BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

MAY • 1954
Vol. XXIV • No. 5

Fellows

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liquid and capsules

The superiority of Vitamin B Complex derived from natural sources has been well established. Jolliffe[1] has attached special importance to this subject and Lewey and Shay[2] have stressed the necessity for natural substances.

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formula:

Each Teaspoonful (4 cc.) contains:

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Riboflavin	3.5 mg.
Niacinamide	25.0 mg.
Pyridoxine (B6)	0.056 mg.
Calcium Pantothenate	2.5 mg.

plus Choline, and other factors of the B-Complex present in the natural base. The Riboflavin content is derived entirely from natural sources.

BASE: Rice Bran, Corn, Liver Concentrate.

SUPPLIED: in 4-oz. Rx size.

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Choline Dihydrogen Citrate	20 mg.
Inositol	20 mg.
Folic Acid	0.25 mg.
Liver Extract (secondary)	100 mg.
Brewers' Yeast Extract	100 mg.

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

BASE: Liver and Yeast.

SUPPLIED: in 50's and 1000's.

1. Jolliffe, N., Special Article, Council on Foods and Nutrition: The Preventive and Therapeutic Use of Vitamins, J.A.M.A., 129:618, Oct. 27, 1945.
2. Lewey and Shay, Dietotherapy, Philadelphia, W. B. Saunders Co., 1945, p. 850.

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OFFICERS AND COUNCIL

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ADVERTISERS' LIST

Our President Speaks

THE PHYSICIANS' RESPONSIBILITY TO ONE ANOTHER

At the recent meeting of The Ohio State Medical Association in Columbus, Ohio, it was my privilege to attend several sessions on Public Relations and the role that the Grievance or Mediation Committee should play at each county society.

Because of frequent findings in the work of the Mediation Committee in societies all over the state that fell into a common pattern, it is the purpose of this editorial to inform our society of just one such factor, which is, careless criticism of another's work.

About 90 per cent of complaints brought before the Mediation Committee, were based upon some physician's loose talk about a colleague which inferred that his work was not satisfactory. The patient remembers almost every word the doctor utters and uses these criticisms or statements that have been said against one another as a basis of their complaint or intended suit.

It seems to me, as I listened to all the speeches in Columbus regarding such matters, that it behooves us to speak carefully at all times, lest we bring a colleague into disrepute without intending to do so.

Anyone who has practiced for any length of time knows that in due course we will all make a mistake somewhere along the line. As a profession, the public does not think too highly of us anyhow at the present time and I feel we should at all times speak with care and not give the public any reason to unjustly condemn us. We must of necessity stick together and be willing to be helpful one to another.

James D. Brown, M.D.

BULLETIN of the Mahoning County Medical Society

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EDITORIAL

PHYSICIAN, HEAL THYSELF

The physician and his family receive the most inadequate medical care. This was again demonstrated when Dr. Merrill Shaw of Seattle could not appear at the Sixth Annual Assembly of the American Academy of General Practice. He was the academy's vice-president but he could not assume his duties because he was home fatally ill. This may have been avoided as Dr. Shaw admitted had he had a personal physician to whom he should have been going for regular complete physical examinations.

It is about time we physicians start to practice what we preach and also remember what is good for our patients is good for ourselves and our families.

It is the physician's responsibility to his family, to his patients and to himself to protect his health. In this way, he will be able to work more efficiently and live longer for his family and his patients.

Every physician and his family must have a personal physician to assume the medical responsibility for the entire household. This should be an **active responsibility and obligation.** This would cut early physician mortality and protect his family's health.

Each doctor must rid himself of the foolish notion that he is imposing upon his colleague. Any physician would be flattered and pleased to be consulted by a fellow-physician.

A. A. Detesco, M.D.

THE DEAN'S PAGE

One occasionally hears that today's medical students are not concerned with their future obligations to society and to their profession. Not infrequently they are thought of as a group anxious to enter the practice of medicine as soon as possible so that they can become a part of the flourishing economic scene and make up for the hardships which they experienced as students.

Most likely, some of the students have a mercenary or selfish point of view. It is refreshing, however, to learn that the medical students through their own organization, The Student American Medical Association, have asked that the medical schools include courses in medical ethics and supporting moral principles in the curriculum for the ultimate best interest of the medical profession and the public. Dr. E. J. McCormick, President of the American Medical Association, has made a similar plea. All of this speaks well for the profession and future leaders, many of whom will come from the ranks of the Student A.M.A.

The great majority of today's medical students possess high ideals. If these ideals are nourished by medical educators and the leaders in the profession, they will inspire the profession to achieve higher levels of service. All of us have an obligation to foster this growth of professional ideals by precept and example.

A realistic understanding of the moral and social obligations of the profession and a willingness to interpret them in our daily practice will create the best public relations program. Service of impeccable quality readily available from all of us must be our goal and the medical students as the physicians of tomorrow should be encouraged to achieve it.

John S. Hirschboeck, M.D.
Dean, Marquette University School of Medicine
Milwaukee, Wisconsin

This message was written expressly for the Mahoning County Medical BULLETIN.—Editor.

CEREBRAL PALSY

Oscar A. Turner, M.D.

The term cerebral palsy, in general usage, implies a state of paralysis or partial paralysis secondary to cerebral damage, and is frequently used to denote cerebral damage which is incident to birth or to neo-natal injury.

The object of the recent interest in this condition is an attempt to give these handicapped children every advantage to develop physically, intellectually, and emotionally, as much as possible, and as much as is consistent with the undamaged nervous system. Of most importance, therefore, is the necessity of properly evaluating the motor, intellectual, and speech disability involved, as well as the capabilities of each child individually. It is of utmost importance that this be undertaken before embarking upon a long, expensive, and unremitting program of training.

The incidence of cerebral palsy has been variously estimated at from 6 to 7 cases born each year per 100,000 population, to 1 person below the age of 18 years in every 1,000 population. The etiologic factors include any process — vascular, inflammatory, neoplastic, congenital, or traumatic — which may involve the motor or pyramidal system. The list of such conditions is obviously too long to enumerate here, but the following outline taken from date given by Courville summarizes the major etiologic agents.

I Antenatal Disturbances
- A. Maternal Disturbances (toxic, circulatory, or infectious)
  1. Accidental X-radiation
  2. Toxemia of pregnancy
  3. Measles
  4. Toxoplasmosis
  5. Syphilis
  6. Uterine infections
  7. Anemia
  8. Shock
- B. Disturbances of Placental Circulation or Blood
  1. Anemia
  2. RH Factor
  3. Malposition of placenta
  4. Syphilis
  5. Umbilical cord disturbances of mechanical nature

II Paranatal Disturbances
- A. Asphyxia neonatorum) with or without
- B. Birth injury) prematurity

III Post-Natal Disturbances
- A. Infectious (encephalitis, scarlet fever, etc.)
- B. Circulatory disturbances (thrombosis, etc.)
- C. Toxic states (Jaundice of erythroblastic origin, etc.)
- D. Traumatic
- E. Tumors (rare)

IV Congenital Defects, not associated with above, i. e., vascular malformation, cortical agenesis, microcephaly.

Despite the variability of the clinical syndrome and the causes listed above, two major types of disturbance are found. The most frequently encountered are the *cortical syndromes* which vary from the simple monoplegia

(involving a single arm or leg) to the severe quadriplegia or the so-called "double hemiplegia" the degree and extent of the disturbance dependent upon the distribution and severity of the cortical damage. A second group, almost as large as the above, are those with damage to the *corpus striatum,* this involving the extrapyramidal system and occurring as an independent symptom complex or in association with the cortical syndrome. In this group are found those children with symptoms of athetosis, choreoathetosis, the hyperkinetic syndromes, all of which add to the problem of physical rehabilitation. In either of the above may be present associated speech disturbance and not infrequently convulsive seizures, both of which not only add to the problem, but aggravate the pre-existing retardation and disability.

In the light of the above, the prognosis as well as the therapy must depend upon careful and most complete evaluation of each individual case. The following has been generally recognized as the minimum workup of a case of cerebral palsy, and without it no child with cortical and/or extrapyramidal system damage can be considered as having received the proper foundation for intelligent and effectual treatment of the disability.

1. Complete clinical history
2. Complete general physical and neurologic examination
3. Psychological testing for evaluation of intellectual capacity
4. Psychological study for evaluation of emotional state and/or emotional problems
5. Evaluation of the type and extent of speech disturbance
6. Dental examination

Special examinations, such as electroencephalography, x-ray of the skull, and pneumoencephalography, are very often required to bring to light the extent of the damage or for completion of study where the etiologic factor is obscure.

From the above it can be seen that the problem of cerebral palsy is a complex one which needs the combined efforts of many individuals with various talents, — most of all the individual who must accept the key responsibility — the family physician. Nothing can be gained by relegating the responsibility for treatment of an incompletely studied patient into the hands of a physiotherapist technician except the expenditure of considerable time, effort, and money. Likewise, massage either manually or given by some electrical gadget is no substitute for intelligent therapy based upon careful study of the patient's organic and functional defects. Such shortsighted treatment is not only a waste of valuable time but plays cruelly upon the parent's hopes and expectations. Persistent treatment of a patient with a major intellectual or emotional defect is wasted effort, and those patients with handicaps so severe as to be uncorrectable must be recognized. Evaluation of the neurologic problem without consideration of the orthopedic disturbance will do the patient little good and the reverse is just as true.

For determination of prognosis, Courville has divided these individuals into four major groups and the recognition and placement in the proper group is considered by the writer to be the prime factor in the intelligent handling of these cases.

Group 1 — Patients with relatively minor disability, who require little or no special training to fit into the average social, intellectual, and economic environment.

Group 2 — Patients who with special treatment and training can become self-supporting and made to fit into the average environment with minor reservations.

Group 3 — Individuals with palsy who can be trained to be self-contained by taking care of their own physical needs, or who may help about the home, but who can never be totally self-supporting or self-sufficient.

Group 4 — Patients who have so severe a physical handicap as to be uncorrectable and/or an intellectual deficit so severe and profound as to be beyond the influence of educational measures. These individuals can be considered as completely helpless and entirely dependent upon others as long as they live.

Disjointed and uncoordinated efforts at treatment of these patients has in the past wasted much time and money and accomplished little. The recent campaign for improvement of these children, like so many previously publicized money raising efforts, has concentrated upon the money raising efforts and little has been said concerning the plan or means of using that money — particularly at the local level. The collection of funds from the public implies a promise — a promise that the monies collected will be used wisely, effectually, and where the greatest amount of good can be obtained, particularly at the local level where the money is collected. It seems to the writer that there remains much to be done to fulfill these obligations by those who initiate many of the fund raising campaigns.

(1) Courville, C. B.: *The Problem of Cerebral Palsy*, Bulletin Los Angeles Neurological Society, 1953, 18, 157.

—o—

Coitus is not responsible for the various complications of late pregnancy, delivery, and the puerperium frequently attributed to it — particularly on a charity obstetric service. Thus, there is no necessity for emphasis on abstinence during the final weeks of pregnancy.

Pugh, William E., and Fernandez, Frank L.
Obst. & Gynec., December 1953.

—o—

A tumor of the kidney or bladder is the most common cause of painless or symptomless hematuria. Cystoscopy, as a diagnostic procedure, should be performed immediately, during the time of the actual bleeding.

Stambaugh, E. L.: Med. Times, March 1954.

—o—

Many cases of staphylococcal sepsis, unresponsive to penicillin because of the development of resistant bacterial strains, respond effectively to treatment with the new antibiotic, Erythromycin.

Shoemaker, E. H. and Yow, E. M.
A.M.A. Arch. Int. Med., March 1954.

"Delay is responsible for more failures, more lack of success than any other circumstance."

Alex Lewyt

"The most underdeveloped territory in America is under men's hats."

Norman Dryden

PROCEEDINGS OF COUNCIL

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, April 19, 1954 at the office of the Society, 202 Schween-Wagner Bldg., Youngstown, Ohio.

The following doctors were present: J. D. Brown, President presiding, I. C. Smith, M. W. Neidus, S. W. Ondash, G. E. DeCicco, F. G. Schlecht, Asher Randell, E. R. McNeal, C. A. Gustafson, V. L. Goodwin, A. K. Phillips, comprising the Council.

Dr. Brown read letters from the Nurses' Alumnae of Youngstown Hospital and St. Elizabeth's Hospital regarding their problem of allowing Practical Nurses to wear caps and uniforms which would in no way show distinction between the Practical and the Registered Professional Nurse. Dr. Brown asked the Secretary to answer the correspondence.

Dr. McNeal, Chairman of the Arthritis Committee, reported the activities of his committee to date.

Council was of the opinion there was great need of research in this field, but at this time the local facilities were adequate and additional funds for local purposes were not needed.

A motion was made, seconded and duly passed, that "the Society go on record as favoring a fund raising drive, providing the funds are used for National Research purposes only."

Dr. DeCicco discussed the problem of physicians referring patients to a specialist for consultation and that in some instances, the physician to whom the patient has been referred, fails to report back to the referring physician. Council passed the following resolution.

Be it resolved that: "When a physician refers a patient to another physician for consultation, the physician to whom the patient has been referred should send a report to the referring physician. In no instance should the second physician refer the patient to another physician but instead should refer that patient back to the original referring physician." The resolution is to appear in the next news letter going out to our members.

An underground Civil Defense Center was discussed. Some plans are being made by Mr. Robert Hay, Youngstown-Mahoning County Civil defense director, to set up an underground civil defense communications center and disaster governmental offices at Mahoning Tuberculosis Sanitorium. Some opposition to the plan has been met by City and County officials. Under the plan, they are asking $5000.00 from the City and $5000.00 from the County. The Commissioners advised that contributions from the County cannot be made before the end of the year, if then. Mayor Kryzan opposed the plan on the ground that it would mean making the sanitorium a A-1 target.

A motion was made, seconded and duly passed, to refer the matter to the Medical Advisory and the Civil Defense Committees.

Dr. Rappoport and Dr. LoCricchio, Chairman of the Blood Bank Committee of the Mahoning County Medical Society, submitted the final set-up for a Blood Bank Club for approval of Council. Council approved the plan and the following motion was made, seconded and duly passed. "That two copies of the plan be submitted to Mr. Endres and Dr. Rummell, Youngstown Hospital Association and Sister Adelaide of St. Elizabeth's Hospital for their approval. If they approve the plan, they are to keep one copy for their

files and sign the other and return to us. Our committee will then take the necessary steps toward creating a joint coordinating committee with responsible members of the hospital blood bank staff.

Dr. Schlecht in discussing the dinner dance to be held May 8th, suggested favors for the ladies. Council instructed Dr. Schlecht to arrange for favors for the ladies.

The following applications were presented by the censors:

FOR ACTIVE MEMBERSHIP

Dr. James L. Calvin, 3119 Market Street, Youngstown, Ohio

FOR JR. ACTIVE MEMBERSHIP

Dr. Marie Louise Porter, 404 Terminal Building, Youngstown, Ohio

FOR INTERNE MEMBERSHIP

Dr. Lloyd G. Foster, North Side Hospital, Youngstown, Ohio

Dr. Emmeleine E. Ferguson, 204 Francis Street, Youngstown, Ohio

Unless objection is filed in writing with the Secretary within 15 days, the above become members of the Society.

The dinners for speakers previous to the regular monthly meetings were discussed.

