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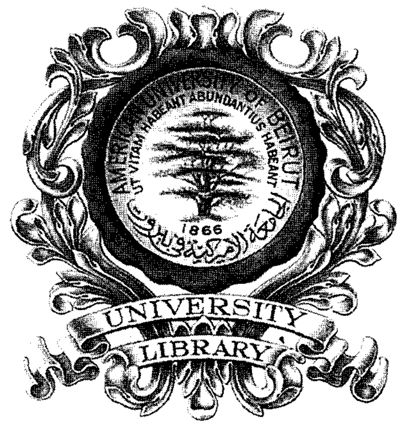


medicus

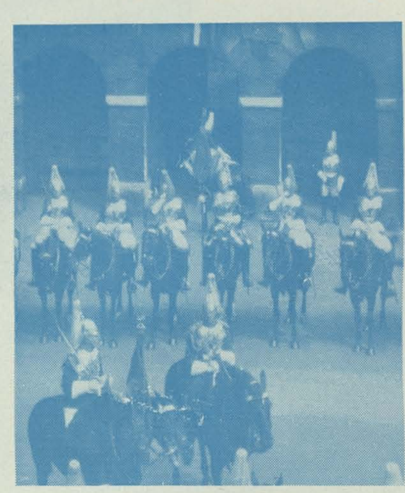
. 13 NO. 1 OCTOBER 1974

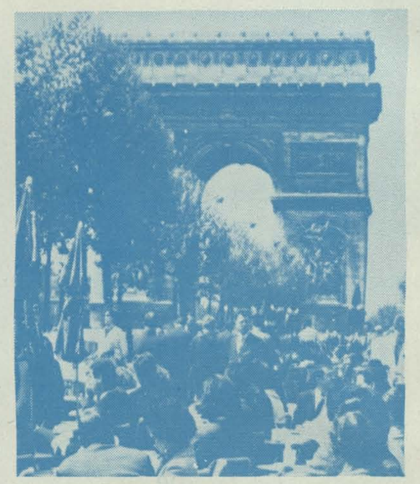
Inside: Interview with Dr. Asper

THE NEW HORIZONS

شبكة خطوط طيران الشرق الاوسط
تشمل ١٤ مدينة في أوروبا

سواء أكانت رحلتكم للأعمال أم للترفيه،
اعتمدوا طيران الشرق الاوسط
الذي يقدم لكم مجموعة لامثيل لها من الرحلات الى أوروبا





TOP OF THE MONTH

COVER STORY : THE NEW HORIZONS Page 5

To begin the 13th year of publication, MEDICUS paused to examine the past, the present and the immediate future of the Hospital and the Medical School that was founded 107 years ago. It was in fact an assessment of heritage and a rapidly changing horizon. Associate Editor **NIZAM PEERWANI** (Med. IV) made all the contacts and located the necessary references—with some assistance from Ms. Shermine Dabbagh (Med. II) and Ms. Najwa Najjar (Med. II).

INTERVIEW WITH OMAR SHARIF Page 23

At the beginning of this month, the Lebanese Bridge Federation was the host for the International Bridge Tournament. And so once again, Omar Sharif was in town. To find out what a women-addict thought of homosexuals, MEDICUS met the famed actor at the Holiday Inn Hotel. It was already past midnight and Omar had already been presented with his trophies by the time MEDICUS could get him for a brief discussion by the poolside.

FACING MEDICUS Page 27

With this issue, MEDICUS begins regular series of interviews entitled **FACING MEDICUS,** with prominent personalities both within AUB and outside. To mark his first year in office as the newly arrived Dean from Johns Hopkins, MEDICUS turned to Dr. Samuel Asper as its obvious candidate for this first interview.

OUR HERITAGE AT CROSSROADS Page 31

Winston Churchill said, few realize that the aged amongst us may have the youngest ideas of us all. He might have been saying it in self defense, but he was also very right. With this issue, MEDICUS begins a special section that will look at the people from amongst us who have by their philosophy, efforts and contributions, imparted a special quality to School and the hospital. George Zaytoun and Ms. Narmin Nabil (Med. IV) begin by looking at Dr. **AFIF MUFARRIJ** who just retired from the Department of Human Morphology.

FEATURE ARTICLE: HOMOSEXUALITY Page 34

What was thought to be a social deviation, might prove after all to be a result of more than circumstances alone. New findings indicate a possible hormonal and enzymatic derrangement at the basis. Associate Editor, Ms. **ADLETTE INATI** (Med. IV) extensively investigates the status of this phenomenon with assistance from George Zaytoun (Med. IV), Najwa Najjar and Nabil Mufarrij (Med. III). University Psychiatrist, Dr. **FUAD ANTUN** and Professor **PETER DODD** from the Sociology Department also sent their own assessments.

FOR OUR COLLEAGUES IN MEDICAL SCIENCES 43-47

To end our increasing alienation from our fellow students in the other Schools of Faculty of Medical Sciences, MEDICUS begins its 13th year of publication by introducing a section for the students in the School of Pharmacy as well as the School of Public Health. At the same time, we are expanding the traditional Nursing Page into a three-page setion.

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A MONTHLY JOURNAL PUBLISHED BY THE MEDICAL STUDENTS OF THE AMERICAN UNIVERSITY OF BEIRUT.

VOL. 13 NO. 1 OCTOBER 1974

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COVER Designed by : Abdallah Farukh
Title : THE NEW HORIZONS

History of medicus

It was in the summer of 1962, that a group of Medical Students began to work on the idea of publishing a journal for the medical students. And in the November of that year, the first issue of MEDICUS appeared, under the pioneering editorship of Suhayl Uthman—now a gastroentrologist and Assistant Professor in the Department of Internal Medicine.

What was then a trial has now become an assumed tradition, accorded a certain priority, by all the succeeding Medical Students Societies. In the best of times, MEDICUS has been a monthly magazine; at other times, it has appeared much less frequently. Once again this year, however, the Editorial Committee will be trying hard to restore this regular schedule.

* * *

In recognition of the efforts and spirit of all our predecessors who have worked to bring MEDICUS to its present status, we are printing below the list of all those who have held the office of the Editor-in-Chief during the last 12 years.

1962-64 : Suhayl Uthman
1965 : Bassam Barakat
1966-67 : Hartune Armenian
1968-70 : Hagop Akisal
1971-72 : Henry Nasrallah
1973 : Suhayl Nasr
1974 : Nuhad Krunful

suhayl uthman — m.d.

OUR MOTTO

WE DISAPPROVE OF WHAT YOU SAY, BUT WE WILL DEFEND TO DEATH YOUR RIGHT TO SAY IT ! !

medicus EDITORIAL THE BEGINNING

There is something peculiar about a beginning, that's not duplicated at any other time. Some say that's the only time one is still hopeful and can afford to think of things high above the deep waters. Beyond the beginning, it's only struggling to stay on the surface.

Clearly or not quite so obviously, it's a beginning for many people at many levels. A new Editorial Board has taken office to edit MEDICUS, with a directive from the MSS Cabinet to «begin things all over again». But that MSS Cabinet is also new, and still beginning its term of office. A new class has entered the Medical School—the largest Medicine I class in all these 108 years; some new Faculty members are beginning their career at AUH; after a massive strike on campus that destroyed certain precedents and certain naive concepts, we have begun the 109th academic year with attitudes that reflect the beginning of an intensive re-evaluation, of our nature, our purpose, and our potential for viability. Meanwhile, a few of our fellow medical students are beginning a new student life on university campuses elsewhere, after having had to leave us because of academic shortcomings or disciplinary deficiences. So indeed it's a beginning in many ways.

Ultimately it becomes the purpose of a magazine like MEDICUS to keep track of these events: to report on these isolated incidents, to synthesize them into meaningful concepts, to interpret them in a context of patterns and policies, and all the while keeping a student community—and some others also—a little better informed.

MEDICUS was started in November 1962. Dr. Suhayl Uthman, in his first Editorial, justified the need for creating MEDICUS by saying that he hoped «to bring further in MEDICUS the doctor as a jack of few trades besides his knowledge of the layers of a hernia», and also hoped «to better the standard of the medical students and the student nurse.»

Inevitably, MEDICUS will be read by people outside our Medical School, and actually we even intend to have it so. But MEDICUS does not, and perhaps cannot even adequately reflect the multidimensional aspects of the medical student body. To sell MEDICUS as a total embodiment of the AUB Medical School would be committing the same error that Heirocles did who went to sell his house and took a brick as a specimen. Yet human nature being what it is, our readers will often tend—of course wrongly—to assess not only our literary talents, but also our academic caliber, our life-styles and our extra academic spirit from the pages of this magazine. Unable to prevent this interpretation, though, we can maybe try to repond at least partially to this challenge of a misinterpretation.

The Editorial Board of MEDICUS '74-'75 will make a strong attempt to integrate all sectors of the Hospital and the Medical School—the students, Residents, Faculty, Administration, the nursing students and staff, as well as the paramedical personnel. We hope to reach them all thru circulars and announcements on the special MEDICUS Bulletin Board and hope to be reached in turn thru feedbacks dropped in the MEDICUS boxes. In addition, we have also contacted our colleagues in the other Faculties of the Medical Sciences—in the Schools of Pharmacy and the Public Health. However, MEDICUS will by definition remain a student publication all along. Inevitably! It will raise student issues and give favorable hearing to student complaints. It will seek to protect student rights in manners that will not sound clichés. But we will also seek to insulate MEDICUS from pressures and à-la-mode attitudes that would condemn it to adopt partisan positions. The issue of expelled students could even be taken up! If it sounds fair, why not? But it is equally essential that we do not all get eroded by getting stuck to obstinate positions in a game of stalemates; that during crisis there will prevail a force that's at once respected, that's objective and that can promote resolutions thru constructive channels. We do not have to resort to old history: we have learnt our lessons, hopefully, in our own life-time and more recently thru campus experiences in the summers of '71 and '74. MEDICUS will value the laws of diplomacy over the obsessions of obstinancy. We will seek to be able to talk of reconciliation, and push for reconstruction when these often get forgotten in the pursuit of rebellion and counter-reaction. The territory of objective neutrality will prove more difficult to inhabit, and inhabit for long. It will require courage and a determined resolution to stand by these convictions. And once again we can quote in anticipation of an uncertain future what someone said, at the beginning of an academic year «What our lands and our University holds for us, we know not......». But whatever circumstances may come, we hope MEDICUS will not lack the adequate resources. In doing so, we only hope to do justice to those who founded MEDICUS... justice to their efforts and justice to their hopes as well.

* * *

As a policy statement this year, we can say that MEDICUS will seek to promote COMMUNICATION, TEACHING, RESEARCH and PATIENT-CARE within our school and the hospital. To make this undertaking more meaningful, we hope it will be a joint undertaking on the part of all of us here. It would be flattering to breed a community of faithful and expectant readers; however, it would be much more satisfying to be able to create a community of participants and contributors as well.

* * *

Byron once said: «I like to begin from the beginning». We bought his philosophy and in this first issue, we begin with a cover issue that surveys our past, describes the present, and briefly looks at the forthcoming projects in the immediate future. And we stopped in the midst of a past and a present and a future to interview a retiring faculty member to investigate the action of time on the vigor and spirit of a man. It was all challenging to evaluate the total appropriateness of what has been labelled as our «Heritage of Excellence». But more than challenging, it was inspiring to begin on a note of optimism and look at the months ahead,..... watching for the new horizons! !

Letters

Dear Editor:

In the past, Nursing Students haven't been given the attention they deserve in MEDICUS. This year though, a change can be noticed. Suddenly Nursing Students are considered important enough to be given three pages instead of one in MEDICUS and moreover there is a general positive approach towards them, reflecting the importance of cooperation between Medical and Nursing Students. Now, I wonder who brought the change and how did it come about?

We do appreciate the change and hope that you'll keep on in this track of mind.

Leda Zanoyan, President
N.S.S.

Dear Editor:

Whenever I think of a hospital, the keyword that enters my mind is «organization.» With my joining of the AUH, which is considered the best hospital in the Middle East, I was sadly disillusioned on this point. The hospital runs with a «laissez faire» attitude. A patient who comes from far at 6:00 a.m. to the O.P.D. and waits till 10:00 a.m. to see a doctor illustrates this point. I hope that the hospital will try and remedy the situation and I in turn am wiilling to put in all effort to build a more efficient hospital.

Sawsan Hijab, BSN III

Dear Editor:

As we embark upon a new academic season we are forced to take a look at the past year and maybe learn a thing or two. To some, it may be distasteful to reflect on the past, but to most the past contains many good lessons than can be helpful in shaping a better future.

Youth is a wonderful thing. One is filled with ideals, with enthusiasm but also unfortunately with an overdose of: «I am right and everyone else is wrong; to hell with everyone else!». What this overzealous young person does not realize is that often when everyone else «goes to hell» they drag him along and he finds himself worse off than when he started.

Life usually goes on and our overzealous young friend finds his zeal waning in a reverse proportion to his increasing responsibilities in the care of his wife, his children, his aging parents and often simply in the ever-increasing difficulties of day to day survival. This is when he looks back over his years of vigor and regrets that he did not use this overflow of energy in a way that would insure him and his fellow citizens of the world a better future.

Ideals and ideologies are essential to ones maturity but they should not be allowed to degenerate into anarchy and therefore replace in age-old time-honoured principles exemplified by the Golden Rule. I therefore urge all who read this letter, before they write me off as an old fogey, to do to others while they are young as they would like others to do to them later when they become old.

You are lucky to be young and carefree my friends, please help make our world happy and carefree too. Do everything in love; do nothing in malice; banish hatered from your hearts an let your life overflow with the light that dispells all future darkness.

William A. Nahhas, M.D.

Dear Editor:

I have been wondering what MEDICUS '74-'75 is all about. So far, it seems a lot! The «start» has been encouraging and impressive. The inexhaustible energy and versatility of its staff, the immediate spontaneous addresses to various student, resident and faculty societies, the welcoming tea-party to Medicine I students...... what a sincere, honest and well expressed call for cooperation and merging of efforts among all those who have the potentialities and the will to do something positive. What a warm and challenging invitation!

But who knows? There might be a tremendous paradox between what «appears» and what «actually exists.» Much is expected from MEDICUS '74-'75 both in introducing novelty and in making up for some of the inadequacies of the past years. Only time can tell us whether MEDICUS will live up to the expectations.

As a new nursing graduate, I have to admit that rapport between Nursing Students' Society and the Medical Students' Society is entering into a glorious phase and a very interesting one too! In the past, the gap between the 2 societies was not only distressing but horrifying. Now, all of a sudden, we are experiencing such a facilitated, peaceful and effective relationship that so very many of our nurses are eager and indeed looking forward to devotedly working in your MEDICUS and other MSS committees. What is more gratifying than to witness the creation of such a stable and variegated relation nourished by medical, social and intellectual communication? It is high time for both groups to realize that if their roles are not complementary, the outcome will be disappointing for both.

I look forward to a stimulating and nourishing MEDICUS.

Randa Milki, BSN Graduate

THE NEW HORIZONS

(Ordering a dozen posters! A dozen felt-pens! Many things we did by dozens while trying to get started in MEDICUS this year. We soon got used to the dozen. And ironically enough, MEDICUS turned out to have been started a dozen years ago.

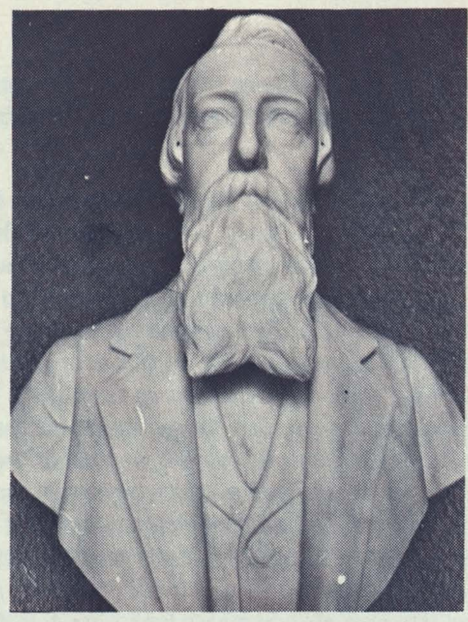
The decision was made then. The cover story at such an appropriate moment in the history of MEDICUS— as we enter the 13th year of publication—had to be on «THE NEW HORIZONS». A story we thought would survey all that which constitutes the AUB and its sister AUH! That would look at the past and record it again in a nutshell; talk of the present, and be informative in the process; look at the future and become conscious of things to come. The assignment was massive, or at least became so; time was short though. To do all this synthesis became the responsibility of our Associate Editor, Nizam Peerwani, who also determined what shape to give to the story. Assisting him was Shermine Dabbagh, who also tried to contact some of our oldest living medical graduates to provide a living touch to this historic account; but unfortunately she failed to reach them for various reasons! To get some of the necessary information about the Medical Center, Najwa Najjar saw the Hospital Director, Mr. David Edgee. Deadlines were approaching fast. We found some consolation in knowing however that a few others had written against deadlines also: like Daniel Bliss writing his reminiscences; or President Stephen Penrose writing his historical account of AUB «THAT THEY MAY HAVE IT ABUNDANTLY». Nizam went thru old records, thru many long-dated AUB and Faculty Bulletins. And finally to climax it all, he switched to more powerful and glaring lights to keep himself on all thru the nights going thru Presdient Penrose's book, cover to cover. How did he feel when he had finished? «I had heard many times of the greatness of AUB,» he said; «Of a heritage beautifully described now as a 'heritage of excellence'. It had all sounded good. But now somehow I can also feel it; so closely! Perhaps few understand me. But hopefully, not to few!»)

The story of AUB and its medical school began on December 3, 1866, when a small newly founded Syrian Protestant College (SPC), with Rev. Daniel Bliss as its President, opened its doors to 16 students. The college was housed in a rented building owned by a certain Butros Bustani. From the very beginning, a deep desire was felt to establish a medical department at the earliest possible date, but it was not until one year after SPC had begun, that 6 students enrolled in the newly created medical school. There is no doubt that Rev. Bliss played a major role in realization of this desire—however, the day to day burden and the enormous task of steering the new school in the right direction fell on three founding fathers. They were:

1. Dr. Van Dyck (1818-1895).
   He became the Professor of Internal Medicine and Gross Anatomy and also lectured in Ophthalmology (see box).
2. Dr. John Wortabed (1827-1908).
   Born in Sidon to an Armenian priest, Dr. Wortabed studied medicine in America and theology in Scotland. At SPC, he became the Professor of Anatomy and Physiology.
3. Dr. George Post (1839-1909).
   Son of a surgeon, Dr. Post studied theology and medicine in America and served 4 years as a medical missionary in Tripoli before being appointed a Professor of Surgery, Materia Medica and Botany at SPC.

Right from the start, the SPC medical school required a 4-year course of study; at that time, a very few medical schools even in America offered more than a 3-year course (Harvard being one of the few exceptions). But those earlier days posed many problems—for instance, in 1867 there were practically no medical text-books in Arabic (Arabic was the medium of instruction) and hence the professors were obliged to write their own text which the students copied. Again, to teach medicine and surgery without a hospital or clinical material was of course an impossible task—thus for a few years, the school maintained a small hospital and a dispensory in its rented quarters and the few patients that could be accommodated were nursed by students who took turns. This was of course recognized as a makeshift arrangement pending the acquisition of a satisfactory hospital building. This opportunity arose sooner than reckoned when the staff of the «Prussian Hospital», a 60-bed hospital built by the Knights of St John in the early sixties of the 19th century at an excellent site near the west-end of the town, walked out

CORNELIUS VAN DYCK



If Cornelius Van Dyck had not devoted his lifetime to medicine, he would yet have secured fame for having successfully translated the Bible into Arabic in 1864.

Cornelius was a first generation American, born in New York in 1818, to Dr. Henry Van Dyck and his wife Catherine Val Alen, both of whom had emigrated to USA from Holland. Dr. Henry Dyck was a country practitioner and it was under his tutorship that Cornelius first began studying medicine at Kinderhook Academy before joining the Jafferson Medical College at Philadelphia where he graduated with M.D. in 1839.

In youthful adventure young Cornelius, fresh from Medical School, embarked on a mission, little knowing what lay in store for him. It was to Syria he went in 1840 as a medical missionary for the Dutch Reformed church. There, for the first time, he studied theology and arabic.

When the medical school at the Syrian Protestant College opened its doors to its first students in 1867, Dr. Van Dyck was one of the three founding fathers. He was the Professor o Internal Medicine and General Pathology, but also lectured on Ophthalmology. Besides these, he taught Chemistry, Astronomy, Meteorology and directed the Observatory. In addition to all these occupations, Dr. Van Dyck was the Director of Mission Press, supervising all publications and specially the new edition of his arabic Bible; he wrote numerous Arabic texts on Chemistry, Internal Medicine, Physical diagnosis, Trigonometry and Astrology and Translated into English, with critical commentary, the great Al-Razi's (850-932 A.D.) classical treatise on small-pox and measels.

From 1867 to 1882, when he resigned in sympathy with Dr. Lewis who had delivered a controversial commencement speech on Darwinism and whose contract was subsequently terminated by the Board of Trustees. Dr. Van Dyck devoted his entire time and energies to uplight the school and when he passed away in 1895, our Medical School had already established itself in the region and beyond as a veritable seat of higher learning in the field of medical science.

as a result of internal feuding. SPC medical school promptly offered the Knights of St. John, the gratitous services of its medical faculty in exchange for the privilege of using the out-patient and in-patient services of the hospital. The knights whole-heartedly accepted this condition! This agreement continued in force until America joined the Allies against Germany towards the end of the World War I in 1918.

As the college began to grow bigger, the Board of Managers were forced to think of buying their own land. This task was entrusted upon President Bliss and Rev. Dodge. Describing this process, President Bliss wrote, «.....many places were visited in Beirut. We rode everywhere through the city, looking as we rode. Finally we saw the site where the college stands and fell in love with it at sight, and immediately decided that we had found the finest site in all Beirut, if not all Syria.» Soon payment of nearly $8,000/- was made on January 22, 1870 and the land secured. Dr. Post, whose hobby was architecture, drew up plans for the Medical Building in June 1870 and by January 1872, ground was broken for the Medical Building. (Dr. Post also planned the Post Hall which bears his name).

It seems incredible that a good medical school could be maintained with only 3 professors; however, for a number of years, Dyck, Post and Wortabed carried the full load impressively and it was not until 1872 that Dr. Richard Brigstocke, an English medical practitioner in Beirut was appointed as the lecturer in «Obstetrics, Diseases of Women and Children and Medical Jurisprudence.» The school thus gradually grew and by 1881-82, there were a total of 62 medical students. But, at the end of that year, an event occured which nearly brought the budding school to the brink of collapse. However, the results were far-reaching, one of the more immediate being that Arabic was once and for all given up as the language of instruction and English formally adopted. The events unfolded as thus: At the commencement in 1882, Professor Lewis (of Chemistry and Geology) was selected to give the annual address to the students. In his address, he appeared so distinctly to favor the theories of Darwin on evolution that several of his associates were vividly alarmed. This was conveyed to the Trustees, which taking into consideration the strong Christian nature of the College, ruled that «.....(they) would not be willing to have anything that favors what is called «Darwinism» talked of or taught in the College.» Professor Lewis was thus forced to hand over his resignation! Matters did not end there for Professor Dyck, Wortabed and Brigstocke, all from the School of Medicine, also handed over their resignation in protest against the rough way Professor Lewis was treated, thus leaving merely Dr. Post to manage the school all on his own. Also about 15 medical students who apparently sympathesized with Professor Lewis were abruptly suspended, to be later accepted on signing an apology and a pledge of good behavior. But in the meanwhile a rebellion by the students of the medical school was in the offing and the idea to permanently close it down was seriously entertained. But time was a healer for it let reason prevail. The storm slowly subsided and the school briskly set about to fill in the faculty vacancies by Professors from USA. They, however, knew no arabic and could hardly be expected to learn it in time—thus English was formally accepted as the language of instruction. This marked the turning point in the history of the school, which now could keep abreast with the voluminous new research taking place both in England and in USA..

DR. FAYSAL MELHIM HASAN, M.D.

Commenting on the quality of our medical students, Dr. Faysal Melhim Hasan, who has recently joined the Internal Medicine Department (Respiration) as a self-supporting full-timer with a status of Assistant Professor, remarked that they have an inherent handicap in that they are easily intimidated by the Attending staff and are too shy to express their knowledge! This along with their apathetic nature, as far as seeking medical knowledge is concerned, most definitely gives American medical students, who are avid readers and who maitain a serious and mature outlook in pursuit of their career, a lead over us. An average 3rd year medical student in U.S.A. for instance has a minimum of 2 subscriptions to medical journals and thus by the time he is a Resident, he has a depth of 4 years.

Dr. Hasan, who was born in Beirut in November 1944 entered AUB after his high school as a sophomore pre-medic in 1961. He obtained his B.S. in 1964 and the following year joined AUB medical school from where he graduated with an M.D. in 1969. He next went to the Upstate Medical Center at Syracuse, New York, where he did one year of internship before doing 2 years of Residency program in the Department of Internal Medicine, on completion of which he became a Clinical Research. Fellow in 1972 at the Pulmonary Unit of Massachusetts General Hospital, Harvard Medical School. There he underwent an intensive training in Respiratory Diseases and worked extensively on Acid-Base balance.

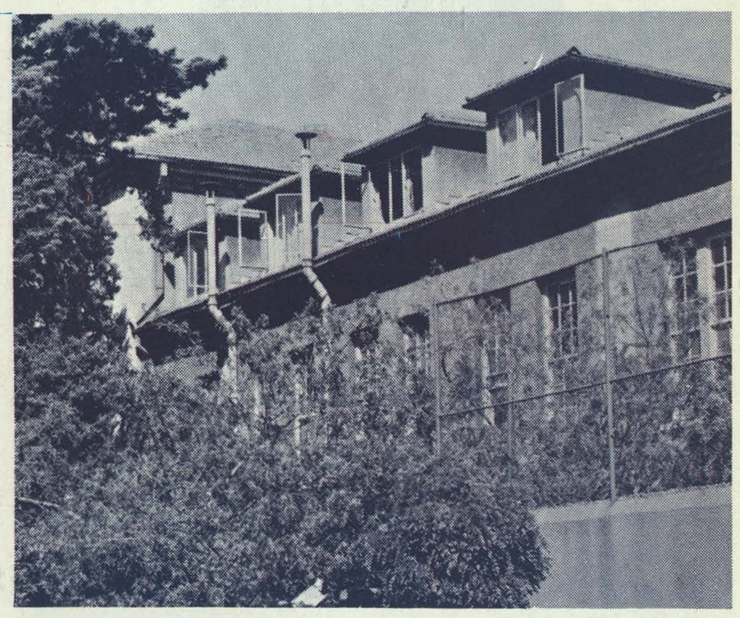
Articulate and very professional looking, Dr. Hasan is eager to put into practice many of the skills he has acquired. Although his clinical research and clinical teaching will be curtailed by 5-half days he has to put in at the Private Clinics as a self-supporting full-timer, he has already begun giving serious considerations to many projects he has on mind, some of which are:

1. Pulmonary Function tests in Patients with Acromegaly.
2. Effect of intal on levels of cyclic AMP in mast cells (in collaboration with Drs. Fuleihan and Faysal).
3. Measurement of CSF HCO3- rise in patients with Respiratory Acidosis.

PUBLICATIONS

1. Khayat, G., Hassan, F.M., Iliya, F. and Bickers, W.: Delivery after a Previous Cesarean Section. Intern. J. of Gyn. & Obs. 7:93-100, 1969.
2. Hassan, F.M., Najjar, S.S. and Asfour, R.: Growth of Lebanese Infants in the First Year of Life. Arch. Dis. Childhood. 44:131-133, 1969. (Presented at 5th Symposium on Health & Nutrition in the Near East, AUB).
3. Hassan, F.M. and Kazemi, H.: Progress Report: U.S. Beryllium Case Registry—1972. American Review Resp. Disease. 108:1252-1253, 1974.
4. Hassan, F.M., Auchincloss, J.H. and Gilbert, R.: Thromboembolic Disease and the Cardiorespiratory Syndrome of Obesity (submitted to N.Y. State J. Medicine and accepted.
5. Hassan, F.M. and Kazemi, H.: Chronic Beryllium Disease—A Continuing Epidemiological Hazard. Chest 65:289-293, 1974.

FAYSAL HASAN : « Me ! »

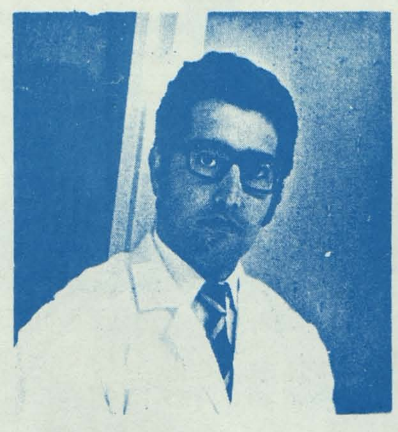


By the turn of century, 12 medical departments including zoology, chemistry, histology, anatomy, physiology and hygiene, materia medica and therapeutics, dermatology, children's diseases, eye and ear, Obs.-Gyn., surgery, pathology and practice of medicine were in full force. Then during the summer of 1902, land lying S.-E. of medical gate was purchased for $25,000/-. It had an area of about 3 acres and contained one large house, which used to be the residence of the famous Adham family. This house was re-modelled and used as hospital pavillion until it was burnt down in 1939. At this new site, a Women's pavillion was built in 1908 and soon construction on Eye & Ear pavillion along with Children's pavillion was begun.

DR. KHALED TABBARA, M.D.

Dr. Tabbara, a member of the Lebanese Ophthalmology Society and the Association for Research in Vision and Ophthalmology, was born in Beirut in April 1943. After his elementary school, he joined I.C. in 1955 and upon graduation entered AUB as a Sophomore pre-medic in 1962. He obtained his B.S. in 1965 and M.D. in 1969, after which he completed three years of Residency program from 1969-'72 in the Dept. of Ophthalmology at AUH. He then proceeded to University of California at San Francisco where he was a fellow at Proctor Foundation, having been awarded the Public Health Service International Fellowship Award. During two years of stay there, Dr. Tabbara studied extensively the external eye diseases, along with Ocular microbiology and immunology, and came up with an impressive list of original publications.

As a student, Dr. Tabbara took a very active part in extra-curricular activities; for instance, he was a member of the MSS Cabinet '67-'68 and the Vice President the following year. He also participated fully in MEDICUS and was nominated as the Editor for Arabic section ('68-'69).



khalid tabbara — m.d.

Married and with a son, Dr. Tabbara has joined the faculty staff at AUH as a self-supporting full-timer with the status of Assistant Professor in the Department of Ophthalmology. He has many clinical research projects in mind and has begun working with full vigor on some of these. Amongst his projects are:

- **Use of 7-chloro-dioxy Lincomycin in the treatment of Ocular toxoplasmosis in Lebanon.**
- **Effect of systemic steroids and other immunosuppressive agents in patients with Sjögren's syndrome (in collaboration with Dr. F. Frayha).**
- **Eye findings in progressive systemic sclerosis (in collaboration with Dr. Frayha).**
- **Lymphocytic transformation test in the presence of uveal antigen in Behçet's disease (in collaboration with Drs. R. Frayha and Geha).**

In addition, Dr. Tabbara is also attempting to establish a microbiology lab in Eye-OPD to study eye-scrappings and eye-cultures.

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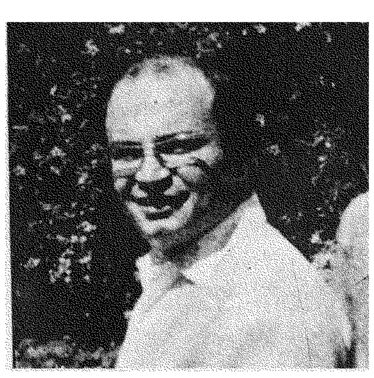
Dr. NABIL KRONFUL, M.D.

A candidate for D.P.H. at Harvard University, Dept. of Health Services and Maternal & Child Health, Dr. Nabil Kronful has recently joined the Dept. of Health Services Administration as an Assistant Professor. His doctorate thesis will be on «The supply and demand of medical manpower in Lebanon» for which he meticulously traced all our medical graduates currently residing in U.S.A. As he puts it, the problem of «brain-drain» is appalling as far as Lebanon is concerned—Lebanon is the 4th largest supplier of M.D.s to U.S.A. (after Korea, Philippines and Iran, in order). To illustrate his point, he stated that in 1970, Lebanon produced 84 M.D.s (AUB and FFM, of which 53 permanently left Lebanon as emigrants! Having had been in close contact with many of our medical alumni in U.S.A. and having studied this problem from all points of view, Dr. Kronful is of the conviction that the basic fault lies both in the present system of health planning and in health education. Many of our graduates are aspiring to return to Lebanon but they lack the right opportunity and adequate support.



Dr. Kronful, who as a student played a very active role in various M.S.S. committees and for a year was the M.S.S. President, was born in Beirut on August 1, 1944. After his Bacc. II, which he obtained with distinction, he joined AUB as a sophomore pre-medic in 1962 and in 1964 entered the school of medicine. In 1965 he was awarded his B.S. with distinction and in 1969, he graduated from the School of Medicine with M.D., following which he did two years of Residency training in the Department of Pediatrics at AUH. He then did two more years of Residency training at the Children's Hospital in Boston. In 1973, he was awarded his M.P.H. by the School of Public Health at Harvard University.

His publications are:

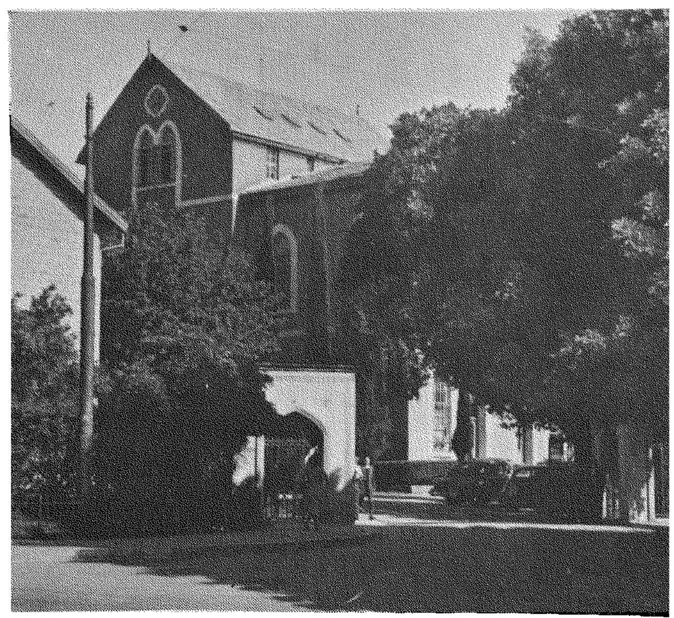
Books: «Dealing with sick kids—A manual for mothers.» 1974. (In press).

Journals: 1. Recurrent hydatiform moles, Leb. Med. J., Nov. 1968.

2. Leprechannism—Amer. J. Dis. Child., Nov. 1971 (Der Kaloustian, Kronful, Khazen, Sinno).

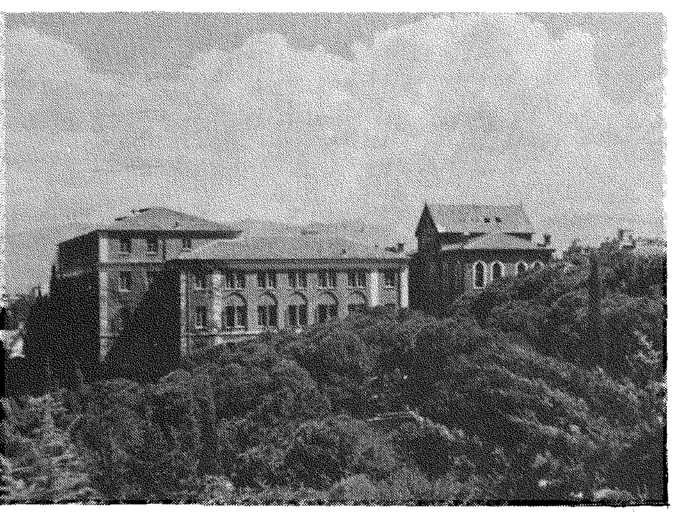
3. Tuberculous meningitis—Idriss, Z., Kronful (in press).

Thesis: «The Supply and demand of medical manpower in Lebanon.» (In preparation).



As soon as the school had established its own hospital, a Nurses' training school was established in 1905 and its first superintendent and nurse supervisor was no other than Mrs. Gerald Dale, the eldest daughter of President Bliss. She was superbly qualified to take this position and besides the excellent administrative abilites she possessed like her father, she could write and speak fluently Arabic, French, Turkish, German and English. (Mrs. Dale passed away in 1930 at the age of 75 years).

Although it had been debated as early as in 1901, it was not until after World War I, with the French occupation of Syria, did the Trustees vote unanimously to change the name of the institution to the American University of Beirut. Formal application was made to the Board of Regents of the University of State of New York for amendment, which was finally granted on November 18, 1920. The establishment of French control over Syria, however, posed a serious problem to the medical school—the French Department of Public Instruction forced upon the school, a revision of curriculum, the principal change being the establishment of a fifth year of medical training to provide clinical and practical hospital experience. The school could not possibly cope with this requirement for it lacked hospital facilities, including up-to-date lab equipment and



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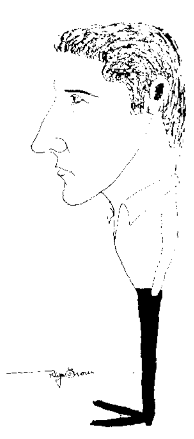
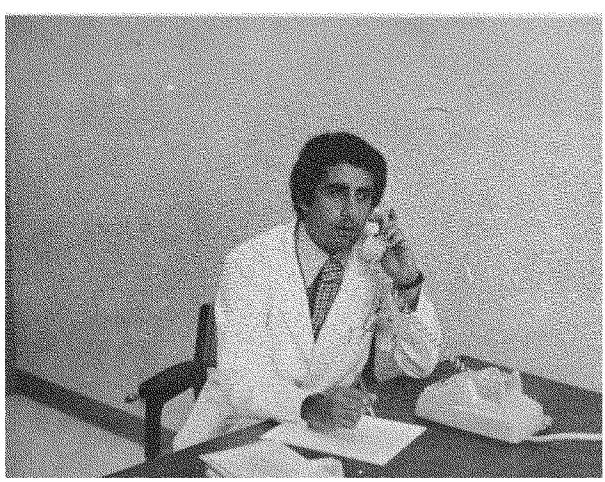
DR. RIDA FRAYHA, M.D.

Serious and full of enthusiasm, Dr. Frayha, who has recently joined AUH as *a self-supporting full-timer* with a status of Assistant Professor of Medicine (Rheumatology) explained how Connective Tissue diseases have come to gain a frontier position in Medicine. His interest in this field of medicine dates back to the time he was a resident in the Internal Medicine Department and even earlier. During those times, he came up with various publications ranging from specific disease entities such as Juvenile Ankylosing Spondylitis to Sweet's Syndrome.





Born in Beirut in February 1944, he finished his secondary education at I.C. before joining AUB as a sophomore pre-medic in 1962. He entered AUB dical school in 1964, obtained his B.S. in 1965 and finished his M.D. in 1969. He next did his Residency program at AUH in the Department of Internal Medicine from 1969-72. On completion, he joined the Division of Connective Tissue in the Department of Medicine at Johns Hopkins as a post-doctoral fellow. That year, he was also the physician of the University Health Service. The following year, 1973-74, he continued as a *post-doctoral fellow at Johns Hopkins* and was also the Chief Resident of Rheumatology at Good Samaritan Hospital, Baltimore.

Although work facilities are far superior in USA and although living standards are higher there also, Dr. Frayha elected to come back to the land of Cedars to b eamongst his people. Talking of Rheumatology, he feels that it is grossly underestimated in this part of the world, and is recognized only as the knowledge of «pains and aches.» Connective Tissue diseases engulf a wide variety of medical disciplines- **infact** the current saying is, «If you know LUPUS, you know your medicine.» Thus his primary mission here at AUH is to impress the importance of this specialty. Currently there are merely 1 full-timer and 2 part-timers devoted to teaching it, and thus he will have to shoulder heavy responsibilities.

Dr. Frayha has many plans and projects. Amongst the ones which head his list are:

— **Group all C.T. diseases and Auto-immune diseases into a single clinic at Medicine OPD.**

— **Set up a formal program for the teaching of C.T. diseases.**

— **To study the Familial Mediterranean Fever in greater detail, along with Dr. Geha.**

— **To study, along With Dr. K. Tabbara, the effect of systemic steroids and other immuno-suppressive agents in patients with Sjögren's syndrome.**

— **To conduct a double-blind study to elicit therapeutic efficacy of the agent MK 231 in Rheumatoid Arthritis.**

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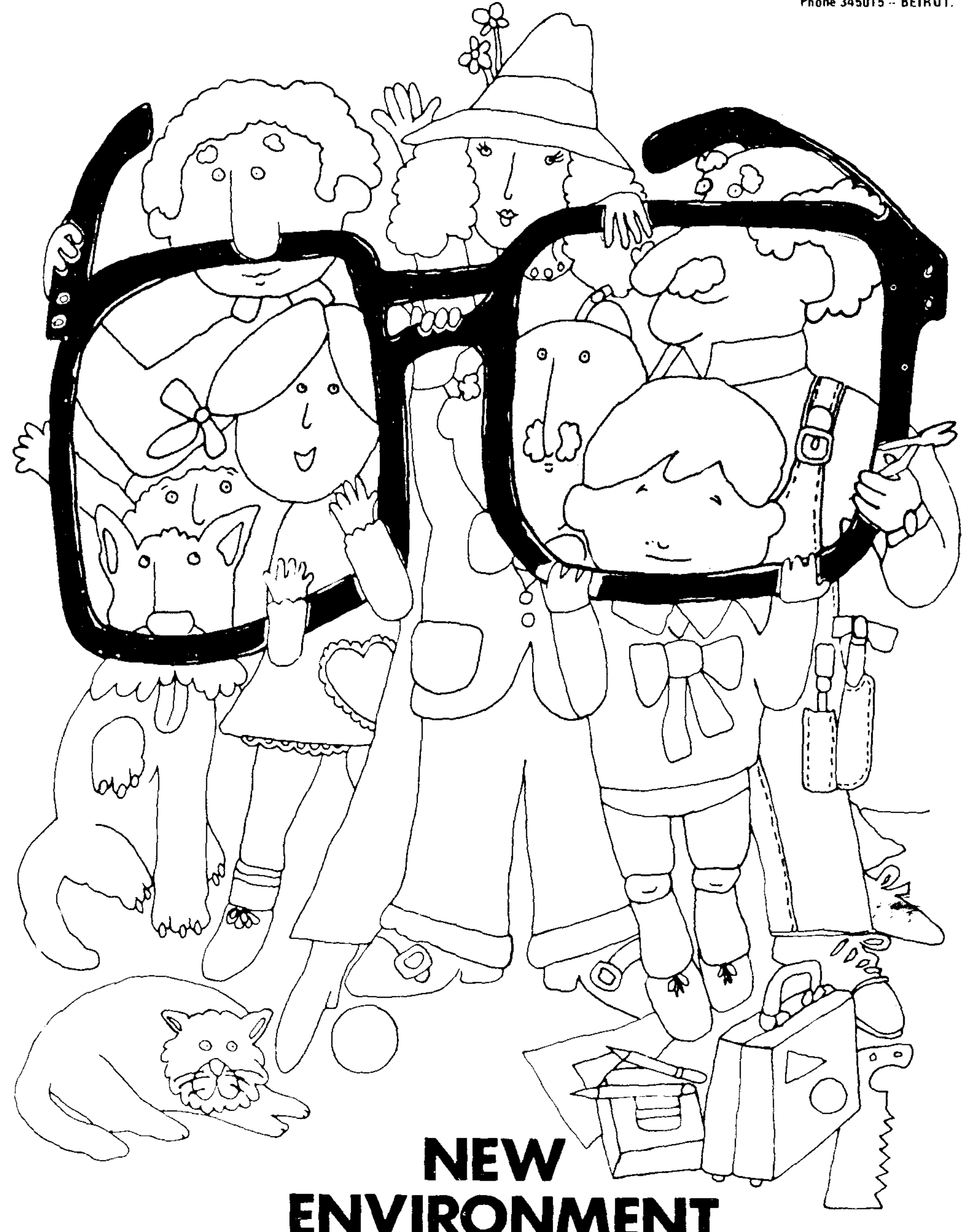

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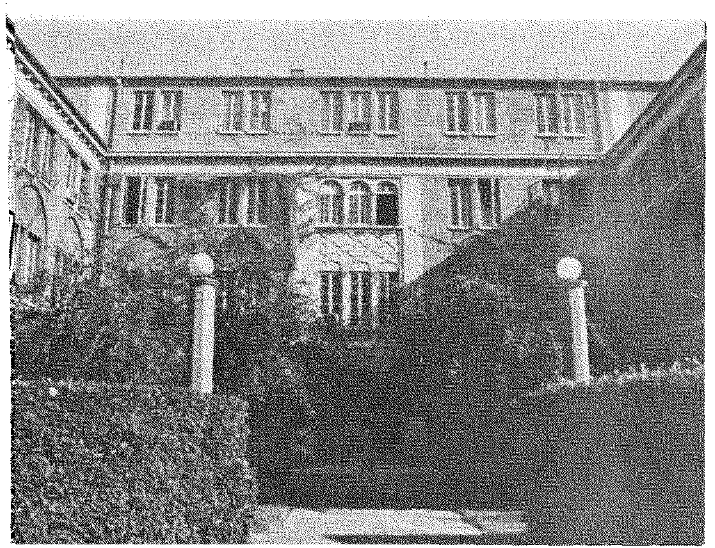

adequate staff. The problem was temporarily solved by sending fifth year students to the University of Montpellier and Lyons. Looking at it from another angle, this was perhaps a blessing in disguise, for the necessary expansion forced the school to seek out new sources of finances.— Amongst others, Rockfellars were approached, who dispatched Dr. Victor Heiser to Beirut in 1921 and again in 1922 to evaluate the situation. What Dr. Heiser saw, immensely impressed him and thus henceforth, finances from the Rockefellar Foundation were readily available. In all, from 1924 to 1931, 3 separate grants were made, of $125,000, $1.0 million and $450,000. These appropriations made possible, a complete re-orgaization of all the departments. Plus, a new medical library, a new medical sciences building and several wings to the hospital were built. With this, pre-requisites for entering medical school were stepped up and thus from October 1935, it has become necessary to accomplish 3 years of collegiate training (Freshman- Junior) to be eligible for selection.

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THE CHANGING CURRICULUM

In earlier days, there may have been a common intuitive understanding of what a physician was and what he did. With the marked advances in medicine and the associated complexity and fragmentation into specialties, any common understanding has become blurred. As a result, there is a growing tendency among medical educators to adopt integrated systems of teaching for medical students. These systems aim at studying Man as a meaningful whole, emphasizing the interaction of Man and his environment and bringing out relationships and interactions of various parts that constitute the whole.

Having this in mind, some members of the Medical Faculty assisted by students have set forth on a campaign of changing the present curriculum in a manner that will offer both students and faculty the chance of transcending departmental boundaries. The first change was introduced in 1966 when there was a shift from the conventional subject-approach to the integrated or broad fields-approach of medical education. Consequently, the all-familiar second semester (Med. I) system evolved with its five integrated courses on Cardiovascular system, Nervous system, Homeostasis, Metabolism and Social and Preventive medicine. All this was to be followed by 10 hours of integrated review. However, what this system lacks is clinical correlation material, that is presented weekly and in seminars, which will enable the students to correlate the normal with the clinical condition.

This year with the approaching date for inauguration of Phase III, the committee has decided to press for a number of new changes that will not only affect the pre-clinical years but will also include the clinical students. For one, it is proposed to have a basic clinical clerkship whose objectives is to provide the student with a core of basic clinical skills before starting with different clinical clerkships. The duration of this clerkship would be 4 weeks before the beginning of Med. III. The participating departments will be Internal Medicine, Clinical Pathology, Surgery and Pediatrics. The students will be taught the techniques of taking medical histories, doing physical examinations, in addition to being taught the clinical skills both at the bedside and in the laboratories.

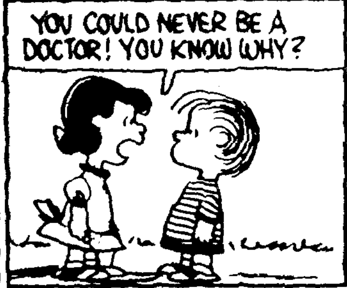
As for th etwo clinical years, the trend lies in treating them as a single curricular unit with no recurring clerkships. The inpatient and outpatient classification will also be discarded. There would be a clinical science core that would provide the student with a minimum body of knowledge and skills which are essential for the M.D., leaving adequate time for the pursuit of personal interests in the field of medicine. Thus the shift would be from the general to the particular as a student is promoted from Med. III to Med. IV. This would encourage integration, correlation and the interdepartmental approach to instruction.

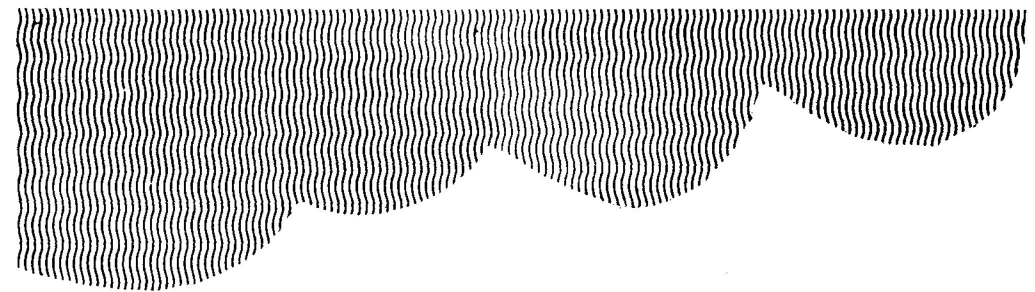
The committee proposes having Med. III students pass thru the major departments of OBS-GYN, Pediatrics, Medicine and Surgery which would give a student the clinical exposure necessary in choosing his field of specialization. Both inpatients and outpatients will be examined. The IV year will be run on an integrated basis whereby the subject matter will be divided into 4 categories: Metabolism, Cardiovascular-Pulmonary, Infectious Diseases & Public Health, and Neuropsychiatry. The students will be exposed to the departments of Internal Medicine, Pediatrics, Surgery, plus any other department they will select within each category. However, room will also be made for the departments of anesthesia, ophthalmology and ENT thru which each student will be obliged to pass.

The committee is also considering the combined M.D.-Ph.D. program with the objective of training highly qualified number of students for a professional career in the basic and clinical sciences. Concurrent work will naturally allow an economization on time, and the combined program will be completed in a shorter period of time (approximately 6-7 years) than would generally be required to earn the M.D. and Ph.D. degrees separately.

Also under consideration is the incorporation of a combined M.D.-M.P.H. training program, whereby the medical students, following the completion of their first two years in the School of Medicine, will take off one year to work in the Department of Public Health for their M.P.H. This program is obviously designed to train physicians to become capable of planning and evaluating health care.

No definite date has as yet been set to put all these laudable programs into action. But let us all brace up for an exciting future.





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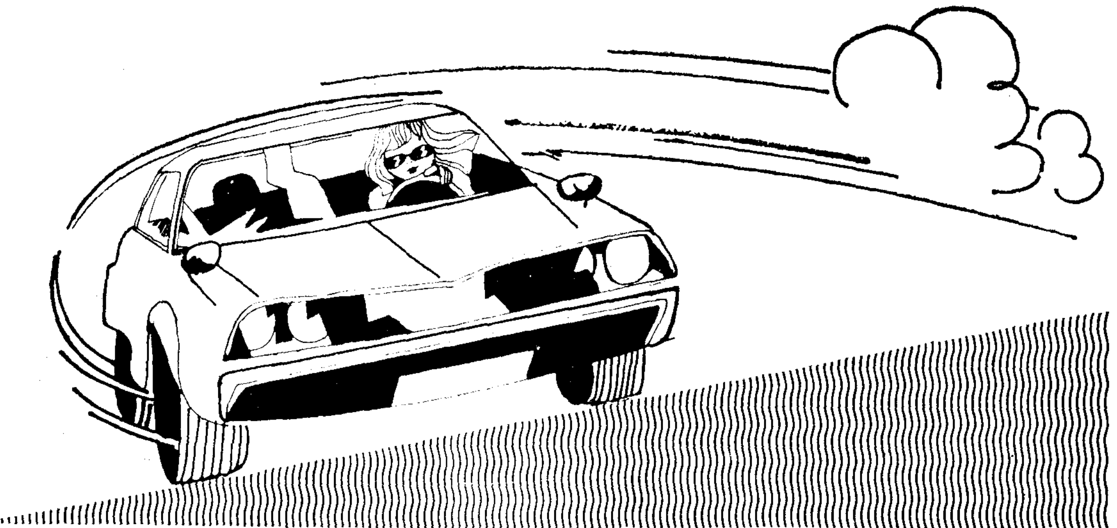

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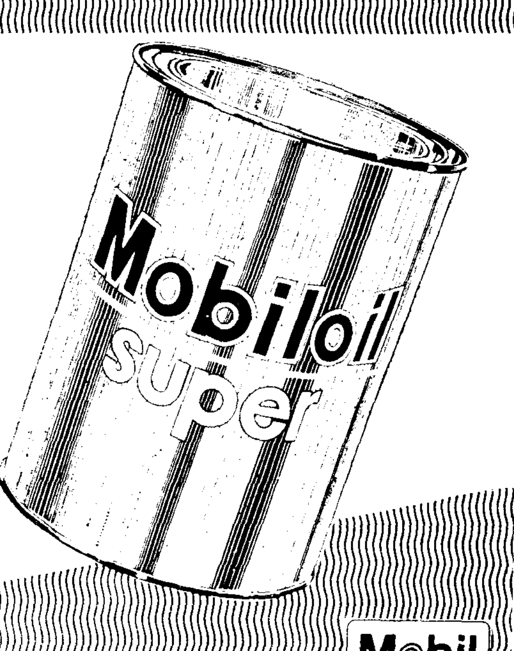

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NEW MEDICAL CENTER

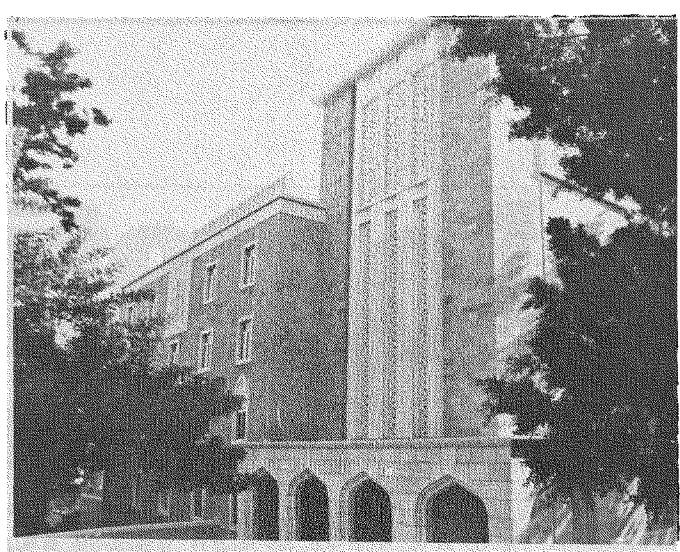
With the inauguration of Phase II of the NMC on 28th June 1970, Lebanon and the Middle East acquired one of the most modern and sophisticated health centers, comparable in standards and quality of health care with similar hospitals in Western Europe and U.S.A.

NMC, which has been financed by AID (total cost will amount to U.S. $30.6 M), will consist of 3 phases when finally completed. The fundamental design was the work of Haines Lundberh and Waehler, while the construction drawing was done by Dar el-Handasah. Plan to construct these stuctures dates back to 1959 when a proposal to this effect was presented to our Board of Trustees. By May 1963, ground was already set for the constuction site and by 1967, Phase I was completed. Phase I includes research and clinical teaching buildings, OPD, ER, Private Clinics, Physiotherapy, X-Ray and Lab Research section. Construction of Phase II, which is the 440-bed hospital physically connected to Phase I, was started in 1966 and by June 1970, all the patients from the old hospital were shifted to it. Finally, the work on Phase III began in October 1970; Phase III includes a new Medical Science building for departments of Anatomy, Histology, Physiology, Biochemistry and Pharmacology, a new Medical Library with a capacity for 100,000 volumes and 1,600 periodicals, and a Postgraduate Medical Education building where refresher and postgraduate courses will be offered and this will have a 470-seat auditorium with Audio-visual facilities. Phase III will also include a surface and underground parking for 650 automobiles. Since the new Medical Science building is located in the main AUB campus, it will be connected to the rest of the Center by an underground tunnel passing under Bliss Street. As for the old Medical building (which was constructed in 1872 and is the oldest medical school building east of Suez in the Middle East), it will be renovated to house the Administrative Offices of the Faculty of Medical Science.

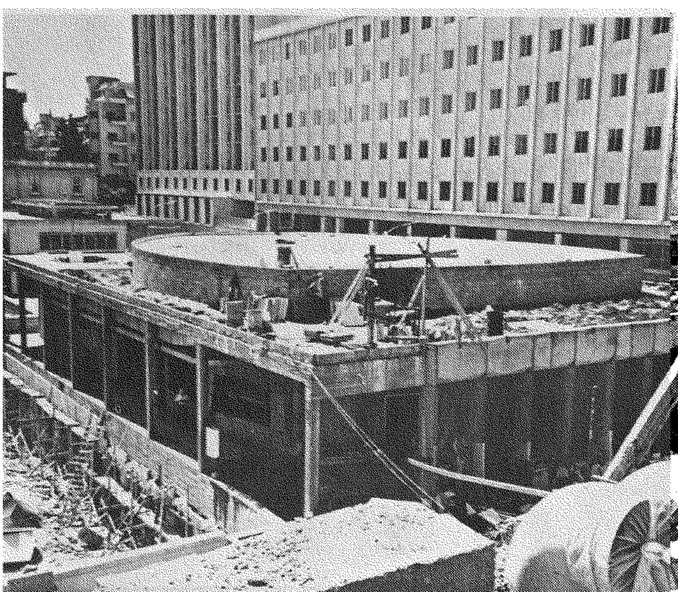
Here are some of the highlights of the NMC:

* **AUH is a member of the American Hospital Association (AHA), Association of American Medical College and the Joint Commission on Hospital Accredition (JCHA), which accredits AUH every 2 years. Only 2 other hospitals besides AUH, and outside USA are similarly accredited: American Hospital at Paris (accredited by AHA) and Aramco Hospital (accredited by JCHA).**
* **Currently there are 407 beds being used of which 40% are for ward patients.**
* **There are approximately 1,000 employees, 120 nurses, 90 residents and 153 part-time and full-time physicians.**
* **During the year 1973-74, 16,200 patients were admitted to AUH with an average stay of 8.4 days/patient. Also there were 4,300 ambulatory pt/month at OPD and 4,500 pt/month at ER. (In comparison, 1967 saw 9,000 patients being admitted with 4,160 pt/month at OPD and 2,100 pt/month at ER).**
* **The Center is also, of course, equipped with an independent power source: a 380 kilowatt generator which automatically takes over in case the city power fails.**

** (MEDICUS wishes to thank Mr. Edgee, the Director of A.U.H. for the information he provided)



The school has gone a long way since those early days when there were 3 professors and 6 students. This academic year, 63 new students entered the school of medicine—the largest ever. We now also have a well trained and dedicated faculty comprising of 153 part-time and full-time physicians distributed amongst 15 separate departments (see box). But most of all, a sophisticated well equipped New Medical Center has been added to the ever burgeoning medical school. The new center consists of 3 phases and when finally completed, will cost U.S. $30.6 M (financed by AID). Phase I, which includes OPD, Private Clinics, ER, and X-Ray departments was begun in 1963 and completed in 1967. Phase II, the 440-bed hospital, was completed in June 1970. Phase III, which includes the new Medical Science Building, a Medical Library, Underground Parking and a Postgraduate Training Center, is currently on the verge of completion. It is the changing concept of medicine which has necessitated the construction of such a complex. Physician today, is a part of a highly specialized team and although he may still be the prime-mover, his medicine is seriously compromised in the absence of trained personnel. Modern hospitals, besides physicians, nurses and orderlies, need dietitians, X-Ray technicians, Lab technicians, cafetaria supervisors, house-keepers, plant engineers and scores of other trained people. Thus,



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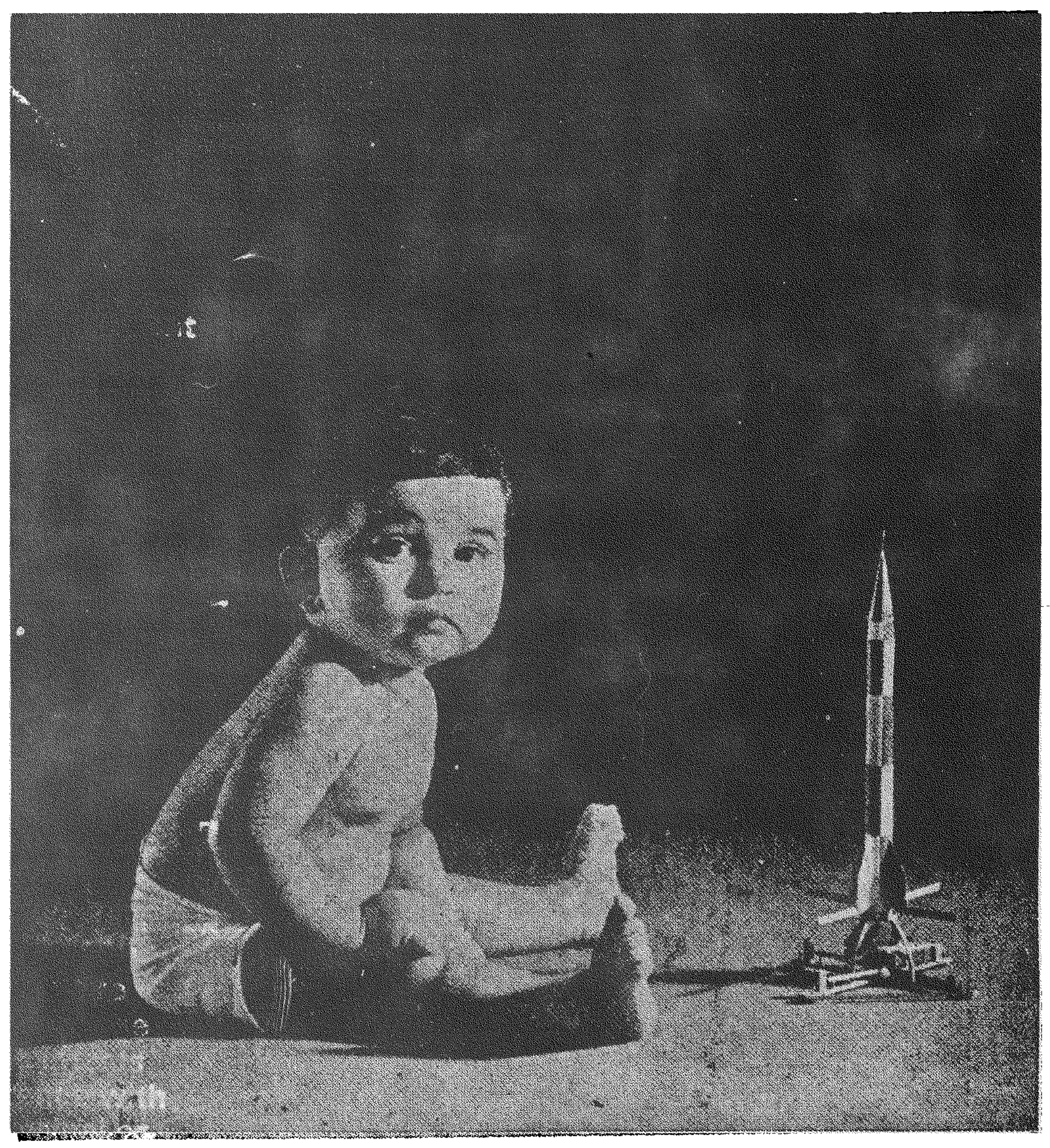
   plus 7 staff members
2. **Dept. of Bacteriology and Virology**
   Chairman: Dr. Garabed Garabian
   plus 4 staff members
3. **Dept. of Biochemistry**
   Chairman: Dr. Usama Khalidi (acting)
   plus 4 staff members
4. **Dept. of Clinical Pathology**
   Chairman: Dr. Samih Alami
   plus 5 staff members
5. **Dept. of Human Morphology**
   Chairman: Dr. Adel Afifi
   plus 5 staff members
6. **Dept. of Internal Medicine**
   Chairman: Dr. Riad Tabbara
   plus 57 staff members
7. **Dept. of OB-GYN**
   Chairman: Dr. Samir Hajj
   plus 14 staff members
8. **Dept. of Ophthalmology**
   Chairman: Dr. Camille Matta
   plus 7 staff members
9. **Dept. of Otorhinolaryngology**
   Chairman: Dr. Salah Salman
   plus 4 staff members

10. **Dept. of Pathology**
    Chairman: Dr. Victor Nassar (acting)
    plus 5 staff members
11. **Dept. of Pediatrics**
    Chairman: Dr. Samir Najjar
    plus 19 staff members
12. **Dept. of Pharmacology**
    Chairman: Dr. George Fawaz
    plus 4 staff members
13. **Dept. of Physiology**
    Chairman: Dr. Raja Khoury
    plus 7 staff members
14. **Dept. of Roentgenology**
    Chairman: Dr. Raffic Melhem
    plus 7 staff members
15. **Dept. of Surgery**
    Chairman: Dr. Ibrahim Dagher (acting)
    plus 3 staff members

* In addition, there is a Nutrition Lab whose director is Dr. Donald McLaren who is assisted by 3 staff members.
* Four new chairmen took office as of September 1974. They are:
  — Dr. A. Baraka: Anesthesiology
  — Dr. S. Alami: Clinical Pathology
  — Dr. S. Hajj: OB-GYN
  — Dr. S. Salman: Otorhinolaryngology



Il aura 26 ans en l'an 2000...
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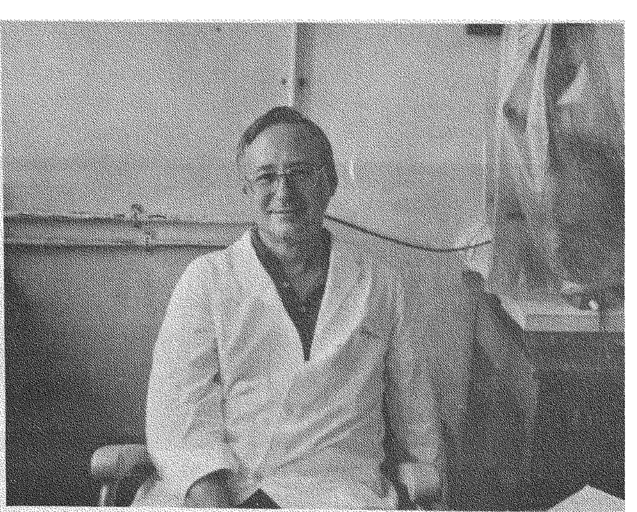
AUH has become a city within a city. Besides its teaching departments, it has 27 separate service departments, some of which are larger than «outside» business. For instance, AUH has its own laundry which can process more than 800,000 kilograms of laundry a year. The kitchen, which prepares food for both patients and employees, served 675,601 meals last year! Patients' comfort has also been thought of and now they are accommodated in air-conditioned rooms with the convenience of piped oxygen, vacuum and a two-way intercom nurses' call system. The hospital also includes an electronic coronary care unit, kidney dialysis unit and improved open heart surgery facilities.

AUB medical school may be playing a magnanimous role in training physicians and allied health personnel, but the question to be posed is whether it is giving the right sort of training? And whether it is training the right sort of people? In 1970, Lebanon produced 84 M.D.s (31 AUB and 53 FFM) of which 53 permanently left Lebanon as emigrants! Infact, Lebanon is the 4th largest exporter of M.D.s to U.S.A. (after Korea, Phillipines and Iran). Are we training physicians who can only provide care for the seriously ill in hospitals staffed and equipped in a manner found in U.S.A. or in a center like ours? Recently, Dr. Rida Frayha joined the Department of Internal Medicine as an Assistant Professor in the division of Rheumatology (see box). In an interview with MEDICUS, Dr. Frayha stated that he would have most definitely given a second thought to the idea of coming back to Lebanon if he had not been offered an opennig at AUH, although he felt alienated in U.S.A.! Many of our young physicians, after their specialty training, have found it very difficult to integrate into the «health market» which they claim is saturated. Infact, some of them have even seriously contemplated going back to U.S.A. Lebanon has a population per physician ratio of 1,100 compared to 13,000 of Saudi Arabia, 4,800 of Jordan and 35,000 of Tunisia (from Demographic Year Book 1964, a United Nations Publication). If therefore, Lebanon is experiencing «Brain Overflow» rather than «Brain Drain», shouldn't AUB medical school curtail the number of Lebanese students entering as Medicine I, prefering Saudis, Tunisians, Jordanians and other Arab nationals, to them? For, after all, AUB's policy is to serve the entire region and not merely Lebanon!

To survive and to play a meaningful role, the school will need to relate closely and responsively to the society it serves. In this context, it is gratifying to note that the school has recently drawn up a contract with the Saudi government to provide training to 40 medical department employees in hospital and health care administration. (The old Dale Home has been vacated of nurses and is currently being renovated to accommodate the Saudis). Major curriculum changes are also in the offing and an emphasis on Public Health training with the creation of an M.D.-M.P.H. program is anticipated (see box).

The school has indeed gone a long way, but the end is by no means near. Medicine is a dynamic process and as such, newer horizons merely replace the fading ones. With the courage and zeal for perfection inherited from the founding fathers, the school has relentlessly made an effort to keep abreast with the changing times and in many ways, it has admirably succeeded!



DR. RONALD A. BERGMAN, Ph.D.

Joining AUB medical school as a professor in the Dept. of Human Morphology, Dr. Ronald A. Bergman has brought with him a vast experience of teaching in varied fields. For instance, he has taught cellular physiology, elementary and advanced mammalian physiology, histology, gross-anatomy, neuroanatomy, etc...

Born in June 1927 at Chicago, Illinois, Dr. Bergman obtained his B.S. from University of Illinois in 1950. He continued his postgraduate studies and completed M.S. and finally Ph.D. in 1955 (major: Physiology, Zoology and Analytical Chemistry). He next spent one year at Stockholm's Karolinska Institute as a NFIP fellow in 1955, following which he became an Instructor in the Dept. of Epidemiology at Johns Hopkins University, School of Hygiene and Public Health. In 1957 he joined the Dept. of Anatomy at Johns Hopkins University School of Medicine as a Research Associate and two years later he was promoted to the post of Assistant Professor and finally Associate Prof. in 1968.

Besides his teaching career, Dr. Bergman has also been on various committees and councils at the Johns Hopkins School of Medicine — Admission Committee (1970-75), The Johns Hopkins Medical School Council (1970-72), The Provost's Advisory Council (1972-73), etc... He is also a member of American Association of Anatomists (1961), American Society of Cell Biology (1963), Electron Microscopy Society of America (1954) and Sigma Xi (1954).

Charming and eloquent, Dr. Bergman has resumed heavy responsibility as the only full-timer to teach gross anatomy to Med. I students. Amongst his plans are:

1. to revise radically, the Anatomy lab. manual.
2. to promote closer contact between students and staff.
3. to decrease number of didactic lectures and to make students devote a greater part of their time with cadavers.

Dr. Bergman, who is the author of over 40 original articles and participant in many national and international conferences, is married and has 4 children who have all joined school here in Beirut. MEDICUS warmly welcomes Dr. Bergman and his family and hopes they will have a memorable stay.

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INTERVIEW WITH
OMAR SHARIF

Omar Sharif, the well-known Egyptian movie-star who made his big break-thru on the Western screen with his capturing role in «LAWRENCE OF ARABIA», was back in the Lebanese capital this month. This time again, it was bridge that had brought him here; at least officially, he had come to participate in the International Bridge Tournament held at the Holiday Inn.

For our Feature Article on Homosexuality, MEDICUS had sought the comments of various people in different walks of life. Here was another candidate to be interviewed new. Beyond the mere curiousity of interviewing a man of his stature, we found it equally appropriate to hear the views of a masculine figure whose preoccupation with members of the opposite sex has made headlines. To hear then of what a committed heterosexual had to say about homosexuals, MEDICUS arranged to meet Omar just on the eve of his departure, at the farewell Gala dinner organized by the Lebanese Bridge Federation.

