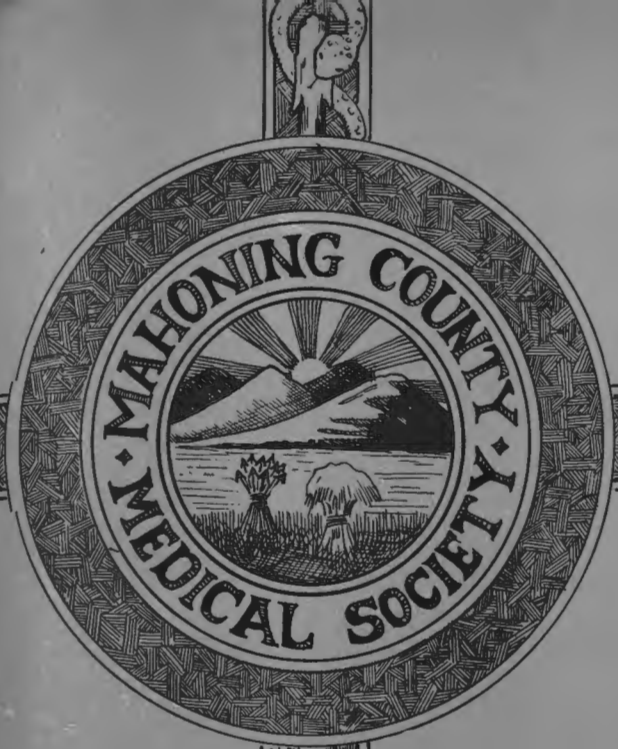

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

October • 1953
Vol. XXIII • No. 10
Youngstown • Ohio

OFFICERS AND COUNCIL

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Volume XXIII—No. 10 **October, 1953**

ADVERTISERS' LIST

Our President Speaks

November 4 is Election Day. A recent survey showed that all our members are registered qualified voters. I cannot emphasize too strongly the importance of exercising our privilege "to go to the polls and vote".

COMMERCIAL HEALTH INSURANCE

A U. S. Chamber of Commerce survey of commercial insurance companies and insurance societies shows these organizations are making steady progress in selling individual hospital, medical, and surgical insurance policies. *Not included* in the survey are Blue Cross, Blue Shield, mutual benefit associations, salary-continuance plans, union benefit lans, and other methods of voluntary group coverage. Thus, the findings do not show the total extent of coverage. The study covered 1952, and is based on information or estimates from 233 firms or societies issuing individual policies. By type of insurance, the survey showed:

> Medical Expense (excluding surgery): The highest percentage increase, 21%, from 4.2 millions covered in 1951 to 5.1 millions in 1952. *Surgical Insurance*. The largest numerical increase, with 2.8 millions more covered, from 16.4 million to 19.2 million, a percentage increase of 17%. *Hospitalization:* Most popular of all, it increased 10.1%, from a coverage of 21.6 million in 1951 to 22.3 million in 1952, or a numerical increase of 700,000. *Disability Insurance* (payment to workers kept from the job by sickness or accident): Only a slight increase, from 12.5 millions covered to 12.6 millions.

LOCAL SURVEY

Blue Cross reports paying for adult patient days about	40%
Other hospital insurance about	29%
Workmen's compensation, including Industrial, about	3%
State and City, about	9%
Community Chest, about	1%
Self paying, about	16%
Free Care and Special Fund, about	2%
	100%

BULLETIN of the Mahoning County Medical Society

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VOLUME 23 OCTOBER, 1953 NUMBER 10

Published for and by the Members of the Mahoning County Medical Society

H. J. Reese
3720 Market Street

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EDITORIAL

GOOD MANNERS

Editorials come from various sources. A few days ago one of our colleagues, Doctor A, asked that this be written. He was still angry at an incident which had occurred earlier in the week. He had been called to the telephone by the secretary of Doctor B, and after answering, had waited a full five minutes before his medical caller came to the phone. Doctor A felt that Dr. B was thoughtless in his action. Did Dr. B think that his time was more valuable than Dr. A's? Dr. A didn't think so. He felt that an apology should have been forthcoming. Dr. B forgot this nicety of manners. We may be sure that Dr. B did not increase his popularity with Dr. A.

This is not an isolated example. Many of us have had the same experience. Many of us have seen or heard other examples. These breaches of common courtesy are not many, but to the one who is the recipient of the discourtesy, they are long remembered.

Courtesy is not expensive. Discourtesy is never excusable. Let us, as physicians always remember this in our relationships with physicians, with nurses—in fact, with everyone with whom we come in contact. This, too, can be considered as good "Public Relations".

H. J. Reese

DR. CASBERG, ASSISTANT DEFENSE SECRETARY, ADDRESSES SOCIETY

Over 175 members attended the first Fall meeting of the Society which featured a stimulating address by Dr. Melvin Casberg, Assistant Secretary of Defense for Health and Medical Affairs, a position long advocated by the American Medical Association.

Dr. Casberg was associate professor of surgery and dean of St. Louis University Medical School before becoming vice-chairman and then chairman of the Armed Forces Medical Policy Council and later Assistant Secretary of Defense. He was introduced by Dr. Stephen W. Ondash, program chairman. Dr. Vernon L. Goodwin, president, presided at the meeting.

"One doesn't realize the global nature of the problem involved in the Medical Department of Defense," declared Dr. Casberg in speaking on the medical care of Korean casualties. "With our men fighting shoulder to shoulder with a cross section of World Allies, a standardization of basic techniques among nations in the treatment of casualties is necessary. Furthermore, we must meet the changing effects of weapons used in the major conflicts of the future," said the Assistant Defense Secretary. "With the added horrors of atomic weapons we face a tremendous task and responsibility among medical leaders and medical care must be constantly reorganized in these ever changing times."

Giving statistical illustration of improvement in medical care, the Secretary stated that 104 soldiers of every 1,000 died of disease in the Mexican War. In similar groups, 75 died in the Civil War, 16 in World War I, 0.16 in World War II, and 0.5 in the Korean conflict. Of every 100 wounded in action 15 died in the Mexican War, 14 in the Civil War, 8 in World War I, 4.5 in World War II, and 2.3 in the Korean conflict. The reason for this, declared Dr. Casberg, is quite evident. It demonstrates a wealth of progress in the medical care of the sick and wounded in combat areas and is a reflection of highly co-ordinated activity between civilian and military medical personnel.

In accounting for the reduced mortality and morbidity of men wounded in action, Dr. Casberg presented the following criteria:

1. Improved method of evacuation of patients and improved mobility of professional personnel. "Some battle casualties were in large hospital centers or hospital ships in the hands of trained surgical teams within two hours after injury. Even in our modern cities, a street or industrial casualty can't, in the same time, be under the care of highly trained specialty teams.

Only 5 deaths were recorded in a series of 400,000 evacuations from the battle front. Swiftly moving mobile hospitals manned by highly skilled professional men enabled battle casualties to receive the finest medical and surgical skills promptly. This factor accounted for the greatest chances for survival of even the most seriously wounded, in all history.

2. Improved pharmaceuticals, antibiotics and equipment. These provide other reasons for the tremendous reductions in mortality and morbidity rates. Plasma expanders, notably Dextran, are one example of effectiveness in the treatment of shock.

3. Whole Blood. The immediate availability of whole blood in combat areas in sufficient quantity has had a tremendous influence upon the survival

rate. The transportation of whole blood from the point of donor areas to the wounded in Korea has been reduced from 14 to 7 days. One can hardly appreciate the tremendous amount of blood utilized in the treatment of the wounded.

4. Professonal competence. 'On the Spot' presence of highly skilled surgeons and other medical personnel largely accounted not only for the decreased mortality rate but the improved morbidity statistics in the Korean conflict, representing even an appreciable improvement over World War II statistics.

While the greatest advances in World War II were in the management of chest injuries, advances in vascular surgery appear to be the highlight of the Korean conflict. There has been a reduction of 50% in the amputation rate after major surgery of the extremities. Overall, there was a 10% amputation rate among wounded in Korea. American medicine can be proud of the results achieved in vascular surgery performed in close proximity to the front lines.

5. Research projects. The presence of research teams in combat zones where, for the first time the factor of fear, exhaustion and shock have been carefully studied has resulted in a great impetus to management of casualties. The presence of artificial kidneys at the front line provides incredible testimony to the thoroughness in the management of our wounded even in the most forward areas.

