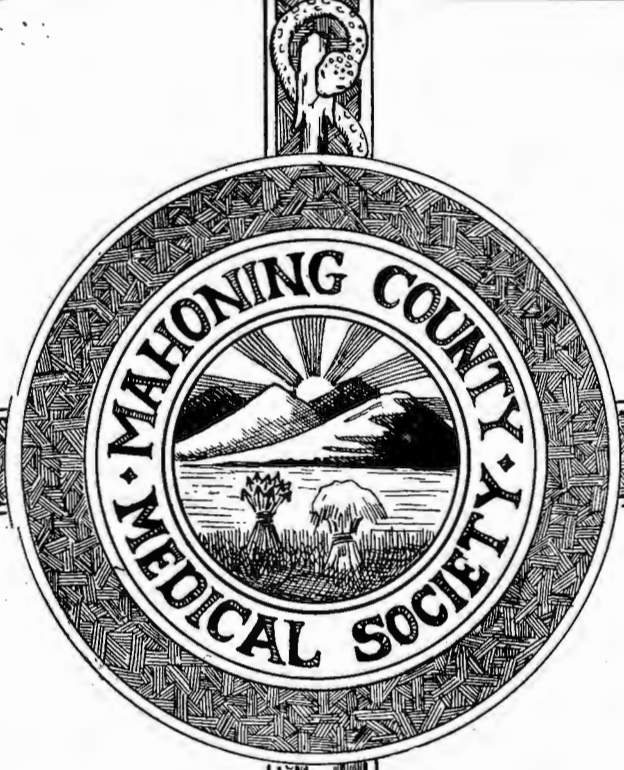

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

AUGUST • 1955
Vol. XXV • No. 8
Youngstown • Ohio

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ADVERTISERS' LIST

Our President Speaks

POLIO

As usual at this time of year, "Polio" is with us. At the beginning of the year, we had great hopes that the "Salk Vaccine" would begin to show some effects in reducing the incidence of paralytic polio by this time. Due to several unforeseen factors, this hope is not being realized this year.

So far, the picture is just about the same as in preceding years. The actual figures are not available, but it would seem that the total number of cases is about the same. The percentage of paralytic and bulbar cases would also seem to be about the same. Judging by questions put to me from time to time, there is considerable uncertainty about the possibilities of contagion and possible preventive measures available to contacts. Last year the National Foundation furnished gamma globulin for certain contacts of persons contracting the disease. This free globulin is no longer available. Commercial globulin is available and it becomes necessary for the doctors to advise the families of a patient whether it is advisable to give gamma globulin to other members of the family. Under last year's system, I personally do not feel that the course of our experience in this vicinity was in any way altered by the use of globulin. When the expense of the preparation, particularly for adults or older children is considered, I do not believe it is advisable to recommend it. There is, however, no harm in giving it if it will allay the anxiety of the parents and they are willing to make the investment.

As to the chances of close contacts of persons who contract polio, getting the disease, it becomes necessary for us to keep a calm attitude and realize that we have never had enough polio in this vicinity to even approach the epidemic stage. It seems very unlikely that person to person contact has been a factor in spreading the disease in this community. Therefore the chance that an individual contact will contract the disease is at most remote. Since no effective preventive measure is available anyway, an attitude of reassurance to contacts, at least on a mathematical basis, is justified.

Possibly our experience this year is better than appears on the surface because weather conditions have been of a nature which usually seem to increase the number of cases admitted to the hospitals. Certainly there are no more cases at this time than there were last year. Let us hope that the numbers will remain low.

Ivan C. Smith, M.D.

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio Annual Subscription, $2.00

VOLUME 25 AUGUST, 1955 NUMBER 8

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

EDITORIAL

August with its blooming flowers and buzzing bees has brought in a wave of sweltering heat and humidity that makes the best of intentions wilt. At least mine have!

And so the jousting windmills, as to the polio vaccine hassle, creeping socialism, state medicine, public health, medical morals, politics and our society reorganization, will simply have to wait until I have the strength to return to the fray. We fight no battles on hot, humid days!

But seriously, the thorny problems will still be there this fall and we shall all have the chance to assault them with renewed vigor and perspective. Each of the members of the Mahoning County Medical Society is invited to submit to Dr. Paul F. Mahar any pertinent or disturbing issues to be discussed at the September meeting. This will be a unique business meeting featuring a roundtable of member participants who will express the pro or con facet of each question.

Now is the time and opportunity to bring your own particular question, gripe or peeve into true focus. It is sincerely hoped that an open exchange of individual opinion will result in a strengthening of the Society's common purpose.

Robert L. Tornello, M.D.
Editor

GUEST EDITORIAL

Is the Medical Society Representative?

It is sometimes whispered in the cloak rooms of hospitals and in lobbies of medical meetings that the medical society is not truly representative of the doctors of the community. The allegation takes many forms. When a society — whether the A.M.A., or a state society, a specialty group, a hospital staff or a county medical unit — issues a resolution, there are those who say it does not speak for the profession generally. It is said that a few leaders make all the decisions and force the rank and file to accept them under threat of some dark and mystic penalty. Or that a cabal representing one hospital, one geographic area, or one school of thought, has somehow seized the society's machinery.

It is certainly true that a member can effectively disfranchise himself by never going to meetings, by tossing all mail ballots into the waste basket, and by failing to perform committee service when asked. And if 60 per cent of the members evade all society contacts, then perforce, the remaining minority must make decisions and take actions. However, under those circumstances, it seems scarcely fair for the coat-holder to tell the fighter how to fight.

There is indeed a magic pass-word to medical society participation. No, it is not a Greek letter fraternity phrase, nor is it a slogan reflecting the old school tie. It is not a secret word known only to the initiate. It is a simple phrase of four English words, uttered with sincerity to one of the officers of the society. The pass-word is: "How may I help?"

Almost any member who drops a hint that he is willing to serve on a committee, who attends meetings regularly, who stands on his own two feet and says so when he disagrees with a proposal, almost any such member will be given a chance to participate. Maybe, in fact, one medical association or another does not sensitively reflect the opinions of the general membership. It could be. But whose fault is *that*? If the "unrepresented" member never voiced his opinion, never went to a business meeting, never offered to serve on a committee, who is to blame for his failure to make an impression?