It was past midnight by the time the prizes for the winners had been distributed. Omar had once again taken the best and the biggest number of trophies. With his confidence enormously boosted now, he met the Editor and the Social Program Coordinator, Ms. Najwa Najjar, by the pool-side of the Holiday Inn Hotel.

Omar seemed to like the idea of being interviewed by medical students. It was quite a change, he confided thru a close friend of his. Professional journalists usually distorted his statements; this time he appeared less worried though. He reminded us how terrible journalists are. But certain that he would never be able to read what we wrote in MEDICUS, we felt reassured that he would never find out how terrible we'd prove. Or maybe, how good! Suddendy the fabulous, over-powering hero on the screen was talking live-just in front of us. Omar did not prove as handsome as one would have expected. Still his personality was impressive, and captivating. And above all, he was friendly. Our questions could no longer be confined to homosexuality alone.

Below, some excerpts from the interview:

MEDICUS : What do you think of a homosexual?

Omar Sharif : Nothing.

M : Please elaborate.

OS : Everything is alright with him. There's nothing right or wrong.

M : Omar, we came to hear more, please!

OS : There's nothing wrong with anything so long as you are not disturbing your neighbour.

M : How does the oriental society look at him?

OS : In the orient he is looked upon as a person not to be looked upon.

M : As a highly socialized person—almost addicted to women—can you conceive yourself having a fulfilling relationship with a member of the same sex?

OS : Well, in females I do look for an intellectual companionship and it's possible to find this in men too. But I have both men and women as friends. Although sexual companionship is necessary, yet I like a female friend for the tenderness and affection that she gives and vice versa.

M : How do you rate doctors as social beings?

OS : I don't classify people by nationality, religion and similarly, nor by profession. I don't think of them as doctors. People are people. But doctors are more busy than people in other professions, and they have duties that cannot be avoided. Doctors are busy and tired, unless they are successful.

M : Have you had any encounters with doctors?

OS : Not on a professional level—but social encounters, yes!

M : Why do you play bridge, Omar?

OS : It is a hobby.

M : A hobby or an obsession?

OS : No, obsession is a strong word! Obsession is the extreme of a hobby. I am simply passionate about bridge.

M : If psychiatrists were to look at it, could they say it's a compensation for something?

OS : Psychiatrists are mad people, and it's normal for them not to be normal. I don't believe in analyzing what you do—and you don't start talking in terms of a mother's image or things like that (a reference to certain explorations that have been ventured sometimes to explain his preoccupation with women.)

M : Do you know of any doctor who is a good bridge player?

OS : It's incompatible to be a doctor and a good bridge player. I knew of doctors who were good bridge players, but then they stopped being doctors.

* * *

All along, Omar Sharif had been extremely friendly; and elegant, graceful and immensely masculine. We had already decided by now what we thought of him. Suddenly, Najwa who had till now been taking down notes for the interview, dropped her pen and almost gave away the signs of a certain overpowering need to know what Omar thought of her in turn! ! !

Najwa : What do you think of female doctors?

(the question drew a smile and he already seemed to have decided on the answer).

Omar : Well, actually I would like to be treated by a female doctor, provided she has good bedside manners.

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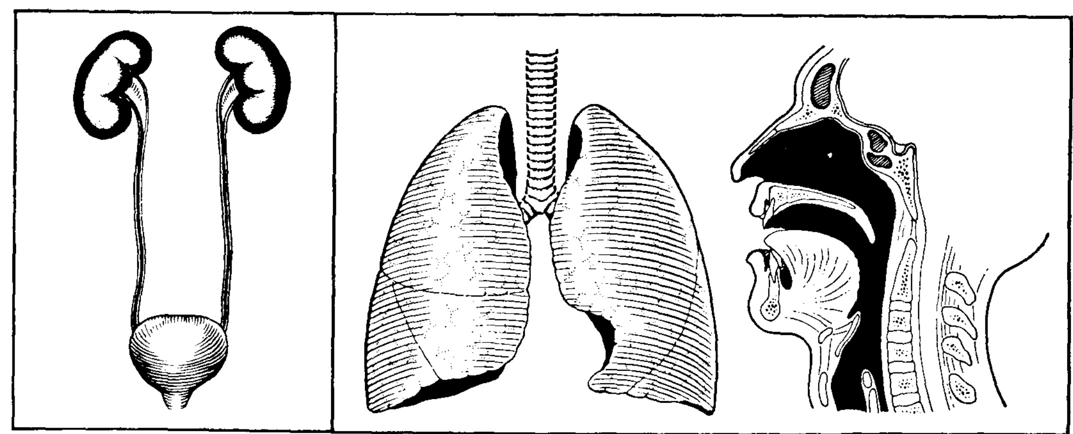

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BABINSKY SIGN

The life and work of Joseph François Felix Babinsky (1857-1932) provide a striking illustration of the fact that research need not be confined to the laboratory. Many of the really great discoveries in medicine have been made by those rare spirits who possess the seeing eye, and having seen, demand of themselves the explanation of a phenomena that they, in common with their contemporaries and those who have been gone before, have witnessed time and again at the bedside or in the consulting room. So it was with Babinsky. Extension of the great toe in the pyramidal disease had always existed, but its significance was not understood until Babinsky explained how it occured.

The son of a polish emigrant, Joseph Babinsky was born in Paris, and the whole of his life was spent in France. He graduated with an M.D. in Paris in 1885. Babinsky commenced publishing valuable papers on a variety of medical subjects when he was a medical student; from 1883 until almost the end of his life he contributed three or four articles to medical journals every year.

Babinsky was a disciple of great Charcot (the famous French psychiatrist, who among other things described the peculiar osteo-arthritis associated with diseases of nervous system, particularly tabes dorsalis, now known as 'Charcot's joints'), and he eventually became the chief of his clinic. In 1890 Babinsky was appointed Médecin des Hôpitaux, and soon after the death of Charcot in 1893, he became the head of the neurologic clinic at the Pitié, one of the largest of Paris hospitals. Here he followed in the tradition of his celebrated master by holding clinical lecture-demonstrations that drew a host of undergraduate and postgraduate students.

Babinsky first described his famous sign in 1896. It was a simple statement that the normal plantar response consists of flexion of the toes, and that in certain cases of organic diseases of CNS a similar stimulus evoked not a flexor, but an extensor response; the toes on the affected side, instead of flexing when the sole is stimulated, execute an extensor movement on the metatarsals. Two years later, he gave a full account of this phenomena in La Semaine des Hôpitaux, a weekly journal. Despite the passage of time, little or nothing has been added to this classical description.

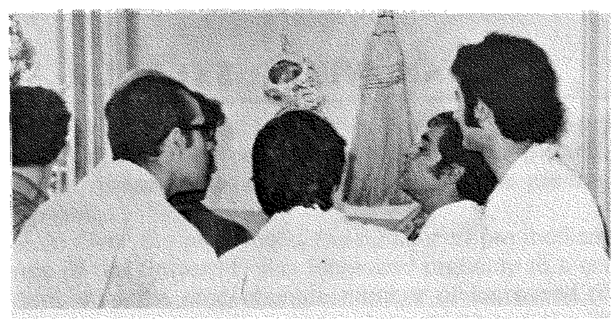
Babinsky died at his home in Paris at the age of 75 years. Surveying his work as well as his character, it would probably be correct to say that Babinsky possessed neither the brilliance, nor the striking personality, and neither the theatrical flair nor the fluency of his master, Charcot; but he was more logical and his observations were more detailed and searching.

THE 108th CLASS BEGINS

«It seems to me to be a very hard year,» complained a first year medical student. After having had two weeks of classes, several students are starting to realize that awaiting us beyond the pre-medical program is not exactly a bowl of cherries. When we entered Van Dyke Thursday morning on October 3, we were all filled with a sense of exaltation, and a deep feeling of satisfaction. To us it was an achievement indeed to have crossed the deep waters of the pre-medical years; but only we were to find that we had reached deeper water, and that it was necessary to swim hard to keep abreast of this new current of learning.

However, Medicine does have its light moments. We are still new to Anatomy, but many of us can appreciate the skill our fellow classmates show in performing their dissection!

The number of nerves and vessels that have been cut with such ease has left us flabbergasted, and has left Dr. Bergman speechless! Surprisingly enough, most of the students interviewed have showed a preference for the Anatomy course, stating that to them it was the most interesting of the courses being taken. May be it has something to do with the smell of formalin: as bees are attracted to flowers, medical students are drawn to the Anatomy lab. Raffi Kaloustian said, «Anatomy to me is the most interesting, the most intensive and the most disgusting course in our program.» He was perhaps also reflecting the views of many others. The students were asked their opinion as to whether they considered the courses they were taking now relevant to their future work as doctors. Most of the students stated that they considered none of the courses irrelevant. Some of them said that they could not judge the relevance of the courses now, as it was too early to form an opinion; but these students retained full confidence in their superiors' ability in planning the program. One student is already finding application to his future work in Anatomy lab: Dr. Bergman was instructing us in the art of good dissection technique and to show his complete appreciation of Dr. Bergman's work, this student calmly took a piece of tissue paper and gently wiped Dr. Bergman's face and forehead!



Medicine is not easy. Not by a long shot. But no one will deny that it is extremely interesting. And as a class, I am sure we can agree with Aida Dajani (one of our fellow students) when she says: «For the first time in my life at A.U.B. I find the subjects interesting (except for a few pre-med. courses). It is hard, yes, but also challenging and stimulating. Perhaps the professors do expect a lot from us—but then it is difficult for them to do otherwise, since we have assumed a life long responsibility, and the medical field is so vast and we have so little time.»

JUMANA HIJAB & AISHA JASSAR
Medicine I

THOMAS COOK

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SAFARI EAST AFRICAN TOUR	20 Dec. - 05 Jan. '75
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FACING MEDICUS

(It was a year ago that Dr. Samuel Asper left Johns Hopkins, (where he was, among many other things, the Vice-President for Medical Affairs at the John Hopkins Hospital) to take up his position as our Dean of the Medical School .Dr. Asper was actually returning to Beirut, since he was already familiar with AUB—which he had first visited eleven years ago, as Visiting Professor.

Shortly after taking office, MEDICUS had interviewed Dr. Asper (vol. 12, No. 2, *Dec.-Jan. '74*); *he had indicated a number of plans and priorities then. One year is a long time during which much can happen. Much indeed did happen, but only as far as producing set backs. The October War, when moods, circumstances and orders of priorities became altered as attention also became shifted to a national scale. Then the campus strike, when once again any forward program of action had to be replaced with a preoccupation with crisis management. We appropriately begin this series of interviews, FACING MEDICUS, by turning to Dr. Asper. Primarily to mark a years' end in office, but this time MEDICUS decided to interview him much more widely than had been done last year. When Dr. Asper heard of our press deadlines, he kindly accepted to see us immediately the next day. For two hours, he talked to the MEDICUS editors—and we shot beyond the assigned appointment time, as he answered questions on practically everything affecting the school, the students, the faculty, the hospital and the patients as he talked of a «heritage of excellence» as well as hopes for yet further improvement. Below, some of the excerpts:

MEDICUS: *From Johns Hopkins to AUB! Dr. Asper,* people have wondered if it was an easy decision?

DR. ASPER: Yes, it was an easy decision. In the past I had not been able to accept the kind offer of President Kirkwood to come to AUB because of various commitments, not only to Hopkins but also to the American College of Physicians. After I finished the presidency of the College and after our daughters had grown and married, the decision was easy.

Q: People always begin with hopes, projects and programs—like we are doing in MEDICUS now. What about you?

A: At AUB, I saw a great opportunity. The old hospital and the medical school always had a great spirit; one of my major objectives in coming to AUB was to keep the hospital in a very close relationship to the medical school and to maintain the same kind of spirit within the new institution that it had long had in the old.

Q: Looking back at this one year you have had with us here, what comments would you have to make?

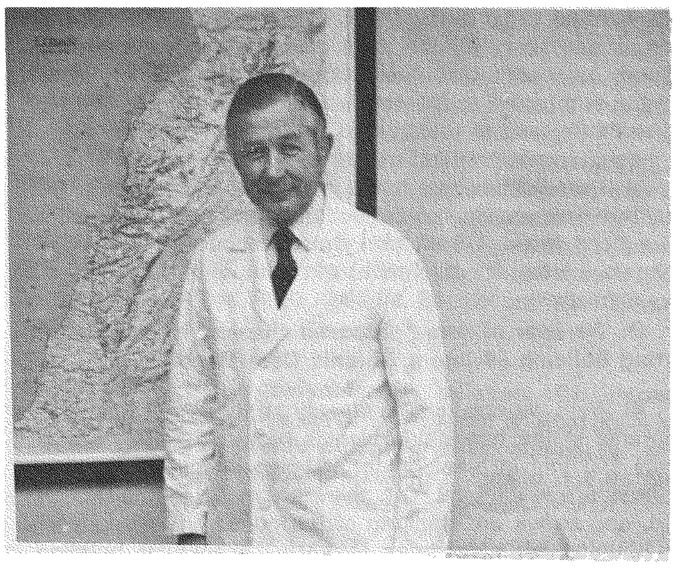
A: Well, of course some of the big plans I had in mind which I had been forming over a period of years before I came here were rapidly put aside by the war which began on 6th October 1973. But the year was not lost by any means. Even though it was a difficult year, I think it made everybody in the medical faculty and in the medical student body sit back and take a look at things and determine what their priorities are.

Q: Dr. Asper, according to you, what is it that gives an institution its special status?

A: Almost entirely the people who work in it—the individuals working together as a team. The interpersonal relationship that exists among the staff and the student body is what creates the spirit around the place along with the wish to do good work and to do this work not for personal gain but for the gain of humanity in general. I think this is what makes an institution great.

Q: What do you look for in a medical student?

A: Six major things, I think: intelligence, motivation, inquisitiveness, diligence, good manners and tidiness—tidiness of dress, tidiness of record-keeping, etc.; these are the things that make a good medical student and a good doctor as well.



Q: What we want to know is how do grades as yardsticks for academic performance fit into the picture; for after all, these are what count, at least in the pre-medical program?

A: Over the past years, the number of pre-medical students in the University has increased probably to a greater extent than the proportionate number of increased places in the medical school (roughly from 40-50 to 64). Thus a large number of students come to AUB with the major objectives of being admitted to the medical school. And so, over the past years, the general approach has been to accept students in the medical school completely on the basis of their academic achievements, with little consideration of the other factors which I have mentioned. Selection of students based solely on grades is, I think, not 100% fair, although steps have been taken on the campus to achieve a well defined and fair grading system. For instance, I find it very difficult to say that a student with a grade of 84.26 is better than a student with a grade of 84.24. One has to, therefore, look at some of these other factors when admitting students into medical school.

Q: Besides the anonymity of a foreign institution, what other factors make it difficult for our medical students to obtain acceptance abroad for post-graduate training?

A: Well, there are multiple factors playing a role here. In the recent years, there has been a very large influx of so-called Foreign Medical Graduates in the United States. Admittedly, not nearly so many from AUB and Middle East schools as from other schools such as those in the Phillipines and Taiwan. For these doctors, then, it is not merely a matter of seeking graduate medical education but it is a matter of immigrating to the United States. A good number of AUB graduates have emigrated and the United States is better off for it, because our graduates are good. But there is now in the US a move towards creating more medical schools and trying to solve the medical manpower needs. Many teaching hospitals are cutting down on the number of foreign graduates which they formerly accepted.

When I say that there is in the US a medical manpower lack, it is true generally, certainly in terms of general practitioners and certainly it is true in terms of location of physicians. But at the same time, there is an over-supply of other kinds of doctors, particularly neuro-surgeons and to some extent cardiac surgeons. So that for a graduate of AUB wanting to go to the US to study neuro-surgery, it has become necessary for the local government or some other agency to assure that the Doctor on completion of his training will return to his native country. These are some of the multiple factors that make it difficult to obtain places for post-graduate training in the US.

AUB medical school has a good training program and therefore you should not expect me to recommend you to institutions in the US which I think are inferior to AUB in their standards for this will limit your opportunities for advancement.

Q: We hear of some proposed changes here, like converting Building 56 into a Chronic Care Ward.

A: Well, we are looking closely at some of our clinical programs in the hospital, which is running at 90% occupancy and this is pleasing for it is an indication that our services are in demand. Yet, there are many things that we need, and so we are thinking of the possibility of converting Building 56, which was formerly a hospital building, back into a hospital. At first glance, this looks like a good idea, but one must take into consideration that the nursing school occupies the 1st and 2nd floor and that a lot of money was spent to build the school and to convert rooms on the upper floors into quarters for personnel. Thus in the long run, it would be simpler and perhaps less expensive to build new facilities which will allow us to meet more of our needs in clinical areas, such as Oncology Unit, Cardiovascular ward, Orthopedic ward and even a ward for Psychiatric patients, at least acute cases. In answer to your question, therefore, I doubt that Building 56 is gonig to be the answer to our problem.

Q: Dr. Asper, are you contemplating any major changes as far as teaching, research or patient-care is concerned?

A: As you may have heard, we have planned to expand our work in Allied Health Services. There is no doubt that in the Middle East at present, the greatest need is for persons who work with doctors: nurses, technicians, respiratory therapists, dietitians, admitting clerks and so forth. Such people are not sufficiently available here—for instance, in the Gulf States, there are sophisticated, well equipped hospitals lying idle for lack of trained personnel. Doctors should recognize the importance of Allied Health Services and should hold themselves responsible for the education of such people. AUB needs to develop a commanding role in the teaching of all kinds of hospital personnel. We have already signed a contract with Saudi Arabia whereby a group of 40 young students will be coming here for training. We are now making similar arrangements with Qatar.

Q: Different departments have different priorities; which department has required your greatest attention?

A: All have taken time—maybe Medicine department, by virtue of being the biggest department has taken more time. On the other hand, some non-existant departments, such as Psychiatry and Bio-medical Enginering have taken up some of my time as we try to figure out ways of getting money to start such departments.

Q: In implementing your different plans, does AUB offer any special difficulties that you didn't encounter at Johns Hopkins?

A: It's a difficult question to answer; the departments are almost the same, the patients same and the problems of students are not much different. On the other hand, the problems relating to the management of this institution are considerably different. Specifically there is a need at AUB for de-centralizing some of our operations as the medical school and the hospital keep expanding.

Q: Some feel that AUH is gradually becoming inaccessible to the poor. As Chief of Staff, how do you feel?

A: I don't believe it! No I don't think so! But be sure, I shall watch this point very closely. 40% of our patients are indigent patients, yet the standard of their care is the same. I recently had a chance to look at our charges and I find that our rates are very reasonable. We have got to have them so, because of the amount of money people have here. Take an example, at Johns Hopkins the cost per patient per day is US $164/- To convert to Lebanese pounds multiply this by 2.2, the current exchange rate. And now compare this with the cost of L.L. 55/- we charge for a semi-private room!

Q: This hospital is both a teaching and a treating institution. In assuming this double role, don't you think it is failing in both?

A: Failing in both? Oh no, I don't think so. A really good doctor looks at every patient as a challenge to him. The doctor who takes patients to the hospital and justs treats them in a routine fashion is only a technician; he is not a doctor for my book. AUB is a teaching hospital in that each doctor takes his patient as a challenge and in turn imparts what he learns to his fellow doctors, to the nurses and to the rest of the medical team. No, on the contrary, we excel in both fields. It is always comforting when someone like Dr. Henry Clay Frick, who is with us as visiting professor, from Columbia Presbyterian Hospital of New York, one of the best hospital in the US, finds the patient care here excellent.

Q: Dr. Asper, a special question on behalf of Medicine IV students—By over-loading Medicine IV students with

patients on Medicine Private Wing, don't you think the teaching potential of these cases is compromised?

A: I appreciate that question. In fact I was discussing it only recently with the Department of Internal Medicine. There are 2 sides to the question. On the one hand, I don't look on Medicine IV students as «acting interns»; that's an incorrect and unfortunate term. On the other hand, I do look upon them as very much part of the medical team. To give a fourth yearer the responsibility for immediate, moment to moment care—a role that an intern should have—is **WRONG!** And I hope we can correct it. About the sense of greater responsibility? At AUB, there seems to be, or at least there is said to be, the necessity of giving Med. IV students more to do than is fair, because of the large number of patients taken in. We shall resolve this. My own attitude is that Medicine IV students are Medicine IV students, that is their participation in patient management should be commensurate with their level of training. They should not be asked to do more nor should they be allowed to do less. They should not have a professional responsibility, unless that responsibility is very closely supervised.

Q: The ratio of the full-timers to part-timers can be taken as an index of the quality of a teaching institution. How does AUB medical school compare with the institution you have been affiliated in the past?

A: Do you think there is an ideal ratio?

Q: No, but there is some appropriate ratio that guarantees a certain quality of teaching.

A: Well, the ratio here is about what it is at Hopkins, a ratio I am familiar with. But who is a better teacher, a part-timer or a full-timer? **As a matter of fact, a part-timer who thinks that a teaching hospital exists only to accommodate his patients and that medical students serve only to take his patients' history and interns to follow his orders, does not merit an academic appointment.** He should be a teacher as much as a full-timer. I sincerely believe this is the spirit and attitude of our part-timers, who share the responsibility of teaching with our full-timers.

Q: Is it possible that we are not adequately trained for rural practice?

A: No. I don't think you would want to be any less trained as a doctor than you are being trained at AUB. It is difficult to make doctors do things that they don't like—they all want to practise in big cities.

Q: How much can AUB help a returning specialist in getting started?

A: An important question. A medical school can absorb only a limited number of its own graduates, approximately 5% from every class. Opportunities at AUB are definite and clear in areas where we need faculty but limited to the extent of our facilities and funds. But AUB should try to help its graduates get located and to find opportunities for them.

Q: How is the issue of expelled medical students being resolved?

A: Here I will talk personally. I don't look upon them as expelled. That's a wrong word to use; an unfortunate one too! I look upon it as the University saying 'we do not want to admit you as of the present time...' it's a matter then that's open for re-consideration at a future date. I personally worked long and hard with each of these affected students to try and see what they wanted to do and assist them in reaching their goals which they should achieve, if they are capable. In a year or two or even three, a new look at things can be taken.

Q: Ultimately, the issue of the M.D. at the end of the fourth year is a question of paid internship, perhaps. Any new developments here?

A: We made a step in this direction last year. AUB does have financial difficulty but on the Medical School and the Hospital side, the situation is not at all depressing. Our cup is not over-flowing but we are doing all right, and we are going to do even better. As an aside to your question, I'd like to point out that I was much impressed by the maturity of the Senior AUB pre-medical students—the students who had not been taken at the end of the Junior year by the Admissions committee. I think AUB has been rushing things much too fast as far as pre-medicine is concerned. It is a subject I hope to talk to the pre-medics about this year. I would prefer if the pre-meds took that Senior year rather than engage in a race-course to enter the Medical School.

Q: In what areas do you think our MSS should concentrate this year?

A: MSS should work with the heads of the departments and examine the role of Medicine IV students. It can work in close consultation with Dr. Raja Khuri and the Curriculum Committee. AUB students are a little too apprehensive about exams—perhaps, new ways for examination can be found. MSS can look at scholarships and continue to help needy students. I am already working with Zuhayr Hemadeh (MSS PRESIDENT) to locate the best opportunities here and in other Arab Middle East countries for our graduates.

Q: Talking of student-faculty relation, Dr. Ramez Azoury once spoke of a certain Chairman at Hopkins who saw two groups of people without prior appointments...the Residents and the medical students. Should this be our standard for student-faculty relation?

A: Yes, it should be our ultimate philosophy. Yet, maybe even that Chairman at Hopkins could not fulfil his aims completely. But I agree that the open-door policy ought to be the standard to go by.

Q: You seem to be well acquainted with student journals. What role do you think MEDICUS ought to play?

A: If it can play the same role it has always played, that would be excellent. Even 11 years ago, when I was here as visiting professor, I thought that it was a very fine publication. I still think it is. Maybe you can increase your circulation to graduates in other medical fields as well as to pre-medical students. Once in a while, it could also carry an article about how our graduates are doing elsewhere.

Q: Dr. Asper, do you have any other message to medical students?

A: I wish you success in all your endeavours and if at any time you feel depressed, go talk to Dr. Gravinis (see Departmental Notes) and he will cheer you up! !

For his contribution towards promoting education in Lebanon, Dr. Asper was decorated with the Order of Cedars by the Lebanese President in 1970.

THE NATURAL RESISTANCE OF SCORPIONS TO RADIOACTIVITY

The scorpion figures among the most ancient of terrestrial animals. Originating during the ordovician period about 500 million years ago, the animal has retained its initial shape and appearance, which are so familiar that detailed description is superfluous. Features making it impossible to mistake the scorpion for any other animal are its pedipalpi provided with pincer, its four pairs of legs (it belongs to the class Arachnida), and its «tail» of five annular segments which terminates in a telson carrying a poison gland with a very effective sting. Although the poisons of certain species are among the most virulent in the animal kingdom, it is neither the sting nor the legendary aspect (Scorpio is after all one of the signs of the zodiac) which have attracted the attention of biologists during recent years: a totality of physiological peculiarities coupled with a weak evolutionary capacity make the scorpion a most remarkable animal!

Earlier observers were quick to note its extraordinary resistance to fasting: the animal can do without food for months, even years. There have been many cases of scorpions living for 15-18 months, even longer, without food. Yet their resistance to asphyxia is no less remarkable than that to hunger: the scorpion is able to survive 24 hours under water. Even its hemolymph (the circulatory fluid containing hemocyanin as respiratory pigment) can be replaced by physiological serum without causing the animal any apparent damage. The scorpion is also able of surviving great extremes of temperature: it recovers rapidly after several hours in an ambient temperature of O°C. And then it has recently been demonstrated that it possesses a remarkable defence mechanism against microbes normally pathogenic for man and arthropods alike. In short, the scorpion appears to have an extremely developed resistance to unfavorable environmental factors. The most spectacular aspect of this is perhaps the animal's resistance to the lethal effects of ionizing radiations. The term ionizing radiations may be broken down into the following groups; first, particulate radiation that is directly ionizing and consists of electrons and protons which carry on electric charge; second, indirectly ionizing radiation such as neutrons or electromagnetic radiation like that produced by X and Y-rays.

For the purpose of comparison, here are a few figures for the theoretical case of a single irradiation of the whole body: in man, LD50 is 600 rad, a value identical to that in monkey, goat, donkey or pig. Corresponding values for the dog or guinea pig are lower, being about 350 rad. Vertebrates having the highest resistance are tortoises (1,500 rad) and tritons (3,000 rad). Invertebrates, arthropods in particular, are frequently more resistant to radiation. In the scorpion, LD50 over 30 days may attain the following particularly high values for certain species: 40,000 rad for **Androctonus mauretanicus,** the black scorpion of Morocco; 60,000 rad for **Androctonus australis** of Algeria and Tunisia, the most dangerous species for man; 80,000 to 90,000 rad for **Androctonus amoreuxi,** the great yellow scorpion of the Sahara. These high values are not valid for all scorpions. Although only a small proportion of the 600 different species of scorpions have been tested with X-rays and Co60, it nevertheless appears that the species most resistant to radiations are of the numerically most important family, the Buthidae, which also include those species having the most powerful poison.

It is good to note that no somatic mitosis takes place in the scorpion except when sloughing and in the tissues of the genital organs. According to a law established in 1906 by Bergonié and Tribondeau ,the intensity with which ionizing radiation acts on cells is proportional to the rapidity with which they reproduce and to the length of their karyokinetic life; this intensity is however inversely proportional to the degree of cell differentiation both with respect to morphology and function. One is tempted to read into this the principle explanation for the scorpion's resistance to radioactivity:, by virtue of the absence of cellular divisions, radiolesions remain latent. Yet irradiated scorpions present with a minimum of physiological disorders. Neither their respiratory activity nor their respiratory quotient is modified after irradiation. Proteinemia remains stable after doses of irradiation less than LD50—per—30—days level. With an increase in the dosage scorpions become anorective. Their glycemia is little affected.

How can these phenomena be explained? It has been observed that a relationship exists between the size of the nucleus and radiosensitivity: the greater the size of the nuclei, the greater is the radiosensitivity of the cell. The nuclear size is proportional to the DNA content. Analysis of scorpion tissue demonstrated a low DNA content, thus indicating small nuclei. In the Buthidae, karyotype comparison shows the presence of small chromosomes that are few in number; chromosome numbers vary from 6 to 26 in accordance with species. While comparative data on radioresistance for different species is still far from being complete, it may be tentatively stated that species most resistant to radioactivity belong to the family having the lowest number of chromosomes and in which the «target» offered to irradiation is smaller.

Does the scorpion possess a natural defence mechanism against the indirect effects of irradiation? In order to answer this question let us consider briefly the radiolysis of water; it will be remembered that hydrogen peroxide and organic peroxides are formed which are toxic for the cell. It has been well established that the presence of enzymes capable of decomposing these peroxides must constitute an advantage for the cell under irradiation, as is the radioprotective action of catalase, and the action of peroxidase. The scorpion's hepatopancreas is rich in a chemically stable catalase which is very active, even a few days after the death of the animal. If this enzyme is inhibited the scorpion will die very quickly when hydrogen peroxide is injected. The normal scorpion easily survives.

(Continued on page 42)

OUR HERITAGE AT CROSS - ROADS

Dr. AFIF MUFARRIJ

(We might accept the definition that History is a biography of small **deeds of great men. But talking of our own AUB heritage, we prefer to redefine it as the biography of** great **deeds of perhaps small men.**

And so in the process of working on «The New Horizons», we stopped in the midst of a past and a present and a future to look at the lives of men who have had a special impact on the AUB Medical School. We begin this series «OUR HERITAGE AT CROSSROADS» **by looking at** Dr. *Afif Mufarrij* **who retired from the Department of Human Morphology in June 1974 after having taught Anatomy since 1931.**

To gain a closer insight, MEDICUS assigned George Zaytoun and Ms. Narmin Nabil—both Medicine IV students—to interview Dr. Mufarrij on the different aspect of his life. In so doing, we were in essence trying to look at the last 43 years of the history of our School and the making of generations of doctors and medical students.

Dr. Mufarrij accepted to meet our reporters at 6:00 p.m. on a Monday, but the meeting had to be delayed. Reason? Patients of course! But MEDICUS raised no complaints, and in doing so we also silently acknowledged the scales of values of a man who has held the welfare of his patients above his own and that of his family, and who has assured patient care a priority above all his other preoccupations.

When they finally met, it was a kind of reunion. With thoughtfulness that was so typical and simplicity that was so disarming—both qualities that had characterized his entire life—he brought out ice-creams that he had already ordered for them in anticipation. The discussion began then.

Working on assignment was indeed an experience for Narmin and George. As they commented, Dr. Mufarrij embodied a triad. It was a re-encounter with a man so humble, so simple and yet so enriching; a doctor so knowledgeable, talking of experience that was almost history now; and a professor who rightly derived some satisfaction in having taught a generation of doctors.)

With a captivating smile and a genuine delight, Dr. Afif Mufarrij, who was not too long ago our tutor and who has been the tutor of so very many classes in the Medical School warmly welcomed us in his cosy bureau and over delicious ice-cream, unfolded to us, his life story.

«I will begin by saying how much I admire the students of today. Your life is so very much different from that of ours. When I left Tripoli in the fall of 1924 to join AUB as a Freshman, Ras-Beirut was more like a jungle, rather than the busy commercial center of today. People were hardly seen around and women were indeed a rare sight—and they dressed so very differently! ! It was immoral to smoke, to dance or even to go to parties, if at all they took place. Our students now have so many varied distractions and so many temptations that I wonder at times as to how they manage to concentrate and acquire knowledge. They are so actively involved in politics, in their social affairs and what not! At other times, I grow sad when I realize that so very little is done to make them attain a spiritual maturity—and here, we the educators, are solely to blame. During my student days at AUB, we were involved in so many stimulating activities which built up our spiritual lives. We used to regularly attend «morning services» at the University Chapel which brought into our lives peace and humility. Our talks were not merely confined to the realms of religion. For instance, when I became the University Physician, I spoke about great men like Walter Reed or Osler at these services. Our interests in subjects were varied—let me ask you, how much do you know about the history of medicine? Medicine is now given to you dry and with mathematical precision. Gone is the fascination and the richness it embodies; forgotten for ever are those exalted thoughts and ideas which inspired men and moved nations. Do you for instance know that lovers called each other 'my liver' ? It's because during those early days, anatomists believed that the spirit and the mind were concentrated specifically in liver and not distributed between the brain and the heart as it is now! Also, what do you know about legal medicine or medical ethics? Very little, unfortunately.

About Anatomy, do you know how we used to be taught Anatomy? We had to learn the minutest detail and often we were stuck with one single structure, say the temporal bone, for a whole week. We were taught descriptive anatomy, applied anatomy, surgical anatomy and regional anatomy. And as a matter of fact, Anatomy was one course which was taught throughout our training and believe me, it was tough! I began teaching Anatomy to medical students way back in 1931 and from the very onset, I have endeavored to trim the course down, so as to bring out the clinical application.

Do you know that the greatest book to be written on Sociology was by Prof. Dodd from AUB and he based all his data from the facts gathered here in Lebanon? On several of these visits, I have participated; we reached Akkar and even Mesiaf, far deep in Syria.

During my career as a teacher at AUB, I have taught besides Anatomy, Histology, when Professor Shanklin was on leave, Neuroanatomy, Dental anatomy when we used to have the School of Dentistry and even Physiology. During the World War II, all the Professors at AUB who were americans left for States and thus heavy responsibility was laid upon us. Incidentally, I was also appointed as a chairman of what was then called 'War Protection Committee' —the committee was responsible for digging ditches and building shelters in AUB in case of aerial bombardment. Of course I hadn't the foggiest idea how to get the things done and this is where Dr. Meyer was a great help; apparently, Dr. Meyer was a man of some experience, having had lost two of his fingers during an air-raid, whilst he was busy in his operating room. As the University Physician, I was also the Chairman of a committee called 'Social Hygiene'— this was of course a misnomer and that fancy name meant nothing else but 'sex education'!

Of course the remunerations in those days were very meagre—not worth mentioning. But then, we never thought of material gain. I worked hard to achieve excellence and build up my reputation and money never entered the picture. It is a shame that such a noble and grand profession like ours has been tainted by those who seek fortune in medicine. The pleasure one obtains from dedication is far more rewarding than the monetary gain. In fact, as the saying goes, if you run away from money, money will run after you.

In those earlier days, we used to have the Pharmacists Association, before the Medical Association was founded. I naturally took an active part in it and we had many things done together. After the Medical Association was founded, I worked very hard to get AUB medical graduates actively participate thus luring them away from the ivory towers of AUB. The 'Order of Physician' was founded in 1946 and there was a lot to do—to get it organized, to win support and recognition for it and again to see that our AUB medical graduates were accepted. Those days were hectic ones and I faced many criticism for my endless enthusiasm and untarnished hopes. But I survived and the Order was finally accepted as a proper institution. When I was elected as its President, I had the greatest satisfaction of having four of our own graduates on the cabinet.

Medicine is so vast—it is in fact a way of life and you will fully appreciate the impact of this when you have graduated and when you go out into the world out there. I found out how little medicine I knew many years after I had graduated. (Dr. Mufarrij graduated with a distinction).

During our times, we had to write a thesis to be a successful candidate for M.D. So naturally, I was preoccupied with thinking-up something original. One day, I came across a title in a journal, «Test for Pregnancy». I Was quite excited about this and rushed to my advisor, Dr. Dorman, who was also the chairman of OB-GYN department. Dr. Dorman had never heard of this but provided me with proper encouragement and backing and there I was, day in and day out, sleeping on wooden benches in the old Van Dyck Hall, working on the urine of mice and rabbits and studying the vaginal smears from them until I finally documented that this test was 95-98% positive in pregnant females. This was a great day for me, for henceforth, the test was formally introduced at AUH and in the whole of Lebanon. (On one incident, when the test was carried out on a couple, the male turned out to be pregnant!) After graduation, I spent nearly 5 years working on **Sepsis** and therapeutic value of UV light in sepsis. During this time, Mr. Tilikian was my constant assistant.

In those early days, we did not confine ourselves to the walls of University—in fact, we carried out many pioneering activities. For instance, we went out to the rural areas of Lebanon and Syria, where we studied the sanitary conditions along with the social standards of the inhabitants. Amongst others who participated in such projects, were Dr. Z. Shakhaushiri, who is now working for NIH, Mr. Roux, Mr. Salah Hibri, now a prominent businessman in the town and the father of one of our very young AUB doctors. We visited Bekaa area and travelled on donkey's backs, dispensing medications to the sick and giving talks on hygiene and sanitation. It was so nourishing for me to learn lately that you students have begun carrying out similar projects (Dr. Mufarrij was refering to the projects carried out by the SOCIAL MEDICINE COMMITTEE).

I would like to say that the coming generation of medical students is very often misguided or rather not guided at all. This is so because they lack what I may call an ideal example—in my days, we were directed and inspired by the selfless dedication of our superiors and their zest for work and excellence acted as a beacon in the stormy seas of learning and temptations. There is nothing which influences students more than the performance of their superiors for unconsciously, they will always try and imitate them. Education is not merely being taught facts— education is a moulding process, a process involving the moulding of character!

«We no longer grow old gracefully. Years of experience are not always valued. Instead of using the wisdom of age to help solve our problems, we have turned the aged themselves into a problem. Our preoccupation with youth has made us forget that often people considered «too old» have the youngest ideas of ALL.»

WINSTON CHURCHILL

M S S

When the role of the other student societies on AUB Campus was diminishing and their very survival becoming doubtful, a third year Medical Student, Farid Sami Haddad (M.D. '48) thought of creating a student society in the Medical School. The year was 1945! Farid gathered the representatives from each of the five classes, and with the encouragement of Dr. Stanley Kerr from the Department of Biochemistry, formulated a constitution for the Society.

A Medical Student Society had been born thus. The first President, «believe it or not,» was none other than Edmond Shwairy (M.D. '46)—yes, the sage!—with Farid becoming the Secretary. The first Cabinet stayed in office for six months only, but had laid the foundations for an election of successive cabinets before the start of the summer vacation each year. Maurice Deraney (M.D. '48) was elected the President for the academic year 1946-47, followed by Na'aman Boustany (M.D. '48) and then by Jacob Thaddeus (M.D. '50) for the two successive years (1948-50). Many of the students who participated or started new activities are familiar names. The Society, specially in its early years, had concentrated on scientific and social activities to supplement the academic life of the medical students. Farid and his brother Fuad Haddad had started a «Journal Review Group» that also featured a «Differential Diagnosis Group.» Maurice, during his term of office, had started the «Music Hour» held in Dale Home. The M.S.S. badge had also been designed that same year by Maurice, Farid and Raif Nassif, who incidentally was also elected as Secretary to serve with Na'aman (1947-48). Philip Antypas had taken charge of the sports activities in the meantime, and most significant of all perhaps, the M.S.S. Anniversary Show had been also started. Quite a few innovations took place during the presidency of Jacob Thaddeus who had, among the others working with him, Samir Azzam (M.D. '51) as Secretary and Fuad Askkar and Amal Kurban as committee members. Dr. George Fawwaz had been taken as their advisor. The cabinet meetings became more regular, a student lounge was started in the basement of Van Dyke; a series of «popular» Medical lectures was also started in West Hall for the rest of the University Students but soon discontinued. The social activities had also become more numerous.

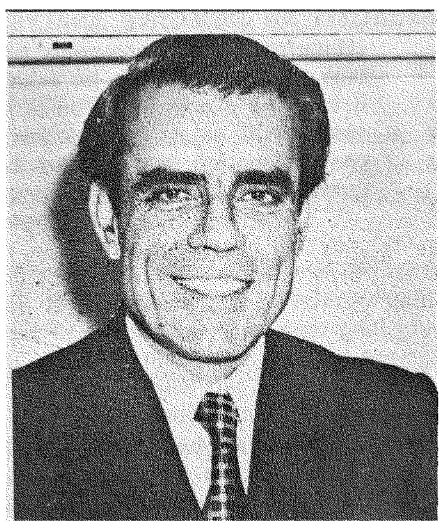
Taking up the idea of Sa'ad El Issa (M.D. '51), an annual variety show had been started, that gained the M.S.S. quite a bit of fame all over Ras-Beirut. Again some of those who distinguished themselves as actors or Masters-of-Ceremonies are familiar names today. To mention a few, these included Vicken Kalbian, Jacob Thaddeus (M.C.s'), and actors like Munir Shama'a, John Yacoubian, Raif Nassif, Suhail Bulos, Shermine Rawdah (later Mrs. Bulos), Gaby Sabgha, George Rubeiz, Vahé Puzantian and John Malak. Later, John Racy (M.D. '56) even joined these ranks.

But the M.S.S. had also engaged in acts that reflected a sense of social and civic responsibility. During the Palestinian exodus, Samir Azzam took charge of two clinics, one in Joffre and the other in Mar Elias refuge camps, where the fourth and fifth year students went to attend to the sick. Samir was closely assisted here by Dr. Bahij Azoury and Dr. Najib Abu Haydar from amongst the Residents.

Finally when the M.D. graduate of 1950 were to wear hoods during the commencement, that had been designed by their own society, it was probably an act symbolically significant, representing the involvement and strong establishment of a society during the preceeding few years.

By 1950, M.S.S. had built its foundations adequately to guarantee a meaningful survival for many years to come. To lead the society thru these subsequent years became the responsibility of Elias Husni, Ernest Barsamian, George Rubeiz, Joseph Bahuth, Samir Shehadeh, Ramez Azoury, Dr. Adel Afifi—and so many others.

And on till 1974! The present M.S.S. Cabinet was elected on June 14 this year to take office for the current academic year, 1974-75 (see next page). MEDICUS hopes that this M.S.S. Cabinet, under the Presidency of Zuhair Hemadeh, will carry on with the fine tradition they have inherited from the ideas and efforts of Dr. Farid Haddad and Dr. Edmond Shwairy.



Dr. Edmond Shwairy — m.d.

M.S.S. CABINET '74-'75

PRESIDENT:	Zuhayr Hemadeh, Med. V
VICE-PRESIDENT:	Ghazi Zatari, Med. IV
SECRETARY:	Wael Muakasah, Med. IV
TREASURER:	Tarik Fakhri, Med. III
MEMBERS:	Nabil Mufarrij, Med. III
	Raffi Tasjian, Med. III
	George Atweh, Med. II

(This year the M.S.S. Cabinet is envisaging a very active program, and to implement some of these plans, the Cabnet has set up an efficient supervision over its sub-committees. In the next issue, MEDICUS will report extensively on the work of the Cabinet.)

HOMOSEXUALITY

(The doctors, like the sociologists, have a responsibility of educating the society and helping in updating the social and conceptual judgements of people, specially as regards certain social deviations. In the first of its Feature Articles, MEDICUS discusses one such topic: 'HOMOSEXUALITY'. Initial research indicates that probably there are bio-chemical dictates underlying this phenomena; however, as renewed medical interest appears to focus on this field again, to the extent of even inviting an official comment from the Soviet leadership recently, we found it timely to explore the subject in depth. And this became the responsibility of our Associate Editor, Ms. Adlette Inati.

To guarantee objectivity she looked at the problem from all the aspects. Dr. Fuad Antun provided a psychiatrist's viewpoint, while Professor Dodd, from the School of Arts and Science provided the Sociologist's opinion. With the help of Najwa Najjar, a questionnaire was designed and distributed to Medicine I students. George Zaytun, in the meantime, worked to collect the opinion of the layman, and to capture some of the hard-core prejudices, took a taxi to downtown Beirut. Nabil Mufarrij managed to interview 3 homosexuals who accepted to talk under protection of anonymity. And finally when Omar Sharif suddenly appeared in Beirut, MEDICUS also reached him at the Holiday Inn Hotel to report on what a man famed for heterosexual preoccupation thought of homosexuals.

Working against her heavy load at the Emergency Room, Adlette co-ordinated this entire assignment. And as she crumpled her notes at the end, she suddenly commented—«You know, I was beginning to get fascinated...». But before we could reflect on her statement, she was already on her way to the Emergency Room. Only her laughter could be heard behind!)

HOMOSEXUALITY: AN OBJECTIVE ANALYSIS

> «Homosexuality is assuredly no advantage, but is nothing to be ashamed of; it can't be classified as an illness, we consider it to be a variation of the sexual function produced by a certain arrest of sexual development» ...
> Sigmund Freud, 1930

Homosexuality may be best regarded as a form of sexual development in which the person's object of sexual arousal is another person of the same sex. It has been around for a very long time and was enough of a problem in the old testament to merit the death penalty. «If a man also lies with mankind, as he lies with a woman, both of them have committed an abdomination. They shall surely be put to death; their blood shall be upon them (**Leviticus 20:13**).

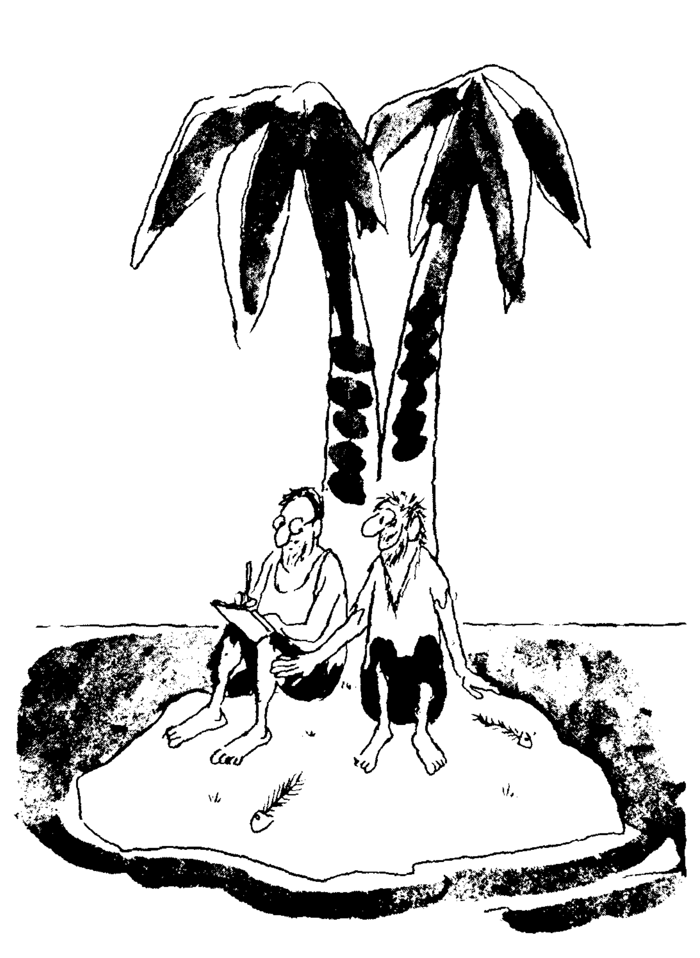
To the best of our knowledge, there is no homosexuality in any creature other than man.

In recent years, homosexuality has become such a widespread practice that it has become a phenomenon and a movement: «The Queeeye Phenomenon and the Gay Liberation Movement.» At present, homosexuals in the west are exerting tremendous pressure in order to get representation in various official sectors.

A person is labelled as a homosexual not merely on the basis of a homosexual act per se for there are two categories of homosexuals even since the days of Freud:

1. **Facultative or Situational: Here one retain a preference for the opposite sex but under conditions of deprivation, as in army camps and male dormitories, this preference is shed as the same person engages in a genital relation with a member of the same sex.**
2. *Exclusive or obligatory: Here, one predominantly or always has sexual experience with people of the same sex. They form the group of true homosexuals about whom this review is designed.*

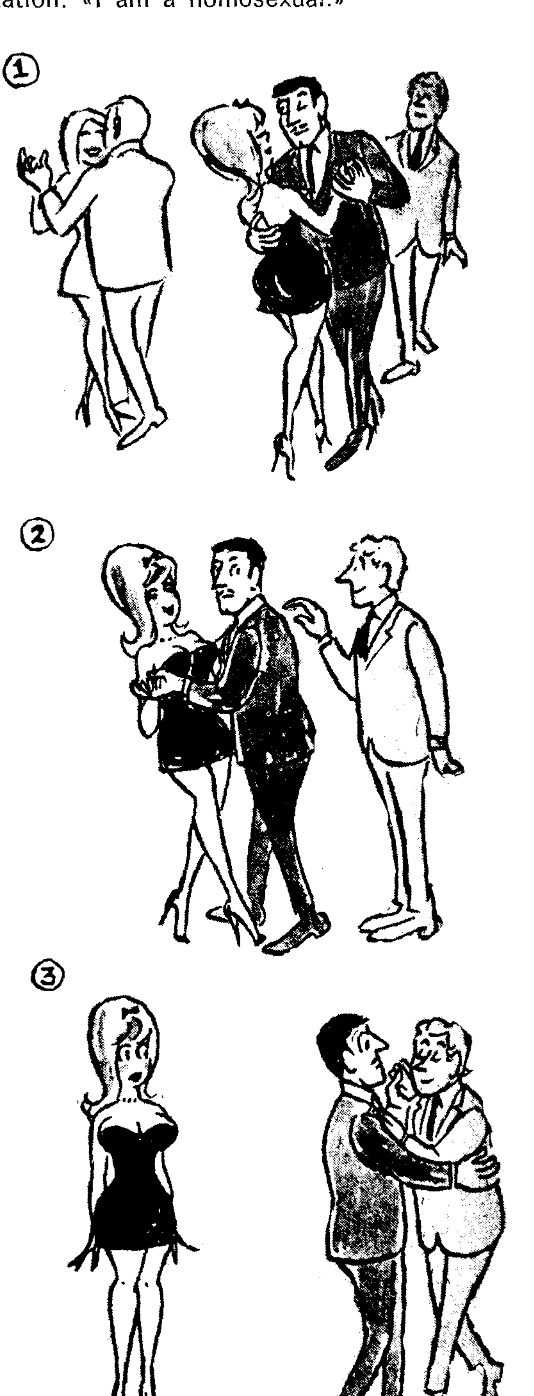
«Bisexuality» refers to a special category of people who copulate basically as homosexuals but on some occasions, they have heterosex, an act not done by a typical homosexual.



«It's our 254th day on this island without seeing another human being. Multon is beginning to behave rather strangely . . . »

A phenomenon considered important in the process of developing a homosexual identity is known as «coming out». This term designates the time or event of introducing a person to the homosexual culture as a potential overt member who stops feeling ashamed of his behaviour. «Coming Out» for many homosexuals represents an opportunity to establish a new image of themselves and to become involved in a new life style. It is a point of great challenge and full of impediments, both intrinsic and extrinsic, to the one undergoing such an experience. Developing a homosexual identity does not come overnight.

Interviews with young homosexuals of ages 16-22 years **(Roester & Diester in Washington 1971)** showed that the following events usually precede the individuals' self designation: «I am a homosexual.»



1. **Early sex play (pre- or postpubertal).**
2. **Actively seeking homosexual experiences in parks, gay bars, tea rooms... etc.**
3. **«Coming out.»**

The average duration required to attain the last stage was found to be around 4 years. The difficulty of passing through the above process is indicated by the fact that almost half of the above subjects had seen a psychiatrist or sought a mental institution or even made suicidal attempts at one time prior to «their coming out» a phenomenon indicating the intense unhappiness and instability of these young homosexuals. This is anticipated, for it is quite clear that homosexual ideation and feelings are the most difficult for the adult to incorporate into his ego, and especially if he is endowed with a strong superego which many of these homosexuals have. Besides, the institutions from which people normally derive security as church, family and school are not only nonsupportive but very antagonistic when a youth reveals homosexual tendencies. It is only after these institutions fail that a youth seeks a physician for help.

One of the common misconceptions about homosexuality is regarding its terminology. For the sake of clarification, I will say: The word «homosexuality» is not restricted to males but includes both

1. **male homosexuality,**
2. **female homosexuality, or lesbianism. This term was derived from the Greek island of Lesbos where the poetess Sappho in around 600 B.C. extolled and encouraged female homosexuality.**

At this stage, it would be interesting to comment on some of the differentiating feature between male and female homosexuality:

1. **Female homosexuality is less common than its male counterpart.**
2. **Female homosexuals tend to be less showy than male homosexuals, and their relation with their partners tends to last longer, is more emotional, and involves fewer specifically.**
3. **Female homosexuals are more often bisexual than male homosexuals, and often females are preferred than males.**
4. **Female homosexuals were found (M. Saghir 1970) to show more prevalence of psychiatric disorders than their male counterparts. These disorders included alcoholism, excessive drinking, use of nonprescribable drugs and suicidal attempts. An interesting finding by Saghir was that despite the increased prevalence of psychiatric disorders in homosexuals and despite the fact that all the young homos show a period of risk from dropping out of college during periods of intense personal conflicts, these same people have been proven to possess an equal, if not a higher capacity for achievement, adaptation, and productivity than control heterosexuals.**

Studies of female homosexuals matched with female heterosexuals on the basis of intelligence, age and education **(Hopkins 1969)** revealed that homosexuals are more independent, dominent and self sufficient with higher adaptability to misfortunes than control heterosexuals. These

PSYCHIATRIST'S POINT OF VIEW

Dr. FUAD ANTUN, M.D.

PRACTICALLY DEFINED

Someone who practices psychiatry without a license would have to be called a SIGMUND FRAUD.

Homosexuality perhaps is the most studied of the sexual deviations. Although recent contributions have been valuable in the understanding of its epidemiology, its social structure and its characteristics, very little progress has taken place concerning **etiology.** The two most important concepts about homosexuality are firstly that it is not absolute or exclusive; in other words it can exist with heterosexuality in the same person in both sexes. One therefore can understand earlier permissiveness of cultures where homosexuality was favoured or even legalized. Examples drawn here is the prevalence of male homosexuality in ancient Greece and Mideaval Europe; to add female homosexuality was perhaps first encountered in the Greek island of «Lesbos» at the time of the Greek dynasty. Hence the term «Lesbionism» is given to female homosexuality. Secondly homosexuality can occur in certain instances or conditions yet when these disappear heterosexual relations are resumed. Examples here are derived from prisons, monasteries and the concept of «Latent homosexuality» where homosexual drives are realized and acted under moments of lack of inhibition such as alcohol intoxication, or projected such as in pathological jealousy.

For the above reasons the current classification of homosexuality is Kinsey's where homosexuals are graded from those who are exclusively homosexual to those who have homosexual fantasies but not practices. Such grading will encompass all forms of homosexuality, whether passive or active. However such classification does not take into account etiology. The concept of etiology is still a big controversy, and theories range from psychoanalytic (both Freudian and Neo-Freudian) to social; and or exposure theory to the genetic or biological (constitutional) theory.

After this introductory discussion one wonders whether, after such loose definitions and criteria, homosexuality is a true deviation from the norm, that is it we are to accept that the «norm» is heterosexuality. Within this scope then, Kinsey's reports estimate homosexuality at above 40% between adolescent to middle age With slightly higher figures for female homosexuality.

There is little room to answer all the queries and questions about this topic. However, one can briefly summarize that **homosexuality** is not **a disease but a deviated state,** the norm of which is biologically and socially determined. It occurs in both sexes in varying degrees of practices with both active and passive roles interchanged at times. There is however more consistence of role in female homosexuality i.e. the partner who performs the active role usually does not take the passive one. She usually behaves in a masculine way and dresses so, while the passive one is very submissive and feminine. Such characteristics are lacking in male homosexuality where the masculine-looking partner may be totally passive and vice versa. Moreover, contrary to common belief, masculine rather than feminine features are sought for sexual eroticism.

Homosexuality can co-exist with other sexual deviations such as transvesticism, sado-masochism and compulsive masturbation; paedophelia on the other hand, is more associated with heterosexuality. The social organization or structure of homosexual practices and way of life can range from a pattern compatible with community living such as marriage and family life, ordinary social contacts and social integration, to exclusive «Clannish» existence with pure homosexual contacts. This latter way of life in the past was denounced by most cultures and societies. However, nowadays a «blind eye» is cast over its existence in most cultures. In few others it has been accepted even. This does not mean at all that the heterosexual-homosexual pattern of life is more socially acceptable. This is because homosexual contact in the former, as a rule, is done with utmost discreteness while in the latter it is not so due to the larger degree of need for homosexual gratification.

Treatment of homosexuality should always take into account the willingness of the subject. It ranges from individual psychodynamically-oriented psychotherapy, to group therapy, to behavior therapy. Drug therapy in the form of hormone and hormone analogues that suppress sexual desires has been tried with limited success. The overall outcome of therapy varies but largely depends on the motivation and the personality structure of the subject and the environmental conditions.

results, however, should be accepted with caution for they are still very limited. In another study (**Eisenger 1971**) on the other hand, lesbians were found to be more neurotic and less extrovert than average, but in all respects are normal especially regarding physical built and female genotype.

Several factors render research into homosexuality difficult and far from being rewarding; the lack of clear boundaries, self conflict, social isolation... That is why there are still several gaps in our present knowledge of the etiology and pathogenesis of homosexuality. For our purpose, we will be satisfied by saying that in the minds of most psychiatrists working in this field, homosexuality has a multifactorial etiology, a statement which by itself shows our degree of ignorance about this trend. Following is the list of **etiologies** that have appeared in the literature so far.

1. **Hormonal etiology:** In the past many eminent investigators have considered human sexual orientation to be strictly a psychosocial phenomenon.

3. **Genetic studies** lend support to an innate predisposition to homosexuality. Kallman's study (1957) found 100% concordance for homosexuality in 37 pairs of probably monozygotic twins compared to 72% concordance in 26 dizygotic twin pairs. This etiologic relation is still vague however.

4. **Family background:** Characteristically, parents of homosexuals maintain a poor relation with each other. Most mothers of male homosexuals have been found to be overprotective, very intimate with their sons, interfering with the development of their independence, and humiliating their husbands. Their fathers were detached, disinterested and hostile to sons. In most instances, fathers were hated and feared by their sons. On the other hand, mothers of female homosexuals were found to be either neglecting, defeminizing, or highly possessive and controlling. Their fathers were rejecting, nonaffectionate and overpossessive.

OMAR AL SHARIF AND HOMOSEXUALITY

«Homosexuality» does not ring a bell to Omar Al Sharif, the internationally known Egyptian movie star. To him, there is nothing absolutely wrong or right,and as long as there is nothing wrong with a person who does not disturb his neighbor, nothing's wrong with a homosexual either. However, he can't conceive of himself as having a sexual relation with a man.

Men can be very fulfilling as intellectual companions but tenderness, love, and affection are to be offered only by members of the opposite sex.

At present with the precise measurement of hormone levels by radioactive I assay protein binding methods, much emphasis has been put on the level of testosterone in homosexuality. Nevertheless till now, there is no definite relation for various workers have given conflicting results ranging from lower plasma testosterone levels in homosexuals than in heterosexuals, and a correlation between the degree of clinical homosexuality (high Kinsey number) and lower testosterone level (**Kolodney et al 1971**), to normal hormonal levels in both homo and heterosexuals (**Birk and Torney 1973**), to higher plasma hormone levels in homosexuals than in heterosexuals (**Brodie 1973**).

2. **Anatomic etiology:** In the psychiatric literature, one encounters several clinical examples of persons showing markedly altered pattern of sexual behaviour concomittant with stimulation or destruction of specific brain parts.

For instance, Davis and Monganstern 1960 have reported an overwhelming desire to cross dress (Tranvestism) in association with cerebral calcifications due to cysticercosis; and Blummer and Walker have found hyper- and hyposexuality in temporal lobe epilepsy. Despite these isolated findings, the exact anatomic etiology of homosexuality at present is still far from being well delineated.

A study of 17 women married to homosexual men (**Hattern 1974**) revealed the following common denominators in their character and histories:

1. Marked feelings of inadequacy in various areas of their gender and erotic identification, and retarded psychosexual and social development following marriage.
2. Marked disturbances in relations between these women and their fathers.
3. In effectual mothers who were poor models with low self esteem and low expectation of their own husbands and appearing as victims of marriage.
4. In many cases the woman's need to maintain the contact of marriage resulted in a denial of the husband's homosexuality and this attitude in itself will propagate the husband's homosexual tendencies.
5. Psychosocial etiology: According to the classical psychoanalytic theory, the male child takes his mother as his first love object, then he engages in a period of intense sexual rivalry with the father for the mother's love, and begins to fear in the process that his father will castrate him. At ages 5-6, this conflict is resolved with the father and the child starts seeking females

SOCIOLOGIST'S POINT OF VIEW

Prof. PETER DODD (Dept. of Sociology)

HOMOSEXUALS IN CONTEMPORARY SOCIETY

Homosexuality, in the past few years, has become a matter of public attention in Western society. In the major cities of Europe and North America, Gay Liberation Movements have been formed, demonstrations by members of these movements have been held, and the mass media have given much attention to the actions and life-style of both male and female homosexuals. Leaders of the 'gay' movements have urged covert homosexuals to 'come out of the closet', while those who have recently 'come out' have told how good it feels to move from covert to overt homosexuality. 'Gay' dances have been held, gay bars and other meeting-places have flourished.

This general phenomenon has received serious attention from sociologists and other analysts of society. They have attempted to establish the extent of the homosexual 'movement', to speculate about the causes of the movement and its recent move into the public eye, and to guess about its future. Serious analysis has to begin, however, with the recognition of one fact: very little reliable knowledge is available about homosexuality and homosexuals in contemporary society. Time and again one finds the basic source of data to be the surveys made by Professor Alfred Kinsey and his colleagues of sexual behavior in the United States of America. These surveys, however, consist of interviews with volunteers, a very serious source of bias from the sociologist's point of view, in that people with a strong drive to «tell all» are likely to be over-represented. Furthermore, the surveys were completed twenty-five years ago and therefore do not depict contemporary society in any sense of the word.

More recent survey material has been collected, but it almost always relies on the self-reports of individuals, without possibility of verification of the statements made. Another source of data, and an extremely valuable one, are the clinical records of psychiatrists and clinical psychologists. These records also suffer from bias, however, because the patients have been defined as 'sick', either by themselves or by social agencies. They do not represent the 'normal' society, since the 'normal' person is less likely to come into treatment by a therapist.

Gradually, however, reliable material on homosexuality is becoming available to social scientists: carefully collected survey data, case studies, ethnographies of homosexual groups and social activities. These do not permit one to say definitively whether the extent of homosexuality is growing in Western society, but they do provide a basis for a serious discussion of homosexuality.

One major clarification must be made. There are at least three different kinds of homosexual behavior, each with very different patterns of action, implications, and social sanctions. They can be distinguished by the age of the homosexual partners. The first kind is homosexuality between young adolescents, a form of early sexual experimentation. This type of homosexual experience is common in most societies, but it is not taken seriously either by the individuals involved or by the society. The emotional attachments are weak and short-lived, and the individuals are not likely to become 'fully' homosexual adults. While parents and school teachers may express shock and dismay at this adolescent behavior, the law is hardly ever involved and the only penalty is disapproval.

At the other extreme, in terms of social disapproval, is the type of homosexuality where one partner is a number of years older than the other. If the younger member of the pair is a juvenile, social censure is very strong and legal penalties are invoked.

A third type of homosexuality takes place between 'consenting adults'. It is this type that has been brought to the forefront by the 'gay' movements, as well as by such responsible government inquiries as the British Wolfenden Report. This type of homosexuality may develop into a long-term stable relationship like that of 'normal' heterosexual marriage, with deep mutual affection, common property, joint residence, and the patterns of social behavior characteristic of marriage.

Recent changes have raised the question as to the normality or eccentricity of this third type of homosexuality. Many people still react with dismay and strong disapproval to this type, defining the homosexual partners as deviant, queer, and morally defective. Others see homosexual behavior as neither more nor less normal than heterosexual behavior. They question, as did the Wolfenden Report, the traditionally strong social sanctions that have been applied to overt homosexuality, and suggest that acceptance of homosexual behavior should replace disapproval and legal punishment.

(SOCIOLOGIST VIEW POINT Cont'd)

Into this debate three powerful institutions play a role: the family, religion, and the state. Homosexuality threatens the family, it is argued, because alternatives to marriage are presented. Children are confronted with adult roles that do not involve parenthood. A society that permits and accepts homosexual households will be less supportive, it is thought, of the nuclear family composed of parents and children.

Most religions strongly support marriage and the 'normal' family. In Christianity, marriage is a sacrament joining two persons of different sexes, while baptism is a sacrament explicitly emphasizing the parent-child relationship. Often, religious prohibitions of homosexual behavior exist, partly on moral grounds and partly because such behavior is logically inconsistent with heterosexual marriage and family relationships.

A third party in this debate is the state. Like religion, the state supports and strengthens marriage and the family. Husbands are legally responsible for wives, parents for their children. State services are often provided from families in trouble: widows, unwed mothers, orphans and other dependent children in need. The state has tended, in many countries, to define as deviant individuals who do not accept and fit into this pattern of heterosexual family relationships. Homosexuals are viewed as unfit for military service, they are seen as unreliable and as security risks. A tradition has been built up of state policies and regulations that define homosexual adults as inferior if not as criminal.

The recent movement in sympathy with homosexual relationships between consenting adults, therefore, runs into powerful opposition from the established social institutions. To this opposition is joined condemnations in terms of moral decay and future risk to the society. It seems, however, that much of this opposition is grounded in moral values and past practice rather than in scientific evidence. There is not enough knowledge about homosexuality to permit a definitive assessment of its harm to society and to family structure. If anything, the clinical experience of physicians and psychologists suggests that past condemnation of homosexuality has been so strong and so unyielding as to have extensive negative consequences for many individuals in the society. These negative consequences have formed the basis of the support for current movements to view homosexual behavior between consenting adults as lawful and socially permissible. Whether this permissive attitude will have adverse effects on morals and family structure is a question that the next ten years in Western society may be able to answer.

other than his mother. Essentially, homosexuality is seen as a disorder arising from the carrying over of a conflict from an earlier phase of life and functioning, and resorted to as a defense against the fear of castration.

In the past, the concensus among physicians was that there was no therapy for homosexuality. At present, successful results have been reported with:

1. **Aversion therapy,** that involves associating unpleasant stimulus (generally painful electric shock) with stimuli evoking homosexual arousal (generally photographic slides of men). It seems that this therapy weakens homosexual drive in the majority of patients treated, but the evidence that it increases heterosexual drive is less convincing.
2. **Psychotherapy:** Here the role of motivation is very important in effecting change into heterosexuality.

Other modalities of treatment, mainly behaviour therapy and drug therapy, have also been tried. Till the present day, the therapeutic aspect of homosexuality like the other aspects, is still controversial.

A homosexual comes to a physician for two reasons: first is to seek help to change his sexual orientation. Secondly, he seeks assistance to help him accept his homosexuality, and thereby reduce his feeling of guilt over this issue. It should be emphasized that no single homosexual can be converted into a heterosexual against his will. There are certain prerequisites for successful psychiatric treatment of homosexuals:

1. A desperate will to renounce homosexuality.
2. An experienced resolute psychiatrist who is dedicated to do more than make his patient a happy one.
3. A lot of hard work.
4. An adequate dose of good luck.
5. Concomittant treatment of the wife of a homosexual

In an attempt to add to the objectivity of the above analysis, MEDICUS thought it would be both interesting as well as mandatory, to have the opinions about homosexuality from various categories of people. Hence a MEDICUS reporter crossed the frontiers of this medical school to fetch people with life styles too different from ours. Result? Theirs' were conceptions that might sound too bizarre and too original for many of us. Just to give an insight into this fascinating «laymen's» world:

A Fruit Juice Seller: يا حكيم my wish is to open up the head of one of these homosexuals and see what the hell is going on inside. I think they need some of my vitamins to make this thing up there (pointing to his head) function properly.

A saleswoman in a shoe shop: «Homos are only good to throw in a waste basket; my dear friend ,these crazy people have something wrong up there. Once I meet one of these, I will not let him go away before creating in him a healthy attitude towards us, females.

A vendor: «You can't imagine يا معلم what fun it is for me to whistle and laugh at these homos.»

Porter: «My son, you may be a حكيم and God give you strength to carry on. I may be a porter but I tell you that these people are sick up in their brain and they are to be blamed. Our almighty created them like this as he created the deaf and the blind. But I know of one (a distant cousin of mine) who became a homosexual because he had a very bad mother: she used to spank him a lot and keep shouting at his father, so he became complexed. You see, blaming these people is harsh.» (A porter or a psychiatrist?)

A female hair-dresser: «You may or may not believe it, but these homos enter this «Salon» and get their hair fixed, and behave like any other respectable lady. For me, they are masculine-females, not the opposite. They excel

in applying makeups to the extent that they can fool even the sharpest observer amongst us.»

House Maid: «God protect us from them يا حكيم They are inhabited by the devil (God bless me!) because only this can make a man behave so foolishly. You are a doctor and you should make a drug that kills this demon, and cures these people eventually.»

Service Driver: «Quite a few come into my car every day so that I have developed quite an instinct for recognizing them. I think they are simply crazy .For God's sake, can you imagine me desiring a male when I see hundreds of women around?»

A middle aged lady was so outraged when questioned about homosexuality and said: «Your place, my young doctor, is not here but in a mental asylum.»

A young man when asked about this new trend, felt greatly offended and said: since when does your majesty know me so well to joke with me this way?

Another taxi driver: Could not conceive of a medical student asking him about «these stupid people» unless the student was a homosexual himself. His response was:

يا حبيبي روح شغلك شي واحد متلك تسلّى معو ..

No doubt the opinions of those who are the directors and the players of the game remain the most enlightening in any analytic survey.

Based on this assumption, MEDICUS conducted interviews with few of the homosexuals in the city of Beirut. To keep within the reference of the present study, MEDICUS chose to confine itself to two of those interviewed, who showed genuine interest and responsiveness-though expressed the wish remaining anonymous. Our first friend is a 27-year old American artist whose immediate response to the questionings of MEDICUS reporter was «I am a bisexual rather than a homosexual, however in my mind, there isn't much of a distinction between the two.» His first encounter with homosexuality was at the age of 14 when one of his classmates took him to a forest near his school where they started playing around. That night when he went to sleep, his head was loaded with the most annoying feelings of guilt and the next morning he experienced the utmost depression anyone can ever pass thru. It did not take him long however before he could «come out» and declare «I am a homosexual.» In few years, he started going to places where homosexuals usually meet: pubs, gay bars, and friends' houses.

When asked about the kind of bondage tying homosexuals together, he enthusiastically said, «the relation between 2 homosexuals can develop into love. I've had 2 love affairs with men that lasted for quite an appreciable time. You all tend to underestimate the strength of these emotional ties. It is only because you are living in a world that aims at denouncing the value of such relations.

Being an overt homosexual, can you comment on your relation with girls?

«Often people falsely believe homosexuals develop hatred toward females. You would be amazed to know that I've had 2 love affairs with women that were as solid as with men.

Yet I would not like to approach a female. If she reveals an interest in my person, I wouldn't mind taking her as a friend.»

QUESTIONNAIRE, 1st YEAR MEDICAL STUDENTS

In addition to the contacts that MEDICUS tried to establish with sociologists, psychiatrists, laymen and homosexuals, a questionnaire was also prepared for distribution to a random sample of Medicine I students (27 in all); the questionnaire has been designed by MEDICUS staff with the purpose of assessing the attitudes and behaviors of this sample of future physicians towards a current mode of living: homosexuality. The selection of Medicine I students for this questionnaire had a special significance to us. Failure to contact Medicine I class, our alternative would have been to sound out the attitudes of the entering Freshmen students. Laymen, as indeed a great sector of the society, tend to hold opinions that we know get modified through the insight and liberal exposure that education affords. In addition to this inevitable but perhaps slow change, there are certain professions that automatically expects their members to be more tolerant.

MEDICUS was assuming that the ideas of a Freshman are particularly interesting as they reflect the tolerance index of a student at the threshold of a university education. But, what of a student that has already been 2 or 3 or even 4 years of such education and is embarking on a career that almost expects the student to be liberal enough... even to the extent of recognizing a homosexual as a normal human being. We tried to elicit these opinions. What we found did not necessarily conform to our expectations.

Whereas only 10 of the 27 students could conceive of a homosexual as a normal human being, an even smaller number (10) were willing to accept such a person as a close friend. Two of the 27 were frank enough to admit having had indulged in a homosexual act at one time in their life while the rest denied such an experience.

When questioned about legalization of homosexuality—an issue recently pushed for very strongly by various social groups in the West—five favored such a step while rest showed their disapproval. On the otherhand, four approved of marriage between homosexuals; the rest considered such a partnership unacceptable social institution.