6. The armored vest. The use of the armored vest has resulted in a tremendous reduction in war wounded. Wearing of the vests has resulted in an 80% reduction in wounds due to fragments and a 20% reduction in wounds from high velocity missiles, i.e., bullet wounds and machine gun wounds. The vests are being constantly improved. Plastic head gear will probably replace metal and other protective garments will serve to decrease incidence and severity of wounds.

In a graphic description of his recent tour of the Korean battle fields, Dr. Casberg held his audience in wonder of the superb management of our injured fighting men in far flung battle fields. Spicing his remarks with descriptions of research projects, he pointed out that even the most severely injured, if picked up in reasonable time, had 97% chance of being alive.

"Many problems remain to be solved", concluded Dr. Casberg, "but the American poeple can be assured that the Medical Department of the Armed Forces working in close co-ordination with civilian medical leaders, is meeting the changing problems of health and type of injuries sustained in wars being fought with ever changing weapons. Research is meeting the challenge of these situations and dictates the constant reorganization of medical care by military and civilian leaders who must bend to the task of more effectively preparing for response to atomic and other horrors of any future conflict.

Enthusiastic response greeted the address of the Secretary. In his opening remarks he urged Society members not to relent in their effort to provide for a Board of Health in our Community. His reference to a Board of Health was prompted by Dr. W. M. Skipp's review of committee progress in that direction.

The Society sponsored dinner meeting was a combined meeting of the Mahoning County Medical Society and the Mahoning Academy of General Practice. It was also a "Get Acquainted" party with old members meeting new and the in-betweens getting re-acquainted with both.

KEEPING UP WITH AMA

By Wm. Skipp, M.D.

The Senate Foreign Relations Committee has received assurances from the State Department that in the future bilateral treaties will carry exemptions for the professions, which includes medicine. A number of over-all treaties have granted reciprocal rights for practice without regard to state licensing regulations.

One proposal states that reciprocal national treatment would not be extended "to professions which, because they involve the performance of functions in a public capacity or in the interest of public health and safety, are state licensed and reserved by statute or constitution exclusively to citizens of the county, and no most-favored-nation clause in the said treaty shall apply to such professions."

VA reorganization went into effect September 7. Acting VA Administrator H. V. Stirling said Vice Admiral Joel T. Boone will continue as chief medical director of the Department of Medicine and Surgery as at present. The plan will have these advantages: "In Washington there will be fewer officials reporting directly to the administrator; staff and operating responsibilities will be clearly separated at all levels and there will be increased delegations of authority to the field.

Major appointments in health and related fields made by President: Melvin A. Casberg, M.D., is Assistant Secretary of Defense for Health and Medical Affairs: Harvey V. Higley of Marinette, Wisconsin, is to be head of the Veterans Administration (We know this physician as he talked to the Society at the September meeting); Russell R. Larmon is to be an Assistant Secretary of Health, Education and Welfare.

Federal survey shows abuse of veterans' hospitalization. General Accounting Office officials who reported on a survey they made last year of 46 VA hospitals. GAO investigators selected about 350 recently discharged cases where VA records disclosed "strong presumptive evidence of ability to pay." They found incomes ranging from $4,000 to $50,000 a year, with 25 of these having real property and other assets between $20,000 and $500,000. The GAO concluded: "It is clear that there are veterans being hospitalized on the basis of the unable-to-pay affidavit prescribed in the present law who are fully able to pay their hospitalization and others who are able to pay in part . . . the present law and regulations in effect discriminate against the more honest class of applicant.

William S. McNary, chairman of the American Hospital Association council on Government Relations, also stated: 1. Congress should vote no further expansion of VA hospital system if quality of care is to be maintained, 2. Number of beds now available in VA hospitals is more than adequate to meet need of veterans with service connected disabilities, and 3. Any new construction simply will be for care of disabilities having no service connection.

New Senate procedure in calling up treaties. To prevent any treaty or constitutional amendment from passing the Senate with only a few members on the floor, the leadership has decided that such matters be considered only upon a quorum call and a yea-and-nay vote. Acting Majority Leader William Knowland told the Senate: "I believe that it is sound policy and procedure . . . We shall endeavor to follow that policy as standard operating procedure from now on."

The Bricker Resolution was carried over to the next session of Congress.

AMA calls pesticide bill inadequate protection. In a statement filed with the House Interstate and Foreign Commerce Committee, says a pending bill on marketing of foods containing harmful pesticides doesn't have enough safeguards for the public. The AMA statement said in part: "According to our interpretation . . . there is no provision for prohibiting the marketing and general use of foods containing a pesticide before the determination of a safe tolerance limit of the pesticide in such foods has been made."

A TEMPEST IN A TEAPOT?

The growing problem of abuses of Veterans' Administration medical care by men with non-service-connected disabilities is certain to be an issue when the 83rd Congress reconvenes in January, 1954.

1. The AMA, the NMVS, the AHA are convinced abuses can be halted only by unequivocal language in a law that will rule out non-service care in VA hospitals except for long-term tuberculosis and neuropsychiatric cases.

2. Veterans organizations with one notable exception (AMVETS) are inclined to view the whole matter "a tempest in a teapot." They maintain non-service connected medical care in VA hospitals is a right of all indigent veterans and that the VA should not have to investigate inabilitiy-to-pay affidavits. In other words, no change in the law is necessary.

3. Supported by AMVETS, the American Dental Association struck hard at the "scientifically unsound" theory of the service-connected tooth and said the practice "goes beyond the obligation of the government to the veteran."

Better Business Bureau sets doctors straight. The general manager of the Indianapolis Better Business Bureau says it has been receiving many complaints from doctors and dentists throughout the country regarding a tubeless radio manufactured by an Indianapolis corporation. Advertising by the company states that the radio does not require tubes nor electricity, and that there are no batteries to replace. The Better Business Bureau says it has made repeated attempts to buy one of these radios from the company but has never succeeded. The bureau warned doctors to be careful.

Speaks his mind on AMA policy. In a recent issue of the Utah Medical Bulletin, Dr. K. B. Castleton puts down some pertinent statements regarding AMA policies.

"Many doctors are very critical of the AMA leadership and policies. Many feel that the AMA does not adequately represent the private physician, is undemocratic, ultraconservative, and 'asleep at the switch.'

"After attending the last two House of Delegates meetings, I am convinced that the AMA is conscientiously attempting to do the best job possible, not only for the doctors but what is of much greater importance for the people of this country as a whole so far as medical care is concerned.

"I believe it is a democratic organization, its policies being determined by the House of Delegates, the members of whom are elected by us. I am convinced that these men are honest, hard working, unselfish, intelligent men who are devoting an enormous amount of time, thought and energy to our affairs, and we all owe them a great debt of gratitude. Their work, I am sure, is not appreciated as it should be. If any of you have any doubts along this line, I would suggest that you make it a point to visit the House of Delegates meetings during the next few conventions and watch it work.

"If any of you do not like the way the AMA is run, you should make your ideas known at your county medical meetings, introducing resolutions which may be carried to the House of Delegates of the Ohio Medical Associa-

tion, thence to our delegates and thence to the AMA. Every member of our organization has the right and privilege to express his own feelings and to inaugurate changes which will be carried through if there are enough members of the Society who believe as he does."

Passed by both houses and sent to President in closing days:

1. Authorizing Food and Drug agents to make inspections (but not of pharmacies) after presentation of written notice.

2. Authorizing certain western states to cooperate in constructing and maintaining medical and dental schools.

3. Extending Hill-Burton hospital construction act until July, 1957.

4. Liberalizing VA care of veterans suffering from tuberculosis.

Committee named to investigate foundations. Rep. Carroll Reece (R.Tenn.) has been named chairman of a special House committee to investigate tax exempt educational and philanthropic foundations and similar organizations, many of which are heavy contributors to medical education and research . . . is under instructions to determine if the organizations . . . are using their resources for purposes other than the purposes for which they are established, and especially to determine which such foundations and organizations are using their resources for un-American and subversive activities, for political purposes, propaganda or attempts to influence legislation.

Social Security showdown with AMA is approaching. The President's proposal to extend it to physicians and dentists signals approaching showdown on this touchy issue. Scarely had President's message reached Capitol Hill than Acting Secretary Ernest Howard of AMA commented that the Association is "definitely and officially opposed" to compulsory coverage of members.

At its annual meeting in June, 1949, the AMA House of Delegates adopted a resolution voicing disapproval of the extension of "social security" to self-employed individuals, including physicians. Similar actions of disapproval have been taken by the American Bar Association, the American Dental Association and the American Farm Bureau Federation.

