The dust we tread upon was once alive. —*Byron*

BULLETIN

of the MAHONING COUNTY MEDICAL SOCIETY

Youngstown • Ohio
VOL. XXI No. 8
AUGUST • 1951

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BASE: Rice Bran, Corn, Liver Concentrate.

SUPPLIED: in 4-oz. Rx size.

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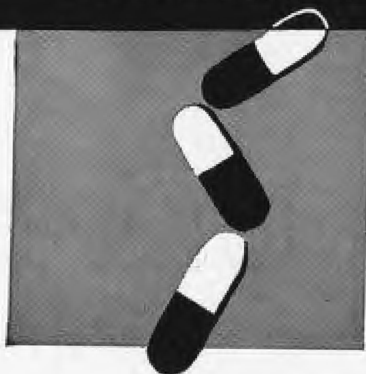

formula:

Each Capsule Contains:

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Niacinamide	100 mg.
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Liver Extract (secondary)	100 mg.
Brewers' Yeast Extract	100 mg.

plus other factors of the B-Complex present in Whole Liver.

BASE: Liver and Yeast.

SUPPLIED: in 50's and 1000's.

1. Jolliffe, N., Special Article, Council on Foods and Nutrition: The Preventive and Therapeutic Use of Vitamins, J.A.M.A., 129:613, Oct. 27, 1945.
2. Lewey and Shay, Dietotherapy, Philadelphia, W. B. Saunders Co., 1945, p. 850.

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Representative to the Associated Hospital Service
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PRESIDENT'S PAGE

On May 16th, 1951 announcement was made of the establishment of the National Fund for Medical Education by a group representing business, industry, agriculture, and labor. The honorary chairman is Herbert Hoover and the President, S. Sloan Colt, president of the Banker's Trust Company, New York.

The objective of the Fund is to raise $5,000,000.00 annually from voluntary sources for the support of the nation's medical schools. The American Medical Education Foundation has announced it will merge contributions with those of the national fund. The A.M.A. has already appropriated $500,000.00 as a nucleus for the amount to be raised by the medical profession in 1951. Voluntary contributions are solicited from individual physicians, state, and county societies. It has been suggested that the profession should accept as its minimum for 1951 the sum of one million dollars.

Physicians should make their contributions to the American Medical Education Foundation at 535 N. Dearborn Street, Chicago, Illinois.

This program offers an opportunity for every physician who believes that medical schools should not have to depend on Federal support, to contribute towards a program to solve the financial problems of our medical schools in a voluntary way. Physicians may designate the school to which their contributions are to be earmarked. Contributions are deductible from gross income.

In Mahoning County a committee has been set up to stimulate interest in this worthy endeavor and every member will undoubtedly be contacted.

E. J. Wenaas, M.D.

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio

Annual Subscription, $2.00

VOLUME 21 | AUGUST, 1951 | NUMBER 8

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

S. W. ONDASH, *Editor*

2710½ Mahoning Avenue

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O. M. I. INSURANCE CONTROVERSY

The attention of physicians throughout the State has been focused upon a consideration of the Ohio Medical Indemnity's "payment in full contract", insurance plan, in a proposal of the Ohio State Medical Association to extend and modify the extant inadequate type of coverage.

That the proposal presents controversial grounds is evidenced by divided opinion on the merits of the plan and its place on the insurance coverage horizon. There is no question but that proponents of both sides of the issue have true merit in their notions on the matter. There is no question too, that sound voluntary payment plans must be presented to a demanding public to provide a tangible balm for the burden of medial expenditures. The reduction in the number of exceptions, the broadening of the type of protection and the inclusion of a greater number of people in these programs is well indicated.

The immediate problem then lies in careful evaluation of the O. M. I. plan and a determination as to whether it provides proper answers to established and unquestioned needs.

It would be well for each and everyone of us to be a sounding board for the proposal, that we weigh the "pros" and "cons", ask questions and then arrive at a sound conclusion that will reflect a near unanimity of opinion. The matter is at your desk now. Will you be one who will disregard it until a vote is called for and then find yourself perplexed, confused and unprepared to add a "yea" or "nay" to a matter of vital concern? Spare yourself such an impending dilemna and sound off on the issue *NOW*.

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TUBERCULOSIS CLINIC AND CHEST PLATES

Status of Radiological Service Clarified

The public has responded unusually well to the aim of the Tuberculosis Association to have a miniature chest film on all adults of the community. A number of cases of unsuspected tuberculosis and other chest conditions have been found and remedial steps promptly taken.

There has been some misunderstanding, however, on the part of a number of doctors as to the function of the Center and the type of case that is to be referred there for large films. The Center is primarily a tuberculosis detection center for presumably healthy adults. If a doctor has a patient with chest symptoms that he is concerned about, and if he wants an x-ray, he should refer this patient to a private radiologist for a large film. He should never depend upon a miniature x-ray if the patient has symptoms. If the patient is medically indigent, he may be sent to the Center for a large film. A number of doctors have been sending patients to the Clinic for a free large film when they could well afford to pay for one. If a patient is unable to pay the full x-ray fee, the local radiologist will be glad to charge this patient a reduced fee if the doctor will call the radiologist and explain the circumstances to him. Many physicians charge some of their patients reduced rates and it is only proper that the radiologist reduce his fee in occasional cases.

What yardstick is to be used in determining which patients are to receive free large films? It is suggested that if the physician does not charge the patient any fee for his own services, then this patient should be permitted a free x-ray.

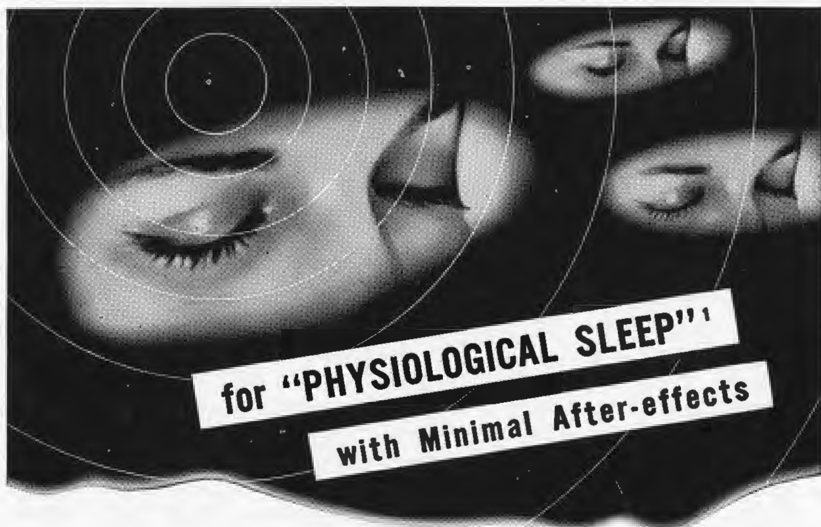
From a survey standpoint, children under the age of fifteen should not have miniature chest films as the incidence of asymptomatic tuberculosis in these individuals is negligible. Occasionally the parents want their children to be x-rayed. They should be discouraged but if they insist, the films will be taken. Children should not be referred for miniature films to rule out thymic enlargement or cardiac pathology. They should be referred to private radiologists for large films unless they are medically indigent. *It must be remembered that the Clinic is a tuberculosis detection center and not a diagnostic chest service.*

The local radiologists read all of the miniature films and reports are sent to the family physician. They occasionally recommend a large film. *These large films are to be taken at the Center only if the patients are medically indigent.* Abuse of the privilege can well be another step on the road to State Medicine. They will soon find a way to get free laboratory work, then a free medical work-up, and free surgical operations.