A motion was made, seconded and duly passed, that the Society pay for the Speaker, and the members pay their own expenses.

The result of the voting on where our meetings will be held, was as follows:

94 Elks Club and 79 Youngstown College.

G. E. DeCicco, M.D.
Secretary

AUXILIARY NEWS

Over 125 Mahoning County high school girls interested in making nursing their career, were entertained as guests at a tea at St. Elizabeth's Hospital March 16th, with members of the Women's Auxiliary to the Mahoning County Medical Society presiding as hostesses.

During the meeting of the Auxiliary the girls were taken on a tour of the hospital and nurses' home and the advantages and requirements of nursing as a career were explained to the girls.

Mrs. W. E. Maine, program chairman for the day, introduced Dr. Pauline Powers, teacher of the blind at Chaney High School, who gave a very interesting talk on Braille. Miss Shirley Condriet of Niles, a sophomore at Chaney, gave an excellent demonstration of Braille.

Following the meeting Mrs. Patrick Cestone, social chairman for the day, and her committee served a very lovely tea to the girls and the Auxiliary members. The tea table was decorated with a silver bowl of green carnations and white gladioli between silver candelabra carrying out the St. Patrick's Day theme.

There were five members of the Auxiliary who attended the annual meeting of the Women's Auxiliary to the Ohio State Medical Society in Columbus, April 12-15. Mrs. Morris Rosenblum, president, and Mrs. Ivan Smith, president-elect, were delegates; Mrs. W. H. Evans and Mrs. W. E. Maine, alternates.

(Continued on Page 283)

COUNCILOR'S PAGE

At no time previously have our people been as conscious of social obligations as we are now. The number of civilian organizations for education, relief and prevention of special diseases, furtherance of art, music and drama, etc., is increasing constantly. With this widespread interest in human welfare there is, however, no abatement of drinking, gambling, crime, licentiousness and vulgarity. One would expect these evils to decline as a result of the information given and made available by these welfare groups and by the contacts that attend their efforts.

These organizations are admirable and efficient, and though non-political, are an adjunct of government. Yet we have wondered if the influence of the individual self has not been sacrificed when it became submerged into group activity. Not only may an influence be lost, but the individual may have transferred his interest and responsibility to the group and thereby impoverished himself.

The early Hebrews were aware of the value of personal service: "Withhold not good from them to whom it is due, when it is in the power of thine hand to do it." It remained with them a strong element in character building; but later, embodied in the law and worn as a phylactery, it became a dangerous deception. We do not put our faith in phylacteries; we join movements, support drives, contribute to causes, and go cheerfully along our way.

In our enthusiasm for democracy and the fruits of freedom, we must not forget that human excellence is not an accident. Circumstances influence the attainment of excellence and its recognition; but the capacity to attain and the incentive to accomplish are individual. That the group may attain its objectives, it must first resolve itself into individuals, each with his own inducement.

C. A. Gustafson, M.D.

AUXILIARY NEWS *(Continued from Page 254)*

Mrs. Craig Wales, state chairman of Civil Defense, was moderator for a panel discussion with Mrs. Rosenblum and Mrs. Morton Crow of Trumbull County participating.

Mrs. W. H. Evans, state chairman of Nurses Scholarship and Loan Fund, acted as moderator for a panel on nurses recruitment with Mrs. Ivan Smith a member of the panel.

Mrs. W. E. Maine, state chairman of Radio and Television, announces that the Auxiliary is sponsoring a series of programs on *"Lives of Great Composers."* Starting April 23rd, these programs will be heard on *WFMJ* each week for thirteen weeks at 10:45-11:00 p.m. Dr. W. W. Bauer gives the bright highlights of the life and struggles of the composer whose music is being heard. Hope you will all be listening!

Jane B. Brown
Publishing Chairman

"Today's goal can be tomorrow's starting point."

P. Rogers

"Nothing is so empty as a day without a plan."

Anonymous

It is difficult to change nature.

Seneca

A HISTORICAL REVIEW OF THE MEDICAL-DENTAL BUREAU, INC.

by R. B. Poling, M.D.

From the days of Hippocrates, it has been the prime ethic and central thought of members of the Medical profession to render services of the healing art to all mankind. This has been provided regardless of the economic status of the individual, race or creed. The mere recognition that he or she is a human being has been sufficient prime facie evidence for a claim to the healing arts.

In due time, there was developed a change in social and scientific affairs. This change created greater demands of members of the healing arts and sciences and required infinitely more preparation and facilities on the part of those who dispensed these services. It seemed that the general populous failed to recognize this but continued to consider medical indebtedness of secondary importance.

In spite of the generosity and unbusiness-like approach of the medical profession, the great depression precipitated a crisis. It is common knowledge that there was not a sufficient amount of currency to cover the peoples indebtedness in the majority of instances. As a result the customary thing to do was not to share the small income with those who made the least demands on it. It was usually the medical attendant who made the least demand. This became a serious matter because members of the medical profession were unable to meet operating expenses in many instances, thus endangering the general public to the lack of proper medical care. Relief organizations were established but these were quite inadequate and cumbersome. The practicing physician was caught in a dilemma.

For several years following the devastating stock market crash in 1929, plans were in the making to improve the business phase of the medical profession in keeping with proper consideration of the general public. Always the foremost thought was given to the public welfare. This process reached a climax during the year when Dr. A. E. Brant served as president of The Mahoning County Medical Society.

To unveil the thinking of the early days of the depression some quotations will be made from the Medical Bulletin of the Society.

In January, 1932, Dr. Brant stated that "no single person but has been affected by direct financial loss or decreased income!" He further stated that "I wonder what it is that we have to be coaxed, urged and so often forced and threatened into doing the things we know are for our own good."

"You know that in these shifting times of national crisis, economic stress, blocs and political differences, it behooves us to think somewhat of ourselves.

"It has been proven without a doubt that nothing can be accomplished without an efficient organization which will function well under any and all conditions. It is apparent, to some extent at least, that we must cast aside our cloak of indifference and respectable aloofness and get into the game. It does no good in isolated groups to air our grievances, rant about injustices, discuss with dismay the question of State Medicine and an unappreciative public, unless to blow off steam. It does do good to give these questions real thought, to honestly analyze them and to act constructively even though the benefits we expected may only come several years hence. If we are wrong, let us enter into a program of correction. If the public is

wrong, let us educate them. How, really, can we expect our friends and others to do things for us, when we make no attempt ourselves, or not even intelligently inform them? An organization in the business world that wants something goes after it. Why can't we, and still maintain our ideals and self respect? We can.

"This is not a depression letter but an earnest expression of the thought that we are not making the most of a great opportunity to better ourselves, and of also taking steps that necessity demands for our own welfare.

"Let us all give serious consideration to the trends of the times, how we can keep pace and not be lost in the shuffle."

Secretary Dr. Wm. Skipp reported in June 1932 that "since the first of May, your council has met regularly every Monday for discussion and being advised on ways and means of opening our own Collection Bureau, central office, telephone exchange."

In July 1932, Dr. Wendell H. Bennett, chairman of the central office committee, made a comprehensive report on the progress that had been made towards the planning of a central office for the Mahoning County Medical Society.

Dr. James L. Fisher, editor of the Bulletin, stated that, "To consider the first reason for medical organization, surely there is no doubt that the public will benefit through increased efficiency if we have our own Central Office with a telephone exchange handling our calls with supplies of culture tubes, vaccines and sera on hand. Where will our organization be when State Medicine comes, and we firmly believe that it will come sooner or later?"

In his president's page in January 1934, Dr. J. B. Nelson stated that "Murmurs of prosperity are once more audible. To make a metaphor, we wonder if he (Prosperity) will again knock at the physicians door, and in what form he will appear. Will he be dressed as in former years, or will he wear the garb of health insurance, or the guise of definite social medicine? These things are to be thought about for there is real cause to consider that they will be of importance in our activities before many months have passed. There never was a time when unity of action was so imperative, for it is likely that we shall have to ask for what we want from this time on. I am afraid that for us there will be no manna from Heaven. Keeping in mind always our responsibilities, both to the community and to ourselves, I pledge to the Society my best efforts."

The central office committee as well as members of Council gave a great deal of effort and time in the attempt to realize this feature. It was deemed a necessity because of the many and various issues and questions that required attention. An executive secretary to manage the activities of the central office was deemed important. Our society had expanded and grown which is the reason that busy practitioners of medicine found a limited amount of time to execute all details involved. Discussions to establish the above functions were continued through most of the year.

Because of differences of opinion in regard to the mode of operating a bureau for all functions this issue was delayed but not forgotten.

In 1934 when Dr. J. B. Nelson was president of the Mahoning County Medical Society, an attempt to establish a central business office for the members of the County Medical Society again took root.

A committee was appointed with instructions to develop a modus operandi for organizing a central business office. Various plans were considered with the aid of men who had had experience in this field.

A desire of the practitioners of medicine and dentistry over a period of many years for a central business office to facilitate the proper handling of the economic phase of their practices became a reality.

A group of fourteen physicians meeting as individuals and acting upon their own initiative voted to sponsor the formation of a business organization, and sought the support and cooperation of all eligible physicians and dentists in Mahoning County Medical Society and the Corydon-Dental Society.

On March 15th, 1934, a general meeting of forty-seven representative physicians and dentists was held under the chairmanship of Doctor R. B. Poling. After much discussion by the doctors present, a plan was adopted and the establishment of a bureau was begun. The Medical-Dental Bureau was legally incorporated May 18th, 1934. The first directors were: Doctors S. M. McCurdy, W. H. Hayden, J. H. Chessrown, H. E. Hathhorn, W. M. Skipp, J. B. Nelson, and R. B. Poling.

The following officers were the first to serve the Bureau, Doctor S. M. McCurdy, President; Dr. W. H. Hayden, Vice-President; and Dr. H. E. Hathhorn, Secretary and Treasurer. A membership committee under the chairmanship of Dr. Paul Fuzy was appointed, and 97 members were enrolled in ten days. From that time on the growth of the organization was rapid and on June 4th, 1934, offices of the Medical-Dental Bureau were officially opened at 801 Central Tower. On July first, 1934, the collection department was inaugurated, and on September first, 1934, the credit rating and physicians' telephone exchange departments were put into active service. The Medical-Dental Bureau now has a membership of two hundred and sixty, and the offices are now located at 202 Schween-Wagner Building, 125 W. Commerce St. The purpose of the Bureau is to perform any and all services related to or connected with the Medical and Dental professions which are non-professional in their nature, and that may be strictly limited or defined as business duties or services.

Other services perhaps less important to the patients but desirable from the doctors point of view is a credit bureau whose records enable the doctor to determine the eligibility of patients to pay. Also, doctors, through our Bureau, give their patients the benefit of paying accounts through our Auditing Department before they are recorded against their credit. This service has proved very beneficial to the patients.

All physicians and dentists who are members in good standing of their respective societies are eligible to membership in the Bureau. The most important to both the community and the doctors is our 24-hour telephone answering service, which serves such groups as the Cancer Society, the Red Cross and many others.

In addition the residents of this community who have taken advantage of this service in the past, know its value. When an emergency arises in a family, the Medical-Dental Bureau will be able to find a physician or a dentist to give the services needed.

It has been a great influence in promoting better business methods, sensitizing the public to the importance of proper physician-patient relationship, and it has served as a focus for many facets of professional and business activities in this community.

PERSONAL PATTER

Have you heard....

That Dr. David Gitlin is now associated with Dr. L. Jay Goldblatt in the general practice of medicine in the Central Tower?

That Dr. Hugh N. Bennett is convalescing at home after leaving the North Unit of the Youngstown Hospital Association? While a patient, Dr. Bennett successfully completed the Part II examination of the American Boards of Internal Medicine, and he will return to his practice this September as a Diplomate of the American Board of Internal Medicine.

That Dr. David R. Brody and Dr. Robert L. Tornello were certified as Diplomates of the American Board of Surgery in March of 1954 after successfully completing the Part II examination of the American Board of Surgery?

Have you met....

Dr. James L. Calvin who became an Active member of the Mahoning County Medical Society in March? Born in Salineville, Ohio, in 1923, Dr. Calvin received his medical education at Western Reserve University and graduated in 1947. His internship was spent in the Grasslands Hospital in Valhalla, New York from 1947 to 1948, and his medical residency training was obtained in the Youngstown Hospital Association from 1948 to 1951.

The U. S. Army Medical Corps claimed the services of Dr. Calvin from January of 1952 until November of 1953. This was a particularly active tour of duty which included front line aid station duty on Heartbreak Ridge in Korea and finally he was stationed in a Station Hospital in Yokohoma, Japan. While in Japan, he successfully completed the Part I examination of the American Boards of Internal Medicine.

Dr. Calvin returned to his practice limited to Internal Medicine in February of this year. His office is located at 3119 Market Street. Dr. Calvin, wife Isabelle, and energetic son Peter reside at 17 Elva Street in Youngstown, Ohio.

Each great epoch in the history of medicine has resulted from the work of many men, but there are always superior minds and skills that distinguish the period. William Halsted was such an outstanding investigator of his time, a period in which the practice of surgery was advanced nearly to its present status. Indeed, this was an age of remarkable progress in many branches of medicine. In 1880 Pasteur discovered the streptococcus, staphylococcus, and pneumococcus. In 1881 Laveran discovered the malaria parasite, and Billroth successfully resected the pylorus for cancer. In 1882 Koch discovered the tubercle bacillus, and the next year Klebs discovered the diptheria bacillus.

"No matter how lofty your ambitions may seem, do not ridicule or stifle them. Live them. Sleep them. Dream them. Keep on and on and your ambitions will come true."

Edward R. Larrabee

KEEPING UP WITH A.M.A.

by Wm. M. Skipp, M.D.

President-elect Walter B. Martin, testifying before the House Commerce Committee on National Health, got into several verbal battles with the Chairman, Charles A. Wolverton, when he said there was a distorted picture being drawn of the health needs of the Country.

There was an unusual situation: where before it was the Democrats taking a slap at the A.M.A., now they were defending.

Dr. Martin said there is not a total shortage of physicians but the distribution may be bad; but more physicians are being turned out now than ever before; and there is no need for Federal intrusion in medical education. There is no great hardship as far as medical care is concerned. Certain types of aid may be necessary such as hospitals, nursing recruitment, voluntary health insurance should be encouraged, the care of medical indigent is a local and State problem.

Chairman Wolverton became rather indignant at Dr. Martin when he tried to get him to define socialized medicine; said the A.M.A. had put roadblocks in many prepayment requests, and was angry because Dr. Martin did not mention the President's health setup; and did not like the remarks of the A.M.A. that medical departments are an important problem of the citizens of the Country.

It is the feeling that the A.M.A. may be giving up some of its stubborn resistance to some of the medical plans of the Administration, such as a compromise on medical care for service men's dependants.

The National Commander of the Legion, Arthur J. Connell, called the A.M.A. the "most powerful and monopolistic medical guild" because the A.M.A. is doing nothing more than attempting to protest the physicians' interests. The Legion insists that all veterans should, regardless of ability to pay or whether the illness is service-connected (and now that their dependents be included) be paid for by the Federal government. We should read the many speeches our A.M.A. President has made on this subject. If the plan, as now presented, continues the entire citizenry will be under government medicine.