President Eisenhower has said that the bigger the government gets the more complex it is. "Don't let it (Government) get deeper into our lives. Watch it closely and do not let it get too big."

Self-employed professional groups for some time have been supporting the Jenkins (Reed) Keogh bills to establish voluntary pension plans.

New revenue legislation being drawn up: Jenkins-Keogh uncertain. The House Ways and Means Committee staff, in cooperation with the Joint Committee on Internal Revenue Taxation has started reviewing the whole complicated problem of revising the income tax laws.

At this stage it is not known whether the proposed bill will include the Jenkins-Keogh plan for allowing self-employed to defer income tax payments on money put into retirement plans.

American Medical Association, American Bar Association and virtually all other organization representing the self-employed are strongly in favor of tax deferral of the Jenkins-Keogh type.

Rep. Carl Curtis (R.-Neb.) chairman of a Ways and Means sub-Committee at recent hearings voiced his concern in these questions: "When these persons (the self-employed) put aside money for their old age, how do the tax laws affect them? Do the tax laws in operation treat all individuals equally with respect to providing through their own efforts for old age and retirement?

• **PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN** •

Do the tax laws permit and constructively encourage (among the self-employed) a sense of responsibility?"

Manion heads intergovernmental relations commission. Clarence E. Manion, South Bend, Indiana, attorney and former dean of Notre Dame University's Law School, will direct a study of Federal-State relations as chairman of the Commission on Intergovernmental Relations.

An effort will be made to determine what services now financed in part by the federal government could better be handled by the states, and what services might be eliminated altogether.

Dr. Manion, 57, is an authority on international and constitutional law. Earlier this year he supported the Bricker resolution at a Senate hearing where the chief opponents were Secretary of State Dulles and Attorney General Brownell.

Medicine behind the Iron Curtain. A former professor of pediatrics at the Charles University in Prague now practicing in this country gives the following evaluation:

"The revolution and regimentation that the medical profession is undergoing behind the Iron Curtain will make it increasingly difficult for physicians to exercise their profession according to pre-Communist standards. Political reliability has become a necessary adjunct to professional skill in qualifying for good positions in hospitals. All internes entering a hospital are carefully screened by a committee composed of janitors, clerks and nurses."

In Czechoslovakia and Poland, he said, serious deficiencies are found in the medical care and insurance systems. For example, a Prague publication of March 5, 1953, said concerning the new reorganized health service: "Public ignorance of the new organization is still serious. The workers do not know whom to approach in case of illness, where to find a practitioner, where to apply for new glasses, etc. Frequently a patient goes from one medical center to another wasting precious working hours. One of the main shortcomings is still lack of good relationship between the medical workers and the patients, and the lack of kindness and sympathy for the ill person. This is the reason why patients have little confidence in the doctors."

In Poland, since Communist absorption, physicians are under the supervision of so-called "elements of social vigilance". No free medical associations exist.

In Roumania, political indoctrination courses are compulsory and failure to pass them means dismissal from medical school.

Dr. McCormick speaks on Vets medical care. President Edward J. McCormick delivered a hard-hitting speech on veterans medical care before the Rocky Mountain Radiological Society in Denver, August 21. "There still is a determined effort on the part of some special interest groups to foist upon the American people a national health program that will ultimately evolve into a chain of federally-operated medical super markets. . . .

"Among the so-called realists in public life it is considered politically unwise to oppose benefit programs for veterans. As a result, common sense is oftentimes tossed out the window in favor of political expediency. What the realists forget is that the majority of veterans are self-sufficient, intelligent, taxpaying citizens who do not wish to be relegated to second-class citizenship by the misguided few who would make them dependent upon the government for their every basic need. Some leaders of veterans' groups claim preferential status for all veterans. In a democratic nation we cannot have two

types of citizenship. To serve one's country is a duty and an honor and the only claim which any of us have as basic right is that principle for which we fought—individual freedom and dignity. We did not follow the colors to become wards of the government.

"Certainly no one can deny that a man who has served his country in uniform and has become physically handicapped as a result of this service is entitled to special consideration. AMA is in complete accord with the overwhelming sentiment of the American people in this regard. And the AMA feels strongly that the federal government should provide the finest medical care obtainable for such veterans. This feeling has been demonstrated conclusively by the efforts of the medical profession to raise the quality of veterans' medical care."

The Veterans of Foreign Wars, holding their 54th Encampment in Milwaukee, approved a major welfare resolution that calls for the expansion of government hospital and medical care for veterans.

Joseph W. Mann, Michigan V.F.W. service officer, said the AMA and the various medical school deans were more concerned with the training of students than in the treatment of veterans at VA hospitals. Mann said he was convinced the "AMA is a bunch of reactionary old dodos."

A VFW service officer from Oregon demanded to know whether the VA is being dictated to by the AMA or whether it is attempting to treat the veterans in accordance with the way the law reads.

Curtis charges Department is withholding Social Security data.

Rep. Carl Curtis (R.-Neb.) charges that information is being withheld by officials of the Department of Health Education and Welfare.

1. He and his staff have made repeated attempts to get specific information from the Department.

2. The only reply, received seven weeks after the orginal request, was a "studied evasion of what had been asked."

"All we want," Mr. Curtis said, "are the facts. We intend to get them. I will not tolerate delays, evasive answers or anything that falls short of full cooperation."

Dr. Melvin Casberg, Assistant Secretary of Defense for medical matters . . . .A spokesman for Dr. Casberg emphasized that there is often a long delay between receipt of individual letters informing the physicians they will be called and their actual orders carrying the date to report. Most of the men involved want to postpone closing out their practice or making other personal arrangements until they receive more definite word as to when they must leave civilian life. That definite word comes with the orders which specify a definite date. A minimum of 30 days is provided between receipt of the order and the date for reporting for duty.

No doctor draft calls expected for 12 months, committee advises.

National Advisory Committee to Selective Service believes there will be no further calls for physicians registered under the doctor draft law for about a year. In a report dated September 2, and sent to state Selective Service directors, chairman of state advisory committees: "It is not expected that there will be additional calls for physicians placed against the Selective Service System by the President for the next 12 months."

Judge rules in favor of Army in new contest of doctor draft law.

In the first legal contest under the newly amended doctor draft law, a

federal district court judge has ruled that the law passed by Congress last June does not make it mandatory for the armed services to commission a physician or dentist called up under the amendment.

The dentist, Dr. Herbert L. Nelson, was inducted May 28. On two occasions in filling out applications for commissions he declined to state whether he had been a communist or a member of a communist organization. He filed a statement admitting membership in the Young Communist League while in college and later in the International Workers Order. The Army informed the court that upon completion of basic training, Dr. Nelson would practice Dentistry in the Army, probably at Fort Lee, Virginia, but that he would not be commissioned nor allowed to handle any restricted or confidential material. Attorney for Dr. Nelson argued that if his client is to be retained for duty, then the Army is required to commission him in light of the new amendment. It states a physician or dentist, "shall, under regulations prescribed by the President, be appointed, reappointed, or promoted to such grade or rank as may be commensurate with his professional education, experience, or ability." The court did not agree. The petition for a writ of habeas corpus was denied.

Secretary Oveta Culp Hobby says that "our doctor shortage looks nonexistent at first glance, but we should not delude ourselves. Before World War I we were graduating roughly 6,000 doctors a year. And now, we are graduating only about 7,000 a year, while the population has jumped from 105 million to 160 million, the number of doctors graduating each year has climbed only 1,000."

No way has yet been found to save the average American family "from destruction by catastrophic illnesses," Mrs. Hobby states and adds that the answer lies within the private enterprise system. To this end, she would have all organizations in the field of medicine apply "their brains, their experience, and their funds to the solving of this problem." Other points made by the Secretary: 1. The overwhelming majority of the American people have no desire whatsoever for socialized medicine in any form. 2. The uneven distribution of doctors finds a patient in a major city with recourse to six or eight specialists, while a person in a small town may have no doctor within 50 or more miles.

NO DOCTOR DRAFT CALLS EXPECTED FOR 12 MONTHS

National Advisory Committee to Selective Service believes there will be no further calls for physicians registered under the doctor draft for about a year. The committee, in a report dated September 2 and sent to state Selective Service directors, chairmen of state advisory committees, deans of medical schools, and others, states: "It is not expected that there will be additional calls for physicians placed against the Selective Service System by the President for the next 12 months." It adds:

"As a result of Call No. 16 in August (for 542 physicians) and the increased number of volunteers, there have been commissioned a sufficient number of physicians to meet the needs of the armed forces for the immediate future. Those who have been commissioned from either the voluntary list or the Selective Service call will be brought to active duty from time to time until this reservoir is exhausted." The committee says there may be some calls for dentists after several months.

