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of the
MAHONING
COUNTY
MEDICAL
SOCIETY

JULY • 1955
Vol. XXV • No. 7
Youngstown • Ohio

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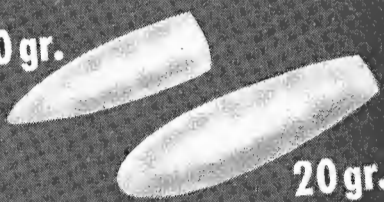

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Representative to the Associated Hospital Service
H. E. PATRICK

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ADVERTISERS' LIST

Our President Speaks

VACATIONS

With the month of July, vacations for the summer really get under way. County Medical Meetings and council meetings are suspended. Some of our members apparently started vacation ahead of time as we didn't have enough members at the June meeting to form a quorum so that we could vote on the important matter which was discussed in such lively fashion. So action on that matter must be postponed. Perhaps that is for the best as more thinking may be required before we can act wisely.

It is not as easy to go on vacation as it used to be. More things have to be decided. Articles appearing in newspapers advise the leaving of lights in the house and other advisors recommend leaving the house dark. One columnist reported that the best way to spoil any housewife's vacation was to wait until she got where she was going and ask her if she remembered to turn the gas off on the stove. She won't be able to remember and won't be able to rest for worrying about it.

You must be prepared with anti-motion sickness drugs, antibiotics, and other necessities including snake bite remedies if you are going to be where such necessities are unavailable.

So far as doctors are concerned, the most important thing about a vacation is a rest and a change. It is well to keep in mind then that you shouldn't do so much that you are more tired when you get back than when you started. Also, physical activities should be kept within the capabilities of the individual's circulatory system. In addition to all this, drive carefully and everyone have a fine vacation. Don't forget to turn off the gas!

Ivan C. Smith, M.D.

BULLETIN of the Mahoning County Medical Society

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VOLUME 25 **JULY, 1955** **NUMBER 7**

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

EDITORIAL

The Youngstown Community Theater Campaign

At the time of this writing, an energetic campaign is being conducted to request of the good people of our town an investment of $250,000 for a new community theater . . . a modest investment which would pay dividends of a richer kind of living for all of us.

This proposed 500 seat theater would vastly broaden our educational and cultural facilities in many ways; by providing drama classrooms and stage space for the Youngstown University drama department; by affording a better place for the children's plays of the Civic Children's Theater; by offering an attractively adequate facility for professional, business, social, fraternal, and cultural groups for special functions. It would be an auditorium for musical concerts and be available to churches and to the Boy Scout and Girl Scout Organizations for their jamborees.

The Youngstown Playhouse, since its modest beginning thirty years ago in a converted barn on the North side, has been a well organized unit operating constantly in the black under its own budget. It has never had to ask the public to pick up the tab or assume its debts. It has enriched the lives of thousands of people and will contribute much more to a broader, more intelligent and pleasanter community life if given the chance to express its maturity.

This project is all the more attractive when one realizes that it enlists private energies, enterprises, talents and aspirations in contrast to growing tendency to rely too much on government or professional entertainment for everything. In any case, the Playhouse campaign is a highly worthy cause and it is sincerely hoped that the physicians of the Mahoning County Medical Society will continue their generous support when approached to donate for construction of the new theater.

Robert L. Tornello, M.D.
Editor

GUEST EDITORIAL

The Medical Rat Race

Only a few decades ago, doctors swore that Fowler's solution was specific for chorea and colchicum was a sovereign remedy for gout. They used to remove gall stones and leave the gall bladder in. Apparently in medicine you have to unlearn as fast as you learn. Nearly every medical maxim is subject to change without notice. The pace is so fast today that if you spent just one year away from medicine, you'd miss many significant changes. On your return you'd be writing prescriptions for remedies that even the pharmacists would consider old-fashioned, and you'd be ignorant of several brand new developments.

To keep up with the dizzy tempo of medical change would really require the doctor's full time. It would take weeks to understand the mode of action of antibiotics and more weeks to know what ACTH was all about. Since he has to practice too, the physician must work out some method of keeping up with medicine without throwing his patients out of the reception room.

In the February 26 (1955) *Journal of the American Medical Association,* Dr. D. G. Vollan reports on a survey of the physicians' graduate educational technics. He points out that there are five fields for learning: professional contacts, hospital staff meetings, formal graduate courses, medical society meetings, and the primer maker of full men, reading. The doctor puts in anywhere from 15 to 22 per cent of his total professional time on learning. But no physician thinks that this is enough.

Of course many medical articles are repetitious, many fail to deliver any new ideas, and some are misleading. The trouble is that it takes time even to screen them out. If a doctor has hospital affiliations, he has two or more institutions insisting that he go to monthly staff meetings, plus monthly service meetings, and there sometimes is a real "papa spank" sanction behind the plea. The medical society, the academy, possibly a specialty society also clamor for his time. The medical journals may remain in their wrappers in virginal intactness, for who has time to read journals when so many live societies (and now television instruction) demand the doctor's time? (What are you doing reading this item when you ought to be improving your mind at a meeting, conference, seminar, colloquim, or vide-clinic?)

So the trend towards abstracts. The journals select the cream of the crop, so every article is an abstract of a massive project. Then there is the summary or conclusion section at the end, an abstract of the abstract. Then there are periodical abstract services plus year books of various sorts which abstract the abstracts of the abstracts.

There ought to be a law. The doctor has to see patients and go to medical society meetings, read journals and read books, attend hospital staff meetings and take an occasional graduate course. He has to listen to detail men, read the wrappers around the samples, study the legends on the free blotters he gets, and fill out forms for Blue Cross, Blue Shield, Workmen's Compensation, Social Security, Veterans Administration, Internal Revenue, Sickness Indemnity Benefits, Life and Casualty Companies. If he doesn't study the books and journals he's an old stick-in-the-mud. If he doesn't fill out the forms he's non-cooperative. If he spends all his time seeing patients, filling out forms and keeping up with the literature, then he remains within the narrow walls of the medical rat race and never enjoys any hobbies, cultural reading, leisure time, music or other amenities. And you know what *that* makes him!

But let's not ask for pity. We probably love it this way.

