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August • 1953
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Youngstown • Ohio

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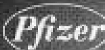

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Our President Speaks

The second annual report of the American Medical Education Foundation gives some startling figures of which we should be proud.

Physicians made direct gifts totaling approximately $2,250,000 to the country's medical schools, and contributions totaling $906,553 to the Foundation.

Much progress has been made since 1951 in stimulating voluntary contributions from members of the medical profession. The Foundation's program during 1952 was evidenced by a 287 per cent increase in the number of contributions, from 1876 in 1951 to 7259 in 1952. Contributions by individuals to the foundation during 1952 amounted to $291,000, a 210 per cent increase over 1951.

DOCTOR DRAFT LAW

On June 29, President Eisenhower signed the bill passed by Congress, extending and amending the Doctor Draft Act. It is identified as Public Law 84. Elsewhere in this issue of the Bulletin, a digest of this law is published for the information of our members.

MOTOR-VEHICLE DEATHS

"Most motor-vehicle accidents are avoidable," it was stated editorally in the current (July 18) Journal of the American Medical Association.

It is our responsibility, as physicians, to proffer advise to patients who, we believe, should not operate a motor vehicle. The editorial pointed out that "individual evaluation as to whether or not a person should drive an automobile should be made for persons who have just had certain types of physical examinations or who have just received an anesthetic; of persons taking certain drugs, such as antihistamines and sedatives; of persons with mental instability, uncontrolled diabetes, and certain forms of epilepsy; and of persons with heart disease or severe phyertension."

V. L. Goodwin, M.D.
President

BULLETIN of the Mahoning County Medical Society

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EDITORIAL

"VALOR"

Each Day's Newspaper Carries The Story of Heroism.

The story of the soldier, who died defending his post in Korea?

The U. S. Senator, who devoted his life to his country's legislative phases?

The general practitioner, a physician and member of the Mahoning County Medical Society for fifty years, who gave his life in providing life for his fellow man?

HEROES ALL, BUT EACH LEAVES A DIFFERENT MARK. The soldier, remembered only by his family and by the survivors of his company, may lie forever in a soldier's grave on the battlefield.

The senator, after a sad farewell in his nation's capital, goes to a tiny country churchyard.

The physician lies enshrined forever in the hearts and minds of all who knew and loved him.

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KEEPING UP WITH AMA

By Wm. M. Skipp, M.D.

Doctor Draft Law

The President has signed the law extending and amending the doctor draft act, which is known as Public Law 84, replacing 779, which was extended to June 30, 1955. The AMA has already stated it will actively oppose any further extension of the doctor draft.

While the law set up a schedule of obligated duty based on prior service, there is almost no chance of priority IV men being called during the two years, barring a general war or other national emergency.

All physicians, dentists, and veterinarians not members of an armed service reserve component and under 50 years of age must be registered with their local draft board. They remain liable for induction up to age 51. Men on graduating from medical school have 10 days to register and ask for deferment for a year to complete internships. A physician must register under the doctor draft even though he has previously registered for the regular draft.

Much has been written about this in national and state journals giving all details. If you are involved keep yourself posted.

WHAT IS THE DEFINITION OF PRIOR ACTIVE DUTY? The law defines active duty as time spent either as enlisted man or officer since Sept. 16, 1940, on: 1. active duty in Army, Navy, Air Force, Marine Corps, Coast Guard, and U. S. Public Health Service. Not counted as active duty is time spent under military auspices in: ASTP, V-12, or similar training programs, 2. intern, residency or other postgraduate training, 3. senior student programs prior to receipt of the appropriate degree, 4. active service performed for sole purpose of undergoing a physical examination, and 5. active duty for training entered into subsequent to enactment of the law.

HOW MUCH SERVICE IS REQUIRED UNDER THE LAW? Maximum service under the doctor draft is 24 months, which is required of all physician who have had less than 9 months of prior active duty. Graduated periods of service are provided for others as follows: 21 months if prior duty ranges between 9 and 12 months, 18 months if prior duty ranges between 12 and 15 months, and 15 months if prior duty totals 15 or more months. The foregoing is applicable to reservists as well as registrants under the act.

Priority II doctors with 17 or more months' service prior to entry on current duty are classified in Priority IV, and no doctor with 21 months' prior service can be called during the life of the present act. The law also requires release within 90 days of all men on active duty who would not have been called had the new law been in effect, but they must apply for release.

WHAT CHANGES ARE MADE IN PRIORITIES? The new law continues the four priorities, but effects two changes of importance: A. It lowers from 21 to 17 months the amount of active duty required to move a man from priority II to priority IV. B. It credits all active duty of any nature subsequent to Sept. 16, 1940. (Priority I doctors are those who either received all or part of their professional education at government expense, or received educational deferments in World War II, and who served less than 90 days on active duty. Priority II are those similarly educated or deferred, but who served between 90 days and 17 months. Priority III are men with no military

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service. All others make up Priority IV. Priorities I, II, III, will be called before Priority IV.)

DOES THE LAW PROVIDE FOR CONTINUING EQUALIZATION PAY? The $100-a-month equalization pay is continued for all commissioned physicians and dentists.

IS IT POSSIBLE TO RESIGN COMMISSION? Physicians obligated only under the doctor draft are discharged from their commissions on completion of active duty performed in carrying out doctor draft obligations. Reservists who would be liable for doctor draft except for their membership in a reserve component may resign their commissions upon completion of the period of obligated service.

ARE ALIENS ELIGIBLE FOR COMMISSION? A registrant under doctor draft no longer is held ineligible for appointment as an officer on the sole ground he is not a citizen of the U. S.

HOW IS DUTY IN U. S. PUBLIC HEALTH SERVICE CREDITED? Full credit is given for service in the commissioned corps of U. S. Public Health Service. PHS, unlike the military, may not hold a man against his will. Consequently, under the old law, it would be possible for a doctor to serve in PHS for a few days, then resign and give up his commission and move to Priority IV. To forestall this, the new law requires that the Surgeon General of PHS approve termination of a commission if the time served is to be credited under the doctor draft law.

BRICKER AMENDMENT: Whether this will be considered before adjournment cannot be foretold at present, but the House of Delegates in New York, June, 1953, reaffirmed its stand to support this Amendment, Senate Bill, S. 1901.

It is touch-and-go whether this will be considered before adjournment. The Senate Majority Policy Committee, attempting to work out language the administration will accept, has invited Attorney General Brownell to discuss the question with Senator Bricker.

AID TO EDUCATION: Senate has agreed to a proposal to use federal revenue from "outer continental shelf" — oil and gas for national defense during the emergency, then to earmark the money for grants-in-aid to education, including medical and dental schools. A House-approved bill would have the money go into the general treasury. One estimate is that the total return for the next 50 years would average out at about $100 million a year.