The A.M.A. does not advocate that all necessary care of the indigent veteran be denied but it does say this — care should be at the State and local level which would include the veteran's dependents. But the A.M.A. does say that those that can afford to pay for non-service connected disabilities should be borne by the veteran, not the Veterans Administration.

Indigent Medical Care

William S. McNary, of the American Hospital Association, feels that indigent care is a local problem and federal aid be not enlisted. That the prepayment plans will function better if the federal government will stay out of the picture. That the insurance picture could be improved for government employees if payroll deductions were permitted. The government has a vital role in health problems but it should stay out of the insurance picture.

Federal Employee Health Insurance Proposed

William S. McNary's proposal of payroll deductions of government employees has been suggested by the Administration who has asked that a program of contributary medical care and hospital insurance be set up.

1. The government and the employee to share equally premium costs up to $25. per year per employee, with the latter paying all costs above that figure. The employee would have his choice of hospitalization, surgical care and medical care, or all three, for himself and his family, but the U. S. contribution would not exceed $12.50.

2. Private insurance groups — Blue Cross and Blue Shield, White Cross, and co-operative group health plans — would handle the insurance. There would be no set formula. It is proposing also that Congress authorize federal contributions toward life insurance policies for U. S. employees.

All Obligated Physicians Due for Active Service by July 1, 1955

During the next fiscal year, starting next July 1, the Defense Dept. expects that all hospital interns and residents obligated for military service will have to be called to active duty. According to Asst. Secy. Berry, the demand may not be heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. Hospitals are urged to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

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 Dept. to request delay in call for men the Department recommends for additional training.

Enlisted Status Proposed for Some Physicians

To make it possible to use suspected subversive physicians and dentists in noncommissioned rather than commissioned status, Defense Dept. 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." A recent Court of Appeals decision ordered the Army to commission or discharge Dr. Herbert L. Nelson, a dentist, who refused to fill out his loyalty questionnaire. The now celebrated case of Dr. Irving Peress, another dentist, is similar, except that in this instance the Army kept him as a commissioned officer after learning that he had not filled out the loyalty questionnaire.

PENDING

On Feb. 26, 1954, a vote was taken in the Senate to an amendment proposed by Senator George (D., Ga.) but failed to pass by one vote.

The George amendment provides for enabling legislation by Congress when any international agreement affects internal affairs. A majority vote would be required. No enabling legislation would be required for treaties. Treaty ratification would require a roll call vote. .

The A.M.A. supports the Bricker and George amendments because without a change in the Constitution of the U. S., the social structure of the country, including the practice of medicine, can be altered by international agreements and become law of the land without Congressional enactment.

H.R. 8149 Is A Rewritten Version of H.R. 7341

They are bills extending the scope and purpose with more clarification of the over-all picture of the extended Hill-Burton Law for hospital construction. Two or more states may cooperate in certain construction projects, with

• PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN •

50% maximum cost to the Federal government. Osteopathic institutions may participate but chiropractic care is not sanctioned. To get Federal aid a nursing home must be connected with a regular hospital, or supervised by persons licensed to practice medicine in the State.

This bill covers needed institutions, such as homes for the chronically ill, nursing homes, out-patient clinics, non-profit and rehabilitation centers.

The A.M.A. has approved, in principle, this bill for broadening benefits of the Hill-Burton law, as it goes along with the principles of better medical care for all the people.

H.R. 8149 (Wolverton) This bill was passed by the House with restrictions as given.

A.M.A. Supports Grants Bill

The Administration bill cuts out a number of health grants and sets up three broad groups for grants to states. The A.M.A. has always promoted improvement in STATE and local health services. H.R. 7397 provides three types of grants: Type 1 grants to help states meet costs of public health services; Type 2 grants to aid states in initiating projects for extension and improvement of services; and Type 3 grants which would assist states as well as public and other non-profit groups to launch special projects of regional or national significance.

The A.M.A. proposes lumping 1 and 2 into one category, thus making the State health officer responsible for extension and improvement of services. Another suggestion is that the language of the act be clarified to require the Surgeon-General to consult with State health authorities before making grants.

The bill should spell out percentages of total funds to be used in each category with the amounts of Type 3 held to a small amount.

Dr. Lull recommended that the findings of the Commission on Intergovernmental Relations be considered before definite consideration of this legislation.

H.R. 8356 and S. 3114 has been introduced to cover the program proposed by the President for reinsuring prepaid health insurance. The program would not reinsure a policy-holder or a carrier, but would protect a carrier against a bad experience in the aggregate under a particular reinsurance plan. The government would pay 75%, the carrier 25% of the cost.

Twenty-five million dollars would be set up, the object to make the plan self-sustaining within 5 years. Responsibility would rest with the Secy. of H.E.W., who would fix rates and could cancel contracts for cause. Any insurance company . . . voluntary, profit, non-profit . . . can be approved as long as they comply with conditions and standards as set up.

Conditions and requirements for types of plans, taking into consideration these objectives: extension of coverage to persons not now protected, extension to new geographic areas and provision of benefits and services not now readily available. Plans would not be approved unless (a) financially sound, (b) operating according to state law, and (c) worthy of public confidence. The Secretary would specify minimum benefits and waiting periods, and set up safeguards against undue exclusions based on such things as preexisting conditions and specific illnesses. Plans of a given kind or type could be reinsured only if reinsurance on comparable terms and conditions, were not available from private sources.

Tax Revisions H.R. 8300 Bill allows a deduction for medical costs from taxable income if they exceed 3% instead of the present 5%.

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Maximum limitations for medical 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.

Also permits costs of medicines and drugs to be included in medical expenses only to the extent the items exceed 1% of adjusted gross income.

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

National Conference on Rural Health, sponsored by the Council on Rural Health of the A.M.A., at Dallas, Texas. From these hours of discussion one point became crystal clear: the medical profession and farm leaders now possess a unity of purpose and performance in stimulating rural people to attain a fuller and more healthiful life.

Several speakers stressed the fact that medicine is no longer a matter for the doctor alone — it's a problem for the community. In fact, the health of the community, is part of the duty of the community itself.

Federal Military Scholarships

Board of Trustees of A.M.A. approved federal military scholarships. This program would not aid needy students or increase the number of enrolled students but would finance the medical education of a set number of students in return for a pledge to serve after graduation in the military establishment.

This scholarship program is necessary to aid in procuring doctors for the medical corps of the Armed Services on a career basis. It should, ultimately, aid in reducing the necessity for the Doctor Draft Law.

Dean Slaps Down Legion Officers Charge

The Commander of a Legion Post in Covington, Ky., W. J. Owens stooped to mudslinging recently when he charged that Communists might have infiltrated the A.M.A. to promote a shortage of doctors and nurses.

His charge, made in a lengthy letter to Congressman Wm. E. Hess, was quickly answered by Dr. Stanley E. Dorst, dean of the University of Cincinnati's College of Medicine. Dean Dorst said: "Does this man know anything about the A.M.A.? It's a body that could be expected to lean over backward in keeping Reds out — and remember, too, it is dedicated to fight against socialized medicine.

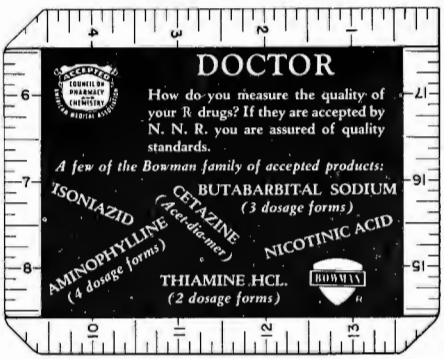
"And also, the A.M.A. has no more to do with the number of students in a medical college than it does with a college of liberal arts."

H.R. 8149 The Revised Hill-Burton Hospital Construction Act

There was very little opposition when this bill was brought up for vote but an amendment was offered by Dwight Rogers (D., Fla.) which makes it clear that all types of construction for hospitals, clinics, diagnostic and medical centers, nursing homes, etc. aid to these same facilities will also be honored if directed by osteopathic physicians. This amendment was passed.

Health Legislation

Right now there is more legislation on health matters in Congress than there has been for a number of years. The bills going through the hopper have to be scrutinized very closely for sleepers as the legislative committee of the A.M.A. is doing. Do not forget, most of this new legislation will affect all the Allied Professions: hospitals, nurses, physicians, dentists, etc.



"It is the greatest of all mistakes to do nothing when you can only do a little. Do what you can."

Sydney Smith

"People are always blaming their circumstances. I don't believe in circumstances. The people who get on in this world are the people who get up and look for the circumstances they want, and if they can't find them, make them."

George Bernard Shaw

DO YOUR PATIENTS REALLY LIKE YOU?

by Ernest Dichter, Ph.D.

President, Institute for Research in Mass Motivations, Inc.

Nothing is a safer topic for conversation than doctors and the medical profession. A group of people may have had violent disagreements, but when the discussion is shifted to doctors, most of the people present will probably agree. Unfortunately, in most cases, they will agree on negative facts about the medical profession. Even those people whom you would not consider capable of unfairness and subjective attitudes, will join in gleefully to report incidents from their own experience where doctors were wrong, overcharged, drove around in Cadillacs after only one year in practice, split fees, and a long list of comparable horror tales.

From a public relations viewpoint, and to the researcher in human motivations, a big question mark poses itself. How come? Why, from among all the various possible scapegoats in modern human society, are doctors picked, and what can be done about it? How can we make patients like their doctors more? Several years ago I was asked by the Alameda Contra Costa County Medical Association, to investigate this doctor-patient relationship, to find out what was wrong with it and what could be done about it. Since then, I have conducted a number of additional studies. One major one of C.P.S., the California Physicians Service, on specific problems in connection with health insurance, and a number of experimental studies to determine in what ways the doctor-patient relationship can be improved.

First, was the diagnosis. What was wrong? Summarizing our findings, what had happened was that while the world was changing and changing very rapidly; while the patient in this world was changing at least at the same pace; while all the medical equipment, medical knowledge and drugs were developing at an ever increasing rate; the HUMAN aspect in the doctor-patient relationship had fallen behind. A psychological lag had taken place. We discovered that most doctors choose their profession for idealistic reasons. Though a good income is usually expected, and this factor does enter into the picture, the idea of helping humanity and doing something worthwhile, uncommercial, and out of the doldrums of everyday life, of devoting oneself to helping others, is very strongly accented. Something vital and very important happens to the young doctor during the course of his major studies and particularly during his internship. The young doctor discovers the harsh realities of life. These realities very quickly clash with his initial, highly exaggerated idealism.

The patient, as well as the doctor, becomes aware of this conflict. The doctor often exaggerates his idealism to over-compensate for the recognition that in many ways, he really has to behave like a businessman. The patient on the other hand, is asked and expected to pay respect comparable to the kind of reverence that one pays to a saint, and then a few days later he receives a bill—again a conflict is the result. A further difficulty stems from the fact that while the modern patient is catered to by most other business and professionals, and even large corporations, the medical profession as a whole has failed to acknowledge that this patient has been growing up, is insistent on his right to be treated as an equal, and spoken to in clear understandable language. The modern patient doesn't want to be called a "layman," he doesn't want to have complicated Latin phrases thrown at him,

which he feels he would understand quite well if they were translated. Every time he is in contact with a doctor, he feels he is confronted by a clique. He is the outsider, the child, the ignoramus.

The modern citizen, and thus the modern patient, has been invited to become a participant, rather than a passive recipient in more and more fields. There are profit-sharing plans; do-it or make-it yourself is the latest and most modern development in many fields of industry. The home workshop, the ready-mixes, fix-it yourself plans; new approaches in labor-management relationships, where labor becomes a participant in management decisions, all point to an entirely new direction. His relationship with the doctor seems to be in complete contrast to this. Instead of being permitted or invited to be a participant, he is told to simply hold still and follow instructions.

A further important trend which has been observed in our modern culture, is the desire for emotional security. Before the last election, it was predicted that in times of prosperity, the party in power stays in power. This prediction was wrong. Why? Because a psychological factor was overlooked—that people in general want more than just financial security. They need emotional security as well. Applied to the medical field, it means that the technological assurance, the mastery of x-ray machines and antibiotics, while highly desirable, is not enough. We often overlook the fact that progress does not take place in a straight ascending line, that a much more correct picture is the one of a spiral development. While it seems logical that progress has such a steady development, that greater and greater efficiency and scientific expertness on the part of the doctor was all that was demanded, our studies show conclusively that not only in this field, but in many other fields, people really want to be assured of the return of this spiral development. They want to come back to the kind of relationship on an emotional level that they used to have with their doctor. But in a more developed and scientifically more dependent form.

Even in the industrial field, our studies showed that such companies as General Mills, General Motors, Ford, etc., have to take care of the emotional problem. A company like General Mills had to invent a personality like Betty Crocker in order to establish a relationship between themselves and the consumer—a relationship of a psychological and emotional form. In other words, it is not enough for them to produce an excellent flour and to have perfect production facilities, what is even more important and what finally determines the success of their commercial undertaking, is the existence or non-existence of this emotional tie.

Comparably, therefore, the modern doctor too can have the most perfect laboratory equipment in his office, be qualified through medical knowledge in the most unquestionable fashion, and yet be completely deficient as far as the basic requirements of his profession are concerned. These requirements of having an emotional relationship with his patient used to be the standard equipment of any good family doctor. A modern patient feels that he has been cheated, that he has x-ray machines instead of human relationships. He clamors, therefore, and with a great feeling of justification, for the old family doctor to be brought back, minus the horse and buggy, of course, and equipped with the x-ray machine and all the other scientific advances.

In our surveys we discovered that the doctor is proud of his rugged

Annual Dinner

r Dance . . .

individualism. Yet, this individualism is as outdated as the frontiersman who totes his gun, would be today. The modern patient is no longer allowed to be this kind of rugged individualist. Recently it was pointed out that there are hardly any employers left. Most of us are employees of a large corporation or business enterprise. In the final analysis, even the president of General Motors is an employee, with all the psychology that goes with it. What right has the doctor to consider himself beyond the law, above the restrictions that are imposed on almost every other citizen in our society?

Therefore, the modern patient demands that his doctor interest himself in community affairs as much as he himself is expected to participate. He demands that the modern doctor accept his responsibility as far as medical care is concerned. This is another source of conflict, another source of jealousy and frustration.

I cannot go into all the details of the various studies concerning the Doctor-Patient relationship which we conducted. The diagnosis can be summarized in the following way:

It is not the high medical fee; it is not even the threat of catastrophic illness nor the imperfection of medical science; nor any other surface reason given by people when asked directly, which can serve as the explanation for this lack of love on the part of the modern patient for his doctor. We have to dig deeper, as we did in our pschoanalytic approach to the problem, in order to find out what some of the real faults in this relationship are. As the examples we have presented demonstrate, most of them point to a feeling of frustration. The modern patient wants to be loved by his doctor. The modern doctor would like to love his patient, have a personal relationship with him and spend as much time as possible with him. Both, in a sense, are caught in this dilemma. The modern doctor is not permitted to be the idealist he *really* feels he ought to be. The modern patient feels he is not being treated the way he *really* feels he ought to be treated. He states, as one of our respondents did, "All he did was make me well."

You might say, "This is the typical, ungrateful attitude of a patient."

As a psychologist, I would say, "No, this is the outcry of a person who feels let-down, neglected, and robbed of what he thinks his doctor should have given him—love, interest and affection."

