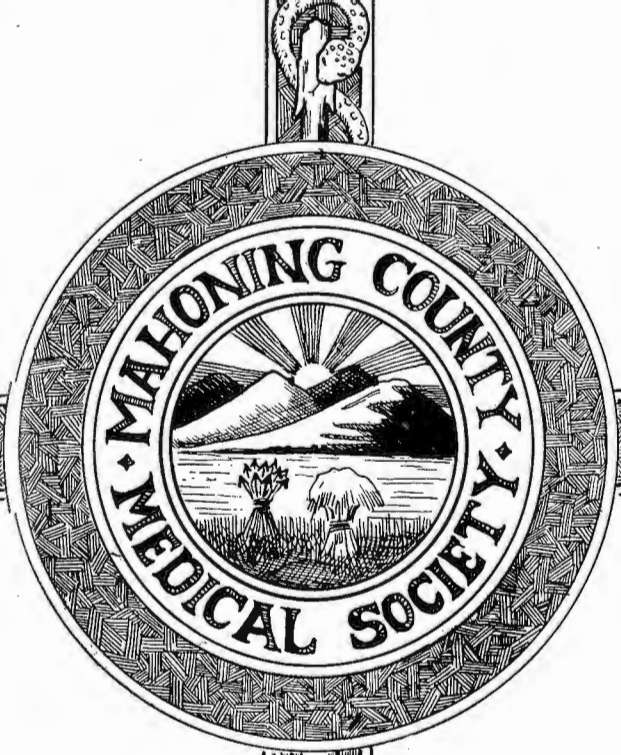

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

SEPTEMBER • 1955
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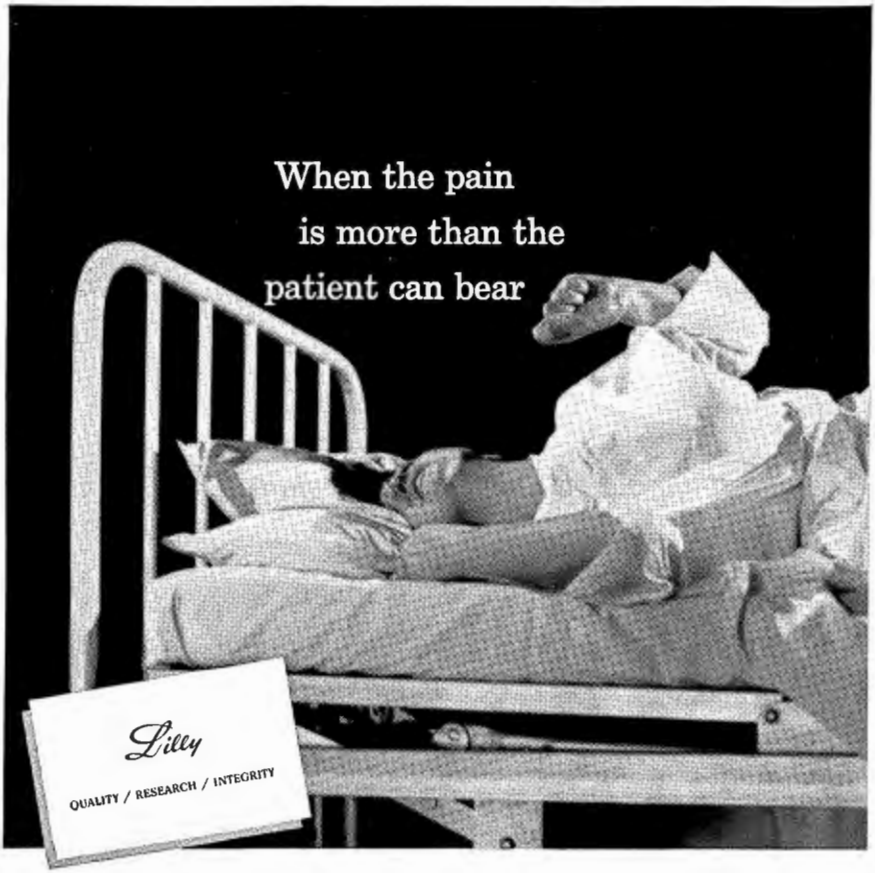
Youngstown • Ohio



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Representative to the Associated Hospital Service
H. E. PATRICK

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Vol. XXV—No. 9 **September, 1955**

ADVERTISERS' LIST

Our President Speaks

TO WHOM IT MAY CONCERN

We are approaching the annual campaign to raise money for the Community Chest. Nearly everyone agrees that the Community Chest idea is sound, and most of the citizens of the community support the drive to the best of their ability.

In the past, there have been some differences of opinion on policy between the medical profession and the Community Corporation, which manages the affairs of the Community Chest. Many of our members (the writer included) have been loath to contribute to an organization which we felt was working at cross purposes with us. It is probable that some of the membership still refrain from supporting the Community Chest to a degree commensurate with their ability because of these differences of opinion. However, for several years now these differences have been resolved, and it is the purpose of this editorial to point out that your president feels that there is no longer justifiable reason for withholding full support of this campaign. It is not, however, my intention to dictate your actions. Each individual must decide for himself.

Certain facts can be pointed out. About one fifth of our membership contributes approximately one half of the total contribution of the medical profession, to the Community Chest fund. The other four fifths, for either good or poor reasons, obviously are not carrying their share of the burden. I am asking you, in the light of changed conditions, to reexamine your thinking on the subject before deciding upon the amount of your contribution this year.

I am well aware (which sometimes it seems the community in general is not), of the great amount of charitable work you contribute over and above the cash contribution you make. But remember — the previously mentioned one fifth of our members also do a like amount of charitable work. When a minority group — in this instance the medical profession — is at odds with the thinking of the population in general, it would seem that we might profitably consider the possibility that the minority group may be mistaken. As the Quaker said, "everyone is wrong but thee and me, and sometimes even thee."

In any event, when the canvasser approaches you, please bear these statements in mind, then let your conscience be your guide. Knowing you as I do, I have no doubt that an honest appraisal of the facts will influence you to do the right thing. If we give proportionately as much as the humblest laborer in the community, we will make a much better showing than we have in the past.

Ivan C. Smith, M.D.

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio Annual Subscription, $2.00

VOLUME 25 SEPTEMBER, 1955 NUMBER 9

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

EDITORIAL

Not one man among us, in his practice of medicine, is a stranger to prayer. Some 800 years ago, Maimonides, in his "physician's prayer" recorded thoughts which have always been a fountain of inspiration for me.

I hope you will enjoy them.

