BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

JULY • 1954
Vol. XXIV • No. 7

Fellows

vitamin b complex

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.

Natural Base

formula:

Each Teaspoonful (4 cc.) contains:

Thiamine Hydrochloride	2.5 mg.
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.

NOW CONTAINS VITAMIN B_{12} - 1 mcg

formula:

Each Capsule Contains:

Thiamine Hydrochloride	10 mg.
Riboflavin	15 mg.
Niacinamide	100 mg.
Pyridoxine	1 mg.
Calcium Pantothenate	10 mg.
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.

Samples on Request

Fellows MEDICAL MFG. CO. INC. Pharmaceuticals

26 CHRISTOPHER STREET NEW YORK 14, N. Y.

OFFICERS AND COUNCIL

OFFICERS

J. D. BROWN, President
706 Home Savings & Loan Bldg.

I. C. SMITH, President-Elect
210 Home Savings & Loan Bldg.

G. E. DeCICCO, Secretary
1008 Market Street

A. K. PHILLIPS, Treasurer
250 Lincoln Avenue

MRS. MARY B. HERALD, Executive Secretary
125 West Commerce Street

Censors	Delegates	Alternate Delegates
E. J. WENAAS ('54)	W. M. SKIPP ('54)	ASHER RANDELL ('54)
C. A. GUSTAFSON ('55)	S. W. ONDASH ('55)	E. R. McNEAL ('54)
V. L. GOODWIN ('56)	M. W. NEIDUS ('56)	FRED G. SCHLECHT ('54)

THE COUNCIL

J. D. BROWN	C. A. GUSTAFSON	A. K. PHILLIPS
G. E. DeCICCO	E. R. McNEAL	ASHER RANDELL
A. A. DETESCO	M. W. NEIDUS	FRED G. SCHLECHT
V. L. GOODWIN	S. W. ONDASH	W. M. SKIPP

I. C. SMITH E. J. WENAAS

Representative to the Associated Hospital Service
H. E. PATRICK

TABLE OF CONTENTS

Vol. XXIV—No. 7 **July, 1954**

ADVERTISERS' LIST

The Dean's Page

Northwestern University extends greetings to its many alumni in Ohio. There are over 2,000 general alumni of whom 122 are graduates of the Medical School. Ohio stands fourth among the states in the number of applications and accepted students enrolled at Northwestern University Medical School. Also, the performance of Ohio students has been excellent; this speaks well for the superior training afforded by Ohio's undergraduate colleges.

Northwestern University Medical School was organized in 1859 as the Medical Department of Lind University of Chicago; its first annual course of medical instruction began October 9, 1859. The Medical School has occupied the beautiful Montgomery Ward Building since 1926 and uses the first 7 floors, the 14th and 15th floors and all of the tower of this building. The Archibald Church Library, located in the east wing of the first floor, contains over 125,000 bound volumes, which make this Medical Library one of the largest in the country. The Outpatient Clinics occupy the first 3 floors. Affiliated with the Medical School for its clinical teaching are Wesley Memorial Hospital (560 beds), Passavant Memorial Hospital (260 beds), Evanston Hospital, (296 beds), Veterans Administration Research Hospital (523 beds), and Children's Memorial Hospital (233 beds). Other hospitals not directly affiliated with the Medical School and not in the Medical Center are St. Luke's Hospital (579 beds), Chicago Maternity Center and Cook County Hospital (3,500 beds).

Northwestern has gained an outstanding reputation for producing well rounded clinicians and, in addition, has an envious record for its production in research and its training of academic personnel.

Richard H. Young, M.D.
Dean, Northwestern University Medical School,
Chicago, Illinois

This message was written expressly for the Mahoning County Medical Society Bulletin

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio Annual Subscription, $2.00

VOLUME 24 JULY, 1954 NUMBER 7

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

EDITORIAL

DO UNTO OTHERS . . . .

There has been much written and said lately in an attempt to undermine public confidence in the medical profession. While we have been busy beating off attacks from without we have overlocked the fifth column within our own ranks. This is that group of physicians who, usually in a subtle manner, destroy public faith in the profession by degrading their colleagues in an attempt to aggrandize themselves. This is done by innuendo, inflection and half truths. Many remarks are made which disparage the diagnostic and therapeutic ability of other physicians.

Let us be honest and fair with each other and let us recall and paraphrase what Adlai Stevenson recently said, "he who throws dirt always loses a little ground."

Andrew A. Detesco, M.D.—Editor.

DO'S AND DON'TS WITH NARCOTICS

There is no worse trouble a doctor can get into than trouble with the Treasury Department over narcotics. There is no need to if he follows the rules laid down by the Harrison Act. Yet, a doctor sometimes does get in trouble innocently or carelessly and the result is most damaging to his prestige and his pocketbook.

Never hesitate to prescribe a narcotic for a bona fide patient who needs it. Narcotics are valuable drugs mostly used for the relief of pain and relief of pain is one of the greatest services a doctor can give. Write your prescription legibly, specify the amount, the dose and the time; put your licensed number on it (don't have it printed) and give it to the patient. If the patient needs more, see and examine him and write a new prescription.

Don't call the druggist and ask him to refill and you will send the prescription later, even for codeine in a cough syrup. That makes both you and the druggist liable for infraction of the law, and inspectors are sticklers for the law.

When you need narcotics for personal administration fill out a narcotic order blank and get it from a supply house which holds a wholesale license. Don't write a prescription for some patient and keep the drugs yourself.

You don't have to keep a record of narcotics you personally administer but if you leave a supply with a patient you have to make a record of it and keep the record on file for two years.

Don't be fooled by addicts. They have the most convincing stories. You can spot them when they say "Nothing helps me but a hypodermic." A bona fide patient in great pain says "For heaven's sake do something" but an addict says "I always have to have a half a grain." One time a nurse came in my office clutching her abdomen, all bent over and said, "I think I have a kidney stone, give me a hypodermic quickly. Dr. Smith took care of me the last time I had one and he gave me morphine."

I gave her a container and showed her to the toilet to get a specimen. She brought it back and it had blood in it. I gave her a hypo, put her in my car and took her home. The next day I called Dr. Smith and he said "She is an addict, don't let her fool you." She took me in that time but not again.

Another story they give is "I am on my way to a Sanitarium for cure of my habit but I ran out of drugs. Just give me two or three tablets so I can get there." The answer is "no."

If you are soft and easy, the word gets around and you will have many more of these phony emergencies.

Don't try to treat addicts by the withdrawal method, or any method outside of an established institution. You can't do it at home nor in a general hospital. Leave it to the experts who work in sanitaria where there is close supervision. They advertise in the medical journals, so leave it to them. Don't give an addict a supply of narcotics to reach his destination. He will use it up and appear in your office for more. They are the most unreliable people in the world.

Last but not least, fill out your inventory and get your renewal of your license in on time with the M.O. for a dollar. If you don't, you will be asked to explain why you have been dispensing narcotics without a license, and may be requested to make a cash offer in settlement for your infraction of the law.

Your forms are sent a month in advance and that should be plenty of time. Follow the letter of the law and you will have no trouble with narcotics.

J. L. F.

WHY SOME DOCTORS TAKE DOPE

The following is a paraphrasing of an article by J. DeWitt Fox, M.D.—Editor.

The American public is opening its eyes to the dope menace. We abhor the crime stories of teen-age youth having marijuana parties then hot-rodding down our highways at 80 per. We shudder at the thought of some "pusher" seducing our sons and daughters into houses of ill-fame.

But all too often the man nearest the narcotic needle overlooks the menace in his own little black medical bag.

Dr. Harris Isbell, Director of the U. S. Public Health Service Hospital in Lexington, Kentucky, the Nation's leading treatment center for addiction, says, "Scarcely a week passes that a physician who is a Demerol addict is not admitted to our institution." (Since Demerol made its appearance most new physician addicts take to it rather than morphine.)

Of course, all physician addicts are individuals, and their stories concerning the onset of addiction are different, but there are three common patterns into which physician addicts fall. According to Dr. Isbell these are:

1. Alcoholic physicians who relieve hangovers with opiates.
2. Tired doctors who habitually blot out fatigue with a narcotic.
3. Doctors suffering pain from disease, who overdose themselves with opiates.

What most physicians need is a good night's sleep, more vacation time, release from tension, a quiet place for meditation. Yet few of us are willing to take time from a busy practice. When a person gets wound up tight nervously he may do a lot of reckless things. Even a doctor is not immune to the temptations that lure the layman in search of nervous release. In fact, a physician is in greater danger than any layman, because of the tense, tiring life he lives, and because of his easy access to the drugs.

Yet little or no instruction on narcotic dangers is given among physicians or in medical schools. It is high time that medical schools begin telling students the dangers and pitfalls they will face once they get a narcotic license, and have easy access to morphine, Demerol, codeine, and the other narcotic drugs.

The outstanding feature of these cases of physician addicts appeared to be a lack of warning of young doctors before they went out to practice.

To avoid this insidious "disease," remember:

1. You are human, subject to the temptations of laymen.
2. Never let easy access to narcotics be an excuse for your first "shot."
3. Don't get overly tired and fatigued. When you are worn out, take a vacation. It's a lot safer, and a lot more fun.
4. Don't drink. Alcoholism can lead to drug addiction.
5. If you have surgery or get sick, don't ever take narcotics on your own. Keep in mind what Benjamin Franklin said: "The man who treats himself has a fool for a doctor."
6. As a monitor against easy escape from an emotional problem, always think of your family, your future, and your prestige. Best of all breathe a prayer for God to keep your hand off any narcotic during time of stress.
7. Take time to relax each day and meditate on the many blessings God has given you. This will "up" your spirits. Only depressed doctors take dope. Keep a happy mental outlook, and you do much to prevent the world's most insidious and most hopeless habit.