Fiske Fund Prize Dissertation: The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce the following subject for the prize dissertation of 1951:

"The Present Status of Adreno-Cortical Hormone Therapy—
Its Uses and Limitations."

For the best dissertation a prize of $200 is offered. Dissertations must be submitted by December 2, 1951, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also agree to read his paper before the Rhode Island Medical Society at its Annual Meeting in May, 1952. Copy must be typewritten, double spaced and should not exceed 10,000 words. For further information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.



Chloral hydrate, used in medicine since 1869, is, even today, "the standard hypnotic of its class."[1]

Goodman and Gilman observe that it "is unfortunately neglected today," and that the present widespread use of the barbiturates has ". . . caused the physician to lose sight of the fact that chloral hydrate is still one of the cheapest and most effective hypnotics."[2]

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[1]N.N.R., 1947, p.398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

Available in 8 fluidounce bottles. Adult Dose: As a sedative: ½ to 1 teaspoonful with water, every 3 or 4 hours or as directed. As a hypnotic, 1 to 2 teaspoonfuls or more with water at bedtime, or as directed.

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THE LOWER RIGHT RECTUS INCISION IN THE FEMALE

J. J. McDonough, M.D.

With few exceptions, the splitting of the lower rectus abdominus muscle longitudinally to gain entrance to the abdominal cavity is unwarranted. It is anatomically unsound and often leaves a poorly healed and weak scar.

Anatomically, any approach to the abdomen should be made with the least possible damage to the structures of the anterior abdominal wall. When the rectus abdominus muscle is split, usually in or near the center, substantial injury is done to both the nerve and blood supply.

There may be some argument about impoverishing the blood supply of the rectus muscle, since all muscle tissue appears to be generously supplied. Yet splitting the rectus in lower abdomen nearly always interferes with the inferior epigastric artery. It is usually ligated. This does impoverish the muscle.

The nerve supply to the rectus muscle is definitely impaired. The segmental distribution of the spinal nerves enters the rectus muscle at a 60 to 90 degree angle and when the lateral part of the muscle is retracted the medial part suffers a loss of nerve supply for a variable distance. To be sure, there is some overlapping from the nerves above and below the incision, but nearly always more or less damage occurs with a degree of atrophy to the medial aspect of the rectus muscle. Later the weakness is noticed in the scar.

Unfortunately the atrophic process is slow; it is not impressive for perhaps a year. By that time the surgeon will have forgotten the operative procedure. This is not always the case with the patient. She will notice the gradual widening and weakening of the scar. Moreover, if she engages in moderately heavy work or becomes pregnant, it may show still greater weakness. In some instances a true incisional hernia will develop. I do not mean to suggest that every incision which splits the lower rectus muscle will herniate, but I do feel that they are all unsound anatomically, are potentially weak and often lay a perfect groundwork for herniation.

Surgeons who use this incision nearly always remark that they have not seen many hernias following its use. As we all know, that's not a good defense. So often we do not see our own mistakes either in diagnosis or treatment.

I have been prompted to cry out against incisions splitting the lower right rectus muscle when in six weeks, five patients who had incisional hernias following such incisions, presented themselves for surgical treatment. Three patients had had appendectomies with pelvic exploration. Two had primary adnexal procedures. One patient in the first group developed her hernia shortly after her original appendectomy and pelvic exploration. Since then four attempts at repair were made without a cure. I made the fifth attempt. Tantulum gauze mesh was used and a satisfactory result obtained. A second patient had two procedures through the same rectus incision. The hernia developed after the second operation. The three other patients developed their hernias after the primary operation.

In each of these five cases extensive surgical reconstruction of the lower anterior abdominal wall was necessary. The approach to the hernias was made by a long transverse elliptical incision, excising a moderate wedge of skin and subcutaneous tissue. The remaining available fasciae of the rectus muscles was liberated freely above, below, and lateral to the herniation. The hernia sac was excised and a transverse closure of the fascia and peritoneum partly accomplished using interrupted sutures of No. 30 alloy steel wire. Since

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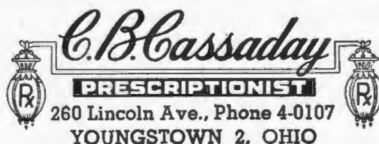

SURGICAL DRESSINGS SICK ROOM SUPPLIES

MEDICAL-DENTAL BUREAU OFFICERS

The following officers were elected by the members of the Medical-Dental Bureau, Inc., at the annual meeting August 9, 1951: W. H. Hayden, D.D.S., president; C. A. Gustafson, M.D., vice-president; G. E. DeCicco, M.D., secretary; M. W. Neidus, M.D., treasurer; and R. A. Hall, M.D., assistant treasurer.

The officers and the following comprise the board of directors: G. M. McKelvey, M.D.; E. C. Brown, D.D.S.; H. E. Kerr, D.D.S.; V. L. Goodwin, M.D.; Mr. Carl W. Wolter, representative of the Credit Bureau of Youngstown; and Mary B. Herald, executive director.

moderate to extensive defects still remained, tantulum gauze mesh attached to a firm base in the surrounding fascia was then used to cover the defect.

Each case offers a different problem and a certain amount of improvising is necessary. In the five above-mentioned cases tantulum was used in each instance. The final results were excellent. There is no evidence of recurrence and all patients have returned to normal activity.

It is noteworthy that each wound drained profusely during the postoperative period. The exudate was a clear straw-colored serous fluid and gradually diminished in amount. Antibiotics or antiseptics did not seem to influence the course of the serous drainage.

Strangely, in one of the patients, a 61-year-old female in whom dicumerol was used because of extensive varicosities about both extremities, there was no serous drainage. The wound healed primarily. Perhaps more meticulous hemostasis would have resulted in less serious drainage in the first four cases.

For those unfamiliar with tantulum mesh it should be said that it is easy to use. It is soft and pliable and can be attached to the surrounding fascia securely. Experimentally, it has been found that fibrous tissue strands will grow up through the mesh and form a solid mass of integrated fibrous tissue. The final result is much like forcing a wire screen over soft cheese, the cheese coming up through each opening in the screen. Tantulum is completely inert and produces no foreign-body irritation.

DISCUSSION: The lower rectus muscle splitting incision is used most often in the female when a tentative diagnosis of acute appendicitis is made and the differential diagnosis of pelvic pathology cannot be ruled out. This is well taken. However, in most instances a careful history and pelvic examination will rule out pelvic pathology and a firm diagnosis of acute appendicitis can be made. If a mistake is made the original small McBurney may be closed and a true paramedian incision made. In this way, the rectus muscle, intact, can be wholly retracted and an adequate exposure of the pelvis obtained. Both of these incisions are anatomically and surgically sound, will heal well, and produce a minimal amount of injury to the anterior abdominal wall.