A. M. A. Washington Letter No. 36

PAUL MYRON KAUFMAN, M.D.

May 15, 1898 August 23, 1953

Dr. Paul Myron Kaufman, 55, of 309 Broadway, prominent Youngstown physician and surgeon, died of a heart ailment at his home early Sunday, August 23.

Dr. Kaufman first had a heart attack in January, 1949. He had had recurring illnesses since then, but continued his practice until early this year when he had a serious attack while in Florida.

He had practiced here for 25 years and was on the active surgical staff of the Youngstown Hospital Association.

Dr. Kaufman was born in Port Chester, N. Y., May 15, 1898, a son of Morris and Rose Rosenbloom Kaufman. He came to Youngstown when he was a child.

He graduated from Rush Medical College and took advanced work in surgery in Vienna in 1929. He was a member of the College of International Surgeons, a fellow in the American College of Surgeons, and a member of the Ohio State and Mahoning County Medical Associations.

Dr. Kaufman entered the Army early in World War II, becoming a captain in the Medical Corps in July, 1942.

He received two citations for his work in the Army Medical Corps overseas. He entered training at Fort Benjamin Harrison and saw service in Africa, Corsica, France, and southern Germany.

Dr. Kaufman was looked upon by the nurses as a friend, interested in their problems. No nurse patient ever received a bill from him for care and he always was deeply appreciative of the nursing care given his patients.

He was a member of Youngstown Lodge F.&A.M. and was a 32nd degree Mason. He also was a member of American Legion Post 726, the Jewish War Veterans of Hyman Greenblatt Post, an honorary member of Sigma Psi Fraternity and a member of the Jewish Community Center, Squaw Creek Country Club, the Jewish Federation and of Rodef Sholom Temple.

Dr. Kaufman will live on in the hearts of his many patients and in the profession that knew him and his worth as a friend and surgeon will always be remembered.

H.J.R.

HELP WANTED!

"Hello Doctor! May we have your attention for a minute or two? Just want to ask if you will help us encourage young men and women to enter the nursing profession.

"It is a worthy career, has good pay and gives a chance to serve in many fields. Young people look to you for good advice and information. Have them inquire at the city's nursing schools for more detailed information.

"Thanks so much for stopping for this little chat. We will be most grateful for any help you can give us."

Muriel L. Dunlap, Director, School of Nursing,
Youngstown Hospital Association
Ethel Hopkins, Director, School of Nursing,
St. Elizabeth Hospital

OCTOBER MEETING

6th Councilor District
ANNUAL POSTGRADUATE ASSEMBLY
St. Francis Hotel, Canton, Ohio

WEDNESDAY, OCTOBER 28, 1953

PANEL MEMBERS

Moderator

DR. ROBERT M. ZOLLINGER
Division of Surgery, Ohio State University
Columbus, Ohio

DR. JOHN BEACH HAZARD
Pathologist, The Cleveland Clinic
Cleveland, Ohio

DR. SARA JORDAN
Gastro Enterology, The Lahey Clinic
Boston, Mass.

DR. E. N. COLLINS
Gastro Enterology, The Cleveland Clinic
Cleveland, Ohio

DR. PHILIP F. PARTINGTON
Surgeon
Cleveland, Ohio

DR. KENNETH W. WARREN
Surgeon, The Lahey Clinic
Boston, Mass.

PROGRAM

8:30 to 9:15 Registration

9:25 Introduction ..... Dr. Clair B. King
President, Stark County Medical Society

9:30 "The Thyroid Nodule" ..... Dr. John Beach Hazard
Cleveland Clinic, Cleveland, Ohio

10:00 "Fibrosis of the Terminal Common Duct" ..... Dr. Philip F. Partington
Cleveland, Ohio

10:30 to 11:00 Intermission to View Exhibits

11:00 Panel—"Acute and Chronic Relapsing Pancreatitis"
Moderator—Dr. Robert M. Zollinger
Ohio State University, Columbus, Ohio

1:30 "Gastric Ulcer—Medical or Surgical Treatment?" .. Dr. Sara M. Jordan
Lahey Clinic, Boston, Mass.

2:10 "The Most Detectable Internal Cancer" ..... Dr. Richard H. Overholt
Boston, Mass.

2:45 to 3:30 Intermission to View Exhibits

3:30 Panel—"Chronic Ulcerative Colitis and Regional Enteritis"—
Moderator—Dr. Robert M. Zollinger
Ohio State University, Columbus, Ohio

DIABETIC DETECTION WEEK

November 15 - 21, 1953

Speaker:

DR. GEORGE HAMWI

Director, Section of Endrocrinology and Metabolic Diseases, Ohio State University, School of Medicine, Columbus, Ohio

Subject:

"General Clinical Endrocrinology in Practice"

OCTOBER MEETING

Date:

Tuesday, October 20, 1953, 8:30 P. M.

Place:

Elks Club, 220 W. Boardman Street

Speaker:

DR. NED SHNAYERSON

Clinical Professor of Surgery and
Chief, Peripheral Vascular Section, Poly Clinic Hospital,
New York, New York

Subject:

"Recent Advances in Diagnosis and Therapy of Peripheral Vascular Disease"

The subject of peripheral vascular disease holds mounting interest and Dr. Shnayerson's talk should command the interest of all practitioners. Don't Miss This One!

INVITATION

Members of the Mahoning County Medical Society are invited to attend the

CORYDON PALMER DINNER DANCE

Date:

Saturday, Dec. 12, 1953

Place:

Elks Club

Time:

Cocktail Hour 6:30
Dinner 7:00
Dancing 9:00 - ?

FORM YOUR PARTY NOW
$12.00 per Couple

THE COUNCILOR'S PAGE

Our State Legislature adjourned some two months ago. There were about eighty bills proposed that involved the medical profession in one way or another. We think no bad bills were passed, but it took a lot of work on the part of our Columbus office, our councilors, legislative committees, and many others to keep the bad bills from becoming laws. Some of the bills, for instance the Chiropractic Bill, came very near passing. On many measures legislators from the Sixth Councilor District voted contrary to the way we think they should have voted. In fact, on some bills the vote was very much against our point of view. On one measure the vote was two for our side and thirteen against. I cannot help but feel that the vote was not so much for the opposition—the Chiropractic Bill, for instance—as it was against the medical profession. This points to a tremendous need for better public relations and better acquaintance with our lawmakers. The Sixth Councilor District seems to need this more than any other section of Ohio. Had the lawmakers all voted like those from our district, some of the bills we think bad would now be laws.

As our September OHIO JOURNAL states editorially on page 832 under the heading *How about a Chat with Your Congressman?*, "Now is the time to renew acquaintance with your Congressman. As the Washington Letter of the A.M.A. Washington Office pointed out:

"With the Nation's lawmakers home or on their way home, this is a timely week to suggest that you look them up. Let them know, not only how you feel about medical legislation, but why. If they have been helpful to us, you will do the Washington staff a great service by thanking them for their support. Some of the Senators and Representatives may not agree with you, but it's a rare one who doesn't welcome the opinion of a doctor who knows what he's talking about."

The following is a pertinent quote from the CONNECTICUT STATE MEDICAL JOURNAL:

"Election day is the only day you can vote for candidates. But there are hundreds of days when you can vote for representative government.

"Every time you make your views known to your legislators (state or national), you are voting for good government. They can act with resolution when they know what their constituents think."

Read your State Journal carefully. See what your councilors and committees are doing. We work for you and we listen to you. The next meeting of the state council will be held at Granville on October 2, 3, and 4. If we can help you on any problems, please let us know so that we can present them.

You have all received registration cards for the Postgraduate Day at Canton on Wednesday, October 28. Many of us are apt to put those cards aside thinking that we will pick them up later and send them in. If you have not sent in your cards, please do so tomorrow before you begin your office hours. Stark county has always been a good host. The banquet in the evening is for the ladies, too. The speaker is excellent! His subject, "The Fourth Dimension in Thoracic Surgery", isn't as formidable as it sounds. It promises to be very interesting. Let's have a good crowd. Summit County will be host next year.

C. A. Gustafson, M.D.
Councilor, Sixth District
Ohio State Medical Association

PROCEEDINGS OF COUNCIL

September 14, 1953

The regular monthly meeting of the Council of the Mahoning County Medical Society was held at the office of the Society, 202 Schween-Wagner Building, Monday, September 14, 1953.