"May the love of fellowman and the love of my art ensoul me. May not thirst for gain nor craving for fame mingle in my service. For these are enemies of truth and charity. . . . Preserve the strength of my body and of my soul, so that I might be unperturbably ready to help the rich and the poor, the good and the bad, the enemy and the friend. . . . May my mind be always on the alert. While I stand at the bedside let not alien things intervene to rob me of attentiveness. . . . Grant that the sick have confidence in me and in my art, and that they heed my advice. . . . Banish from their side all quacks and the host of counseling kindred. . . . If wiser men wish to teach and correct me, may I follow them and be grateful; for the compass of our art is large and wide. But if zealous fools upbraid me, then let the love of my art keep strong. . . . Thou hast chosen me, in Thy grace, to watch over the life and death of Thy creatures. . . . Be with me in this great work, so that it may avail. . . ."

Robert Tornello, M.D.

Editor

EDITOR'S BULL-PEN

In view of the popularity of the topic, we would be negligent in our duties to posterity if this issue of the *Bulletin* went to press without some comments about the Salk Vaccine. From the outset, it should be made clear that I love little children, respect pregnant women and every day in my humble way, I try to stamp out disease. Furthermore, to Dr. Salk and his entire staff of workers, right down to the man who washes the test tubes, I give my heartfelt thanks for what promises to be the greatest step toward polio control ever accomplished. It would be fair to say that every medical man I have met shares the above views and backs up his attitude by volunteering services in the joint venture to vaccinate the selected school children.

A few related thoughts have been ever present in my mind, since the public announcement of the proposed use of the vaccine. I could not help remember the encouraging reports of the vaccine's progress that I read in my medical journals, heard at conventions and special announcements for the past two years. Those who were interested, followed the general, brief reports through official medical channels.

Although we weren't given elaborate, or specific details, we always seemed to take for granted that the final word would be said in these journals someday. Whether the news was good or bad, there was the prospect of reading a scientific report as is customary for men of Science. The surprise came when there was a general public announcement of the proposed statistical report, cost and use of the vaccine. Via press, radio, television, everyone seemed to know "all about" the vaccine except the doctors who were to use it in practice.

The medical profession generally has wisely kept a discreet, polite and professional demeanor through all the excitement. One indignant public health doctor was quoted as saying: "The National Foundation is running this thing like a soap opera." In my opinion, this statement was an example of masterful restraint.

The reasons for the N.F.I.P. conducting the Salk Vaccine project with the kind of finale we are witnessing, would be difficult to conceive. Some publicity minded individuals, have said that N.F.I.P. wanted to indelibly impress the public with the fact that the March of Dimes money was not spent in vain and subsequent donations would be easier to solicit. We await the answer from N.F.I.P.

The great traditional manner of presenting medical progress to the profession and the public has been discarded by N.F.I.P. We trust that everyone involved can learn from the mistake that has been made and the N.F.I.P. guide itself accordingly in the future.

The medical profession must now take prophylactic measures to keep this unprofessional N.F.I.P. type of experience from happening in the field of cancer, heart disease, cerebral palsy, multiple sclerosis, muscular dystrophy, and mental retardation, to name a few.

It would be most unfortunate if the medical profession would have to get all the details about new drugs and cures from the local newspapers. We look forward to better days.

—H. W. KORNGOLD, M.D., Editor

Sacramento County Medical Bulletin

1955

IMPORTANT - - Change in Policy

TO: Boards of County Commissioners, Health Departments or Commissioners, Referring Physicians, Tuberculosis Associations.

Subject: The Ohio Tuberculosis Hospital

This bulletin is to inform you of certain changes in admitting policy and to remind you of available services of the Ohio Tuberculosis Hospital.

(1) *Nonpulmonary Tuberculosis.* The hospital is now able to accept patients with bone and joint tuberculosis, and those with kidney and other forms of nonpulmonary tuberculosis.

(2) *Diagnostic Problems.* Patients with obscure pulmonary disease which may be due to TB are admitted for diagnostic study. Naturally, counties are hesitant to hospitalize such patients because of the expense. To meet this problem, legislation was obtained exempting counties from payment as soon as a patient is found to be nontuberculous (usually a week or two after admission).

(3) *Type of Care.* The hospital continues to accept patients for long-term therapy and for surgical or other specialized care.

(4) *Rate.* The per diem rate of $7.25 is continued. This is a net inclusive charge, covering all medicine, x-ray examinations, surgery, anesthesia and transfusions.

You will be interested in the attached statistical summary showing the growth of the Ohio Tuberculosis Hospital. The people of Ohio can take pride in this splendid institution and the service it offers.

Ralph E. Dwork, M.D., Director
Ohio Department of Health

FROM THE BULLETIN

TWENTY YEARS AGO — SEPTEMBER 1935

Last month there was a special meeting called to consider economic problems connected with the care of the indigent. It was well attended, discussion was lively and some definite conclusions were reached. This is the resolution that was passed:

1. Whereas, the physicians of Mahoning County have in the past accepted the burden of the medical care of the indigent, with little or no compensation, and

2. Whereas, during the existence of the FERA, the physicians of the Mahoning County have attended the indigent at rates below actual cost, and

3. Whereas, the Medical-Economics Committee has been advised that on or about September 1st, the FERA will no longer be responsible for the care of the unemployable of this county, and

4. Whereas, the PWA employee will still have insufficient funds for severe illnesses, and

5. Whereas, the taxing districts are legally responsible for the medical care of the indigent, therefore,

BE IT RESOLVED:

1. That a minimum fee schedule be adopted by the Council and the Mahoning County Medical Society.

2. That the Society go on record as opposing all forms of private contract practice in the care of the indigent because it is not in accord with the accepted principle of free choice of physician, and because past experience has demonstrated absolutely that this method does not furnish adequate medical attention to the indigent sick.

3. That if it is the will of the Council and the majority of the Mahoning County Medical Society, it will then become unethical for a member of this Society to accept a contract or an agreement for group practice for the indigent. Such unethical practice will be considered just cause for expulsion from the Society.

4. That it is the sense of this Society that the duties of the city Department of Health shall include only preventive medicine, such as sanitation, quarantine, etc., and in addition thereto, the administration of indigent sickness relief in cooperation with the physicians of Mahoning County; and, further, that the duties of no city physician shall include the treatment of the indigent sick, the latter being the responsibility of the physicians of Mahoning County, to whom reasonable compensation shall be paid for such services; and that the committe of three provided for by these resolutions shall include this section in their negotiations.

5. That the Society, through a special committee of three, appointed by the President, present these demands to the County Commissioners and all subdivisions of Mahoning County.

More about the outcome of their demands next month. The President appointed W. K. Stewart, W. M. Skipp and Henri Schmid to do the job and they came through with a perfect score.

TEN YEARS AGO — SEPTEMBER 1945

The war was over. V-E day and V-J day had passed and preparations were being made to receive the returning Veterans. Dr. W. K. Allsop was appointed to form a committee to give any necessary aid to our members coming home from the service. The Association of American Physicians and Surgeons sent a letter to President Truman demanding an investigation of the delay in releasing physicians from the armed forces. That was fast work!

