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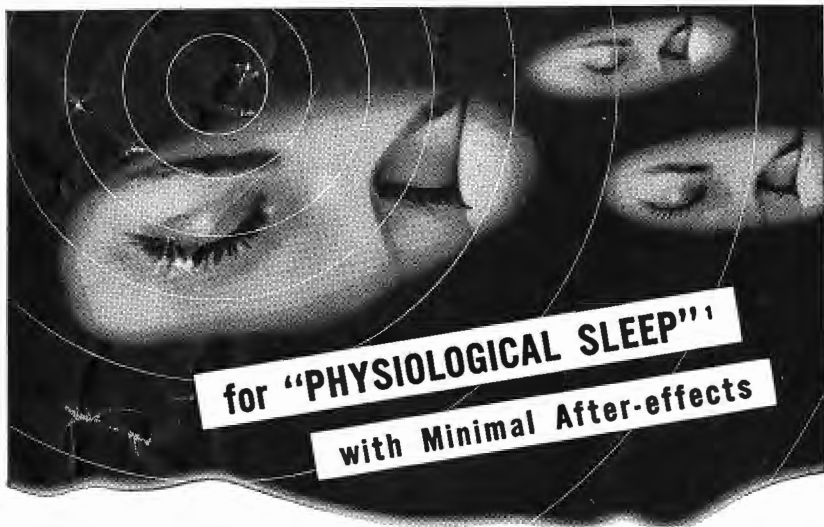

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[1]N.N.R., 1947, p.398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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Representative to the Associated Hospital Service
H. E. PATRICK

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Our President Speaks

PROGRESS

Webster defines progress as a moving forward or onward, a forward course, development or an advance toward perfection or higher state.

From a material standpoint, progress of medicine in the Mahoning Valley has been tremendous in the past twenty-five years. We have exceptionally fine hospital facilities in St. Elizabeth Hospital, Youngstown Hospital Association, Woodside Receiving Hospital, and the Mahoning County Tuberculosis Sanatorium. The scientific set-up in this valley is second to none, for which we should all be justly proud.

The success of the many fund raising drives for medical research is another step forward in improving the health of all the people.

All of these things are right and necessary to move forward scientifically. However, in the practice of medicine, or better stated, in the art of the practice of medicine, progress must of necessity have both a material and a spiritual value. Although the material progress is tangible and apparent to all, the spiritual value is more elusive. In addition to the modern hospital with its fine scientific equipment, the benefits of recent medical research, and the added years of training, the spiritual values that have been handed down from our predecessors must be kept intact, if we are to uphold the chief reason for our existence.

Surely, no one will question the necessity of the patient's faith in his physician nor the importance of his complete confidence to secure cooperation. Even though we have more advanced scientific knowledge and more modern techniques in dealing with his illness, the importance of the patient as an individual is still of prime importance.

When we speak of progress, then, we must move forward scientifically and materially, but retain the spiritual qualities of the practice of medicine. Each disease that is conquered or controlled and each year added to life's span is most gratifying and rewarding, but the patient and spiritual value of the physician-patient relationship is still the most important in the practice of medicine. As we move forward in material progress, may we ever retain the spiritual values of the art of the practice of medicine.

James D. Brown, M.D.
President

BULLETIN of the Mahoning County Medical Society

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The opinions and conclusions expressed herein do not necessarily represent the views of the Editorial Staff or the official views of the Mahoning County Medical Society.

VOLUME 24 — **APRIL, 1954** — **NUMBER 4**

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

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2921 Glenwood Ave.

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EDITORIAL

THE FOURTH ESTATE

Our public relations are determined by what our patients think and say about us and by what the press thinks and prints about us. The attitude of doctors to medical science reporting has improved tremendously from the time Osler said: "Believe nothing that you see in the newspaper — they have done more to create dissatisfaction than all other agencies. If you see anything in them that you know is true, begin to doubt it at once." Today the antithesis to Osler's concept of medical press relations must prevail. All controversy comes as a result of a lack of understanding of the merits of those reporting medical news. Most newspapers have medical reporters highly trained in the evaluation of medical progress. They should be given the facts about medical developments so that they won't obtain them from unreliable sources. We doctors must facilitate the publicizing of authentic information. Bad publicity often is the result of a lack of conformity in the manner in which medical news is given to the press. Some national organizations, specialty groups and others, give abstracts, others give the full context of papers and others give medical news prematurely. A national code of cooperation must be formulated to make for uniformity of dissemination of medical news.

Until all the problems of press relationship have been reconciled, the press is urged to be patient with the medical profession which is slow to accept all changes whether they be medical or otherwise. Physicians are entreated to be patient with the press which is sincerely endeavoring to appreciate the physicians deep rooted conviction of what is to be printed.

Andrew A. Detesco, M.D.

GUEST EDITORIAL

Francis J. Wise
Vindicator City Editor

I have been asked by the Editor of the Mahoning County Medical Society *Bulletin* to comment, as a working newspaperman, on public relations as they concern hospital, or medical news, and the public.

Only with the very young, the very brash or the inexperienced, lies the boldness to declare unequivocally, on any occasion, what is absolutely right or wrong — what should be done, or what should not be done, whatever the problem may be.

I am inclined to be compassionate, to be sympathetic, where human suffering is present, whether it is the son or daughter who has been hurt physically, or the parents who have been hurt in other ways.

On the other hand, if I perceived a downright attempt to withhold information that rightfully belonged to the public, to deceive, or lie, I would do everything possible to learn the truth.

That is all the newspaperman wants — the truth.

The newspaper has an obligation to the public.

This is no fancy statement. It is a fundamental, ground into the mental processes of every cub reporter and, you might say, a commandment of every experienced newspaperman.

The hospital, too, has an obligation to the public. There is no question about this. It is an indispensable part of community welfare just as the newspaper is.

While the public benefits from the service of the hospital, yet it is the public which in the first place (and time after time) has provided the money to build and equip the hospitals.

The public is educated to the services of the hospital and to the needs of the hospital largely through the public press. The records will prove the amount of space the press has given the hospitals in fund campaigns. But co-operation should not operate always on a one-way track. The press is more than willing to do everything possible for the hospital. It appreciates similar consideration.

Because it concerns human suffering, hospital news or public relations, whatever you may decide to call it, merits mature thinking, mature handling, by both the medical people and the newspaper.

The news itself cannot be stifled but, if the truth is known, it can be handled understandingly because experienced newspapermen have the quality of understanding.

The general public has much more intelligence than sometimes it is credited with. Give the public the plain, undecorated facts and it will be satisfied. Hold back the truth and you create suspicion, speculation, and gossip that can keep an incident, or accident, alive much longer than is necessary.

In this respect the hospital has an obligation to protect the patient from his own inexperience. Where the patient's case may involve an accident, or an unfavorable incident, his first impulse often is to ask for suppression of news concerning himself, without realizing that his neighbors, his co-workers, accident witnesses, and perhaps the police as well, already have enough information, or mis-information, to start an erroneous, sometimes

harmful, story. This story will continue to spread until the facts are nailed down.

We must think of the public in another way, too — There are scoundrels, of course, but most people, because they, too, have had misfortune, are understanding and humane.

Boiled down, the relationship between the medical field and media of information should be entrusted to agents, in both cases, capable of understanding, with the medical field, on the one hand, providing the truth, and the media, on the other, handling it factually and with due regard to humaneness.

PROCEEDINGS OF COUNCIL

March 8, 1954

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, March 8th, 1954, at the offices of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio.

The following doctors were present: J. D. Brown, Pres. presiding, V. L. Goodwin, G. E. DeCicco, E. J. Wenaas, S. W. Ondash, M. W. Neidus, C. A. Gustafson, F. G. Schlecht, W. M. Skipp, A. K. Phillips, E. R. McNeal, I. C. Smith, comprising the Council, also Dr. J. N. Thanos.

The following resolution was adopted by the Mahoning Chapter of General Practitioners and a copy sent to St. Elizabeth's Hospital, Youngstown Hospital and the Youngstown Laboratory.

WHEREAS:

There exists some confusion caused by the practice of private individuals, making direct requests to laboratories for clinical laboratory tests, especially in the matter of premarital blood examinations.

BE IT RESOLVED:

That, the members of the Mahoning Academy of General Practice request the Youngstown Hospital Laboratory, the St. Elizabeth's Hospital Laboratory, and the Youngstown Medical Laboratory to make no clinical laboratory test on their private patients without a written requisition from the physician concerned.

BE IT FURTHER RESOLVED:

That this request is in no way intended to interfere with mass testing connected with health programs sponsored by a recognized health agency.

David H. Levy
Secretary
Mahoning Academy of General Practice

Dr. DeCicco mentioned that several members had asked about pins for men in practice 35 years.

The members will vote on it in the near future.

A report on the activities of the Arthritic Clinic at St. Elizabeth's Hospital was submitted by Dr. Neidus to Dr. McNeal, Chairman of the Arthritic Committee. The purpose of the Clinic is for the care of indigent and relief for the Arthritics, and to stimulate interest and study among interns and residents in the hospital.

G. E. DeCicco, M.D.
Secretary

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THE DEAN'S PAGE

The main objectives of medical schools are:

(1) The training of well-qualified physicians

(2) The advancement of medical knowledge

(3) The Social goals involved in service to humanity

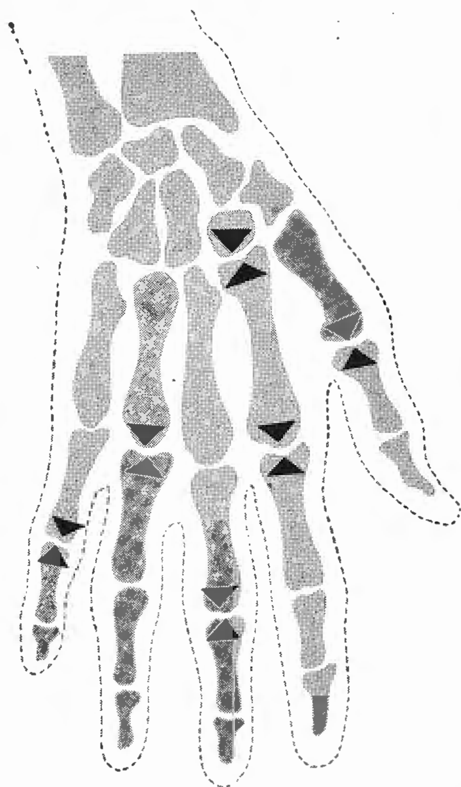
Should the aims be reached, and they must, then our medical schools form the most important element in the health equation of the United States. They deserve the active support of every citizen as they must be kept self-reliant so as to insure ever improving health standards.

Each of us should give and should give freely to his alumni organization, the American Medical Education Foundation or the National Fund for Medical Education.

Physicians play the leading role in scientific medicine and through their active cooperation with the National Fund for Medical Education, by contacting their lay friends they can aid the Fund in achieving its aims and objectives — namely, to mobilize new sources of private voluntary support for the benefit of this country's medical schools.

George A. Bennett, M.D.
Dean, Jefferson Medical College of Philadelphia

This article was written expressly for the *Bulletin* of the Mahoning County Medical Society.



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COUNCILOR'S PAGE

C. A. Gustafson, M.D.

The American Medical Association, as most of you know, maintains a Washington staff whose duties are to keep the medical profession informed about impending medical legislation, and about legislation which would affect the practice of medicine. F. E. Wilson, M.D. is director and has two assistants, Cyrus H. Maxwell, M.D. and Thomas H. Alpin, M.D. They send a letter to state and national officers every week. These letters, or their summaries, are also published in the A.M.A. Journal and in the State Journals.

As a follow-up of what I said last month, I would like to quote from the A.M.A. Washington Letter that came to my desk today.

> Because you may be getting the wrong impression, I want to be emphatic about one thing: the fight for the Bricker amendment is not lost. For those who think there should be some check on international agreements, there is a lot that is encouraging in the five-week Senate debate on the amendment, even though the resolution failed. For one thing, the well-publicized debate interested a wide section of the public in the issue. A more tangible gain is the fact that almost two-thirds of the Senators are now on record as wanting to curb executive agreements; one less opposition vote and the resolution would have carried by the required two-thirds. And as a result of the half dozen or so separate votes, sponsors of the resolution now know just which Senators oppose any sort of a check, and which favor a restraint of some kind. If your Senator was among the 60 who voted for the final resolution, I suggest you write him expressing your appreciation. Remember that the medical profession is not "mixing in something that's none of our business." Unless a safeguard is written into the Constitution there is the very real possibility that future international agreements will impose on us social and medical care programs that Congress itself would never enact.
>
> The American Medical Association supports a constitutional amendment along the lines proposed by Senators Bricker and George. It points out that without a change in the Constitution the social structure of the country, including the practice of medicine, can be altered by international agreements which can become domestic law even without the enactment of Congressional legislation.

SPONSORS BLOOD ANEMIA STUDY

Since very little is known about hypo-plastic anemias which sometimes develop following the use of certain drugs, a sub-committee on blood dyscrasias recently was established by the A.M.A.'s Committee on Research to investigate this problem. Because it is impossible at the present time to predict the occurence of these anemias by means of animal tests and only after a drug has been in use for a considerable length of time do reports of such anemias become manifest, it was felt that a complete study of the problem should be made. Plans will be laid for the further development of better laboratory testing methods at a meeting of the committee some time in May. A forthcoming editorial in the Journal of the A.M.A. calls attention to the need for better and earlier reporting of these conditions.

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CODE OF COOPERATION BETWEEN DOCTORS AND PRESS

PURPOSE

The purpose of this Code is to promote cooperative action between the medical profession and those who report medical news. It is mutually agreed that the primary responsibility of the doctor and hospital is the welfare of the patient. It is also agreed that newspapers, radio and television exist for the common good and function to bring matters of general interst to the public quickly and correctly. With these understandings in view, the following considerations are given:

DOCTORS

1. The officers, committee chairman or designated spokesmen of the Mahoning County Medical Society shall be available at all times to the Press, Radio, and Television in order that authentic information on medical subjects be obtained as promptly as possible.

2. A list of current spokesmen shall be supplied by the Mahoning County Medical Society to editorial executives of each newspaper, radio and television station, and kept up to date.

3. These spokesmen may be quoted by name. This shall not be considered by their colleagues as self-seeking, since it is done in the best interests of the public and the profession.

4. In matters of private practice, the wishes of the attending physician shall be respected regarding use of his name or direct quotation. But he shall give information to reporters (where it does not jeopardize the doctor-patient relationship or violate the confidence, privacy or legal rights of the patient) as follows:

a. In case of accident or other emergency: the nature of the injuries; degree of seriousness, probable prognosis.

b. In cases of illness of a personality in whom the public has a rightful interest: the nature of the illness; its gravity and the current condition.

c. In cases of unusual injury, illness or treatment; the above facts plus any scientific information that will lead to a better public understanding of the progress of medical science.

d. The Society shall urge all doctors becoming aware of such unusual developments to supply the facts for public information.

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"I DON'T WANT TO GO HOME IN THE DARK"

The practice of medicine rests upon science, sense, and sentiment. In the minds of patients, the greatest of these is sentiment. The patient travels swiftly over diagnostic facts in pursuit of the prognosis. Here the doctors' opinions and the patients' emotions mingle with the hope of full cooperation and mutual understanding. Though this is not as easy as in days past, let no physician think it is not essential. It remains the most direct and the surest way to the patient's heart, all other flights are on wings of wax.

