prevention of many diseases by immunization and the cure of others by the newer

antibiotics has been a great advance. We are reaping the fruits not only of saving babies but of the baby boom of the post-war period. Increased population, survival of the handicapped, and longevity pose new problems. The new physicians need to be made aware of the changes that have taken place and their role in meeting the new challenges but this can be pointed out without deprecating the earlier physicians. It was a distasteful method used for winning some applause for himself.

In the seminar that followed, I pointed out that diseases still exist, not all poor health is due to social, economical or emotional factors. It is too bad that even professors resort to emphasizing only one side of a problem instead of giving students greater perspective.

April 30, 1968.

For the past week I have attended the lectures and laboratory sessions in physiology. These have covered respiration, vital capacity and acid-base balance. The demonstrations need up-dating. The techniques for studying physiology and biochemistry have changed so markedly that the old vital capacity machines seem very outmoded.

The anatomy lectures have been few this quarter but have been well presented and well received. The students have settled down to learn the necessary anatomy. Sort of grin and bear it attitude.

The lectures in Community Medicine continue to be on pertinent subjects. The lecture on the whole gamut of birth control and abortion was one of the best lectures I have heard on any subject.

I have rotated through the different seminars held after the lectures in community medicine. The students are very reluctant to talk; the leaders have difficulty in getting a discussion going. These sessions should be lively!

The mood of the students undulates, it is an interesting phenomenon. The Pass-fail question dominated the winter quarter now "Student Power" is on the up. A meeting was called for the discussion of the curriculum and other school problems. The meeting was held in Millberry Union, but not more than ten students attended. The first speaker listed a number of things that should be demanded. His demands were the things already instituted as participation on committees etc. It is amazing to find students ~~so find students~~ of this age and intelligence to be as immature as they are.

Steps have already been taken to correlate some of the material in Epidemiology with Community Medicine. There is a need for discussion of pollution, ecology, and world health but the courses as given at present do not seem to arouse or stimulate the students to the extent that the subject matter warrants. Maybe the time is not quite ripe!

May 15, 1968.

Dr. Bell's lecture on fatal illness was excellent. The Health professionals have not devoted ~~enough~~ enough time in education of students to deal with death, grief and prolonged illness or hospitalization.

May 21, 1968.

The students' "Missionary Zeal" is now being directed toward recruitment of minority students for all the Health Sciences. When I asked one of the "activists" if things had improved or was there something further tha faculty could do, his reply was, " Everything is fine, the faculty is really great."

At a staff meeting of the Freshman faculty to discuss the revision of the curriculum, it was a surprise that they seemed unaware of unrest and discontent among the students. Five of the members were "Acting Heads" of Departments which reminded me of a cartoon which depicted a professor as a man with a briefcase going to an out-of-town meeting. The group seemed aware of the deficiencies in the first year e.i., repetition, the failure of integration of subjects, the overloading of the winter quarter etc.

To recapitulate and summarize some of the impressions of this first year on a second time 'round!'

I. Possible curriculum changes:

- 1). Community Medicine should be given in the Fall and continued through the winter quarter, and expanded to include more information on local services such as:

Well Child Centers	Infectious Disease control
Mental Hygiene	Emergency Hospital services
Youth Clinics	Teenage pregnancy care etc.
- 2) Some of the courses in Epidemiology might be integrated into this course and the statistical part given with the laboratory studies.
- 3) Anatomy started in the Fall and continued through the winter quarter with Histology paralleling it. Neuroanatomy given the second quarter or these two subjects could be reversed.
- 4) Biochemistry, physiology and Endocrinology in the third quarter.
- 5) Instead of allotted time for electives for all students, the opportunity for some original work should be made available to students who are advanced enough and mature enough to desire it.

II. To further emphasize the relevance of the basic sciences to clinical medicine, the following suggestions :

- 1) Photographs of clinical cases can illustrate the relationship of the subject to clinical medicine.
- 2) X-Rays and angiography could illustrate many of the anatomical features, especially the gastro-intestinal tract, kidney, cardiac and pulmonary systems.

- 3) Many more sessions on surface anatomy correlating the external findings with the organs underneath, the selection of sites for punctures, the correlation of certain stigmata with disease syndromes etc.
- 4) Some anthropology might be introduced by comparison of physical characteristics within the group: color, height, facial features.
- 5) Some experience with clinical procedure might be illustrated, such as pulse taking, respiratory counts, temperature readings, taking blood pressure, auscultation and palpation. This could be demonstrated on the students and they should be encouraged to practice on each other at home.

Comment on Sit-ins and rebellion.

In observing the students and noting the rather universal rebellion of youth, I have searched for an understanding of it. It is a revolution!

The past quarter of a century has seen a phenomenal growth in science and industry. Those between 20 and 25 years have been part of this experience and have known nothing else. It has been an age of affluence, permissiveness, stratification by age groups and a breakdown of the family. Children have been deluged with toys, games, books, radio, TV, nursery school, kindergarten, music, dancing, movies, travel, you name it!! There have been few limits set but very little real communication has existed between the old and the young. Children have reacted with a feeling of alienation. At the same time they have been aware of the flaunting of standards by parents and adults in general. It seems logical, therefore, to hear them say, "Money isn't important". Breasted in his book "The Dawn of Conscience" attributes the "Dawn" in the fertile valley of the Nile to abundance. When man no longer needed to struggle for mere existence, he became interested in his family and then in his fellow men. I am enough of an optimist to believe something similar is happening to this generation.

May 31, 68.

In the last few weeks in an effort to find out more of what children are taught in the grades and high schools, I have talked to many children, some parents and a few teachers. At a teachers meeting a film and a series of slides were shown on reproduction. These were used in many of the schools starting at the third grade. The anatomy of the reproductive system was given in detail with the correct terminology. One mother told me her 10 year old boy gave her a description of the reproductive process and stumbled on only one word, episiotomy. He then went on to describe his other courses, all in the same vein. It is not surprising if some children should get their data confused. When one little fellow was hit by a ball in the abdomen he complained to his mother, "It might have ruptured my uterus".

Children are absorbing a tremendous amount of information. The most urgent need is to up-grade teaching to meet the challenges.

September 30, 1968. A SOPHOMORE!

On this first day, Dr. Speck congratulated the class on the magnificent orientation given the incoming class. His key note "Communication!" In retrospect the gripes of last year boiled down to lack of communication. A real effort should be made to correct it, since the institution will not have a truly loyal alumni group until it does.

As one of the young men stepped out of the elevator the other day, he said to his companion, "When I leave this institution, I shall never set foot in it again". This statement was made repeatedly when I was teaching the students. Only a week ago, when I mentioned an article in the Alumni-Faculty Bulletin, an alumnus said, "I toss the Bulletin in the waste basket, I was so angry with the place when I left it". Even the people now say it is a cold unfriendly place. I wish it weren't! A comment from the students at Childrens was, "We like it here, every one is so friendly". An old timer at Childrens however, said "I am afraid we are loosing it. We are getting too big". "Bigness" certainly is a deterrent to easy, friendly communication.

After two and a half days experience, the clinical faculty members seem a bit more humane than some in the basic sciences. The lecturers have introduced themselves, their associates and assistants, and attempted to orient the students on the approach to patients as human beings,- not as disease entities. Hopefully the institution is ready for such a change in its public relations and it should not take much effort to change the atmosphere from "cold and unfriendly" to "warm and concerned".

After viewing the film, "What makes a Flea Jump?", I wondered if some super-human being (God or Devil) was breathing CO₂ onto our earth at this time causing all the riots and violence among humans,- especially on the Campuses!

The introduction to Pathology was excellent. The lecturer introduced himself, wrote his name on the Board and talked clearly and distinctly as well as with confidence. The lecture on Parasitology, also was well done; many illustrations and pertinent examples.

I have asked several students about the selection and pursuit of a specialty while still undergraduate and the usual reply has been along this line, " I want a better perspective of all fields before I make up my mind".

10/8/68

The mood of the group has changed. At the beginning of the Sophomore year, it is high, one can sense how much easier it is to lecture to a receptive audience. The students are much less critical even when the speaker is less than an orator. The relevance of the subject to clinical medicine is emphasized much more than it was last year.

Epidemiology formerly meant the spread of contagious diseases; now it covers anything from viruses to mini-skirts and the growth of beards. Both faculty and students are much more aware of world problems. When I was a student and told one of the professors that I was planning to practice in India he gasped, " My God, girl, why do you want to waste your talents over there." Times are a changing!

Cytogenetics intrigues me. A picture of a mongol (~~Down~~ Syndrome) was shown during the lecture. Turners and Klinefelters syndromes should have been shown also. It is not wise to say, " You will be seeing them later". The learning process is like immunization; the primary shots are given and then immunity is maintained by boosters over the years. Over lapping of material as described earlier is wasteful, but recalls at appropriate times ~~as~~ important.

October 15, 1968.

The sophomore year is really exciting. I have not yet visited a Freshman class but shall do so soon. Think I will choose Biochemistry as there are rumblings from that quarter.

Epidemiology and World Health is more sophisticated than Community Medicine. The seminars in both courses and in psychiatry fail, in general, to get the students involved. I wonder if some one could help the younger faculty to improve their technique in conducting seminars. Maybe an outside person from a teachers College or from Berkeley might conduct a "Seminar" on the subject.

It seems apparent that the subject matter in World Health, Community Medicine, Military Medicine and eventually probably Space medicine will overlap; the main personnel in these fields should sit down together and discuss their respective areas to avoid duplication whenever possible. It should not be difficult to distribute the subject matter equitably and produce a unique course with an encompassing name. I like "Human Ecology", but others do not. Such a course should have independent status and not be a part of any of the existing departments. Since the Hooper Foundation is world famous, this seems the natural location for it. It also has the Laboratories and staff to do the research in this field. One member is now studying Anthropology in Australia. Physicians and other health personnel must have more training in world health problems, such as food shortage, population explosion, endemic and epidemic hazards.

The sophomores are really high this year. Last Fall they were reluctant to even get up and make an announcement. They were "afraid the speaker would resent having his time cut short". This year 3 or 4 of them get up to talk sometimes delaying the speaker as much as ten minutes or more. Today one of the profs made a snide remark about it, but in enough of a humorous vein not to offend.

At a class meeting today, the recruitment of minorities was discussed. One brave girl got up and stated that women were a minority group and what was being done to recruit more of them. She drew no comment.

The class has sent a letter to the lecturers asking for " Hand-outs" on the subject matter in all _ courses. One speaker said he would do it if the material was utilized but if he found it was not, he would discontinue it. Another one will probably get a follow up letter because he failed to produce!

The Hooper Foundation puts on a noon topic every other Thursday. The last lecture showed slides of Swietzers work in Gabon. Maybe with a little encouragement these could be announced so other interested personnel could attend . I miss the Wednesday noon topics and hope that the Monday films are not discontinued See.' I am a sophomore and a little high too!

October 25, 1968.

Today was a return to classes after the Pediatric meetings in Chicago. After a lecture on Cholera a film was shown. As the old Chinese say ^{ing} goes, " Picture speak louder than words". This picture certainly did!

The second hour was on the healing process in surgery. I hope the head of that department is teaching the younger members to present a subject as well as he did. If Nixon's delivery has been improved by coaching, our younger faculty should profit from some teaching along these lines.

At the Academy meetings, the pediatricians seemed much more concerned about world problems than other physicians; eleven talks related to community and world problems; there was an excellent exhibit on delivery of health services. There was an all day seminar on the delivery of child care;

four papers on growth and development in deprived areas (One from Africa); The Head Start session had a very interesting report from Micronesia and another from an Indian Reservation. Pediatricians get good exposure to these problems. In this period of history, all medical students should have some instruction on world problems and some of this should be in the core curriculum.

October 31, 1968.

Dr. Speck's lecture on meningitis was sheer delight to me. Over the years I have treated probably several hundred cases of meningitis and in one hour he covered the basic principles so thoroughly, I could not think of a single thing he omitted. The students probably did not appreciate how thoroughly the subject was covered. If the "Computer" in the little black box recorded it for them, they will retrieve much of it with the first case they encounter, - I hope! The advantage of "imprinting" and recall that they do not seem to understand.

The second seminar at Langley Porter was far superior to the first. When I asked a student why it was so, he replied, "He treats us like adults". In the preceding lecture the students had seemed very unresponsive and the reason given for that was "He was condescending". They sure are a touchy crowd, - call them "boys" and see the reaction! One of the disadvantages of the seminars is the variability of the moderators. It is difficult to get 10 or 12 members of the faculty with superior teaching ability. If we could get them interested in self improvement, I am sure the quality of teaching could be raised. If the students initiated some of the discussion or topics it would help. It is hard to turn on a critical or at times a hostile group.

Dr. Jawitz showed his pictures of Persia and Teheran the other day. It was a delightful hour for me as I have not yet been there, but seeing the Taj Mahal made me eager to see more Persian architecture and art.

The exhibits on the 13 floor are interesting. I am not sure that any of the other students look at them, but this sophomore enjoys them!

Suddenly it seems the students look worse again- maybe it is because they are not seeing patients this quarter. Several dress atrociously, have long unkempt hair and untrimmed beards. I wish a few patients would refuse to see them. Maybe if they had played more with mud pies and finger paint in early childhood and spent less time in barbers' chairs, they would have gotten some of this out of their systems before entering medical school. The pediatricians, at the recent Academy meeting here, did some soul-searching as to where they had failed. I am sure permissiveness and failure to set limits is reflected in some of these reactions.

November 1, 1968.

Dr. Goldsmith's lecture on population control got the biggest hand yet. She rescued the division of "World Health and Epidemiology" and her performance gave that group a real boost in morale.

In looking over some of the reprints on Medical Education, I found a note on "Human Ecology" from the first world conference on Medical Education held in London in 1954. Under a section called "Social and Preventive Medicine" it was stated that the greatest problem was time in an already over crowded curriculum for new subjects. It was the consensus of the group, however, that human ecology must be taught to undergraduate students in order that all physicians be exposed to world health problems and not only the relatively few who enter Public Health.

November 6, 1968.

At last I visited a Freshman class in Biochemistry, but I missed my classmates and decided to stay with the sophomores. There has been no improvement in dress or hair do's in the past years.. The first year class look pretty unkempt. By the time the fledglings get into their white coats, they look a little more mature and presentable. There are several who are well groomed and many handsome young men in both classes.

Pathology seems to be a well organized, well presented and well received course. It could be better correlated with Introduction to Clinical Medicine.

Although there is still considerable repetition of subject matter, the students do not seem to mind it. One of them said, "It is interesting to get it from different angles". For instance, amebiasis was discussed in "World Health and Epidemiology", in Microbiology and in Pathology.

In viewing the microscopic slides today, I thought it would be interesting if a slide had a piece of normal tissue of the organ to compare with the pathological one, on the same slide. There may be some slides prepared that way but I have not seen them. In the seminars, it seems that the younger faculty, and especially the residents and fellows present more detail; and this is appreciated by the students. For example, in a lecture on malaria and syphilis, it was mentioned that malaria is not seen very often in this part of the world and with the availability of antibiotics the advanced pathology of syphilis is not common. At the seminar, the fellow in pathology mentioned that, although malaria may not be common in private practice, he had seen several cases in the Veterans hospital. He also pointed out that late syphilis is seen in skid-row people who simply do not call a doctor. He also emphasized the importance of always considering the rare cases in differential diagnosis and showed specimens of pathology diagnosed only at autopsy.

Very often when an exam is announced, the class is told that it will be easy, which irks me and the students usually laugh. Students do not need easy exams. Last year the favorite course was neuroanatomy and the faculty members stated that the course was tough and the exams would be so; but with the usual addition, "But I know you can do it." The students like to be challenged.

November 9, 1968.

Judy Stein showed me the anatomy Manual from Wisconsin, really more of a "Hand-out" than a Manual. It answers the type of questions the students have been asking as to what is important and what not.

The seminars at Langley Porter are rather interesting (so far there have been no lectures) each conducted as the leader desires and are, therefore, different. Usually a patient is interviewed by one of the students. The discussion takes place after the dismissal of the patient. The psychiatrists succeed somewhat better than the staff in other departments in getting the students involved. Some of the Pathology seminars have done very well.

The lecture this morning on psittacosis, trachoma and lymphogranuloma was interesting but the lecturer failed to bring in some of the drama connected with a disease like psittacosis. The search for the etiology required as good sleuthing as in most detective stories and the reactions to quarantine, particularly parakeets and parrots entering from other countries, at times has been as dramatic as some of the events in drug traffic control.

The virology lecture this afternoon brought me up to date on culture media, strains of viruses that continue to reproduce and modify, Hela cells etc.

The pathology lecture today took me back to my first year as Chief of Pediatrics at Childrens when I organized a ^{hem}atology lab under the direction of Drs. Aggeler and Wallerstein. It was on hemophilia

The noon film, Carnival under the Sun, was great. I am sorry the Wednesday noon topics have been discontinued.

The course, " Introduction to Clinical Medicine" is well organized and well presented but it might have been more appropriate some years ago when students were more willing to listen and store information for future use. The students say " More appropriate after seeing patients." This generation want to be involved. One faculty member said " Everything you learn in medicine should be preceded by something else, so you have to start somewhere."

The last seminar at Langley Porter was interesting; after the patient had been interviewed by a student, he discussed his own reactions, his hesitancy in pursuing certain questions, etc. The other students then referred back to previous sessions for comparison. It was a good performance. Since students now are beginning to interview patients the relevance of some of the lectures are becoming more apparent to them. Maybe " Introduction to Clinical Medicine" should be given a little later or clinical interviews started earlier, in order to get the full impact of the pertinence of the lectures to patient care. I found the lectures on the cardio-vascular system delightful after my experience in practice of medicine.