Interns in our hospitals those days were the now active members James Patrick, Wayne Hardin, Gene Fry, J. F. Steckshulte, Martin C. Raupple and Alex Rosenblum.

ANXIETY AND DEPRESSION

There are many well known and accepted drugs available for the treatment of the very common syndromes of anxiety and depression. Continued use of these drugs can start a vicious cycle of more symptoms, more medication, more symptoms. This is especially true in the aged. Physicians have had experiences with the fact that medications that help anxiety often increase depression and anti-depressive drugs stimulate anxiety.

A greater knowledge of anxiety and depression can help us in our effective treatment of these reactions. This paper is not an attempt to discuss the psychodynamics or psychotherapy of these syndromes.

First, a theory about anxiety and depression must be formulated. A theory is simply a point of view that should help us, it must not be accepted as precisely correct or infallible, and we should not delude ourselves into permitting "theory" to become "fact" simply because we use it and find it helpful. An assumption made in this paper is that the rather mechanistic concepts of Pavlov regarding facilitation and inhibition and the general adaptation syndrome of Selye are somewhat compatible and can help us understand the problem. Facilitation is here used as describing an increased tendency to activity and the subjective experience of this; inhibition is used to describe the limitation in the amount and range of activity and the subjective experience of this.

It is known that facilitation and inhibition vary in relationship to each other in the same person (as well as in different people). Also, inhibition tends to surpass facilitation as a result of an increased degree or duration of stress.

Therefore, the signs and symptoms of anxiety can be understood in terms of facilitation:

1. Cannot relax; tense.
2. Considerable interest and response to environment as source of possible concern and threat.
3. Anxiety may be successively attached to a considerable number of topics.
4. Chronically anxious.
5. Acute anxiety with feelings of losing one's mind or dying.
6. Talks as much as or more than usual.
7. Talk is as rapid as usual.
8. Talk is primarily about his anxieties.
9. Gastrointestinal, cardiovascular, and skeletal muscle symptoms (gas, tight throat, nausea, epigastric discomfort, tachycardia, precordial distress, throbbing and pressure headaches, tremor, unsteadiness).
10. Cold, wet extremities.
11. Hands and feet get numb.
12. Disturbed by noises.
13. Cannot sleep; detailed description of lying awake for hours before falling asleep, thinking of symptoms, fears, and worries.

The depressed person has signs and symptoms of his inhibition:

1. Slowed down; takes longer to do things.
2. Walks slowly, limited stride, limitation of associated and accessory movements.

3. Talks slowly and in limited amount.
4. Talk tends to be limited to topics of concern.
5. Unhappy; can't see any future.
6. Feels lonely.
7. Very little interest in or response to environment.
8. Loss of confidence.
9. Poor appetite; concern with bowels.
10. Difficulty in concentrating, making decisions, remembering.
11. Tires easily.
12. Increased guilt feelings.
13. Cannot sleep; more important, awakes early feeling terrible, then feels somewhat better as the day progresses.

Proper treatment of anxiety and depression depends upon the severity, their coexistence, and awareness that one can replace the other.

Mild anxiety can be treated by explanation, reassurance, teaching the fundamentals of relaxation, organizing recreation, searching for the insecurity contributing to the anxiety, teaching the patient to recognize and handle situations in which anxiety arises, and the use of sedatives and hypnotics.

Many facilitated patients respond better to a mild hypnotic a few times during the day rather than a sedative at night. The tiredness and apathy produced by heavy sedation can start a chain of depression.

There is a wide selection of drugs to use for anxiety. The problem is not so much the choice of a particular medication as it is to make certain that anxiety is being treated by an anti-anxiety drug (that is, proper diagnosis first) and that depression is not induced by the drug.

Severe anxiety must be judiciously treated by drugs. This degree of anxiety can respond to electronarcosis (electric convulsive treatment without a convulsion) or sub coma (somnolent) insulin.

Electric convulsive therapy is the treatment of choice for severe depression. This therapy is extremely effective for depression or primarily depressive reactions (that is, when the severity of inhibition is more severe and disabling than the degree of facilitation). Convulsive therapy generally tends to increase the anxiety that is present; electronarcosis is more effective for anxiety.

The drugs that are most frequently found effective in depressive reactions are the amphitamines and the newer drugs that are reputed to have their pharmecological effect at the diencephalon.

Psychotherapy for a depressive reaction must include any measures (exercise, activity, interests, discussion of problems) that help to overcome the patient's inhibition. Unfortunately, advice all to frequently fails because the patient is too inhibited to follow this advice.

Obviously, the mixed depressive and anxiety reactions can be treated by the available drugs alone with great caution (usually, but not always, treating the most prominent syndrome first) or by appropriate combinations of these drugs.

The older age group presents these same problems as well as some others. Pure anxiety reactions are not common in the aged. Moreover, most of the sedatives and hypnotics not only have a cumulative effect but also impair the already damaged cerebral functioning. The frequently seen increase in symptoms when the aged are being treated for anxiety may really be due to treating this group of people for anxiety rather than the more common depressive reaction.

Patients who are anxious and depressed often appear to have the same complaints. This can lead to an error in diagnosis and treatment which, in turn, can cause increased complaints. If the physician keeps in mind the concepts of facilitation and inhibition in relationship to anxiety and depression, and thinks in terms of each patient's total behavior, a better therapeutic result can be obtained. Finally, any effective therapy depends upon a good doctor-patient relationship.

Frank Gelbman, M.D.
Am. J. of Psy., 102:3 November, 1945

TREATMENT OF PLANTAR WARTS

A method which has been used at Groote Schuur Hospital, Cape Town, for the past 4 years is reported as giving better results than any other yet tried. The patient is given a general anesthetic and the foot is thoroughly cleaned with Benzalkonium chloride and alcohol. The wart is then curetted out with a Volkmann's spoon. Great care must be taken to remove every particle of the white, friable warty tissue, which may extend laterally as well as downwards. When the cavity is clear of warty tissue a considerable amount of bleeding occurs. On swabbing the cavity, the smooth, shiny basement membrane can be seen. The cavity is then packed with dry potassium permanganate crystals, which control the hemorrhage and prevent secondary infection. A dry sterile gauze dressing is applied with an 'elastoplast' bandage over it. This dressing remains on the foot for 10 days, and the patient is given strict instructions to keep the foot dry, for a severe burn will result if the potassium permanganate crystals become wet. He is allowed to go home on recovery from the anesthetic.

After the 10 days the dressing is removed and the cavity is seen to be clean, dry and granulating up from below. The remains of the potassium permanganate crystals are gently removed and further dressings are unnecessary as a rule.

Two hundred warts have been treated at Groote Schuur Hospital by this method; there have been 16 known recurrences, which are regarded as possibly being due to small shreds of warty tissue left behind in the cavity.