What is the answer? What can be done about it? How can we make the patient love his doctor? What therapy, as far as public relations are concerned, can we prescribe? It is my conviction that the answer does not lie in political maneuvers, in lobbying, or any other form of high pressure advertising approach. We must give each individual physician a manual, a prescription, or better yet, the tools to develop insight into his own relationship with his patients and urge him to put these things into practice bit by bit. Only by such a systematic approach, starting with each individual doctor, can we hope to achieve a generally improved relationship between the doctor and his patient. Here is a list of concrete recommendations:

1. Do you have the right kind of patients?

Make a list of all the patients whom you have treated in the last year or so. Next to their names, jot down your own personal feelings about them. How many of them do you really like, how many of them do you detest, how many of them are you indifferent to? If there is an undue number of patients that you would rather not have further contact with, your public relations with your patients is not too good.

2. How many of your patients would you permit to call you by YOUR first name? How many of your patients do you call by their first name?

If the ration, the difference, is a very large one, again I would say that here you have another symptom of poor public relations between yourself and your patients. One of the important aspects of our study revealed that authoritarian relationships between the physician and the modern patient are on their way out. While many doctors claimed that the patients wanted them to feel authoritarian, experiments that we conducted not only in the medical field, but also in labor management fields, proved that it is quite often the opposite that is really true. For example, we found that the doctor who took his patients into his confidence, who admitted that he didn't know all the answers, who dealt with them on an equal, non-authoritarian basis, reaped great benefits from this kind of relationship. The patient, rather than losing confidence in his doctor, had increased confidence in his humanitarian and ethical principles and trusted him even more than if he simply pretended to be the authority.

3. How many of your patients lose contact with you after you have cured them?

We found that the desire for continuity is a very important one in the modern patient. He does not want to have contact with you only when he is sick. He wants to have the feeling that you watch over his health and his family's health all year long. We found that patients remembered the days when their family doctor carried their whole destiny and recorded all their family events in his little black book. This knowledge of continuous care and interest on the part of their doctor is a very important one for the improvement of the doctor-patient relationship.

Have you ever sent your patients cards? Do you ever inquire, after you have prescribed a treatment, whether it actually worked or not? Do you consider the relationship has ended when the patient has paid his bill? Do you ever send a thank you note after you received your payment, inquiring at the same time about the health of your patient? We conducted a number of experiments which showed that the patient was puzzled at first, then tremendously pleased by this demonstration of a new era, a new philosophy, on the part of his doctor. Contrary to the fears which some doctors expressed, that this would be interpreted by the patient as solicitation and commercialism, the modern patient interpreted this to mean that the doctor too has finally acknowledged the fact that it is his job to please the customer. This principle of continuity is practiced by insurance companies, gas stations, dentists, lawyers. The patient feels that the doctor should not think himself above this, should not feel himself exempt.

4. How much participation do you grant your patients?

We found that when you write out your diagnosis, when you fill out those mysterious sheets in your office, the patient wonders what it is that you are putting down. We found dramatic and miraculous effects, when the doctor tore off the top sheet, handed it to the patient with proper explanations and informed him what all this mysterious writing meant. In this way, the doctor demonstrated that he considered the patient his partner, not a "layman," who had to be dealt with like a child.

5. How much medical information, specific or general in nature, do you disseminate in your own community?

Many doctors complained that the patient read articles in popular magazine indiscriminately, and then pestered the physician with questions, suggesting therapy himself, and so forth.

While it is perfectly correct that much of this information may lead to misinformation, a large part of the blame really falls back on the medical profession. The modern patient wants to have the Bible translated into English. He wants to know what is going on. He feels that anything that concerns his own body is primarily his own prerogative. If he cannot get information from his doctor, his medical association, or the medical profession within his community legitimately, he will try to get it somewhere else. No complaints will ever be effective until the medical profession understands that this is a justified need of a psychological nature for the modern patient, which must be satisfied one way or another.

Why shouldn't medical associations disseminate this information themselves, with the help of local newspapers, radio stations, television stations and so forth. Why would it not be possible to send out monthly or quarterly bulletins signed by the county medical association, with the names of the doctors who work in the county listed. This would give patients the feeling that all they need to know about diseases, epidemics, adjustments to seasonal changes and so forth, is made available to them by the medical association.

6. Have you looked at your waiting room lately?

To a certain extent, the waiting room is the display room, the show window of the medical practitioner. Why call it "waiting room" to begin with? Nobody likes to wait. In our studies, we found that the patient has a great desire to learn more about his doctor. He wants to establish an emotional relationship with him. What are you doing to help it? For example, there is nothing wrong with having a family album in the waiting room, which would show the patients what you did during your last vacation; introduce him to your family; give him insight and information about yourself as a living, human being and not just a technician in the medical field. What are you doing to make your patients more comfortable while they wait? How old are your magazines? Are there any cigarettes or candy offered? In what other ways can you help make the waiting period more pleasant? Have you considered slide projectors?

7. Do you explain your apparatus to your patients?

More and more, modern factories have introduced open house sessions which permit the families of their employees, factory workers, etc., to visit all parts of the enterprise and familiarize themselves with various machines. Couldn't something similar be done as far as the medical profession is concerned? We found that many of the modern patients were quite eager and curious in not just an idle fashion, to learn more about the various apparatus and instruments their physicians use. It is quite conceivable that the nurse, an assistant, or the doctor himself should show the patient his facilities and explain his apparatus and various instruments to him.

8. As a physician, how do you participate in your community?

It is possible to cooperate on a community level with schools, for example. Certain school periods could be used to introduce various medical practices and medical apparatus to the children and familiarize them with

these. This would diminish their fears and teach them to consider the doctor a professional man with special knowledge, and not one who is a saint, nor a medicine man with magic, mysterious, dangerous apparatus at his disposal.

9. What is the role of your medical association?

Most patients consider the medical association of their county a mysterious building where secret sessions take place. Patients think of their doctors meeting as members of a clique to protect themselves against the intruders. Why not make these buildings open to the public, arrange exhibits in them, invite the community to come and see; to sit in on some sessions. Perhaps some day, medical associations will have the courage to invite so-called "laymen" to become members of the association and representatives of the patients. They might even be granted a vote in some decisions.

10. Are your nurse and/or wife helping you?

The doctor's wife and his nurse have many functions which can be used to facilitate the practice of the doctor. Often a patient feels frustrated because there's not enough time for him to discuss all the details with the doctor. Couldn't the nurse be trained to have sessions of this sort, in the way that an investigator, a researcher who works with the scientist, would do? She could more readily afford to spend half an hour with the patient, prepare all the information for the doctor so he is aware of the problems when he deals with the patient.

11. What is your reaction to standardization of fees?

In my opinion, the fee problem, though dependent to a large extent on emotional frustrations, deserves a specific approach of its own. It is not so much the absolute figure of the fee, the cost itself, that the patient objects to, as the feeling that he has developed that "biological blackmail" is exerted on him. He feels he is charged for the value of a limb to him, the value of his life to him, instead of on what he considers a fair basis — the doctor's knowledge, time, effort and responsibility.

It is my belief, that at one point, open and above board standardization of fees will have to be introduced. It has been done in some counties with excellent results, as far as the public relations value is concerned. We found that the patient does not object so much to *what* he is being charged, as to not knowing in advance how much he will be charged. We found that a president of a large corporation, earning $150,000.00 a year feels just as strongly about being "blackmailed," as he called it, as the factory employee who earns $75.00 a week. What they resent is being reminded of their helplessness and having the doctor take advantage of his power. It is only natural, therefore, from a psychological viewpoint, that they are waiting for the day when they can take this power away from him.

I've tried to list a number of concrete suggestions. Again, I must say these are only a few examples.

What we must realize is that the problem of socialized medicine versus free medicine, like any other problem in our modern life, cannot be approached simply from a political or economic viewpoint. In most of the discussions in this sphere, very little acknowledgment was made of this apparently overlooked, and apparently insignificant factor—The Human Mind. When your son starts to grow up, you will not get very far by disciplining him, refusing to let him ask questions and denying him the right to make

his own decisions. You will lose out in the end because you are working against his growth and maturity. A wise approach is to acknowledge the fact that your son is becoming a man.

The patient, too, is growing up. He insists on his right to ask questions. He wants to be loved, not in a condescending, paternalistic fashion, but as an equal partner in the fight against the difficulties of modern life.

I think that the answer to improved public relations will not lie in insistence on rugged individualism and absolute freedom, nor in federalization and socialization of medical care. The answer will lie in a new democratic form of cooperation where the individual gives up some of his prerogatives, accepts the responsibility of the health of the community, recognizes the rights of his patients and learns to cooperate with them.

The answer to how to make your patients like you more lies in recognizing the fact that this world is a changing one, that the patients are changing, and that you too must learn to change with them.

New York Medicine—October, 1953

ALL THREE TYPES OF POLIOMYELITIS VIRUS SHOWN IN PURIFIED FORM BY DR. A. R. TAYLOR, VIROLOGIST

Atlantic City, N. J., April 13 — Purified cultures of all three types of poliomyelitis virus were shown here this afternoon by a Parke, Davis & Company scientist in highly magnified electron-microscope pictures.

Dr. A. R. Taylor, research virologist for the pharmaceutical firm, made the presentation at the meeting of the American Association of Immunologists, held in connection with the Federation of American Societies for Experimental Biology.

His paper, "Electron Microscopic and Ultracentrifugation Studies on Purified Tissue Culture Poliomyelitis Virus Strains," was accompanied by slide films showing the purified virus of all three types — Mahoney, M.E.F. 1, and Saukett.

Dr. Taylor said this presentation augmented the work he reported last fall, when photographs of the Mahoney strain were shown.

One significant factor in the new study, Dr. Taylor pointed out, was that for the first time scientists were able to grow poliomyelitis virus in high enough concentration to show the virus directly in crude tissue culture.

Purification of the virus, which is grown in monkey kidney tissue, is done by means of ultrafiltration and by sedimentation in an ultracentrifuge that rotates at 40,000 revolutions per minute. The material is sedimented twice in the ultracentrifuge.

Dr. Taylor said the study showed that the size of each Mahoney (Type 1) and Saukett (Type 3) poliomyelitis virus was approximately 33 and 31 millimicrons, respectively, while the M.E.F. 1 (Type 2) strain was somewhat smaller. One millimicron is equal to 1/25,000,000 of an inch.

Dr. A. R. Taylor said the results of this work would enable the virologists to study the fundamental chemical and physical properties of all three strains of the poliomyelitis virus together, thereby aiding the overall program to eliminate poliomyelitis.

Associated with Dr. Taylor in the paper were Dr. F. D. Stimpert, director of microbiology; Dr. I. W. McLean, Jr., assistant director of microbiology; and Dr. A. E. Hook, virologist.

THE FUTURE OF THE PRIVATE PRACTICE OF MEDICINE*

by Chester S. Keefer, M.D.

I believe that you will agree with me when I say that it is extremely hazardous to make any predictions concerning the future of medical practice. But the subject is not new. The future of medicine and its practice has been the subject of considerable debate, especially in the past 50 years.

The organized profession of medicine has turned attention periodically to the current and future trends of private practice in the United States, and it is well to review the subject periodically.

In 1921, the late Frank Billings, one of America's great physicians, wrote an essay on the "Future of Private Medical Practice," and with your permission I shall quote a paragraph from this paper.

"In the evolution of modern life, society has been and still is characterized by financial greed and by extravagant expenditures for luxuries and pleasures which appeal to the physical rather than to the spiritual man. The cities afford opportunity for display, social pleasures, and for possible success in a professional and financial way. This tempts migration of the professional and the business man, including the young men of the farm, from the country to the city. This migration has increased within the last few years in spite of the more livable conditions of village and rural life, through the advantages of rural free delivery, the interurban trolley and motor cars. At the present time more than half the population of the United States is urban. Thus there is an excess of physicians beyond the need of the city public, and a dearth of medical men to supply the need of the rural population. This breeds discontent and disappointment in the medical profession in the city, and the rural public suffers from the need of a sufficient number of doctors. The country physician lacks modern facilities for diagnosis and for the needed hospital treatment of his patients."

Many of the statements made by Dr. Billings in 1921 are applicable today.

Medical practice in any community reflects the health knowledge of the people, the accessibility of facilities and health personnel, and the education of the physician. In the past three decades, phenomenal changes have occurred in all of these factors that influence medicine. The changes have been so rapid and so numerous that it is difficult for either doctor or patient to assimilate them completely.

The trends and shifts of emphasis in medical practice suggests to me that the physician and the profession will determine the nature of medical practice in the future as in the past. However, the medical profession will determine their future and their destiny only if they continue to consider themselves a part of the general public. The profession must be devoted to the welfare of the public and continue its practice and pursue the art of medicine as a public service. The tradition of the medical profession is a duty to the patient, to the profession, and to the public. Professional service to the public is authoritatively declared in the codes of professional ethics that are taught by precept and by example, and they are made effective by discipline of the organized profession.

*Delivered at the Stated Meeting of the Medical Society of the County of New York, January 25, 1954.

FROM THE BULLETIN

TWENTY YEARS AGO — MAY, 1934

The Secretary reported that 400 doctors attended Post-Graduate Day in April. It was a tremendous success.

At the special meeting held last month to discuss care of the indigent, an important resolution was passed which said in part: "Free medical service rendered to a deserving patient in his own practice is a *physician's* charity. Free service rendered to groups of patients by lay organizations is *their* charity, not the physicians. The fee for medical service rendered to a ward of such organization shall be paid to the physician by the organization promoting the philanthropy."

Legal counsel employed by the Economics Committee reported that bills for the care of the indigent would be paid. The State Relief Commission announced the following fee schedule: Office calls $1.00, House call $2.00, night calls 50 cents additional. Obstetrical: normal delivery $20.00. Forceps or time over 12 hours $5.00 extra.

Dr. A. E. Brant proposed an amendment to the By-Laws providing for ballot by mail to elect the officers of the Society.

Dr. J. G. Brody quoted McCrae who said that the tars liberated by combustion of automobile fuel and increase in cigarette smoking coincided with the increase of malignancy of the bronchi.

The speaker that month was Dr. John H. Stokes from University of Pennsylvania who spoke on "Recent Advances In The Treatment of Syphilis."

Dr. E. H. Jones wrote an interesting historical sketch of the College of Medicine, Ohio State University which was celebrating its 100th anniversary.

Some complaint was noted about too many meetings. A doctor's wife wrote in and said "Why not have a Women's Auxilliary?"

Dr. C. D. Hauser was licensed to practice in 1896. W. W. Ryall in 1897, C. R. Clark in 1899.

TEN YEARS AGO — MAY, 1944

Much news from doctors in the Service: Major Steven Ondash was awarded the Legion of Merit for outstanding service in Greenland. He also served in the British West Indies, Canada and Alaska. Joseph Keogh was home after two years at Pearl Harbor. John Russell was serving at McArthur's advanced headquarters in New Guinea.

Capt. Sidney Davidow was home on leave after spending a year in the Aleutians where he participated in the Attu landing. Capt. Morris Rosenblum was back after a year in Puerto Rico. Brack Bowman, J. L. Scarnecchia, H. E. Hathhorn and John Welter were in England. Bert Firestone and John Rogers had been in Africa but were probably in Italy by this time. Fred Schellhase was heard from in New Guinea serving with the 5th Air Force.