Having once established such an understanding, the patient-physician relationship should follow its ideal course toward recovery. If all therapeutic efforts fail and death becomes inevitable, the physician must accept his role in that last act of life's incomprehensible cycle. When the gift of science fails, the art must carry on. This is in the tradition of medicine and in spite of modern progress it is inescapable and must be observed if professional integrity survives.

Robert Burton pictures Democritus deep in the study of melancholy, dissecting both books and beasts, searching for tangible evidence of this morbid condition. Socrates, returning from the Thracian Wars, reported that the doctors in Thrace could not cure the body without first treating the mind. He hoped the Grecian physicians would do likewise. That hope was realized through the psychosomatic concepts of Hippocrates. Plato said, "The great error of our day is that physicians separate the soul from the body." It is said that Virgil on his deathbed embarrassed Augustus Caesar's court physician by the emphatic query, "Is there any healing at all without magic?" Montaigne believed in the power of imagination and the force of suggestion. A rich patient considering the means of recovery said to the great physician, Simon Thomas, "They are in your presence and the liveliness and freshness of your face."

With these things in mind, the wise physician will tap the seat of reason, analyze his patient's psyche, appraise his character, interpret his moods and observe his response to environment.

Though the people have changed and the good old fashioned family doctor has passed with the good old fashioned family, and though the flesh clings to the spirit longer than ever before, these has never been a time when people were so in need of a capable medical mentor. Science can never take the place of his presence at the bedside. Dedicated to the service of his patients, the good physician should vouchsafe his satisfaction. His concern and his counsel should reach from the cradle to the grave.

As the end approaches, often there is a biological desensitization that blunts the sting of death and assures an easy exit. But even those who are so favored have their last lucid moments when they look for the doctor. Motivated by medical tradition they have a right to expect his presence. Involuntarily, they may reach for his hand and search his face with a strange light in their eyes. They have been taught that medicine means friendship, sympathy, and service through sickness and suffering, even unto death.

O'Henry, the famous writer of short stories, after contending with the grim reaper throughout the night, said to his doctor, as dawn approached, "Turn up the lights. I don't want to go home in the dark."

It must have meant much to this lonely traveler to have his doctor light him home. Such attentions are not easy but there is recompense in the thought that when the physician is mustered out, the Master will look for scars, not medals and degrees. Merit born of mercy will determine the reward.

Lewis J. Moorman

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FROM THE BULLETIN

TWENTY YEARS AGO—APRIL, 1934

Several important things were done that month. There was a big Post-Graduate Day with a group from McGill University including J. C. Meakins, Wilder Penfield, John R. Fraser and J. B. Collip; an imposing list of names.

Then the inauguration of the Medical-Dental Bureau which happened this way: There was a growing need for a service agency to help the profession in the business side of practice. The group in control of Society affairs was determined to start one and R. B. Poling had been appointed to head a committee to work on it. But there was considerable opposition from some of the older members to participation by the Society in any activity of a business nature.

Things were not making much progress when a fire-ball named McGhee who was running the Akron Medical Bureau came over and offered to help. His plan was simple and workable. He said to include the dentists and let every member of the Dental or Medical Societies who wished to join pay ten dollars and get the thing started. Thirty of them did at the first meeting. Later forty five more joined which made enough capital to start an office with three telephone girls and a switchboard. Instead of being operated by the Society it was operated by the members, which satisfied everybody.

Those of you who take for granted a smoothly efficient Bureau do not know of the long hours of work spent to get it started. McGhee would come over every Saturday and the Board (J. B. Nelson, McCurdy, Skipp, Hayden, Hathhorn, Poling and Chessrown) would meet with him at the Tod House in sessions that would last far into Sunday morning. There is not space here for the whole story but someone should tell it as it is an important event in our history.

Another important meeting that month was a special one called for the purpose of deciding the attitude of the Society in regard to the future care of the indigent. No one was being paid. By voice vote the Economics Committee was empowered to hire legal counsel to determine how the Society should proceed in regard to unpaid bills of the Public Emergency Relief.

Dr. J. C. Hall and L. W. Weller were new members.

TEN YEARS AGO—APRIL, 1944

Post-Graduate Day was reported very successful in spite of wartime restrictions. Drs. Eugene Whitmore and Ross Veal came from Georgetown University. Drs. E. C. Baker and W. D. Collier helped out to make a well rounded program.

The Youngstown Municipal Hospital was officially closed as a contagious disease unit. President Elmer Nagel was plugging for it to be opened as a mental hospital.

An article by Judge Beckenbach warned of a serious increase in Juvenile Delinquency and pointed out the lack of facilities and personnel in Ohio to deal with it.

Major Walter Tims was heard from in England. He said the island was getting overcrowded. Conditions were to be changed on June 6th but he didn't know that.

O. M. Lawton was promoted to Commander. Lts. David Brody and Robert Heaver were graduated from field service school at Carlysle Barracks. Ray Hall was home on sick leave after spending ten months in the Atlas Mountains where he worked with Major McElroy caring for casualties from the Tunisian battlefront.

O'LINN'S

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AUXILIARY NEWS

By the appointed hour of one-thirty p.m. on Tuesday, February 23rd, three hundred women had gathered at Rodef Sholom Temple to get a glimpse of the very latest spring fashions. The members of the Women's Auxiliary to the Mahoning County Medical Society and their guests at the annual guest day benefit for the nurses' scholarship fund were seated at small tables attractively decorated with bouquets of spring flowers. Each place was marked with a small flacon of perfume and the one fortunate enough to find a green florist wrapping paper under her plate was awarded the table bouquet at the close of the program. Mrs. Fred Resch, chairman, and Mrs. Fred Schlecht, co-chairman, with their social committee are to be commended for the gracious and efficient manner in which the dessert was served.

Mrs. Earl Young, Mrs. Asher Randall and Mrs. George Altman were responsible for the attractively decorated stage and the improvised runway. Our own members were models for the style show presented by the G. M. McKelvey Co. with Mrs. Fred Friedman as narrator and Mrs. Ernest Gottesman, the pianist.

Original verse written by the program committee, Mrs. Harold Chevlen, Mrs. David Brody and Mrs. James Smeltzer introduced the theme of the show, "Through the Looking Glass" and our second generation models, Vickie Shorr, Diane Phillips and Frances Goudsmit. Models were Mrs. Paul J. Fuzy, Jr., Mrs. Samuel Zlotnick, Mrs. Wayne B. Hardin, Mrs. Sidney Keyes, Mrs. A. E. Rappoport, Mrs. Elmore McNeal, Mrs. George M. McKelvey, Mrs. John Noll, Mrs. Stephen Ondash, Mrs. Martin Raupple, Mrs. John Statler, Mrs. Alfred Cukerbaum.

The grand finale was a glamorous wedding scene with Mrs. Cukerbaum as a bride, wearing a princess gown of chantilly lace and nylon tulle over taffeta with a fingertip illusion veil.

Two delightful affairs, the fall dance and the guest day tea, have combined pleasure with fund raising for the nurses' scholarship fund and set the stage for our next meeting — an afternoon tea for prospective nurses to be held Tuesday, March 16, at 1:30 p.m. at St Elizabeth Hospital.

Trudging through the snow February 1, and March 1, were a number of our group placing and retrieving plastic hearts and ringing your doorbell February 14, "Heart Day" were still others. This was another service in our effort to aid the Medical Society in any way we can.

Jane B. Brown

THE A.M.A. AND OSTEOPATHY

The American Medical Association has not established a firm policy in relation to osteopaths. This issue was debated at the last meeting of our House of Delegates and it was decided that the matter should be referred to the respective states for their opinions. The states were asked to answer the following questions: (1) Should M.D.'s be permitted to teach in osteopathic schools? (2) Is osteopathy a cult? Each state medical society was requested to answer these two questions and to report back to the House of Delegates of the A.M.A. at its meeting in June of this year. Until such time as the reports from the respective states are received the Judicial Council of the American Medical Association has stated that osteopathy is a cult.

Leo E. Brown
Director, Dept. Public Relations
February 22, 1954

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KEEPING UP WITH A.M.A.

Brief of testimony, Jan. 28, 1954, by President-elect Walter B. Martin, before House Committee on Interstate and Foreign Commerce:

The A.M.A. admits there is much yet to be accomplished in medical achievement. We know there are many medical mysteries that need solution. We are aware in some areas of inadequate or improper distribution of medical personnel. We want all the people to have the best medical care possible, regardless of economic status, and there should be some relief from chronic, or long-term, illness.

There has been a great effort on the part of many to create public sentiment in favor of State medicine. The picture has been distorted and, at times, exaggerated. Many testifying have stressed the cost of medical care, but all costs have risen: living costs, 91%, medical, 65%, wages rose 165% while physicians' fees rose 48%. The average person now only works 60% as long as before the general increase in all costs.

The individual loss of time from work due to illness is shortened, likewise the stay in hospitals, or length of an illness, due to better drugs and physician training. So the medical bill is less than it was 15 years ago.

Some point out the increased death rate from heart disease and cancer. This shows signs of great medical progress. The median age at death has increased from 30 to 66 years. This will gradually increase. A physician can never conquer death, he can only postpone it.

A shortage of physicians has been alleged, but actually there are more physicians to hundreds of persons in this country than any other country in the world except Israel. Physician population has increased more rapidly than general population in the last 20 years. The number of medical students and graduates is gradually increasing. The picture is brighter than many would have you believe.

The A.M.A. has fought, and will continue to do so, to increase standards of education, stop quackery, improve and maintain ethical standards. These cover many fields like school health, rural health, and industrial health.

The A.M.A. has, for over a hundred years, promoted better public health. These programs have been concrete, to bring better health to all our people.

Today the United States is the healthiest large nation in the world. Babies born today can expect to live 20 years longer than those in 1900. Mothers can go through a pregnancy and delivery with less fear.

Many of the infective killers have been brought under control such as typhoid, smallpox, diphtheria, pneumonia, by the use of antibiotics and sulpha drugs. Many other dread diseases — polio, cancer — are showing signs of being conquered. The physician's effectiveness has been increased 30% in the last 15 years.

Better and more physicians are being produced, with better and higher standards of education. Better and broader intern and resident training is available.

Physician distribution has broadened with better service in the Allied Professions; larger, better equipped hospitals with many more beds over wider areas of the country are now available. There is no physician shortage. The economic problems are being solved by prepaid voluntary medical and hospital insurance, sponsored by the profession and hospitals.

The A.M.A. has urged in the past, and still urges, each County Society to provide medical care for the indigent. This cost cannot be estimated and is part of the physician's daily task, so that all have good and adequate

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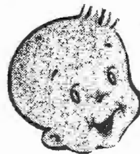

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medical care. The care of the indigent is a problem of local and State, not the Federal, government.

Testifying before this same Committee:

Kenneth Williamson, Executive Vice Pres. Health Information stated:

It is wise that any consideration of health plans with government participation be such that arrangements be made at the local level which is closest to the individual family and its health problem.

Gerhard Hirschfeld, Director, Research Council for Economic Security:

The more we analyze our date, the more we are conscious of the tremendous amount of additional research that is needed before we can come close to a final solution of the health problems of our people.

Benjamin Lorber, Universal Pictures, Inc.:

The Wolverton reinsurance bill "might unduly reward the ineffective and extravagant plans; its benefits will be predicated upon such ineffectiveness and extravagance. . ."

S. 2759 Smith (R-N.J.) amends Vocational Rehabilitation Act.

This act will assist handicapped persons in three ways: (1) extend services and grants to aid states to meet cost. (2) 6 year grants to states to improve services. (3) Grants to states, to public, and other non-profit organizations to meet cost of unique projects, as an aid to National and local problems.

This will not provide grants for major new construction.

The payments under unique projects will be on the approval of Secretary of H E & W.

The state will agree to cooperate with Bureau of Old Age and Survivors' Insurance.

S. 2778 Smith (R-N.J.) To improve public health service by better use of federal funds.

This bill has similar setup as in S. 2759, except that it states public health instead of rehabilitation. (1) The grant formula would be based on states population and resources, as followed in the Hill-Burton Act.

H.R. 7448 Reed (R-N.Y.) Children's Service Act.

This act combines separate grants in maternal and child health, crippled children, and child welfare. (1) Gives states aid to finance child health and welfare. (2) Over 6 years period, state to continually improve child health, etc. (3) Grants to states, public, and non-profit institutions of higher education to meet the costs of projects to solve child health and welfare.

This program would be carried out as in the Hospital Construction Act, that is, child propulation and per capita incomes of the various states.

S. 2571 Magnuson (D.-Wis.) Cancer Research.

Establishment of Robert A. Taft Memorial for cancer research. Passed, unanimously by Senate.

Tax Reductions

The House Ways and Means Committee voted to increase tax allowances for medical expenses, providing medical costs can be deducted from taxable increase, if they exceed 3% instead of 5% of adjusted gross income.

Maximum limitations for deductions would be doubled from $1250 to $2500, multiplied by the number of exemptions, with a limitation of $5000 on single taxpayers and $10,000 for heads of families or married couples filing a joint return.

Costs of medicines and drugs could be included in medical expenses only to the extent these items exceed $50 or 1% of adjusted gross income.

Transportation expenses, where travel is prescribed by a physician could be deducted but not the cost of meals or lodging.

The Bricker Amendment

The Bricker Amendment has been discussed by many of our profession, some for, some against. Still there are many reasons why the A.M.A. and the Ohio State Medical Society have approved this Constitutional Amendment. Senator Bricker proposes 4 points, 3 advanced by the Senate Republicans:

(1) No treaty to become the supreme law of the land unless made "in pursuance of the Constitution."

(2) A provision of a treaty or executive agreement in conflict with the Constitution to have no force or effect.

(3) A Senate rollcall required on ratification of all treaties.

(4) This provision would have two distinct effects. It would require passage of Congressional legislation (both houses before any international agreement could become effective as internal law. Treaties would also require Congressional legislation to become effective as internal law, unless the Senate, at the time it is approving the treaty decides by a ⅔ vote that such legislation is not necessary. Such things a health standards would come under the definition of "internal law." (As proposed by Senator Bricker, not approved by White House.)

The Bricker Amendment may seem to be dead because of the close margin (receiving a one-vote margain against, or needing only one vote for a ⅔ majority of the Senate necessary to put into effect a Constitutional Amendment). But it behooves each one of us of the medical profession to still read, learn, and study why your A.M.A. and State Society have endorsed this Constitutional change. Senator Knowland of California says it is not dead and will be a very prominent issue in the coming November elections. Please do not pass it by. Keep on the alert.

A.M.A. Endorses Bill for Expanded Hill-Burton Program

The Administration has proposed a 3 year program for $60,000,000 a year, to build non-profit homes for chronically ill, nursing homes, diagnostic or treatment centers, and rehabilitation centers. Dr. G. F. Lull says: (1) "That facilities for the chronically ill and impaired should be near a conventional hospital. (2) That the original purpose of the Hill-Burton Plan should be reaffirmed, so that it is definite that any added facilities are for the benefit of the whole community." Since 1948 some 50,000 beds have been constructed under this Hill-Burton program. Projects have been allocated to areas where most needed.