Chairman B. W. (Pat) Kearney, R., N.Y., of the Hospital Sub-committee of the House Veterans Affairs Committee outlines scope of VA hearings. Dr. Walter B. Martin, the president-elect, will testify for AMA. A rider to the bill would have: A. authorized VA to look behind "inability to pay" oaths on non-service connected cases, and B. directed VA to collect from non-service cases according to the veteran's ability to pay. AMA supported the first proposal but opposed the second, contending it would result in a vast new non-service program. It will also attempt to determine whether "inability to pay" by non-service cases should be based on income of the veteran, his net worth, or his local credit rating; also the question of whether a veteran's possession of hospitalization insurance should operate as a bar to VA hospitalization. The AMA's position is that hospitalization should not be offered to non-service cases, except for such long-term illnesses as tuberculosis and mental and neurological conditions where the veteran is unable to pay.

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S. 2168, Langer (R., N.D.) College Scholarship Loans. Would authorize an appropriation of fifty million dollars as a revolving fund to be administered by the U. S. Commissioner of Education for loans to students for vocational, technical, academic, or professional education beyond high school. Loans to an individual could not exceed a total of $1,000, and could be used only for tuition, books, supplies, board, lodging, and other necessary educational expenses.

S. 967, Taft (R., Ohio) Extending the Hospital Construction Act, two years beyond June 1955. The Senate June 18 passed this bill on the Unanimous Consent Calendar.

S. 1748 (Taft) Granting a federal charter to the National Fund for Medical Education. This bill was called on the Senate Unanimous Consent Calendar for June 18 and was amended by dropping the name of George Meany, AFL, from the list of Trustees. This bill was reported favorably to be voted on by Senate and Judiciary Committee.

Testifying for AMA before the Defense Department's Commission on Medical Care of Dependents of Military Personnel was Dr. Walter B. Martin, who said that this question should be answered by Congress and not the administration. 1. That government hospitals are competing with civilian hospitals for interns and residents; 2. This policy is producing wasteful duplication which is threatening civilian programs which is increasing the cost of civilian health programs; 3. Doctors are being drafted to take care of civilians; 4. The present program is based on a very slender foundation of law dating back to Congressional action of 1884.

Dr. Richard Meiling testifying, said that for years funds for medical care of military dependents have been a "hidden item" of the various military budgets; — that such funds be "carefully and honestly accounted for as are the funds of the Quartermaster Corps for Food." He said a serviceman could have two petions in the event Congress saw fit to provide by law "allowances for medical care, treatment and hospitalization." Depending on the local situation his family would be eligible for: 1. Dependent care at sliding rates established by the Budget Bureau at facilities of military medical services where available and staffed; or 2. Care to dependents through civilian channels with payment through such voluntary programs as Blue Shield or Blue Cross.

Mrs. Hobby, Secretary of new Department of Health, Education, and Welfare, said in an address to the General Federated Women's Clubs — defended budgetary cutbacks — not excluding retrenchments within her own Department — and hailed forthcoming survey of inter-governmental fiscal relations. "It could end dependency on the Federal Government which is one of the evils of our times."

VOLUNTEER NOW, ARMY ADVICES INTERNS. The Army reminds the 3,000 or so physicians under 30 who are completing their internships or residencies this month that it may be to their advantage to volunteer for the Army Medical Service instead of waiting for a call through the doctor draft. "The physician who volunteers at least knows the exact date that he is to enter the Army. Also he will not lose out financially during the several months interim between the time his civilian training has been completed and the date he comes into the Army."

S. J. Res. 1 (Bricker et al) To Outlaw Treaties and Executive Agreements which Supersede Laws of the U. S. The Senate Judiciary Committee agreed

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*U.S. Pat. #2,505,681.

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to completely rewrite language. Amendment proposed by the new language would read as follows: 1. Provision of a treaty which conflicts with this Constitution shall not be of any force or effect. 2. A treaty shall become effective as internal law in the U. S. only through legislation which would be valid in the absence of treaty. 3. Congress shall have power to regulate all executive and other agreements with any foreign power or international organization. 4. The Congress shall have power to enforce this article by appropriate legislation.

HEW Sec'y. Oveta Culp Hobby averted another anticipated tempest by a masterful speech. Her convincing repudiation of government medicine, along with her explantation of delays attending appointment of special assistant for medical affairs (. . . "and I might add that he will be a doctor of medicine . . . ").

LEADERSHIP IS SOLICITED. Shrewdness of HEW Sec'y. is shown by manner in which she suggested AMA assume leadership "to make available the best medical care possible for all people." Subtly, but unmistakably, Mrs. Hobby employed AMA's own petard in calling upon organized medicine to start accentuating — as that popular song went — the positive.

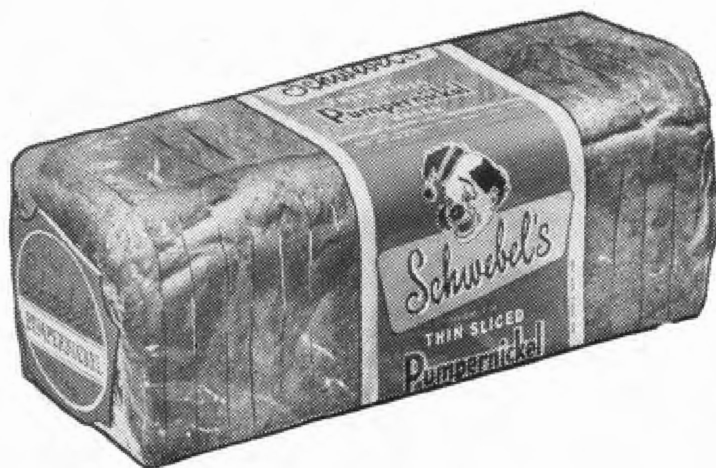
AMA strongly urges the House Appropriating Committee to critically review the hospitalization rider in the VA appropriations bill. We are convinced beyond any doubt that if the rider is enacted intact the eventual result will be to make millions more veterans fully eligible for hospitalization for all non-service connected conditions.

Under the first major provision of this rider VA would be authorized (but not required) to turn away veterans who could obviously afford to pay the entire bill, but would admit those unable to pay the entire bill. Under the second, VA would be direced to attempt to collect the veteran's share for the bill, a percentage which could be determined only by means of a sliding scale based on income or financial resources. In every case the federal government would bear the remainder of the cost.

This second provision is a new concept of federal medical care, one found nowhere else, to our knowledge. It would constitute, in effect, a standing offer on the part of the federal government to pay part of the cost of medical care for every veteran suffering from a non-service connected condition.

This rider would bring about an unwarranted, dangerous, and incalcuably expensive expansion of the VA's medical program, in competition with non-government medical care and non-government hospitals, — an uncontrollable program of government-subsidized medicine for a large segment of our population. The long run effect would be more, not fewer, VA hospitals and larger, not smaller, medical and supporting staffs to care for the men whose conditions are not the result of military service.

STATEMENT BY DAVID B. ALLMAN, AMA MEMBER OF BOARD OF TRUSTEES RE: DEDUCTION OF MEDICAL AND DENTAL EXPENSES FOR INCOME TAX PURPOSES. TO COMMITTEE OF WAYS AND MEANS, HOUSE OF REPRESENATIVES. The Committee on Legislation, AMA, has considered a number of bills introduced during the 81, 82, and 83 Congresses to authorize the deduction of all, or a larger percentage of medical expenses, from gross income for income tax purposes. The effect would be to reduce or remove the limitations on such deductions imposed by existing laws. Certain of



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these bills would also redefine the term "medical expenses" to include amounts paid as premiums for prepayment health insurance.