The Women's Auxiliary met at the home of Mrs. W. O. Mermis. Mrs. R. B. Poling was President, other members mentioned were Mrs. Sidney Moyer, Mrs. Earl Brant, Mrs. Waldo Baker and Mrs. J. B. Nelson.

J. L. F.

"Nothing great was ever achieved without a purpose."

Louis Flayton

Where there is no vision, the people suffer.

Proverbs 29:18

MISCELLANY

Vice Admiral Ross T. McIntire is resigning as chairman of the President's Committee on Employment of the Physically Handicapped, preparatory to running for the Democratic nomination for the House of Representatives in the 30th California district. Dr. McIntire is a former Navy surgeon general and a former medical director for the National Red Cross. . . . The U. S. Office of Vocational Rehabilitation has received the research award of the American Pharmaceutical Manufacturers' Association for its pioneering work in vocational rehabilitation. . . . National Science Foundation is surveying about 500 colleges and universities to learn more facts about graduate study and its sources of financing. NSF wants to learn the number of fellowship holders, the number of teaching and research assistants available and the amounts and sources of funds. The study is concerned only with students studying for master's or doctor's degrees.

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Typhus was so rampant in the 1700's that the period was recorded in medical annals as the "Century of Typhus." Typhus and famine always had gone hand-in-hand. During the mid-1800's, some 30,000 people died of typhus in England, while in Ireland, where 18,000 starved to death, 290,000 died of dysentery and fever, largely typhus.

After World War I, 3,000,000 Russians — not to mention countless Serbs and Poles — died of typhus. Egypt experienced one of its most severe typhus epidemics in 1943, with a mortality rate of 18 percent.

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A fifteen-year research has demonstrated that some pelvic cancers can be discovered in an early and curable stage and that many inflammatory lesions of the uterine cervix, commonly believed to predispose to cancer, can be discovered by means of the periodic pelvic examinations of presumably well women. The examining physicians believe the small number of cancers of the uterine cervix found in the volunteer group is due to the discovery and elimination of 247 lesions of the cervix. They conclude that the death rate from pelvic cancer could be reduced if married women, 30 years of age and older, might have the benefit of a pelvic examination twice a year. This fifteen-year research has also demonstrated that cancers of the breast, not detected by careful examiners, can, in less than six months, develop into lesions readily detectable by the women themselves. The examining physicians conclude that women 30 years of age and older should be taught and should practice a monthly breast self-examination and should report any unusual findings to a physician at once.

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Aetius of Amida, first eminent Christian physician of antiquity, wrote in Tetrabiblion, Book XVI, Chap. 1:

"The uterus, known to the Greeks as *metra*, is called *matrix*, because from it life originates as it does from a mother. It is also called the *hystera*, because it lies posterior to all other viscera."

Of the cancerous tumors of the uterus, some are ulcerated and others are not. In the absence of ulcerations, the tumor found at the cervical os appears hard to the touch; it is uneven, pronounced, feculent, red, or livid in color. It may cause sharp pains in the groins, in the abdomen, in the vulva, and in the loins. These pains are of greater severity after a manual examination and after the application of certain drugs. If the cancer mass

is ulcerated, the ulcerations are of a corroded type and are irregular. Some are foul, prominent, and whitish in color; others appear feculent, dried, reddish, and bloddy. From these ulcers there oozes a thin, watery, black, or yellowish discharge possessing a "strong" odor. Often these ulcers bleed, especially when an active inflammation is present. This disease, as Hippocrates stated, is incurable; it can, however, be mitigated by medication.

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John Leake, in 1792, in his text on female diseases, gave a remarkably clear presentation of manifestations of cancer of the cervix and of its method of spread. He recorded that women at or past the menopause who had prolonged periods and passed blood clots often developed cancer. He stated that the seriousness of cancer of the womb is not the destruction of that organ but its involvement of the surrounding structures. He recorded difficulty in discovering the disease until it was too far advanced for complete extirpation. Then all that could be done was to assuage pain and combat the intolerable stench. He recommended tampons soaked in carrot paste. He described terminal cancer:

"The cancerous matter frequently fixes upon some other glandular part, so what was at first only local, now becomes a universal malady, and like a pestilential blight overspreads and lays waste the constitution. Thus reduced to the extremest weakness, and destitute of hope, she lives in a long continued state of exquisite misery, a prey to the cruel disease, till death's benumbing opium composes her to final rest and at once puts a period to her life and suffering."

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Treatment of Hypertension with Drugs

The treatment of hypertension should be undertaken only when that disease under observation represents a hazard to a patient's life or health. Drug therapy is usually directed at the neurogenic factor. A variety of drugs is available for blocking the motor synapses and nerve endings concerned in the excessive sympathetic nerve discharge believed to be a factor in hypertension. For the best results this should be defined by testing procedures in advance of and during treatment. The limiting factors are usually tolerance and side actions. At the cortical level, barbiturates are the most useful drugs, although these may be replaced eventually by Rauwolfia serpentina. At the hypothalamic level, l-hydrazino-phthalazine and protoveratrine are the most effective, whereas at the ganglionic level, hexamethonium bromide or chloride is the drug of choice. Parenteral administration of this drug is preferred to oral administration because of the inherent serious dangers of the latter. Block of sympathetic nerve endings, smooth muscle or of capillaries is at present of minimal practical value in the treatment of hypertension. Salt depletion by diet and dietary adjuvants appears to affect the non-neurogenic or intrinsic factors in hypertension. Sympathectomy should be reserved for patients with a large neurogenic element who fail to respond to adequate medical therpay. In many cases, judiciously combined treatment provides the most satisfactory results.

Milton Mendlowitz, M.D.
The Treatment of Hypertension with Drugs,
Annals of Internal Medicine, November, 1953

Duodenal Ulcer in Women

It is curious that the syndrome of ulcer in women is often so indistinct as to be unrecognizable even by an expert—a history suggestive of ulcer being uncovered only after a roentgenologist has found a deformed duodenum. In men with an uncomplicated ulcer, the syndrome is usually so typical that anyone can make the diagnosis from the history.

Many women with ulcers have slight atypical pain overlaid with many symptoms of neurosis. Often this becomes more apparent after surgery, when the woman no longer has pain but still complains bitterly of symptoms of nervous origin. Because of my uniformly poor experience with women operated on for duodenal ulcer, I practically never turn one over to a surgeon. It would be bad enough if the woman were to come back only with her neurosis; but occasionally she returns with a phenomenal dumping syndrome which lasts for years.

Doubtless surgeons could report happier experiences than I have had with women operated on for ulcer. Unfortunately, a consulting gastroenterologist tends to become a pessimist about these cases because the patients he sees are the ones with disastrous results.

What is sad is that almost all of these women I see could have done well enough without any operation. Some had only an ulcer deformity revealed by roentgenogram, without definite symptoms of ulcer; some had ulcer symptoms easily controlled by diet; some had symptoms caused more by neuroses or unhappy lives than by their ulcers; and some were so psychotic that they should never have been sent to surgery.

W. C. Alvarez

Money, Money, Money

The commonest and most neglected illness in the U. S. today is money-sickness, Dr. William Kaufman told the American Psychiatric Association in Boston. And one reason why it is not often detected, said the Bridgeport (Conn.) psychosomaticist, is that many doctors have their own unresolved problems regarding the use of money. This serves as an unconscious check which keeps them from recognizing or investigating the abnormal psycho-economic behavior of their patients.

An individual's attitude toward money, whether healthy or not, is usually determined early in life, said Dr. Kaufman. If it is unhealthy, it may touch off a variety of psychosomatic illnesses, such as headaches, anxiety states, hysterical paralysis, panic reactions, depression, or disorders of the digestive system, heart and lung function, or muscular control.

DOCTOR, HAVE YOU HAD YOUR CHEST X-RAYED RECENTLY

You, as a physician, practicing medicine or surgery, obstetrics, or any of the subspecialties, owe it to yourself, your family, and your patients to have your chest X-rayed once yearly if under 40 years of age, and twice yearly if over the age of 40. Likewise, I believe that what is good for your health is most certainly excellent for your patients. We physicians, like the minister, must practice what we preach.

It is up to us to convince our patients, all of them, that the prevention, detection, and the cure of tuberculosis are possible if we begin a wholehearted, concentrated effort on this score now.

I. Phillips Frohman, M.D.

TRENDS AND EVENTS

Dr. Magnuson Critical of Administration Reinsurance Plan

Dr. Paul Magnuson, chairman of the 1952 Truman Health Commission, believes the administration's plan for reinsuring health plans might not accomplish what Congress would expect from it. Appearing before the House Interstate and Foreign Commerce Committee, Dr. Magnuson made these points:

1. The plan is not specific enough, and would result in a mass of fine print in contracts when the administrators attempted to interpret congressional intentions. If it enacts the plan, Congress should state definitely what is to be covered.

2. The question of the indigent or the medically indigent should be left to the judgment of the local community; as far as he knows, Dr. Magnuson said, there are no indigents who cannot be taken care of in this country by existing local facilities.

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82% of Needy Aged 'Able to Care for Selves'

A new survey by the Bureau of Public Assistance indicates that 82% of the needy aged receiving public assistance are able to care for themselves, and less than 4% are bedridden. The study also found that 80% of the recipients are more than 70 years of age and 25% are past 80. It was determined that although most aged persons live in cities, a majority of those receiving public assistance live in rural areas.

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"Government reinsurance of health insurance plans would introduce no magic into the field of financing health care costs. Reinsurance can distribute risks among insurers just as insurance distributes them among policy-holders, but no matter how far this distribution is carried, it must be sound to succeed. Reinsurance does not increase the ability of the insurer to sell protection to the unwilling buyer. Reinsurance does not reduce the cost of insurance. Reinsurance does not make insurance available to any class of risk or geographic area not now within the capabilities of voluntary insurers to reach."

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Procedure Set for Doctor Draft Loyalty Cases

In anticipation of passage of the amendment to the Doctor Draft act, Defense Secretary Wilson has established a policy for handling all suspected loyalty cases arising under the act. (The amendment would permit the Armed Forces to retain, in noncommissioned status but assigned to professional duties, any physician, dentist, or veterinarian whose loyalty is questioned.) If the amendment is enacted, the following procedure immediately will become effective: (1) If questions of loyalty interfere with commissioning, an "intensive investigation" will be conducted; a 90-day limit is placed on the investigation, except in unusual cases, (2) if the man is found to be a security risk he will be "expeditiously processed out of service with an appropriate discharge," which will state that he was discharged *because his retention was not consistent with the security of the United States,* (3) if investigation clears the man, he will be offered a commission at the appropriate rank, (4) during the investigation, the individuals concerned will be "retained in an enlisted status and used in their professional capacity under necessary safeguards."

Cites Need for Unity of Opinion on Legislation

A plea for unity of opinion of the profession on legislative matters was sounded by A.M.A. Trustee David B. Allman, Atlantic City, at one of the recent regional legislative hearings.

The trustees, he pointed out, study each legislative issue carefully and thoroughly on its merits and then adopt a formal position in the light of the facts and the best interests of public and profession. Then one man usually is designated to present that opinion at a hearing on the bill in Washington.

However, Dr. Allman continued, it is not unusual for some congressman to pull out a letter from a physician back home expressing an opinion opposite to that of the American Medical Association. The medical spokesman is thus embarrassed and the value of his statement weakened.

Everyone has a right to his opinion, of course, Dr. Allman said, but if he wants it reflected in the profession's formal announcements, he should write to the American Medical Association.

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During Tom Gardiner's 45 years of service with the A.M.A., Tom has held several positions, including one that concerned the collection of unpaid subscription accounts.

Tom Gardiner has grown with the American Medical Association. We all know him as a fast-moving, untiring worker, who has considered this Association a project to which he has given his total energies, his best years, and his wisest guidance. The profession can well feel proud of his long and faithful service.

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Joint Committee to Study Indigent Medical Care

Representatives of five different groups — the American Hospital Association, the American Dental Association, the American Public Health Association, the American Public Welfare Association, and the American Medical Association — held their first meeting in Chicago recently for the purpose of exploring areas in which the different groups might work together to improve medical care for the indigent and the medically indigent population.

General Practitioners Have Successful Meeting

With a total physician attendance of 2,872, the American Academy of General Practice, meeting in Cleveland, March 22-25, chalked up one of the most successful sessions it ever held. The total registration was 5,817.

A.M.A. President Edward J. McCormick spoke on the personalized services of the family doctor on the opening day.

"The general practitioner is the backbone of American medicine," Dr. McCormick said in addressing the several thousand persons who packed the big Cleveland auditorium. "Whatever we do to expand the opportunities of general practice will eventually help us to overcome many of the difficulties we are meeting every day on the national level in the way of criticism directed at the medical profession as a whole."

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Writing in the Chicago Daily News, London Correspondent Ernie Hill says that under the British health service, patients have now discovered that they can sue the government if they don't get well.

Under the legal aid scheme, which is a separate Socialist institution, they can get the government to furnish them a free lawyer to handle their suit.

If they win, the government pays off. If they lose, the court costs still have to be paid by the government. "So have a go," Hill says. "It's all on the welfare state."

He adds that a rash of lawsuits against hospitals under the National Health Service has broken out all over the place.

"Medical authorities," he said, "estimate that some 200 suits for damages have been filed in the last three years."

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Union Paper Carries A.M.A. Story

It isn't very often — it's seldom, in fact — that a union newspaper carries a positive story about the American Medical Association. When it does, it's news.

The March 3 national edition of the Trade Union Courier, officially endorsed by 2,000 A.F.L. unions in the United States and Canada, carried all of Dr. Edward J. McCormick's recent testimony before the Wolverton committee in Washington. It titled the article: "American Medicine Ahead of the World." In his statement before the committee, the A.M.A. president recited the positive story of American medicine and the advancements that have been made in medical science since the beginning of the 20th century.

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Stop Those Highway Killers!

Tragedy on the highway caused by Highway Killer Number Three — the drinking driver — is aptly depicted in a new exhibit now being offered to local medical societies by the A.M.A.'s Bureau of Exhibits. "Alcohol Tests for Drinking Drivers" points up the fact that the drinking driver ranks third in traffic violations resulting in fatal accidents and is lead only by violations of excessive speed and failure to keep on the right side of the road. Advantages and disadvantages of different methods of testing the drinking driver are visually demonstrated in this attractive exhibit, and a series of simulated windshields show the progressive changes in the drinking driver's vision through the four stages — sober, fuzzy, dizzy and drunk.

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Dr. David B. Allman, chairman of the A.M.A. Committee on Legislation and a member of the Board of Trustees, appeared in Washington last Monday and outlined the American Medical Association's position on the proposed bill calling for federal reinsurance of prepaid health plans.

"The bill will not fulfill its intended purpose," Dr. Allman said in appearing before the Committee on Interstate and Foreign Commerce of the House of Representatives.

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VA Administrator Harvey (Doc) Higley . . . in extemporaneous talk before big throng attending opening session of Legion's 31st annual rehabilitation conference . . . did neat bit of diagnostic probing into motives of *American Medical Association* in their attacks on VA free hospitalization program . . . decided all symptoms of socialized medicine were present.

VA chief . . . who is son of doctor and father of doctor . . . used best bedside manner in talks before Legion groups . . . showed own skill with verbal knife in performing major operation on A.M.A. . . . cracked that upper income bracket doctors "probably pay plenty of taxes — on *the income they*

report" . . . after full minute of Legion applause confessed remark was "little below the belt" . . . charged A.M.A. accusation that VA pays doctors too much "certainly isn't true" . . . paradoxically said "as long as we can make 'em stick to the truth, I hesitate to go on warpath."

