I. The following is reprinted, with permission, from The Organ, the Journal of the Stanford University School of Medicine:

Editorial

by David Zucker, SMS IV

Buckminster Fuller once said "We are all born perfect, and some of us grow up even more damaged than others." To be a physician is to be with broken people. If we deny our own broken parts, we lose a vital reality that we share with our patients. We become technicians and scientists, intellects operating in an abstract world. When we don the white coat and hang the stethoscope around our neck, we do not erase this unity. We simply take on a role which can be useful in the healing process. It is our part in the drama of medicine.

From this perspective, our work takes on the flavor of good literature: intense interactions among people, each unpredictable and unique. Suffering as a common underlying theme clearly emerges, and action builds around directly facing and fully appreciating the dimensions of this suffering. Out of this context, change occurs: life struggles toward a new beginning or further pain and death assert themselves.

Indeed, the literary can help us in our work as physicians. We are ultimately faced with human interaction in medicine, and literature deals masterfully with human interaction. Basic science does not. In this sense, viewing our work through the literary model is more fitting than viewing our work through the scientific model. This is a strong argument for including more humanities in medical education. Yet our work is not literature, and to think of it as such is simply another abstraction, no better or worse than scientific abstraction. Both science and the humanities serve only to inform us about the territory we walk through as physicians. The work itself is palpable, not abstract. Our acts have real consequences, and these consequences can be life changing. Although study of literature and science can help prepare us to make intelligent decisions, no amount of study can prepare us for the immediacy of contact with our patients and their pain.

It is precisely here that a profound healing can occur. If we have faced our own pain, if we are not afraid to feel it, we will be able to face the patient in all of his or her pain. And through this act, a connection is made which has the power to transcend any disease. We acknowledge a primary reality which we both share and over which we have limited control. We give legitimacy to the struggle, and thereby give hope that recovery is possible.

Dealing with our own pain is not an easy process. Yet it is essential to the physician who is capable of healing at an emotional as well as physical level. Medical school is a time to learn. Unfortunately, the learning is strongly biased towards the scientific and abstract, and does not explicitly support understanding human suffering. Indeed, scant attention is paid to this reality in mainstream medical literature. It can be argued that this kind of learning is intensely personal and has no business in a medical school curriculum. Perhaps this is correct. However, this intensely personal learning has the curious potential to bring us closer not only to ourselves, but to our patients as well. The acknowledgement of pain and its reality gives strength to those who would embark upon the difficult journey of understanding its meaning. This kind of learning must be seen as central in the education of the physician.

II

GREETINGS EVERYONE!!

Yay! We finally have a tentative schedule of the spring meeting in April. You will find a copy of it in this newsletter. If anyone has any suggestions- hints, complaints, speakers, etc. - please call me immediately at (206) 935-2530. The number you are calling is in Seattle and you will have to leave a message with my grandmother (talk loud) and I will get right back to you. I am currently playing musical clerkships and there is no telling where I might be found. She is ALWAYS there and will take any message you leave.

A couple of points- some of the speakers have already been filled so the schedule is incomplete in that respect. Second- we have a couple of business meetings at Asilomar which are important to attend. The first business meeting we will cover things like what OSR is, getting everyone's names, what issues are being discussed at the AD Board, and we will start taking nominations for the western regional chair elections. The elections themselves will be held on Tuesday afternoon. We will also be discussing what the region thinks are pressing issues for med students to be working on, so bring the issues that you have been working on or thinking about and lets think of ways to carry them forward at this meeting. Should be a good time to do it with all the people working on change effectiveness. On Tuesday evening, after we have had a chance to have two sessions on change and a chance to talk about some of the issues ourselves, we will be having dinner with the Deans. This year it will be published in the schedule that the Deans are having dinner with us so its a good opportunity to do some effective lobbying. I suggest that we stay at Asilomar for dinner for a larger concentration of people. Lots of good issues going to be discussed so I hope you can all make it and bring shirts with roll-up sleeves so we can get some work done.

Another item I have included in this newsletter is a copy of House bill #3669 introduced by Representative Mickey Leland (from Texas) and the California delegation on developing an international health service corps similar to the national. Since we are having a session on international health, you might find this interesting. The bill is in its developmental stages and needs a lot of work- which means it needs a lot of constructive criticism and helpful input.

The first true AD Board meeting will be held in WA at the end of February. I will fill you in on what happened in the next newsletter.

Finally, a lot of credit and kudos must be given to Sheila Rege who has worked so hard to keep this newsletter going. Any of you who have articles or information, please send them to her. And a big thanks for the work, Sheila. (By the way, anyone who has changed addresses or phone number or any other vital information- please send that in so we can keep our lists updated)

More information next month....