You'll be getting a notice of a county medical society meeting soon. No one is diverting your mail or standing guard at the door to keep you out.

Welcome, thrice welcome.

The Journal of The Medical Society of New Jersey

The Bald One: Man of the Future

The first known written medical record contained a remedy for baldness, including fat from the lion, hippopotamus, crocodile, goose, serpent, and ibex. It had one thing in common with modern "cures."

It failed to cure baldness.

One of the reasons baldness "cures" have continued to appear for thousands of years is that baldness is a "mysterious condition about which people can be easily fooled," according to Veronica L. Conley, assistant secretary of the American Medical Association Committee on Cosmetics. The "pseudo-scientific arguments supporting most baldness cures are frequently so convincing that their unsound basis can be detected only by scientists."*

For instance, "before and after" pictures of bald men whose hair grew again after using a "restorer" are among "the most potent advertising weapons." But in many types of baldness, hair will return regardless of treatment or lack of it. This type of baldness and spontaneous regrowth often follow infectious diseases accompanied by fever, including erysipelas, pneumonia, typhoid, and influenza. Serious hair loss sometimes follows childbirth or surgery. In these conditions, normal hair growth returns without help.

But for ordinary baldness, massage and hair tonics with or without vitamins, hormones, ultraviolet light, diets, sulfa drugs, and antiseptics have no special place in treatment. A complete physical examination to discover a possible cause in disease is wise. Regular and gentle scalp massage, brushing, and intermittent tugging at the hair to lift the scalp are "measures for good scalp hygiene."

However, once ordinary baldness gets underway, "it is progressive and permanent and there is no known way of preventing or retarding its progress," Mrs. Conley said. The tendency toward baldness is hereditary but will appear only where there is a normal amount of male hormone.

Scientists are mostly optimistic about an eventual solution to the problem of baldness, except for one factor.

"In the course of evolution there has been a marked reduction in the amount of hair covering the human body," she said. "The loss of scalp hair may be part of an evolutionary trend. If this is true, future centuries will bring not a cure but the appearance of more and more bald men."

To Members of
MAHONING COUNTY MEDICAL SOCIETY - - -

In order for your Medical Bureau to help you keep good DOCTOR-PATIENT relations and to give you both prompt and efficient service, it is imperative that we have the following information at all times.

1. **WHERE YOU CAN BE CONTACTED**
2. **WHEN YOU ARE OUT OF THE CITY (and date of return)**
3. **TO WHOM YOU WANT YOUR CALLS REFERRED**
4. **CHANGE IN OFFICE HOURS**
5. **CHANGE IN PERSONNEL**

G. E. DeCICCO, M.D., Secretary
Medical-Dental Bureau

FROM THE BULLETIN

TWENTY YEARS AGO — AUGUST, 1935

The President was in a dither that month about reports of "chiseling" by doctors. He attempted to show in his column how the doctor was being chiseled by the Industrial Commission, the Emergency Relief, the Federal Government and by large sections of the general public.

The annual golf party was rained out but the men had a good time later, to quote from the report: "In the evening they enjoyed an excellent dinner and then came quiet conversation, lovely music, and all those dignified diversions to which our serious dispositions dispose us." Golf prizes were awarded by drawing numbers and the lucky ones were Cafaro, Sisek, Joe Ranz, L. G. Coe, Scofield, Taylor, E. C. Baker, and Goldberg.

New members of the Society were Paul Mahar, Raymond Cafaro, Charles Warnock, Sam Schwebel and Enrico DiIorio. Fred Coombs was physician at Camp Fitch. Paul Fuzy was studying proctology at the Mayo Clinic. J. N. McCann was taking a course in Cardiology at Michael Reese Hospital in Boston. Sam Tamarkin passed the examination of the American Board of Radiology.

There was an interesting article written by Dr. Patrick about Dr. C. R. Clark who opened his office in Youngstown in 1899, when a few streets were paved with cobblestones and the rest were dirt roads. His office on Bryson St. with Dr. J. A. Sherboudy was a landmark for many years, and Dr. Clark was engaged in active practice until fairly recently.

A special meeting was called that August to consider a new fee schedule and discuss economic problems. More about that next month.

TEN YEARS AGO — AUGUST, 1945

President Bunn announced the plan for a survey of the public health needs in Youngstown with a view to informing the public what is lacking in health supervision and what alterations will have to be made to improve the situation. Today we know what is lacking and what is needed but we are still trying to persuade a stubborn Council to take necessary steps.

Mary Herald was appointed manager of the Medical Dental Bureau, a post she still covers more efficiently than ever.

Majors Sears and McConnell were home, released from active military service. Walter Tims was home on leave and saw his 32-month-old son for the first time. DeTesco was heard from in the Pacific where he survived the Okinawa landing. Lieutenant Commander R. V. Clifford was there too and said it was the biggest show yet. Captain Richard Goldcamp was home for a short stay after a year in Germany. DeCicco was home on leave after twenty-nine months in the Pacific, yellow with atabrine. Major Sam Goldberg was chief of anesthesia at the 135th General Hospital in Leominster, England. Major Brack Bowman was back from England and waiting to be sent to the Pacific. Sam Klatman was back from the war and opened his office.

The end of the war was in sight and we were all anxious to get home. On August 14th the Japs quit and the scramble was on. Days never were so long and time never passed so slowly as it did during that period of demobilization.

J. L. F.

ANY COMMENTS?

RETIREMENT PROPOSAL

Sirs: . . . I'd like to suggest a practical plan for the many physicians who aren't able to save enough money to retire. It's a plan that would permit *all* of us to share the slight burden of helping our less fortunate colleagues enjoy a comfortable—and *proud*—old age:

Let the A.M.A. buy a plot of land in a warm state such as Florida; and let the Association put up about a thousand prefabricated homes, each to accommodate a retired doctor and his wife. On the grounds of this project there could also be built a small golf course, an infirmary, and a central building with a library, a lecture room, and a movie theatre.

