BULLETIN

of the

Mahoning County Medical Society

Organized 1872

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ΑΣΚΛΗΠΙΟΣ ΑΣΚΛΗΠΙΟΣ

May Meeting

TUESDAY, MAY 18TH, 1937

YOUNGSTOWN CLUB

8:30 P. M.

PROGRAM:

The Treatment of Chronic Arthritis.

By

DR. J. DOUGLAS TAYLOR

Montreal, Quebec, Canada

THE MAHONING COUNTY MEDICAL SOCIETY BULLETIN

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PRESIDENT'S PAGE

Prices of medical supplies and equipment have risen recently. Building costs, food, clothing and shelter have all increased considerably. Our drugs, bandages, gauze, etc., have all advanced in price.

Our fees have been stationary since 1919, while during the depression, we fitted the fee to the individual's ability to pay. Today the risen costs of living have caused the masses to go after the payroll. From skilled labor down to common labor, wages have been raised. The hospitals have been forced to increase their room rates. We should not be labeled as "mercenary" if we take all these facts into consideration and advocate a "commensurate" increase in fees for the physician.

We are always loath to alter precedent, but it looks as though we will be forced to consider it seriously.

P. J. FUZY.

BULLETIN
of the
MAHONING COUNTY MEDICAL SOCIETY
MAY 1937

THE AMERICAN FOUNDATION REPORT

In the March issue of the Bulletin the original letter sent by the American Foundation to several thousand physicians in the United States was published. The editors requested answers which were in turn to be presented to the society in the pages of the Bulletin. Several such responses have been received.

Since that time, however, the report of the American Foundation has been published. The first release was apparently a review of the report written by the secretary in the April Atlantic Monthly.

The report has excited a great deal of comment. The New York Times of Sunday, April 4th, carried a press release, a magazine article, and a column editorial on this report which should be widely read. The editorial particularly criticised the "laissez faire" attitude of the American Medical Association toward making adequate medical care more available.

Extracts from the original report, the editorial and the book "American Medicine, expert testimony of our court, What is wrong—and what is right—with American Medicine," appear below.

The following are some of the questions which the Doctors discussed, are submitted for your consideration. Won't you sit down and give them some thought and let us have your ideas as to what can be done about this matter. Unless the Doctors bring some constructive measures to bear upon it, the public may resort to changes unsuitable to the Doctor. So let us not be like the ostrich.

The Mahoning County Medical Society is a good cross section of the medical profession. Some of you have been up and down this valley for 40 years, more or less, which time should have given you some ideas as to why the medical profession is under fire. Your communications must be signed, but signature will be withheld if requested.

1. Is radical change needed in the present organization of medical care?
2. What is "adequate" medical care?
3. What is meant by "available"?
4. Are there practicable ways of reducing present costs of medical care?
5. Is the public really demanding modern scientific medical care of high grade?
6. If it were "available" now to all, would half the population still

prefer quacks, cultists and patent medicines?

7. How far, in the world as at present organized, can the individual citizen be responsible for his own health?

8. Where does government enter the picture?

9. Should government's concern be confined to the sickness of the indigent and the low income group or should government promote positive health for the whole population?

10. Is the old line of demarcation between preventive and curative medicine any longer practicable or desirable?

11. Is improving medical education and the personnel of the medical profession the first step in improving the organization and distribution of medical care?

12. Can an individual doctor really furnish scientific medical care alone or are organized laboratory and consultative assistance an absolute necessity?

13. In the medicine of the future will the practitioner function as an individual or as a member of a group?

14. Is there too much specialization?

15. What is the present status of the family doctor—is he "passing"; or is a new version of him just coming into being?

16. Is the "doctor patient relation" an obsolete sentimentality or has it a practical value in modern scientific medicine?

17. Is there too much surgery?

18. How can higher standards of surgery be achieved?

19. Now that the age of philanthrophy is passing, how are hospitals to be supported?

20. Is insurance—3 cents a day —or direct use of tax funds the answer?

21. Should the United States have a ministry of health and set up a Federal Department of Health in the President's Cabinet?