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III Copy of the House Bill #3669 from the **Congressional Record** :

INTRODUCTION OF THE INTERNATIONAL HEALTH CORPS ACT

HON. MICKEY LELAND

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 20, 1987

Mr. LELAND. Mr. Speaker, today, I am introducing the International Health Corps Act, a humanitarian proposal to share the abundant health care resources of the United States and other cooperating nations with the developing countries of the world.

We are all only too aware of the grim statistics surrounding chronic hunger, malnutrition, and inadequate health care in this world. Over 40,000 people—primarily children—are lost each day due to the ravishes of hunger and the onset of infectious diseases associated with severe malnutrition. Most of these people succumb to preventable and treatable diseases and many could be saved with simple, inexpensive inoculations or basic health care services.

The International Health Corps will launch a coordinated international health assistance program. The United States, with its substantial health care expertise and capabilities, is in a unique position to assist developing countries establish sustainable and effective health care systems. We can help countries lower the toll of those who needlessly die, become blind or handicapped or lose the ability to become productive members of society from a lack of basic health care.

These efforts will not only promote our commitment to improved world health standards, but will also build trust through humanitarian cooperation with other nations. I believe such an effort will help foster world peace.

The International Health Corps is comprised of the International Health Emergency Corps and the International Health Development Corps. In addition to a permanent staff, the International Health Corps is comprised of commissioned officers of the Public Health Service, practicing physicians and other health care professionals who agree to volunteer their time. Upon the formal request of a country needing health care assistance, the Secretary of Health and Human Services may assign members of the International Health Corps to serve in that country.

The goal of the International Health Emergency Corps is to provide short-term assistance in responding to an emergency involving a significant number of persons who are at risk with respect to health and safety, including those at risk from acute malnutrition and imminent starvation. The International Health Emergency Corps will provide temporary medical assistance in response to natural or manmade disasters such as the earthquake in Mexico City, the famine in Ethiopia and the accident at the Chernobyl nuclear plant.

The purpose of the International Health Development Corps is to increase the capacity of developing countries to meet their long-term basic health care needs. After returning to the United States, health professionals who participate in the International Health Development Corps will serve as a resource pool which could be called upon to respond to international emergencies through the International Health Emergency Corps.

A Loan Repayment Program will be established to assure an adequate supply of trained physicians, dentists, nurses, and other health care professionals for the International Health Corps. The primary individuals eligible for the program are those persons who: Are full-time students in their final year of medical or dental school; are working to complete a residency or graduate program; or have received their degrees and completed any residency or post-degree program.

Under the Loan Repayment Program, up to $20,000 in educational loans may be forgiven for each year an individual spends in the International Health Corps.

Mr. Speaker, I insert a section-by-section summary of this bill in the RECORD for the benefit of my colleagues:

A SECTION-BY-SECTION SUMMARY OF THE INTERNATIONAL HEALTH CARE ACT

SECTION 395—ESTABLISHMENT AND COMPOSITION OF THE IHC

The IHC will be established within the Public Health Service (PHS), consisting of an International Health Development Corps (IHDC) and an International Health Emergency Corps (IHEC). [See Sec. 396.]

The IHC will be comprised of officers of the PHS, civilian employees and volunteers. [See Sec. 297]

SECTION 396—PURPOSE AND PROCEDURE

A country must make a formal request to the United States government for assistance from the IHC. The request must be approved by the Secretaries of State and Health and Human Services. The requesting country must agree to provide financial assistance to the IHC, to the extent practicable, as determined by the Secretary of HHS.

In addition, a request for IHDC assistance must identify the specific forms and length of assistance requested and the goals expected to be achieved during such assistance.

The IHDC will help train local health care professionals in the development of the infrastructure necessary to meet the long-term health care needs of the country.

The IHEC will provide short-term assistance to a country experiencing a medical emergency.

SECTION 397—UNCOMPENSATED SERVICE BY HEALTH CARE PROFESSIONALS

The Secretary of HHS shall disseminate information about the IHC and recruit health care professionals. The Secretary may provide for subsistence and transportation for professionals who volunteer their services.

To participate in the IHC, health care professionals shall agree to volunteer their services for at least three months.

SECTION 398—LOAN REPAYMENT PROGRAM

A Loan Repayment Program will be established to assure an adequate supply of trained physicians, dentists, and nurses for the IHC, and—if necessary—other health care professionals, such as optometrists, pharmacists, veterinarians, and nurse practitioners.