We are of the opinion that a greater measure of relief should be provided in this way for those individuals who have suffered from the financial burden resulting from the expense of a serious, long-term illness.

There are certain misconceptions concerning the present cost of medical care. Recent surveys indicate that only 3% of American families have medical bills over $200, and that 80% have no medical debts of any kind. Despite this fact, it is realized that a serious long-term illness can be a financial catastrophy to almost any family. Thus, for some time, several insurance companies have been writing "medical disaster," or "catastrophic" coverage. Agencies established by medical associations are also underwriting this newer version for protection.

The provision of bills pending before this Committee which are designed to permit deductions from gross income for the cost of prepayment health insurance should act as an inducement for people to join medical and hospitalization plans.

The House, June 18, deleted a section of the VA appropriations bill which AMA had described as a "standing offer on the part of the federal government to pay part of the cost of medical care for every veteran suffering from a non-service connected condition." Also another section which would have permitted VA to make financial investigations where there was reason to question an "inability to pay" oath of a veteran applying for hospitalization for a non-service connected condition.

READ IN THE AMA JOURNAL, June 20, 1953, Vol. 152, No. 8, Page 726, Dr. Ed. McCormick's point program. It is worthwhile.

Walter B. Martin, M.D. TO THE COMMITTEE ON WAYS AND MEANS RE: DEDUCTION OF COLLEGE AND EDUCATIONAL EXPENSES FOR INCOME TAX PURPOSES. AMA has not taken any position with respect to the deduction of all college and educational expenses for income tax purposes. However, the Association is vitally interested in the deduction of postgraduate educational expenses. The present tax laws permit such deductions for ordinary and necessary expenses in a trade or business, there is no express provision permitting professional persons to deduct the cost of securing additional education. In connection with postgraduate medical education there is a total of 784 postgraduate courses available. These courses are designed to be of assistance to physicians in general practice as well as to specialists in increasing their medical proficiency as well as to prepare them for specialty board certificates.

For years the House of Delegates and Board of Trustees of the Association have expressed concern over a ruling by the Commissioner of Internal Revenue holding that expenses incurred by a physician in pursuing postgraduate medical education are personal in nature and therefore not deductible for federal income tax purposes.

It was learned that there was pending before the U. S. Tax Court a case in which a lawyer has been denied the right to deduct expenses incurred by him in attending postgraduate courses on taxes. In view of the fact that the case involved was quite similar to the one in which the medical pro-

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fession was interested, AMA filed a brief as amicus curiae. The tax court held against the taxpayer and an appeal was made to the U. S. Court of Appeals. On April 14 the U. S. Court of Appeals reversed the decision of the U. S. Tax Court, holding, in effect, that expenses incurred by the attorney in taking a postgraduate course were deductible for income tax purposes.

It is not clear just how far the Bureau of Internal Revenue or the courts will follow this decision. From the wording of the decision, that a deduction would be disallowed in cases in which the taxpayer fails to show that he was bound, either contractually or morally, to keep abreast of changes in his particular field, and that attendance at an institute or refresher course was the proper way to do it.

In view of these areas of doubt the issue should be settled by new legislation rather than be left to administrative interpretation or judicial decision.

DOCTORS RATED LAST AS BUSINESS SPENDERS. Physicians are rated last on the list of spenders for entertainment for business purposes according to a study of members of the Diners' Club, a credit card system covering hotels, night clubs, florists, etc.

Advertising agency executives are the biggest spenders and a shade below are public relations men, closely followed by manufacturers representatives and distributors and theatrical booking agents.

DR. McCORMICK's SON ORDAINED A PRIEST. At AMA meeting in June Dr. McCormick was inaugrated as president of the Association. June 17, the McCormick's son, Richard Arthur, 30, was ordained a priest in the Jesuit order at West Baden College, West Baden, Ind. The following Sunday, June 21, he celebrated his first mass at 10:30 a. m. in Toledo's Gesu Church, the McCormick's home parish.

SURVEY SHOWS 87% OPPOSE SOCIALIZED MEDICINE. A cross-section of the 60,000 replies received in answer to 600,000 questionaires sent out in the fall of 1952 by a "National Committee of Republician Voters" reveals that 87% were opposed to the adoption of socialized medicine in the U. S. More than 7% were in favor of it and almost 6% were against socialized medicine but in favor of some form of national health insurance. Highly significant to the medical profession is the fact that even among those definitely opposed to socialized medicine, a substantial proportion of voters throughout the country expressed the opinion that some way must be found to protect people, especially those in the middle income groups, against the unexpected costs of serious illness.

BACKING INTO SOCIALIZED MEDICINE. Howard Buffett, who retired last year from Congress where he served four terms as representative from the second Nebraska District, has written an excellent article entitled "Backing into Socialized Medicine." It has been distributed in printed form at a nominal price (6 copies for $1.) by Human Events, 1835 K Street, N.W., Washington, D. C.

Mr. Buffett has taken a new, up-to-date slant on the subject of socialized medicine which, he says, ought to be a dead issue in America but isn't. He believes we are edging towards socialized medicine whether we want it or not. "We are backing into it," he said, "by way of militarism."

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HEALTH EDUCATIONAL EXHIBIT — CANFIELD FAIR

Under the direction and supervision of our chairman, Doctor M. M. Szucs, the Mahoning County Medical Society is again sponsoring a Health Educational Exhibit at the Canfield Fair September 3rd to 7th, 1953.

The Canfield Fair is one of the biggest of all the county fairs in our state and is still growing. Last year over 63,000 fair visitors registered at the Health Exhibit and with an even larger and more interesting exhibit planned for this year it is hoped that the visitors will be in excess of last years registration.

Two separate tents will be used this year, one for the exhibits themselves and the other, of specially treated canvas to exclude light, so that motion pictures may be satisfactorily shown during the day light hours. Several of the organizations participating have promised a number of interesting and educational motion picture shorts.

At this writing the subject matter of the organization is incomplete but to date the following organizations have reserved space in the tents.

1. Youngstown Society for the Blind
2. Youngstown Area Heart Association
3. Youngstown Hearing Society
4. Youngstown Hospital Association
5. St. Elizabeth's Hospital
6. Mahoning Chapter Academy of General Practice
7. Corydon Palmer Dental Society
8. American Red Cross
9. Women's Auxiliary to the Mahoning County Medical Society
10. Visiting Nurses Association
11. District No. 3 Ohio State Nurses Association
12. Ohio State Optometric Association
13. Mahoning Valley Chiropodists Society
14. Eastern Ohio Pharmaceutical Association
15. Mahoning County Health Department
16. American Cancer Society
17. Mahoning County Arthritic Society
18. Ninth Ohio District of Osteopathic Medicine

Your committee would like to take this opportunity to point out that the majority of our members approved this undertaking. With this in mind they hope that each of our members will, in their visit to the fair, spend some time at the exhibits and be interested in showing the other visitors the accomplishments and achievements of our own profession and its closest allies. We have done and we are doing a great service to these people, each and every one, so let us cast aside the " it was nothing attitude" and give the visitors a chance to laud our accomplishments and let us take this opportunity to point out to them what we hope the future will bring to further insure their health and happiness.