Mrs. Hobby asked for Committee approval—that this would add a 5 point construction program which is on sound footing and which are urgently needed by most communities. This program (Hill-Burton) is one of the most popular ever set up by the Federal government.

Year-end Financial Picture of Two Fund-Raising Organizations:

The American Medical Education Foundation and The National Fund for Medical Education.

The A.M.E.F. recorded gross return of $1,089,962. This is the first time annual income has passed the million mark. The number of contributors increased by 149%. Likewise the National Fund received $1,367,979 from 994

corporations, an increase of 74% in contributions and a 193% increase of firms giving.

The two fund-raising organizations have distributed nearly five million dollars to our medical schools, and 51% of this is from the medical profession and others in the medical field. But we must not let up on the oars, we must continue to work. Our schools need at least ten million dollars a year.

Profits from New Project go to Education Foundation.

The California Medical Association, through its recently formed subsidiary, Audio-Digest Foundation, is promoting a new means of communication for medical learning.

A.M.E.F. Secretary Hiram W. Jones estimates that if 20,000 subscribers sign up, nationally, the medical education foundation can reap approximately $1,000,000 annually.

Dr. Charles W. Mayo criticizes the A.M.A. stand on Bricker Amendment

In a newspaper interview, the above, a former U. N. Delegate says:

"This action by the House of Delegates . . . has the effect of abrogating the right of individuals to make up their own mind. It is almost like being presented with an ultimatum."

The House of Delegates acted favorably in behalf of the principle of the Bricker Amendment on two occasions, once at the Chicago session and later at the Denver Clinical session.

Dr. Mayo informed Minnesota senators he was opposed to Bricker's proposal.

Manion Commission Starts Survey.

As the Chairman of this Commission has now been discharged, the program will still be carried out and is of interest to all of us that are taxpayers. Research has been started in 5 states, Kansas, Wyoming, Michigan, Mississippi, and Washington. 22 Federal grant aids of three billion dollars annually, representing 87%, will be investigated which will include hospital construction, public health, venereal disease, tuberculosis, mental health, cancer, heart disease, housing and slum clearance.

This will show which, if any, of these funds should be reallocated between State, local and Federal government, if they should be changed, stopped, or modified because of over-lapping, unnecessary controls, or excessive costs.

Krebiozen Controversy Cancer Cure:

An Illinois legislative commission, which has been investigating off and on since last April, ruled last week that there was no "conspiracy" on the part of the A.M.A., the Chicago Medical Society and the University of Illinois against the so-called cancer drug.

The hearing stemmed from charges by Dr. Andrew C. Ivy that there was a conspiracy to oust him from his post as vice-president in charge of professional colleges at the University of Illinois and to ruin him professionally because of his research into krebiozen.

The A.M.A. contended that the drug was worthless in the treatment of cancer.

While a commission statement specifically absolved the A.M.A., no mention was made of Dr. J. J. Moore, pathologist, and treasurer of A.M.A., and two Chicago business men who were accused specifically of trying to gain "distribution rights" to krebiozen in the United States.

Dr. Moore has contended that Dr. Ivy's charges that he aided the two

Chicago business men in trying to gain "distribution rights" for the drug were ridiculous and without foundation.

Physicians are Still Opposed to Social Security Taxes.

A New Jersey Congressman says the rank and file of physicians want to be included in and covered by Social Security.

Paul C. Schaefer, executive secretary of the Arkansas Medical Society, immediately set out to learn if the Congressman knew what he was talking about. A simple questionnaire was mailed to 1,230 physicians in Arkansas, asking if they opposed compulsory extension of Social Security taxes to cover physicians, or whether they believed that doctors should be included in the program.

Mr. Schaefer received 713 replies opposing doctors' inclusion under Social Security. Only 122 favored being included under the program.

The poll not only proved that doctors wanted no part of this type of compulsory "insurance" from the government, but it also made many of them conscious of the pending legislation.

Apparently many of them had not even considered or had never even heard of the bill and the poll did have the effect of making them take notice of what was happening.

A.M.A. Editorial on Bricker Resolution:

This editorial is not long but gives each of us an insight and whyfore of the Association's stand. It is found in the A.M.A. Journal, Feb. 20, 1954, Vol. 154, p. 680.

NEWLY FORMED OHIO STATE SURGICAL ASSOCIATION MEETS

The annual meeting of the newly formed Ohio State Surgical Association will be held on Monday, April 12, a day prior to the meeting of the Ohio State Medical Association at Columbus, Ohio.

Organized in late 1952, the Surgical Association has progressed rapidly and has a larger membership than had been anticipated. The functions of the Association are designated to: (a) protect the practicing surgeons from inroads of selfish or other interests, (b) to acquaint all surgeons throughout the state with one another, (c) to improve the care of the surgical patient, (d) to function as an aid to the American College of Surgeons and National Boards of Surgery rather than to compete with them, (e) to abolish at a grass roots level evils that are difficult or impossible to accomplish in a higher echelon, and (f) to discuss regional personal problems for the good of all members.

Dr. Clyde S. Roof of Cincinnati is President of the Association. Other officers are: Dr. Thomas F. Lewis of Columbus, Secretary; and Dr. Bert M. Hogle of Troy, Treasurer. The Board of Governors consists of representation throughout all sections of the State.

Local surgeons interested in membership can apply to Dr. Tom F. Lewis, Secretary, 350 E. Broad Street, Columbus, Ohio. Any clinical surgeon active in practice who is qualified by training and doing general surgery and meeting other requirements is eligible for membership.

Surgeons attending the Monday meeting of the Association must remain only an extra day in order to attend the surgical sessions of the Ohio State Medical Association which will be held on the following day.

STOP, LOOK and READ CAREFULLY! !

The following excerpts are of outstanding caliber. They should stimulate all of us to take inventory of our way of professional behavior. We are indebted for the following advice to the column In and Out of Focus by the Observer in the Medical Annals of the District of Columbia.—Editor.

"Look Again, Doctor!"

Doctors can hardly be blamed if they become weary of being told what is wrong with them and what they must do to win friends for themselves and their profession. Much of what has been said on this subject has been repetitive and, in your Observer's opinion, somewhat dull. Happily, there are exceptions, and the 75-minute symposium on "Look Again, Doctor!" which was presented in the auditorium of the Medical Society Building on November 4, 1953, is in this category. He cannot recall an instance when criticism and advice have been served more palatably. It was apparent to your Observer that the audience, consisting of doctors and their wives, thought so too.

"—Your Office—"

All of us have had the experience of returning home after a long absence and seeing familiar surroundings in an entirely new and sometimes disillusioning light. Things that had escaped our notice were so apparent that we wondered how they went unnoticed; why had we not observed the frayed upholstery, the faded drapes, and the discolored walls? The explanation is obvious: We had become so accustomed to our surroundings that their deterioration had not registered with us.

This also happens in the doctor's office, and too frequently nothing is done about it. He soon drifts back into his routine, and the disorder, the dog-eared magazines, the unattractive furnishings, the worn and rickety furniture again go unnoticed. But patients do observe and, understandably, some of them wonder. Their comments are frequently far from complimentary.

Dr. Paul Jaquet, Jr., the young Washington internist who opened the symposium, not only observes his surroundings with a critical eye but does something about them. His topic was "Have You Looked at Your Office Lately?"

"Physicians, no less than their wives," he said, "are often influenced by first impressions. From rather careful observation of physicians' offices over the past several years, I have been motivated sufficiently to inquire, 'Why do so many of us ignore the marvelous opportunity of making that first good impression in our offices?'

"The new patient usually arrives in our waiting room with a mixture of fear, apprehension, self-consciousness, and often downright panic. He usually has to wait. This waiting period, though often carried to excess, affords a critical time of inspection which will result in some impression being gained. How unnecessary that it be anything but favorable!"

Dr. Jaquet then proceeded to make definite suggestions.

The waiting room should be cheerful but not garish. Restful colors in drapes, slipcovers, rugs, as well as for walls and furniture are recommended. Plants and a 10- or 20-gallon aquarium stocked with tropical fish also brighten an office and make waiting much pleasanter.

Furniture should be arranged so patients do not face one another. Some find the opposite arrangement disagreeable.

Large wall mirrors enhance and emphasize the beauty of the office.

Soft music from a standard or FM radio tuned in on a good music station or piped-in music helps soothe disquieted patients.

If rooms are small, a quiet exhaust system may be necessary.

Indirect lighting is preferable to ceiling fixtures which "glare down upon the patient."

Comfortable and convenient surroundings for the secretary are essential.

Muffled telephone bells and a good buzzer signal system do much to keep the office operating quietly.

The efficient operation of the office is also facilitated by a telephone-intercom system. It will save the physician and his assistants many unnecessary steps.

These are, in Dr. Jaquet's opinion, some of the essentials of a smoothly conducted and pleasant office.

"Patients Are People"

Perhaps the most frequently heard criticism of physicians is that they have become impersonal in their relations with patients. Medical leaders and others in the medical profession who have spoken on this subject have not hesitated to admit that to a considerable extent this is true. Among the major reasons given are overemphasis on science to the exclusion of the art of medicine, and specialization.

Dr. Josephine E. Renshaw, whose topic was "Patients Are People," is one of those who is inclined to go along with this view. People, she said, are asking, "Where is the old family doctor?" Dr. Renshaw contends that it is not the old family doctor people want but his sympathy and understanding.

She urged that whenever the opportunity offers, even when the patient comes in for routine examination, doctors not overlook the importance of the human touch. There are procedures in such examinations which, she said, "shock the patient's dignity. The experience is frighening to him." This could be minimized by doctors if they would take the time to explain the reasons for the procedure and what the trouble is. If this were done, she said, "patients won't be running off to look up their troubles and cures in magazines."

"—Other Doctors"

The deterioration in relations between physicians has been cause for deep concern among thoughtful observers in the medical profession. For upon mutual respect and friendliness rest not only stability but the very existence of medical practice as it is known today.

What then are the disturbing factors in this situation? These are set forth eloquently by Dr. Zigmond M. Lebensohn, whose topic was "What You Owe Other Doctors." Emphasized by him is the tendency among physicians to make disparaging remarks about their colleagues. Sometimes this is due to thoughtlessness; at other times, to put it charitably, it is done with unkind intent.

Equally to be deplored, Dr. Lebensohn said, is the neglect of the amenities of medical practice, such as a physician's failing to inquire if a patient has recently been attended by another doctor and, if so, if he has discharged him. In the latter event, it is only courteous for the physician to call his colleague and tell him that the patient has come under his care. However, this is done so seldom that a physician who received such a call would, to say the least, be astonished.

Pointed out too was the physician's failure to recognize that he is not only obligated to adhere to the Principles of Medicals Ethics but to conform to the customs in the community. Equally important, he is expected to show good taste in his professional activities.

These and other facets of this problem are dealt with by Dr. Lebensohn. His remarks were considered so timely and important that they are published in full on page __ of this issue.

"A Soft Answer—"

Your Observer can well understand the feelings of the weary doctor or his harassed secretary when on particularly trying days they are deluged with telephone calls. The temptation is to give vent to their irritation either by being coldly impersonal or abrupt.

Under such circumstances the telephone can become a destructive instrument, destroying in a matter of seconds what may have been excellent physician-patient relations. On the other hand, if properly handled, the telephone can contribute much to the efficiency of the doctor and generate the good will so important to him.

This was engagingly stated by Dr. Hugh H. Hussey, whose plea was for "a soft answer—." In the course of his remarks, Dr. Hussey said:

"It is up to us to learn to live with the telephone—to become tolerant of the enormous increase in demands that it makes upon us—to use it as an instrument for promotion of good will. We cannot expect patients to stop calling us, but we can teach the majority of them to place the majority of their calls at times most suitable to us. Also we can train ourselves and all who work with us to have good telephone manners.

"Used in this way, the telephone does three things. It improves the quality of the medical care we give, it saves time, and it does promote good will.

"There are a number of ways in which good use of the telephone improves the quality of medical care. A prime example is the 'follow-up' call, made for the purpose of extending the doctor's observation of the course of a patient's illness. In this connection, the doctor should be discriminating as to whose responsibility it is to make the 'follow-up' call. Not all patients can be relied upon to report as requested.

"No one questions that the telephone is a time-saver. It would be even more effective if certain simple rules were generally observed. These are: 1. Make salutations informative without unnecessary embellishment. 2. Be realistic in appraisal of the possibility of delay. 3. Make delay as painless as possible for the waiting caller. 4. Try to group calls so that other activities won't be interrupted.

"Promotion of good will by telephone is largely a matter of easy tone and pleasant manner, a willingness to make service or information easy to get, and an avoidance of indiscretions. In addition, the people in a doctor's office and home should be prepared for special handling of all kinds of emergency calls, whether or not the doctor is there.

"Attention to these and other details, then, is a means for developing good telephone manners. For anyone who wonders whether or not he has such manners, here's a simple test.

"When you talk with someone on the phone, do you always talk as though that person were seated with you in the room in which you are talking? If your answer to this question is Yes, you are using the telephone

to improve your 'public relations.' If your answer is qualified or an honest No, use of the telephone is bad for your 'public relations.' But don't blame Alexander Graham Bell or the telephone; blame yourself. You don't have good telephone manners."

What the Grievance Committee Hears

One of the most enlightening and not infrequently onerous assignments which can come to a member of the Medical Society is service on the Grievance Committee. As those who have been or still are members will testify, their emotional reactions to complaints made by patients against their fellow physicians range from admiration for their colleagues to utter dismay.

"Suppose someone wrote a letter to the Medical Society complaining about something that you had done or had not done. This is not a theoretical question, but one that has a practical application to every member of this Society, and, more broadly, to every member of the American Medical Association.

"Since July 1, when the new Grievance Committee took office, 28 complaints have been reviewed by the Committee, and decisions have been handed down both to the plaintiff and to the doctor against whom they were directed. It is interesting to note into what category these complaints fall, to investigate some of the reasons for the filing of the complaints in the first place, and some of the dispositions of these complaints after the Committee had reviewed them carefully.

"Of the 28 complaints, 20 had to do with fees. The patient thought the doctor had charged him too much; the patient felt that the doctor had been inconsiderate in the duplication of services and charges; the patient didn't necessarily complain about the size of the charge, but didn't understand why it was made and had been unable to get satisfaction from the doctor's office with regard to this. All of these things had so intensely annoyed the patient that he then wrote a letter to the Medical Society, or, at times, directed one to the American Medical Association, and it was referred to the District Medical Society.

"Of the 8 cases in which the complaint was not directly about charges, 3 were cases in which the Committee felt that it had no jurisdiction. For example, the Committee will not consider any case before the Courts of Law. It feels that it has no responsibility or privilege to render a decision in such a case. Three of the various cases not involving fees had to do with matters of professional ethics. In such a case, one doctor will complain that another doctor had not conducted himself properly in his medical and public relations. Two cases involved a complete misunderstanding as to what the doctor had in mind, and why he did the tests which were done and instituted the treatment that he performed.