The primary individuals eligible for the Loan Repayment Program will be: (1) full-time students in their final year of medical or dental school; (2) individuals working to complete their residencies or graduate programs; and (3) individuals who have received their degrees and finished any residencies or post-degree programs.

Up to $20,000 in loans may be forgiven for each year an individual spends in the IHC. The forgiveness will apply to loans for reasonable educational expenses.

SECTION 399—INTERNATIONAL COOPERATION

To the extent practicable, the activities of the IHC will be undertaken in a cooperative effort with other countries.

SECTION 399A—ADVISORY COMMITTEE

The members of the advisory committee for the IHC shall include representatives of the Health Resources Services Administration, the Alcohol, Drug Abuse and Mental Health Administration, the Centers for Disease Control, the Peace Corps and the United States Agency for International Development. The chairperson shall be the administrator of the Health Resources Services Administration.

SECTION 399B—BUDGET AUTHORIT

Such sums as may be necessary [illegible] be authorized to carry out the IHC [illegible]ct for each of fiscal years 1988 through 1990.

IV

TENTATIVE PROGRAM: WAAMC MEETING, APRIL 24-27, 1988-ASILOMAR

THEME: "Medical Education in the Information Age"

Sunday, April 24

9:00 - 6:00 p.m.	GME Special Program: Workshop for Curricular Affairs Deans
3:00 - 6:00 p.m.	Registration
3:00 - 6:00 p.m.	MAS program: Tracking minority medical students- Database demonstration project
4:00 - 6:00 p.m.	GSA Dean's fireside chat
4:00 - 6:00 p.m.	OSR BUSINESS MEETING
4:00 - 5:00 p.m.	WAAHP New advisor's workshop
6:00 - 7:00 p.m.	Dinner
7:00 - 9:00 p.m.	Keynote address- Dr. Jack Myers, University of Pittsburgh
9:00 - 10:30 p.m.	Wine & Cheese reception

Monday, April 25

7:30 - 9:00 a.m.	Breakfast
9:00 - 10:30 a.m.	PLENARY I: "Teaching medical students about information management"
10:30 - 11:00 a.m.	Break
11:00 - 12:00 a.m.	Four concurrent sessions- TBA 1) The "automated" Dean's letter 2) Toward a curriculum in medical information sciences 3) Automation in the admissions process 4) MAS: Perspectives and insights in recruiting and retaining native american students
12:00 - 1:00 p.m.	Lunch
1:30 - 3:00 p.m.	PLENARY II: "The role of medical schools in physician oversupply: Congressional perspectives"
3:00 - 3:30 p.m.	Break

3:30 - 5:00 p.m.	OSR: International Health Opportunities and Indian Health Service
3:30 - 5:30 p.m.	WAAHP: Building a Library for pre-meds and their advisors
6:00 - 8:00 p.m.	Bar B Que
8:00 -	GME, GSA, MAS, OSR Fireside chats (all seperate)

Tuesday, April 26

7:30 - 9:00 a.m.	Breakfast
9:00 - 10:30 a.m.	PLENARY III: "Medical student well being
10:30 - 11:00 a.m.	Break
11:00 - 12:00 a.m.	Three concurrent sessions- 1) The impaired student- diagnosis and treatment 2) Faculty development vs. course development- how to work with student and faculty to improve curriculum 3) Change effectiveness- the role of students
12:00 - 1:00 p.m.	Lunch (OSR with pre-med advisors)
1:00 - 2:30 p.m.	GSA: NRMP report WAAHP: Admissions officers & pre-health professions advisors meeting GME: Clinical competence examinations/ Assessment of clinical skills MAS: National Boards and minority student performance OSR: Computers in medicine: medical students perspective
2:30 - 3:00 p.m.	Break
3:00 - 4:30 p.m.	WAAHP: Advisor reports on Dentistry, Optometry, Osteopathy, Podiatry, & veterinary medicine
3:00 - 5:00 p.m.	GSA: Handling negative information in the dean's letter: round 2
3:00 - 4:30 p.m.	OSR: Issues in change effectiveness & communication
3:00 - 5:00 p.m.	GME: Research planning meeting:

		assessing outcomes of medical education
3:00 -	5:30 p.m.	MAS: Student development: The medical scholars program at UCSF
4:30 -	6:00 p.m.	OSR: BUSINESS MEETING NUMBER 2
4:30 -	5:30 p.m.	GSA/GME: Student Affairs/Academic Affairs administrators: Computer applications in student affairs offices
5:00 -	6:00 p.m.	GME: Business meeting MAS: Business meeting
6:00 -	7:00 p.m.	Dinner (OSR with Deans)
7:15 -		Trip to the Monterey Aquarium (pre-registration required)