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THE YOUNGSTOWN AREA HEART ASSOCIATION, INC.

The following booklets, recently published by the American Heart Association, are available through your local Heart Office for general and professional use. These booklets should be distributed either through the physician or upon request from the physician to the Heart office:

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HEART DISEASE AND PREGNANCY

This booklet is prepared for young women with heart disease who are planning to have children. To be distributed through physicians only.

DIAGNOSIS OF CONGENITAL CARDIAC DEFECTS IN GENERAL PRACTICE

This handbook, designed primarily for general practitioners and pediatricians, present briefly the clinical and physiological findings and the indications for surgery in common congenital cardiac defects.

NOMENCLATURE AND CRITERIA FOR DIAGNOSIS OF DISEASES OF THE HEART AND BLOOD VESSELS

A copy of this handbook has been presented by the Youngstown Area Heart Association to the library of each hospital in this area, and the Heart Association will be glad to order it for any physician requesting it. Price $4.95 per copy.

This is a completely revised and greatly expanded edition of this handbook which has come to be accepted as the standard work in its field. It is intended primarily to standardize and clarify the language used by the medical profession in diagnosing cardiovascular diseases. By enabling physicians to record their findings more precisely, it assists them in communicating vital information to other physicians or clinic personnel who cooperate in the management of the patient.

STAFF MEETING OF THE ST. ELIZABETH'S HOSPITAL

The regular monthly staff meeting of the St. Elizabeth Hospital was started at 8:00 a. m. on Friday, July 10, 1953.

1. Clinical Pathological Conference conducted by Dr. John LoCricchio.
   a. A case of primary carcinoma of the liver (hepatoma) based on a pre-existing cirrhosis was presented. Case was discussed by Dr. E. Weltman and Dr. M. W. Neidus.
2. Business meeting opened at 8:45 a. m. Dr. W. H. Evans, Chief of Staff, presided.
3. Minutes of last meeting were read and approved.
4. Dr. S. D. Goldberg moved that the Ex-Interne Day Committee be congratulated on the fine day we had. Seconded and approved.
   Dr. J. LoCricchio reported on the movies he took of the doctors on Ex-Interne Day.
5. Dr. J. N. Thanos reported on the prevalence of schistosomiasis in the immigrant Puerto Rican population.
6. Meeting adjourned at 8:55 a. m.

H. J. Reese, M.D.
Secretary

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A TEMPEST IN A TEAPOT?

The growing problem of abuses of Veterans Administration medical care by men with non-service-connected disabilities is certain to be an issue when the 83rd Congress reconvenes in January, 1954. This became quite clear as hearings of a House Veterans Affairs subcommittee came to a close. The problem, warmly debated during two weeks of hearings by the subcommittee headed by Rep. B. W. (Pat) Kearney (R., N.Y.), boiled down to the following:

1. The American Medical Association, the National Medical Veterans Society, the American Hospital Association and similar groups, are convinced abuses can be halted only by unequivocal language in a law that will rule out non-service care in VA hospitals except for long-term tuberculosis and neuro-psychiatric cases.
2. Veterans organizations with one notable exception (AMVETS) are inclined to view the whole matter, as one witness put it, as "a tempest in a teapot." In general, they maintain non-service-connected medical care in VA hospitals is a right of all indigent veterans, and that the VA should not have to investigate inability-to-pay affadavits. In other words, no change in the law is necessary.
3. Supported by AMVETS, the American Dental Association struck hard at the "scientifically unsound" theory of the service-connected tooth and said the practice "goes beyond the obligation of the government to the veteran." This is one of the chief contributing causes to the projected high cost of the VA dental program which threatens to assume huge proportions.
4. In the absence of any formal report from the Kearney group, collective committee thinking is lacking. However, a VA suggestion that the whole matter be handled simply by administrative changes — a redrafting of the inability-to-pay affadavit to include a man's net worth — was well received by members of the subcommittee. Chairman Edith Nourse Rogers of the full committee informed the House near the close of the hearings that the VA proposal seemed "very logical."

Background of the Hearings

Significantly, when the hearings opened Chairman Kearney warned his colleagues that unless the committee came up with some concrete proposals for ending abuses the matter could very well be taken out of their hands by an aroused Congress which, in turn, might, as he put it, "jam something through we will all be sorry for."

Still fresh in the minds of committee members was the highly controversial rider attached to the VA budget by the House Appropriations subcommittee. On the surface, the rider sought to end abuses of non-service care in VA hospitals. Careful analysis showed, as the AMA made clear to all members of the House, that it was simply "a standing offer on the part of the federal government to pay part of the cost of medical care for every veteran suffering from a non-service-connected condition." The House voted down the rider, including another section which permitted the VA to make financial investigations where there was reason to question the inability-to-pay affadavit.

SEPTEMBER MEETING . . .

Melvin A. Casberg, M.D.

TIME:

Tuesday, September 15, 1953, 6:30 p.m.

PLACE:

Elks Club, 220 West Boardman Street, Youngstown, Ohio

PROGRAM:

Dinner (no cost). This is a get-acquainted gathering and a kick-off for the fall meetings

SPEAKER:

Dr. Melvin A. Casberg
Assistant Secretary of Defense (Health and Medical). Former Assoc. Prof. of Surgery and Dean, St. Louis University School of Medicine.

SUBJECT:

"Military Medicine"—covering all aspects of this subject at the Department of Defense level.

Mark this date on your calendar—this will be the first meeting of the Fall series. *Plan to attend!*

The House then instructed its Veterans Affairs Committee to go into the matter and to report back as soon as practicable. Two weeks of hearings ensued. They concluded July 21, subject to the call of the chairman.

A Summing Up

On the final day of the hearings, telling evidence was presented by two officials of the General Accounting Office which functions very much as an independent firm of accountants called in by a business firm. The witnesses told of a survey of veterans with non-service conditions discharged from 46 VA hospitals. The government's chief accountant, Comptroller General Lindsay Warren, summarized the survey: "It is clear that there are veterans being hospitalized on the basis of the unable-to-pay affadavit prescribed in the present law who are fully able to pay for their hospitalization and others who are able to pay in part . . . The present law and regulations in effect discriminate against the more honest class of applicant"

The subcommittee thus may feel the answer lies in a change of VA regulations. Others, including the AMA, are convinced the problem calls for more definite legislation if, in the words of Dr. Walter B. Martin, we are "to reorient our thinking and to recognize the dangers which threaten the foundations of our basic philosophy before we reach the point of no return in terms of collective socialistic planning."

A.M.A. Special Report, No. 9
July 29, 1953

ST. ELIZABETH HOSPITAL BREAKS GROUND FOR NEW ADDITION

Bishop Walsh gave the principal address at the ground-breaking ceremonies for the $4,500,000 addition and modernization program at St. Elizabeth Hospital on Sunday afternoon, Aug. 2nd.