"From the above it will be apparent that money and misunderstanding are the basic complaints about doctors. When a complaint is made, the usual procedure is as follows. The Medical Society's office will accept such a complaint only in writing, and when the name and address of the doctor involved are specifically stated. The letter is then reviewed by the Chairman of the Grievance Committee and the Secretary of the Medical Society, and, in most cases, a letter is directed to the plaintiff acknowledging receipt of the letter and stating that he will be notified of the Committee's decision at some future time. At the same time, the doctor against whom the complaint

is made is sent a letter asking him to come to the Medical Society, to review the material on hand, and to submit in writing the information that is available to him. Frequently it is necessary to contact several doctors in order to obtain related information, and, at times, with the patient's permission, hospital and other records are reviewed to obtain all relevant information. It should be stated here that much time and grief would be saved the Committee and the Medical Society at large if in his reply the doctor would state succinctly and briefly what he has done for the patient and what his charges have been, in detail.

"After the necessary information has been obtained, the material is then presented to the members of the Grievance Committee. This Committee consists of 10 members, 6 of whom have served previously, and among these 10 members general practice and the various medical specialties are well represented. After reviewing carefully the information available, the Committee decides whether the doctor has been at fault, whether the patient is at fault, or whether there has simply been a misunderstanding and neither is truly at fault. Following this, the Chairman of the Committee directs to the doctor and to the patient a summary of the Committee's thoughts. In this summary, the doctor may be told that his actions were completely justified and that the patient was not justified in the complaint, or, on the other hand, the Committee may tell the doctor that his fees should be reduced in toto or in certain respects, and that the acknowledgment of this decision to the Committee should be made by the doctor. At the same time the plaintiff is told that the Committee has reached a decision and that the doctor will get in touch with him soon and discuss with him the complaint and its settlement.

"Almost invariably the doctor realizes that the Committee has acted for his good as well as the patient's and accepts the decision that has been handed down. However, should the physician decide that he will not accept the Committee's decision, it is then necessary to cite that physician to the Executive Board for whatever disciplinary action it feels is wise. Fortunately, this rarely has to be done, but the Committee does not hesitate to follow such a course when it seems necessary."

"The chief reasons for the complaints filed with the Grievance Committee are due to a lack of understanding of the fee involved or to a failure on the part of the physician to thoroughly explain the medical condition with the tests and treatment necessary. The Committee recognizes that it is not feasible in many instances to enter into prolonged and involved explanation, but it does feel that a few words and an attitude of sympathetic understanding will avoid much ill will. A satisfied patient gets well faster.

"Three words of advice, then, from your Grievance Committee to you: 1. Discuss fees as early in the course of treatment as possible. Don't hesitate to initiate the discussion if necessary. 2. Discuss the medical condition as thoroughly as circumstances will allow. 3. Remember that one vocal and dissatisfied patient can do more harm to you and your colleagues than ten satisfied patients can undo."

"—Your Secretary—"

Dr. Darrell C. Crain, last speaker on the symposium, recognized that a humorous approach might be made to the topic assigned him, "Have You Looked at Your Secretary Lately?" He surmised that the question posed in

the title has "been answered rather promptly by many of you—and in many different ways."

"Some of you may facetiously have said, 'Sure, but don't tell my wife.'"

However, Dr. Crain had no intention of discussing his subject lightly, for he said: "It is hardly an exaggeration to state that the doctor's secretary is on many occasions and in many respects, his 'alter ego'—and what she does and how she acts profoundly affects his practice.

"I have frequently remarked that patients do not come to a doctor because of his secretary, but they will stop coming because of her. Such being the case, it is the responsibility of every physician to see to it that his secretary assists him in maintaining an office which is at once an efficient medical organization and a progressive public relations institution.

"Now—the attributes of a good secretary need not consume our time here; that she should be neat, courteous, efficient, quiet, punctual, mild-mannered, poised, self-assured but humble; long-memoried for some things and short-memoried for others; that she should have the knack of saying the right thing at the right time and being able to please all people at all times is, of course, the ideal.

"But we are not concerned with the traits themselves as much as we are with how we physicians may help the secretary attain and maintain them."

He offered the following suggestions to his fellow practitioners. The first, he stated, was suggested by a secretary.

"'For goodness sake,' she said, 'tell the doctors not to treat us like pieces of office furniture.' It is indeed true, however strange, that a doctor may be quite conscious of each detail of the personal life of his patients and yet neglect even the common courtesies in regard to his own office personnel. But a secretary, too, will work better if the boss remembers to have a cheerful word for her at the beginning and end of the day, to notice her new hairdo, or new uniform, to compliment her on her handling of office affairs, and even to be interested in her personal life—her husband, or boyfriend—provided, of course, that he does not pry too closely into her private affairs.

"The second point I would like to make is that a secretary should be given a job to do—and then be left alone to do it. Too many employers—doctors as well as others—are so continually looking over the shoulders of their employees that the subordinates never feel free to make decisions or to consummate original projects.

"Closely allied to this is my next point: As a general rule—keep your family out of the office. Few things are more distracting to a secretary than to have the boss' wife flitting in and out, dropping by at odd hours, upsetting the routine, checking the records to see who has been in to call on her darling husband, and checking the cash drawer to see how much she can appropriate. I think there is even less excuse for the wife to help in the office—even once a month for the sending of bills and statements.

"I am glad you women are here tonight. I am not telling you that your place is in the home—Heaven forbid—but I am telling you most emphatically: except on rare occasions your place is not in your husband's office!

"But I suppose I must hasten on to my next point. This has to do with the attitude of the physician toward the secretary when there is more than

one girl in the office. This is a rather complex matter and no one generality will hold for all circumstances.

"Women who work together are extremely jealous. As a matter of fact, men are too, but we are not talking about them tonight. But the women can be jealous of just about everything—jealous of each other's duties, of each other's hours, of each other's salary, and particularly jealous, unless he is very careful, of the boss' attentions. Solomon, who should have known about such matters, said, 'It is better to dwell in the wilderness than with a contentious and angry woman.' And nothing makes for contentious and angry women in an office like one being favored above another.

"Closely related to this is another minor point—the manner of addressing the secretary. I abhor the growing tendency to call secretaries by their first name. The only possible exception to this would be if the doctor is quite old and the secretary quite young. And even here I feel it is in poor taste. . . .

"The final point I should like to make has to do with the financial remuneration granted secretaries for their work. This of course varies with the experience and abilities of the secretary, and even with the financial status of the employer.

"The salary of the secretary should certainly be adequate to take care of her needs—and to guarantee that she does not have to seek other work so as to be able to live comfortably. But I feel it should go beyond this. I believe that in every business there should be a plan whereby the employees share in the profits. . . ."

Dr. Crain concluded his remarks with the following: "Those of you who are students of the New Testament know that one of its greatest passages is the Thirteenth Chapter of the First Letter written by the Apostle Paul to the Church he founded in Corinth, Greece.

"In it, Paul exhorts the early Christians to have true love for all people and describes to them the virtues of that love. I should like to paraphrase that letter to apply to a secretary and read it to you in this manner:

Though I speak with the tongues of men and of angels, but have not a good secretary, I am become as sounding brass or a tinkling cymbal.

And though I have the gift of prophecy, and understand all mysteries, and all knowledge, and though I have all faith so that I could remove mountains and have not a good secretary, I am nothing.

And though I have studied at the best universities, and have attended the noblest clinics, and though my diagnostic acumen is the finest and my therapeutic mastery the greatest—and have not a secretary who can collect the bills, it profiteth me nothing.

A good secretary suffereth long and is kind, envieth not, vaunteth not herself, is not puffed up; doth not behave herself unseemly; seeketh not her own welfare, is not easily provoked, thinketh no evil; rejoiceth not in iniquity but rejoiceth in the truth; heareth all things, believeth all things, hopeth all things, endureth all things. A good secretary never faileth.

And now abideth knowledge, a bedside manner, and a good secretary, these three—but the greatest of all is the secretary.

"Gentlemen—may you find such a secretary, and having found her, may you know how to keep her."

MEDICAL ETHICS REVISION ON PUBLIC INFORMATION MEDIA

ST. LOUIS — The House of Delegates, the policy-making body of the American Medical Association, (December 3, 1953) approved a revision of one section (Section 5, Chapter I) of the Principles of Medical Ethics of the A.M.A. which clarifies the relationship of physicians to all forms of public information media—the press, radio and television.

The revision was made by the A.M.A. Council on Constitution and By-laws, headed by Dr. Louis A. Buie of the Mayo Clinic, Rochester, Minn.

Dr. Buie and four other members of the Council undertook some time ago to clarify the wording of this section of the Principles dealing with public information. The clarified section, as revised by the Council and adopted by the House of Delegates, reads in full:

The Relationship of the Physician to Media of Public Information

Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not always easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. On the other hand, it may often happen that the representatives of popular news media are the first to perceive the adaptability of medical material for presentation to the public. In such a situation the physician may be asked to release to the public some information, exhibit, drawing or photograph. Refusal to release this material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation.

An ethical physician may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published, and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies. Spokesmen should be empowered to give prompt and authoritative replies and a list should be issued which identifies them and discloses the manner in which they may be reached. These provisions are made with full knowledge that the primary responsibility of the physician is the welfare of his patient but proper observation of these ethical provisions by the physician concerned should protect him from any charge of self-aggrandizement.

Scientific articles written concerning hospitals, clinics or laboratories which portray clinical facts and technics and which display appropriate illustrations may well have the commendable effect of inspiring public confidence in the procedure described. Articles should be prepared authoritatively and should utilize information supplied by the physician or physicians in charge with the sanction of appropriate associates.

When any sort of medical information is released to the public, the promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

MISCELLANY

The Senate Finance Committee has completed hearings on House-approved H.R. 3685, authorizing VA to furnish office facilities at VA establishments to representatives of veterans' agencies maintained by states. Under present law representatives of national veterans' associations and the Red Cross have this privilege, but not state officials . . . Brig. Gen. Oscar Peter Snyder has been nominated as assistant surgeon general of the Army with rank of major general . . . Legislation for creating federal medical and other scholarships is held up in Defense Department, but the department's proposal for improving dependent medical care is expected to clear the Budget Bureau in a few weeks . . . Awaiting the President's signature is legislation to allow 76 full colonels in the Regular Army Medical Service Corps, rather than the 19 now permitted.

Right now there is more action in Congress on health legislation than at any time in the last few years. More than a dozen public hearings have just been completed or are scheduled for the immediate future . . . Most important development of the week was announcement by Chairman Wolverton that his House committee would start hearings on the administration's reinsurance plan on March 24. So the A.M.A. can reach a policy decision on this bill as soon as possible, a special joint meeting of the Committee on Legislation and teh Executive Committee of the Board of Trustees has been called for March 31 and April 1 in Chicago . . . At the Senate hearings, Secretary Wilson said that for security reasons commissions were being withheld from 20 physicians and dentists called up under the Doctor Draft act. Incidentally, five months ago the total was exactly the same — 20.

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Reader's Digest Article on Vet Care

The March issue of Reader's Digest contains an article on the problem of providing medical care for veterans with non-service-connected disabilities. It was written by Holman Harvey, a staff writer. This article, which is entitled "Must We Follow the VA Route to Socialized Medicine?", gives powerful support to the stand taken by the American Medical Association on the non-service-connected problem. The opening paragraph sets the theme of the article in stating: "The American people had better decide soon whether or not they want free government medical care. For it is descending upon them with bewildering speed."

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Medical Society Editor Thanks Dr. McCormick

A.M.A. President Edward J. McCormick recently addressed a joint meeting of the San Francisco Chamber of Commerce and the San Francisco Medical Society. Last week Robert C. Combs, editor of the Bulletin of the San Francisco Medical Society, devoted a page editorial to Dr. McCormick's talk, closing with this paragraph:

"Those who heard Dr. McCormick certainly felt a reawakened pride in the achievements of our profession but were made to realize too that only by the continued excellence of medical care and constant devotion to our patients could this generation of physicians continue to merit this esteem. There is no doubt that organized medicine is doing a splendid job on a national scale but, as has been previously expressed on these pages, the cornerstone and foundation of good medical public relations are the 1,000,000 plus daily contacts between the members of our profession and our patients—the public we serve."

PERSONALITY OF THE MONTH

This month our visiting personality will be Dr. Murray M. Copeland, Professor of Oncology at Georgetown University Medical Center, Washington, D.C. A descendant of one of Georgia's first families, Dr. Copeland was born on June 23, 1902 at McDonough, Georgia.

A graduate of Johns Hopkins University School of Medicine in 1927, Dr. Copeland received his surgical training at the Mayo Clinic, Rochester, Minnesota, and at the Union Memorial Hospital in Baltimore, Maryland. He also completed a clinical fellowship in cancer research at the Memorial Hospital, New York City, before entering surgical practice in Baltimore, Maryland in 1937.

When his professional career was interrupted in 1942 by the Second World War, Dr. Copeland had advanced to the position of Assistant Professor of Surgery at the University of Maryland Medical School. As a Reserve Officer, he was called to active duty in the Medical Corps as a Major and served overseas for three years, first as an operating surgeon, and subsequently becoming Commanding Officer of the 142 General Hospital in the grade of Colonel. Upon his return to the United States, he became Chief of Surgery at Valley Forge General Hospital and then Chief of Surgery with the Veteran's Hospital at Memphis, Tennessee. Dr. Copeland was decorated by the United States Army in 1949 when he received the Legion of Merit.

Dr. Copeland joined the faculty of Georgetown University School of Medicine, Washington, D.C., in 1947 as Professor of Oncology and Director of the Department of Oncology. Since that time, he has been engaged in the development of the Department of Oncology and in the diagnosis and treatment of tumors. He has contributed extensively to medical literature and is co-author, with Dr. Charles F. Geschickter, of the textbook "Tumors of the Bone."

Mrs. Copeland, the former Jean Brown of Yonkers, New York, is a graduate of Wellesley College and the Johns Hopkins University School of Nursing. She has been active in fields of lay and nursing education and is currently active on the Georgetown University Hospital Ladies Board, Washington, D.C.

Dr. Copeland will speak on "Lumps In The Breast—Their Significance" at the April 20th meeting of the Mahoning County Medical Society.

APRIL MEETING

Combined Meeting

of the

MAHONING COUNTY MEDICAL SOCIETY

and

MAHONING ACADEMY OF GENERAL PRACTICE

TIME:

Tuesday, April 20, 1954

8:30 P.M.

PLACE:

ELKS CLUB

220½ W. Boardman St.

SPEAKER:

MURRAY M. COPELAND, M.D.

Professor of Oncology, Georgetown University Medical Center, Washington, D. C.

SUBJECT:

"LUMPS IN THE BREAST - - -
THEIR SIGNIFICANCE"

DINNER DANCE

Mahoning County Medical Society

and

Corydon Palmer Dental Society

SATURDAY, MAY 8, 1954

Youngstown Country Club

Dancing 9:00 P. M. until 1:00 A. M.

Cocktail Hour 6:15 P. M. to 7:00 P. M.

Dinner 7:00 P. M.

Contributions To

THE BULLETIN

from Society members are welcome - - - any article, news note, letter to the Editor, or item that you think will be of interest to your confreres. Type copy double space.