Microbiology continues to be a good lecture course though I am not so sure about the laboratory. This week the virulence of diphtheria was demonstrated; I was surprised,- I had almost forgotten about the test after not using it for some 20 or 30 years. Maybe it still is pertinent to distinguish between bacteremia and toxemia and diphtheria is an ideal organism to illustrate it, but there are so many lab procedures essential to understanding today's problems that I thought there might have been a better choice.

I visited Histology today, another freshman class. The students liked the lecture and also praised the surface anatomy demonstrations. Biochemistry is still criticized. I think there is greater variation in students preparation for advanced chemistry than in any other subject and this probably accounts for the frequent complaints about the course.

It was stated today that a special "Task Force " was going to review the laboratories and the teaching exercises in these. The last issue of " World Medicine" is devoted to medicine and technology, illustrating the changes in diagnostic procedures with the advent of technology.

In a recent conversation with a friend who works in a bank, he stated he had occasion to give a lecture to a group of bank employees. He got very little feed-back. At the same time he had his talk video-taped for presentation to the employees in a branch bank. Later he ran the video-tape to his original group to compare the reaction and he said he had a tremendous feed-back. His comment was that this generation is so accustomed to television that they need to see to learn.

November 20, 1968.

The Sophomores met yesterday to report on the analysis of student opinion of exams, with some of the faculty of Microbiology and Pathology also attending. Unfortunately, the microphone was out of order, it was difficult to hear the presentation and the session dragged. Finally a member of the Faculty said he could waste no more time; could it not be summarized quickly. It was. Very little was accomplished. In discussing the session later with some of the students, I got the impression that the " Silent Majority" was fed up with the " Activists." They said teaching was excellent, the faculty members were really knocking themselves out to give them a good training and the only feed-back was criticism.

November 21, 1968.

The lectures on poliomyelitis and malaria both got big hands, one student remarked, " That was a real inspiration." One of the speakers opened the lecture with the comment, " I have tried didactic teaching and you threw me a tomato; then I tried making you talk and I got more tomatoes, from now on I am going to do my thing". Like children, if no limits are set, they keep pushing to get a reaction. When limits are set, the pushing ceases.

Talked to an alumnus from UCLA about medical education in the South City and she said all lectures had been discontinued and no formal course in anatomy was given. (I think I will seek a physician of the old school if I need one!)

Some students raised this question with me: If I were to draw up a curriculum for a new area or a foreign country how would I plan it? I'll play that game for a while in my spare moments.

In " Pediatric Research", Sept, 1968, is an article by Alan Ross entitled, " Listening to Students". It is interesting and worth reading.

November 26, 1968.

Last Friday I was asked to show my African Pictures to Second and Third graders in Sausalita; an integrated school with about 45% black. November had been designated " African" month. (It was Thanksgiving and Early American when I went to school!) I was impressed by the similarity of the student behavior at these grades to that of the first two years of medicine. They acted on impulse, moved around at will and talked to any one at will; it was bedlam most of the time. At the end of the pictures I asked for questions. They wanted to know if I saw any snakes and why didn't I have any pictures of them. I even got the question, " How much did it cost?"! Present behavior of young adults, even in medicine, is a reflection of child rearing practices. It will be interesting to see what clinical experience will do for them. I am told that the " Silent Majority" finally had their say to the class. Sorry I missed it.

The morale of the faculty in some of the departments is low. There is repeated evidence of depression over the indifference and rudeness of the students., and unfortunately , there is not much communication between the departments.

There is considerable duplication in Microbiology, pathology and epidemiology, some of which is undoubtedly necessary and good. There is great temptation when discussing a virus or bacterium to also discuss the disease, its spread and control. The clinical and epidemiological aspects might be left to practitioners. Integrated courses here would be ideal, that is if the lecturers were willing to plan the courses and method of presentation in advance and with joint discussions.

The session with the Black Students Union and the Black Caucus was an example of patience and understanding on the part of the faculty and the administration. I came away pleased with the discussion, and then a couple of days later a violent letter to the chancellor was read to the class by a black student. He stated there would be no time for discussion at this time. There was no student response to the reading but a sort of dumb-founded silence. There was a weak "Clap" from one faculty member present.

December 6, 1968. The last day of the first quarter of the second year! Microbiology has been a very thorough course and exceedingly well presented. The profs have good rapport with the students, both in speech and dress, including hair-dos! Dr. Jawetz has not resorted to this fashion but has enough style of his own to get by.

The pathologists less flamboyant, have put across their course very well.

The psychiatrists have given the students a good learning experience both in interview techniques and in interpretation of the interviews. There have been no lectures and the management of the seminars have varied considerably, some students, therefore, have had a better experience than others. Lectures have the advantage of uniformity in presentation for the students,- that is if they attend.

Of all the courses, I enjoyed World Health most . But then I have been around a bit more than the rest of the students.

Introduction to Clinical Medicine certainly represents great effort on the part of the staff. It was an excellent review of adult medicine. The students are so eager to get involved with patients they fail to appreciate what excellent background material they are getting.

The freshman's meeting and discussion of the " Carbone" method showed the class as very different from the sophomores. They seem more mature, probably due to the difference in the leadership of the class.

It was interesting to chat with the 5 junior students assigned to Childrens Hospital surgical division; they were already regretting that they had not worked harder in anatomy. Only one said he had enjoyed his first two years but guessed he was somewhat naive. It is obvious that the modern medical student must see to believe and the curriculum better provide opportunity to see patients on some regular basis the first two years. The basic scientists are in a tough spot when it comes to teaching medical students.

December 12, 1968.

This will be an attempt as a pediatrician to interpret the recent discussion of the curriculum. The " Over thirty" group born before World War II lived through a period of history foreign to the next generation.

In the period before anti-biotics, severe illness and death was a far more general experience. Many of the present students have had no contact with sick people, handicapped individuals or deprived groups. They will not see the relevance of the basic sciences until they have had contact with disease. On the other hand they have had a great many other experiences that their elders did not, - radio, television, books, travel etc. This makes them more sophisticated in a sense but actually they are very naive in many ways.

In the pre-war era there were fewer internes and residents and it was relatively easy for a student to get part time work in a hospital. Many students had to work their way through as there were few scholarships or other means of support,- parents were not as affluent. Probably most of the students who earned their way through medicine did so by working in hospitals part time. When I was a Junior, I spent my spare time on the Obstetrical service at the Swedish Hospital in Minneapolis where I delivered over 100 babies simply because there were no internes or residents on that service in a private Hospital. My senior year was spent at the County Hospital in the same city. Some students took a year off to make money. The students, in general, were more mature and very few were unfamiliar with illness. After the war many of the students were veterans, also an older and more experienced group than the present entrants.

The size of the class is often given as a reason for the poorer relationship between faculty and students of the present generation. I do not accept this as valid although it may contribute. The ratio of students to faculty has not changed, it may even be better. A more likely cause has been the post-war emphasis on research. Faculty members were chosen for their interest in research and often also for their ability to attract research money. Teaching was neglected. Promotions were made on the basis of success in research and the phrase " Publish or Perish" was coined with a good deal of justification.

There is a reversal in attitude and teaching is again being emphasized. All of these experiences can be synthesized into the new curriculum. I dont think we will find any other faculty or administrative staff more patient, attentive and receptive to suggestions than the group on Parnassus hill.

December 20, 1968.

After three meetings of the curriculum committee in one month, I shall make a stab at writing my own, with this apology: I come from a family of engineers and tend to approach the body as a machine,- to counter this I am the proud owner of the International humanitarian award!

First Year Medicine. (After orientation).

- I. In order to satisfy the "Involvement" demands of modern students, the courses Community Health and World Health could combine much of the work into a course on Human Ecology. The course should have independent status with faculty chosen from several departments using only those best qualified. The lectures and seminars should be modified accordingly.

On the spot training as follows:

1. Hospital visits to SFGH, Veterans, Kaiser, Shriners, and a private one. This would illustrate the different types of delivery of patient care in hospitals.
2. Public Health Agencies,-- Public Health Offices, Public Health School in Berkeley, Emergency hospital, Well baby clinics.
3. Mental Health Services,-- Laguna Honda Home, Recreation Center for the Handicapped, School for Emotionally disturbed children. Services for the retarded.
4. Seminars devoted to the discussion of questions arising from the visits with especial attention to unmet needs and improvement of services.
5. Some seminars should be devoted to discussion of other facets of Ecology,-- population control, pollution, violence etc.
6. Some time should be devoted to comparison of local problems with world problems in order to get a better understanding of the inter-relationships in an ever decreasing size of the planet.

- II. An in depth study of Homo Sapiens. The body is a super machine, evolved over billions of years and survival against great odds.

1. Surface anatomy devoted to close scrutiny of the body and graded on observations as follows:

Hair : color, texture, cut, cowlicks, hairline.

Eyes: Color, glasses, size of pupils, equality of pupils, strabismus.

Ears: Size, shape, location, symmetry, hearing(Rough test) cerumin.

Nose: size, shape, obstruction, secretion.

Mouth: teeth, gums, palate, tongue.

Throat: tonsils, size, color, exudate.

Skin: color, texture, lesions.

2. The organization and functioning of the body: Emphasis should be on seeing and thinking. All available aids should be used, - models, pictures, video tape, stereos, X-Rays and dissection. (Preferably assisted by surgical fellows.)

The study should continue in a systematic fashion:

Cranium. Encloses the brain, a fabulous "computer" with "inputs" from vision, hearing, smell, taste, and touch. Dissection of the brain.

Digestive system. The power supply. Gross and microscopic anatomy; input from related glands with gross and microscopic examination of these and a study of the function of the secretions.

Cardiovascular system. Transportation. Gross and microscopic study of the heart and circulation; the relationship of the lymphatics and and gross and microscopic anatomy of these.

Pulmonary system. Ventilation. Gross and microscopic study of the lungs; a study of gas exchange.

Kidneys. Filtration and elimination. Gross and microscopic anatomy; function; urinalysis.

Reproductive system. Gross and microscopic study of male and female reproductive organs.

Skeletal system. The supporting frame work. Gross and microscopic study of the bones and joints possibly with the orthopedic residents as laboratory instructors.

Muscles. Motor power. A study of the major muscles and their mode of functioning; their relationship to the bones and the joints. Locomotion.

Skin. Structure, gross and microscopic, and function.

Nervous system. Gross and microscopic anatomy.

3. After familiarity with the location of the organs of the body, a second round of surface anatomy with particular emphasis on the relationship of surface markings to internal anatomy might be given; this to include sites for various punctures, biopsies, taps etc. X-Ray should be used to help visualize the inner organs.

This should conclude the first year and should cover inconsiderable depth anatomy, histology, biochemistry, neuroanatomy and in part only, endocrinology, and physiology. Human Ecology would provide some opportunity for interviews with patients and some familiarity with community resources.

Second Year of medicine.

Hopefully the students now have a fairly realistic concept of the organization of the body and its functioning. The second year will be devoted to take an overall look at the things that may go wrong with it.

- I. The first year course in Ecology will be followed by a course in psychiatry with more opportunities for the students to interview patients and in small seminar groups discuss the results.
- II. The system method would continue with discussions and demonstrations of:

Pathological conditions in each system, correlated with the lectures in Introduction to Clinical Medicine. Gross and microscopic studies would be made.

Microbiology. The study of bacteria, viruses and parasites would be illustrated with both clinical cases whenever possible (When not by pictures) and by laboratory studies of specimens, gross and microscopic.

Pharmacology. Introduction to drugs and their uses.

Third year of medicine. From here on the clinical faculties tend to take over

but they should utilize the basic scientists more than is done at present.

The best Rounds that I attended the past year were on Harelip and Cleft Palate with the anatomy presented by an anatomist and the repair by a surgeon. There should be more of these joint meetings. Another recent co-operative effort was the presentation of a case of Weil's disease, discussed by K.F. Meyer.

January 4, 1969.

The associate Dean of the Medical School asked me to review a report that had just arrived. It was entitled, "Report of a Conference on Meeting Medical Manpower. The fuller Utilization of Women Physicians".

The following are my comments:

- I. The image of the woman doctor in USA as compared with that of some other countries.

When the United Nations met in San Francisco after World War II, some members of the County Medical Society of S.F. gave a dinner for foreign medics attending the meeting. At the dinner I happened to sit next to a Russian M.D., a man who spoke English very well and we had a delightful discussion. When the dinner was over, the thought came to me, "I was treated exactly like an equal by the Russian Doctor". The difference is very subtle and difficult to explain, - it is felt.

When the World Medical Association met in London, nine doctors from USA, including two other women doctors and myself, went on a planned tour of Czechoslovakia, Poland and Russia. In all of these countries there was a higher percentage of women M.D.s than in USA. Russian M.D.s were 70% women. There was no reference to this by the Russians at the various medical meetings, -- qualified physicians, male and female, presented cases. I chose to see the pediatric activities and visited several Day Care Centers. A couple of the surgeons in the group attended operations and were invited to scrub and assist. The Russian surgeons were women. This caused considerable comment in our group, but the men admitted that the women surgeons were excellent operators.

Shortly after the war, there was an International Women Physicians meeting in Holland. The Danish Women invited the Americans to visit there enroute to Holland, which some of us did. In Denmark a group of male physicians volunteered to take us on sight seeing trips and handle the mechanics of it to free the women for entertainment of their guests.

In Holland, the Medical Society of Amsterdam gave a dinner for us and the president, a male, congratulated the women for being the first International group to meet after the war. Several others gave laudatory speeches. I can't see anything similar happening in USA. Even the Academy of Pediatrics, which was organized in the early thirties, has never had a woman officer or a woman on the Executive Board. Dr. Hattie Alexander was the only woman president of the American Pediatric Society.

The attitude toward women in medicine has changed considerably in USA the last few years and articles by men urging more women to enter the field have appeared. I don't know ^{why} we are behind the European countries and Russia in this, unless the transfer from the old to the new world caused an arrest in development??

II. Comparison of the work hours of men and women in medicine.

Some years back the Women Physicians Club of SF invited the women students of UC and Stanford to an evening discussion on combining a medical career with marriage. Several of the somewhat older women were asked to give their experiences. Some conclusions could be drawn from the discussion:

1. When both husband and wife were M.D.s, the wife often was discouraged by her husband in pursuing her career after marriage and especially after children arrived.
2. Women who married outside the medical profession received greater support from their husbands to continue practice whether the men were dentists, lawyers, preachers or educators.
3. Certain specialties in medicine were easier than others for the combination of marriage and continuing practice, - positions with regular hours, part time positions, like Well Baby Clinics or school health; specialties like Dermatology, Radiology, Research, Administrative jobs.
(Many male physicians have jobs with Pharmacuetical firms, Charity organizations such as March of Dimes, Cerebral Palsy etc; are these men " Drop-outs "?)

Women physicians who do not pursue their profession in any of the ways , may still contribute to health. Very few medical women let their licensure drop. Many so-called " Drop-outs" are active in community work such as PTA, Girl Scouts, Red Cross Etc. where their knowledge is utilized.

For years I have been interested in what happens to the children of women physicians as an indication of the success or failure of this dual role. As a pediatrician, I have cared for a great many of these children and I cant recall a single failure. In one family all three children studied medicine; in another all three insisted on attending the same college their mother had. I once read an essay in the form of an autobiography of her first 15 years by a girl whose parents were both M.D.s. She weighed the advantages and disadvantages of having a mother who is an M.D. and the advantages came out way ahead.

III. The work load of a double job.

Wives tend to evade discussion of home work now as compared with the past. For over 10 years I have done my own house work and it really is fairly simple. Machines will wash, dry, mangle, wash dishes, dispose of waste, vacuum clean; maintenance service for window washing and other heavier duties are available; caterers will take care of entertaining; ready prepared frozen or canned food is often indistinguishable from home prepared. (I have fooled many of my friends.) Children love nursery school from 18 months on and will pull temper tantrums more often when leaving than on arrival. It is the quality not the quantity of care that matters. Children love their fathers even though they do not spend many hours a day with them. A woman does not have enough to do at home during much of her life time unless she has some additional interest. Unfortunately these activities sometime take the form of wine parties, gossip etc., which may lead to greater neglect of children and husband than a job.

- IV. Are there any basic differences between men and women that might be pertinent to roles in medicine?

The following comments are based on my studies of growth and development of children: Girls mature earlier than boys, this is generally recognized at adolescence but has not been so at ages five and six. Many of the problems of little boys entering school are due to this developmental lag. They are not ready for the tasks while the girls are. This often is very unfair to the boys.

Girls identification with mothers comes about naturally from intimate association; boys who as infants have this same association must then switch to the father image for his identification. (this may be a reason why little boys go through a phase of disliking girls.) An interesting observation of handicapped and retarded children is that boys have a better prognosis for continued growth than girls.

Pregnancy and the birth of a child seems to satisfy the creative urge of women, they may level off and be content with their accomplishments. Fatherhood, on the other hand, increases responsibility to perform and produce.

The experience of pregnancy adds a dimension to women's growth that men cannot experience. This is a reason for encouraging more women to enter obstetrics. So many times mothers have stated that they were concerned about the outcome of a pregnancy because of unusual symptoms only to be told by the obstetrician that pregnant women always imagine things are going to happen.

Men and women complement and supplement each other and women can add more to medical knowledge than they have, but they should not replace men in the profession, we need both. Some male nurses in the military made a real contribution to the nursing profession. We used many of them when we had polio patients. Both men and women in respirators preferred them.

- V. What about the modern situation?

One of the black men asked me during a seminar session if I had encountered much prejudice when I was a student "first time round". After the class one of the girls said, "there is prejudice still". At the last Student Welfare session there was a discussion of Student-faculty social gatherings and the blacks were mentioned. I then raised the question about the girls and was told that the lists were made out alphabetically.

The suggestion that black applicants be interviewed by both black faculty members and black students was reminiscent of a period some years back when it was suggested that women applicants be interviewed by women physicians.

