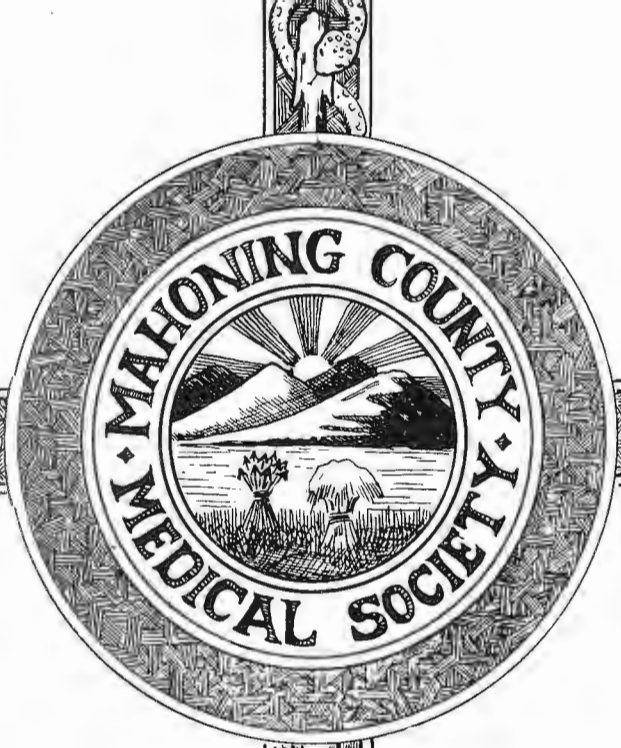

BULLETIN

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COUNTY
MEDICAL
SOCIETY

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Youngstown • Ohio

BLOOD BANKING IS NOT A MESS IN YOUNGSTOWN

A recent article (2-17-58) in "Medical Economics" described an alleged "mess" concerning the procurement and distribution of blood in the United States.

I do not believe that there is a "mess". The contradictions and controversies mentioned in that report reflect the evolutionary process taking place to increase the efficiency of Blood Banks in their fundamental job of making blood available to every patient in the United States who needs it. While it is true that occasionally opposing philosophies exist between the American Association of Blood Banks (AABB) and the American Red Cros (ARC), it seems that these differences are an indication of the universal desire to do a better job in furnishing the ever increasing amounts of blood needed in modern medicine.

ARC Blood Banks evolved during World War II and were re-activated shortly before the Korean War, at which time, large quantities of blood were procured for the military services and for local use. The ARC is a quasi-official agency and the blood program represents but one aspect of its total program.

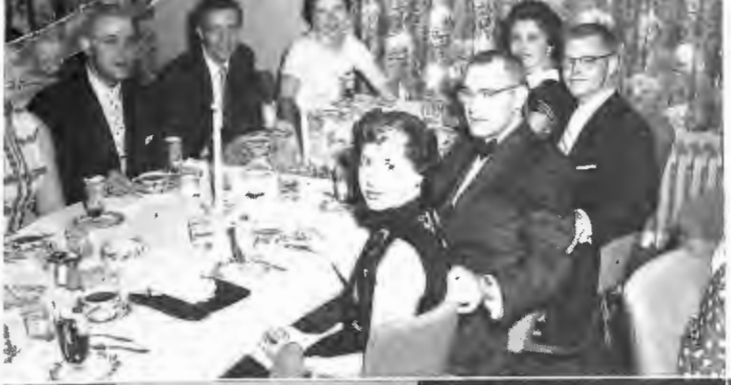
The American Association of Blood Banks (AABB), as its name implies, is an organization of banks and persons interested in blood. It is a medical organization run by doctors, technologists and lay people working together to solve the same problems by private, non-governmental means. The alleged "mess" arises out of the difference of opinion concerning the role of the ARC in private medical problems which the AABB considers is a function of private medicine.

Be that as it may, there is no "mess" in Youngstown. The Youngstown Hospital Association Blood Bank works with the AABB and the ARC, cooperating with both and helping both for the successful achievement of its fundamental mission of furnishing blood to an ever increasing number of patients.

Few people realize the extent of the activities of the Blood Bank of The Youngstown Hospital Association. I would like to discuss this matter in order to clarify the local situation.

In 1957, 5799 units of blood were collected and dispensed to patients in The Youngstown Hospital Association. Of these, 2403 pints of blood were obtained through "Blood Club" activities. Our blood clubs include: The Mahoning County CIO (comprising 46 individual union locals), The Youngstown Sheet and Tube Co., Republic Steel Co., General Fireproofing Co., and a host of fraternal, social and religious organizations, including the ARC in Columbiana and Trumbull Counties. Briefly, each club is organized as a mutual self-help group, in which members agree to make donations to the blood bank in advance and, in return, to establish credit for themselves and for their wives and children and all other club members agreeing to make such donations. By such a mehod, it is possible for a blood club member or his dependent to receive blood on a one for one basis. In 1957, 2403 pints of blood were made available under this system, representing 41% of the total amount of blood collected. Such a system makes it considerably easier for patients to settle their blood obligations. The pressure upon the physicians to exhort their patients to replace blood is reduced and the blood bank can plan an actuarially sound replacement program.