I figure this would cost about $5 million. But if every doctor in active practice contributed $10 a year to the plan, that would give us an annual income of over $1 million.

Another possible source of income: Doctors who for ethical reasons have refused compensation for their medical discoveries could with perfect propriety request that royalties be paid to the A.M.A.'s retirement fund . . .

The original cost of the project could be paid off in a very few years; thereafter, there'd be only the comparatively small expense of maintenance. Retired or disabled doctors and their wives, as well as doctors' widows, would be entitled to live in the project free of charge, paying only for their food and clothing . . .

As I see it, the plan has many advantages: The retired doctor could continue to live in a medical environment, without the financial hardship of trying to live up to a high-priced social standard. He could fish, play golf, and participate in other sports, depending on his physical condition. And he wouldn't be accepting charity, since he would have made his contribution to the private, independent organization during his active life.

I have discussed this plan with many members of our local medical society, and all of them have urged me to try to interest doctors elsewhere and everywhere . . . What do you readers think? They *must* agree that the cause is worthy. Don't they agree, too, that this suggestion of mine is feasible?

John Peters, M.D., Oak Park, Ill.

(From "Letters," Medical Economics, March, 1955)

CREDO

Let me state for myself, as simply as I can, what it is I feel that general practice holds that makes it satisfying to me.

I think it is the opportuntiy it gives for doing things in my own way for my own patients, and going on doing so, not at one special time, but through all their lives; not for one special ailment, but in all their illnesses and tribulations; getting to know them and their families, their homes and their jobs, their habits and their fads—in fact, being their family doctor. I want to do as much as I can for them myself, but I realize that to do so I need a variety of help: help which can extend my usefulness to them. Finally, when they are beyond help, I still want to offer what solace I may, to them and to those who care for them.

A. T. Rogers, M.D.: The Philosophy of a General Practitioner, *M. World*, London, (November), 1954, *via PB*

WANTED TO BUY: Used Direct Writer Electrocardiograph in good condition. Box 21, c/o Bulletin.

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What Is "Renal Failure"?

Because the kidney has an effluent which we can see with the naked eye, we tend to think of it as a faucet, that is, something which is either on or off. This has been preserved in our thinking by placing the emphasis on the quantity of effluent rather than its qualities in relation to the body economy. Thus the term "anuric patient" comes easily to the tongue even though completely anuric persons rarely are seen, and the statement "this man is suffering from oliguria" is commonplace even though it has at most an indirect and limited clinical significance. Our thinking would be improved if we compared the kidney with the heart, for example. We say a man has cardiac insufficiency or failure after weighing his work load against his cardiac output. If we cannot increase the latter, we decrease the former and a cardiac-insufficient laborer becomes a cardiac-sufficient hemstitcher. The kidney differs only in the complexity of its function and in the fact that its output is important for its qualities rather than its volume. Thus the recent clinical terminology for renal failure has emphasized the physiologic rather than the morphologic approach to this subject, and such terms as "renal failure," "renal insufficiency" and "the ischemuric episode" have replaced "anoxic nephrosis," "lower nephron nephrosis" and other terms which are more pathologically than physiologically oriented.

George L. Schreiner, M.D., "The Treatment of Acute Renal Insufficiency," M. Ann. District Columbia, October 1953

M.D. IN THE COMICS

Latest in the "Entertaining Comics" series is a luridly colored, 7 by 10 paper called M.D. Its letter-to-the-editor page is called *The Needles.* In the first issue this page includes a copy of the Hippocratic Oath and an acknowledgment to a surgical instrument manufacturer for "technical assistance."

The general tone is theatrical, and medical items are oversimplified and over-dramatized. Thus, on the first page is a picture of a repulsive-looking ape-man, under which is written "Infectious diseases, accidents, old age, all of these resulted in AGONY . . . humanity stood helpless in the face of disease . . . in the days before modern medicine." There are strips which show the operations of prehistoric medicine men. the advancing front of the bubonic plague, the development of anesthesia, and growth of hospitals. The authors delight in the gruesome phrase ("your leg is rotting," "mankind remained in agony" and the like). There are also several stories — one of a girl whose leg had to be amputated, one account of an emergency tracheotomy and another of an appendectomy. Even the economic problems of the physician are considered and patients are chided for calling the doctor first and paying him last. Throughout these pages of exaggeration, excessive color and lusty language, runs the thread of the heroism of the physician.

It is a curious commentary on education and on our public relations. Shall we condemn this and its sister publications for their cheapness, their appeal to crude thrill-seekers and their fantastically over-dramatized language? Or shall we say that here is the one medium of popular appeal that will really work, and that we are simply too proud to use?

The same company just announced two new magazines. One is called "Psychoanalysis." The other is called "Mad." We can hardly wait . . .

KEEPING UP WITH A.M.A.

By Wm. M. Skipp, M.D., Delegate from Ohio to A.M.A.

THE SALK VACCINE is still in the forefront, with the politicians trying to get a hand in the pie. The Ohio State Medical Association has taken a stand that they as physician members of the Association, cooperate with all health departments, that all recommendations of U. S. Health Dept. be followed, and that vaccine be furnished by local communities free to all persons unable to pay and give the vaccine in such cases without cost to the patient, but that the local Welfare Dept. cover the administration cost.

The A.M.A.'s stand is that all physicians cooperate with all health departments and authorities. Fees should be charged and no free vaccine be furnished except to the medical indigent.

Many bills have been introduced covering all phases of the problem — safety, manufacture, distribution and administration, and hours of hearings have been held. To date no solution has been forthcoming.

The whole situation smacks of socialism and is being watched and fought by the A.M.A. The idea is that the social uplifters see a means whereby they can get their feet in the door for free medical care for all the people.

H.R. 6207 would give sweeping authority to a federal agency to pass on the medical use of biologicals. The drug industry and the A.M.A. are not going to take this without a fight. This is called the Priest bill. If passed is not just stand by legislators.

Our Secretary, George Lull, says: "The Macs and Joes, and the Marys and Helens who make up the American public apparently have taken to heart the old A.M.A. Campaign motto, "The Voluntary Way is the American Way."