January 8, 1969.

(Introduction to Clinical
medicine
ICM)

Back to classes! There is unnecessary duplication in pathology and ICM.

In discussing the pathology of the heart, considerable time was spent on clinical symptoms,- material that had been very well covered in the ICM lecture. These two courses, pathology and ICM, could be beautifully correlated. Maybe another year it will be done.

Dermatology is given for the first time. Apparently dermatologists haven't changed. The lecture and demonstrations reminded me of an event many, many years ago. I got angry over something and said "DAMN" rather loudly. An old Scotch janitor was mopping the floor nearby and I apologized. His response in a heavy brogue was, "There is nothing that needs to be said that cannot be said in good English." I have remembered the rebuke. This is only the second lecture in 4 quarters where "good English" was not always used. That is better than on my first time round in medicine.

Pharmacology is the other new course this quarter. I am looking forward to it. This is one specialty that has boomed since my first round. As my elective I chose "Teratology" under Dr. Monie.

January 10, 1969.

Yesterday was a real "RED LETTER" day. It started off with the elective, "World Health Problems". Although the department gives 7 electives, it seemed to me over half the class came to this session.

The first period was followed by a brief history of Pharmacology presented in his usual brilliant manner by Dr. Leake. Also at one time in the lecture he turned to a student and said "If you are bored get up and leave". This is the first disciplinary action I have encountered. The reaction of 22 year olds is very much the same as 3 or 4 year olds,- they respond favorably when reasonable limits are set. The world needs more of it.

The real highlight of the day, however, was the ICM lecture by our Acting Dean which fulfilled all requirements, - introduction of self, a short explanatory statement for the course, and then a sharing of information with the students on the respiratory system, beautifully illustrated down to the last detail. The second hour, on the X-Ray findings of the chest, was the perfect sequel. Someday I hope the students will go to their pathology sections from these lectures and see the corresponding pathology, gross and microscopic.

January 13, 1969.

I didn't go to school today. It was raining and blowing and the newscaster warned little cars to keep off Waldo grade. Maybe having a birthday on Saturday didn't help matters either. It all was reminiscent of childhood in northern Minnesota this time of the year. We had 2 miles to school, there were no snow plows and no autos. In spite of my wailing and begging, ~~so so~~, mother would not let me go. I would watch the clock and wonder what was going on, who was there and what was I missing. I don't think any one has ever loved school more than I did. Maybe that is why I am back now. I missed most my elective on teratology, but I was sorry also to miss the film on the Blue Danube! It was muddy and not blue when I was there, but after Russia, Vienna was light, gay and lovely.

January 18, 1969.

In defence of the students in the upper ten percentile!

One of the lecturers repeated the old cliché, "It isn't necessarily the top student grind who succeeds in Medicine". This statement always irks me.

It probably is "Sour grapes" and an attempt to comfort the average or below student; it is unfair to the person who by natural endowment is in the upper percentile without even trying. "Grinds" seldom get there no matter how hard they may work for grades. The top students with rare exceptions are

highly motivated, creative and curious. Dr. Termans follow up of 1000 bright boys after 30 or 40 years found that the great majority continued their high performance and were leaders in their communities. Although an equal number of girls were tested, he could not do a satisfactory follow up on them because most of them were housewives and he had no way of evaluating them. I had a number of these women as mothers in my practice and I found them delightful, capable as mothers and wives. Interestingly, they were the ones who were most apt to choose a woman physician.

Today I had a long visit with a child psychiatrist. She has her specialty boards in both psychiatry and pediatrics, a graduate of UC SF and Langley Porter. She stated that during her medical school days the place bristled with hostility. The chiefs of departments often did not speak to each other and even in lectures would make disparaging remarks about other faculty members. I insisted that this had changed but she remained skeptical, maybe I am naive. but I think people should love each other!

For the first time, on Friday the lecturer stopped by me on his way to the podium and asked if I were there to report on him. He said it with a smile and he was quite young so I didn't mind. He put on a good performance and I told him so. Most of the lecturers pay no attention to my presence; (outsiders often ask me if my attendance is disturbing to the lecturer.)

I thought there was some indication at the last curriculum meeting that some members of the staff might be interested in some extra training or preparation for teaching. Maybe eventually the school will provide some instruction for graduate students and others going into academic work, in the art of teaching.

January 20, 1969.

I am enjoying my elective in Teratology. Clinicians should work more closely with the basic scientists. Human development as a part of medical training has been sorely neglected. Faulty or stunted development of any part of the body is often an antecedent to later disease and may be a determining factor in longevity. It is the most challenging field for study in pediatrics and of greater importance to all of medicine than is generally recognized.

The noon Film was on Westminster Abbey with narration by Mr. Mason. Its reverent atmosphere and great beauty as well as its fascinating history made me feel there is hope for the world as long as there is an England!

January 22, 1969.

The session at Langley Porter today was like a Billy Graham confessional. There were ten young men in the group including a chinese and a black. At the suggestion of one of the students the group would be more at ease if we knew each other better and gave his own background as well as his reason for studying medicine. The others followed suit. My earlier interpretation of present youth was confirmed and I gained some additional insight into the psychology of the young. One student said these two-hour seminars at Langley Porter were like an oasis in a desert; he looked forward to them all the rest of the week. All the students were from affluent or fairly affluent homes. Two said they were reared in Catholic homes and attended Catholic schools until they entered the University. Practically all of them in the course of their conversation mentioned that they were "A" students. All but one seemed to have been free to choose and pursue any line of study they desired; two of them expressed the wish that they had had more guidance from their parents. Only one seemed to feel relatively sure that he had chosen the right field; the others expressed definite ambivalence over their choice. The father of the

black student was a professional person in Nassau and apparently there was plenty of money in the family. His education had all been in Black schools until he came to California. He said it was still hard for him to believe the stories told him by blacks here because he had not encountered prejudice before; there had been a few chinese and whites in the schools he had attended, but color had never been a factor in student relationships. The Chinese student had attended a school in Southern California which was largely black and in the grades he was often "mugged" for food or nickels by his classmates who came to school without lunch. When he approached adolescence he was smaller than his classmates and had to be more cautious,- if he heard footsteps behind him on his way home, he ran.

After listening to these stories, another characteristic of these young should be added, namely, self confidence. In addition to affluence and permissiveness they have been reared to have a high opinion of their own ability. In the practice of pediatrics it was always startling to me to hear a mother boast about her child's ability in his presence; it was in direct contrast to my own rearing where the watch word always was "Pride goeth before a fall". There should be a happy medium.

I can visualize these young men, some 15 or 16 years ago, as well groomed little boys, hair cut and neatly combed, Santa bringing them every thing they asked for for Christmas and each mama telling her bridge-mates what a smart little boy Johnny was. What are little boys made of? Maybe this explains a lot; maybe their dress and hairdos are an expression of frustration in childhood, when little boys should be boys.

The black student from Jamaica said he was very confused when interviewing black student applicants for admission to the medical school. He tended not to agree with some of the ratings of the rest of the interviewers.

A woman member of the interviewing committee said she thought the male criteria of women applicants often was biased and unrealistic. Present statistics indicate that women are admitted in the same ratio as men, but are not applying in equal numbers. The women students say that girls from high school on, are discouraged from applying by counsellors and often by parents and friends.

Dr. Diamond mentioned that many pediatricians in the East after retirement are given no rôle in the University and are unhappy and depressed. We discussed Hastings Law school etc. I have talked to a few of the emeritus staff here and hope to have a luncheon with some of them to see if a similar situation exists here. It seems to me this school is most generous in continuing the emeritus staff on in some capacity.

January 30, 1969.

At the Pediatric Grand Rounds this morning, Dr. Monie gave the developmental background for the discussion on conjoined twins. It adds dimension to the session to have this type of presentation. I wish it would become routine. There should be much greater contact between the basic and the clinical sciences.

The ICM lecture this morning was presented by the Department of Pediatrics, and I was proud of my colleagues in the field. The examination of the newborn came over television directly from the nursery, presenting a normal newborn, a premature and a series of infants with abnormalities. This was supplemented with colored slides and with hand-outs covering History taking, physical examination and growth charts. This could not be improved upon!

At noon I met with William Crawford of the SF State faculty. He has his degree in Educational Research and has spent two years at one of the Chicago medical Schools. He showed me some interesting material on programmed learning. Some of this could be used for "dry runs" in lieu of laboratory tests.

The students seem rather unaware of the limitation of human material to work with. In practice I became very sensitive to the rights of the sick. They

want a personal physician. Many people do not go to the University Clinics or Hospital because they feel as if they were being used as guinea pigs for the students. Many parents take their children to Kaiser Hospital for routine examinations and immunizations, but if the child becomes acutely ill they call their own personal physician. The same thing happened in the Navy. Some of our top physicians were at Oak Knoll yet many of the service personnel would prefer to go to a total stranger of their own choosing than to have a military doctor. Mr. Crawford said he played the role of patient at one time in order to experience the patients' side of medical education. His identity was not known to the students. But I suppose some day both doctors and patients may get accustomed to other methods of health delivery services the turn things are taking in this country.

January 31, 1969.

ICM continues to have excellent presentations; today a well illustrated lecture on vascular disease particularly emphasizing arteriosclerosis and embolic phenomenon. Comment from student after the lecture, "As easy to understand as plumbing!" And a comment from the faculty member, "The ICM lectures are the most difficult to give because you have to bridge the gap between the basic sciences and clinical medicine, and you don't know what they know and what they don't know."

In some of the electives there are only 3 or 4 students. It seems like a tremendous amount of work for the faculty with such little response especially when the sessions are so very relevant to the students' future work in medicine. Also the exhibits on floors 13 and 14 are excellent and one scarcely ever sees any one studying them. They probably will discover their error some time in the future, but it may be too late to return for it.

The Monday film took us to Venice; it was fun and "Standing room" only.

February 4, 1969.

An eventful day! At a Langley Porter session, a beautiful girl , 16, from a normal middle class home was interviewed. She had attempted suicide. Again I was impressed with the necessity of setting limits for children. Her story was that noone scolded her or got angry with her no matter how hard she tried to provoke a reaction. I asked some of the boys later , if the medical faculty was too permissive with the students and they promptly said, " YES". It continues to irk me when the instructor says " You dont have to remember this", or " The exam will be easy, dont worry about it". I prefer Leake's stance, " If you are bored, get up and leave." Why all this molly-coddling!

At noon we had a meeting regarding the Emeritus staff. Dr. Diamond is president of the American Pediatric Society this year and will call a meeting of the Emeritus members of that organization at the annual session. Dr. Roger Wilson , from continuing education gave us a good run down on requests for for speakers at medical meetings through— out northern California , these come from hospital staffs, from county medical societies or other groups. We will continue to have discussions as we gather more information.

The women of our class and Mrs Cartwright will meet at my house to discuss any problems they may have.

February 6, 1969.

I read a letter from the Medical Womens Association regarding sex education in medical schools and will get the women students reaction to this also. Maybe Earle Marsh is already doing enough to satisfy the demands of the students. A controversial film is being shown in the schools to high school and grade student. It leaves very little to the imagination and is meeting with considerable opposition from parents. The Chronicle had an article about

" artistic" film on the subject put out in Italy; we can import our educational material. An "underground" film is being shown here. It probably is time to introduce an official course properly presented by some faculty member well qualified.

FEBRUARY 10, 1969.

Yesterday we had a reunion of the original staff of the Child Development Center including the speech-audiologist, psychiatrist, occupational therapist, psychologist and nursery school teachers. I used the opportunity to pry into the problem of marriage, children and a career a little further. (Am ready to drop the subject.) The girls are married, have children and homes scattered about the Bay area. The nursery school teacher has published her first book, "A Child's Guide to San Francisco". It has sold over 10,000 copies. She is working on a second book.. The rest are working part time in their communities at their professions. They have beautiful children, they are happy and they are interesting and stimulating women. It has meant quitting a job, sometimes moving into another community, taking time out to have two or three babies and reestablishing themselves in their work. Women must be more flexible than men,- more adaptable. They can do it with a little help and understanding from husbands. In a few instances, usually among artists, there might be a reversal of roles with the mother being the bread winner and the father working in a studio at home attempting also to care for the children. It is not very often a satisfactory arrangement.

I tossed out to the group, for feedback, another idea I have mulled over for several years . When working with retarded and defective children, stigmata are prominent. Not infrequently some stigmata are found in " normal" individuals,-a abnormal hand prints as an example,- what is the significance of these? What ideal for perfect development have we? The ancient Greeks

had physical ideals depicted in their statues. With increased knowledge of cell structure, body chemistry and the subtle abnormalities of these, a far more complicated ideal would have to be considered. Plants and animals have been improved by selection and breeding, should human biologists and physicians take a more careful look at human development and possibly through education and counseling attempt to limit the reproduction of inheritable defects? If we are going to attempt to control population explosion, should we not give more serious thought to prevention of defects and the perpetuation of defective strains? The opinion of the women in the group mentioned above, was that people with inheritable diseases should not reproduce. There also was a strong feeling that the mentally retarded and the psychotic should not reproduce. Even though the condition may not be inheritable, the environment in which a child is reared under these circumstances precludes normal development. This view is contrary to the teachings of many who take the attitude that these individuals have the right to have children if they so desire ;but who then looks out for the rights of children who cannot speak for themselves? Students in the Health Sciences should have the opportunity to discuss these matters.

The Hitler period and now racism sets us back hundreds of years. In the evolution of the species this is only an iota of time, but it is interesting to speculate on what might happen.

Winston Churchill, Albert Sweitzer and Herbert Hoover all died the same year at ages over 80 years. They were physically strong, intellectually superior, emotionally and socially well adjusted and they lived long. They must have been very well designed human beings. Should we not strive to have more like them?

February 11, 1969.

The lecturer from Davis campus today presented some interesting material. I particularly enjoyed the film strip from New Zealand and Australia, which reminded me of a visit a few years back. The recording of a song sung by the farmers of New Zealand at the annual "de-lousing" meet was played at the end of the lecture-- a good finishing touch! Davis offers a wonderful opportunity for exchange of ideas and experiences between medical personnel, veterinarians and agriculturists. The primate colony alone is a tremendous asset. I hope they make the most of their opportunities.

Yesterday we had another type of trip to down under via the film, "Australian Aborigines". Again I wished for an opportunity to study objectively and without prejudice the human animal and its different types. If some infants from these aborigines were reared from birth in an Australian, European or American home what would they be like? This should have occurred at some time in the long history of Missionary work among remote cultures. Even collecting scattered and diverse incidents of reported experiences might be revealing. Practically every country has a native culture such as the Eskimos, Maoris, Lapps, Indians, Africans etc.. The New Zealanders, like the Hawaiians, have integrated to such an extent that pure natives are hard to find. I would really like to know whether or not there are any basic differences between peoples other than skin color and facial features. According to some studies, the American Negro is between 20 and 30% white. They also are mixed with American Indian, Fillipinos and probably many other ethnic groups. Ethnic histories are interesting and often relevant to certain anomalies like Spina Bifida in Wales. A good subject for some Emeritus to pursue!

The visual problem of crayons and blackboards remains unsolved!!!

At the lecture on the kidney, the speaker interspersed some history, which adds spice to the subject. There should be a Medical History Department for students and faculty who are interested and I gather from exhibits and contact with some faculty members that there is a good deal of material about. Again, I wish there were some of the Emeriti or alumni who would be interested and do something tangible about it. How about using the library for exhibits?

Duplication continues! The chiefs of ICM and pathology should correlate their presentations and when ever possible also tie it in with the clinical presentations. It would be ideal teaching. It would mean work, but this is an educational institution and should concentrate on improving teaching methods.

The students are learning that "patient material" is not limitless. The comment was made that at the County hospital patients would say "not again" !

In many of the electives the time is spent almost entirely in lecturing, with very little time for discussion or actual involvement. This generation of students want to be involved so desperately, it becomes very frustrating to them to be talked to constantly. So far the psychiatrists have done the best at involving them, but then they should be the first to interpret the students,- it is their stock in trade!

February 17, 1969.

Yesterday we had the seminar on " Women in Medicine" at my house, with plenty of discussion! The girls are very sensitive about the image they have. They do not want to be set apart as another minority group, but at the same time they have many questions they need and want to discuss.

I wonder how we can provide for this type of counseling without making them feel conspicuous? The type of problems they raised were:

Where can couples get information regarding internships and residencies that can be taken together or at least in the same city?

Are there any internships or residencies that can be taken on a part-time basis, - as taking two years to finish the usual one-year service- for women with children?

What opportunities are there for refresher courses after time out for family duties?

What opportunities are there for part-time positions when the children are young?

If several years have been spent at part-time jobs, what are the chances that you can get a residency in some specialty and get your certification?

Information regarding these questions should be gathered and kept up to date. The American Medical Women's organization, possibly H.E.W., Woman's Medical College in Philadelphia and even the AMA might be consulted.

I agree with the girls that we do not want to split off into any more minority groups. Our "melting pot" is already undergoing too much "electrophoresis". The girls are extremely sensitive about the present attitude, apparently expressed frequently as, "What do you expect, when you invade a mans field?" One said she was interviewing a patient in a double-bed room and the husband of the other patient asked her if she was just starting her nurses training. Her comment was, "You muster all your courage to go in and take a history and then you have all the pins knocked out from under you by a comment like that." All agreed that changing the image so that women will be accepted as doctors like men, will be a slow process. Most of them have been discouraged by parents, counselors, physicians and often by interviewers at Medical Schools. In families where the mother is a professional of any type, it is easier for the

daughters to enter the field. If the image in the home is that of the mother being a housewife, adjustments are more difficult.