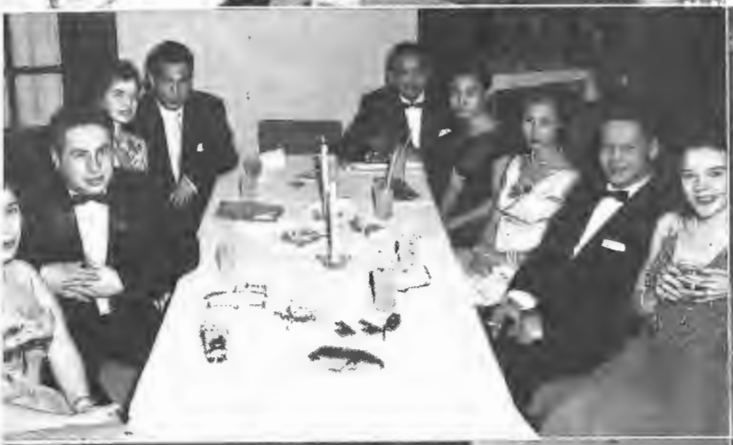
As an extension of the blood club concept, the AABB has recently organized the so-called "National Clearing House" system whereby it is possible to give blood to patients hospitalized in The Youngstown Hospital Association which has been donated in any city within the United States by friends or relatives. Conversely, it is possible for blood to be made available to inhabitants of Mahoning County who are hospitalized in distant cities, and whose