From the Journal of The Medical Society of New Jersey

TAX DEDUCTION OF PROFESSIONAL ENTERTAINMENT EXPENSES

Although the tax court[1] appears to have recognized that physicians may incur validly deductible expenditures for entertainment that is ordinary and necessary in the practice of medicine, the American Medical Association has received complaints that internal revenue agents in some instances refuse to recognize any deductions for "business" entertainment. These agents have contended that such expenditures are "unethical" and consequently not deductible. In some instances agents are reported to have made the assertion that the American Medical Association considers expenditures for business entertainment as unethical.

To correct this misunderstanding, Dr. Lull sent the following letter to the Commissioner of Internal Revenue, T. Coleman Andrews, on Feb. 21, 1955:

"We have received complaints from various parts of the country to the effect that Internal Revenue Agents have taken the position, in examining the returns of physicians, that business entertainment expenses are not allowable deductions for physicians. These agents contend that such expenditures are 'unethical' and hence not valid deductions for Federal income tax purposes. In some instances, we are informed, the agents even go as far as to assert that the American Medical Association considers such expenditures as unethical.

"In an attempt to clarify this same situation, the Judicial Council of the American Medical Association, which has the responsibility of resolving questions of medical ethics, issued a formal report in 1951 regarding business entertainment expenses, in which it stated: 'The Council does not consider such expenditures as per se unethical. There are circumstances under which a professional obligation may rest on a physician to entertain other physicians. It is a usual and necessary concomitant of the practice of medicine. It is certainly not an uncommon practice and is recognized by the profession generally as entirely proper and justifiable.'

"This report was unanimously adopted by the House of Delegates of the American Medical Association.

"We believe that the same standards applicable to lawyers, architects, engineers, and other professional men, or business men in general, should be applied in the tax recognition of a physician's business entertainment expenses.

"We would appreciate your action in informing those charged with the responsibility of examining tax returns, that it is not unethical for physicians to incur legitimate business entertainment expenses and that the American Medical Association does not consider the incurrence of such expenditures as unethical or contrary to public policy. Please advise us as to your disposition of this matter."

On March 2, 1955, an acknowledgment of Dr. Lull's letter was received, and on April 21, 1955, a reply was received in which the director of the audit division of the Internal Revenue Bureau agreed to call the attention of his field personnel to the "circumstances" cited in Dr. Lull's letter. It will be noted from this reply set forth below that the substance of the position of the American Medical Association is not challenged:

"This is in further response to your letter of February 21, 1955, addressed to Commissioner Andrews, relative to the position being taken by internal revenue agents that business entertainment expenses claimed by physicians on their Federal income tax returns are 'unethical' and, consequently, not

allowable. You have been informed that in some instances our agents have asserted that the American Medical Association itself considers such expenses as unethical.

"You state that your association does not consider legitimate entertainment expenses incurred by physicians in the pursuit of their profession as either unethical or contrary to public policy, and you believe that in the examination of income tax returns physicians should be accorded the same treatment as that accorded other professional men, or business men in general.

"Under the circumstances you request that those internal revenue agents responsible for the examination of income tax returns be advised accordingly.

"The administration of the provisions of Section 23a(a)(1)(A) of the Internal Revenue Code for 1939 (Section 162 of the Internal Revenue Code for 1954), which allows 'ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business,' involves a factual determination. Accordingly, the allowance of such expenses must be based upon the facts in each case. Since you did not call to our attention any specific cases, we are not in a position to determine whether entertainment expenses have in any instance been improperly recommended for disallowance.

"In order, however, to insure uniform application of this provision of the law, the circumstances which you have recited will be brought to the attention of our field people.

"Thank you for calling this matter to our attention."

Physicians whose professional entertainment expenses have been challenged as "unethical" may find support from this correspondence in dealing with revenue agents.

1. Richard A. Sutter, et al., 21 T.C. 170. Bernard L. Shackleford, 7 T.C.M. 694.

J.A.M.A., June 18, 1955

Twilight of the Waiting Room

In his idea-packed book,* Jim Bryan suggests that the doctor never refer to his reception room as a "waiting room" and that he never allow any one else to use that term.

We think that the author is right. After all, a "waiting room" suggests something passive: the patient waits; he sits; he is forgotten. It conjures images of cold, poorly lighted rural railway stations. By contrast, a reception room suggests something active. Here something is done to and for the patient. He is received. To put it another way, he is welcomed. The phrase "reception room" has an aura of elegance about it.

As the idea of an "appointment" practice (for GPs as well as specialists) catches on, there will be less use for this room anyway. When it must remain, it could approximate the living room where your guest waits while your wife puts on those last and mysterious finishing touches. Maybe if we all thought of these spaces as "reception rooms," we'd begin to look at them with more critical eyes. The light, the heat, the decor, the reading matter, the spaciousness, the friendly arrangement of chairs — all this goes into good "reception." Whether as an actual room or only as a word, the "waiting room" could well be retired from active duty. Let patients no longer just wait. By all means let them be received. Maybe we ought to go the whole way and call it a "welcome room."

**Bryan, James E.: Public Relations in Medical Practice. Baltimore 1955. Williams & Wilkins.*

AV MANAGING DIRECTOR ARRESTED FOR FRAUD

- Clarence E. Richard, managing director and co-founder of the National Anti-Vivisection Society, has been arrested by States Attorney Gutnecht (Cook County, Illinois) for embezzlement. Gutnecht charged that Richard had taken illegally some $8,000 of the anti-vivisection society's funds and his investigators were still going through the organization's books, some 1200 pounds of which they had subpoenaed.

- Richard looked tanned and healthy when he appeared in court to be charged, having just returned from a Caribbean cruise. He said that the charge was "ridiculous" and that his organization spent more than $8,000 per year on postage.

- States Attorney Gutnecht pointed out in reply that the National Anti-Vivisection Society was a "very loosely run" organization, in reality one man — Richard — and not a true society at all.

- At a court hearing on April 15, Richard was granted a continuance to a later date, at which time he may or may not be indicted for fraud and embezzlement. He is currently on $10,000 bond.

- It has been learned that the auditing firm for the National Anti-Vivisection Society resigned last year explaining that they could not morally certify the propriety of NAVS financial affairs. Two of the Society's three employees have also resigned, and are understood to be helping the States Attorney in his investigation.

- Richard has long been known to have earned unusual benefits from his position with the anti-vivisection organization. He has taken numerous vacation trips with funds from the organization, and drives an expensive late model automobile, with all expenses again footed by his organization.