It should be advantageous to have counselors not only from the faculty but also from practicing physicians for the girls to talk to . They wondered about a room somewhere on the campus where they could meet and talk once in a while, maybe at luncheon time while consuming a sandwich. In many Medical Schools there is a medical sorority with a house where the women, students and faculty, can meet. There is no such place on this campus or in the neighborhood and the women in the different classes often know none of the members in the school except those in their own class.

The men will have to change the image. This should be done unobtrusively, without confrontation, perhaps first by the announcement of a counseling service on domestic and other family problems of students. The women were pleased that the Deans office was interested in them.

It was the opinion of the group also, that there should be a course on sex education, planned parenthood, family counseling, etc., but were less sure of when or how the course should be given, - in OB, Psychiatry, Community Medicine? The men might be polled to see how much interest there is in the total group.

The noon film took us on a tour of Leningrad and some of Russias history. It makes a film more interesting if the place has been visited, and how do you have time for this in a profession as time consuming as medicine? Stay single and miss most of the problems discussed above also!

February 21, 1969.

A lecture on malnutrition with pictures of starving youngsters really shook us up today. Pictures still speak louder than words. The second lecture on "Shock" was also a bit shocking. The modesty, ^{sic}erity and dedication of the faculty is indeed impressive.

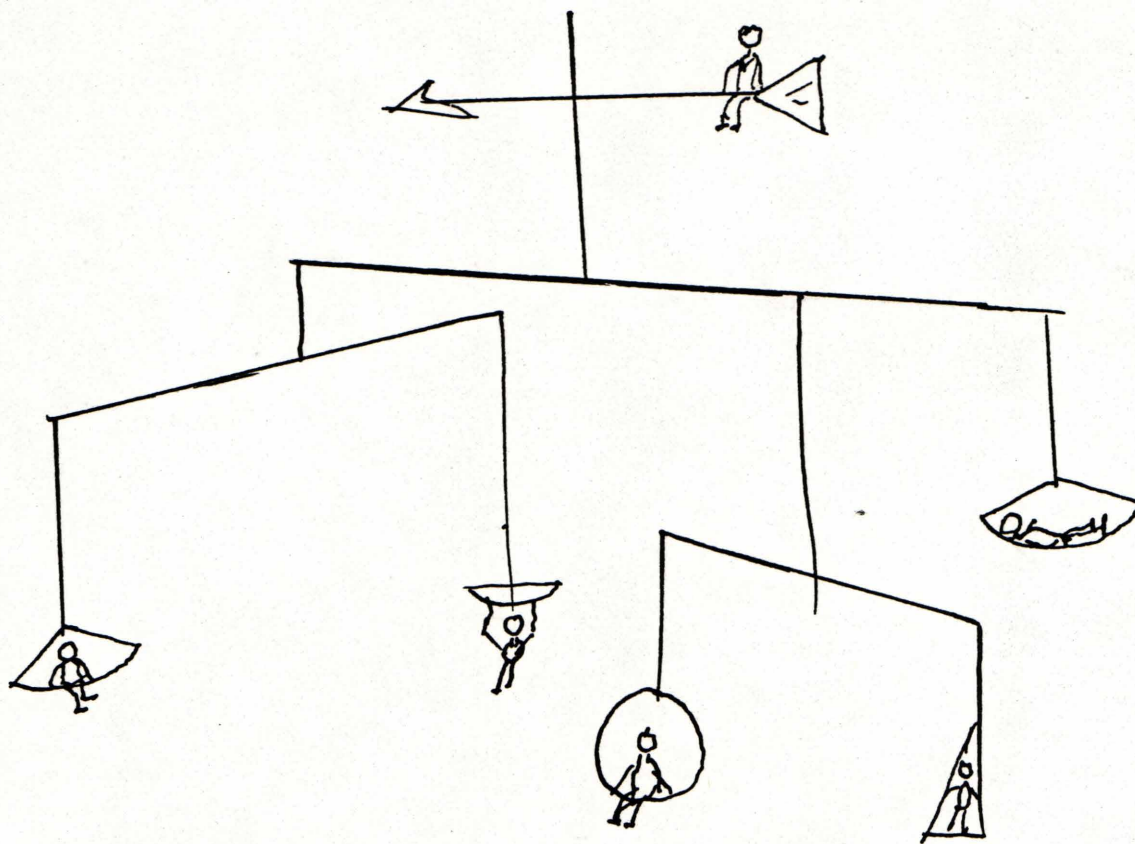
I wish I had a tape of the men in the class attempting to undress the new borns. Maybe they should have some experience doing ^{it} with dolls first. One of the students asked me for the name of a pediatrician, - he was not one of the group in the nursery!

A maturational process is taking place. Today, one of the men who was an activist last year, after looking at the morning headlines, said, "I feel a generation gap developing between me and the under-graduates already." The students are tidying up a bit; with hair a bit trimmed, beards likewise and white coats they are looking more professional.

Repeatedly the past two years I have been reminded of my $2\frac{1}{2}$ days in Hitler's Germany in 1939. It is only lately that commentators have referred to Hitler's youth when discussing violence. Although warned by friends not to go to Germany, I was skeptical, having been reared in a community with many German families and associated with their children. I expected to encounter the same type of people in Germany; instead I came home very frightened by what I had seen and experienced, - there was complete lack of manners and a rudeness that was hard to believe could exist. In Weisbaden I met an elderly couple who seemed more the picture of Germans I had known, but when I spoke to them, I learned they were from Denmark and they said this would be their last trip to Germany - it was so changed. When I arrived in New York, most of my friends laughed at my fears of war; the general feeling was that Hitler and Mussolini were phonies. War was declared when I was in flight home.

February 21, 1969.

After the nonchalance of the basic science faculty, I am amazed at the number of members of the pediatric staff who say I make them nervous when they have to teach in my presence. This strikes me as curious. The faculty say the students get brighter every year, the basic scientists think the clinicians know more than they do, the physicians in practice think the Academicians have much more information than they have and vice versa. The students are overwhelmed by the amount of information they must acquire and the entire group is a bit fearful of the Administration. Maybe this type of uneasy equilibrium is conducive to progress. It reminds me of a mobile:



February 26, 1969.

At a seminar in Langley Porter, two hours were spent discussing the plight of the patients at SF General and Moffit Hospitals. A summary of the conference will be sent to the administration, but it may be weeks off.

These were the main concerns: the patient was exposed to too many examinations and had to repeat his history to too many people; it was inhumane to treat a patient in this manner. After all of these examinations and interviews the patient got no feed-back; no one sat down and answered his questions or explained his condition to him and he did not know who his doctor was. The faculty member treated the patient as a "thing"; rounds were described as "duck walking" and the examination as "ripping" the clothes off without greeting or explanation.

Students who were assigned to other hospitals were asked if they had similar experiences; one from the Veterans Hospital said the patient he interviewed was from out of town and expressed pleasure to have someone to chat with. The faculty there were very considerate of the patients and also very helpful in discussing the findings with the students. The report from the Public Health Hospital was similar, as were those from some of the private hospitals. The students from Laguna Honda expressed horror.

How should a student be introduced to a patient? Should he be called Doctor, Student-doctor or simply mister? Should the student explain that he is not yet an MD? If he did not do so, he might feel he is being dishonest and might easily get caught in a dilemma that would be embarrassing because he was not an MD. Should the administration have a definite policy regarding the title for students and solve the dilemma?

The doctor-patient relationship at SFGH and Moffit should be of grave concern to the school, and steps should be taken to remedy it. My period of practice spanned a change in pediatrics from marked rigidity to extreme permissiveness. In the thirties, Dr. and Mrs. Anderson Aldrich published a book entitled, "Babies are Human Beings" and changed the trend in child care. After the war, the regulations at Childrens Hospital were modified and made it possible for parents to visit a sick child at any time and stay as long as they wished. The surgeons resisted but finally came around. UC was slower but made the change. Formerly, one frequently heard, "Pediatrics would be fun if there were no parents to deal with". This is seldom heard any more. For years Shriners Hospital allowed no visitors within the Hospital wards, - once or twice weekly parents could talk to their child through the closed window!

This is probably a very crucial period in American Medicine. Hopefully a system can evolve which will provide health care, adequately financed, without interfering with a free choice of doctor by the patient and the personal relationship between physician and patient be maintained.

The noon films continue to be a delight.

The lectures in Pharmacology are very relaxed and the speakers seem to interact pleasantly with the students. Why this is so is not obvious, but perhaps it is because pharmacology is "Drugs" and drugs are as ancient as disease.

March 2, 1969.

The class in teratology visited the Recreation Center for the Handicapped Wednesday to have a look at living anomalies. Mongols (Down's Syndrome) constitute the largest numbers, but we could also demonstrate pituitary obesity, Spina-Bifida, Hydrocephally, microcephally, blindness and even a case of the "Battered Child Syndrome". It seems one never becomes so inured to defective children that seeing a group of them ~~seeing a group of them~~

is not a shocking experience. The students showed it in their reaction, a picture is not the same as having one of them walk up and shake your hand. It is important for students to see patients early in their training even before they take histories or do physicals. There should be more visits to hospitals and institutions and some one there or a faculty member should explain or describe the service.

the school should have a group of people, basic scientists and clinicians, studying birth defects. It is important for all branches of medicine as every system of the body may have anomalies which are the basis for superimposed disease.

The oft-repeated statement that we do not know the cause is a worn out cliché. Although the human body is too complicated to expect to find many disease causes as specific as that of thalidamide or German measles, a careful history will usually reveal factors that singly or acting together are sufficient to explain the condition. As children on the farm we learned that the farmer selects good seed, plants it in good soil and hopes for a favorable climate to get a good result or yield. The human fertilized ovum should be entitled to as much consideration. We have learned a great deal about heredity and the transmission of defects and prospective parents should have access to counseling. Parents seek it and want it, even fairly young siblings in families with defects have come for counseling. An adverse environment during the first trimester of pregnancy will not invariably produce defective babies, but this does not rule out the possibility that the incidence of defects under adverse circumstances is increased. Nutrition, anemia, infections, drugs, trauma, emotional upsets and age may combine in a variety of ways to produce an unfavorable environment. In the second trimester threatened abortion or miscarriage is a common history. Many mothers with such a threat would like to abort instead of worrying for six months

that the infant will be abnormal. Usually she has no say about it, the obstetrician is so intent on reducing the figures for lost pregnancies that in spite of protests, he puts the woman to bed with hormones and other drugs. (We need more women obstetricians; men have never been pregnant.) In the third trimester the Rh factor must be considered, also toxemia, trauma and a host of other conditions. During labor, too often the mother is given medication for her comfort without much consideration for the child she is about to deliver.

An educational program in the schools starting in the grades should ^{ha} emphasize the importance of parenthood, the proper age to have babies, the responsibility, costs etc. More definitive sex education should follow this in High School and College. At present there is too much hang-up on sex. One Swedish girl is quoted as saying " Sex is corny". I agree with her.

March 5, 1969.

Fasal introduced a novel and amusing innovation in his lecture. He used colored slides of Chessmen to emphasize the major divisions of his talk on skin diseases. The diseases were well illustrated with colored slides. His only comment regarding his innovation was that he enjoyed a Chess game. The final slide was of a red rose which he said was for the ladies in the audience.

The noon talk at Hooper was on Malaysia. The Hooper staff has a wealth of experience in world travel and public health investigation. Apparently there is a great need for lecturers and consultants in medical schools of the developing countries. This could be an interesting experience for some of the ambitious emeriti who might like to travel .

Yesterday I spent some time at the meeting "Concern". Again I felt that the faculty handled the situation well. There was no evidence that this school was contributing to the war effort although there undoubtedly is a place for concern in laboratories developing bombs and missiles, as during World War II among scientists working in the atomic field. Medical students, who supposedly are scientists, should investigate what is or has been done before they barge ahead with accusations. A good example of such premature action was the students recruiting of minorities without first learning what action had already been taken by the administration. The kids may be bright but they are very naive, impetuous and undisciplined, - that is the "activist" group. There are many students who are conscientious and not involved in these activities.

A subject that might well be integrated into the teaching program was brought up at one of the seminars yesterday, - how do you tell the parents that they have a defective child? Or how do you tell a patient he has a fatal disease such as cancer? Even at Langley Porter it was stated that psychiatrists have not given much thought to this.

March 8, 1969.

In the "World Health" course, Dr. Dunn, who recently returned from Maylasia talked on taboos and magic in primitive cultures (and some not so primitive) I have not heard any one mention "ethnic origin" as an important part of history taking, possibly in part due to our present hang-up on racism, which often is carried to ridiculous extremes. Some hospitals have deleted race and color from records and, on the radio, an interviewer in a definitely hostile tone, asked why the Blood Bank recorded race or color on their charts. In my work with Birth Defects, I found a careful ethnic history helpful for both diagnosis and for counseling. There are definite racial differences in frequency of certain anomalies,- blacks seldom have harelip and cleft palate, they are prone to polydactyly and syndactyly and sickle cell anemia; in a certain part of Italy there is a high incidence of congenital hips; in Baja California, of club feet; the Scandinavians have a higher incidence of PKU, a rarity in dark skinned races; Wales has a high incidence of Spina Bifida, etc. When we were in New Zealand at a medical Symposium, English and Maori physicians discussed diseases peculiar to Polynesians. In USA with its emigres from all countries and frequent inter racial marriages, an ethnic history is very important. It is also interesting to note how persistent are certain traditions and superstitions which may give rise to family problems in mixed marriages. A knowledge of this may be helpful in counseling. Some of the most interesting genealogies of hemoglobin factors have played an important role in tracing the migrations of people.

Ethnic histories on American blacks are particularly interesting; a beautiful mulatto mother said her grandfather was a redheaded Irishman. She has three children, one of them much darker than the rest,- so he is called "Blackie". I have not experienced any difficulty in questioning blacks about their origin, most of them have a fine sense of humor.

Recent lectures in Pharmacology have dealt with drug advertising, the Kefauver report and recent legislation on drug control. The Medical profession should take a much stronger stand on drug practices than they have; drugs should be included in Medical Ethics. There should be no drug advertising, no drug salesmen, and no commercialization of drug manufacture. New drugs of any value are discovered in medical research laboratories not in pharmaceutical firms. Physicians should get their information from medical centers through regular medical channels and medical journals AND NOT FROM THE ADS IN THOSE JOURNALS.

Drug salesmen are seducing even the freshmen medical students by giving them that horrible little black bag filled with a poor grade of instruments. (My medical bag was RED, and salesmen never got by my secretary.) The American Academy of Pediatrics decided some years back to pay for their own entertainment at the meetings and not accept it from drug firms. I am not sure that they have maintained it .

In several of the seminars at Langley Porter the patients interviewed have been young drug addicts. It is a very tragic thing to see the deterioration that takes place. The psychiatrists recognize that often this is organic and not reversible. Psychiatrists are turning to neurology for information, and this at a time when students and even some teachers say anatomy is not relevant for certain specialties, citing psychiatry. I shall continue to plead for a good course in anatomy for all doctors .

Nor do I like early pursuit of a limited specialty; we already have dentists, podiatrists, oculists, why encourage more narrow specialists and give them an M.D.? All M.D.s should know the structure and function of the human body! The trend away from such study is a hazard for the profession.

If medical students get their knowledge about anatomy, physiology, pathology microbiology and the other basic sciences only piecemeal as they encounter disease entities in patients, not very many of them are going to be

erudite physicians. I am sure the students will recall and with gratitude the course given in neuroanatomy the first year and in microbiology the second year. In both of these courses the teachers emphasized thoroughness,-- the need to know a subject from A to Z. I hope UCSF medical school maintains its high standards.

April 5, 1969.

At the end of the last quarter a junior and a senior student each gave a lecture to the sophomore class; both ended with, " It is a darn good school you are attending." I was pleased to hear this and agree with them. I was amazed to hear both students' ~~their~~ fear and dread of confronting a patient the first time. I thought only girls had such qualms! It is a good idea to have more advanced students talk to those who are just ready to embark on definite patient studies.

Dr. Wellington presented his views very well on dress, grooming and cleanliness when meeting patients. He stressed that in a teaching hospital, the patient is captive, he has no choice so the doctors concern should be to respect the patient and act and dress in a manner which is not offensive to the patient. In private practice the patient makes the choice and the doctor there has a right to dress as he pleases,-- the patient can go elsewhere if he does not like his appearance or dress.

I have gathered some information that should be of interest to the girls in the class. Childrens Hospital is giving some part time internships and residencies and other hospitals are talking about doing likewise.

April 7, 1969.

I am enjoying the course in neurology. The chief mentioned today that phrenology is at times important. This amused me for at CDC I said I had become a palmist and a phrenologist, all I needed to add was astrology and I would be back to the beginnings of medicine. The chief works hard and well at teaching neurology. He not only talks, he writes and acts out the diseases. Neuropathology after a good course

in neuroanatomy is very exciting. When discussing the ophthalmic exam he commented that it would be difficult and might be embarrassing to the patient if it was done with a big beard. I spose some of the boys will hang on to their beards, long hair and dress in defiance.

April 9, 1969.

The class was supposed to discuss the curriculum but only 14 were present. There was some discussion later on the qualifications of MDs, their dedication and commitment, with some questioning of their own fitness as MDs. The stage of soul-searching!

April 10, 1969.

Dr. Wallerstein gave a most delightful lecture on bone marrow. He introduced the subject by showing some slides of tulip gardens and added that to a hematologist a bone marrow smear was equally beautiful. Dr. Diamond followed with a lecture on the Rh factor giving a brief history of its discovery and the progress since made. I revel in these bits of history as background to the lectures.

Discussed the possibility of having some discussions on prevention of birth defects with some pediatricians. This subject is more pertinent than is generally recognized; obstetricians have been very slow in focusing attention on the fetus and other physicians are unaware or else don't care.

After Saturdays session, I am sure no other faculty or administration in USA has the patience of UCSF.