Wednesday, April 27

7:30 -	9:00 a.m.	Breakfast
9:00 -	10:30 a.m.	PLENARY IV: AIDS and medical education
10:30 -	11:00 a.m.	Break
11:00 -	noon	Wrap-Up
12:00 -		Lunch

"THE SECOND SLICE OF LIFE" VIDEODISC

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The Videodisc, "Slice of Life" was first produced in 1986 and contained 10,000 images. "The Second Slice of Life", produced in 1987, contains 22,000 still images. The videodisc is a visual database or encyclopedia of images. The disc capacity is 54,000 still images. Material on the disc came from eleven different institutions, one professional society and includes contributions from over 60 individuals. The cost for mastering the disc was shared and amounted to $300.00 per institution plus $35/hour for pre-mastering studio time. Pre-mastering entails placing the image on 1" videotape. The producer/director was Paul Burrows. Individual discs cost $25.00. Discs like this are known as "generic" discs. They have no specific purpose but can be "repurposed" as needed in various instructional programs. This permits the same images to be used in multiple ways.

At the University of Utah the disc is being used in histology, neuroanatomy, cytotechnology and pathology. Special programs for radiology and neurosurgery resident training have also been developed. Electrocardiology is presently in progress. Initially no attempt was made to be comprehensive and thorough, but editorial review of material on the disc as well as future selection criteria are being implemented. The current plan is to enlarge the disc's scope to include the core of basic medical science on one disc.

The videodisc master was produced by 3M from the 1" premaster videotape made at the University of Utah Instructional Media Services Studio. Most images were taken from 2x2 slides. Pre-mastering was done by projecting and videotaping single frames (the "off the wall" technique). Other images were transferred from 1" tapes produced elsewhere, from models in the studio or off of x-ray light boxes. Sophisticated controls for enhancement, chrominance and luminance were employed.

The videodisc index is a database of 22,000 records. The database structure includes 25 different fields which can be used to create special indices. It was designed to go with the SMARTWARE (Informix Software Inc.) database manager. The index is also available as ascii.text files or dbase III. This permits the searcher to look by title, author, image type, organ, disease, or nomenclature codes etc.

The 12" videodisc can be played on any videodisc player and can be interfaced with either IBM compatible computers or the Mac Plus, MacII or MacSE. The computer talks to the videodisc player through an RS232 serial port as if it were a printer. We currently use a 2 screen system which is much cheaper than a one screen system. The disc, however, works fine with the IBM InfoWindow System. Graphics overlay with one screen is feasible if you have a monitor that can do color mixing (NTSC and RGB) and add a color graphics adapter card (i.e. EGA, on Line, New Media Graphics etc) to your computer. At the U of U we are using a local area network (Novell) with five IBM compatible terminals. We also have five MacIntosh SEs with 20 megabyte hard discs. Ten SONY LDP2000/1 videodisc players with high resolution TV monitors can be attached to the computers. Each work station costs about $3,500.

"The Second Slice of Life" was distributed to those participating in its production. Letters from individuals and institutions interested in participating in the "Third Slice of Life" are welcome particularly from areas where expansion is needed (clinical pathology, microbiology, electromicroscopy including scanning, transmission, and freeze fracture, gross anatomy, neuroscience, embryology, physiology, microbiology, and pharmacology). No copy-righted material, unless there is written permission from the owner, may be used. One of the reasons for restricting distribution to participants in the past was to encourage participation in sharing materials, and particularly sharing in the development of courseware using the videodisc. The possibility of future distribution (at a higher price) to non-participants is being investigated. There are no available copies of the "Second Slice of Life". A demonstration videotape (1/2" VHS) is available for $25.00. It demonstrates over six different uses of the "Slice of Life".

The "Third Slice of Life" will begin production Summer, 1988. The core neuroscience portion of the disc will remain on the disc and will also be placed on a separate videodisc "Slice of Brain" for which multi-institutional participation is also solicited. "Slice of Brain" will expand to include clinical neurology, neurosurgery, neuroradiology etc.

On June 21 & 22, 1988, the University of Utah is planning a special workshop on issues of hardware and software for use with videodiscs in education. The program will include project proposals and design, authoring systems, evaluation, production, software and hardware. Over 30 different program participants and 20 different configurations will be demonstrated by experts in hands on sessions. Workshop registration is $55.00 before June 11, 1988. Students or house staff are $30.00. If you have questions or are interested in more information about the workshop or in participation in the videodisc project, please contact Suzanne Stensaas at (801) 581-8851.