22. Which, if any, of the following is the answer to present problems; the status quo? compulsory insurance? various forms of voluntary insurance? thoroughgoing state medicine? evolutionary increase in governmental authority and functioning, integrated with private practice?

SPEAKERS' BUREAU

April 5—Youngstown College—Dr. Wm. Skipp, "Venereal."

April 6—Parmalee School—Dr. Wm. Skipp, "Venereals."

April 7—Monroe School—Dr. C. A. Gustafson, "Venereals."

April 12—Youngstown College—Dr. Wm. Skipp, "Sex Adjustment in Marriage."

April 8—Lincoln School—Dr. Henri Schmid, "Venereals."

April 5—Radio—"Habit and Digestion," Dr. M. H. Steinberg.

April 7—Washington School—Dr. W. Mermis, "Venereals."

April 12 — Radio — "Nervous Breakdown," Dr. I. C. Smith.

April 19 — Radio — "Sudden Death," Dr. J. P. Harvey.

April 26 — Radio — "Emergency Aid," Dr. Paul J. Mahar.

News Items

Drs. Chalker, B. J. Dreiling, Kupec and W. J. Jones presented a series of papers on Diseases of the Colon at the April meeting of the Staff of St. Elizabeth Hospital.

Dr. W. O. Mermis had his appendix removed recently. He is recovering nicely and should be back on the job any day now.

Drs. Kramer, A. M. Rosenblum and J. Rosenfeld attended the recent meeting of the American College of Physicians in St. Louis.

THE HEALTH OF THE NATION*

By ESTHER EVERETT LAPE

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**A resume of the opinions of over two thousand physicians as to what is wrong with American medicine, and what to do to correct the condition.*

I

THE innocent bystander can hardly be blamed for not knowing what the fight on "state medicine" is all about. A battle of words has been noisily waged, even high-school children during the past year debating the subject as if it were a question still to be answered. Yet every doctor and every intelligent layman must admit upon reflection that we already have a sizable degree of state medicine, and that extensions of it are constantly being proposed and carried through without shocking the most rugged of the individualists. The press reports that the Republican State Committee of New York has petitioned the legislature for funds for three more cancer hospitals. It has not been many years since cancer was regarded as a purely individual affliction, belonging in the bailiwick of the private practitioner. Now it develops that cancer is endowed with a public interest and that the state is concerned. And the Republican State Committee, whose history does not suggest a disturbing degree of radicalism, does not seem to turn a hair in recognizing the situation.

No, "state medicine" is, on the lips of the alarmists, a conveniently inflammatory phrase, but state medicine is not the real issue. The issue is, to put it sharply, whether government shall more properly concern itself with the relief of one group of the population, the underprivileged, in illness, or whether it shall concern itself with better health for all groups of the population, the privileged and the underprivileged alike.

This is the dominant question in connection with the Federal legislation on health and security to be expected in the not distant future.

Up to the present, proposed national legislation has been rather in the first of these two directions—the social welfare or, colloquially, the "uplift" approach, doing something for the needy, preoccupation with their "negative" health rather than with "positive health" for all groups of the population, a higher standard of physical and mental health for the individual citizen, greater industrial competence and more continuous employment, greater personal enjoyment of life.

It is no secret that when the Social Security Act was being drafted a few years ago a number of the advisers were of the opinion that "social security" ought to include insurance not only against impoverished old age and unemployment, but also against the "hazards arising out of illness." It was proposed to include in the Social Security Act a compulsory health insurance programme. ("Health insurance" is the term used, but it is in a way a misnomer, for the real stress is on relief in illness.) In view of present constitutional limitations, the compulsory health insurance proposal was dependent upon legislation in the several states, involving, however, the principle of Federal grants-in-aid to the states that appropriated funds and passed the necessary legislation. The proposed health legislation, in short, brought sickness within the province of social security motivation—extending the power and funds of the Federal Government to give the underprivileged security in misfortune arising from old age, unemployment, or illness.