The following doctors were present: V. L. Goodwin, President, presiding; A. Randell, A. K. Phillips, G. E. DeCicco, W. M. Skipp, I. C. Smith, C. A. Gustafson, G. G. Nelson, E. J. Wenaas, M. W. Neidus, and H. J. Reese, comprising the Council, also Dr. E. J. Reilly.

Dr. Reilly reported on the venereal disease survey which Mr. D. R. Mellon, Acting Health Commissioner, recommends for Youngstown. It is estimated that there are approximately 100,000 people in Ohio today in need of treatment for syphillis. If we are to further reduce mental hospital admissions, cardiovascular and neurological disability due to syphillis, some means must be taken to locate these people before they become disabled. Most of them do not know they have syphillis.

It is proposed that a serologic survey be done, involving selected segments of the population. Such a survey is currently underway in Dayton and is proving to be highly productive. During the past year, similar surveys have been conducted in Cincinnati, Gallia, Lawrence and Scioto Counties. Cleveland is making plans for a survey in the spring.

The council of the State Medical Society has approved the objective and survey method. The county medical society in each county concerned to date has given active support to surveys in its area. After hearing Dr. Reilly's report, council discussed the details of such a plan and approved the survey.

Dr. Wenaas, Chairman of Committee for Supervision of Publicity, reported on the study of his committee with reference to closer working relationship with press, radio, TV, hospitals and the medical profession.

Dr. Wenaas stated that the Code of Cooperation used by the Franklin County Medical Society was a constructive development and suggested we use it as a basis or pattern after asking permission from their secretary.

A motion was made, seconded, and duly passed to accept Dr. Wenaas' report and recommendation and instructed the secretary to write to the secretary of Franklin County Medical Society for permission to use their Code as a basis for the committee to work on.

Dr. Skipp reported on a meeting with a Committee of Osteopathic Physicians of our area to discuss such subjects as emergency calls at hospitals, consultations and other problems of mutual interest to both professions.

Dr. Rappoport, chairman of the Blood Bank Committee, submitted a report on a meeting with representatives of the Youngstown District of Osteopathic Medicine concerning the American Red Cross Blood Bank and Blood Bank techniques. Also, Dr. Rappoport reported on several meetings with labor groups with reference to the blood program.

Dr. Goodwin appointed the following committee, consisting of a representative from each hospital and one from council to make a study of the problems involving the osteopaths and physicians and asked them to report back to Council. Dr. W. M. Skipp, Chairman; Dr. C. A. Gustafson and Dr. J. N. McCann.

Dr. DeCicco, Chairman of a committee to revise the by-laws reported. A motion was made, seconded, and duly passed instructing Dr. DeCicco and

his committee to completely revise the Constitution and By-laws bringing them up to date.

The duties of the Mediation Board were discussed.

A motion was made, seconded, and duly passed that "the Mediation Board cast a closed ballot on matters referred to them."

A motion was made, seconded, and duly passed instructing the secretary to write a note of appreciation to Dr. M. M. Szucs and Dr. C. W. Stertzbach for their untiring efforts in making the Canfield Fair a success.

The result of the balloting with reference to the day off for our members was as follows:

For Thursday off	113
For Wednesday off	64

The result of the voting on "whether or not the Society should pay for Interns and Residents at functions such as Dinner Dance, Annual Banquet, Postgraduate, Golf Meet, etc." was as follows:

Yes	146
No	36
If it does not increase dues	1

G. E. DeCicco, M.D.
Secretary

THE YOUNGSTOWN AREA HEART ASSOCIATION, INC. RHEUMATIC FEVER PREVENTION PROGRAM

Encouraged by the result of the Rheumatic Fever Prevention program to date, the Youngstown Area Heart Association again requests the cooperation of members of the Mahoning County Medical Society in this effort to lessen the incidence of rheumatic fever among school children.

Last year 872 throat cultures were taken, of which fifty-two were proven positive for beta hemolytic streptococci. As far as we can ascertain, the incidence of rheumatic fever in this district was less than anticipated. This could have been due to the fact that more children were taken to the physician at the earliest appearance of sore throat, for we are certain that the education of parents in this district through the press, radio, teachers in public schools, and P.T.A. organizations is definitely bearing fruit.

This year Lincoln School has been selected for a continuation of this study.

It is suggested that if a child is brought to the physician with a proven streptococcal sore throat, 600,000 units of procaine penicillin in oil be given at once and the same amount repeated on the fourth day. This has been successful in preventing rheumatic fever in army camps and should be adequate in children.

Last year the County Medical Society members sent back 756 return postcards with the data requested on rheumatic fever. This school year return postcards will be sent each month asking for names and addresses of patients with acute rheumatic fever. In this way we may be able to set up the beginning of a registry so that these cases may be followed in future years.

W. H. Bunn, M.D.
President

ST. ELIZABETH HOSPITAL STAFF MEETING

The regular monthly staff meeting of the St. Elizabeth Hospital was held on Tuesday, September 1, 1953. Meeting was called to order at 8:30 P. M. Dr. W. H. Evans, Chief of Staff, presided.

The medical section consisted of the following clinical case presentations:

a. Thyrotoxicosis in Pregnancy—presented by Dr. R. Vernino; discussed by Dr. B. I. Firestone.

b. Diverticulitis—presented by Dr. D. R. Dockry; discussed by Dr. J. M. Ranz.

The minutes of the last monthly meeting were read and approved.

Dr. A. Randell, chairman of the Records Committee, asked that all charts be completed by October 1. After that the ten-day rule on patient admissions will be enforced.

Dr. R. V. Clifford was congratulated and thanked for the fine staff picnic.

Dr. J. LoCricchio reported for the Tissue Committee on 1,836 cases which were studied.

Dr. S. W. Ondash announced that the Mahoning County Medical Society meeting in September will be a "free" dinner meeting as a social "get-together" with Dr. Melvin Casberg, Assistant Secretary of Defense, as speaker.

Meeting was adjourned at 9:40 P. M.

H. J. Reese, M.D.
Secretary

NEWS

Dr. John Keyes has been appointed Area Consultant in Ophthalmology to the Veterans' Administration, Washington, D.C.

FROM THE BULLETIN

J. L. Fisher, M.D.

TWENTY YEARS AGO — OCTOBER, 1933

The Secretary reported a thorough discussion at the meeting of our Council on the closing of the public schools because of the polio epidemic. Although the medical profession and health authorities were subject to some criticism from the local press, Council felt that they had done the right thing in view of the public alarm which had been aroused. It was suggested that the Board of Health pool all the blood donations obtained from convalescent cases and make the serum available to the doctors. The epidemic soon waned and nothing came of the suggestion.

George Madtes of the Vindicator made a reply to the remarks of Dr. Scofield (mentioned in this page last month) which was a masterpiece of the soft answer which turneth away wrath, yet which showed the newsman to be extremely well read on the subject. Dr. C. S. Lowendorf wrote a timely article on the management of the post-paralytic sequelae of polio. Dr. Gordon Nelson wrote on "Avertin, a Basal Anesthetic".

The candidacy of Dr. H. E. Patrick for Board of Education was announced. A course of eight lectures in Hematology given by Drs. Doan and Wiseman of Ohio State University started this month. Fee for the course, three dollars.

The picnic that year was a big disappointment. Not many showed up.

TEN YEARS AGO — OCTOBER, 1943

Dr. John Tucker of the Cleveland Clinic gave a lecture on the new antibacterial substance, Penicillin. He stated that it was the most powerful antibacterial agent known.

Dr. E. C. Rhinehart of Struthers died August 29th.

Dr. John Noll moved to the Station Hospital, Jefferson Barracks, Mo. Joe Colla was down in Virginia where "we have a swimming pool, a horse for each officer, a golf course and no expenses". Brack Bowman was at Laguna Beach down below Los Angeles. Barclay Brandmiller was at Fort Ord at Monterey, California, touring the country and seeing the sights. Luke Reed was at the Army Air Base at Monroe, California. J. A. Welter was promoted to major and stationed at Camp Beale, California. Walter Tims was still in England, a major now. E. M. Chalker was at Los Vegas, N. M.

Myron Steinberg and Jacqueline Lieberman were married September 19th.

McKelvey's store announced their 60th anniversary dedicated to the purchase of a giant 4 motored bomber to be named "The Spirit of Mahoning County", the cost to be $300,000.