"Some 104 million persons will have voluntary health insurance against hospital expenses. About 89 million people will have surgical expense protection, and 50 million will have regular medical expense protection."

"Benefit payments for loss of income due to disability totaled in excess of half a billion dollars last year. Blue Cross and Blue Shield type plans paid 39% of the total.

A total of nearly 39 million workers had protection against loss of income due to disability. This figure represents about 60% of the total civilian labor force in the nation at the time.

OUR DR. ED McCORMICK RECEIVES HONORARY DEGREE. He struck out against any solicitation of federal funds for the Catholic University's new medical and dental schools. "Taxation has already become confiscation," he told the graduating class. "A continually expanding federal government and loss of states' rights spells disappearance of religious freedom, freedom of speech and of the press, and of individual rights, and eventual loss of democracy."

Critical of government-generated dependency, Dr. McCormick said "many young men and women today in their philosophy do not resemble our forefathers who made a great country from a virgin wilderness. They are likely to think not of what they may accomplish to become independent, but of pensions, social security, and fringe benefits."

CHICAGO TRIBUNE HITS DOCTOR DRAFT. "The real reason for the extension of the doctor draft is disgraceful" the editorial said. It closed with this:

"The doctor draft is unjust. Its extension would mark the first time in our history that any group of citizens has been singled out for conscription in peace time because of their professional skill."

S. 1859 (Humphrey, D., Minn.) FEDERAL AID FOR PUBLIC HEALTH EDUCATION. Provisions: 5-yr. period, $5 million for outright subsidies, $5 million for construction grants (on a 50-50 matching basis) and a total of $1,250,000 for scholarships. The bill provides for grants on the basis of 15% of basic operating costs of graduate instructions plus an additional $500 for each full-time student in excess of average past enrollment and an additional $500 for each enrollment in excess of 30 students.

S. 1976 (Morse, D., Oregon) This Senator has repeatedly tried to get into the act on polio vaccine, treatment and after care of the polio victims. Now he wants all persons who contract polio subsequent to April 12, 1955, to be paid for all expenses, medical, hospital, wheelchairs, trusses, braces, etc. Another socialistic scheme of this turncoat politician.

H.R. 6311 (Rogers, R., Mass.) would have chiropractors appointed to V. A. Department of Medicine if they are licensed to practice in a state and if they have practiced for two years. This has been opposed by veterans' organizations and A.M.A.

By this time you know the Doctor Draft has become a law again over the continued opposition of A.M.A. It will still carry $100 per month equalization pay. Dentists do not like their law and are fighting.

MEDICAL PUBLICITY AS A DOCTOR SEES IT. Dr. L. H. McDaniel of Tyronza, Ark., chairman of A.M.A. Secont on General Practice: He walked where doctors usually feared to tread; he predicted tremendous victories for medicine in the next 50 years, including such major goals as eradication of infectious diseases, a cure for the common cold, and surgical transfer of vital organs. But "there will always be a need for the physician with an understanding heart." His speech was widely reported and he said: "Little did I think at the time that my talk would make the front page of every newspaper in America and in many foreign countries."

DOCTOR DRAFT CHANGES NOT RETROACTIVE: Defense Dept. explains that physicians already in uniform are not eligible for release even though they would not be subject to induction under the amended act. The changes exempt two groups: (a) those who have reached their 46th birthday, and (b) those who have reached their 35th birthday and at any time have been rejected for a medical commission solely on physical grounds.

DISABILITY INSURANCE: What Bill would do: Democratic members are pushing a plan to amend the social security act to provide cash benefits for disability, to lower the pension age for women and in other ways to liberalize the law.

A.M.A. is firmly opposed to disability insurance because: 1. machinery at the federal level to supervise the certification of disability would put the government firmly in the middle of medical practice, and 2. pressures would be applied on physicians by patients for speedy certifications.

NEW QUARTERS FOR VENEREAL CLINIC

Venereal Clinic has moved from St. Elizabeth Hospital to South Side, Youngstown Hospital, using same quarters as the dispensary. Hours are 4 to 6, Tuesdays and Fridays.

CANFIELD FAIR HEALTH EDUCATIONAL EXHIBIT

Sponsored by The Mahoning County Medical Society and supervised by Dr. H. P. McGregor, chairman of the Fair committee, the Society will have an Educational Health Exhibit at the Canfield Fair, September 1 to 5, 1955.

The Canfield Fair is the largest of all the county fairs in the State of Ohio. Last year there were 64,300 fair visitors registered as the Health Exhibit. An added feature to insure comfort to our visitors is two ventilating fans. Several of the organizations participating will have a number of interesting and educational pictures.

The following organizations have reserved space in the tent for exhibits: American Cancer Society, American Red Cross, Corydon Palmer Dental Society, Eastern Ohio Pharmaceutical Association, Mahoning Chapter Academy of General Practice, Mahoning County Board of Health, Mahoning County Medical Society, Mahoning County TB and Health Association, Mahoning Valley Chiropodists Society, Mahoning County Polio Chapter, Ninth Ohio District of Osteopathic Medicine, Woodside Receiving Hospital, Youngstown Area Heart Association, Youngstown Hearing Society, Youngstown Hospital Association.

Your committee wishes to take this opportunity to invite all our members and those of the Auxiliary to visit the fair and spend some time at the exhibits, and, where possible, show other visitors the accomplishments and achievements of our profession and its allies. We are doing a great service to these people each year and let's call their attention to the fact that we hope the future will insure "Better Health and Happiness".

H.P.M.

THE DAY-TIGHT COMPARTMENTS

Throw away, in the first place, all ambition beyond that of doing the day's work well. The travellers on the road to success live in the present, heedless of taking thought for the morrow, having been able at some time, and in some form or other, to receive into their heart of hearts this maxim of the Sage of Chelsea: Your business is "not to see what lies dimly at a distance, but to do what lies clearly at hand." *(—Osler, Address before the first graduation class of the U. S. Army Medical School, Washington, D. C., Feb. 28, 1894).*

This teaching of Thomas Carlyle was one of the earliest and strongest influences in shaping Osler's manner of life. In a later address *(Montreal Medical Journal,* 1899) he said:

"As to the method of work, I have a single bit of advice, which I give with the earnest conviction of its paramount influence in any success which may have attended my efforts in life—*Take no thought for the morrow.* Live neither in the past nor in the future, but let each day's work absorb your entire energies, and satisfy your widest ambition."