The secretary to the Alumni-faculty organization thinks a "Think Tank" for the Emeriti a good idea,-- and then today over the radio Kilmer Meyer of Grace Cathedral announced that he and some other clergy were organizing a "Think Tank". I am sure the world's problems are about to be solved!

April 14, 1969.

The concluding lecture in neurology on the spinal fluid covered everything from color to chemistry. If only the students appreciated what a superb presentation it was! Again, if the students could have gone directly from the lecture to the lab and seen all the things described! It would not be difficult to set up a series of tubes showing color- from clear through pink, bloody, Xanthochromic, purulent and borderline, with instructors there to answer questions. When polio was rampant and we were examining 6 to 8 fluids daily, we tried guessing the number of cells from viewing the tube. We became rather expert at that guessing game.

One of the girls when asked to do a rectal exam said she must have turned green because the instructor asked her if she felt faint.

A senior student said he wished he could practice doing some laryngo or esophageal intubations, but cadavers were too rigid. At Childrens we arranged for house officers to intubate still born and newborn deaths as preparation for emergencies calling for such procedure. Anaesthetists are good teachers for this maneuver also.

April 16, 1969.

Many of the community problems that concern the students, are and have been the concern of practicing physicians for many years. When the Child Development Center was started in 1952 it was almost unique; now almost every pediatric department in the country has some variation of such a service for handicapped and retarded children. The literature in pediatrics, psychiatry, and public health particularly, have articles pertaining to " The Whole Child", " The Team Approach", " Family Medicine" etc. The courses in community medicine and comprehensive care cover these questions also. The students are naive and, in general, have not learned to review the literature before setting out to change the world.

The medical school image as an Ivory Tower in the community is also changing. There is no longer the great gap between "Town and Gown" and the present administration has played a big role in decreasing the gap.

My traveling companion commented on the beautiful documentary film on Polynesia and how much more it meant having been there. Similarly, seeing a patient, - even just looking at him, makes the history of his disease more real to the student than a lecture or even a lecture with pictures. It should be a part of the study of surface anatomy, ^Ateaching to look and see.
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April 21, 1969.

The chief of surgery presented three cases and for each one called on a student to come down front and tell what he saw. Like several other lecturers he emphasized the importance of treating the patient with dignity and compassion. This is emphasized by so many of the speakers it is hard to believe it is not always practised as reported by some of the students. Can it be that a different group of doctors, not as sensitive as the chiefs, are responsible for the bedside rounds? If so maybe some instruction is called for.

To emphasize appearance, the patient was told that the examiner did not wear a white coat because he was still a student. A second student, 6½ feet tall with a long hair-do, jeans and a plaid shirt looked so comical in the role of a doctor that the entire class burst into laughter.

April 23, 1969.

Student criticism of a lecturer brought out that they thought he was condescending. If the speaker does not please, they turn him off and do not hear anything he says. If a person is really interested in learning, he can get a great deal from even a poor lecturer providing the material is there.

April 26, 1969.

When ever I have lunch at Childrens I get quizzed on medical education. A young MD from another state said that when animal experiments ~~were~~ were done as a lab procedure in his class, some of the students brought arsenic tablets and gave them to the animal and then went off to study for the three hours. The utilization of the clinical laboratory in medicine has increased tremendously and it seems that the type of animal experiments formerly a part of medical training should be replaced by new techniques now used, such as electrophoresis, tissue cultures, chromosome studies and the like. The routine laboratory procedures might be part of the early studies or be presented later when working more with diagnoses. Maybe laboratory excercises should be reviewed.

It is gratifying that " Teaching Methods" are often discussed at curriculum meetings.

Have listened to more lectures on history taking with out any mention of ethnic background or possible familial diseases other than the old routine of tuberculosis, rheumatism etc!

Some of the Faculty women feel that the girls in the classes are so afraid of being set apart that they will not come to a meeting. I get a different viewpoint in talking to the students. It will take more study and analysis of the problems that really bug the girls before we can help them. Maybe the time is not just right yet.

April 28, 1969.

At A picnic for the class at my house, about 40 came with some infants and young children. Comments from the neighbors, " What a nice group of young folks". They are!

April 30, 1969.

One of my joys in attending classes has been to have new material put into perspective with a bit of history, experimentation, modification and final acceptance. Dr. Monie in teratology showed a picture of an umbilical cord anomaly from a paper in the early 1800s, which led to a discussion of early observations and discoveries. The students need to know that important discoveries date back centuries. The review of literature is now often limited to five years and as a consequence, it is not unusual to see material presented as original that has been reported ten or fifteen years earlier.

A useful learning exercise as a student or intern is to go through the ward ^{2~}examining all the patients for one element only, in lieu of single complete examinations,-- listen to all the hearts or look at all the throats, or all the ears. This type of concentration and comparison is helpful for a beginner.

I have been asked to represent the emeriti on the Alumni-faculty Board. The local emeriti seem busy at research, writing, substitute teaching etc., they are not "Fading away". Dr. Diamond had a good response from his group at the meeting of the American Pediatric Society. Dr. Bowman has an interesting report from his work in Alaska setting up a mental hygiene program there.

At the lecture today on fetal circulation some pertinent points on drugs was was presented. Again I hoped we could have a group interested in fetology and birth defects for discussion of this very important subject. Such a group should include basic scientists, genetisists, pharmacologists, and of course obstetricians if we can get them involved. The other day one of them spoke of pregnancy as a disease! If medical women would be women first and MDs second, they could make some valuable contributions to this field from personal experience. Men are known to have "morning Sickness"

in sympathy, but to my knowledge there have been no cases of even pseudo-pregnancy! The women in medicine are not yet performing at their best potential they are suffering from a "minority complex" and are afraid they will be or do something the men wont like. Midwifery was practised long before we had men OBs.

May 10, 1969.

In pondering the question of what we might do to help the girls in the medical school, (-one of my friends spoke of "the girls" in her bridge group, and her grandson said, "do you mean the girls with the grandma faces?" No.), I wonder if it would be possible to incorporate a counseling service for them in the student welfare division. If we had a list of prominent women MDs who had dealt successfully with the problems involved in combining marriage and a career maybe this alone would be sufficient. A choice of people to talk to might have greater appeal than only one. Also if the service were available to both men and women it might attract couples contemplating marriage and thus make it more useful. The choice of specialty might be involved also.

In addition to counseling we should continue to collect material on internships and residencies, part-time services, refresher courses etc., which would help to solve these problems for women facing marriage and careers.

The girls have expressed a wish for a room where they might visit with each other, eat their sandwiches etc., and thus meet members of other classes. So far I have found only one comfortable spot on the campus, the reading room off the library--near the entrance. Millberry Union has some comfortable chairs and sofas, but the main room is either being used for meetings or the TV is blaring away; it is not a place where you can let down your hair, chat, gripe or just rest. The nurses section is too remote and usually occupied.

The Board of Governors room or the Music room or possibly half of the Library lounge with a door from the hall could be used. Possibly the Governors room could be changed to the Madrone room.

When Dr. Carr gets going on his new post, possibly the alumni and emeriti could rent a Club room in the new Parnassus Medical Building. The Alumni-Faculty should be able to pay their own way and not be an additional burden to the Medical Center especially with its struggle for funds.

I am concerned about the "Evaluation forms". I doubt if many students will take the time even in class to fill them out conscientiously. It might work as a research project repeated at intervals with different classes. I sense an uneasiness and concern among some faculty members. Faculty people are also human and need some positive feed-back. Why should criticism be a one way street? I am not sure that "modern youth", especially freshmen and sophomores, are good judges of teaching or the relevance of subject matter. Some of the hard facts in medicine, like the musical scale, must be learned no matter how tiresome and difficult it is to master.

Maybe some day we can have a course in Human Development. Embryology is not enough; development should include genetics, fetal environment, nutrition etc. All physicians may treat pregnant women so that pregnancy and the fetus must be the concern of every one in medicine. With the present concern over a burgeoning population, producing good babies should be of utmost importance, - concern about well designed human beings, physically, mentally and socially.

May 15, 1969.

It has been a disruptive week. The American Academy of Mental Retardation is meeting here and "visiting firemen" have kept me busy; but even so I got in a few good lectures, like the one on rheumatic fever, another on appendicitis and others on injury and acute surgical conditions.

The lecturers at the Medical Center compare favorably with outsiders; they are prompt, (much more so than the students!) they have the material well organized and seldom go over the hour. In general slides are used effectively and hand-outs are comprehensive. The chief of surgery even used personal errors in diagnoses in a very impressive way; his description of the difficulties encountered in diagnosing acute appendicitis in a young child almost threw me into a state of acute anxiety just remembering the woes of trying to make such a diagnosis in a screaming four year old.

Another lecture from an internist on diagnoses was well presented and prompted the remark from one of the students, " I wish I had had it earlier". A freshman suggested that the first quarter be spent as an apprentice to a practicing physician in order to get a better idea of the relevance of present studies to future practice. Maybe it would be feasible when accepting a student, to suggest that the intervening time until classes be utilized start, either making rounds with a physician or working in a hospital.

May 20, 1969.

Over the weekend I read " Doctor or Drop-out " in the Journal of Medical Education, 1966. The article covered the subject thoroughly except there was no question relating to early childhood; a stable, secure early childhood, (infancy to 7 years) should help a superior child to organize his life to meet challenges. A study some years back of " Famous People" found greater stability in those with a secure childhood.

Monday May 29, 1969 we celebrated K.F. Meyers 85th birthday with champagne!

Last night at PUMC, Dr. Tupper of Davis campus outlined his plans for the Medical School there. An interesting place for a medical school.

Dr. Margaret Brown told briefly the experience at PUMC in giving a refresher course to MDs who had been out of practice for a period of time. The first

class consisted of 19 women and 2 men. This sounds like a good innovation.

Dr. Diamond reported on the Emeriti meeting at Atlantic City. He had some 25 letters from people unable to attend; there were 10 or 12 at the luncheon and one pediatrician offered to donate \$100 to get a project going. With the constant complaint about medical man-power shortage, we cannot afford to waste talent.

May 22, 1969. Confrontation days!

Coincidental or intentional, the pharmacology lectures covered the gases!!-- mace, pepper, mustard and all the rest even those that might occur in homes, mines or caves.

Dr. Edmunds gave a superb presentation on extra-corporeal perfusion, using the instruments and also supplementing the presentation with slides. He gave a brief history of the development of the technique going back to Alexis Carrol and Colonel Lindberghs experiments. (1971 comment- A new book, " The War Journals of Charles Lindbergh" describes some of his work with Carrol and also refers to his old home in Little Falls Minnesota- my home town too.)

May 27, 1969.

The Alumni-Faculty luncheon went off well; the attendance was good and Dr. Tupper's lecture excellent-- even better than the one at PUMC, Possibly he feels more akin to us. The emeriti attending seemed to enjoy themselves. When Jesse Carr takes over the directorship and Bob Sherman the presidency maybe we can make more progress.

At luncheon the other day, two house officers who were here from other schools complained bitterly over the deficiencies in their medical education, expressing the wish that they had had it here. One said the students at his school were pushed into the wards before they had a chance to learn the basic sciences!!! One even added that he was going to try to take

the biochemistry course here. I wish we could play a tape recording of the discussion for the first two classes. This switch in attitude might occur with too much clinical material too early. It is extremely difficult to go back and take a course that has been missed or neglected. No matter how much one forgets, if the computer (the brain) has been programmed for a subject once, it is easy to get a recall and I dont think we have found any substitute for this in the learning process.

A young surgeon made some interesting comments the other day. He said that at 33 years of age and after completing his formal surgical training, fully qualified, capable and eager, he spent his first three years sewing up lacerations. He felt this was a great waste of medical manpower, but offered no solution. Is there one? In pediatrics there are so many part-time jobs that a beginner can earn his bread and butter while working up a practice. There are some opportunities in emergency hospitals for surgeons.

June 6, 1969.

When the sophomores gathered for class Monday morning, the boys looked scrubbed, combed and starched even if a bit long-haired. My comment that the group looked professional, brought the reply, " It isn't only the clothes, a subtle change takes place in attitudes and ideas too." The girls seem to lag behind the boys, with hair down to the waist line and skirts up to it.

In a letter just received I was reminded of our sensitivity discussions, unfortunately there are physicians insensitive to patients. This friend had sprained her ankle, it was exquisitely sore and painful, but neither the nurse or the doctor were the least bit considerate, they were impersonal, and rude. She said she finally said to the MD, " You know I am not stupid", which seemed to bring him to his sense of responsibility. It is very disturbing when doctors and nurses present this calloused attitude toward patients. This attitude is not condoned by the faculty of this school!

Earlier the complaint of students from Moffit and the SF general Hospital regarding treatment of patients, was mentioned. If true, it should be corrected.

The morale of the Biochemistry Department is low, probably due to a long period without a chief and possibly fear of replacement when one does arrive.

I was asked by one of the students the other day if I intended to continue with them the third year. Since most of the time the third year is spent in hospitals it will be difficult to follow through but he said the morale of juniors was low and he hoped the cause could be ferreted out. Flattering!

The juniors at Childrens said there were too many layers of students at Moffit and SF general, which makes the lower echelons feel superfluous and frustrated. When asked about the other hospitals, they said the patient load was better but often the help and instruction from superiors was lacking. Medical education is not easy!

Arrangements are in the making to have a meeting, probably a tea, for the women students and house officers at Milberry.

June 9, 69.

The Library as seen by the emeriti.

Several emeriti have expressed interest in the library and I interviewed four people on the subject. All agreed that the acquisition of books was excellent. The chief complaint concerned rigid regulations and often the indifference of personnel, sometimes amounting to rudeness at the front desk. The librarian in the reference room was praised. Some of the regulations were described as suitable for young children rather than the faculty of a medical school.

A suggestion was made that more material be micro-filmed or that microfilms be purchased to save space and prevent loss.

There was a grave complaint about the mutilation of books and Journals

by tearing out desired material. This vandalism by faculty and students might be a response to the rigid rules regarding loans. (1971 comment. Library has improved.)

Report from a freshman: At luncheon one of the first year men said that the students pushing for early involvement with patients were a small vocal minority; most of the students saw the need for thorough training in the basic sciences before such involvement. The curriculum revision seems to be following a middle course with reasonable success. This same young man thought that appointments to committees were made often from the vocal group and did not necessarily represent majority opinion.

A preliminary report on the replies to the questionnaires sent to the emeriti.

1) Many of the emeriti expressed interest in public relations and a willingness to act as liaison between the medical school and the hospitals of the community. Dr. Bell said he gets frequent calls from physicians in the state regarding referral to UC. These physicians find it easier to call him and have him make the arrangements than try to reach a house officer. Dr. Shaw undoubtedly serves the pediatric department in the same way. With new medical schools both to the north and the south, SF needs to keep up good communication with the physicians of the state in order to keep the flow of patients coming this way. It is possible that other emeriti residing in other parts of the state could take a more active part in interesting local physicians to send patients here. If we are going to utilize other hospitals it will be important to have friends in them.

2) Several were interested in monitoring some classes. This might be valuable in helping the students see the relevance of basic science to the practice of medicine and it might also introduce some practical points of practice into academic teaching. More and more of the full time teachers come up the academic pathway and have had little or no experience in the rough and tumble world of

private practice. If classes are to be monitored, it probably would be wise to discuss this in advance with the head of the department to avoid any misunderstanding. An emeritus member could be an addition to a seminar- provided he didn't talk too much!

3) Several from private practice expressed interest and willingness to discuss with students or house officers the choice of specialty and some of the problems in selecting a place for practice, setting up an office etc.

4) Only a few seemed interested in lobbying if called upon.- Drs. Shaw, Leake and Geiger expressed willingness-- all would be effective speakers.

5) Several said they would be willing to meet and escort visiting firemen. This might be a service at times especially in handling unexpected visitors. Foreigners tend to drop-in and also may be very sensitive about how they are received.

6) almost all expressed willingness to lecture sometimes either here or at other hospitals.

7) Some said they are taking care of the families of students and faculty. This service might be expanded if more of the students had a chance to meet and know the emeriti.

October 2, 1969.

The Junior year!

The new curriculum got off to a good start. In the first hour of the quarter, the freshmen saw the film, "Birth of a Baby". I don't think this could evoke the comment so often heard, "The same old stuff we had in college". If the film on sex education gets shown in the schools, future medical students may be that sophisticated.

The section on communication skills was good, the students appeared receptive, and asked many questions. They did not do any interviewing,-- maybe that will come later.

The combination of clinical or surface anatomy with gross anatomy and dissection should make the latter more meaningful.

The first period of biochemistry was boring but the next one on cell structure was very interesting. Some students may have had this in chemistry before. They were given the option to leave if they had. Biochemistry seems to be the subject in which the preparation of the students varies the most. It lends itself best for elimination by examination. Also it might ~~be~~ better with physiology and clinical laboratory procedures.

The increase in minority members this year was obvious. There were still long-hairs and jeans. (I wonder what they looked like when they were interviewed?) I am sure some of them would not get by if they looked then as they do now. The majority looked OK and seemed less hostile than the entering ~~classes~~ the past two years, maybe it is too early to judge. They even said, "pardon me" when they climbed over you to get to a seat beyond.

With the curriculum revision largely accomplished, thoughts might now turn to improving the way information is handed out to the students. The scheduling and instructions were as late and as confusing as ever.

They were not available until this week and then alterations were superimposed and the final one had an error in room assignment. There may have been reasons for delay this year with the change of curriculum but it was equally confusing the two previous years. Why not give the students a map showing the locations of the rooms and how to get there.

Many students are new in the city also and do not know how to get to other hospitals. Judy drew a map for them this year but why should not such information be contained in the original hand-outs or in a permanent manual. There should be some provision made for transportation; it might be possible during orientation to set up some car pools. This should be helpful particularly for the minority and out-of-town students.