All Members:

You will be contacted to support the American Medical Education Foundation. Please do not put off mailing your check to

AMERICAN MEDICAL EDUCATION FOUNDATION
535 Dearborn St., Chicago

or

the school of your choice, earmarking it for that school.

TALKING BOOK SERVICE INFORMATION FOR THE BLIND

TALKING BOOK MACHINES FOR THE BLIND

Talking book machines are similar to commercial recording machines except they will play the talking book records only. These machines are provided by the Government and loaned through this agency to all reliable blind persons 16 years or older having not more than 20/200 visual acuity in the better eye with correcting glasses, or visual acuity greater than 20/200 but with a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees. The degree of such blindness shall be certified by a duly licensed physician or ophthalmologist.

Eligibility is established by having the interested individual's duly licensed physician or ophthalmologist execute an eye examination form. All such eye examination reports are reviewed by the State Ophthalmologist and if the individual's visual acuity comes within the above definition, the report is approved and a talking book machine is assigned.

The person may use the talking book machine indefinitely. It is repaired or exchanged for another machine when necessary.

TALKING BOOK RECORDS

A wide variety of books are available which include the Bible, historical novels, Readers Digest and many books of fiction, poetry and biographies. There are two distributing libraries in the state of Ohio, one in Cleveland which serves the northern part of the State, and one in Cincinnati of the southern part of the State.

A library card, properly addressed, is enclosed in the carton when a machine is sent. This serves to register the person at the library and the library sends a catalog from which selections are made. Records are mailed to and from the library postage free. The records may be dropped in any large mail box or mailed in whatever manner is most convenient in the area.

INSTRUCTIONS IN THE USE OF THE MACHINE

When a talking book machine is assigned, the Home Teacher in the area is advised of the assignment. She makes a demonstration call in order to instruct the person in the use of the machine, as well as to check the machine.

There is no charge for any part of this service.

Any blind person (visual acuity of 20/200 with correction) should be referred to us for this service:

YOUNGSTOWN SOCIETY FOR THE BLIND
629 Bryson Street Youngstown, Ohio
Phone RIverside 7-7034

THE MANAGEMENT OF DISTURBED CARDIAC PATIENTS*

Mandel E. Cohen, M.D.
Boston, Mass.

The purpose of this report is to describe for practicing cardiologists and other physicians the problems of disturbed behavior which arise in cardiac patients or in patients suspected of cardiac disease. This outline is based on clinical impressions and memories of actual patients and the problems they represented and is based on personal experience in the fields of cardiology and psychiatry. No attempt has been made to summarize the literature on these topics; also we have deliberately avoided presenting speculative explanations of possible psychologic or physiologic mechanisms involved in these problems. This report will take up a variety of situations in which the doctor learns that his patient with cardiac disease is upset, confused, over-active, or noisy. Sometimes it turns out that the disturbed patient with "cardiac" symptoms does not even have heart disease. Before discussing the matter of the different kinds of disturbed states, it is well to ask, "Under what circumstances should a physician suspect that some unusual disturbed state is present?" Obviously in severe disturbances the patient's shouting, struggling, running down the corridors, or weeping will command attention. Mild or early disturbed states may reveal themselves when the patient complains of insomnia, is tearful, does not speak, loses his temper at some fancied slight, demands his clothes so that he can go home to attend to some important business, refuses food, sniffs at his medicines, or protests because he is being discriminated against and is receiving tardy bed pan service. It is well to record these events as they may presage more abnormal behavior. One should record exactly what patients say or do, with the same exactness as describing the time, location, and intensity of a heart murmur. Usually, when a nurse reports that Mr. Smith doesn't seem to be acting right or seems mental or "balmy", it means that something is wrong. An exact recorded statement of the patient's words or behavior is much more helpful for exact diagnostic purposes than such vague statements as, "He had a strange look in his eyes."

INDIVIDUAL CONDITIONS TO BE RECOGNIZED

The disorder which seems to be secondary to heart disease and heart failure is delirium, and this will be discussed first. Other conditions, some common and some rare, described later sometimes accompany heart disease and should be thought of in all disturbed patients seen in cardiology.

1. Delirium (toxic psychosis)

Delirium is a state of disturbed behavior and perception which is secondary to some other disease, complication of disease, or drug. In cardiac patients it may occur with any type of heart disease and probably in general in the sickest patients. Its relation to heart failure is not entirely clear since at times it appears when breathing is easier, chest is clearer, edema has disappeared, and the patient is, in other words, improving. The exact mechanisms of brain disturbances are still not clear, and explanations such as special personality structure, anoxia of the brain, cerebral edema are not proven. Probably elderly people, children, and patients with damaged brains are more apt to become delirious than young or middle-aged adults. The characteristic features of delirium are:

a) *Disturbance and Lability of Mood*—Mood lability takes different forms. There may be extreme irritability and argumentativeness. The patient may

* From the Cardiac Research Laboratory, Department of Medicine and Neurology, The Massachusetts General Hospital and the Harvard Medical School.

refuse to follow orders or may become very tearful and sentimental. The patient may appear more jovial or easily amused, or at another time he may be frightened, his fright varying from mild uneasiness to extreme fear and panic. At times the patient may change from one mood to the other. He may flare up and be extremely angry and soon after may make amusing remarks.

b) *Disorientation*—In general, delirious patients become confused as to where they are, as to what day it is, or as to how long he has been ill, and as to who the people are around them. This may not be constant or absolute as the patient may be confused at night, but in the day time he may be fairly clear. Also the patient may not know the date and may not be clear as to how long he has been in the hospital. He may tell one examiner that he is at home, and later on he may correctly name the hospital.

c) *Illusions*—(misinterpretations and hallucinations)—These are not usually pink elephants or purple snakes. An illusion is a false perception based on a misinterpretation of something that is actually there. For instance, a bed sheet is interpreted as a visitor, a rattling steam pipe is interpreted as rifle fire or the voice of a relative, a sun dial is interpreted as a woman selling flowers on the lawn, or the moulding on the ceiling is interpreted as a set of books stored around the top of a room. The patients may be over-alert to noises in the hall and may attach various personal meanings to these noises, or the patient may have true hallucinations—that is, false perceptions where the stimuli leading to them are not obvious to the examiner—the patient feels bugs are crawling over him, or that a bird is circling about, or that little chickens are walking around on the floor.

d) *General State*—The patient may have a general feeling that something is wrong in the atmosphere and that the doctors and nurses are "up to something," or that a party is going on in the ward, a meeting being held, or that his next door neighbor needs his attention.

The first step in the management of a patient with a delirious state is to determine what abnormal factors are present that might be corrected. Such factors as fever, heart failure, drugs, bacterial endocarditis, Sydenham's chorea, alcoholism, and various medical disorders are often found in patients who are delirious. In most of these cases in my experience several of these factors are present. A sound attitude for the examiner to take is to act on the assumption that, when a cardiac patient becomes delirious, something is wrong with the treatment and its course or that complications discovered or undiscovered are present.

Fever—It is well to re-examine the patient, look for fever and a cause of fever. Is there complicating pneumonia, a new coronary occlusion, or are there emboli, or is there an unrelated new infection?

Heart Failure—I have seen heart failure evidence itself by a delirious state in patients believed to be doing well from the cardiac standpoint. On re-examination after delirium appeared, it was found that the patient had rales in the chest and diminished vital capacity, which suggested that the patient was again decompensated. In general, decompensated cardiacs are more apt to be delirious; sometimes they become so while improving.

Drugs—It seems that almost all drugs are capable of either causing or contributing to the delirious state. Foremost on the list are sedative drugs such as barbiturates, opiates, and bromides; in addition diuretics, digitalis, atropine, cortisone, adrenocorticotropic hormone (ACTH), salicylates in large amount, alcohol, and some of the chemotherapeutic drugs seem to provoke

deliria. Bromides are usually taken before the patient enters the hospital. In any case of delirium it is wise to estimate blood bromides. When the level is more than 150 mg. per 100 c.c. of blood, bromidism is suggested as an explanation of delirium. Digitalis and the various diuretic drugs have also seemed to be related to delirious states. It is less certain that digitalis is responsible where there are not other toxic manifestations. Usually one does not find complete correlation between starting a drug and the onset of delirium or or stopping a drug and the disappearance of delirium. Probably deliria related to long-acting drugs persist longer. The general rule of management is never to omit a life-saving drug because of delirium but to try to change to another form of it if possible. If the use of a drug is optional or experimental, it is best to omit it.