—Editorial, South African Medical Journal, August 7, 1954

Off on a Tear

I was hunting with some friends in the hinterlands of Tunisia when an Arab galloped up and asked if there was a doctor in our party. I stepped forward and put myself at his service.

"Excellency, my wife dies," said the Arab. "Please come quickly."

I did. I examined the woman. I told her husband she had pneumonia and ought to be taken to a hospital in Tunis.

Before I left, the Arab implored me to write a prescription. "All right," I said, handing him one. "Give her some of this every hour. But get her to the hospital promptly."

Some time later I returned to the same region. My Arab friend greeted me with smiles and salaams. He said his wife was completely cured.

"You took her to the hospital?" I asked.

"Oh no, Excellency," he said. "It was the magic of your writing."

"You mean my prescription?"

"Yes, Wonder-Worker," he replied. "I tore it in pieces and gave her some every hour, as you advised."

—Ludwig C. Kalnin, M.D.

Rx—DANCE THERAPY? — PRESCRIBE WITH CARE!

By Len Welch, Feature Writer, County Medical Society Magazine Group Editorial Service

If you feel your patient would benefit from the mild exercise and mental release of social dancing, be sure to issue a warning with the prescription.

The dispenser who fills your prescription may not have the ethics of a pharmacist. He may be a practitioner of one of America's most vicious business enterprises. And your patient may become his prey.

If your patient is of advanced or middle age, she (or he) may often turn to the professional dance studio. And she may pay dearly for following your advice.

The ethical professional dance studio will receive her warmly, teach her skillfully, and enable her to find companionship with a sociable group of her own age.

But she may not be so lucky. She may find she has signed an unbreakable contract for a course of instruction at $10 to $15 an hour, a total fee of from $2,000 to $10,000. She has fallen into an all-too-common trap, and before long her health won't be bothering her nearly so much as the bank account which suffered a sudden relapse when she withdrew her life's savings.

Unfortunately, some dance studios prey on the unfortunate, the aged, the lonesome. And their high-pressure salesmen have been trained to recognize these symptoms in your patient.

In one studio's voluminous sales manual, the salesman finds specific instructions to cover your patient's case. In his best bedside manner the salesman suggests it is regrettable your patient has missed so many years of fun by not dancing.

"Perhaps," he adds, "if you had danced more you might have kept away from the doctor. I'm sure that once you have some lessons you'll forget all about your physical troubles and have more fun than you've ever had."

Sounds attractive, thinks your patient. Just what the doctor ordered. But she's just begun. Next she finds she'll require private lessons, $5 a lesson. Of course, these are just half-hour lessons and the salesman next points out that she really needs hour-long instruction at $10 a lesson.

Next step is the contract, 200 hours of instruction for $2,000. Sounds impossible? Well, some victims have bought as many as three lifetime contracts for many thousands of dollars.

And your patient may find she has no escape if she becomes too ill to continue with the lessons or tires of them. Because she has signed not a contract but a promissory note for the entire amount.

These are the shocking details of the shrewd web some of America's best known dance studios spin for the unsuspecting. And all unnecessary. The operator of an ethical dance studio explains:

"One of the most valuable points in dance therapy is the patient's realization she can hold her own when integrated into a group of people. That, together with the social activity, the opportunity to make new friends, and the enjoyment derived from dancing, makes a strong argument in favor of class instruction. The patient should be getting class instruction at about $1.50 an hour instead of private lessons at $10 per hour. A contract is completely unnecessary."

The patient does not need to assume any long-term financial obligation. Studios that do not permit a pupil to pay for each lesson as it is taken should be regarded with suspicion.

Rx — dance therapy? Help your patient dance to health — not to the poorhouse.

HOW TO AVOID PATIENT IRRITATION AT UNDULY DELAYED APPOINTMENTS

An alert secretary can minimize patient complaints and ill feeling resulting from long delays in waiting to see the doctor, if she scheduled appointments properly.

Many an overworked and harassed secretary will probably say, "Oh, yeah! Try and do it in *my* office." No matter how crowded the office, intelligent planning can reduce the pressure on the patient, secretary and doctor.

In one of the busiest yet most efficiently run general practice offices in the mid-west the secretary keeps the patients happy by adroit scheduling. While the office policy is not to work by appointment because of the size of the patient load, the secretary skillfully sets up a flow chart which minimizes waiting time.

She has fixed up one of the examination rooms as a waiting room for patients who are in merely for shots so that the nurse can see the shot case load and clean it up quickly.

Each new patient who comes in is queried as to the reason for the visit, and if there is a long waiting period ahead she suggests that the new patient take care of errands and return in an hour or two at a definite appointment time. Old patients are encouraged to phone before they leave for the office so that their visit can be delayed if the load is too heavy.

Whenever possible, mothers with children are immediately put into examination rooms provided with picture books and small toys. She puts a paper cup of water on the shelf and leaves a lollipop or two.

Keeping a list on the doctor's desk of the patients with a brief note as to the reason for the call makes it possible for the doctor to rearrange his schdeule to take care of the most urgent cases without undue delay.

Cancer Pain

What seems to me to be the most needlessly cruel of all aspects of cancer treatment is the neglect of doctors to stress the plain fact that cancer pain is not necessarily the most frightful of all pains. It has come to be such a corollary of the disease that cancer must be uncontrolled, unmitigated physical horror that no one expects anything else. Certainly I didn't.

It is not a pleasant thing—that much is admitted. No pain ever is. But since I was, at the last, given only a few days to live, I reason that I must have suffered just about all that one suffers from death by cancer, and I wish to shout it from the housetops that my greatest agony was in waiting expectantly 24 hours a day for the unbearable pain that I confidently expected to begin any minute. Never at any time did I suffer unbearably. There was a time when I leaned rather heavily on medication . . . but it worked. When the flame-tipped arrows that pierced my interior burned too fiercely, I soon learned many ways of coping with them. If I had been sure that nothing worse was going to happen to me, I could have been spared about half of my suffering.

—Edna Kaehele, Living With Cancer

Tired mothers find that spanking takes less time than reasoning and penetrates sooner to the seat of the memory. *—Will Durant*

NEW RADIOISOTOPES POLICY ANNOUNCED BY AEC

The United States Atomic Energy Commission will make radioisotopes for all biomedical and agricultural research and research in medical therapy available to domestic users at 20 per cent of catalogue price, effective July 1, 1955, Chairman Lewis L. Strauss announced recently.

Since 1948, the Commission has subsidized the distribution of radioisotopes used in cancer research and therapy. Initially, radioisotopes for use against cancer were made available without charge for production costs. Since 1952, a charge of 20 per cent of the catalogue price has been made.

Under the policy announced April 21, reduced prices heretofore available only for cancer will be extended to all biomedical and agricultural research. The discount will not be available for radioisotopes used for routine clinical treatment.