In the event that the surgeon does not wish to use or trust making two incisions, a transverse McBurney can be used if a mistake has been made and the pelvis must be entered. The rectus muscle can be cut transversely, going from one anterior iliac spine to the other if necessary. The re-approximated recti muscles heal very well and there is little injury to the blood supply and virtually none to the nerve supply. Here again complete exposure of the pelvis can be obtained.

It would seem that the surgeon should take great care to protect the anterior abdominal wall in the female.

CONCLUSIONS: 1. With few exceptions, the splitting of the lower rectus abdominus muscle longitudinally to gain entrance to the abdominal cavity is unwarranted.

2. Lower right rectus muscle splitting incisions are a hazard in the female since subsequent pregnancies will place great stress and strain on the anterior abdominal wall.

3. Greater use of the McBurney incision should be made in the female. A careful history and pelvic examination will give the confidence necessary for its use.

4. Where extensive herniations exist following the muscle-splitting incision, tantulum gauze mesh may be used in the repair with excellent results.

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PHYSICIAN INCOME SURVEY RELEASED

Commerce Department recently released results of the nation-wide mail survey carried out in 1950 on physicians' incomes. The project was conducted jointly by the department's Office of Business Economics and the A.M.A. In this connection, the department said the survey broke all previous response records of both Commerce and A.M.A. A detailed analysis of the survey by Frank G. Dickinson, director of A.M.A. Bureau of Medical Economic Research, is scheduled for the July 28 issue of the A.M.A. Journal.

Average net income of physicians in civilian practice including salaried and independent practitioners amounted to $11,058 before taxes, in 1949, the survey reports. Those in independent practice averaged $11,858, compared with $8,272 for salaried physicians. About four out of five physicians derived most of their medical income from independent practice.

Among independent physicians, full specialists reported average net income of $15,014, which was 70 per cent more than the $8,835 average reported by general practitioners. Part specialists earned an average of $11,758. A department statement on the report, which is published in the July Survey of Current Business, observes: "The report also indicates that the income differential between general practitioners and full specialists has narrowed appreciably since 1929, while at the same time the number of full specialists has increased markedly." Highest income of specialists was for neurological surgeons, $28,628; followed by pathologists, $22,284.

On the average, incomes were highest in Far West and lowest in New England; Minnesota had highest average ($13,175) and Vermont the lowest, ($7,527). Other findings: (1) highest average incomes earned by independent physicians are in cities of about 350,000 population, (2) independent practitioners reached their peak earnings ($15,000 average) between ages of 45 and 50 and salaried physicians ($10,000) at about the same age. (3) members of a partnership averaged $17,722 as against $10,895 for those in individual practice. (4) Memphis, Minneapolis, and Portland, Ore., among cities over 300,000 with highest average physician incomes.—*Capitol Clinics.*

GOVERNORS POLLED ON DOCTOR DISTRIBUTION

Senator James E. Murray (D., Mont.) chairman of the Committee on Labor and Public Welfare, has written all governors in an effort to round up information on physician distribution. In his letters, Senator Murray remarks that "it has been proposed that federal subsidies be used to persuade doctors to move to areas where there is an acute shortage of medical personnel", but he explains that the request is in no way "an attempt to commit you regarding merits of any such proposal, but solely to provide this committee with such information as would enable us to decide whether the existing situation warrants serious consideration of that or related proposals."

Governors are asked to reply promptly to the following questions:

1. Has your state too many, not enough, or just about enough doctors to meet the needs of its residents?
2. What cities seem to have more than enough doctors and would probably feel no alarm if special efforts were made to persuade physicians located therein to relocate (a) elsewhere in civilian practice, (b) in Veterans Administration hospitals, (c) in the armed forces, U. S. Public Health Service or health missions abroad?—*Capitol Clinics.*

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KEEPING UP WITH THE A.M.A.

W. M. Skipp, M.D.

. . . . . . Reporters aplenty, more than ever before, covered the 100th Annual Session of the A.M.A. at Atlantic City; 82 science writers covered the medical meetings and more than 200,000 words were sent out over the wires to all parts of America.

. . . . . . Physicians and newspapermen have joined together in Denver, Colorado in a move to stop medical advertising abuses. The Colorado State Medical Society has appointed a three man advisory committee to act on questionable ad copy in health and medical areas.

Dr. Ervin A. Hinds, President of Colorado State Medical Society, hails this as a "move to inspire public confidence in newspapers and the profession".

. . . . . . For a long time Labor Unions and the profession have been at each other's throats over socialized medicine. Now, through the voluntary insurance plans, Labor's antagonism is diminishing. Labor and the profession can now work together assuring better medical care at a reasonable budgeted cost.

The St. Joseph County Medical Society (Ind.), working with unions at the Studebaker Corporation, has a committee of both factions which meets monthly and is ironing out problems in the Union's insurance plan. The workers in the Corporation will not be sold any socialized medicine.

. . . . . . To bring better public relations between the physician member and his State Association, Arkansas and Indiana are sending out teams to sell the State Association to the members. They discuss everything: rural health, school health, health councils, hospital-physician relations, and public relations in general. This should be a *must* with every State Association.

. . . . . . The Ohio State Medical Association and the Ohio Agricultural Extension Service have cooperated to produce a better understanding of the health problems of all communities. There is a booklet on "Health Councils" which points out that the County Society is the "Family Doctor to the community."

. . . . . . On May 2, 1951, HR 3931 (new bill) was introduced by Heller, N. Y., to create the United States Medical Academy as a medical training school for the armed forces. The candidates are to be 20 to 25 years of age and qualified to enter a medical school. These students shall be appointed by the members of Congress, four to each congressman, and after graduation the candidates shall serve five years in some branch of the armed forces or P. H. S. The Secretary of Defense and Surgeon General of P. H. S. will make the rules and regulations but a purely advisory committee made of up chairmen of Committees of Congress shall make suggestions.

. . . . . . May 7, 1951, HR 3996, Jones, Alabama, states that any tumor developing five years after a person is separated from the armed services shall be presumed service-connected.

. . . . . . Bureau of Labor Statistics reports that medical care rose 2.3% between June, 1950 (prior to the Korean War) and December, 1950; living costs up 5.1%; G.P.'s up 1.1%; specialists 1.2%; drugs 2.5%; hospital rates 4.9%.

. . . . . . The House Appropriations Committee believes that there is a definite waste of medical and dental manpower by keeping them on administrative staffs in the U. S. A. It feels that there should be a cut in appropriations and professional personnel should be replaced by other personnel.

. . . . . . In March, 1933, President Roosevelt gave executive order to, and in June, 1948, Congress passed, Public Law 748. This order and law gave to a veteran a "chronic disease status" for practically every disease if contracted one year after service. Now changes are being made every day in chronic

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and tropical diseases affecting veterans. The 81st Congress passed Public Law 573 setting a time limit of appearance of disease three years after separation. Psychoses were not included, but in May, 1951, it was included. Now several bills are being introduced to include many more diseases such as multiple sclerosis, and up to the time of as much as seven years after separation. This again shows the trend toward the socialized program that is being proposed piecemeal. Many of these diseases are not service-connected but there is a clause that makes these individuals medically indigent.