The compulsory sickness insurance part of the social security proposal was vigorously resisted by "organized medicine." There is no question that an organization group fought it narrowly, making no constructive counter proposal. They fought it not on

the ground of difference in philosophy, in conception as to *how* government should meet the problems, but on the ground that government should not act at all. They fought, in other words, "state medicine." At the clarion call, *"Aux armes, medecins, formez vos bataillons,"* doctors in every hamlet ran forth with their muskets to line up against state medicine, government interference with their livelihood, the socialistic programmes of swivel-chair social economists.

The compulsory sickness insurance proposals were not included in the Social Security Act as passed; but the possibility of including them was not considered closed. The Social Security Board was given a mandate to study further the subject of the "economic risks arising out of illness." Moreover, as the old-age pension and unemployment insurance provisions of the Social Security Act have been put into operation, they have emphasized how often old-age pensioners are also ill and how great a factor illness is among the unemployed—and the unemployable. The emergence of these truths is considered to point the need for complementing the Social Security Act by extending coverage to "economic risks arising out of illness."

There is, obviously, more to come. While well-known prophets do not seem to anticipate decisive action on any far-reaching health legislation at the present session of Congress, pressure for action still continues—and so does misunderstanding.

II

The American Foundation, whose dominant interest is to relate the result of accurate studies to confused present situations, felt that a large problem that concerns all of us has been falsely narrowed into a controversy, not between doctors, but between organized medicine, regarded by the other side as a guild of reactionaries defensively protecting a vested interest, and the social-welfare group, carrying the banner for the underprivileged. A difficult, complex, and delicate question has been distorted into a shallow debate: "Shall we or shall we not have state medicine?" And from the whirlwind of superficial discussion the only harvest is a collection of cliches and slogans for and against state medicine.

To the Foundation there seemed to be three other parties in interest: first, leaders in scientific medicine who on a broad question of national need certainly would not take a narrow guild point of view; secondly, the public, privileged and underprivileged alike; thirdly, the government.

Ultimately the government will be the umpire. The Administration will be in the best position to strike a balance between the intransigeance of a certain group of doctors on the one hand, and on the other the intransigeance of those so obsessed with the needs of the underprivileged that they conceive of the government rather as a continuous relief agency for certain economic groups than as the initiator and guardian of better standards for *all* groups—*including* the underprivileged, but without limiting the government's functioning and its vision by their needs.

It seemed desirable to broaden the base of discussion, summon the other parties in interest, and break down the false alignment of medical science against social science. With the idea that a disinterested outside organization, assuming its capacity for integrity and for impartial procedure, might be able to perform a work of notable clarification, the American Foundation, as a first step, addressed to a selected list of leaders of scientific medicine in all parts of the country, who have been in practice or teaching for twenty years or more, the following questions:

Has your experience led you to believe that an essential change in the organization of medical care throughout the country is needed?

If so, in what direction? If you

do not consider that radical change is indicated, what, if any, evolutionary possibilities would you stress?

A similar letter was sent to a young group, as a control—graduates of the past five years recommended by deans of sixty-six "grade A" medical schools. The theory was that these young men have been exposed to a vastly revised system of medical education, and have also come into their medical maturity in a period of great social changes. Their views as to the proper relation of government and medical practice have not been tested by experience—but by the same token they are not inhibited by it. Included also was a smaller group of men who have been in practice for approximately ten years. There was no questionnaire; the doctors' analysis of the situation was not restricted.

In our judgment the three following conclusions may be fairly drawn from the results of the inquiry, consisting of approximately 5000 full and frank letters from doctors in every state:

First, leading medical scientists of the country are almost unanimous in recognizing that modern scientific medical care is not available to a great majority of the population, and that the problem must now be met.

Secondly, while medical scientists agree with social scientists on the existence of the problem, they state the causes very differently.

The social scientist thinks the problem is largely reducible to terms of cost. The medical scientist thinks costs are too great, but that there are two other important reasons why good medical care is not available to most of the population: namely, the fact that much of the public continues to prefer patent medicines, quacks, and cultists, and—most important of the three causes—the fact that there is not, as yet, enough scientific medical care of first grade to "distribute," even if (as he does not agree) it were distributable.