KEEPING UP WITH THE A.M.A.

The following material was forwarded from the A.M.A. meeting in San Francisco by Dr. Wm. Skipp.—Editor.

CONFERENCE OF PRESIDENTS AND OTHER OFFICERS OF STATE MEDICAL ASSOCIATIONS

Tenth Annual Meeting, Sunday, June 20, 1954 (Wm. M. Skipp, M.D.)

SPHERES OF MEDICINE — Percy E. Hopkins, M.D., President-elect of the Conference

Duties of the physician were quite simple — "Take care of his patients," with Art of Medicine doing away with suffering of mankind. A doctor was devoted to his patients.

The doctor now has other spheres of activity such as public relations, insurance, Veterans' care. He must serve on these committees. Some doctors will not serve and, therefore, put on others what they should do. It is our duty to fight socializers who would take away our duty to our patients. We must face the facts and change our course because of what has been forced on medicine. There is change in hospital standards, we are stopping quackery.

Many bureaus in A.M.A. were set up to cope with new problems and still are increasing. Farmers' medical care has been instituted and must be carried out by physicians. Medical care of Armed Service must be met. A Department of Public Relations has been set up and a Washington office opened. The Washington office watches legislation in which we are interested. These things are for the public good and physicians must take part and thus fight socialized medicine.

Doctors must do the job, and not just give money as some of us think is enough. Doctors must do this in their offices. Relations of press evolves around the individual physician. Voluntary insurance is a job the physician must do, but the physician must remember he is not in the insurance business. He must use his influence to aid in the social and economic problems of his patients. We will carry out the old ideas, even if 100 different new ways are used, for the benefit of our patients.

Young doctors today have a lot more confronting them than the olde. men had when they started to practice.

PANEL DISCUSSION ON DOCTORS AND THE PRESS

1. *From a Magazine Editor's Point of View — Mr. Steven M. Spencer, Associate Editor of The Saturday Evening Post.*

Stated this conference was very important because of where the men attending came from, all over this land of ours. They give sound advice, not in medical practice alone but in community benefit also. They are opposed to government in medicine. They want to practice medicine as the doctors want to practice. Our meetings have been opened to the press to address medical students and medical meetings. Therefore, there is starting to be better relations with the press but sometimes the press and profession upset all of this. In some places this may still be bad because one doctor may get a little self-advertising. The press must have names, material facts, and pictures.

Information about new drugs and special kind of work that a doctor is doing must be reported by the press as they see the facts, not as some doctor thinks. The Constitution of the U. S. gives this right and people want to know the facts — for this reason the facts must be given correctly to the press because the press tries to give people true facts.

Medicine is in the front rank of news. Sulpha was the first wonder drug to be used, then penicillin, and facts about them must be reported correctly. A lot of diseases are reported. These are widely read and help some people a great deal. Press reporters are not prophets and must report just what they see.

Reporters must have the cooperation of physicians and must be given facts. Physicians will not give name, or allow pictures, unless others are in pictures or several names are mentioned. Editors cannot see anything immoral in printing a doctor's name, or picture, nor can they see why a doctor should be censored by his profession because he has done nothing but state facts. Tongue depressors should now be taken out of the doctor's mouth so he can talk. But this privilege must be guarded because of some members who would abuse this press relation. Good progress has been made in Code of Ethics. Ethical physicians can discuss what has been given at a medical meeting. (Code of Ethics, Dec. 1953 St. Louis meeting, should be read).

2. *From a Science Writer's Point of View — Mr. Alton L. Blakeslee, Associated Press.*

Definition: News is what is interesting to human beings, which includes medical news. Medical news can be anything new, or anything dangerous.

Some of the news on new drugs can give good and also bad effects. Reporters are bombarded with questions by people (those not trained in medicine), quacks, etc., just to make money.

Reporters cannot always take what top-notch man may say because he may be hipped on his own subject or own ideas. They must look out for what they are told.

What is done in the House of Delegates is news and the public should be told for it is for their benefit. We insist on using names at all times as this gives more weight to the reported material. Good medical reporting does more good than no medical reporting. The people can protect themselves if given the proper reporting.

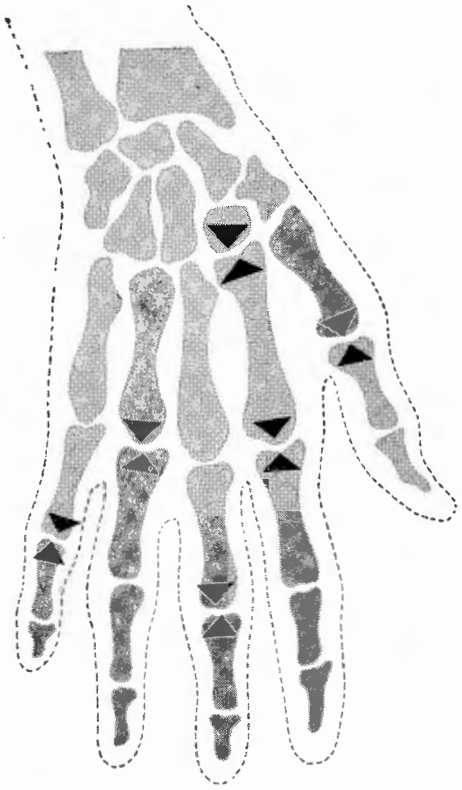
New heart surgery, polio and cancer aids, could not be of as much benefit if not properly reported. Reporters try not to mislead people. After reports have been published, people will come to physicians. You should be kind to these people, they are seeking aid. Be sympathetic, tell them you will try to find out for them. A news story cannot be a text book, but will give step-by-step the progress of disease. Medical organizations are helping make good reporting by giving reprints, etc.

How the public regards press, and their response to reporting, is good. There should be better press relations in your own community. It must start there. Both sides have ethics, and both should use same for the good of the people.

3. *From a Physician's Point of View — Herbert P. Ramsey, M.D., Co-Chairman, Committee on Blood, A.M.A. President, The Medical Society of the D. of C.*

His press contacts started 20 years ago, and he has written newspaper columns on medical subjects. He is going to grouch a litttle but not about the two men heard here this afternoon. This is the fifth freedom, press, radio and TV.

Some doctors will be classed as publicity hounds and reporters will not seek him out. Many men will think the place where he practices is the head



in
arthritis
and allied
disorders

Rapid Relief of Pain
usually within a few days

Greater Freedom
and Ease of Movement
functional improvement in a significant percentage of cases

No Development of Tolerance
even when administered over a prolonged period

BUTAZOLIDIN

(brand of phenylbutazone)

Its usefulness and efficacy substantiated by numerous published reports, BUTAZOLIDIN has received the Seal of Acceptance of the Council on Pharmacy and Chemistry of the American Medical Association for use in:

- **Gouty Arthritis**
- **Rheumatoid Arthritis**
- **Psoriatic Arthritis**
- **Rheumatoid Spondylitis**
- **Painful Shoulder (including peritendinitis, capsulitis, bursitis and acute arthritis)**

Since BUTAZOLIDIN is a potent agent, patients for therapy should be selected with care; dosage should be judiciously controlled; and the patient should be regularly observed so that treatment may be discontinued at the first sign of toxic reaction.

Descriptive literature available on request.

BUTAZOLIDIN® (brand of phenylbutazone), coated tablets of 100 mg.

Geigy

GEIGY PHARMACEUTICALS
Division of Geigy Chemical Corporation
220 Church Street, New York 13, N.Y.
In Canada: Geigy Pharmaceuticals, Montreal

357

of practice of medicine, such as Boston, Philadelphia, etc. The time has come where hospitals, clinics, medical schools are out for publicity.

Ability is not always matched by responsibility and reporters should watch out for such. Can we trust all our doctors? Or can we trust all our reporters? Scientific reporting is hard to understand. The man reading the paper may say it said so-and-so, which may not be the truth. No physician is free from patients who have read some cure in the papers or magazines, which may not be true. Many health stories are good however.

Doctors are fair game to be attacked. Medicine is in for debunking by news reporting, more so now since the New Deal, etc. But we try to understand each other.

ARE PUBLIC RELATIONS PROGRAMS WORTH WHAT THEY COST?

Mr. Robert L. Stearns, Director Boettcher Foundation, Denver, Colo.

We must differentiate between advertising and public relations. Public relations of medical societies cost must be evaluated by what it has accomplished.

We want to use it to give the public information about what we want to do. The public is told what we understand by socialized medicine: — the patient will use the right to select his own doctor, the doctor will not be able to practice as he sees best. The doctor does not want government in his practice. Organized medicine has tried to prevent this by having personnel to combat socialized medicine.

The increased cost of medical care, which has spiralled, specialization, cost of drugs, good nursing care, all the blame for these is laid at the door of the physician. It is not his fault. If P.R. has given results the cost is all right, if not the money should not have been spent. There are 1930 county medical societies in the U.S. having P.R. setups, which has cost a great amount of money.

Laws in states say corporations cannot practice medicine, which includes hospitals. Therefore, they cannot hire pathologists or X-ray men and patients are fearing higher costs because of this. Medical schools cannot hire doctors to do their work.

At first physicians opposed health insurance, now they have to change, because of the benefit to the patients who can get better care with insurance coverage.

Specialists are setting themselves up as better than ordinary doctors. As long as they stay in their own field this may be all right, but if they step into other fields there will be resentment and laws will be passed to stop this attitude.

Doctor's answering service is bad when a physician does not answer his own telephone. Follow-up calls are good, no charge call, how is patient doing after the last call. (Note—Regardless how your office is covered notify the Bureau when you are away.)