...... Rhode Island's compulsory cash sickness insurance went into the red $839,554.00 last year, showing that even on a small scale the taxpayers will be paying for any compulsory plan.

...... June 4, 1951, HR 4322, Mitchell, Washington, comes back with the old bill that was defeated in the House after passage in the Senate, which grants aid to the States to make adequate provision for the health of school children, to set up a school service in the prevention, diagnosis, and treatment of physical and mental defects and other conditions. This would give free diagnosis and treatment to all children of school age without regard to financial ability of parents to care for their children.

...... At the present time there are seven bills before Congress which would provide federal subsidies for medical schools. They cry a shortage of physicians and stress national defense and security, which can only be overcome by subsidizing medical schools so more physicians can be turned out regardless of educational and clinical facilities to make better physicians. S 337 introduced by Murray of Montana may be called for a vote at any time. It would grant $500.00 for each student in normal enrollment and $1,000.00 for each over the normal. Two House Bills are identical to S 337; HR 1781 Klein, HR 2707, Bolling. HR 2152, Burnside, provided $150,000,000 for building new medical schools on a five year program; and this same bill also provided $150,000,000 for improving existing health schools.

HR 3371, McKinnon, asks the whole problem be turned over to the National Science Foundation for a five year program. HR 3511, Kelley, would create a corporation within the Federal Security Agency called the "Medical College of the United States". A Medical College Commission would select sites for two medical colleges to accommodate 400 students each. Each student would have to serve in the Armed Services.

...... The latest proposal by Truman and Ewing to get piecemeal socialized medicine, or a back door approach, is the free hospitalization of all persons over 65 year sof age. They would be eligible even if they are earning enough to make them ineligible for old age pensions. Seven million persons would come under the plan, and would give 60 days hospital care per year. The cost is not known.

...... $95,000,000 has been passed by the House for hospital construction under the Hill-Burton program. HR 4405, Mr. Clemont, N. Y., June 12, 1951, provides that patients may deduct from gross income all medical and dental bills for self and dependents, which include prevention, diagnosis, mitigation, and cure treatment. Health and Accident insurance premiums are included.

...... HR 3298 revised, approved by Interstate and Foreign Commerce Commission, gives Mr. Ewing authority to compile a list of drugs that cannot be refilled on a physician's prescription. This measure, while being heard at public hearings, was called "a bureaucratic step toward socialized medicine."

...... At the Atlantic City meeting in June one of the British physicians remarked that he was amazed to see how cheerfully the leaders of various

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branches of medicine made themselves available to the small town practitioner. Nowhere else in the world is such consultation and advice possible. . . . . . . The House has passed a bill to build 16,000 more hospital beds for the V.A., which will bring the total to 131,000. There is quite an uproar over this addition when it is not definitely needed. Cost is high, and with all the taxes now, many organizations are fighting hard to stop this unneeded expenditure. The new hospitals will be on a 160 acre tract three miles north of Van Nuys Hospital, and will be connected with the new U. C. L. A. Medical School. . . . . . . The U. S. Drug and Food Administration is asking the physicians to warn diabetics against a remedy being mailed from Mexico which is worthless and extremely dangerous to a diabetic if employed as a substitute for insulin.

If physicians know of any diabetics who have received cacalla Composita Mexican Indian Root they should notify F.D.A. who will contact the patients immediately.

BESIDE THE TRAIL

The cat lies on the library table watching the birds which come to the feeding-tray just outside the window. The window is closed and the drapery also hangs between those birds and death. There are repeated twitchings of the cat's jaws while its eyes are fixed on the prospective victim. At times the cat poises for a sudden leap, though it has found this to be futile. There has been no time during this cat's existence when birds had been necessary as food. It has been well fed, even to excess, with no effort on its part being required. Yet there it is, a potential killer, a bit of the jungle lying on the library table.

On the wall of this library, overlooking the scene of this battle with the propensities, is the mounted head of a white-tailed deer. Silent though it be, its eyes seem to be able to see through the thinness of man's disguise and convict him of inconsistency. How near to the jungle are we all!

What is it that man, after his long trek out of the wilderness, retains in common with the lower forms of life that can account for his behavior under such greatly altered environment? He has choice of means to his desired ends, and has so increased the facilities to accomplish them that he often mistakes these for the ends. He has put behind him necessity as an excuse for pleasure and extension of power. He has definements in methods which have so far outgrown their source as to confuse us as to their origin.

Yet these are the habit patterns of the primitives, persisting in man despite the change of values that has resulted from his long experience and increased capacity to understand. He remains a potential killer; and in this respect, differs only from the lesser forms of life in that he seeks a justification for his propensity. Though he has removed the forests, the jungle still lies very close.

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CARE AND FEEDING OF DOCTORS

A Scientific Treatise on That Rare but Deadly Malady Commonly Known as "Malpractice Disease"

R. Crawford Morris, Attorney-at-Law

(Editor's Note: The following article on malpractice should provide repeated reminder of a disease to which all of us are susceptible and none immune. It is reprinted from the "Bulletin" of The Academy of Medicine of Cleveland).

Now comes the plaintiff and for her cause of action says that the defendant is now and at all times herein complained of was holding himself out to the general public as a duly licensed physician and surgeon, skilled in the practice of his profession and ready, able and competent to undertake the treatment of the sick and to use and employ all proper medical and surgical means for treating their illness * * * whereas defendant was not so skilled but on the contrary was so reckless, careless and negligent in the treatment that he rendered plaintiff, which treatment was wholly inappropriate and not in accordance with good practice as known or practiced by the medical profession in this community * * * that plaintiff has suffered and is still suffering the most excruciating pain and distress * * * all to her damage in the sum of $100,000."

Sorry, doctor, but you might as well know the truth. You have contracted the rare but deadly malady popularly known as "Malpractice Disease". We'll do all that we can to cure you, of course, but your case is now so far advanced that it will probably require heroic treatment. The above clinical finding in your case is symptomatic of the final and generally irreversible stage of the disease. Therapeutic measures should have been instituted long before this. Best of all, of course, would have been preventive prophylaxis in the first place. We have an old saying in our profession, you know—"an ounce of prevention is worth a pound of cure"—but then, no one ever heeds it. Perhaps you should know the nature of your affliction.

Malpractice Disease (Medicus Malformans Accusans), like all other diseases, is no respecter of rank, title or position. It can happen in the best of medical families and occasionally does. Generally speaking, the virus is spawned in a culture of two components: (a) an unsuccessful result; (b) poor public relations. The former may be beyond your power to prevent, however skillful you may be (contrary to the demands of some of your patients, you doctors are no miracle workers—nor does the law require you to be); but the latter is very much within your control and is very much your responsibility. There is an extremely rare type of this disease (Medicus Manformans Accusans Meritorius) which I need not tell you about. Your case, of course, is not of that type. (The prevention of meritorius malpractice cases is beyond the scope of this discussion, lying wholly within the jurisdiction of the medical profession and the standards it sets for itself).