Thirdly, the medical scientist opposes to the social scientist's programme of compulsory insurance a programme that involves at least as much "state medicine" as does compulsory insurance, but in very different ways. The medical scientist's programme, an integration of an expanding degree of state medicine with private practice, rests upon two principles: *evolutionary* extension of the participation of government in public health services and medical care, and retention of the private practice of medicine. It "socializes" certain medical services, but does not socialize the doctor. It may be called, synthetically, "limited state medicine with private practice." It will be described more fully hereafter. For the moment it will be enough to say that the programme in support of which scientific medical leaders from one angle or another seem most nearly to converge involves *direct* use of tax funds for the development of public health services, Federal, state, and local; partial tax support of hospitals in proportion to amount of care given to the indigent and near-indigent; extension of public laboratory facilities to make the scientific aids to diagnosis generally available at low units of cost and free to the indigent; admission that the medical needs of the indigent and the near-indigent are a fair charge on tax funds—as fair as their need for corned beef and doughnuts and a bed.

III

Let us consider the first of the three conclusions—the doctor's estimate of the need. The social scientist has felt that the doctor's realization of the extent of the social need has been deficient. It is quite true that some doctors are satisfied with the situation in their communities, but this is not the "net" of their testimony. The realized experience of years in these 5000 letters — from not only the Old South and the wide agricultural stretches of the West, but also cities

with million-dollar hospitals—seems to us a more current, straighter, and vastly more moving record than voluminous surveys. "Facts," as one of our correspondents points out, "keep no better than fish." The practitioner's daily life is a direct social experience. He constantly sees stark pictures not merely of tragic physical illness but also of sharp economic pressure, of social inequality at its most unequal. He is daily brought without ceremony into the heart of the individual and the family life. Not often in these days does he perform operations on the kitchen table and help mop up the kitchen afterward, but he still sees the picture of human need in more direct perspective than do most of the rest of us. Why not ask him what he thinks—from what he has seen?

One correspondent, who happens to be a member of the public health service of a Western state, presents the following picture:

In this state approximately one-third of the people die without consulting a doctor even in their fatal illness. The death certificate says "no medical attendant" and cause of death is "unknown." In six of its thirty-one counties, less than one quarter of the mothers have medical care in childbirth. In seven of this state's counties more than three quarters of the babies that die have had no medical care.

No one has ever tried to calculate what it would cost to provide adequate medical care for these thousands that receive no medical care at all. But there are a few considerations which suggest that the cost is far beyond this state's ability to pay.

Many of our families live twenty miles or more from the nearest physician. Under the present system, the doctor charges one dollar per mile for country calls. It is possible that a socialized system could be devised which would reduce the cost of calls into the country, but under *any* system each call would mean many dollars. And today adequate care means several calls. Twenty years ago the doctor might call once and pronounce pneumonia, and that single visit might be considered adequate enough. But today the sputum must be "typed," the appropriate serum selected and administered. Perhaps the next day more serum will be required. Oxygen may be needed, and a skilled attendant to administer the oxygen. To provide such service at twenty miles from our base will cost, under any system, well into three figures. . . .

A conservative estimate from a health survey of this state made two years ago places the number of cases of active tuberculosis at not less than 15,000. At present there are no free beds for tuberculosis and very few of these patients can pay for sanatorium care. There is no provision for surgical treatment to save the patient's life and stop the spread of infection. The same survey proves that there are in the state 20,000 people whose blood shows the presence of syphilis. Only one thousand are under the care of a physician.

The infant mortality in this state is the highest in the union. It was 126.1 per 1000 live births in 1935.

It is clear that the bill for adequate care will be a large one. What resources has this state to meet such a bill?

Health insurance can hardly be the answer in a state that has scarcely any industries. There is already an income tax and a two per cent sales tax. Taxes on property cannot be increased without a change in the state's constitution; they have reached the maximum allowance of twenty mills in the dollar. If this state cannot afford to guarantee to its children life as well as liberty and the pursuit of happiness, what does the national government propose to do? How many states are there like this?

The first step, surely, is to define "adequate medical care," and the next

step is to employ cost accountants to estimate its cost. Neither step has been taken at the present time.