* **What do you understand by homosexuality?**
  - **26/27 — it is sexual relation between two individuals of the same sex.**
  - **1/27 — it is similar to heterosexuality because it is a way of expressing one's feeling through tangible acts in sexual behavior.**
* **Are you interested in knowing about homosexuality?**
  - **16/27 — Yes.**
  - **11/27 — No.**
* **Where have you gathered your information about homosexuality from?**
  - **2/27 — own experience.**
  - **25/27 — mass media or experience of others.**
* **In your opinion, what is the most important driving force in homosexuality?**
  - **11/27 — social maladjustment.**
  - **14/27 — psychological problems.**
  - **2/27 — no answer.**
* **If you were approached by a homosexual, you would be:**
  - **9/27 — disgusted.**
  - **10/27 — indifferent.**
  - **6/27 — aggressive.**
* **If you were to identify a homosexual in a street, you would do this by observing:**
  - **4/27 — the way he talks.**
  - **14/27 — the way he dresses.**
  - **9/27 — cannot identify him.**

When MEDICUS interviewer commented on the activist role played by homosexuals in the West in order to effect legalization of this pattern of behaviour and to get the right of marriage between homosexuals, our friend said, «I am for legalization of homosexuality but the value of this by itself remains little if society at large keeps on looking at it as a taboo. I am absolutely for marriage between homosexuals if those concerned want it. This however would decrease promiscuity in many of us.»

MEDICUS interviewer later learnt that our friend has lived in a family where parenteral relations were very wavery and where the mother was quite dominant and overprotective thus masking the image of the father who had only a casual relation with his son.

The second homosexual MEDICUS interviewed was a 26-year old clerk who, ironically enough, was instructed about sex by a priest since the age of 12. His first sexual contact with men was at the age of 13 when it was just a simple sex play. At the age of 16, he experienced anal sex. «Ever since childhood, I was attracted to males. At no time, did I have any yearning for girls or could I conceive of females as potential sexual companions. Yet I do not bear any grudge against them.» When questioned about special qualities of his partner he said, «those that I have homosexual relation with are usually people that I do not know, and once I know them, I never see them although I do not try to avoid them.»

Contrary to what one would expect, the way by which he would pinpoint a homosexual is not by his style of walking or dressing but rather by the quality and content of his conversation which is usually very special. Our friend, MEDICUS reporter discovered had a conception about marriage and legalization of homosexuality that is quite distinct from that apparent in the previous interview. He is with marriage between homosexuals if those concerned want it. But as a person, he would not undergo such a contract for he believes it would not be apt to last long: it will be monotonous—a thing he can't withstand. Yet, once a marital bond is agreed upon, it can be as stable as a heterosexual one with an equal amount of love and affection.

«I am not sure if I am with legalization of homosexuality. Probably I am not because to me, part of the pleasure in a homosexual act is the feeling that I am doing something that is looked at as bad and unacceptable.»

When asked about his opinion in one of the current etiologic themes of homosexuality mainly that of relation of a particular family to the development of the sexual orientation, he said «I think this is a very significant cause. In my case, I was closer to my mother than my father and my parents' relation was very distant.»

What about your future view of homosexuality?

«To many, the number of homosexuals is increasing; I do not agree but would instead say: nowadays, the already existing homosexuals are coming out more into public and are prepared to be looked at as 'gay'.»

MEDICUS WELCOMES MEDICINE I

MEDICUS took an unprecedented step this year by welcoming the entering Medicine I class to a tea-party on October 3, 1974 at 7:30 p.m. in S.B. 101. Ms. Adlette Inati, the associate editor of MEDICUS started her welcoming speech by saying, «the aim of this informal gathering is to welcome you all to your new academic life, to introduce you to the various activities of MSS and in particular MEDICUS, and to acquaint you with the various channels through which you can contribute to the success of these activities.»

She then commented on the stimulating, challenging and therefore gratifying experience one undergoes while working in MEDICUS. Dr. Freiha, MEDICUS' advisor for the year 1974-75, who was introduced «as being the greatest asset to all of us» urged all those present to contribute fully and freely to MEDICUS and not to consider this as just a time consuming job but rather as a very nourishing experience which adds so much to the worth and to the meaning of a medical student's life.

Following Dr. Freiha's address, the members of MSS Cabinet, «the pillars of the medical students' body», as well as the Chairmen of the different committees were also introduced. Mr. Zuhayr Hemadeh, the President of MSS (1974-75) called for a serious, continuous, and sincere participation in all the MSS activities and he commented on the immense achievements of some of the MSS Committees despite their short life.

At the end, and amidst the cakes and the chats, the «surprise» of the party was announced. The surprise was a questionnaire on homosexuality which was distributed randomly to 26 of the 60 Med. I students present.

To quote some of the Med. I students that were present at this tea-party, the gathering had served not only to welcome a new class to this Medical School but rather to make this same group aware of the important responsibilities expected from it both in the academic as well as the extra academic fields. The Editorial Committee in turn felt entirely satisfied with the success of the event and hopes to establish a tradition of welcoming the entering Medicine I students every year. Needless to say, such an event would also offer an opportunity to congratulate the students on their acceptance into the school! !

EXCHANGE PROGRAM: WORK OR PLEASURE

To some the exchange programme means spending one month in a hospital abroad; to most it means a cheap vacation. Theoretically it is supposed to be a bit of both.

This summer nineteen students from Medicine I & II swarmed abroad. The countries they visited were: W. Germany (9 from Med. I), Sweden (6 from Med. II), Poland (2 from Med. II), Denmark (1 Med. II), and Finland (1 Med. I). The total number of exchange openings was 41.

Sex, food and lodging were the main subjects that came up in our interview with few of these people. Not forgetting to mention about the medical aspect of the exchange programme in itself, here are some of the impressions and reactions we were able to gather.

GERMANY: Those who went to Germany ranged from satisfaction to dissatisfaction. Those that were happy about it liked most the social life and excursions. One thing about the Germans is that they encourage and offer lots of tours to the different German cities, especially W. Berlin. The tours are frequent and easy to join.

Most rated the food in Germany as good. Moreover some 200-300 Deutch Marks were offered to cover some of the food expenses, as most of the hospitals offered only a limited number of free meals. The lodgings were near or in the hospital. Many of the social activities were organized mainly by IFMSA but in some places, even IESEC (an internal exchange program for students of business and economics), participated.

The departments visited were mainly internal medicine, surgery and dermatology. One of our friends that went to Erlangen claimed to have spent nine hours a day at the hospital. He was satisfied with the serious work he did and claimed to have learnt thoroughly about liver cerrhosis and claimed to have learnt thoroughly about liver cirrhosis there.

He however felt that the standard of teaching was a little low: lots of theory and little practice.

As for social life, he was satisfied—especially with the cheap facilities offered to students, such as pubs, discotheques and restaurants. German girls? He described them as liberal.

The reactions of two of our friends that went to Tubingen/W. Germany were quite different. On the whole they weren't very satisfied. No activities were arranged by the German exchange officers; they were on their own in the bush! They commented by saying that they didn't like the Germans, especially the elder Germans.

Their problem there appeared to be mainly one of language and the hostile German attitude towards strangers; especially Americans for which our friends were mistaken.

Some of our friends also complained about the difficulty they got in obtaining their visas to Germany. Others received their acceptances too late to contemplate travelling.

At this point it's also worth mentioning that the two people that applied to Spain got no answer in response.

POLAND: Things in Poland, however, were quite different. One of our students spent only a few hours per day in a hospital there. He learned little due to the difficulty in language. Moreover, he only frequented the hospital for the first ten days of his visit as there was so much to be seen and done outside the hospital boundaries!

The board and lodging were poor, the food «bad». No activities were organized for him. As a Lebanese he found it difficult to get used to the idea of standing in a queue to get whatever he wanted.

The only consolation he had was the liberal social life in Poland. He found the Polish girls very friendly, neither snobbish nor arrogant, they were easy to communicate with. But then, or actually that's why, was his second visit to Poland! Maybe explains everything!

FINLAND: Free beer is what our fellow in Finland enjoyed most. Moreover, he was quite flattered with the Finnish interest in his Mediterranean character and physique. He was quite impressed by the size and modern design of the hospital. When he worked in the Dermatology department, no wonder they were so interested in his complexion!

SWEDEN: Six of our second yearers went to Sweden; but one came back after a two week stay. On the whole they were quite satisfied. The exchange officers there managed to organize many interesting activities such as drinking parties, visits to Swedish social institutions and factories. The social life in Sweden was nothing compared to that of Poland.

L. Partamian Med. II
R. Tarabishy Med. III

(SCORPION & RADIOACTIVITY
Continued from page 30)

What is more, the hemolymph of scorpions contains a quantity, about 80 gms/ml, of a copper- containnig pigment with peroxydatic activity called hemocyanin which supplements the action of the catalase by eliminating a certain number of the peroxides. Furthermore, hemocyanin limits the proportion of dissolved oxygen in the blood which seems to play a role in radiosensitivity—when present. It has been postulated that there exists a direct relationship between the copper content of tissue and resistance to radioactivity. While mammalian tissue contain from 2 to 12 mg of copper per kg. dry bodyweight, those of insects contain 92 mg and certain marine invertebrates as much as 170 mg. The scorpion contains a proportion of 18% in homocyanim and has a blood concentration of copper of 0.130 mg/ml. To this can be added the stock of hepatopancreatic copper, the natural reserve for the biosynthesis of the hemocyanin molecule.

The intervention of a requlatory mechanism peculiar to the scorpion seems reasonable when one is to consider that presented with radiation this arachnid shows a single phase of a weak and sustained hyperglycemia and not the succession of alternating phases of hyperglycemia and hypoglycemia observed in other radiated animals. The importance of these mechanisms has been established at the level of the DNA; it is known that enzymatic systems exist capable of excising and rejecting an anomalous segment from a damaged DNA molecule and restoring noral DNA structure. (It should be realized that ionizing radiations are powerful mutagenic agents capable of changing the sequence of bases.)

It is evident that scorpions possess a structure concurring with what is already known about resistance factors in ionizing radiation. This peculiarity has earned them the title of «the guinea pigs of the atomic age.» The core of the subject lies in the unchanging nature of this animal throughout its evolutionary history which renders it difficult not to correlate it with its radioresistance, not forgetting its ability to resist such varied aggressive biological factors as anoxia, hunger, bacterial infection and ionizing irradiation.

SHERMINE DABBAGH
Med. II

NURSING SECTION

FOR OUR COLLEAGUES IN MEDICAL SCIENCES

To end our increasing alienation from our fellow students in the other Schools of Faculty of Medical Sciences, MEDICUS begins its 13th year of publication by introducing a section for the students in the School of Pharmacy as well as the School of Public Health. At the same time, we are expanding the traditional Nursing Page into a three-page setion.

We hope that the Nursing, Pharmacy and Public Health Students will respond enthusiastically to the call of their respective MEDICUS representatives in contributing to MEDICUS. Ultimately, no innovation is worth, unless the results justify the spirit of this innovation.

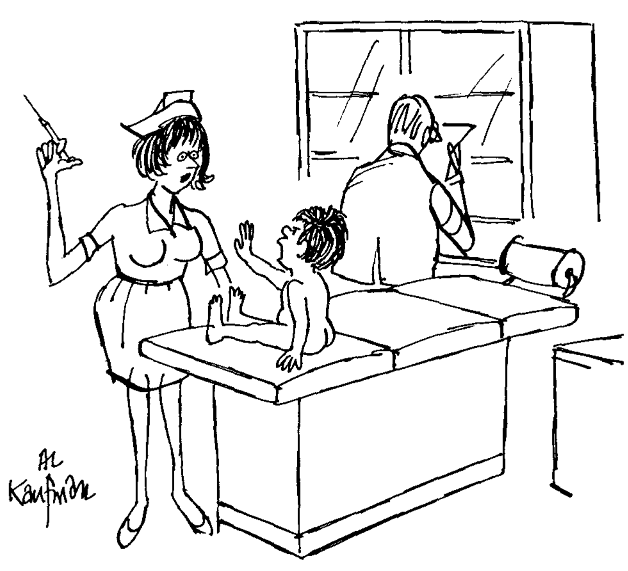
GENERAL ASSEMBLY

The Nursing Students Society had its first General Assembly on Thursday October 10, 1974 in SB 101 at 6:00 p.m.

Miss Leda Zanoyan, the NSS President, presided over the Assembly. The nursing students were given an idea of what the NSS really is and what are the requirements of being a member in it.

The different committee chairmen were asked to present their reports. Dr. Salim Walji (The editor-in-chief of MEDICUS) presented MEDICUS to the students and Dr. Zuheir Hamadeh spoke a few minutes about the importance of MSS-NSS cooperation.

Mrs. Shaya, the NSS advisor was present. There was a good response from the students and with their questions quite a few matters were clarified.



"Okay, hold it! Read me my rights!"

ROLE OF A NURSE IN CCU

The principle of a Coronary Care Unit (CCU) is to recognize minor arrhythmias following a myocardial infarction and to correct them before they develop into fatal ones.

CCU nursing is an advanced system. It is rightly called a nursing unit, because the number of lives saved with this specialized care can be directly related to the competence of the nurses in the CCU. I'll be concentrating on the extra challenges a CCU nurse meets and copes with and will omit most of the roles taken for granted. In order to understand the role and responsibility of a CCU nurse, we took a brief look at our own CCU. We see RNS, who after graduation had a minimum of three months of training in CCU. These RNS are directly involved with their patients who total twenty when the house is full. Eight of the patients occupy beds that can be constantly monitored while the other 12 are in post-monitor beds. This, the head nurse says, is a very important reassurance to the patients who are to leave the monitor. At least there is a consistency of the nurse caring for them and they won't have to be transfered to some other unit.

Now, one RN is continuously involved in monitoring the patients' cardiac status. She should therefore have a reasonable knowledge of EKG for she is expected to distinguish significant arrhythmias and administer anti-arrhythmic drugs according to a doctor's order or in dire need, solely on her own judgement. She should also be able to administer periodic shock (defibrillation) in the absence of a physician. A CCU nurse should also be able to administer oxygen, perform cardio-pulmonary resuscitation, as well as take a 12 lead EKG.

As for the routine nursing care, it is usually carried out by efficient and specially trained practical nurses who work under the supervision of a professional nurse. Besides her specialized role, a CCU nurse should be able to identify emotional reactions of patients by thoughtfully interpreting their verbal and non-verbal clues thus being in a position to impart a sense of security and well-being if need be. The nurse also collects and records data, since she is constantly in contact with the patient. She should observe and record any significant changes and should notify the physician or take prompt actions if necessary.

She also does a lot of teaching aimed at allaying the patients fears and decreasing his anxiety level. She starts by familiarizing him to the unit and to the strangee quipment in it. Then to help him to limit his physical activity thus minimizing the work load on the heart; but at the same time maintaining his optimal body mechanisms with passive exercises. Last but not the least, patients need instructions about their sodium restricted diet and this takes a lot of encouragement and is quite difficult to achieve. Thus, a well trained and a dedicated nurse plays a very serious and responsible role where even a minor mistake could cost the life of a patient.

HILDA BARAN
BSN IV

WORRYING

«The Lord may forgive us our sins, but the nervous system never does!»

Do you know what worry may do to you?

Do you know that sometimes you do not get stomach ulcers from what you eat but you get ulcers from what is eating you?

Do you know what worry does to the heart?

Do you know that high blood pressure is fed by worry?

Do you know that Rheumatism can be caused by worry?

Do you know how worry can cause a cold?

Do you know what is the relationship between worry and the thyroid?

Do you know that unpleasant emotions such as those caused by worry: fear, nagging ..... upset the body calcium balance and cause tooth decay?

Do you know dear nurses that few things can age and sour a woman and destroy her looks as quickly as worry?

Do you know that those who keep the peace of their inner selves in the midst of the turmoil of a modern city are immune from nervous diseases?

Do you know that doctors and nurses lead tense lives and pay the penalty?

Do you know that businessmen who do not know how to fight worry die young?

Finally I would like to ask you one more question:

What would a man profit if he gains the whole world and loses his health?

Even if he owned the world, he could sleep in only one bed at a time and eat three meals a day. Don't you think so?

Fundamental facts you should know about worry.

«Rule 1: If you want to avoid worry, do what Sir William Osler did: Live in «day-tight compartments.» Don't stew about the future. Just live each day until bed time.

Rule 2: The next time trouble—with a capital T—comes gunning for you and backs you up in a corner, try the magic formula of Willis H. Carrier: a. ask yourself, «What is the worst that can possibly happen if I can't solve my problem?»

b. Prepare yourself mentally to accept the worst if necessary.

c. Then calmly try to improve upon the worst which you have already mentally agreed to accept.

Rule 3: Remind yourself of the exorbitant price you can pay for worry in terms of your health.

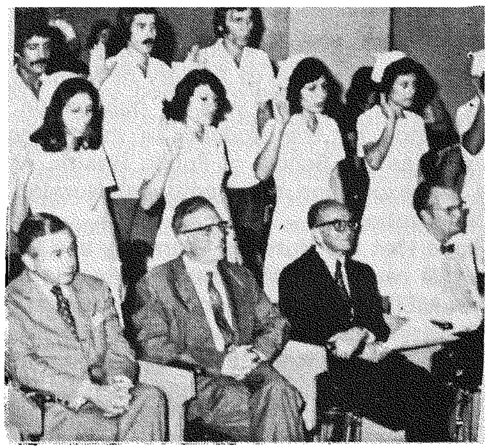
«Businessmen who do not know how to fight worry die young.» »

Source : **Dale Caregie**
How to Stop Worrying and Start Living.
Micheline Khalaf, BSN III

GET TOGETHER

The nursing students GOT TOGETHER on Monday 7th of October for the first time this year. The students and faculty enjoyed the games and the food. The spirits were high for two whole hours.

23 New Graduates



Diplomas were awarded last Friday to 23 men and women graduates of the Practical Nurse Training Program offered at the Medical Center. The special graduation ceremony, held at the Hospital was attended by President Samuel B. Kirkwood, Vice President George Hakim, Dean Craig S. Lichtenwalner, Dean Samuel P. Asper, Miss Esther L. Moyer, Director of the School of Nursing and a large group of parents and friends of the graduates.

Mr. M. Kuzayli, Acting Hospital Director praised in a word of welcome the career of a practical nurse. Mrs. M. Abboud, Coordinator of the Practical Nurse Program said the fresh group of nurses had worked hard to complete their intensified program.

The graduating address was delivered by Dr. Samual P. Asper, Dean of the School of Medicine and Chief of Hospital Staff who congratulated the graduates. Dean Asper said the graduates had around fifty years of work ahead of them. Wondering what new developments will Nursing witness from now until the year 2025, he stressed that the immediate care of patients will remain unchanged.

Dean Asper concluded by speaking of AUB's heritage of excellence, saying he was confident this high standard would be maintained.

The Practical Nurse Training Program was established in 1966 and has so far graduated 152 Practical Nurses. The program is designed to reinforce the nursing staff at AUH and at other hospitals in view of the need for nurses in Lebanon and the Middle East.

(From "AUB BULLETIN", Oct. 10, '74)

PHARMACY SECTION

INTRODUCING PHARMACY

The Pharmacy students, for the first time, are joining the «family» of Medicus, and with the few pages that have been given to us, we hope to rejuvinate an ambitious magazine. Our membership in the publication is not however a privilege but more of a right; a right for we are members of the A.U.B. Medical Faculty.

There have been claims made that the pharmacy students are far off from the Medical activities (MSS) or even far away geographically (in their isolated building). However the distance from A.U.H. to the School of Pharmacy is shorter than the distance to the Medical Library (Van Dyck) or to the Milk-Bar. Therefore a geographical claim is incorrect. Perhaps the «distance» idea exists only in the minds of the Medical students themselves. They seem to have a tendency to view our major as distant, unrelated and practically with no connection to Medicine. While on the contrary, one does not need much insight to be able to realize that we strive for the same goals: the use of scientific knowledge and its direct application in aiding people, and to fulfill the responsibilities of our profession; the respect and cure of human life, a proof enough for the same moto of our two professions. Nevertheless this slight, so called innocent difference originated in our student life, has clearly manifested itself now among members of the two professions in society causing a great discrimination. Unfortunately, pharmacy rankes much lower, and instead of the two professions supplementing each other, one is being forced out. I see this as perhaps a major indirect factor which has served in phasing out the school of pharmacy...

Despite the unpleasant situation we now face, our ambitions as future pharmacists still exist, and we still hope to make the best of our present, socially and academically, not forgetting our zest to restore a long continuity of our school and acquire all the rights of our profession.

Thanks to the members of MEDICUS who sincerely believe that pharmacy belongs to the Medical Faculty, we are now able to express the students opinion for our cause. Also a step has been taken in bridging the unnatural gap among students of Medical Faculty.

SAMIR KANAAN
Pharmacy Representative

FROM THE CABINET

The Pharmacy Students' Society is co-operating this year with MEDICUS; as elected representatives of all Pharmacy students, we feel that the purpose of the Pharmacy Section in MEDICUS is to serve as a medium for discussion and analysis of our problems and secondly to present valuable information on scientific subjects of current interest.

Pharmacy, as a profession, forms a very integral part of the whole medical profession and its importance can be demonstrated at more than one level:

1st — On a scientific and therapeutic basis, it has the sole responsibility of manufacturing drugs and carrying out extensive and intensive research programs to continuously provide better and more efficacious medications to humanity at large.

2nd — As a source of scientific information as far as the drugs are concerned, Pharmacy plays a very important role for it keeps the practising physician constantly informed about various new studies and progresses made. Infact, in the rapidly proliferating world of medical knowledge, a physician has hardly any time to keep up with his own literature—a handy knowledgeable pharmacist is often his ready source for information about different drugs and their toxic and side-effects.

3rd — At the level of masses, pharmacists play a very important role in dispensing a correct prescription with appropriate dosage.

As more drugs are being produced for therapeutic and diagnostic purposes and as more drugs are sold over the counter, pharmaceutical profession is entering into a new era with the emergence of such new specialities like Clinical Pharmacy, involving pharmacist-patient-physician interaction.

But in AUB, the future for the pharmacists is a bleak one. Just as the Faculty members of the School of Pharmacy were on the verge of completing a totally new and impressive curriculum which took into account all the new trends, the very unfortunate decision of the Board of Trustees to gradually phase out the School was made official.

Having taken into consideration that AUB's standard of education remain the best in the Middle East and compares very favorably with similar institutions in the West, and that the School of Pharmacy had hitherto always maintained a similar standard, we the students of the School of Pharmacy cannot sit idle while such a drastic decision is being taken, which will affect our lives as well as the entire Medical Faculty. We thus urge all the students and members of Staff of the Faculty of Medical Science to give this matter an appropriate re-consideration and let us all remain optimistic about the final outcome.

George Breidi
President, PSS

GLIMPSES :

1 Being a pharmacy student who had been in direct contact with the work of the pharmacist last summer in one of the Hospital pharmacies of Beirut, I was really amazed to see what the pharmacists there were doing. I know I have no right to criticize people who have been working since years and years especially that I am still a second year pharmacy student, but I was really disappointed. I thought that the practice in a hospital pharmacy would be much more challenging and interesting. I expected the pharmacists working there to be of greater service to the patient, physician and nurse; to apply their professional trainings and abilities more directly and intimately. While in the hospital pharmacy all I could notice was that the pharmacist is only recognized as a person responsible for the safe distribution of prescribed drugs, narcotics, and poison. Most people visualize him as the white-jacketed man available to dispense their prescriptions. I am writing here neither to blame these people, nor to criticize those pharmacists; but I want to emphasize that the pharmacist is not an ordinary trademan; he is not just the seller or the dispenser of medicines. He serves his job as a prime source of information on health topics; he checks a patient's prescription before giving him the drug; and even much more than that, doctors rely on pharmacists for information about various drugs. Certainly dispensing drugs is one of the main critical jobs of a pharmacist, and it holds within it a great responsibility; but what I am trying to say is that such a kind of work limit my ambitions and the ambitions of many other fellow student. Maybe it is the fault of our country which lacks various opportunities in which a pharmacist can apply his abilities. Of these opportunities: clinical pharmacy and industry are of the newest approaches. And certainly there are many opportunities in the Hospital pharmacy other than dispensing... I really feel sorry for being one of the students of the last unluckiest class in the school of pharmacy. But let us work all together and be cooperative to do our best to reopen the school with better plans for a better achievement and a wilder field of specialization.

ABLA MEHIO
Pharmacy

2 Every morning I find myself in the mood of writing when I walk up the parlour of the school of pharmacy with its long stairs to the class. I find myself obliged to write about my feelings and situations especially that we are in the first month of the academic year...

When I reach the old-fashioned class with its wooden floors, I wish to take a history course, but alas, all our wishes vanish when I watch the professor talking all day about science and only science. Four years of our lives pass, going from class to laboratory to get our B.S. degree in pharmacy, and to be named «qualified pharmacists.» Yes, we are qualified in every respect! ! !

Many suggestions for the improvement of the school of pharmacy were planned and accepted by the Dean of the school with the help of the professors. They tried to prove that a pharmacist is not a merchant as most people believe. A pharmacist, I am sure, cares for patient's life and not his pocket.

All those suggestions vanished, when the university declared that the school will be closed. Hence, we are the last pharmacy graduates in Lebanon from A.U.B. But being a pharmacy student, does not mean that we have to live on memories of past days; for we must struggle to improve our profession and open the school again.

HANAN KHALIL
Pharmacy

3 «I think therefore I am.» Thinking is the essence for existence from which arises self satisfaction making a person socially fit. He can serve his society, cope with its demands and manufacture its needs. And being a medical faculty member gives him the privilege for direct dealing with humanity. ...A pharmacist is not a businessman who buys and sells and becomes well off! He is not an inferior person who is being destructive to his group. A pharmacist is always the one who is searching for better means, in nature, plant and animal kingdom and everywhere in order to serve man; at AUB our pharmacy group is a small one whose members are trying to fight and struggle for better existence. They are responsible, independent group yet a group who have no rights but duties. They feel restricted to their group only. Their identity at AUB is not distinguishing although they are serving society as well as any other faculty. But they are always there and will always be, ready to serve, eager to contribute, generous to give. Their service is needed all over the world. Chemical and pharmaceutical companies are being established, food problems are arising, oil manufacture has been progressing. And all this activity is looked after by trained pharmacists as well as by other trained personnel.

So we always have to keep up to the level, hard workers, courageous as ever, hopeful as life continues and united as humanity exists. We will not be defeated because this means our society will be degenerating rather than progressing if we stop our march.

FATINA MALAS
Pharmacy

PHARMACY STUDENTS' SOCIETY
CABINET 1974-75

PRESIDENT :	George Breidi, Phar. IV
1st VICE-PRESIDENT :	Sawsan Kayyali, Phar. III
2nd VICE-PRESIDENT :	Dikran Kapriehan, Phar. II
SECRETARY:	Marline Alfa, Phar. II
TREASURER:	Garo Konyalian, Phar. II
IV-YEAR REP.:	Adil Mastari
III-YEAR REP.:	Rufayl Kandalaft
II-YEAR REP.:	Mahmud Sabbagh

«You want to live?»
«It depends how.»
«One can also die in various ways.»
«At least one doesn't have the choice......»
«Do you think one always chooses one's way of living?»

PUBLIC HEALTH PAGE

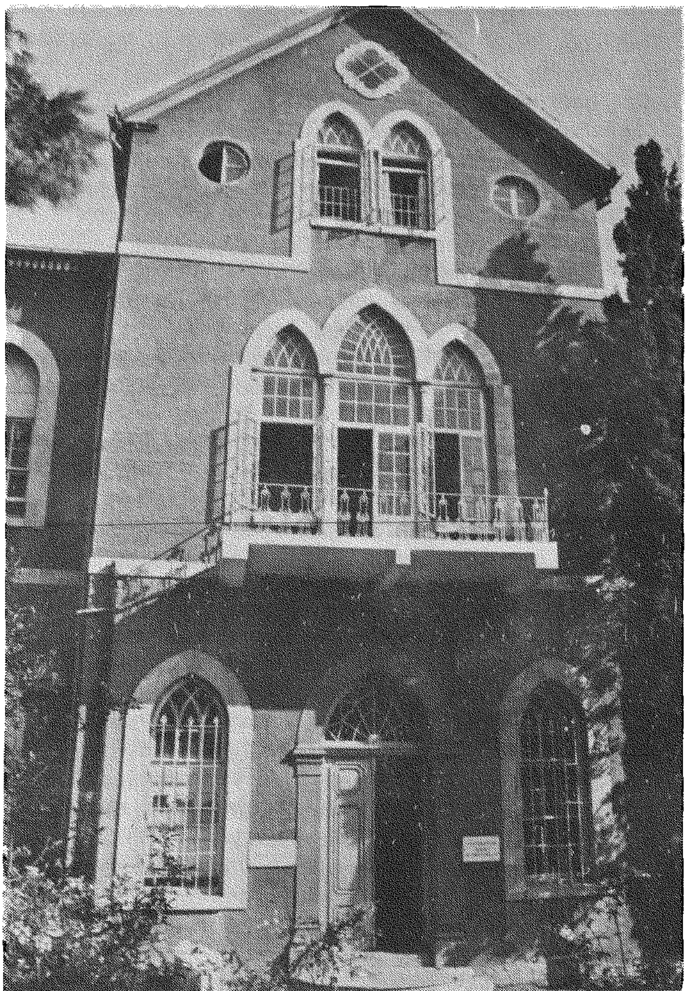
The fate of the school of public health is being increasingly questioned these days. The school, one of the four in the faculties of Medical Sciences, was opened in 1954. Some even have a wrong feeling that the school is being closed down, along with the school of Pharmacy, for various financial and academic reasons. However, in its last meeting in New York on March 9-10, 1973 the Board of Trustees decided to retain the School of Public Health provided that the status of the school improves in the coming months.

We, students in the School of Public Health, believe that this school is necessary especially in this part of the world where little, if any, attention is directed towards public health measures.

In its present form, the school comprises five departments:

1. Department of Community Health Practice.
2. Department of Environmental Health.
3. Department of Epidemiology and Biostatistics.
4. Department of Health Service Administration.
5. Department of Tropical Health.

To emphasize the role of the school in this area of the world a brief review of certain activities of each department might be in order.



COMMUNITY HEALTH PRACTICE:

The Department of Community Health Practice recently engaged itself in four study programs. It participated in the teaching of Preventive Pediatrics to medical students, and in the teaching of Public Health Nursing to basic nursing students. Research was also done to investigate the fertility patterns and the use of contraceptive devices in Lebanon, and finally conducted some operational research in health care delivery at the Mreyjeh.

ENVIRONMENTAL HEALTH:

The Department of Environmental Health has started a program of consultation services on limited scale, against some nominal fee. The services include chemical and bacteriological laboratory examinations for analysis of sewage water and industrial wastes. A research project on air pollution will also be initiated through financial assistance from the Lebanese National Council for Scientific Research. This department together with the division of Sanitary Engineering have been recognized jointly by W.H.O. as a collaborating institution for their international reference center for community water supplies and waste disposal.

EPIDEMIOLOGY AND BIOSTATISTICS:

In the Department of Epidemiology and Biostatistics the main research has focused on continuation of the studies on epidemiology of human reproduction, jointly conducted with other groups in Iran, Turkey and India. Other research is directed towards education and mental illness as well as studying the relation between social class and mental illness, the health status of Beirut school children is also being studied.

HEALTH SERVICE ADMINISTRATION:

The Department of Health Service Administration participated in consultations in Saudi Arabia with members of the Saudi ministries of Health Education and Finance, for the development of model health services center in the Kingdom; recently the school has been asked if it would be willing, and be able to serve as a consultant to the government of Nepal for assistance in setting up a prototype of health care delivery system.

TROPICAL HEALTH:

Finally, in the department of Tropical Health, parasitological research has been going on for many years. Some of the aspects that had been previously elucidated were in the fields of physiological chemistry and the pharmacology of hydatid diseases; histological chemistry of ticks; Immunological Studies on Trichomonas; and Ecology of Filariasis. We find it worth mentioning here that 25 students have graduated with a Master of Sciences degree from the Department during the past 18 years and eleven of them worked towards their Ph.D. degrees, and participated in various areas of research in Lebanon and abroad.

A final word indicating the importance of the School of Public Health is the extreme cosmopolitan nature of its student body, that represents some 20 different countries from distant corners of the world.

GEORGE BAHR
Public Health Representative

COMMITTEE REPORTS

ATHLETICS COMMITTEE

This committee, as the name implies, is responsible for the planning and the implementation of various sports activities both inside the medical school and between the medical school and the rest of the schools in AUB. Despite the fact that this year's program has not crystallized, yet there are some changes the newly formed committee is anticipating. These are:

— Activities supervised by the Committee will encompass a wider range than that of the elapsed years.

— Starting from the last week of October 1974, AUB play courts will be reserved each Wednesday and Sunday (at 6:30 p.m. and 2:30 p.m. respectively) for all those medical students interested in either attending training sessions or practising on their own.

— The Committee will take the responsibility of keeping the medical student body informed of all the programs in the field of sports. It is also looking forward to a fuller and richer participation from all groups in the school.

Following are office bearers in the Athletic Committee:

Chairman : Yousef Hajj, Med.
Members : Sami Costantine, Med. V
Ghassan Dagher, Med. V
Walid Salamoun, Med. IV
Walid Baddura, Med. IV

CURRICULUM COMMITTEE

The MSS Cabinet has restructed the Curriculum Committee this year in order to facilitate student participation. Following changes have been introduced:

* The Student Curriculum Committee will be composed of 5 members, one student from each class (Med. I-V). This committee will meet once every week to decide upon any suggestions to alter the curriculum before handing them over to the Faculty Curriculum Committee.
* Two of the above five students who were directly nominated by the MSS Cabinet will act as liason officers between the student body at large and the Faculty.

The Faculty Curriculum Committee has 8 task forces or sub-committes, which will study the curricular program of 7 medical years (from sophomore pre-medicine to Med. V). Each of these task forces will report to the committee according to a present agenda.

All medical students are welcome to participate in any of these sub-committees and are requested to contact their class representatives for further information.

EDUCATION COMMITTEE

The projects of the Education Committee of MSS for the present year can be summarized as follows:

— Seminars, to be conducted by students, residents and Attendings.

— Bi-weekly film projects followed by discussion co-ordinated by an Attending specialized in the respective field. The first such film, on **«Anemia»** was projected on October 18, 1974 and was followed by a work-up of an anemic patient by Dr. Nabila Wehbe.

— A course on principles of electro-cardiography will be conducted during the month of November 1974 and will be co-ordinated by Dr. Riad Tabbara, Chairman of Dept. of Internal Medicine. In essential, it will consist of 10 seminars, spread over 2 weeks. The exact date will be announced soon.

— Another course, **«Principles of cardiology»**, will also be organized in the forthcoming months.

— A contest will be held where the participants will present either original or review articles. A special session will be held to present the winning papers.

— Subscription to **«Medical Letter»** at special reduced rates for medical students.

The Education Committee welcomes all suggestions and participation at any level. The Chairman for this year is Ghazi Zatari, Med. IV and the Co-Chairman is Leila Khouri, Med. III.

EXCHANGE PROGRAM COMMITTEE

This Committee is a member of the International Federation of Medical Students' Association (IFMSA) which aims at:

1. establishing solid relations among medical students' associations all over the world and
2. offering clinical clerkships to medical students who are members of the above associations through a yearly exchange program.

During the past few years and particularly last year, the Committee has been expanding its domain of activities so much so that AUMC received this summer, 15 exchange students. On the other hand, a higher number of medical students benefieted from this exchange program in various European countries.

The Committee hopes to further promote its plans for this year so as to accommodate more clerkship. Previous experience has taught the workers in this field that this step would facilitate the medical learning process in more than one aspect.

Following are office bearers in The Exchange Program Committee:

Chairman : Walid Baddura, Med. IV
Members : Platon Papadopolus, Med. III
Mohammad Bulbul, Med. II

GENERAL KNOWLEDGE COMMITTEE

The main «raison d'être» of the General Knowledge Committee is to enrich intellectually, the milieu of medical students. Hitherto, its sole task was to organize general knowledge contests—this of course falls short of what the committee ought to be doing and hence this year, we shall be working on a revised plan. Some of our activities this year will be:

— A permanent representation in the Arabic pages of MEDICUS.

— Sponsoring panel discussion on topics of general interest, such as birth control, etc...

— Organizing lectures covering para-medical fields, such as acupuncture, etc... and promoting photography.

— Keeping up with the time-honored tradition of having general knowledge contests between various classes and schools.

— Carrying out collective projects in collaboration with other MSS committees.

The chairman for this year is Nicola Abourizk, Med. IV.

ISCTH COMMITTEE

July 1975 will mark the tenth anniversary of the International Student Conference on Tropical Health (ISCTH), an activity which is sponsored by the IFMSA and which attracts students from various countries from Europe to Africa.

This conference offers foreign medical students, specially those from Europe, to be acquainted with a number of infectious and tropical diseases which they do not so frequently come across and which are not taught in their regular medical program. For the African students, our excellent lab facilities and the vast experience of our Faculty members specialized in these fields, offers an opportunity to appreciate disease entities which are endemic in their regions.

This year, the committee will mostly adhere to the well-organized programs laid out in the past by presenting seminars, case-discussions and lectures coupled with several trips to interesting and historic sites of Lebanon. Work has already been begun in a big way and IFMSA has been contacted to advertise the coming conference. The committee welcomes all participation and wishes to inform the students that it holds a weekly meeting every Monday.

This year's chairman is Ziad Shehab, Med. IV.

SCHOLARSHIP COMMITTEE

The major goal of this committee is to provide some financial assistance to needy medical students, through loans rather than free grants. It does not claim to cover an appreciable amount of these needs. However with time, it is expanding its domain so that a bigger number of students will benefit from loans as the year progresses.

The choice of students depends primarily on an urgent and genuine financial need which if not met will ultimately compromise the continuity of the medical education of such students. It is worth nothing that scholarships are distributed only in the second semester and this is due to the fact that during the first semester, means are sought to raise the necessary funds. In the previous years, some of the sources were:

1. AUB Alumni society.
2. Social activities sponsored by the Committee itself or the Social Committee of the MSS.
3. Medical Students' Society.
4. Miscellaneous.

This year, the Committee has already been in touch with various agencies and the response so far appears very encouraging.

LAST YEAR'S REPORT (ACADEMIC YEAR 1973-74)

Class	No. of students	Total amount (L.L.)
Med. I	5	2,700
Med. III	4	1,800
Med. II	10	2,525
Med. IV	4	1,500
	TOTAL L.L.	8,525

Following are office bearers in the Scholarship Committee:

Chairman : Tarek Fakhri, Med. III
Members : Kamel Abu Dahr, Med. I
Nabil Fuleihan, Med. II
Ghazi Zatari, Med. IV

SOCIAL COMMITTEE

The Social Committee of MSS has been established with the aim of promoting social activities and inter-action between students and faculty and at the same time raising funds to support the scholarships for the needy medical students. Obviously, the success of this committee depends mainly on the enthusiastic participation of all students and faculty members.

The first activity of this year will be the traditional **Pin Party,** scheduled to take place on November 2, 1974 at the Mary Dodge Hall, AUB Campus. It will be organized as a joint activity with the Social Committee of NSS participating and its sole purpose is to officially welcome new students of both the schools.

The committee will also organize in the forthcoming months, a **Cinema Gala** and the annual **Medical Grand Ball.** All students who are interested in participating in the organization of these activities plus others, are requested to contact Fayez Takieddine, Med. V, who is this year's Chairman.

SOCIAL MEDICINE COMMITTEE

This experimental committee in community health was started in August 1973 with the following main objectives:

1. Promote health in deprived Lebanese sectors essentially through preventive medicine by offering:
   a) Health services as vaccination against DPT, poliomyelitis, family planning procedures as tubal ligation, mosquito control campaign, etc. This step is considered a prerequisite for establishing a good rapport with the local community thus laying a more solid ground for, (b) which forms the crux of the health plan of this committee.
   b) Health education in the form of informal talks delivered to school children, females in child bearing age and young men. All this to be supported by Audio-visual tools.
2. To let medical students take an active role in planning the above experiment under appropriate guidance.
   Infact, the planners of the said experiment are a small group of medical students and the implementors are students from all AUB school. The field of work is a locus of villages in the South of Lebanon (Nabatieh for the year 1973-74). Residents and Attendings from the medical school, as well as students and faculty members from various AUB departments have greatly contributed to the success of the committee's work in the past year.

For the year 1974-75, the Committee will be working in 2 villages in Qaza Tyre: Bazourieh and Shehabieh. Already one vaccination campaign has been conducted on October 13, 1974. The plans for this year will conform to the above objectives. More concretely, they will comprize of:

i) Vaccination against DPT and polio.

ii) Visual screening for recommended age group of children.

iii) Health talks particularly directed to females of child bearing age and to school children.

iv) A campaign for infectious diseases.

v) Distribution of calenders and X-mas cards. These were adopted from paintings done by school children from 6 villages of Qaza Al Nabatieh.

vi) Organization of several social campaigns as painting schools, building yards, etc. These will be under the supervision of students of Arts & Science society.

3. In the minds of the planners of the Social Medicine Committee, mobilizing the whole AUB student body and directing its potentialities and interests to the needs of our people is by far more important than the practical number of activities achieved.

Following are office-bearers in the Social Medicine Committee:

Chairman : Nadim Karam, Med. III
Officers : George Atweh, Med. II
Adlette Inati, Med. IV
Tony Hajj, Med. II
Advisor : Dr. Elias Srouji

DEPARTMENTAL NOTES

(As of this year, MEDICUS is launching a new feature entitled «Departmental Notes». Chairmen of all the departments of the School of Medicine along with the heads of various divisions are welcome to contribute. Contributions can be in the form of changes in program, report about any staff member attending local or international meetings, announcements of any special post-graduate programs to be held, notices to students, etc...)

ANESTHESIA DEPARTMENT

* Dr. Anis Baraka was appointed the Chairman of the department, effective September 1974. Dr. Baraka is known for his research on neuromuscular transmittors.
  During the month of May 1974, Dr. Baraka was invited to the **Mid-West Anesthesia Conference,** where he presented 2 papers and participated in a panel discussion on **Neuromuscular transmission.**
  At Madrid, Spain, Dr. Baraka attended the **European Congress of Anesthesiology** in September 1974, where he talked about Galen-ethamine versus other anti-cholinesterases.
* The department is anticipating the arrival of Drs. Halim Habr and Samir Fuleihan both of whom did 2 years of Residency training here at AUH after which they proceeded to USA for further specialization.

BACTERIOLOGY

* The usual 10-week **Basic Bacteriology** course offered to Medicine II students has been expanded to 16 weeks and will now incorporate Parasitology.
* Graduates of the department are actively involved in various projects ranging from **Endemic Diseases** to **Flies as vectors of diseases.**
* Dr. Uwayda, who is one of the most active members on the staff, was away for 2 months to the States and England, where he attended several conferences.

HUMAN MORPHOLOGY

* A post-graduate course on Anatomy will be held some time in February 1975.
* Dr. Afifi, the Chairman, was away for a whole year on sabbatical leave.

INTERNAL MEDICINE

* Dr. Sawaya, the energetic young cardiologist, was once again abroad, this time to Bucharest, where he attended from August 4-16, 1974 an **International Conference on Epidemiology and Prevention of Cardio-vascular Diseases.**
* Dr. Sami Kaid-Bey, travelled this summer all the way to Buenos-Aires, where he attended the **International Cardiology Society** meeting.
* Dr. Farid Fuleihan, head of the division of Respiration, announced the introduction of a new **Fibro-optic Bronchoscope** for routine clinical diagnosis.
* The division of Respiration has as of this academic year introduced Thursday afternoon conferences, which will be held between 4:00-5:00 p.m. in S.B. 99.

OPHTHALMOLOGY

* Dr. Khaled Taboara has recently joined the department as a self-supporting full-timer with a status of Assistant Professor (see box under **NEW HORIZONS**).
* Dr. Tabbara and Dr. R. Frayha (Internal Medicine) will be working on a joint project centering arou.ıd **Rheumatoid Arthritis and Dry-Eye Syndrome.**
* Dr. Fares and Dr. Tabbara are carrying out a clinical trial with Clindamycin as treatment for Toxoplasmosis.
* The department has organized a Post-graduate course between November 1-2, 1974 on **Trauma to the Eye.** All the staff members will participate.

OTORHINOLARYNGOLOGY

* Dr. Salah Salman, the Chairman talked of the need to establish an **academic department,** rather than a service department. Talking about research, he said that he would like to leave it to the very end and give a priority to undergraduate and post-graduate teaching and patient care. Planned expansion (without sacrifising quality) of the faculty by training ENT graduates in States according to the needs of the department will be one of the projects which the department will undertake.

PATHOLOGY

* Dr. Zuher M. Naib, a Syrian by origin, was here this summer at AUH, where he conducted a special course to train AUB cytologists. Dr. Naib, who is the Professor of Pathology and Director of Cytology Lab at Emery University and Grady Hospital at Atlanta, Georgia, is the proponent of the theory, which is now widely accepted, that the causative agent of the Ca of Uterine cervix is H. simplex II.
* Dr. Michael B. Gravanis is currently very actively involved in teaching the **Basic Pathology** course to Medicine II students. Dr. Gravanis, who is of Greek origin, is the Professor and Chairman of the Pathology Department at Emery University. Medicine II students are enthralled by his warm personality and his Greek accent!
* Middle East faces a very acute shortage of trained Pathologists. Currently, there are 5 Pathologists in Lebanon, just 1 in Syria and 2 in Amman! ! Dr. Victor Nassar, the Hopkins' trained Chairman (Ag.) of the Pathology Dept. here at AUH, is most willing to give appropriate guidance and advice to all medical students wishing to pursue pathology for their post-graduate training. He is available all the time in his office at 3rd floor, Phase I.

PEDIATRICS

* Dr. S. Najjar, the Chairman, is starting on a research project, on **Pathogenesis of Groiter.** In the month of September, Dr. Najjar attended the **Iranian Pediatric Society Meeting,** where he gave 5 lectures.
* Dr. Der Kaloustian, spent 2 months in Holland where he attended the **International Conference in Genetics.**
* Dr. R. Geha recently attended the **International Immunology** meeting from where he went to Switzerland for a course in in immunology.
* **The 5th Arab Child Conference** held in Amman this summer was attended by Drs. A. Barakat, Bitar, Dabbous, P. Haddad, Najjar and Sanjad. All, except Dr. P. Haddad, presented papers.
* Dr. P. Haddad and Dr. Idriss participated in the **International Pediatric Meeting** in Argentina during the summer.
* Pediatrics Department, one of the most well organized and active departments at A.U.H., has many research workers carrying out various projects. In the next issue of MEDICUS, details of these projects will be released.

REVIEW OF JOURNALS

HYPERPARATHYROID BONE DISEASE IN CHILDREN UNDERGOING LONG-TERM HEMODIALYSIS; TREATMENT WITH VITAMIN D.

The article presents experience with 17 patients all children who had been in a hemodialysis program for more than 6 months; three had hyperparathyroid bone disease before entering the program and five developed it after 2-17 months of dialysis. The incidence of bone disease was related to the duration of azotemia and not to the duration of dialysis, to the dialysate concentration of calcium, or to the predialysis serum concentrations of urea nitrogen, calcium or phosphorus.

Six children with bone disease were treated with vitamin D in average daily doses ranging from 32,000 to 57,000 IU for periods of five to 13 months. In three the bone lesions healed, in 2 they were improved and in 1 there was progression until a renal transplant was performed. Hypercalcemia was slight; conjunctional calcification was the only form of metastatic calcification observed. The calcium content in the skin of the children was less than that in adults who had had dialysis for comparable periods of time.

From the «Journal of Pediatrics»
Volume 85, July 74, no. 1, page 60

CEREBRAL DWARFISM

The article presents the clinical, neurologic, and endocrine investigations of 10 children with cerebral dysfunction and growth retardation. The neurologic abnormalities include mental retardation in all children with evidence of cerebral damage in one or more of the following: Neurologic examination, dysrhythmia on EEG or cerebral atrophy on PEG.

Severe microcephaly was found in six of the 10 children; growth retardation was associated with delayed skeletal maturation in all. The rise in serum immunoreactive growth hormone (IRHGH) after arginine and insulin stimulation tests was found to be limited in 3 patients; in 5 only, the response to arginine was blunted. There was no significant increase in serum IRHGH concentration during sleep in 5 patients. Two children had a low circadian variation of plasma cortisol levels and a low rise in urinary 17-ketogenic steroids during a metapyrone test. It was therefore concluded that there was an abnormality in hypothalamic function associated with prenatal or perinatal cerebral anoxia resulting in a deficiency of some of the hypothalamic releasing factors.

From the «Journal of Pediatrics»
Vol. 85, July 1974, no. 1, page 36

LONG TERM THERAPY IN CONGENITAL ADRENAL HYPERPLASIA

The article discusses the experience with treatment of 93 cases of congenital adrenal hyperplasia due to 21-hydroxylase deficiency and analysis has been directed with respect to growth, bone maturation and steroid excretion. Doses of hydrocortisone, prednisone and cortisone have been established to produce optimal effects and the question of the time of the day when such doses are best administered is discussed. It was found that the best basis of therapy recommends a dose of oral hydrocortisone of 25 mg/square meter. The danger of over or undertreating patients appears to be minimized by giving the larger part of the dose in the morning.

From the «Journal of Pediatrics»
Vol. 85, July 1974, no. 1, page 12

MANAGEMENT OF MALIGNANT HYPERTENSION COMPLICATED BY RENAL INSUFFICIENCY

Criteria for chosing patients:

- severe essential hypertension
- papilledema
- BUN 50 mg/100 ml.
- absence of complications

Twenty such patients were chosen and were administered aggressive hypotensive drug therapy combining a thiazide diuretic, hydralazine and guanethidine. Eleven of the patients lived for 1 year, four for five years and two for 7 and half years. One is still alive beyond 8 years.

Eleven died of Uremia. In patients surviving for only weeks or months the arterioles and small arteries were most affected. For those who survived longer, pathology was in the larger arteries. So: aggressive reduction of blood pressure does not necessarily result in deterioration of renal function and may prolong survival.

«NEJM», Vol. 291, July 4, 1974
Number 1, page 10.

BONE-MARROW TRANSPLANTATION FOR HEMATOLOGIC NEOPLASIA IN 16 PATIENTS WITH IDENTICAL TWINS

NEJM, Vol. 290, No. 25
June 20, 1974

Sixteen patients (11-67 years of age) with hematologic neoplasia refractory to conventional therapy were treated with cyclophosphamide 60 mg/kg/day on 2 occasions, a supralethal dose of total body irradiation (1000 rads) and a bone marrow transplant from a normal identical twin. Twelve patients also received immunotherapy consisting of subcutaneous injections of the patient's own leukemia cells irradiated with 10.000 rads and intravenous infusions of peripheral blood lymphocytes from the normal twin. Fourteen patients experienced complete remission. Six patients (2 with acute lymphoblastic leukemia, three with acute myelogenous leukemia and one with lymphosarcoma-leukemia) remained in complete remission at 11-44 months without any maintenance chemotherapy and the others with acute myelogenous leukemia were in complete remission at 2 and 3 months. One patient died of viral hepatitis without leukemia.

Five patients relapsed at 3-7 months. This approach can thus induce frequent and induring remissions in end stage patients.

RISK FACTORS FOR BRAIN ABSCESS IN PATIENTS WITH CONGENITAL HEART DISEASE

Data in 26 cases of cyanotic congenital heart disease and brain abscess between 1960 and 1973 were reviewed and compared with data in a control group of cyanotic congenital heart disease without brain abscess.

Brain abscess occured in 2% of the population with CCHD. Tetralogy of Fallot and dextrotransposition of the great arteries accounted for 81% of the cases (21 out of 26). The mean arterial O2 saturation in the patients with brain abscess was 75% compared with 86% in the control patients. Morbidity and mortality were inversely related to O2 saturation levels. Since brain abscess is exceedingly rare in patients under age 2 years, corrective surgery before this age would probably reduce the incidence of brain abscess in patients with congenital heart disease.

From «The American Journal of Cardiology»
Volume 34, July 1974, page 97.

مديكوس

مجلد ١٣ العدد ١ ١-١١-١٩٧٤

المرأة ذو المظلة الحمراء ١٩٣٣
في الفن والحياة

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الصفحة العربية

عبر التاريخ ، لكل أمة مجدها ، والمجد لا يكون الا بالجهد الذكي ، فالعرب بنوا حضارة عريقة كغيرهم من الامم ، وبناء الحضارات لم يبدأ من الصفر عند اي أمة من الامم ، فالعرب لما دخلوا بلاد الشام نقلوا العلوم الشرقية واليونانية الى لغتهم فكان ما سمي بعهد الترجمة وكانت طبقة المترجمين ، ومن ثم نظر العرب في ذلك التراث الكبير فتاثروا به ، وطوروه ، ومن ثم زادوا عليه ، وبعد اكتشفوا . ولما فتن العرب بما حققت ايديهم التهوا فيما بينهم ، حتى غزاهم الافرنج تحت راية الحروب الصليبية . وكان بين الافرنج من يدرك قيمة العلوم والفنون التي توصل اليها العرب ، فاستشرقوا والموا باللغة العربية ، حتى غدا بعضهم يعرف اصولها اكثر من اهلها ، ثم نقلوا التراث العربي الى لغة بلادهم وفعلوا به فعل العرب بتراث بلاد المشرق واليونان . وبينما كان العرب يغطون بنوم عميق كانت اوروبة تتفاعل مع المعرفة فتبدع حضارة، وتمتلك القوة ، فاخذوا بلادنا بغفلة من اهلها . وها هم شبابنا اليوم ينكبون على منابع العلم اينما كانت ، ذلك خير وابقى ، ولكن بينما نحن ننهل من ثقافة الغرب ونغوص في بحر ما توصلوا اليه من علم ومعرفة وتنظيم نكون عرضة الذوبان فنتيه عن أرضنا ، ولهذا اردنا هذه الصفحة العربية ميدانا ، نمارس فيها حبنا لامتنا .

وانا الان اتوجه اليكم داعيا ، من امن بوطنه على تعدد مذاهب تفكيره ، انه اذا ما توصل الى ناصية فكر او حصل على مركز قوة او يتذكر انتمائه الى امته وان يكون نصب عينيه ان عليه ان ينير الطريق بمصباح معرفته .

عبد الله فروخ

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الفن والحياة

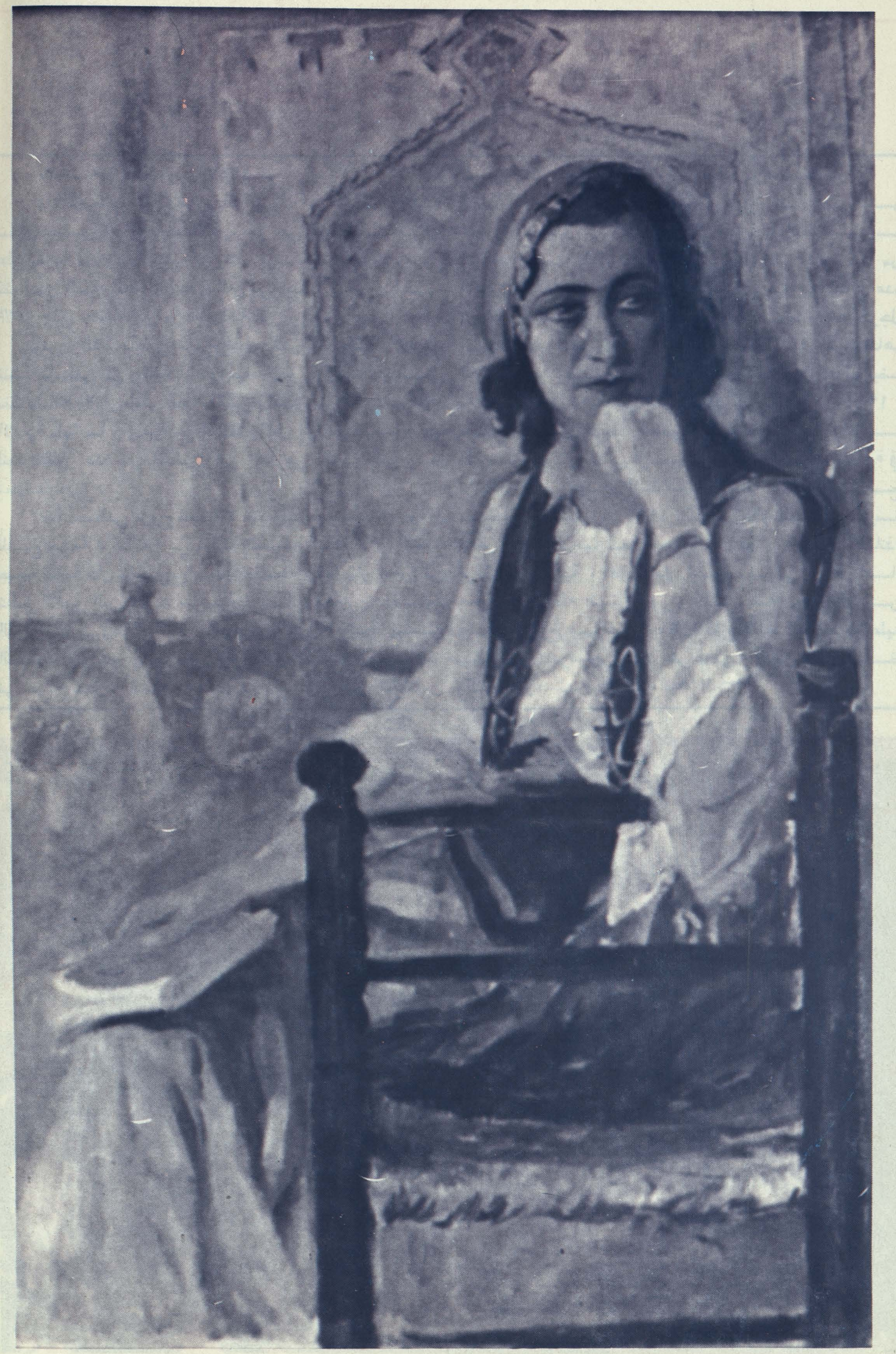
نشأته (١٩٠٢ ــ ١٩٥٧)

ولد مصطفى فروخ في مدينة بيروت في اسرة محافظة تسكن حيا من الاحياء المحافظة ، هو حي البسطة التحتا ، على مقربة من وسط مدينة بيروت . وقد ورث مصطفى فروخ كثيرا من الذكاء الفطري الذي كان في ابيه ، كما كان اخوه الاكبر على جانب كبير من البراعة .

وتوفي والد مصطفى فروخ قبيل الحرب العالمية الاولى فنشأ مصطفى في رعاية امه واخيه الاكبر . ولفت مصطفى منذ نشأته الاولى نظر اخيه الاكبر وانظار نفر من افراد الاسرة كلها بما كان فيه من الذكاء والميل الى فن الرسم ، كما لفت انظار عدد من المعلمين في المدارس الاولى التي بدأ تعلمه فيها .

بدأ مصطفى فروخ تعلمه « عند الشيخ جمعة » ، وكان للشيخ جمعة « كتاب » في منطقة البسطة التحتا ، اما الشيخ جمعة نفسه كان قاسيا في معاملة تلاميذه ولكنه كان قديرا في تعليم الامور التي كانت اساسية في ذلك الحين : حفظ القرآن الكريم وكتابة الخط وشيء من القراءة وشيء من الحساب . ويبدو ان مصطفى فروخ كان منذ ذلك الحين الباكر في حياته تتحرك انامله باشكال من الرسوم يظهر عليها من العبقرية اكثر مما هو مألوف في اترابه من الاطفال .

أما المعلم الاول في حياة مصطفى فروخ فقد برز في نحو عام ١٩١٠ وكان في ذلك الحين في مدرسته الثانية ، مدرسة كان قد اسسها طاهر التنير ، وهو رجل على جانب كبير من العبقرية العملية . غير انه كان قد استخدم عبقريته تلك في عدد من المشروعات من غير ان يثبت على واحد منها . هذا الرجل اكتشف عبقرية مصطفى فروخ واستفاد منها . ولم يعرف طاهر التنير عبقرية مصطفى فروخ في الرسم فقط ، بل ادرك ايضا مقدرة مصطفى فروخ في الكلام فعهد اليه (نحو عام ١٩١٠) بالقاء خطاب في الحفلة السنوية التي ختمت بها السنة المدرسية . ولا ريب في ان مصطفى فروخ كان يتمتع بمقدرة في فن الالقاء وفي حسن اللفظ ايضا . واذا علمنا ان الشيخ مصطفى الغلاييني (ت ١٩٤٤) كان في ذلك الحين في مدرسة طاهر التنير مدرسا للغة العربية ، وهو من اعلام الاساتذة في اللغة العربية ، ادركنا بان اختيار مصطفى فروخ لالقاء خطبة في الحفلة السنوية (ولو كانت خطبة مختارة لم يكن لمصطفى فروخ فيها غير الحفظ غيبا والالقاء الذي دربه عليه مدرس من المدرسين) دليلا على مقدرته الفطرية في الحفظ واللفظ وحسن الالقاء .



ولما اغلق طاهر التنير مدرسته (١٩١١ ؟) انتقل مصطفى فروخ الى مدرسة دار العلوم التي كان قد اسسها عبد الجبار الهندي ومكث فيها نحو ستة اشهر من عام ١٩١٢ ، لان مدرسة دار العلوم اغلقت ابوابها في ذلك العام لاسباب يبدو لنا انها كانت تتعلق بالسياسة .

وفي ٧ — ١٢ — ١٩١٢ انشأ طاهر التنير مجلة «المصور» فتذكر تلميذه القديم مصطفى فروخ وجعل يعهد اليه برسم صور لتلك المجلة بالحبر الصيني .

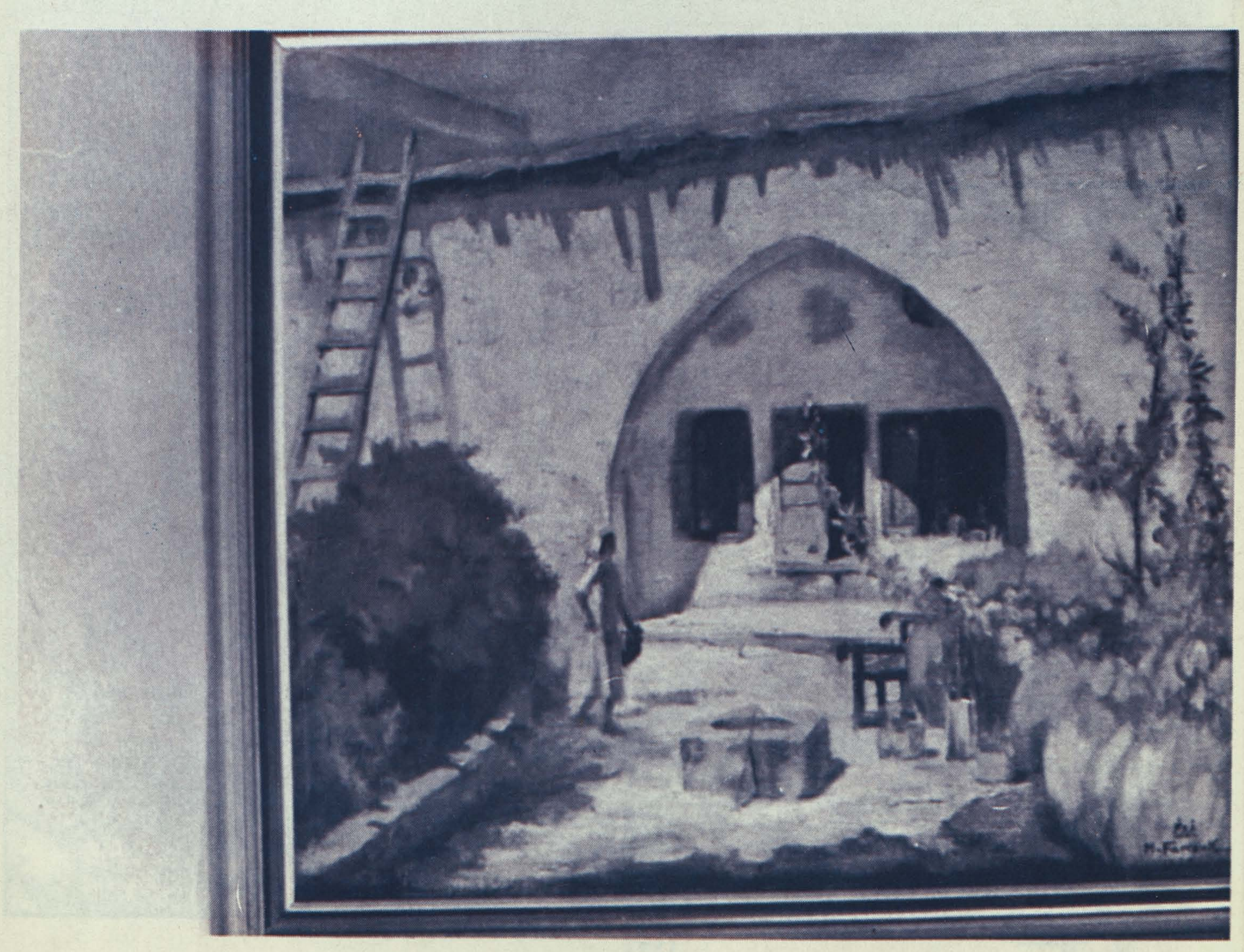
أما دراسة مصطفى فروخ المنظمة في فن الرسم فبدأت حينما اتصل مصطفى فروخ بالمصور الفوتوغرافي يوليوس ليند (الذي اشتهر في بيروت باسم جول لند) ، وهو رجل الماني كان يدير محلا للتصوير الفوتوغرافي في محلة الزيتونة (بيروت) مكان المصور اسعد الدقوني اليوم . وكان ذلك في عام ١٩١٢ في الاغلب .

ويبدو ان رسم الصور بالحبر الصيني لمجلة « المصور » (لصاحبها طاهر التنير) قد فتح امام مصطفى فروخ باب التكسب بالرسم . فقد رسم صورة لاحمد مختار بيهم وللحاج سليم البواب ولسليم علي سلام (وهم من وجهاء بيروت) ، كما كلفه رشيد بيضون (وكان رشيد بيضون في ذلك الحين طالبا في الكلية العثمانية) ان يصنع لوالده الحاج يوسف بيضون صورة كبيرة على طوله (وكانت هذه الرسوم كلها بالقلم الرصاص) .

واتيحت لمصطفى فروخ فرصة الاتصال بالمستر هوارد بلس رئيس الكلية السورية الانجيلية (الجامعة الاميركية اليوم) وبالشيخ احمد عباس الازهري مؤسس الكلية العثمانية (الكلية الاسلامية ، فيما بعد) وصاحب جريدة « الحقيقة » ، اذ كانت مجلة « المصور » لصاحبها طاهر التنير تطبع في مطبعة جريدة الحقيقة . ومع ان هوارد بلس عرض على مصطفى فروخ دخول الكلية السورية الانجيلية مجانا ، فان والدة فروخ واخاه الاكبر قد فضلا ان يدخل الكلية العثمانية . وفي الكلية العثمانية كان الاستاذان كامل الكردي وسليم البواب يشجعانه على المضي في التمرن على التصوير.

وفي عام ١٩١٦ انشأ الاستاذان صلاح اللبابيدي ومدحت البنا في بيروت ناديا رياضيا (لم يكن له اسم خاص ، اذ لم يكن في ذلك الحين في بيروت ناد رياضي سواه) . كان مركز هذا النادي في ميناء الحسن (ميناء الحصن) على الساحل الشمالي من بيروت (على مقربة من اوتيل سان جورج اليوم). وقد اختار صلاح اللبابيدي ومدحت البنا لهذا النادي رئيس شرف هو جلال بك بن الوزير التركي شوكت باشا . وكان جلال بك رياضيا بارزا قوي الجسم نازل المصارع المشهور اسكندر دبروفيتش . اما الرئيس الفعلي لهذا النادي فكان محيي الدين بك مدير البوليس في بيروت .

أراد الاستاذ صلاح اللبابيدي ان يصنع صورة كبيرة لجلال بك تكون اعلانا عن النادي ونشاطه فزار مصطفى فروخ



في بيت ابيه (وكان مصطفى قد عرف عنه انه يتكسب بالرسم ، ولكنه كان لا يزال صغير السن في نحو الخامسة عشرة من العمر ، كما كان لا يزال يرسم على الفطرة وباسلوبه الذي يرتاح اليه : بان ينبطح ارضا وامامه ورقة يرسم عليها بالقلم الرصاص) .

ولما انتهت صورة جلال بك اعجب بها الاستاذ صلاح اللبابيدي وعجب من ذكاء مصطفى فروخ ومقدرته . وطلب مصطفى فروخ اجرة للصورة مجيديا واحدا (نحو عشرين قرشا ذهبا) فدفع اليه الاستاذ صلاح اللبابيدي اربعة مجيديات .

ثم خطر للاستاذ صلاح اللبابيدي ان يصل مصطفى فروخ بالاستاذ حبيب سرور ، وهو رسام لبناني كبير اشتهر برسم صور لرجال الدين المسيحي بألوان قاتمة ومات مهملا في بيته لم يدر به احد ، عام ١٩٣٨ .

اعجب حبيب سرور بالصورة التي رسمها مصطفى فروخ لجلال بك ثم ابدى عليها عددا من الملاحظات اليسيرة (كما يقول مصطفى فروخ نفسه) . وكانت هذه الملاحظات تتعلق بأوضاع العضلات .

منذ ذلك الحين طلب حبيب سرور من مصطفى فروخ ان يأتي اليه مرة بعد مرة ليستفيد مما يرى . فكان حبيب سرور يفقه مصطفى فروخ في عدد من قواعد الرسم ويثقفه بعدد من الملاحظات . وربما عهد اليه في تعميق بعض الجوانب في اطراف عدد من اللوحات او في معالجة ريش التلوين وراحة الالوان .

١٩٣٦

واتفق ان شاهد عزمي بك والي بيروت صورتين لمصطفى فروخ احداهما لسليم علي سلام والثانية رسم فكاهي (كاريكاتوري) لمختار ناصر احد الموظفين في بلدية بيروت ، وكان مختار يمزج شيئا من المرح بشيء من التشرر . فطلب عزمي بك من مصطفى فروخ ان يصنع صورتين صورة لعزمي بك وصورة لابنته ثم نقده اجرهما ثلاث عشر مجيديا .

وصنع مصطفى فروخ رسمين واحدا لجمال باشا واخر لانور باشا . وسأل انور باشا مصطفى فروخ اذا كان يحب ان يذهب الى المانية لمتابعة درسه .

فاستشار مصطفى امه واخاه الاكبر ، وهما بدورهما استشارا الشيخ احمد عباس الازهري فاشار عليهما الشيخ احمد عباس بصرف النظر عن الذهاب الى المانيا بسبب الحرب العالمية الاولى الدائرة على اشدها في اوروبا .

وطال تردد مصطفى فروخ على حبيب سرور فنصح حبيب سرور له بدرس اللغة الفرنسية واللغة الايطالية للاستعداد للذهاب الى فرنسة والى ايطاليا للتثقف بفن الرسم .

وانتهت الحرب العالمية الاولى فلم يعد مصطفى فروخ الى الدرس في مدرسة نظامية ، بل كان يتعلم على نفسه ثم يقضي معظم وقته في الرسم تحصيلا للمال حتى يستطيع ان يجمع مبلغا كافيا لرحلته التي كان يحلم بها الى روما او بارس لتعلم الفن على اصوله وللبراعة فيه . فتم له ذلك في عام ١٩٢٤ .

الكردي ١٩٣٤

وبذكر مصطفى فروخ انه كان له هيام بالفن والجمال وبالمثل العليا ، اذ كان يرى للفن رسالة روحية سامية . وكانت امنية مصطفى فروخ ان يبرع في الرسم وان يعود ببراعته هذه الى وطنه لينشر في وطنه رسالة الفن السامية .

ودخل مصطفى فروخ الاكاديمية الملكية للفنون الجميلة في روما ثم تخرج فيها بعد ثلاث سنوات حصل على شهادة وكان في اثنائها مثالا للجد وللانصراف عن معظم اوجه اللهو في الحياة للاستفادة من دراسة الفن التي هجر موطنه حينا من الدهر من اجلها . وقد عرضت احدى صوره في المعرض الدولي في روما .

وبعد الانتهاء من الدراسة في روما زار عددا من المدن الايطالية ثم سافر الى باريس وقضى فيها نحو ثلاثة اشهر . هذه الزيارة الى باريس كانت للمشاهدة لا للدرس . بعدئذ عاد الى بيروت في اواخر عام ١٩٢٧ بطريق البحر بعد ان عرج على البندقية ونابولي (في ايطالية) وعلى اثينا (اليونان) وعلى استانبول .