WHAT YOU OWE OTHER DOCTORS

Zigmond M. Lebensohn, M.D.
Associate Professor of Psychiatry, Georgetown University School of Medicine

The title of this dissertation deserves a note of explanation. To begin with it was not chosen by the writer, but rather by the Program Committee, to whom the writer is greatly indebted. To be sure, the title "What You Owe Other Doctors," may occasion mild wonderment at the best, and gross misinterpretation at the worst. In fact, some of my more facetious colleagues have twitted me for writing a learned paper on the technic of fee-splitting! I hasten to disclaim any such interpretation. Indeed, my contribution has nothing whatsoever to do with the economics of medicine but rather with the ethical concepts which bind all doctors together for the good of thier patients. However, I have retained the revised title for more than capricious reasons. The habits and patterns of medical audiences are such that had I used the title "Medical Ethics" the audience-resistance would have been overwhelming and my colleagues, fearing just another sermon, would have stayed away in droves.

To return to our title, what is it that you owe other doctors? The primary debt we owe other doctors is two-fold: first, a debt of respect for them as fellow-workers; second, a debt of respect for the relationship which they have established with their patients. This implies an understanding of, and a respect for, the interpersonal relationships involved. Since psychiatry has often been defined as the study of interpersonal relationships, I suppose this is why a psychiatrist was invited to discuss this matter.

Since what you owe other doctors is chiefly ethical behavior, it may be well to examine carefully just what we mean by this word "ethics." People often have confused ideas of its meaning. Webster's Dictionary defines ethics as "the science of moral duty; more broadly, the science of the ideal human character and the ideal ends of human action." In other words, ethics can be defined as "moral principles."

It is in the carrying out of these "moral principles" that we can say that we are subscribing to a code of professional ethics. Although many pamphlets on this subject are available, this code is much more the unwritten law to which medical men willingly adhere and by which they practice. It is a code of conduct based on the highest moral principles. Its aim is simple and clear, namely, to help the doctor serve his patient with humanity and dignity.

Contrary to popular belief, the code of professional ethics was designed to protect the patient, not the doctor. It is true, however, that the doctor who really understands the wisdom of ethical conduct and follows the code intelligently will rarely get into difficulty with either his colleagues or his patients.

To get down to cases, what are some of the specific things you owe other doctors?

1. *Respect for your colleagues' integrity and ability.* Altogether too often do doctors make disparaging comments about one of their colleagues, often in public. We may hear Dr. A say something like the following: "Oh, Dr. B? Why I wouldn't let him treat my dog!" Dr. A may well disagree with Dr. B's technics, his school of thought or his methods, but he does a great disservice to himself and to all of medicine by indiscriminately spreading such alarming tales. In making such a statement Dr. A may be attempting to indicate his own superiority to Dr. B. If so, it is a crude attempt and in the poorest possible taste. What Dr. A really succeeds in doing is to under-

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mine the confidence of laymen in all doctors, a confidence which the science of medicine has labored for hundreds of years to build. This confidence is the most precious ingredient in the whole practice of medicine. Without it all other medicines fail. We must guard it zealously at any cost. And the cost is eternal vigilance of our personal conduct.

2. *The second obligation you owe other doctors is to respect their relationships with their patients.* Conversely stated, a doctor must not entice patients from his colleagues. This applies particularly when consultants are employed. We find that some doctors in general practice are now reluctant to refer patients for specialized attention to certain groups or certain medical buildings for the fear (often justified) that they will never see their patients again. If this is true, we should all take every possible step to correct it. How can this best be accomplished? I suggest the following:

a. A wider acceptance, particularly among specialists, of the priceless value of the patient's relationship with his family doctor. If this relationship is good and firm it is the consultant's solemn obligation to keep it good and firm. If it is weak, it is the consultant's obligation to strengthen it.

b. Placing greater emphasis on the physician's role as a teacher. All doctors are teachers; the very word "doctor" means teacher. Hence, a doctor is one who teaches his patients to get well and stay well. The consultant, however, has a double obligation. Not only must he teach the patient how to get well, but, equally important, he must teach the referring doctor something about his patient and the illness from which he suffers so that he may be better able to treat him in the future. Most specialties have been oversold but undertaught. It is the present-day responsibility of the specialist to teach his colleague with every case he shares.

3. *Careful understanding of the dissatsified patient.* Special mention should be made of the problems involved in treating the patient who has been bitterly dissatisfied with his previous physician. It is so easy for Doctor No. 2 to sit in judgment and to nod his head in sympathetic agreement as the patient recites in gory detail all the mistakes made by Doctor No. 1. But is all this really helping the patient? Or is it merely contributing to the smugness of Doctor No. 2? And, more to the point, isn't it also contributing to our rising malpractice rate? Isn't it better to remain noncommittal and to concentrate on treating the patient as soon as the facts are known? An honest attempt to understand without bitterness is often rewarded by the establishment of an excellent doctor-patient relationship. Even more important, the patient's feelings toward medicine in general will have been greatly improved. This cannot be accomplished if Doctor No. 2 adopts a "holier than thou" attitude toward his predecessor.

There are many other obligations we owe our colleagues, but limitations of space permit me to mention only a few more.

4. We owe other doctors the best possible advice and assistance concerning their own personal and family medical problems.

5. We owe other doctors the practice of restricting our work to our own special field of competence.

6. We owe other doctors the courtesy of reporting, and reporting well, on the progress of a mutual patient. It is chiefly by such interchanges of information that the highest type of postgraduate medical education takes place.

7. We owe other doctors the obligation of keeping confidences, not only for the colleague's sake but for the patient's as well.

8. We owe all doctors the exercise of good taste and common courtesy in all our dealings. Common courtesy, like common sense, is altogether too uncommon in these days of rush and hurry. Common courtesy is not a quality which can be successfully mimicked. If it is a pure surface gesture, it will be as transparent as a phony bedside manner. It must be deeply felt in order to have any true meaning to either the patient or to our medical colleagues.

The criticism may be made that my remarks have been too philosophical and too much concerned with ethics. My reply is that this is the greatest trouble with medicine today. Not enough attention is being paid to ethics in daily practice. Medicine is at a dangerous crossroads. Public confidence in the family doctor is waning. Frank cynicism is replacing the once familiar attitude of respect and adulation. Malpractice rates are soaring. Why all this? The complete answer is difficult to give. But one of the most important reasons is our failure to live fully to our code of professional ethics—a failure to give to other doctors what we owe them—call it respect, common courtesy, or ethical conduct. We must remember that ethical considerations enter into every phase of a doctor's life, not only during his office hours, but at all times.

We could probably discard all the minor rules in the guides and pamphlets and still practice the highest possible standard of ethics if we followed only one rule. It is an old rule, a simple rule, and a familiar one; but if followed faithfully it surpasses all the rest. It is: "Do unto others as ye would have others do unto you."

PRIVATE MEDICAL PRACTICE

I foresee the *family doctor* of the future as the most important single unit in medical care. Like the family doctor of the past, the family physician of the future should serve as health adviser and health educator and as a leader in developing the health resources of the community. He will differ greatly from the family doctor of the past, however, in the resources at his command. In addition to his black bag he carries with him the potentialities for ready access to top-notch consultants in the medical specialties, to hospitals with their resources, and to a wide range of preventive and rehabilitative services. Through him, the patient will be assured continuity of care, adequate interpretation of his health needs, and understanding of his problems as a person, without sacrifice of the quality of care he receives. In good medical care there is no substitute for the doctor-patient relationship.

Specialism. The specialist is and will of course remain an essential, necessary and important person in medical care. As medical knowledge expands, new specialties will emerge, each requiring years of study to assimilate and augment techniques of diagnosis and treatment. In the future, however, specialists can be used more wisely if their services are properly correlated with those of the family doctor.

Our problems of the past have derived mainly from the isolation of the various specialists from each other and from the lack of "generalists" to interpret and integrate the several fields. In pediatrics, however, and in the emerging specialty of geriatrics, the specialists are also generalists for a whole age group. We need to develop equally rewarding concentration on the total person in his most productive years of life. The family doctor will help to fill this gap.

Chester S. Keefer, M.D.

SPECIALIZATION

At present there is a helter-skelter trend toward specialization in medicine. This specialization applies to medical teaching and research as well as practice. In a field of knowledge as vast as that of medicine some specialization is inevitable, and some is sound. It is inevitable because no one mind can encompass the entire field of medicine; it is sound because good teaching, research and medical care demand deep knowledge. It is unsound, however, when the specialization becomes so narrow that the teacher or physician no longer appreciates how his special body of knowledge relates to the whole of medicine.

There is a harmony to medicine. Each field of medical science, each area of practice, contributes to the teaching of medicine. These various areas must not isolate themselves, for each gains strength from the others.

The harmony or unity of medicine is broken by specialization. When a specialist's interest is pursued without due thought of the other medical sciences and other areas of medical practice it becomes isolated. Teaching, research and care of the patient suffer. When a special interest is pursued, therefore, its relation to the whole of medicine must constantly be reviewed and appraised.

Furthermore, education, in contrast to research and practice, deals primarily with the general aspects of the subject, with concepts rather than details. Specialization is out of step in basic education because it is concerned with details, and details in profusion obscure concepts. It is not until the student is advanced that he should be involved with specialization.

Thus, undergraduate medical education should deal primarily with the concepts of general fields. A special field should be explored only as an example of a point of view, and of the ways and benefits of research. The undergraduate years cannot hope to cover the points of view, technics or knowledge of all the special fields of medical science and practice, and the specialist who limits his teaching to his special field of interest is a discordant teacher of the undergraduate phase of medical education. These principles apply to all teachers, including the biochemist, the bacteriologist, the internist and the surgeon.

Oliver Cope, M.D.
New England J. of M., Jan. 7, 1954

ASCORBIC ACID FOR STRESS

In his review of the relation of vitamin C to adrenocortical function, Pirani wrote, "Under normal conditions man is supplied with stores of ascorbic acid more than adequate to cope with the metabolic need of acute stress. Administration of ascorbic acid, however, would seem indicated in severe chronic stress, especially after traumatic injuries or burns, and during protracted stimulation of the adrenal cortex." Following the lead of the National Research Council, Pirani recommended these dosages: 1 to 2 Gm. of ascorbic acid daily for severe stress; 300 mg. daily for moderate stress—*(Metabolism, 1:197, 1952).*

PERSONAL PATTER

Have you met - - - -

Dr. James L. Smeltzer who recently became a member of the Mahoning County Medical Society? Born in Youngstown, Ohio on December 24, 1922, he carries on the medical tradition of the Smeltzer family in a practice limited to internal medicine at 243 Lincoln Ave.

After graduating from Duke University School of Medicine, Dr. Smeltzer had a rotating internship on the Stanford Service of the San Francisco City Hospital, in San Francisco, California. He stayed on for one year of medical residency and then moved on for two additional years at the San Diego County Hospital in San Diego, California.

Dr. and Mrs. James Smeltzer with their four children reside at 238 Crandall Avenue.

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Congratulations to Dr. Robert L. Tornello and Dr. David Brody who have been certified as Fellows of the American College of Surgeons, March 1954.

WHY DO DOCTORS LIE TO THEIR PATIENTS?

The following are a few excerpts from an article with the above title written by Leila T. Ammerman in The American Mercury, March, 1954.—Editor.

Why do doctors conceal the truth from mature, although fatally ill, patients? Is it really because they feel that it is best for the patient—or is it, rather, because they, themselves, find death something to be feared? I believe their "hush-hush" attitude about fatal illness reveals a subconscious reaction of their own fear.

Death is one of the processes of the physical nature, like birth—or the very process of growth itself. God designed physical nature to conform to certain rules and processes—and whether animate or inanimate nature, we still follow a similar design: the process of natural birth into this world of the physical, the slow growth to maturity and the period at the peak of the physical life. Then the decline toward the last natural process, which ushers us from the world of the physical into that of the spirit.

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How much better if a family can face the fact together, as a unit, and go on to the peaceful, quiet enjoyment of each hour and minute together—rather than spend these hours in trying to deceive each other into thinking there is hope for recovery in this world.

I believe that doctors, in admitting they will lie to patients in the event of mortal illness, are destroying the trust they strive so hard to build up within the minds of their patients.

—o—

Surely we who believe that the truth is important in every case deserve a doctor who considers well before he deceives his patients. He may be undermining those things in which he most believes. He surely is fostering the idea that physical life is paramount.

Two thousand years ago we were told: "Know the truth, and the truth shall make you free." Free of fear and dread and horror of the natural processes through which our physical being must go. Free of the anguished fighting to cling to failing breath. Free of the necessity of fooling our dear ones into believing that *they* are fooling *us!* Free—yes, free to plan our last months and days if (death should give us warning) and to enjoy each moment with our loved ones in peace and complete understanding.

EXPLOITATION OF HEARTBREAK CASES A SHAM

Lately, all of us have been seeing more and more exploitation of heartbreak cases by television, radio and newspaper.

A "heartbreak case" was defined as an appeal for funds through television, radio or press to pay for extensive medical care or an operation, the cost of which is overwhelming to the person involved.

Dr James D. Tyner, Newark, stated that investigation of many heartbreak cases showed that patients did not consult with hospital authorities or ask their county medical societies what could be done. "Instead," he declared, "they chose to glamorize their plight."

"The patient must be informed that regardless of ability to pay he need only ask to receive the services of a doctor or hospital care," Dr. Tyner stated. "In these cases, the county medical society, state welfare department and voluntary health organizations are ready to help every deserving person.

"How many people know that doctors in wards and clinics of hospitals throughout America give their services daily without charge? The average doctor spends 12 percent of his working hours doing charity work. The dollar value of the time given to charity patients by the average M.D. is more than $3,000 annually and his donation of time from 1947 to 1951 increased 15 percent."

In addition to the medical profession's deep concern with the problem, he pointed out that the social welfare laws of New York State make it mandatory upon the welfare district to provide medical and hospital care for those persons unable to secure necessary medical and hospital care.

"Physicians are already giving service to thousands of potential heartbreak cases in their everyday duties," Dr. Tyner said. "We must let the people know this fact, and try to prevent the few cases that are dramatized from damaging the good name of American medicine."

THE TUMOR REGISTRY OF THE YOUNGSTOWN HOSPITAL ASSOCIATION

The Tumor Registry of the Youngstown Hospital Association is now processing the tumor cases of both the North and South Units. In 1952, Dr. A. E. Brant, Chief of the Surgical Service, Youngstown Hospital Association, appointed a Cancer Committee of the Surgical Service consisting of W. J. Flynn, Chairman, D. E. Beynon, D. R. Brody, R. A. Hall, W. B. Hardin, P. L. Jones, E. A. Shorten. This committee in conjunction with Dr. A. E. Rappoport, Director of Laboratories, formed the nucleus for the origin of the Tumor Registry. The Registry has now grown to encompass all cancer cases at both hospital units.

Due to the concentrated effort by the Tumor Registry, and the excellent cooperation of the Doctors, approximately 700 new cancer cases have been processed. The diagnosis, treatment, and follow-up data has been compiled in an additional 2,500 cases including the years 1945 - 1953. The unusual interest shown by Mr. Roy Mellon, Commissioner of Health, providing vital statistics to the Tumor Registry has been a great aid in compiling these statistics.

Facilities of the Tumor Registry office located in the Lab in the North Side Unit are available to all Staff Doctors. The personnel are anxious to provide any statistics that are desired concerning the cancer patient. The Staff Doctors are urged to take full advantage of this service.

A.M.A. NOT JUST "AGIN" EVERYTHING
THE KANSAS CITY STAR, SATURDAY, FEBRUARY 6, 1954

The following editorial assails the A.M.A. as it has often been assailed. Dr. E. J. McCormick's reply follows.—Editor.