- However, these and other lush appurtenances of his job as managing director have all been provided for him with the knowledge and approval of the NAVS Board of Directors.

- It is understood that his current difficulties arise from entirely different circumstances where evidence has been found of actual defalcation of Society funds. It appears that in at least one instance a bequest of several thousand dollars never found its way into the Society treasury, despite the fact that the lawyer for the estate received a receipt signed by Richard for the bequest check.

- Clarence E. Richard founded the National Anti-Vivisection Society in 1929 in conjunction with the late George Arliss, well known actor, who footed the organization's bills during its early years. Richard, 54, is a former newspaperman and claims to have been a captain of field artillery during World War I. He was 17 when World War I ended.

- An informed source has told the NSMR that investigation of the National Anti-Vivisection Society books gives real reason to question the tax-exempt status of the organization, especially in the light of Richard's handling of the group's funds.

ST. ELIZABETH STAFF MEETING

The quarterly meeting of the Staff of St. Elizabeth Hospital was held on June 7, 1955. Meeting was called to order at 8:40 p.m. by Dr. T. K. Golden, Vice-President of the Staff, in the absence of Dr. W. H. Evans, who was at the meeting of the American Medical Association.

I. Minutes of the previous meeting were read and approved.

II. Reports of the standing committees were given.
The Intern Committee report as always evoked the greatest amount of discussion.

III. The following applications for privileges were read:
Dr. L. P. Caccamo for Courtesy Privileges in Internal Medicine and Cardiology.
Dr. M. Murray for Courtesy Privileges in Plastic Surgery.

IV. The Executive Committee minutes of the past three months were read.

V. Report of the Treasurer was read.

VI. An amendment to the constitution which had been approved by the Executive Committee and the Committee on Revisions of the Constitution changing Article III, Paragraph I, in regards to "Membership" was read as enclosed.
It was moved by Dr. J. L. Scarnecchia, seconded by Dr. R. J. Scheetz and passed unanimously by the staff.

VII. There being no further business the meeting was adjourned at 9:40 p.m.

W. E. Sovik, M.D.
Secretary

PROCEEDINGS OF COUNCIL
June 13, 1955

The regular monthly meeting of the Council of the Mahoning County Medical Society was held at 9:00 P.M. on Monday, June 13, 1955, at the offices of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio.

The following doctors were present: I. C. Smith, president presiding, E. R. McNeal, S. W. Ondash, A. Randell, F. J. Schlecht, C. A. Gustafson, G. E. DeCicco, A. K. Phillips, W. M. Skipp, V. L. Goodwin, M. W. Neidus, J. D. Brown and A. A. Detesco comprising the Council, also Dr. Logan Robertson, director of Occupational Health Service.

Dr. Robertson elaborated on the program and answered inquiries.

The special Committee appointed to study the Occupational Health Service and specifically the local plan, submitted their report.

A Public Relations display at the Court House was discussed. The Executive Secretary was instructed to turn the matter over to the Public Relations Committee.

Dr. Gustafson discussed the Indoctrination Program. Council was of the opinion that the Society should have two a year, depending upon the number of applications.

The following application was presented by the censors:

ACTIVE MEMBERSHIP

Dr. James L. Finley, Petersburg, Ohio

If no objection is filed in writing within 15 days, the above applicant becomes a member of the Society.

(Continued on Page 313)

FROM THE BULLETIN

TWENTY YEARS AGO — JULY, 1935

The Society voted to endorse the following report of the Public Relations Committee: 1. We recommend the use of the Municipal Hospital on Indianola Avenue for a Psycopathic Hospital. 2. We recommend the employment of a well trained psychiatrist who shall not engage in the private practice of medicine except by consultation and on demand of a physician. 3. We recommend the patient and his family have the right to employ their own physician if they so desire.

There were five articles in this issue on the pros and cons of medical relief. During the depression our Economics Committee had done considerable pioneering in setting up a system of medical care for the indigent sick. They had insisted on the right of free choice of physician, they had channeled relief cases from the dispensaries and the city physician to the doctor's offices. They had obtained a fee schedule which many physicians considered acceptable. But there was never enough money to pay the bills. Money was appropriated by the State on the basis of $1.00 per month per family on relief. When the money was insufficient, the doctor's bills were pro-rated so that if the medical expense (including drugs) was twice the amount of funds available, the bills were cut by half. Pro-ration for June was 59%.

The doctors were up in arms and in Trumbull and Columbiana Counties they went on strike. The articles showed a wide divergence of opinion. Some were in favor of sending the indigents to the hospital dispensaries, some advocated having no system at all but just taking care of people whether they could pay or not.

The difficult thing to remember ~~twenty~~ thirty years later is that many of our doctors were distressed during the depression and their patients were nearly all on relief. The amount they got from the State was an important item to them. Our committee was fighting to see that they got it, while other members of the Society who were well enough fixed to feel individualistic were trying to chuck the whole thing.

The solution of the dilemma came with business recovery and improvement in employment. We have retained much of the system evolved then. Instead of the Emergency Relief we have the Mahoning County Welfare Department where indigent patients present themselves for slips authorizing them to see the physician of their choice. Fees still lag behind the minimum schedule but there is no pro-ration and the controversy has simmered down.

TEN YEARS AGO — JULY, 1945

News was received of the death of Dr. Walter F. Bartz while a prisoner of the Japanese. Dr. Nate Belinky was a prisoner, somewhere in Japan.

There was a long article on the "Rehabilitation of the Returning Medical Officer." Excerpts: "The returning medical officer needs a home and a place to practice. Some . . . will return literally homeless, officeless and penniless. According to a questionnaire about 80% were eager to obtain additional medical training. It is the duty of the medical profession to assist such physicians to reach these goals."

W. M. Skipp was elected President of the Medical-Dental Bureau. Medical Economics published an article from our *Bulletin* on "Hospital Visitors."

Majors Wm. Neidus and Sam Tamarkin were home on leave. ~~Clarita Hovirson and Dr. Reupple were married.~~ Major Sam Goldberg was heard from in Germany. Tims was spending a couple of weeks on the Riviera. This writer was heard from in the Philippines. It was a hot summer.