وفي ١ — ١ — ١٩٢٨ اقام مصطفى فروخ معرضا في بيروت ثم اقيم له معرض في الجامعة الاميركية في بيروت . وفي عام ١٩٢٩ قام برحلته الثانية الى باريس للتخصص بعد ان كانت رحلته الاولى اليها من روما للتفرج والاستجمام . وفي عامي ١٩٣٠ و١٩٣١ قبلت لوحات له في صالون باريس ، ولا تقبل اللوحات في صالون باريس الا اذا كان فيها قدر كبير من البراعة والابتكار . وفي العام ١٩٣٠ نفسه قام مصطفى فروخ برحلة الى الاندلس (اسبانية) من فرنسة ووضع في اثناء ذلك اسس كتابه القيم « رحلة الى بلاد المجد المفقود » وهو كتاب درس فيه خصائص البناء العربي في الاندلس الناحية الفنية ، بالاضافة الى عدد من الملاحظات الاجتماعية الدقيقة البارعة .

وعاد مصطفى فروخ الى بيروت من باريس عام ١٩٣٢ .

وفي عام ١٩٣٥ بدأ مصطفى فروخ تدريس فن الرسم في جامعة بيروت الاميركية . وفي ذلك العام تزوج ثريا بنت احمد تميم ورزق منها صبيا هو هاني (٢٣ — ١١ — ١٩٣٦) ثم بنتا هي هناء (عام ١٩٤٥) . وكذلك كان يعلم الرسم في دار المعلمات اللبنانية . وفي عام ١٩٥٦ سجل اسمه في قاموس الفن العالمي

ونشب في مصطفى فروخ داء اللوكوميا . ولكنه لم يتنبه لهذا المرض الا بعد مدة طويلة ، في عام ١٩٥٢ . وعولج من مرضه الذي كان يقعده في فترات متقطعة . ودخل المستشفى مرتين او ثلاثا . ثم توفي في الساعة الخامسة صباحا من يوم السبت (١٦ — ٢ — ١٩٥٧) في مستشفى المقاصد في بيروت .

تطور الفن عند فروخ :

بدأ مصطفى فروخ يتكسب بالرسم باكرا . ولم تكن له في الرسم مذهب بين لصغر سنه يومذاك — قبل ان يبلغ الخامسة عشرة من العمر — ولانه كان يرسم للزبائن كما يريد الزبائن اعلانا لبضاعة او صورة لبناء او رسما لرجل . وهذه كلها تستمد خطوطها وظلالها من الواقع .

واول اتصال لمصطفى فروخ ولتعلمه اصول الفن كان على يد حبيب سرور . وحبيب سرور كان من انصار الفن الواقعي : كانت خطوطه رصينة وألوانه قاتمة في الاكثر ، وكان اكثر رسومه لرجال الدين المسيحي . وهكذا ثبت المذهب الواقعي من محاكاة الطبيعة في فن فروخ .

وذهب مصطفى فروخ الى روما فبهرته الرسوم القائمة على المذهب المألوف (الكلاسيكي) : رسو ميكالانجلو ورفايل الايطاليين ثم رسوم رمبرانت وروبنس الهولنديين . ولم تفارق هذه الاسماء احاديثه ولا كتاباته لما كان يحمله في قلبه من الاعجاب باصحابها . وكذلك كان لرودان الفرنسي في نفسه مكانة سامية لما في تماثيل رودان ونحيتاته الممثلة للطبيعة الواقعة من القوة في الخطوط ومن بالغ الاثر في النفس . وكان انطونيو كالكانيادورو الاستاذ الاول لمصطفى فروخ في روما من انصار الخطوط الرصينة القوية . وكذلك كان — فيما يبدو — سائر الذين تعلم عليهم من الفنانين الفرنسيين امثال شاباس وكورمون وبومبار ولافرو . ثم قبلت له صور في « الصالون » (المعرض الدولي للفن في باريس) ، ومذهب

هذا المعرض ايضا مذهب مألوف . واذا نحن استعرضنا الرسوم التي نقلها تمرسا بطرائق اصحابها في الرسم ، في مطلع حياته الفنية ، وجدناها كلها من الرسوم المألوفة (الكلاسيك) لمشاهير القدماء ولرواد النهضة الحديثة . كل هذه قد الفت بين موهبة مصطفى فروخ وبين الخطوط القوية والالوان الرصينة والظلال الطبيعية .

غير ان هذا كله لم يمنع مصطفى فروخ ، حتى في دوره المبكر ، من ان يلجأ الى الالوان الزاهية المشرقة بين الحين والحين . ففي الصورة « ذات المظلة الحمراء » نجد بهجة تعبر عن نفس مرحة في شيء من قلة المبالاة بالناس . وكان مصطفى فروخ حريصا على هذه الصورة لم يبعها في حياته ، وكانت رغبته الا تباع بعد وفاته . ولعله كان قد رسم هذه الصورة بعد لفتة نفسية في زمن الصبا .

وقد ادرك مصطفى فروخوشيكا ان الطبيعة لا تستطيعدائما ان تحقق نفسها تحقيقا كاملا . ان الرتابة في الطبيعة من الاسباب التي تسلب الطبيعة احيانا شيئا من جمالها ، من اجل ذلك ربما تلاعبت انامله في المنظر الطبيعي فنقل شجرة من مكان الى اخر او اطال شجرة وحنى رأس شجرة اخرى من اجل ذلك رأينا مصطفى فروخ يجعل للفنان رسالة من دعائمها « تحسين الطبيعة » على الا يخرج الفنان في ذلك عما تجيزه الطبيعة نفسها لنفسها .

وبعد ان استكمل مصطفى فروخ عدته الفنية في باريس سافر الى اسبانيةوتملى برؤية الاثار العظيمة التيخلفها العرب في قرطبة واشبيليه وغرناطة خاصة ، ارثا خالدا للانسانية . لما اصدر المستشرق الافرنسي هنري بارس كتابه « اسبانية كما رآها الرحالة المسلمون » قال : « ان مصطفى فروخ هو الذي اعطانا اخيرا ذلك الكتاب الذي كان من حقنا ان ننتظره من مسلم يزور تلك النماذج الجميلة من الفن العربي في اسبانية » .

ولما زار مصطفى فروخ اسبانية وشاهد فيها الاثار العربية الرائعة انفعلت نفسه بذلك المجد اللامع فخط في كتابه « رحلة الى بلاد المجد المفقود » بيروت ١٣٥٢ هـ — ١٩٣٣ م ، ص ٣٦ — ٣٧ ، ملاحظاته الفنية الخالصة في لغة واضحة الى جانب شعور قومي فياض ، فهو يقول :

« ... فأدركت ان الفن الحقيقي هو ما يتعدى المادة وان (الفنان الحق) لا يرى في الرسم والالوان والقماش وسواها الا عواطف وتاريخا وعظات كبيرة بل لغة تنطق بوضوح عما يكنه صدر المصور من تأثيرات نفسية فيخلد بريشته تاريخ امته ومجد بلاده » .

وعاد فروخ من باريس واسبانية شديد الايمان بالخطوط القوية والالوان الرصينة والظلال التي تحمل الرائي من اللوحة الملونة الى الطبيعة الحية ، ولكن الوانه اكتسبت اشراقا جديدا وزهوا .

اما ميزة مصطفى فروخ الكبرى فكانت في رسم الرؤوس والوجوه . كان مصطفى فروخ منذ مطلع حياته الفنية الباكر مشغوفا برسم الناس ، وكان الذين تكسب بفنه منهم يطلبون ان يرسم لهم انفسهم او لاقاربهم . ثم انه بدأ رسم بنفر من ذوي الجاه والصلابة على الدهر من امثال سليم علي سلام وجمال باشا .

وأغرم مصطفى فروخ برسم الرجال والنساء من الذين حفلت تقاطيع وجوههم بالعزم والقوة وكان لوجوه بني معروف من ريشته نصيب كبير . ثم امتاز مصطفى فروخ بقراءة ما وراء صفحات الوجوه من خبايا النفس الانسانية . ولما جاء الاكراد المهاجرين الى لبنان ، بعد الحرب العالمية الاولى نالت وجوههم من ريشته عناية كبيرة . وكذلك كان للبدو من الرجال والنساء عناية منه صحيحة ولقد استطاع مصطفى فوخ ان يخلق شخصيات من شيوخ الدروز والبدو والقرويين والاكراد .

ومع ان فنانا ايطاليا قد سبق مصطفى فروخ الى رسم صورة الامير بشير الشهابي الثاني ، فان التعبير الذي اضفاه مصطفى فروخ على وجه الامير بشير هو الذي افاد صورة الامير بشير رسوخا في الاذهان . وهو واضع الصورة الرسمية للامير بشير .

ولمصطفى فروخ بالحبر الاسود روائع عبقرية ، فقد يرسم الرأس خطا واحدا مستمرا بلا ظلال فتقوم تعاريج ذلك الخط الواحد مقام الالوان والظلال .

وكان مصطفى فروخ لا يحب علب الالوان الجاهزة .

لقد كان يمزج بنفسه ويقول ان في الطبيعة في عدد من الاحيان ظلالا لا نجدها في علب الالوان . ثم ان اللون الواحد لا يكون عادة واحدا في الطبيعة ، بل يختلف ما بين جانب وجانب منها او بين وقت واخر فيها . وكثيرا ما يختلف اللون الواحد باختلاف موضعه من الصورة .

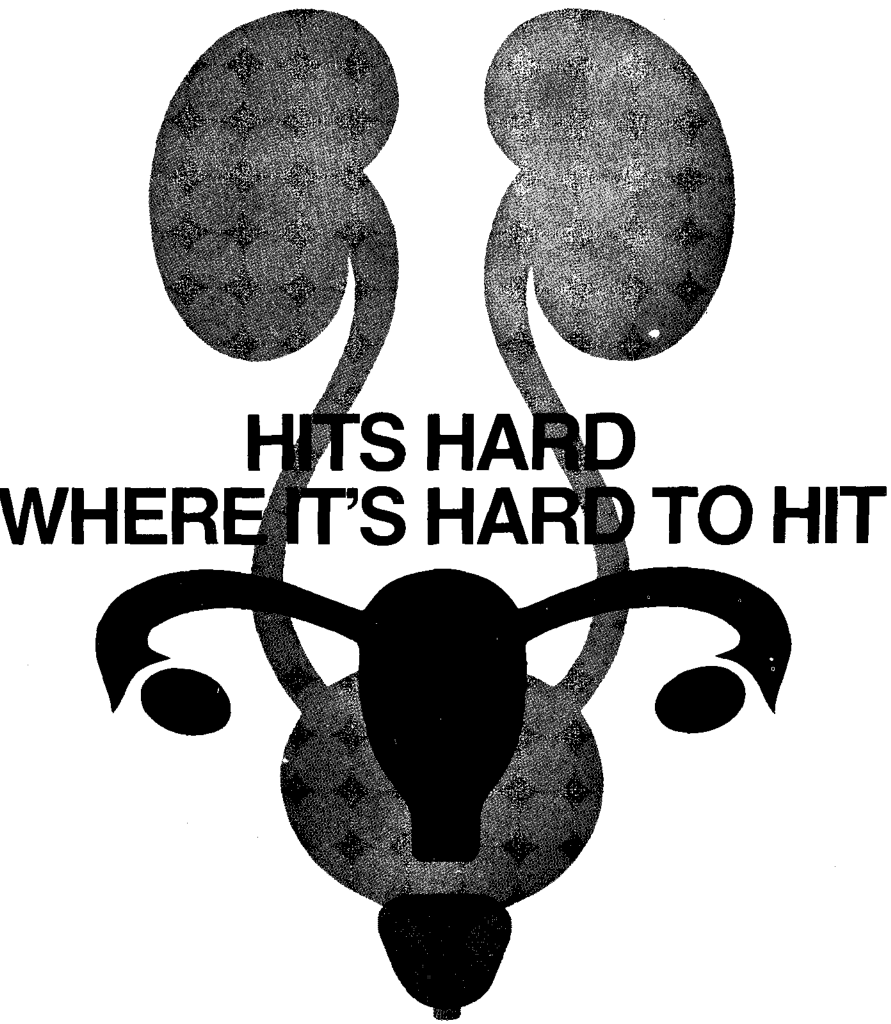
وفي اواخر حياة مصطفى فروخ زادت الالوان عنده اشراقا ، ولكن خطوطه ظلت قوية رصينة . ولولا هذه الرصانة في الخطوط لظننت ان صورة من حياته الاولى وصورة من حياته المتأخرة ليست لفنان واحد ، بل لفنانين عبقريين في مذهبين مختلفين في الرسم ! .

الدكتور عمر فروخ

MINOCIN*

Minocycline HCl Lederle

The Maxi Spectrum Antibiotic



Minocycline simplifies therapy of G.U. infections that are hard to treat because of increasing bacterial resistance and the complex nature of the G.U. tract. Unaffected by food or milk, one low, standardized dosage—200 mg stat, 100 mg q 12 h—rapidly provides high serum and tissue levels for prompt resolution of urinary tract infection, syphilis and other venereal diseases. A single dose—300 mg stat—achieves excellent response in gonorrhea.

Hits hard where it's hard to hit: acute and chronic cystitis and pyelonephritis; urethritis; prostatitis; pyelitis; gonorrhea; syphilis.

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*Trademark

البيمارستان

فيما يلي كلمة موجزة في تاريخ المستشفيات ، وهي التي كان يعبر عنها بكلمة بيمارستان في العهد الاسلامي الى العصر الحالي اي الى انشاء مستشفى ابي زعبل بضاحية القاهرة وهو اول مستشفى انشيء على النظام الحديث في مصر سنة ١٨٢٥ م .

لم تكن مهمة البيمارستانات قاصرة على مداواة المرضى . بل كانت في نفس الوقت معاهد علمية ومدارس لتعليم الطب ، يتخرج منها المتطببون والجراحون « الجرائحيون » والكحالون كما يتخرجون اليوم من مدارس الطب .

تفسير كلمة بيمارستان .

البيمارستان « بفتح الراء وسكون السين » كلمة فارسية مركبة من كلمتين (بيمار) بمعنى مريض او عليل او مصاب وستان بمعنى مكان او دار فهي اذا دار المرضى ثم اختصرت في الاستعمال فصارت مارستان كما ذكرها الجوهري في صحاحة .

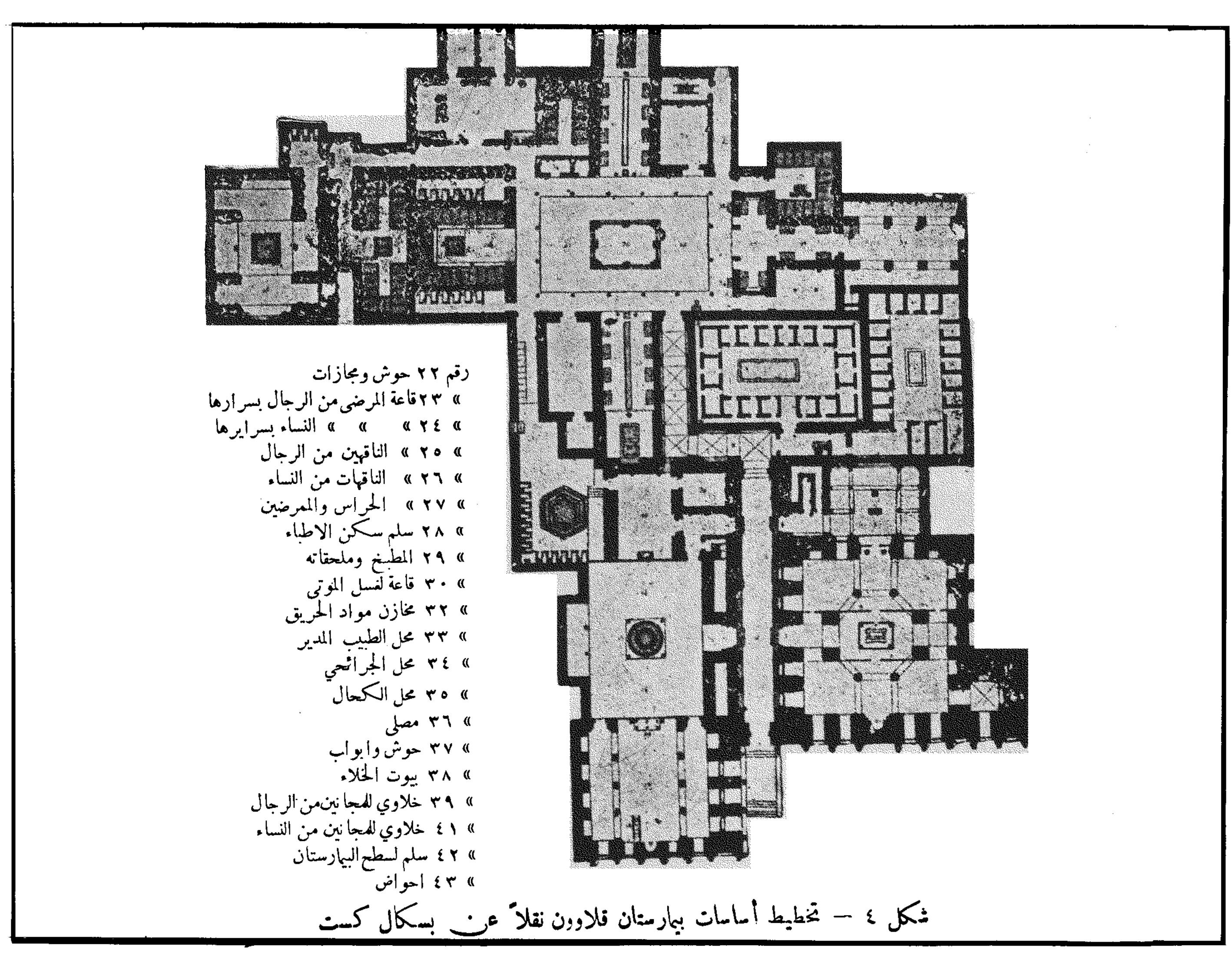
وكانت البيمارستانات من اول عهدها الى زمن طويل مستشفيات عامة ، تعالج فيها جميع الامراض والعلل من باطنية وجراحية ورمديه وعقلية ، الى ان اصابتها الكوارث ودار بها الزمن وحل بها البوار وهجرها المرضى فاقفرت الا من المجانين حيث لا مكان لهم سواها . فصارت كلمة مارستان اذا سمعت لا تنصرف الا الى مأوى المجانين .

— خيمة رفيدة :

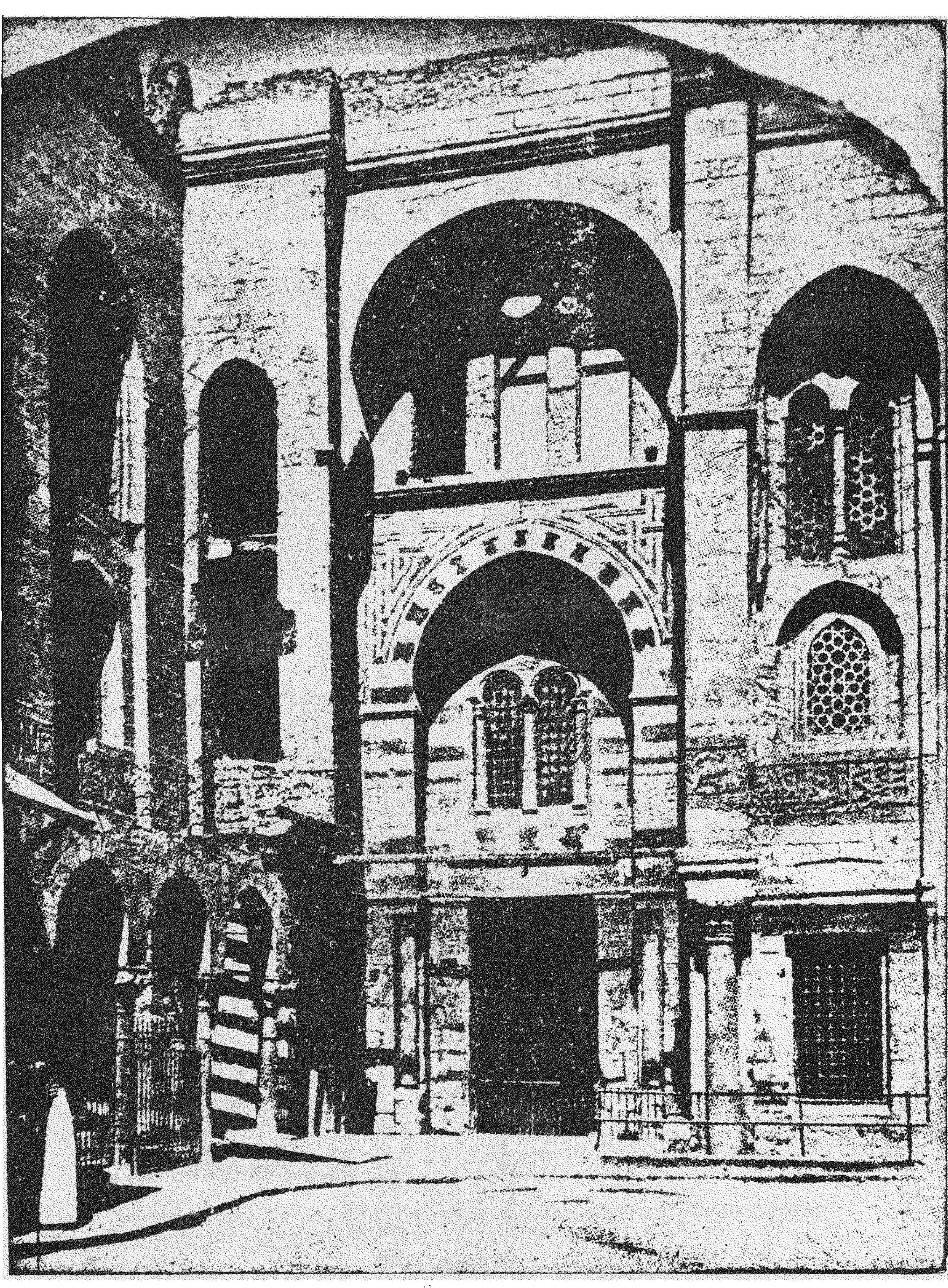
روي عن عائشة رضي الله عنها انها قالت : اصيب سعد بن معاذ يوم الخندق ، رماه رجل من قريش ابن العرقة ، رمي في الاكحل . فجعله رسول الله صعلم في خيمة رفيدة وهي امرأة طبيبة كانت تداوي الجرحى وتحتسب بنفسها على حذوة من كانت به ضبعة من المحاربين وغير المحاربين وكان هذا مثل عن المستشفى الحربي المتنقل .

الوليد بن عبد الملك

عن تقي الدين المقريزي : اول من بني البيمارستان في الاسلام ، الوليد بن عبد الملك الخليفة الاموي في سنة ٨٨ هـ



شكل ٤ — تخطيط أساسات بيمارستان قلاوون نقلاً عن بسكال كست



(٧٠٦ م) وجعل في البيمارستان الاطباء واجرى لهم الارزاق وامر بحبس المجذمين (١) لئلا يخرجوا واجرى عليهم وعلى العميان الارزاق . واعطى كل مقعد خادما وكل ضرير قائدا .

انواع البيمارستانات

كان للبيمارستانات نوعان : ثابت ومحمول .

فالثابت ما كان بناء ثابتا من جهة من الجهات ، لما ينتقل منها وهذا النوع من البيمارستانات كان كثير الوجود في كثير من البلدان الاسلامية لا سيما في العواصم كالقاهرة وبغداد ودمشق ... الخ . ولا يزال اثر بعضها باقيا على مر الدهور الى الان كالبيمارستان المنصوري (قلاودون الان) بالقاهرة ، والبيمارستان المؤيدي بالقرب من القلعة بالقاهرة ايضا ، والبيمارستان النوري الكبير بدمشق والبيمارستان القيمري بدمشق ، وارغون في حلب ...

البيمارستان المحمول

وهو الذي ينقل من مكان الى مكان بحسب طروق الامراض والاوبئة وانتشارها وكذا الحروب ، وهو المعبر عنه في العصر الحاضر بكلمات Ambulance بالانكليزية ، Feldlazareth بالالمانية ...

ومن المرجح ان المسلمين هم اول من انشاه وهو عبارة عن مستشفى مجهز بجميع ما يلزم للمرضى والمداواة من ادوات وادوية واطعمة واشربة وملابس واطباء وصيادلة وكل ما يعين على ترفيه الحال على المرضى والعجزة والمزمنين والمسجونين ينقل من بلد الى أخرى من البلدان الخالية من بيمارستانات ثابتة او التي يظهر فيها وباء او مرض معد .

ولنضرب مثلا على ذلك ما ذكره ابن خلكان وابن القفطي قالا : « ان ابا الحكم المغربي عبدالله بن المظفر ابن عبدالله المرسي نزيل دمشق ، كان طبيب البيمارستان الذي كان يحمله أربعون جملا ، المستصعب في معسكر السلطان محمود السلجوقي حيث خيم .

المكفوفون والنساء يتعاطون التطبيب

كان تعلم الطب ومعاناه التطبيب مكفولين كأي كان ذكرا او انثى مبصرا أو مكفوفا . كانت زينب طبيبة بني أود من الماهرات في صناعة الكحالة عالمة بصناعة الطب والمدواة ولها خبرة جيدة بمداواة الام العين والجراحات ولقد ذكرها ابو الفرج الاصفهاني في كتاب الاغاني . ولقد انشد فيها ابو سماك الازدي .

امحترمي ريب المنون ولم ازر طبيب بني اود على الناى زينبا

ومنهن رفيدة الاسلمية التي مررنا على ذكرها ، وكانت ايضا اخت الحفيد ابي بكر ابن زهر وبنتها عالمتين بصناعة الطب والمداوة ولهما خبرة جيدة فيما يتعلق بمداواة النساء

الاطباء المكفوفون

منهم ابو الحسن علي بن ابراهيم بن بكس ، وكان يدرس الطب في البيمارستان العضدي ويفيد الطالبين وكان اذا اراد معرفة سجنات الوجوه وحال بول المرضى حول على من يكون معه من تلاميذه في وصفه ذاك .

ومنهم ابو الحن بن مكين البغدادي الضرير ، كان ابو الخير يهجنه في كتاب امتحان الاطباء وقال : من قاد اعمى شهرا (يعني ذلك الطبيب) تطبب وعالج واهلك الناس .

وابو عبدالله محمد بن سليمان بن الخياط المكفوف الشاعر الضرير القرطبي وكان من أوسع الناس علما بعلوم الجاهلية والاسلام بصيرا بالاثار العلوية حاذقا بالطب والفلسفة ماهرا في العربية والاداب الاسلامية ولد اعشى ضعيف البصر متوقد الخاطر فقرا كثيرا في حال عشاه ثم طفىء النور في عينيه بالكلية فازداد براعة ونظر في الطب بعد ذلك فانجح علاجا .

التقسيم الفني للبيمارستان

لم تكن البيمارستانات تسير اتفاقا بغير نظام ولا ترتيب بل كانت على نظام تام وترتيب محمود تسير اعمالها على وتيرة منتظمة .

كانت البيمارستانات منقسمة الى قسمين منفصلين بعضهما عن بعض قسم للذكور وقسم للاناث وكل قسم مجهز بما يحتاجه من آلة وعدة وخدم وفراشين من الرجال والنساء وقوام ومشرفين .

وفي كل قسم من هذين القسمين عدة قاعات لمختلف الامراض : وقاعة للامراض الباطنة ، وقاعة للجراحة ، وقاعة للكحالة ، وقاعة للتجبير . وكانت قاعة الامراض الباطنة منقسمة الى اقسام اخرى : قسم للمحمومين وهم المصابون بالحمى ، وقسم للمحرورين وهو لمن بهم المرض المسمى (مانيا) وهو الجنون السبعي ، وقسم للمبرودين اي المتخومين ولمن به اسهال قاعة ...

وكانت قاعة البيمارستان فسيحة حسنة البناء وكان الماء فيها جاريا .

وللبيمارستان صيدلية تسمى شرابخاناه ولها رئيس يسمى شيخ صيدلي البيمارستان .

وللبيمارستان رئيس يسمى ساعور البيمارستان . ولكل قسم من اقسامه رئيس . فكان فيه رئيس للامراض الباطنة ، ورئيس للجراحية ، ورئيس للكحالين (١) . وللبيمارستان الفراشون من الرجال والنساء والمشارفون والقوام للخدمة ايضا ولهم المعاليم الوقية والجامكية الوافرة .

خزانة الشراب :

هي الصيدلية في البيمارستان قال ابو العباس القلقشندي: هذه الخزانة هي المعبر عنها في زماننا (القرن الرابع عشر ميلادية بالشرابخاناه وهي الحواصل المعبر عنها بالبيوت ، ذلك انهم يضيفون كل واحد منها الى لفظ خاناة كالشراب خاناة والطشت خاناة والطبل خاناة ونحوها وخاناة لفظ فارسي معناه

البيت فتأويلها بيت الشراب . ولقد كان الكحالة :

فيها من انواع الاشرابة والمعاجين النفيسة والمربيات الفاخرة واصناف الادوية ، والعطريات الفائقة التي لا توجد الا فيها وفيها من الالات النفيسة والانية الصيني من الزباري والبراني والازيار ما لا يقدر عليه غير الاغنياء والملوك . وقد كان لكل مارستان خزانة للشراب كاملة كما في دقفيه المارستان المنصوري وغيره . ولكل شراب خاناة مهتار يعرف بمهتار الشرابخاناة (ومهتر بالفارسية تعني رئيس) متسلم لحواصلها له مكانة عالية وتحت يده غلمان عنده برسم الخدمة يطلق على كل واحد منهم شراب دار .

نظر البيمارستان ورتب اطبائه :

كان للبيمارستان ناظر ينظر او يشرف على ادارته وكان النظر عليه معدودا من الوظائف الديوانية العظيمة . وقال خليل بن ايبك الظاهري « ان للبيمارستان شادا وظيفته من وظائف الدولة تقضي لمن يستقر فيها امرة عشرين حاجيا .

والقاب ارباب الوظائف من اهل الصناعات هي :

١ — رئيس الاطباء وهو الذي يحكم على طائفة الاطباء ويأذن لهم في الطبيب ونحو ذلك .

٢ — رئيس الكحالين وحكمه في الكلام على طائفة الكحالة حكم رئيس الاطباء في طائفة الاطباء .

٣ — رئيس الجرائحية وحكمه في الكلام على طائفة الجرائحية والمجبرين كالرئيس المتقدم .

وكانت اعظم الوظائف الصناعية في الدولة الفاطمية بمصر وظائف الاطباء فكانت القاب ارباب الصناعات الرئيسية كرياسة الطب من الدرجة الاولى درجة المجلس او امرة المجلس وموضوعها التحدث على الاطباء والكحالين ومن شاكلهم ولا يكون الا واحدا وفي المرتبة الاولى مرتبة المجلس العالي .

ارزاق الاطباء في البيمارستان وفي الخدمة الخاصة

اطباء الخاص (اي المنقطعون للخليفة او السلطان) وكان اثنين لكل منهما في الشهر خمسون دينارا ولمن دونهم من الاطباء وهم نحو ثلاثة او اربعة ، المقيمين بالقصر ، لكل واحد منهم عشرة دنانير ولكل طبيب بالمارستان ما يقوم بكفايته . فكان للاطباء بالمارستان على العموم خمسة عشر دينارا وكان لبعضهم رزقان اي ثلاثون دينارا في كل شهر لعملين مختلفين من المستملح ان يعرف اهل زماننا الحاضر مقدار ما كان يتناوله الطبيب في ذلك العصر السالف اجرا لعملية اجريت لمرض .

قال سليمان بن حسان : حدثني احمد بن يونس الحراني قال : حضرت بين يدي احمد بن وصيف الصابيء وقد حضر سبعة انفس لقدح اعينهم (وهي العملية التي تعمل للماء اي الكتركتا) وفي جملتهم رجل من اهل خراسان ، اقعده بين يديه ونظر الى عينيه فرأى ما تهيا للقدح ، فساومة على ذلك واتفق معه على ثم انين درهما اي ما يعادل عشرة اليوم وحلف انه لا يملك غيرهما ، فلما حلف الرجل اطمان وضمة الى نفسه فوقعت يده على عضده فوجد فيها نظاما صفيرا فيه دنانير . فقال له ابن وصيف : ما هذا ؟ فتلوى ، فقال له ابن وصيف : قد حلفت بالله وأنت حانث وترجوه رجوع بصرك اليك ! والله لا اعالجك اذ خادعت ربك فطلب اليه ، فابى ان يقدحه وصرف اليه الثمانين درهما ولم يقدح عينه .

نظام المعالجة في البيمارستان

الدرس بجانب المريض

كان في البيمارستان طريقان للعلاج : علاج خارجي اي ان المريض يتناول الدواء من البيمارستان ثم ينصرف ليتعاطاه في منزله . وعلاج داخلي يقيم المريض في اثنائه في البيمارستان في القسم الخاص بمرضه حتى يشفى .

ففي الطريقة الاولى كان الطبيب يجلس على دكة ويكتب لمن يرد عليه من المرضى للعلاج اوراقا يعتمدون عليها . ويأخذون بها من البيمارستان الاشربة والادوية التي يصفها الطبيب .

واما العلاج الداخلي اي في داخل البيمارستان ، فكان المرضى يوزعون على القاعات بحسب امراضهم ، وكان لكل قسم من اقسام البيمارستان طبيب او اثنان او ثلاثة اطباء بحسب اتساعه وكثرة المرضى .

وكان اذا دعا الحال يدعى الطبيب من قسم اخر غير القسم الذي فيه المريض للاستشارة . وكان الاطباء يشتغلون في البيمارستان بالنوبة فجبريل بن بختيشوع كانت نوبته في الاسبوع يومين وليلتين .

يتبع

المراجع :

تاريخ حكماء الاسلام — لظهير الدين البيهقي

— تاريخ البيمارستانات في الاسلام — للدكتور احمد عيسى بك ١٩٣٩ م

— طبقات الاطباء لابن اصيبعه

"من الاطبـــاء العرب"

ابو القاسم الزهراوي

ابو القاسم الزهراوي اعظم جراح في عصره واعظم جراح عند العرب عاش في الاندلس وترك موسوعة طبية اسمها « التصريف لمن عجز عن التاليف » ترجمت الى عدة لغات ودرست في جامعات اوروبا حتى اواخر القرن الثامن عشر تحتوي على اكتشافات عديدة واول صور الالات الجراحية .

حياته

ولد ابو القاسم خلف ابن عباس في مدينة الزهراء فنسب اليها وسمي الزهراوي ومدينة الزهراء هذه بناها امويو الاندلس بين عام ١٩٣٦ و ١٩٦١ على تلة تقرب ٨ كيلومترات الى الشمال الغربي من قرطبة . ولم يبق منها اليوم سوى الاطلال والحفريات ونستنتج من ذلك ان الزهراوي لا يمكن ان يكون قد ولد قبل سنة ٩٣٦ م . اما اصله فيرجح انه يرجع الى المدينة لانه سمي في بعض مخطوطاته بالانصاري . وكتب اسمه اللاتين بعدة اشكال اكثرها شيوعا : Albucasis

١) مستشفى الشرق ، بيروت

حداد ، فريد سامي

المجلة الطبية اللبنانية ، ١٩٦٦ ، ١٩ : ٢٩

اننا لا نعلم الا الشيء الوجيز عن حياته فقد عاش حياة مليئة بالاعمال الطبية وترك آثارا عظيمة . قيل انه طبيب لعبد الرحمن الناصر ولابنه الحكم المستنصر ولابي عامر المنصور . وقد توفى ابو القاسم سنة ١٠١٣ م .

وبذلك تكون وفاته حصلت ٤٨ سنة بعد وفاة المتنبي و ٢٤ سنة قبل وفاة ابن سينا فيكون من المرجح انه عاصر الاثنين مدة من الزمن . ويستدل من كل ذلك انه عاش في اوج الحضارة العربية في الاندلس في بيئة توفرت فيها جميع الوسائل للانتاج العلمي والفكري والعقلي .

كتابه

وان ضن التاريخ علينا بالمعلومات التاريخية عن هذا الجراح الفذ فانه لم يقو على طمس آثاره العلمية فلقد ترك الزهراوي تصنيفه المشهور « التصريف لمن عجز عن التأليف » وهو كتاب كبير جعله على ٢ مقالة وهو كثير الفائدة تام في معناه . لم يؤلف في الطب اجمع منه ولا احسن للقول والعمل . وهو من اعظم مؤلفات العرب الطبية . وهو موسوعة طبية وصفه البعض بانه دائرة معارف وقال عنه الآخرون انه ملحمة يقسم الى ثلاثة اقسام : الاول في الطب والتشريح (مقالتين) والثاني في الادوية والاغذية (٢٧ مقالة) والثالث في الجراحة (مقالة) .

ولم يبق من هذا الكتاب النفيس سوى نسخ مخطوطة معدودة اكثرها ناقص يبلغ عددها اربعون نسخة يزاد اليها النسخة التي حفظت في دمشق واخرى في مكتبة المرحوم والدنا الدكتور سامي حداد . واقدم هذه النسخ محفوظة في مكتبة بانكيبور في باتنا في الهند تحت رقم ١٧ يرجع تاريخ نسخها الى عام ١١٨٩ م وهي تحتوي على المقالة الثلاثين مع رسوم الآلات الجراحية . ويوجد رسوم جميلة للالات الجراحية في المخطوطات التالية ايضا :

١) رقم ٢٤٩١ من المكتبة السليمانية في استانبول تاريخ نسخها ١٢٦٥ م .

٢) مخطوطة الدكتور مفاغر في طهران تاريخ نسخها ١٣١١م

٣) رقم ٢٩٥٣ من المكتبة الوطنية في باريس .

٤) رقم ٩١ من مكتبة برلين ، حاليا في توبنغن تاريخ نسخها ١٥٠٩ م .

٥) رقم ٢٨٥٤ من المكتبة السليمانية في استانبول تاريخ نسخها ١٧٦٣ م .

٦) مخطوطة حيدر آباد .

٧) رقم ١٩٩٠ في سراي توبكابي في استانبول .

واكمل النسخ المعروفة نسختان موجودتان في المكتبة السليمانية في استانبول تحت رقم ٥٠٢ و ٥٠٣ يرجع تاريخ نسخ الاولى الى ١٤٩٦ م والثانية ١٧٠٣ م .

وفي مكتبة الدكتور سامي حداد نسخة عن المقالة ٢٩ غير كاملة تبحث في تسمية العقاقير باختلاف اللغات وفي بدلها بعضها من بعض اذا عدمت وفي اعمارها . تقع المخطوطة في ٦٩ ورقة حجمها ١٧ × ١١ سم . وفيها ايضا نسخة فوتوغرافية من مخطوطة دمشق واخرى عن القسم العربي من طبعة شاننغ .

مآثره

لم يكن الزهراوي جراحا ماهرا نحسب بل كان حكيما ذا خبرة واسعة وحنكة وعلم وقد افرد قسما مهما من كتابه لوصف الامراض وعلاماتها وعلاجها وهو اول من اكتشف ووصف نزف الدم المسمى هيموفيليا ولاحظ انه ينتقل بالارث عن طريق الانثى الى الذكر .

اما القسم الثاني من الكتاب وهو يحتوي على ٢٧ مقالة فلقد خصصها الزهراوي للبحث في الادوية المفردة والمركبة على انواعها وافرد مقالة خاصة للمقاييس والمكاييل واخرى للاطعمة وغيرها للزينة .

فلو لم يشتهر الزهراوي بالجراحة لكان امام اطباء العرب فقد كانت معرفته بالطب والادوية لا تقل عن معرفته ومهارته بفن الجراحة فقد جمع بين جميع فروع الطب وكان ماهرا فيها جميعا . وصح فيه قول المعلوف « انه اشهر اطباء العرب الثلاثة وصنواه الرازي وابن سينا » .

IMPORTANT INFORMATION

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

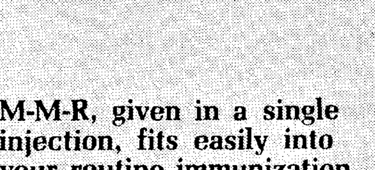
- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

*Trademark of Merck & Co., Inc.

اما القسم الثالث من كتابه (اي المقالة الثلاثون) فقد ضمنها جمع فروع الجراحة فاحتوت على امراض الاسنان والراس والعين والاذن والفم والحنجرة والولادة والعظام والمجاري البولية والجراحة العامة .

وقد اشتهر قسم الجراحة اكثر من القسمين الباقيين بكثير وهو اهمها وهو اطيب ما انتجه العرب في هذا الفن ويحتوي على اكثر من مئتي شكل للالات الجراحية التي استعملها الزهراوي بنفسه والتي اخترع اكثرها (راجع الرسوم) .

وقد فصل فيه استخراج الاسنان بلطف وتؤدة وصف ذلك جيدا وصور الادوات والآلات المستعملة والادوية القاطعة للنزف وحذر من الاقتداء بالدجالين والجهال وطرقهم السريعة التي قد تؤدي الى كسر في الفك فهو بذلك وكأنه من اطباء القرن العشرين بشهادة مؤرخ طب الاسنان الاميركي Absell ووصف تنظيف الاسنان وجردها بالحديد وبحث في خلع اصول الاضراس واخراج عظام الفكوك المكسورة ونشر الاضراس النابتة على غيرها وعلى غير مجراها الطبيعي وتشبيك الاضراس بخيوط الفضة والذهب ، وهو اول من كتب عن علاج عاهات الفم والاقواس السنية .

وبحث كذلك في قطع اللحم الزائدة في اللثة ووصف الماء الذي يجتمع في رؤوس الاطفال وعلاجه واخترع آلة جديدة لشفاء الناسور الدمعي . وهو اول من استعمل الصنارة لاستئصال الثآليل النابتة في الانف وعالج موضوع قطع الرباط الذي يعرض تحت اللسان ويمنع الكلام وموضوع اخراج الضفدع المتولد تحت اللسان واستئصال اللوزتين وقطع ورم اللهاة المسمى عنبة واستعمال شق القصبة بالعرض وخياطة القصبة المجروحة .

وبحث في الولادة والقبالة وهذا القسم من كتابه كنز ثمين فقد وصف وضع Walcher والحبل خارج الرحم واستخراج عظامه من البطن والمشيمة الملتصقة وكيفية استخراجها واستعمال الصنارة لاستخراج الجنين الميت (انظر الرسم) .

وبحث في قطع الاصبع الزايدة وشق التحام الاصابع ووصف اربع طرق لرد فك المنكب ، منها الطريقة المستعملة اليوم والمعروفة باسم Kocher ووصف ايضا عملية بتر فلكة الركبة وهذا العلاج لم يصفه من قبله احد وقد عاد الجراحون سنة ١٩٣٧ الى عملية ابي القاسم هذه بعد مرور ٩٠٠ سنة .

وفي مجال المجاري البولية وصف الشق عن حصاة المثانة وكسرها وثقب حصاة مجرى القضيب والشق عليها والشق في المهبل لاستخراج الحصاة البولية في النساء وكان اول من استعمل عملية تكسير الحصاة وبحث كذلك بالادرة المائية .

وفي الجراحة العامة كتب عن علاج ثدي الرجال الذي تشبه ثدي النساء وعن استئصال سرطان الثدي بكليته على الطريقة الحديثة مع تفضيل الكي على الشق وقد عاد الطب مؤخرا الى تبنى هذه النظرية بعد مرور عشرة قرون . ووصف ايضا ضم جراح الامعاء بالخياطة بخيط دقيق من مصران الحيوان وعلاج الناسور المعوي البرازي وعلاج الكثير من الامراض بالكي مثل الذبيلة والآكلة وغيرها نخص بالذكر منها قطع نزف الدم . وهو اول من استعمل ربط الشرايين بخيوط الحمشة . وهو ايضا اول من استعمل القطن بالجراحة .

ويستدل من هوامش الكتاب ومن المشاهدات الخاصة العديدة المدونة فيه على ان الزهراوي لم يكن كاتبا ومعلما ومؤلفا فحسب بل كانت خبرته واسعة جدا مما جعله من اشهر الجراحين واحذقهم على الاطلاق .

وكان ذو ميزة علمية تتعلق بآداب التأليف العلمي فقد قدم مصادره في اول كل مقالة من كتابه فكان بذلك امينا وفيا يعطي صاحب الحق حقه شأنه في ذلك شأن الكثير من اطباء العرب وعلماء العصر الحديث .

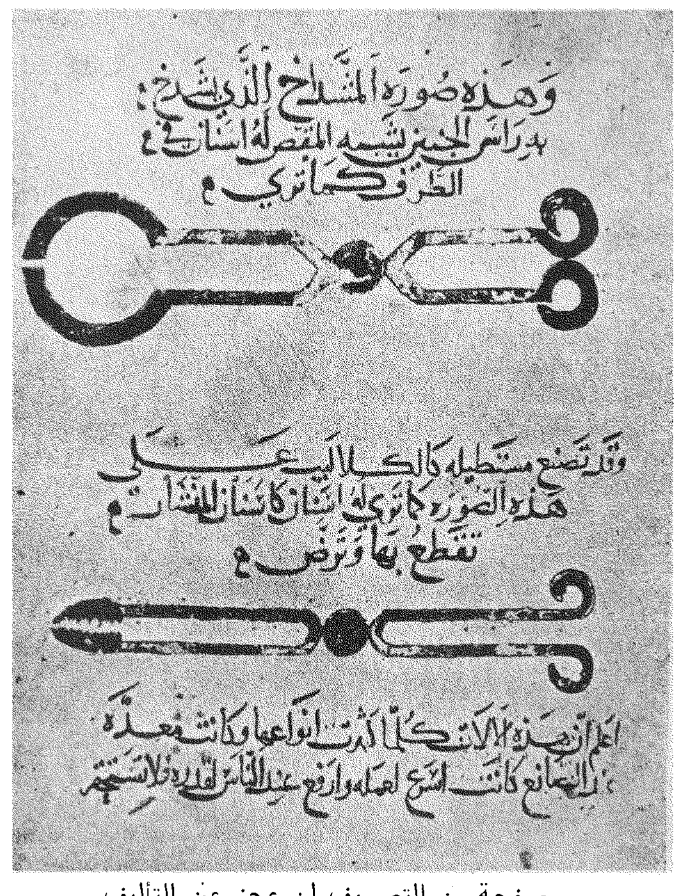
طبعات وترجمات كتابه

ان القسم الاول من التصريف الذي يبحث في الطب قد نشر في اوجسبورغ سنة ١٥١٩ م .

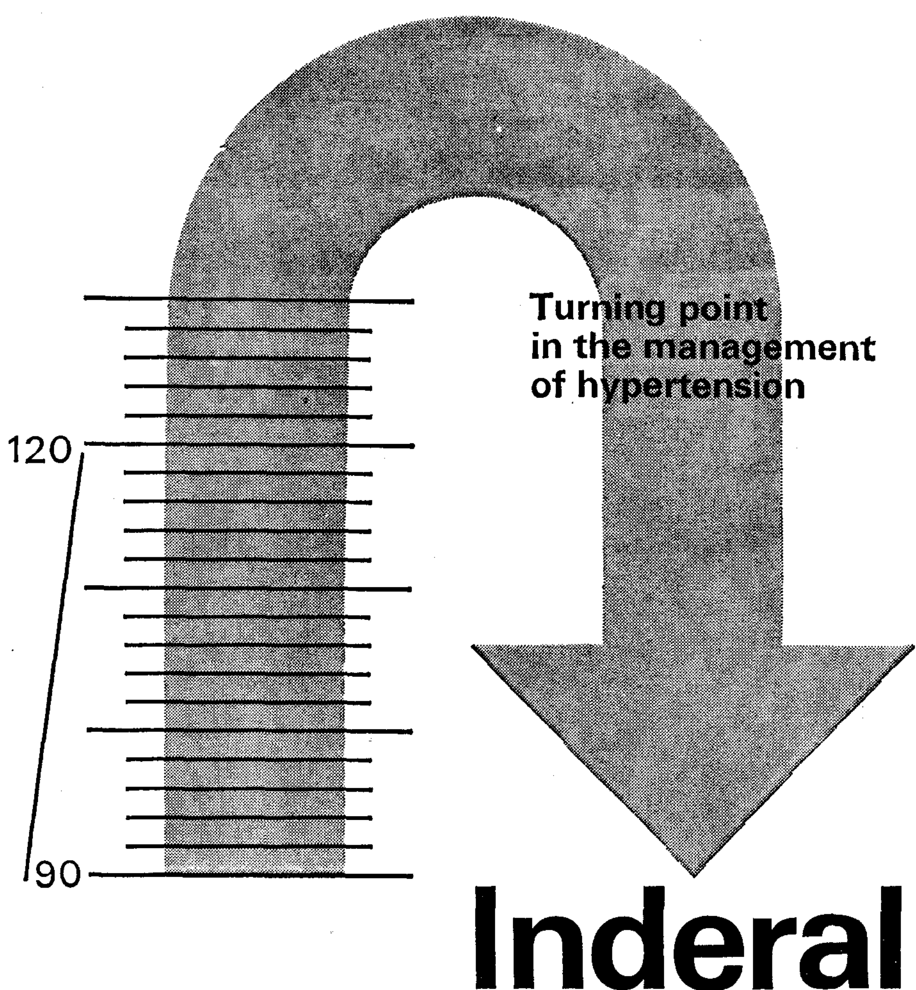
والقسم الثاني في الادوية نشر في فنيز سنة ١٤٧١ م .

اما القسم الثالث في الجراحة فقد ترجمه جيرار دو كريمونا الى اللاتينية وترجم ايضا الى العبرية والى اللغة البروفنسالية (ويقول المعلوف الى لغة اهل قطلونة) وقد نشر باللاتينية مع كتاب غي دوشولياك في فنيز عام ١٤٩٧ و ١٤٩٩ و ١٥٠٠ و ١٥٠٦ و ١٥٣١ و ١٥٣٢ ونشر مجددا في بازل سنة ١٥٤١ مع صور محفورة على الخشب .

ونشر النص العربي مع ترجمة لاتينية جون شاننغ في اكسفورد عام ١٧٧٨ م وقد ترجمه لوسيان لوكلير الى الافرنسية



صفحة من التصريف لمن عجز عن التأليف
منقولة عن مخطوطة الهند باذن خاص من الدكتور صلاح الدين المنجد



Inderal

TRADE MARK

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Excellent control — of blood pressure

Simplicity — thrice-daily dosage

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Renewed well-being — no interference with mental, physical or sexual activity

'Inderal', with concomitant thiazide diuretic therapy, effectively controls blood pressure in more than 80% of hypertensive patients.

Detailed information is available on request

'Inderal' is available in packs of 50's, 10mg & 40mg.

Imperial Chemical Industries Limited
Pharmaceuticals Division
Alderley Park Macclesfield
Cheshire England

ونشره في باريس عام ١٨٦١ م .

وبقول المعلوف ان التصريف طبع بكامله في الهندسة ١٩٠٨م برسومه ولكن لم نر نسخة منه ونشك ان يكون التصريف قد نشر بكامله !

اثره

كان اثر الزهراوي عظيما في اوروبا فقد درس كتابه فـي جامعاتها الطبية واقتفى اثره الجراحون الاوروبيون مثل غـي دوشولياك الذي يذكره اكثر من مئتي مرة في جراحته الكبـرى وينقل عنه بعض المقاطع حرفيا وكذلك باري Paré **وغيرهم من الذين اقتبسوا عنه حتى وانهم في كثير من الاحيان انتحلوا بعض اكتشافاته دون ان يذكروه كمصدر اولـــي مثل نقولا السالرني .**

وقد اهتدى أطباء اوروبا بمؤلفه المشهور من اوائـل القـرن الخامس عشر حتى اواخر القرن الثامن عشر .

ووضعت صورته الملونة على الزجاج القديم في احد شبابيك كاتدرائية ميلانو الشهيرة . وقد رأينا اثناء زيارة قرطبة عــام ١٩٦١ شارعا يحمل اسمه .

وفي الختام نشكر الدكتور صلاح الدين المنجد لسماحـــه لنا باستعمال لوحتين من كتابه « الكتاب العربي المخطوط » طبع القاهرة ، ١٩٦٠ .

الطبيب فريد سامي حداد

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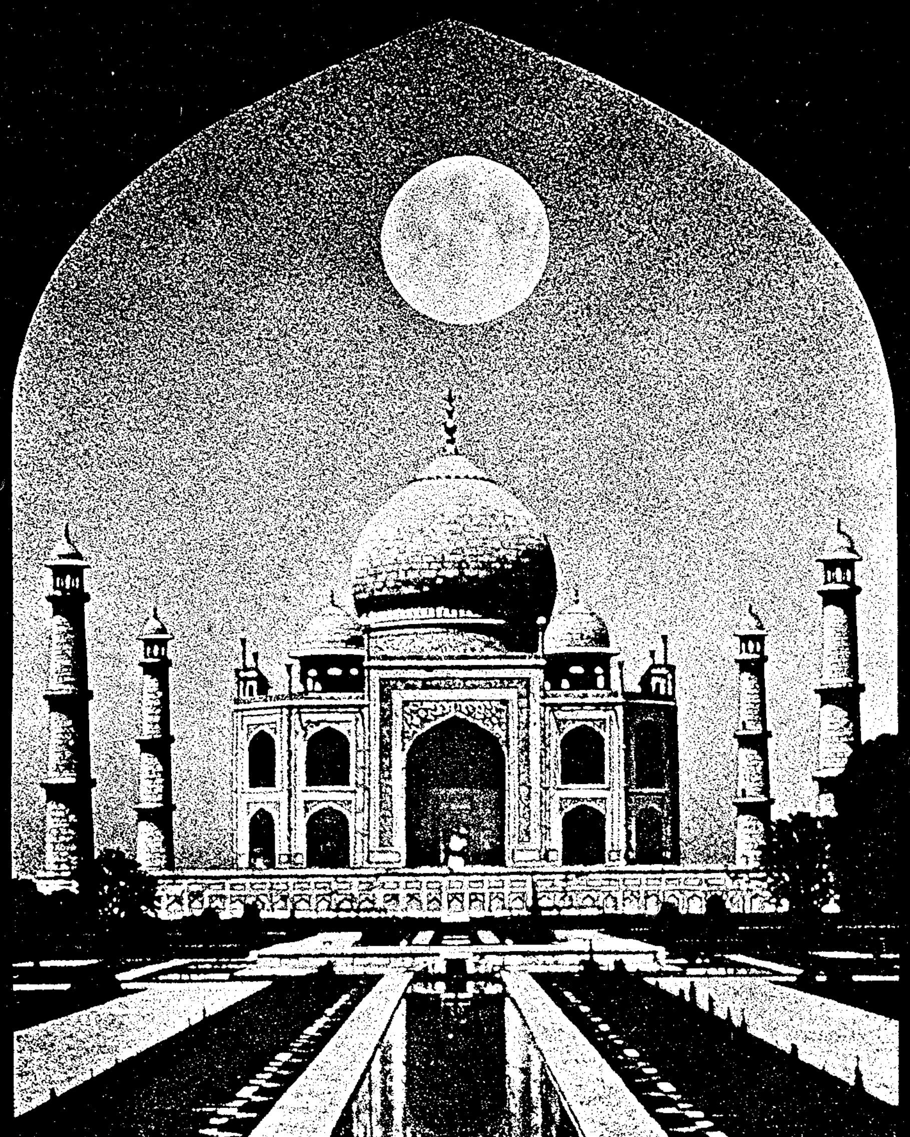
صفحة من التصريف لمن عجز عن التأليف

منقولة عن مخطوطة الهند باذن خاص من الدكتور صلاح الدين المنجد



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Selective inhibitory effect on structures of the limbic system specifically concerned with the integration of emotional reactions;

low toxicity demonstrated both experimentally and clinically;

clinical efficacy well documented in 124 publications on 11,000 patients.

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‹Mogadon› contains as active substance the benzodiazepine derivative 1,3-dihydro-7-nitro-5-phenyl-2H-1,4-benzodiazepin-2-one (nitrazepam). For detailed prescribing information, please consult the packing slip or The ‹Roche› Vademecum.

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العلم في سبيل بلدنا

ان ما طرحناه من وجوب الانكباب على المعرفة ، يوجب نظام تعليمي رسمي حكومي يعمم التعليم الرسمي ويوسعه . ومن اهم خواص ذلك النظام ان يحقق فرصا متكافئة في هذا الميدان لابناء جميع اللبنانيين على السواء ضمن خطة تعليمية مدروسة في اطار متطلبات لبنان ، بعيدا عن التقليديات ، ضمن احتياجات الامة العربية .

فاذا عامل نظام التعليم الطلاب حسب الفروقات الطبقية فانما يبارك بذلك هذه الفروقات السياسية والاقتصادية والقانونية التي لها تأثيرها الاكيد على الفروقات الثقافية . ولما كانت حاجة امتنا الى كل فكر ذكي في بلدها فانه اصبح لزاما علينا ان ندعو الى نظام تعليمي لا يعتمد في غربلة تلاميذه طبقتهم الطائفية او الاجتماعية الاقتصادية .

لذلك فان وجوب تطوير الجامعة اللبنانية معناه وجوب محاولة الجهاز الرسمي اللحاق بالمستوى الموجود في الجامعتين الاميركية والياسوعية . فاذا ما توصلنا الى ذلك ، فاننا بذلك ، نتخلص من الحواجز التي تحدد التناقض بين طبقات اللبنانيين ، الفقيرة منها والغنية ، فلا يعود هنالك فرق سوى في بناء الجامعة .

وانطلاقا مع شعور بعض الطلاب في كلية الطب بمسؤولية وطنية قام قسم منهم بدرس الجهاز التعليمي في لبنان وتبيان هيكليته الطائفية

من دراسة سنة ٧٠ — ٧١

— لكل ٣٢٫٩ طالب في الدولة استاذ ، يقابله استاذ لكل ١٧٫٨ طالب في المدارس الخاصة .

— لكل ٣ طلاب جامعيين في لبنان هنالك اكثر من طالب لبناني يدرس في الخارج .

٤١٪ من المدارس الابتدائية في لبنان دينية مسيحية ومعظمها للكاثوليك

٦٤٪ من المدارس الثانوية في لبنان دينية مسيحية

١٢٪ من المدارس الابتدائية دينية سنية وشيعية

٣٪ من الثانويات دينية سنية وشيعية

١ — هذا يعني أن ٥٣٪ من المدارس اللبنانية دينية ابتدائية

٢ — وهذا يعني أن ٦٧٪ من الثانويات دينية ثانوية

ولا حاجة هنا لنبين الدور الطائفي الذي تلعبه المؤسسات التعليمية في تفتيت الارض الصلبة التي يجب ان تتواجد في بلدنا لنتخلص من مشاكله الطائفية والتبعيات السياسية اللاوطنية وليدة الطائفية .

— مثلا من دراسة « لجان بران » (استاذ علم في لبنان ويدير حاليا معهدا في فرنسا)

١٠٪ فقط من طلاب المعاهد الكاثوليكية (اهم المدارس الخاصة الدينية) ينتمون الى طبقة الفقراء والمعوزين التي تكون ٥٠٪ من المجتمع اللبناني ، بينما ينتمي ٥٠٪ من طلاب هذه المعاهد الى طبقة الاغنياء والميسورين .

٣١٪ اميون ، مما يجعل لبنان من الدول المتخلفة في ميدان التعليم .

٥٠٪ الى ٣٥٪ من الاطفال الذين تتراوح اعمارهم ٥ سنوات خارج المدارس ، من اسباب ذلك عدم قبول الاطفال قبل خمس سنوات في المدارس الدينية بينما الحد الادنى للقبول في المدارس الخاصة هو ٣ سنوات، بالاضافة الى ان هذه المدارس على مستوى منخفض من حيث تدريس اللغة العربية واللغات الاجنبية خصوصا مما يقف عقبة امام هذا الطالب المتثقف في مدارس رسمية من دخول الجامعات التي تعتمد اللغة الاجنبية كالانكليزية مثلا والفرنسية .

٧٥٪ من القطاع الابتدائي رسمي وخاص مجاني

٢٥٪ من الثانوي رسمي وخاص مجاني وانه من السهل الانتقال من مؤسسة خاصة الى رسمية ولكن ليس العكس .

٥٤٣٠٠٠ طالب في المرحلة الابتدائية

٢٠٤٠٠ في المرحلة الثانوية

ومقارنة هذين العددين تظهر بوضوح ارتفاع نسبة ترك الدراسة وهي موزعة كما يلي : ١/٣ من الطلاب فقط ينتقلون من المرحلة الابتدائية للمرحلة التكميلية

١/١١ من الطلاب ينتقلون من المرحلة الابتدائية للمرحلة الثانوية يضاف الى ذلك صعوبة دخول الجامعات وخاصة في بعض المجالات .

واذا نظرنا الى توظيف متخرجي الجامعات في لبنان

١ — الجامعة الاميركية : الكوادر العليا في القطاعين الخاص والعام

٢ — الجامعة الفرنسية : الوسطى والعليا في القطاع الخاص — العليا في القطاع العام

٣ — الجامعة اللبنانية : الكوادر الوسطى والسفلى في القطاع العام — الكوادر السلفى في القطاع الخاص .

فانه من الظاهر والواجب على شبابنا المثقف ان يرتفع بجامعته اللبنانية الى مستوى الجامعتين الاميركية والفرنسية ، فعدم فتح فروع تطبيقية وعملية ذات مستوى معترف به دوليا يعبر عن الرغبة في ابقاء الدراسة في هذه الفروع ملكا لا وطنيا .

حسام

بيان من اللجنة الثقافية في جمعية طلاب الطب

« هل نقوى بالمعرفة ؟ »

الكلمة التي نرحل فيها الى البكاء تصبح معبدا . والبكاء يعجننا كل يوم ، كلما اصبحت المسافة اقرب . قلقنا اليومي ، التساؤلات ، التنازلات ، والاشياء الكبيرة والتفاصيل تشبه حضارة ، تشبه تداديس المعرفة التي تضج حولنا كل لحظة . في وجوه الناس مطروحة كل الاسئلة مثل آلاف الاطفال في مدينة الجوع . العالم شبابيك يقتحمها النزاع النفسي والنزاع الاجتماعي والنزاع الجنسي والنزاع السياسي . اللعبة خطيرة والحب صعب .

ثقافتنا تساوي قلقنا في هذا الحب .
ثقافتنا تساوي الصمود في الاوقيانوس .

هناك دائما شيء غيئب يشبه اللذة يرافق دراسة الانسان ، شيء يحيط باللعبة الطبية ويعطيها بعدا شعريا في غوصها اليومي داخل الصراخ . والآلام ، في مباطحتها تلك الظاهرات التي تتحدى الكيان الفكري وتحركه . عملنا في المستشفى ليس التزاما بمهنة ، هو نوع من احتفال عابق ، معاناة حميمة جدا تحاول الاقتراب من الحقيقة الانسانية ، تحاول عبر الضجيج والبكاء والوجع والضحك ، الطلوع الى فعل الحب مع الانسان .

ومن هنا ، فالتكوين الانساني والثقافي لدارس الطب يصبح حركة حية رسولية تقلق في طريق الحقيقة .
فاللعبة سهلة ، سهولة انقاذ العالم !

هذه هي المرة الاولى التي تأخذ فيها اللجنة الثقافية في جمعية طلاب الطب مكانا خاصا لها في مديكس . هناك شعور عام بان على هذه اللجنة ان تتخطى واقع كونها هيئة تنظيمية لمسابقات في المعلومات العامة فقط . انطلاقا من تصورنا لتلك المعاناة الفكرية التي تغلف عملنا اليومي في دراسة الطب ، نرى ان تكون هذه اللجنة احدى المحركات لوضعنا الثقافي في هذه الكلية وان تكون الامتداد الطبيعي للبعد الفلسفي لدراستنا وبالتالي الالتزام بمسؤولية تشغيل واجهتنا الفكرية .

فاللجنة هذه السنة ، ستتحرك ضمن هذه الافكار العامة عاملة على تحقيق مضمونها على الشكل التالي :

١ ــ اتخاذ زاوية ثابتة في مديكس لمعالجة قضايا هي في صميم بنائنا الثقافي .

٢ ــ العمل لتقديم مناظرات في مواضيع هامة مثل قضية تنظيم الاسرة ، وقضية النفط في العالم .

٣ ــ العمل لتقديم محاضرات في مواضيع شاملة مثل الفلسفة والفلك [قدمت اللجنة في السنة الماضية محاضرتين عن الوخز الابري والتصوير الفوتوغرافي] .

٤ ــ العمل لتنظيم مباريات في المعلومات العامة كما جرت العادة .

٥ ــ التشديد على التفاعل مع اللجان الاخرى لان في اعتقادنا ان العمل الثقافي هو عمل ديناميكي منفتح يتحرك ابتداء من البعد الاجتماعي وحتى البعد العلمي .

أخيرا . همنا الكبير يقع في حب الناس . هؤلاء الذين في وجوههم مطروحة كل الاسئلة وكل الآلام . هل نقوى بالمعرفة ؟
عن اللجنة الثقافية
نقولا ابو رزق

مختارات من طرائف العرب

١ ــ قالوا : ما اشد الحاجة الى الحذر في اوقات الامن .

٢ ــ قيل : جلس معاوية بن ابي سفيان يوما في مجلس ، فسأل معاوية الاحنف ابن قيس وقال صف لنا الناس يا أحنف ؟ فقال : رؤوس رفعها الحظ ، وكواحل عظمهم التدبير ، واعجاز شهرهم المال ، واذناب اتحفهم الادب ، ثم الناس بعدهم بهائم ، ان جاعوا صاموا ، وان شبعوا ناموا .

٣ ــ هم بقتلهم .. فأجازهم

حكي عن معن بن زائدة الشيباني انه اتى بجملة من الاسرى ، فعرضهم على السيف ، فقال له بعضهم : اصلح الله الامير ، نحن اسراك ، وبنا جوع وعطش ، فلا تجمع علينا الجوع والعطش والقتل . فأمر لهم بشراب فأكلوا وشربوا ، ومعن ينظر اليهم فلما فرغوا ، قال احدهم : اصلح الله الامير : كنا اسراك ونحن الان اضيافك . قال : قد عفوت عنكم . فقال الرجل : ايها الامير ما ندري اي يوم اشرف . يوم ظفرك بنا او يوم عفوك عنا . فأمر لهم بمال وكسوة .

٤ ــ علامة النبوة

● ادعى رجل النبوة فقيل له : ما علامات نبوتك ؟
قال : انبؤكم بما في نفوسكم
قالوا : ماذا في نفوسنا ؟
قال : في انفسكم اني كاذب مخادع لست بنبي

٥ ــ غرف القصور

قال رجل من العرب :
رايت البارحة في منامي ، كأني دخلت الجنة ، فرأيت جميع ما فيها من القصور ، فقلت لمن هذه ؟
فقيل : للعرب .
فقال رجل عنده من الموالي : اصعدت الغرف ؟
قال : لا
فقال : فتلك لنا ..!

امثال من بلدنا

بــاب الالف

١ ـ اما عدواه بمروه واما صداقه بفتوه
٢ ـ امشي بجنازة ولا تمشي بجازة
٣ ـ اقطع نهر هايش ولا تقطع نهر هادي
٤ ـ ان عشقت اعشق أمير وان سرقت اسرق حرير
٥ ـ ان وجعك بطنك لا توجع بطن الجيران
٦ ـ ان غاب القط ، العب يا فار
٧ ـ اجا تيكحلها ، عماها
٨ ـ ابن الستين هيله السكين
٩ ـ ابن الخمسين زهر البساتين
١٠ ـ ان سمن الكلب لحمه ما بيتاكل
١١ ـ ابن الدوري دوري
١٢ ـ ابو حشيشة بحالو غلبان
١٣ ـ اصبر على الحصرم بتاكله عنب
١٤ ـ ان كنب بتقرب للمرى ، نوت بلا مشوره
١٥ ـ اذا جوزى راضي لشو فضول القاضي
١٦ ـ اختيار يدللني ولا شاب يذلني
١٧ ـ اخر العنقود سكر معقود
١٨ ـ اخر البطون اعز ما يكون

بــاب التــاء

١ ـ تيتي تيتي متل ما رحتي متل ما جيتي
٢ ـ التكرار بعلم الحمــار
٣ ـ تفركش برماد السيكاره
٤ ـ تلم الاعرج من التور الكبير
٥ ـ التوب ما بيعمل راهب
٦ ـ توب العياره ما بدوم وان دام ما بدفي
٧ ـ تخاذق الريح والبحر طلعت الفله على المركب
٨ ـ تزاوروا تتجاوروا
٩ ـ ترك الذنب اهون من طلب التوبه
١٠ ـ تميت صلى حتى حصلي ، ولما حصلي بطلت صلي
١١ ـ توبه العاصي بعد شهر وتوبه المقامر بعد دهر
١٢ ـ تزوج الاصيلة ولو كانت على الحصيرة
التوب الجديد من كثر اللبس بيعتق

بــــاب الجيم

١ ـ جوزناها تانرتاح منها رجعت وجابت معها
٢ ـ الجمل بدرهم ودرهم ما في
٣ ـ الجنــون فنــون
٤ ـ جبنا سيرة القط اجا ينط
٥ ـ جبنا الاقرع تيسلينا ، كشف قرعته وخوفنا
٦ ـ جهل الكبار ما الو دبــار
٧ ـ الجوز ما بيتاكل الا بالكسر
٨ ـ جوع شهر بتعيش دهر
٩ ـ الجود من الموجود ـ والجود حراره من الجدود
١٠ ـ الجار ولو جــار
١١ ـ الجــار قبــل الــدار
١٢ ـ جبنالها زوج قالت عنــو اعــور
١٣ ـ جمل معدوم ، حمله بيقوم
١٤ ـ الاجر ما بتدب الا مطرح ما بتحب
١٥ ـ جوزي ضربني عام اول ، والسنة طلعت لي دملة
١٦ ـ جوزك على ما عودتيه ، وابنك على ما ربيتيه
١٧ ـ جابو الميه لحاره السقايين

بــاب الحــاء

١ ـ حسن الجوار عمار للديــار
٢ ـ الحره اذا جاعت ما بتاكل من ثوبها
٣ ـ الحق بالوقيه والبخشيش بالقنطار
٤ ـ الحساب بالمثقال والبخشيش بالقنطار
٥ ـ الحجر بارضــه قنطــار
٦ ـ الحقيقــة بتجرح
٧ ـ حلاقة بالفاس ولا عازه الناس
٨ ـ الحق الكذاب لبــاب الــدار
٩ ـ حظ اعطيني وبالبحر ارميني
١٠ ـ حظه بالسما يلي ما عنده حما
١١ ـ حط دوا وشيل دوا علة الموت ما لها دوا .
١٢ ـ حسنها وجمالها لخالها
١٣ ـ حاميهــا حراميهــا
١٤ ـ الحق سلطان والحق نطاح

بــــاب الخــاء

١ ـ خلت روحها مكروب وراحت تشوف المطلوب
٢ ـ خذ من النساء الشلق ، ومن اللحم الحرق ، ومن الفجــل الورق
٣ ـ خذ من الجزمه عود والباقي تحمله القرود
٤ ـ خليها بالقلب تجرح ولا تخرج من الفم تفضح
٥ ـ خلي العسل بجراره حتى تجيله اسعاره
٦ ـ خساره وعزاره
٧ ـ خير ما تعمل شي ما تلقى
٨ ـ الخبر يلي بفلوس بكره بصير ببلاش
٩ ـ خير الكلام ما قــل ودل
١٠ خذ البنات من صدور العمات
١١ ـ خاف من الكريم اذا جاع ومن البخيل اذا شبع
١٢ ـ الاخرس بيعرف بلغــة الخرسان
١٣ ـ خذ من الدهر ما صفا ومن العيش ما كفا
١٤ ـ سنبلة القمح المليانة بتطوي راسها وسنبلــة الــزوان الفارغة بترفــع راسهــا .
١٥ ـ خمنا الباشا باشا تيرى الباش زلمه
١٦ ـ خليك ماكن واترك لي كلمة لكن .