The early symptoms of this comparatively rare disease are usually an unnecessary medical call (to avoid the Statute of Limitations), a feverish telephone call from the patient or an office visit by both patient and spouse, accompanied by elevation of temperature, followed by the onset of a chilling letter from the patient's attorney. It should be noted, however, that these early symptoms are diagnostically unreliable. The disease may manifest itself in any one of a myriad symptoms, some of which defy diagnosis. Great caution should be exercised at this early stage of the disease, however, for a

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careful diagnosis at this time followed by immediate remedial medication may possibly arrest development before the disease's drastic final stage is reached. Unfortunately, by the time the true diagnostic symptom appears (as in your case) the disease is generally too far advanced to be reversible or arrested. Conversion of asymptomatic medicus malformans accusans into irreversible symptomatic medicus malformans accusans occurs with the onset of court summons accompanied by unfriendly legal language (similar to the above clinical findings obtained in your case), which invariably produces severe chills and fever, loss of professional hours, and expense. Once this stage is reached, diagnosis is certain but prognosis is questionable. Sometimes the course of the disease can be arrested before trial occurs; but more often, and usually, the disease must run its course, sometimes persisting through the years of painful appellate review. Treatment at this stage is unpleasant and expensive, calling for such measures as depositions of yourself and staff—with criticism of office routine and records, legal investigation and photostating of hospital records, medical examination by super experts, further x-rays, etc. With the exception of those cases arising from a virus culture of such hyper-active components that the disease has been transmuted into its more virulent form of personal vindication (medicus manformans accusans vindicatis), that powerful drug "aura-my-sin" (more popularly known as "filthy lucre") almost invariably works a spectacular and immediate cure. This glittering drug must be administered sparingly and with extreme caution, however, not only for the irreparable damage such a settlement may do to your reputation, but also for possible after-effects in encouraging this dangerous disease to spread into an epidemic.

Like all diseases, medicus malformans accusans is best combatted by preventive prophylaxis prior to inception, rather than by cure after occurrence. Such prophylaxis, where rigidly followed, not only greatly reduces the number of cases of the disease but also lessens the virulence of each case that does occur while at the same time greatly increasing the patient's chance of successful recovery.

PREVENTIVE PROPHYLAXIS

1. At the outset you can always protect yourself by *refusing to take the case.* If you do take it, remember that the law will impose upon you the duty of using that care consistent with good practice. If there are any features of the case which indicate the likelihood of future trouble, you need not take the case. Such features may be a history of prior unsuccessful surgical interventions with complications rendering future surgery doubtful and difficult, or obscure trouble difficult of diagnosis and requiring some experimentation, plus the caliber and character of the patient herself (some people go about looking for trouble and easy money).

2. If you do take the case, *never guarantee a cure,* unless you mean to be held to it. You are free to make any contract you wish and if you voluntarily contract with a patient to cure her and fail to do so, the law will hold you liable to her, not for malpractice but for breach of contract. In this regard, consider your language as to prognosis in discussing the case with the patient. Do not mislead her into expecting a cure, unless you intend to guarantee one.

3. *Watch the time-factor.* The law of Ohio requires patients to commence any malpractice suit against you within one year. Under the decisions of our Supreme Court this one-year period begins to run at the time of *termination of the doctor-patient relationship,* not at the time of the alleged malpractice. What happens is this: You complete your treatment, the patient is discharged;

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more than one year later the patient decides to sue. To get around the one year (by then elapsed) bar, she (probably after some "advice") revisits you and you in good faith at her request unsuspectingly re-examine the same area. The relationship is thereby reinstated and she has another year within which to sue. If you have any reason to fear a malpractice suit, refuse to re-examine or treat the patient for the same ailment once your year's protection has accrued. Perhaps it should be mentioned here that a subsequent treatment on the same patient for a wholly unrelated ailment will not affect the case as to the former treatment. It is the final termination of the doctor-patient relationship for that particular ailment that is determinative. Unrelated treatments for other ailments constitute separate unrelated employments.

There is a reverse side of this time factor, too. It is advisable not to sue your patient for unpaid bills until after one year has elapsed since final termination of the doctor-patient relationship. Otherwise your lawsuit may provoke the patient into filing a substantially larger suit for malpractice against you (to avoid payment of your bill by forcing you into a mutual dismissal of both cases). The law allows you six years in which to sue for collection of unpaid bills. You have plenty of time, therefore, and can easily afford to wait until after your one year protection has accrued. Then you may sue without fear of such retaliation.

4. *Keep up with the advance of medicine.* The standard of care to which you will be held grows as the generally accepted knowledge and usage of medicine grows in your community or neighborhood. Keep abreast of developments in your profession. Use the generally accepted tests and approved techniques.

5. But not too far up. *Do not experiment—without the patient's permission.* Generally speaking, you experiment upon a patient with new drugs or new theories at your own peril. The standard to which you are held is that which constitutes good practice as *generally* practiced in your community. If you embark upon an unorthodox or unaccepted technique and an unfortunate result occurs, you may not have met the test of good practice as generally practiced in your community. Experimentation may be desirable or even necessary in some instances but you can protect yourself by explaining the situation to the patient and obtaining her permission to proceed (preferably in writing; at least in the presence of witnesses friendly to you—for proof should the need arise at some later time) or by professional conference with other doctors.

6. *Get the patient's consent* for everything you do. In the eyes of the law it is an assault and battery if you operate on a part of the body not consented to by the patient and you are liable regardless of negligence. There is an exception to this which the law recognizes: a sudden emergency necessary to protect life (the patient may be unconscious and unable to consent, time may be a vital factor, etc.). Protect yourself even here, however, where possible, by getting consent of any available relatives and the concurrence of other available doctors that such a procedure is advisable and necessary.

7. Good Housekeeping. *Keep good records*—full and adequate. Learn to think in terms of proof—for use at some later date against the testimony of your patient, her spouse and her cousins by the dozen. They may all gang up on you and you may be standing alone to face them—except for your records. Records make wonderful witnesses—they have been called "witnesses whose memories never die". Make them as complete and accurate as possible. Enter a report of all tests you used and the results of those tests. But be

meticulous about it; records can be harmful witnesses, too. Keep them factual, precise and detailed. Do not enter opinions, except where opinions belong (under diagnosis, impressions, etc.).

In this connection (i.e., later proof of a past event), it is advisable to have a nurse or assistant present whenever possible, as a living witness to what transpired. This is especially true of surgery performed in the office. (In the hospital you have the operative staff to corroborate your version). We appreciate that if you made proof sufficient to satisfy a trial lawyer, you probably would have no time left to practice medicine. Like much of life, this rule is but an ideal to be approximated where possible. But it should be approximated, to some extent at least, by sustaining records. You must keep as good records as possible—to help obviate claims and win lawsuits improperly filed.

8. *Cooperate with your profession.* Many malpractice suits are engendered by a doctor's thoughtless exclamations over a fellow doctor's prior work with which he professionally may not happen to agree. Such exclamations often make a patient feel she has been "wronged" by the earlier doctor and start her to thinking along malpractice litigation lines. If you find evidence of earlier medical work with which you do not agree, pursue the course you prefer, but do so without audible fanfare. You need not promote questionable feeling in lay people in order to carry out your preferred course of treatment.