Is there still a hang-over that such planning is babying them? I think it is more important to portray an efficient organization and a desire for good rapport with the students. All together should recognize that there is lots of work ahead and let's get on with it efficiently.

10/28/69.

Today was the first gripe session for the new class and as on previous years only about a third of the class made an appearance, this even though Judy appeared before the class and urged them to attend. Those present seemed much less hostile than the freshmen of the previous two years. They have manifested less hostility in the class rooms also, appear more courteous and easier to communicate with.

They echoed the same complaints, however, namely, - too many professors presenting isolated topics with no one telling them what it is all about. This is a legitimate gripe and it should not be difficult to remedy it. Dr. Crede did it very well in his course. He defined the purpose of the course in the first hand-out and then had Chancellor Lee reiterate it in his first lecture. The chiefs of the other departments could do this as easily. Most of them

prepare hand-outs and an introductory note should suffice.

Biochemistry is still a headache. It is a difficult subject to teach, probably in no other field has so much new material been added and with as much variation in presentation. There also is great variation among the students both in interest in chemistry and in the amount of it they already have had.

The course in Human Development did very well for the first trial run. There will be changes made but on the whole it worked very well. Some seemed to feel too much time was spent on embryology, but as the sessions moved on and more illustrative cases were demonstrated the pertinence of a review of development became more evident. More time is needed to give genetics and to view the development of the young child especially at present when so much is heard about early deprivation.

The revised course in anatomy must be more satisfying as less gripes are heard. Clinical anatomy has added zest to it.

Communication techniques came in for at least one criticism from a student, he thought interviews both in this class and in community medicine was over doing it a bit this early in the course. It is impossible to please !

Duplication and repetition is still a problem. Every chief wants to give his subject from A to Z . The structure and function of the cell is given in biochemistry, microbiology, genetics, human development, obstetrics and probably will be repeated in endocrinology, histology and neuroanatomy. It is also taught in the grades and in college.

It might help solve this problem if priority was given to one department and let the others refer back to the original and then take the subject from there right on! There should be better communication between staffs.

November 11, 1969.

The radiologists won a good point at the last curriculum meeting. They should have a spot on the core curriculum. Every doctor uses X-Ray at some time and in addition, we have exposure to other radiation hazards varying from TV sets to atomic testing. Not long ago shoe salesmen fluoroscoped the feet, and many pediatricians routinely scoped their infants for enlarged thymus. Every doctor should have a thorough course on the use, abuse and hazards of radiation.

Apparently the time is at hand to shift clerkships and the new assignments are not ready. Into my third year and I have no explanation for these delays; is it inevitable or should the department be jacked up?

Aha! It was interesting today to hear my classmates on the surgical service deplore the fact that they had so little time to learn anatomy and they could not understand a still further cut this year. I told them about the clinical anatomy and the pre-dissection that had been done to facilitate the understanding of anatomy, but one of them said, "The only anatomy I really know is the femoral triangle because I dissected it myself. Looking at a specimen dissected by some one else did not help me at all." Most of them felt that involvement with patients before you had any real preparation for it was useless and embarrassing. They did admit, however, that it was a traumatic experience to graduate from college and then go right back to a new series of lectures in the medical school.

The many layers of attendants at Moffit is discouraging to the low man in the series. One of the nicest chaps in the class said he felt like he was floating around at the periphery without any real involvement, decisions being made and treatment carried out by others.

I have found one member of the class who likes OB. I hope Howard Jacobson succeeds in putting midwifery back into service. In Russia women in labor

were admitted to the hospital and a midwife monitored each case through labor and delivery. There was always a doctor in the hospital. He,- or in Russia, usually a "she"- was called for any abnormality occurring during labor or delivery. OB needs a feminine touch.

On re-reading this I sound as gripy as the rest of the class. Is this a characteristic of Juniors?

November 28, 1969.

I am still dividing my time between the first and third years. " Human Development" is good for a first round; it should be better next year. The first part moved too slowly and part of it was a bit ^erepetitious; the last part was better. Dr. MacFarlane got the biggest hand yet. She gave a summary of her experience and findings watching the development over 40 years of the babies selected for study 40 years ago. It was a fascinating report. She was infinitely better than Margaret Mead! One of the blacks asked if there were any minorities in the group. She said there were three blacks who have all done well,- one is a journalist in New York. She pointed out that the selection was made by picking every third birth certificate in Berkeley and inviting the parents to participate . The population of Berkeley 40 years ago differed from the present.

The discussion on the neurological problems irked me a bit. Doctors are too apt to call a patient cured if he is able to leave the hospital. Children with neurological problems should be followed at least until they enter school and preferably a life time. The sequelae can be very subtle.

I am concerned about the junior year. So far I have checked mostly the surgical clerkships with some contact with the students on OB and Pediatrics. Both at the County and at Childrens the surgeons are making a great effort

to give the students meaningful work, but I am afraid there will be rather big gaps in their training. Some of the faculty share my concern; a few lectures, such as the radiologists are asking for, seem indicated.

I had the opportunity at Childrens to get some students' reactions to the residents " demands". They felt that the demands were justified, reasoning that after years of training, at their age and with increasing responsibilities they deserved that much pay. (No question whether they earned it!') They compared their position with that of skilled and unskilled workers, who had been earning money since they graduated from High School. It is an interesting philosophy but I dont buy it. In Russia the students are supported through their training period, but they then are assigned to their jobs,- no free choice. I wonder if our youth would buy that? Childrens Hospital has decided to decrease its resident staff next year. Some even said " Let them all go, we can run the hospital without them"; and they undoubtedly can.

An article in " United Nations" reminded me of this student philosophy. Quote: "All these demands are made by Africans and other developing nations, in the expectation, which they regard as justified, that it is up to the developed countries to close the " widening gap" between them and the third world." The author called this the Cadeau Philosophy" (The philosophy of gift-giving.)

The surgeons are complaining that the students dont know their anatomy. One said they ~~acnt~~ cant draw the portal system or put in the spleen on a chart of the human body.

The juniors commented on the 3 day week end. I said it gave them more time to study, take electives or in other ways be on their own. The reply was, " most of them will goof off."

December 12, 1969.

The era of protests and confrontations seems to have gone the way of the panty raids. Youth must have its fling!

At the end of the course on "Human Development" one of the graduate students said it was his best course to date. It was OK for a first run, and will be improved another year. The weak spots were: 1) The start was too slow; the film on birth was not as good as it might have been and it would be more timely a little later. 2) The part on the placenta was too long and detailed for this course, 3 hours was too much. 3) the lectures on the nervous diseases must be up-graded. 4) The video tape presentations were noisy and the timing was poor.

On the plus side were: 1) Continuity--which was greatly enhanced by Dr. Monie's presence at all the meetings, his excellent presentations of the embryology and well prepared handouts stating the objectives. 2) the presentation of the course as an over view of the subject with detail and depth to follow in other courses:- OB, pediatrics, neurology etc.

Some Educators , especially in advanced training, like to present the subject in detail from A to Z, starting with the minutae and proceeding to the gross. Although students of medicine are " graduates " in a sense, the field of medicine is new to them and needs to be approached as such. An over view of the subject matter with the statement of the objectives of the course and pointing to the relevance of the present study to future courses will eliminate much of the criticism now being directed at the school by the students.

The last part of the course which dealt with physical and mental growth of children, the acquisition of language etc should be expanded .

Anatomy has been less traumatic and more acceptable since clinical anatomy,

more illustrations and more demonstrations have been added. Dr. Asling did a lot of hard work!

The freshmen have asked for a noon hour volunteer seminar to discuss some of the practical problems,- setting up an office, type of practice etc., much the same subjects suggested by the Alumni-faculty

Even the faculty seem more interested in teaching; this with more receptive students should have a good result.

The increased enrollment in medical schools is creating a great demand for internships and residencies; hospital beds have not expanded as fast as the medical schools; but more important, medical care is becoming more ambulatory care and , especially in San Francisco, there is now a surplus of accomodations. Graduate medical training will have to be modified to fit the change; this applies more to medicine and pediatrics than to the surgical specialties. We need to take a new look at our total organization of health care. The under-developed countries are taking the best ideas from the more advanced ones and avoiding their mistakes. The Western countries in turn, may learn from these new attempts at delivery of care. Mr. Pandit in a noon talk, elaborated on India's program and in my travels in Africa I saw similar attempts at solving the problems of health delivery.

In general and briefly, the plans include local health centers for care of minor problems and screening of major ones, a small community hospital, a larger district hospital and at the top, the University Hospital and Medical Center.

Pediatrics should lead the way in this change. It now more nearly resembles psychiatry than surgery or adult medicine in its services. Very few children are hospitalized; the great bulk of the work is done in out-patient clinics and doctors offices. There are eight hospitals in SF with pediatric departments.

A recent check found some with bed occupancy between 20% and 45%; the attendance at the clinics was in the thousands. Obviously a change is called for. It would be fairly simple, except for possible lack of co-operation, to continue ambulatory clinics in these 8 settings but use only two or three hospitals for in patient care, preferably only two in SF.

February 1, 1970.

The curriculum meeting on Wednesday was very traumatic-- and this after my fine impression of the class! I discussed the session with some of my classmates now at Childrens. One of the boys said he roomed with two freshmen and they griped about the hours, lack of time, and asked " why was there no lab work?" Even the juniors failed to understand them. The generation gap develops early.

The reports from the students at Childrens is favorable. They even suggested that medicine and upediatrics be given there also. Too bad that OB got off to a bad start. I don't know how much was the fault of the faculty there and how much that of the " Hippie-like" type that first hit the place.

I have attended some of the lectures in genetics. It is not as well organized or presented as "Human Development". Three hours of lectures, especially when preceded by other lectures, is rather formidable for any one to take. As usual, the department feels obliged to present the subject from A to Z making no allowance for courses that students may have had elsewhere or which may follow--- but then it is a first attempt and should not be too severely criticized.

How come the faculty doesn't object to being rated by the students when the students get so "Het-up" about grades? Is this another generation gap?

After 40 years delivering health services and some twenty years conducting an Ecology seminar, I find myself vociferously defending the basic sciences. There is a middle way.

In todays Chronicle-Examiner even Hearst blamed Spock for the behavior of the modern youth.

February 27, 1970.

The freshman who presented the concerns of the class to the curriculum , committee, did a very good job without hostility or arrogance. The class showed good judgement in selecting him.

The staffs of the various departments seem more willing to confer with each other on teaching and planning schedules. The main problems to be overcome are : 1) the desire (and a legitimate one) of each department to present his course in depth; and 2) the desire to have the different aspects of a subject presented by the specialist in that subject. The result is frequent duplication and lack of continuity . If the chiefs compared notes, priorities could be assigned to different departments and better over-all presentations made with less repetition and duplication.

Clinical pathology is going through " growing pains". The surgeons want tissue diagnoses and the internists are more concerned with chemistries; technology as applied to the health sciences has advanced so rapidly that a new look at all laboratory teaching and training is in order. In Sweden, a new medical school was built next to an engineering school in order to facilitate THE UTILIZATION OF engineering techniques.

March 25, 1970.

I am still concerned about the third year clerkships. The students who rotate through Childrens surgery seem to be doing OK. The staff there has assigned the head of each surgical specialty to conduct case studies and hold seminars with the group; they have even participated in surgery. The students like it.

I asked Dr. Spicer if the faculty could keep up this pace with a change of students every 6 to 8 weeks and he said there would be breaks which hopefully would revitalize them.

The pediatric group at Moffit are somewhat discouraged, chiefly because there are so many layers of trainees that students do not get much feedback. Also, there seems to be no logical plan whereby the juniors can get some real core material in this subject. (This is the last time the whole class gets exposed to pediatrics.) Practically every physician is called upon at some time to treat a child,-- GPs, ENT, eye, radiologists, surgeons and even internists. There are very few pediatric surgeons and the general surgeons are trained primarily on adults. At some time as core material, all physicians should learn the basic differences between children and adults,-- the fluid and chemistry variations, the healing process, the emotional needs , the acute emergencies etc. There were only a few surgeons to whom I would entrust my children.

The juniors get very little experience in the pediatric clinics and most pediatric work is ambulatory and preventive.

I tremble when I think of some of the students getting MD.s . Most of the far-out ones are going into ps⁴chiatry and possibly they can do less harm there than in other fields and if an¹alysis continues to be required for the trainees, this may help them. When I read in the papers what psychiatrists are up to in the courts, I shudder some more.

April 12, 1970.

This will be an attempt to analyze what might be considered as core material for the third year, --what every physician should know regardless of his specialty.

The rotations the past year have included the four major divisions--medicine, surgery, obst¹etrics and pediatrics, with some inclusion of sub-specialties.

What are the juniors supposed to get out of this experience? Have the profs had any specific objectives ? If not, are the students sophisticated enough that they can select and learn the essentials?

I wish we could give the students a questionnaire after the manner of the ones given to the freshmen and sophomores, to learn how they actually view the third year.

Surgery.

There has been a uniform good report from surgery at Childrens Hospital. Dr. Spicer has put in almost full-time on the program and it has paid off. The students participated in seminars, ward rounds, case work-ups and in operations. The seminars reviewed the body from head to foot with surgical specialists from ophthalmology, ENT, orthopedics, plastic surgery, chest and abdominal surgery and pediatric surgery. I sat in on a couple of these seminars and they were excellent. The reports from the other surgical services were not as uniformly favorable.

Pediatrics.

The students from pediatrics(Moffit) , gave varying reports; some liked it, partly because they liked children and enjoyed working with them, but also they seemed to enjoy the conferences, rounds etc., Others said they got very little out of the service as there were too many layers of physicians in training and as the most junior ones, they were neglected.

See preceding page for details.

Obstetrics.

This department is probably the weakest in the school. It is geared to research and to Gynecology. There are no women on the staff and I found only one in training and she was not very happy. Every physician regardless of his specialty may be treating a fetus while treating a mother and should

be made aware of the possible hazards that fetus may be exposed to.

Medicine.

Although the students have had some experience in interviewing patients and taking histories, the medical service is the place to get experience in both history taking and doing physical examinations. To this should be added experience in diagnosis,- selection of laboratory procedures, and outline treatment. Feed back from the staff on this service is essential. It should be the laboratory for learning the practice of medicine;- the other departments; can then build on this knowledge and expand the students experience in the other specialties. The chief of the service or his delegated representative should be responsible for the instruction. It should not be left to the house staff. This responsibility could be delegated to faculty members in rotation, each one being responsible for a specific class, thus minimizing the problem of layers of trainees.

In summary: the third year needs more structuring. Each department should define its objectives for this stage of a students training and provide time for feed back to see that the student actually gets the experience offered.

May 27, 1970.

The last weeks have been so disturbing that I almost became a drop-out; First the seniors criticism in Synapse, then the demonstrations with pickets and slogans in front of every Hospital door, then the black strike, and now all kinds of continued protests. Three times the past week, I have been asked by outside doctors, "What is wrong with medical education? House officers don't know their anatomy; they have no medical vocabulary etc."

I attended a senate meeting for the first time, expecting a dignified session only to find support for the dissidents;- faculty members wearing black arm bands, peace pins etc. Is this not inappropriate when serving captive patients? I am opposed to the war in Vietnam and to all wars; I hope the Western World will never again go to war unless attacked, but I don't think

these demonstrations are going to shorten the war and they most certainly give comfort to the enemy.

After attending a meeting at Stanford honoring Dr. Harold Faber, I visited the Hoover Institute. It was sad, tragic and seemed utterly nonsensical to see that building vandalized, windows broken, objects destroyed etc. Patient care can not be unaffected in this kind of atmosphere. Do some faculty go along with it just to be palsy-walsey with the students?

July 9, 1970.

Some thoughts on shortening the medical training period.

During World War I, the University of Minnesota introduced an accelerated course in medicine by instituting the quarter system and conducting classes four quarters. This system was still in effect when I entered medicine (and may still be) I was admitted after two years of premedic work and by attending school the year round finished six years later with a B.S., an M.A., and an M.D., the latter by substituting a year of graduate work for the required internship. (For good measure AOA and Sigma XI.)

I have no regrets.

It would seem more logical to let bright students take high school and college in three years each, then have a year or two of employment or travel before entering on their medical career.

July 10, 1970.

The teaching staff appears more concerned about the curriculum and teaching methods; there have been more interdepartmental meetings etc.

The students seem to be pushing harder and harder to get their own way, - like young children, this pushing may mean they need and want guide lines. It may be time for the administration and the faculty to take a firm stand.

The members of the Board of Examiners for pediatric certification are concerned about their candidates. They have had to fail about twice the number they did formerly, - something like 39% instead of 15%.

July 15, 1970.

Again I feel a generation gap developing between me and the freshmen. Since they think they are so mature, they might assume more responsibility for their own education instead of resorting merely to criticism of the instructors. If a seminar or discussion group is not stimulating, is it not their fault as much as the moderators? Every member of the faculty has something to give and he is at least as bright as the students. If his efforts are met with silent hostility, it is difficult to communicate the information he has. The students should share the responsibility for making a seminar a learning experience. In one seminar, the case for discussion was an infant with esophageal atresia; when discussion lagged, I said, "If the child were a Downs Syndrome how many of you would operate and how many would let him die?" The discussion suddenly became very heated. Any student can make a seminar interesting with a provocative question; since they are accustomed to confrontations, why not confront a dull leader with a challenging question!

December 18, 1970.

Yesterdays curriculum meeting was one of the more productive ones. The psychiatrists need to be watched; they are too aggressive and want to take over too much of the training. Why should two of them be put in charge of planning pathways? If "Family Medicine" means improved "General Practice", that pathway, most assuredly, needs some very able planning by internists and surgeons. Pediatrics is "General Practice" for an age group and I am sure pediatricians would object strenuously to have their training program planned by psychiatrists. There even was objection raised to their participation in "Human Development".