Is competition cutting out the personal contact of the old physician? The good to each patient is team work. All must work together, the weak one in the chain breaks the entire good.

Bringing back public confidence to the family doctor can be done by education and good will of the physician. But it must be done by the physician himself at once, and he is the public relations agent alone in his office, patient's home, telephone calls, etc.

OUR COMMON AIMS — Mr. James Mussatti, General Mgr., California State, Chamber of Commerce

Our common aims are: 1. Preservation of free enterprise; 2. Provide the American people best medical care that money can buy.

Free enterprise is deep in the roots of the American people. All business and professions are included. Our people earlier, and now, were instilled with resourcefulness and their determination to succeed. To be successful we cannot have barriers. Each individual had, and has, the freedom to give himself more and better living conditions without government interference.

We made better living conditions by conquering the whole land. Medicine came along with this. We did not get this without work, we had to work together. Every man got a chance, he could do whatever he wanted to do. No one told him what he could not do. He had individual liberty in all fields of production. Free minds can do more than enslaved minds, including those in medicine.

In this country every individual has been given the God-given freedom to work as he wants to work, organize and think as he pleases, elect his own government. Freedom of choice of physician and patient is essential to maintain the best medical care. No man is good enough to govern the other without being given consent. When you let government intervene with compulsory medical care you are getting socialized medicine.

The following are facts from a study made by the California C. of C. of people covered by insurance.

In 1951, 41% of the people were covered by some type of insurance 59% of all people covered by hospital, surgical and medical care. There has been a 1,000% increase in insurance coverage from 1941 to 1951. This will fight off socialized medicine, by business and medicine working together. No bill in California would have done so well.

The government cannot do anything, the people have the power and will do the job. If you let this go on you get apathy, then bondage by the government.

—o—

Dr. Dwight H. Murray, Chairman of Board of Trustees, made the nomination for the distinguished service award which went to Philadelphia's Dr. William Wayne Babcock, aged 82. He was one of three nominated, the others were Dr. Howard T. Karsner of Washington, D. C. and Dr. Torald H. Sollman of Cleveland Heights, Ohio.

Dr. Edward J. McCormick, retiring president A.M.A.: Stated praise is evanescent, but criticism is hard to bear, even though it may be at times deserved, but mostly the result of misquotation and misdirection of facts by groups that desire to change radically our American way of life, such as unions, social workers, etc., who would like to see "government" medicine. This is true also in the field of veterans affairs, where instead of reporting that doctors are more than willing to care for the indigent veteran at the state and local level, so that the veteran can be cared for by the doctor of his choice, it is made to seem that doctors by opposing care of non-service-connected disabilities in Veterans hospitals, are attempting to refuse all care to veterans.

He discussed the progress made on the nine points of activity he has listed in his address to this House in N. Y. C. June 1, 1953. 1. Great progress in doctor distribution. 2. An increasing number of county medical societies

have instituted emergency call services. 3. Untiring help of the grievance or mediation committees of state and county societies in answering the hundreds of letters of complaint from patients, and urges continuance of these committees. 4. There has been definite advance in physician hospital relations but still room for improvement and state and county societies should study the code accepted by A.H.A. and A.M.A. for continued understanding and fairness in this field. 5. Through county and state societies voluntary prepaid health and hospital insurance plans have expanded at an ever-increasing pace, with long-term illness insurance being "born." It becomes evident we need no government interference in this field particularly in view of the insurance coverage and the industrial, charitable, veterans care, custodial care by state government, crippled children care, etc. also being done. 6. Better P.R. through activity of physicians in increasing numbers in civic, social, church and fraternal organizations throughout the country. 7. Improvement can be shown here, however, in the clearing of the misunderstandings that arise in the physician's office through overcharging, disinterest in patients, etc. and an educational program should be formulated to drive home the point that we are members of a priestly profession and have certain inescapable duties to humanity. 8. Still have room for improvement in our relations with press and radio by trying to root out those who "knock" medicine by misquoting, leaving out part of quotations, reading out of context, etc. 9. Still room for unity within the profession.

Dr. McCormick discussed health insurance, suggested that the profession should consider creation of average fee lists or fee schedules that would prevail on an area or regional basis which would establish appropriate values for professional services and help the insurance underwriters to know what schedules of benefits to offer in each area, thus making it possible for the policy holder to know how much would be needed, if any, to supplement the insurance benefits. Suggested the time has passed when physicians can base their fees on the ability to pay of the patient, stating this causes resentment.

—o—

President-Elect, Dr. Walter J. Martin, feels that the low income or non-insurable group is the responsibility of state and local, not federal government, and state and local medical societies should assume responsibility for working out this program. He feels it is the responsibility of the members of House of Delegates to see that such programs be inaugurated at state or local level.

Introduced Frank Berry, Assistant Secretary of Defense for Medicine. He works with many departments in Washington government and has to do with drafting of physicians and dentists. Hopes this will cease in June, 1955.

President Harriman of A.H.A. introduced and reported that 2½ billion dollars is spent yearly on hospital help. He praised the relations of the A.M.A. and A.H.A. and urged that this good work be kept up. Also feels the Hospital Accreditation Committee in our Code should be continued and hospital administrators will carry this out and follow our code rules.

Dr. J. A. McCalf, President of The American Veterans Medical Association and a past high ranking officer stated he felt both associations have always been very close and that he appreciates the aid given to his association. They are opposed to compulsory insurance, socialized medicine and social security.

The American Dental Association was represented by Drs. Leslie M. Fitzgerald and Dr. Kingsbury. Spoke of the very successful story over the years, the last chapter of which has not yet been written. Stated health is the nation's greatest asset and is closely connected with dental health.

Mr. Fransoni, American Pharmaceutical Association, believes we have always worked together and the stand taken by us and presented to their association on Code Rxs is one their association follows. What is done in this house usually makes for better understanding and a meeting of medical and pharmacy minds.

—o—

SUPPLEMENTARY REPORT OF BOARD OF TRUSTEES

Definition and Scope of Oral Surgery: Board of Trustees confers with American Board of Oral (Dental) Surgery to the end that a clear definition of medical and dental services be established. The following definition was accepted: "The specialty of oral surgery is that part of dental practice which deals with the diagnosis, the surgical and adjunctive treatment of the diseases, injuries and defects of the human jaws and associated structures." This practice shall be within the limits of the professional qualifications and training of the individual practitioner and within the limits of agreements made at the local level by those concerned with the total health care.

Call-up of Physicians under Doctor Draft Law: Whereas, the call-up of 1,000 physicians at that time under the provisions of the "Doctor Draft Law" would unnecessarily disrupt the lives and practices of the physicians involved.

The Board wishes to recommend to the House that the Association request the Director of the Office of Defense Mobilization to defer the induction or involuntary recall of physicians during the second quarter of 1955 other than those liable under the basic Selective Service Act. Passed.

Report of Committee on Blood: After several conferences with appointed representatives of the American National Red Cross, the American Hospital Association, the American Association of Blood Banks, and the American Society of Clinical Pathologist, the Committee on Blood has submitted a proposed plan for a National Blood Foundation. The legal obligations, if any, have not been determined.

The principles on blood banking are:

1. Determination by the county medical society of the type of blood banking facility to service their area.
2. Medical policies of blood banking to be under jurisdiction of medical groups.
3. Blood replacement responsibility by the recipient's relatives, friends, place of employment or affiliation.
4. Unit for unit exchange of blood between blood banks.
5. Nonprofit operation with provision for assessing all service costs to the recipient.
6. Accreditation of Blood Banks.

The program contemplated is entirely voluntary and therefore its success will require the active cooperation of the great majority of blood banking facilities.

The Committee on Blood recommends that constituent and component societies continue their efforts to stimulate the establishment of blood banking facilities where needed in their areas. Approved.

• PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN •

REGISTRATION OF HOSPITALS: A resolution concerned with the discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals was submitted by the Council to the Board of Trustees and was approved by the Board. Recommended: 1. The registration of hospitals by the Council be discontinued; 2. The Joint Commission on Accreditation of Hospitals be requested to undertake registration of hospitals in addition to its present accreditation activities; 3. The "essentials of a Registered Hospital" be declared no longer in effect. Disapproved.

EVALUATION OF FOREIGN MEDICAL SCHOOL GRADUATES: That this problem be referred back to the Council on Medical Education for continued general study; that the A.M.A. sparkplug the formation of a commission to be known as the Joint Commission on Evaluation of Foreign Medical Graduates. That an agency be used to determine by examination the professional fitness of the applicants; that a method of screening the applicants be formulated. The question of states rights in this matter is important. It must be clearly understood that the only duty of the Commission is to determine the general fitness of applicants.

Report of Dr. Louis Bauer on *American Medical Education Foundation* showed that last year we collected $1,089,000 from over 12,000 subscribers, but we are not doing so good this year.

Mid-year meetings were discussed, and it was felt they should be continued regardless of cost, since these meetings are held in different parts of the country and are good public relations.

Resolution 5 concerning Cooperation with National Health Organizations was approved in principle but it was suggested that all new drugs be given proper approval before use, such as vaccine to be used for polio, etc. This passed.

Resolution 53 Selection of Family Physician (for doctors and their families) referred to Committee of Hygiene and Public Health.

Resolution 60 Condemning Establishment of Service-connection for diseases arising after termination of Military Service.

Resolved: That the A.M.A. adopt a firm and unequivocal position in opposition to the establishment of service-connection, by presumption, for disabilities developing after the termination of military service. A.M.A. has gone all out in opposing this type of practice.

Resolution 55 Resolved: AMA does hereby go on record as being opposed to compulsory Social Security taxation, the waiver of premium provisions and its extension. This House has opposed this before. Resolution adopted.