THE INEPT A.M.A.

We like doctors. We are very much against socialized medicine, just as they are. For the devotion to research and the great progress in medicine and extending the life span, we can't pay high enough tribute. But, frankly, we can't refrain from remarking that the American Medical association (A.M.A.) has about the most stupid and impossible public relations imaginable. It probably isn't intended. But whoever is setting up as a spokesman, supposedly for the doctors of the nation, is certainly inept, to put it in the most charitable fashion.

The public is getting the impression the A.M.A. is against almost everything under the sun. We don't believe doctors, as a rule, feel that way at all. Just recently the A.M.A. has taken on the veterans' organizations by campaigning against admittance to government hospitals of veterans with nonservice connected disabilities. It is feared this might open the door to socialized medicine. We are not quarreling so much with the soundness of the protest as the general effect flowing from it.

Most of the veterans' groups are sore as a boil at the A.M.A. and all needlessly. If there is an abuse it's one in which the veterans' groups should be consulted, with the Veterans administration itself leading the cleanup if there is to be one.

President Eisenhower has even more recently put before the country a broad program extending not only social security but the health activities of the government to reach more millions. It explicitly emphasizes that it stops short of socialized medicine and that completely. It entails more government aid for hospitals and clinics, possible government reinsurance of private group hospitalization plans, especially those on the border line, to include the more needy.

The acclaim with which the A.M.A. spokesman received this program was so silent as to be almost vociferous in its implication. Even friendly members of Congress are asking just where the A.M.A. stands on this general welfare program and if it really represents the thinking of the average doctor. We don't believe it does. The height of absurdity has almost been reached when it has been suggested the A.M.A. favored the Bricker amendment to the Constitution, because the door might be opened to socialized medicine by some international agreement flowing from the United Nations. Or maybe the A.M.A. reached its "agin" peak when it opposed federal aid to medical schools and that when this whole country is in desperate need of doctors.

The sure and certain way to get socialized medicine is for the vocal leadership of the medical profession to become chronic "aginners." Just being against something doesn't stop it. We are going to progress in medicine and care of the people's health one way or another. It can and should be done short of socialized medicine and within the bounds of our private enterprise system. Doctors should take the lead. If it doesn't come that way, we will have socialized medicine, sure as fate. The whisky and brewery interests opposed everything until we got the experiment in prohibition. Big business used to see a bogey man behind every move that represented

progress until big business itself became the whipping boy of the politician and the demagogue. Business began to show sense. The bigger the business usually the harder the work on the problem of public relations now. It has changed the climate.

We are ready to believe that the impression being left by the A.M.A. spokesman comes from inexperience in the field of public relations more than intent. But there should be a quick shift from "agin everything" to lifting the banner high and spearheading the drive for carrying better health programs to more millions with the A.M.A. taking the lead. That's the way to stop socialized medicine. And we believe this reflects the real opinion of the great majority of our fine folks of medicine.

THE KANSAS CITY STAR, FRIDAY, FEBRUARY 12, 1954

Speaking the Public Mind

A.M.A. NOT JUST "AGIN," ITS PRESIDENT SAYS—

The American Medical association has been under attack for many years by the proponents of government medicine. This attack has centered on two points: (1) that the A.M.A. does not represent the true thinking of the rank and file doctors and (2) that the A.M.A. is a "standpat" organization which is "agin" all health progress. Both of these charges are false, but both were repeated in a Kansas City Star editorial on February 6.

Let me emphasize that the A.M.A. is a democratic organization. Its policies are decided by majority vote of a 190-man house of delegates, representing every state in the union and all the specialties and general practice. Missouri doctors not only are represented in this house, but have a member serving on the A.M.A. board of trustees.

In support of the second point The Kansas City Star characterized as "needless" the A.M.A.'s stand against the admittance of nonservice-connected cases to veterans hospitals. Particularly, it said this stand shouldn't have been taken without consultation with the VA and veterans' groups. The truth is that the A.M.A. has been meeting with these groups for over twenty years without solution of the problem. The veterans groups want more and more hospitals for veterans.

Doctors feel that sufficient VA hospitals have been constructed to care for all service-connected cases and see no reason why American taxpayers should finance the medical care of veterans whose illness has absolutely no connection with service. According to the VA's own figures, such cases now total 65 per cent of the daily patient load in VA hospitals.

For All the People

Doctors are not against veterans; they are for all the people. We believe tax funds should be used to help build community hospitals, chronic disease centers and other medical facilities open to all the citizens of a community, including veterans. This is what President Eisenhower has proposed and we strongly endorse it. This stand does not make the A.M.A. popular with veterans groups, but we believe it has the support of the majority of citizens and will result in better care for all in the long run.

The editorial also criticized the A.M.A. for its supposed silence regarding President Eisenhower's health program. This is what the A.M.A. said in a nation-wide press release on January 24:

"The board is pleased to find so many of the ideas and principles for which the A.M.A. has striven for so many years. The board endorses the general objectives of the President to extend needed facilities, to promote further research, to increase coverage under voluntary health insurance and to rehabilitate the disabled."

The A.M.A. has reserved judgment on the proposal for federal reinsurance of voluntary health insurance because to date this is just a vague idea. No specific bill has been presented. There is also serious question in the private insurance industry as to whether any such program is necessary since companies already reinsure each other.

On Health Deductions

The A.M.A. has, however, taken a strong stand in favor of allowing all medical bills, including health insurance premiums, to be deducted from taxable income. This would require no additional federal bureaucracy, and would help those who need help most—the people who have suffered a serious illness or injury within a given year.

The A.M.A. supports the principle of the Bricker amendment because there are at the present time several international agreements under study by the State department which would institute government medicine. These could be adopted by a two-thirds vote of the senators who happened to be sitting in the Senate chamber at any time and would supersede all previous decisions to the contrary. We favor an amendment which would insist that any treaty or executive agreement involving domestic law must be passed by both houses of Congress, as all our internal laws now are passed.

In a blanket manner, the editorial criticized the A.M.A.'s stand on federal aid to medical schools, implying A.M.A. was against training more doctors. The association is strongly in favor of expansion of our medical schools, and has demonstrated so repeatedly. The only question is how this can best be done.

Against School Subsidies

A.M.A. has opposed yearly subsidies to medical schools because of the danger of federal control of education. It has however, supported one-time federal grants for the construction of medical school facilities, a proposal similar in nature to the Hill-Burton hospital construction act, which the A.M.A. has always endorsed. The American Medical association is spending thousands of dollars annually through its council on medical education and hospitals to encourage the improvement and expansion of medical schools. In addition, it has established a nonprofit foundation to raise money for medical schools which has contributed $2,830,000 in the last four years.

The editorial seemed to imply that doctors public relations would be better if we were never "agin" anything. We do not believe our responsibility is to pose as Pollyannas. We believe our responsibility is to be honest with the people. This means pointing out dangers and opposing unsound measures as well as pushing many projects for improvement in the health field. While we say "bravo" many times, it is necessary to say "no" in a very definite manner on occasion. After all, seven out of the Ten Commandments begin with "Thou shalt not . . ."

We agree with The Kansas City Star that the A.M.A. should lift the banner high and spearhead the drive to carry better health to more millions.

That is our aim. However, in the constant bombardment under which we have been working, it is often necessary to shore up our fortifications as well as lead the attack. Our job would be easier if we doctors were not subjected to the kind of uninformed heckling which appeared in The Kansas City Star editorial.

Edward J. McCormick, M.D.
President, American Medical association

HOW GOOD IS AN FBI REPORT?

The following is presented to point out how an FBI report may be misused by any individual with a McCarthy complex.—Editor.

In 1924, when he was Attorney General, the late Chief Justice Harlan F. Stone abolished the Division of Investigation which had played an ugly part in the arrest and deportation of aliens under the attorney generalship of A. Mitchell Palmer and established in its place a Bureau of Investigation with J. Edgar Hoover as its director. In doing so, he issued the following statement regarding the Bureau's role:

There is always the possibility that a secret police may become a menace to free government and free institutions because it carries with it the possibility of abuses of power which are not always quickly apprehended or understood. . . .

The Bureau of Investigation is not concerned with political or other opinions of individuals. It is concerned only with their conduct and then only with such conduct as is forbidden by the laws of the United States. When a police system passes beyond these limits, it is dangerous to the proper administration of justice and to human liberty, which it should be our first concern to cherish. Within them it should rightly be a terror to the wrongdoer.

"There are probably several million reports on individuals in the FBI files," former Attorney General Francis Biddle observed recently. Are they concerned only with "such conduct as is forbidden by the laws of the United States?" If not, they can become, in the hands of a police chief less scrupulous than Mr. Hoover, or in the hands of an ambitious politician, a terrible instrument of oppression.

How good is an FBI report?

Without impugning in any way Mr. Hoover's indubitable patriotism and zeal, or the excellence of his bureau's record in law enforcement, the time is overdue to ask the question. It is imperative to ask it for three reasons: first, because the available evidence would seem to suggest that the value of an FBI report depends upon who is evaluating it; second, because counter-intelligence is too important today to become a political shotgun for those who hunt heretics instead of spies; and third, because a skeptical attitude toward the police is an indispensable attribute of a free people.

Alan Barth, Harper's Magazine, March, 1954

FOR RENT — 3 large rooms suitable for doctors offices, full bath — south side — parking no problem — RI 3-9618.

A little learning is a dangerous thing.

Alexander Pope

THE VALUE OF A BOOK REVIEW

The value of a good book review to the publisher, plus a summary of its attributes, is described by Martin Matheson in a recent issue of *Science:*

It is not out of order, it seems to me, to make some comments on the part played by the review in selling books. Two years ago Wiley (John Wiley and Sons, Inc., New York) ran a study on the effectiveness of various selling methods. The results showed that critical reviews ranked immediately behind direct-mail advertising. I use the word "critical" advisedly in describing a book review. Too many reviews consist of a summary of the book's contents; others repeat the publisher's jacket blurb or his circular copy. The review that really is significant and useful to potential readers is the one that can be written only by an authority in the field who has given the book careful study. He must even read the preface to make certain he understands what the author has tried to do, and above all what he has intentionally omitted. The signed review, the practice of most of the better scientific journals, is usually a much better performance than the unsigned one. If a book reviewer knows that his comments will appear over his name, he will in the nature of things exercise more care and will be more thorough in evaluating the book. In the final analysis, he is working for the prospective user, and stating as frankly as he can whether a book should be bought or avoided.

CHARLES CARLIN

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ALCOHOLIC BEVERAGES

It is of interest to turn occasionally from the usual consideration of the gastronomic and social aspects of alcohol consumption to a contemplation of its position in the world of industry. Recently the American Business Men's Research Foundation, a nonprofit organization for business research, issued some figures regarding the personal consumption, expenditures and costs of various items in the national life. These figures for 1951 were as follows: alcoholic beverages, $9,150,000,000; meat, $11,500,000,000; milk and dairy products, $8,000,000,000; tobacco, $4,703,000,000; bakery goods, $2,957,113,-000; and soft drinks, $1,200,000,000.

Referring further to the increase in consumption in the eighteen-year period since prohibition ended, the report states that there was an increase of 162 per cent in consumption of beverage alcohol from 1934 to 1952. Beer consumption increased 115 per cent and wine consumption 507 per cent; whiskey with its minor relations, brandy, rum and gin, has increased 203 per cent, though it is of interest that in the period from 1946 to 1952 there has been a drop in the per capita consumption from 1.39 gallons to exactly 1 gallon in the latter year. The figures for really big business, such as the automotive industry ($18,415,000,000), housing ($21,765,000,000) and clothing and repairs ($18,455,000,000), run much higher, though the total consumption figure for alcoholic beverages is impressive, exceeding the figure for milk and related products and being more than three times that of all bread and bakery goods.

As these data, emphasizing the bigness of alcohol as a business, were being reviewed, a reprint discussing another phase of the alcohol question — that is, the terminal stage of alcohol consumption — appeared.* This was a study of the records and information gained from the families of 500 deceased alcoholics. The average longevity was fifty-two years; 16 per cent lived to the age of seventy-five or over, and 12 per cent died under the age of forty. Directly or indirectly 28 per cent died from the effect of alcohol through violence or illness. In 29 per cent the drinking continued throughout their lifetimes. About 22 per cent stopped drinking during prolonged terminal illness. In 10 per cent the drinking gradually became more moderate until at the time of death alcoholism had not been a serious problem for many years. Eleven per cent stopped drinking permanently (exclusive of a terminal illness), and 8 per cent stopped for three years or longer, only to relapse at a later date.

The merchandizing of alcohol as a beverage, even with taxes, seems to be profitable and will gradually increase if the figures for the last three years are any guide. It is a far cry from the clean, well lighted package store, with its well bottled shelves, from the glittering music-filled cafes and restaurants and even the average bar room to the terminal stages in hospital, home and hovel. The contrasts are obvious; the remedies are not. One widely heralded remedy, the great American experiment of prohibition, failed, human nature being what it is.

**Lemere, F. What Happens to Alcoholics. Am. J. Psychiat. 109:674-676, 1953*

New England Journal of Medicine
January 7, 1954

If we live truly, we shall see truly.

Ralph W. Emerson

MEDICOLEGAL DISCLOSURE OF INFORMATION WITHOUT CONSENT IN ABSENCE OF PHYSICIAN-PATIENT RELATIONSHIP

The fundamental consideration is whether the physician-patient relationship was established or was not established. Pertinent criteria in arriving at an answer include:

1. Who called the physician?
2. What was the purpose of the physician's visit?
3. What treatment was rendered?
4. What provision for further examination and/or treatment was made?
5. Who paid the physician?
6. The type of medical facts found and their relationship to the purpose of the visit.

For example, a small child is hit by an automobile and the driver of the car insists on calling his physician to check up the physical condition of the child. The driver pays the physician for his visit and the following week the physician receives a request from the driver's insurance company for a full and detailed report of his findings. In this case, no physician-patient relationship had been established and such disclosure of information is permissible.

But the situation is not always so simple by any means. Some facts that would complicate disclosure in the above case would be that the driver had called a medical society to send a physician for the emergency, some treatment had been rendered to the child during the first visit and treatment has been continued at subsequent visits at the request of the mother, the physician responding to the call had given the child's mother two treatments for syphilis late in her pregnancy with this child, the child was or was not known to have been born syphilitic and had or had not received adequate treatment for syphilis by this physician.

The decision as to the establishment of the physician-patient relationship is not always easy to determine and in doubtful cases, the physician will do well to seek legal advice before giving any information to a third party. It is safer to err on the side of non-disclosure, although one does not wish unnecessarily to be obstructive. In certain instances, disclosure will have to await court action.

The ordinary insurance company examination on behalf of a defendant in a personal injury action involves no establishment of a physician-patient relationship. In this instance, the physician is clearly engaged to serve the interests of his employer, the third party. However, he nevertheless owes a duty to the person examined not to disclose information obtained by the examination promiscuously to others than his employer.

Timely Food For Thought

Following completion of a sentence of eighteen months in a federal penitentiary for income tax evasion under the federal statutes, the Ohio State Medical Board revoked the license of the defendant physician to practice medicine on the ground that he had been guilty of a felony.