J. L. F.

THE CURRENT DEBACLE

The days following the news of the Salk vaccine have been so replete with cyclic unpleasant sequences as to bring thoughtful minds to a state of ad nauseam. Instead of a calm and rational modus operandi, so deserved by such an important discovery, the entire aftermath has developed into a fiasco, mirroring nary an iota of credit to our vaunted national intelligence and humanitarianism.

Somewhere in Shakespearean lore is a quote akin to "all the world is but a stage and we all are but actors." Paraphrasing (somewhat freely) into present day lingo, "there is a little ham in all of us and we all want to get into the act." Sad but true, is this aphorism as applied to the antics of our political, health and business leaders in their avidity "to get into the act," creating a tempest to be described as ludicrous, if not for the possible tragic consequences.

'Tis an unhappy spectacle to see the petty bickerings, the silly vacillations, the frequent, almost daily changes in the vaccine set-ups. "Passing the buck" has become the slogan on national and state levels, and particularly culpable are those in Washington who are trying to make a political football of a national health problem. The incalcuable harm created by the chaos can only be measured by the future, with the real victims at the present time being the anxious parents and the potential polio-sufferers.

The implanting of further doubt and fear in already apprehensive parents is not cricket and not in keeping with our American sense of fair play.

We can recall the introductions of immunizations against Diphtheria, Scarlet Fever and Whooping Cough, which were accomplished without fanfare and through medically approved channels without interference from the Cabinet, Congress, Public Health Bureaus, Social Service Agencies and privately endowed bodies. We are sure that if Dr. Salk had his choice, he would have preferred the more orderly and time honored avenues for distribution of the polio vaccine.

We trust some order will soon arise from the present furor and the benefits of the scientifically proven Salk vaccine will soon be available in sufficient amounts to expedite immunization to those who need it most. The medical profession, in its traditional manner, stands ready to cooperate in every way possible to facilitate the polio inoculations.

To those who think Socialized Medicine with governmental controls is the panacea for medical problems, just remember the manner in which the Salk vaccine has been handled or mishandled.

—M. R. Goldman, M.D.
from the Bulletin of Allegheny County Medical Society

IN MEMORIAM OF

Arthur C. Tidd, M.D., who died at the age of 74. A member of the original staff of St. Elizabeth's Hospital and a pioneer in the specialty of ENT, he also had great interest in the Mahoning County Boy Scout Organization of which he was a founding member. He maintained a perfect attendance record for 22 years in the Downtown Kiwanis Club. It is with respect, affection and warm remembrance that the members of the Mahoning County Medical Society acknowledge the passing of one of its longtime members.

SMOKE, SMOKE, SMOKE THAT CIGARETTE!

Approximately 38,000,000 Americans are regular cigarette smokers, although a million and a half have quit smoking entirely in the last 18 months, according to estimates based on a representative sample of about 40,000 persons surveyed by the U. S. Bureau of the Census for the National Cancer Institute of the Public Health Service, Department of Health, Education, and Welfare.

The data will be of value to National Cancer Institute statisticians and physicians who are studying the incidence of cancer in the population — particularly lung cancer — in relationship to smoking habits. A number of laboratory and field studies are being done by the Public Health Service, and by other agencies and institutions with the aid of Federal grants or other financial support. These studies are designed to provide more information on the question of whether or not lung cancer is related to cigarette smoking.

A report containing more detailed findings of the Census Bureau survey is in preparation but will not be ready for several months.

The figures released jointly by the Census Bureau and the National Cancer Institute are preliminary results based on interviews conducted early this year by census takers with both men and women over 17 years of age in the urban non-institutional population. The survey covered 230 areas consisting of about 450 counties scattered through all regions of the country.

Estimates based on the data thus far give the following information about the smoking habits of Americans:

The 38,000,000 cigarette smokers include 25,000,000 men and 13,000,000 women.

About 4,000,000 of the men who are cigarette smokers consume less than half a pack a day. One-half million smoke more than two packs a day. The majority smoke 10 to 20 cigarettes a day. Two million others smoke cigarettes occasionally.

Two out of every three men 25 to 64 years old in the total population smoke regularly in one form or another.

Non-farm men are heavier smokers than those who live on farms and white men smoke more than non-whites. In the South, for example, about one-fourth of the white men who are cigarette smokers use over one pack a day, whereas only about one-eighth of the non-whites smoke this much.

Two and a half million men smoke one or more cigars daily; 7,500,000 smoke them occasionally.

An estimated million men and half a million women have stopped cigarette smoking entirely since the fall of 1953. One year earlier, between the fall of 1952 and the fall of 1953, about 600,000 men and women quit smoking. Most of those who gave up cigarettes during the past year and a half were under 45 years old. It should be remembered, however, that some of those who quit smoking recently may start again at some future date.

Despite the relatively large increase in the number who have given up cigarette smoking, about half of the men and a quarter of the women in the country are still smoking cigarettes daily. The inquiry revealed that men who become smokers tend to start early in life. Out of the total adult male population of 50,000,000, about 34,000,000 are either regular or occasional smokers, it is estimated. About two-thirds of these men started smoking before they were 20, and most have been smoking regularly since then.

The findings indicate that there are larger percentages of smokers among men of the 25 to 64 group than among those below or above those ages. Greater diversity in smoking practices among women was disclosed, however, ranging from 35 percent of the 25 to 34 group, to only 4 percent of those 65 and over.

KEEPING UP WITH A.M.A.

By Wm. M. Skipp, M.D.

A.M.A. SUPPORTS HEALTH BILLS. The Association has appeared before the Health Subcommittee of Senate on Title VI of S. 886, S.J. Res. 46, S. 724, and S. 848. These bills have one common interest (mental health). Testifying were members of the Board of Trustees and with them were 16 additional professional groups all interested in getting a non-governmental commission set up to make a thorough and complete study of this problem. This should not be a permanent program, but just long enough to get a definite program set up in the U. S. This is one instance wherein the government is considering a group of non-government agencies to undertake a specific task and report back to Congress.

These measures approved by committee for 1¼ million dollars.

NEW HOUSE LEGISLATION. H.R. 4813 Mailliard, R. Calif. H.R. 4822 Shelley, D. Calif. These would put general hospitals, owned and operated as non-profit institutions, under the same classification as municipally owned hospitals. Estate and gifts would be tax free as long as the facilities were: 1. open to the public; 2. that all funds were used for the hospital; 3. no one got a profit; or 4. the hospital did not attempt to influence legislation.