Resolution 29 Physicians in Military Service, Medical Military officers being used to make routine examinations at recruiting stations. Substitute resolution read that physicians should not expect that their professional abilities be used in making these routine physical examinations but that a local physician be used. Passed.

Supplementary Report L, Dependent Medical Care: Should be made available by military physicians in military facilities in overseas areas and in remote areas in the U. S. where civilian facilities are unavailable. Otherwise by civilian physicians in civilian facilities in all other situations.

Resolution 7 Care of Non-Service Disabilities for Veterans: Resolved: That favorable consideration be given a plan whereby medically indigent

veterans with non-service-connected disabilities will be given medical and hospital care in their local communities, that a means test which is sound be used to determine such indigency and that voluntary health insurance plans be used by federal government to provide such medical and hospital care. The committee asked that this resolution be disapproved, and it was.

Resolution 11 Program of Benefits for Veterans. That veterans who require hospitalization for the following types of disabilities be eligible for services in veterans' hospitals: A. Service-connected disabilities. B. Tuberculosis. C. Mental illness. D. Other forms of chronic illness which require hospitalization for more than 90 days. E. Disabilities in dispute as to whether service-connected or not.

Resolution 45 Allocation of Total Payment by Blue Shield Plans. Upon certification by operating surgeon the scheduled amounts available for services rendered may be paid by the plan to a physician other than the operating surgeon provided that such other physician has properly rendered such services. That each physician submit his individual report and charges to the plan according to services rendered the patient. That the plan make separate payment to each physician. That the plan notify the patient of each payment made by the plan. This is being used now by Blue Shield plans. Approved.

Resolution 42 Memberships for Special Groups of Physicians. Resolved that this House of Delegates go on record as endorsing a type of membership, either with no membership fee or a nominal fee, for physicians who are graduates of approved schools and who are serving internships, residencies, or fellowships, in approved hospitals. Approved by Committee and House.

Resolution on Frank Lahey's death approved.

Resolved: That the privilege of membership in the AMA be permanently withheld from any physician whose discharge from the military service was for reasons proved to be inimical to the security of the U. S. through his wilful action. No action taken now. Referred to Legal Council.

Report of Judicial Committee: Concerning billing of patient, and recently the case of joint billing to some of the non-profit insurance companies. In many cases these insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks.

The Judicial Council would remind the House of Delegates of the frequency of publicized discussions on fee splitting filled with reference to the "Golden Rule and common honesty" in terms of great importance to the public and our profession.

The Council would recommend a moratorium from the constant discussion of "principles" about fees rather than with emphasis on the maintenance at all times of high professional standards.

Resolution 25 Medical Fund Drives: Resolved that organizations which solicit and collect money from the public for the advancement of medical knowledge and medical care in specific fields be urged to allocate a proportion of their funds to the AMA Education Foundation for the general program of schools. Approved.

Supplementary report concerning Committee for the Study of Relations between Osteopathy and Medicine. The committee was created by the House of Delegates in June 1952. The report has been under consideration for one year. It has been subjected to criticism which has been both valid

ANNUAL GOLF MEET

THURSDAY, AUGUST 19, 1954

Youngstown Country Club

—o—

MAHONING COUNTY MEDICAL SOCIETY

CORYDON PALMER DENTAL SOCIETY

MEDICAL-DENTAL BUREAU

—o—

GOLF	12:00 Noon
DINNER	7:00 P. M.

—o—

NO dinner tickets sold at Club

NO dinners served without reservations

and they must be in by August 12

Details of program will be mailed at an early date

and invalid. Significant improvement in the relations between the two professions is dependent upon action which would make doctors of medicine available as teachers in schools of osteopathy and which would permit the state medical associations faced by dissimilar conditions to determine the relationship of their members to the osteopathic profession within the respective state.

The justification or lack of justification of the cultist appelation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools.

It was agreed that each school would be visited by two members of the committee accompanied by an individual of established experience in inspection of medical schools. The studies would be of sufficient duration, breadth and depth, to establish the nature and scope of the educational program and determine the quality of medical education provided.

The Conference Committee favorably recommended this proposal to the Board of Trustees of the American Osteopathic Association which considered it at a special meeting on February 6-7, 1954. It has referred the question to its House of Delegates which will act upon the proposal in July 1954. If the action of the House of Delegates of the American Osteopathic Association be favorable the on-campus observations can be carried out in the fall of this year.

Recommendations: 1. That no action be taken on this report at this time and that final action be deferred until December 1954. 2. That the Committee be continued until December 1954. Passed by House, referred to Committee.

Resolutions 28, 17, 12, 4, all concerning relations between Osteopathy and Medicine. Resolution 4 concerned the above study by the committee on this matter. Officials of AOA apparently have not yet made known any desire for a comprehensive collaboration with the medical profession; there is no apparent tendency by the existing colleges of osteopathy to abandon or abrogate the original concepts which made the practice of osteopathy a cult. Further progress on the possible solution of any mutual problems of medicine and osteopathy can come only when responsible officials of the AOA shall manifest a sincere desire to discuss mutual problems, and when the colleges of osteopathy shall give evidence of abandoning or abrogating the original concepts which classify the practice of osteopathy as a cult.

Resolution No. 13 Hospital Accreditation (This was introduced by **Dr. Wm. M. Skipp** of the Ohio delegation). Resolved: House of Delegates of AMA request the Joint Commission on Accreditation of Hospital to take the following actions: 1. That the commission repeal the existing requirement concerning attendance at hospital staff meetings. 2. That the commission omit entirely from its regulations any requirement for staff meeting attendance as a part of the hospital accreditation procedure. 3. That the commission adopt the policy that the matter of attendance at staff meeting be left to the autonomy of the medical staff of the individual hospital. Action not to be taken by House. Referred to Commission on Accreditation of Hospitals.

"Competitors pay dividends out of business you overlook."

Robert Lawton

AGENCY AS IT AFFECTS PHYSICIANS

In law, "agency" denotes the relation between a person or a corporation and another person or corporation, under which one acts for and in the place of the other, the actor being the agent. In its broad meaning, "agency" includes principal and agent, master and servant (employer and employee), independent contractors, and often partnerships. It has been defined as a contract, by which one of the parties confides to the other the management of some business to be transacted in his name, or on his account, by which that other assumes to do the business and to render an account of it.

Agency is a fiduciary relationship, that involves the good faith of the agent, who must have no adverse interest and make no secret personal profit. The agent is the alter ego of the principal and notice to the agent during the course of his employment is notice to the principal. Payment to his agent is payment to the physician; the latter cannot charge the payer with the consequences of his own misplaced confidence. Criminals are either principals or accessories and not agents, except under the statute prohibiting the sale of liquor.

Classifications of agents as to the nature of their services, the origin, period and extent of their authority and the presence or absence of compensation, are particularly valuable as guides to legal rights. Merely by virtue of his title, the superintendent of a railroad company has no power to employ a physician to attend an injured passenger and bind the company for payment. A physician may authorize another to do for him whatever he may lawfully do for himself, except that he may not, generally speaking, delegate to another a power already delegated to him as agent. His liability will be tested by "to whom is the credit given"?

In the last analysis, the physician's liability depends upon the ostensible authority of his agent. In determining the apparent authority of his agent, the conduct of the physician is considered and there is no rule of law requiring anyone to use even ordinary care to prevent another from holding himself out as agent, the breach of which will create a liability. Agencies by agreement and by ratification rest on assent; but agency may arise by implication or by a false representation of agency by the physician-employer or by necessity. Inquiry is required by third persons regarding the authority of special agents, such as equipment, surgical supply or book salesmen.

The physician is not a guarantor of his employee's good conduct. He is responsible if the employee's negligent act is within the scope of his employment, but not for wrongful conduct not directed or that he could not be supposed to have authorized or expected. He is liable for fraud of his agent, if the acts were within the apparent limit of the employment, though not within the actual scope thereof. Departure of the employee from his employment must be distinguished from his departure from or neglect of a duty connected with that employment.

Agency is revoked by operation of law in the following instances:

1. When known, the death, insanity and bankruptcy of the principal.
2. Change in status or condition of the party or business.
3. Change in law which renders the contract illegal.
4. Sometimes, by declaration of war.

Revocation of an existing agency is justifiable, if the employee was guilty of a default of duty, the natural tendency of which was to injure his business; actual injury thereto need not be shown, but the mere habitual use of mor-

phine without a showing of failure to perform required duties is not sufficient. Express revocation may not be effective, unless brought to the notice of third persons previously dealt with.

A physician or surgeon may be liable for the damage caused by neglect or default of his employee, his servant, or _____ of his assistant (even another physician), who is working under his directions. The duty to exercise care cannot be delegated to another without recourse. Liability for leaving a gauze sponge in the abdominal cavity, is joint as between the surgeon and family physician who advised the operation, recommended the surgeon, was present at the operation and participated in all that was done with the exception of handling the knife. But, two physicians may treat the same patient concurrently, and neither be liable for the negligence or lack of skill of the other. Similarly, a physician or surgeon may, on leaving town, or in other case of need, recommend or employ another physician or surgeon to treat a patient for him, and in the absence of negligence in such selection, will not be liable for the negligence or lack of skill of the substituted practitioner.

Appellate Court decisions have held that the surgeon employed to perform an operation upon a patient is not liable for the negligent acts of a fellow surgeon, engaged by him with the implied consent of the patient to administer the necessary anesthetic, when it appears that there was no negligence in the employment, and no participation, active or passive, in the negligent conduct of the other surgeon; an operating surgeon is not responsible for the misuse of drugs prepared by the hospital unless the ordinarily prudent use of his faculties would prevent injury to a patient upon whom he operates; and, a physician, who was employed by another physician and who directed a nurse, also employed in the office, to give a patient an injection, was not liable to the patient for damages from the alleged negligence of a third employee (apparently an office attache charged usually with minor nonmedical duties) to whom the duty of treatment was delegated by the nurse.