Attorney G. F. Hammond, president of the hospital advisory board, presided at the ceremonies. Speakers included, Judge Ford, Campaign chairman, Mayor Charles P. Henderson, the Rev. Roland Luhman, representing Protetsant clergy, and Congressman Michael J. Kirwan. Dr. Sidney Berkowitz, rabbi of Rodef Sholem Congregation, sent a telegram expressing his regret that he was out of the city and could not take part.

Mother M. Lorita, H.H.M. general superior of the order and president of the board of trustees of the hospital, turned the first shovelful of earth. She was followed by Sister M. Germaine, directoress of hospitals for the order and former superintendent of St. Elizabeth's, and Sister M. Adelaide, present superintendent.

NOTICE

The South Dakota Board of Medical Examiners has announced the passage of legislation creating an annual registration fee for licensees in that state in the amount of $2.00. The registration takes affect January 1, 1954. If you are licensed in South Dakota and wish to maintain that license by payment of the registration fee, please contact the South Dakota Board of Medical Examiners, 300 First National Bank Building, Sioux Falls, South Dakota.

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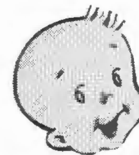

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DR. WARREN D. COY, 81, DIES; PRACTICED 49 YEARS IN AREA

Dr. Warren Deweese Coy, aged 81, of 20 W. Florida Ave. died in North Side Hospital at 7:30 p. m. July 16, 1953 after being stricken by a cerebral hemorrhage.

Dr. Coy had practiced medicine in the Youngstown district since 1897, first at Canfield, and 11 years later coming to Youngstown, where he was a general practitioner before his retirement in 1946.

Dr. Coy was on the staff of the Youngstown Hospital Association and was president of the Mahoning County Medical Society in 1919. He also was a member of the Ohio State Medical Association, the American Medical Association and the American College of Surgeons.

At one time he was active in the affairs of the Unitarian Church and was a past president of the Unitarian Laymen's League.

In 1948 he was included in a group of Youngstown physicians who were recognized for practicing medicine here for more than 50 years.

Student of Classics

Dr. C. A. Gustafson, past president of the Medical Society, said today that Dr. Coy was a man of "unusually broad interests in the literary field, a scholar and student who had the classics at his fingertips. He wrote very well and had written some poetry of unusual beauty and depth of understanding. Some years ago he made several contributions to "The Bulletin," official publication of the Mahoning County Medical Society."

Dr. Coy was born at Greenford June 20, 1872, a son of Dr. Lewis and Laura Bowell Coy. He graduated from public school, then from Northeastern Ohio Normal School in 1892, Electric Medical College in 1897 and the college of medicine of the University of Illinois in 1901.

Kept Up to Date

During his early years as a physician he used a horse and buggy to travel to his patients, but was among the first to adopt the auto as a means of transportation. Although advanced in years, he urged the use of the modern hospital laboratories to heal the sick and kept up his studies of new advancements in medicine.

Dr. Coy leaves his wife, the former Alma Shollenberger, whom he married Nov. 3, 1915. —J. H. R.

PRIZE ESSAY ON CARDIAC SURGERY

The Trustees of one of America's oldest medical essay competitions, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's prize dissertation "RECENT ADVANCES IN CARDIAC SURGERY." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $250 is offered.

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CARDIAC PAIN

Dr. Hugh Hussey

Associate Professor of Medicine of Georgetown University School of Medicine; Director of the medical service of Gallenger Municipal Hospital affiliated with Georgetown University; editor of "General Practice Journal."

Presented at the Annual Reunion of the Ex-Interne Association of St. Elizabeth's Hospital on June 25, 1953.

Editors Note:

This discussion is being published because of the simplicity and excellence of presentation. All who heard Dr. Hussey unanimously acclaimed it as being amongst the finest papers they had ever heard, it is a real review of the subject. The slides referred could not be included in the Bulletin.

Chest pain is important to all physicians because they have either had chest pain or they're going to get chest pain which they think is due to heart disease. There are many ways in which cardiovascular disorders may provoke pain in the chest and there are many conditions unrelated to the heart and blood vessels which provoke chest pain which mimics that type due to cardiovascular diseases.

Of course, the principal stimulus in the development of pain from cardiac disease is myocardial ischemia. Without belaboring the physiologic aspects of this kind of pain you'll recall from years back that it is a referred pain, which is to say that it seems to be felt in part of the chest wall although it has its origin deep in a viscus. This brings up the question of the innervation of the heart and it is important again to recall to you that the nerves that carry sensory impulses are chiefly those which reach the spinal cord in the cord segments T1 to T4. I say this is important and I hope to support that by another bit of evidence in a while. At this time it is important because other viscera and other structures also have sensory nerves which reach the same cord segments of the spinal cord.

At times the sensory nerve supply reaching the cord spills over as it were and radiates into adjacent cord segments so that the location of cradiac pain resulting from myocardial ischemia is not strictly limited to those areas of the chest wall supplied by segment T1 to T4. Along with the sensation of pain there will be tenderness in the area supplied by these nerves and commonly there will be a reflex muscle spasm. Some people believe that such reflex muscle spasm in the chest is responsible for some part of the sense of constriction that accompanies cardiac pain. Commonly too, as part of the phenomenon of disturbed innervation there will be viscero-secretory reflexes, so that the patient salivates excessively or has nausea or vomiting or diarrhea or all three, or has an increased frequency of urination. Some of these things I mention because they begin to indicate clearly how cardiac pain may be confused with disorders in other viscera and how at times we are required to think of cardiac pain when the disorder is, indeed, in another location.

The final influence which has something to do with the location of the pain is given the fancy term "summation of effect." It is known, without our being able to explain it quite fundimentally, that when a patient has felt pain in a location not too far from the chest from some cause other than cardiovascular disease, the development of pain as a consequence of myocardial ischemia is likely to cause this patient to feel the pain in the

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area where he had it before. Now if that seems complicated recall the simple case of a patient who had had a lot of trouble with the teeth and, when he develops coronary occlusion, in addition to having an element of chest pain, has jaw pain. Sometimes this summation effect is so powerful that the pain will be felt only in the unorthodox location. Some of you may have seen people who have had peptic ulcer or gall bladder trouble or even appendicitis, when it's a bad appendicitis, and when they develop coronary artery disease they do not feel pain in the chest but only in one of these areas of the abdomen where there has been previous disease.

I mentioned I was going to support the importance of the innervation by one other point. Anatomical diagrams show the sensory nerves running off from what looks like the top part of the heart, reaching the spinal cord via the sympathetic ganglia. The point worth noting in this is that the nerves carry sensory impulses-all of them by way of the sympathetic chain for a comparatively limited area, and a good portion of nerve supply, sensory that is, passes through the stellate ganglia, as shown in this area. I mention this as important because it gives an idea of why a surgeon can improve a patient with chest pain due to heart disease; at least, relieve his pain by interrupting some part of the sympathetic nerve supply; Or indeed why an anesthetist, or internist, or anyone competent to do the job, can interrupt the sensory pathways for coronary pain by injecting the stellate ganglion or the region of the stellate ganglion with procaine solution.