I liked Dr. Edmunds comments,- pathways started in the third year will not produce capable physicians, even in the specialties, except possibly in a few very superior and highly motivated individuals.

The curriculum for the first two years should now be allowed to shake down without any more alterations. There should be no further erosion of the basic sciences. Students with considerable training in biochemistry in college should be permitted to take an exam^{or} if they pass be given credit without repeating the work the freshman year.

Clinical anatomy, Human Development and continuing superior course in neuroanatomy, has added enough emphasis on clinical relevance to meet the criticism of the first year students.

The fourth year might be a substitute for the rotating internship, providing the hospitals are well chosen for interested and qualified instructors. The practicing physicians who have had students in their offices say it slows their work considerably if they are going to do any teaching of the students.

A clinical teacher said he was told by one of the full time faculty members that he need not go into detail about the anatomy and pathology of the ENT area, just give the student some general information ; this disturbed the instructor for this was the only time the students who were not specializing in ENT would have a chance to get it from some one interested and knowledgeable and every physician should be exposed to it at least once during his training period. Dr. Edmunds pointed out that it is almost impossible to go back and pick up basic knowledge missed on the first round. On the other hand knowledge once learned is readily retrieved at a later date even if long forgotten.

Early choice of a specialty is not usual. It has even been said that the student with early fixed ideas is apt to be one with narrow views and not the most successful. Many choices are based on accident or are influenced by an inspiring teacher. I never considered pediatrics as a student; the choice of Childrens Hospital for internship was an accident and the pursuit of pediatrics another one when Drs. Fleischner and Shaw invited me to join them. My choice of courses in the basic sciences were, however, the best preparation I could have had, - embryology with Dr. Scammon, including dissection of a newborn; neuroanatomy under Dr. Rasmussen and work in obstetrics during my junior year with Dr. Adair.

January 6, 1971.

A few luncheon meetings with the emeriti members have been held at 610 Parnassus but very few have attended. The ones who have been rehired or are continuing on a volunteer basis are not interested. Some do not like to admit they have reached that status!

Dr. Joseph Moldover from Colombia met with six of us to discuss the work he has started in the counties around New York city. Dr. Moldover is from Belgium but has been at Colombia for 20 years. He is a neurologist. He became concerned about the foreign students who came to USA for advanced training and could get positions only in non-affiliated hospitals where they ~~they~~ might not be getting the best training. They might leave with the impression that what they saw was all America had to offer. To correct the situation, he enlisted recently retired personnel to consult and instruct in these hospitals. He has a contract with NIH to pursue this plan. He has an advisory board from both the medical faculty and from administration. He has canvassed all the hospitals and the medical schools in the area for cooperation and help.

Dr. Walter Sterling says the Los Angeles group have organized and there is a group in East Bay and another in Florida. It seems likely that eventually there will be a nation wide interest in utilizing retired members of the profession more effectively. There probably are many other areas in the community where their services would be welcome. The Recreation Center for the Handicapped has several retired individuals on its board who have been very helpful in finances, insurance, legal advice, etc. Hastings law school is a shining example.

January 14, 1971.

Dr. Cartwright, Dr. Golberg and I met with some 12 or 15 girls representing all four classes. Dr. Cartwright gave them a report on her study by interviews of the girls last year. There was time for discussion and the girls asked many questions. They were told also that the room at 610 Parnassus was available if they wanted to use it for meetings as some girls had mentioned last year. However, every group has its own hang-ups and other classes may not be interested. We have given them the opportunity.

Two of the freshmen medical students asked to discuss with me the possibility of working with handicapped children during the summer months. I will take them out to the Recreation Center. When asked if there were any specific problems where the emeritus staff could be of service they suggested opportunities for beginners to talk about the relevance of the first year courses to clinical practice! When asked if the present class was less critical than the preceding ones, they ^{said} "No. Just suffering from student apathy now prevalent across the country."

February 3, 1971. National Boards have been discussed at various meetings.

The National Boards were new when I graduated and they were voluntary. I took parts I and III in Minnesota and part III at Stanford. I hoped by having taken them it might some day be possible to practice in any state or even in another country without taking local exams. The impression

was that eventually National Boards would replace State Boards but to date this has not happened.

March 3, 1971.

Lillian Cartwright, Judy Stein and I lunched with five of the Stanford women who had been involved in the study of women physicians status on the "Farm". The first reports from that group 2 or 3 years ago were critical and rather beligerent; the attitude now was very different; a comment on this brought the reply that there had been a marked change. Women as a minority group are profitting from the efforts of other minorities. This group like the local one had not been very successful in enlisting the interest of the women students. This is due in part to the present mistrust of the "Establishment" by all students and in part to the great desire of the women to be one of the class and not set a part. When these hang-ups have been resolved, women physicians can begin to make their own unique contributions to medicine. This is sorely needed, especially in the areas where men biologically can not have personal experience,- pregnancy, lactation, breast feeding, abortions, menstruation and even in "maternal instinct."

The group sensed that it was important to educate the public as girls were still being adviced and counseled not to go into medicine.

April 6, 1971.

The practicing physicians who put in some time teaching either at the clinics at UCSF or take students at other hospitals seem a bit miffed because they have no recognition at the school,- no representation on committees, no promotions and no status. This is a bit of public relations that could easily be improved, probably more oversight than willful neglect.

There is also need for a visitors center or bureau of some kind on the CAMPUS. This came up at the Alumni-Faculty meeting and has been discussed with the director of the auxilliary who heartily agrees.

April 4, 1971.

Dr. Kathleen Stewart sent me a copy of a monograph from Duke University entitled "Guide lines for an Information and Counseling Service for Older Persons". The set-up described was very much like that of the Child Development Center at Childrens Hospital. Kathleen is a UC graduate and has her certification both in pediatrics and psychiatry. After many years of practice in Berkeley, she took a year at Duke in Gerontology; the reason given was that when she first started practice, the parents brought their children to her with problems, but now many of these same children were bringing their parents to her with their problems. Is there a need for such a center at UCSF?

May 1971.

In lieu of the routine clerkships given the senior year, I decided to take another pathway and spent most of the year in a study of the Day Care Centers and Nursery Schools in San Francisco. It proved to be an interesting arbeit and the Editor of the San Francisco County Medical Bulletin was kind enough to publish it for me. I had promised the directors of the centers that I would report back to them and this is now possible. A reprint is attached to this Diary.

THE DEPARTMENT OF PEDIATRICS OF CHILDRENS HOSPITAL.

In 1875 when the Dispensary for Women and Children opened in San Francisco, under the supervision of two physicians, Charlotte B. Brown and Martha E. Bucknell, most physicians were General Practitioners, specialization had not reached its present peak. Pediatrics as a specialty was not recognized by the American Medical Association until 1880 and the American Pediatric Society was not organized until 1887.

The two physicians soon added a third and a group of consultants with special interests in certain diseases although they did not necessarily limit their practice to that specialty. At this period, therefore, we cannot think of pediatrics as a separate department. The sick child was treated by the physician best prepared to meet his special needs. Women and children generally were grouped together.

In 1885 Harry M. Sherman, who was particularly concerned with the crippling diseases of childhood, was appointed to the staff. He was to continue on the staff for 35 years. George McChesney, who succeeded him, described Dr. Sherman to the nurses in 1925 as "The first specialist on the West Coast for deformities of children". The number of patients seeking his services increased rapidly and it became necessary to find or build larger quarters for his clientele. A drive was put on in the name of "Little Jim" a crippled child who was in need of a hospital bed. The first Little Jim ward was built in 1895. It was at that time the only special facility for crippled children in the city. Later the two Universities had accommodations and still later the Shriners Hospital shared in the work.

The contagious diseases, before the introduction of immunization and antibiotics, posed an equally ^{grave} problem to the Hospital. To prevent cross-infection, a special pavilion was put up on the Hospital grounds for easier isolation of these patients from the rest of the children. William B. Lewitt was placed in charge of the contagious diseases in 1903. (The further growth and development of this service will be told by Dr. Edward B. Shaw.)

Quarantine *Heim*
The obstetrician, in general, took care of both the mother and infant.

In 1885. ten years after the opening of the Dispensary, Emma Sutro Merritt was placed in charge of the Medical and Surgical Diseases of Children, a post which she held for the next 20 years. She was joined later by Dr. Francis Sprague. At this time two outside Clinics were started, one at the Chinese Methodist Mission at 952 Washington Street and the other at the Boys and Girls Aid Society on Clement Street. New staff members had been added and these two clinics were conducted at various times by the following doctors,- E.R. Field, E.J. Fifield, Isabel Lowry, Elizabeth Lowry and later by many others. An Eye, Ear, Nose and Throat Clinic was started by Dr. Elizabeth Sargent, who was assisted by Dr. George Powers of the Consulting Staff.

Many famous San Francisco names appeared on the consulting staff through the years. Among them were Drs. Henry Gibbons Sr., John Morse, J.D.B. Stillman, J.H. Wythe, C.E. Blake, D.W. Montgomery and William Watt Kerr. Later the terminology, apparently, was changed and instead of a consulting staff, the positions were designated as Visiting, Assistant Visiting and Dispensary Clinicians. At all times there were both men and women on the staff. By 1890 the major departments had been established; these included Medicine, Surgery, Pediatrics, Obstetrics, Communicable Diseases, EENT, Pathology and Dentistry.

In 1887 the Hospital was opened on its present site on California Street. This was a long distance from its previous location and must have caused some difficulties in transportation of the sick and handicapped children. There is no mention of this in the reports.

It is interesting to note the Agencies that referred children to the Hospital. These included:- Society for Prevention of Cruelty to Children.
Sisters of the Holy Family.
Associated Charities.
Pacific Rescue Home.
Boys and Girls Aid Society.
California Foundling Home.
Methodist Chinese Mission.
St. Marys Hospital.
Graeco-Russian Church Seminary.
German Benevolent Society.
French Ladies Benevolent Society.
Sheltering Arms San Jose.
Good Templars Home for Orphans.
Bishop Armetage Orphanage, San Mateo.

The report of 1900 lists the diseases treated. This forms an excellent basis for comparison with the diseases of children at later dates. The Orthopedic service saw and treated 96 children with tuberculosis of the skeletal system, the spine, bones and joints. The other conditions mentioned were fractures, dislocated hips, spastics, club feet etc totaling 43 in addition to the tubercular problems.

There were 77 surgical admissions which included many of the same problems seen at present. The striking difference, however, was in the number and types of cases requiring surgical drainage of abscesses. There were 26 admissions for such treatment and these included Cervical Glands, Osteomyelitis, Empyema, mastoiditis and boils. One year listed 5 mastoidectomies and the next twelve.

The Pediatric admissions were numerous and varied, including, naturally,

many diseases still common among children. Significant is 46 cases of malnutrition. The major problems, then as now, were the respiratory diseases. The complications of these, however, were far more serious then and complications were also more numerous. Tonsillitis, frequently, was followed by swollen cervical glands which might last for weeks or months and often ended by abscess formation requiring drainage by surgery. Otitis Media often progressed to mastoiditis and surgery; Bronchitis frequently resulted in pneumonia and this might progress to pleurisy or empyema. Lobar pneumonia caused by the pneumococcus was alarming; the child might run a very high fever for seven to nine days and then drop by crisis. Death was not rare. The Dysenteries were very serious and very debilitating, especially in infants. Other late results of Streptococcic infections, such as rheumatic fever and nephritis, were not recognized as sequelae until much later. Rickets, scurvy and congenital syphilis were not uncommon.

Probably the worst recorded statistics, although not the year of the most admissions, were in 1906 when 703 children were admitted and 96 deaths occurred. The population in the early nineteen hundreds in San Francisco was not as great as at present.

The first years of the twentieth Century finds more familiar names on the staff. Dr. Emma K. Willets, after 3 years as resident physician, was highly praised by the Board and was made chief of the surgical services. This probably was the first true separation of the children into surgical and medical divisions. Dr. Merritt had been in charge of both. Dr. Mary Boftsford became chief of Anaesthesia in 1908 after a year of internship at the Hospital. By 1910 the visiting staff had increased to 27. Some of the old remaining ones were Drs. Wanzer, Sherman, Von Hoffman, Lewitt and Watt Kerr. New names appearing were Adelaide Brown, daughter of Charlotte Blake Brown,

Wallace Terry, Langley Porter, Anna Flynn, Elizabeth Keys, Rachel Ash, George Ebright, and Anna Rude. The specialties were still not clearly defined, especially Pediatrics. Thus Rachel Ash had substituted in Pediatrics at the University of California Medical School for Dr. William Palmer Lucas when he accompanied Herbert Hoover to Holland after WWI. Later Dr. Ash^h became Chief of Medicine at Childrens Hospital.

After the first White House Conference on Children and Youth in 1910, there was ~~marked~~ increased interest in the health of children at local levels.

Dr. Adelaide Brown was concerned about the quality of milk reaching the City and was instrumental in the formation of a Milk Commission to study both the milk and the sanitary status of the dairy farms and their workers. The result was certified milk. It remained in vogue until pasteurization became routine. Two other doctors greatly concerned about the childhood infections were Karl F. Meyer then in charge of the Hooper Foundation at the Medical School and E. Charles Fleischner who was later to be Chief of the Communicable Disease Department at Childrens Hospital.

The decline of many diseases of childhood before the advent of immunization and antibiotic therapy was ^{due} to public health measures taken to assure pure water, clean milk, better nutrition and improved living conditions.

In 1913 Dr. Julian Wolfson was appointed neurologist for the hospital, Dr. James Watkins was added to the orthopedic staff and Walter Alvarez was the first Radiographer, - the same Alvarez who later was to win fame at the Mayo Clinic and whose son was to win the Nobel Prize.

The name of Florence Holsclaw first appears on the records in 1915. Associated Drs. with her later were Jewel Booth, Jessie Bierman and Charlotte Boehme. Drs. Myrl Morris, Rena Piper and Clain F. Gelston were at various times with Dr. Langley Porter. Dr. Fleischners name does not appear in reports until 1917

although he came to the city in 1910 and worked with Dr. Brown on the Milk Co Commission and in the Well Baby Clinics as noted earlier. Pediatricians associated with Dr. Fleischner were Drs. E.B. Shaw and H.E. Thelander. He had others with him for short periods of time among them was Dr. Lloyd Hardgrave. Apparently even some psychiatry was practiced at this early date since the name of Olga Bridgeman appear in the records of both UCSF and Childrens Hospital.

In 1924, when I came to Childrens Hospital as an intern, Florence Holsclaw was Chief of Pediatrics. She also supervised the infants of "Babys Aid" an organization that provided homes for abandoned and orphaned infants. The mortality in this group was high. Many of them were admitted to the hospital for treatment of dysentery or respiratory infections. Pediatrics was located in one of the early round buildings facing Sacramento street. This was a three story building and the so called clean cases were kept on the first floor, the mildly infectious ones on the second and the orthopedic problems on the third floor or "Jim Ward" as it was known. Surgical Pediatrics was on the third floor of the main building. Maternity and the newborns were in a small building, since removed. Dr. Fleischner was Chief of the Communicable diseases, Dr. McChesney of Orthopedics, Dr. Keys of Obstetrics, ^{Dr. Willets} ~~Dr. Willets~~ of Surgery and Dr. Flynn of EENT.

The Hospital had twelve interns and two residents, all women. One resident supervised the surgical services and the other the medical ones. The house staff had quarters on the top floor of the Nurses Home. They were on call day and night with no specified time off but with permission and a willing relief were permitted to take an afternoon or an occasional week end off. Board and room were provided and they received a stipend of \$15.00 a month.

In general the University Hospitals did not pay their interns, and for this reason some felt that to receive pay was an indication that the internship was inferior to that of the Universities. The stipend was seldom mentioned! It was a very interesting group of interns in 1924; one was from Scotland, one from England, one from Canada and the rest from all parts of United States. Dr. Bronson who was in charge of the Cardiac Clinic, had studied in England and was responsible for the British physicians coming all the way to California. Edith Bronson drowned in Yosemite when vacationing there with her British friends. This was a tragic event for her friends and for the Hospital. One interne, Virginia Milner, contracted a strep infection from a surgical patient and died of sepsis and meningitis.

Dr. Holsclaw died in 1929. Members of the pediatric staff at that time included Drs. Myrl Morris, Clain Gelston, Rena Piper, Jessie Bierman, Charlotte Boehme, Hildegard Henderson and Hulda Thelander. Clain Gelston was elected chief of the Department in 1932 and served until 1951. In addition, he was Hospital Administrator from 1933 to 1942. Dr. Gelston asked Drs. Bierman and Thelander to assist him on the Pediatric service.

The service was already well developed. The Out-patient Department had special clinics for well babies and pre-school children; specialty clinics in Allergy, Cardiology, Neurology, Chest, Eye, and by now, Ear, Nose and Throat had its own clinic. There were also specialty clinics in other Departments serving children. These included, Dermatology, Orthopedics, Genito-urinary diseases and surgery. Dr. Morris retired from practice very early, she said she retired at the insistence of her brother, also a physician. She later stated that it was a grave mistake to retire early and warned the younger women entering medicine to stay on the job. Dr. Morris died in 1973. Dr. Piper died in 1954. Dr. Hildegard Henderson, although never very active in private practice did introduce Hematology as a field of special interest to the hospital.

Jessie Bierman elected to go into Public Health and has served well in that field at local, State and National levels. She also participated in the World Health Organization and did an in-depth study of children in Hawaii.

The years of depression in the nineteen thirties were tragic for many patients and also for several young doctors who got their first practice experience by working in poverty programs. Several older ones ready to retire or already there, lost so much in the crash of 1929 that they returned to work. These years were followed by World War II, a time when the population of San Francisco increased rapidly and its profile changed due to the influx of workers to the Ship yards and the Military Headquarters located in and near the City.

