Such a program should prepare the student and provide the faculty with a sufficient base for the selection of candidates from this group to be enrolled into the second year medical school class. Those students who have demonstrated less aptitude should be directed toward training as an "advanced physician's assistant" or accepting one of the medical technological traineeships.

To encourage "upward mobility" and "the ability to achieve" in this group, it should be emphasized that after one or more years in the supporting career role, candidates may again apply for re-examination for medical school matriculation.

This project outline presents a broad base which permits the evolution and continued advance in the practical education of the participating students, stimulation of the practicing physicians, and widened horizons of medical center staff participants. A concomitant medical service should assure provision for increased primary medical care for patients and future physicians for these communities.

Effectiveness of the project will depend upon the concentration of action and coordination of interest stimulated by the participants and from the public itself.

CARROLL B. ANDREWS, M.D.
Sonoma

REFERENCES

1. Medical education in transformation (Editorial): Calif Med 115:53-54, Nov 1971
2. Nicholson HC: Americans in foreign medical schools (Editorial). JAMA 217:1857, Sep 27, 1971
3. Mason HR: Foreign medical schools—Organization and expenditures in 13 schools attended by more than 2,000 US students. JAMA 217:1845-1846, Sep 27, 1971
4. The medical manpower shortage (Editorial): JAMA 217:1857-1859, Sep 27, 1971
5. Hunt GH: Medical education and American students at Guadalajara and Bologna (Congress on Medical Education). JAMA 218: 869-871, Nov. 8, 1971

No Dearth of Opportunity

To the Editor: During a nine-month period, March-November 1970, the Office for Health Manpower and Continuing Education of the Dean of the School of Medicine, University of California, San Diego, recorded brochures received through the mail announcing formal programs of conferences on various aspects of medicine for post-graduate education.

In 275 days, 211 separate offerings were received. The distribution by months was as follows: March, 39; April, 37; May, 14; June, 15; July, 8; August, 9; September, 40; October, 20; and November, 29. The conferences were distributed geographically as follows: San Diego area, 12; elsewhere in California, 30; west of the Mississippi, 66; east of the Mississippi, 96; Canada, 4; Europe, Africa and the Pacific, 1 each. The conference length was distributed as follows: 1 day, 30; 2 days, 58; 3 days, 59; 4 days, 22; 5 days, 12; 6 days and longer, 10; 17 were non-consecutive. Total conference time was 635 days, not counting travel.

Of the topics offered, 80% were primarily clinical. The most popular subject was cardiology, with 36 entries, endocrinology and metabolism were represented by 13, surgery by 11, neurology 8, cancer 8, immunology-hematology 8, pulmonary 5, and pediatric 5. Among the non-clinical topics, the most common were environmental health with 8, biochemistry with 7 and laboratory animals with 5. Sex, in one or another combination, was mentioned in only 4. And 3 were extensive medical tours.

We tried to post the notices, but quickly ran out of bulletin-board space. Our capable secretary threw in her glove, which she seldom wears.

No conclusions or morals are drawn.

MICHAEL B. SHIMKIN, M.D.
Formerly Associate Dean for Health Manpower
University of California, San Diego
School of Medicine

Dermatologic Radiotherapy—R.I.P.

To the Editor: Doctor Epstein's article in the November 1971 issue, "Dermatologic Radiotherapy—R.I.P.," is an example of how the inappropriate use of statistical methods can provide misleading and confusing information. This article would better be titled "Acne Radiotherapy —R.I.P." If the purpose were to obtain the opinions of the nation's dermatologists on the use of ionizing radiation in the modern practice of dermatology then the questions should have been so formulated. By limiting the inquiry to

acne a built in skew-factor has been added which does the subject matter of the title a gross injustice.

This "tunnel-vision" view of dermatologic radiotherapy leaves untouched the many other skin diseases, dermatoses and tumors for which radiotherapy may be and often is used with good results. This is a vast subject and even vaster is the use of dermatologic radiotherapy in the treatment of malignant skin lesions. Only after adequate inquiry into attitudes and practices in these and related fields such as the use of grenz ray therapy for benign dermatoses can one draw any conclusions about the death or survival of dermatologic radiotherapy.

I join Doctor Epstein in decrying the lack of training which has become the vogue in many residency programs. Even sadder is the emergence of third parties in the form of malpractice insurance carriers as arbiters of medical decisions in the choice of therapies. I, too, am a victim of the "pulled plug syndrome" having opted to discontinue the use of grenz and x-ray therapy rather than pay thousands of additional dollars in premiums to have available an infrequently used modality which was not paying even the fees to cover the annual premiums.

J. David Brayton, M.D.
Assistant Clinical Professor
Dermatology
L.A. County-USC Medical Center

The Author Replies

I doubt if Dr. Brayton's criticisms are significant. The treatment of acne is the prime indication for the control of benign dermatoses with x-radiation. Grenz rays is an entirely different situation because of the softness of these rays. Its minor absorption eliminates most of the alleged hazards of x-radiation therapy—including leukemia, genetic damage, thyroid cancer, shortening of life, etc. This survey shows definitely that the interference in training in dermatologic radiotherapy dooms this modality.

Ervin Epstein, M.D.
Oakland

DRUGS FOR TACHYARRHYTHMIA IN PATIENTS WITH MYOCARDIAL INFARCTION

Lidocaine is best given as a bolus of 50 mg and then given as an infusion of 1 to 2 mg per minute. If you start lidocaine infusion in a patient with ventricular ectopic beats in the first 24 hours after myocardial infarction and arrhythmia recurs, it is worthwhile not to increase the infusion rate but rather to give another bolus. Increasing the infusion rate to 3, 4, or 5 mg per minute sometimes leads to drug toxicity without subduing the arrhythmia. . . . .

Lidocaine is effective in about 80 percent of patients who have multiple ectopic beats. In the remaining 20 percent, it will fail. The drug of second choice, in my view, is procaine amide. To control recurrent ventricular arrhythmias, this agent should be given in doses of anywhere from 250 to 500 mg to as high as 1 gram every three hours. It's rapidly dissipated.

If procaine amide is not effective, if the patient has many ventricular ectopic beats and the rate is 60, sometimes by raising the rate to 70 or 80 with atropine, you'll find that lidocaine becomes very effective or it may not even be required.

—Bernard Lown, M.D., Boston
Extracted from *Audio-Digest Internal Medicine*, Vol. 18, No. 1, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1930 Wilshire Blvd., Suite 700, Los Angeles, Ca. 90057