And in his Yale essay, *A Way of Life,* he re-emphasized the theme:

"Now the way of life that I preach is a habit to be acquired gradually by long and steady repetition. It is the practice of living for the day only, and for the day's work, *Life in day-tight compartments.*"

And Omar said:

"There are two days about which I will not be anxious — the day that is yet to come, and the day that is past."

The American Journal of Psychiatry, August 1954

MEMBERSHIP MEETING

September 20, 1955

8:30 P. M. — Elks Club

● ● ●

This will be a business meeting in which many issues pertinent to the members of The Mahoning County Medical Society will be discussed by a roundtable of member participants.

● ● ●

You are invited to submit any subjects you wish to have discussed to Dr. Paul F. Mahar, our program chairman.

TAX DEFERMENT FOR THE SELF-EMPLOYED

(Ed. Note: This article is an abstract from the testimony of Frank G. Dickinson, Ph.D., director of the A.M.A. Bureau of Medical Economics before the House of Representatives Ways and Means Committee. The subject is tax deferment on retirement funds for self-employed persons and others not covered by pension plans, a principle strongly supported for years by the A.M.A.)

Mr. Chairman and Members of the Committee on Ways and Means:

During the past several years misconceptions have grown up about this proposed voluntary pension system. . . . First, it has been implied that what we really need is lower income tax rates for every taxpayer — the self-employed as well as the employed. . . . This is a most disturbing illusion. . . . We are here today to discuss an inequality which will not be removed by a general reduction of income tax rates. There are *only* two ways this inequality can be eliminated: the provision for tax deferment in Section 401 can be repealed or legislation can be enated which abolishes the requirement of an employer-employee relationship for pension plans under Section 401. These are the only two ways of removing this obvious inequality which is admitted widely, even by persons opposed to the Jenkins-Keogh bills.

Second, the illusion has been created that these are bills for rich men. This implies that the eleven million self-employed persons are rich and the fifty million employed persons are poor. (Dr. Dickinson then cited U. S. Department of Commerce statistics to show only slight difference in average income of the employed and the self-employed). . . . Needless to say, these data *do not support* the contention that the self-employed are richer or "better off" than the employed.

Third, it has been implied that fringe benefits for employed persons are too small to worry about. The Chamber of Commerce of the U. S. reports that fringe benefits for 130 identical companies amounted to 20.2% of payroll in 1953 as compared with only 15.2% in 1947. Admittedly, not all of these fringe benefits are applicable to the self-employed, but pension and profit-sharing benefits are definitely applicable to the self-employed. For these two types of fringe benefits the 130 identical companies contributed 8.0% of payroll in 1953 as compared with only 5.6% in 1947. Probably two-thirds of these specific types of fringe benefits mature as retirement benefits. . . . This conclusion is inescapable: There is an upward trend in fringe benefits for employed persons. We live in an era of expanding fringe benefits. But the self-employed person is on the outside looking in, paying his taxes and paying a higher price for consumer goods resulting, in part, from the addition of fringe benefits to labor costs of production.

Fourth, one illusion that has been created about this bill is more disturbing than the others. I refer to the claim that the passage of the Jenkins-Keogh bills would create inequalities against employed people. I want to examine this claim very carefully. According to the U. S. Department of Commerce, $4,927,000 was paid out by employers in the U. S. in 1953 as contributions to private pension and welfare plans. Of this $4.9 billion, $3.1 billion was contributed by employers to all manner of profit-sharing plans that normally mature as taxable pensions to the employee. And an additional $1.4 billion was in the form of contributions by the employer to pay premiums on "free group insurance." The remaining $0.4 billion represented employer contributions to other health and welfare plans.

So before this legislation could create unbalanced discriminations against employed persons, it would first be necessary to remove the existing discrimination against the self-employed—and, to some extent, against the pensionless employed. . . . Those who look under the bed for new discriminations from this type of legislation should examine pertinent data from the Department of Commerce very carefully and should, moreover, appreciate the great and growing extent of present discrimination against the self-employed.

(Dr. Dickinson then examined the claim that the proposed law would discriminate against the employed because it would give the self-employed a "vested interest" in his pension plan. He said: ". . . there are no provisions in these bills which provide for the full and complete vesting in the industrial pension sense of the term 'vesting' until after age 65." He explained that although in the case of death before 65 the self-employed's estate would benefit from his pension plan, "this is not a discrimination . . . against the employed person whose pension is being provided by his employer (because) $1.4 billion was paid out by employers in 1953 for free group insurance." An employee with a $5,000 or $10,000 life insurance policy, Dr. Dickinson pointed out, is going to leave a bigger estate than most of the self-employed tax-payers who die before age 65.)

Fifth, there is an illusion that the revenue loss to the government would exceed $100,000,000 a year from the actions of the self-employed taxpayers alone. . . . For reasons which I cannot understand, the Treasury Department has not provided your Committee with estimates of revenue loss (but) it should be painfully clear to everyone who gives any thought to the question that very few of the self-employed or the pensionless employed will ever put *all* of their eggs in one basket, in this case all of their savings in a voluntary pension fund which these bills clearly state cannot be withdrawn until age 65 unless the qualified person dies or becomes disabled for long periods of time. The annual revenue loss on the more than $3 billion now being set aside by employers in approved plans is certainly 10 times as great.

Sixth, there is the illusion that these bills will aid only persons of high income. It is closely related to the second illusion—the notion that all the 11 million self-employed people are rich and all the 50 million employed people are poor. . . . Are the rich people in your neighborhood the only ones who save money? Are the poor people in your neighborhood, employed or self-employed persons, the only ones who do not save money?