Bacterial Endocarditis—In cardiac patients, particularly those with rheumatic heart disease, fever and delirium may indicate that bacterial endocarditis has developed. Delirium sometimes may be the presenting abnormality. Delirium may occur whether brain embolism has or has not occurred.

Sydenham's Chorea—In mild Sydenham's chorea, it is characteristic for the patient to show emotional lability, to be tearful, irritable, and out of sorts. In severe Sydenham's chorea, there may rarely be frank delirium. Also there is some evidence to suggest that a small proportion of patients develop unreasonable so-called psychopathic behavior as a sequel.

Alcoholism—In patients who have imbibed an excessive amount of alcohol for a number of years, it seems that development of heart failure, fever, or some other factor may provoke one of the so-called alcoholic psychoses. *Delirium tremens,* an illness of a few days' duration, is characterized by tremor, disorientation, mood disturbance, and rather vivid hallucinations. This may be preceded by convulsions. Other alcoholic psychoses may include a combination of Wernicke's and Korsakoff's syndromes with strabismus, nystagmus, retentive memory defect, confabulation and neuritis. It is not clear to what extent nutritional disturbance plays a role in the alcoholic psychoses, but Wernicke and Korsakoff's syndromes also occur in non-alcoholic patients with severe nutritional disturbances. Withdrawal of alcohol is again being considered as a factor in delirium tremens. Beri-beri heart disease is not usually seen with these complications in this country. In addition to the specific alcoholic disturbance there is the clinical impression that chronic alcoholic individuals are more apt to get non-specific deliria than the non-alcoholic patients.

Various Medical Disorders—We have the clinical impression, based on individual cases and without statistical substantiations, that disorders of various kinds such as hepatitis, severe anemia, pernicious anemia, gross imbalance of electrolytes including Na, K, Cl, use of cation exchange resins, uremia, infarction and hemorrhage of any part of the brain may contribute to delirious states in cardiac patients.

No one factor, but several factors may be associated with delirium and the same patient may have several of them. One may find in looking for the provoking factor of delirium in cardiac patients, or in any patients for that matter, that the patient is in heart failure, has fever, is taking a variety of drugs, and perhaps also drank too much whiskey in the past. The relation of various factors to delirium or to each other is not clear. Nothing has been said about the previous personality of the patient. There is no psychologic knowledge which allows the physician to predict which of his patients is apt

to become delirious. Most statements which allege that the previous personality of the patient is responsible for the delirium are really involved in predicting the past—that is, merely stating at the present state of our knowledge that the type of person who gets a delirium must have been the type of person who was destined to develop a delirium.

2. Neurocirculatory Asthenia (anxiety neurosis, neurasthenia, effort syndrome).

This condition is mentioned here only because it is common; it is almost never a source of disturbed behavior. It may be the cause of a so-called heart attack which may bring the family physician to the patient's home in the middle of the night to reassure a patient in panic having an anxiety attack consisting of palpitation, breathlessness, smothering and choking, and a feeling of fear that she may faint, fall, or die.

3. Manic-Depressive Disease (depressed state).

This disorder may present primarily cardiovascular-respiratory symptoms resembling neurocirculatory asthenia. However, other symptoms include: feeling of hopelessness and unworthiness, insomnia of a kind which wakes the patient early in the morning, the patient's feeling worse in the morning and better as the day goes on. There is anorexia, weight loss, and constipation. This disorder should be suspected if a patient seems to have neurocirculatory asthenia who has never had it before age 35 or if "neurocirculatory asthenia" does not respond to reassurance. This disease may appear alone, or, since it is not an uncommon illness, it may appear along with hypertension, or hypertensive or coronary heart disease in middle-aged or elderly patients. It is important to recognize this illness and not to conclude that the patient has neurocirculatory asthenia or that he is just upset because his blood pressure is elevated and that he is worrying about this. This crucial point about this disorder is that it has one grave danger—*suicide*—which is an ever present risk even in these patients. It is well to share the responsibility of management of these patients with a psychiatrist. The question may arise in cardiac patients with depression as to whether the cardiologist should allow the psychiatrist to give electric shock therapy. Although most psychiatrists are convinced that electric shock therapy should be recommended for depressions, some recorded data suggest that this procedure neither shortens attacks nor leads to an unusual number of cures. Many cardiac patients with depressions are given this type of treatment, and it seems that cardiac accidents are infrequent. I know of one case, however, in which electric shock procedure was given to a patient with bundle branch block with the result that the patient died during the second electric shock procedure. The important point, then as far as depressions are concerned, is for the cardiologist to think of this condition in a patient who seems to be upset, paces the floor, seems unreasonable about future prospects, and who seems to have developd "neurocirculatory asthenia" late in life. Thinking of this diagnosis may prevent a suicide.

4. Thyrotoxicosis.

Thyroid disease should be thought of as a rare but treatable cause of unexplained psychiatric disease especially if there is tachycardia or auricular fibrillation. The cases which the author has seen have been characterized by disturbance of mood and activity, sometimes with delusions and hallucinations. The diagnosis of thyrotoxicosis is made mainly by remembering the possibility. A normal or low basal metabolic rate, if the patient will co-

operate for the test, makes thyrotoxicosis improbable. A blood level of protein-bound iodine above 8 gamma percent, provided no iodides have been administered, or a radioactive iodine uptake of over 60 percent of original dose in a 48-hour test indicates thyrotoxicosis. For completeness, one may mention a rare form of tachycardia plus disturbed psychologic state. At times, malingerers or psychopathic personality patients ingest thyroid secretly. Emotional over-reaction, tachycardia, tremor, and sometimes unreasonable ward behavior characterize this state. A confession or detecting the patient taking thyroid makes this diagnosis as does a discrepancy between a high level of protein-bound iodine concentration and a radioactive iodine uptake which is nil. Myxedema may include in addition to cardiac involvement irritability, unreasonable behavior, and disturbed mood, especially a depressed mood.

5. "Epilepsy."

Recurring seizures or convulsions may occur in cardiac patients, just as they may in other persons, and require investigation. After a convulsion, there may be a period of confusion with disturbed, combative, or sullen behavior. This is apt to go on for hours or a few days but not for weeks or months. The diagnosis is difficult when the convulsion itself has not been observed. Cardiac patients may have convulsions on the basis of Adam-Stokes syndrome. Sometimes embolism leads to an immediate convulsion. Sometimes cortical infarcts lead to recurring seizures and, although other causes of seizures should be sought for, Dodge and Richardson have showed that about 5% of patients with pathologically proven cerebral infarction or hemorrhage and about a quarter of these with old cortical infarcts have recurring seizures presumably on that basis.

6. Vascular Disease of the Brain.

Patients who have had strokes with or without heart disease may show disturbed behavior. The relation of disturbed behavior to specific lesions in the brain has not as yet been determined although we are impressed with the possibility that temporal lobe or midbrain lesions may show special association with such disorders. Many patients show marked changes in mood, thinking, and behavior on the basis of multiple brain infarctions. This condition is sometimes referred to as *cerebral arteriosclerosis*, and there is usually a history of strokes and neurologic signs.

7. Paresis.

In patients with syphilitic aortic insufficiency or syphilitic aortic aneurysm, disturbed behavior may sometimes suggest not delirium but actual general paresis (syphilitic meningeo-encephalitis). In this country, this is rare, but should be thought of since it is treatable. I recall a patient who was being managed for rheumatic aortic insufficiency, in whom the discovery of general paresis turned the attention toward the correct diagnosis of syphilitic aortic insufficiency and aortic aneurysm. Paresis is an illness with the onset about twenty years after syphilitic infection, which includes progressive deterioration of memory, ability to calculate judgment and behavior, mood disturbances, and neurologic signs which include Argyll-Robertson pupils, slurred speech, tremors, and exaggerated deep tendon reflexes. There may be paralyses and convulsions. Patients may become noisy, overactive, depressed, overtalkative, may walk on the ledge of the hospital windows, demand to leave the hospital, or may become combative. Characteristic spinal fluid includes positive Wasserman, high protein, lymphocytic pleocytosis, and sometimes a first zone (paretic) gold sol curve.

8. Senile Psychosis.

This is a common condition and a growing problem. It may complicate heart disease, or heart disease may complicate it. It is my impression that the disorder is unusual before the age of 70. Perhaps the rare patient diagnosed as having Alzheimer's disease represents the identical disorder in younger patients. This should not be confused with vascular disease of the brain. Patients may show poor memory particularly for recent events and in some cases lose ability to make new memories. A patient's general behavior may be uncontrolled; he may wander around the home or street unclad, set himself or the house on fire by carelessness with cigarettes, or make unprovoked remarks or scenes. In contrast to delirium where the prognosis for recovery is excellent, this disorder does not have a good prognosis either for improvement of behavior or for life. These patients survive only about two years after institutionalization.