I mentioned the areas of the chest wall corresponding to thoracic cord segments. The anatomical studies show that the areas for C8 to T5 allow for some spilling over of the sensory innervation as it were, and you'll notice that the mixed areas, which are the corresponding dematomes, are distributed in a rather neat anatomical fashion. As you know from personal experience with patients having heart disease, that cardiac pain by no means restricts itself so neatly as a diagram will show.

Indeed, in cardiac pain, when myocardial ischemia is the precipitating factor, the pain is likely to be felt more toward the left side than toward the right side of the chest. When the pain develops in the arms as well as in the chest, it is likely to be quite vague and not follow these neatly sketched diagrams.

I apologize for all this disgression into facts of a fundamental sort. Now to come to the types of cardiac pain. Essentially there are seven of them. The commonest and most important from a clinician's view point is the pain due to rheumatic carditis, pericarditis, aortic aneurysm, a dissecting aneurysm which has a somewhat different mechanism, pulmonary hypertensive pain and finally neurocirculatory asthenia. Quite an impressive list from length at any rate.

Coronary insufficiency, which is by and large the most important type, can be explained quite readily by a diagram. In effect there are several ways within the mathematical limits of such a diagram, in which the blood flow through the coronary arteries may be insufficient. Consequently, there will be myocardial ischemia and cardiac pain. Normally, supply and demand are in balance. When anything causes demand to increase, supply increases accordingly. At times coronary insufficiency results when there is no change in demand but supply is suddenly curtailed. This would be exemplified by the development of a fresh coronary occlusion. At other times without any change in supply, the demand increases and coronary insufficiency develops

because supply does not keep pace with it. This would be exemplified by the patient having a rather generalized coronary atherosclerosis without specific occlusion at any one point and in whom the increased demands of exertion or some other factor provokes pain, because the supply is not adequate in view of the rigid character of the arteries. Finally, of course, both things may happen at the same time. A patient having some occlusion may increase demands for some other reason — coughing, vomiting, etc. — ; and therefore provoke greater coronary insufficiency than he otherwise might have had.

I wish to impress upon you that there are many factors that contribute to the development of coronary insufficiency. These include diseases of the arteries themselves. You are most familiar, of course, with the most common one — coronary atherosclerosis. But there are other diseases that do involve these arteries anatomically. For example, a single coronary artery, an anomaly if you will, will provoke coronary insufficiency. In dissecting aneurysm, coronary insufficiency may result because the dissection extends to involve the coronary orifices and the same kind of local involvement of these orifices may result in bacterial endocarditis when the vegetations extend to occlude them partly at their point of origin. The list goes on through compression of the coronary artery. Another is anything which changes cardiac output and therefore diminishes coronary filling — a severe hypotension of shock is the most important of these. In aortic stenosis the coronary filling is impaired partly because cardiac output may be reduced and partly because blood injected through the narrowed aortic valve strikes the aorta at a point somewhat above the coronary orifices. Instead of gushing out of the aortic valve as is normallly the case, the blood strikes in a jet above the coronary orifices and may not fill them adequately. In practice few conditions provoke coronary pain in the absence of some degree of coronary atherosclerosis.

There is no question that coronary insufficiency, in the physiologic sense, may exist without there being any pain. You are aware of the patients who have just heart failure as their only manifestation of coronary insufficiency. The pain syndromes of coronary insufficiency include the familiar angina pectoris, the badly termed "coronary failure," myocardial infarction and that's all. The other syndromes, not painful necessarily, include congestive heart failure, disturbances of rhythm and conduction and, of course, sudden death.

There are three factors that influence the development of pain in coronary insufficiency. One is the degree and duration of myocardial ischemia. When the myocardial ischemia is of brief duration and relieved quickly, the pain will correspond in duration and intensity. However, other things which influence coronary pain include the sensibility of the patient. Some people feel pain more than others. It is difficult to define those people — it just happens with them. Finally, there is the intelligence of the patient. I don't mean that stupid people don't feel pain; indeed they do. In this term, "intelligence," I'd like to include the intellectual rapport that develops between doctor and patient and the patient's articulateness. There are people who have some kind of discomfort which they can't put into terms which ring a bell in your mind as representing pain. So it is that "misery" may mean anything from pain to sense of nausea, and you may not be able to get the inarticulate patient to express himself clearly to you. Problems of language,

colloquialisms, all these make for difficulty in ascertaining pain and in evaluating its type of severity.

Let's turn to angina pectoris, which I listed as being the first kind of pain due to coronary insufficiency. At the start, let's remember that angina pectoris is very easy to confuse with dyspnea. The patient, who has this mild sense of discomfort in the front of his chest as he walks along the street or exerts himself in some other way, may describe it to you as a feeling of shortness of breath. No matter how you question him you may be unable to shake that description. Sometimes these patients have shortness of breath, too. At other times you can make the distinction and decide that it is indeed angina rather than a true dyspnea by some collateral evidence. One bit of useful collateral evidence is the patient's reaction to his discomfort. A patient with angina is likely to stop what he's doing in the way of exertion soon after the discomfort starts. A patient with dyspnea is more likely to go on for a while before he recognizes it more fully as dyspnea. One of the commonest tricks of a man with angina pectoris is this business of stopping as he walks along the street and window shopping. There's nothing in the window that he's interested in but he's embarrassed, whether or not he has a companion, to admit to himself and much less to the public that he's having any kind of chest discomfort which makes him stop and stand still for a moment. So he uses the dodge of looking into a window and that hides the fact of his angina—partly from the public and partly from him.

I've dwelled on exertion and of course almost all patients with angina pectoris have their discomfort during exertion. They may have it at other times but certainly during exertion. Exceptions include only those patients who do not exert themselves ever. A bed-ridden man, for example, develops angina while he's in bed, if his coronary arteries become badly enough diseased. Other factors which go with exertion may be influential. Examples include eating—the man who eats a big meal and then takes a walk—the old trick after Thanksgiving dinner of "let's take a walk and work off the meal"—that's a potent factor for the development of angina for the first time. Exertion that is accomplished by changes in temperature or other weather phenomenon. On a very cold day, for example, if a man exerts himself, he may develop angina which would not come on a warmer day, or a day when the humidity makes the weather very oppressive, angina is more likely to appear. Emotion may provoke angina by itself. Exertion while under emotional strain is a more potent cause.

Returning to the matter of cold, once in a while a patient has angina solely from cold. He may not be exerting himself at all. Going out of doors on a cold day is enough for some patients. In this connection there are some trigger areas of the body which seem especially to provoke the pain. One of these is the area around the nose, another the volar surfaces of the forearms. Chilling these areas provokes angina more readily than when some other parts of the body are chilled.