سعــد

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الجنس كبعد حيوي

بقلم سليم مجاعص

نرى الحب الجنسي ، الدفق الحيوي الامثل ، حاجة اولية غير محددة . ليس غريزة. هذه تعني تقريرا للارواء في مبعثه وطريقته واساليبه . شأن تقريري جبري جامد لا تحوير فيه ولا تبديل . سنة في الاثارة والتحقيق ، في التحريض والخطة النهائية في ارواء التحريض التي لا تحول ولا تزول . مملكة الحيوان ، هي . التخفيض فيها وتحويلها وترويضها وتثقيفها ملكوت الانسان في وجوده المدني الثقافي . قد يضعف التخفيض ، ويفشل التحويل، ويموحل الترويض ، وينحرف التثقيف ، ويتشابه الارواء والتقرير الغرائزي ، لكنه لا يبلغ ابدا التحدد الغرائزي ، بل يبقى على توحشه وفظاظته مطاط التحقيق ، قد يقرب آلية الغريزة بالجهل ، ويغشاه الجهل لدرجة الحماقة والقساوة والوحشية ، لكنه ابدا يعود مطاطا في امكانية ارتقائه . هذه الحاجة دفق ودافع ، وهي ، من حيث لا تحديدها ومطاطيتها في التحقيق ، اي من حيث المصلحة في ارواء هذا الحب ، المرتقية الى اعلى مراتب النفسية والمنخفضة الى ادنى مراتب الحيوانية البيولوجية ، تجعل التوسع في فهمها يشمل كل ما تنطوي عليه النفس الانسانية في علاقاتها .

هي تضرب في الاساس التفرع ، تشرش وتورق ، وتفترض بعدا ثقافيا في نظام اجتماعي ، مؤسسة تكفل تحقيقها . تنبع من الشعور وتتحدى الفكر لان الشعور الانساني ذاته متصل بالفكر اتصالا وثيقا في النفس . هي تشمل النفس ، كل النفس ، لان ارواءها يؤثر في جميع وظائف وامكانيات النفس بتعدد مواهبها . لذلك ، يجب ان نعي نحن ، اثناء عملية الارواء ، اهمية الشمول في الارواء . اي ان تكون الممارسة التحقيق عملية انسانية واحدة في الوعي والادراك والتفاعل المتعي ، ولا تنحصر في اماكن الاحساس المتعي التقليدية . هذا لا يعني تقليلا من اهمية هذه الاماكن في التحقيق ، بل يعني الانتقال بالتحقيق من عملية ميكانية يقضي فيها الرجل وقتا معينا عند الحلمة المعينة ، حتى الشموخ المعين ، ثم الانتقال الى اختها ، الى حرير الساقين وتكور الارداف ، تتابعا ، كلعبة شطرنج او كانتاج صنائعي ، الانتقال الى اشتراك الشؤون المتأثرة من التحقيق في التحقيق ذاته . المثل الوحيد حيث بساطة العمل الطبيعي، بالمعنى الانساني تساوي الارتقاء الارفع، المثل الوحيد حيث البساطة والسهولة والتمامية ، دون التعقيد والتخطيط ، الحضارة الكاملة والثقافة الاروع . كممارسة انسانية هي تحقيق قيم ومفاهيم ، نظرات حياتية ومزاج نفسي عقلي شعوري . فعل القيم كشؤون مجتمعية . تداخل الوجود الانساني الكامل ، المجتمع ، في اكثر الشؤون الحميمة دقة وخصوصية . هكذا ندرك الانسان مجتمعا والفرد وجود واحد احد بفضل المجتمع وليس رغما عنه او تصادما واياه . القيم مجتمعية ، ظاهرة نظام ثقافي حاو نظرات المجتمع الحياتية القيمية في الغاية والمثال والاهمية والطريقة . مولد التنوع الانساني، حصيلة تنوع المجتمعات ثقافيا اكثر من تنوعها فقط في خصائص النوع الانساني ، الا في حالات مفردة واضحة . وبتداخل المجتمع واساسيته في تكوين النفس وتطورها وتبدلها يضيف العمل الجنسي الى صفته الخصوصية الحميمية صفاته المجتمعية ، ويصبح حالة اجتماعية اشمل من عملية الجماع . تنوجد في بناء المجتمع الروحي كما في اساسه المادي بتمييز وارتقاء دون فصل وتحديد . لكي ندرك اهمية التحدد في النظام الاجتماعي، تفيدنا اقامة مقارنة بين الجنس عند الانسان وعند الحيوان . الجنس لدى الحيوان تقرره الغريزة في مبعثه وتحقيقه وغايته البيولوجية ، اما لدى الانسان فنلاحظ ، كما مر معنا وكما اثبتت دراسات كوزرد لورنز تخفيضا واضحا في الغريزة، يقابله ازدياد في الحساسية الجنسية ، وفصل بين الاحساس والغاية البيولوجية في حفظ النوع .

الوجه الثاني للاختلاف هو غياب الدورات الموسمية التي تتحكم بالدفق الجنسي . الفرق الاساسي الجوهري هو في كيفية فهم المحيط من الوجهة النفسية . اي ، فيما يختص بالظواهر النفسية ، الوعي والاحساس والارادة والفكر والتصور والتقاليد التي لها مساس عميق بالنفس ، المكونة البناء النفسي للاجتماع . من بامكانه ان يذكر حالة واحدة للوفاء عند الحيوان !! مسألة اخيرة العري . ارتباطه بالتقاليد والنظرة الى الحياة .

اذا دخلت فجائيا على امراة عارية : السويدية ، الفرنسية او الاميركية تحاول ان تغطي بيديها، منطقة الحوض، اللاوسية ثدياها ، السلبية ركبتاها، الصينية قدماها، الساموية سرتها! وفي النظرة السويدية الحديثة ، والاوروبية الشمالية عامة ، نجد باعتبارها الثياب هي تثير . ارتداء المرأة ثوبا ، يعني دائما رجل يفكر في ما يخفيه الثوب . القطع الصغيرة من الثياب ، هي اكثر اثارة ، مركزة الانتباه والنظر على اماكن معينة من الجسد . الرجل العاري ، في نادي عراة ، وهذه الاماكن لديه ولدى الاخرين ظاهرة ، لا يثار !

مهما يكن رأينا في هذه النظرة ، لقد اثبتناها لنظهر وجهة الاختلاف في كيفية فهم المحيط من الوجهة النفسية . واذا تابعنا تاريخ العري الحديث نرى تغير النظرة تبعا للمحيط

وتبدل المحيط بتأثيرها . بدأت حركة العري الحديثة ، نظريا ، في المانيا عام ١٩٠٧ مع نشر كتاب « العري » . يدعو الى مجتمع عراة يتخلص فيه الناس من الاغراء الممنوع ، ويتعلمون المساواة بينكل اقسام الجسد ليزول الاغراء والزنى والانحراف وبعد ذلك بقليل ، بتأثير الكتاب ، انشأ بول زينمرنن معلم مدرسة فرارع انشأ بناته الاربع في كره الثياب — اول نادي للعراة . ومن شروط الدخول الاقلاع عن الكحول والتدخين واللحوم ، وطبعا ، الثياب . وفي مدة عشرين سنة ارتفع عدد العراة في المانيا الى خمسين الفا . وانتقلت الفكرة الى سويسرا ، اسوج ، نروج ، انكلترا ، وسنة ١٩٢٩ الى اميركا . ذلك العام كان انتصار العري في المانيا ، فعلى مسرح برلين الشعبي عرضت مسرحية بممثلين عراة : ٤٠ سنة قبل « هـــير » !

ليس صدفة ان يبدأ العري في المانيا وان ينتصر فيها سنة ١٩٢٩ . فمن دراسة الاحوال المجتمعية على جميع الاصعدة بامكاننا الفهم . فمن الازدهار المتصاعد الى انحلال الروابط والعلاقات في الحرب — المجزرة الاولى ، الى الازمة الاقتصادية والديون المالية والعوائق والرقابة الخارجية ، الى التضخم الشهير الذي في ظلال ذهبه المزيف انتقل العري الى اميركا . وعلى ضوء مسألة العري نفهم بعض الاسباب التي دفعت هتلر الى التساهل مع هاين اللواطي ثم لاسباب سياسية تسلطية امر بتصفيته . ثم كيف كانت مبشرات ال ب.د.م. يعلمن ضرورة « انتاج » الرجال لعظمة الرايخ الثالث ضمن الزواج او خارجه .

العري قصد التخلص من الفصام الثقافي المراوغ الفاسد واعادة قيمة الجمال الجسدي الانساني وازالة جميع المفاهيم التي تربط بين الجسم والعار والعيب . لكنه انحرف الى رفض اي تنظيم في البناء الثقافي لانه ، كحركة ، عجز عن اقامة بناء ثقافي جديد . في اية حال التجربة مستمرة ولا يمكن الحسم في النتائج قبل تبلورها . والتاريخ مالك البلور وصاقله !

حياة الانسان الجنسية لها وجهة وقواعد ثقافية . واي بحث في تغيير الفهم والممارسة فيها يجب ان يشمل هذه الوجهة وهذه القواعد ، اي تغيير جذري في النظرة الى الحياة ، وهدفها (من ضمن نظرة الى الكون) ، وجمالية ممارستها وارتقائها وجودتها (من ضمن نظرة الى الفن) ، وعلاقاتها الانسانية . التغيير يتطلب الانبثاق من نظرة الى الحياة والكون والفن تؤسس نظاما اجتماعيا جديدا وعلاقات انسانية جديدة في فهم الدور وممارسته . هذا هو المنطلق — الاساس .

ان التأسيس (نسبة الى مؤسسة) الثقافي للدفق الجنسي يجب ان يعتبر بين اولى التحقيقات الحضارية والحاجات الاولية للانسان ، نسبة الآلة والنطق .

الغرض من الحب الجنسي اقنوم منفصل عن غرض الحب نفسه . الاقنوم الثاني الحب النفسي . ليس من فصل بل وحدة مدرجية — حب مدرجي . غرض الحب السعادة الانسانية الاجتماعية الكبرى. انه حالة اجتماعية لها خصائصها النفسية . السعادة الانسانية غاية ، اذا مصلحة ، فارتياح النفس في المتعة المرتفعة فوق اللذائذ البيولوجية تصوغها سلما لبلوغ الاعلى . اعتمادها سلما لا يعني ابطالها او رفضها ، بل ابطال كونها بذاتها غرضا نهائيا مبعث الرذائل والحقارات . الغرض ينعتق من قيود بقاء النوع الى ما هو اسمى ، امثل ، واجمل ، والمتعة تتبدل قوتها وفق اللقاء الحساسي المتعي للشركاء ووفق الوعي الفردي لهذا الاختبار الجماعي . ليكون توازن ولا يتخلخل الاساس ، يجب ان يرافق ارتقاء النفس فن عناق الاجساد .

في بعض مناطق امتنا لفقدانهما تبتدىء اكثر تجارب الحياة الزوجية بعملية اغتصاب ، او مراوغة لتفادي الخوف ، او جهل تام واستسلام كبضائع الاستهلاك . المرأة تنشأ في معرفة وظائفية رحمها في الانجاب ، واهمية غشاء بكارتها عنوان « الشرف » و « الكرامة » المخبأة « بحكمة » بين الفخذين ! وترى على اساس دور استسلامي مطاوع بين يدي الزوج ، ويصور لها العمل الجنسي كواجب زوجي ، بل واجب كريه لما يرافق شرحه من التحذيرات من الالم المانع للمتعة . المرأة تثقف انه ليس لها البحث عن المتعة ، بل الاكتفاء بالسماح للرجل ان يستمني داخل فرجها ، وان اي احساس بالمتعة في هذا العمل دليل انحراف وانحلال . وقد تكتشف هي بنفسها، او من اترابها ، كما هي اكثر الاحوال ، ان لها مناطق احساس متعي قد تؤمن لها بعض المتعة عند الملامسة ونشوة عند المداعبة ، وان الثديين ليسا فقط للرضاعة، وان جسدها وجود جميل حي نابض يستحق اهتماما وعناية وارتقاء في الوظائفية والقيمة والاهمية . لكن هذا الاكتشاف يأتي متأخرا ، وفي اكثر الحالات ينظر اليه المجتمع كدليل انحطاط وهفت فتقع حالة الانفصام .

الرجل يربى وعنوان اعتزازه وافتخاره عضوه وامكانياته الفائقة . ممارسة العمل الجنسي حقه الذي لا يناقش . ينشأ في مفاهيم وغايات عقيمة وتغرز فيه اذواق جمالية خاصة . اهمها تفضيل الفروج الضيقة المؤمنة احتكاكا وضغطا مناسبا لتأمين متعة اوفر . النكاح لا يفرق بشيء عن عملية الاستمناء السرية . هو يستبدل يده واوهامه وخيالاته بجسد المرأة ، واحساسه بالنشوة المفترقة عن نشوة الاستمناء ليس سوى ان اوهامه وتحسره وحرمانه تعلمه ان هذه ارفع من تلك ، ليس انه حقا يعي الفرق . اثناء اللقاء الجسدي اهتمامه الاوحد ، كما اثناء مداعباته الخاصة ، الوصول الى نشوته المحدودة بعضوه ، جميع انتباهه ومداركه واهتماماته ، او ما يتبقى منها ، هي ان يمرر شفتيه ويديه على المناطق مواضيع شهوته . عملية اللقاء هي عملية خاصة في اسكات فحيح الاوهام وتوحش الطلب . المرأة بـ ين يديه آلة ذات مهمة وظائفية في تلبيته . هذا هو الواقع السيء الناتج عن رؤية الحياة السيئة ، ومفهوم العلاقات الانسانية المنحط الى مهاوي هي المثال المستحيل الكامل عن مبعث الرذائل والحقارات !

عندنا الدفق الجنسي في الحب يتناول جميع شؤون الحياة — السعادة الانسانية الكبرى — كل شؤون الانسان وحياته هي في ارواء هذا الدفق بارتقاء . هناك دائما امكانية تجنيس ومتعة . الاساس البيولوجي لا يغيب ويتفوق عليه بالترويض المدني والتثقيف الحضاري ، وبتحويل الدفق الى ميادين خلق وابداع ليست جنسية جذريا .

من الحقائق التاريخية ان الحضارة غير ممكنة الا بتحويل الدفق ، بل ان درجة ارتقاء الحضارة متناسبة مع درجة تدرتها على تحويل الدفق . ففي العصور الهومرية كانت قوى الرجال تصرف في اعمال القتال والحرب ، والنسوة اليونانيات كن ينصرفن الى احتفالاتهن الخاصة بافروديزيا ، التي كانت تنتهي باعمال جماعية وممارسة ما يعرف اليوم بالسحاق . كذلك المستحيلة الجمال « فرينة » ، اروع امرأة وجدت ، كانت ترد مداعبات براكسيتلس ، بان تحوله الى اعمال خلق من النحت ، وتقف له مثالا ، حتى انتج اروع اعماله التي عادت واوحت لابليس وبوتيشلي اجمل اعمالهما .

وقد تنبه فرويد الى ان الاساس البيولوجي لا يغيب ، وفهمه على اساس القوى الحيوية كطاقة مخزونة ورأى كيف الحضارة تحول قمع وازالة هذه الطاقة ، دون ان تنجح في هذه الاخيرة ، وتوسع في معالجة النتائج السيئة . لكنه لم يعالج مسألة القمع باستبداله بعوامل تثقيف وتحويل حضارية ثقافية عمرانية ، بل انصرف الى تصوير الواقع السيء . نقول ان الاساس البيولوجي لا يغيب لكن هناك امكانية لتحويله وتثقيفه .

من اشد الخطأ حسبان التسامي وراء الوجود وحده روحية والتسامي ضمن الوجود مادية . نحن ندعو ، في مفهومنا للحب،الى التسامي ضمن الوجودباتنوميه النفسي والجسدي. الرقة ، اللطف ، الفن ، والاشتراك بالمتعة في العمل الجنسي، تصور نفسيات راقية متحابة بلغ لقاءها التفاعل ، وهي بدورها واسطة لتعميق هذا اللقاء « بالانسكاب » النفسي . نحن نقول بمادية راقية وبروحية تعنى بالوجود وبتسامي الحياة ضمن الوجود الانساني. التثقيف الجنسي الراقي يجب انيلازم التثقيف النفسي الراقي في الحب . كان الفكر الكنعاني السوري مع سنكونياتن يرى الرغبة المحبة في اساس تكون الوجود في السديم وهذه الرغبة السامية التي رآها الفكر السوري العريق سبب نشوء الكون وتطوره ، يراها الفكر الجديد طريق نشوء جيل انساني جديد في علاقات انسانية جديدة .

ماذا يعني هذا على الصعيد الحياتي الممارس المباشر ؟ هذا يعني ان الحب لم يعد فكر صوفية وهمية في المخيلات ان تنتظر الفتاة الفارس الجميل الواحد الوحيد . الحب عملية مستمرة من التجارب، لا يكتفي بالممارسة الواحدةبل يتعداها الى المدة، وكل مرة يبلغ مستوى اعلى من التوتر النفسي والالتقاء الوجداني وشفافية الصدق . يستمر ويتصاعد ليتحقق وجودا دائما ابديا في الاطفال ثمار الالتقاء التام على الصعيد المدجي. و « وكلما بلغنا قمة تراءت لنا قمم » .

هذا يعني التخلص من مفاهيم ومسلمات نهائية في النظرة العتيقة الى الحياة ، لان التطور لا يكون بلغة الماضي. الوصول الى الحب التام في الوصال النفسي والجسدي التام ، يستوجب المرور بدورات من الحب والتوتر الشعوري المرهف بالعطف والعطاء والمناولة (بالمعنى المسيحي) النفسية الجسدية . ويستوجب ايضا التخلص من الخوف من الجسد ، ومن الانفصام بين متطلبات النفس وتعبير الجسد . فكما ان التاريخ لا يسجل الاقوال بل الافعال والاعمال ، كذلك الحياة لا تكون الا بالممارسة المدرجية التامة باتنوميها النفسي والجسدي في اروع ظاهراتها الحب ــ المتعة ــ السعادة . الحب النفسي من نفسه لا يرتوي ، والحب الجنسي من نفسه يصب في فراغ . ممارسة الحب في الحداثة المستمرة ابد الحياة لتوليد المتعة والسعادة ، موضوع الحب وعنوانه ، تتطلب الانعتاق والعطاء. وليس فيهما مس بالطهارة. الطهارة في الوصول الى المتعة ، في الحب ، تعني التواجد المحب المتفاعل متعيا في الحاضر والمستقبل . في ممارسة المتعة الماضي لا وجود له الا بايجابيته كزخم ومعرفة من اجل الوصول بممارسة الحاضر وامل المستقبل الى طبقات ارقى صعدا . والوفاء في الحب هو في الاستمرار نحو المستقبل، تماما كما هو الوفاء للحياة . ابرز ظاهرة للوفاء للحياة هو في احتفالات الميلاد الخاص . فعندما يحتفل احدنا بذكرى ميلاده، ويطفىء الشموع ، يفرح لقدوم عام جديد ولا يتحسر لفقدان عام . يفرح لان الاعوام التي مضت زودته تجربة وخبرة ومعرفة واملا وزخما لان يحيا الاواتي السنين افضل واروع. الطهر والوفاء في الحب هو طهر الحياة والوفاء لها ، لان « الحياة لا تسكن في منازل الامس » (جبران) ان تعشق الفتاة في صباها وتحب وتقبل وتلثم وتلمس فليس ذلك بضائر حبها المستقبلي . بل ضرورة لمبدأ الحداثة لارتقاء المتعة . الحداثة التي تنمي المعرفة لتكون لها قيمة افضل . الحداثة تكتسب قيمتها متى ادركتها معرفة نمت بفعلها . ان تعشق الفتاة وتقبل وتلثم فذلك يعودها الرقة في العطاء وفهم درجاته واعماقه ، والحنان في الملامسة ومعانيها الجديدة المتجددة اللاهبة ، والرقي في المعرفة النامية ، والروعة في اللقاء بين المحبين .

مفهوم ضرورة الحداثة للمتعة يتكشف عن ممارسة حياتية تامة وعن علاقات انسانية جديدة . يعني تهديم مفاهيم معيقة مانعة . فالشاب الذي يطلب ان تحفظ الفتاة له من اول ما تخرج الى الحياة الانسانية المجتمعية ثم تولد وتنمو دون ان تحب وتعشق حتى يأتي هو ، يطلب فرضا وممارسة قسرية لانانيته وجبنه . يريد الفتاة في ماضيها ، وماضيه ملك له لا يمس ولا يذكر . يريده « فجة » لم تلمسها يد محبة او تقبلها شفة عاشقة ، ويأتيها « ناضجا » يرفل في « امجاد » تاريخه . وهو يجبن ويخاف ان تمر الفتاة في دورات حب قبل ان يصل فلا يستطيع ان يقدم لها دورة ارفع ، وفي الزواج الدورة المستمرة المتصاعدة بذاتها ، المتكاملة بذاتها بفضل تماميتها ، الحارة المشوقة الملتهبة حنانا ورقة ، الدائمة النضرة ، نضرة حقول الاحلام الخضراء .

نريد نفوسنا نيرة صريحة جميلة ترى الوجود نيرا صريحا جميلا . فقط بفهمنا الجديد للجنس وتصرفنا الجديد في الجنس نصل طهرنا الكامل وتماميتنا . فقط عندما يكون فكرنا وفعلنا في الحب الجنسي في تناسق وتناغم ، بل تواز وحلول ، عندهافقط نحقق تماميتنا وتصقل انسانيتنا وتتفتح مثل الزنابق امسام الشمس الململمة الندى في كل يوم من الزهر . مهمتنا اليوم ادراك الحب الجنسي ، لان الادراك التام الكامل له يكاد يكون اهم من ممارسته . لقد مارس اجدادنا الجنس كثيرا دون

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DOSAGE: One or two capsules at mealtime, preferably taken during the meal.

PRECAUTIONS: Not for pediatric use. For adults, maximum recommended daily dose is 6 capsules. There are no known contraindications to the enzymes. Administer Levsin (l-hyoscyamine sulfate) with caution to patients with glaucoma, heart disease and prostatic hypertrophy. Phenyltoloxamine may cause drowsiness; if so, driving and operation of machinery should be avoided.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Bottles of 50.

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عقله فاصبحت الممارسة آلية بشعة مخيبة للامل والتمني . الادراك الصحيح الندي فقط يعيد حيوية ، طراوة وندى التجربة الجنسية . نحن بحاجة الى الوحدة المدرحية الرائعة بين احساس الجسد بالتجربة والتجربة نفسها وذلك بعقلنا للتجربة . المعادلة بين وعي العمل والعمل نفسه . اعادة الصلة بين الفكر والواقع .

ان فكرنا لفي خوف من الجسد وطاقات الجسد، او في انحراف عبودي له ولطاقاته . نحن بحاجة الى تحرير الفكر ليصبح في مستوى الوعي الجسدي — النفسي الجنسي الجديد . الخوف من الجسد يدفع بالشباب الى الطرف الاخر حيث يصبح الجسد دمية نلهو بها ، دمية نزقة ، لكن رغم ذلك قادرة على توفير بعض المتعة قبل الهرم . ليس عندنا فقط بل في كل انحاء العالم.

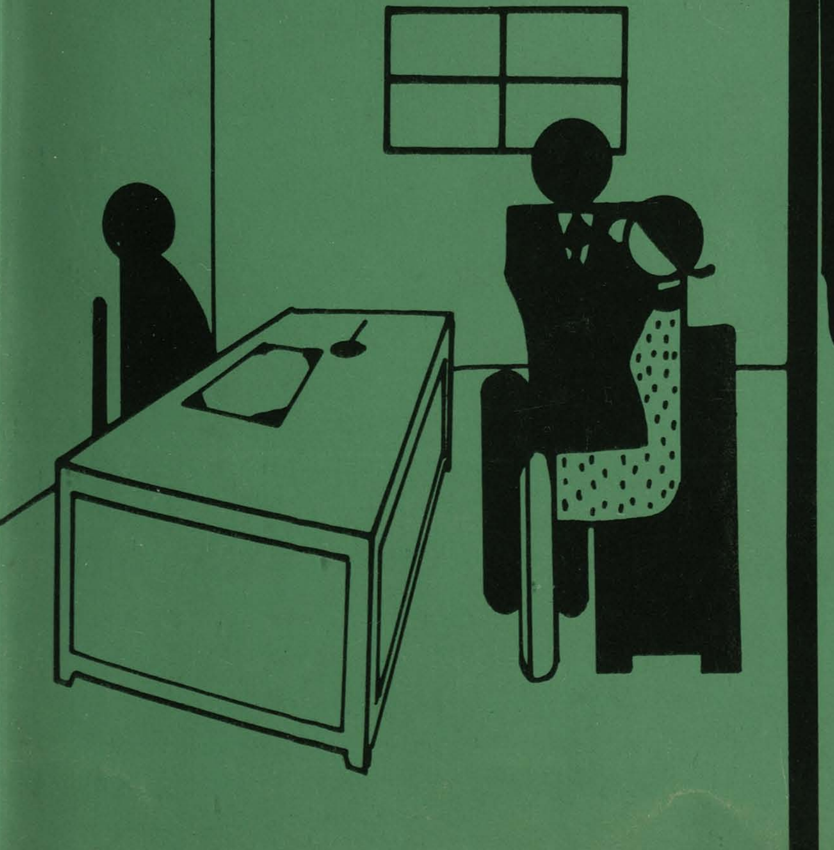
الحياة لا تحتمل الا عندما يكون الفكر والجسد في تناغم ، خارج الوحدة المدرحية عدم في عدم . نحن اليوم في حالة مفارقة لانفسنا لان ذواتنا الشعورية الفكرية الحقيقية مخصية في قمقم التقاليد والمفاهيم التي تسحبها هذه التقاليد على حياتنا . نحن نعيش اشكالا قبلية (نسبة الى قبل لا قبيلة) ، اشكالا تعلمنا مجالا معينا من العواطف والاحاسيس لا نحيد عنها ولا نميد . ما يجب ان نشعر وما لا يجب وكيف واين ومتى . هذا بالذات ما تدعو الى تخطيه ورفضه ورفسه ونقضه وتحطيمه ورميه في مزبلة المفاهيم الميتة المنحطة . ندعو الى نظرة جديدة الى الحياة والكون والفن ، اوجدت فهما جديدا للقضايا الانسانية . الاشتراك في فهم جمال الحياة وممارسة هذا الجمال في الفكر والشعور وكل الاختلاجات . الوصول الى « الحقيقة الاساسية الكبرى التي يستقر عليها الفكر ويطمئن اليها الشعور » ، الى الفهم الصحيح النقي للحب الذي لا يرذل الجسد ولا يؤلهه ، بل يدعو الى تحقيق الحب — حب «لو اطفىء لظى الشهوة الجسدية وقضت النزعة البيولوجية وطرحا لظل لظاه يلذع النفوس ويعذبها حتى تجد له تحقيقا — من اجل خذل الاقبح والاسفل والارذل والاذل ، ورفع الاجمل والاسمى والانبل والاعز . فلا تكون هنالك اختلاجات حب الا ضمن دائرة هذا الوعي الذي يرفع قيمة الانسانية طبقات جوية فوق القناعة براحة النزعة البيولوجية ذات الارتباط المادي ، الغافلة عن المطالب النفسية الجميلة » .

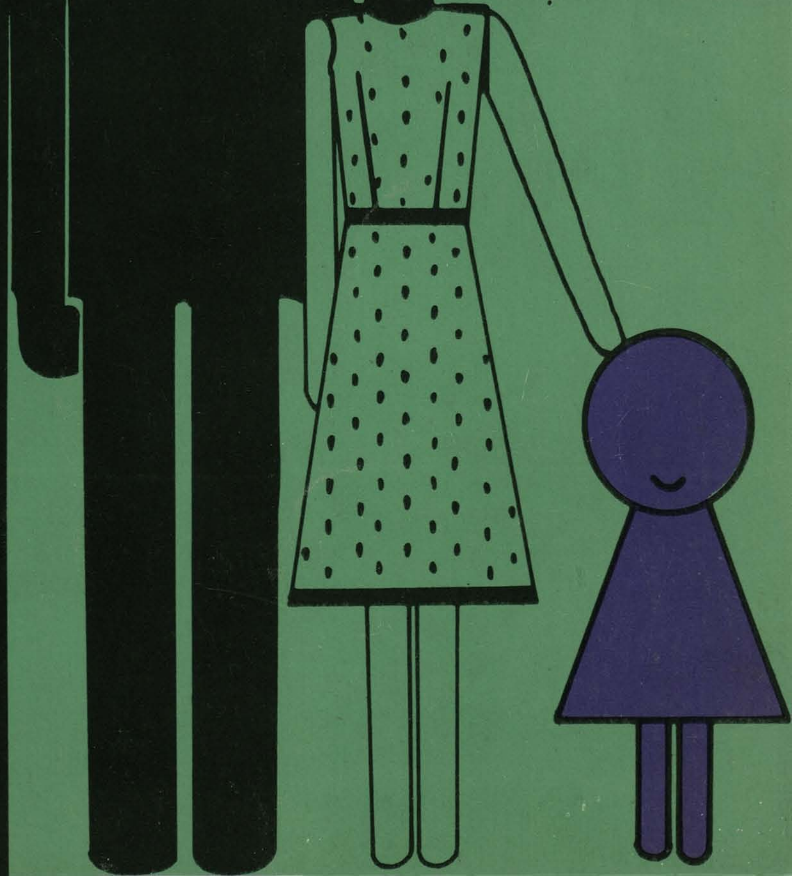
لم يعد الجنس يعني ثياب المراة الداخلية والعبث هناك وبها، لم يعد يعني نساء بلا معنى . الرجل الذي يرى ثياب المراة الداخلية اروع واكثر جزء اثارة فيها ليس سوى بربري متوحش . لم يعد الجنس عملا وثيابا ، لم يعد بربريا متوحشا غبيا . هو جنس مزيف يتداول في البغي والنكاح ، وبه الزواج فراغ هائل. وفي الحقيقة ان اكثر تعاسة الانسان تنبع من هكذا زواج . لا اريد ان اتوسع هنا في علاقة الجنس بالتقاليد والزواج لكني اريد ان اثبت فهما جديدا للعمل الجنسي : المناولة ، التجدد . الملامسة التي تحيي وتعيد حيوية العلاقة بين الرجل والمراة . العودة الى الحياة الدائمة . الخصبة . في الولادة والوفر . في النعمة والبركة والحرية والتحقيق . الرعشة الدافئة الحميمة. في القرب . السعادة — المتعة .

medicus

VOL. 13 No. 2 DECEMBER 1974

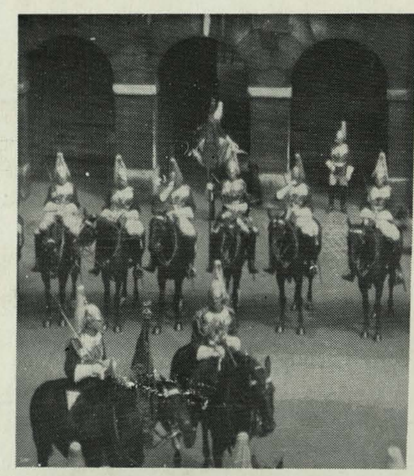
ORPHANAGES & ADOPTION

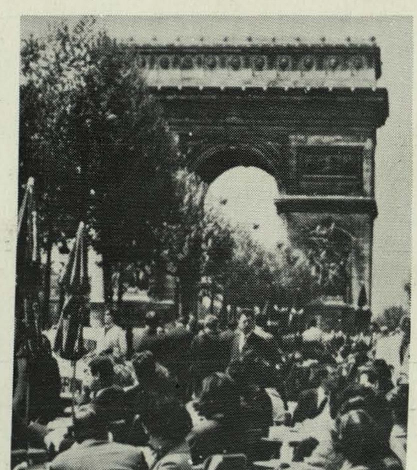




شبكة خطوط طيران الشرق الاوسط
تشمل ١٤ مدينة في أوروبا

سواء أكانت رحلتكم للأعمال أم للترفيه،
اعتمدوا طيران الشرق الاوسط
الذي يقدم لكم مجموعة لامثيل لها من الرحلات الى أوروبا





MEA

TOP OF THE MONTH

COVER STORY Page 7

The coincidence of an year's end and the festive mood of a celebrating world did not obscure our concern for others. In an attempt now to extend the attention of the Medical community beyond the confines of our hospital, and to the Social Welfare needs of any society, MEDICUS undertook to report on those members of our society who begin life on a less privileged note. Associate Editor, **NIZAM PEERWANI,** with some assistance from **LABIB HAJJ,** Med. III, compiled this cover story: **ADOPTION AND ORPHANAGES IN LEBANON.**

FACING MEDICUS Page 27

Diversity in teaching methods and differences in the educational milieu has probably helped produce a certain indifference towards each other amongst our own medical graduates at AUB and those of the Faculté Française de Médecine. To break thru some of these barriers of mutual alienation, MEDICUS met the newly appointed FFM Dean, **PERE HOURS,** for an insight into what FFM stands for!

FEATURE ARTICLE Page 35

As the patients and the general public at the receiving end become more enlightened as well as more concerned about the nature and limitations of the medical therapy they receive, it's possible that the Medical world might soon go thru a process of intensive reevaluation of the present medical sacraments: attitudes and previous decisions on **EUTANASIA** might well be reassessed. Outgoing Associate Editor, **ADLETTE INATI,** with some help from the rest of the MEDICUS Staff, examines this issue, with numerous supplementary interviews to reflect the current mood.

AS I SEE IT Page 19

Beyond the academic prerequisites for admission, the medical students continue to reflect on the other requirements of their demanding career—many of which, appropriately or inappropriately, remain abstract and philosophical. And in the process, they certainly stop to ask themselves: Is it all worth it? We begin this section, **AS I SEE IT,** in which, we'll invite contributions from some top educators to reflect on this aspect of Medicine and Medical students—as they see it. We start with an article from our Director, **DR. RAIF NASSIF: SOME RAMBLING THOUGHTS!**

MEDICAL SCIENCES Pages 54 – 61

The hope of bringing together in some way—be it thru the pages of MEDICUS or thru joint participation in its affiliated activities like MEDICUS NIGHTS—a community of Medical Sciences was certainly well received. In this issue therefore, we retain both the **PHARMACY** and **PUBLIC HEALTH** pages, in addition to the traditional and almost imperishable **NURSING SECTION.**

OUR HERITAGE AT CROSS-ROADS Page 31

This Section was started with our last issue to explore the lives of some of our own medical personalities whose local impact continues to carry some inspiration to the medical students. For this issue, **NABIL ATWEH,** Med. III, **RADWAN KHURI,** Med. II, **ROSEMARY BUSTANI** and **JUMAN HIJAB,** Med. I, turn to **DR. YERVANT JIDEJIAN** to examine the depths of an ever-growing personality who recently retired from AUB after 44 years of surgical service.

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medicus

A QUARTERLY JOURNAL PUBLISHED BY THE MEDICAL STUDENTS OF THE AMERICAN UNIVERSITY OF BEIRUT

VOL. 13 NO. 2 JANUARY 1975

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LOOKING FORWARD

Obviously, there has been some delay in the publication of this issue of MEDICUS. But those who have been associated ever with this magazine, or who have a better insight into the nature of our curriculum, might find it easier to understand our position.

Following our first issue, there was an overwhelming support for the Magazine. Both verbally and thru writing. We do apologize for the many letters that could not be printed here. However, when the exact intensity of our assignment was beginning to dawn upon us more clearly, this support offered some consolation.

We have started some new sections in this issue. We still have two more issues, hopefully, before the class of 1975 begins to leave us.

And meanwhile, we are considering the possibility of breaking ice in another place with the start of a regular MEDICUS LETTER, purely devoted to scientific articles, approaching subject reviews. And for this assignment, to help our Science Editors, we will have the expert assistance of DR. MICHEL NASR, from the Department of Physiology and Internal Medicine.

Acknowledgement

We are grateful to the following Fine Arts Students for their assistance in illustrating this issue:

Ms. Anni Mugritchian, Senior Arts (Front Cover)
Mr. George Irani, Sophomore Arts (Back Cover & Cartoons)
Mr. Lawrence Yacoubian, Soph. Arts (Illust. Dept. Notes)

OUR MOTTO

WE DISAPPROVE OF WHAT YOU SAY, BUT WE WILL DEFEND TO DEATH YOUR RIGHT TO SAY IT !!

EDITORIAL ON THE NATURE OF THINGS....

The Stat! And then the defibrillators! The Coronary and Intensive Care! The Inhalation Therapy! The drugs and antibiotics! The numerous tests! All in a way have become part of the routine protocol of a modern doctor as he seeks to achieve his ultimate aim today - give his patient a longer life! In the determined pursuit of this goal, the doctor often forgets to ponder on what could have been the original purpose of the medicine-man! The great mission of early medicine-men was purely to heal the patient, and cure him of his wounds. Death being considered sacred, they only sought to make the remainder of a patient's scheduled life more comfortable.

Our growing preoccupation with statistics at all levels have helped perpetuate the present situation. We have learnt to formulate parameters to express quantity, while quality still remains an abstract concept. The triumphs of medicine have, unfortunately, been measured in terms of figures - in terms of declining infant mortality or other indices of survival.

The attitude persists. The oncologist for instance, like many of his other medical colleagues, gets satisfied if he manages to push the five-year survival rate of a disease, forgetting almost to consider if this is only achieved at the expense of making the patient sterile, bald, or what have you.

Great strides have been made since medicine's early attempts at healing. This continued progress has generated an ever-increasing pressure on physicians to adapt; and approaches and attitudes have become modified in the process. For instance, we appear entirely prepared to try any new medical approach if it can prolong the five-year survival of a disease. Our goals somehow have become more impersonal: giving a patient a longer life is certainly more impersonal than giving him a better life. In the twilight haziness of this great impersonalizing process, the emphasis clearly appears to have shifted: from life to existence.

Automation will of course also acquire the status of fondness. The recent construction of the spectacularly computerized 12-bed ICU unit at the Mayo Clinic by IBM might well become a model for imitation. Many suspect that the intuitive and the psychic aspect of medicine will soon disappear. And with the resulting tendency to chart and understand patients only in terms of diseases, and diseases in terms of only tests and results, the doctors certainly face the danger of losing the public and time-honored distinction of being humanitarians. Psychiatrists will soon become the remaining few to retain that ability, and they too will soon lose it over to sociologists as they too get obsessed with their ever-increasing jargon and their growing affection for biochemistry and enzyme-levels.

* * * *

A few years ago, Professor Christiaane Bernard was in New York, still explaining to the medical world how he had accomplished his staggering feat - the heart transplantation. Late for his scheduled address, he hurriedly took a cab and asked the chauffeur to "press on it" (the accelerator). "I've got to make it". Not aware of whom he had picked up, the chauffeur quickly retorted: "There are only two things you've got to do in this world, mister! Pay taxes, and die!!". And through a simple man, the ultimate limits of life had dawned on the great surgeon battling with the mechanisms of death. Recognizing this, not only the purpose of our mission but also our locus of emphasis should become clear.

Indeed then, there is a limited life span that medicine can probably push for - or even SHOULD ONLY push for. And during that life span, we should concentrate much more on the quality we can attain. Like all moralists, or perfectionists, quality should remain the primary goal, and added quantity or longetivity ought to come as the automatic bonus. That we probably already know this does not still change what we ought to do. There is a growing feeling thought that emphasis in the medical world has changed. What should have been equally the concern of doctors has been handed over to social workers, public health personnel, sociologists, psychologists and philosophers!

* * * *

We begin a New Year. That by itself provided a moment for reflection. But we also begin a '75 and thus the last quarter of a century. In the long context of a medical history this is of greater significance. The shape that medicine will take during the remainder quarter of the century will be determined not by the magnitude of progress made but by the spirit in which this progress is made and in turn reconciled with. It will be determined by our concern, our attitudes and our scales of values in a life that we are seeking to prolong.

* * * *

And so in this issue of MEDICUS, we devote our two most important articles to issues that essentially reflect on these values of life. Our Cover Story deals with Orphanages and Adoption in Lebanon. But certainly the problem is much more universal and with greater connotations. The doctor ought to share the concern of the moralist, the Sociologist or the Social Worker as they all seek to improve the future of those who begin life on a more unfortunate and underprivileged note. The concern for human welfare in a way is indivisible: its boundaries certainly extend beyond the confines of a hospital. And through the Feature Article, we explore the multidimensional aspects of one of the greatest medical controversies still unresolved. Advocates of Euthanasia will continue to clinch to, as their strongest argument, the desire to give a better quality of life even to their dying patients - by way of termination.

It will be up to those already in the field as well as those that will join, to put the progress, the attitudes and the expectations of an inspiring century into more exact perspective. And seek to alter, where alteration is necessary!

Letters

الجامعة الأميركية في بيروت

AMERICAN UNIVERSITY OF BEIRUT
BEIRUT, REPUBLIC OF LEBANON

مكتب الرئيس
OFFICE OF THE PRESIDENT

CABLE ADDRESS: AMUNOB

November 2, 197[illegible]

Mr. Salim Walji
Editor-in-Chief
Medicus

Dear Mr. Walji:

Thank you very much for extending an invitation to Mrs. Kirkwood and me to attend the first of the Medicus Nights.

It was a most enjoyable evening. You have had a promising beginning for your series. I shall be much interested in following the programs throughout the year.

I wish you all good luck in the publication of Medicus this year. You can rest assured you will have my cooperation for an objective and professional type journal.

With all good wishes.

Sincerely,

Samuel B. Kirkwood
President

SBK:hi

American University of Beirut

NEW YORK OFFICE • 380 MADISON AVENUE, NEW YORK, NEW YORK 10017 • (212) 490-8740

December 3, 1974

Mr. Zuhayr Hemadeh
President
Medical Students Society
American University of Beirut
Beirut, Lebanon

Dear Mr. Hemadeh:

Dean Asper recently passed along to me a copy of Volume 13, Number 1 of MEDICUS. While I was unfortunately unable to read the issue in detail, it impressed me very much on the basis of my rather cursory examination.

While I realize that the publication is intended primarily for the medical students at AUB, I think that certain of the contents would be most useful to me in the fulfillment of my responsibilities.

Therefore, I would ask that, if it is possible, you add my name to your mailing list. It would be most beneficial if you could air mail me copies of the October and November issues, and if you could continue to mail me copies as they are published.

Thank you for your consideration in this matter, and my best wishes for a successful year.

Sincerely,

Richard L. Schaplowsky
Director of Communications

cc: Dean Samuel P. Asper

Dear Editor:

A healthy medical school is that which constantly evaluates the relevance and content of its various undergraduate and post-graduate programs. Nowadays, we are witnessing in most medical schools an acute awareness by medical educators for the need to change their curricula in order to prepare their students better for the true health needs of their communities. Such a process naturally involves de-emphasi[illegible]ing the irrelevant detail and re-structuring the curriculum so that maximal student participation in his own education is achieved.

The subject of the relevance and proper planning of a medical curriculum is exceedingly important and deserves the concern of administration, faculty and students. However this short essay is not intended to discuss it in any detail except to point out that historically, it appears that one undesirable feature of medical educators has been their obsession with the large volume of the material actually taught.

Over-teaching is believed by some to be the inevitable outcome of the expanding medical knowledge. I wish to propose that it is not necessarily so. Thirty years ago when medical knowledge in all disciplines was much less than what it is today, the medical curriculum was as crowded and as long as it is today. Anatomy used to be a 2-year course covering the utmost detail of the human body and in the course of Internal Medicine, 40 lectures were given on typhoid alone! These are only some examples.

In brief, over-teaching is not a new phenomenon but is deeply rooted in medical education. Its origins are not readily apparent but it is easy to conceive how in a traditionally conservative profession like ours, this tradition was difficult to break and was copied by one generation after another.

Today the medical curriculum is as crowded as it has always been. While we are planning and revising it to fit better the needs of one community, perhaps we could give some attention as to how to break the habit of 'over-teaching. This process requires an open mind: the same kind of liberal attitude that made it possible to reduce the course of anatomy from a 2-year course to a concise but relevant semester course! This, as far as can be seen, has not so far reduced the quality of medical education.

Ibrahim Salti, M.D.
Dept. of Int. Medicine

Dear Editor:

Congratulations on a very fine job. Your first issue came with a boom!! I know the hard work it took to produce it. In as much as I want to see such quality productions to continue, I would like to suggest that MEDICUS should look in depth at the problems of the home-base — AUB and the Medical School—here and now; problems relating, for instance, to curriculae or to relevance of medical education at both the pre-& post-doctoral levels.
I wish you continued success.

Victor Nassar, M.D.
Dept. of Pathology

Dear Editor,

I would like to congratulate the staff of MEDICUS for their excellent job in preparing the first issue of our journal. It was quite an interesting and voluminous work full of many articles and news from different branches of the Medical Sciences. This is the first time MEDICUS tries to be the journal of the whole Medical Sciences, and was a good start.

One thing which irritated me in this issue was the long and repetitious interview with Omar Sharif appearing at different pages which I thought was completely out of place in our journal. Another question which kept bothering me was about the article on Homosexuality. Does the editorial board want us to get interested in this subject (or rather in these people) with such a long article? I think too much space was allotted to that particular subject. Otherwise the journal was read with interest.

There is no doubt that all those who have worked in preparing this issue have allotted a lot of their leisure time and nobody has the right to criticize them. They are to be congratulated and praised for their courage and devotion.

Jean Missirian Med. V

OPEN LETTERS

(Of the many letters of a similar nature reading the MEDICUS Box, authors of the following three, signed letters requested that their identity be withheld in print. — Eds.)

Dear Editor:

Since MEDICUS appears to have shifted to professional journalism—so far—with impressive compilation of articles, may I suggest some interesting topics for the Cover Stories for your next **three** issues: X-Ray Department and the Records Room; X-Ray Department and the Records Room; X-Ray Department and the Records Room;—where so much of the medical students' precious time is lost day after day after day, trying to locate X-Rays or Charts. Unless of course MEDICUS is afraid to take up this challenging task, I am confident that three cover stories can make at least some difference!

(Name Withheld Upon Request)

Dear Editor:

Thru MEDICUS, I would like to communicate with the Chairman of the Anniversary Committee who has ended up breaking our long tradition of M.S.S. Anniversaries. Is there any hope that we might still have an Anniversary Night before the coming June? MEDICUS could investigate, if the answer is no!

(Name Withheld Upon Request)

Dear Editor:

I suggest that MEDICUS should start a fund-raising campaign to help replace the fast-diminishing spoons, the cracked-cups and the deformed glasses in the Cafeteria! Since the aging Mr. Ali Kaddouh no longer seems interested to provide desserts to supplement the shrinking, subsistence menu—becoming more and more expensive day by day—and the Administration or the Nutrition Experts don't seem to care either, may be MEDICUS can take up the challenge to call for improvement!

(Name Withheld Upon Request)

(More Letters on p. 80)

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COVER STORY

ORPHANAGES AND ADOPTION IN LEBANON

New Year invariably becomes a moment for reflecting on the values of life and as our work in MEDICUS took us towards a fast-approaching '75, the timing and mood of the outside world instinctively directed our thoughts towards the provision of a better and more comfortable life. These thoughts ultimately got reflected in the basically common theme underlying the different problems taken up by our EDITORIAL, COVER STORY and the FEATURE ARTICLE.

Characteristically, the betterment of fellow medical students ought to remain the primary concern of a student journal, and indeed the confinement and social isolation into which medical students are increasingly being pushed through pressure of work and duties was clearly at the back of our minds. This was ever a tempting subject for our cover story. And this sense of social deprivation, particularly rendered more acute as the outside world tuned itself to a celebrating mood for the approaching festivals while clinical students preoccupied themselves instead with working out duty schedules during the Id, Christmas and New Year vacations, hardly made this temptation any less. Yet, typically in the generous tradition of making the year-end a time to consider the welfare of others, we looked for issues beyond the confines of our own problems and our own hospital. Immediately, we thought then of responding instead to the challenging need of promoting a sense of civic responsibility amongst the community of Medical Sciences.

And almost unanimously, the Editorial Committee decided to take up the problem of ORPHANAGES AND ADOPTION IN LEBANON. Indeed, as one M.M. (Medicus Member) reflected, in the scale of social deprivation, the orphans and the adopted easily surpassed the score of medical students. Somehow the statement *sounded logical* !

***Coordinating for this cover story* once again became tne task of our Associate Editor, Nizam Peerwani. Labib Hajj, Med. III, who joins MEDICUS ranks along with his camera with this second issue of MEDICUS '74-'75, assisted the team as indeed he also took turns with Nizam to make the repeated Saturday afternoon attempts to drive through the thick mist-covered *mountain roads to reach the* S.O.S. *village—one of the best organized orphanages* in Lebanon! But as they soon found out, they had to break through the mist elsewhere too: literature and statistics on the subject was as lacking as it was difficult in turn to locate the appropriate experts and the responsible people. But piece by piece, photographs and part of the story *soon began to reach the* MEDICUS *desk. Their determination* had paid in the end, and in the process both had become confirmed M.M.s!!**

Adoption is an institution that, in some countries at any rate, dates back to antiquity; its purpose and nature, though, have varied very much according to the period and the country. The earliest recorded adoption is the story of the birth of Sargon I, who founded Babylon in the 28th century B.C. By 2250 B.C., the code of Hammurabi enunciated a legal basis for the practice of adoption; among the Hindus, in India, adoption is recorded in the most ancient legal codes and is discussed in Sanskrit; among the Japanese, adoption is recorded for the first time in the 13th century. Involving as it does a breaking of the ties which bind a child to his natural parents and substituting new ties with the adoptive parents, adoption has been deeply influenced in law and in practice by the more or less sacred character attributed by society to family bonds.

Apart from civil law adoption, the aim of which is to create a fictitious filiation between the adopter and the person adopted, there have been public law adoptions inspired by political and social reasons, such as the designation of the heir-apparent of the ancient Roman Empire; or Napoleon's adoption of the children of his generals, officers and soldiers killed in the Battle of Austerlitz; or again, the adoption by France of the children orphaned in the 1914-1918 war.

SOCIAL WORKER

Married to an Engineer and a mother of three children, Mrs. Nahil Agha has put in fifteen years as a social worker. For several years, she worked with UNICEF and the Office of Social Development. She has also taught social work for one year at the University of Damascus and three years at the Arab University.

A graduate (M.S. in Social Science Administration) from the Case Western Reserve in Cleaveland, Ohio, Mrs. Agha is a hard and dedicated worker, always ready to listen, always ready to help. For the past seven years, she has been working in AUH. Here her work entails much more than orphans and adoption. However, during her one and half decade of experience, she had been very often called upon to deal with orphans or abandoned children; to seek for them a family for adoption or to place them in a Founding Home. In a candid interview with MEDICUS, Mrs. Agha unfolded some of her experience.

MEDICUS: *As a social worker what is expected of you as far as adoption and orphanages are concerned?*

Mrs. AGHA: In the medical setting, it is not usual for me to be involved — but very often, we have disrupted families, dying patients, etc., which necessitates placing of uncared children in Founding Homes or for adoption.

Q: *With the legalization of adoption, have people's attitudes altered in any positive way?*

A: Yes certainly! The idea of adoption is much more acceptable and this could very well be due to our upliftment of educational standards; in fact, at the moment, demands far exceed the supply and we have long lists of Americans in USA and those employed by ARAMCO seeking children for adoption. Also — before, people adopted out of sympathy; now, because they need a child to fill the emptiness in an otherwise childless marriage.

Q: *Do only childless couples adopt?*

A: Not necessarily, but majority are!

Q: *What do you look in a family before you let them adopt a child?*

A: Education; positive relationship and stability in marriage; personality of the couples; attitudes towards adoption; age (should be generally less than 40 years); money (not necessarily rich) — in short, we seek a family who can adequately provide the necessary love, care and education to the child.

Q: *Does race, color or religion play a role?*

A: Definitely not! There is no prejudice as far as race, nationality, color or religion of the child or couple is concerned. However, adoption in Lebanon is sectarian and as such, for example, Moslem institutions generally take care of Moslem orphans. At Crèche, for instance also, the nuns take care of Roman Catholic Orphans only. Here at AUH, we are left to deal mostly with Protestant orphans.

Q: *Are there any single persons (celebates or widows) seeking adoption?*

A: In the US at the moment, it is à la vogue to be single and to adopt. Here in Lebanon, we have had no such demands as yet.

Q: *What are your feelings about orphanages?*

A: Personally, I do not believe in orphanages — the rightful place of a child is his home. In Lebanon, a vast number of children are turned over to orphanages annually because of sheer financial incapacity on the part of their parents to support them. Thus, if I had money, I would rather strengthen a home than give money to support orphanages. For instance, one could buy a sewing machine for a needy family whereby the wife could put in some hours of work and thus supplement family income.

Q: *What about the SOS village? (See box).*

A: Well, if you must have orphanages, then do have them in the form of SOS villages where the children are brought up — or are attempted to be brought up — in a family setting with the retention of a mother image, in addition to the love, the care and the close interaction. As I see it, it is a lesser of the 2 evils.

In civil law, too, there have been different conceptions and developments. In ancient Rome as well as in several other societies, the aim was primarily to ensure the transmission of the family. By adoption, individuals could be raised to a higher social class; or else, certain difficulties in civil law in regard to filiation could be overcome. For instance, it is simpler for a man to adopt his illegitimate child than to recognize him.

In a number of countries, adoption fell into abeyance when its original purpose lapsed; in others, it survived merely as an indirect means of acknowledging an illegitimate child or evading succession laws. During the 19th century, several national legislations even prohibited it. But, at the beginning of the 20th century, and particularly after the 1914-1918 war, adoption took a surprising leap forward: there was primarily a desire now to provide new homes for the war orphans and the homeless children. Again, World War II, some years later, gave a similar impetus.

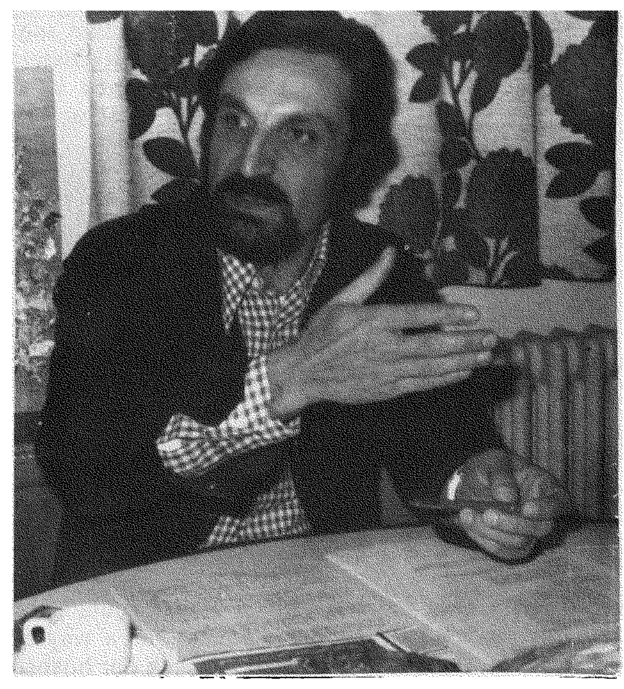
However, in the Near East and in Lebanon, both amongst Muslims and Christians, the ancient stigma of illegitimate birth was, and to a certain extent still is, very strong—bastard children were the product of sin; because of the sins of their parents it was felt that they could neither be normal in morality nor perhaps in intelligence. The birth of an illegitimate child besmirched the honor of the family and threatened the strong pattern of familial inheritance of name and property. So threatening to a family was the pregnancy of an unmarried girl that it was the duty of her brother to kill her in order that an illegitimate child would not be born in their family. With this as the background, it is quite easy to understand why adoption did not gain a strong impetus in this region. It should be borne in mind, however, that Near Eastern people did adopt children of their near relatives who were killed in many of the wars or who died of natural causes. But here, there was no question of creating new filial ties and in many instances the adopted children still were regarded as the off-springs of the deceased person and as such the question of inheritance posed no great problems. The 20th century, however, brought rapid influx of European cultures into these regions and with the acquisition again of European education, people began to part from the ancient hostile attitudes towards adoption. Adoption was thus finally given an official status in Lebanon by the promulgation of special laws in 1956 (see box).

Over the years, attitudes towards adoption have not only changed, but also matured. Formerly, the primary function of adoption was to meet the needs of one or two adults. The child available (legally now) for adoption was used as a means to give a bored rich woman something to do, as a new toy with which adults could play, as a cure for neurosis for childless women, as a way to meet the lacks in a woman's marriage because her husband was too busy with business or too interested in alcohol to pay attention to her. Very often, a child was a tool for preserving a disintegrating marriage. From the stand point of the child, his needs were considered met if the adoptive parents were of the proper religious faith and attended church or mosque. Others considered adoptive parents suitable if they were desirable citizens of the community without consideration of what they were as people. In short, merely the emotional and physical demands or adoptive parents

ORPHANAGES IN LEBANON

Provinces	No. of Orphanages				No. of Vocational Training Centers	No. of ORPHANS
	RC	M	GO	TOTAL		
1. BEIRUT	5	3	3	11	4	3,249
2. MT. LEBANON*	36	1**	1	39	8	4,148
3. N. LEBANON	8	6	2	16	4	2,173
4. BEKA'A	2	3	2	7	2	321
5. S. LEBANON	3	5	—	8	4	973
TOTAL →	54	18	8	81	22	10,864

* Plus one non-sectarian, viz. SOS village (see Box, page 10).
RC = Roman Catholic.
M = Muslim.
GO = Greek Orthodox.
** = Druze.



RIAD FIKANI :Director of S.O.S.

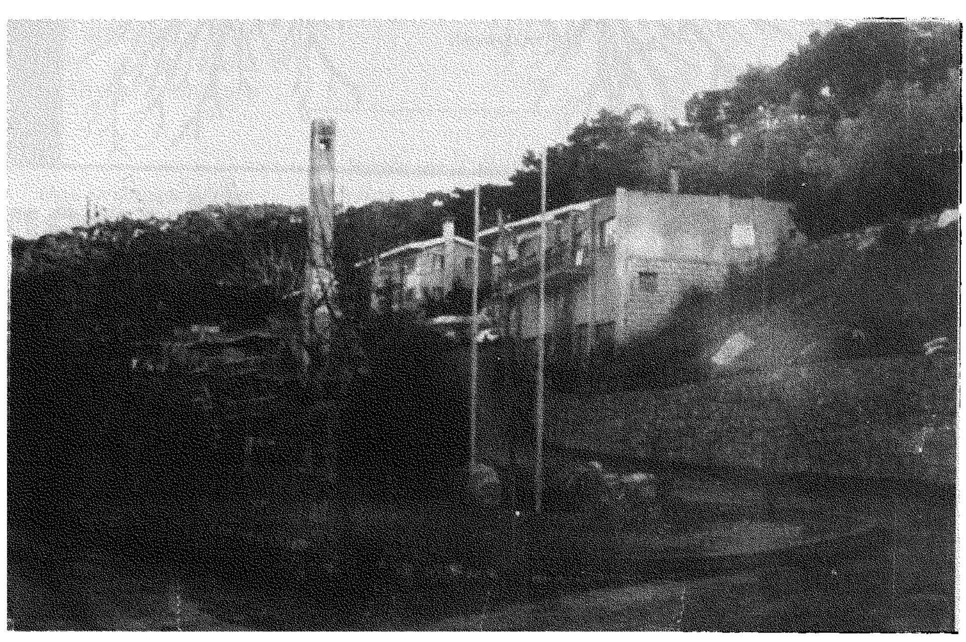
S. O. S. VILLAGE

The founder of children's villages—SOS—was an Austrian-born **Dr. Herman Gmeiner.** Himself an orphan from a very young age, he experienced during World War II the misery and anguish of orphans and refugee children either stranded by their parents, or else separated from their parents. Thus the first SOS village was built in Austria to house the war-stricken children.

Since then, 81 villages, representing 800 families have been created—spread over 47 countries and 5 continents. Amongst these villages, is the one in Lebanon situated at a picturesque countryside at Bhersaf. This SOS village at Bhersaf (between Bikfaya and Bhannès) consis ts of 10 huts each housing a «family» with altogether 91 orphans. The village owes its existence to Sheikh Michel Louis Gemayel and his wife who worked diligently since 1964 to create the village.

Children of one of the houses.

A Typical House in the Village.

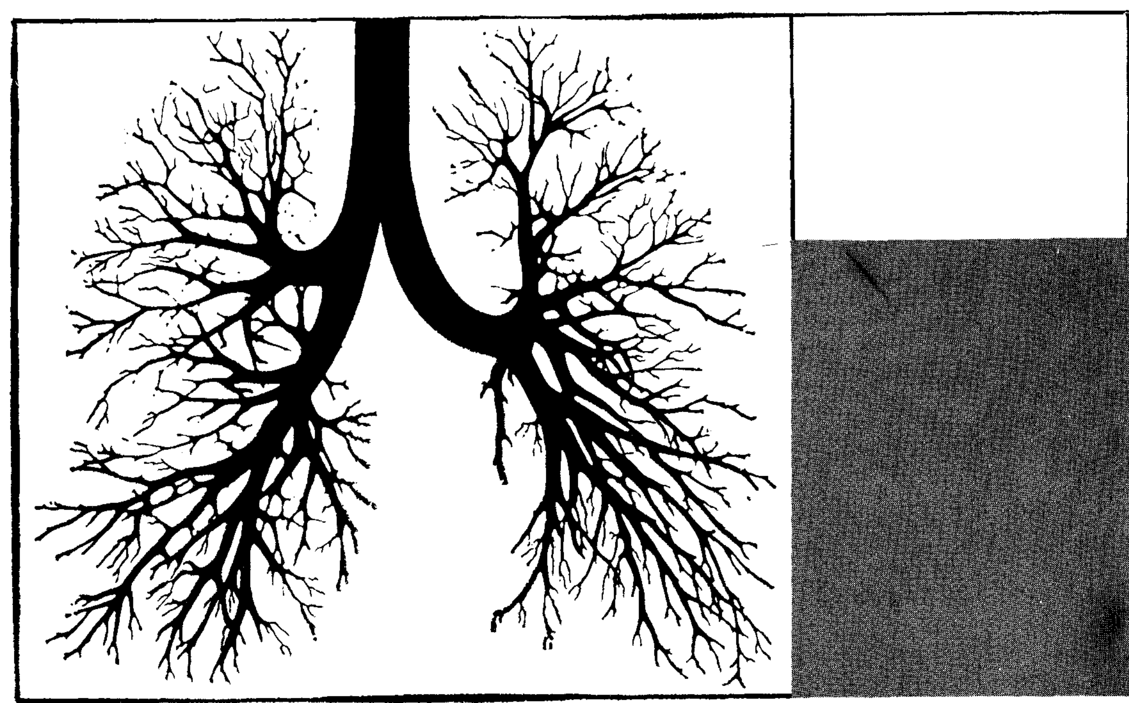


Entrance to the S.O.S. VILLAGE

The aim of the village is to rehabilitate the orphans or the abandonned child into a natural environment: the family! Thus each hut has a mother—either single or a widow, who is carefully selected to play the important role of bringing up «her children» with love, care, concern and tenderness. Every hut has about 8-10 children, ranging from the age of 2 years to 18 years. These children appropriately call their care-taker «mamma» and from all points of view, regard her as a mother-figure: within a family, the girls and boys live as brothers and sisters.

Since each child retains his or her original religion, the children are thus «adopted» by a Moslem or a Christian family at the village. Of the 91 children (52 boys and 39 girls), 51 are Christians and 40 Moslem. 18 of the children are between the age group 2-5 years; 40 between 5-10 years; 16 between 10-14 years and 7 between 14-19 years. Those below the age of 5 years stay at home with their mothers; the rest attend school at Bikfaye. 3 of the children who are above 17 years are training to be a nurse, cuisinier and hair-dresser respectively. They stay away from their families during the week-days but are at home during week-ends.

This experiment in founding homes is a new approach: although relatively recent in Lebanon, it has been in existence for over a quarter century elsewhere. The success of such «families», judged by the psychological adjustment and attainment of genetically potential intelligence, often very much depends upon the involvement of the «mother», her dedication and concern. On the whole, these children at Bhersaf—unlike their counterparts in various other orphanages in Lebanon—have a richer environment and more genuine opportunities to fare reasonably well in life.



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were the essential criteria. But because of the increasing emphasis upon the effect of emotionally deprived children and because of the widespread tendency towards prevention rather than cure, there is now an increasing emphasis being placed upon providing a childhood that will foster maturation towards an adulthood characterized by happy adjustment for the individual and constructive adaptation to the adult social world. Thus, the child's and not the parents' needs have become the center of focus. The would-be parents are now meticulously scrutinized by adoptive agencies and by social workers (see box) who seek in them a stable married life and an ability to provide love, affection, care and education. Those would-be parents who cannot meet these basic requirements are weeded out and turned down.

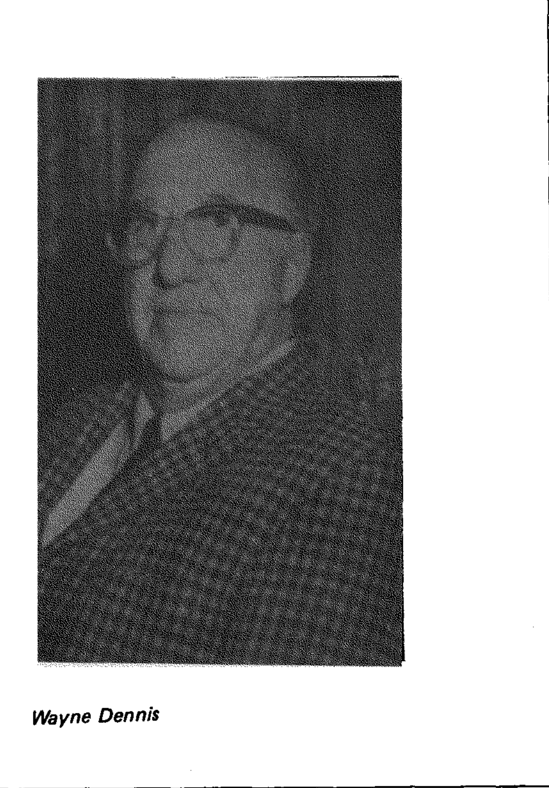
If adoption as an institution is gaining grounds only now, orphanages on the other hand have been deeply entrenched since many decades. In fact now there are 81 orphanages in Lebanon which altogether house nearly 10,900 children. All of them (except for SOS village which is non-sectarian) are sectarian, run by different religious groups (see box), such as Roman Catholic, Greek Orthodox, Shias, Sunnis, etc. Although the Lebanese government has no official say in the day to day management or about their policies in general, it heavily subsidizes them financially. In fact about 45% of the budget is provided thru ODS. These grants are of two types:

— *Grant per child per day this ranges from L.L. 2.00 for ordinary children to L.L. 8.00 for handicapped children.*

— *Lump-sum grant: this varies according to the collections of National Lottery and is distributed to various orphanages according to the accepted communal population ratio.*

In addition, these orphanages also receive grants in kind, such as food-stuffs, equipments, etc., from UNICEF, UNDP and other philanthropic agencies.

Although these foundling homes may be catering for these unfortunate children physically — i.e. providing for them shelter from sun and rain, giving them 3 meals and clothing them — what about their psychological needs? In an attempt to elucidate this point, **Prof. Wayne Dennis,** Professor of Psychology at Brooklyn College, N.Y. and visiting professor at AUB during the years 1955-56 and 58-59, carefully studied institutionalized children in Lebanon. Essentially, he worked at Crèche, which was established in 1850 at Beirut by the Nuns of St. Vincent de Paul. The children were brought to Crèche shortly after birth because they were illegitimate or occasionally, because of the death of the mother, became the legal wards of the Roman Catholic order. These foundlings remained at Crèche until about the age of 6 years when they were transfered to one of the two institutions for older children—the girls went to an institution called Zouk, near the village of Zouk and the boys to Brumana, in the village of Brumana. These institutions cared for girls until the age of 16 years and boys until the age of 14 years.



Wayne Dennis

While at Crèche, the foundlings who were normal in behavior in their first and second months, soon became retarded in their rate of behavioral development and by 1 year of age, both boys and girls had a mean behavioral quotient of about 50, which they retained as long as they remained at Crèche. Also by the time girls at Zouk and boys at Brumana had reached the age of 16 years, a significant difference in IQ had developed — the girls had an average IQ of just 50 and boys 80 (the difference being due to contrast in cognitive experience offered by these 2 institutions).

Because of legalization of adoption, it was possible to evaluate the foundlings of Crèche who were adopted. When adopted during the 1st two years of life, they attained a mean IO of 100. However, those children adopted after the age of two years, although increased the means score of 50 as far as the behavioral quotient was concerned, retained the absolute deficiency in mental age which they had when they left Crèche.

This low IQ, according to Prof. Dennis, is secondary to the paucity of cognitive experience. Many objects normally available to children did not exist at Crèche — there were no building blocks, no sandboxes, no scooters, no tricycles, no climbing apparatus, no swings, and no pets or animals of any sort. The few pictures on the walls were mainly of things never seen «in life» by Crèche foundlings, and hence meaningless to them! The windows were so high that the children could only see the sky and occasionally birds flying past. No mirrors were available and the household objects such as mops and brooms were used only by the staff and were locked up in closets when not in use. Light switches and faucets were beyond their reach. During the 1st year of their life, the babies lay on their backs in their

LAWYER'S VIEWPOINT

To reflect the changing attitudes of our Middle Eastern Society, on the question of Adoption and Orphanages, the MEDICUS team had extensively interviewed many knowledgeable people. But perhaps while society and social norms can change dramatically in a short passage of time, it needs much more than public media and simple exposure to outside cultures to change the legal verdicts. Law is basically static. To find out then what the Lebanese Law has to say here, we sought a prominent expert in the field—MR. ISSAM KARAM, a lawyer practicing here in Beirut

Q: Are there particular and clear by-laws for Adoption in Lebanon?

A: The Lebanese law did not mention the matter of Adoption except in a by-law dated April 2, 1951, stating, under Article No. 4, that the matter of Adoption is a jurisdiction of the Religious Authorities.

The above by-law has defined Adoption under its **Article No. 98**, as follows:

«Adoption is a judicial and ceremonial contract that creates between two persons the bonds of legitimate fatherhood and infancy.»

The above referenced by-law of April 2nd had dedicated the by-laws of the Christian Sects, that alluded to the matter of Adoption; these by-laws are:

1. The Personal Affairs By-law of the Evangelical Sect, issued by the Supreme Council of this Sect, for Syria and Lebanon, during a session held at the Religious Conferences Center in Dhour-Shweir in Lebanon on 14th August 1949.

2. The Personal Affairs By-law of the Catholic Sect, that includes the Maronite Sect, the Royal Greek Catholic Sect, the Armenian Catholic Sect, the Syriac Catholic Sect, the Latin Sect and the Chaldean Sect.

The above by-law had been issued by a Papal letter dated 22 February 1949.

3. The Personal Affairs By-law of the Orthodox Sect. This by-law was decreed at a session held in the Holy Council at the Patriarchal House in Damascus on April 2, 1952, which re-instated that the Personal Affairs By-law of the Orthodox Sect had been issued after the date of the by-law of April 2, 1951, and not prior to it, like the by-law of the Catholic and Evangelical Sects.

Q: Is Adoption limited for Children of a specified age?

A: This varies according to specified by-laws:

1. **The Evangelical Sect's by-law:** This by-law did not limit an age neither for the Adoptor nor for the Adopted. It has, however, stipulated that the Adoptor should be of an age older than that of the Adopted by at least 18 years, and should be Evangelical, of a good reputation, un-married or married but without children and has no hope to have children from the marriage bound at the date of Adoption. In case the Adoptor or the Adopted is a minor or under protection, the Evangelical By-law has stipulated that Adoption should not occur except by the acceptance of his trustee or executor.

2. **The Catholic Sect's By-law:** Also this by-law has not limited the age for the Adopted. It has, however, limited the age of the Adoptor, stipulating that he should have completed the age of 40 and should be of an age older than that of the Adopted by at least 18 years. It has also stipulated that Adoption should be to the benefit of the Adopted and the Adoptor should be of a good reputation, a layman (a man or a woman), a Catholic—not necessarily of the same liturgy—(that means any Catholic of the sects included in Personal Affairs By-law of the Catholic Sect is entitled to adopt another Catholic of the sects mentioned in this by-law).

This by-law has also stipulated that it is not authorized for one person to be adopted by more than one person, unless the Adoptors are two married persons. It has also stipulated that non of the married couple can adopt or be adopted except by the agreement of the other. In condition that they were under abandonment, or it was impossible for either of them to give his or her opinion, then the agreement of the Bishop is required.

In case the Adopted is a minor, his agreement is required if he is at the age of discrimination and the agreement of his parents is required or the alive one of them or the guardian of the minor if the parents are under continuous abandonment or have broken their marriage.

In case they were dead or it is impossible for them to give their opinion then the Archbishop should take the control.

3. **The Orthodox Sect's By-law:** Again, this by-law did not limit an age for the Adoptor nor for the Adopted. It has, however stipulated that the Adoptor should be order than the Adopted «by at least 18 years, as the age of complete maturity» and the Adoptor should be a relative of the Adopted or one of those who have benevolent sympathy towards him, and should be of a good reputation, has no children and has no hope in having children because of his age, his sickness or illness, approved by a sick report.