When you have been an attending physician or surgeon in a case you may find yourself compelled by subpoena to testify in court in an unmerited malpractice case against your brother physician. Upon such occasions you are free to confine your testimony to what you found and what you did as you observed the patient. Probably you were not present during the performance of the other doctor's work, and many factors unknown to you may have intervened between the performance of such work and your first consultation on the case. Under such circumstances you may well feel unable to form any opinion as to the merit of such earlier work.

9. *Negligence.* In general, negligence in malpractice cases is the failure to use ordinary care, i.e., that care which an ordinary prudent doctor would use in the same or similar circumstances. Our Supreme Court has defined the standard of care to which doctors are to be held as follows: "Whether the defendant (doctor) in the performance of his service did some particular thing or things that physicians or surgeons of ordinary skill, care and diligence would not have done under the same or similar circumstances, or failed or omitted to do some particular thing or things which physicians and surgeons of ordinary skill, care and diligence would have done under the same or similar circumstances." There are several factors to bear in mind here: (1) you will be held to the standards of your own school of medicine only and not to procedures and practices of different schools unless you voluntarily enter into other fields, whereupon you will be held to the standards of those fields; (2) you will be held to the standards of localities similar to that in which you practice (rural doctors are not held to the standards existing in great medical centers); (3) you will be held to those standards in existence as of the time of your alleged malpractice (you cannot be held to later advancements but you are held to all standard advancements as of that time of your alleged malpractice; you are to be judged by foresight and not by hindsight); (4) achievement of an unfortunate result is not, in and of itself, evidence of negligence; (5) where there are two or more accepted ways of treating a patient, and you choose one of them and an unfortunate result occurs, no negligence will be predicated on your choice; (6) where the proper course of treatment is in doubt

you will not be held liable for an honest mistake of judgment, providing you are not negligent in using all known means to get all the facts upon which to base your judgment.

Basically, no one can help you here. You are on your own. You know more about the particular case in question than anyone else because you saw it develop. Behind you lies the excellent training your years of study and experience have brought to your command. Use them with all the diligence and common sense you can muster in the treatment of each patient. Be thorough (it is no defense to you that you were too busy; it is in fact negligence for you to deliberately take on more patients than you can properly and adequately treat). Get all the facts you can upon which to predicate your judgment (whether in diagnosis or choosing a course of treatment). Use all the known tests that are applicable. Get reports of these tests and keep them in your files. If you are in doubt, consult other doctors (juries are not so apt to believe two doctors both negligent). If you feel the case is beyond your ability, don't hesitate to call in a specialist for consultation and advice. (Remember if you enter a field not your own, you will be held to the skill of others in that field). Explain the problem to your patient and shift the burden of decision to her where possible. This is especially important if you pursue an experimental or heroic treatment.

10. *Public relations.* This is a very important consideration. And it is the most flagrantly violated.

Let me begin by saying that in the eyes of a jury (ordinary fellow citizens of yours who someday may play gods in passing judgment upon your medical career) you doctors have a priceless asset—inestimable good will in the community. To most people you are still the "man in white," the country doctor going his rounds in all kinds of weather, helping people who desperately need his help—and you are essentially that person. If, from the evidence presented before them, there remains even the slightest doubt that you were negligent, they will give you the benefit of that doubt, every time. This asset you should cherish and guard and foster in the development of your professional life.

Yet you do not seem to guard this asset as you should; on the contrary, sometimes it seems as if you were deliberately setting out destroy it. The trial of a malpractice lawsuit, like a divorce action, is almost invariably a bitter thing. (I have been physically assaulted in the court room only twice; once by opposing counsel in the heat of battle; once by a plaintiff (patient) in a malpractice suit, who was so bitter over the jury's failure to find the doctor guilty that she abused me). Part of this bitterness springs naturally enough from the intense suffering that may accompany any unfortunate result in the medical field. But a great deal of it also springs from poor public relations on the part of the doctor toward the patient, toward even her family. Uttering careless words, thoughtless words, sometimes stupid words—perhaps in the field of ego; joking about her illnesses, making fun of them; flippant remarks about your own convenience or inability to answer a call. Consider your remarks! Do not say (as some of my defendant doctors have been accused of saying): "I can't get there today, I've got a golf game."—"Oh, your baby's bowels must have moved inside you." (Recto-vaginal fistula induced by prolonged labor—Testified the patient in tears: "I didn't know about these things, I thought maybe it could have happened.").

There is an exception to this rule, as there is to all rules: it may become necessary, for therapeutic reasons, to divert your patient's attention from her

illness, to minimize in her mind her affliction. Where this is expedient. do it with tact and common sense.

The rules are simple. *Be as careful with your tongue as you are with your scalpel.* Think before you speak. Remember, you are speaking, not to bone, muscle, flesh, but to sensitive human beings—the most complex organism known to man as you know and as any psychiatrist will tell a jury. The behavioral response your words trigger off is extremely complicated. Tolerance, humility, understanding, common sense—these are the rules. If you joke, joke about their hobbies, the weather, their mothers-in-law, but not about their ailments, nor your treatment of them, nor the practice of your profession. In its context, your joke may not sound too bad; but in a cold, printed record or from an embittered patient on the witness stand, it may be considered sadistic—and fatal to the lawsuit.

Public regard, however, does not imply reserve or silence. Telling your patient too little may be worse than taking her too much into your confidence. If you leave her in doubt as to her condition, the nature and purpose of your treatment, etc., she will imagine and worry, and, aided by lay "advice" and unauthentic magazine articles, begin to doubt your treatment and ability. Give her the frank and full report to which she is entitled under all of the circumstances, but be considerate of your language. Remember—"tain't what you say, it's the way how you say it, that counts."

And finally, never forget that, as a doctor, you are a member of a relatively small fraternity in the vast commonwealth of men. As such, as any responsible minority leader can tell you, whenever you fail in your professional public relations, you are condemned not as "Mr. Jones," but as "Mr. Doctor"—a representative of the entire medical profession which is thus condemned with you, and suffers because of your conduct. I have heard a prominent judge, irked at the conduct of many doctors in court cases, exclaim (upon a doctor's abuse of the privilege of testifying out of order at a trial accorded him by court and counsel alike to conserve his valued time)—"these doctors think they are a law unto themselves". You are not a law unto yourselves, let me assure you. Nor should you give that impression to jury or judge. The community needs you. It will always need you. But, you too, need the good will of the community. And in these uncertain times you will increasingly need the good will of every person wherever you practice your profession.

Beyond your need lies your community's need of you. You must serve that need in all of its amplified aspects. For, in a larger sense, this is what it means to be a professional man.

CONCLUSION: These then are a few of the basic rules of preventive prophylaxis for combatting Malpractice Disease. "Study well before using. Take daily, as directed."

Here endeth the suggestions.