Consider carefully the above when choosing your nurse, x-ray technician, physiotherapist, office assistant, receptionist etc., as you are responsible for their acts. Be explicit with your instructions to the Medical Dental Bureau, so that the extent of their authority to act for you is well defined. Inquire as to the authority of salesmen, especially regarding the down payment. Authority can become a question of fact for the jury upon the whole case.

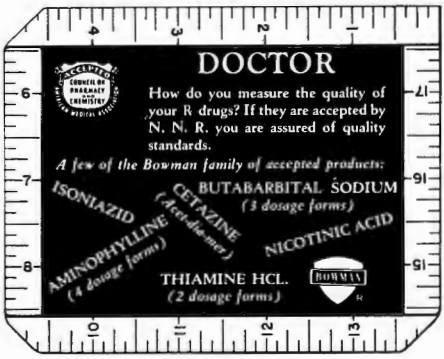
Sidney Franklin, M.D., LL.B.

Simplification of Insurance Claim Forms

A program for arriving at a series of uniform claim forms involving more than 600 companies is a substantial undertaking. Much already has been accomplished, but still more time is needed to come up with the soundest answers. The importance of this project can be envisioned when one realizes that hundreds of insurance companies, each with its own versions of forms, run up the variations into very high figures.

One of the first requirements is to settle upon forms which are reasonably brief and simply and clearly worded, as well as being adequate from the standpoint of sound insurance principles and practices.

Naturally the work on the final uniform claim forms will have the benefit of consultation with hospital and medical groups both at the national and local levels.



GYNECOLOGICAL OPERATIONS

The following advice by Dr. R. W. TeLinde is deemed worthy of reproduction here.—Editor.

Probably one of the greatest surgical sins of our generation is the unnecessary removal of the asymptomatic fibroid uterus. There are definite indications for removal of the fibroid uterus.

These are limited to the following:

Excessive bleeding.

Discomfort from pressure of the tumor or evidence of damage to an organ such as the kidney from pressure on the ureter and occasionally pain from a tumor twisting on its pedicle.

Distortion of the abdomen due to the size of the fibroid.

Effect of the tumors on past, present or future pregnancies.

Evidence suggesting malignant change.

Uncertainty in making a differential diagnosis between a fibroid and an ovarian tumor.

Let us consider these symptoms individually. Excessive bleeding at the time of the period may be and often is due to fibroids, but the excessive bleeding in the presence of a fibroid uterus does not necessarily indicate that the bleeding is due to the fibroid. Other pathological lesions, such as an endometrial polyp, may be the cause and the fibroids may be incidental. After all, how frequently does one encounter even large fibroids with normal or even scanty menstruation! Hence, frequently when there is menorrhagia, and especially of only a month or two duration, a curettage should be done instead of rushing into a hysterectomy. Curettage may accomplish several important things: It may remove an endometrial polyp and cure the patient's symptom. It will remove hyperplastic endometrium and temporarily or permanently relieve the patient. It will tell you whether the uterine cavity has become irregular due to the submucous position of a fibroid. This information will be of great value to you in deciding on hysterectomy in the future in case there is a recurrence of the bleeding. By curettage, combined with cervical biopsy, a diagnosis of malignancy of the endometrium or cervix can be made or excluded. It is particularly important to carry out this simple diagnostic procedure when there has been intermenstrual bleeding, for this symptom is not usually dependent upon the fibroid. Curettage may often suffice in the woman with a small bleeding fibroid who is approaching her menopause. Having excluded malignancy by curettage, the patient may in a short time undergo her menopause after which no further treatment will be necessary.

When a fibroid is large enough to give rise to symptoms due to pressure on pelvic nerves or on other organs such as the bowel or bladder it had best be removed. However, one often sees some rather large fibroids which surprisingly give no pressure symptoms. Before advising the patient to keep such a tumor it is well to have intravenous pyelograms done to determine whether there is ureteral obstruction. When there is ureteral or kidney pelvic dilatation due to tumor pressure the uterus had best be removed. Surprisingly, this may often occur without any discomfort to the patient.

Often a fibroid of considerable size gives rise to no symptoms except abdominal distention. No woman should be required to appear as though perpetually pregnant or to have a permanently distorted figure and I believe this constitutes a reason for surgery even without other symptoms.

A history of repeated miscarriages in a woman with fibroids of reasonable size constitutes an indication for myomectomy, but a woman with small fibroids, pregnant or desiring to become pregnant, should not be subjected to immediate laparotomy. I am constantly impressed with the number of pregnancies which go to term in the presence of large tumors. On the other hand, fibroids that are rapidly increasing in size in women desiring children but failing to become pregnant constitute a legitimate reason for myomectomy. In reference to the problem of pregnancy and fibroids one can only say that each case should be considered carefully and individually before deciding on the best course.

When a woman is told that she has a fibroid uterus and is advised that it may be safely kept under observation the natural question is: "What about malignancy?" The chance of fibroids undergoing malignant change is very slight. Evans, in a large series of fibroids removed at the Mayo Clinic, found sarcomatous change in only 0.7 per cent. Actually the percentage of malignancy in fibroids is much less than this, for this percentage was based on the fibroids removed for proper indications. If the percentage of malignancy had been based on all existing fibroids, it would have been much smaller. Certain it is that the risk of malignant change is no greater than the risk of surgery, so the possibility of its occurrence does not constitute a legitimate reason for removal. On the other hand, when there is reason to believe that malignant change is probable, as evidenced by rapid growth, fixation of the tumor or variation in consistency of the tumor, surgery is indicated in the absence of symptoms. Likewise, when there is a question as to whether the tumor arises from the uterus or the ovary, it had best be removed because of the possibility of malignancy in the ovarian tumor.

Much has been written in recent years about carcinoma-in-situ of the cervix. I believe its presence constitutes a legitimate reason for hysterectomy, but I am sorry to say that the publicity given this disease has been responsible for many unnecessary hysterectomies. The usual reason for this is inadequate knowledge on the part of the pathologist. He is doubtful about the lesion and, therefore, recommends hysterectomy to the surgeon to play safe. *Carcinoma-in-situ of the cervix never constitutes a surgical emergency.* There is always time to get another opinion on the pathology, and if necessary, to get further evidence by cytological smear and biopsy.

Another sin which has been all too common in the field of surgery in recent years is the attempt on the part of surgeons and gynecologists to perform the radical Wertheim type of hysterectomy with lymph node dissection in Stages I and II of cervical cancer. This operation is being done by a very few expert pelvic surgeons in selected cases with results equal to the results with irradiation. Hearing or reading of this, many unqualified surgeons are attempting this difficult operation. In many instances, difficulties are encountered and the operation which actually is accomplished is far from that which is carried out by the few experts. *Indications* for operability in cervical cancer are also being extended by over enthusiastic surgeons. As a result, serious postoperative complication such as ureteral or vesical injury are frequent and many lives are made unbearable by complications that could have been avoided had the lesion been treated by irradiation. Such surgery is not only unjustified but is dangerous.

There are two minor uterine lesions for which hysterectomies are often unnecessarily done—chronic cervicitis and functional bleeding. There is some

evidence that chronic cervicitis may at times predispose to cancer, but this does not constitute a legitimate reason for a hysterectomy. There are lesser procedures by which the cervical infection can be eradicated. One often hears an attempted justification for this surgery as being a prophylaxis against cancer. A surgeon may observe that the lacerated cervix appears bad and he fears that it may harbor malignancy or ultimately become malignant. The biopsy and smear are simple procedures available to every practitioner and the time to find out whether malignancy exists is before definite treatment is undertaken. If such a "suspicious" cervix actually harbors malignancy and an ordinary total hysterectomy is done, the patient has been treated inadequately. If malignancy is not present, she has had an unnecessary hysterectomy.

Functional uterine bleeding is also frequently treated unnecessarily by hysterectomy when a curettage is all that would have been necessary to establish a diagnosis and often cure the patient. Although many cases of functional bleeding are not relieved by curettage, many are. Not infrequently the bleeding which is thought clinically to be functional, turns out to be due to an endometrial polyp which can be removed by currettage or with the polyp forceps. In young individuals functional bleeding can often be controlled with proper hormonal therapy. However, when after curettage reasonably severe functional bleeding recurs, hysterectomy or irradiation may have to be considered. Younger individuals should always be given a trial at hormonal therapy. As the age of the patient increases the indications for hysterectomy in this group of patients with *recurrent* functional bleeding become less rigid. This is particularly true when symptomatic cystocele and rectocele are present. When I perform a hysterectomy for recurrent functional bleeding I prefer to remove the uterus vaginally, whether vaginal plastic surgery is necessary or not.

ST. ELIZABETH HOSPITAL EX-INTERN REUNION

Members of the Ex-Intern Association of St. Elizabeth Hospital, members of the Staff and area medical students participated in the annual reunion of the Association on Thursday, June 17, 1954.

Dr. S. W. Ondash, retiring president, was in charge of activities. Newly elected officers are Dr. J. B. Kupec, President; Dr. C. E. Pichette, Vice President; and Dr. L. Zeller, Secretary-Treasurer.

Dr. Robert D. Taylor, Associate Professor of Medicine at Bunts Educational Institute, Cleveland Clinic, was the speaker at the scientific session held at the Nurses' Home in the morning. He was introduced by Dr. John LoCricchio, Director of St. Elizabeth's department of pathology and laboratory medicine.