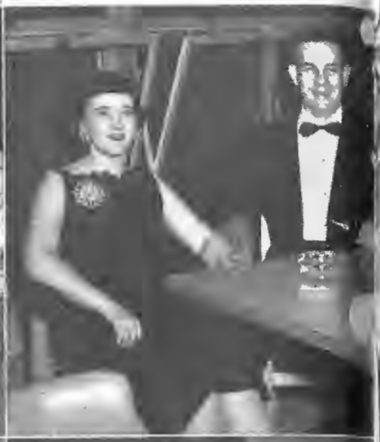


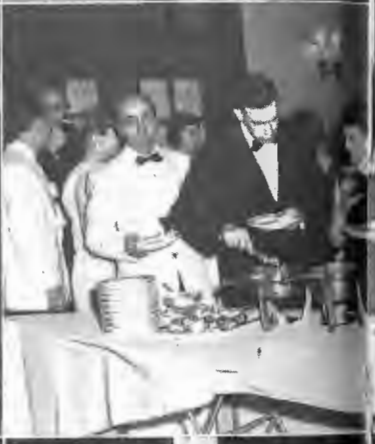
MEDICAL
DINNER

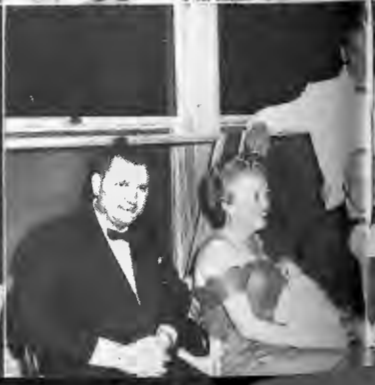
SQUAW CREEK

APRIL





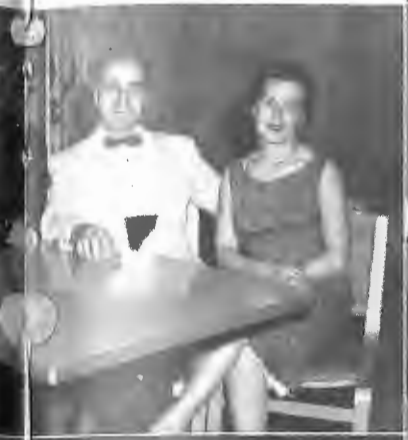


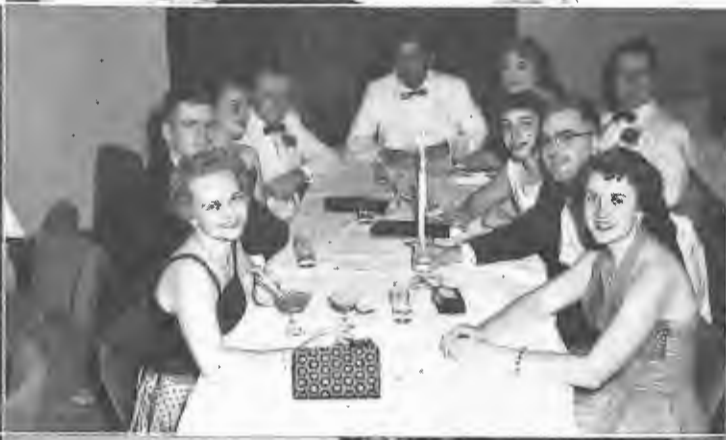


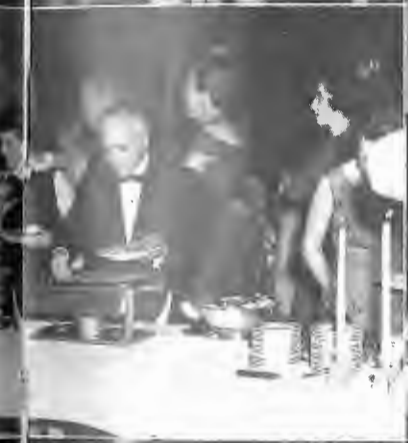
L-DENTAL
k DANCE

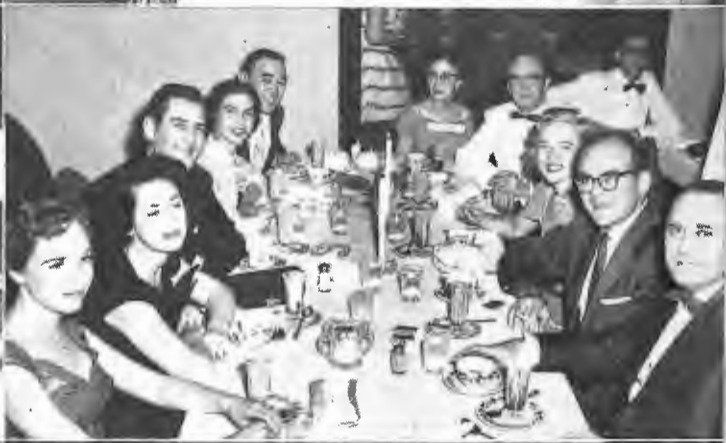
K COUNTRY CLUB

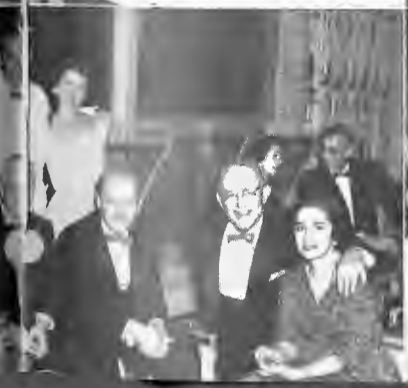
- 19, 1958











donors reside locally. These donors may donate to the Youngstown Hospital Association. The blood will be transferred either as such or as credits, to the hospital wherein the Mahoning County resident is hospitalized. With such an exchange system, it is possible for people to settle their distant blood obligations equitably, economically and rapidly. The National Clearing House System is an independent operation maintained as one of the functions of the AABB. By means of this organization, we have transferred blood to Florida and Tennessee and have received blood from as far as California.

Another means by which the scope of the blood bank of The Youngstown Hospital Association has been expanded has been achieved in association with the ARC. Many residents of Trumbull and Columbiana Counties are hospitalized and transfused at The Youngstown Hospital Association. These out-of-county patients' blood obligations at our hospital are a responsibility of the ARC Regional Blood Bank in Cleveland. Because of this, the Regional Blood Bank in Cleveland is constantly indebted to The Youngstown Hospital Association. It is thus possible to transfer blood to residents of Mahoning County who are hospitalized in distant hospitals using those Cleveland Red Cross credits and the National Red Cross system. We have had opportunities recently to transfer blood credits to patients who were hospitalized in Cleveland, New York City and Chicago because of specialized surgical procedures available in those centers. These patients' blood requirements are large, but they have been met by debiting our account with the Red Cross. Their friends and relatives make direct donations to our bank to meet this obligation.

By such methods, the gradual integration of blood bank activities throughout the country is being accomplished successfully. There is a great deal yet to be done but the fundamental position of The American Association of Blood Banks permits intelligent and successful growth within the framework of private medicine. I feel that the duty of the patient and his relatives to meet their blood requirements should not fall upon governmental or quasi-official agencies. It is possible to meet their personal obligation by becoming members of local blood clubs or by asking members of his family to do so.

The problem of blood will steadily become larger as medicine progresses. further extension of the benefits described above should not be delayed. All residents of Mahoning County should become members of blood clubs, either through their fraternal, religious and industrial organizations or sport clubs. I think that it should be possible to obtain an overwhelming majority of residents of Mahoning County to participate in blood bank clubs. If such were the case, the present requirement of two units for one unit for the first three transfusions could probably be reduced to two for one for the first two transfusions and possibly, in the future, on a one for one basis.

Medical science has made enormous strides in creating methods to achieve replacement of this precious material. A great deal has yet to be done. Doctors can serve the community and their patients in an intelligent and effective fashion by promoting the growth of the blood club concept, by supporting the activities of The American Association of Blood Banks and by avoiding fruitless and non-productive polemics concerning the merits of the various organizations concerned with blood procurement. History will determine which will be the most effective. History has proved that private medicine can do the job successfully, efficiently and rapidly through good will and cooperation by all.

Arthur E. Rappoport, M. D.
Director of Laboratories and Blood Bank
Youngstown Hospital Association
Ohio Representative
American Association of Blood Banks (AABB)

IN MEMORIAM

Dr. Charles David Hauser, one of Youngstown's most distinguished surgeons, expired in St. Elizabeth's Hospital April 17, 1958. He was born in Girard, Ohio, June 11, 1875, the son of David and Mary Bixler Hauser. Following his graduation from Girard High School he spent a year studying medical practice under the preceptorship of Dr. A. E. Warren in Girard. After three years' attendance at the University of Buffalo Medical School he graduated in 1896 with the highest honors. He was one of the youngest candidates to receive the doctorate degree in medicine from that College. He spent one year as intern at the Buffalo General Hospital under the guidance of Dr. Roswell Park, Dr. Charles G. Stockton, Dr. Matthew D. Mann, and other celebrated physicians and surgeons.

Dr. Hauser started the general practice of medicine in Youngstown in 1898. Early in his career he was a member of the attending medical staff at the Youngstown Hospital. In 1901 during a severe epidemic of smallpox he served two months, under quarantine, as chief medical officer in the old Mahoning Valley Hospital. Later in 1906 he pursued post-graduate studies in London. On his return to the United States he restricted his practice to general surgery. He received a fellowship in the American College of Surgeons in 1914 and attended clinics in Europe shortly afterward with the tour of the Clinical Surgical Congress.