Read . . . . your **News Letter** which is periodically sent out by the secretary of your Society. It is designed to keep you abreast of matters of importance to you and Organized Medicine. The last letter contained a "question and answer" review of the Ohio Medical Indemnity, Inc.'s "Payment in Full Contract" proposed by the Ohio State Medical Association. It merits your close review in conjunction with timely Bulletin articles on the same issue.

LOCAL HOSPITALS ANNOUNCE RESIDENT STAFFS

Superintendents of area hospitals have announced appointees for their interne-resident staffs for 1951-52. The reports indicate a significant decrease in the number of internes, a situation which seems to be prevalent in non-University hospitals throughout the country. Appointments to the resident staffs are more nearly complete and reflect a fair adequacy of complement in the graduate training programs of the hospitals submitting the report.

The interne-resident complement of the various hospitals for the ensuing year is as follows:

YOUNGSTOWN HOSPITAL ASSOCIATION

INTERNES: Drs. Ben C. Berg, Jr. and Gordon B. Clappison, graduates of Iowa University; Drs. Maybard H. Brucker and Richard A. Keffler, graduates of Marquette University; Drs. John T. Scully and Robert G. Warnock, graduates of the University of Maryland; Dr. David B. Brown, graduate of Ohio State University, and Dr. William W. Parmenter, a graduate of Western Reserve University. The dental interne is Dr. A. E. Billett, a graduate of Ohio State University.

RESIDENTS: *Anaesthesia:* Drs. Charles N. Giering and Robert W. Parry are first year residents.

Medicine: Drs. Robert A. Brown and Charles A. Hefner are third year residents; Drs. Clifford E. McParland and R. L. Jenkins are in their second year and Dr. Fred M. Friedman is the first year resident.

Obstetrics: Drs. Lambert Hucin, Ramero Ornelas-Ponce and Richard S. Herring are special assistants on the Obstetrical division.

Orthopedics: Dr. R. M. Foster is resident on the orthopedic service.

Proctology: Dr. Joshua A. Maglieri is completing his residency on the proctological service.

Radiology: Dr. Earl E. Brant is the third year resident in radiology.

Surgery: Drs. Richard D. Murray, Paul J. Fuzy, Jr., Irvin Zeavin, John M. Snelling, Jr., William Muesing and Antonio Dow are the third year residents; Dr. L. F. Fagnano is second year resident, and Drs. Thomas A. Ferguson, John W. Foderick, David Kazemi, Matthew M. Mischinski and J. Sewell are the first year residents on the surgical division.

ST. ELIZABETH'S HOSPITAL

INTERNES: Dr. Milan Halmos, a graduate of the University of Budapest, Hungary; Dr. Frank W. Morrison, graduate of Ohio State University, and Dr. Salvatore Squicquero, a graduate of Loyola University of Chicago.

RESIDENTS: *Surgery:* Chief resident is Dr. Albert Luchette who is completing his fourth year of training. Dr. Edmund A. Massullo is the assistant chief resident; Dr. Joseph Crawford is junior surgical resident; Dr. Robert Hancock is the second year resident, and first year residents are Drs. Donald Bernat and James R. Sofranec.

Medicine: Chief medical resident is Dr. Vaclav Jelinek.

Obstetrics-Gynecology: Dr. Robert Bruchs is chief resident, and Drs. Jeanne K. Beach (Holmquist), Herman Rubin and James Rhys Williams are assistant residents.

MAHONING COUNTY TUBERCULOSIS SANATORIUM

Dr. Hugo Sotolongo, a graduate of the University of Havana, Havana, Cuba, and who served his interneship at St. Margaret's Hospital, Hammond, Indiana, is the resident physician at the Mahoning County Tuberculosis Sanatorium.

RULES ON HERNIA

(Editor's Note: The following rules on hernia coming under Industrial Commission are worthy of review and should serve to obviate disclarity from the standpoint of physician and paitent. These rules are set forth by the medical section of the Industrial Commission of Ohio.)

All hernia claims shall be considered on their merits, special stress being laid on the following general principles:

The Commission considers hernia as a disease or physical weakness which ordinarily develops gradually and is rarely the result of an accident. A pulsation in the internal ring without definite protrusion is not considered a hernia. A large hernia extending to the external ring or farther discovered within a short time following the injury without severe pain and prostration is considered unrelated to the injury. A hernia appearing two years or more after the operation at the side of the operation should not be considered as the result of the original injury or operation.

(a) The claimant must establish by competent proof:

(1) That the injury resulting in hernia was sustained in the course of and arising out of his employment.

(2) That the hernia appeared immediately or within a short period following the injury.

(3) That the hernia did not exist prior to the injury.

(b) If and after the claim has been allowed:

(1) Medical and hospital expenses shall be paid for the radical cure of a hernia in accordance with the scheduled fees. Compensation will be allowed for the disability resulting from the operation.

(2) If the hernia recurs before the claimant returns to work following the operation and it is found that there has been no unusual stress or strain applied to the operative site, the operating surgeon will be expected to repair this hernia without charge. The hospital bill for the additional period will be paid if the hospital has not been responsible for this recurrence.

(3) If operation is refused by the claimant, compensation shall be paid for a period not to exceed two weeks from the date the claimant stopped working.

(4) If the operation is contraindicated on account of advanced age, heart disease, or any other physical condition, compensation shall be paid according to the medical proof as in other claims.

(5) Compensation shall not be paid for more than two weeks prior to operation unless it is conclusively shown by medical proof that the hernia could not be retained by a truss.

(6) Compensation and medical expenses shall be paid in case of strangulation of a new or preexisting hernia when it is proven that the strangulation was due to injury received in the course of and arising out of employment.

(7) A reasonable allowance will be made for a truss when ordered by the attending physician, provided the hernia claim is allowed. This will be paid according to the Fee Schedule on mechanical appliances and applies only to the first truss supplied following the injury. If subsequent trusses are needed authorization must be obtained from the Industrial Commission before they are purchased.

FROM THE BULLETIN

J. L. Fisher, M.D.

TWENTY YEARS AGO (AUGUST 1931)

Dr. Morris Deitchman, now in Phoenix, Arizona, edited the Bulletin that month. The feature article was a scholarly paper on Andreas Vesalius, early anatomist of Brussels, who showed the fallacy of many of the teachings of the great Galen. The article was written by the editor's brother, the late Louis Deitchman, who was an ardent collector of old books and first editions.

Dr. E. Henry Jones returned from post-graduate study and opened his office in the Central Tower for the practice of dermatology.

The Fred B. King Co. announced their new Town-car model invalid coach. It was a Cunningham in two-toned purple and chromium, the last word in custom car building.

Lembke's Ethical Pharmacy and Laeri The Apothecary advertised that they filled prescriptions exclusively. Incidentally, Lembke had some very fine imported Spanish sherry which was a popular item in those prohibition days.

TEN YEARS AGO (AUGUST 1941)

The featured articles were: "Paroxysmal Ventricular Tachycardia" by Ben Green, interne at the Youngstown Hospital, and "Hemolytic Jaundice" by D. J. Birmingham, interne at St. Elizabeth's Hospital.

Bill Welsh and John Rogers were tied at 78 for low gross at the golf party at Southern Hills. Later on, Rogers won the play-off and the Medical-Dental Bureau trophy.