Upon appeal, the Supreme Court of Ohio held in 1951 that conviction of a violation of a federal statute punishable by imprisonment in a federal penitentiary satisfies the requirements of the medical practice act and the general code, as well as does violation of an Ohio criminal statute. The revocation of the medical license by the Ohio State Medical Board was therefore affirmed.

Sidney Franklin, M.D., LL.B.

"THE LEAVEN IN THE BREAD —"

One often hears that so-and-so had a premonition that death was at hand. Usually, something the individual said or did led a relative or a friend to this conclusion. There was no evidence of this in the recent tragic death of Dr. Edward D. Spalding of Detroit. Nevertheless, he left an impressive final 'testament' which his fellow physicians might well ponder.

On December 1, press dispatches relate, Dr. Spalding left his office in Detroit's Professional Building, one among many in the evening rush of persons hurrying home from their day's work. A few minutes thereafter, he lay dead on the pavement, shot, police said, by a former mental patient who got the wrong man.

At noon of the day he died, Dr. Spalding, who was Associate Editor of Wayne County Medical Society's *Detroit Medical News*, submitted copy for what proved to be his last contribution to the Editor's Page of his publication. In it he showed deep concern because it was his belief that physicians generally, and those preparing for a medical career in particular, were losing sight of the fundamental fact that "the cornerstone on which all medical practice rests is that of *personal service;* intelligent and kindly individual attention."

"Medicine as a science," he continued, "has made prodigious strides in the last half century, and yet it seems the more we progress as scientists the more impersonal we become. These two attitudes however are in no sense incompatible, and proficiency in the one in no way requires neglect of the other."

"In years past when the apprentice system prevailed, the young physician starting out had more of an opportunity to observe the professional habits of his senior colleagues in their dealing with patients, and their manners developed through long years of practice. Today the medical student is first saturated with all the latest scientific developments pumped into him in medical school. He is then presented with thousands of proprietary medications furnished him by the pharmaceutical houses, delivered with all the pressure of modern advertising. It is no wonder that soon he is apt to find himself doing a 'land-office business' on a purely commercial level.

"But this is not the practice of medicine as it should be. In the conduct of a practice the physician, in addition to his intelligence and scientific skill, should give something of himself to each patient whom he serves—a *kindly personal human interest*. This is the leaven in the bread that makes the whole loaf of scientific knowledge rise, and without which technical facts become cold fare indeed. It is the lack of just this element which is one of the fundamental faults of the medical profession today, and the reason for much of the social unrest and dissatisfaction with medical service as it is now offered.

"The remedy lies not in public propaganda, published articles, and radio broadcasts, but in the consulting room of every doctor, and how he deals with each and every patient that he sees."

Laziness travels so slowly that poverty soon overtakes him.

Benjamin Franklin

AEQUANIMITAS 1954

Justin Dorgeloh, M.D.

Prologue. Probably most of us disapprove of the artificial (always call the patient by his first name), insincere (feign poverty by foregoing Cadillacs) and fantastic (music for the patient's ears, and tea and cakes for his stomach) excesses of Public Relations enthusiasts in some quarters. I would be distressed, however, if the following expose were misinterpreted as carping at those in our own Medical Society who have labored earnestly in our behalf to cope with genuine patient-physician problems.

Scene. The recently modernized office of A. G. Gotterdammerung, M.D. The soothing decor, conceived by a certified environment-psychologist, includes several large paintings of pastoral scenes, innumerable aquariums, and well-modulated indirect lighting. At the center of the room is a tea cart stocked with goodies approved by a certified food-psychologist. On the walls are framed printed placards exhorting patients to discuss any little misunderstandings with their doctor, soft music emanates from cleverly disguised high-fidelity loudspeakers, and the cash register has been artfully concealed in a soundproof false-bottom chair.

Dr. Gotterdammerung (In ill humor. The tea and cakes he must partake of with each patient have given him indigestion, and the piped-in music is featuring Bach, whom he detests. He addresses his office nurse.)

What's that racket in the waiting room?

Miss Phipps. Why Dr. G. Your patient states that his trouble is urgent, entitling him to precedence over the others waiting to see you.

Dr. G.: But why the disturbance in the reception room?

Miss P.: He's screaming that he'll turn you in to the newspapers and the Patient-Physician Relations Committee if you callously neglect him one minute longer.

Dr. G.: (paling and clutching a diathermy stand for support): Show him in, Miss Phipps! The poor man obviously needs immediate attention!

(Exit Miss Phipps. In a moment the outer disturbance ceases, the door opens, and the patient enters. He is Muggsy Burke, a burly fellow with an irresistible, good-natured grin. After visiting the tea table to stuff a handful of ladyfingers into his pocket he sinks himself into an easy-chair, props his heels upon a Gray's Anatomy conveniently located on Dr. G's desk, lights a cigar and utters a sigh of sheer contentment.)

Burke: Hi, Doc!

Dr. G. (jovially): Hello, my good man. Now just tell me your first name, and what's been——

Burke: Not so fast, Doc! First let's see your credentials.

Dr. G., quite surprised and thought it an unusual request.

(Dr. G. searches his desk, finds the transcript, and reluctantly hands it to Burke. The latter inspects the report carefully, and with obvious interest).

Burke (frowning): I don't like this C-minus you got in Biochemistry II, Doc. How about it?

Dr. G. (apologetically): I've tried to make it up by taking postgraduate courses in biochemistry, and . . .

Burke: O.K., O.K. Now what about a fee schedule? I didn't see none on the wall outside.

Dr. G.: Well, each case is a special problem, and . . .

Burke: Listen, Doc, I'm not gonna help pay for no yellow Cadillacs. Do I get to see that fee schedule or don't I?

(Dr. G. sighs. He extracts a large card from a file marked "Confidential" and hands it to Burke, who examines the fee schedule as one would a menu, reading it from right to left.)

Burke: Say, Doc, what's a hysterectomy?

Dr. G. (warily): Cutting out the uterus.

Burke: Oh. Are you one of them guys that does unnecessary hysterectomies?

Dr. G. (flushing): Certainly not! I never take out uteri unnecessarily. I only take out unnecessary uterio. I mean . . .

Burke: Don't get your blood pressure up, Doc—it's bad Public Relations. Anyway I don't want no hysterectomy. (He laughs uproariously, obviously pleased with himself.)

Dr. G. (coldly): Well, what do you want?

Burke: Rhinomycin, Doc. My nose got stuffy this afternoon, and the *Layman's Weekly Review of Medicine* tells how fifteen guys took rhinomycin and not a damn one of 'em caught a cold.

Dr. G.: Don't you think that I'm the one to diagnose your illness and prescribe treatment?

Burke (becoming angry): Look, Doc, push the patient around and you'll get socialized medicine. Just hold back on that rhinomycin and let me get pneumonia and you know who'll be in hot water, don't you?

Dr. G. (resignedly): Oh, all right. (He writes the prescription.)

Burke (in good humor again): Thanks, Doc. Send the bill to Blue Cross, and fix the date up right if you wanta get paid—my policy ran out last month.

(Exit Burke.)

(As the curtain slowly falls, Dr. Gotterdammerung is seen silently contemplating the placards posted on the walls, his face enigmatic and thoughtful.)

Bulletin of the Alameda-Contra Costra Medical Associations

50th ANNIVERSARY OF THE NTA

The 50th Anniversary Meeting of the National Tuberculosis Association—first of the voluntary groups organized on a nationwide basis to fight a specific disease — and the 49th Annual Meeting of its medical section, the American Trudeau Society, will be held May 17-21 in Atlantic City. The Ambassador, Chelsea, and Ritz Carlton Hotels will be used.

Beginning Monday morning, May 17, there will be medical sessions on basic considerations in tuberculosis; nontuberculous pulmonary diseases; environmental considerations in tuberculosis; laboratory developments; surgery in the treatment of tuberculosis, and nonpulmonary tuberculosis, and panel discussions on the epidemiology of cancer of the lung, the treatment of tuberculosis in infants and children, and changing concepts and modern treatment of tuberculosis. There will also be a number of small seminars on various aspects of tuberculosis treatment and research.

The general theme of the anniversary meeting will be "The Challenge of the Future." There will be a number of general sessions, the first of which will be Monday afternoon when the program will be built around "The People Against Tuberculosis — in Medicine, in Government, in Voluntary Agencies."

DOCTORS AND THE PRESS

The following article is from the Medical Annals of the District of Columbia by the Observer.—Editor.

Following the appearance of an item entitled "When a Reporter Calls" in the November, 1953, issue of the *Medical Annals,* your Observer received several communications and telephone calls. Their general tenor was that the advice given was much needed and worthy of repetition.

This was in part the inspiration for further comments on doctors' relations with the press. In your Observer's experience, physicians frequently become disturbed by the critical tone of medical news stories. Admittedly, some of them are disturbing because they contain erroneous statements which, if repeated often enough, come to be accepted as fact. But that is the exception rather than the rule. For there is nothing newspapers shun more than 'old stuff'; news must be up-to-the-minute and have what newspapers call reader interest. On the basis of these conclusions, the following is offered for the consideration of physician-readers:

1. There is nothing as perishable as a newspaper 'story.' Yesterday's news is all but forgotten except by a small minority who because of some personal interest recall what "stood in the paper." There are too many world-shaking events for an ordinary incident to hold more than fleeting attention.

2. Nothing can be gained by keeping alive controversial issues unless they are of such momentous nature as to warrant it. Issuing statements or writing communications to the editor usually serve only to stimulate those who disagree to write more statements and communications.

3. There is no such thing as having 'our side' presented to the exclusion of those who do not agree with us. Most newspapers endeavor to present both sides of an issue, but complete objectivity is rare, human nature being what it is. Reporters, as your Observer has written previously, are influenced in what they write by their background, experience and troubles.

4. It should not be necessary to state that doctors or their medical organizations are not infallible. They make mistakes like everyone else. Some of them are news and a few make the headlines. When this occurs, physicians should submit to the inevitable with good grace.

5. Without wishing to minimize the influence of the press, causes are seldom won or lost because of individual or sporadic news articles. Some years ago, upon the suggestion of the Medical Society, a local newspaper began an investigation of a medical institution with the result that shortly thereafter very critical and highly provocative articles appeared, directing attention to the deplorable conditions which existed in the institution. Six months later your Observer learned that nothing had been done to correct the situation, so he called it to the attention of the newspaper, which again published a series of excoriating articles. Under these circumstances one would think that public indignation would be such that something would be done; but the situation remained as it was for several months thereafter. Even today conditions at this institution are not what they should be.

Long and persistent effort is required to remedy as bad a situation as

this was, including the wholehearted and continuous support of one or more newspapers.

In the light of these observations, what should individual physicians and medical organizations do to obtain generally favorable treatment by the press? Here are a few suggestions:

1. They should see to it that the press has knowledge of all constructive efforts made by the medical profession to protect and improve the public health.

2. Where there are injustices, they should see to it that their 'story' is told at the proper time. Negativism, however, can only lead to public disapproval and an unfriendly press.

3. Wherever and whenever conditions warrant, officials of medical organizations should discuss frankly with press representatives the problems facing the profession. Under proper circumstances, this can also be done by individual physicians. In either instance, it may be desirable to do so for the purpose of providing background information only and not with a view of being quoted or credited with supplying the information.

While it is what medical organizations do and not what they say which counts most, it is important that they say what they have to say at the proper time. It is as simple as that!

After the event even a fool is wise.

Homer Iliad

A GOOD TIME FOR ALL

The Eli Lilly Company cordially invites the members of the Mahoning County Medical Society to visit its laboratories on May 19, 20, 21. Each member is urged to bring along his wife. Everyone will be guests of the Eli Lilly Company. The only obligation each member will have is his transportation to and from Indianapolis. Once in Indianapolis everything is on the house.

The new polio vaccine procedure along with many other pharmaceutical methods will be demonstrated.

There will be an added attraction on May 22nd. This will be the third day of time trials for the 500 mile race.

Please make your reservation immediately with Mrs. Herald at the Mahoning Medical-Dental Bureau.

TRENDS AND EVENTS

All Obligated Physicians Due for Active Service by July 1955

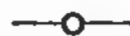
National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. This will remove them from the jurisdiction of their draft boards, and allow Defense Department to request delay in call for men the Department recommends for additional training.

This information is contained in a statement from Dr. Berry, in charge of medical and health matters for the Department of Defense. Dr. Berry also presented the results of a poll of medical school deans, who were requested to ask fourth year students the following questions: 1. If given free choice, which service would you prefer? 2. Do you prefer to serve your time immediately following internship? 3. Or following internship and one year of hospital training? 4. Or following full residency training? The results showed 27% of the students preferred the Army, 37% the Navy and 36% the Air Force. 39% preferred service immediately following internship, 15% preferred it after two years of hospital training and 46% preferred military duty after full residency training.

Audio-Digest Offers "Two for the Money"

Busy physicians cannot afford to pass up this opportunity to get "two for the price of one" in the form of postgraduate medical education and a chance to support the nation's medical schools. The American Medical Education Foundation recently announced that a new source of funds now is available to medical schools through physician-support.

State AMEF chairmen have been asked to support the national promotion of this new service as an additional means of raising funds for medical education. This should prove a tremendous boost to the AMEF's 1954 campaign drive for two million dollars from the medical profession to assist the country's 79-approved medical schools.



How many persons in your town have a family doctor? Judging from the results of a couple of Pennsylvania surveys, here's the answer: fewer than you probably realize.

A ten-month study completed in Philadelphia last year reveals that 639 of 1631 emergency calls during the period came from individuals who said they had no doctor—or, at least, no doctor in Philadelphia. And when Pittsburgh took a good look at the 179 calls its emergency service answered in a recent month, it found that people who claimed to be doctorless were responsible for 123 of them.

Obviously, as is pointed out in the discussion of emergency call programs that appears elsewhere in this issue, emergency callers aren't typical of the public at large. Most Pittsburgh and Philadelphia families probably do have a regular doctor. But there are plenty who don't.

And that's one more good reason for private medicine to keep up a high level of public relations and public education.

The Doctor and the Press

Doctors and representatives of the press may differ: The doctor searches cautiously for the exact truth. The press representative is interested in the exact truth immediately. The doctor is technical: "a compound comminuted fracture of the tibia and fibula." The press representative prefers simple words: "a broken leg." *Doctors and representatives of the press are alike, too!* Neither likes to be inferior to anyone. Both will fight against odds; one to help his patient, one to supply news to the public. Both prefer facts to rumor. Both like help on the difficult cases (as well as the easy ones). *In working with representatives of the press also keep in mind:* Do not ask for favors. Do not resent articles. Do not deny minor errors. Do not forget to say "thank you."

—Public Relations Committee, West Virginia Medical Association via Indust. Med. & Surg., July 1953

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Col. James H. Defandorf, Washington, specialist in chemical and biological warfare, FCDA, states new and highly toxic chemical warfare agents, such as the nerve gases, and the greatly increased speed, capacity and range of military aircraft make chemical attacks a serious hazard in critical target areas.

"Relatively few bombers would be required to saturate a large area with casualty-producing or lethal concentrations of nerve gas," Col. Defandorf reported.

American industrial might has been a major factor in winning two consecutive World Wars. No potential aggressor could contemplate a third global conflict without first planning to eliminate the sources of our productive power beforehand.

—o—

"In 1900, perhaps one-half of the industrial workers 20 years of age could expect to live to the age of 65," Dr. Dickinson said. "Now, more than four-fifths of them are destined to reach that retirement period.