S. 849 (Hill & Bridges) FEDERAL AID FOR LABORATORY CONSTRUCTION. Grant 90 million dollars on a matching basis to construct new facilities which has been endorsed by many research organizations such as cancer, Sloan-Kettering, Roosevelt Hospital, Michael Reese Hospital, Optometric Foundation. They feel they would have more money if construction could be marked off.

A.M.A. feels that new facilities will not improve research and objects to Federal subsidy. State and local would have no say as the federal administration would make the awards. States and communities should support welfare and educational projects within their own laws.

Federal taxation can ultimately so deplete local and state resources and dry up private funds so that federal money will be all that is available and all will become totally dependent on and subject to the will of the federal administrator.

A.M.A. testifying on federal grants on practical nurses and medical school support states it is the same as any other subsidy and has expressed its views as such.

In federal aid, with its concomitant federal regulation and control, we see a serious threat to the ability of communities and states to discharge their responsibilities and solve their problems by methods suited to local conditions and customs. Federal aid is a dangerous device and in our opinion is justified only in an emergency . . . No such emergency has been shown to exist in the field of vocational education of practical nurses and auxiliary hospital personnel. Virtually all of the states have strengthened their own programs to the extent deemed desirable or feasible in view of local requirements and conditions.

Senator Lester Hill, D. Ala. and Rep. J. Percy Priest, D. Tenn., both are requesting their respective committees to report out aid to medical schools and hospitals for improvement and expansion which they feel will be an incentive to education and research. The American Medical Colleges Association has approved such a plan.

MALPRACTICE COMPLAINTS AGAINST U. S. CONTINUING. Noted is a rising volume of damage suits in which malpractice was charged. New complaints are coming in almost daily. They are based on alleged errors of omission, rather than commission; for example, failure of a government physician conducting a preemployment physical examination to discover a disease condition (which subsequently was diagnosed).

The same thing is happening to the physicians in general practice of medicine, all branches. See that your insurance is in force, and above all guard your tongue when you are seeing a patient that has been treated by one of your colleagues because a malpractice suit cannot be started or prosecuted unless some other doctor goes along with the complaint. Stop, look, and listen, as chickens may, and will, come home to roost right on your own doorstep.

WHY DO THE DOCTORS WANT THE BRICKER AMENDMENT? The A.M.A. indorses the principle of the Bricker amendment because under 20th century conditions treaties and executive agreements can and do reach down to affect the general public — and the doctor of medicine. The framers of the Constitution could not have anticipated the extent to which treaties would come to affect the domestic life of the country. In 1801, only 15 years after the Constitution was adopted, Thomas Jefferson, considered this same issue and declared: ". . . the Constitution must have . . . meant to except out all those rights reserved to the States; for surely the President and the Senate cannot do by treaty what the whole government is interdicted from doing in any way." Safeguards were written into the Constitution to protect the people against abuses from the old-fashioned treaties. The search now is for a safeguard against the modern form of treaty and agreement which concerns itself with broader domestic conditions and relationships.

The House of Representatives does not vote on a treaty. The Executive Department regards an executive agreement as effective when it is signed — it need not even be submitted to the Senate for approval. Executive agreements are less dependent on implementing legislation by Congress of being passed by both houses and signed by the President.

When a treaty goes into effect it becomes the supreme law of the land. Thus, a treaty on licensure, compulsory health insurance, disability insurance or any other subject in the medical field would displace all conflicting state laws on the subject. And the only Congressional action needed to put it into effect would be approval of ⅔ of the senators who happen to be on the floor when the treaty is ratified, which may be only two or three.

Treaty provisions have injected themselves into some medical areas. Licensure is one example. Until 1923 treaties of friendship and commerce did not attempt to deny states the right to bar aliens from medical and other professional practice. In 1923 the U. S. entered into a treaty with Germany that established a new policy on state laws and regulations. For the first time it applied "national treatment provisions" specifically to the professions. This forbids states to bar a person from the practice of medicine solely because of his alienship. During 1951-52, 3 additional treaties with provisions on the practice of professions were submitted to the Senate. Because of mounting objections to the alien provisions, the Senate delayed confirming these treaties. In 1953 the Senate Foreign Relations Committee concluded: ". . . if a state by its own constitutional processes required that an individual seeking to practice a particular profession should be a citizen of the U. S., such laws should not be nullified by the national treatment provisions." and recommended to Senate that no treaty carrying the "national treatment" clause be extended.

The State Department has agreed to put this reservation in future treaties. So, for the time being, no new treaties will override state licensure provisions, but the older treaties will do so. It should be remembered that this is a "gentlemen's agreement," and that it can be terminated at any time.

HAVE YOU HEARD . . . . . .

that Dr. Sidney Franklin addressed the Annual Meeting of the American Board of Legal Medicine at Atlantic City on Saturday, June 4, 1955 on the subject "The Relationship Between the Medical and Legal Profession?" He then remained to attend the Session on Legal Medicine at the Annual Meeting of the A.M.A. where he participated in the discussion of "Trauma and Cancer."

that Dr. F. G. Kravec, 243 Lincoln Ave., was elected a trustee of the Cleveland Society for Chest Diseases at the annual dinner meeting at the Hotel Alcazar in Cleveland?

that Dr. Edward G. Rizk, 77 E. Midlothian Blvd., has been elected to the American Academy of Pediatrics?

that Doctors Harold Chevlin, Frank Kravec, William Skipp and Robert Tornello attended the June Meeting of the American Association in Atlantic City?

that a post-graduate course in pulmonary disease planned especially for general practitioners will be held at the OSU Health Center in Columbus on October 7-8, 1955? This is sponsored by the College of Medicine, Ohio State University, OSMA, Ohio TB and Health Association and the Ohio Trudeau Society and is approved for seven and one half formal hours Credit by the Ohio Academy of General Practice.