This legislation would not compel anyone to save for his old age. It would encourage the self-employed and the pensionless employed to save for their old age. But the propensity to save is not confined to any one income class, to any one population group, to persons living in cities of a given size, or to one section of the country . . . most young earners, particularly those under age 35, are in the low earning period of their lives. As they grow older they will become more proficient in their jobs, they will earn more money, and as they get closer and closer to age 65 they will think more and more about providing in advance for their old age. But the claim that this is a rich man's bill, it seems to me, is nothing but an illusion. It must be stressed over and over again that these bills would not *compel* anyone to save for old age. To those who believe in a free society this is one of the crowning virtues of these bills.

Perhaps you can't buy happiness with money, but you can't buy groceries with happiness, either.

1955

ANNOUNCEMENT OF COMING MEETINGS

A postgraduate course in pulmonary diseases, planned especially for general practitioners, will be held in Columbus at the Ohio State University Student Union Building, High Street and 13th Avenue, and at the Neil House, Friday and Saturday, October 7 and 8, 1955. The course will cost $15 and attendance will be limited to 150. The session has been approved for nine hours credit by the Ohio Academy of General Practice. As an additional attraction, a block of seats to the Ohio State-Illinois football game for Saturday, October 8th, has been obtained.

A postgraduate course for Practitioners covering "Recent Advances in Clinical Practice" will be sponsored by the University of Buffalo School of Medicine from September 12-17, 1955. The fee for the course is $75.

The Ohio Academy of General Practice will conduct its Fifth Annual Scientific Assembly at the Dayton-Biltmore Hotel in Dayton, Ohio, on September 20-21, 1955. Post Graduate credit for AAGP members will be 10 hours.

The Columbus Surgical Socety is holding its first "Fall Graduate Assembly" at the Deshler Hilton Hotel and the Ohio State University Medical Center on October 14-15, 1955. The Society has obtained 100 tickets for the Duke-Ohio State football game.

The Twentieth Annual Congress of the United States and Canada Sections of the International College of Surgeons will be held in Convention Hall in Philadelphia, Pennsylvania, September 12-15, 1955.

HAVE YOU HEARD . . . . . .

. . . . that Dr. John J. McDonough has limited his practice to gynecology, infertility and obstetric consultation and that he has discontinued the active practice of normal obstetrics?

. . . . that Dr. Michael J. Kocialek has announced the association of Dr. Donald R. Bernat in the practice of general surgery?

. . . . that Dr. Robert E. Carr has announced the opening of his offices at 243 Lincoln Avenue for a practice limited to thoracic surgery and diagnostic broncho-esophagoscopy?

. . . . that Dr. George B. McAleese has announced the opening of his offices in the Home Savings and Loan Building for a practice limited to thoracic surgery?

. . . . that Dr. Richard Murray has announced the opening of his offices at 220 Lincoln Avenue for a practice limited to plastic, reconstructive and maxillofacial surgery?

INCOME TAX DEDUCTIONS

Interpretation of Section 213 of the Internal Revenue Code of 1954 indicates that Accident and Health Insurance premiums may be deducted if they, together with medical expenses, are in excess of 3 per cent of adjusted gross income. HOWEVER, to be included in the above, a portion of the policy must provide reimbursement to the insured for medical expenses, which would mean hospitalization, surgical or medical reimbursement coverage. A policy offering weekly indemnity alone would not be included in the above.

For those under age 65, there are two steps in computing the medical expense deduction.

First, compute the total of all monies paid for drugs and medicines. If the total exceeds 1 per cent of the adjusted gross income, apply that excess to the total of all medical bills and Accident and Health premiums for policies which, in total or in part, include reimbursement for medical expenses. If this total exceeds 3 per cent of adjusted gross income, that excess is a deductible item.

For those over age 65, the only restriction is 1 per cent of drugs and medicines. The 3 per cent restriction on medical bills does not apply.

AHA STUDY PLANNED TO HELP DETERMINE RELATIONSHIP OF WORK TO HEART ATTACKS

The relationship between work and exercise and heart disease and heart attacks, which has long troubled the medical profession as well as workers and employers, will be the subject of a study to be supported and supervised by the American Heart Association. The project will be directed by Sidney Weinberg, M.D., Assistant Medical Examiner of New York City. Dr. Weinberg has accepted assignment as responsible investigator. He will work with a team of clinical and laboratory scientists.

The project will be under the jurisdiction of a joint Committee on Strain and Trauma. A grant of $13,750 has been approved by the Association's Board of Directors to finance the effort.

Another aspect of the strain and trauma and heart disease question is also to come under study by the Association within the next few months. A project is being organized, which will have as its purpose the critical analysis of legal decisions concerning cardiovascular cases in relation to workmen's compensation.

TO TELL OR NOT TO TELL

Bernard P. Harpole, M.D.

There is a great contrast between the unanimity of opinion regarding the treatment of cancer and the great variety of opinions regarding the treatment of a patient with cancer. This variance has to do with the decision as to whether, when and how to break the news.

As a student I asked one of my teachers what a physician should tell his patients with cancer. His answer has been my guide, "After the shock of surgery is past, and the diagnosis has been established, the patient who should be told, will ask a straight question. If and when he does, give him an honest answer. It's better to postpone the answer several days until the patient is well enough to accept it, but if he asks, he should be told. The few who shouldn't be told will not ask."

This sound advice has served me well in each decision I've had to make, but several articles[1] in the recent literature have made me reexamine my teaching. I conceived the idea of a series of surveys that might throw some light on this problem. Admittedly the research was done, as are a few other research projects, with an experiment designed to support a foregone conclusion, but the results are worth reporting.

A questionnaire was sent out to 375 patients, asking for answers on a return card, to several questions. Within 2 weeks 141 replies were tabulated as follows:

1. If you have a cancer, or any serious illness that is a direct threat to your life, do you want to be told?
   97% Yes 3% No
2. If you want to be told, when do you think you should be told?
   a. As soon as possible? 85% Yes
   b. When death is predictable? 9% Yes
   c. When death is inevitable? 2% Yes
3. If it's a member of your family, do you think HE should be told?
   a. It's your parent? 90% Yes
   b. It's your spouse? 95% Yes
   c. It's your child? 6% Yes
4. Do YOU want to be told if it's: your parent, your spouse, or your child?
   All answers 98% Yes

The conclusion I'd started with was proven by the questionnaire, namely, that 97% of normal, healthy people want to be told the truth about their illness.