Dr. Hauser joined the surgical staff of St. Elizabeth Hospital when that hospital was first started. His services at St. Elizabeth's continued for many years. For several he was director of surgery and later president of the staff. He contributed much to the development of St. Elizabeth Hospital both professionally and materially. He donated its first X-Ray equipment.

Most of Dr. Hauser's operative work was in the field of abdominal surgery. His very active practice brought him many varied and unusual problems. To mention a few—a repair of omphalocele in an infant only a few hours old; another in the opposite age group, an intestinal obstruction in a patient in her nineties; both with successful results.

His example influenced three of his nephews to become doctors of medicine. All three were associated with him at some time during his career. Two of them, Dr. Kelly Allison and Dr. Karl Allison preceded him in death. The third, Dr. David Hauser resides in Youngstown.

Dr. Hauser was president of the Mahoning County Medical Society in 1914 and president of the Sixth Councilor District Assembly in 1921. He was a member of the Ohio State Medical Society, the American Medical Association and the American College of Surgeons, and attended all their meetings assiduously. He possessed a splendid medical library and his surgical armamentarium reflected his desire to give his patients every advantage in modern equipment. Alert to the rapidly changing methods of diagnosis and treatment, he kept abreast of the times by extensive travel to clinics in this country and abroad.

Dr. Hauser is survived by his wife, the former Mary Larson of Wausau, Wis., a former Red Cross Nurse. Marriage culminated following a courtship while both were serving in World War I. He is also survived by his daughter, Mrs. Mary Elizabeth Lindsay and three grandchildren of Akron, and two sisters, Mrs. A. C. McKinney and Elizabeth Hauser of Girard.

He was kind, generous, charitable, and devoted to his parents. He had a keen and wholesome sense of humor. He was one of the first of the local practitioners to use the automobile. He enjoyed the theater and good literature. He will be greatly missed by his many friends in and out of the profession and by numerous grateful patients. *F. W. McNamara, M.D.*

SOCIAL NEWS — YOUNGSTOWN HOSPITAL

It was a pretty skimpy month for social news, but it was one of those situations when no news is good news. There were no broken bones, no serious auto accidents and nobody that I know of lost his appendix. There were two sad notes, however. Dr. and Mrs. Henry Holden lost a newborn baby at North Side Hospital, and we extend to them our sincerest sympathy. At last report, Bob Foster was still in South Side Hospital recovering from a spinal fusion operation which will keep him out of circulation for quite some time. What a fate to befall an orthopedic surgeon.

Dr. Andy Miglets, president of the Mahoning Academy of General Practice, attended the national A.A.G.P. meeting in Dallas, Texas in March. Dr. Dick Murray left on the 23rd of March for a six-weeks tour of Europe.

Dr. and Mrs. Harry Fusselman celebrated their 40th wedding anniversary April 1st. No April fool there! They had their two sons, Harry and Randy home for the event.

Dr. David Brown spoke before the Campbell women volunteers for the Mahoning Cancer Society on March 22nd. Dr. Oscar Turner spoke on Epilepsy at the spring dinner meeting of the Mahoning Valley Chapter, International Council for Exceptional Children, on March 26th. Dr. S. Franklin was Program Chairman for the affair.

R. R. Fisher, M.D.

HAPPY BIRTHDAY ! ! !

May we take this opportunity to extend our best wishes on your birthday and wish you health and happiness for many more.

May 18
S. F. Gaylord
May 22
V. C. Hart
May 23
M. W. Neidus
May 24
A. Calder
N. J. Nardacci
J. J. Wasilko
May 25
B. B. Burrowes
May 26
J. M. Benko
May 27
G. B. Pugh
May 28
H. Segall
May 30
H. L. Allen
C. A. Gustafson
May 31
J. B. Kupec
H. J. Reese
June 3
B. C. Berg
June 4
H. B. Hutt
H. H. Ipp
R. B. Poling
J. Schreiber
June 5
J. W. Tarnapowicz
June 6
E. R. Brody
E. Shapira
June 8
A. DiDomenico
G. G. Nelson
June 9
W. H. Gross
K. C. Kunin
J. Noll
June 10
R. W. Parry
June 11
W. Z. Baker
June 13
J. G. Guju
R. L. Jenkins, Jr.
F. A. Resch
June 14
R. R. Fisher
June 15
U. H. Boening
A. R. Cukerbaum

BOX SCORE
At the Annual Medical-Dental Dinner-Dance
14%
of our Society was in attendance.

At the April Trauma Meeting on the 29th
23%
of our Society was in attendance.

MEDICAL GLEANINGS

Jaundice, Hyperlipemia, and Hemolytic Anemia: A Heretofore Unrecognized Snydrome Associated with Alcoholic Fatty Liver and Cirrhosis

Annuals of Internal Medicine — March 1958

By Leslie Zieve, M. D.

Dr. Zieve reports on 20 patients that have been observed who exhibited an interesting group of manifestations not recognized as a distinct syndrome before, and who have a predictable course.

The essential clinical features are jaundice, hyperlipemia, or hypercholesterolemia, and hemolytic anemia. The illness follows excessive drinking and improves rapidly once the drinking stops. The hyperbilirubinemia and hypercholesterolemia recede over a few weeks. Hemolysis is generally slight and of short duration. The anemia is mild or moderate and does not persist. Hepatic function is usually mildly disturbed and improves rapidly. The anatomic abnormality on liver biopsy is fatty infiltration and minimal to moderate portal cirrhosis. The author suspects that the mechanism of the hemolytic anemia is related to the hyperlipemia and that an abnormal lipid may be present to account for this. ——o——

The Value of Aminopyrine

Annuals of Internal Medicine — March, 1958

By Drs.