A general practitioner in a South Dakota town leaves no doubt of "inadequacy" in his state:—

Last year there was not enough raised on many farms to feed one horse or cow, and the price of feed was so high that one had to sign up to pay in the future a large price for this feed.

If we can have a reasonable crop with a reasonable price, we can get ahead considerably, but it seems that year after year we wait for that to happen, but it does not happen. . . .

There is hardly a person living in this county with rich soil who at the present time is able to go to a hospital for attendance.

A surgeon told me the other day people are brought to him just before they die.

The following letter pictures a county about thirty miles wide and forty miles long in a Southern state:

The population is both white and colored; the natives are dependent upon the soil for a livelihood, the timber has been cut and sold; there is no industry to which to look for a steady payroll. The patients cannot budget, for the simple reason that they depend upon a pay crop; they have no say in setting the price; they must combat the elements, have no assurance of a given yield, cannot judge the future by the past. They have necessary expenses that must be paid first; if there is a surplus probably the doctor also will be paid, but more often the charge must be carried on his books. The physician has no way of figuring his income from year to year. . . .

It is all very nice for the medical fraternity to sit back and oppose state medicine, but for the rural sections I cannot see anything else, and the problem will have to be looked after by the Federal Government. The state, at least my own, and other neighboring states, are just as badly off: the conditions are the same as ours.

Insurance is not feasible, as the clientele could not pay the premiums. I can see only the one solution, for the Federal Government to take over the medical care of the rural sections at least.

An annual report sent through to us, covering the work of the county doctor in a Middle-Western state, reveals industry and accomplishment certainly, but hardly adequate medical care for the poor. He receives $1400 a year, but out of that he must buy the gas and oil for his car, amounting to $200 for last year (his calls out of town totaled 2194 miles), and out of it he must also buy all drugs and supplies, costing $365 for last year. While measles, mumps, and rheumatism make the usual demands, surgery bulks large in the year's record, which includes 542 teeth extractions, 55 obstetrical cases, 5 hysterectomies, 72 other abdominal operations.

Nor is most of the surgery minor: to run down the list, there are noted twenty-five tonsillectomies, eleven operations for piles, three eyes removed, one cancer of the lip, one cancer of the stomach, one gall bladder removed, one leg amputated, three cases of paracentesis of the ear, three of thoracentesis, one hernia, one prostatectomy, and all kinds of dislocations and fractures, including a fractured hip.

This county physician never "refuses" a fence of any height. Whatever the operation, he does it. And what if he did not? Better in some cases, of course, but not in all. At the rate of 8⅓ cents for removing an eye, or a cancer, or a gall bladder, which sum is exactly what he averages for each operation, this county doctor is not ravening on the poor, but—

Are the indigent sick of the county getting "adequate" medical care?

A general practitioner in a Ken-

tucky town points out that even when a modern highway brings "adequate" medical care almost to the door of some of the natives, they will still not build the last mile of road that would connect their cabin with the highway:

They have lots of idle time, idle teams, and certainly plenty of rock to do it with, but they just don't and they won't. . . .

Not all of these people are desperately poor, as many social workers, calamity howlers, and "state medicine" advocates would have one believe. Very few, if any, go hungry. Still fewer suffer from lack of proper clothing; and while they are quite willing to pay good prices for rattletrap automobiles, coon dogs, fox hounds, fiddles, banjos, French harps, and mean liquor, almost to the last man of them they are not willing to pay a doctor's bill, if they can get out of it. . . .

Insurance would not solve the problem of the last muddy mile of private lanes, from the highway to the home.

The above are not horrible examples from the social worker's collection; they are from the doctors' own daybooks.

IV

The Kentuckians who "just won't" build the last mile of road that would connect them with medical care illustrate the medical scientist's protest to the social scientist that the cost of medical care is not the whole story. We have not as yet, he points out a public that is asking for scientific medical care. Legislatures backed by uninformed public opinion repeatedly defeat legislation aiming at higher standards of medical and surgical practice. The public kills efforts to control advertising of quack remedies. Congress failed to pass the Copeland food and drug bill last June.