GENERAL APPROACH TO THE PROBLEM OF DIAGNOSIS

Obviously the correct diagnosis is important in deciding what to do for the disturbed patient. It is well to consider as a minimum the conditions mentioned above when cardiac patients exhibit disturbed states. General steps should include:

(1) Determine from the family whether the patient has had previous psychologic disturbance, or whether he has been institutionalized. Determine whether the condition was of acute onset or whether the patient had been developing psychologic or behavior difficulties over a number of years. Sometimes the patient's history must be obtained by telephone from relatives, neighbors, or friends. In addition to observing the patient's disturbed state, it is also important to do a new physical and neurological examination, as new disease may have developed. A disturbed state developing in a cardiac patient indicates that the whole medical situation should be re-evaluated.

(2). Examine the temperature chart for evidence of even slight fever.

(3). Re-examine the list of drugs to consider whether the patient is being over-drugged, or if any drug can be omitted; determine if the patient has been given drugs by another physician.

(4). Perform certain tests. A determination of blood bromides may reveal unsuspected bromide poisoning; electrolyte studies or determinations of CO_2 content or combining power of the blood may show abnormalities; lumbar puncture may disclose evidence of paresis, meningitis, or brain hemorrhage. It should be remembered that patients with high venous pressure have high spinal fluid pressure. To what extent high intracranial pressure under these circumstances contributes to symptomatology is not known. It is well to determine the level of nonprotein nitrogen or urea in the blood: this is often an improtant negative finding. Generally speaking, renal failure or uremia does not explain most disturbed states in cardiac patients.

MANAGEMENT AND TREATMENT

1. Specific Treatment.

The most important step in the treatment of disturbed states complicating heart disease is the specific treatment whenever specific treatment is available for the medical disease which accompanies the disturbed state. For instance, if the patient has Pneumonia, bacterial endocarditis, or heart failure, treat them appropriately.

2. Specific Treatment of the Delirium.

Except for special states such as bromidism, where the treatment is gradual substitution of chlorides for bromides, the specific treatment for delirium is for most part specific treatment for the major illness or for its other complications.

3. Management of the Delirious State.

a.) *Protection of the Patient*—This involves seeing that the patient does not fall out of bed, run out into the snow, or jump or fall out of the window, fall down steps, or pick open a surgical wound. The best single adjunct here is a trained nurse or attendant. It is a wise precaution to see that the windows are secured in such a way that the patient cannot fall or jump out. It should be remembered that the patient can wander into the next room or kitchen where the windows may be open. If the cardiac patient refuses to stay in bed and wishes to sit in a chair or walk around the hall, it is a matter of judgment to decide whether it is better to allow the patient to do this peacefully or to let him fight and struggle while he is forcibly restrained by the attendants, or whether it is better to over-sedate the patient. If mild sedation and subtle persuasion are ineffective, I personally prefer, even though I know there is a risk of a fresh coronary occlusion, to allow a patient to sit in a chair, go to the bathroom, or go for a peaceful stroll rather than to render him stuporous with drugs or to have him fighting and shouting. In some cases, one gains the impression that the general situation is actually improved by allowing the patient to sit in a chair, even though the experiment may seem hazardous.

In some case, restraint of hands and feet have a place in the short term management of patients, particularly in those patients who have had surgery and whose restless hands pick wounds and dressings, such as after cardiac surgery or the sympathetic system. If the patient is restless and not sleeping and seems frightened, one should put on the light; if, however, the light keeps the patient awake, it is best to do without it. Sometimes having a relative sit at the bedside is helpful, particularly, in my opinion, with sick children. However, it should be remembered that many relatives find attending delirious patients a very disturbing experience.

b.) *Feeding the Patient*—Disturbed patients somtimes eat only upon being coaxed to do so, or sometimes refuse food entirely. If artificial feeding must be resorted to, recall that the stomach is a good place for food. To pass a small nasal tube skillfully is not a difficult operation, and through this one may give fluids, medicines, food, and almost everything the patient needs. One must make sure that the tube is in the stomach and not in the lungs before putting in food. One should first place the end of the tube in a glass of water to see if bubbles appear; then when the tube is in place, a small amount of water should be run through to be sure that this does not provoke coughing or strangling. If bubbling, coughing, or strangling appear, the tube is not in the stomach and it should be removed and replaced in better position. Besides the fact that stomach feeding is more satisfactory, it probably is a safer route than the vein for the administration of fluids to cardiac patients.

c.) *Drugs*—The rule to follow here is to omit all drugs that are not clearly necessary, to continue with all drugs which are specific and perhaps life-saving, and to substitute other forms of drugs for drugs that are necessary and of which there are various forms. If sedatives are necessary for sleep

or for extremely disturbed behavior, we prefer paraldehyde or chloral hydrate to other drugs; a dose by mouth of 8 c.c. (two drams) of paraldehyde in ice cold ginger ale is tolerated well by patients and this can be repeated with safety as the situation demands.

d.) *Oxygen*—In patients for whom oxygen is deemed necessary, the patient may unfortunately sometimes struggle and fight in the oxygen tent. In these circumstances, try giving the oxygen by nasal catheter. If the patient still fights against this, it is then best to omit oxygen for a while and then try again, or discontinue oxygen altogether if it still provokes struggling.

e.) *What to Tell the Family*—It is well to explain to the family that delirious states are usually secondary to the patient's general condition and that, when he improves medically, the delirium will go away. It should also be explained to the family that delirium is not like ordinary "insanity," and that there is no evidence to show that this runs in families and that there is no reason to believe that the patient's past problems or difficulties caused the trouble, or that the family caused it. Families may be greatly upset by the appearance of disturbed states, particularly in cases where the patient is clear before coming into the hospital, and then becomes confused and develops abnormal behavior during hospitalization.

f.) *Where to Take Care of the Patient*—In general the best place to take care of the patient is in the place where he is. In certain types of medical institutions the nurses and staff may feel that the disturbed cardiac patient is too difficult to manage. However, even the most administratively formal hospital can be persuaded to keep a patient for a few days for a medical emergency, which these disturbed states really are. Some municipal hospitals are particularly adept at managing these patients. A modern hospital should be especially equipped to house a few disturbed patients. If the patient's behavior is extremely abnormal or if the patient is terribly combative or suicidal, one might finally transfer the patient to a psychiatric institution and arrange for his cardiac supervision there. If a patient's cardiac condition seems terminal and if he is in an excited condition, adequate sedation rather than commitments to a mental hospital is more appropriate. If the patient's heart disease or heart failure is merely an incident in unmanageable senile psychosis, institutionalization is sounder both for patient and family.

CONCLUSIONS

The problems of management of disturbed cardiac patient involves: (1) Precise diagnosis; (2) seeking out hidden complications; (3) treating what can be treated specifically; (4) nourishing the patient and protecting him against the hazards of his disturbed behavior.

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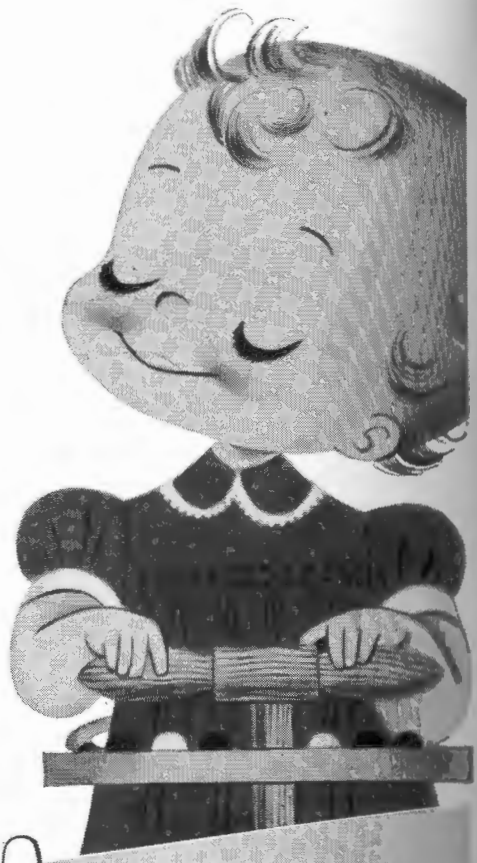

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