This by-law has also stipulated that the Adopted himself should agree to his adoption if he is mature, otherwise the agreement of his trustees, by charge or by will, is required.

Q: Is it a statute that the Adoptor should be of the Adopted's Sect?

A: In the Evangelical and Catholic by-laws, this has been stipulated clearly. While in the Orthodox by-law, this has not been mentioned clearly as in the above two sects, but only stated, «the Adoptor should be a relative of the Adopted or one of those who have benevolent sympathy towards him.»

Therefore, the condition of having the Adoptor and the Adopted of the same sect is not clear in the statement of the Orthodox by-law.

Q: Can the original father and mother claim back their child after he or she had been adopted by another person?

A: 1. In the Evangelical by-law, there is no clear reference to this. It has, however, mentioned the possibility of annulling the Adoption with the agreement of both the Adoptor and the Adopted and the approval of the court or against a judgement from the court according to a claim from either of them, or a claim submitted by the trustee or the executor of the Adopted in case he is a minor or under protection, if the court sees it necessary.

2. In the Catholic by-law, there is a primary limitation in claiming for annulling the Adoption, which could be affected only by the Adoptor or the Adopted—and no one else—except by the Advocate at the Spiritual Court, only in certain cases as stated in Article No. 116 of this by-law.

3. In the Orthodox by-law, there is no mention regarding the annulling of Adoption.

Q: Is the Adopted son entitled to inherit from his «new» parents?

A: 1. In the Evangelical by-law, the Adoptor is bound towards the Adopted by rights and duties equivalent to the rights that bind the legitimate children to their parents and vise-versa. However, Article No. 68 had particularized the matter of inherittance as mentioned hereunder:

«...except the rights of inherittance which are under the observed Civil Customs and Laws.»

2. In the Catholic by-law, the Adopted is entitled to inherit the Adoptor if the later dies with no ascendants nor descendants; and his portion of the inherittance would be equal to the portion of the legitimate child, in case this later exists. In case the Adoptor has either ascendants or descendants, brothers or sisters, then the Adopted is entitled for half of the portion of the legitimate child.

3. In the Orthodox by-law, there is no mention regard ing inherittance between the Adoptor and the Adopted.

Q: Is the Adopted child entitled to refuse his «new» parents «claiming» to return to his original parents and to re-bear their names?

A: 1. In the Evangelical by-law, there is no mention of that, except for the statement that Adoption does not abolish the original mother's right for suckling.

The Adoption also does not deprive the Adopted from his rights to his original parents, except if he cedes these rights at the age of maturity and by his full liberty.

2. According to the Catholic by-law, even if the Adopted has been given the name of the Adoptor's family, he remains a member of his original family, enjoying his rights on it and rendered to his duties towards it, except the parental power rights that are limited for his Adoptor, as long as this later is alive and has the ability for that. But, when he dies or loses this ability, this power returns to his original parents.

Lastly, for reference, the Islamic Religion does not authorize adoption according to a verse in the Koran.

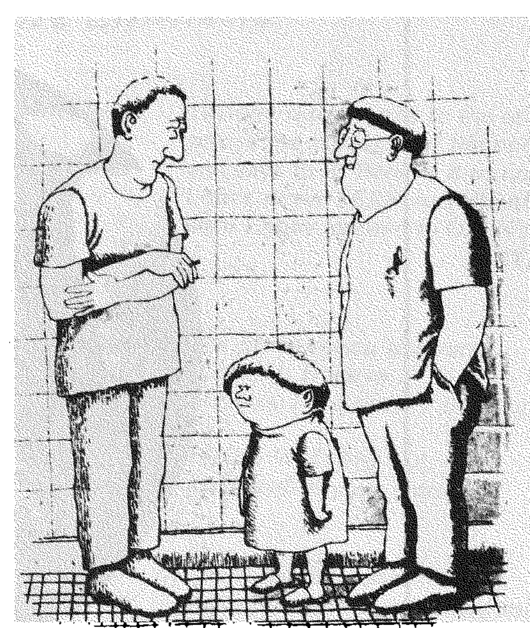
cribs throughout the time — as a result they could hardly sit up unsupported by the age of one year and could not walk by the age of two years. A very few toys were placed in their play pen — but they were always the same toys. They hardly talked or were talked to and very rarely did

S.O.S. Children at prayer time.

visitors come. Also they knew nothing of the life beyond the walls of Crèche for they were never taken out. In short, the children were in a continuous state of boredom and inaction!

Finding it appropriate to hear the views of a responsible expert on the pathetic situation existing in many of the Lebanese orphanages, MEDICUS reached **Freida Haddad,** Director of the Welfare Institution established at Hadat in 1969. Freida asserted that many of these orphanages probably did more harm than good! This institution which has over 150 full time students, trains students at various levels to become social workers. Some of the programs include:

- *Child Care Worker: a ten-months' course after Bac. I.*
- *Auxiliary Social Worker: a two and half-years' course after Bac. I.*
- *Graduate diploma course: a nine-months' program after B.A.*



"He says he's willing to donate his tonsils."

Cartoon supplied by LUTFI ASAD.

These social workers, who have been trained over the years, are doing an admirable job trying to ameliorate the existing conditions. Some of the changes they have brought about are:

- *Upgrading nutritional aspects in orphanages.*
- *Enacting a sort of «cohesive» or «family care» for children within the orphanages.*
- *Increasing extra-currirular activities such as games, summer-camps, excursions to historical sites, etc.*
- *Taking an active role in the promulgation of the new law which requires one qualified child care worker per 30 orphans.*

Also about 64 social workers regularly inspect various orphanages and assist them as far as they can. They have also helped in establishing several vocational training centers — 22 all in all — at different orphanages which teach carpentary, leather-work, weaving, agriculture, etc. to the boys and sewing, secretarial-work, home-economics, child-care etc. to girls. Thus although orphanages as yet lack a lot that is still to be desired, they have, over the past decade, showed an encouraging attitude and have begun caring for the helpless foundlings with much greater love and dedication.

THE END

«for mercy has a human heart, pity a human face»
william blake

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Protochemie, A. G. Suisse

POEM

Isn't It Amazing that We See Everything in Color ??

Sunday morning
Very early
5.00 a.m.
OPD Medicine
The window against the coffee machine.
Nobody.

....

Two eyes
Swallowing beauty
Beauty bathing the atmosphere.
The Unseen rays of beauty
Charge the batteries
Of a pair of retinae

....

Dawn
Night shaking hands with day
As they exchange shifts.
«Night duty» is over
He is going home now
Over and across the mountain

....

The mountain
Erupting from the sea
Jubilantly ascends to its high throne
While its mother, the sea
Embraces its foothold
And washes its feet afresh
With loving waves...

....

A few remaining stars
Twinkling in the sky;
— Windows of heaven
Thru which the eternal glitter
Peeps, glides, and squeezes itself
Down to earth.
The stars-windows start to close their shutters.

....

Some clouds are going far a walk.
Together they go
Embracing and fondling each other
CONDENSING the unseen VAPOR of romance
Into space and time

....

The sky starts to breathe its blue
In and out
And the drops of color
Start to sprinkle everything

....

At the horizon
Where sky, mount and sea meet
The clouds gather
To start their daily sport
Whereby they bring the BLUE of the sea
Back to where it originally came from:
The BLUE of the sky.
Cloud after cloud gracefully ascends
The gorgeous steps
Of the royal staircase of the mountain,
Adoringly caressing the sea's BLUE
And carrying IT carefully in its moist bossom
All the way up
To deliver IT
To an expectant sky
Which grows increasingly
BLUE...

....

The earth sends up its antennae
Into the sky,
To feel the degree of radiating beauty;
These are the long trees
At the AUB campus.
They tower high.

Seemingly higher and higher
As the day breaks.
ADSORB unseen beauty,
Swallow it,
Digest it, metabolize it,
And transform it:
Into green beauty.

....

There's music in the air.
Music notes are dancing all around
Fluently jumping
From one oxygen atom in the air
To the other.
The whole breeze smells
With music.....

....

The birds start to yawn
Take their morning shower of beauty
And sing joyfully
As everyone does, under a shower...
Their «chief of staff» whistles
And everybody gets ready
For their morning «rounds».
Ahoy! Here they go!
With their «escort service» ahead of them...
They discuss matters of supreme importance
Everyone of them gives his «Bird's Eye Views».
And as the discussion heats up
Voices are raised the more,
and you think they are singing....

....

The one retina turns to the other
across the «bridge» of the nose
and says to it: Believe it or not,
I have never SEEN such BEAUTY
until I have learned to OPEN my EYE....

....

The other retina answers:
«Careful, Honey»;
For now I see beauty starting to come out
FROM WITHIN YOU
dissolved in your tears!

....

The rods and cones
Have an urgent committee meeting
The cones confide to the rods:
'We have unanimously decided
TO IMPART COLOR
To whatever beauty
We SEE!'
The neurons of the optic nerve
Telex the message
And the board of trustees
Instantaneously assembles
At area 19 of central headquarters,
Wires back the answer:
'Message received.
Conceived, approved:
BEAUTY AND COLOR COME FROM WITHIN!'

....

The pair of eyes triumphantly converge
Look upon each other,
Hug each other,
And kiss each other;
As saps of beauty
Start to hesitantly flow
OUT OF both of them...

....

The eyelids close
And it is the end, and the beginning
Of a NEW DAY.

VICTOR WEHBY, M.D.
FELLOW, Dept. of Endocrinology

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from **BENCARD** (a branch of Beecham group)

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- AMOXIL t. d. s.
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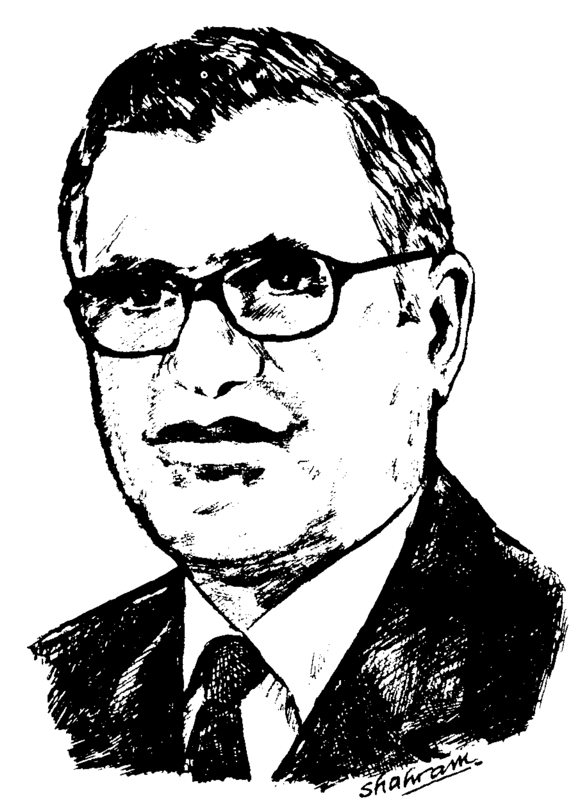
AS I SEE IT:

SOME RAMBLING THOUGHTS



Every entering medical student stands at a threshold of an infinite medical history. He has already heard of Hippocrates and his sacred oath many years before, and has probably also had the chance of being moved by the atmosphere of profound serenity on a June evening as this oath is administered to the graduating doctors on the Green Field each year. Then as he enters the medical school, he is reminded during the welcoming address of the scores of codes, of morals and ethics, that remain uniquely attached to the Medical Order. It might be in his interest to propagate this philosophy of sacredness, because in a world where human nature sometimes punctuates social hierarchy with exaggerated dimensions, this might guarantee him a unique place. But hopefully he also recognizes that nevertheless it's mandatory to abide by this historical and deeply-rooted pattern of precedents because in a world of eroding morals and increasing materialism, the doctor's assumed spirit of sacrificial commitment might be the only reassurance of quality care to a public seeking medical attention.

However, the awe-inspiring nature of medicine also ultimately makes it a demanding career, and free from the initial, mystic submission, the student might well ask himself «Is it all worth it?» It's as basic a questi as it's equally profound.

Probably every medical student at one stage goes through this troubling process of re-evaluation. True, many soon take the conclusion for granted and for others, still, the rigors of training and daily work-load on the floors make such reflection a cynical luxury they can hardly afford.... Yet,.... Yet, for those that still retain the taste and interest though, or perhaps even the need for such philosophical thought, MEDICUS begins a Special Section «AS I SEE IT», in which we will invite outstanding educators to reflect on the qualities of Medicine and Medical Students—as they see it.

We begin by asking Dr. Raif Nassif, our Director of the School of Medicine, to contribute for this section. Well-known to us locally as probably our own expert in History and Ethics of Medicine, Dr. Nassif has chosen to title his article, 'Some Rambling Thoughts'. Only some!

In my chats with students I am often asked questions such as: what makes the «good» medical student; whether the medical student is different from other students at the University; and whether medicine is worth all the effort and toil its study entails. These and many other questions in the same vein indicate a genuine concern of the students for the career they have chosen and for their future.

To answer these questions is not an easy task because they raise issues which are fundamental to our profession. With this in mind, I shall attempt to highlight a few points in the hope that my comments may help the student to arrive at his own answers.

The medical student is indeed different from other students for he is a Student Doctor. He has embarked on the most dynamic—and possibly the most respected career. He cannot permit himself to be deviated from his goal and must learn to bear the responsibilities and obligations of the profession. He must train to assume his role of leadership in society, to help the sick, to prevent disease, to rehabilitate and to organize. It is essential for him to acquire the correct attitude and frame of mind to love and serve the most demanding mistress of all—medic

He must know the healthy man well before he can recognize ill health and cure it. He must be a cultivated man to be able to function in society well. He must learn to be objective and not to permit his own beliefs and biases to interfere with his responsibilities and duties. This should not be interpreted to mean that the medical student is insensitive to the aspirations of his society or community. On the contrary, I believe he should be, and is, more sensitive; but he should know how to temper emotion with reason, and how to be constructive rather than destructive. Thus, although he is different from other students, he remains an integral part of the University and should be a constructive leader.

Perhaps the most important quality for members of our profession is imperturbability. This means «coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgement in moments of grave peril.» It is this quality which is most appreciated by patients. The physician who betrays indecision, or who shows that he is flustered in ordinary emergencies loses rapidly the confidence of his patients. Imperturbability is based on wide experience and knowledge of the varied aspects of disease.

Some of us are born with this quality but many have to acquire it by hard work and self-discipline. And yet, we must always guard against «hardening the human heart by which we live».

Is medicine worth all the effort and toil its study entails? I wish to answer this question with a story and a paraphrase.

«Ibn Rushd, one of the greatest Arabian physicians of the MiddleAges, once set forth on a trip across Spain in search of gold. On his white Arabian mare, he crossed plains blazing under the sun, and climbed high sierras carpeted with the ermine of snow, until he finally reached the coast, where sparkling white foam necklaced the bronzed shores of the Mediterranean. But nowhere did Ibn Rushd find the gold of Spain. Finally, tired and disappointed, he wondered if the only gold in Spain might be the gold in her sun, whereupon, using his magic arts, he seized three rays of sunshine and buried them deep in the sacred black earth of a mosque, where they have remained buried to this day. The legend is that should a physician search for the place where the rays are buried and discover it, he will find three bars of gold.»

If the student takes from medicine its three rays of sunshine—knowledge, ideals, and humaneness—and buries them deep in his mind and his heart, the day he becomes a physician he shall see them turn into wisdom of mind, greatness of soul, and simplicity of heart— the three bars of gold that can be the reward to those magic words: «I want to be a doctor.»

ATLAS OF MICROSCOPIC ANATOMY

ATLAS OF MICROSCOPIC ANATOMY
BY BERGMAN AND AFIFI
PUBLISHED BY W.B. SAUNDERS (Philadelphia)

DR. RONALD A. BERGMAN, who left Johns Hopkins last October to join our Department of Human Morphology, together with DR. ADEL K. AFIFI, Chairman of the Department, have now manifested their long friendship in print as well, by co-authoring a 426-page ATLAS OF MICROSCOPIC ANATOMY, to serve as a COMPANION TO HISTOLOGY AND NEUROANATOMY. The Atlas contains numerous colored photomicrographic reproductions of slides, many of which were prepared actually for the purpose of the Atlas but include some which, as the authors mention in their preface, have been passed on to them thru generations of microscope anatomists. Below, a Medicine I student from the MEDICUS Staff reviews what is to-date probably the most important publication to come from our School of Medicine.

Having sold more than 10,000 copies from the first print only and now a reprint already done in November 1974, this book has become one of the most widely circulated atlases in the medical schools in the United States and other countries. The reason for this is obvious: the authors have overcome the reluctance so many face, in reproducing an atlas with color micrographs because of the great cost involved. It is not only from an asthetic point that we are concerned here, but the value that such color micrographs have to the student is obviously tremendous. Since the stain is one of the most important markers of the function of the tissue—and therefore of the tissue itself—the need to have the micrographs in color is clear. As a simple example, to know the fact that the nucleus is basophilic due to its DNA content and then to see it stained metachromatically blue with H & E is a great aid in remembering, and more important, in understanding this elementary fact.

Moreover, the authors have preceeded every section with a brief résumé about the tissue. Each slide is explained and its salient features are emphasized and related to the parent tissue as a whole. The book will, therefore, serve as an excellent source for review for the student. Compare reading a whole chapter of 30 pages in a Histology textbook to a reading that will highlight most of the facts in a couple of pages and minutes. The authors have concentrated on four major magnifications of the sections. More than 95% of the micrographs are 50, 162, 612, or 1416 the original. To be able to compare two unrelated tissues at the same magnification provides a greater scope for the student to appreciate the relative shapes and sizes of the elements in individual tissues.

Finally, the authors have not included any electron micrographs in the atlas. On the one hand, this has omitted the help that an electron micrograph can give in relating structure to function: for example, the junctions of epithelial cells as a protective mechanism. But, on the other hand, the atlas has specifically done away with all those small details of electron micrographs which the specialists can neither agree upon, nor explain, and which merely confuse the student only more. In effect, then, the authors have succeeded in providing the student with a highly presentable atlas that will be helpful during his student days, to say the least, and prove an excellent reference for the future.

A BED-TIME STORY

By Dr. SUHAHYL UTHMAN, M.D.

It was the night of All Saint's day. I knew this because my little brother was not going to school the following day. Schools days were over for me. Two months after graduation, the M.D. seemed less than what I aspired it to be and I realised I had a long way to go. Further training, which I was engaged in at the hospital, was interrupted one day by my mother: «Son», she said, «now that I have seen you a full blown doctor, my happiness will only be completed when you get married.» That was a matter of absolute fact where mother was concerned and no argument that erupted over this matter in the following days at home, by telephone, even in the hospital could change her mind.

Wedlock, in my mother's philosophy, was something to be arranged and not a whim of the moment. She was ready to find the proper bride, make all the social and financial arrangements and I, the bridegroom, was to feel like an invited guest. Having put this in my mind, she proceeded to the next philosophy.

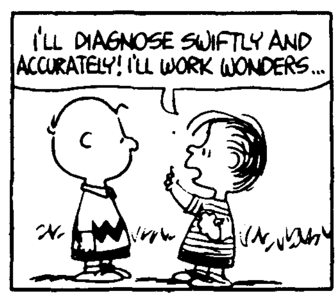
«Son», she said, «one woman is not enough for one man; that is why God has allowed you four.» I was already half out of my mind, but she continued «Women get sick, give birth, tire easily, sleep early, are moody — so you will always find some solace in at least one at anytime»; I felt a little sympathetic to Women's Liberation Movement all over the world. Of course for a while I thought she was joking for where would she find four women in our community ready to marry one man! She solved that problem too, for far away in a distant village in Syria on the Turkish borders there were such women, and she had already chosen four of the fairiest of them all: a blonde, a brunette, a moletto and one of the dark side to satisfy all moods and tastes.

Yes, there was a big wedding too and this was the night of All Saint's day. Of course there were only men at the gathering. I did not get to see the brides yet, for this was to be the climax of the wedding. How the evening passed I cannot recall, but my hands and face were already sore from shaking hands, embracing and kissing and being kissed in turn by men with thick mustaches and beards. When everybody had departed and we were ready to go home, mother took me aside for a final advice: «Take it easy, son; you should not rush into things.» Blood was rushing in my brains, that's what I felt and I really felt like crying on my mother's shoulder and begging her to spare me the coming ordeal. That was unmanly, I concluded. At the anointed house already furnished with the best, which mother was good at picking, the maid was waiting at the door and she nodded towards the bedroom direction «they are inside.»

«Holy Saints!» was my first expression as I opened the door of the bedroom and saw them propped up in the big quadruple sized bed—all four of them! The loveliest, prettiest, softest maidens on earth!! Young, healthy, beautiful, and already naked from the waist up!!! A crimson crispy sheet covered the lower half of their bodies. Their smiles were innocent and they were unafraid. May be mother was doing the right thing. I forgot about the hospital in a moment of joyous admiration of God's beauty on earth.

I had fear no longer! Blood was no more rushing to my brains. As I held the edge of the crimson sheet to uncover them completely their smiles widened but their eyes glittered. I took it away with one snatch and.... held my breath! What was below the waist was breath holding! There was nothing, absolutely nothing, from the waist down!! «Half maidens, Half maidens! O' mother!! where are you mother! Half maidens! half maidens!» I shouted as I ran away from the house.

I was still shouting when I barely opened my eyes to the noise of voices above my head and somebody shaking me up. It was my kid brother. «What's wrong with you sweating all over and shouting like this in your sleep? You must have had a bad dream! Wake up, it's an All Saint's Day holiday and you promised to take me to Syria today.»



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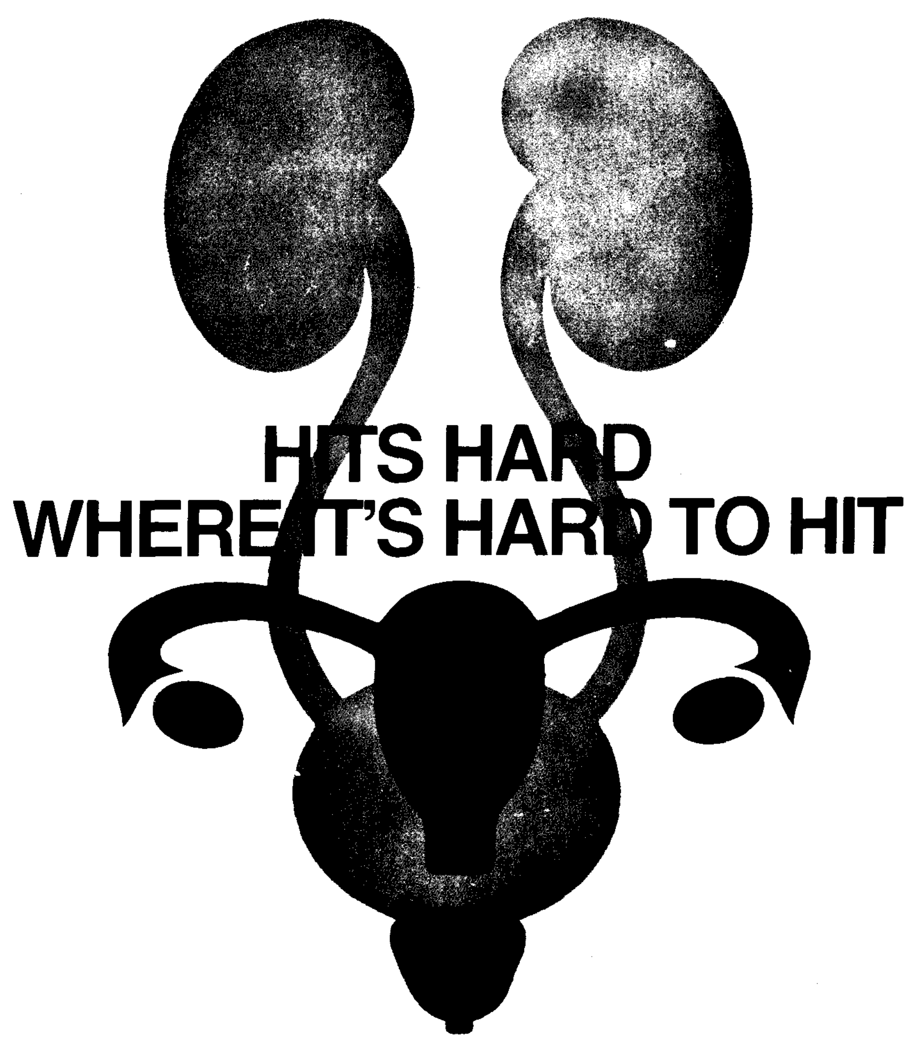

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RELEVANCE, AN ABUSED WORD IN EDUCATION & RESEARCH

Dr. GRAVANIS, M.D.

Here as Visiting Professor in the Department of Pathology during the time the last issue of MEDICUS came out, DR. MICHAEL GRAVANIS easily got involved in MEDICUS during his short stay. Partly this only reflected his own extrovert personality but partly also, it confirmed that taking him around was somebody none other than Dr. Victor Nassar, his counterpart here, and an old timer in MEDICUS ranks. Shortly before Dr. Gravanis returned to Emory University, where he's the Chairman of Pathology, he delivered a talk to an Alpha Omega Alpha gathering on Relevance in Education and Research. Because of some of the valuable technical insight it offers, we are reproducing it here.

I like to believe that you would agree with me that we are in the midst of an era in which education is challenged from inside and outside of the institutions of higher learning.

Education is challenged by the student but also challenged by whatever the authority might be—a ministry, a legislative body and last but not least by the tax payer.

Both forces are demanding relevance in education although their motivations and their offered recipes are quite different.

Let us now look first at the students' grievance so familiar to all of us who teach basic sciences.

Although my experience is strictly with the medical student I believe that I can state that students of every discipline often wrestle with the question of the relevance of education. The medical freshman readily falls victim to the anguished doubt that his early professional education is somehow not relevant to becoming a physician. His fears are not lessened as he learns that his professors for the most part are not clinicians but researchers who are highly specialized in some field of scientific endeavor not necessarily directly related to clinical medicine. Hence a genuine dichotomy of basic science versus clinical medicine arises in the mind of the student.

Allow me to share with you a brief statement made by a student of mine when he was finishing his sophomore medical year.

> «I have spent many, many laborious hours over the past two years in my attempt to accept medicine's challenge. I have committed to memory the seemingly infinitesimal number of branches of this or that artery; the number of cubic centimeters of air which could be inhaled, exhaled or preserved in the lung at any time; the name, etiology and pathogenesis of diseases. I could not even spell or they didn't even exist in my country, which were often caused by organisms I could not see.
>
> All of which cannot help but clutter the mind. It is a very folksy notion that the mind is like a cupboard with only so many shelves. This might well be unscientific, but in many times over the past two years I could have claimed its veracity.»

And yet Charlie entered medical school like many of his classmates with the headstrong idea of serving mankind and with the poetic ideal of becoming the complete physician.

Perhaps now we can look at the other force that is the state, the national organization, the ministry, etc. and see how they approach the same problems of relevance in education. Their usual way is to appoint a committee or commission someone to study the matter!

Although it was well over a half century ago, in 1910 to be exact, that Flexner submitted his landmark report to the Carnegie Foundation on medical education in the United States, his basic criticism of the majority of medical schools as «practical and uninspiring» still applies today.

In a subsequent report in 1923 Flexner described the basic system in almost Dickensian terms:

«Shoulder to shoulder, phalanx fashion the classes being clamped together and kept apart by term and annual examinations to which the students must all alike submit at the appointed time.»

A medical school, Flexner maintained, cannot in any event transmit to the student more than a fraction of the actual treasures of the science; but it can at least put him, the student, in the way of steadily increasing his holdings.

Flexner, well versed in the tradition of medicine as it had evolved from Hippocrates to Osler, did not want to see medicine divided into two camps, the thinker-researcher forging ahead and the practitioner mitigating the sufferings of the sick. Yes Flexner must have read the Homeric poems where the physician of the antiquity was grouped together with the singer and the builder among those craftsmen whom everybody welcomes. In those times the average physician had a certain technical proficiency; he knew medicine as the phrase goes. He acquired his skill through apprenticeship with another physician and when he became a master of his own right he practiced his craft or art, as crafts and arts are always practiced. He prescribed remedies which had proved helpful before. While learning his trade he was not a «student of medicine»; while carrying on his business he was not a «scientist».

On the level of common medical practice, biological and physiological inquiries were neither presupposed nor were they actually made.

It is therefore not astonishing that even in the second century A.D. there were physicians who were unfamiliar with the difference between arteries and veins, a difference that had been recognized 500 years before. Yet they were

successful and respected practitioners for they relied upon experience, adroitness and manual perfection rather than on study or research.

It is in contrast to these craftsmen that a relatively small number of medical men aspired to overcome the narrow limits of their craft. If it is characteristic of all scientific achievement that it was the feat of individuals following the bent of their own minds, these doctors certainly were among the finest examples of unsolicited curiosity and delight in learning. They patiently observed the courses of diseases, gave etiologies, elaborated a theory of prognostics and formulated methodical rules of treatment. Doing all this and much more than I can mention here, some of them also realized that the study of the human body must form the basis of medicine.

Returning again to the modern times after the brief look in antiquity, I would like to remind you of another report submitted in 1970 on «Higher Education and the Nation's Health.» Written by a committee of 19 (not a single physician included) the report abounds in such terms as «health manpower education», «health care delivery», etc. etc. The main conclusion of this report is how to turn out more MD's more rapidly.

Apparently the complete physician has been put to rest or at least fresh-frozen for some future cryogenicist's thawing out.

The message is rather clear. Cut out all the so-called irrelevant part of medical education. Create, as Martin Gross so well put it (in the Doctors) the modern doctor-technician who may well be «the least intellectually articulate, the least creative, the least philosophically developed of all professions of all times.»

Edmund Pellegrino who some time ago turned down an offer to be Nixon's leading medical official in HEW expressed his concern in his essay entitled «The Non-Renaissance Man» about the failure of many physicians to display an educated intellect.

The same Dr. Pellegrino in another essay «Humans in Medicine» wants to assure us that student demands for relevance, a movement toward man is not really a flight from reason.

In subsequent writings Dr. Pellegrino has after much soul-searching altered the classic priorities to conform to what he feels are the current demands of society. The classic requisites of the intellectually complete physician—education, compassion, competence—must today be reversed to meet social needs. All three of these levels of perception, according to Dr. Pellegrino, may not even be necessary. No matter how distateful it is he put it in the most eloquent way which I quote:

> «A professional must be competent in the field he professes and this is the first requirement of the physician's existence. Clearly to be competent most of tomorrow's doctors will be required to be doctor-technicians and society can accept nothing less. This in itself will be demanding and a life long task if all relevant knowledge is to be brought to bear on each patient's illness. The average physician will have neither the time nor the inclination to do much more than this. Humanistic studies and a social orientation while highly desirable are not absolutely essential to this kind of competence. If society must choose, and it will have to, it must demand competence first for the majority of its physicians-technicians.»

I think the message again is very clear. In the name of the most abused word, relevance in education, we have expediency in disguise. We have the demand for mass and fast production of MD's, the cook book type of medicine, the short cuts in curricula, an involution back to the antiquity and its craft medicine.

I don't consider myself insensitive to the present day social needs, but I like to look at this rather serious problem from a simplistic point of view. That is how much society is willing to invest for its present health care and also the care of future generations. The answer to the above question should settle the issue once for all.

As one who went through the required years of undergraduate education, I look at relevance as that elusive quality common to all experiences which serve to fit me better for a patient's trust. Every effort, every exercise, every event which has by any route however tangential contributed to my fitness for the trust.

Relevance then can emerge from any crevice of a physicians life; it knows no bounds of place or time. But of all the places and of all the times the experiences of medical school are the foremost. I look then particularly to those experiences for salient aspects of relevance and find five.

First, thankfully relevance is sometimes obvious. It takes no contemplation to perceive the relevance of cardio-pulmonary ressuscitation. One must know the steps A B C. Must know the tools: handbag, I.V., EKG, bicarb, epinephrine, calcium and for each when and how much.

Secondly, relevance is often frustratingly subtle. As a freshman we learn the metabolic pathway to uric acid because we had to. To pass a test. I suppose we all knew that uric acid was implicated in a disease called gout but frankly the genuine relevance of us knowing its biochemistry never crossed our clouded minds. It was a few years later after the first or second gouty patient we had to reconstruct that pathway again to understand the action of colchicine.

Thirdly, relevance is retrospective. I was utterly mystified one day in my senior year by a soft cystic mass I found bulging out of the upper anterior midline of a young boy's neck. Someone identified it for me as a thyroglossal duct cyst. Yet in an instant of reflection I recalled my anatomy professor's imposing diagram of that very duct, and I was gratified to have the concept of the development of the pharyngeal pouches buried in the far reaches of my mind. Relevance is retrospective.

Fourthly, in the same manner it is prospective. Experience enables you to anticipate relevance. One can, for instance, recognize the usefulness of a good article on headaches. Every physician sees hundreds of those and must somehow discern which merit aspirin and which merit a brain scan.

Finally, relevance is individual. It becomes your own discriminating observation and correlation and assimilation of what is essential for you.

I have recently become a student of Lebanese history. In doing so I ran into a rather interesting, high spirited and quite shrewd governor. He is Daud Pasha, first governor of autonomic Lebanon (1861-1868).

He was not elected but appointed, therefore he ran into lots of resistance (not that the elected one's don't run into trouble nowadays). However he managed to stay on and be relatively successful. In a speech to the notables of Lebanon he used the following illustration to solicit their support. He told them

> «A doctor f[illegible] sick and called in a fellow physician and said [illegible] him. We are three, you, I and the disease. [illegible]ou will help me we will conquer the dis-

ease. If you help the disease it will conquer both you and me.»

One can picture a similar straight talk, not in the open of course, from the appointed heads of the different granting agencies in Washington to the anxiously waiting monetary support researchers throughout the United States. The implication is very clear and the hypothetical talk could go something like this.

«If we are to conquer the disease you do as you're told and you will get your support, and for us, we will remain in our appointed positions.»

This is called in the modern jargon, targeted research or disease-oriented research as exemplified by the current approach to cancer. This philosophical approach to research nowadays is a reflection of the current sentiment of the congress and most important of the tax payer.

Health industry consumed in fiscal 1973 approximately 8% of the total national product that is approximately 100 billion dollars per year. For this impressive sum of money the public demands greater accountability and more than that, demands relevance in research.

Perhaps research has fallen victim of its own success. While it scored some miracles in the past, particularly in the sphere of infectious diseases, it has not come recently with any impressive breakthrough especially in the two diseases most dreaded by the public namely, cancer and heart disease.

The trend of course is not new. Although subtle in the mid- and late sixties, it became a way of life in the seventies. So we are witnessing the gradual disappearance of the individual or non-targeted research.

Let us go briefly over the virtues of the targeted versus non-targeted or individual project research.

Virtually all sponsored research is to some extent targeted in the sense that priorities are set up by sponsoring agencies. For example in fiscal year 1974 the budget of the National Cancer Institute has approximately 400 million dollars and those were funds to be made available for research which might elucidate a greater understanding of neoplastic processes. In contrast the National Institute for Dental Research had a budget of approximately 39 million dollars for the same period. The priority is apparent. However the question that comes immediately to mind at this point is who set those priorities. Is it strictly an intramural function of the institutes such as NIH or a large policy making scientific body? Or is it a reflection of an unrealistic often ambitious goal set for by a politician campaigning for national or even local office. A prime example was the dramatic and distatefully theatrical announcement by the Nixon administration about the war against cancer. That they were to conquer cancer by year 1976 simply by making enough money available to the scientific community and to create approximately 10-15 cancer centers. Pretty much in the same fashion they put a man on the moon. Many laughed at the naivety of the announcement in particular the fixed date, which subsequently was pushed further down the road. At the same time the individual, non-targeted research was hit really hard since the extra money allocated for cancer research were not really extra but redistributed from other agencies. So they rob Peter to pay Paul.

Most people understand targeted research to mean that the establishment of questions needing to be answered is performed by the granting agency not by the investigator. This concept then leads to the research contract. The individual researcher bids amongst many others to provide the agency with an answer to the question.

Early this year I was having lunch in Washington with an old acquaintance of mine, and nowadays a high ranking official in the NIH. He was quite excited from a recent trip to Africa and some preliminary work done in relation to the Pigmy's blood levels of growth hormone. I rushed back to Atlanta and told my people to start preparing anything he can master in regard to cellular receptors. Sure enough an inquiry was out from NIH soon soliciting applications in that subject .A priority set by, by one man? Who knows The only thing I never learned to this date is if the Pigmys themselves complain or not about their short stature!

Targeting can also be done in a broader basis employing a mixture of contract research with research projects that are applicable to a defined area. Such a mixture is currently being employed by the National Cancer Institute and as you might know the effectiveness of this approach is being seriously questioned not only by scientists but by administrators and legislators alike.

In defense of targeted research I should admit though that we often need to know the answers to specific question which can most economically be obtained through contract research. For example two conflicting modes of therapy may be in vogue for the treatment of the same disease. Large quantities of data which may be subject to statistical analysis may be necessary to answer the question. Such a question could be answered if contracted to a number of research centers and the data combined, whereas if the question were left to the initiative of the individual investigators themselves the answer may never emerge.

The individual or non-targeted research, quite often branded also as non-relevant research, has its own disadvantages. One outstanding disadvantage is that duplication of experiments cannot be avoided.

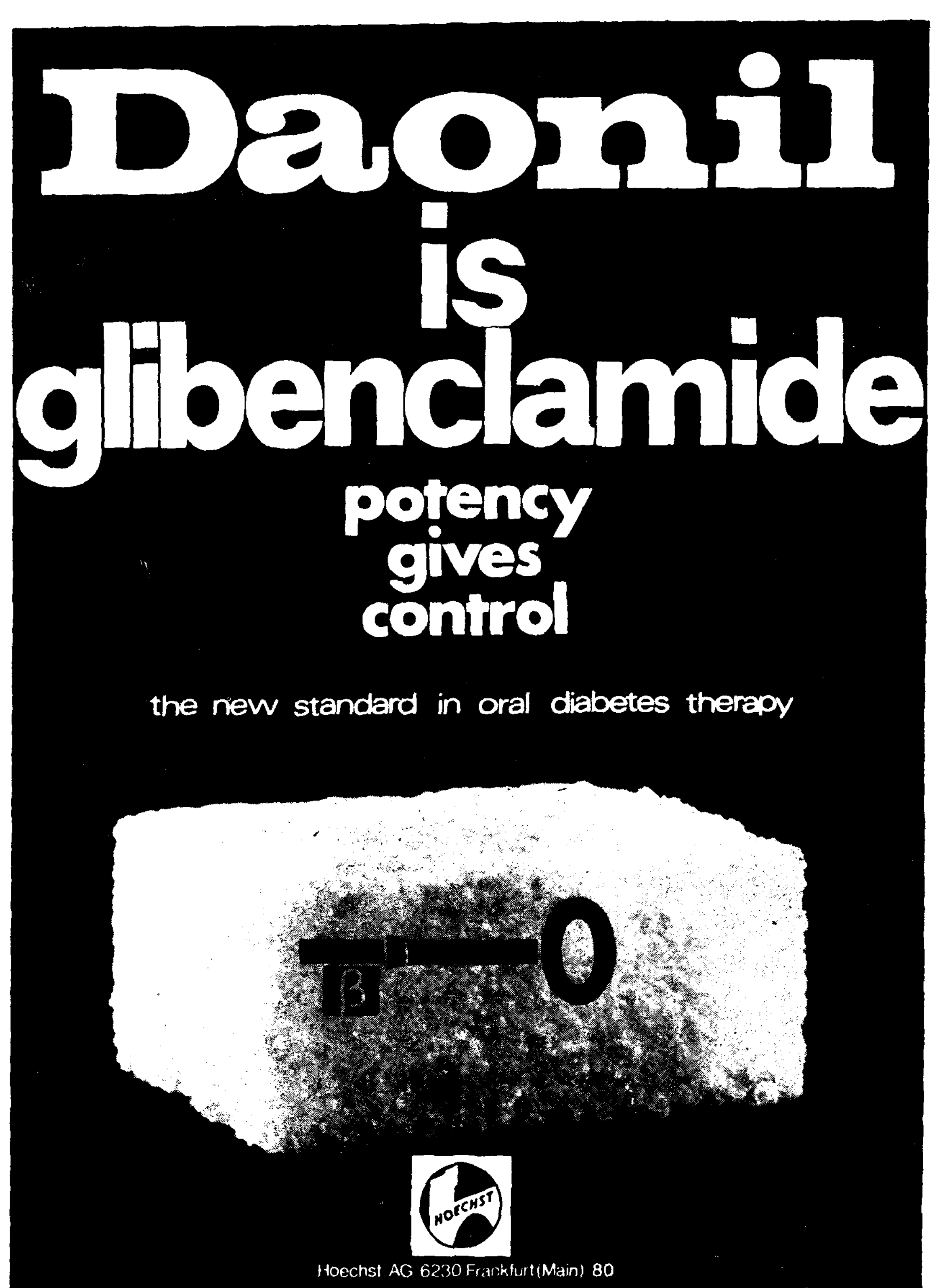
However, the advantages are many. Let me mention a few. Individual project research is not only concerned with the abnormal but also with the study of the normal. This is almost totally lacking from targeting research.

New and significant advances in the understanding of biological phenomena almost always come from individual efforts of individual scientists. Often they arise because of an imaginative understanding of accidental observations. History is replete of such examples. Thus only in a situation in which the investigator has the freedom to explore such observations are truly significant advances likely to be made.

Concluding I would like to say that in my understanding there is no such a thing as non-relevant research. Its relevance might not be apparent to the establishment of a certain era.

The beginning of wisdom is the admission of one's ignorance, and man can creatively use his powers, and to some extent transcend his limitations, only as he humbly and honestly admits these limitations to begin with.

Socrates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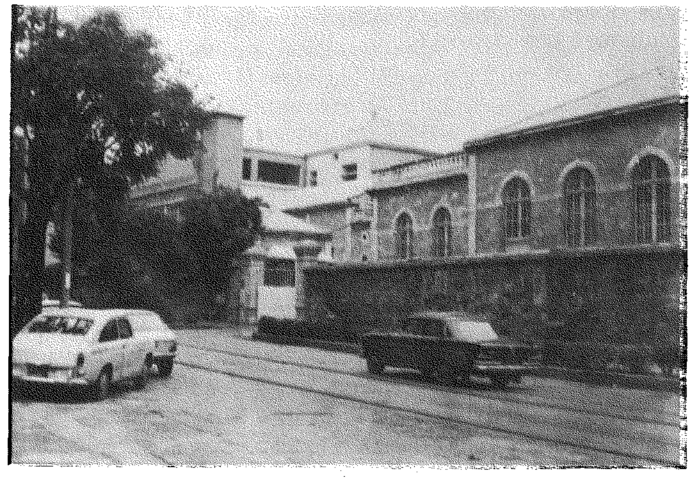
FACING MEDICUS

Probably the best reflection of inherent differences in the teaching approaches of two different international systems of education—although in question is no less a more exacting discipline than Medicine itself—is illustrated by the intrinsic alienation between the graduating students of the Faculté Française de Médecine et de Pharmacie (F.F.M.) and our own graduates. Time alone can reconcile the differences between the French and American systems of education, but MEDICUS took an initiative of at least partially bridging the gap between these two local institutions that represent this educational diversity. In an attempt to break through our own ignorance about the French Faculty, we met the newly appointed Dean of F.F.M., Père Hours, for the second in our series of articles, FACING MEDICUS. We launched this section in our last issue with an intimate interview with our own Dean, Dr. Samuel Asper, in which he extensively spoke of the present and the future of our School and the Hospital. We sought to equate this now by turning to the F.F.M. Dean!

Only some two kilometers seem to separate A.U.B. and F.F.M. Yet on that Saturday afternoon as we *drove into the F.F.M. campus, we appeared to have entered a* new environment about which we had invariably heard so often but frankly never bothered to discover its nature or contents. Père Hours appeared understanding of our shortcoming and seemed equally enthusiastic to establish a new rapport, and for about two hours, he talked to the *MEDICUS* team, *including the Editors, Nabil Atweh, as well as Labib Hajj.*

Below some excerpts:

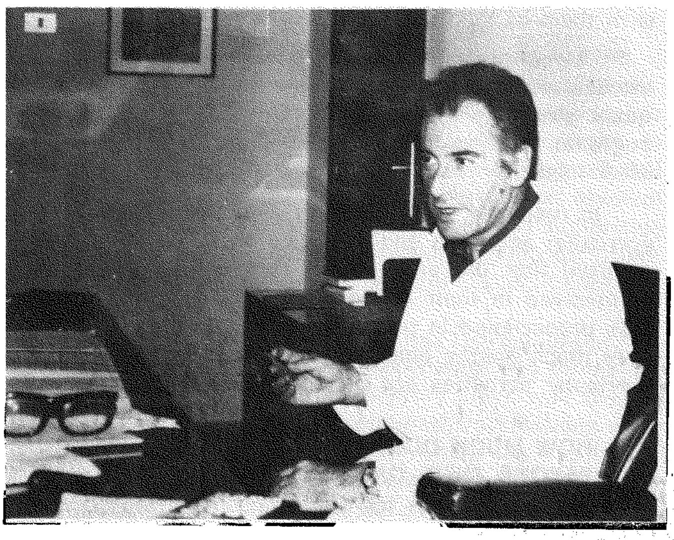


FFM has, no doubt, contributed to the advancement of medical care in Lebanon. It is an educational center which gains the hearty attachment of its graduates, for the care and concern that it lends to them. This, of course, requires a lot of sacrifice from the «all roles» man, namely, the chancellor. For the above reason, Père Madet, the ex-chancellor, resigned, after having exhausted himself, and Le Père Chancelier Hours has been appointed.

Our talk to Père Hours was initiated by the question of appointing him, a non-medical man to the post of chancellor. Following is an exposé of the information given to us.

«There is not any special reason behind my appointment as Chancellor of the FFM. In the dubious way of the Jesuits, there is just a reason «why», and very simple: F. Pierre Madet was tired, and asked to resign. There was no other medical Jesuit to take the job, so they appointed me.»

Then he explained to us that one of the major problems presently confronting FFM concerns the rumors about the possibility of the Jesuits deserting the FFM and added that it is certain that the persistance, not only of the FFM, but of all the St. Joseph University is a problem under much discussion. He aded that the problem is not a financial difficulty but a problem of manpower. «The contracts signed with the French Government to recognize the validity of the diplomas and degrees has been signed by the Jesuits. Un-



fortunately, since the Jesuis population is diminishing in the whole world, the existing proportion cannot possibly support the organization; the best proof is that we had to nominate for the FFM a Chancellor who is not a physician. To withstand this problem we are leading in a direction of having more participation from non-Jesuits in the administration of various faculties.»

ON FFM's FINANCES:

Concerning the financial problems and resources, Père Hours answered briefly that it is always normal to have financial difficulties, and that the only financial resources are the tuition fees and an annual grant from the French Government.

Encroaching more on the relation of the FFM with France we have been informed that FFM receives professors from French universities for temporary or permanent basis and that the jury for the examinations is appointed by a special council: «Le Conseil Supérieur de la Faculté Française de Médecine et de Pharmacie».

ON STUDENTS:

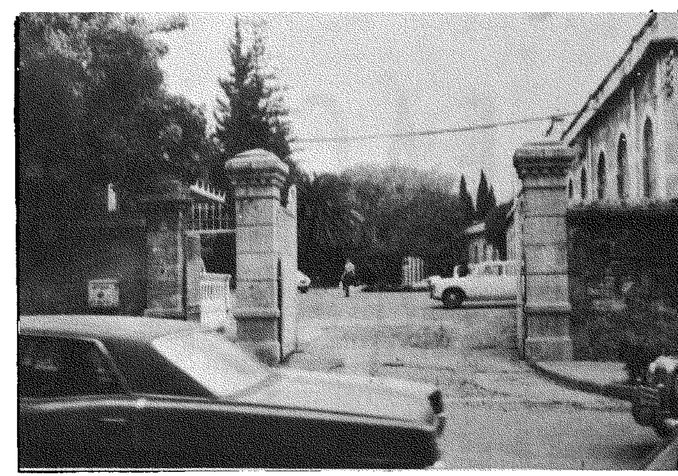
Shifting to the students' affairs in general, Père Hours said: «I do not know if there is a philosophy in the French system concerning the student-faculty relationship, and you can hardly say that the system of the FFM is the French system. It is something very peculiar. Any way, my own philosophy is to work with the students and collaborate with them as much as possible.»

«Myself, a non-medical man, I am going to impart to my medical students the image of a complete man with adequate emphasis on human qualities; that a medical man ought at least to be competent, honest, and not running after money.»

In response to our inquiry about the students' extracurricular activities and politics, Père Hours said: «I have realized that the students of FFM are very much deeply involved in their academic acquisition and definitively less preoccupied in politics. However, I have encountered very much apathy amongst my students as far as extracurricular activities are concerned.»

HOW MUCH DOES FFM ASSIST ITS STUDENTS BEYOND THEIR GRADUATION?

FFM does assist its graduates in getting accepted at Medical Centers in France for further specialization. Moreover, they are not only interested in French centers but



also in medical centers in USA and Canada. This is because of many reasons, one of which is the fact that the present arrangement with the hospitals does not give the students enough clinical experience.

FFM does really encourage research and supplementary academic programs, but for certain difficulties postgraduate programs in pediatrics and biochemistry only are given and research programs planned in the fields of biology, chemistry and histology, with some emphasis in genetics.

ON RELATIONS BETWEEN FFM AND AUB:

Asking several questions to provoke his commends about the relation between FFM and AUH, we learnt that only a few graduates find opportunities of having their residency training in AUH. But, no doubt, they would hope for more intimate relationships in the field of basic sciences and research.

The Jesuits founded FFM with a certain sense of mission; do you think the present results are satisfactory?

«Who can be satisfied, if one seriously tried to realize effectively one's ideal? It is true that the sense of the mission has changed, not only for the Jesuits of USJ, but also for the Presbyterians of AUB, and it is good. But the same kind of Mission remains: teach the medical students to be honest, to work not only for money but primarily to sincerely help others. The rest is up to them: they are free to listen or not.»

And finally, we asked Père Hours to comment on the most troubling aspect about FFM: **How does he rate its future?**

«Concerning the future of FFM, the interpretation changes at times—but we remain optimistic all along, I think.»

THE FFM

The French Faculty of Medicine was founded in 1883. The City of Beirut was chosen among several other cities because it was a prosperous harbour, midway between Cairo and Istanbul and because there were enough qualified candidates to undergo medical training, due to the presence of several French secondary schools, established in Beirut previously.

The beginning was very modest; in November 1883, 4 professors (2 Jesuits, a Navy physician and an Obstetrician from Marseille) inaugurated teaching in the presence of 11 students. The latter were offered the Title of «2nd class» physician after 2 years of study and a diploma of «1st class» physician one year later. Students were required to pass in the French language examination before obtaining the degree.

During its early years, the French Faculty was encountering many difficulties, and its survival was constantly being threatened. Cholera in 1884-1885 was omnipotent in Egypt and it delayed the arrival of books and the scientific equipment. Moreover, Lebanon was under Turkish occupation and the Ottomans were requiring the students to pass a Colloquium examination—just as any other graduate from a foreign school. The young physicians were thus obliged to travel to Istanbul to pass their exams. It was only in 1899 that the Ottomans accepted that a jury formed of 3 French professors and 3 delegates from Turkey would travel to Beirut instead and deliver the newly graduated doctors their degrees.

The Faculty was progressively prospering. In the beginning of the Century, students registered from Erzerum, Alexandria, Cairo, Damascus, Baghdad and Greece. In 1900, there were 160 students. In 1905, they were 233. The establishment of a new Medical school was decided upon, as the one present then was being outgrown.

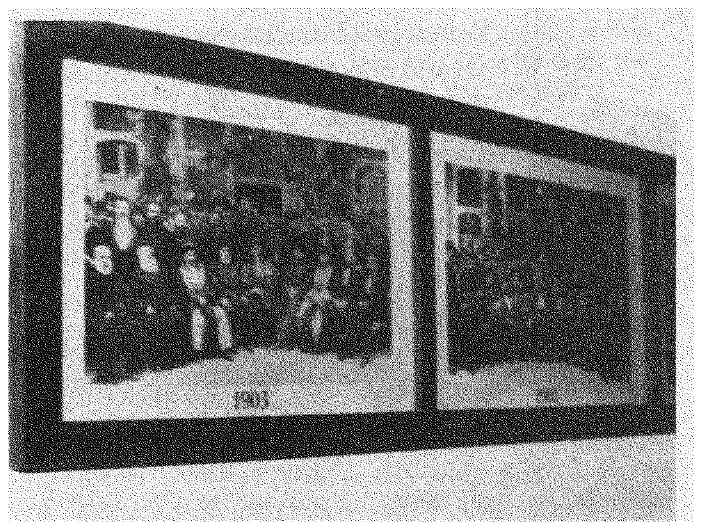
On November 21, 1911, the foundation stone of the present school was laid in Damascus street in a place which then was in the suburbs of Beirut. In 1912, the new building was inaugurated, and 300 students registered. Even at that time, the need for a hospital directly attached to the Medical School was being recognized, especially as the existing «Hôpital du Sacré-Cœur» had not originally been intended to be a teaching hospital. Funds were thus collected, the land was appropriated and the works were just going to be initiated when the first World War started. 355 students were then registered and the academic year lasted only for 3 weeks: on November 2, 1914, diplomatic relations between France and Turkey were severed; on November 7, the last class was conducted; and finally, on November 23, the Jesuits were expelled from Lebanon. The Faculty was closed and used successively as a school for Telegraphist students and then as a police station...

When the war ended in 1918, the Faculty was reopened; it took 5 months to restore it back to its original shape and on February 4, 1919, the first post-war entrance examinations were held.

On May 27, 1923, «The Hôtel-Dieu de France» was officially inaugurated by General Weygand, and in 1924, all courses of clinical medicine and surgery were given in the new hospital. An Anti-rabies institute, a center for research and bacteriological analysis were also started. The school of Dentistry was founded in November 1920, and the first eight diplomas were awarded on July 1923.

In 1926, and for the first time, 3 female candidates registered at the Medical school. In 1925, a physiotherapy and anti-cancer department was instituted, and in 1929 even the Nursing courses were started. In 1932, a special dispensary, as part of a campaign to fight against Tuberculosis, was founded. In 1938, the «Maternité Française», was inaugurated, just facing the school, designed to accommodate some 70 patients.

The second World War did not have the ill-omened effect of the first one. Courses were only interrupted once – in May 1941— and the Academic year was reduced by one month only.



In October 1941, and because of the ever-increasing number of applications an entrance selection exam was decided upon whereby the number of foreign students were to be limited henceforth to 12 only.

In 1942, a Nursing school was founded and in 1948, it was given official recognition by the French Government. Once the war ended, newer horizons were at sight: Lab technicians and Anesthesist nurses began to graduate. In 1955 and in 1957, courses in legal medicine were offered to physicians. And since then, too, every year, Medical Assemblies (Journees Médicales) are held and authorities from all over French—and Arab-speaking countries meet. This probably is the counterpart of AUB's Middle East Medical Assemblies.

Students in the French Faculty has the opportunity on several occasions to offer their knowledge and forces for national causes. In 1948, an ambulatory clinic was created to take care of the Palestinian refugees. Vaccinations were carried out, a tremendous work for which the Faculty received on March 31, 1950, the **«Bernadotte Medal»**.

(Source: Booklet published by the FFM)

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HERITAGE AT CROSS-ROADS

As medical students kept responding favorably to the need of exploiting the personalities of some of the most senior of our Faculty Members, MEDICUS screen ed the obvious list of some of these distinguished candidates for our second in the series of articles 'OUR HERIT AGE AT CROSS-ROADS'.

Beginning with the last issue, this series was sta rted to discuss the careers and experiences of some of our oldest teachers and doctors—who through 'their philo sophies, efforts and contributions, have imparted a special quality to the Medical School and the Hospital'.

Trying to screen the list of possible candidates for this Section, the Editorial Board ran into obvious dilemmas. Fortunately, however, as more information reached u s, a more thorough reassement was possible and initial dilemmas were finally overcome as MEDICUS unanimously turned to Dr. Yervant Jidejian, the surgeon who retired from A.U.B. in 1971.

In the minds of the more older amongst us, his n ame has an established prominence, but despite his retirement and withdrawal from the A.U.H. front, even the yo gest and newest amongst us continue to carry at least the rudimentary information that has many a times helped us s core in a general knowledge contest in the school.

Despite his packed schedules that he still continu es to have beyond his 44 years of hectic service at A.U.B., his long association with our school and his fondness for MEDICUS offered him little excuse to avoid us when we finally sought him. In the luxurious confines of his office, a MEDICUS team of Labib Hajj (Med. III), Radwan Khoury (Med. II), Rosemary Bustani, and Juman Hijab (Med. I) t ried to explore the making of a man who was voted by the A.U.B. Alumni Association as its Man of the 1974. Below, Juman files in her report:

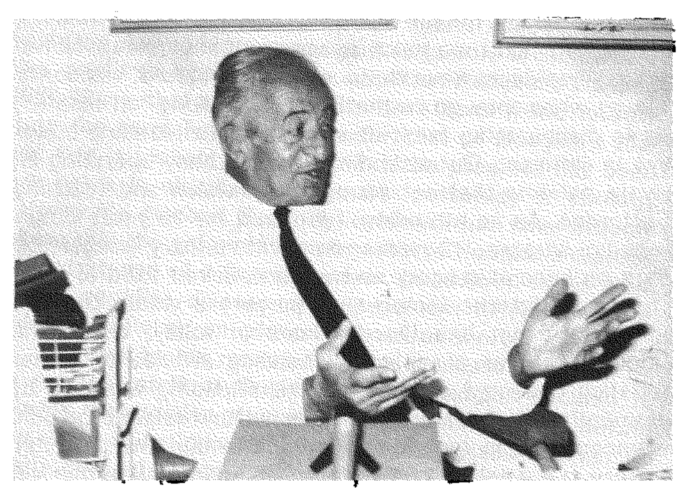
It was a pleasant experience for the MEDICUS team to visit Dr. Jidejian. Moreover, it was an opportunity for us to fully appreciate the capacity of man to extend kindness, generosity and goodwill to his fellow man. In effect, this visit disclosed to us how man can be humble, and yet use all his potentialities to achieve a sense of «grandeur» that adds to the glory that is man. Undoubtedly, then, one can be actively idealistie and realistic at the same time.

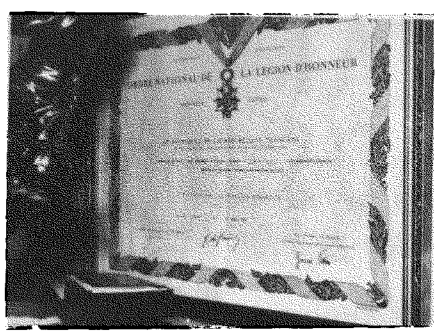
Dr. Jidejian put us immediately at ease in a manner that clearly reflected his long and tremendous interest in MEDICUS. 'I have been an enthusiastic reader of your journal' he assured us, 'since its early publication

With all barriers to communication so smoothly removed, we began our interview. Our first question, naturally enough, was to ask Dr. Jidejian to provide us with an exposé of his personal and professional experiences.

Dr. Jidejian was born in Aleppo in 1906, in «the days of Noah», as he called it. He was educated at the Syrian Protestant College in Beirut, and many a time, working at school was the only means he had of continuing his education.

As with all prominent people, there must have been a figure who stood for an ideal in the early formative days of youth. It was in Dr. Altonian that Dr. Jidejian found his ideal. Dr. Altonian was a neighbor of the Jidejians during the early part of the twentieth century, and a surgeon by profession, practicing in Aleppo. Such was his incredible ability and stamina that he continued to perform operations up to the age of 93. Since his early childhood, then, Dr. Jidejian had medicine, and in particular, surgery, as his goal. It was a great day for him as he graduated from our medical school on a June evening of 1928.





To really understand a person—it is said—one must know his friends! Dr. Jidejian keeps in his office a picture of Dr. Douglas Fuchsen, who, he explained, had been a brother, an advisor, and the best friend that he had had at the time of his graduation. (Following graduation, Dr. Jidejian continued as an intern in surgery; Residency training did not exist at that time.) From Dr. Fuchsen, Dr. Jidejian received advice on many aspects of life, on ethics and finally on surgery. The hippocratian standards he has maintained throughout his life are in part the product of that friendship. According to Dr. Jidejian, the desire to serve should remain the primary goal, excluded from all associated thoughts about monetary returns. And yet, it's amazing, he explains, how money and success nevertheless follow these initial, selfless efforts.

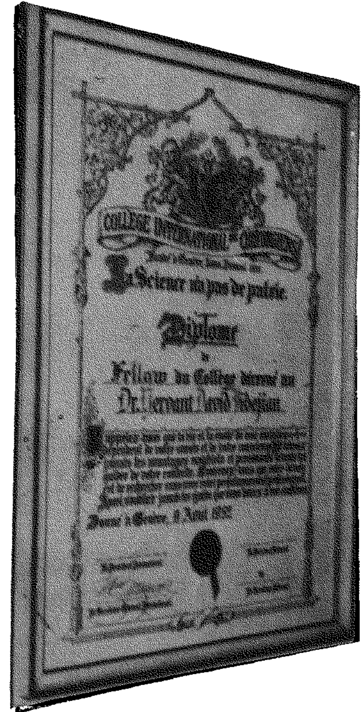
The majority of Dr. Jidejian's patients used to be poor, yet quite willingly he operated on them free of charge. He was, and still is, a hardworker; you can say that he has had no vacation in the real sense of the word since his graduation. In fact, Dr. Jidejian recalls the times when he used to be the only surgeon in the hospital!That was a great responsibility, by all means, but records indicate that he executed it with considerable skill.

Dr. Jidejian has practiced all the different subspecialities of surgery, and at a time when no technique for surgical operations was known, he developed his own style by helping pioneers in the field in Edinburgh and London Hospitals. In Beirut, he performed the first prefrontal lobotomy, attempts at arresting subdural hemorrhage, and surgery of brain tumors. Dr. Fuad Sabra assisted him in the operating room. He was the first one to perform total pneumectomy, the first bilateral transplantation of the ureters to the rectosigmoid, and the first prostatectomy.

When asked for his opinion about residency training, he said: «At that time teaching was well supervised. Nowadays our residents have to do additional years of residency training when they go to the States. Speaking 'en famille', this is discouraging for it denotes that our teaching nowadays is deficient. Our attendings are too busy operating on private patients that not enough supervision and teaching is afforded. As an attending, I lectured for 10 years on orthopedic surgery, 12 years on genito-urinary surgery, 9 years on general surgery and when I retired I did at least : hours of didactic lectures on surgery a week. Didactic lectures are not like the seminars of today, where the resident prepares a subject by reading articles to gather statistics collected abroad and the attending ends up by commenting for only a few minutes. Our residents should be encouraged to look into statistics in our own hospital, for here is a wealth of information and experience that yet remains unexplored.»

He had quite a busy life, in addition to being the Chairman of the Department of Surgery; he was also a member of the Municipality of Beirut for several years. And above all he seems to have had an equally delightful and colorful social life. «I don't deny being a great flirt!! I always liked girls and women. I see nothing wrong with them. But remember, that having female company is pleasant as long as you don't do them any harm. I hate to see somebody promise marriage to a girl merely to take a momentary advantage of her and then just drop her away.»

Hearing of his obvious sympathy towards females, we tried to sound his opinion on female doctors. He proceeded by saying that a female physician would not be able to have a normal life as a wife if she is at the same time, say a surgeon. «Dr. Suzan William, a gynecologist, was an excellent physician at the expense of having had to get married and divorced several times.» But it seems that at that particular moment, Dr. Jidejian almost forgot that although he stood on the other side of the fence—being an excellent, but male, physician—he still remained on the same platform, with the same disadvantage or advantage, with a history of two divorces attached to his own record too! Still, he would encourage female physicians to specialize only as Pathologists, Bacteriologists, X-Ray Therapists, or 'things of that sort', if they wanted a stable life as females. Invariably, he had strong reservations about female physicians, as he clearly indicated in his subsequent remarks. He somehow believed, he said, that the public still scorned female practitioners, and did not retain much confidence in them. Was it possible Dr. Jidejian that the public that he knew had since changed over the years? Instead of answering, he moved on, with an obvious smile on his face, to relate a story: «Some people were meeting once at a dinner table, with members of both sexes represented, and where some Masons happened to be present also. One of the gentler sex asked how Masons had been able to keep their secrets so well-guarded over decades and centuries, and a Mason immediately responded: 'Simple! We have no female Masons!»



Somehow, both his manner and his talk gave one an unmistakable impression that Dr. Jidejian obviously loved life, and every bit of it, and even more so, loved his profession. We could then probably understand the man and his remark when suddenly the brief silence that had followed, was broken by a deep voice saying in a tone so clearly wrapped with sentiments suggestive of

a long and active service. «I have been at AUH for 44 years, and frankly I didn't like the idea of putting a fullstop to my work. In some Universities elsewhere, retirement is an event determined by different criteria—like failing health—but here...» His body spontaneously twitched to defy any such suspicion of failing health. «...Well, regulations and laws are to be respected. Now I am working in outside hospitals, but I do not like to perform major operations there because I fell it is unfair to the patient, especially as the advanced facilities we have got used to in AUH are not found elsewhere. Anyway, I am beginning to limit my work now, and more and more often now, I am forcing my patients to go over to my students (!), who have by now, over these long years, turned into excellent specialists themselves.»

We had already begun to look at Dr. Jidejian in the context of a historical process... against the background of an evolving AUB history. Looking at him trying to develop his technique for the first prostatectomy here, or trying to remember him as the lone surgeon on duty, we could not help visualize him as a lonely figure determined to struggle and beat the records—his own or that of an inspiring neighbour—and finally coming back with resounding scores of achievements. The numerous decorations that adorned his office walls bore some proof of that accumulating success, and in turn gave us the retrospective justification for turning towards him to build up the records of Our Heritage. We shifted our conversation to these decorations and soon discovered, in their midst:

— Légion d'Honneur of the French Government, from Général de Gaulle.

— All the notable ranks from the Lebanese Government—Chevalier, Commandeur, Grand Officier.

— Two decorations from the Catholic Church of Soviet Armenia, and the Orthodox Church of Lebanon.

Quite easily, we were reminded of the M.S.S. Anniversary Show, where Dr. Jidejian was once portrayed as examining his patient with all sorts of decorations and medals pinned to his white gown and obscuring his ancient stethoscope !!!

Any secrets for success? We asked him if he had any advice for his younger colleagues, the medical students—some of whom might well be aspiring to become Jidejians, and beyond, over the years. He gave his code:

— Be generous: you make a lot of money, but give a lot of money away too.

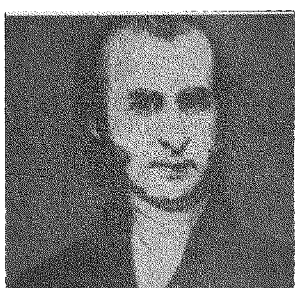
— Talk to shoe-shiners as well as to Presidents, because you learn from all people.

— Study and read medical journals to be up-to-date, and don't forget to look into other people's experiences.

— Remember always to keep some time for your enjoyment and non-medical and cultural enrichment!

In those few hours, we had discovered the elements not only of a busy life—after all, who would admit these days that he's not busy—but also of immense depth and variety. Probably also a mix-up of things, perhaps great things. No wonder, he hardly blames his former wives for not understanding him. So we put forward the obvious question, that certainly didn't sound crude at the time: 'How come you are stable with your present wife?' His answer came more promptly than we had expected. «Because she is as busy as I am. Being a writer, she has remained quite busy, writing her many books about Sidon, Tyre, Byblos, Beirut and Ba'albeck Through the Ages...» We figured out that probably a person who could appreciate the literary value of archeology thru the ages might also have the talent to appreciate the value of a Jidejian—a self-made man, having evolved with a determined pace thru the ages also.

HODGKIN'S DISEASE



HODGKIN'S DISEASE

THOMAS HODGKIN (1798-1866), the discoverer of Hodgkin's disease, was not appreciated in his day and generation. Indeed, he may be described as a failure. He failed to obtain a position on the staff of Guy's Hospital, and met with little success in private practice. He eventually gave up the practice of medicine altogether.

Thomas Hodgkin was born at Pentoville, the son of John Hodgkin, who was a fashionable tutor and instructed young ladies in mathematics, classics and especially handwriting, in which he excelled. John Hodgkin was a Quaker, and throughout life his son retained the distinctive dress and demeanour then characteristic of members of that sect. He studied medicine at Guy's Hospital and graduated M.D. Edinburgh in 1823. He then visited Paris and learned the use of the stethoscope from its inventor, that great physician, Laennec. Hodgkin was one of the first physicians in England to adopt what his contemporaries called 'a new-fangled contrivance'.

Believing a study of pathology would help to make him a better physician, Hodgkin became Curator of the Museum at Guy's Hospital, and in 1832 he read a paper with the title «On Some Morbid Appearances of the Absorbent Glands and Spleen», based on specimens of morbid anatomy that he had collected. The dissertation contained a description of that peculiar disease of lymph-nodes now known as Hodgkin's disease. In spite of the fact that the majority of these specimens were true examples of the disease that bears his name (as can be verified in the collection still preserved in Guy's Hospital) this article attracted little or no attention at the time. Thirty-three years later Sir Samuel Wilks disinterred it and added a considerable number of his own cases. It is greatly to Sir Samuel Wilks' credit that he called the condition Hodgkin's disease (1865). Since that time, attempts have been made to substitute the term lymphadenoma for that of Hodgkin's disease; this is probably unfortunate. Little progress has been made since in elucidating the exact pathology or etiology of Hodgkin's disease. Recently, evidence has been brought to bear that the enlarged lymph-nodes of Hodgkin's disease are metastases of a thymic tumour. In addition to his work on this peculiar disease of enlargement of lymph-nodes, Hodgkin published an admirable book on morbid anatomy.

Dejected by his repeated failure to obtain a position on the medical staff of Guy's Hospital, Hodgkin decided to abandon the practice of medicine, and thenceforth to devote himself to questions of reform and charitable works. He finally died of dysentery contracted at Jaffa, «whither he had repaired on a mission of relief to the Jews.»

Doubtless, if the Governors of Guy's Hospital had appointed Hodgkin to their staff, medicine would have been enriched still further, for no young physician ever gave greater promise.

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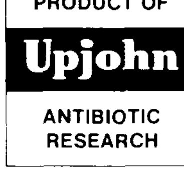

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EUTHANASIA

As any teacher of ethics would have told us, the welfare of the patients cannot be excluded from our other frontiers of concern. But though not told, the point wasn't missed.

Indeed there was much at the year's end to remind us of the patients' concern: the glittering floor decorations, the cheering music tunes pumped over the corridor loudspeakers, the scheduled children's parties.... And yet, ironically, any visit through the Coronary Unit, the Intensive Care, or the Kidney Room in the same atmosphere, could not but inspire a few lasting thoughts of different nature.

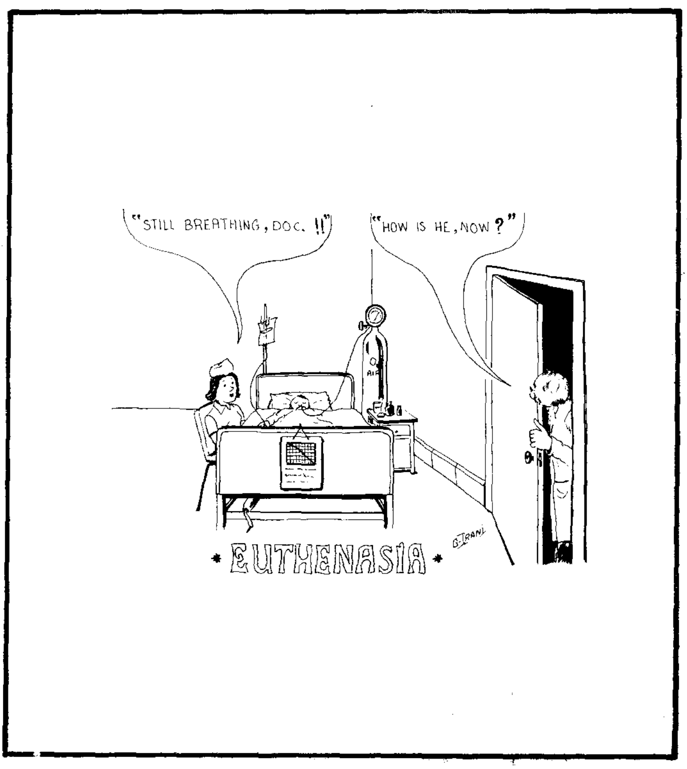
Tuned to this reflective mood and to conform to the high-pace of producing this issue of MEDICUS, we took up one of the most controversial issues facing the medical world: the problem of EUTHANASIA, or mercy-killing. The recent panel discussions organized by the British Medical Association, as indeed previous high-powered debates have only raised more questions; despite being probably one of the first questions to have bothered even the earliest medicine-man, the dilemma remains unresolved yet.