Sister M. Adelaide, superintendent of the hospital, was hostess at a luncheon at the hospital.

In the golf tourney held at the Youngstown Country Club, Dr. Breesmen was winner at low gross and Dr. Mahar at low net. Blind bogey awards went to Drs. F. Morrison, J. J. Sofranec and S. W. Ondash. A banquet followed the golf tourney.

"No one rises so high as he who knows whither he is going."

Oliver Cromwell

TRENDS AND EVENTS

Should interns and residents carry malpractice insurance coverage? . . . Best advice from various sources is: "Yes, especially if they hold license to practice."

—o—

The total number of physicians — 218,522 — licensed to practice in the United States set an all-time record in 1953. Official figures from the 52nd annual report on medical licensure of the A.M.A.'s Council on Medical Education and Hospitals indicate that 7,276 persons were added to the medical profession in 1953. During the same period, 3,421 physician deaths reported to the A.M.A. Headquarters gives a net increase of 3,855 in the physician population of the country. In 1952, an increase of 2,987 was reported.

—o—

'Shouting in the Dark' is the title of a guest editorial which John L. Bach, director of A.M.A. press relations, wrote in the May issue of the Medical Annals of the District of Columbia.

The piece analyzes two specific cases, pointing to an overlooked fact in medical public relations today: that articles written by physicians and published in medical journals for the enlightenment and educational benefit of their colleagues can be picked up by lay writers and twisted into a more or less sensational story for lay readers.

"It appears today," the editorial said, "that what a doctor writes frankly and objectively for the betterment of his profession and the advancement of medical science, can actually boomerang to the detriment of the profession as a whole."

'After the Doctor Leaves' is a fine book. Marguerite Clark, who has been a good writer-friend of the medical profession for many years, has just published an excellent book entitled, "After the Doctor Leaves."

Mrs. Clark, who is medical editor of Newsweek magazine, discusses the 12 most important medical classes of disease and gives readers some fine practical help to supplement the advice of the family physician. She did a good job of telling people how to live with chronic ailments.

—o—

The Eisenhower administration has forwarded to Congress, *with a recommendation that it not be ratified,* the International Labor Organization's convention on minimum standards of social security.

The medical care section stipulates that a country may qualify as ratifying if it agrees to provide one of the following: (a) a system of compulsory health insurance, (b) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (c) private, voluntary health insurance administered by insurance companies but under government "supervision." Half the population would have to be covered.

—o—

Secretary Hobby has strongly urged the National Association of Insurance Commissioners to reverse its stand and support legislation for federal reinsurance of health insurance programs. (The association opposed reinsurance at Congressional hearings).

—o—

The House Appropriations Committee, in reporting out a $1,637,615,011 budget for the Department of Health, Education, and Welfare for the next fiscal year, was highly critical of Secretary Oveta Culp Hobby's administration and her budgeting for some health programs.

Doctor Draft Act Amendment. The House on June 11 passed and sent to the White House the Doctor Draft amendment which permits utilization of physicians, dentists and specialists in enlisted grades of the Armed Forces.

—o—

Veterans Administrator Harvey Higley says the agency is planning on a 110,000 daily patient load for its hospitals in fiscal 1956 (starting July 1, 1955). On the basis of a current staffing of 114,000 beds and a 90% occupancy, the new figure would mean approximately 8,000 more beds would have to be added. One estimate of hospital experts is that the cost of the 8,000 additional beds would be well in excess of $120 million.

—o—

Kaiser urges press to support his mortgage loan bill. In an address before the National Press Club in Washington, Henry Kaiser urged newsmen to get behind his proposal for federal guarantee of loans for constructing and equipping group practice facilities. The industrialist, who started the Kaiser Medical Foundation, said that now "millions are being forced into financial bondage" because of medical care costs, but that if the press would help to publicize his ideas, a "ground swell" of popular support would put the plan over.

The "Kaiser plan" is embodied in H.R. 7700, now before the House Interstate and Foreign Commerce Committee and sponsored by the chairman, Charles Wolverton. The American Medical Association has three principal objections to the bill: 1. Facilities already are being provided for medical care without federal intervention. 2. Group practice would be favored at the expense of the individual practitioner. 3. To be eligible for loan guarantees, a group's patients would have to be predominently from prepaid health plans. (Mr. Wolverton is willing to remove the last requirement.)

Cooperation of private M.D.'s with clinical center cited. The director of the National Institutes of Health has informed Congress that the year-old Clinical Center at Bethesda has had exceptionally good working relations with medical societies and private practitioners.

Dr. Sebrell noted that when a physician refers a patient to the Clinic, "he knows that the patient is going to get the best that modern medicine can do for him in terms of research and advanced procedure and I think our whole future depends on this kind of relationship." He estimated that by July 1 NIH expects to have between 200 and 250 beds opened in the Clinic with about 80% occupancy.

—o—

A series of short postgraduate courses designed to keep medical officers in outlying installations informed of current medical advances will be conducted by the Army starting July 1. **They will be open to civilian doctors, medical officers on active and inactive duty,** physicians from other government agencies, and Navy and Air Force personnel.

—o—

Some 900 workers labor in the Chicago A.M.A. building that contains the world's most powerful medical organization. Their duties on behalf of 140,000 doctors range from laboratory studies to legal wrangling, through lobbying, publishing journals, books and pamphlets, and investigating. The A.M.A.'s newest venture is a program to promote mental health. The association says 60 per cent of its $9,000,000 annual revenue is spent on its scientific activities.

—o—

It is difficult and often impossible to tell hypochondriacal neurosis from early schizoid or affective psychosis.

—o—

Long-term follow-up studies of women treated with X-rays for sterility and menstrual dysfunction reveal that X-irradiation, when used properly, is harmless to the women and to their offspring. Second and third generation offspring of these women also showed no adverse genetic effects.

Kaplan, I. I.: Am. J. Obst. & Gynec., March 1954.

MISCELLANY

MEDICAL WITNESS

Basically, to be a good medical witness requires attention to the following list of do's and don'ts:

1. Tell the truth.
2. Come prepared.
3. Don't be afraid, but be modest and natural in actions and speech.
4. Listen to questions, and answer only what is asked.
5. Admit if you don't know. Don't hedge or become flustered.
6. Speak up, be courteous, do not lose your temper, and do not be belligerent.

Always remember, that once in the courtroom the lawyers for both the defendent and plaintiff are in command. You are on unfamiliar ground and just another person present to answer questions to the best of your medical and surgical ability and knowledge.

I. Phillips Frohman, M.D.

TODAY'S THOUGHT: Success—making more money to meet obligations you wouldn't have if you didn't have so much money (anon.).

—o—

Caleb Fiske Prize

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "MODERN DEVELOPMENTS IN ANESTHESIA." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $250 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

—o—

PR Institute Set for September 1-2

That's the time for A.M.A.'s third Medical Public Relations Institute to be held at the Drake Hotel in Chicago. Designed primarily for public relations personnel and chairmen of state and county medical societies, this year's informal sessions are designed as an "idea exchange — a public relations seminar" — to stimulate the exchange of ideas in all areas of medical public relations.

—o—

Says It's The Spokesman

Does the A.M.A. really speak for America's doctors?

The A.M.A. says it does. It says surveys show that the vast majority of doctors approve A.M.A. policies. And the A.M.A.'s governing body, or house of delegates, is organized to represent all members of county and state medical societies on a proportional basis.

Dr. Walter B. Martin, president-elect of the A.M.A., recently concluded a discussion of the A.M.A.'s "constructive program" with these words:

"The American Medical Association has always accepted and carried out the responsibility of leadership in safeguarding the public health, raising the standards of medicine, and making good medical care available to the people.

"This nation's medical progress over the past half century has given the United States the world's highest standards of health and medical care . . .

"That progress has been achieved under a voluntary system which emphasizes free enterprise, individual initiative, and responsibility, and cooperative effort . . .

"Our most urgent effort should now be directed to the solution of the problem of the medically indigent and the chronically ill. We believe that this objective can be reached without major change in our existing mechanism."

—o—

Verdict of Unethical Advertising Upheld

By secret ballot in closed executive session the House of Delegates of the Medical Society of the State of New York has upheld the verdict of unethical conduct in the case of a Queens County physician affiliated with a medical group of the Health Insurance Plan of Greater New York (HIP).

The verdict, in essence, was that a physician, Dr. Ben E. Landess, Medical Director of the Jamaica Medical Group and affiliated with HIP, was guilty of unethical conduct under that portion of the Code of Professsional Conduct dealing with unethical advertising.

The Code of Professional Conduct is specific on this point. The group practice of medicine is not of itself unethical. BUT each such medical group shall obey all the rules of ethics as would an individual physician. Since a physician in private practice cannot advertise for patients, the same rule applies for physicians in groups. Hence Dr. Landess was found to be unethical when his name appeared in HIP literature.

—o—

Kenneth B. Babcock, M.D., will assume his duties as director of the Joint Commission on July 1, coming to Chicago from Detroit where he has been director of the Grace Hospital.

As the Commission Chairman, Dr. Newell W. Philpott of Montreal, said in announcing the appointment recently: "We are delighted that Dr. Babcock has accepted the important task of directing the Joint Commission on Accreditation of Hospitals. There is perhaps no more vital program than this effort by doctors and by hospitals to constantly elevate hospital care standards by a vigorous and voluntary method of self-discipline. Dr. Babcock's career, first as a physician and surgeon and then as a hospital administrator, guarantees the sound continuance of this program which got off to such an excellent start."