Sometimes patients having coronary disease develop angina when they are lying down—this is called angina decubitus. When this happens, ordinarily the prognosis is grave. We assume that the coronary artery disease is advancing rapidly and we anticipate that myocardial infarction is impending or indeed has already developed. Once in a while, though, the prognosis is not so grave. This is the case when the recumbency is incidental to some other factor. An example is the man who has diabetes

and has recently been put on a long-acting insulin preparation. He may develop angina pectoris while he's in bed during the middle of the night. This seems grave at first sight, but, remembering that the long-acting insulin may have provoked hypoglycemia around this time, the answer becomes clear and the condition becomes reversible by a reduction in the dose of insulin.

Ordinarily angina is vague in its localization. A patient doesn't say I've got pain here — he says I've got a pain here, accompanying this with an appropriate gesture. Sometimes he helps you in defining the quality of this pain by his gesture. Instead of simply saying "I have pain here" or "I have pain here," if he's going to use one hand—incidentally he uses the right hand—not just because he's right-handed, but because the right hand extends better toward the left side of the chest when you want to make a gesture. In addition to indicating that the localization is vague by covering a big area of his chest, his gesture may tell you the quality of the pain and that quality is of interest to you. He may say "well, doctor, I don't know just what it is I've got here—well, it's just a discomfort." The way he is using his fists describes to you that he is having a pain that gives a sensation of tightness. People having a pleurisy-type pain or pain having some quality other than this sense of constriction do not make this gesture. At other times there is no ability on the part of the patient to define the quality of the pain. His description is vague and that is true in 30% of the cases. At other times he says that it is an ache or a burning sensation—that's not unusual. Rarely does he define it as a sharp discomfort. Much more often, angina is mild than severe; often enough, indeed, that the patient will not disclose to his physician at the time of an annual physical check-up that he has been having angina pectoris. It has been so mild that he has overlooked it.

For patients in a certain age group, properly couched questions are important to disclose this abnormality. Another clue in a patient in middle life or beyond is the development of intermittent claudication which should make you seek always for coincidental development of angina pectoris. Many patients who have begun to have pains from arterial insufficiency in their legs will almost simultaneously have begun to have chest discomfort and they'll fail to mention that; perhaps, because the leg discomfort is more prominent in their minds.

You know that the pain of angina is defined in part at least by what happens to it when you do something about it. So it is that when it comes during exertion and goes away promptly during rest, that helps to define that it is indeed angina pectoris. You know that when nitorglycerine relieves the pain you have some reason for supposing that it is angina, although nitroglycerine will relieve other types of pain. As a matter of fact the use of nitroglycerine for a diagnostic test in this way is not a very satisfactory method. There is a better way to do it. This consists in having the patient use a tablet of nitorglycerine 1/200 grain under his tongue before undertaking a type of exertion which he knows will provoke the pain he has been describing. So it is the man knows that when he walks the three blocks to the bus stop each morning he gets this discomfort. The doctors tell him that the next morning before he sets out from the house—*just before*—to put this little tablet under his tongue and see what happens. If, on that occasion, there is no provocation of pain and that experiment can be duplicated, then you have somewhat confirmed the diagnosis of angina. Now turn it the other way—suppose the doctor tells the patient that when he gets to the bus

stop the following morning and he gets the pain, to put the little tablet under his tongue—the patient does that, comes back and reports to the doctor that his pain went away. The doctor thinks that is fine. But is it fine? What happens to the patient's pain when he doesn't use nitroglycerine and gets to the bus stop—it goes away. So you can't prove from that that nitroglycerine has been helpful.

The pain of angina pectoris is greatest in intensity along the left border of the sternum or immediately in the middle of the chest. That is a rule that is rarely broken. In myocardial infarction the pain sometimes is felt more laterally out toward the apex of the heart but this is very rare in angina pectoris. That is helpful, of course, in evaluating chest pain; because so often pain confused with angina is felt more toward the apex of the heart.

There are two worrisome things about diagnosis of angina pectoris. First of all, from everything I've said, it must be clearly evident that you have no way of making a diagnosis of this disorder except by the patient's history. I have not mentioned the physical findings, because there is none to mention which is distinctive for a diagnosis of angina. Oh, the heart may be big, or it may not be. The electrocardiogram may be somewhat abnormal or in some 20 to 25 percent of cases it is entirely normal. Therefore, history taking is our only mechanism for surely establishing this diagnosis. The other worrisome fact about it is that in fully 75 percent of patients who do have angina pectoris there is some other factor present and discoverable by careful examinations that could equally well be a cause for the same kind of chest pain in the same location. Most of the other causes in that group of 75 percent are musculoskeletal. In addition to having coronary artery disease the patient has bad shoulders, or a neck which has developed some stiffening or perhaps a little thoracic vertebral arthritis—things that could be provoking the same kind of chest pain. The outlook after angina develops isn't bad. Patients expire at a rate of something like 10 percent per year, which means that life expectancy on the average runs about ten years. Many patients with angina pectoris survive this length of time and some of them, of course, live on to old age, having had angina begin in middle life.

The second kind of coronary insufficiency that provokes pain I call coronary failure and I mentioned that the terminology for this is poor. There are various ways of describing it but I think best of all it should be defined as that kind of coronary insufficiency that is about midway between angina pectoris and the attack of myocardial infarction in clinical significance and other features. So it is that coronary failure resembles angina in its location and intensity, although sometimes it is more intense than angina. It differs from angina usually in the fact that it comes on without reference to exertion and tends to last sometimes hours and more rarely days. What is the significance of this kind of attack? Actually, it is a more prolonged myocardial ischemia. Worse than that—it is usually evidence that myocardial infarction is impending or in some instances has already taken place. By this latter I mean to describe the kind of patient in whom there is an episode of chest pain and in whom the diagnosis of coronary failure is suspected, because the pain lasts a long time; but there is nothing to substantiate the impression that myocardial infarction has developed. The temperature, pulse, leucocyte count, sedimentation rate, all are normal. Electrocardiogram during the first several days shows no evidence of myocardial infarction. Nevertheless, the patient is treated, rightly, as a case of myocardial infarction impending. With serial electrocardiograms and no other technic two or three weeks later it

becomes apparent that this patient has indeed had a myocardial infarction. Thus, myocardial infarction has, as a permonition of its development, this kind of pain or some other sort of chest pain such as angina. Such premonitions of myocardial infarction are discovered frequently in proportion to the physician's search for them. A doctor working a private practice, who questions patients carefully, and who is interested in looking for premonitory pain will find it in at least 35 percent of his patients.

The last kind of coronary insufficiency which I mentioned as a cause for cardiac pain is myocardial infarction. Fully 95 or 96 percent of patients having myocardial infarction have chest pain as the principal manifestation for it. The ones who don't have chest pain either die too soon so they can't tell the doctor about it and there is no indication, therefore, that there has been chest pain; or they had some other symptom that is so overwhelming in its discomfort that the patient's chest pain is marked. Witness the patient who develops myocardial infarction and has acute pulmonary edema and you can undertsand that it would be unlikely that he would appreciate a component of chest pain in the face of the severe dyspnea that attends his acute pulmonary edema. At other times the pain is not recorded in the patient's record simply because the doctor has not taken a good history.