The decision to legalize Euthanasia, many argue, might well force a redefinition of the sacred, life-preserving role of the doctors; other argue equally forcefully that the refusal to recognize the practical value of mercy-killing is to well deny the mortality of man and push him beyond the limits of his own desire for a comfortable, useful and meaningful life.

It was in this context then that the timing and overall theme of our Second Issue of MEDICUS—towards a better life—made Euthanasia such a compelling title for our Feature Article. Once again, coordinating for this Article became the responsibility of Ms. Adlette Inati, our outgoing Associate Editor. Having coordinated for our previous Feature Article, Homosexuality, we felt she might be better tuned now to deal with unresolved controversies.

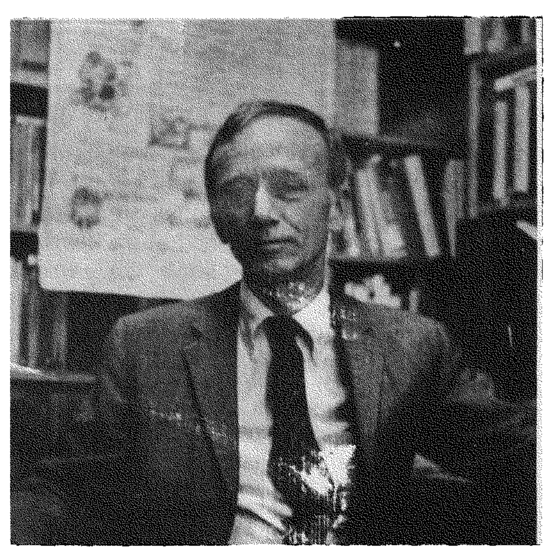
As the Euthanasia team soon realized, arguments for either side of the issue were equally convincing, and it was difficult for MEDICUS to reach its conclusions without invariably overlooking the other side. Hence, it felt the need for an extensive sounding of opinions. Thru interviews with Dr. Hovsep Yenikomishian, Dr. Vasken Der Kaloustian, Dr. Philip Salem, as well as with the Nurses—Ms. Astrik Avakian, Ms. Elizabeth Kazieh, and Ms. Kay Krause—while in an equally inspiring contribution, Prof. Richard Scott sent his own assessment from the Dept. of Philosophy.

Euthanasia, a term derived from the Greek language and literally meaning «good death» is defined as mercy killing or «the termination of the life of a person suffering from an incurable, painful, physical illness.» (Examples of such illnesses would be brain death, advanced cancer, terminal neurologic disease...). **Positive** euthanasia is to wilfully administer an element that will cause death to a terminal patient as giving him a lethal drug. **Negative** euthanasia which can take place in hospitals, every day, is withholding any help that might keep the patient alive, thus allowing him to die a natural death.



Since the very first days of medical practice, the issue of euthanasia has been a real dilemma and has experienced great modifications with time. Yet till the present day, the consideration and application of euthanasia are still surrounded by big questions that probably will remain unsolved despite the immense and diverse evolution of human and medical knowledge.

A review of Euthanasia in the literature, written by scientists, philosophers, moralists, and religious men, would imprint in the minds of the readers one basic impression: Euthanasia was, is, and will always remain a multifaceted dilemma. This is actually anticipated as long as the issue of euthanasia is a multiple one where moral, religious, socio-economic, and scientific parameters intervene and thus expected to be very seriously considered. Above



Dr. RICHARD SCOTT FROM PHILOSOPHY DEPT - SAYS....

The question before us is: Whether there are circumstances to which **euthanasia** is an appropriate response. My attempt to answer this question will follow a method the steps of which I shall now outline. I shall begin by considering cases of different types, hypothetical cases chosen because in their contrasting ways euthasania might be a relevant response to cases of each type. In order to make a judgment in each case it will be necessary to simplify ideally, i.e. to reduce the variables to a bare minimum. We cannot consider everything at once, and thus, for example, we shall assume that there are no legal or theological injunctions which have to be taken into account. We shall consider each case as it presents itself and presuppose only criteria of better and worse which are prevalently used in our society. In this way a judgment will be made in each case, and the criteria to which it appeals will be made explicit.

When we have run through the selected cases and the judgments made, I shall ask that we look back upon our procedure to discover, if we can, some **rule** which exhibits itself as the principle of the judgments. If we can discover such a rule, then the validity of the judgments relative to the data taken into account will depend upon the validity of the rule. We can then, in the final portion of this paper, consider how to establish the validity of the rule of judgment.

II

Let us now proceed to consider some cases and try to arrive at a judgment in each case.

(i) Our first case is an extreme one, a man whose brain has been irreparably damaged, to such an extent that the «man» if he continues to exist will be more vegetable than animal..Unable to care for himself in any way, he will have to be waited upon hand and foot (so to speak) by others. To call such a being a vegetable is indeed unfair. It is unfair to vegetables, for they have their own perfection in the realization of which they fulfill themselves and may contribute to the fulfillment of human beings. It would be more accurate to compare the case in question with a rotting or diseased vegetable fit only for withering and death. There is no doubt, in my judgment, that in such a case euthanasia is indicated.

(ii) In our second case the brain damage is also irreversible but is not so severe. The man can get around on his own, but is like a child in that he must be cared for. Unlike a child the man's adaptive potentialities are impaired so that he cannot adjust to the reality of his condition. He is incapable of sustained socially-useful labor. Would it be better or worse for others if this man were quietly and painlessly put permanently to sleep? If we look at the matter dispassionately and objectively, would we not conclude that it would be better? Perhaps. But such objectivity and dispassionateness are not yet prevalent in our society. Cases of this type are too frequent or are too similar to cases (like senility) which are very frequent indeed, and are embedded in complexes of moral sanctions and customs and religious ordinances which at present are too strong, for me to conclude that euthanasia should be applied to such a case.

Dr. RICHARD SCOTT SAYS....

(iii) The third case shows no brain damage. Indeed the man's mind is as sharp as ever. But he is a «basket case.» He tried to commit suicide by throwing himself in the path of a speeding car. Instead of losing his life he lost his legs. Loss of his legs would not be an insurmountable difficulty were it not for the fact that the man has no family or friends to take care of him. Worse yet, the society of which he is a member has no facilities for taking care of such cases free of charge. Furthermore, the man has no money. The suicidal tendency which produced his disability is more determined and intense now. It is clear that if the social environment were different in crucial ways, this man has plenty of potential for building a life worthwhile both to himself and for others. Nevertheless the opportunities as we have described them seem nil. The man begs for euthanasia. If we cannot help him in any other way, surely we must give him the mercy for which he pleads. Given his situation as we have characterized it, euthanasia would seem to be the only way of helping the man to put an end to suffering which would otherwise only be intensified in the days to come. Nevertheless, there are no clear criteria for judgment in this case, none prevalently used in our society. Hence, in such an ambiguous situation one must either invent or let events take their course.

(iv) Our final case is a woman suffering from a painful disease which is taking her slowly but inexorably towards her death. Her family have expressed their wish that her agony could be shortened. Everyone regrets that she must die, but everyone prefers that her death come sooner rather than later, in order that she may rest from her pains. In this case there is little doubt that euthanasia is in order.

III

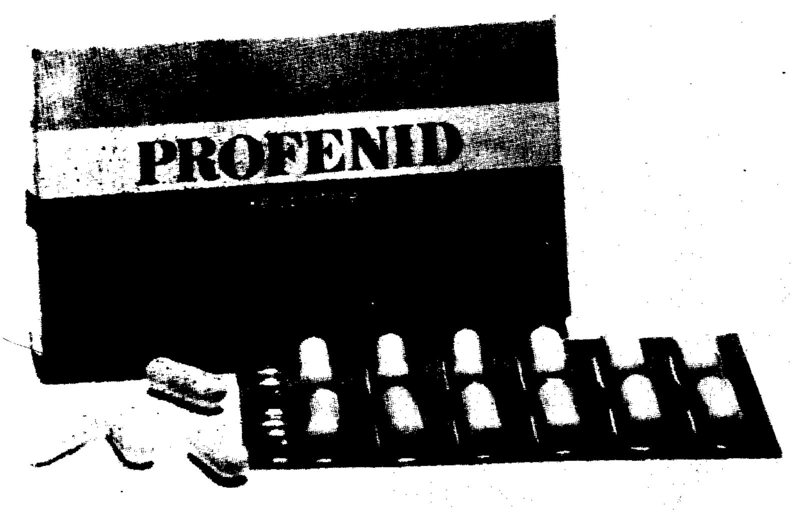
In two of the cases considered euthanasia looks better for others who are most closely connected with the sick person, while in the other two cases it is for the sake of the afflicted that it seems better. In the second and third cases, however, the prevalent attitudes of society are involved in special ways. In the second case those whom euthanasia would release from a burden are conditioned by these social attitudes to resist euthanasia. In the third case the very plight itself of the man who had lost his legs was in part the result of social indifference. Thus his society had no provision for his rehabilitation.

If we ask then for the rule which is the principle or judgment, in so far as it was possible to make a judgment in these cases, the rule would seem to be: Use euthanasia in case (1) it would relieve the social environment of the afflicted person of a burden which saps its well-being and in case (2) it would not deprive the afflicted of any fulfillment which a reasonable man would regard as the right of a human being. If this is the rule which emerges from our survey, then the legless man would be deprived of certain fulfillments to which he has the right as a human being by his own suicidal act and by the absence of social provision for his care and rehabilitation. If so, it could be argued that euthanasia would not, under the circumstances, deprive him of any fulfillment to which he could otherwise reasonably look forward.

IV

In this brief paper it is not possible to do more than point out a direction in which we must think if we seek to establish the validity of the rule of judgment. The rule's validity would be established if it could be shown that its use would contribute to maximizing and channeling human energies and thereby to human society's gaining control over itself. As a corollary of this, the rule's use should contribute to bringing death under the control of life, thereby making it to that extent a manifestation of life.

A dominant theme of philosophy from Plato through Spinoza to Dewey and Whitehead is that the goal of human intelligence is social well-being. John Dewey has argued that intelligence should be regarded **«as the purposeful energetic re-shaper of those phases of nature and life that obstruct social well-being.»** I have written this essay to suggest that euthanasia, instituted with appropriate safeguards against its abuse, might contribute to this reshaping. It might also contribute to the development of the individual as, in Dewey's words, **«the agent who is responsible through initiative, inventiveness, and intelligently directed labor for recreating the world, transforming it into an instrument and possession of intelligence.»**



Le Profénid en rhumatologie

Indications

• Rhumatismes inflammatoires chroniques :
polyarthrite rhumatoïde
pelvispondylite rhumatismale

• Rhumatismes dégénératifs en poussée :
coxarthroses
gonarthroses

• Rhumatismes abarticulaires :
périarthrites, tendinites...

• Goutte

Tolérance et précautions d'emploi

Les effets secondaires observés sont surtout d'ordre digestif (gastralgies, nausées, douleurs abdominales). Ils ne conduisent qu'assez rarement à l'arrêt du traitement.

Il est recommandé d'éviter l'emploi du Profénid chez les malades présentant des antécédents digestifs, notamment de type ulcéreux.

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Boîte de 24 gélules, dosées à 50 mg de kétoprofène, présentées sous plaquettes.

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S.P.E.C.I.A.

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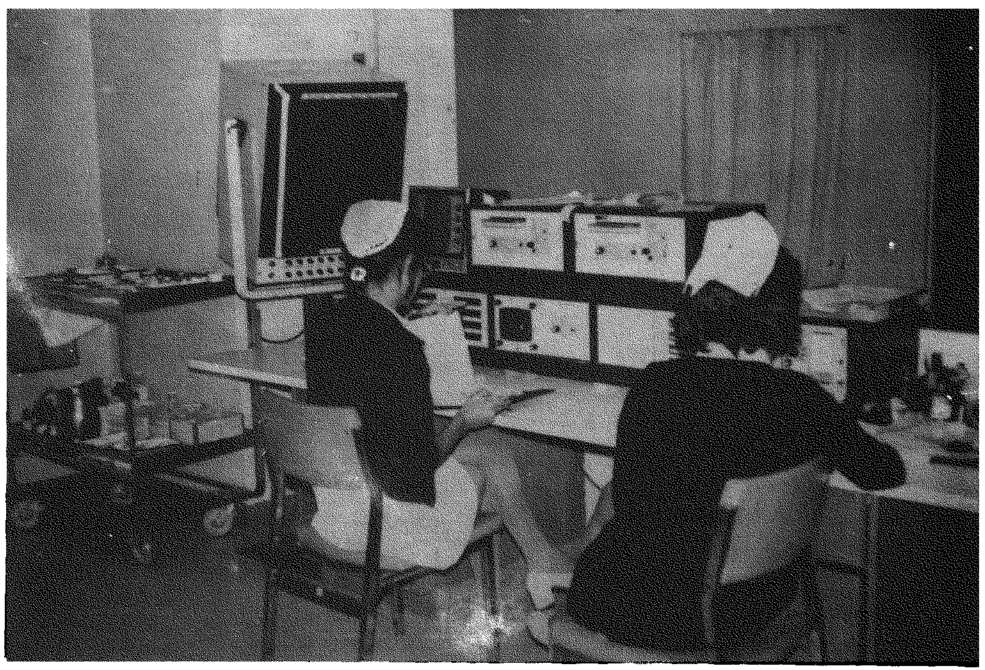

all, the question of life and death, the question of the right to live and to die, the question of the right to decide to prolong or end one's life, and the question of human integrity—questions that have since antiquity puzzled the greatest of minds and challenged the deepest thinkers are the ones to be dealt with very closely and elaborately in Euthanasia. What complicates the picture further is that human rights are as difficult to define as to establish, even when they enjoy much popular support.

According to Christianity, man is a created being with a moral responsibility to his Creator, part of which includes the 5th commandment «Thou shalt not kill.» Human life is sacred and it is not for man to decide when it should cease. As long as life is a gift of God, it is only God that can take life away. This should not be falsely understood to mean that according to religious teaching, we are morally obliged to preserve life in **all** terminal cases.

The Romans who contributed so much to the «natural law's» view of human rights strongly advocated that life and death should remain under the individual's control. This is very nicely illustrated by Seneca, one of the most articulate supporters of this view: «To death alone it is due that life is not a punishment, that erect beneath the frowns of fortune. I can preserve my mind unshaken and master of myself.»

A study of the Nazist attitude towards euthanasia would show that what they practiced was merciless killing either genocidal or for ruthless experimental purposes. At no time, did they engage in mercy killing.

«If we will the end we will the means» said Immanuel Kant one of the most outstanding German philosophers. According to him, as long as we look at a dying person as a dehumanized and miserable one, death would eliminate this state of non-well being. To reach this end, any means, euthanasia being one, can be used regardless of its ruthlessness or mercifulness.

Despite major scientific progress, attitudes to death remain in our present society, entrenched in irrational fear and prejudice. Death is still regarded as the worst of all choices rather than a natural and possibly desirable option under certain circumstances—mainly a hopeless incurable life. Life and living are used synonymously by many who fail to realize the importance of the **quality** of life. On the other side of the spectrum, are people who firmly believe that every human life should be considered inviolable because of the very fact of its existence and should have a sanctity of its own regardless of its quality. Such people would strongly disagree to putting immediately to death patients with Down's syndrome for example. They would think there is an enormous difference between not fighting death and actively putting an end to life for the former is compatible with respect for human life and thus with social mores. To them, there is always an evil in killing or rendering a previously alive person dead. Respecting a dying person may demand that we stop the art of healing so that we can help the patient practice the art of dying.

The traditional concept of death is that «death is the transition from the state of being alive to the state of being dead.» This concept which evidently is a very vague and undefined one has pushed many modern scientists to redefine death to fit more the context of human integrity and mental functions: one such redefinition is: «A person is considered dead once the function of his cerebral cortex ceases.» After this state of end of cerebration, there is no point in keeping anything else going no matter how many other spontaneous or artificially supported functions persist in the lungs, heart, kidneys... . To insist on preserving life with these modern resuscitation and transplantation techniques is placing biologic survival as a first order value followed by human integrity and dignity. One can infer from this that humaneness is primarily rational and not physiologic and is a function of the synthesizing

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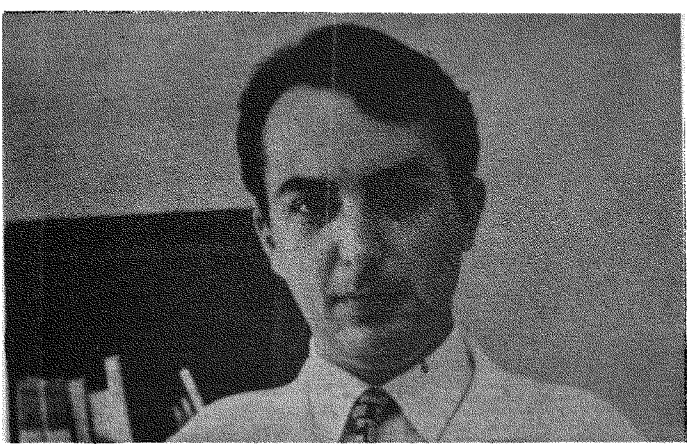
Dr. DER KALOUSTIAN



True, the dilemmas involved in Euthanasia become minimal as the patient's prospective span of life decreases. An Internist, dealing with adult patients, frequently encounters thus, patients at the farewell end of life, who leave him little choice to talk of improving their future. Such patients might offer the least hesitation for an advocate of Euthanasia.

In contra-distinction, a different psychology of the human mind might be at work when one is at the welcoming end of life and dealing with the infants and children who have a minimal past but a potentially vast future. Curious about the hesitation invoked in deciding to terminate such youthful lives, MEDICUS turned to a Pediatrician, DR. VASKEN DER KALOUSTIAN. With his special interest in Genetics, as his over 30 publications would clearly indicate, we had a suspicion that he might be more interested in the mechanics of birth rather than in the alternatives of death. Below is what the MEDICUS reporter came back with!

Rather than just answering the main questions directed to him, Dr. Vasken Der Kaloustian preferred to start the interview by emphasizing some important principles which form some sort of basic criteria for his philosophy on euthanasia: attitudes and issues, be they moral, religious, civil... are put down by a society as a set of rules or ways of behavior that have proved to be of practical importance in leading a good life in that particular community. Every society puts down regulations and norms that would serve their welfare and offer the best for them These regulations are apt to show variations among different societies and at different times. Even taboos follow a certain wisdom. Moral issues should not be rigid for they evolve with time and thus the rule of the absolute should not exist. Concepts and behaviors change with the change of these rules that are the outcome of the experience of societies. For instance, attitudes and practices of contraceptions and abortions, have witnessed remarkable change with time.

Any concept or mode of behavior is good or bad in relation to these set of rules. Euthanasia is one such example.

When asked about his attitude upon encountering a newborn with multiple congenital anomalies or with incurable ailments, he said that besides pitying the family, he would be concerned mostly with what can be done to this particular child. He does not take these cases as completely hopeless for knowledge of lethal disease change. For example, it was only in August 1974 that the treatment of Acrodermatitis Enteropathica, a disease entity considered all along to be lethal, was finally discovered. At present, this disease is even easier to treat and bring even better results than, say, diabetes. At any rate, there is no disease that is completely curable.

Q: Do you think a physician has the right to decide when life should cease? If not, who possesses such a right?

A: «I do not think a doctor should be the only master of the situation. More than one party is involved. The opinions of the patient's family should be taken into consideration. The physician should maintain his heroic attempts in therapy no matter how hopeless a patient's situation is, if the family is very much attached to the patient and pushes for intensive treatment. If the doctor refrains from doing this, he will hurt the family and will have violated moral and social rules.

If on the other hand, the family pushes for terminating the life of the patient—like, for instance, by weaning him off the respirator, I, as a physician cannot do this, unless I know his EEG is flat.»

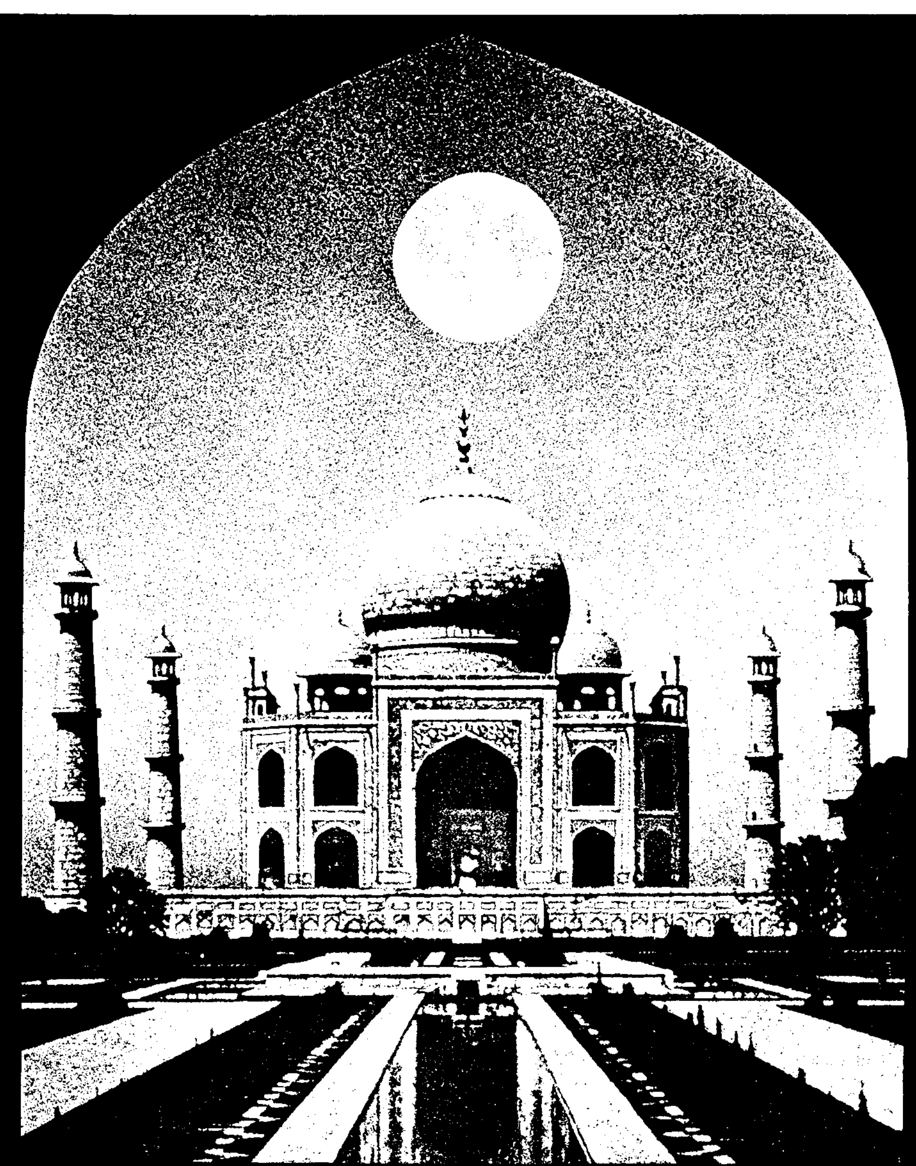
During this interview, Dr. Der Kaloustian emphasized one very important point: With the tremendous progress of scientific knowledge and new methods of therapy ever evolving, especially in the treatment of diseases that were considered incurable in the past, a physician should be aggressive in his therapy and prolonging the life of his patient as long as he can for «who knows when cure would come?» In fact, he had an unhappy experience with a child who died of Acrodermatitis Enteropathica in early August 1974, just during the same month as the advent of treatment for this disease. Another important premise in his decision making process is the following: «As long as there is no mental disorder, treatment is not hopeless.» Thus, patients with cystic fibrosis should be kept alive as long as they can be; their brains are normal

Of course, the issue of euthanasia remains a big dilemma, according to Dr. Vasken Der Kaloustian. «The question is to put the limits and to be able to individualize your patients. At any rate, the child should be given the best treatment. Importance, however, should by all means, be given to the opinions of the family, to moral issues, to the role of scientific progress, and to the medical state of the patient.

When it comes to a relative, a situation he has already faced, the decision of Dr. Vasken Der Kaloustian regarding the practice of euthanasia would not be different from that on an unrelated patient.

Q: Would you push for legalization of euthanasia in incurable pediatric disorders?

A: Of course not. I respect moral issues and the good they serve. For example, incest, which has been condemned all through history, is known to result in more congenital anomalies. So we should respect the wisdom of certain moral rules established by our society through the experience of centuries



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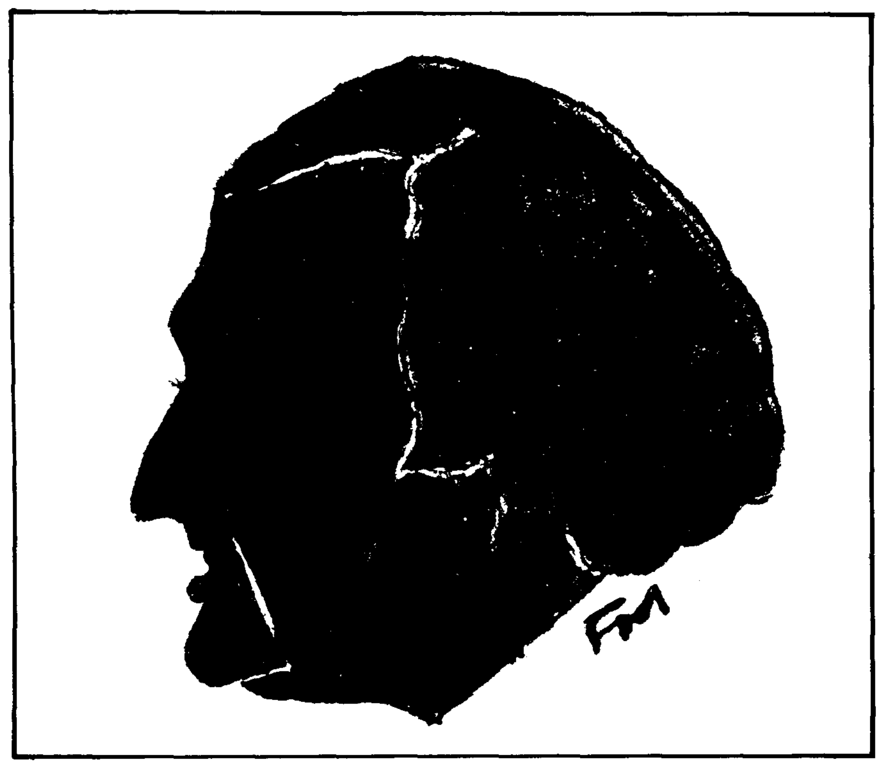
Dr. PHILIPH SALEM



More than any other medical specialist, an Oncologist is placed in a position to encounter the highest number of terminal and incurable patients. Directly exposed to dying patients, he is constantly bombarded thus by the nagging philosophy of Euthanasia.

It's for this reason that we found it so appropriate to include the views of our Oncologist, DR. PHILIP SALEM, in this Article.

An Assistant Professor in the Department of Internal Medicine, he still belongs to the new generations of doctors, fresh and full of abundant enthusiasm. His beard and long hair partly betrays a much-deeper personality as he seemingly knows so well; but despite this and because of all this perhaps, he remains amazingly approachable.

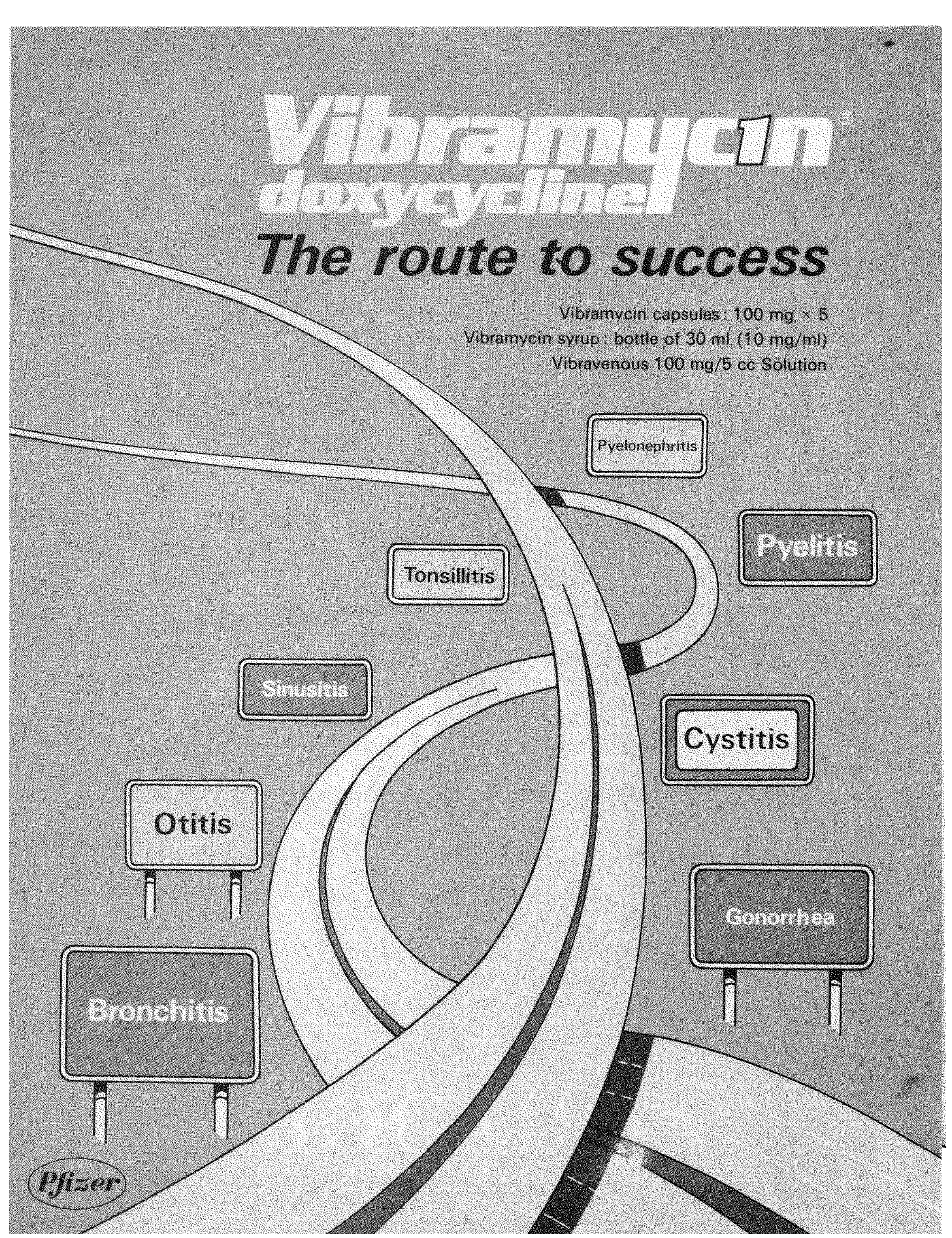
May be because of his own intellectual reserves or may be because of the very nature of his speciality, he has evolved a philosophy of life. It's difficult therefore to talk to Dr. Salem about Medicine alone; one invariably ends up talking about Medicine and more so about the application of Medicine in human life, with all its passions, and all its shortcomings.

Terminality, according to Dr. Salem, is a question of degree. To him, there are no terminal patients in cancer: Every single patient is a challenge which he undertakes and he never gives up for often unexpected optimistic results might be got. To illustrate, he cited the example of a patient with extensive rhabdomyosarcoma with pulmonary metastases. This case seemed terminal to many, yet amazingly enough the patient showed a good response to treatment and is still alive one year following the diagnosis of his disease. «Once I diagnose cancer, I feel there is a long journey to make with my patient and this presupposes a very intimate relation between both of us. All through this journey, I work to help my patient through a scientific and rational approach rather than just a humane attitude where I pity him the way many doctors, medical students and nurses do. Of course, I grasp the human aspect of the problem.» However, it is very vital to make the patient feel he is not being left alone but there is a physician who is ready to help him as sincerely and as fully as possible.

«What worries me» continues Dr. Salem, «is the quality of life of a human being. Never has death worried me. My primary interest as an oncologist is not in dealing with death, although I will be facing this in an appreciable number of my patients, but in improving the quality of life and in rendering my patients as happy as possible.»

MEDICUS: Does a physician, in your opinion, have the right to decide for the death of a terminal patient?

DR. PHILIP SALEM: I am against a physician deciding for this. This decision has to be made with the patient's family and implemented only after a committee of specialists, rather than one doctor alone, agrees on this.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Perhaps one of the most important and unique comments made by Dr. Salem during this interview was regarding the active role of the patient in deciding for the termination of his life. This role is often neglected by many physicians who tend to forget that in the first and final analysis it is the patient's life rather than the lives of those around him that is at stake and that the patient should therefore have a say in this. Elaborating on this very important point, Dr. Salem said «Physicians should start involving the patients in decisions regarding their life but they ought to be very tactful and diplomatic in this and realize that a patient can't decide alone. *I would say a major decision relating to life and death should be made by the family, physician and patient.*» Clearly enough, the patient himself would be the ideal person to make decisions about the application of euthanasia on him. In this way euthanasia might cease to be a big dilemma! One would be surprised to know that 95 percent of Dr. Salem's patients know they have cancer but their knowledge is «diluted with lots of optimism.» Used to working with poor follow-up rates, the regularity with which the cancer patients report to him might come as a surprise. But may be it shouldn't if one realizes a fact that many tend to forget — a patient wants to feel he has a physician who respects him and in whom he has confidence. That is why Dr. Salem feels that medical students should be educated regarding the above points in order that they start involving their patients in making decisions about their life.

Q: *In an end stage of malignancy, would you first give palliative treatment or would you push for further cancer therapy despite your realization of the futility of the latter and its financial burden?*

A: In an incurable stage of malignancy, provide your patient with the maximum comfort both psychologic and physiologic. The best way to achieve this is by a rational approach to the disease and not first by an emotional attitude for this latter is most inhumane and tortuous.

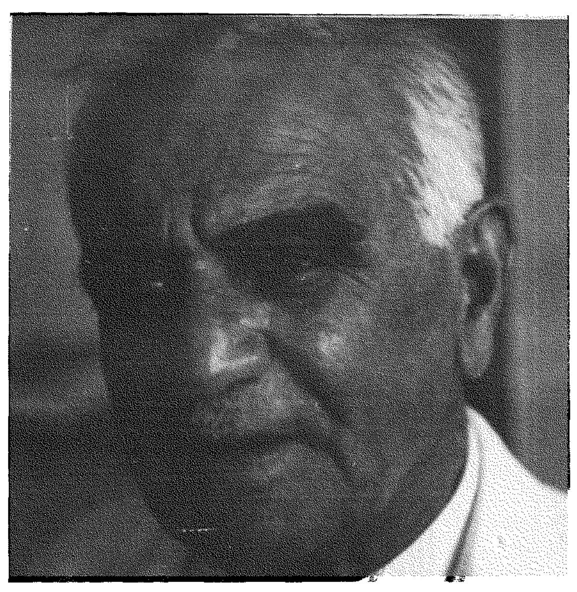
Talking about euthanasia without touching upon life and death is like writing about the Greek philosophy without mention of the soul and the body, or the mind and the matter. Dr. Salem did not want to let the interview end without commenting on this:

«It is the quality of life rather than just life which is important. Death is the end of life. People should accept it with grace as an inevitable occurance. We should work to educate people and make them develop this attitude towards death. In the Middle East, people have a pathologic attitude to death and this sometimes has a negative effect on the practice of euthanasia.»

Dr. YENIKOMESHIAN

DR. YENIKOMISHIAN: «Three parties are concerned in making a decision regarding euthanasia: The patient, his family, and the physician.»

The well known, Dr. Hovsep Yenikomishian, received his M.D. from the Syrian Protestant College in 1918, and retired as Emeritus Professor from the Department of Internal Medicine in 1966; ever since though, he has retained an unyielding zeal for science and for pursuing the vast and yet advancing medical progress. To his credit, he has more than 10 publications in Gastroenterology and Tropical Health. Invariably, in his long career, Dr. Yenikomishian has thought a lot about the problem of euthanasia, with its multiple implications. Talking to MEDICUS, he said, «Euthanasia is an important problem that concerns every practicing physician.» It obviously needed a discussion, and so with his characteristic smile on an ever-cheerful face that soon turned into a fatherly look, he sat down to discuss with the MEDICUS reporter, in an appropriately ancient grand chair, and amidst a remarkable collection of Chinese, Persian and African art work.



When asked about his concept of euthanasia, Dr. Yenikomishian made a clear distinction between the 2 main types of euthanasia:

— Passive, which means leaving a terminal patient to die in peace and dignity rather than prolonging the state of his agony; and

— Active, which eases the passage of a terminal patient with an extra dose.

According to him, euthanasia is and has always been a controversial issue, not only to the physicians, but to the world at large. It has been discussed in Parliament on more than one occasion, he recollected, and as anticipated, no unanimous decision regarding its practice could be arrived at. Doctors are actively fighting, and this is due to two main causes:

1. On the part of the doctor who feels that his duty is to preserve and prolong life against the threat of death. They are solely concerned with this threat of death.

2. On the part of law-givers who do not have full confidence in the judgement of a physician to terminate the life of someone else, no matter who he is.

«Death is just as natural as being born, and one has to accept it gracefully, get old gracefully, and die in a becoming fashion. Life is to be lived. Live as fully as you can. All society thinks life is sacred and likes to preserve it. But **people often can't differentiate between life and living.** Being alive needs more than continuity of vital functions.»

When it comes to the question of the kind of approach a physician should adopt towards his patient i.e. a wholistic or a dichotomic approach, Dr. Yenikomishian is strongly against a dichotomy, for, to him, soul is an attribute of life and cannot be torn apart from body. Besides, such a fractionation will lead people astray and render them unappreciative of life.

Going back to the practice of euthanasia he said: **«I will not advocate euthanasia in any acute ailment, no matter how hopeless the situation appears and regardless of the age of the patient.** However, the situation differs in a person who has got a well-established, and a definitely diagnosed, progressive illness which will deteriorate as time goes on i.e. an irreversible disease.» His attitude will not be conditioned by the relation he has with the patient (an unrelated patient vs. a relative) for to his mind, every single patient is an individual problem and must be considered according to his particular situation.

Of course, the right to decide to end one's life is not possessed by a treating physician alone (in this aspect Dr. Yenikomishian holds the same attitude that most medical doctors adher eto at present).

Rather, **three parties are involved in arriving at this decision. The patient, his family and the physician.** The best thing would be to have the authority from the patient and the family passed a priori to the physician for this may decrease the immensity of the dilemma of euthanasia. However, it is quite difficult to do this for terminal patients, who are still conscious, need to be calmed down rather than being given insight into their disease. «But, I will depend on my wife's advice if I were such a patient for she will know what is best for me.» he added, while stealing a glance at his wife who sat there, admiring every word he was uttering.

Q: With the tremendous advent of resuscitation techniques, do you think that the dilemma of euthanasia has become more prominent and/or has acquired new dimensions?

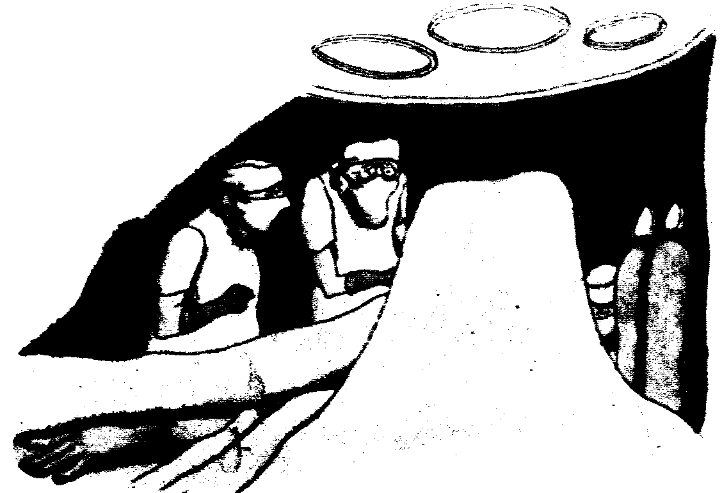
A: Yes, this has given more scope to the activity of a physician who strives to preserve and prolong life at all costs. However, in patients suffering from progressive, irreversible diseases, this has only helped to prolong their misery.

Q: Dr. Yenikomishian, any message you would like to convey to the new generation of medical students?

A: 1. I'm for more learning. The best in life is learning. 2 The world should move towards socialized medicine.

Indeed, talking with a profound teacher as Dr. Yenikomishian and discovering touches of wisdom in every word he said was a very nourishing experience and a source of genuine stimulation and gratification.

Despite having talked to Dr. Yenikomishian, the dilemmas involved in the practice of euthanasia had remained unresolved. But we could hardly think of a better topic that would have allowed us to revisit a man in retirement and be exposed to the philosophy and wisdom of a man that uniquely remain the product of unrivaled years of experience and exposure.



"Sometimes I miss how it was in the old days . . .
the hidden laboratory in the ancient castle . . .
the graveyard raids . . .
the angry crowds of peasants bearing torches. . . ."

INTERVIEW WITH MED I

MEDICUS formulated a questionaire to assess the views of Medicine I students on euthanasia. This step was considered essential in order to know how entering and would-be physicians, who have not been exposed yet to the practical or clinical aspect of medicine and have not yet been conditioned by the life of a hospital, tend to think about a principal human problem. Very soon in their medical career, they will be confronted by terminal patients on whom they have to make a decision regarding euthanasia. For the sake of clarity, the questionaire included an introductory definition of euthanasia and its 2 types: positive vs. negative.

This questionaire was distributed to the whole Med. I class. 30 students answered it. Following is a summary of the attitudes of these Med. I students regarding euthanasia. euthanasia.

We know that according to many thinkers involved in *euthanasia, mental integrity remains one of the most important factors considered before a decision regarding euthanasia is made.* And as such, physicians who adhere to the above attitude, *tend to advocate euthanasia if a patient* has irretrievably lost the capacity of cerebration—that is, when the patient no longer knows that he knows. This is in strong contrast to the thinking of an appreciable number of Med. I *students* (18/30) *who believe that biologic integrity* is as important as mental integrity. Furthermore, 7 Med. I students believe that continued biologic survival is even more important than mental integrity. Only 5 students said that mental integrity surpasses biologic survival.

When asked if a physician is morally obliged to preserve life in terminal cases, 20 students answered positively; *and responding as to who ought to make the final* decision about the fate of such incurable cases, 15 students wrote that the doctor is the one to make such a decision; 8 thought it should be a group decision; 5, the community with its legal status, and only 2 *said the patient can decide* for his fate. 21/29 students will keep a patient physiologically alive even though he is mentally dead. This attitude contrasts sharply with the evolving trends regarding euthanasia.

To a subjective question about their reaction if a more courageous person could step in and decide to terminate the life of their patient but without putting blame on them, the response of Med. I students was very encouraging: *more than* 75% responded negatively, and maintained their previous stand about keeping the patient alive. This reaction was based in most cases on a firm belief in the following: *Courage is not a determining factor. A physician* is the one solely responsible for his patient and by nature of this relation, nobody else should be permitted to intervene and decide for terminating the life of his patient. Regardless of the hopelessness of the situation, blame is not an *important* issue. Only *one student expressed relief* at the idea of a more courageous person stepping to end the life of his patient—for it is difficult for him to make decisions on others' lives, he felt!

Of course, the attitude of medical students regarding legalization of euthanasia remain one of the most important variables to assess, for this issue has been raised in the parliament more than once; but till the present time, there is no general concensus about it. The majority of Med. I were against the *legalization of euthanasia, especially* positive euthanasia: 26 did not want **positive** euthanasia to be legalized while 3 wanted it to be; whereas for the **negative** euthanasia, 20 did not while 9 supported its legalization.

Q: The patient has a right to live. Do you consider him still *alive if instruments have replaced his organs and* he can no longer think?

A: Yes: 16; No: 12; no answer: 2.

Q: *Will you practice euthanasia on the terminal cases* without the consent of the relatives involved?

A: Yes: 3; No: 25.

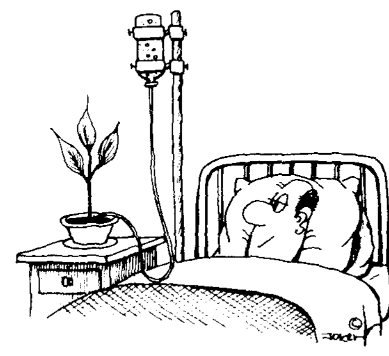
Q: *Will* you practice euthanasia in a terminal case if the patient has

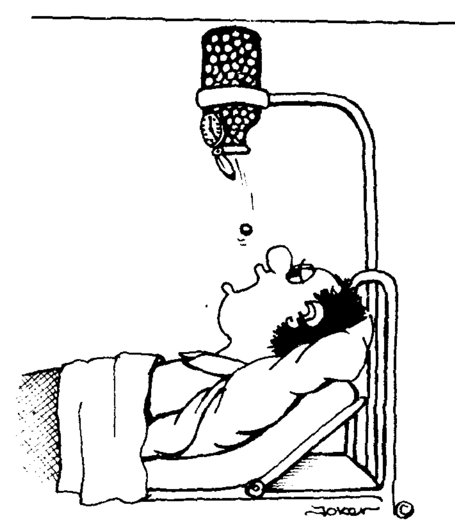
	Yes	No	No answer
1) **5 years more to live?**	1	28	1
2) **1 year more to live?**	7	22	1
3) **1 month more to live?**	12	17	1

Q: Do you consider the efforts that go in maintaining a terminal case alive, wasted?

A: Yes: 7; No: 22; no answer: 1.

IDEAS AT WORK





NURSES ON EUTHANASIA

On an issue such as Euthanasia, the most revealing comments might well come from the people who have the greatest and most intimate contact with the patients. Responsible for administering the almost minute-to-minute care of the patients, it's probably correct that the nursing staff is not only in a better position but also so much more prepared than most of us to build the kind of close and passionate human bonds that become increasingly necessary towards the closing moments of life.

To add these deeper dimensions to our study, MEDICUS interviewed three AUH NURSES — that we felt were strategically placed in the context of this article — MS. ASTRIK AVAKIAN, an administrative supervisor since 1956, but who with her 50-plus years of Nursing Service is by far the oldest and most overtly-passionate nurse in the hospital; MS. ELIZABETH KAZHIEH, an Oncology Nurse working with Dr. Philip Salem for the past two and half years; and MS. KAY KRAUSE, the ICU-Head Nurse, involved in ICU Nursing for the last eight years and whose skilled concern for the patients balancing between life and death ever seems to be on the rise!

Ms. AVAKIAN ;The locus of Nursing.

MEDICUS: What do you understand by euthanasia?
MISS AVAKIAN: Euthanasia is a difficult, a deep, and a complicated subject. To my mind, it means the termination of the life of a hopeless medical case.

Q: Would you as a nurse advocate euthanasia in terminal, incurable cases?
A: I am with the practice of euthanasia only in the absolutely hopeless cases. The life of such patients should be stopped so that the patient can die quickly and peacefully. But there are moments when one cannot tell the distinction; there are also moments when a patient is aware of what is going on. In such cases, strict rules of practicing euthanasia should not apply and the patient should be approached very emotionally and quietly. This is a personal attitude, but as a nurse, I'm not in a position to object to the intervention of physicians for they are the ones to decide on ressuscitating or not in such critical moments.

Q: Who do you think has the right to put an end to the life of a terminal case?
A: God has given Life and only God can take it away. No human being possesses such a right. Of course the opinion of the patient's family is very important in such situations and the ultimate decision has to depend on an agreement between the physician and the family. In this part of the world, the family interferes a lot and often, early in the game, begs the treating physician to prolong the life of their relative despite the incurability of his disease; however after some time elapses, they prefer to take their child out of the hospital to die near his relatives (this applies more to the low socio-economic group). On the other hand, physicians are sometimes accused by the patient's family of killing the patient if they wean him off the respirator or discontinue aggressive treatment. The financial state of the patient plays a vital role in modifying the decision regarding the practice of euthanasia.

Q: In what way do you think the remarkable advances in medical technology has affected the current thinking about euthanasia?
A: Well, artificial technology has made euthanasia come more to the front in our present time. In the old days, there were all sorts of horrid diseases where means for ressuscitation were also lacking; so the problem of euthanasia was not a big one and not encountered as much as today.

Q: Would you approve of legalizing euthanasia?
A: No, for no human being has the right to put rules and regulations to terminate one's life. This is my strongest reason against the legalization of euthanasia.

MEDICUS: How do you feel when you first meet a cancer patient?
MRS. KAZHIEH: Difficult to say. My primary concern is the patient. I realize that this patient has a disease which will not be 100 percent cured and so I feel sad especially if he is young. If he is old, I say, «why should he be in affliction for the few remaining years of his life?»
Q: *Do you realize that when you are dealing with cancer, you are dealing with death and cancer treatment is only delaying death?*
A: No, I don't think cancer is death. Everybody is going to die and nobody knows when he will die, for I believe God has given life and he will take it. But I do not deny treatment that is essential.
Q: *Are you with the practice of euthanasia in terminal cancer patient with generalized metastases?*
A: As a nurse, I can't decide for a patient for it is somebody's life. I will give just a personal opinion. Do not ressuscitate in such cases and do not be aggressive in your therapy. Just sedate the patient and offer him palliation. Leave him to die in peace; alleviate his pain but refrain from giving cancer treatment. If he is on the respirator, I find it difficult to wean him off it if I had the choice to decide on this. Let's not however pay no attention to the opinions and wishes of the patient's family for often they are a determining factor in the kind and extent of treatment. If the physician can know before hand the wish of the patient regarding the euthanasia on him, it would be the ideal situation. But this is very difficult for a physician cannot be frank with all patients since not all of them can tolerate such a shocking, desperate situation. Cancer patients are very sensitive and usually become very apprehensive once they advance to a terminal stage. So one should be very careful with giving them insight into their disease.
Q: *If you were a terminal cancer patient, how would you like to have your life terminated?*
A: Theoretically, with euthanasia. But it is not easy to anticipate my behavior under such unfavorable circumstances. I will make a general statement however: Let me die in peace and not have pain with no cancer treatment. Just sedate me, put me in coma, and do not ressuscitate me.

MEDICUS: What do you understand by euthanasia?
KAY KRAUSE: Simply, mercy killing.
Q: *If you were asked about your attitude regarding the practices of euthanasia, what would you say.*
A: I am with euthanasia if the patient and his or her relatives agree to it with full knowledge of the hopelessness of the situation. I am for leaving such patients die naturally without vigorous treatment. We would be better devoting our interest for better life. This does not mean that I as a nurse would stop caring for such a patient. Why should we ressuscitate leukemias and cancers, why should we leave patients with brain damage first to occupy beds. To keep such patients and more importantly to actively prolong the life of terminal cases is a waste of good professional work, of finances, and of time that can be better given for a more acute patient carrying a better prognosis. But the big problem is where can you stop euthanasia? *Do you terminate spine bifida or a mongol or a case of anencephaly? Time of killing these cases is difficult to decide.* Very rarely (1%), a patient that was thought to be completely incurable surprisingly gets better and you as a physician are in a bad shape then.

Q: *What parameters should one consider before making a decision regarding the practice of euthanasia?*
A: The physician, the parents, and the patient are the people most closely concerned with making such a decision. These responsible people should agree on a step of action. Of course, these people are conditioned by exogenous factors for instance, their own culture. In England, the situation is very much different from the Middle East: Parents often ask the treating physician to do all he can to end the misery of their child once they realize the deteriorated medical state he has reached to. In the Arab world the family is very much integrated and every member is concerned greatly about his relative so that it is difficult to get to a unique and frank decision. Often parents here are afraid to say to the doctor they want to stop the life of their child or cease ressuscitating him because they may be misinterpreted by their social surroundings.

The role of health education in modifying the concept of the public about euthanasia is very important. Such a modification will inevitably need time for people do not evolve very quickly.
Q: *If you were terminal case, would you ask for euthanasia to be practiced on you?*
A: If I were terminal, if I had the ability to end my own life, I will do it or ask somebody to do it for me. As long as to me, heaven and hell do not exist it is no problem and I do not feel guilty for this decision of mine.
Q: *Would you propagate euthanasia yourself?*
A: If it is legalized, then change will do the propagation. If it is illegal as it is at present, I will find it difficult to do this for one should respect the social set up he is living in and should continue to function within the limits of law.

Lomotil

acts to stop diarrhoea within one hour

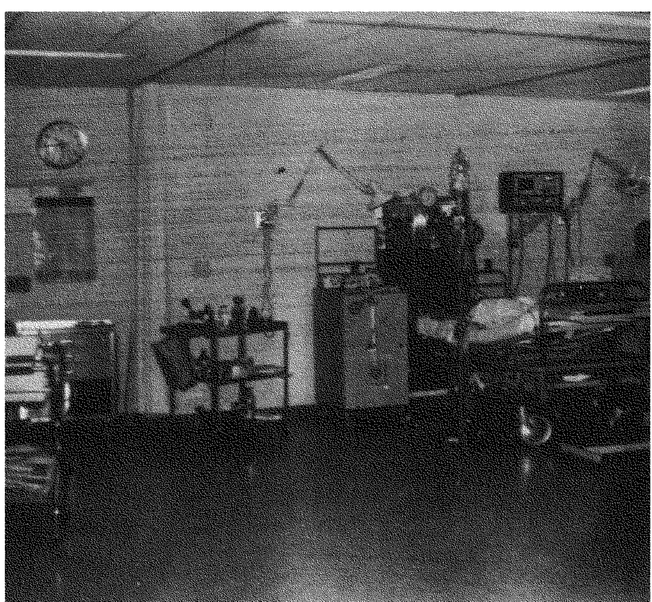
Used by Astronauts on Apollo Moon trips and included as a first priority item on many expeditions on Earth where speed of action is essential.

available in tablet and liquid form.

mind rather than of the other passive body organs. «Being human is more valuable than being alive.» Human life is far more than a metabolizing mass of organic matter rigidly obeying rules of conservation of mass and energy. It is complex interaction among the individual cells and between the totality and environment that gives rise to the concept of human personality.

The same school of thinking equates abortion and birth control to euthanasia: genetics and fetology have developed to a point where we now have effective control over the start of human life. If we are morally obliged to put an end to a pregnancy when an amniocentesis reveals a terribly defective fetus, we are equally obliged to put an end to a patient's hopeless misery when a brain scan reveals advanced cancer metastases.

For a while, the equation might appear easy to accept if we ignore some other very important parameters that enter the picture of a dying person—family pressure, moral issues, legal affairs, financial situation, medical evolution, ... etc. First — a fundamental principle of medical ethics is that patients be treated as whole persons and not as specimens of biologic life. The human person is violated when either the body or the personality is violated. This implies the moral obligation of preserving health and sometimes even prolonging life which in turn poses many difficulties and limitations. But should it not be that the purpose of medicine is health and not simply the unlimited prolongation of life or the conquest of disease and death?



The I.C.U.; Where life stops, machines take over??

— A second important parameter to consider in a decision on euthanasia is the pressure of the patient's family, the love, affection, and respect of those people who once knew the patient as a fully living useful individual and can't conceive of their child or relative otherwise Sometimes, pressure is exerted on physicians by relatives to carry out euthanasia rather than keeping a mute but apparent living corpse for years in close association with them: for instance to wean the patient off the respirator, or to stop his I.Vs, antibiotics... But once this is done, the consequences might become uncontrollable. More commonly however, the family begs the physician to prolong the life of their relative no matter how hopeless his situation is for his pseudo-existence makes their life happier and easier. It is in such conflicting circumstances that a decision on euthanasia becomes extremely difficult. It is a judgement which few can make with certainty. Indeed, the one who is in the best position to make such a judgement is the patient himself especially if he has thought his fate in advance. It is for this reason that the Voluntary Euthanasia Society is encouraging terminal patients to make a declaration of their wishes with respect to practice of euthanasia on them and leave this will of theirs with their doctors. This again is not as simple as it sounds, and is dependent on parameters as:

a) Soundness of the patient's mind.
b) His relation to his physician.
c) Type of personality of physician and his trustworthiness.

— A third parameter would be the financial pressure exerted by the continuous and costly resuscitation—a parameter gaining considerable importance in patients with low economic status. Other perhaps more important costs would be the diversion of scarce medical resources from younger people temporarily threatened by acute but potentially curable illnesses to hopeless terminal cases.

Two other parameters have been added thanks to the vast medical progress. The first is the possibility of the utilization of major body organs of such terminal case and their transplantation in a much younger and potentially more vigorous people. The second parameter is with the rapid advent of therapeutic techniques, some physicians prefer to delay the death of their hopeless cases awaiting for a hopeful oncoming treatment. This would be more significant in the congenital newborn diseases (refer to interview with Dr. Der Kaloustian — Acrodermatitis Enteropathica).

Finally the legal factor comes into play. Till the present time, no law has been enacted and passed down to legalize euthanasia. This is not strange for legalization of euthanasia is like granting a license for the killing of human beings—which is clearly and absolutely unacceptable, both by the medical profession as well as by the social norms and rules of ethics.

Indeed, thinking about euthanasia is a fascinating experience. Acquainting yourself with its multiple diimensions, its ambiguities, and its uncertainties is a long assignment, which makes you rack your brain and will eventually puzzle you. The starting and ending points of this assignment might look the same except that the journey in between offers you a rich and variegated, though questionable understanding of the human mind and its attributes; of life and death; and of social and moral values.

THE END

IMPORTANT INFORMATION

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

Recommendations on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

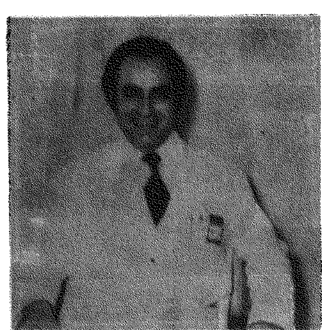
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

*Trademark of Merck & Co., Inc.

LEBANESE ORDER OF PHYSICIANS



The annual elections of the Council Members of the **Lebanese Order of Physicians** (LOP) was held on Sunday, December 15, '74 — for the term of office beginning January 1, '75.

The new year will see the retirement of three of our AUB Alumni Members: **Dr. Amal Kurban, Dr. Jacob Thaddeus,** as well as of **Dr. Joseph Azar** from his hectic term of Presidency.

Dr. Henry Mishalany and **Dr. Riad Khalifeh,** the only two candidates from our AUB Alumni side seeking nomination this time, were unanimously supported by a large AUB turnout at UNESCO and easily carried over into the three-year term of office. Joining them were **Dr. Joseph Ashkar** and **Dr. George Azzi,** both from the Faculté Française de Médecine (FFM).

With the retirement of Dr. Azar, the biannual office of presidency was also being contested. From an arrangement stemming purely from silent consensus between AUB and FFM Alumni, the candidates for this office were all from the FFM this time. As Dr. Robert Karam (brother of Dr. Jamal Karam Harfoush) failed to get elected into the council in the first place, his FFM colleague, **Dr. Fuad Chemali** was elected president unopposed, for the term 1st January '75 — 30 December '76.

The LOP has engaged in bitter controversies lately, a reason why the medical students have probably become more aware of this organization. It has had to take strong stands in order to safeguard and guarantee the organization's stature. It is not difficult to presume that the necessary strength could not have been lacking with the impeccable Dr. Azar as the president. The question of who retains the right to represent the doctors on the National Social Security Fund (NSSF) has thus been kept alive. In addition, the retiring council also succeeded recently in voting to raise the pension of its member-doctors from a variable amount—depending on years of membership—to a fixed 500 L.L. per month, along with securing added benefits to cover sickness and accidents.

MEDICUS learnt that the **program** of president-elect, Dr. Fuad Chemali will essentially entail:

1. — To revive the Disciplinary Committee of LOP.
2. — To settle the issues still surrounding NSSF.
3. — To handle the problem of across-the-counter prescriptions and that of medical reports.
4. — To promote the role of the LOP in medical public education.

The LOP was created in 1946, under a decree by President Bishara El-Khoury. The following year, the first LOP president was elected as well as the first LOP council that consisted of 12 elected members. By a ballot-determined sequence, four members of this first council dropped out each year during the following three years, to be replaced by four new members elected for a three-year term of office. By this initial arrangement, a sense of continuity has been built-in, as four members automatically retire each year, calling for new elections to complete the composition of the 12-member council. The president of the order, elected from amongst the newly composed council, retain office on the other hand, for two years only.

The LOP was designed to be a strong and effective medical body in this country, retaining jurisdiction over all the practising physicians in Lebanon. It is in the LOP that the Lebanese Law invests the final authority to review a physician's right to practice here. Essentially the law invested LOP with the dual functions of:

1. — The Medical Syndicate and
2. — The Medical Order.

The first looks after the material rights and privileges of its members while the second concerns itself with the moral standards of the profession and is entrusted with the role of a judge in this regard.

The Order has come a long way since its early days of 1947, but it is equally certain that its total potential still remains to be fully explored. Greater awareness has to be promoted amongst its present members, as indeed its future members, according to Dr. Mishalany. As the would-be members, the present medical students might well become the likely target of a campaign to promote this greater consciousness.

MEDICUS congratulates Dr. Mishalany and Dr Khalifeh on their election, and in the subsequent issues we hope to explore more fully the recent and the on-going work of the Order.

QUOTABLES

Taking everything with a grain of salt can lead to high blood pressure!

Cosmetic surgery is going from sags to stitches.

Judith West, San Francisco, Calif.

NURSING SECTION

MEDICAL SCIENCES

The hope of bringing together in some way—be it thru the pages of MEDICUS or thru joint participation in its affiliated activities like MEDICUS NIGHTS—a community of Medical Sciences was certainly well received. In this issue therefore, we retain both the **PHARMACY** and **PUBLIC HEALTH** pages, in addition to the traditional and almost imperishable **NURSING SECTION.**

ANNUAL U.S. FOREIGN SERVICE NURSES CONFERENCE

The second Annual U.S. Foreign Service Nurses Conference was held in this medical center for the first time It was extended over the period Nov. 4 to Nov. 9, 1974.

Its participants were U.S. Foreign Service Nurses in Europe, Africa, and Near East Regions. Army Nurses and U.S. Peace Corps Nurses also attended this conference.

The program consisted of lectures of the following topics:

1 — Infectious Diseases.
2 — Radio-Pulmonary topics.
3 — Potpouri.
4 — OB-GYN session.
5 — Surgery session.

The **NSS Educational Committee** presented last month a panel discussion on **«Educational Preparation of Nurses In The Middle East And The Western Countries.»**

The panelists were:

Ms. E.L. Moyer *Director, AUB School of Nursing*

Ms. R. Ambler *Head Nurse, A.U.M.C.*

Ms. B. Illuminati *Assistant Professor, AUB School of Nursing*

Ms. W. Khalaf *Associate Professor, AUB School of Nursing*

The panel was opened by Miss Khalaf (moderator), and the floor was left open to Miss Moyer who spoke about the History of Nursing in the Middle East, in general, and in Lebanon specifically.

Miss Ambler talked next about the Nursing Education in Britain and New Zealand; Miss Illuminati talked about Nursing Education in the States.

At the end, questions were invited from the students; the response was certainly great.

ATHLETIC COMMITTEE

On Nov. 27, the Athletics Committee of NSS invited all the members of its teams to a get-together party in Bldg. 56. Two films on different kinds of athletics were shown. Amongst those present were Dr. Labib Butros, Director of Athletics, as well as Ms. Esther Moyer and Ms. Wadad Shaya, Director and Acting Directors of the School of Nursing, respectively.

Everybody enjoyed the interesting films, which were followed at the end by tea and cookies.

The committee of course intends to give more of these parties in the future.

TRY THIS ON YOUR LARYNX

If you remember how much easier it is to remember what you would rather forget than remember, than to remember what you would rather remember than forget—then you can't forget how much easier it is to forget what you would rather remember than forget, than to forget what you would rather forget than remember.

Source :	*Submitted by:*
«Believe It or Not»	**Houda Hunayni**
William Bolitho	**B.S.N. II**

FROM READER'S DIGEST

1) In explaining a genetics problem, our lecturer wrote «frut fly» on the blackboard as one of the materials that we would be using. Ripples of laughter brought this error to his attention, whereupon he changed the spelling to read «friut fly»—which engendered more laughter. «Oh, bother!» he said, rubbing out once again and writing, with precision: «Drosophila melanogaster».
2) In a science-course discussion on the structure of the atom, our lecturer noticed a student who apparently hadn't read the subject, as she had difficulty in understanding what was said. His suspicions were confirmed when he asked her what a neutrino was. She gave him a guilty look, then suggested hopefully, «An Italian neutron?»
3) A telegram from Ringhardner, a man who could not come to dinner: «Children's night out. I must stay home with the nurse.»
4 Secretary on telephone: «Our automatic answering device is away for repair—this is a person speaking.»
5) As his ball rolled towards the hole the golfing dentist was heard to murmur: «wider, please.»
6) She was posing in her first shift dress for her husband and asked which way he liked it, with a belt or without. «With», he said, «It breaks the monotony.»
7) Psychiatrist to income-tax collector on couch: «Nonsense! the whole world isn't against you. The people of this country perhaps, but not the whole world.»
8) The ideal beauty...
The most beautiful girl in the world constitutes:—
«Gather together the whole bonfire»
«The whole bonfire?»
«The whole bonfire»

Submitted by
Nada Farrukh
B.S.N. II

CONTRADICTING PROVERBS

Great minds run in the same channel;
but also, *Fools think alike.*

One man's meat is another man's poison;
but also, *Sauce for the goose is sauce for the gander.*

A rolling stone gathers no moss;
but also, *A setting hen never lays.*

With age comes wisdom;
but also, *Out of the mouths of babes and sucklings come all wise sayings.*

Too many cooks spoil the broth;
but also, *Many hands make light work.*

God helps him who helps himself;
but also, *Thou shalt not steal.*

Bear ye one another's burden. (Gal 6:2);
but also, *For every man shall bear his own burden.* (Gal 6:5).

Seek, and ye shall find;
but also, *Curiosity kills the cat.*

Nothing venture, nothing gain;
but also, *Fools rush in where angels fear to tread.*

Save for a rainy day;
but also, *Tomorrow will take care of itself.*

Source: **«Believe It or Not» By William Bolith**

Submitted by: **Houda Hunayni BSN II**

Wishes for A Lonely, Depressed Patient

Let me not terrify you with closeness
Nor animate you with barren charms of distance
Let me not gouge out your soul
With too light-hearted a smile or too rapid a tongue
But let me erase the worried rivers of the years
That etch your face with sorrow;
Let me light your silent darkness
With the warmth of my concern.
Will you be with me today?
Will you be — today — with me?

By Mary-Charles Santopietso

The Message

You talk without speaking,
The message is clear,
Trying to use the words
Is really kinder
It gives me the time
To play at Misunderstanding

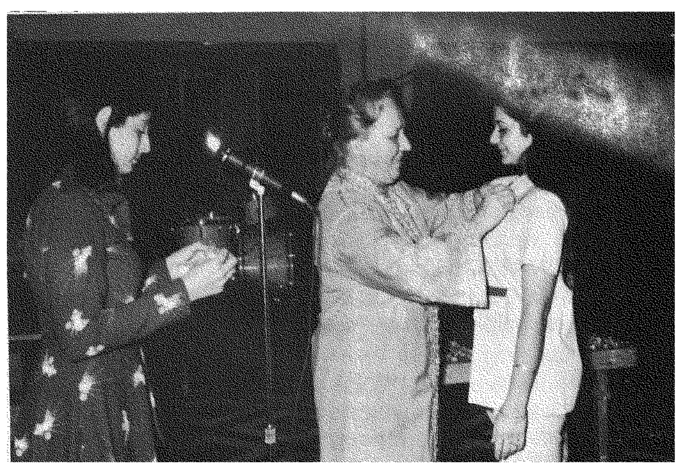
By Judit M. West

Submitted by: **Leda Zanoyan BSN IV**

THE NSS-MSS PIN PARTY: THE NURSES' VERSION

At the beginning of November, the NSS and MSS held their annual Pin Reception in Mary Dodge Hall.

40 Nursing and 46 Medical students came to receive their pins.



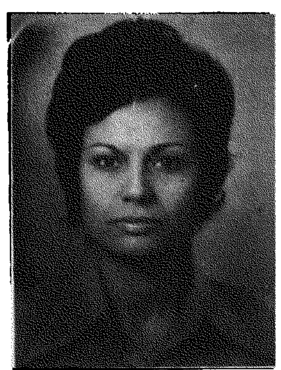
Ms. MOYER pinning the dignity of nursinghood.

The Party: When the stethoscopes and caps are shed off.

Ms. Moyer and Dean Asper gave speeches welcoming the new students in both the schools. NSS President Ms. Leda Zanoyan, and the MSS President, Dr. Zuhayr Hemadeh also spoke, welcoming the new students from both the Societies.

For more than 4 hours, the students as well as some faculty members enjoyed the music (played by the Hot Ice Band), the dancing, and the food. Lotteries were sold also and a good number of people won some exciting prizes.

On the whole the reception was a success!



[MRS. EKBAL KASSEM, a Faculty Member who joined, the AUB Nursing School recently, holds a Master's degree in Medical Surgical Nursing and is working on a doctoral research program in Public Health Administration with special emphasis on medical care of cardiac patients. To introduce her to the Nursing School and the rest of our MEDICUS readers, our Nursing Representative, Ms. HUDA HUNAYNI, along with the NSS President, Ms. LEDA ZENOYAN, met Mrs. Kassem on a Thursday afternoon for an informal interview.]

MEDICUS: Mrs. Kassem, all that the nursing students know about you is that you come from Egypt. Would you like to tell us more about yourself?

MRS. KASSEM: I am a graduate of Alexandria University School of Nursing (BSN program). After graduation I taught there for one year, then left for USA for my graduate studies in nursing. I spent 7 years there during which I received my master's degree from the Catholic University of America in Washington D.C. I tried to continue my Doctoral studies but had to go back home due to family circumstances. I returned to Egypt in 1969 and was appointed a faculty member in Alexandria University School of Nursing, a post which I held till 1973. Then I had to accompany my husband to Beirut since he was appointed a Professor of Business Administration at the Arab University of Beirut. So now I'm on leave of absence from Alexandria University School of Nursing. I spent a year in Beirut during which I missed work, students, and patients and this prompted me to go back to Nursing and join AUB.

Q: Where have you practiced nursing—in which hospitals, and what kind of nursing?

A: As a student, I gained nursing experience at Alexandria University Hospital. In the States, I had my advanced nursing experience at Walter Reed Army Hospital, George Town University Hospital and al-Saint Elizabeth Hospital, which is a psychiatric hospital. Also I had some experiences independent of universities: I worked at the Providence Hospital in Washington D.C. as a staff nurse. Actually when I started working there, I wasn't a registered nurse in USA. So although, I was a graduate student, I started from bedside nursing. And I felt this was very valuable because I learned so much.

During the summers when I didn't have summer school, I worked in hospitals starting from bedside nursing till 1969 when in the same hospital I held the post of an Assistant Director of Nursing Service for the evening Shift.

As far as teaching experiences and masters' program go, I practiced teaching at the Catholic University of Washington D.C., and at George Town University in Washington D.C. After finishing my master's, I did one year teaching as a faculty member in the Catholic University. In Alexandria University I was teaching medical surgical nursing, till I came to Lebanon.

Q: Mrs. Kassem, you have been with us for sometime now. How would you evaluate the AUB nursing students?

A: Although it has been almost 3 months now, it is difficult to evaluate; but I can give you my impression. I was impressed by the enthusiasm and motivation of the students towards learning. And I could honestly say they are intelligent and eager to learn. That's what I can say at this stage.

Q: How can you compare the AUB Nursing students with the students you have had in the States as well as in Egypt?

A: Students are students wherever you go. Students fall in the normal bell-shape curve. We have the very good students, the average students and the poor students. So they are like students elsewhere and I don't think there is much difference. There might be a difference in the cultural and social backgrounds, but here in the Middle East, students are similar.

Q: What do you think of the preparation that the nursing students go thru at AUB?

A: I think the curriculum is very well planned and incorporates all the sciences necessary for B.S. in Nursing in terms of social sciences, natural sciences, and nursing science, and in terms of the needs of this community.

Q: Can you compare our preparation to the preparation the nursing students receive in Egypt?