Leonard Cardon, Oscar H. Comess, Thomas A. Noble, and Mark M. Pomaranc

Six cases are reported to illustrate the potent antipyretic effect of Aminopyrine. In three of these cases—one of periarteritis nodosa, and two of prolonged intractable fever of unknown origin but most likely due to acute exacerbation of rheumatic fever—Aminopyrine was the only drug which controlled the fever and reversed the progressive downhill course of the disease after weeks of inaffective therapy with large doses of chemotherapeutic and antibiotic agents. In these three cases, the action of Aminopyrine simulated that of a specific drug and proved to be lifesaving. Agranulocytosis did not occur even in the cases when the drug was given over long periods of time and a tendency to leukopenia in one case was readily controlled by reduction in dosage.

Aminopyrine is of value particularly in conditions not amenable to therapy with specific chemotherapeutic and antibiotic agents or where these prove to be ineffective, in cases where other antipyretics are not tolerated or have failed, and in cases where one is unwilling to assume risks of therapy with corticotropin and corticosteroids, or these have failed, or some specific contraindication to their use exists in a particular case. However, Aminopyrine may be used in any condition as a primary agent to control higher prolonged fever, alone, or as a supplement to other therapy.

R. L. Jenkins, M.D.

DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship is the primary process in all therapy and the fundamental basis of the practice of medicine.

The following are some observations and opinions about a process that exists each time a patient meets his physician. This relationship begins before the patient sees the physician, it continues after the patient is no longer consulting the physician, and it lingers on in his family and friends if the patient has expired.

I plan in the future to write about the physician and the patient regarding reactions to illness and to surgery. This paper could be appropriately titled "How to Listen" or "How to Keep Your Mouth Shut."

The more the patient senses that the doctor is interested in him and trying to understand how he feels about his complaints, the more trust and confidence he will have in the physician; the more the patient likes the doctor as a physician, the better total therapeutic results will be obtained by the physician. The patient desires and must have more than scientific diagnosis and therapy.

What can the physician do to create this needed relationship? The physician must know how to listen, he must display certain attitudes, he must have some knowledge about each patient's personality and life situation, the physician must be aware of the effects of things he says and does upon the patient.

The evaulating by the physician is no unilateral. The patient is estimating and interpreting the physician. Patients respond to verbal and non verbal cues given by the physician—to his words, movements, intonations, expressed and unexpressed emotions.

A proper attitude for a physician has been called an "I'm for you" and "a lots of time" attitude. This is best created by active and interested listening. As a general rule, the more a patient gets to talk, the more he will tell and the more he will trust the doctor.

The verbal cues given by the doctor in active listening should be simple and direct. Most commonly effective are, "yes", "um", "and", "well," repeating the patient's last word or few words. The physician can shift the emphasis from the patient's subject to the patient's method of communicating. For example, "You appear to be frightened (or concerned) about . . .", "You seem to have difficulty talking about . . .", or a friendly "I can almost see your blood pressure go up (or arteries contract or stomach get upset) whenever you mention . . . "

The patient senses the physician's attitudes—he frequently distorts his impressions to suit his own needs. Many patients respond (after giving a history and even more after the physical examination) to "What are your ideas (or feelings) about your condition?"

Sometimes the physician has the problem of getting a patient off a subject. The simple and effective methods are to show no interest, ask no questions about the subject, introduce another subject, or remark about the patient's emotion rather than what he is talking about.

Naturally, patients are more aware of and can verbalize their dislikes much easier than their likes. They have summarized their favorable impressions by "interested", "took his time", "treated me with respect", "cared (or understood) how I felt." A patient reacts favorably to the physician (including his staff and office procedures) who makes him feel that he is a fellow human being—not simply some speciman of disease. Most people prefer a physician who obtains the case history in an informal manner—getting or taking the

case history by a series of questions from a piece of paper creates the impression that the physician is a gatherer of facts rather than an interested therapist.

Patients react negatively to any of the following:

The physician's not paying attention.

"I understand"—one person rarely believes another understands until he has talked at some length and expressed his emotions. The same applies to reassurance given quickly.

The physician who shares his own experiences. Patients do not desire to hear the physician's problems and complaints.

"What are you worried about?"—This is usually accepted as a hostile or disgusted comment. The patient will present his worries when he is ready and when the physician has picked up the hints about his problems that he has offered.

Ridiculing or minimizing the patient's questions or ideas. Physicians have encouraged the public to be informed—therefore, we should neither prevent patients from stating their doubts, fears, and misconceptions obtained from reading, friends, and relatives nor coldly reject what they offer. All too frequently, the physician answers a patient's question before the patient has stated his real question. A safe general rule and an excellent technique is not to answer a question until the patient is made to answer why he asked the question.

As a result of the emphasis on psychosomatic medicine, the patient often feels he is asked intimate and personal questions while he is still a stranger.

The physician has the constant problem of time. It would be impossible to give each patient all the time that the above material would seem to require. The factor of time is highly relative. The physician who establishes a good doctor-patient relationship by his attitude and skillful methods really does not require more time. In fact, the satisfied patient is constantly amazed that the physician has given him so much time only because interested and undivided attention has made him feel that a few minutes is a long time. *F. Gelbman, M.D.*

MEDICAL-DENTAL DINNER DANCE

The medical-dental dinner dance was held this year at the Squaw Creek Country Club on April 19th. It was a warm clear night, perfect for a spring formal, and it brought forth a delightful display of new summer dresses and evening gowns. Even the men felt the urge of spring, as there were many white evening jackets, and pastel ones too.