The policy of providing radioisotopes at reduced cost was broadened to include other fields as well as cancer for these reasons:

a. Radioisotopes have proven useful in study of other important human diseases.

b. The distinction between cancer research and fundamental studies in biology, biochemistry and biophysics is not always clear. Such fundamental studies may produce information of value in cancer research.

c. Stimulation and encouragement of the use of radioisotopes in the life sciences in general, as well as in cancer research, is considered to be in the public interest.

Under the new policy, radioisotope users will make application to the Atomic Energy Commission, Division of Biology and Medicine. Upon approval of an application, the Division will authorize the user to purchase radioisotopes at 20 per cent of catalogue price. The investigator or institution receiving the discount must agree to publish the results of the research.

WHAT TO TELL THE PATIENT FACING DEATH

How the physician and minister should work as a team in cases of persons suffering from far-advanced malignancy was emphasized in a talk made by The Rev. Russell L. Dicks at a recent postgraduate symposium at St. Luke's Hospital, Cleveland.

Among the many good points made by Rev. Dicks was his opinion on the much-debated question of how much the dying patient should be told. His views were expressed as follows and warrant the serious consideration of every physician:

"Experience has given me the conviction that the patient should be told he is facing death when:

"(1) He is a person who has handled difficult situations well;

"(2) When there is some significant reason that the patient should know what he has;

"(3) When he asks the doctor, straight out and with no hesitancy. Then the doctor may ask, 'Why do you ask me this? Is there something you would like to discuss with me?'

"Many patients will discuss death and eternity and their regrets and hopes with the pastor, but they also want honesty and emotional support from their doctors. This they have a right to expect."

Removing the teeth will cure some things, including the foolish belief that removing the teeth will cure everything.

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.

GENETICS OFFERS MEANS OF CHANGING MAN

Chicago — Man has within his grasp more power to change future generations through breeding than he has wisdom to direct changes for the best results.

An editorial in the current (Aug. 6) Journal of the American Medical Association said genetics, the science of heredity, offers the possibility of changing the race. However, no means for improvement of human stock has yet been devised.

There are many difficulties, resulting largely from the complicated behavior of genes, the biological factors which determine heredity.

For instance, it may be possible to control one gene, but it is hard to tell how it will be influenced by other genes. In other words, the effect of a gene may depend on "the company it keeps."

Another problem is the inability to predict long-term results of manipulating genes.

"Selective breeding," as used in cattle, has been suggested as a method of improvement, but this is not likely to gain wide acceptance because of the "violent emotional reactions such proposals automatically arouse."

"The widespread use of a 'perfect donor' through artificial insemination might lead to too great a uniformity in a world where diversity is still highly desirable," the editorial said.

In addition, such a donor might spread hidden bad traits through a large segment of the population before they could be detected. Inbreeding, as has been shown in the past by various royal families, brings hidden traits into the open. "If these are harmful, as they are more often than not, inbreeding will increase the number of persons afflicted," the editorial said.

The proportion of persons with mental and physical defects is increasing in modern civilization because advances in medical science make it possible for them to live longer, the editorial said.

None of the measures advocated to prevent degradation of human stock, such as sterilizing mental defectives, have "made more than a feeble impression on the problem as a whole."

While physical traits are more nearly determined by heredity, they are less influenced by environment than are mental traits. "Social traits or personality, although affected by heredity, are altered by environment with the greatest ease."

The editorial concluded, ". . . it is easier to define good environment than good heredity. So far, the power to change man genetically exceeds the wisdom needed to know in what direction genetic controls should be applied to achieve the best results."

And there are many other opportunities for adventure, whether they be sought among the hills, in the air, upon the sea, in the bowels of the earth, or on the ocean bed; and there is always the moon to reach. There is no height, no depth, that the spirit of man, guided by a higher Spirit, cannot attain. —*Sir John Hunt*

SOUNDS SWEET TO MY EAR

Without music life would be a mistake. —*Nietzsche*

Music, that "food of love," has been a part of man just as surely as eating, drinking, and loving. Obviously, it is true that music means different things to different people and to the same people at different times. Furthermore, the "long hairs" among us deplore the depravity of the boogie beat, whereas the "hepcats" scoff at "squares." In the middle (or possibly off to one side) is the admirer of "hillbilly music."

Therefore, we democratic doctors should pay attention when the preferences of 2,193 young Americans (patients in eight U. S. Army General Hospitals) are made known (see Table 1). According to Colonel D. E. Liston,[1] a library based on these studies should contain the various types of music in the proportions shown in Table 2.

table 1

Percentage saying each type of program should be given.

PROGRAM *Music*	A LOT OF TIME %	A LITTLE TIME %	NO TIME AT ALL %
Sweet, popular, dance	54	43	3
Hot jive and swing	36	56	8
Old familiar	19	73	8
Western and hillbilly	18	59	23
Concert and classical	16	64	20

table 2

Proportion of various types of music in a library based on the preferences in Table 1.

TYPE	PERCENT
Smooth, sweet, popular	47
Operetta, semiclassical	17
Jive, swing, boogie-woogie	12
Hillbilly, cowboy, folk songs	10
Classical	9
Hymns	3
Spirituals	2

Presumably, this sample taste—or lack of it—is a true representation of the preferences of the healthy young adult American male. The proximity of Western and classical music in this table may make some shudder. But is it true that the recent popularization of classical music (that is, music that has lived for years) through inexpensive long-playing records has not spread the gospel of beautiful sound throughout the land?

When we can hear the same melodies and harmonies time and time again without becoming tired or bored, when each time we hear such music we again have certain emotions stirred up—then that music is "good"; it is likely to be great if it produces similar effects in diverse times and climes. Such music deserves the accolade—"classical."

Perhaps the present dividing line between classical and popular music is more temporal than absolute. Even the strongest opponents of the popular style must grant that much music written at the time and in the form of those pieces now generally considered to be classical masterpieces is dull and uninteresting. In his own day, Telemann was considered the superior of Bach. It may be that in two or three centuries, some of the improvisations of a Stan Kenton or a Dave Brubeck may be thought "long hair" by those who follow the rhythm of the day.

Possibly the most important thing is not to like a particular kind but to find enjoyment in some form of music. It was Shakespeare who said:

> The man that hath no music in himself,
> Nor is not moved with concord of sweet sounds,
> Is fit for treasons, stratagems and spoils.

REFERENCE

1. Liston, D. E.: Let's Face the Music, M. Bull. U. S. Army, Europe, 12:19 (January), 1955.

OHIO STATE MEDICAL ASSOCIATION

Columbus 15, Ohio

August 20, 1955

A MESSAGE OF IMPORTANCE TO ALL PHYSICIANS REGARDING THE POLIO VACCINE PROGRAM

A limited amount of polio vaccine is being made available to Ohio physicians through normal drug distribution channels for use by them in their private practice under the voluntary allocation plan set up by the Federal Government and being administered by the Ohio Department of Health.