A As far as the BSN program is concerned, there is not much difference. The curriculum of BSN is almost the same as here. And BSN students should have «Tawjihia» as we call it in Egypt which is equivalent to Bac. II. The diploma program has a different set up in Egypt, for the diploma students do not have to have high school education. In Egypt students go into diploma program with the junior high school certificate which is quite different from what you have here It is essential for the student to go into nursing with Bacc. or complete the secondary school education. Our diploma program is fading out and there is a new set up which has already been put into practice in all the provinces of Egypt and which requires diploma students to have secondary school education. We have another program in nursing which is also coming up. This consists of 2 years after high school; this has already been launched, and plus we have the new diploma program spread over 3 years after high school.

Q: Mrs. Kassem, what do you think of nursing; what is nursing to you?

A: This has been the subject which nursing scientists, pioneers, leaders, etc.—have tried to define. To me, nursing is a way of life. I studied nursing thru my own desire. And thanks to my father who allowed me to travel to USA to continue my education, although the rest of the family were against the idea of sending a girl alone to a foreign country, I was able to pursue my career to the fullest extent.

Nursing to me is empathy, responsibility, eagerness to help others, and also strengthening yourself in your science as well as the other related sciences.

Q: Mrs. Kassem, do you have anything special you would like to tell the nursing students at AUB?

A: I would like you all to be eager, interested, and enthusiastic about nursing, and overcome some of your feelings of dejection when you encounter difficult situations with patients. It might be emotionally upsetting; it distorts your feelings when you come upon a very sick patient for the first time. But one gets used to, thru experience. You mustn't lose interest in the patient, but try to develop instead, a greater sense of understanding.

Houda Hunayni, B.S.N. II
Leda Zanoyan, B.S.N. IV

PHARMACY SECTION

GLIMPSE

What invariably happens is that a number of things choose to go wrong at exactly the same time. It is as if a single important event sets up a chain of reactions. This is exactly what happened three weeks ago when my day, which had started well enough, suddenly got out of control. The events unfolded as such: my elder brother developed some sort of inflammation on his face, probably secondary to some insect bites. However, this progressed at an alarming rate and soon his entire face became edematous. Thus we rushed him to the AUH Emergency Room, where he was adequately taken care of by a physician-Intern on duty.

Being an interested pharmacy student, and seeing all sorts of drugs being used, I asked him what they were. To my disbelief, he was very impolite and told me quite illogically that pharmacy was in no way related to medicine. He even went to the extent of saying that a pharmacist's knowledge of medicine was not only inadequate but, also, unappreciated.

Obviously, the great Hakim was harbouring a delusion and to enlighten him and his kinds, let me assert that pharmacy plays a major role in medicine. In the rapidly progressing world, as a matter of fact, no science alone can claim that **it** is the most important. Pharmacy, Chemistry, Biology, Physics, Medicine all cooperate tremendously to better mankind. In fact without such cooperation, science in the 20th century would become static.

The day ended well, however, with the inflammation of my brother well under control.

HASSAN DAOUK
PHARMACY II

SPORTS IN THE SCHOOL OF PHARMACY

It was thought at one time that sports and the School of Pharmacy stood at different ends of the same rope.

I tried to find a reason why the level of sports in our school was low. Probably, it was due to the small size of the school (around 100 students) or probably because Pharmacy students are usually loaded with studies, quizes and exams. Anyway two years ago we formed our first football team, along with basketball and volleyball teams for both men and women. The teams were quite good, and they started to participate in the different sports' activities of the University.

We entered the intermurals, participated in the Autumn and Spring cup Championship, and also took part in the tournaments sponsored by different societies.

The response to this sudden shift towards sports was surprising on the part of the Pharmacy students. In every game in which one of our team played, you would find a whole lot of Pharmacy students who came specially to cheer their team. In the basketball tournament sponsored by the Mathematics Student's Society the Pharmacy School was awarded a cup for best cheering and sportsmanship. Our girls' basketball team won the University championship for the year 1972-1973.

This year we started off with a very good basketball team; we won our first game vs. Charles E. Frosst Company basketball team by 54-15!

A friendly football game was held earlier this year between the 2nd year students and the 3rd and 4th years' combined team. This game was won by the enthusiastic 2nd year students who received a cup from Professor Amin Haddad, Dean of the School, who was kind enough to come to the field personally to deliver the cup.

Is our school still at the other end of the rope as far as sports are concerned? Obviously not—in fact, we have taken a giant step into the new world of sports.

Raphael Kandalaft
Athletic Committee

Ampiclox

Extra power over infection

The bactericidal power of Ampiclox
destroys a wide range of pathogenic bacteria.
Ampiclox has virtually no toxic side effects.
It can be safely and confidently prescribed
for all ages—even for neonates and
pregnant women. Its safety has been
proved over and over again.
Ampiclox. The safe, sure antibiotic.
Ampiclox is available in capsules, vials,
syrup, neonatal drops and vials.

Among the most common causes of death of pre-adolescents, adolescents and adults are accidents and suicides. Both frequently involve poisons. The increased incidence of both fatal and non-fatal poisonings is related in part to increased availability of potentially toxic materials. At least, accidental poisonings should be preventable in most instances. This is a problem of great public health significance, the solution of which will require efforts of individuals in many disciplines. Among these are pharmacists, who can play a key role in preventing the consequences of accidental poisonings, especially those due to drugs.

I — EPIDEMIOLOGY

Effective preventive measures require a knowledge of predisposing and contributory factors; otherwise little progress can be expected.

Influential factors:

1) **Age:** 70% of poisonings occur in children and are accidental. The critical age period is between one and three years. The remaining 30% cases occuring in adults are mainly suicidal attempts.

2) **Accident-proneness:** There are more accident-prone-situations than accident-prone persons.

3) **Location:** Over 80% of accidental childhood poisonings occur in the home, the highest incidence of which is in the late morning hours, just before lunch; another peak occurs in the early afternoon and another one in the early evening.

4) **Accessibility:** Safe storage of medicines apparently would prevent about less than half the cases of accidental poisonings.

5) **Presentation:** Removing of potentially toxic materials from their original containers is a significant factor in increasing the risk of accidental poisoning, and creates problems of accurate identification if and when poisoning does occur.

6) **Supervision:** adult supervision as it is usually practised is not adequate to prevent poisoning accidents in young children. This is due in part to the fact that parents underestimate the ability of the child to obtain and to ingest a potentially toxic material with lightning rapidity.

II — TREATMENT

Actually, there are very few poisons for which there are effective antidotes; for most cases of poisoning good supportive care is all that can be offered. Even in those instances where antidotes are available, supportive care is at least as important; indeed, the best antidote in the world is of little value without good supportive care.

The cardinal rule for the first-aid treatment of poisoning is to remove the poison from contact with the patient (unless such removal is contraindicated) and to obtain definitive medical care at the earliest possible moment.

Pharmacists are frequently called upon to provide instructions when poisoning occurs, mainly as a prophylactor measure. They also play a key role in the development and the management of many poison control and treatment centers and in establishing the availability of proper treatment materials for use by physicians and in hospitals. In addition, the pharmacist is often the resource person to whom the physician turns for information especially about poisoning due to drugs or about the availability of drugs or about the availability of poisoning.

III — PREVENTION

Total prevention through education is an ideal worth striving for. Instruction is most effective when it includes specific directions that can and should be followed.

IV — ROLE OF THE PHARMACIST

There is much that the pharmacist can do to help prevent poisoning and to improve the treatment thereof. He should not become involved in the therapy of poisoning except for necessary first-aid, but he plays a key role in ensuring that adequate equipment and information are available.

Undoubtedly, the most important role can be played by the pharmacist in the area of prevention. He can and should provide, explain and amplify directions for the proper use of potentially toxic materials.

Pharmacists can also assist greatly in the educational efforts of a community by distributing literature provided by himself or by the local medical or pharmaceutical societies.

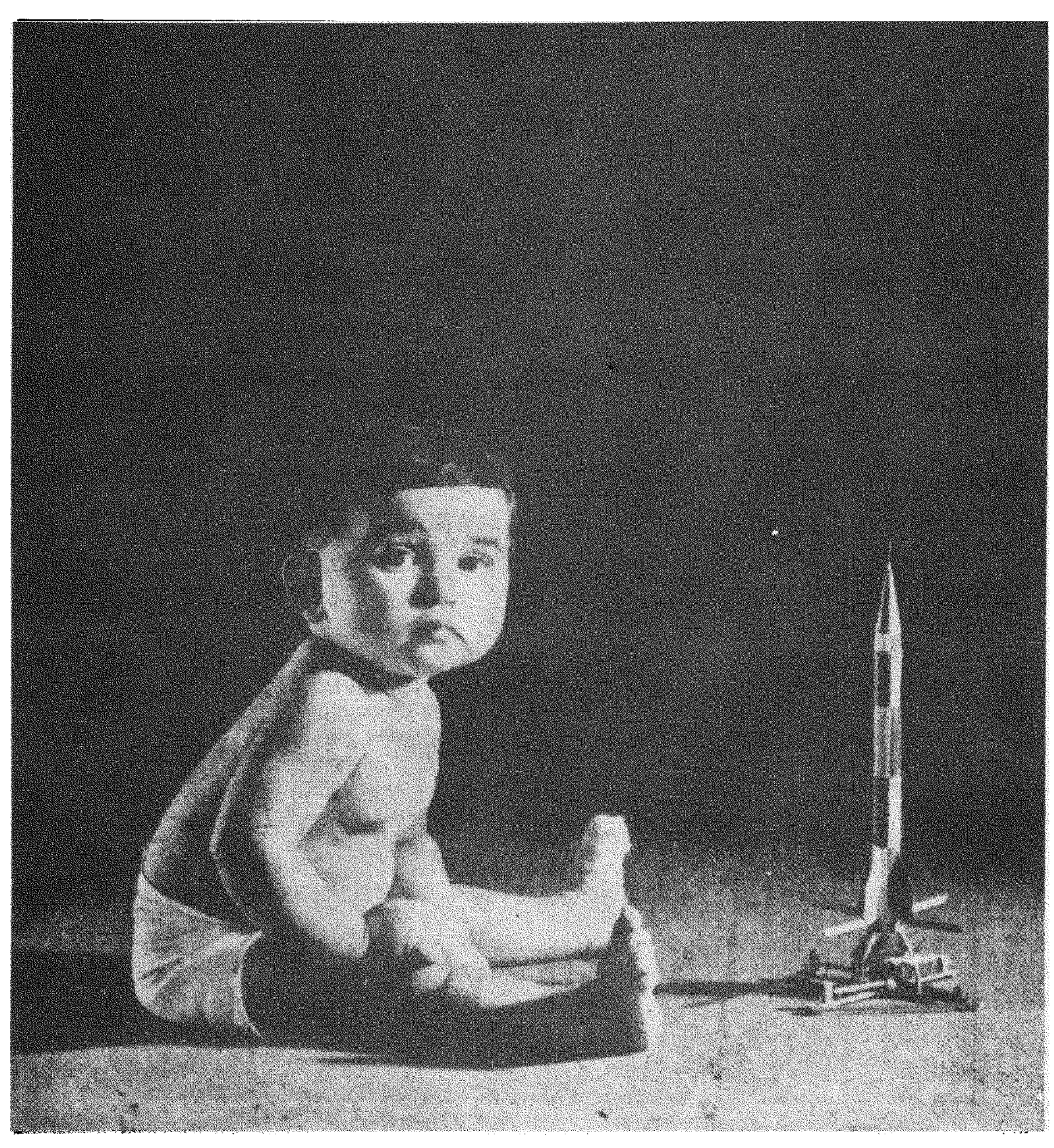
Finally, the pharmacist must do everything possible to eliminate unsafe practices in the dispensing of drugs.

FIRST-AID TREATMENT FOR POISONING

(American Academy of Pediatrics, Subcommittee on Accidental Poisoning.)

1. **Swallowed poisons**
   - A. Call physician, hospital or poison control center promptly.
   - B. Dilute poison by giving water one or two glassfuls.
   - C. Make patient vomit if so directed, **but not if:**
     1. Patient is unconscious or having fits.
     2. Swallowed poison was a strong corrosive (lye, strong acid, drain cleaner, etc...)
     3. Swallowed poison contained kerosene, gasoline, or other petroleum distillates.
2. **Fumes or gases** (fuel gases, dense smoke from fires or poisonous chemicals).
   - A. Get victim into fresh clean air.
   - B. Loosen clothing.
   - C. If victim is not breathing, start artificial respiration promptly.
   - D. **Have someone else** call a physician, hospital, poison control center.
3. **Eye**
   - A. Gently wash eye out immediately, using plenty of water, for 5 minutes with eye-lid held open.
   - B. Remove contact lenses if worn; never permit the eye to be rubbed.
   - C. Call physician, hospital, poison control center.
4. **Skin:** (acids, lye, other caustics, pesticides, etc...)
   - A. Wash off skin immediately with a large amount of water; use soap if available.
   - B. Remove any contaminated clothing.
   - C. Call physician, hospital, poison control center.

George Breedi
Pharmacy IV



Il aura 27 ans en l'an 2000...

Il vivra à la vitesse de la lumière, il pilotera (peut-être) des fusées. Sa résistance et son équilibre de demain, il les bâtit aujourd'hui avec les produits Guigoz.

Guigoz

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Vendu en pharmacie

PUBLIC HEALTH SECTION

By : Rashid Attar
Public Health III

Industrial hygiene is devoted to the recognition, evaluation and control of these environmental factors or stresses arising in, or from, the place or work which may cause sickness, impaired health and well being, or significant discomfort and inefficiency among workers or among the citizens of the community.

Industrial hygienist

An industrial hygienist is a person having a college or university degree or degrees in engineering, chemistry, physics, medicine or related biological sciences who by virtue of special studies and training, has acquired competence in industrial hygiene; such special studies and training must have been sufficient in all of the above cognate sciences to provide the abilities:

1 — To recognize the environmental factors and stresses associated with work and work operations, and to understand their effect on man and his well being.
2 — To evaluate on the basis of experience and with the aid of quantitative measurement techniques, the magnitude of these stresses in terms of ability to impair man's health and well being.
3 — To prescribe methods to eliminate, control or reduce such stresses, and when necessary, to alleviate their effect.

Scope of industrial hygiene

The field of industrial hygiene thus, primarily involves recognition of the stressing environmental factors, evaluating their magnitude, and trying to reduce their impact. Recognition of environmental factors and stresses which influence health requires a familiarity with work operations and processes. The categories of **stresses** that are most frequently of interest are:

1 — Chemical, in the form of liquid, dust, fume, mist, vapor or gas.
2 — Physical energy, such as electromagnetic and ionizing radiations and vibration, extremes of temperature and pressure.
3 — Biological, such as insects and mites; molds, yeasts and fungi; bacteria and viruses.
4 — Ergonomic, such as body position in relation to task, monotony, boredom, repetitive motion, worry, work pressure and fatigue.

The effect of these four areas of stress on man's health and well being must be recognized. It is important to know whether such stresses are immediately dangerous to life and health, whether they produce an acceleration of the aging process or whether they will cause only significant discomfort and inefficiency.

Prescription of corrective procedure, where necessary, to protect health, is based on past experience, knowledge and the quantitative data available. Among the **control measures** that are most frequently used, are:

1 — Isolation of a process or work operation to reduce the number of people exposed.
2 — Substitution of a less harmful material for one which is more dangerous to health.
3 — Alteration of a process to minimize human contact.
4 — Ventilation and air cleaning to provide an atmosphere safe for human occupancy.
5 — Reduction of exposure to radiant energy by shielding, increasing distance and limiting time.
6 — Wet methods to reduce emission of dust to the atmosphere such as mining and quarrying.
7 — Good housekeeping, including cleanliness of the work-place, proper waste disposal, adequate washing, toilet and restroom facilities, healthy drinking water and eating facilities.
8 — Personal protective devices such as special clothing and protective eye and respiratory equipment.

Function of the Industrial Hygienist

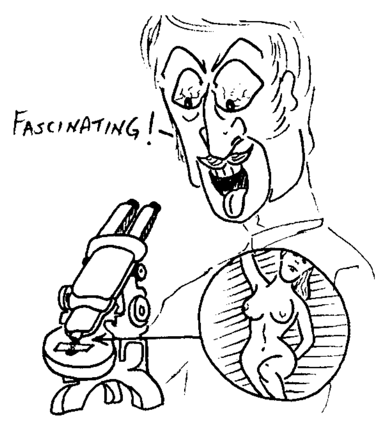
Within his sphere of responsibility the Industrial Hygienist will:

1 — Direct the Industrial hygiene program.
2 — Examine the work environment and environs:
 a) Study work operation and processes and obtain full details of the nature of the work, materials and equipment used, output, number and sex of employees and their hours of work.
 b) Make appropriate measurements to determine the magnitude of exposure or nuisance to workers and the public. In doing so he will:
  i) Select or devise methods and instruments suitable for such measurements.
  ii) Personally or through others under his direct supervision, conduct such measurements.
  iii) Study and test the material associated with the work operation:
 c) Study and test biological materials such as blood and urine by chemical and physical means where such examination will aid in determining the extent of exposure.
3 — Interpret results of the examination of the work environment and environs in terms of ability to impair health, nature of the health impairement, workers' efficiency and community-nuisance and/or damage; and finally, present the specific conclusions to appropriately-interested parties such as management and health officials.

Evaluation of the magnitude of the factors or stresses arising in or from the work place is essential in order to predict the probable effect on health and well being. The Industrial Hygienist by virtue of training and experience and aided by quantitative measurement of the chemical, physical, biological or ergonomic stresses can render an expert opinion as to the healthfulness of the environment, either for short periods or for a life time of exposure.

DEPARTMENTAL NOTES

Illustrations by:
Lawrence Yacoubian
Sophomore Arts



BACTERIOLOGY AND VIROLOGY

A) Teaching

Seminars and Journal clubs were held weekly as in previous years.

Four undergraduate and six graduate courses in microbiology were taught in 1973-74 to a total of 215 students from different schools.

B) Research Activities

— In-vitro activity of Tobramycin.

— Clinical trial with Tobramycin; treatment of patients with infections caused by G(—) bacilli.

(DR. UWAYDAH)

— Bacteriophage typing of pseudomonas aeroginosa strains isolated from clinical sources and hospital environment.

(DR. NABBUT AND Y. FAYDI)

— Transferable drug resistance among clinical isolates of Pseudomonas aeroginosa. *(DR. NABBUT)*

— A potent antimitogenic factor from Group A. streptococci. *(DR. MALAKIAN AND S. KALOUSTIAN)*

— Comparative evaluation of C' fixation, hemagglutination and Indirect Fluorescent Antibody tests in the diagnosis and prognosis of Hydatid disease.

(DR. MATOSSIAN)

— Attempts to convert Vaccinia non-agglutinating erythrocytes into agglutinating erythrocytes by the transfer of RBC receptors.

(DRS. GARABEDIAN AND B. ZEKIAN)

C) Lectures and Symposias

— MEMA, May 2-5, 1974.

— Fifth Science Meeting of the Lebanese Association for the Advancement of Science, December 11-14, 1973.

D) Travel

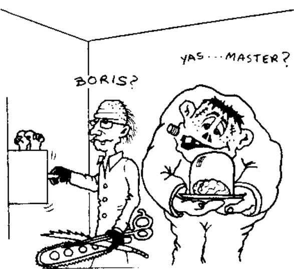
DR. MATOSSIAN was appointed as a representative from Lebanon for a 3-week training course on «Cellular Immunity» organized by WHO at Lausanne, Switzerland, in September, 1973.

E) PUBLICATIONS

A total of 16 original articles were published by different members of the department.

CLINICAL PATHOLOGY

* Following new procedures will be introduced shortly:
  — Determination of Alkaline Phosphatase isozymes.
  — Determination of 5' Nucleotidases.
  — Determination of catecholamines and their metabolites in urine.
* Budget permitting, the department is planning to automatize many routine procedures frequently used.
* The course offered to technicians is in the process of being remodeled with the cooperation of the Public Health Department, and a B.S. program in Medical Technology may instead be offered in the future.
* The Blood Bank, as usual, is perennially short of blood — however, the response of patients and their families has lately been very encouraging. The Department reminds us all that blood can be donated or retributed or put into a donor's account. Kindly contact the Blood Bank for any further information regarding blood donation.

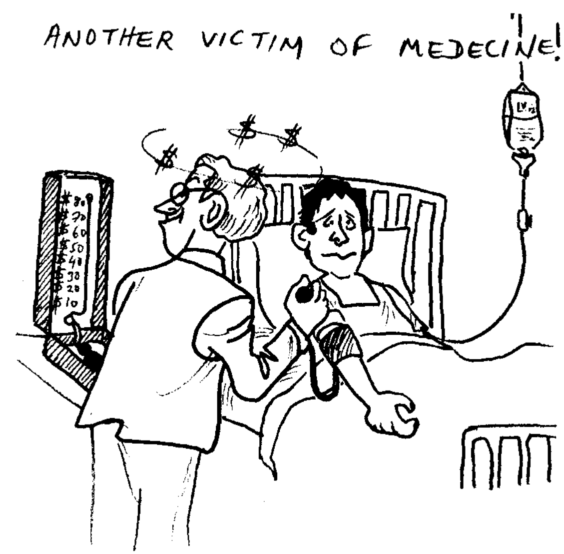


HUMAN MORPHOLOGY

A **workshop,** specially designed for teachers of Human Morphology, is sponsored by the Association of Middle East Medical Colleges, and will take place between February 5-10, 1975 at AUB Medical School. It is expected that all the medical schools in this region will participate in this program where several experts both from the M.E. and the U.S.A. will be present. Topics to be covered are:

* *Undergraduate teaching of Anatomical Sciences:*
  — a half day will be devoted each to gross anatomy neuro-anatomy and micro-anatomy.
* *Integrated teaching.*
* *Audiovisual aids and self-instructional material in teaching of Human Morphology.*
* *Designing learning programs.*
* *Promotion of interaction between various departments of Human Morphology in the Middle East.*

INTERNAL MEDICINE



DERMATOLOGY

A. Services:

— *Daily Clinic:* for only a limited number of patients who come by appointment, the same as in private clinics. We hope this will be an example for other departments to follow to preserve human dignity.

— *Afternoon Treatment Clinic:* which may expand to include specialty clinics e.g. Contact Dermatitis Clinic and Urticaria Clinic.

— *Biopsies:* this serves the AUH and outside services whether in Lebanon or in other countries. Histopathology and interpretation is done by us in the department.

— Total body UV *irradiation.*

— *Consultations* for other services.

— *Mycology:* We have the only mycologists for the entire hospital.

B. Teaching:

— Daily seminars for the 3rd year Medical students.

— Several lectures for 2nd year students integrated in other courses.

— Lectures for Pharmacy students.

— Main teaching however is «*post-graduate courses*» training Residents. We are also active in conducting post-graduate courses abroad i.e. Professors from our department travel abroad to teach.

— Post-graduate courses overlapping MEMA.

— Teaching services are presented by us *in Jordan*, Saudi Arabia, Bahrain and at Aramco and Tapline Hospitals.

C. Conferences:

The following conferences were attended by different members of the department:

— British Association Meeting, July 74 in London.

— Third World Congress of the International Society of Dermatology, September 74.

— WHO meeting on Health Education in Sexually Transmitted Diseases, Geneva, November 74.

— First International Medical Congress of the Association of Lebanese-Armenian physicians, Beirut, Oct. 74.

— Middle East Dermatological Association, February 74, Cairo.

— We hold a monthly meeting of the Lebanese Dermatology Society in the Hospital where patients are presented.

D. Research:

— Clinical Pharmaceutical potency and efficacy of topical corticosteroids in topical anti-candidal agents. *(DR. ZABANEH)*

— Epidemiologic survey of sexually transmitted diseases in AUB community. *(DR. ZABANEH, University Health Service, DR. MATOSSSIAN, Clinical Pathology Lab.)*

— Efficacy of Antibiotics in Gonorrhea and nonspecific urethritis. *(DR. ZABANEH).*

— Efficacy of various agents in Herpes Simplex. *(DR. ZABANEH)*

— Bacteriology of Pytiriasis Alba. *(DR. MATTA)*

— Role of Mycoplasma in various diseases. *(DRS. MATTA AND MATOSSIAN)*

— Methotrexate Myopathy. *(DRS. MATTA AND HARIK).*

— Fibrinolytic Activity in skin diseases. *(DR. A. KURBAN)*

— Histopathology of lesions in Early Syphibis. *(DRS. KURBAN AND ARRAYED)*

— *DR. KAIS KAID BEY* who recently joined the division will be active in a variety of research projects pertaining to photobiology, pigmentation and cellular biology.

— Cytology of Skin Tumors. *(DRS. DAVIS AND TOMB)*

E. Coming:

Our next post-graduate symposium is in May, 75, coinciding with this year's MEMA.

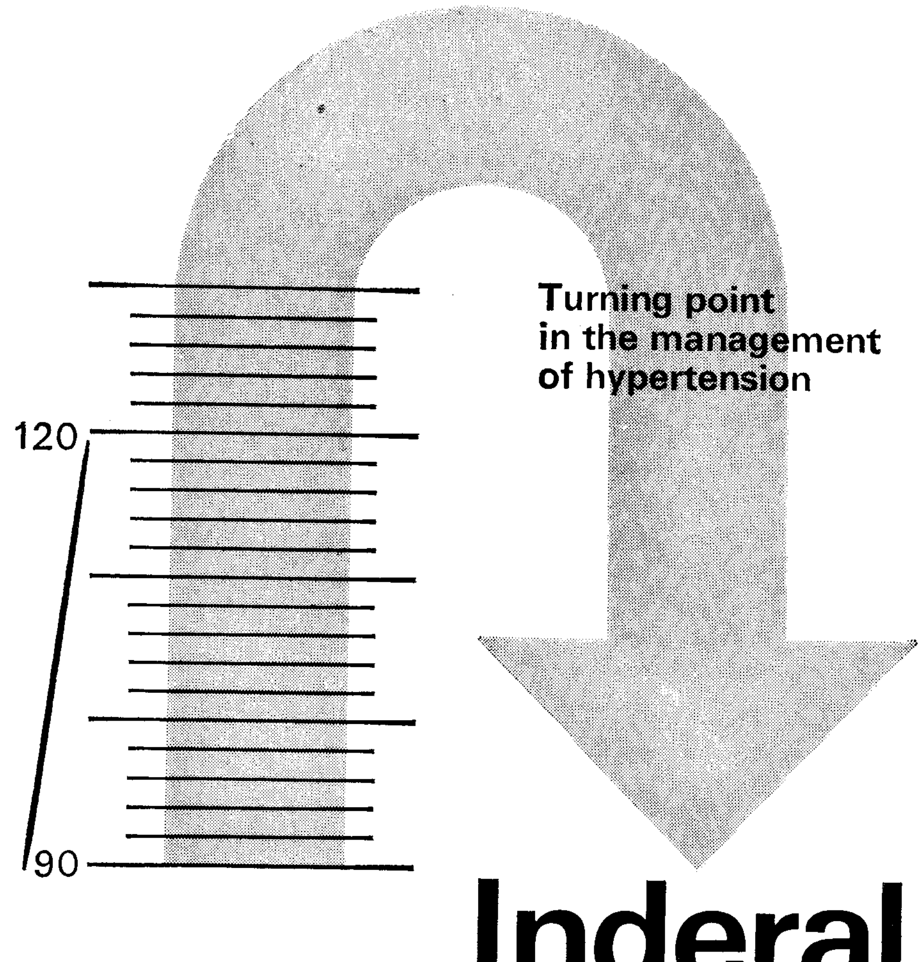
DIVISION OF ENDOCRINOLOGY

* **Dr. Ibrahim Salti** spent 2 weeks as Visiting Professor at the Basrah Medical College (November 15-24, 1974). He also participated in the 14th Annual Arab Science Week held in Damascus between November 5-12, 1974, where he delivered a paper on the role of TSH in Endemic Goitre.
* Plans are being laid for the production of Pan-Arab Journal of Laboratory Medicine. Dr. I. Salti has been invited to serve as a member on the Editorial Board.
* Serum TSH assay are now available on a routine basis at the Endocrine Research Laboratories. Their principal clinical value is in making the distinction between primary and secondary hypothyroidism.

DIVISION OF GASTRO-ENTEROLOGY

The GI-division has rapidly developed over the past few years and currently it can boast of a modestly equipped research laboratory which is geared to the study of Gastric as well as Small-intestine diseases.

* A Liver Registry is going to be started soon. It will compile all cases of liver diseases that are admitted to AUH.



Inderal

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Alderley Park Macclesfield
Cheshire England

The registry will include a detailed clinical protocol, extensive biochemical evaluation including liver function tests, as well as the necessary *immunologic work-up* with the help of Dr. Geha

The GI-division has recently acquired a new pathologist — **Dr. Nabila Nashashibi** — who is going to work, in collaboration with Dr. V. Nassar, on histologic aspects of liver diseases.

Once the above projects get started, a weekly liver biobsy session will be held.

The GI-division is now ready to start its fellowship program; the first Fellow will be **Dr. Imad Idriss.** It also hopes to train fellows and residents in Endoscopy by inauguration of special clinics.

Following are some of the research projects in which our gastro-enterologists are participating:

- *Study of intestinal Lactose deficiency.*
- *Modern treatment of gall-stones with chenodeoxycholic acid.*
- *Hepatic manifestations of shistosomiasis.*

DIVISION OF RESPIRATION

* **Dr. Farid Fuleihan** attended the International Symposium on Beclomethasone for Asthma in London. He also attended the Conference of International Union Against Tuberculosis in Al-Bustan Hotel (Beit Mery) this September.

* **Dr. Khalil Abu Feisal** attended the International Conference on Intensive Care in London a few months ago.

Service Offered: A couple of months ago, the Fiberoptic Bronchoscopy service was established.

Teaching: Grand rounds in ICU every Friday at 8:30 a.m. Chest conference every Thursday at 4:00 p.m. Respiratory Journal Club, Thursdays 12:00 noon-1:00 p.m.

Research: Effects of Noxious agents on Cardio-pulmonary system in dogs.

- Dissociation curves of PO2, PCO2 and pH and 2,3-DPG in banked blood.
- Skin reactivity in typhoid patients to tuberculin and other delayed hypersensitivity antigens.
- Bronchial Reactivity in Bronchial Asthma (completed this month).

DIVISION OF NEUROLOGY

* Head of Division, **Dr. Fuad Sabra** wrote the chapter of spinal cord diseases in Harrison's Principles of Medicine, 7th edition. In January he participated in the **World Committee on Migraine** in London where he discussed his experience with Dexarit as a prophylactic drug in migraine. During the past year, Dr. Sabra was working on «Sinemet» (Levo-& Capri Dopa) in 30 patients suffering from Parkinsonism. It was found that Sinemet was the most rapid, least toxic and most effective treatment of Parkinson's disease.

* **Dr. Adel Afifi** was a Visiting Professor of neural anatomy and neurology at Johns Hopkins Medical School. He, with **Dr. Donald Bergman** published an excellent book **«Atlas of Microscopic Anatomy.»** Dr. Afifi is continuing his research on pain, muscle diseases and basal ganglia

* **Dr. Jean Rebeiz** continued his research in muscle diseases. He also ended up getting married!

* **Dr. Sami Harik** is doing original research on the polyamines of the brain and will soon start determining Dilantin (Epanutin) in the blood of patients being treated for epilepsy.

Dr. Harik and **Dr. Naim Atallah** gave lectures on the CNS drugs and neuroradiology in Teheran in October 1974.

The Division has invited **Dr. Raymond Adams,** Professor of Neuropathology at Harvard Medical School and Chief of Neurology Service of Massachusetts General Hospital, Boston, to be our Visiting Professor of Neurology at AUB during the month of May 1975 (our Division of Neurology is affiliated to the Department of Neurology of Harvard Medical School). Dr. Adams will also give the Penfield Lecture during the Middle East Medical Assembly early in May 1975. (In October, Dr. Adams had flown in as consultant at the request of a patient in AUH. MEDICUS had met him then. See page)

PATHOLOGY

* **Dr. Michael Gravinis,** who had been here as Visiting Professor, left Beirut back for Emory University, USA, where he is the Chairman of Pathology Department.

*** **Dr. Jean Rubeiz,** AUH's handsome neuro-pathologist got entangled into a nuptial knot with Ms. Lina Nahman on November 9, 1974. The Editorial Board of MEDICUS takes great pleasure in wishing them a bright and blissful future.

OBS-GYN

* **Dr. Henry Frick,** sponsored by a grant from the Commonwealth Fund, had joined the department for the last 2 months as Visiting Professor. Dr. Frick returned to the Columbia Presbyterian Hospital around Christmas time.

* The department actively participated in the National Week for Mentally Retarded.

* **Dr. Karam Karam,** attended the International IVD Conference which was held in Cairo this month.

Dr. Bisharra Faris will be participating in the «International congress for the Prevention of Blindness» which is being sponsored by the Egyptian Ophthalmology Society.

Ex-Resident, **Dr. George Asdonian,** who is currently in Chicago, visited AUH for 2 weeks in November. During his stay here, he delivered several lectures.

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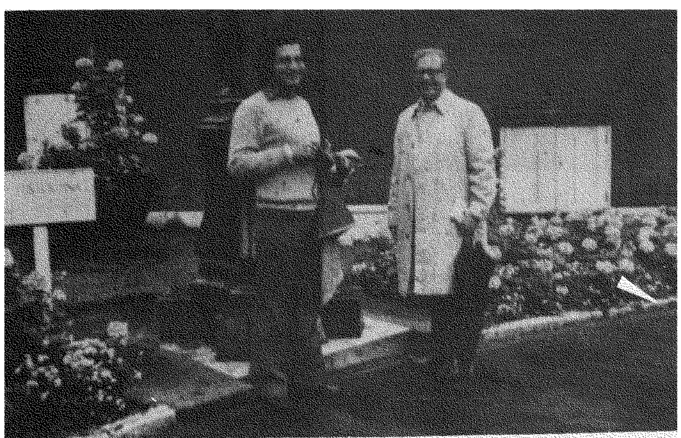


Dr. R. GEHA with Dr. ROSEN at Harvard.

We have a number of research projects that are being conducted in the Immunology Lab. which is a component of a greater unit to which belong **Dr. Fuad Farah, Dr. Artin Malakian, Dr. Zuhayr Awdeh** and **Dr. Raif Geha.**

The **Immunology Pediatric Lab** research program is along two major lines: one is a pure or basic research and the other is clinical or applied research.

As far as the basic research is concerned, we have the following programs:

1. A project which involves the study of the specificity of helper effect on the production of antibodies. The system consists of producing out of sensitized T-Lymphocytes, a factor which induces the formation of antibodies by B-cells, which eventually become plasma cytoid cells. We have been using tetanus toxoid sensitized B-Lymphocytes derived from immunized donors. What we are investigating is the behavior of B-Lymphocytes from non-immune donors amongst which are a number of medical students. These cells are cultured on special Agarous columns. This would permit separation of two sub-populations—one I g G and another I g M bearing cells. We will then study the interaction and possible feedback between these two sub-populations.

2. In summer, research carried out with the cooperation of Drs. Khalidi and Mudauwar enabled the development of a sensitive radio-active method to determine the levels of adenosine deaminase enzyme, associated with severe combined immunodeficiency. This enzyme deficiency was described 2 years ago but up till the present time no precise method existed enabling the determination of serum and tissue levels of the enzyme.

As for the **Clinical Projects,** we have:

1. Study of the 2 patients, already alluded to, who have very high levels of I g M and no I g G. This study is almost complete except for the basic part referred to previously. Here we have demonstrated that the basic defect in this disease which we have called hyper I g M dysgammaglobulinemia is the absence of the maturation of the B-cell chronologically from an I g M bearing to an I g G bearing cell with possible loss of the feedback of circulating I g G on the mechanism of I g M synthesis.

DR. R. GEHA SPEAKS ABOUT IMMUNOLOGY AT AUH

2. In collaboration with **Dr. Philip Salem**, the study of the immunology of Mediterranean Lymphoma with circulating immunoglobulin abnormality consisting of the presence of an α-heavy chain which is a molecule consisting of 2 portions linked together with the heavy chain of the I g A molecule and carrying absolutely no light chains. The study consists of trying to detect the abnormal immunoglobulins in serum, intestinal and the tumour tissue itself since sometimes this abnormal molecule may not be excreted or secreted to the outside. At the same time we will determine the genetic typing of these patients and study their tumour immunobiology in vitro.

— We have done a bone marrow transplant 6 months getting involved in, namely:

— The immunology of malnutrition which is currently hotly debated and where a lot of work has to be done, determining the effect of protein malnutrition on the immune response. This is being done under sponsorship of WHO and with cooperation of **Dr. Z. Awdeh** who studied, long before, the immunology mainly the serum immunoglobulin of children suffering of marasmus.

— The study of the incidence of skin test positivity in the local population both in the children and adult groups. This is done with the help of a medical student, and a Resident.

— Treatment of immune-deficiency diseases. We are following up a number of patients with agammaglobulinemia and carrying an international cooperative study trying to determine the value of transfer factor in some of the immune deficiency diseases using double blind technic.

— We have done a bone narrow transplant 6 months ago on a patient with severe combined immune deficiency. This was done from a father to his son which is in essence an unusual type of procedure because of the inheritance of the histocompatibility determinants. The patient has been doing well.

The courses organized:

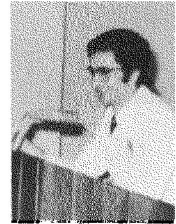
— A yearly course sponsored by WHO and started by **Dr. Fuad Farah** to which the immunology unit participates as a whole. The course is given partly by people here but mainly by people invited from outside. This course was spread over 6 weeks and the participants came from all over the Middle East.

Currently we are trying to have this course every other year, alternating with a symposium. This symposium will feature very restricted topics in immunology and thus will be like a workshop where people will present their research findings which will be compiled into a book at the termination of the symposium.

— Post graduate courses:

In this year's post-graduate course where **Dr. Rosen** was one of the guests, we had exposés on immune deficiency diseases affecting the lymphocyte as well as the complement system in children.

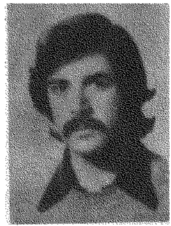
M S S GENERAL ASSEMBLY



The Medical Students Society recently called for a General Assembly to give an opportunity to the different MSS subcommittees to report on their work and at the same time let the medical students get acquainted with these various subcommittees. The MSS President, MR ZUHAYR HEMADEH began by expressing a hope that during this academic year, we might be able to surpass even some of the best records set in the previous years by the different subcommittees. He urged all present to participate and contribute towards the attainment of these ideals.

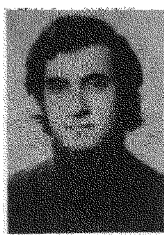
ACADEMIC EXCHANGE COMMITTEE

MR. WAEL MAAKASSAH, Med. IV, and Chairman of the Academic Exchange Committee, introduced this newly-formed Committee, whose purpose is to contact our Medical Alumni in USA and explore the possibility of establishing exchange programs for the students. Ultimately, the Committee hopes that this would lead to greater opportunities for Residency training in USA for our graduates.



ANNIVERSARY COMMITTEE

MR. SAMI KUSTANTIN, Med. V, and Chairman of the MSS Anniversary Committee expressed disappointment at the lack of response from the medical student body to the Committee's call. Pointing out that the Anniversary Show afforded a superb opportunity to express the evaluation of the professors, he requested for a better turn-out at the Committee's subsequent meetings.



ATHLETICS

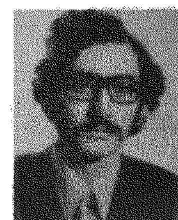
Speaking on behalf of MR. YUSUF HAJJ, Med. V, Sami also gave a résumé of the work of the Athletics Committee, especially of its involvement in the Independence Anniversary Field Day, in which all the different teams in AUB participated.

CURRICULUM COMMITTEE

MR. JOE MALUF, Chairman of the Curriculum Committee outlined the two main projects of the Committee—one in the direction of continued reevaluation of the medical and even pre-medical curriculum, and secondly, about the proposed one-week X-Ray course for Med. IV students.

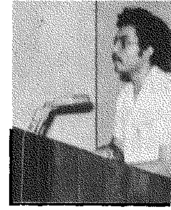
EDUCATION COMMITTEE

MR. GHAZI ZATARI, Med. IV, and Chairman of one of the more active MSS Committees, reported about the very encouraging outcome of the E.K.G. course that the Committee had organized, and that had been offered by Dr. Riad Tabbara, Chairman of the Department of Internal Medicine. In addition to the films it hoped to project, like the one on Chronic Bronchitis, he also indicated the Committee's plan to schedule Panel Discussions, on topics such as Euthanasia.



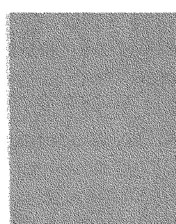
EXCHANGE PROGRAM

MR. WALID BADDURAH, Med. IV, and Chairman of the IFMSA Exchange Committee briefly explained the work of his Committee and promised to try and get better facilities and more opportunities for exchange transfers.



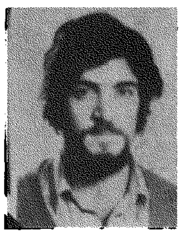
GENERAL KNOWLEDGE COMMITTEE

MR. NICOLA ABU-RIZK, Med. IV and Chairman of the General Knowledge Committee, reported on the success of the Inter-class contest already organized. He also promised, amongst others, of a Students-Residents-Faculty Contest as well as the possibility of holding Panel Discussions in the future.



MEDICUS

A member from the Editorial Board conveyed the appreciation of the entire MEDICUS staff for the overwhelming response it had received following the October issue and the first MEDICUS NIGHT, and hoped that all will share in the joint-task of maintaining it that way.



SCHOLARSHIP COMMITTEE

MR. TARIK FAKHRI, Med. III, and Chairman of the Scholarship Committee underlined the importance the M.S.S. Cabinet as a whole attached to the need ta assist Medical Students in their continued education. Great efforts are being made, he stressed, to tap more sources of income, and help achieve, as a result, a bigger budget for the committee, and the possibility of more scholarships thus.

SOCIAL COMMITTEE

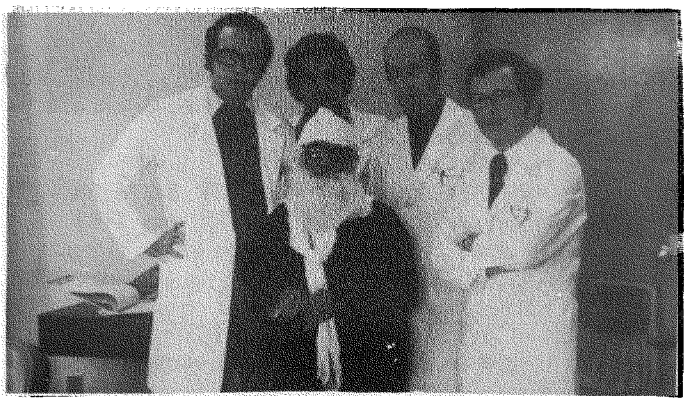
MR. GEORGE ZAYTUN, Med. IV, and Vice-Chairman of the Social Committee, spoke about the success of the traditional MSS-NSS Pin Party held recently then. He also indicated about the forthcoming Grand MSS Ball, and expressed the Committee's determination to improve the social life in the School.

SOCIAL MEDICINE COMMITTEE

MR. NADIM KARAM, Med. III, and Chairman of the Social Medicine Committee, spoke at length about the work of the Social Medicine Committee. Explaining the dire needs of the people whom they intended to serve—mainly in the South—he urged all students to participate in the Committee's program. He also requested more students to join in their regular vaccination campaigns, which he pointed out, needed more volunteers as the Committee's scope kept expanding.

TROPICAL HEALTH COMMITTEE

Recovering from the fits of laughter that his good sense of humor easily predisposes him to, MR. ZIYAD SHIHAB, Med. IV, and Chairman of the Tropical Health Conference Committee, indicated some of the difficulties the Committee was facing in making a start. But he was quite confident, he indicated, that this year's Conference in July will prove very successful.



RECORDS BEATEN!

Recently, Kassem Jaber Nasr, Case Number 353027, visited the OPD Eye Clinic for a visual acuity check-up. With a verified age of 117 years, our investigations rank him as the oldest patient to visit AUH. He surpasses the previous age record of 107 years set by a patient who visited us the last time in 1941! He is pictured here with the Eye Residents who examined him!

X - WORD PUZZLE

This Cross-word Puzzle was prepared by DR. VICTOR NASSAR, Chairman, Department of Pathology, and the first correct entry to reach MEDICUS will be awarded a Transistor Radio, donated by Nassar Radio Company. The Editorial Board's decision is final. No MEDICUS Staff Member is eligible for participation in this contest.

1	2	3	4	5	6	7	8	9	■
10	11	■	12	13	14	15	■	16	17
18	19	20	■	21	22	23	24	25	26
27	28	29	30	31	32	■	33	■	34
35	36	37	■	■	38	39	40	41	42
43	44	45	■	■	46	47	48	49	■
50	51	52	53	■	54	55	56	57	58
59	■	■	60	61	■	62	63	64	65
■	66	67	68	69	■	70	71	72	73
74	75	76	77	78	■	79	80	81	■

ACROSS

1. AUH surgeon with excellent sense of humor
10. Bone
12. Prognostic sign
18. U.S. Electric Company black-listed in Lebanon
21. To render dull
27. Lebanon's Ambassador to U.N.
35. Bad Arabic connotation; yet we all need it
38. Lowest point
43. Intestine
46. Musical Stanza
50. Curse, reversed
54. Occupied Arab territory, reversed
59. Me
60. Similar to
62. Control
66. X-Mas
70. Prefix used for reduced hemoglobin, reversed
74. To attack on all sides
79. A syndrome characterized by fatty liver, and a comatose state

DOWN

1. Italian anatomist and pathologist; founder of morbid anatomy
2. Flat bone
4. St. Claude call
5. Love (Latin)
6. 31-year old, few months ago
7. Insect
9. Japanese currency
17. Ride, reversed
20. Becomes pathologically dilated in syphilis
24. To fluctuate with rhythm
37. Indifference
41. Identical, yet different
53. First supritendent and Nursing supervisor at AUH
58. Rare stone
61. Arrange
66. You
67. We

abdominal

ONE STEP CLOSER
TO TRULY STERILE PROCEDURES ?

BACTERIAL INVASION OF THE SURGICAL SITE NOT ONLY CONTAMINATES THE WOUND BUT CAN CAUSE POSTOPERATIVE INFECTION. BECAUSE STERI-DRAPE SURGICAL DRAPES ARE PLASTIC AND ADHERENT, SKIN BACTERIA ARE IMMOBILIZED BENEATH THE DRAPE, THUS REDUCING BACTERIAL TRANSFER AND AUTOCONTAMINATION FROM AREAS SURROUNDING THE SURGICAL SITE. STERI-DRAPE SURGICAL DRAPES IMPROVE ASEPTIC TECHNIQUE, BRING YOU ONE STEP CLOSER TO TRULY STERILE PROCEDURES.

Medical Products Division

JOURNAL REVIEW

SIGNIFICANCE OF COMPLEMENT POSITIVE COOMBS TEST IN PATIENTS WITH GLOMERULAR DISEASE

A Coombs-test positive for complement, without detectable immunoglobulins was observed in 24 of 164 patients with various types of glomerular disease. 20 of these 24 patients had evidence of intravascular complement activation. 16 had a significant anemia and in 12 the anemia was either present with normal renal function or greater than expected from the degree of renal impairement.

A complement positive Coomb's test could be produced **in-Vitro** after incubation of normal red blood cells with the autologous serum in the presence of inulin. It is suggested that in some cases a complement positive Coomb's test may result from intravascular complement activation and fixation of C3 on erythrocytes by this mechanism and may play a role in the anemia which is a striking feature in some hypocomplementemic patients.

«The Lancet»
Sept. 74, Vol. II, No. 7882

MEMORY IMPAIREMENT AFTER COMMISSUROTOMY IN MAN

This article presents data on 10 commissurotomy patients. (8 with partial section of the forebrain commissures.) The ten obtained subnormal scores on a battery of 6 standardized tests for assessment of memory, including Benton's revised Retention test. Knox tube test, visual sequential memory test.

Although the observed memory impairement is presumed to have been amplified by extracommissural brain damage in most of the cases; it is concluded that the loss of the cerebral commissures is mainly responsible and that these commissures serve selective amnestic functions. In particular the data suggest that the processes mediating the initial encoding of engrams and the retrieval and read out of contralateral engram elements involve hemispheric cooperation and depend upon the function of the interhemispheric commissures.

«Brain»
A Journal of Neurology
Voi. 97, Part II, June 74

RELATIVE VENTILLATION AND PERFUSION OF LEFT v/s RIGHT LUNG IN MITRAL STENOSIS

In this study relative ventillation, perfusion, and ventillation/perfusion ratio of the left v/s the right lung using radioactive Xenon method in 15 seated patients with mitral stenosis were measured. The relative V/Q of the left lung was significantly less in these patients than in 11 normal subjects and there was a significant negative correlation between the V/Q of the left lung and pulmonary intravascular pressure.

There was little difference between relative perfusion of the 2 lungs and the reduced ventillation/perfusion ratio of the left lung seems to be mainly due to relative hypoventillation, perhaps as a result of compression or distortion of the left main stem bronchus.

There was no significant correlation found between the relative V/Q ratio of the left lung and pulmonary intravascular pressure in 10 patients with mitral stenosis studied in the supine position.

«The American Journal of Cardiology»
Sept 74. Vol. 34 **No. 3**

PERIPHERAL NERVE CHANGES IN AMYLOID NEUROPATHY

This article presents observations made on nerve biopsies from 4 cases of amyloid neuropathy. Three of them were sporadic and in one the disorder was dominantly inherited.

All 4 cases showed a severe loss of unmyelinated axons. In 3 there was also severe depletion of myelinated fibers, but in one the loss affected predominantly the small fibers. This pattern of fibre loss could be correlated with the impairement of **pain** and **temperature** appreciation which was the salient sensory change, and with prominent autonomic symptoms. Spontaneous pain was a feature in 3 of the cases.

The amyloid deposits were mainly intrafasicular and were present around endoneurial capillaries and within the endoneurium where they were observed to distort nerve fibres. There was a tendency for these to be related to Schwann cells associated with unmyelinated axons. Deposits also occured in the perineurium and epineurium.

«Brain»
A Journal of Neurology
Vol. 97, Part II, June 74

GREATER FREQUENCY OF VIRAL RESPIRATORY INFECTIONS IN ASTHMATIC CHILDREN AS COMPARED WITH THEIR NON-ASTHMATIC SIBLINGS

This article presents results obtained from a longitudinal, clinical, and microbiologic surveillance conducted from May 1971-1972 on 16 children with infectious asthma and 15 of their non-asthmatic siblings.

The data presented in the paper indicate that:

1) Asthmatic children experienced a significantly greater incidence of viral respiratory infections than did their non-asthmatic siblings of similar age (5.1 v/s 3.8).

2) Although both asthmatics and their siblings usually were infected by the same groups or even serologic type of respiratory pathogen, the former had a significantly greater rate of infection by rhinoviruses.

3) While respiratory infections of identical etiology occuring concurrently in as asthmatic and his siblings were equivalent in severity, illnesses were longer (but not significantly so) in the asthmatic children.

The authors give only a speculation to explain this fact, namely that the innate susceptibility to the virus is the same for both asthmatics and non-asthmatics, so that the reason why the former have a higher rate of infection is related to their necessarily increased indoor life especially in cold climates thus facilitating contact and transmission from other siblings. A direct relationship was proven.

It was also found that the rhinoviruses were the most likely agents to precipitate asthma in this group.

«The Journal of Pediatrics»
Vol. 85, Oct. 74, Number 4

[Submitted By : GEORGE ZAYTUN, MED. IV]

With the Compliments

of

SALON GEORGE

Tel. 344112 GEFINOR CENTER BLOCK C

Dr. RAYMOND ADAMS

Dr. Raymond Adams recently visited A.U.H. as a Consultant-Neurologist for one of our private patients at the request of none other than the patient's uncle: King Feisal of Saudi Arabia. Besides being the Bullard Professor of Neuropathology at the Massachussetts General Hospital in Boston, he's also registered on the Faculty List of our own Department of Internal Medicine. Surprising as it may sound to many thus, Ray is one of us too! Dr. Adams was here only for a week-end but he still showed up for a lecture in the Saturday Neurology Conference, during which he essentially talked of some of the proceedings of the Symposium he had just then been attending in Newcastle, England—where some 750 Scientists had gathered to discuss Neuromuscular Dystrophies.

By the time Dr. Adams had finished his lecture, MEDICUS staff had enthusiastically convened to meet him. Dr. Adams appeared a little taken aback by the idea of being interviewed by student journalists; and indeed the packed time schedule gave him ample excuse to slip away. However, while Dr. Jean Rubeiz — one of his ex-students — provided a reconciliative umbrella for us all, Dr. Adams quickly realized that our purpose was only to try and get better acquainted with one of our least seen and probably most-missed faculty members. «We remain medical students», we assured him!

MEDICUS discussed wide-ranging topics! We recalled how Dr. Adams had described Neurology in his chapter in Harrison: «One of the most difficult and exacting specialties of medicine.» It was also the most confusing we added! He agreed! Was anything being done to change this image? «Obviously yes—hopefully!» Thru good teachers, he instantly explained!

We turned to his association with Harvard. What made it so distinct? «The people», he replied. Funny, we hadn't thought of it! He reckoned our blank looks, so elaborated: «good students and good faculty members!» All right then, what did he think constituted good medical students, we asked? «Well, strong and bright students; then impressive personalities; and, lastly,» he added, «the performance as evaluated by aptitude tests and grades. Often we have taken students from lower grade-sectors though», he emphasized, «because of their personalities.»

How did he look at the idea of so many students yearning to enter the Harvard Medical School? «Place is certainly a problem», he pointed out, «and we easily have ten times the number of applicants than places. After closing the Space Project for instance, 150 Ph.DS applied, and only 20 were accepted. But then, not everybody should wish to come to high-powered schools to learn their alphabet.» Fine, what about the ones intending to go to Harvard for their post-graduate training, we wondered? Dr. Adams offered them his blessings more spontaneously!

We asked Dr. Adams what reputation had A.U.B. graduates established back in States? «Very good!» Was he trying to be simply nice now? No, he insisted! «Many of A.U.B. graduates are even professors, spread throughout many universities and many States, and doing very well indeed!»

Suddenly then, Dr. Adams' legs shuffled a little; and equally suddenly, the Neurology jargon flashed on our minds. Yes, yes, Dr. Adams: «How much do you rely in your clinical work on the knee jerk, the Babinsky or the deep tendon reflexes?» His reply came as a consolation to those who find Neurology somewhat exasperating. «To be frank, very little.» He quickly followed it up with a defensive explanation—but fortunately we missed it. And as MEDICUS was going to press, somebody recalled from his retrospective memories of that Saturday morning encounter how Dr. Rubeiz had blushed a little at Dr. Adams' answer. But then, which Neurologist wouldn't blush at the idea of giving up the Babinsky and the other reflexes!

Before Dr. Adams was airborne again, we conveyed our wishes to one of our other AUB alumni back in States: Mrs. Adams. We also reminded him of his next appointment with us: May 1975, when he will be visiting A.U.H. for a month.

Dr. Adams' literary achievements are certainly impressive. Since he wrote the first scientific book on skeletal muscle diseases, he has become the author of many books and thousands of original articles engulfing a wide range of disciplines in Neurology—with special interest in Cerebral Circulation, Brain and Liver diseases, and his initial Skeletal Muscle Diseases. But to students of medicine, he's probably more familiar as the co-author of Harrison's Principles of Medicine.

Dr. Fuad Sabra who had introduced Dr. Adams as the expert professor of the nervous system—from the cortex to the contraction of the muscle—maintains that despite the accumulating fame in the medical world, Dr. Adams has essentially retained a low profile and his characteristic humility. Quite possible! But somehow, this philosophy sounds more like A.U.B.'s rather than Harvard's !!

MEDICUS NIGHT

LAST TIME

In the continued spirit of innovation to mark the 13th year of publication, the Editorial Board of MEDICUS '74-'75 sought to inject some new elements of life and spirit into the medical and paramedical community.

Within the context of relevance, and yet seeking diversity adequately enough to break the rythym of academic routine, we elected to launch our October issue with the simultaneous start of a new experimental event that will mark the publication of every issue of MEDICUS.

MEDICUS NIGHTS, as the event would be called, will hopefully be held in a different setting each time. But be it organized with the collaboration of the Social or the Education Committee, and be it featuring a Fashion Show, a Variety Program or a Panel Discussion incorporating distinguished participants, the purpose of MEDICUS NIGHTS will remain essentially the same: to bring together a Community of Medical Sciences—in the relaxed and entertaining mood of a Friday evening.

THE IMPRESSED AUDIENCE.

The Fascinating Nurse.

The Medics cheered up by the change..

Beginning the MEDICUS NIGHTS.

Medical Faculty advisor, Dr. Freiha presenting the first issue to Mrs. Kirkwood.

AREN'T YOU IMPRESSED?

Patty's show was preceeded by a display of some Original Nursing Uniforms, designed by Ms. Suad Salloum, from the White Angels. Here, a nursing student, Sana Saba, is seen modelling for one of these designs.

HOW WAS IT?

We began our First MEDICUS NIGHT with a Fashion Show organized by Patty Chamoun and featuring dresses from Grand Stores for Men (G.S.) and Ledra Boutique for the ladies' wear. Typically, the deadlines we had faced in bringing our first issue had required the goodwill of people at many levels—and the first MEDICUS NIGHT was made possible only because our Printers accepted to work overtime in a desperate attempt to beat the nerve-racking countdown and run off the first issue only fifteen minutes before the program started; because Patty accepted to undertake the Show at an extremely short notice and work late hours into the night, against a running fever; because the proprietors of G.S. and Ledra generously accepted to cover the costs of the Show; and because Mrs. Samuel Kirkwood kindly accepted to be our Guest of Honor, while President Kirkwood on his part delayed his flight to New York to be present at the launching ceremony of the 13th volume of a magazine that was started by the medical students while he was still the Dean of the Medical Sciences. Below we capture some of the highlights of this breakthrough MEDICUS NIGHT, made so memorable by a packed and appreciative audience.

SINCE THEN...

Since then, we have had an unprecedented response and outflow of generous appreciation for our work, from all quarters — Students, Faculty and Administration, both local and overseas! Invariably, such an obvious vote of confidence in the Editorial Committee is not only flattering, but more important, provides the only consolation to keep moving ahead, watching for still newer horizons....

AND TONIGHT

As this second issue begins to run off the Press tonight, we will be celebrating our Second MEDICUS NIGHT, this time a New Year Bonanza featuring a Variety Program pieced together by students and a few professionals.

As medical students, we clearly take the pride of taking a lead over the rest of the Student body in bringing together an entire Community to launch a New Year with a collective spirit of such obvious goodwill and optimism.

West Hall during our first MEDICUS NIGHT was easily packed to its capacity of 360 seats; but tonight we move now to a more ambitious and a much more spacious Assembly Hall. On the nature and magnitude of the crowd today will rest our decision of whether to turn what was begun as an experiment into a permanent feature marking the publication of every issue of MEDICUS.

The future of MEDICUS NIGHTS then, will be decided tonight.... on the backstage of the Assembly Hall!

PROSPECTS FOR 1975

During our October issue, we had joined academicians everywhere in taking stock of what a new academic year as well as the immediate future held for us. The result was our Cover Story: The New Horizons. Now, at the threshold of a new year and the last quarter of a century, we join individuals and communities everywhere to predict what a new calender year might mean for us. To sample these prospects, the MEDICUS team spread across the Medical Sciences, and reported what stand as our highlights for 1975 - !

CRAIG S. LICHTENWALNER, M.D.
Dean, Faculties of Medical Sciences

Nineteen seventy-five will be a crucial year in the history of AUB and the Faculties of Medical Sciences (FMS). The University Planning Committee, chaired by Provost Thabet, will complete its deliberations and prepare a preliminary report for the March meeting of the Board of Trustees and a final report for the July meeting of the Board. Implementation of the Committee's recommendations (which I have not seen) may well change the form and structure of AUB and the FMS as we now know them. It is fervently hoped that the recommendations will point the way to a solution of AUB's acute financial problems. On the brighter side, 1975 will see the completion of three major new structures in the FMS building program. The new Basic Medical Sciences Building, the new Medical Library, and the new Postgraduate Medical Education Building will provide superb and much-needed facilities for carrying out our academic programs.
In the world outside AUB, there will continue to be inflation, industrial unemployment, political instability, and efforts at peacemaking. All of these will have their reverberations which will have some effect, direct or indirect, on AUB and all of us. Therefore, we can only hope that 1975 will usher in a new era of peace and prosperity.

SAMUEL P. ASPER, M.D.
Dean, School of Medicine
Past President, American College of Physicians

The year 1975 will be historic in our Medical School and Hospital, for long awaited and much needed additional facilities will be placed in service. We shall see the opening of the Basic Medical Service Building, the Medical Library and the Postgraduate Auditorium. Thus, our educational and research opportunities will be greatly enhanced. The final quarter of this century should be the finest and most productive in our long history.

ADEL K. AFIFI, M.D.
Assistant Director, and in charge of Student Affairs, School of Medicine

Until you asked, I had not stopped to think what my wishes for the new year were; but since then I have come to realize that they are many! Some, obviously, are not material for publication in MEDICUS! But most are. Of the latter, two stand out most prominently: the first is a recurrent annual hope for justice and peace in our part of the world and the world at large; the second is a wish that 1975 will bring an easing of the crisis of our University, not only in the monetary sphere but also, and perhaps more importantly, in the crisis of confidence, sense of sharing and sense of belonging.

FUAD S. FREIHA, M.D.
Department of Surgery
Faculty Advisor, MEDICUS

One cannot but be optimistic at the beginning of each new year and hope for the best: Optimistic towards peace in our part of the world and the solution to many of our internal problems, be it at the national or at the institutional level.
But I have a hunch that 1975 will be a good year. New horizons will open up with the opening of more facilities in our institution.
As for MEDICUS, 1975 will be a very good year. With the enthusiasm and hard work of the Editorial Board and the quality of its production, one cannot hope otherwise.

MR. ZUHAYR HEMADEH
President,
Medical Students Society

For M.S.S., the New Year opens new horizons, and holds evergrowing challenges; challenges we are de-

termined to face with dynamic optimism strengthened by an unshakable faith in the ideals for which our society stands.

Looking back at the past few months, we are encouraged by the enthusiastic spirit that has led to the revival of time-honored activities and even the institution of promising innovations. Suffice it to mention, by way of example, the diligent efforts of the MEDICUS team, an achievement in which M.S.S. takes considerable pride.

However a lot remains to be done if the aspirations of the enlightened are to be fulfilled. There has to be the development of a sense of responsibility towards community health needs, that can be best acquired through active participation in the Social Medicine program, to which the majority are still indifferent. Meanwhile, we continue to work towards the reinstitution of M.S.S. leadership-role on Campus and towards the steps that need to be taken in order to ensure the return of democratic and intelligent student participation in University affairs.

Ultimately to achieve these and other valuable goals, we will all have to pledge ourselves to go by the dictum: «Ask not what M.S.S. owes you; ask what you owe M.S.S.». And thereby we hope that in 1975, M.S.S. will no longer remain merely the prerogative of a chosen few.

DAVID EGEE
Director,
American University Hospital

Being the most resourceful unit of the entire university complex, the Medical Center takes the greatest brunt in supporting an ever faltering budget. Not only must it support itself independently but it has to continue to finance many of the projected plans within the Medical School, in addition to its own expansion. In this latter respect, attempts at increasing the number of beds as well as extending facilities in certain programs—like creating a new Oncology Ward—are likely to become some of the highlights of 1975.

IBRAHIM K. DAGHER, M.D.
Chairman,
Department of Surgery

Advices are cheap, so are messages. Giving a message to the medical student on the occasion of the New Year is just being repetitious: «all has been said». Posterity is not impressively different from ancestry. If, in spite of this preamble, you still insist on a message on the occasion of the New Year, I give in:

— *Technologic informations are doubling about every ten years. You have to double your efforts to cope up: this needs time, but time is limited and hence, you have to sharpen up your classification of values and their order of importance and make time.*

— *Inventions and discoveries in industry, chemistry, physics, etc. affecting Biology are increasing daily and new creations are in process: you have to put up with more new time: eliminate the unimportant time consumer.*
things than your predecessors did; again find

— *Increasing sound and sight «pollution» in a sense lower the threshold of nervous tension: keep your heads on your shoulders and exercise self-discipline; it takes more energy to keep self-discipline.*

— *Morality in the world and the norms of previous societies are being challenged; one is here to stay: the respect to human integrity; every human has his or her own integrity. Keep theirs or else yours will disintegrate: reciprocity is a well established phenomenon which has stood the test of time.*

— *The age of maturity and full responsibility has been brought down to the earlier and more tender years: just assume responsibility and become Men.*

To sum it all up for you: classify values and happily travel on the long way of education, evolution, self-discipline, responsibility, manhood, and respect to human integrity; lead the caravan to where it should go, not necessarily to where it wants to go and remember, you are merely another one on the long way of progress in the service of mankind.

RIAD TABBARA, M.D.
Chairman,
Department of Medicine

The challenge for the year 1975 is to try to keep and improve the standard of teaching and research in the Department of Internal Medicine taking into consideration the financial restraints imposed on all the University by the acute and serious financial crisis. Adding new and well qualified members and finding new resources for research will continue. Unless we do so we will start declining academically.

SAMIR NAJJAR, M.D.
Chairman, Clinical Committee
Chairman, Department of
Pediatrics

Outstanding amongst my many hopes for this new year are essentially three wishes:

— the establishment of specialty certification for post-graduate training programs, which will upgrade

our residency training and give it better recognition by official and private agencies of the area;
— the initiation of a postgraduate (residency) training program in primary care in the belief that this way we will turn out more family physicians—the most needed of the specialties in this country;
— and finally, the acquisition by each medical student of a full set of instruments for physical diagnosis in the hope that it will serve to bring back this rapidly disappearing art to our medical armamentarium. On this particular issue, I have great hopes that the M.S.S. will be instrumental in its implementation.

MS. LEDA ZENOYAN
President,
Nursing Students Society

In this New Year I wish my fellow nursing students would try to leave behind the routine of academic work and aim now towards the rhythm and standards of professional Nursing Service; start visualizing patients as persons not as numbers, and to hold their work as a pleasure rather than a duty that's monitored and ultimately graded.

JOSEPH E. AZAR, M.D.
Retiring President,
Lebanese Order of Physicians

One wish that I would like to make for our medical students at the start of this new year, and for the years ahead, is to become aware and acquainted with the factors and forces that are currently operating and will continue to influence in the future the pattern and level of medical practice in the countries they come from. As important future citizens, our students cannot invest all their talents and efforts in assigned and pre-determined course and curricular work, but should rather participate and become more involved in outside activities that are necessary to complete their medical education. This true and complete education is an active process that requires a will and self-discipline which no one except the individual himself can prescribe. The countries most of us come from need, among other things, people who are medically educated in the true sense of the word, and no such education can be fully obtained during a five-year period at a critical and dynamic stage of one's life from only within the boundaries of any one single institution.

MS. SHEILA HAMMOND,
Director
Nursing Service

For the Nursing Service the coming year should herald renewed and newer initiatives towards establishing better rapport between the patients, nurses and the rest of the medical staff at large. Success of this program will entail a closer and more personal insight into each other's problems and seeing to it that pertinent medical information ultimately gets to the treating physicians. This will upgrade the standards of management and in turn will bring the nursing and medical staff closer together in constituting a coordinated unit in the treatment of patients. We thus begin 1975 on a note of unprecedented optimism.

Ms. LEDIA MANOUGHIAN
Head Nurse, EENT Floor

With continued advances in Medicine, I believe there's a much more acute demand on the part of the Nursing Staff to understand and gain a better insight into the medical problems that we are supposed to be taking care of. Nursin care is increasingly becoming more and more technical. On the local level also, as this hospital keeps expanding, and as a greater sector of the public seek medical attention at this institution, our services will also continue to be in greater demand. As we all stand back to resolve at a moment like this, I hope we, the nurses at AUH, will decide to become even more determined to rise up to the technical and professional standards of scientific nursing and yet at the same time continue to give our work the individual touch that lets Nursing care still remain an art. We look forward to 1975 with so many more hopes thus.

MS. SILVA GUETSOYAN
(Nursing Diploma '74)
Pediatric Ward

The recently graduated Nurses of August 1974 will certainly face the New Year with new confidence. A little experienced now, we shall gladly leave behind the memories of our early, hectic days on the floors. But we will continue to feel new enough still to retain the bubbling enthusiasm and the Nightingation commitment characteristic of the youngest generation of Nurses. We counted on our older colleagues to make 1974 a pleasant year for us all. We will wholeheartedly join them now to make the A.U.H. of 1975 even better !!

JOHN EDESON,
M.B., Ch.B: M.D.; D.Ph.
Acting Director,
School of Public Health

Let us hope that during the peace of 1975 there will be an increased awareness of preventive medicine so that we think more of how we can prevent many people from suffering or dying rather than treating a favoured few. This may not be so rewarding financially but will result in a greater sense of achievement.

MS. ESTHER L. MOYER
Director,
School of Nursing

The School of Nursing looks forward to 1975 with optimism and hope, a state attributable more to our belongingness with the optimistic and hopeful people of the earth than unawareness of socio-economic and political factors operant in our world. A new year presents 365 new dawns as challenges for implementing dreams and plans. Anticipated occupancy of the new Basic Sciences building, a move from the cramped, inadequate library facilities of Van Dyck into the spaciousness of a new Medical Library and eventually availability of the Continuing Education building for use by the School of Nursing and its colleagues in the Faculties of Medical Sciences will, in 1975, constitute dreams made visible.
This New Year will mark an extension of our usefulness to the region as Continued Education Programs for graduate nurses are extended in number and diversity and a discernible trend to great utilization by regional health agencies continues. Arrival by April 1st of all equipment due under the second grant from the Helene Fuld Health Trust will facilitate greater learning effectiveness for students in our School and the practical nursing program of AUB Hospital as new teaching-learning methodologies are developed and utilized through our Helene Fuld Audio-Visual Center. We seek in this year increased enrollment in the Bachelor of Science in Nursing and Administration and Teaching of Nursing Programs and look forward, hopefully, to achievement of this goal through the intensified recruitment efforts of students, faculty and alumni together with physicians, nurses and other members of our University family. The return of Misses Juliette Sayegh and Salwa Makarem with doctoral preparation in nursing and Misses Leila Farhoud and Huda Abu-Saad after master's study in the United States will occur in 1975. A re-study of objectives and curriculum revisions of our Bachelor of Science in Nursing Program will be a major activity of faculty in 1975-76 as they seek more effective ways of providing nurses to meet to-morrow's nursing and health care services. Dreams for a master's program in nursing will need to be anchored to financial and other resources essential to their transformation into realities in the relatively near future.
Above all, we view 1975 as an opportunity to seek and achieve better education of people for better service to society. As people privileged to serve in the health care field, we look forward to the achievement of greater effectiveness in rendering health care services to the people we serve. Students and faculty view the prospects of moving forward in 1975 with hope and optimism.

(Letters to Editor Contd. from p. 5)

Dear Editor:

I would like to congratulate MEDICUS for the wonderful job it is doing and hope it would continue and even progress further. The start of MEDICUS NIGHTS is an excellent innovation comparable to some of the best anniversaries seen in many years. I certainly wish you the very best of success.

Shawki Kanazi
Chief Resident, Medicine

Dear Editor:

I read with much interest the first copy of MEDICUS for 1974-75 that was handed to me right after the marvellous Fashion Show. Please accept my warm congratulations for an excellent debut.

Find enclosed a token contribution from me to MEDICUS.

Nabil T. Nassar, M.D.
Director, U.H.S.

Dear Editor:

I dare say that everybody has realized the last issue of MEDICUS to have been a special one.

What made it outstanding is, no doubt, organization, neatness and wealth of quality, the triad of inevitable success. However, I would have hoped that the Arabic section would have been more related to the name MEDICUS.

Inspite of all, MEDICUS deserves congratulation, an expression of admiration, gratefulness and sincerest wishes for the best of luck.

Nabil Tarabay
Medicine III

Dear Editor:

I would like to convey the appreciation of some of my Nursing Staff for the extra concern some members of the Administration show for us on special occasions like Christmas or New Year! I was certainly happy to see Dean Asper on the Floors on a Christmas Morning, passing to say a Merry Christmas!

Ms. Never Kalaidiian
Head Nurse, Surgery Ward

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