The evening got under way with a FREE cocktail hour before dinner, and this was a delightful innovation. Dinner was served buffet-smorgasbord style and was excellent, with a nice variety and tastefully prepared.

Music was provided by Lou Sikora and his "Society Notes." Someone must have whispered into his ear because for the most part he seemed to play music that most people could dance to, and this too, was a delightful surprise.

About 80 couples attended, enough to make the club comfortably full, and they drank free cocktails, ate, danced and thoroughly enjoyed themselves.

Chairman for the event was Dr. J. J. Wasilko, and his committee: Dr. R. R. Goldcamp, Dr. H. E. Mathay, Dr. W. L. Mermis and Dr. J. L. Scarnecchia. Our congratulations to them for a job well done. *R. R. Fisher, M.D.*

THE IMPORTANT ASPECTS OF DIAGNOSIS AND TREATMENT IN CHILD GUIDANCE CENTERS

The Child Guidance Center of Youngstown was established in 1950 to provide the community with much needed services for emotionally disturbed children. What began as a special project of the Junior League has now developed into an important community resource supported by the local Community Chest and the Ohio State Dept. of Mental Hygiene and Correction. Mental Illness has become one of our most burdensome public health problems and the Child Guidance Center is one of the ways of putting into practice what we know about preventive psychiatry.

Just as in general medical practice or in the various specialties, the diagnostic study is of strategic importance in gaining an understanding of the nature of a child's mental or emotional disturbance and in developing a plan for treatment. While child psychiatry may be practiced in a variety of settings, private practice, in-patient or out-patient clinics, courts, residential treatment centers, the nature, scope and importance of the diagnostic process and evaluation is the same, since this is determined by the nature of childhood itself. The purpose of this paper, however, will be to describe certain basic assumptions essential to the consideration of the diagnostic process and the procedures as they relate to psychiatric services for children given here in the Youngstwn Child Guidance Center, or as they apply to most any other typical mental hygiene clinic giving service to emotionally disturbed children.

Before discussing methodology, in gathering and evaluating diagnostic data, certain basic assumptions relating to current knowledge concerning development of human personality need to be considered. In distinction from adult psychiatry, the child psychiatrist sees a chronologically immature individual who is in a fluid state of incomplete personality development, characterized normally by rapid physical and psychological changes. This plasticity is of immense practical and theoretical importance, since it means the child does not have such a structured ego and is therefore not only more flexible, but more vulnerable to the environmental forces around him.

The diagnosis of child pathology requires first of all the accurate delineation of those aspects of development, which are primarily disturbed, together with some reasonable hypothesis concerning the multiple social, biological, physical or psychological factors that might have operated in the past or present to cause the disability or deviation. This must be based on a body of knowledge concerning normal personality growth. All findings are weighed against the developmental norms for successive changing stages of growth. Because of the profound interconnection between mental, emotional and physical factors in the growth of any child, the medical examination is basic to the diagnostic procedure in discovering the etiology of emotional illness. An established policy of the local Child Guidance Center, is the pre-requisite of a recent medical examination of the child and pertinent medical history. In the field of general medicine, there is growing recognition of the concept that the psyche under stress or in conflict can create emotional impulses which can alter physiological function and vice versa. Such common disturbances as vomiting, anorexia, colic, obesity, ulcers, migraine and etc., have large elements of emotional etiology. In the child, physical examination may reveal minor deviations in his basic somatic equipment such as mild visual or auditory disturbances and these factors are of no less significance than gross physical handicaps or neurological disorders in their potential effect on the child's adaptive qualities. The impact of organic disorder is potentially greater on the growing child than the adult in some respects. The disorder

itself may not be more severe, but it may produce sufficient anxiety in the child and and/or his parents to affect adversely his subsequent physical and emotional development. In these and other disturbances, neurological examinations are often needed in order to make a valid diagnostic study.

With the advances being made recently in the use of drugs, the child psychiatrist needs to know if the child has been receiving drugs or any other medication for treatment of already existing behavioral disability, organic or functional illness. Certain drugs may alter the basic behavior patterns leading at times to depression, hyper-activity, irritability, hallucinations or other symptoms. The whole class of tranquilizers would need to be included now. Regardless, of the setting, the important point is, that physical evaluations are an integral part of the clinical practice of child psychiatry. The usual practice is for the referring physician to complete the physical examination.