"The decline in mortality during the working years of life has contributed greatly to economic progress. It has contributed to the solution of some social problems — the probability of becoming an orphan, for instance, has been cut in half."

—o—

Enlisted Status Proposed for Some Physicians

To make it possible to use suspected subversive physicians and dentists in noncommissioned rather than commissioned status, Defense Department is asking for new legislation. The bill, an amendment to the Doctor Draft act, would authorize the services "to utilize in his professional capacity in an enlisted grade or rank. . ." any person drafted or called to duty "who fails to qualify for or accept a commission, or whose commission is terminated." The bill is awaiting Budget Bureau approval.

A good name is rather to be chosen than great riches.

Proverbs 22:1

A.M.A. Puts Positive Program in Pamphlet Form

The testimony which President-elect Walter B. Martin read on January 28 before the so-called Wolverton committee, which is carrying on a fact-finding study of health problems, has been prepared in pamphlet form and is available from the A.M.A. Public Relations Department. All of Dr. Martin's testimony pointed to "a positive, constructive program of action" on the part of the A.M.A. To have his statement available in printed form is a valuable addition to current medical literature.

After performing autopsy, Corsican physician, Francisco Autommarchi, in 1821 reported scirrhous carcinoma of the stomach as the cause of death of Napoleon Bonaparte.

TO OUR MEMBERS

Our attention has been called to a new wave of magazine solicitations. For information on this matter, call the Executive Secretary of your Society.

CAPSULETTES

Hemoptysis in Mitral Stenosis

It would appear that pulmonary hemorrhage due to mitral stenosis has predominantly a mechanical cause, namely, the sudden pulmonary hypertension induced by increased influx of blood into the lungs without comparably increased outflow, in association with pulmonary arteriosclerosis and with venous and arterial bronchopulmonary varicosities. Brenner states that rheumatic inflamation of the pulmonary arteries is common; active rheumatic fever was present in 12 of the 50 cases of mitral stenosis with hemoptysis, reported by Wolff and Levine. Rupture of an inflamed artery would seem a credible consideration therefore in cases of mitral stenosis with active disease and hemoptysis. A final consideration, mentioned only for completeness, is that very debatable lesion, acute rheumatic pneumonia.

Joseph P. Looze, M.D.

A Rare Cause of Jaundice

Periodically, when causes of obstructive jaundice are being discussed, mention is made of compression or invasion of the common bile duct from adjacent lymph nodes bearing a malignant neoplasm. Cernock encountered such a case—secondary to cancer of the breast—and set out to see just how often such cases have been reported. In his review of medical writings since 1900, he found that only five similar cases have been described. It would seem that this cause for obstructive jaundice gets more attention than it deserves in discussions of differential diagnosis.

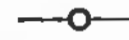
(Ann. Int. Med., 39:369, 1953.)

Life is one long process of getting tired.

Samuel Butler

A brief review is presented of the evidence for the view that estrogens may play an inciting role in the evolution of adenocarcinoma. That exogenous estrogens can produce microscopic patterns indistinguishable from early endometrial cancer and that estrogens cause hyperplasia would seem to leave no doubt. Yet even if we should accept as facts (1) that postmenopausal hyperplasia is related to the development of fundal cancer and (2) that estrogens can produce this hyperplasia, it would still be an unjustifiable syllogism to conclude that estrogens definitely cause adenocarcinoma. One must never forget the importance of the genetic and often-observed familial predisposition to cancer. This genetic factor is too prevalent to ignore, despite our ignorance as to how it works. Despite the lack of proof that estrogens play a definite role in the production of breast or fundal cancer, it would seem advisable to be particularly sparing in any use of estrogens when there is a strong hereditary background of cancer.

Novak, Jama



Efocaine, the vehicle used to prepare Efocaine, 5% butyl-p-aminobenzoate dissolved in the vehicle, polyethylene glycol (molecular weight 300), absolute ethyl alcohol, and 6% phenol destroyed both muscle and nerve tissues. After combined perineural and intraneural injection the changes are identical to those occurring after a nerve is sectioned but occur more rapidly. Regeneration of the nerves began at variable times but usually after 60 days after the use of all drugs studied except ethyl alcohol. Alcohol, phenol, Efocaine, and the vehicle in Efocaine cause anesthesia by nerve destruction rather than by blockade due to their anesthetic effects.

The salient gross and microscopic pathological changes useful in the diagnosis and differentiation of regional ileitis and nonspecific ulcerative colitis are reviewed. The two conditions are morphologically distinguishable, and they rarely coexist. In regional ileitis through a progressive sclerosing granulomatous lymphangitis, an edematous elephantiasic cicatrization of the entire intestinal wall, mesentery, and regional lymph nodes is produced. Ulcerative colitis is generally an exudative inflammatory condition mostly restricted in the colon to the mucosa and submucosa. It may be of indeterminate origin, or may arise by the submucosal coalescence of mucosal crypt abscesses or after intestinal infarction caused by necrotizing vasculitis. The involvement of many body systems suggests that ulcerative colitis may be a disease of the whole body. The etiological influences of disturbed lipid absorption metabolism in regional ileitis and proteolysis in ulcerative colitis are suggested as worthy of further investigation.

In the first century A. D., when Leonides performed mastectomy, surgery was recognized as the best curative procedure in breast cancer. However, few patients survived the primitive amputation in which red-hot irons were used as a crude form of cautery. Fortunately for the breast cancer patient of today, mastectomy has become less and less hazardous. Indeed, the operative mortality in mammary cancer has been estimated to be as low as one per cent. The patient with breast cancer, however, still has a long and arduous way to go to achieve a cure. Some of the obstacles that must be overcome

are inherent in the type of growth, some are created by the patient herself, and others result from lack of adequate medical management. The first hazard to the patient's chance of survival is delay in diagnosis.

Advantages and disadvantages of propylthiouracil

Advantages

(1) Effective and quite safe.
(2) Relatively inexpensive.
(3) Little morbidity—practically no mortality.
(4) No secondary complications.
(5) Better for areas without skilled thyroid surgeons.
(6) Avoids an operation.

Disadvantages

(1) Use necessitates long-continued supervision.
(2) Impossible to foretell remission in any individual case.
(3) Serious toxic reactions may occur.

Advantages and disadvantages of radioiodine

Advantages

(1) Simple and effective.
(2) Inexpensive.
(3) No operation needed.
(4) Use requires less medical supervision than surgery or propylthiouracil.
(5) Nearly devoid of complications.

Disadvantages

(1) Requires special facilities and personnel—not generally available.

(2) Difficulty in estimating correct dose gives high incidence of post-therapeutic myxedema.

(3) Potential danger of producing thyroid cancer.

(4) May cause exacerbation of symptoms following treatment. (May be circumvented by first giving propylthiouracil.)

PERIODICAL PEARLS

Erythrocyte Sedimentation Rate In Gastrointestinal Diseases

Erythrocyte sedimentation rate estimations were performed on 480 consecutive patients whose complaints were essentially gastrointestinal in character. The Westergren method was used and the uppermost limit of normal was considered as 22 mm. per hour. The entire series was divided into three groups:

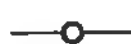
In the patients of the "functional" group, the lowest sedimentation rate figure was 2 mm. per hour, the highest 53 mm. per hour and the average figure was 11.7 mm. per hour.

In the "organic benign" group the lowest figure was 2 mm. per hour, the highest 90 mm. per hour and the average 18.9 per hour.

In the "malignant" group the lowest figure was 8 mm. per hour; the highest 110 mm. per hour and the average 43.9 mm. per hour. Thus, it is seen that the functional and benign organic lesions of the gastrointestinal

tract as a group almost invariably reveal sedimentation rate figures which fall within the normal limit while the malignant lesions show a figure almost invariably above the normal, not infrequently very much above the normal.

Emanuel W. Lipschutz, M.D., F.A.C.P.
Rev. Gastroenterol., November, 1953



Pruritus

Itching is a common symptom of many dermatoses. The presence or absence of pruritis may be an important diagnostic indication. For instance, with a florid eruption in which itching is absent, syphilis should be strongly suspected. Lack of pruritis is also characteristic of parapsoriasis. Most eczematous eruptions itch, as do many other dermatoses, such as lichen planus, dermatitis herpetiformis, etc. In all such cases, the itching can be explained on the basis of the apparent dermatosis. It is a different matter when a patient presents no eruption but complains, often bitterly, of severe pruritus, which may be localized or generalized. It is important to remember that pruritus may be an early symptom of such diseases as nephritis, cholecystitis, diabetes, and particularly of carcinoma. It may occur in pregnancy. It is therefore important in all instances of unexplained pruritus to investigate carefully the various systems in order to make certain that a major error or omission is not made. This applies particularly to generalized or extensive pruritus. In local pruritus, such as pruritus ani, a somatic causative factor is not often discovered.

George M. Lewis, M.D., F.A.C.P., "Practical Dermatology"
Saunders, Philadelphia, 1952

Clinical Note

Protrusion of an intervertebral disc may be confused with the thoracic outlet (scalenus anticus) syndrome, for in both conditions arm pain is the most prominent symptom; tenderness and spasm of the scalenus muscle may also be present in both disorders. Differentiation may be made clinically by the performance of 2 simple maneuvers. In cervical disc the pain may be reproduced by exerting pressure upon the top of the head with the head tilted back and to the side of the pain. In the scalenus syndrome the pain may be reproduced by turning the face toward the side opposite from the pain, depressing the shoulder on the affected side, and having the patient take a deep breath. Pain and numbness from a disc is more apt to involve the thumb and 1st finger; from scalenus syndrome, the 4th and 5th fingers. A cervical disc may protrude in the midline, giving rise to signs indicative of spinal cord compression and at times giving rise to signs closely resembling syringomyelia, posterolateral sclerosis, and amyotrophic lateral sclerosis. A cervical myelogram should be done on every case of spinal cord disease in which the diagnosis is doubtful, because remarkable improvement may be possible if a cervical disc can be removed, and tragedy may result if it is not.

Bull, New England M. Center

For a man by nothing is so well betrayed as by his manner.

Edmund Spenser

Septic Pulmonary Infarction

Septic pulmonary infarction occurs when an infected thrombus arising in a peripheral vein or the right side of the heart becomes dislodged and enters the pulmonary circulation. The infarct is infected from the beginning, in distinction from the occasional case of a noninfected infarct that becomes secondarily infected by contamination through the bronchial tree, resulting in the development of an abscess. This concept of septic pulmonary infarction excludes cases of septicopyemia in which multiple abscesses may occur in the lungs as well as elsewhere.

The sources of the septic emboli are (1) acute bacterial endocarditis involving the right side of the heart; (2) septic thrombophlebitis of the internal jugular vein or its branches following pharyngeal infection or infections of the head and neck; (3) septic trombophlebitis of the pelvic veins following abortion or pelvic infection; (4) septic thrombophlebitis involving a peripheral vein, especially the arm veins in narcotic addicts.

The clinical manifestations are those encountered in septicemia and include intermittent fever, chills, sweats, and prostration. There is usually a polymorphonuclear leukocytosis, and blood cultures are frequently positive for staphylococci or streptococci. Pleural pain, cough, hemoptysis, tachpnea, purulent sputum, and pleural friction rub characterize the respiratory findings. In most cases, detection of septic infarction precedes or leads to the discovery of the septic thrombophlebitis or acute bacterial endocarditis involving the tricuspid or pulmonic valve. The diagnosis of right-sided valvular endocarditis depends on the presence of pulmonary infarcts in a patient with septicemia without any peripheral source for emboli.

The x-ray appearance of the pulmonary lesions is variable. As a matter of fact, the chest x-ray early in the course may be negative. Bronchopneumonia or lobar pneumonia may be simulated. Multiple, rather than single lesions appear. As in any type of pulmonary infarct, there are no characteristic findings before the phase of necrosis. Opacities of variable size and shape may occur. Closely grouped infarcts may overlap or coalesce, resulting in a picture resembling pneumonia. The septic nature of the infarcts is demonstrated by the development of central rarefaction, indicating abscess formation. The presence of a fluid level indicates that the abscess communicates with a bronchus. An area of pneumonitis may surround the septic infarct. The infarct can enlarge peripherally due to increasing tissue destruction, and extension to the pleura results in extensive pleuritis or even empema. With successful therapy the lesions may resolve completely, or they may leave an area of pleural thickening or a strand of pulmonary fibrosis.

Therapy with antibiotics has influenced the evolution of septic pulmonary infarcts. Necrosis with cavity formation may not occur when effective treatment is started early; then the x-ray appearance of septic infarcts may be indistinguishable from that of bland infarcts.

G. P.

Interpretation of Chest X-rays

In a study by Yerushalmy it was determined that in judging a pair of x-ray films for evidence of progression, retrogression, or stability of disease, two interpreters are likely to disagree with each other in about one-third of the cases. A single interpreter reading the same film on different occasions is likely to disagree with himself in about one-fifth of the film pairs. Further analysis indicated that when two interpreters place a film pair in the same category, there is a very high probability that that category is the true one. This is the greatest advantage of such dual reading in that it provides a means of identifying pairs on which a diagnosis can be given with complete confidence.

With regard to the one-third of the film pairs in which there is disagreement by two readers, two modes of approach are available. The first is to leave them in the status of "roentgenographically indeterminate." After passage of some time, additional information may be provided by another x-ray which will give more definite information when compared to the previous film. The other approach is to submit the films with the inconsistent diagnosis to a third interpretation and to accept the results of two out of three agreements as the correct one.

(Dis. of Chest, 24:133, 1953.)

—o—

Fibrositis and the Disc Syndrome

Fibrositis often causes pain which can be mistaken for a ruptured intervertebral disc, according to a recent report by Long and Lamphier. The nature of fibrositis is somewhat obscure, and its characteristics have been described differently by various authors. It is a frequent cause, in industrial practice, for severe low back pain. The pain, sudden and severe, may follow such a simple exercise as digging or bending over to pick up a golf ball. It has been said to be caused by the herniation of fat lobules through weakened fascial tissue, due either to congenital weakness or to trauma. The same type of pain following similar exertion is attributed to disc disorders by many writers.

The authors attempted to rule out the presence of a ruptured disc in a series of fifty-one cases in which a diagnosis of fibrositis was made, by injecting the involved muscle groups with a local anesthetic. Eighteen of the patients had had previous back troubles. Thirty-one had been seen by other doctors, and in twenty-eight, a diagnosis of ruptured disc had been made. After injections with the anesthetic agent, thirty-six recovered following one or more infiltrations plus physiotherapy. They were returned to work, and the complex studies and treatment for a ruptured disc were avoided. The authors recommended that such conservative treatment be employed before considering myelographic studies and surgical exploration.

(Am. J. Surg., 86:414, 1953.)

We don't know one millionth of one per cent about anything.

Thomas Edison

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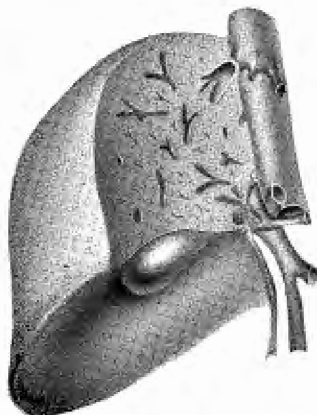

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