It is vital that this limited supply of vaccine be used only for the vaccination of children most susceptible to paralytic polio.

The National Advisory Committee on Poliomyelitis has recommended that current priority be given to the age group of 5 through 9 years. The American Medical Association has endorsed this recommendation. The House of Delegates of our own Association in April stated that those most susceptible should receive the vaccine first.

Therefore, I hope that each Ohio physician will limit inoculations at present to children in the 5 to 9 age group. After there is evidence that the vaccine requirements of children in these age groups have been met and as the output of vaccine increases, physicians then can inoculate younger and older children. Recommendations of the National Advisory Committee, broadening the priorities to other age groups, will be passed on to physicians at the appropriate time.

It may be impossible for us to send you a personal letter like this on later developments. Therefore, please watch The Ohio State Medical Journal and the OSMAgram. Also, we will send bulletins to the officers of your County Medical Society on new data and recommendations.

In conclusion, may I emphasize the suggestion published in the June issue of The Ohio State Medical Journal: Keep a record showing the name, residence and age of each patient vaccinated for polio by you in your office; the site and date of the inoculation; the lot number of the vaccine; and the manufacturer's name. You may find this data valuable for reference.

Charles L. Hudson, M.D.
President

Old Age and the "Vices"

Prohibition of "vices" may do more harm than good. Moderate "vices" should be permitted the elderly people.

—o—

Smoking decreases peripheral blood flow in every instance; this persists for half an hour after smoking. Tobacco is often responsible for the irregularities, palpitations and tachycardias of old people.

I still favor the *moderate* use of tobacco for the aged, if no obvious harm results from its use. Like alcohol, it constitutes one of few pleasures available for the aging patient.

—o—

Insomnia is remarkably common in old people and contributes not a little to their unhappiness; the drugs far the most popular are the barbiturates. No one can question the propriety of an occasional capsule of pentobarbital, amytal or seconal, but how about 1 or 2 every night month after month, and year after year?

—o—

Overeating accounts largely for the prevalence of obesity in elderly women. Fire burns less brightly in old people, they should eat less food than the young. The food should be simple and nutritious and high in vitamin content, supplemented with a daily polyvalent vitamin capsule.

—o—

Idleness is a "vice" which many elderly people enjoy without any apparent harm to their general health. Every physician has aged patients who are bored by idleness—energetic people who desire nothing so much as an interesting and absorbing job. The problem of premature retirement is tied up with this unhappiness of the idle senescent.

—R. L. Cecil, M.D., New York
J. Am. Geriatrics Soc., September, 1953.

Robert Louis Stevenson's Tribute to the Physician

There are men and classes of men that stand above the common herd—the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule—he is the flower (such as it is) of our civilization; and when that stage of man is done with, and only to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those that practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage so that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing.

Medicine, It's Wonderful

It was 1 a.m. The sheriff was on the phone. He had a woman in custody who claimed she had been raped. Could I possibly examine her then?

I said I could. And I told him to meet me at my office in ten minutes.

While the woman was removing her clothes, the sheriff confided that she had been drinking and that he doubted she had been raped at all.

During the examinations, to make some small talk, I said, "Apparently, you've been drinking."

Immediately, her disbelieving, questioning reply came back:

"My God, can you tell *that* down there?"

—D. J. HAFT, M.D.

THE RESEARCH DOLLAR

Gone are the days of the lone researcher, pouring over retorts in the barn or the attic. Modern research is a matter of team work, in stream-lined laboratories with chrome plated gadgets. A single piece of modern research equipment may cost as much as a busy practitioner's annual gross income. Perhaps some new Curie, Pasteur or Koch may flash across the scientific firmament in the future, a lone worker with shabby equipment. But the odds are against it. The single, dedicated worker in his basement laboratory has probably gone the way of the one horse shay, the little black bag and the elegant four-ingredient prescription.

But the new research brings new problems. Finances did not seem so important when the major components of a research project were a high I.Q., a lot of sweat, an indefatigable body and spirit, and ten dollar's worth of wires, glassware and needles. It now takes a king's ransom just to investigate a proposal deep enough to find out if it is worth investigating further. And from what king will this ransom come? Government is wary of spending the tax-payer's dollar on a proposition that, 99 times out of a hundred, will just lay an egg. And science is chary of accepting Government's dollar unless it can be made unequivocally clear that he who pays the piper will *not* call the tune. The pharmaceutical houses, God bless them, do pour millions and millions of dollars into research projects in the hope that one in twenty will pay off. Sometimes the fruit of the research hurts the company that puts up the money. And it is not fair to place companies in *that* spot very often. Medical schools are good places for research, but medical schools have to pass the hat every once in a while just to make up their operating deficits. The big money for research probably has to come from the place where the big money is: which these days means the Foundations. And this is poetically just. Most of the Foundations draw their funds from business enterprises. It seems only proper that the money which came from consumers should now be used for their benefit. Of course there are some who just don't like the Foundations. None of these critics, however, have suggested any better source for the research dollar.

"NON-SERVICE-CONNECTED AND ABLE TO PAY"

Critics of the A.M.A. position on veterans' care frequently attempt to bolster their attack by denying A.M.A. statistical material on care provided, despite the fact that all such material has been obtained either directly from the VA or from its official publications. A commonly used argument is that the VA patients who are "non-service-connected and able to pay" is less than 10 percent and, therefore, a very small portion of the total VA load. "These", say the critics (including Mr. Higley), "are the cases the A.M.A. is arguing about."

The catch is in the phrase " and able to pay". The medical profession has stated, over and over again, that ability to pay is not what we are talking about; the A.M.A. policy is that SC cases are entitled to care, NSC cases are not. Indigency (which is what "inability to pay" amounts to for any citizen) is a community responsibility, not a Federal one. The temporary exception for NP and TB cases is based, not on the cost of such care, but on the shortage of non-VA facilities.

The medical profession is not talking about the 10 percent or less of NSC cases who can pay for private care; it is talking about the 84 percent of VA patients discharged during a year or the 62 percent in the hospital on a given day who are being treated for NSC disabilities, whether they can pay for care or not.

FACIAL WRINKLES

Facial rhitidosis (wrinkles) is a phenomenon that accompanies other events in the physiologic involutionary (aging) process. It is due primarily to regressive changes in the subcuticular connective (chiefly elastic) tissues, which fragment and lose their resiliency; and made more obvious when loss of subcutaneous fat reduces the volume of the substratum of the cutaneous structures.