WHAT YOUR PATIENTS READ AND HEAR

Articles of medical interest in current popular magazines:

1. Dr. Robert B. Greenblatt: "Pre-Menstrual Tension: the Needless Misery" Reader's Digest, May, p. 36.
2. Lois Mattox Miller: "Facts About Mental Illness" Reader's Digest, May, p. 77.
3. William Kaufman, M.D.: "Do Doctors Charge Too Much?" Coronet, May, p. 24.
4. Noah D. Fabricant, M.D.: "A Pain in the Neck" Coronet, May, p. 100.
5. Daniel Lang: "Artificial Insemination—Legitimate or Illegitimate" McCall's, May, p. 33.
6. Vivian Vance: "I Don't Run Away Anymore" McCall's, May, p. 36.
7. Robert Mines: "Is Yours a 'Tired Family'?" Cosmopolitan, May, p. 48.
8. Polio—1955, Cosmopolitan, May, p. 19.
9. L. Emmet Holt: "Nervous Habits" Good Housekeeping, May, p. 130.
10. Maxine Davis: "Acne" Good Housekeeping, May, p. 148.
11. Henry B. Safford: "Tell Me Doctor" Ladies Home Journal, May, p. 45.
12. Benjamin Spock, M.D.: "Dr. Spock Talks With Mothers" Ladies Home Journal, May, p. 118.

Radio and TV programs running currently:

"The Medic," 9:00 p.m., each Monday but the fourth.

THE PRESENT STATUS OF CHEMOTHERAPY IN TUBERCULOSIS

A summary of the report of the Committee on Chemotherapy and Antibiotics of the American College of Chest Physicians, submitted at the Annual Meeting at Atlantic City on June 2-5, 1955.

As in previous years, this report is not intended as a detailed report on the chemotherapy of tuberculosis, but rather as a progress report or statement on currently accepted principles and practice to serve as a guide to the physician treating tuberculosis.

GENERAL CONSIDERATIONS: at this writing there is no generally accepted "optimum" regime in the chemotherapy of pulmonary tuberculosis. Streptomycin, PAS-sodium, and isoniazid are the most commonly used drugs, but there is no unanimity of opinion as to which combination is most effective. However, it is emphasized that the best results are obtained when two or more drugs are combined and given continuously for a prolonged period of time. Most investigators agree that chemotherapy should be given for at least one year, even in minimal cases, and in advanced cases for a total of 18 to 24 months or longer. Others feel that the drug therapy should be continued one year after the patient has achieved an inactive status.

PULMONARY TUBERCULOSIS: the following drugs are useful in pulmonary tuberculosis.

Streptomycin and dihydrostreptomycin continue to be among the most useful and effective antituberculosis agents at our disposal. Each has the same therapeutic value and the dosage is the same for both. They are generally administered in a dosage of one gram twice weekly by IM injection. In this dosage, streptomycin rarely causes vestibular damage and dihydrostreptomycin rarely results in deafness. To avoid even these rather remote possibilities, many physicians prefer a combination of streptomycin 0.5 grams and dihydrostreptomycin 0.5 grams. Hypersensitivity to streptomycin occurs occasionally and is manifest by drug fever, rash, and sometimes exfoliative dermatitis. When this occurs, the patient can often be desensitized to the drug by administering a small amount: e.g., 0.1 gram and gradually increasing the dosage to 1.0 gram. If the patient is acutely ill on admission, some workers give one gram of streptomycin daily for one month and then decrease it to twice weekly.

Isoniazid is an extremely potent antituberculosis agent. The most commonly accepted dosage is 4 mg. per kilogram of body weight divided into three daily doses. Peeripheral neuritis is one of the most common toxic effects from isoniazid and can be prevented and alleviated by the use of vitamin B_6 (pyridoxin) 50 to 100 mg TID. Psychotic episodes may also occur.

Para-aminosalicylic acid (PAS) in the form of PAS-sodium remains an important agent in the antimicrobial therapy of tuberculosis. The most commonly used dosage is 10 to 12 grams daily in four divided doses. Side reactions of anorexia, nausea, and diarrhea are not uncommon.

Viomycin has a useful though limited place in the treatment and is used when the patient is resistant to streptomycin. The usual dosage is 2 grams twice weekly.

Pyrazinamide (PZA) is now undergoing some rather interesting clinical investigations particularly in combination with isoniazid. The dosage usually employed is 30 to 35 mg per kilogram of body weight per day, the total daily dose not to exceed 3.0 grams. This drug can cause hepatotoxicity.

Seromycin (cycloserine) is a new antibiotic derived from a strain of streptomyces which shows promise of another effective antituberculosis agent.

RECOMMENDED REGIMENS: the following regimens give approximately the same clinical results:

1.) Isoniazid—300 mg. daily plus PAS 12 grams daily
2.) Isoniazid—300 mg. daily plus streptomycin 1 gram twice weekly
3.) Isoniazid—300 mg. daily plus streptomycin 1 gram twice weekly plus PAS 12 grams daily.

Surgical intervention in the management of pulmonary tuberculosis is still in a stage of transition. Whether all residual disease processes should be resected is a moot question. The committee is firmly of the opinion that all residual cavities and large caseous lesions should be resected in each case when this is surgically feasible.

Acute Miliary Tuberculosis

Isoniazid has proved very effective with survival rates of 90%. The Committee feels that all three drugs . . . isoniazid, streptomycin and PAS should be used together in this disease. These should be continued for 12 to 18 months.

Tuberculous Meningitis

Survival rates of 80 to 90% are possible when isoniazid, streptomycin and PAS are administered together for 18 to 24 months. Intrathecal administration is not necessary and may be harmful.

Genito-urinary Tuberculosis

This variant responds very well in most cases to triple drug therapy as described above.

Tuberculosis in Childhood

There has been a growing tendency to treat active tuberculosis in children with antimicrobials, especially isoniazid. This should be continued for at least one year.

TB Pleurisy with Effusion

This should be treated as a case of minimal pulmonary tuberculosis using the antimicrobial drugs for at least one year.

Review submitted by Frank G. Kravec, M.D.
Secretary of the Ohio Chapter of the American College of Chest Physicians

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

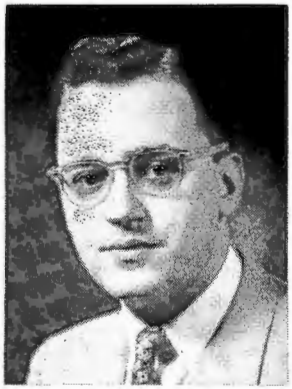
The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28 - September 2, 1955 inclusive, at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

HAVE YOU MET . . . . . .