Another questionnaire was sent out several months later to discover how much the average person knows without being told. This was in the form of a quiz *(see Appendix)*. Brief histories of 50 words or less were written describing 6 illnesses. This was sent out to 400 patients and the first 148 answers were tabulated. The diseases described were diagnosed as follows:

1. Early pregnancy 100% Correct
2. Cancer of Rectum with Colostomy
   73% Correct 12% Wrong
   15% No answer
3. Appendicitis 100% Correct
4. Cancer of Breast with Radical
   100% Correct
5. Cancer of Uterus with Radiation
   90% Correct 3% Wrong
   7% No answer
6. Duodenal Ulcer 100% Correct

This survey supported the conclusion that most people recognize the most common cancers as readily as they do other common diseases, probably as a result of the efforts at education of the public to report early, any symptoms suggesting cancer. It also indicates a need for more intensive education in the earlier recognition of gastro-intestinal malignancy. I expected some of the answers to the duodenal ulcer question to be "Stomach cancer."

In educating the public to recognize the early signs of malignancy and seek treatment, we've forged a 2-edged sword that faces us with a choice of lying to a patient, who already knows the truth by the very nature of his disease and its treatment, or telling the truth when asked, with the hope that

the same homeostasis we depend upon to bring about a physical adjustment to the trauma of surgery will also bring about a psychic adjustment to the trauma of surgery will also bring about a psychic adjustment to the trauma of truth.

Another product of our program of public education is the tremendous increase in the past few years, of negative biopsies in suspected malignancies. We must now, therefore reexamine the results of withholding the truth in the cases of positive biopsies. When 70% of doctors prefer not to tell the truth to their patients with cancer[2] how can the patient distinguish between the sincerity of a negative biopsy report and the fraud of the well-intentioned dissembling of a physician who presumes to deceive his patient after diagnosis of cancer is established? In the same vein, how can a patient, intelligent enough to know he's been treated for cancer, by a doctor who prefers to tell him his lesion was not malignant, ever have confidence in that doctor again?

This is not meant to advise a policy of telling every cancer patient the entire truth. It is merely a suggestion that, in view of the public's increased knowledge of medicine, physicians use greater care in recognizing the patients who have already faced and accepted the reality of their disease.

Conclusion. Ninety-seven per cent of the people want to know the truth about whether or not they have cancer. At least 90% of patients with the most common sites of malignancy know when they have it, as a result of the public's growing knowledge of the early symptoms and treatment of cancer. If these conclusions are valid, we must reexamine our tendency to deny the truth when our patients ask for it.

[1]Grinker, R. R. *et al:* The patient with carcinoma of the breast, G. P., September 1954.

[2]Fitts, Wm. T. and Ravdin, I. S.: What Philadelphia physicians tell patients with cancer. J.A.M.A., November 7, 1953.

1920 N.W. Johnson, Portland, Oregon

Appendix

Dear Friends:

This month I'd like to ask you to help me do another survey. It might look a little silly and, until the results are in I can't tell you the reason for it. The following are some case histories in brief. On the enclosed card I'd like to have you guess what's wrong with the patient.

1. Mrs. Smith, age 23, has been married for six months. She's missed her last two menstrual periods, and vomits every morning.

2. Mr. Jones, age 62, has had some blood in his bowel movement the past four months. He has become increasingly constipated, and has diarrhea occasionally. He has lost 20 pounds and feels tired. He had x-rays made and was sent to the hospital for an operation. Since the operation his bowel opens out on his abdomen.

3. Miss Brown, age 19, woke up with pain all over her abdomen. She vomited several times and later in the day the pain localized low on the right side. Her doctor had a blood count made, and then operated on her. She recovered, went home after five days and has been well since.

4. Mrs. Johnson, age 47, noticed a lump in her right breast. Her doctor sent her to the hospital and operated. He removed the entire breast and the incision went up to her shoulder. Afterward she had 12 x-ray treatments to the scar.

5. Mrs. Collins, age 46, had change of life 3 years ago. Three years later she started irregular bleeding. Her doctor operated on her and put in some radium. Afterward she had 15 x-ray treatments.

6. Mr. George, age 35, gets pain in the "pit of the stomach" about two hours after every meal. He has "acid indigestion," too. He had x-rays taken and his doctor ordered a bland diet, lots of milk, pills and a liquid to take. After 3 weeks he felt better.

Now, on the enclosed card please write what you think was wrong with each of these patients. I'd like as many of you as possible to do this for me. If more than one answers, put down the number answering. Please do this as soon as you can so I can tabulate the results. In my next letter I'll let you know how we made out and why I'm doing this.

Yours truly,
Bernard P. Harpole, M.D.

INSURANCE ISSUES

Medical insurance, which private medicine has so proudly hailed as our answer to socialization, has developed some wrinkles that are in need of ironing. No wonder, considering the fabulous expansion of this type of insurance coverage in the last decade. Our constituents, the public, have taken to the idea with heart-warming enthusiasm, but some disenchantment has developed, and not without reason.

A great amount of complaint comes from recipients of medical care who assumed they were covered by policies but can't collect on claims. All too frequently this arises in group policies carried by employers or labor unions. Westbrook Pegler has been attacking injustices in this field recently in his column and it looks like a good thing for two reasons. First, if his indignation waxes wroth enough, something usually comes of it. Second, his gift of epithet hasn't had a really worthy cause to further for a long time now. The fault, lies as he says, in that the carriers in question are often unscrupulous.

But some of the bitterest howls come from patients who are covered by our own creation, Blue Shield. Their complaints about non-payment for diagnostic services and only partial coverage for therapeutic procedures are, of course, familiar. Doctors at least understand that those are stated conditions of the policies. But what confuses patients and physicians both is no payment whatsoever for a large percentage of standard therapeutic care. It's downright embarrassing when Blue Shield refuses to honor claims for work done on patients because it is not included in their fee and treatment schedules. It certainly must raise the question in the patient's mind of whether what has been done is even legitimate, let alone ethical. As one doctor stated, it looks as if the Blue Shield fee schedules were set up by surgeons and obstetricians, with the most particular interests of urologists in mind.