Not only does the negligent public commit the above sins of omission; even the intelligentsia, quite as numerously as the poor immigrants, patronize the quack. If modern scientific medical care were directly available to them, many would still choose patent medicines, quacks, cultists, and old women.

The medical scientist does not think —and this is the very centre of his position—that the task of providing medical care of high grade to the population can be discussed chiefly in terms of cost and availability. Medical care is neither a commodity nor a constant. It cannot be subject to the laws of commodity distribution. In medical science the field of the unknown is still vast, and the number of those fully competent to apply what is known is still very small. Even if it were possible to "distribute" medical care, there is by no means a sufficient number of adequately trained men to supply it on a broad base. "The best is not yet good enough."

"Until the schools have met the challenge," as one undoubted leader of medical science points out, "regimentation by the state will only make matters worse. Under a democracy the competent and the incompetent are alike before the law. Socialization and bureaucracy will simply make a whited sepulchre for a dead profession." The problem of supplying medical care must be solved only in relation to that of developing medical care of high order, and of training and graduating and sending out to practice men who can supply it. Whatever the solution for present problems, the medical scientist maintains, it certainly cannot be making more mediocre medical care available to more people.

This "adequate medical care" that falls so trippingly from the social scientist's tongue cannot be standardized for distribution—at least not yet. For case A "adequate medical care" consists in providing bread and milk; for case B it consists in providing an electrocradiograph to determine the

presence or absence of a heart lesion.

The medical scientist protests identifying the problem caused by lack of medical care with the more fundamental problem of lack of a living wage. He does not think that anything will be gained by a piecemeal attack on one result of our present economic situation. A man with influenza needs medicine, yes; but of what use is it to give him medicine, and even to keep him in the hospital for a day or two, and then turn him out into the slush again, with no underwear, holes in his shoes, no warm place in which to sit or sleep, and no food? Why, asks the medical scientist, "regiment the doctors—the only should have a more general aim. A professor of medicine in a grade A medical school, a member of the Association of American Physicians, puts it thus:

Because of its social implications and sentimental appeal, medicine has been peculiarly the victim of promoters. Projects devised in biological ignorance have gained support almost in direct proportion to their fantasticality. There is no good evidence that scientific progress can be accelerated by such methods.

The medical scientist, in short, believes that government must do its planning and make its attack along a broader front.

V

It remains to show the more particularized objection the medical scientist has to compulsory health insurance, and to outline more fully what he proposes in its place—limited state medicine with private practice.

On insurance: the medical scientist of course admits the right of any part of the population to insure themselves as they see fit, as a personal and voluntary act. But since a large part of the population will not "choose" to insure themselves, voluntary insurance can hardly constitute the general solution that is being sought. European systems that began as voluntary ended, it is observed, as compulsory.

The medical scientist thinks that government, instead of participating as contributor and organizer of a compulsory insurance system on the "risk" and "average" basis, had better assume directly the cost of services actually rendered in particular cases. This thesis that compulsory insurance "distributes the costs" is, after all, regarded as a fallacy. Compulsory insurance merely substitutes, as a member of the Harvard medical faculty puts it, hidden taxes for direct taxes —a substitution that really "distributes" nothing. The head of one of the departments at John Hopkins conveys the medical scientist's repug- group with whom it is a tradition to give poor people what they need whether they can pay for it or not?

Many medical men feel that medicine has been "picked on" as a particular field for experimentation that nance to the idea that the insurance principle is applicable:

Insurance is a form of gamble, well organized and well intended, but fraught with much carelessness and reduction of the individual share in responsibility. The principle of "equality" is fundamentally wrong and may give mathematical satisfaction but not a basic soundness.

Insurance, according to the type of medical scientist we have put to the fore in this discussion, is more concerned with "distributing" the disadvantages of illness than it is in concentrating—in the individual—the possibilities of health. Even hospital insurance, however voluntary, and however applicable to the quasi-commodity value of hospital services as opposed to the less tangible services of the physician, has the fundamental defect of all insurance: a tendency to focus attention not on the possibilities—and the imperative duty—of exercising preventive effort, but on "accommodations for more illness," which accommodations, some suggest, *would be used* (thus, perhaps, dis-

turbing the law of averages upon which insurance rests). An assistant in medicine in a general hospital in New England, whose tone suggests a cynical knowledge of thrift in the original colonies, wrote:

Any form of insurance providing for a possible two weeks' hospitalization yearly per person would result in many provident New Englanders' spending their two weeks' vacation in the bed provided by taxation (and toward which their savings have been contributed) rather than in Florida.