Dr. John G. Guju who is now a Junior Active Member of the Mahoning County Medical Society? Born in Youngstown in 1924, he obtained his premedical education at Youngstown College receiving the coveted "Y.C." pin when he graduated with his B.A. in 1944. He attended Marguette University School of Medicine in Milwaukee, Wisconsin, and graduated in 1947. His internship was taken at the Youngstown Hospital Association from 1947 to 1949 . . . the first year rotating and the second straight surgical. Following his internship, Dr. Guju completed a year residency in Ob-Gyn at Cleveland City Hospital and followed this with a two and one half year residency in Ob-Gyn at University Hospital in Cleveland. Upon completion of his residency training, he enlisted in the U. S. Air Force and two years of active duty were spent at Keesler Air Force Base in Biloxi, Mississippi. In February of 1955, Dr. Guju opened his offices at 249 Lincoln Ave. for the practice of Ob-Gyn. He is Board eligible in his specialty and a Junior Candidate Member of the American College of Surgeons. Dr. and Mrs. Guju, the former Margaret Ann Poole of Newton Falls, along with son John Howard, reside at 520 Carlotta Drive.

Dr. Joseph V. Newsome who is a new Junior Active Member of the Mahoning County Medical Society? Born in Youngstown in 1924, he graduated from Ursuline High School in 1941 and then served with the U. S. Army from 1943 to 1946 as a sergeant in the Combat Engineers. Returning from the service, he attended Ohio State University for his premedical training and received his B.A. in 1949. He remained there to attend medical school and received his M.D. in 1952. He spent a year interning at St. Elizabeth Hospital and opened his office for the general practice of medicine in 1953. The present location of his office is 2722 Mahoning Avenue. In 1952, Elizabeth L. Stecker became Mrs. Newsome and with daughter Kathleen and son Michael, the Newsome family reside at 427 Caroline.

Ex Post Facto

The tough old Ozark hillbilly steered a gangling, badly mauled youth into the doctor's office.

"Doctor," he said, "I had to give this son-in-law of mine a going-over. Mebbe you'd better patch him up."

As the physician examined the victim's bruised and swollen face, he said, "It's a shame for a man to beat up his own son-in-law like this."

"Could be," drawled the old fellow. "But he wasn't my son-in-law then."

—Jack Kytle

ANNUAL GOLF MEET

THURSDAY, AUGUST 25, 1955

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
Reservations MUST be received not later than AUGUST 15

Details of program will be mailed at an early date

TEN COMMANDMENTS
For Medical Writers

I.

Thou shalt not, unless circumstances be extraordinary, release for publication a paper that neither contains anything new nor sheds new light on something old.

II.

Thou shalt not allow thy name to appear as a co-author unless thou hast some authoritative knowledge of the subject concerned, hast participated in the underlying investigation, and hast labored on the report to the extent of weighing every word and quantity therein.

III.

Thou shalt not fail to place within quotation marks the words of another, nor shalt thou fail to verify the accuracy of thy quotations.

IV.

Thou shalt not consider that to alter the words of another frees thee from the obligation to credit that other with an idea that thou hast borrowed from him.

V.

Thou shalt not publish a reference in such manner that the reader will think thou hast read a certain article if thou hast read only an abstract or paraphrase thereof.

VI.

Thou shalt not write to please thyself but to meet the needs of thy reader.

VII.

Thou shalt not publish, as if thou were sure of it, that of which thou art not sure.

VIII.

Thou shalt not allow one part of thy paper to disagree with another part thereof.

IX.

Thou shalt not mix categories.

X.

Thou shalt not fail to verify, again and yet again, thy arithmetic.

—Richard Miner Hewitt

DECLARATION OF GENEVA

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due;

I WILL PRACTICE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets which are confided in me;

I WILL MAINTAIN by all the means in my power, the honor and the noble traditions of the medical profession;

MY COLLEAGUES will be my brothers;

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely and upon my honor.

★

Adopted by the General Assembly of The World Medical Association at Geneva, Switzerland, September, 1948

THE HUMAN ELEMENT

There are some among us who think medicine is a science, full of test tubes, slide rules, and pills. But most of us know it is an art — or, rather, a scientific art. And no development in automation, cybernetics, or atomic whoop-de-do will ever replace the experienced eye, the nicety of judgment, or clinical intuition.

Since much of the art of medicine still defies analysis, it cannot be taught in any systematic and objective way; nor can there be said to be only one art of medicine. There are many approaches, each fully valid for the physician who follows it. In addition, there are differences in skill and in powers of observation among physicians.

Perhaps nowhere are these multifaceted heterogeneities better exemplified than in the essence of medicine — the examination of the patient. The point is brought out in an interesting study published recently in England on byssinosis, a respiratory disorder of cotton workers. Since there are no specific roentgenographic changes in byssinosis, "the diagnosis is made on an odd but characteristic history of chest tightness and breathlessness on Mondays, gradually extending, as the disease progresses, to other working days."[1]

Two observers (each unaware of the findings of the other) separately examined 187 men exposed to fine cotton dust and eighty-eight control factory workers who were never exposed to conditions that cause industrial pneumoconiosis. Detailed questioning about respiratory symptoms was followed by a physical examination.

The "observer error" was considerable. For example, abnormal chest sounds were heard by one or the other observer in sixty-five of the 275 cases —a disagreement of 24 percent. There was a difference of more than 10 mm. in systolic blood pressure readings in 43 percent of cases. Even chest expansion measurements taken by tape measure at the nipple line revealed observer differences. For example, Dr. A recorded larger (by 0.5 inch) expansions than Dr. B in 42 percent of all patients.

Other examples may be cited. To the question as to whether breathing was more difficult in winter than in summer, both physicians recorded a positive answer in 12 percent of the controls; among the cotton workers, however, Dr. A recorded a positive answer in 13 percent and Dr. B in 24 percent. To a similar question about the effect of fog, Dr. A recorded positive answers in 23 percent of the controls and 44 percent of the cotton workers, and Dr. B's percentages were 21 and 52 percent. Evidently Dr. A was so biased against, or Dr. B toward, the abnormality that the patients were influenced in their replies. Possibly both biases were present.