Jim Brown headed the Social Committee, William Hiram Evans was program chairman, and F. W. McNamara ran the Medical Defense Committee. Luke Reed's committee was busy studying medical service plans.

Mrs. R. B. Poling was president and Mrs. Dean Nesbit was secretary of the new Auxiliary.

CYNICAL SAM

Whether ignorance or falsehood is the greater menace to our well-being, is less important than whether we are satisfied with our ignorance or do not resent the falsehood.

★ ★ ★

We remember one time hearing a fellow call his horse a fool. It did not respond in kind. There was eloquence in the horse's silence.

★ ★ ★

The blue jay's nest, which we have placed on our living-room table, has been interesting to a number of persons who marvel at the bird's ability to build so beautiful a structure out of nothing but waste-products that were at hand. Here beauty and use have been blended, and that which was otherwise worthless has been made to serve purpose. This, without bonus, dole or subsidy.

MILITARY NOTES

H. J. Reese, M.D.

Subcommittee Criticizes Reserve Policy . . . A subcommittee of the House Armed Services Committee sharply criticized the Defense Department for inequalities in its reserve policy whereby members of the inactive reserves were called to duty before members of organized units. The subcommittee on Civilian Components agrees that Defense Department has done a remarkable job in getting troops to Korea but emphasized that it considered the period of enlistment as a binding contract on Defense Department. By law World War II veteran volunteers and recalled inactive reservists can be retained on active duty only 17 months but certain specialists are not covered by this provision. Defense Department has issued orders in compliance with this provision and adds "the release of members of the inactive or voluntary reserve delayed beyond 17 months because of critical rating or specialty (will) be affected at the earliest possible date without regard to the statutory maximum."—*Capitol Clinics.*

Army Details Policy . . . on civilian medical care for service personnel. A 5-page fact sheet of interest to the medical profession has been issued by the office of the Surgeon General of the Army. It outlines current policy on authorization and payment of civilian medical care for Army personnel while on leave in localities without Federal hospital facilities. The Army says the continued cooperation of civilian physicians and agencies is "of utmost importance in providing adequate medical service to the U. S. soldier in time of need."

Among the points made in the report are (1) normally, civilian medical care for Army personnel is authorized only when there are no other federal medical treatment facilities available. (2) first aid or emergency treatment is authorized at any time regardless of proximity of federal facilities. (3) surgical operations should not be performed without prior approval of military authorities unless an emergency. (4) elective medical treatment in civilian facilities by civilian physicians will not be authorized as Army funds cannot be used for payment. (5) bills for authorized medical care and treatment of Army personnel should be submitted to commanding officer of the patient or to military authority who okayed the medical service.—*Capitol Clinics.*

Maj. Gen. George E. Armstrong . . . was sworn in as Surgeon General of the Army in the office of Gen. J. Lawton Collins, Chief of Staff. Gen. Armstrong succeeds Maj. Gen. Raymond W. Bliss, who has retired from the Army after 40 years in service. In an earlier ceremony, Gen. Bliss was presented a testimonial for his long service by Secretary of the Army Frank Pace.

World War II Veterans . . . who fail to get VA approval of GI educational training before July 25 can start their courses anyway, then seek approval under latest VA modification of rules.—*Capitol Clinics.*

A General Practitioner "is a legally, qualified doctor of medicine who does not limit his practice to a particular field of medicine or surgery. In his general capacity as family physician and medical advisor he may, however, devote particular attention to one or more special fields, recognizing at the same time, the need for consulting with qualified specialists when the medical situation exceeds the capacities of his own training or experience."

HERE AND THERE

Born: to Dr. and Mrs. H. B. Munson, a boy, Mark Elliott, at St. Elizabeth's Hospital, June 18.

Born: to Dr. and Mrs. Sam Lerro, a boy, Michael Marmet, at North Side Unit, Youngstown Hospital, July 14.

NEW PRACTITIONERS: Dr. W. B. Hardin announces the opening of his office for the practice of general surgery at 2921 Glenwood Avenue, Youngstown, Ohio.

Dr. Henry L. Shorr announces his association with Dr. David Levy in the general practice of medicine with offices at the Home Savings and Loan Bldg., Youngstown, Ohio.

Dr. Richard D. Murray, won third prize in the class A division in oils at the A.M.A. art exhibit held during the National Convention at Atlantic City. His oil painting, "This Day's Enigma", included an artist's panoramic view of 27 different figures depicting world confusion. The award consisted of a bronze placque.

Dr. P. J. Harvey was a third prize winner in the class B division with an oil painting of a landscape in Youngstown. The oil depicted a view of the steel mills in a snow scene as seen from Glenwood Avenue in the approach to Mahoning Avenue. The prize award consists of a bronze placque.

Dr. Charles Scofield, former health commissioner of Struthers, Ohio, has been named health commissioner for Mahoning County, succeeding Dr. S. G. Patton, Sr., who resigned after serving in the post for the past fourteen years.

UNCLE DUDLEY

We are quite willing to agree with the observation that the plant possesses something definite and distinct which is not to be found in the crystal; but it is also true that there is something in the lifeless material that precedes the crystal which determines form and strives to keep it true. We separate these forces for convenience in thinking, yet not without some risk to truth.

★ ★ ★

It would be well, in our youth, if we could know that sophistication is not an unmixed blessing. What we pay for it comes out of our happiness fund.

★ ★ ★

What a French actress, who now is in Hollywood, says to American women contains wisdom far-reaching in its application. She thinks our men should remain masculine and our women should return to being feminine. This sounds like a voice in the wilderness crying for a return to the way of the Lord. Attention to this would be the salvation of many homes. Woman to be lovable, and man to be worthy of her devotion—What an ideal!

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WHITE'S DRUG STORES

NARCOTICS AND CHILDREN

The increasing incidence of narcotic addiction among children has reached the stage of nation-wide concern. Police authorities are foraging community environs for peddlers and staging drives in an effort to curb the illicit distribution of narcotics with resultant juvenile corruptibility and the creation of a monstrous menace to society.

As physicians we con appreciate more than anyone, the devastation, physical and moral, that results from addiction to narcotics. No one can give better witness or testimony to the dereliction, corruption, immorality and physical chaos wrought by drugs illicitly placed in the hands of adults, let alone to a growing and impressionable youth where harvest of addiction is soon reflected in irresponsible, immoral, senseless, perverted and hapless figures of humanity, easy preys to everything against decency and order.

We should add a strong voice to a plea for a timely remedy to the appalling situation. Open education of the public to the horrors of narcotics and the consequences of addiction is mandatory. Locally, steps have already been taken in that direction. We should shoulder with civic leaders, police authorities, and our educators, so that any evidence of addiction will be relentlessly tracked down and peddlers and their confederates apprehended and punished for their despicable crime.

We should lead our civic heads to a protest of this new peril to American health and to community order, help to the education of dangers greater than those brought on by accident and sickness and furthermore, add to an insistence for legislators to provide adequate punishment to the perpetrators and accomplices of the newest and deadliest of crimes, the distribution of the poisonous venom, *narcotics,* to our youth.

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