The concept that a childs behavior reflects his attempts to adapt to a series of tension producing situations is fundamental to the diagnostic study of children. The well adjusted child's methods are usually socially acceptable and personally satisfying. The emotionally disturbed child's adaptive attempts are not effectual; may not be personally satisfying, and may even be experienced internally as distressing symptoms either on a somatic basis or as outer signs of disability. They may be manafested in behavior, such as stealing, lying, bullying, which is not only socially unacceptable, but often disrupting to others. A basic concept to be agreed on is the belief that normal personality patterns evolve out of inter-personal relationships. The child is always interacting in varying degrees with external social forces, especially his family. In infancy, he depends totally on his parents for all his primary satisfactions, for loving care and protection to sustain life itself. These lay the foundation for further physical and psychological maturation. Through the dependency aspect of childhood, the child is helped to develop an awareness of himself as an organized and separate individual. The growth of a child's sense of his identity is accomplished through certain observable phases of development. His oneness with the mother in earliest infancy passes on as his needs are met and satisfied. In the normal, mutually gratifying symbiotic relationship with his mother, the child and mother's needs are complementary because in anticipating and meeting her child's needs, the mothering person is also fulfilling her own mothering role and function. As the child grows, certain common challenges are inevitably experienced. As he begins to sense his own identity, he begins to recognize the differences in relationships between mother and father, between siblings and himself and siblings and his parents. His previous image of his omnipotence as an infant must give way when he is confronted by these triangular relationships. The unique relationship between his parents, his increased curiosity about sex, bodily differences in himself and others, all give rise to conflicted feelings of love, anger, rivalry, fear and guilt. To meet these universal life experiences, the child needs adult understanding; a kindly, firm appropriate balance of limits and permissiveness; and sound parental standards of identification in order to attain a valid acceptance of himself—of his biological sex, of his native aptitudes, and of his realistic position in his family relations, his peers, and teachers. The child needs parents who, first, individually and somewhat differently as man and woman, and then as husband and wife, and later as mother and father, have attained the maturity of enjoyment and sharing their mutual creative possibilities in fostering the child's continued growth.

In essence, then, the diagnostic process must include two main areas of inquiry: 1. The child himself, his basic physical and intellectual endowment;

the inner bilogical and psychological forces, behavior patterns and ego mechanisms which emerge in the development of his own identity. 2. The environment and all its social forces which influence the child so enormously as he grows. Because of this recognized influence of the family in the environment and the child's inter-action with it, one specific difference in child and adult psychiatry is the inclusion and involvement of the parents in the process of making a valid diagnosis of a child's emotional disturbance. Basic to the understanding of parent-child inter-actions, is the recognition that the parental capacity to meet a child's needs may vary greatly in his different phases of growth. The child's normal behavior at one stage may elicit healthy parental responses, whereas at another it may elicit or reactivate the parent's own immaturities. Inadequate parental responses to the child at any level may vary from overindulgence and excessive permissiveness or overly ambitious and premature stimulation of more grown up behavior, more suitable for a later phase of development. For normal growth, the child needs to exact the appropriate satisfactions to be derived from each stage of development in order to move on to the next. A major aim of the diagnostic process in child psychiatry is the understanding of the breakdown or lack of development of this healthy interaction as it gives rise to behavioral disabilities, learning difficulties, or somatic symptoms as already mentioned.

When the diagnostic study is being made, it is a dynamic process experienced by the child and his parents, which offers them new relationships and meaningful experiences as they face together their problems revealing the various biological, pschological, and social factors involved. Since no unilateral study could show the significant factors operating in a family situation or the cross currents therein, study must be made and sufficient historical material gathered, in order to have a valid evaluation of the child's functioning in all areas, his basic physical equipment, and his intellectual endowment. In order to investigate these various diagnostic areas, and help children and parents deal with their problems individually and together, the child guidance centers have been staffed and structured with the several professional disciplines trained to provide skill and experience in making a comprehensive diagnostic study, evolving realistic treatment plans. The usual clinic staff is composed of psychiatric social worker, clinical psychologist and child psychiatrist. It is the ultimate medical responsibility of the psychiatrist to synthesize the various diagnostic data provided by the social worker, psychologist and the psychiatrist himself, into a comprehensive diagnosis of the child in his environment. It is usually the social worker who implements psychiatric policy at intake and through his professional skill and judgment helps to prepare the parents in their use of psychiatric help. The clinical psychologist conducts psychological examinations which serve as an aid to the evaluation of limitations and assets of children who are referred for psychiatric study. Testing is particularly indicated when there are questions involving learning difficulties, mental retardiation, possibility of brain injury, or the existence of psychosis. Psychological examinations are given not as ends in themselves, but are aids to the child, his parents and to the clinic staff, in their endeavors to find ways and means of resolving difficulties. The psychiatrist, brings to the diagnostic and treatment process his medical and psychiatric knowledge of the whole spectrum of human growth and behavior whereby he sees personality development as a continuum from infancy through childhood, adolescence, and adulthood.

This paper does not deal with the various treatment goals or plans used to help ameliorate or correct the child's emotional disability. It is sufficient

to say that any treatment plan is based on knowledge of the cause of the disturbance. The main emphasis in this report has been to state that the same careful consideration must be given to the diagnosis of a child's emotional problems as that given by the physician who is treating somatic illness. Before any sound treatment plan can be carried through, a dynamic-genetic diagnosis must be made. This kind of diagnosis clarifies what the patient does, how he interreacts with his environment, interprets why he responds as he does, and where and how the problems originated.

This raises the question of nosological classifications which are sometimes of interest to physicians especially. In child psychiatry, these classifications are only the begining of the diagnostic formulation, but they do have a place in the development of concepts and establishment of psychiatric services. The diagnosis of a clinical entity such as conversion hysteria, schizophrenia or a post-encephalitic syndrome is not only helpful in determining the immediate practical management but is important for statistical purposes. It may also furnish other leads in investigating dynamic-genetic factors. Very often, however, classifications are used as labels and are used to the detriment of the child. Actually these nosological classifications label only the pathology and do not include the child's and his family's assets. While some diagnostic classification is made, the classification is difficult, because the clinical entities are not clearly defined since children are in a developmental state. Nevertheless, there is growing interest in this area of child psychiatry and much further work needs to be done to establish acceptable and valid diagnostic classifications for emotional disturbances of children.