After the war, The American Academy of Pediatrics, (founded in 1933) , appointed a Committee to study pediatric services and Education in USA. This was a very intensive study extending down to city and urban levels in all the states. Dr. Warren Sisson was Chairman of the Committee and Dr. John Hubbard was Director of the project. The results were published in 1949 by the Academy in a book entitled, "Child Health Service and Pediatric Education".

However, it was not the war, nor, pediatric education, but laboratory discoveries that changed and revolutionized pediatrics. The possibility of immunizing against certain diseases and the discovery of antibiotics that would kill the infecting organism without injury to the host is undoubtedly the greatest contribution to health of the twentieth century. Smallpox vaccination goes way back; it was followed many years later by Toxin-antitoxin against Diphtheria; Then by Toxoid, a safer agent against Diphtheria, and to it was added immunization against tetanus and then whooping cough (pertussis) now known as DPT. Since then vaccines have been developed against measles, mumps, and best of all, against Polio the dread disease for so many years. Although immunization

against tuberculosis was practiced extensively in Europe, most Americans chose to use testin for the disease with "TBC", isolating the patients, often in Sanatoria and treat it . This method has proven satisfactory.

It is well to review the type of treatment utilized by physicians before the advent of the antibiotics were discovered. Steam was administered for cough either by a bedside kettle or directed into a tent over the child. Mustard plasters were used extensively for chest infections, more by some doctors than others. The discontinuance of mustard plasters probably pleased the nurses more than any other change. Dr. Von Pirquet of Vienna was an ardent advocate of sunlight as therapy. As a substitute in this country, sun lamps were often used during the recovery period. These prolonged illness^{as} of childhood were very debilitating and many children were sent to convalescent homes for several weeks or months. These institutions were located out of town to increase the child's exposure to warmth and sunlight. The best known locally were Stanford Convalescent home in Palo Alto and the Bothin Convalescent Home in Marin. There were also Sanatoria for Tuberculosis.

Infection was such a hazard that very strict rules of isolation of new patients were in vogue; throat cultures were routine, as were tbc tests, Schick tests, and blood counts, urinalysis and sedimentation rates. Visiting hours were very limited, usually two afternoons a week and for parents only. These routine practices were difficult to change, but stimulated by the pediatric studies and the excellent results from the use of antibiotics and immunization, changes gradually took place.

In the early days of the Hospital, the physician who delivered the baby usually also took care of the mother and child. By 1950 the newborn nurseries were under pediatric care.

The Hematology Laboratory was opened in 1949 by Drs. Aggeler and Wallerstein.

Dr. Sylvia Hoag joined them later. The cardiac work was continued by Dr. Ann Purdy, her assistance for many years was Mrs. Lucile Boole, not a physician but a dedicated person who worked not only at Childrens but also at the University heart Clinic where she assisted Dr. Edith Ervine Jones, a Scotch girl who had interned at Childrens Hospital. The physicians who worked with Lucile Boole said she could diagnose a heart condition as readily as the doctors. It was Dr. Purdy who first associated sore throats and the streptococcic infections with such diseases as rheumatic fever of childhood and nephritis. Others were reluctant to accept this concept at first but it is now and has been for years accepted as fact.

In 1951 Dr Gelston died and Dr. Thelander was made Chief of the Department. The work progressed uninterruptedly. The reports of 1950-51 note that all the internships and residencies were filled. The additions to the staff the next few years Drs. Dorothy Orr, Martha James, John Miller, Atkins, Degenhart, Ogara, ~~Leininger~~, Alice Potter, William Kerr Jr., Margaret Reece, Grace Goebel, Lloyd Hardgrave, ~~Leininger~~, George Sherman and John Piel. Pieter DeVries was our first Pediatric surgeon, and he was responsible for the successful separation of our first Siamese twins. Unfortunately Pieter left this community to practise elsewhere. George Hyde is also a pediatric surgeon.

Dr. John Piel organized a youth clinic thus relieving teenagers of the embarrassment of being classified with children during this sensitive period. Adolescents were also given a special area in the Hospital for in patient treatment. Later Richard Brown joined the clinic and finally assumed charge of it. Eventually there was added a maternity service for the adolescents under the supervision of Drs. Gilbert Webb and Brown.

In 1952 the Child Development Center was opened financed by a grant from the Cerebral Palsy Organization. Later when poliomyelitis ceased to be a problem birth defects were added to the Center and these children were financed in

part by the March of Dimes and Crippled Childrens Services.

Childrens Tumor Board was started by Dr. Joseph Kushner. One year 18 tumor cases were discussed by the Board. When the Adult Tumor Board was organized, it seemed wiser to combine the two into one Board. The Cardiac Clinic continued under Dr. Purdy.

The treatment Room for emergency care was implemented and considerable study made of acute poisoning in children in order to try to prevent unnecessary fatalities.

A weekly seminar called " Childhood Ecology" was a joint venture of Pediatrics and Child Guidance to explore all factors affecting children. It started in July with a discussion of pregnancy and the intra-uterine period, and grew up, as it were with the child through the year, ending the next June with a discussion of adolescents. Outside participants were invited, including educators, social workers, psychologists and even judges from the juvenile court. At times parents participated. The group also made visits to institutions serving children such as Sonoma, Napa and convalescent homes then in existence. Most of the old institutions such as orphanages , sanatoria and convalescent homes were no longer necessary. Many had been taken over by other agencies and were serving other needs such as Day Care Centers and Nursery Schools.

The Out-patient Clinics were supervised by pediatricians as follows:

General pediatrics.....	Cabos, Degenhart, Leininger, Macaulay, Baumann,
Allergy.....	Louise Yeasell and Wm. Kerr.
Cardiac.....	Ann Purdy, John Piel, and Grace Goebel.
Neurology.....	Elizabeth Rees and Elsa Cabos.
Well Baby Clinics...	Reese, Sherman, Cabos, Plate and Orr.
Dermatology.....	Francis Torrey.
Otology.....	Ki Martin, Castro and Dorothy Danne.
Urology.....	Oca Goodwin and Olson.

Surgery..... Mary Mathis.

Orthopedics... Abbott and Bost

Treatment room and Poisoning ,.... John Piel and Susan Atwell.

Childrens work in Pathology and Biochemistry was greatly enhanced in 1956 when Dr. Sam Nerenberg joined the staff and became Chief of the Laboratories. Dr. Evelin Sires, was a great help in childhood radiology. Other pediatricians and co-workers with the department were Drs. Leonards, Lester Luz, Edward Smith, Alice Potter, Dorothy English and in childrens orthopedics, Larson, Ashley and Callender; in Child Guidance were Drs. Kaplan and Ryan.

Junior members and new arrivals joining later were,- George Sorokowski, Louise Taichert, Robert Dermot, Margaret Cariss, George Bates and Bradford Cohn. Rex Whitworth M.D. started a branch of the Collaborative Study, a national attempt to study children from conception on and factors interfering with normal development or causing anomalies or early death. After a trial period the National Group decided that the funds would go to University Hospital and Medical Schools and the study was discontinued. Much of it however was pursued in the Child Development Center.

Started also at this time was an Alumni Association, designed primarily to bring former house staff back to the Hospital for an all day Seminar on some pertinent medical problem. These continued for a number of years and then the Medical School instituted Continuing Education in Medicine under the leadership of Dr. Roger Wilson and Dr. Seymour Farber. They suggested, and it was accepted, that all these programs be centered at the University for organization, preparation, mailing of brochures and other assistance even though the meetings be held at Childrens Hospital. Many of the former residents and internes participated in these Seminars. Mentioned among these are Marcia Levin, Ruth and Henry Kempe, Marvin Naman, Sarah Malin, Bill and Pat Clarke

Hildegard Waasa and even two of the internes of 1925 attended when visiting here,- Dr. Madge Onhauser from Canada and Dr. Hilda Davis from England.

Students from the University Medical School had come to Childrens Hospital for some of their pediatrics and particularly for communicable disease teaching ever since 1922. Originally this was arrangement through an agreement that required the teaching to be done by faculty members from UCSF. In 1950 this was changed and all the teaching was carried on by the Staff at Childrens, most of whom were also on the clinical staff at the Univesity Medical School.

In 1954 when the new building replaced the Little Jim Building and the WW round building, diseases of childhood had changed so markedly that orthopedic cases were combined with clean surgical cases thereby eliminating a special ward for orthopedics. This meant ,of course, that tuberculosis was no longer a major orthopedic problem and draining osteomyelitis cases had yielded to antibiotic therapy.

By 1957 the communicable diseases most feared were under control,- there was no more diphtheria, pertussis measles, mumps, scarlet fever or poliomyelitis; the other infectious diseases could be handled either in the intensive care unit or isolated in rooms on the pediatric floor. This meant the closing of the building that had housed the contagious diseases since 1912. What tragedies and triumphs its walls could record!. Dr. Shaw left Childrens Hospital as Chief of CDD in 1958 to become Chief of the Department of Pediatrics at UCSF his alma mater. There have been few Educators with as varied experience in all phases of pediatrics as Dr. Shaw brought to the Medical School. The Univesity has awarded him with an Honorary LLD and made him the recipient of the Gold /Cane . He was also awarded the Abraham Jacobi award in 1973 by the American Medical Association Division of Pediatrics. Dr. Richard Leonards was made director of

contagious diseases and has continued to watch over the epidemiology of the Hospital and teach the House staff and students in this discipline.

My time to retire came in 1961, but I continued to supervise the Child Development Center until 1967 ~~when~~ Jerome Mednick took over. John Piel M.D. was made Chief of the Department of Pediatrics.

The Department continued to expand and the work load of the private pediatricians increased. Eventually it was decided to pay a fulltime pediatrician to take over the organization, supervision and teaching in the Department. Dr. Ira Brandt was selected for ~~the~~ position in 1968 and held it until Jan. 1, 1970. Dr. Samuel Giammona replaced him as Chairman of the Department January 1, 1971. At that time Dr. Mednick was still director of the Child Development Center, Dr. Lillian Blockman was full-time director of the Newborn service and the intensive care unit in that department for prematures and sick infants. Dr. Paul Wilson was consultant to the Ambulatory pediatric patients with William Kiyasu as assistant.

At present, 1974, Dr. June Brady is in charge of the intensive care unit for prematures and sick infants. "The Bambino Special" originally used to transfer babies from other communities to the intensive care unit has been discontinued and its place the regular ambulance service.

The pulmonary Laboratory was set up by Dr. Giammona. For the first time the various hospitals in the city caring for infants and children are co-operating in service and education of the house staff. This means less duplication of services and broader education for students and house officers. The Department now is divided into five sections:- in-patient pediatrics, Ambulatory pediatrics, Newborn nursery service, Youth service and Child Development. The full time physicians are Drs. Giammona, Richard Brown, June Brady and Hilty. The Ambulatory services are now listed as follows:-

Well Baby
Allergy
Cardiology,
Metabolism and Genetics

Hematology and oncology
Surgery
Pulmonary diseases
Neurology

Psychiatry
Infectious dis,
Pathology

Other pediatricians added to the service the past few years are:-

Toshiko Hirata in the Newborn Nurseries, Robert Gray Patten in General pediatrics, Robert ~~Hall~~ and John Bolton elected to the executive committee to serve with William Kiyasu as Vice Chairman.

Medical students from UCSF continue to get part of their training at Childrens. Combined Pediatric rounds are held with Kaiser, Mt. Zion, St. Marys and Childrens. May the Hospital continue to serve Children. And may it also continue to train women in the health sciences.

Hulda E. Thelander M.D.

11/7/74

15

IN DEFENSE OF THE BASIC SCIENCES

AFTER ALMOST a half century of pediatric practice, what is one's reaction to the medical school curriculum upon a return for a *second time around*? Science like technology has made tremendous advances in a relatively short period of time. A concern frequently voiced is, "How can all this new knowledge be learned in the old time period of four years?" This concern is unwarranted for several reasons. An important one is the student himself. He has grown up in the environment of these discoveries and consequently has acquired a great deal of the information from early childhood in school, from television, and from an abundant supply of educational books on almost any subject. The intelligent child is extremely well informed, if naive. The faculty frequently fails to appreciate this.

New discoveries often make it possible to delete old material. This is true not only for lectures and seminars but also, and maybe particularly, it is true for laboratory exercises. It seems a waste of time to go through the old basal metabolism test when in clinical practice it has been abandoned for newer methods. Even the prevalence of certain diseases has changed. Is a complicated animal test for diphtheria toxin appropriate when the modern student may never see a case of the disease?

Does this mean that the basic sciences can be abandoned in graduate education? On the contrary, for the continuous advancement of the health services, the basic sciences are even more important now than in the past.

The time allotted for these courses has been drastically cut over a period of years. The erosion began when the clinical departments requested more and more time for their subjects at the expense of basic training. It continued when the psychiatrists entered the field and pushed their instruction to an ever earlier period. Finally, the modern students, particularly the vocal activist groups with concern for the economic and social problems of the day, seem anxious to abandon all basic training for courses in the humanities and behavioral sciences.

Is there a happy medium? Do we still need physicians who know man—*homo sapiens*—his structure and function and behavior? Does structure in part determine behavior? The mechanic

is expected to know his machine and the veterinarian his animal. Is man alone going to be abandoned without anyone truly knowledgeable about him as a person?

Diseases change whereas man who has evolved over billions of years is not going to change much in a half century.

The end product of a fertilized human ovum like that of any seed depends on the quality of the inheritance, a favorable environment during

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organogenesis, protection during fetal growth and subsequent delivery, and a milieu conducive to optimal development. It is difficult for a student taught Embryology in the twenties by Dr. Richard Scammon to accept preparation for the M.D. degree without knowledge of human development. Sometimes in the years after the twenties, embryology was pushed back to the premedical period and a recent survey of students shows a fair percentage have had no courses in it and it is often no longer a prerequisite for admission to medical school. It took two major tragedies, an epidemic of German Measles in Australia, and the Thalidomide disaster in Europe, to bring the fetus into focus again.

Teratogens may cause intra-uterine deaths and fetal abnormalities, but damage to the fetus is often far more extensive than the obvious changes indicate. When an organism is injured during its period of rapid growth and differentiation, the consequences are seldom confined to one tissue—the whole organism is apt to be involved. Indi-

viduals thus harmed are stunted in their total growth, and are more prone to infection and to degenerative changes of organs. The life span is shortened. Fetal injuries may be the antecedents to many diseases of a later period even in individuals who escape major evidence of anomalies.

The hazards of teratogens to the fetus must become a concern of all physicians. Regardless of his specialty, any doctor may be responsible for damage to the embryo; the internist who prescribes drugs, the surgeon who operates; the anesthesiologist who interferes with oxygen supply; the radiologist who may be called upon to x-ray the patient; and of course, the obstetrician who must appreciate that he is administering to two individuals or in the case of multiple births, three or more.

The quality of the inheritance of the child is transmitted equally by both parents. Heredity is an important element in the development of the individual. A field for investigation was opened up when Lejeune of France reported on the chromosome variation of Down's Syndrome. The importance of his discovery was immediately recognized by researchers the world over. New syndromes and variations due to translocations, mosaicisms and other chromosomal derangements are now glutting the literature. Families with inheritable diseases are seeking counsel regarding reproduction and all physicians must have a realistic knowledge of genetics. Again, this knowledge can be satisfactorily transmitted to all medical students only if it is presented in the Core curriculum.

The time allotted for Gross Anatomy in some instances has been reduced to 10 or 11 weeks or a total of 100 to 110 hours. Although learning-aids such as colored pictures, models, video tapes, films, stereos and predissected specimens have been added, these are no real substitutes for familiarity with the human body through dissection; attesting to this is the return of surgeons to the dissecting table. Utilization of surgical interns and residents in the dissecting room would be advantageous to both student and surgeon in training.

It is not unusual for students and even some physicians to cite psychiatry as the medical specialty in which the study of Anatomy is not very relevant, but a few patients diagnosed as psychotic who succumb to brain tumors will negate this assertion. It might be profitable to recall that

Leonardo da Vinci and Michelangelo resorted to robbing graves for corpses, in order that they, through dissection, might better portray the human form in art. In an era of organ transplants, kidney dialysis, cardiac surgery, and artificial pace makers, medical education cannot afford to neglect Anatomy. Instead it would be well to add some study of Anthropology to the courses. Work with handicapped children reveals marked variation from the normal in human design which is apparent in head size, minor abnormalities of ears and eyes, variations in dermoglyphics and so on. These types of variations also affect behavior. The 13-year-old boy who is 6 feet tall has environmental reactions different from his peers who are still little boys.

A two year old who is as tall as a four year old is confronted with different expectations than a little elfin fellow of the same age. The size of ears or the length of the nose may greatly influence behavior.

Modern technology especially electrophoresis has greatly enhanced our knowledge of the chemistry of the body and it is possible now to get a profile of an individual's enzymes, proteins, carbohydrates and lipids. The appearance of these in abnormal quantities, the absence of one, or a modified one, may be a clue to diagnosis before there are any visible changes. Although this type of work is done in the laboratory the physician needs a workable knowledge of it in order to utilize tests appropriately for diagnosis. The modern physician must be informed on the Biochemistry as well as the Anatomy of the body.

There is a tendency at present for a student to want to elect and pursue his own pathway toward a selected goal relying on counseling from members of the faculty. This methodology could become a sort of apprenticeship en masse. Apprenticeship training did not prove adequate originally and there is real danger that the new version likewise will prove ineffectual. The learning process like so many other human functions depends on early imprinting and repeated reinforcement. Learning cannot be once and for all. The present concern over teaching versus learning is largely a hang up in semantics. Information is acquired through all the senses, vision, hearing, smell, taste and touch. Some prefer reading to listening. The astute student, scholar or physician, trains himself to utilize all the inputs to gain information for storage and retrieval.