—o—

Blood Pressure Study in Persons 65 and Over

The evaluation of blood pressure in old age has become a major problem because of the growing number of older people in the United States and the paucity of data in these age groups. Millions of Americans are now 65 years of age or older. With the increasing life span, many more millions will be added within several decades. It is essential to know (1) the normal range of blood pressure as well as the lower limit of hypertension for each age group over 65 for both sexes, (2) whether the blood pressure continues to increase with age and to vary with sex in those who are more than 65 years old, and (3) whether the blood pressure is related to weight, or (4) to surface area, or (5) to height.

To seek answers to these questions, Dr. Arthur M. Master, Director of the New York Heart Association and cardiologist at Mt. Sinai Hospital, New York, Mr. Herbert H. Marks, of the Metropolitan Life Insurance Company, and Dr. Harry L. Jaffe, New York, have undertaken a statistical study of the blood pressure in people who are 65 years of age and over. The investigation is sponsored by the organizations mentioned above. The American Medical Association has given aid to the project.

—o—

Second World Congress of Cardiology and 27th Scientific Sessions Of American Heart Association Set for Washington Sept. 12 - 17

Physicians and research scientists from many nations will join their United States colleagues in Washington, D.C., next September 12 through 17 for a combined meeting of the Second World Congress of Cardiology and the Twenty-seventh Scientific Sessions of the American Heart Association. This will be the first international medical gathering of its kind ever held in the United States.

Detailed information concerning the Congress is available from the Secretary-General, L. W. Gorham, M.D., Second World Congress of Cardiology, c/o American Heart Association, 44 East 23rd Street, New York 10.

Why Not Encourage the Self-Employed to Build Their Own Retirement Funds?

Employed persons in the United States are at least partially protected for their old age by Social Security. In addition, many of them are the beneficiaries of company pension funds. Payments into such funds by employers, as well as the employers' share of the Social Security tax, are deductible from taxable income. Up to now, however, there is no similar provision for a large group of self-employed people, such as physicians, lawyers or farmers. Their efforts to provide for retirement are hampered by exorbitant taxation.

In the Philadelphia area recent, a physician enjoying a large and presumably profitable private practice retired and took a job in a Government hospital. He gave as his reason for doing so the fact that he had been unable to educate his children and at the same time save enough to provide for eventual retirement. He felt himself compelled to become an employed person in order to receive the benefits of a pension fund. A young doctor or lawyer, after a long and expensive education and apprenticeship, is likely to find adequate saving almost impossible under present conditions.

Congress is now considering a measure which is designed to fill some of these gaps. The Jenkins-Keogh Bill, which was introduced last year, is an outgrowth of several efforts to solve the problem. In general, it provides that any individual who is not eligible to participate in a pension or profit-sharing plan may set aside each year an amount not to exceed 10 per cent of his earned income, and in no case more than $7500, to be paid into a restricted retirement trust or insurance annuity. The amount thus set aside could be deducted from his taxable income. The proposed law places certain restrictions on the means by which these savings can be accumulated and provides that the taxpayer may not tap the fund until he is sixty-five years old, "except in the case of total disability." This would place him roughly on the same footing with employed individuals who are the beneficiaries of private pension funds.

Undoubtedly the proposed measure does give the self-employed certain other advantages over their opposite numbers in the ranks of the employed. For example, the beneficiary of some company pension funds may not accept a job in another company without forfeiting his equity in a pension from his first employer. The self-employed doctor who builds up his own retirement fund may leave his community and set up shop somewhere else and still hang on to his retirement allowance. There are undoubtedly other discrepancies, but if an individual can do better on his own account than through a company pension fund, this might be an important step away from the welfare state. Private saving should be made at least as attractive as reliance on contributions by employers or the Government.

Few reliable estimates have been made of the possible loss of revenue to the Government if such a law were passed. However, as a writer in the Harvard Law Review has observed, "even the possibility that the revenue loss would be so considerable as to necessitate higher tax rates is not a valid objection; it seems more equitable to distribute the tax burden among all taxpayers than to continue discrimination against one group."

(April 24, 1954)

FROM THE BULLETIN

TWENTY YEARS AGO — JULY, 1934

The Depression was not over yet and the doctors were struggling along trying to make ends meet. The old Wednesday night venereal clinic at the Youngstown Hospital was closed and patients referred with welfare slips to their private physicians. Drugs were supplied free by the Health Department.

The physicians in charge of the Baby Welfare Stations presented a resolution to Council urging (1) that the stations should be conducted for well babies only, (2) that no therapeutic medicine should be practiced there, (3) that attendance should be limited to families making not more than $75.00 a month and (4) that no immunizations or vaccinations be performed there.

The President urged all members to join and support the new Medical-Dental Bureau.

You could buy a Knox hat at Scott's for five dollars.

Joseph Keogh was among the new internes at Youngstown Hospital.

The annual Medical Society picnic at Southern Hills Country Club featured golf, horseshoes, archery, trap and crap shooting, croquet, knitting, bridge, mumblety peg and hog calling. The committee said, "If you miss this one, you'll Hate Yourself!"

TEN YEARS AGO — JULY, 1944

It was vacation time but with the war on there was little time and no gasoline for long trips. Train travel conditions were somewhat improved and restaurant eating was better. Some of the doctors ventured out on fishing trips in Canada and for those at home the Society held a Golf Meet for physicians and druggists at the Youngstown Country Club.

Doctors in the service were too busy with the grim business to write many letters to the *Bulletin*. Harold Reese had received a promotion and was transferred to Mobile, Alabama. Sears was back from England and ill in a hospital in New York. McElroy was still in Italy and getting along well.

The late J. H. Collier published a scholarly article on blood transfusions in which he explained the nature and clinical significance of the Rh factor.

J. L. F.

A course in "Newer Developments in Cardiovascular Diseases" will be given at The Mount Sinai Hospital, New York, October 11th through 15th, 1954, under the auspices of the American College of Physicians. As the title implies, the recent advances will be stressed. Dr. Arthur M. Master and Dr. Charles K. Friedberg will direct the course and prominent cardiologists and cardiac surgeons will participate.

"Worry, like a rocking chair, keeps you busy but gets you nowhere."

Bradford Thomas

COUNCIL MEETING

The regular monthly meeting of the Council of the Mahoning County Medical Society was held at the offices of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio, on Monday, June 14, 1954.

The following doctors were present: J. D. Brown, president, presiding; V. L. Goodwin, C. A. Gustafson, S. W. Ondash, G. E. DeCicco, A. A. Detesco, E. R. McNeal, A. Randell, A. K. Phillips, comprising the Council; also Dr. M. P. Mahar, Mr. Franklin Powers, Counsel, Mrs. James H. Walls from the Youngstown Area Heart Association, and Mr. Morgan, from the Blue Cross.

In order to acquaint Council with their suggested instruction classes for cardiac housewives, Mrs. Walls demonstrated and explained in brief their proposed set-up.

Mr. Morgan, from the Blue Cross, explained their proposed set-up on a group plan for professional people and their families. Council suggested that he find out just how many of our members they now have and the percentage needed for enrollment, together with a copy of the benefits and plan and present them at the next meeting of Council.

Mr. Powers submitted a cautionary memo re: Accident and Health Insurance. He stated there are three rather simple cautionary statements that can properly be made by a physician to his patients:

1. Do your best to deal only with a reputable insurance agent.
2. Be sure that you understand the actual coverage afforded by your policy.
3. See that the application for the policy sets forth accurately and honestly your actual physical condition so far as you are aware of it.

Dr. M. P. Mahar reported progress of the newly appointed committee that is working on the various Health and Hospital insurance plans. Some set-ups have not been heard from but he hopes to have a full report at the next meeting of Council if not before.

Dr. Brown discussed the Community Chest drive. Many professional groups are soliciting their own members rather than the Community Chest doing it. Council was of the opinion that the amount of last year's contribution and the expected amount to be given be omitted from the card and that the Medical Society handle the collection from their own members.

Dr. Randell discussed the need in this community for a home for the aged chronically ill. Also, the Society sponsoring a summer camp for handicapped children as has been done in the past.

Dr. Brown appointed the following committee to work with Dr. Randell: Dr. Randell, chairman; Dr. M. P. Mahar, Dr. J. A. Rogers and Dr. C. A. Gustafson.

The following applications were read:

Active Membership

Dr. George L. Altman, St. Elizabeth Hospital
Dr. Cary S. Peabody, 810 Dollar Bank Bldg.
Dr. Milan Halmos, 1647 Mahoning Ave.

Interne Membership

Dr. James R. Sofranec, St. Elizabeth Hospital
Dr. Evelyn M. Bellaire, T. B. Sanitarium

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

G. E. DeCicco, M.D. Secretary

A NIGHTMARE

The other night, in place of restful slumber, I had a dream. After counting the usual quota of sheep, sleep of a sort came, and during this restless sleep, a nightmare.

Somehow, in the peculiar mixed-up ways that dreams have, I was in court. I was both an observer and a defendant, and at times even seemed to be a witness. The judge, an unreal and awe-inspiring figure, called three physicians as defendants to take the stand.

The first was a physician who was specifically accused of sending a large bill to a patient in very moderate circumstances, and for a service which was not unusual in any way. This defendant admitted that he had not determined the patient's ability to pay "because he didn't feel it was fitting for a physician to discuss money matters." Further, he argued, there was the probability that an insurance company was paying part or all of the bill, so "because an impersonal agency was responsible, he was justified in charging a large fee." In my dream I recall being very disturbed because neither the judge nor the jury, as laymen, seemed impressed by the defendant's reasoning.

The second defendant was another physician, not overly impressed with his own importance, but hurried and harried in his manner. He was accused of rendering substandard care, inadequate examinations, both clinical and laboratory, and shotgun therapy. When he explained that he was too busy to do careful work, the court again did not seem impressed. The only comment came from the judge, who suggested that possibly more help was needed in the medical profession.