In conclusion, we would like to reemphasize, that, regardless of where child psychiatry is practiced, either in the psychiatrist's private office or in the clinic in collaboration with other medical or nonmedical specialists the same careful study and treatment of the child, his setting, and the involvement of his parents is needed.

I. Werbner, M.D.

WOMEN'S AUXILIARY NEWS

Mrs. Earl H. Young was elected president of the Woman's Auxiliary to the Mahoning County Medical Society for the coming year at the annual business meeting which followed a luncheon on April 9, 1958 at 12:30 P. M. at the Pick-Ohio Hotel. Mrs. Cary S. Peabody, the retiring president, presided.

With other new officers, Mrs. Young will be formally installed at a dinner May 7, at Youngstown Country Club, when the program will feature a skit which is being directed and will be produced by members of the group.

Mrs. A. E. Rappoport was named president-elect, Mrs. C. E. Pichette, vice president, Mrs. Edward G. Rizk, recording secretary, Mrs. James A. Patrick, corresponding secretary, and Mrs. Edward M. Thomas, treasurer. The report of the nominating committee was submitted by Mrs. Craig C. Wales.

Dr. Allen Schmuller, Westminster College, presented as guest speaker by Mrs. Rizk, the program chairman, gave an illuminating review of the situation facing colleges and universities today. Dr. Schmuller is professor of psychology and director of testing and guidance at Westminster. Speaking on "But Is Everyone College Material? No," he gave as the main reason for students' flunking, the lack of reading comprehension. Of those enrolled in state universities, 67 per cent do not complete four years' study, and only 50 per cent of students majoring in liberal arts finish the course, he reported.

Since Colgate University has 3,000 applications against 300 openings and Pennsylvania University has 10,000 applications against 2,000, closer screening is needed to find the best qualified students for higher education, he concluded. April is being observed as American medical education month.

Spring arrangements of daffodils, forsythia and tulips decorated the luncheon tables at which places were laid for 35. Mrs. Young gave the invocation.

Mrs. Wayne Agey, legislation chairman, urged the members to vote in the primaries. Mrs. S. G. Patton, Jr. gave a comprehensive report on civil defense and asked members to attend the special classes being offered by the local Civil Defense Corps.

Mrs. Robert Bruchs and Mrs. John F. Stotler served on the program committee, and Mrs. George Cook, as social chairman for the day with Mrs. Wayne Agey as co-chairman, were assisted by Mrs. Herman Allen, Mrs. B. C. Berg and Mrs. A. W. Geordan.

Mrs. Harold J. Reese,
Publicity Chairman

MEETINGS — MAY, 1958

AMERICAN ASSOCIATION FOR THORACIC SURGERY, Hotel Statler, Boston, May 16-18. Dr. Hiram T. Langston, 600 S. Kingshighway, St. Louis 10, Secretary.

AMERICAN BRONCHO-ESOPHAGOLOGICAL ASSOCIATION, Mark Hopkins Hotel, San Francisco, May 21-23. Dr. F. Johnson Putney, 1719 Rittenhouse Sq., Philadelphia 3, Secretary.

AMERICAN COLLEGE OF CARDIOLOGY, Interim meeting, Chase Park Plaza Hotel, St. Louis, May 20-24. Dr. Phillip Reichert, Empire State Bldg., New York 1, Secretary.

AMERICAN GASTROENTEROLOGICAL ASSOCIATION, Park-Sheraton Hotel, Washington, D. C., May 30-31. Dr. F. J. Ingelfinger, 65 E. Newton St., Boston 18, Secretary.

AMERICAN GYNECOLOGICAL SOCIETY, Grove Park Inn, Ashville, N. C., May 19-21. Dr. Andrew A. Marchetti, 3800 Reservoir Rd., N.W., Washington 7, D. C., Secretary.

AMERICAN LARYNGOLOGICAL ASSOCIATION, Fairmont Hotel, San Francisco, May 19-20. Dr. James H. Maxwell, Univ. Hosp., Ann Arbor, Michigan, Secretary.

AMERICAN LARYNGOLOGICAL, RHINOLOGICAL & OTOLOGICAL SOCIETY, Mark Hopkins Hotel, San Francisco, May 21-23. Dr. C. Stewart Nash, 708 Medical Arts Bldg., Rochester 7, N. Y., Secretary.

AMERICAN OPHTHALMOLOGICAL SOCIETY, The Greenbrier, White Sulphur Springs, W. Va., May 28-30. Dr. Maynard C. Wheeler, 30 W. 59th St., New York 19, Secretary.

AMERICAN ORTHOPEDIC ASSOCIATION, Shoreham Hotel, Washington, D. C., May 11-16. Dr. Harold A. Sofield, 715 Lake St., Oak Park, Ill., Secretary.

AMERICAN OTOLOGICAL SOCIETY, Hotel Fairmont, San Francisco, May 17-18. Dr. Lawrence R. Boies, Univ. Hosp., Minneapolis 14, Secretary.

AMERICAN PSYCHIATRIC ASSOCIATION, Civic Auditorium, San Francisco, May 12-16. Dr. William Malamud, 80 E. Concord St., Boston 18, Secretary.

AMERICAN TRUDEAU SOCIETY, Convention Hall, Philadelphia, May 19-23. Dr. E. P. K. Fenger, 1790 Broadway, New York 19, Secretary.

June 23-27 American Medical Association, San Francisco.

June 25-July 1 International Congress of Urology, Stockholm.

S. V. ZLOTNICK, M.D.