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Findings of First Year's Study of Doctors in Service

During the first year of the study — July 15, 1952 to Aug. 1, 1953 — a total of 3,948 completed questionnaires revealed that the average time spent in service was 24.7 months; average tour of duty in U. S., 7.6 months; average tour of foreign duty, 17.1 months. Twenty-nine per cent felt there was overstaffing, 20 per cent understaffing and 51 per cent adequate. Of those assigned to domestic duty, 53.4 per cent were engaged in treating military personnel, 28.3 per cent in treating military dependents and 18.3 per cent in "other;" while of those assigned to overseas duty, 51.8 per cent treated military personnel, 23.8 per cent dependents of military personnel and 24.4 per cent "other." Answers to the question regarding the *type of medical care* provided for *other than* military personnel indicate that in the Army and Navy the most frequent type was outpatient care, while in the Air Force it was obstetrics and gynecology.

FAMILY PHYSICIAN
by Paul R. Hawley, M.D.

Nothing of greater significance has been published in the *Bulletin* in recent years than the article by Dr. Stanley R. Truman in this issue. We are indebted to him and to the publisher of GP for permission to reproduce it. ("Why Some Doctors Should Be in Jail," GP, December, 1953, page 32.)

Dr. Truman is a past president of the American Academy of General Practice; and he lends dignity and integrity to the leadership of that organization.

We do not like the term "general practitioner" because it connotes a jack of all trades and a master of none. This is a false implication. The mastery of this art requires attainments equal to, if not greater than, those of the specialist.

We prefer "family physician." There is no nobler title than physician, and no relationship more intimate and more responsible than that of the family. It is intimate because he often shares in the most carefully kept secrets. It is responsible because into his trust is placed the most valuable of all possessions — health and even life itself.

When the family physician meets his responsibilities, we can toss the code of ethics out of the window. This is not to place upon him all of the blame for unethical practices, but merely to say that he holds the key to the solution of this serious problem. He knows the specialists to whom he would go for personal care, and to whom he would take those nearest and dearest to him. He would tolerate no other consideration in such cases than the best interests of the patient.

When he applies the same criteria to the selection of specialists for his patients, he has met fully his responsibility as a family physician.

Our concern is with the unethical surgeon and surgical specialist. Their departures from the moral code cannot be extenuated by economic pressures exerted by family physicians. Because of their longer training and wider

experience in their limited fields, they must be presumed to know better when not to operate. When they yield to any other consideration than what is best for the patient, they are even more culpable than the family physician; "for unto whomsoever much is given, of him shall much be required."

For such physicians as Dr. Truman, the code of ethics is not to be found in the printed word. It is deeply engraved in their consciences, and it cannot be altered by resolutions introduced into the House of Delegates of the A.M.A.

**Bulletin of the American College of Surgeons, March-April, Volume 39, Number 2.*

THE FOURTH R

Many physicians are asked about medical education by prospective physicians. The following article is presented to help the doctor when advising the future M.D.—Editor.

Writing in the Journal of Medical Education for February, 1954, Dr. Ward Darley represented medical education as a simple formula: CM over R—(TP). In this formula, C is the student's intellectual capacity and M is his motivation. TP is the medical school program. R represents the factors that interfere with the student's learning and distract his attention.

Although Dr. Darley had something to say about each of the components in the formula, he was most forceful and complete in his discussion of R. He noted that circumstances that enlarge the effect of R have their origin in premedical education. In that stage, he observed that the student's motivation for study and learning is distorted by preoccupations with grades, examinations, and the competition for entry to medical school. Because of emphasis on these features, Dr. Darley wrote, ". . . the objective of premedical education has become, I am afraid, education to get into medical school rather than education in preparation for the study of medicine." He added, "This perversion of motivation, plus the competitive situation to which it contributes, cannot help but interfere with the development of sound study and work habits, and the proper balancing of cultural, social and intellectual interests and abilities. Furthermore, it cannot help but block, screen or pervert the ethical and humanitarian impulses that should be behind the desire to study medicine. The fact that this same emphasis upon examinations and grades continues on into medical school does not improve the situation."

Foremost among the factors that add to R during medical student days, Dr. Darley placed anxiety. He listed as causes for chronic anxiety the limited opportunities for recreational and social outlets, a wife's resentment of this same limitation, financial stringencies ("Almost a third of the students are in debt when they receive their M.D. degree."), and other worries—"the internship, where? how financed?; military duty, hot or cold?; how long?; residency, what specialty? where? how long? how financed?; certifying examination, what if I fail?; practice, when? where? how?" As aggravators for the resulting chronic anxiety, Dr. Darley appended some acute situations—"the adjustment between college and medical school; final examination weeks; the adjustment between the sophomore and the junior years; the first clinical responsibility; comprehensive examinations; and at home—illness, the birth of children and often the relocation of place and space to live."

It is hard to believe that R exerts its influence only upon the medical student's capacity to study and learn. It seems inevitable that R must also affect his career as a physician, including the direction in which he turns that career, whether as specialist or general practitioner. As the largest group of physicians, general practitioners have the strongest obligation to interest themselves in the R of Dr. Darley's formula, particularly in an appraisal of how it has influenced their careers and how it may influence the careers of their colleagues-to-be. In the final analysis, the interest of practicing physicians may be the most important factor in the development of methods to control the obnoxious fourth R. And if these physicians wonder how they can help, since only a minority are members of medical school faculties, they need only recall that all of them are alumni.

G.P., April, 1954

WHO SAYS, WRONG AGAIN?

The Toledo Times
Thursday, April 15, 1954

During the past few days the American Medical Association has again been attacked as an enemy of the common man, an opponent of social progress and, in general, a prehensile organization interested only in the fees of its members.

Specifically, it has been attacked for opposing the Administration's program to spend $25,000,000 to reinsure voluntary health insurance schemes and to set up a system of compulsory social security for the members of the medical profession. The A.M.A. is "wrong again" say the critics, among them our confreres across the tracks, who made an eloquent, if rather dubious point, by saying the doctors should know the only way to protect themselves against socialization of medicine, with strict government control over their practices, is to go along with the Administration in its program.

All we can say to our brethren, as well as the other critics of the A.M.A., is this: they speak out of a complete lack of understanding of the stand taken by the association. It is obvious that they have not read, in detail, the evidence submitted to the House Commerce Committee a few days ago, else they would not have condemned the association as they did.

We have read, carefully and completely, the testimony submitted to the committee, first by Dr. David B. Allman, of Atlantic City, and, next, by Dr. F. L. J. Blasingame, of Wharton, Tex. We can find nothing in it to prove that the A.M.A. is hell bent for fighting public health insurance. On the contrary, the evidence reveals clearly that the association is in favor of it, but not as a Federal proposition. Well, what's wrong with opposing Federal reinsurance? To be honest, nothing. A little study by the association's critics would prove that.

To begin with, the A.M.A. approves of all voluntary health association programs. It speaks of the great growth of such schemes in recent years, and pledges itself to promote their further development. It is, indeed, engaged in a plan to make them effective, particularly in the protection of the indigent people of the nation, who, after all, are the ones who really need the insurance.

The difference between the A.M.A. and the Administration, in promoting health insurance, is this: it believes that any governmental support should

be on the state and local level. In other words, it maintains that the states and municipalities, not the Federal Government, should underwrite all health insurance plans, if they are to be guaranteed. With this in mind, the association already is establishing a field service of experts to assist state and county medical societies in developing programs of guaranteeing medical services to the people.

What is wrong with making the states and municipalities responsible for such programs? Nothing. It is the states, not the Federal Government, which are responsible in the matter. It is the states which should act, simply because, as sovereign political entities, they are closer to the people. Besides, the first responsibility is theirs. What's more, the Federal Administration itself long since recognized the fact that the central government should not assume the responsibility for such programs. Under President Eisenhower, the tendency in U. S. aid programs is to return to the States complete control of the various social and welfare programs that have become so much a part of American life.

The A.M.A. is supported in this by the insurance companies of the land. These companies maintain that reinsurance by the Federal Treasury does not "increase the ability of the insurer to sell protection to the unwilling buyer." Neither does it reduce the cost of health insurance. Neither does it make "insurance available to any class of risk or geographic area not now within the capabilities of voluntary insurers to reach." Nor does it reduce the cost of health insurance.

What it means, at bottom, is a type of government subsidy, such as the Treasury now pays to farmers. But this is the sort of thing the American people have been trying to get away from. Well, then, the matter is clear: voluntary insurance cannot possibly relieve a community of the burden of providing medical care to the indigent, and reinsurance by the Federal Government does not enhance the power of the insurers to guarantee it. When all comes to all, the Eisenhower program becomes a burden on the taxpayers without any assurance that the program will succeed. Moreover, it runs the risk of placing all voluntary insurance plans under the control of bureaucrats.

As to the A.M.A.'s opposition to compulsory social security pensions for the nation's physicians, we can say only that criticism of it is preposterous. In short, the opposition is wholly within the concept of the American system of free enterprise. It is based on the right of every individual to make his own plans for life. It represents individualism at its best. The doctors say simply that they prefer to provide their own insurance. Every taxpayer should welcome such a stand. Certainly, it entails no burden on the taxpayers, as every other scheme of social security does.

Considering all this, we think the critics of the A.M.A. are both foolish and inept in their stand. Even a long-embraced whipping boy deserves more honest treatment than this.

It is unlikely that multinodular goiters are pre-malignant. The physician should be highly suspicious of malignancy, however, when he palpates a solitary nodule in young or middle-aged patients. In the latter cases, operative removal should be routinely performed with techniques that are designed to completely remove the cancer—if it is present.

Crile, G. E., Jr.: Postgrad. Med., March 1954.

PERSONALITY OF THE MONTH

To tell you of the many accomplishments of our personality of the month would take more space than we are allotted in this article. A man of boundless energy and drive is Dr. T. S. Danowski, our speaker at the May meeting of the Mahoning County Medical Society.

T. S. DANOWSKI, M.D.

Born on September 6th, at Wallington, New Jersey in 1914, Dr. Danowski decided on medicine as a career and in 1936, he graduated from Yale University, and then from the School of Medicine magna cum laude in 1940. His interneship was taken at New Haven Hospital and he was assistant resident in Medicine from 1941 to 1943. His post-resident years were spent at Yale University School of Medicine as an instructor until 1946 when he became Assistant Professor of Medicine.

In 1947, Dr. Danowski moved to Pittsburgh, our neighboring city, and was installed as the Renziehausen Professor of Research Medicine at the University of Pittsburgh School of Medicine, a position he still occupies. He also holds the position of Senior Staff Physician at Presbyterian Hospital, Woman's Hospital, Children's Hospital and Elisabeth Steel Magee Hospital. Besides these duties which would be enough to snow any man under, Dr. Danowski is the Acting Medical Director of the Municipal Hospital, also in Pittsburgh, Pennsylvania.

As evidence of his boundless energy in the field of medical research, a list of the prolific Dr. Danowski's published investigations completely fills seven typewritten pages. His tremendous scope is appreciated when one notes the latitude of his investigations range from Electrolytes and Water on to Cell Constituents, Circulation, Exchange Resins, Thyroid, Carbohydrate Metabolism, Acth and Cortisone, General Endocrinology and end with a category of Miscellaneous which in itself is as varied as the above list.

To name a few of the professional groups to which Dr. Danowski is a member, we mention these and wonder at the energy of the man; Diplomate of National Board of Medical Examiners, Diplomate of the American Board of Internal Medicine, Fellow of the American College of Physicians, a Fellow of the American Diabetes Association, a Fellow of the American Association for the Advancement of Science, a member of the American Society for Clinical Investigation, a member of the American Physiological Society, a member of the American Society for the Study of Goitre, and a member of the Society for Experimental Biology and Medicine. These, I repeat, are but a few of his offices and memberships. How does he do it?

Dr. T. S. Danowski, our speaker for the Mahoning County Medical Meeting on May 18th, will present for his subject, "The Physiologic Regulation of Body Fluid as a Basis for Maintenance and Replacement Therapy."

R. L. T.

MAY MEETING

Tuesday, May 18, 1954

8:30 P.M.

Elks Club

T. S. DANOWSKI, M.D.

Professor of Research Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

Subject:

"THE PHYSIOLOGIC REGULATION OF BODY FLUID AS A BASIS FOR MAINTENANCE AND REPLACEMENT THERAPY"

MEDICOLEGAL DISCLOSURE OF INFORMATION REGARDING PATIENT BEFORE TESTIMONY

Requests to disclose information concerning a patient may come to the practicing physician from his patient's attorney, an opposing attorney, investigator or the claims adjuster of an insurance company. In these instances, there may be a difference between what the physician may do and what he must do, as his disclosure must not violate the existing confidential physician-patient relationship.

The Revised Code of Ohio, Section 2317.02 provides:

"The following persons shall not testify in certain respects:

(A) . . . . . a physician, concerning a communication made to him by his patient in that relation, or his advice to his patient; but the . . . . . physician may testify by express consent of the . . . . . patient, or if the . . . . . patient be deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of such deceased . . . . . patient; and if the . . . . . patient voluntarily testifies, ... the physician may be compelled to testify on the same subject;"

The Revised Code of Ohio, Section 4731.22, provides for disciplinary action by the Ohio State Medical Board in the form of suspension or revocation of authorization to practice medicine and surgery for: "The willful betrayal of a professional secret." Exceptions are venereal disease in the case of contemplated marriage and reporting of communicable disease, abortion, gun shot wound, etc.

The privilege belongs to the patient, not to the physician. The Medical Practice Act of Ohio as well as the Principles of Medical Ethics of the American Medical Association regard the maintenance of secrecy as being for the benefit of the patient. Only the patient has the right to determine whether disclosure to third parties is for his benefit. The physician attending a patient is under no legal obligation to give information to any one with the possible exception of the patient himself, unless subpoenaed to testify concerning facts relative to which the patient has no privilege or has waived his privilege. He is liable in damages to his patient for unwarranted disclosure of information regarding history, findings and/or treatment.

The physician, however, can and should fully inform his patient's attorney regarding the case. When testimony is to be given at his request, it is advisable for the physician to thoroughly review and closely examine all his records in consultation with the patient's attorney. The latter has an obligation to confer with the physician so that he may fully understand all the aspects of the case.

The physician should not discuss his patient's condition or disclose any information to an adverse attorney, investigator or claims adjuster to avoid a violation of the privilege which exists by reason of his confidential relationship. He should refuse any disclosure until properly authorized by his patient or his patient's attorney. It would be preferable to disclose the information only to the patient's attorney and permit him to deal with the adverse party.

When his patient does not have an attorney, the physician should first obtain his consent before disclosure of information to an adverse party. It is preferable to furnish the report of history, findings and treatment to the patient and let the patient deal with the adverse party. In the case of in-

surance, if the insured has not already waived the privilege, the spouse or legal representative of the deceased may do so.

The physician often can and should be of assistance in avoiding litigation, with the patient's consent, even though he is under no legal duty to do so. The refusal of physicians to be helpful in situations which may lead to litigation or to serve as experts tends to concentrate such work in a few members of the profession and to bring disrepute.

If in doubt regarding disclosure of information, the physician should consult an attorney or the medicolegal committee of the Mahoning County Medical Society. There is no excuse for him ever to be unnecessarily obstructive, even if his bill has not yet been paid.