Let the government do directly what it has to do for the indigent and the near-indigent. Compulsory insurance, observes the medical scientist, except with the government as the *whole* contributor, cannot be made to reach those that need it most. Why talk of "distributing" the costs with reference to those that have no contribution to make to the cost? The medical scientist thinks of the hundreds and thousands he has cared for with no savings and no salary from which insurance could be paid; he thinks of the thousands of families with an income so small that anything out for insurance means that much out of underwear, food, or coal. With these in mind, it is not surprising that his attitude toward plans that rest upon "distributing the costs" is sardonic.

Finally, the medical man believes that compulsory insurance—with its stress upon more care in illness (as opposed to stress upon positive health), with its mass therapy, its regimentation both of doctors on the panel and of patients (in spite of devices to save the principle of the personal relation)—subtly and continuously lowers the quality of medical care, the quality of the medical man, the quality of the patient's conception of health.

VI

What does the medical scientist propose? And how—in sum—does his plan differ from the compulsory insurance proposal of the social scientist?

What the medical scientist proposes is first of all the wisdom of depending, not upon a broad new procedure, but upon evolutionary development. The medical scientist's "plan" stresses preventive medicine—more planning for health, instead of more care in illness.

His programme is directed toward the *health* of the *whole* population rather than toward the *illness* of *one part* of the population. He feels that a national health policy, like a national defense policy or a national educational policy, must be framed with a view to the needs of all.

His programme includes the privileged and the underprivileged alike.

His programme recognizes that supplying medical care is only one part—a comparatively small part—of keeping people well, that "the medical problem is only a small part of the general economic problem of the too low living wage of about 80 per cent of Americans," and that the attack must be made upon the broader front.

His programme involves *direct* instead of *indirect* use of tax funds.

It invokes, as compulsory insurance does, the leadership of the Federal Government. It would interpret the "general welfare" clause of the Constitution to mean that the Federal Government may and should assume responsibility for ultimately making accessible to every citizen the full benefits of medical science, not only to protect the population from epidemic and the social consequences of individual disease, but also *to ensure to the individual citizen a new level of industrial competence, a new capacity for personal enjoyment.*

VII

The first "item," then, in the medical scientist's programme is *emphasis on prevention by the marked expansion of public health services, Federal, state, and local.*

The medical scientist knows that

In Memoriam

James A. Sherbondy

August 25, 1877 - April 24, 1937

those of his colleagues who are still trying to build up the fence between curative medicine (reserved for doctors) and preventive medicine (public health officers will please keep over on their own side) are engaged in a hopeless task. Preventive medicine is now coming into the doctor's office—where it has as true a place as it has in the office of the public health service. The doctors themselves grow weary of the negative conception of their task. A physician whose work includes both the research that makes preventive medicine possible and curative attempts to deal with desperate cases in a great city hospital recalls early days on a Southwestern cattle ranch to illustrate the scientist's chagrin at concentrating on reparative labor rather than creatively ministering to the vitality of the race: —

In driving the huge herds overland, the best of the cowboys were stationed at the front of the herd, where the wild-eyed Texas steers were always on the point of "going places." Tenderfeet, like myself, followed after the "drag," the weak cows and forlorn "dogies" needing constant prodding and encouragement to keep them in the herd.

Doctors are traditionally working on "the drag," pulled along by public opinion as it relates to the social aspects of medicine, rather than shaping public opinion. Or they are kept in an idealistic sanctuary, thinking only the circumscribed thoughts Aesculapius and sentimental Americans would have them think.

In one of our hospitals, a poliomyelitis victim with paralyzed muscles of respiration would have died at once but for the Drinker respirator. In it he has lived for more than a year—and has used up all that his family had saved and could borrow and some $10,000 of hospital funds. The child cannot live without this mechanical aid. How long is it our duty to keep the breath of life in him?