Again we return to the matter of difficulty in history-taking because the patient's inability to describe what afflicts him. It is interesting that some years ago the idea was taught that pain is unusual in patient's with myocardial infarction if they negroes. "Negroes don't feel chest pain," they told us. That wasn't so at all. The records of negro patients were inadequate in this respect and anyone used to taking histories from negroes such as anyone who has lived in the South or who has worked with a hospital population which is largely negro, finds that when myocardial infarction develops in these patients, they have chest pain just as much or just as often as the white people.

All of the things I have said about angina with regard to quality, location, etc., might be repeated in myocardial infarction. There are some differences. One I mentioned, the pain of myocardial infarction, is more often felt toward the apex, although the greatest intensity is substernal or left parasternal areas. With regard to factors provoking myocardial infarction, we believe, I think rightly, that except for shock and surgical operatoins, provocation of myocardial infarction by any other factor is almost always a coincidence, or what appears to be a provocation is almost always a coincidence. Myocardial infarction more often causes pain radiating to the shoulders and arms than angina pectoris. Sometimes it actually begins in these areas.

Various factors influence the progress of a patient who has had myocardial infarction. As you know, if you look at all patients the outlook for recovery from the immediate attack is good. Some 85 to 90 percent of patients recover from the first episode of myocardial infarction. The rest die during the first three months after the first episode. After that their prognosis, if they survive the first few months, is about like that of an angina pectoris patient. They die off at about the rate of 10 percent every year. Some live twenty-five or thirty years to confuse their doctors. The factors that have greatest influence upon this prognosis beyond the first few months are all accessory factors—the presence of complicating things like high blood pressure or cardiac enlargement or the development of some other serious disease.

There is one other aspect of myocardial infarction which has become important. This has to do with myocardial infarction that develops at the

time when a patient is working. Is this compensable or is it not? I mention this because the quesiton usually gets asked when anyone talks about cardiac pain.

(Continued in September issue of the Bulletin)

POST GRADUATE DAY, 1953

Postgraduate Day this year will be held at Canton under the sponsorship of the Stark County Medical Society on Wednesday, October 28.

There was a meeting of presidents and postgraduate committees of the Sixth District at Congress Lake Country Club on Sunday, August 2. Twelve members were present. The Stark County Committee submitted their program for discussion and approval. They have planned an excellent program. It will be sent to you, together with a registration card, some time in the latter part of August. You will receive reminder cards on October 1 and October 15.

Notices of this meeting will appear in the State Journal in August, September and October. All hospitals in your area will be supplied with posters. If they are not put up, let us know.

The fee for this meeting is $8.00. Interns and residents may attend the scientific sessions without charge. If they attend the evening banquet, the fee is $5.00. The ladies are invited to the evening banquet. The fee is $5.00.

A program for the day is being planned for the Auxiliary. Further details on this later.

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"Ah Doctor, does it matter who writes the prescription?"

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FROM THE BULLETIN

J. L. Fisher, M.D.

TWENTY YEARS AGO — AUGUST, 1933

Those were the days when the Great Depression showed some signs of lifting, days of the New Deal, the N. R. A.; days of summer doldrums for the Society but Morris Deitchman put out a fat volume of twenty-eight pages filled with what the doctors were doing, talking and thinking.

From Paul Harvey's President's Page: "This is a suitable time to take stock . . . the central office with all the possibilities it entails, should be considered. The committee on the care of the indigent will soon report the probabilities of a more equal distribution of this burden of the past three years. A grave problem . . . is the inadequate facilities for the care of the mentally ill. We must make an effort to provide a place for housing the mental case more suitable than the county jail."

From the editorial page: "It is to be hoped that the Mahoning County Bar Association and the Medical Society will collaborate on a plan . . . to change the antiquate method of handling medical testimony.

From an article by J. B. Birch: "For several years we have seen a steady decline in our incomes. A canvass of a large number of local doctors disclosed the fact that in spite of a marked increase in general employment and ever mounting pay rolls, the doctors incomes showed no improvement and in most instances have declined sharply. It may be pertinent to ask: Where is the New Deal for the doctor? . . . Doctors are human and cannot put forth their best efforts when they are financially pressed and harried."

Some rules quoted from the N. R. A.; "Not to work any accountant, banking, office, service or sales employer in any office, store, department or public utility for more than 40 hours in any week and not to reduce the hours of any store or service operation to below 52 hours in any week. The Maximum hours do not apply to Pharmacists or other professional persons employed in their professions. Not to pay any of the classes of employes mentioned . . . less than $14.00 per week in any city between 2,500 and 250,000 population . . . Minimum rate for office help and janitors is 35 cents an hour.

New members of the Society: Dr. Raymond Hall, Dr. John F. Dulick, Dr. Andrew Miglets, Dr. John L. Scarnecchia.

Dr. Howard Mathay opened his office in Girard. Dr. Walter Tims opened his office on South Ave.

TEN YEARS AGO — AUGUST, 1943

The financial situation was better with the war economy but the doctors were tired, overworked and complaining. Here is what the President-Elect, Elmer Nagle thought about it: "The grim realities of war cast their dark shadows across our paths and thwart us at each turn of the road so that commonplace incidents of today are comparable with the glories of yesterday. When this global war is ended it is our sincere hope that we can return to the usual routine of prewar days."

Some of the fellows sweating it out in far distant places read their Bulletins and said a hearty "Amen."

Major S. D. Goldberg made a flying trip here from Camp Davis, N. C. and back the same day just to have lunch with his family. Craig Wales came up from Texas for a short visit, sporting a new gold bar on his collar. Clara Raven, a former member of the Society, was one of the first six women to be commissioned a captain in the Army Medical Corps.

Four pages were devoted to an article by Dr. George M. Curtis on "The Nature of Blast Injuries" delivered at the June meeting. Fortunately there were no high explosives dropped on Youngstown during World War II. The Civilian Defense Committee was working though, and holding frequent drills when tired doctors had to go sit in blacked out school rooms while the sirens wailed. *J. L. F.*

KOREA TRUCE NOT EXPECTED TO CHANGE CALL-UPS OF DOCTORS

Defense Department officials emphasize the Korean truce won't change plans for call-up of physicians under the doctor draft. The Office of the Army Surgeon General had this to say: "In view of the uncertainties involved during this initial period of the truce, the Surgeons General cannot plan any immediate reduction in the number of doctors in Korea. However, a careful study is being made in reference to filling future requests from the Far East for doctors. This office does not contemplate cancelling any orders already issued for duty in the Far East."

In its most recent recommendation, the National Advisory Committee to Selective Service states that for the next 12 months "it is highly desirable" that calls for priority 3 doctors be limited to those under 30 years of age. The committee adds: "If deferments are not granted in this group, there probably will be a sufficient number available to fill the calls for this fiscal year."

A.M.A. Washington Letter, No. 31

Be sure to read these features in AUGUST issues of *Spectrum*, appearing in the first section of the

Journal of the American Medical Association

The Medical Examiner • Benign Prostatic Hypertrophy • Geography of Disease • Congenital Malformations • Infant Surgery

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