It is, of course, well known that all of the known systems of cosmetic ritual: massage, creams (lanolized or not), hormone ointments and the even more expensive skin "serums" are worthless in the treatment or reduction of wrinkles. Some improvement in the appearance (not the wrinkles) may occur following the restitution of fat (better nutrition) or following the use of a drug with a lipotropic side-effect (e.g., Cortisone).

Permanent elimination of wrinkles may be accomplished by a stretching and fixation of the skin (meloplasty). Those who insist on eliminating wrinkles (during the day) and who do not wish an operative procedure, may consider an interesting prosthesis recently described by Doctor Adolph M. Brown of Beverly Hills, California. This devise is ingeniously simple, inexpensive and easily applied and removed by the wearer without aid. It consists of two small cloth tabs which may be fixed, with a plastic cement (polyvinyl butyral) to the scalp, on a hairless area just above and anterior to each ear. Upward traction is exerted on these tabs by tightening a cloth-covered elastic band which is stretched over the vertex of head and attached to the tabs by small flat hooks (one on each end of the band). The tabs may be easily removed by the use of a little isopropyl alcohol or acetone.

RADIATION EFFECTS ON HUMANS

Recently before a Senate sub-committee, Dr. John C. Bugher, head of AEC's biological and medical section, said that "A . . . possible delayed effect of radiation exposure which has been demonstrated in animals is a statistical shortening of life expectancy. This phenomenon does not result from any specific cause of death but apparently from a general acceleration of the aging. Whether this factor can be recognized in a human population is as yet unknown."

The TV program "March of Medicine" on March 29 was devoted to a report on the long range effects of the atom bomb dropped on Hiroshima in 1945. The report disclosed that there have been a few cases of latent damage to survivors but no significant indications of unfavorable hereditary effects on their offspring. Hiroshima's A-bomb children are generally healthy and happy.

In the hottest Hiroshima Zone there were 185 pregnant women who survived to bear children. Only eight of these children were born with heads slightly smaller than average and they had "some degree of mental retardation." There was some temporary infertility among adult survivors. A high proportion of those in the hot area, 40 percent, developed cataract-like spots on the eye lenses as compared with only 8 percent in a non-exposed group. Adult survivors also developed 16 times as much leukemia as did the general population, but this meant only 44 cases.

—A.M.A. Civil Defense Review

One of the greatest pains to human nature is the pain of a new idea.

—Walter Bagehot

Caduceus

Caduceus versus The Staff. The Staff of Aesculapius, the divine healer, had its origin in Egyptian sources. The Egyptians worshipped serpents for their powers of controlling health. Sir James Frazer explains the transfer to the Greek cults in these words: "It is tolerably certain that originally Aesculapius was neither more nor less than a serpent, which at a later time was transformed into an anthropomorphic god, with a serpent symbol. . . . The ancients explained the connection of the serpent of Aesculapius by saying that it is the natural symbol of the healing art, since it periodically renews itself by sloughing off its old skin." When the Father of Medicine was enshrined in the beautiful temple of Aesculapius, he carried the knotty rod, the symbol of support for the weak and of the difficult problems in medicine, and the entwined serpent, the ancient symbol of health.

Both the royal Army Medical Corps and the French Medical Military Service used the correct Aesculapian emblem. . . . The official symbol of the American Medical Association is *"the knotty rod and serpent of Aesculapius."*

The continued misuse of the Caduceus as a medical symbol is persistent, and, in view of the contributions made by Garrison and other medical historians, inexcusable. The term "Caduceus" is the Latin adaptation of the Greek word which signifies a herald's wand; originally it was a shepherd's crook, a forked olive branch adorned at first with two fillets of wool, then with white ribbons, and later with two snakes intertwined, representing "the magic wand of Hermes."

Hermes, whose only connection with the healing art is that he is said to have been a half-brother of Aesculapius, and to have married the latter's daughter, Hygeia, is *"a god of the high road and the market-place, perhaps above all else the patron of commerce and the fat purse. As conductor of the dead to their subterranean abode, his emblem would seem more appropriate on a hearse than on a physician's car."* A long list of perpetrators of this misuse might be mentioned, but suffice it to mention a few such as Sir William Butts, the famous physician to King Henry VIII, the U. S. Public Health Service and the U. S. Army Medical Corps.

—*Grant Graves, Columbus Medical Bulletin*

"PECULIAR PEOPLE"

"These American are the most peculiar people in the world," wrote de Tocqueville when he visited the U. S. in 1831. "You'll not believe it when I tell you how they behave. In a local community in their country, a citizen may conceive of some need which is not being met. What does he do? He goes across the street and discusses it with his neighbor. Then what happens? A committee comes into existence, and then the committee begins functioning on behalf of that need, and you won't believe this but it's true. All of this is done by the private citizens on their own initiative . . . The health of a democratic society may be measured by the quality of functions performed by private citizens."

What de Tocqueville noted 124 years ago and accurately reported is still a distinctly American trait. U. S. generosity, coupled with the native knack for organization, has made U. S. philanthropy one of the wonders of the land.

Bind your mouth from uttering prophesies and dogmatic decrees. Let most of your statements be conditional. —*Isaac Judaeus*

Consider Open Airway First in Lower Facial Injuries

When confronted with a patient whose face is severely injured in the lower portion, it is most important to initiate treatment by providing an open airway, Dr. Jerome A. Hilger reported at the annual meeting of the New Orleans Graduate Medical Assembly March 9, 1955. The reason, he stated, is that in injuries to the lower portion of the face there is often a fractured mandibular arch which may lead to death from asphyxia. Until such time as a tracheotomy can be performed, the speaker said, the injured patient should be rolled over on his face and his tongue pulled out.

Dr. Hilger cautioned against hurrying to repair soft tissue wounds of the face. Examination for underlying bone damage should be made before the wound is closed, so that a subsequent incision does not have to be made for bone repair, he stated. In bone repair, the speaker said, best results are obtained by using the patient's own parts rather than relying on subsequent repair by means of plastic surgery.

When repair of the mandible is overlooked initially the consequences may be serious. Dr. Hilger showed a picture of one case in which derangement of the jaw caused irreparable misalignment of the teeth and resulted in three distinct biting surfaces.

When treating a "shiner," Dr. Hilger said, one should always X-ray for fracture of the malar bone.

With fractures of the nose the physician should be particularly conscious of damage to the cartilaginous portion, since such damage may be masked by congestion resulting from fracture. This portion of the nose should be re-examined 1 or 2 weeks after injury when swelling has subsided.

—*Common Problems in Facial Injury: Jerome A. Hilger, M.D., St. Paul, Minn., Ciba Reports, Mar. 31, 1955*

La Buyere on Taste in Writing

"A good and careful writer often feels that the expression he has long been looking for in vain, and which he finds at last, is so simple and natural that it is the very one he would have expected to come at once into his mind without any effort.