Another matter that needs some thought is multiple coverage. For example, a patient has a Blue Shield policy and receives medical services. A claim is entered and, as often happens, the physician adjusts his fee toward what Blue Shield allows in that particular instance. Then, lo and behold, the patient requests completion of a form for a private policy that he holds and the benefits of which he collects personally. No solution is offered as an answer to this problem. It is hoped that insurance experts will look into it. It appears to be unsound from a business standpoint.

Then as a final blast, the complicity and multiplicity of medical insurance forms. According to the Journal of the American Medical Association, a committee of the A.M.A. is working on this problem, and they are seeking the cooperation of the major companies that write medical insurance policies. Let it be said that Blue Shield and U.M.W. Health and Welfare forms are gratifyingly simple and practical, as are those of the bigger and more reputable private insurance companies. But when one encounters claim forms of more obscure and unfortunately less reliable organizations, confusion and opportunities for evasion of claims become obvious. We must develop vigilance in this matter and tender our help in correcting a potentially bad situation.

"There is hardly anything in the world that some man cannot make a little worse and sell a little cheaper, and the people who consider price only are this man's lawful prey." (Attributed to John Ruskin)

AN EPITOME OF

EPONYMS

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 . . .

JACKSONIAN EPILEPSY?

KAPOSI'S DISEASE?

KERNIG'S SIGN?

KIMMELSTIEL-WILSON SYNDROME?

KOPLIK'S SPOTS?

KORSAKOFF'S PSYCHOSIS?

KREBS CYCLE?

KRUKENBERG'S TUMOR?

KUPFFER'S CELLS?

KUSSMAUL'S RESPIRATION?

(Answers on next page)

ANSWERS TO EPONYMS

JACKSONIAN EPILEPSY: John Hughlings Jackson (1835-1911), one of the pioneers in neurology, localized epileptiform movements with lesions in the motor area of the cerebral cortex.

KAPOSI'S DISEASE: Named after Moritz K. Kaposi, the Austrian dermatologist, who, in 1872, noted this rather rare hemorrhagic sarcoma of the skin.

KERNIG'S SIGN: The Russian neurologist Vladimir Kernig, who died in 1917, described the pain-producing movement, observed in meningitis, of flexion of the thigh at the hip with simultaneous extension of the knee.

KIMMELSTIEL-WILSON SYNDROME: An eponym for intercapillary glomerular sclerosis, a nephrosis-like syndrome found in diabetes, described by two contemporary physicians in *Am. F. Path.*, 12;83, 1936.

KOPLIK'S SPOTS: Small bluish-white spots on the mucous membranes of the mouth, seen in the prodromal stage of measles; first noted in 1898 by the American physician Henry Koplik.

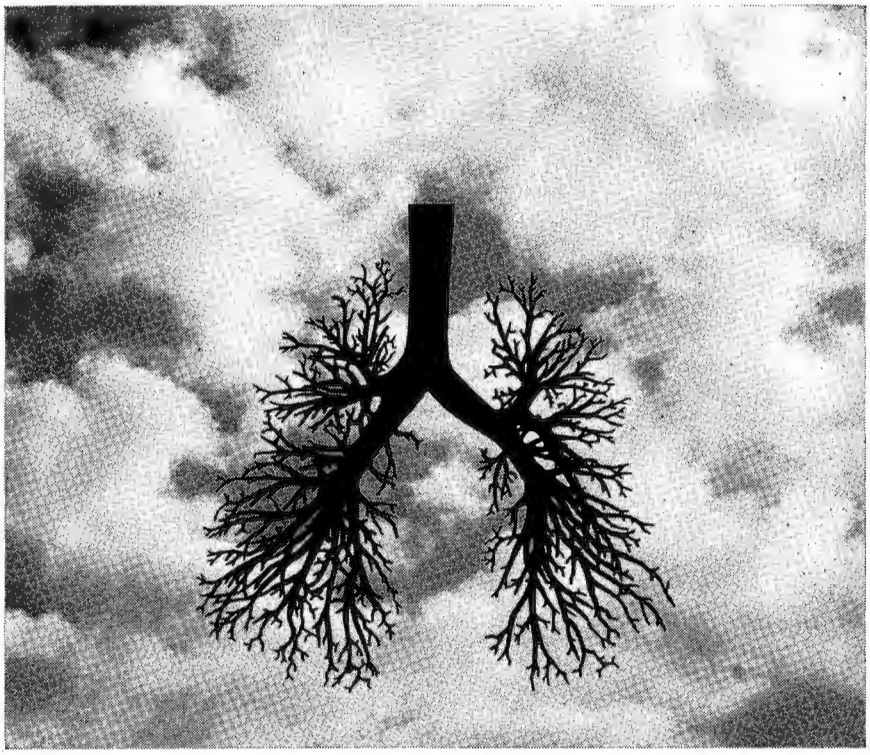
KORSAKOFF'S PSYCHOSIS: Named after Sergei S. Korsakoff (1854-1900), this organic reaction is characterized by gross memory defects and confabulation and is seen frequently, but not exclusively, in alcoholism.

KREBS CYCLE: The tricarboxylic acid cycle in which the fundamental process of cellular energy occurs; named after the recent Nobel prize laureate, Hans Adolf Krebs, now in England.

KRUKENBERG'S TUMOR: A malignant ovarian tumor, usually secondary to gastro-intestinal carcinoma, noted by Friedrich E. Krukenberg, a German pathologist (1871-1946).

KUPFFER'S CELLS: In 1876, the German anatomist Karl Wilhelm von Kupffer observed reticulo-endothelial cells in the walls of the sinusoids of the liver.

KUSSMAUL'S RESPIRATION: Adolf Kussmaul (1822-1902), who also developed the technic of gastric lavage, described the "air hunger" of diabetic coma.



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Procaine Hydrochloride	20 mg.
Propylene Glycol	8 cc.
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