The third defendant was another physician. The man's manner was arrogant and impersonal. He was specifically accused of failing to discuss anything with his patients, either medical or financial. Several witnesses declared that the physician was reluctant to tell them what was wrong, what significance their medical condition had for them, and what their financial obligation probably would be. His attitude was that they were fortunate to be able to retain his services without wasting his time with useless explanation. Again, surprisingly, the court did not seem favorably impressed by the defendant's testimony.

Having heard these three defendants and numerous witnesses, the judge gave his instructions to the jury. He was in the midst of telling them that they must consider fairly the evidence for and against these three medical men, and at the same time decide whether this evidence reflected favorably or unfavorably on the practice of medicine as a whole and the conduct of "organized medicine." Fortunately, at this moment a final witness asked to be heard and this unusual privilege was granted. In his testimony he pointed out that thousands of physicians were practicing honestly, intelligently, and thoughtfully, and that American medicine was a leader in the field of world medicine. He urged that the medical profession not be condemned for the thoughtless, selfish tactics of a few of its members.

This testimony very obviously impressed both the judge and the jury, to the extent that further instructions were given the jury. In these instructions the judge pointed out that the whole medical profession shouldn't be condemned for the acts of a few. He did, however, emphasize the responsibility of "organized medicine" to keep its house in order, to instruct and discipline its recalcitrant members, and to be a leader in providing the best

MARK YOUR CALENDAR —

ANNUAL GOLF MEET

THURSDAY, AUGUST 19

YOUNGSTOWN COUNTRY CLUB

medical care at a price the public can pay. He pointed out that the possible alternative would be Government-sponsored and -regulated medical care.

At this point I awoke in a cold sweat, thanking my stars that this was only a dream . . . . . or was it?

F. D. Costenbader, M.D.
Medical Annals of D. of C.

PERIODICAL PEARLS

Congenital Cysts of the Lung

by Sol Katz, M.D.

The subject of congenital cystic disease of the lung is confusing because of differences in nomenclature and classification. Over thirty terms have been used when referring to cysts of the lung.

Cystic diseases of the lung may be acquired or congenital. Acquired cysts include emphysematous bullae and blebs as well as chronic lung abscesses in which there has been control of infection and subsequent partial or complete epithelialization due to ingrowth into the cavity of cuboidal or columnar epithelium or due to squamous metaplasia. Congenital cysts may arise from the mediastinum or may appear within the lung substance. Only the latter will be considered here. At times it is difficult or impossible to differentiate between an acquired cyst and a congenital cyst on the basis of history, x-ray examination, and even histological study.

Congenital cysts of the lung may be single or multiple and they may contain air, fluid, or both. The cyst wall is lined by bronchial mucosa containing either columnar or cuboidal ciliated cells. Some congenital cysts are of the alveolar type in which the wall is composed of flat cells characteristic of the air sacs. The epithelium may be destroyed by infection.

Symptoms may occur shortly after birth or in childhood. However, in some there are no symptoms until adult life, while in others the cysts are asymptomatic. The symptoms result from infection, with manifestations of pulmonary suppuration, and from impaired pulmonary ventilation due to overdistention and compression of surrounding lung.

X-ray examination of the lungs is the most valuable method of diagnosis. A cyst may appear as an area of radiolucency surrounded by a thin wall. A horizontal fluid level is seen when air and fluid are present. When the cyst is filled with fluid, a round sharply limited density occurs. Even in the presence of infection, the adjacent lung and pleura are often not inflamed. A striking feature is the presence of linear strands traversing the cavity. Some cysts may become hyperinflated due to partial obstruction of the communicating bronchus. These cysts cause compression of the surrounding lung and even the opposite lung and appear as a large area of radiolucency surrounded by a thin wall herniating across the mediastinum into the opposite hemithorax. With multiple cysts there are many round areas of decreased density some of which contain fluid.

"It is better to light one small candle than to curse the darkness."
Confucius

The Benefit of Respiratory Exercises in the Emphysematous Patient

by Warde B. Allen, M.D.
Associate Professor of Medicine
Charles Austrian Chest Clinic, Johns Hopkins Hospital, Baltimore

There is no great problem in recognizing emphysema. A physician from a large chest service in this country stated "we can diagnose emphysema but we don't treat it."

The major features of this condition center around the loss of alveolar elasticity. The respiratory and circulatory readjustments are an attempt to compensate for this loss. Christie has shown that in emphysema the intrapleural pressure is not always negative throughout the respiratory cycle as it is in health, but approaches that of the atmosphere. Because of the inability of the lungs to retract during expiration, there is an increased amount of air in the lungs which keeps them in a permanent state of distention close to the confines of the thoracic cage, even infringing on the abdominal cavity by downward pressure on the diaphragm. The residual air which accumulates in the vesicles is at the expense of the vital capacity, and the vital capacity may closely approximate the resting tidal air, so that an individual at rest may be comfortable, but during any exertion he may have severe respiratory distress.

There is nothing new in using respiratory exercises to treat emphysema. Thomas emphasized, as have Christie and others, that the important phase of respiration in the emphysematous patient is expiration. Christie and others felt that this effort would be of necessity an unnatural effort. However, it is our opinion, indeed, our experience, that it can be developed into a natural effort, by systematic and persistent instruction in the series of exercises here presented.

Method. It is of paramount importance to impress upon the patient that his breathing mechanism can be helped. It is then demonstrated to the patient that instead of struggling to make the thorax move, it is much simpler to use the abdominal muscles. Then it is demonstrated to him that the expiratory phase of respiration is the important feature, and instead of being passive he is able to make it active, with the result that the inspiratory phase becomes passive rather than active. It has been a surprise to observe how rapidly these patients can accommodate their respirations to conform with this newer concept. In fact, this type of respiration is carried over into sleep and has been seen to be maintained under anesthesia.

The first signs of improvement are the feeling of well being, the confidence of being able to breath, the subsidence of respiratory effort and the lessening of dyspnea. Studies of vital capacity have been done routinely but have not shown an increase commensurate with subjective improvement.

There is no set of exercises which can be mimeographed and handed to patients to be done at home. The importance of individual differences and the day to day developments cannot be overemphasized nor can they be anticipated. Therefore, each patient is a different problem and the specific prescriptions are made every day according to progress made and stumbling blocks which develop.

Instruction is given to the individual patient, progressing through the following list of exercises:

1. Patient in supine position with minimal elevation for comfort.

a. Teach easy corrected breathing: air expired through nose; chest relaxed; throat relaxed; abdominal contracting to produce expiration actively; abdominal relaxing to allow inspiration passively.
b. Deepen both phases by increasing expiration.
c. Add retraction of lower ribs to abdominals in expiration.
d. Teach these with the patient lying on his side, right and left.

2. Patient in sitting position, knees apart for stability, arms relaxed.
a. Correct posture and teach exercise 1a.
b. Add exercise 1b, maintaining all corrections.
c. Add exercise 1c, usually an easy step.

3. Patient in standing position against wall.
a. Correct posture without adding tension.
b. Teach exercises 1a, 2a, 1b, 2b, 1c and 2c, progressing only as skill and accuracy are maintained.

4. Teach walking coordinated with easy respiration.
5. Teach lifting and replacing small objects of light weight.
6. Eliminate mouth breathing in expiration except in deep exercise.
7. Teach stair climbing: 2 to 4 steps with expiration, 1 or 2 with inspiration.
8. Translate all usual every-day activities into breathing pattern.
9. An optical procedure is to teach mild posture exercises in all positions within breathing pattern.
10. Encourage gradual increase in walking and stair climbing as criteria of improvement.

No progression of activity must be made until each previous skill is mastered. Practice sessions between treatments are essential. Coughing and expectoration are encouraged. Results are dependent upon understanding and cooperation of patient. Automatic carry-over should begin at about Exercise 3.

(Am. J. M. Sc., September 1952)

—o—

New Pamphlets for Doctors' Waiting Rooms

The American Medical Association's PR Department has just completed publication of four new pamphlets describing medical scientific achievements, doctors' services to the community, and their desire to provide high quality medical care to everyone.

Subjects of the four are: 1) "Quack!" — explains the dangers of going to quack healers for medical treatment; 2) "Health Today!" — tells about medicine's progress during the past 50 years; 3) "On Guard!" — outlines the steps A.M.A. has taken to evaluate drugs, and 4) "Why Wait?" — describes the best way to select a family doctor.

"People buy what they are made to want."

Anonymous

wise addition to the menu
when diet is restricted...

Menu

Lakeside **LIPOLIQUID · LIPOCAPS®**

when special diets are necessary, or food intake is limited for prolonged periods in:

diabetes • alcoholism • geriatrics
obesity • cirrhosis

LIPOTROPICS are needed to prevent liver damage by facilitating normal fat metabolism. LAKESIDE LIPOCAPS and LIPOLIQUID provide optimal amounts of the important lipotropic factors to protect liver function by aiding normal fat mobilization and transport.

LIPOLIQUID

Each tablespoonful (15 cc.) contains:

Choline* (equivalent to 9.15 Gm. of choline dihydrogen citrate)	3.75 Gm.
Vitamin B_{12} U.S.P.	4.20 mcg.
Inositol	75.00 mg.

*As tricholine citrate.

Pint bottles.

Dosage: 1 to 2 tablespoonfuls daily for adults.

LIPOLIQUID is sugar- and alcohol-free.

LIPOCAPS

Each orange capsule contains:

Choline bitartrate	450 mg.
dl-Methionine	150 mg.
Inositol	100 mg.

Bottles of 100.

Dosage: 1 capsule three times daily.

Lakeside Laboratories INC.
MILWAUKEE 1, WISCONSIN

67254