"Among the different words which can render any of our thoughts, there is but one which will do this well. It is not always forthcoming when we are speaking or writing. Still, it exists, and any other is feeble, and will not satisfy an intelligent man who aims at making himself understood.

"There is in art a point at which perfection is reached, corresponding with the goodness or ripeness of Nature. He who feels and loves this has perfect taste, and he who likes what comes short of or exceeds this is faulty in his taste. There is, then, good taste and bad taste; and we are justified in discussing the difference between them."

—*J. Internat. College of Surgeons, Oct., 1954*

Whim and Wisdom

The speaker sat quietly and attentively while the chairman made a long and flowery speech of introduction. At last, rising to his feet, the speaker began: "Folks, after an introduction like that, isn't it funny what pops up before you?"

GREATEST GIFT TO SUFFERING HUMANITY

Within the life-time of some of us a strange and wonderful thing happened on the earth — something of which no prophet foretold, of which no seer dreamt, nor is it among the beatitudes of Christ Himself; only St. John seems to have had an inkling of it in that splendid chapter in which he describes the new heaven and the new earth, when the former things should pass away, when all tears should be wiped away, and there should be no more crying nor sorrow. On October 16, 1846, in the amphitheatre of the Massachusetts General Hospital, Boston, a new Prometheus gave a gift as rich as that of fire, the greatest single gift ever made to suffering humanity. The prophecy was fulfilled—*neither shall there be any more pain;* a mystery of the ages had been solved by a daring experiment by man on man in the introduction of anaesthesia. As S. Weir Mitchell sings in his poem, 'The Death of Pain'

> Whatever triumphs still shall hold the mind,
> Whatever gifts shall yet enrich mankind,
> Ah! here, no hour shall strike through all the years,
> No hour so sweet as when hope, doubt and fears,
> 'Mid deepening silence watched one eager brain
> With Godlike will decree the Death of Pain.

Hospitals are no longer the scenes of those appalling tragedies that made the stoutest quail. Today we take for granted the silence of the operating-room, but to reach this Elysium we had to travel the slow road of laborious research . . . and then brave hearts had to risk reputations, and even life itself in experiments, the issue of which was for long doubtful.

Sir William Osler

Current Medical Digest, Nov. 1954

Weather Is Worth Talking About

Blaming the weather for "blue" moods and bad colds is not at all unscientific, says Noah Fabricant writing in *Today's Health* (January 1955). Weather changes are reflected in all of the body's processes, and can have an effect on emotions, colds, asthma, heart disease, and suicide. The weather can be "the straw that breaks the camel's back."

Every change in weather involves a physiologic adjustment in everyone. Colds increase when temperature drops because the membranes of the nose and throat become altered and fall easy victim to invading germs. The form of the nose depends on the climate — the colder the climate, the narrower the nose. Eskimos have narrower noses than Africans.

One way to prevent the shock of going from an air-conditioned room into the heat, or from a heated room into the cold, is to have a closer adjustment between the two atmospheres. A number of diseases will respond to controlled weather and climatic conditions. Though more than a beginning has been made toward deflating the common cold nuisance, it is reasonable to expect that in the future attention to controlled atmospheric conditions will play a role in ameliorating colds.

The word "tax", we are told, comes from the Latin "taxare", meaning, "to touch sharply." No further wisecrack is needed.

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 . . .

SJOGREN'S SYNDROME?

SKENE'S GLANDS?

SOUTHEY'S TUBES?

GRAHAM STEELL MURMUR?

STELLWAG'S SIGN?

STENSEN'S DUCT?

STEVENS-JOHNSON SYNDROME?

STILL'S DISEASE?

SULKOWITCH TEST?

SYDENHAM'S CHOREA?

(Answers on next page)

ANSWERS TO EPONYMS

SJOGREN'S SYNDROME: Deficient secretion of lacrimal, salivary, and other glands of external secretion (especially mucous glands), with dryness of mucous membranes and, sometimes, arthritis or scleroderma-like changes in the skin, described by Henrik Sjogren, of Sweden, in 1933.

SKENE'S GLANDS: The nineteenth-century American gynecologist Alexander J. C. Skene described the mucous glands of females which open just beside the urethral meatus.

SOUTHEY'S TUBES: Cannulae of small caliber thrust into edematous subcutaneous tissues to drain edema fluid. They were devised by the nineteenth-century English physician Reginald Southey.

GRAHAM STEELL MURMUR: The murmur of relative pulmonic valve incompetency which may be heard in mitral stenosis and which resembles the murmur of aortic insufficiency, named after Graham Steell (1851-1942), an English physician.

STELLWAG'S SIGN: Carl Stellwag von Carion, an Austrian ophthalmologist, noted the infrequent winking and the staring expression in exophthalmic goiter.

STENSEN'S DUCT: The excretory duct of the parotid gland, named after the seventeenth-century Danish anatomist Niels Stensen. It is also called Steno's or Stenon's duct.

STEVENS-JOHNSON SYNDROME: An eponym for a form of erythema multiforme exudativum with severe stomatitis, fever, conjunctivitis, and other lesions, described in 1922 by Albert Mason Stevens and Frank Craig Johnson, American pediatricians.

STILL'S DISEASE: In 1897, George Frederic Still (of England) delineated a form of rheumatoid arthritis that occurs in children.

SULKOWITCH TEST: A semiquantitative urine test for the presence of calcium, devised by the contemporary American physician Hirsh W. Sulkowitch.

SYDENHAM'S CHOREA: The common form of chorea (St. Vitus's Dance) related to rheumatic fever was described by Thomas Sydenham, who also differentiated measles from scarlet fever and wrote a classic description of gout.

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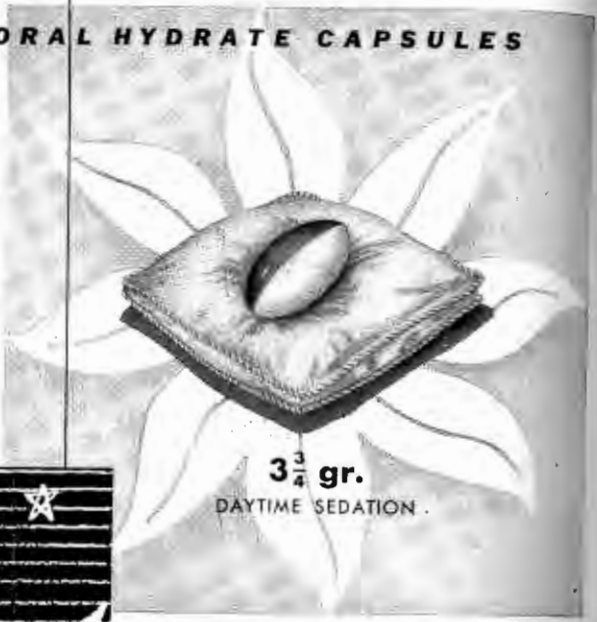

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