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

EASE TAX BURDEN TO HELP FAMILIES MEDICALLY

The A.M.A. recently urged the Senate Finance Committee to act favorably on legislation to ease the financial burden of families with unusual medical care expense. The association endorsed a section of the omnibus tax revision bill (the House-passed H.R. 8300) now before the committee. Under present law only medical expenses in excess of five per cent of taxable income may be deducted. The bill would reduce this to three per cent.

The association's position was set forth in a letter which I sent to Chairman Eugene D. Millikin. I mentioned that the A.M.A. Board of Trustees consistently, over the last five years, has urged Congress to liberalize tax deductions for medical expenses.

As an example of the tax savings under the proposed change, a family of four with taxable income of $6,000 would save enough extra in taxes to pay for nearly four months of both hospital and surgical insurance coverage.

The A.M.A. said it also favors the inclusion of health insurance premiums as part of medical expenses for tax purposes. My statement said:

"This provision will serve as inducement for more families to join voluntary medical and hospitalization plans, will further encourage the improvement of existing health plans, and will help reduce or eliminate the financial burdens of long and costly illness.

"Most important of all, it will encourage the voluntary approach to the solution of health problems rather than promote more dependence on government."

Dr. Lull

A review of 20,016 needle biopsies of the liver indicates clearly that at present this is the most useful adjunct available for the diagnosis of clinical liver disease. In the hands of unqualified persons, misled by its apparent simplicity, the procedure is hazardous, but, when performed by experienced personnel, it is remarkably safe, having a true mortality of less than 1:1000. The proper use of needle biopsy can save many lives by permitting early diagnosis and prompt institution of correct medical or surgical therapy.

Zamcheck, Norman and Klausenstock, Oscar
New England J. Med., December 1953.

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The results of strangulated hernia repair are better if, when no risk is involved, the hernia is reduced under anesthesia and surgical repair is done at a later date.

Bate, J. T.: Am. J. Surg., March 1954.

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KAISER OFFERS CURE-ALL

Proponents of closed-panel medicine hope to make this a big year. Industrialist Henry J. Kaiser, for instance, apparently has ambitious plans for extending his Pacific Coast Kaiser Foundation (formerly known as Permanente). His new proposal: a national string of 1,000 health centers, staffed by 30,000 doctors, set up to give comprehensive care to 30 million persons for as little as $3.25 a month.

About $1 billion in private capital would put the plan in business, says Kaiser. What's more, he declares, his program would dispel the threat of socialized medicine and provide doctors with incomes of at least $20,000 a year.

Medical Economics, March 1954.

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The above is Henry J. Kaiser's latest health scheme calling for a nationwide string of closed-panel plans. The following article presents interesting and informative details on this type of health practice.—Editor.

One Man's Experience With the Kaiser Plan

*by Paul DeKruif, Ph.D.**

This is a confession of personal error and a statement of what the present writer has learned as a result of that mistake.

From 1943 through 1949, in magazine articles and books, this writer described the Kaiser-Permanente health plan with enthusiasm. He believed that, if generally adopted, the plan would bring medical care to the American people at a cost within the reach of the great majority.

Events since 1949 have convinced this writer that the Kaiser-Permanente health plan is *not* a model for a method of bringing good medical care to the country.

Here, briefly, is the story of this writer's disillusionment. In 1943, observing the beginning of the plan's operation, he understood that the profits of closed panel, prepaid group practice would be used for the following purposes: To amortize the cost of the Oakland Permanente hospital, built on loans; to build new hospitals; and to support medical research.

The first two objectives have succeeded, brilliantly. The last, that is, the development of medical research, has not been attained. And without active medical research to keep medical care up-to-date and to advance it as it is now progressing revolutionarily—without medical science animating medical care, the finest hospital is only the simulacrum of a whited sepulchre.

In 1943, the present writer was assured by the principals of the Kaiser-Permanente organization of their eagerness to co-operate with the medical profession as a whole. This writer pointed out to Mr. Henry J. Kaiser and Dr. Sidney R. Garfield that the medical staff of their organization could not progress without intimate, cordial and constant contact with organized medicine—namely, with the entire medical profession outside the Kaiser-Permanente organization.

. . . a sad story

This was what the Kaiser-Permanente authorities said they wanted. And so, to test their intent, the present writer was instrumental, again and again, in bringing together top level representatives of Kaiser-Permanente with top level representatives of organized medicine, county, state and national. The record of these conferences is a sad story of misunderstanding and failure.

Of course it takes two sides to make a fight. Yet, the present writer with regret must report, that a certain atmosphere pervaded these conferences, as follows—

The representatives of organized medicine asked one change in Kaiser-Permanente's procedure as a condition essential to organized medicine's co-operation. Namely, that the closed panel be changed to open panel; that subscribers to the Permanente plan, if they wished the services of physicians or surgeons other than the full-time medical employees of Kaiser-Permanente, could have that service and be indemnified for it. This to the present writer seems reasonable, for if Permanente's medical care is truly outstanding, then few subscribers will ask for non-Permanente doctors; and the plan will therefore not suffer economically.

Against this proposal by organized medicine's representatives, Kaiser-Permanente's officials have been obdurate. Again and again, Kaiser-Permanente's principals assured this writer that the medical profession as a whole hated and feared Kaiser-Permanente, that Kaiser-Permanente was persecuted by organized medicine. A curious and contradictory dichotomy seems, to the present writer, to pervade the thinking of the Kaiser-Permanente authorities—

On the one hand, they say organized medicine has nothing to fear from the growth of Kaiser-Permanente, indeed, that Kaiser-Permanente's existence will make the private practice of medicine more prosperous. On the other hand they believe that the private practice of medicine as we know it is outmoded and will soon be a thing of the past.

If the present writer had been less stupid, he would have seen the futility of trying to bring Kaiser-Permanente and the medical profession together. This writer should have taken warning, long ago, from Dr. Sidney R. Garfield's point of view regarding the relationship between patients and their doctors.

According to Dr. Garfield, this human relationship is no longer necessary. According to Dr. Garfield, teamwork by specialists streamlined under a hospital roof has made the doctor-patient relationship obsolete. To this writer Dr. Garfield illustrated that by examples—

Where does the doctor-patient relationship come in when a radiologist examines your chest by fluoroscope in the dark? What's the need of doctor-patient relationship for a rectal surgeon who proctoscopes you and operates on you, strictly from behind?

To the present writer this point of view seemed a bit premature. Has medicine really become so scientific that cold technique can completely replace warm human understanding, that medical robots can replace medicine's human practitioners, just as guided missiles promise to make human jet and bomber pilots things of the past?

An Anachronism

This production-line point of view of the Director of Kaiser-Permanente became more and more disturbing to the present writer as he took up the study of the Alameda plan. The personal physician, the new man of medicine, emerging in California, is a medical advance fully as important as the new antibiotics, vitamins and hormones. Indeed, the chemical revolution has put a new mighty power into the hands of general practitioners. They can understand and love their patients as of old and at the same time treat them more skilfully than could the greatest specialists in many fields, ten years

ago. Kaiser-Permanente medicine is an anachronism, built rigidly as it is around specialist teamwork, in some specialties already in their twilight.

In the Kaiser-Permanente health plan there is no room or function for the personal physician, the new man of medicine. The personal physician must be his own man, must be free. What is more, from the personal experience of the present writer, (who here refrains from personalities) at Kaiser-Permanente there is no thorough appreciation of the fantastic power of the new chemical medicine.

As citizens, as sick and suffering people, what do we want from our doctors? We want much more than prepaid medicine at a few cents a day and more than an air-conditioned room in a hospital that is an interior decorator's dream. *We want love from our doctors—plus knowledge of how to use what's new in science.*

The Old Dream

The present writer's enthusiasm for Sidney Garfield's original dream of a Mayo Clinic for the common man, died hard. It was remarkable how Sid could build hospitals and pay them off. But what had become of his old dream of research?

Two years ago, after efforts for peace between Kaiser-Permanente and the C.M.A. had stymied, this writer made a last try. He came to California with a plan. Did Mr. Kaiser and Dr. Garfield want medical research to be an integral part of the growth of Permanente? Did they really want Kaiser-Permanente to co-operate with organized medicine as now privately practiced? They said they did.

On the other hand, did the leaders of the C.M.A. want to kill Kaiser-Permanente? They said they did not.

Relying on the good faith of both parties, this writer presented his little plan to Kaiser-Permanente principals. The plan was simple. It involved just one element, a human being, a man of such integrity, wisdom and high standing that he would serve ideally as an arbiter and co-ordinator.

World-famed

The name proposed is that of a man scientifically famous not only in California, not only nationally, but world-famed. California's men of medical science look up to him as their master. California's physicians know him and respect him. The state's leading citizens value his rugged honesty and are proud of his achievements, vital to California's industry as well as its health.

What has been this man's attitude toward the Kaiser-Permanente health plan? When it was unpopular to do so, he went on public record regarding its services in medical care, and its then promise for the future. And his attitude toward organized medicine? While unsparingly critical at times, it was an attitude of cooperation and friendliness.

Many leaders of California's organized medicine were approached regarding the suitability of this great man of medical science and public health as an arbiter of the difficulties between Kaiser-Permanente and organized medicine. With the exception of one physician—who was skeptical that even this man could bring the unfortunate war to a peaceful end—all other medical leaders were enthusiastic.

The candidate himself was cordial to the plan, provided he would be given a free hand. What were his activities to be? He would serve as Di-

rector of Kaiser-Permanente research, and as co-ordinator of its relations with the medical profession as a whole.

In July, 1951, stated on less than one page of double-spaced typescript, the plan was placed by the present writer before Mr. Henry J. Kaiser, Mr. Henry J. Kaiser, Jr., Mr. E. E. Trefethen, Jr., Dr. Sidney R. Garfield and Mr. Robert Elliott.

"What would we have to pay him?" asked Mr. Kaiser.

"To give him executive authority, it would seem he should be paid what you pay Dr. Garfield," this writer replied.

The present writer was assured that the man would be invited for discussion of the project. By now readers may be curious as to his identity. The man was Dr. Karl Friedrich Meyer, Director of the Hooper Foundation.

As of today, that promised discussion has not taken place, and not because of hesitancy on the part of Karl Meyer.

Thus ended the present writer's hopes for the Kaiser-Permanente health plan. Such has been his mistake and for that he can only admit—"*mea culpa.*"

In California's medicine he has high faith. California's medical honesty is creating a new kind of doctor, the personal physician. Of that new type of human being this writer hopes to tell in a book (a tough job that will take a long time) *The New Man of Medicine.*

G.P., Oct. 1953.

**Dr. De Kruif, one of the world's best known writers on popular health subjects, has, for a long time, been the subject of complaint and criticism from organized medicine for what the American Medical Association and other groups have felt was a too idealistic and sensational attitude, one that parted from reality. Now he has done a public about-face.*

NARCOTIC SUPPLIES

From time to time there have been published in *The Journal* statements on the responsibilities of physicians under the Harrison Narcotic Act. In addition to having a registry number that must be renewed each year, the practicing physician must exercise control over his supply of narcotics if for no other reason than to protect himself. In the same light, pharmacists and drug wholesalers must observe certain responsibilities if they are to avoid difficulties with the Federal Bureau of Narcotics.

Physicians cannot obtain nonexempt narcotics directly from pharmacists (unless they are registered as narcotics wholesalers) for use in their offices; they must obtain official order forms to secure narcotics for their practice. They can, of course, prescribe narcotics for patients and expect such prescriptions to be filled at pharmacies and in hospitals. However, an interesting aspect of the prescribing of narcotics concerns the liability of the pharmacist, who is responsible under the federal law for determining if the prescription was written by a physician (or other authorized practitioner) and who thus must always be on the alert for forged signatures and for prescriptions that have been stolen. When in doubt the pharmacist should consult with the physician whose signature appears on the prescription and when he takes such action he is not being arbitrary but rightfully cautious.

A narcotic order received by telephone cannot be delivered until the pharmacist or his manager receives a written prescription. The prescription cannot be mailed or delivered later. Furthermore, a narcotic prescription cannot be refilled; nor can it be signed by anyone other than the physician, who

JUNE MEETING

Tuesday, June 15, 1954
8:30 P.M.

ELKS CLUB

Guest Speakers will be - - -

INTERNES AND RESIDENTS FROM

Youngstown Hospital

and

St. Elizabeth Hospital

must sign, not type or stamp his name. He cannot even ask his nurse to sign for him. Nor can he sign several blank orders and leave them with a pharmacist to be used later as the need arises. Each prescription must contain the date on which it is written, the full name and address of the patient, and the name, address, and registry number of the prescribing physician.

Physicians are likely candidates for addicts to approach in the hope of obtaining narcotics or an order for them by one trick or another. The excuses offered in the average doctor's office are almost too numerous to mention, but nevertheless the physician must always exercise his best judgment to detect such falsified tales if he wishes to avoid innocently coming into conflict with the law. In addition, his car if recognized as belonging to a physician may be broken into by addicts looking for narcotics; or his office may be ransacked. Or he may even be held at gun point by the more desperate. Regardless of the method of attack by an addict the doctor must account for his narcotic supplies, and it may even be wise for him to keep his narcotics divided for hiding in several places. At all times they should be kept under lock and key.

There are comparatively few honest persons who would deliberately invite trouble by carelessly handling narcotics. There are others, however, who risk embarrassment and misunderstanding because of thoughtlessness or even ignorance of good practices. The safeguarding of narcotics is a responsibility of several interested groups—doctors, pharmacists, drug wholesalers, drug manufacturers, and law enforcement officials. Each usually tries to use common sense and to respect the laws. On occasion there may be an unintentional slip, and when such occurs a tolerant attitude can be taken only when there is evidence of unquestionable good faith on the part of the offender. Thus it behooves everyone to appreciate not only his own responsibilities but the problems of others who are involved in the handling, use, and control of narcotics. It is too serious a problem to permit impatience and intolerance.

THE CHAMBERLENS

But what of the Chamberlens, father and sons and grandsons. I was interested in Peter the Elder, born in England in 1560, who lived in London and was said to have invented the "iron tongs,"—obstetrical forceps to you. He was a barber surgeon, and as such was forbidden to prescribe; he could only teach anatomy with readings from Versalius, Galen and Harvey, dissect, bleed, cut, or do midwifery. The slur is gradually being lifted from the male midwife. Barber surgeons were definitely of a lower order than the great physicians, and to this day in England surgeons retain the once degrading title of "Mister," now considering it a mark of distinction.

Peter Chamberlen the younger was also born in England and there was much confusion between the two, although both were equally chastised by the Great College of Physicians, and even imprisoned, for presuming to prescribe medicine and not sticking to their leeches or blood-letting basin. As all of you know, the red and white striped barber pole represents a bloody bandage around an arm or a leg, while the basin with a circular notch in one side, hung outside of barber shops, especially in England, represents the blood-letting bowl.

Be that as it may, the Chamberlens carried the partial secret of the iron tongs through at least three generations, but finally came to grief. Hugh, the grandson of Peter the younger, came upon hard times and tried to sell his

forceps in France for 10,000 livres, about $2,000. He said he could deliver any difficult case in a few moments, but in a test by the famous Moriceau, foremost French obstetrician of the 17th century, Hugh killed both the mother and child. The forceps apparently were not sold. But as he needed money, he journeyed to Holland and there sold the family secret to Roonhuysen for a sum. It came out, however, that he held back a little; he sold only one forceps blade, pretending he knew nothing of the second.