Again, kyphosis was diagnosed by Dr. A in 19 percent of the cotton workers and in 20 percent of the controls but only in 11 and 8 percent respectively by Dr. B. Here, grading was in terms of severe, moderate, and normal, and only the personal standards of the observer served as a guide.

Another way in which this human element can play a crucial role in clinical investigation is well illustrated by the experiences of Shapiro *et al.*;[2] in retrospect, they found that the effectiveness of an antihypertensive agent had been greatly modified by the psychological attitude of the clinician. When the investigator was enthusiastic about the study and believed in the efficacy of the agent being tested, both the patients on active medication and those receiving placebos had much lower blood pressures than were recorded

when the investigator lost interest in the study and became skeptical of the value of the agent. This difference was seen equally in both groups of patients and was independent of the effect of the medication itself.

Individual variability in observation is perhaps of less significance in hospital or other multimedical practice because diagnosis seldom depends on single observations. Although it is true that a "good" physician is, by experience, able to discount the unreliable and to evaluate the significance of signs and symptoms, nevertheless, the observer error is probably more important in ordinary clinical work than is generally recognized. Physicians should overcome any unwillingness "to appreciate their own unreliability."[1]

It was old Hippocrates who said, "Life is short, and the Art long; the occasion fleeting; experience fallacious, and judgment difficult."

REFERENCES

1. Schilling, R. S. F., Hughes, J. P. W., and Dingwall-Fordyce, I.: Disagreement between Observers in an Epidemiological Study of Respiratory Disease, Brit. M. J., 1:65 (January 8), 1955. 2. Shapiro, A. P., Myers, T., Reiser, M. F., and Ferris, E. B., Jr.: Comparison of Blood Pressure Response to Veriloid and to the Doctor, Psychosom. Med., 16:478 (November-December), 1954.

Pruritus

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

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

(Continued from Page 296)

The following resolution was adopted:

WHEREAS: The Mahoning County Medical Society has in the past, at considerable expense to the Society sponsored Interne and Resident Members at social functions including the Golf Meet, Dinner Dance, and Annual Banquet; excluding, Sixth Councilor District Postgraduate Assembly.

BE IT RESOLVED: THAT: The Society will sponsor Interne and Resident Members and such persons whose applications are pending at social functions including the Golf Meet, Dinner Dance, and Annual Banquet; excluding Sixth Councilor District Postgraduate Assembly. FURTHER: That such guests of the Society will be expected to attend at least five monthly meetings during a year.

A. A. Detesco, M.D.
Secretary

AN EPITOME OF

E P O N Y M S

Here is an opportunity for refreshing (and frustrating) relaxation.

Can you define the following, sometimes and unfortunately known by the name of an early describer?

(We, too, deplore the use of eponyms to describe medical entities; but we fear that, for the present, they are very much with us.)

A score of 60 percent makes you erudite.

what is . . .

DOROTHY REED CELLS?

ROSSOLIMO'S REFLEX?

RUBIN'S TEST?

RUMPEL-LEEDE SIGN?

SCHICK TEST?

SCHILDER'S DISEASE?

SCHULLER-CHRISTIAN'S DISEASE?

SHWARTZMAN'S PHENOMENON?

SIMMONDS' DISEASE?

SIMS'S POSITION?

(Answers on next page)

ANSWERS TO EPONYMS

DOROTHY REED CELLS: The giant polynuclear cells that are the most constant feature of the lesions of Hodgkin's disease were first described by the contemporary American pathologist Dorothy Mendenhall Reed. Because of the subsequent studies of Carl Sternberg, a German pathologist, these cells are sometimes called Reed-Sternberg cells.

ROSSOLIMO'S REFLEX: Plantar flexion of the second to fifth toes following tapping of their plantar surfaces was described by Gregorij I. Rossolimo, a Russian neurologist.

RUBIN'S TEST: The contemporary American gynecologist Isidor C. Rubin devised a test (1917) for the patency of the uterine tubes by means of insufflation with air or other gas.

RUMPEL-LEEDE SIGN: The appearance of petechiae following vascular constriction (tourniquet) of the arm (noted by two physicians, Theodor Rumpel and C. Leede) is used as a test of capillary fragility.

SCHICK TEST: An intracutaneous test for immunity to diphtheria devised by the Austrian pediatrician Bela Schick, who now lives in New York.

SCHILDER'S DISEASE: Paul F. Schilder, a noted neuropsychiatrist, described a disease of massive demyelinization of the brain with progressive blindness which terminates in complete dementia.

SCHULLER-CHRISTIAN'S DISEASE (also known as Hand-Schuller-Christian disease): A generalized xanthomatosis of childhood, with diabetes insipidus, exophthalmos, and bone defects, reported by Artur Schuller in 1915 and fully described as a syndrome by Henry A. Christian in 1919. (Also noted by Alfred Hand in 1893.)

SHWARTZMAN'S PHENOMENON: Gregory Shwartzman, an American immunologist, devised a test for local tissue reactivity based on the intravenous administration of an antigen twenty-four hours after a preparatory sensitizing injection into the tissue.

SIMMONDS' DISEASE: Also known as hypopituitary cachexia, this disease was described by the German physician Morris Simmonds about forty years ago.

SIMS'S POSITION: The famous American surgeon James Marion Sims, one of the fathers of gynecology, advocated the semiprone position (on the left side, with the right leg drawn up) used in proctology and gynecology.

'Co-Pyronil'

(PYRROBUTAMINE COMPOUND, LILLY)

The allergic patient can enjoy summertime to the fullest: 'Co-Pyronil' often eliminates distressing symptoms without causing side-effects.

Because 'Co-Pyronil' is unusually long-acting, it affords the patient continuous relief without the inconvenience of frequent doses. Also, the bedtime dose keeps the patient symptom-free throughout the night.

Each pulvule provides the complementary effects of:

'Pyronil' (Pyrrobutamine, Lilly)	15 mg.
'Histadyl' (Thenylpyramine, Lilly)	25 mg.
'Clopane Hydrochloride' (Cyclopentamine Hydrochloride, Lilly)	12.5 mg.

Dose: Usually 1 or 2 pulvules every eight to twelve hours. Increase or decrease as needed.

Also: Suspension CO-PYRONIL
One-half the above formula in each 5-cc. teaspoonful. Deliciously flavored.

Pulvules CO-PYRONIL, Pediatric

Tablets PYRONIL, 15 mg.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.