W. W. Boyd, M.D.

"THE M.D.'s ARE OFF THEIR PEDESTAL"

Mr. Herryman Mauer in the February issue of Fortune attempts to answer the question, why has the halo that once set evenly upon the physician's head been twisted askew?—Editor.

"The layman's suspicion of the doctor's income may be the ostensible reason," Mr. Mauer writes, "but basically, if subconsciously, the real reason is better medical practice. Paradoxically, the more specifically and successfully the physician treats patients, the less is his personal prestige. Compared to the physicians of past generations, he keeps a considerably greater percentage of people in every age barcket alive, an even greater percentage in general good health. But he can no longer surround primitive methods with an aura of mystery and authority. He no longer dozes beside a sickbed the night long. Such procedures once gave confidence to the patient and his family, kept away intruding neighbors, and—since, as doctors themselves point out, nature worked cures in most cases—won the physician acclaim as 'the man who pulled Aunt Emmie through.'

"Today, however, the old-fashioned doctor has gone with the old-fashioned family. With new aids to diagnosis, new treatments, and new drugs, any competent physician can accomplish more and quicker cures than he can with any amount of bedside attendance. Under these circumstances patients credit the treatment, not the physician, with keeping them well. The uncritical awe that used to be given to the individual physician is now given to medicine in general despite the obvious fact that medicine can be nothing more than the activities of the men who practice it. There is public ignorance of the state of the medical profession. Therefore there is public and sensational controversy."

P.S. Maybe we should re-evaluate our public relations programs. — Editor.

MEDICAL JOURNALISM—WITH AND WITHOUT UPBEAT

In a recent issue of the *Saturday Review*, there appeared an article by Edith M. Stern, herself a writer of medical articles for the laity, expressing serious qualms about the effect they were having on lay readers. In her article "Medical Journalism—With and Without Upbeat," she states:

"Sometimes I feel like sitting at my typewriter with my hands folded. I don't like popularization. It has gone too far. The little learning—with illustrations—which the magazines have been pouring into a thirsty public has become a dangerous thing.

"One reason is that false hopes inspired by medical articles with such recurring titles as 'There's Hope For . . .' and 'Good News About . . . ' can

disrupt peace of mind and body far more than honest acceptance of the facts. Take my own case, for instance. I've sincerely believed the many articles I've both written and read about how chronic conditions can be prevented through regular physical checkups and how the aging needn't be old—after all, weren't these pieces documented by quotes from reputable physicians? When I developed mildly incapacitating osteoarthritis, therefore, I underwent quite an emotional shock; this shouldn't happen to anybody, and couldn't happen to me! My uninformed mother and grandmother, who had only old Doc to educate them, would have shrugged off twinges and creakings like mine as something quite to be expected in their early fifties."

"Since reputable writers and editors (motivated by a combination of self-protection and integrity) tend to get expert checking before publication, factual inaccuracy as a rule is least among the factors which transmute what should be merely a report on a hopeful experiment into joyous hailing of a sure cure. An important one is readers' wishful thinking. Another is the highly competitive slicks' need for scoops; hence new medical discoveries are played up, truthfully enough, before time and further research play them down."

Miss Stern says she does not suggest a moratorium on lay medical articles, neither would she "pass a law" to restrict medical information to scientific journals, but she insists that "there is a way of ending the wrong kind of popularization." She recommends that "publishers and publishers, editors and editors, writers and writers, make gentlemen's agreements among themselves never again to distort 'This is so' into 'This is it!' or to fan cool facts into hot news. All of us, no worse off competitively than we are now, ought to eat as well—and we would sleep better!"

TEACHING WITH PRIVATE PATIENTS

As the indigent patient disappears from the American hospital scene organized medicine must find and adopt means for carrying on its teaching program with private patients.

The need for constant and continuous teaching is almost as well recognized by the lay patient as by the profession itself. The willingness and even preference for some of our large clinics by well-to-do patients is evidence of this fact. The general satisfaction with this aspect of care in armed service and veterans hospitals has the same significance.

Many thoughtful people believe that economic segregation is discriminatory and certainly bad. The effort of most city hospitals to look like private hospitals to their patients is part of the effort to avoid the stigma of indigence. Individual physicians have always professed to believe that good care should not depend on financial means. Indeed, the noblest aims of the profession have been met on this exact point. However, there is a popular feeling that indigent patients have not infrequently been subjected to certain indignities in the name of teaching. Whether this is true or not, many private patients have been frightened by tales of exposure to a long line of clumsy examiners and have been almost more concerned to buy privacy than competent treatment.

It may be concluded logically that if a young physician is in training to take up a private practice, there are certain things to be had only by dealing with private patients. It has frequently been noted that residents from teaching services utilizing indigent patient wards have actually had to go back and learn some of the requirements of kindness and courtesy before

taking on successful private practice. How much better it would have been for the art of medicine to have been developed along with its science!

It is becoming commonplace to bemoan the loss of teaching services which are still confused in common thought with indigence. It has been thoughtlessly suggested by not a few that Blue Cross-Blue Shield patients may properly be used for teaching instead of "private patients." This confused view possibly stems from the belief that those who voluntarily embrace insurance coverage are receptive to regimentation. The number in this group, however, is becoming great enough that such an attitude must be corrected. As a matter of fact, many who have such coverage feel that they, more than ever, have satisfied the traditional requirement of the private patient to pay his own way.

Again, the mounting costs of hospitalization are making it more important for a private hospital to receive from every patient, directly or indirectly, income which pays most of his way. And, those in the private rooms are no longer able to pay a rate which is sufficient to carry ward beds on a free or even a very cheap basis.

Thus it seems certain that the apparent reduction in ward beds and outpatient clinics is real and is based on progressive changes. One may be sure that if the new Government proposals do anything at all in this field, they will result in further reduction in the number of indigent patients. These developments may well result in city hospitals as now commonly organized becoming outmoded institutions.

Organized medicine is faced with the urgent need to modify traditional teaching forms so that private and voluntary hospitals are not working at a disadvantage. This rather specifically involves accreditation programs. There is a present tendency for heavy concentration of American graduates in a limited portion of the whole hospital group. Many private and voluntary hospitals with fine attending staffs and all facilities for good teaching are functioning with makeshift house staffs. This creates a vicious cycle because no hospital can build a good teaching program, especially with private patients, without a fine supporting house staff. It would seem to be a problem for medical statesmanship to find some solution for this dilemma. Certainly means must be found to train many more of our American medical school graduates with private patients or we will find that the new generation does not know the old.

Donald Stubbs, M.D.

TEACHING OF MEDICINE AND SURGERY

Medical education, and medical practice, may be visualized as being carried along by a wheel. The various medical sciences and areas of medical practice are spokes of the wheel. Each spoke in turn and at the appropriate moment bears the weight. The hub of the wheel, to which each spoke relates, represents the unity of medicine. If medical education is carried on too far out on a spoke — that is if education is too narrow and too specialized — it is cut off from the hub and no longer carries weight either in education or in sound practice.

Surgical specialties in their preoccupation with technic have tended to get too far out on the spoke. Otolaryngology and urology in particular give evidence of having lost contact with the hub. The other specialties too, such as gynecology and orthopedics, must be alerted to the shortcomings of the

trend. It is time that they were drawn back. And newer areas of special interest, such as thoracic surgery, should not be allowed to sever their contact with the hub. The practical step is the reintegration of otolaryngology, urology, gynecology and other special surgical interests into a broad department of surgery.

Though it has resisted better than surgery, medicine has also suffered from the disintegrating force of specialization. In addition to special areas of practice such as cardiology, diabetes and allergy, which have grown aloof from the parent, new ideas have sprung up in the form of a department. Social medicine and preventive medicine, concepts inherent in good medical practice and teaching, have appeared overnight in a number of medical schools as separate teaching departments. Medicine must resorb these special fields of interest.

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

HYPOFIBRINOGENEMIA

Incoagulable blood as a result of hypofibrinogenemia is an obstetrical syndrome of unusual clinical significance. Death from unmanageable hemorrhage may be the penalty. Prompt recognition of the condition and appropriate therapy is an obligation of the obstetrician.

This condition is known to occur in two complications of pregnancy. First, and most widely recognized is abruptio placentae, second, is prolonged retention of a dead fetus in an Rh-isosensitized mother. Incoaggulable blood from a deficiency in circulating fibrinogen is an outstanding pathological characteristic, common to both conditions.

Stored blood alone, rarely corrects an afribrinogenemia. Prompt replacement therapy with fibrinogen and ample quantities of fresh whole blood, is indicated. Until recently, the only form of fibrinogen replacement possible was by plasma or whole blood transfusion. However, in 1949 Maloney, Egan and Gorman, reported a case of coagulation defect associated with abruptio placentae, successfully treated with Cohn's Fraction I (containing fibrinogen). Since that time a means of further purifying fibrinogen has been developed. Numerous cases of this disease and other fibrinogenopenic states now have been successfully treated with Parenogen.

Parenogen is dried human fibrinogen prepared from normal human plasma. The product is bacteriologically sterile, non-pyrogenic and has been subjected to ultraviolet radiation. However, this method of sterilization cannot be relied upon to inactivate completely, all viruses, including homologous jaundice virus, if such contamination is present in the original plasma. Altho, the product has a three year dating, the limited supplies have made it necessary that hospitals do not overstock. It has been deemed advisable to maintain not more than six grams in an area. It is rather expensive, a gram will cost the patient about the same as a pint of blood.

The Youngstown Hospital Association has been able to secure only two grams of this drug, which is stocked at the North Side Hospital Blood Bank, for the use of our staff doctors.

Pauline M. Tweeddale, R.N.
Director Blood Bank, Youngstown Hospital Association

THE ART OF MEDICINE*

Medicine is composed of a very careful blending of two basic elements. One is the science of medicine, and the other is the art. To my way of thinking, unless this potion (the practice of medicine) is blended in proper proportion, the end-results are not as good as they might be.

What is the science of medicine? The science of medicine is that broad stream into which many tributaries have poured scientific knowledge. Link after link has been forged in the chain of scientific medical progress. This progress is handed on to the individuals who follow. I as a professor of surgery may develop certain technics which can be passed on to my successor. Sir Alexander Fleming developed the great antibiotic rootlet that has now grown into the broad spectrum of antibiotic therapy, and on the foundation he has laid others can build stone upon stone. This is purely a mechanical thing; the science of medicine is the mechanics. In other words, an individual can carry out diagnostic and therapeutic procedures without the art of medicine ever touching him. Take a patient with hyperthyroidism. You can have a basal metabolism test and blood iodine determination run on him and finally give him radioactive iodine with control of the thyrotoxic symptoms. This is purely the scientific part.

Now what is the art of medicine which must run hand in hand with the science in order to develop a pure type of medical practice? The art of medicine is that which is envisioned as the physician-patient relationship. The art of medicine is not handed down from the professor to his student as is the science of medicine. One cannot lay a foundation in the art of medicine upon which the next individual can build. The art of medicine must be learned anew by each neophyte who accepts the practice of medicine as his vocation. The art of medicine is like the art of painting. The great painter who paints on the canvas cannot simply, by handing down a formula, transmit the ability that he has to depict on the canvas a scene which he sees in life. When the artist dies, enshrouded with him goes the art which he developed during his lifetime. And so in medicine, the art of medicine is a factor which each neophyte must learn anew, and which, to my way of thinking, is an extremely important part of the total practice of medicine. Actually, in the early days there was a great deal of art and not too much science. Now we have tipped the scales the other way, and there is a great deal of science but not enough time for art.

What has happened to the art of medicine? As soon as the day came when no one individual could cover the whole spectrum of medicine it was natural that medicine would become fragmented and fractionated. So we developed specialization, and I certainly do not decry that development. However, with that came a fractionation, so that we began to think of the individual as a physiologic or anatomic complex. We began to speak of Mrs. Jones not as Mrs. Jones the patient from Podunkville whose husband has been so and so, and has five children; no, we speak of Mrs. Jones as the peptic ulcer case in bed 49. We seem to be drawing completely toward the scientific side and neglecting the art of medicine. The art of medicine is not just hocus pocus. It is the dispensing of medicine with an element of human warmth, with a personal interest, and in the long run it brings about better therapeutic results. The art of medicine is not just an accessory; it is an essential part of the dispensing of medicine. Not only must the right

medicine be selected and the prescription accurately filed, but it must be given in the proper way.

What has given rise to this change of emphasis besides the fractionation of the human patient due to the development of specialization? Briefly, all of the educational system, to my way of thinking. Our educational system is getting more and more pragmatic. We are not thinking in terms of educating the student to become a broader thinker, and to give him a broader base for getting along in life; education is pointed toward a degree. All of the fringe benefits we might need are trimmed off to streamline the educational process of getting a degree, which immediately, whether it is a law degree, a medical degree or some other degree, we weigh on the scales against an annual income. Possibly I am overcritical; perhaps I am wrong, but I don't think I am. Even our high schools are getting to be extremely technical in their development. Anything that can be proved in a test tube or by a mathematical formula on the blackboard is right. Anything that can't—well, it may not be wrong, but certainly it is not as sound as what is proven on the blackboard or in the test tube.

We seem intent on becoming a practical, pragmatic nation, and that part is wrong. I am not decrying scientific growth and gadgetry. I use gadgets and love them, but I am saying that with scientific development we must have a philosophy that goes along with it. The reward of the physician who practices the art of medicine, I hardly need to relate to those who practice it. The most satisfying reward one gets as a physician is not necessarily financial, but the respect of one's patients and one's community. It is the practice of the art which develops that respect. Interest in your patient should extend beyond the fact that an antithyroid tablet will cure his hyperthyroidism.

I should like to sum up what I have tried to say by quoting a Persian poet, who lived many centuries ago. Translated into English, this Persian poet so spoke:

"Shoulds't thou then repair to thy larder and there of thy once bounteous store find but two loaves of bread remain. Yet would I counsel thee, to sell one wherewith to buy white hyacinths to feed thy soul."

Melvin A. Casberg, M.D.

*This is a portion of the address Dr. Casberg delivered before the students of George Washington University School of Medicine at the opening of the 130th Academic Session, September 21, 1953.

It is smugly satisfying to look back upon the practice of medicine of fifty or a hundred years ago. We like to think of those days as a dark age in medicine. It may well be that fifty or more years hence (let us hope sooner) physicians will look back upon our present gropings in that vast, still largely unexplored wilderness known as the field of hypertension, smile knowingly and say that we, too, in the mid-twentieth century are living in a dark age medically speaking. In the meantime, it behooves us, as we continue our probings, to do as little damage as possible and to remember that in patients with essential hypertension there is particular pertinence to the concept that we must not lose sight of the patient in our concern over some of his physiological maladjusments.

Samuel Proger, M.D.

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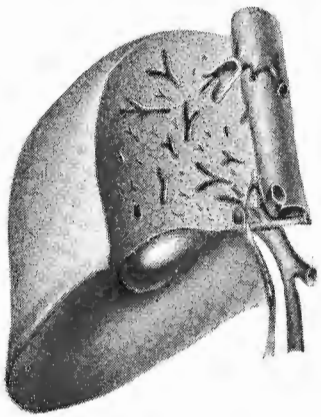

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