By a contraption which prevents

(Continued on Page 166)

WHEN PICNICS

Jackson's Gu

1. Not known.
2. H. L. Beers.*
3. W. P. Connor.
4. John Heberding.
5. R. M. Mossman.
6. R. D. Williams.
7. P. O. Miller.
8. W. K. Allsop.
9. Jos. Watson.
10. J. U. Buchanan.
11. Not known.
12. Breese.
13. H. A. Zimmerman.*
14. D. J. Leethouser.
15. H. E. Patrick.
16. Not known.
17. Dean Nesbit.
18. M. P. Jones.*
19. H. Metca
20. K. W. A
21. C. D. H
22. R. D. G
23. S. H. Sed
24. Not know
25. Not know
26. J. L. Wa
27. R. D. Fe

DR. C. R. CLARK IN A "RELAXING MOOD"

Cornersburg, 1913

Left to right: D. B. Phillips, Unknown, R. H. Stieve, C. R. Clark, A. M. Painter, W. E. Ranz, Galvin.

May

WERE PICNICS

lch, 1915

28. R. R. Morrall.
29. A. M. Painter.*
30. B. B. McElhaney.
31. H. E. Blott.
32. V. V. Wick.
33. Lamar Jackson.*
34. S. W. Goldcamp.
35. J. F. Lindsay.
36. A. M. Rosenblum.
37. Fred Bunn.*
38. J. A. Sherbondy.*
39. J. P. Kenny.*
40. Hunt.*
41. Cunningham.
42. Harry Evans.*

*Deceased.

September, 1914

Standing: Metcalf, Fenton, McCurdy, Whelan, Slosson, Galvin, Hauser, Clark, Morrison, Gibson, *Buechner, *Fred Bunn, Brant, *Evans, Heberding, Phillips, W. E. Ranz, *Sherbondy, Charles Starret Roller, *Tobey, S. W. Goldcamp, Patrick.
Sitting: Joe Ranz, Bierkamp, Connor, *Washburn, Lindsay, Mossman, *Kenny, *Painter.
*Deceased.

1937

THE HEALTH OF THE NATION

(Continued from Page 163)

bladder infections we keep paralyzed patients alive in our public wards for months or years instead of, as formerly, for weeks. Illustrations could be multiplied.

This writer would use the $10,000 of hospital funds for research designed to make control of disease more and more possible.

The conception of governmental responsibility moves steadily on. Nobody's "views" are going to stop it. Statutes against evolution have not greatly retarded it. For many years government limited its responsibility to the insane. Later tuberculosis was assumed. Now, year by year, one disease after another is discovered to have a claim upon public interest that brings it under state functioning—either because it threatens the health of society as a whole, or because it involves treatment too long and too expensive for the individual to compass. Massachusetts takes hold of cancer; New York takes hold of pneumonia. Arthritis, cardiac diseases, rheumatism, are now under consideration as diseases endowed with a public interest.

People begin to see that if the state does not deal at an early stage with the *disease,* and organize and pay for curative treatment, it will end by dealing *later* with the *diseased* as a public charge, paying for dependency what might have gone into a chance of cure. There is at this moment in operation a venereal disease programme stimulated by the United States Public Health Service, based upon recognition that institutions of all kinds are full of the end results of syphilis, and that venereal disease is indeed a *social* problem, with which other governments, notably Sweden, have been able to deal.

When the list of diseases with a "public interest" is finally complete, how long will it be?

VIII

The second proposal of the medical scientist's programme is *tax support for hospitals.*

This proposal is based upon recognition of the fact that the hospital has become the centre of medical practice and of medical education, and that as such it cannot logically depend upon private philanthrophy—already failing. The proposal is that tax funds should be allocated to private hospitals in direct relation to the amount of care they give to the indigent and the low-income group—in the hospital or in the dispensary or in the home. On the basis that the indigent sick have a logical call upon tax funds, Federal grants-in-aid to the states are proposed to cover payment both to hospitals and to private practitioners for care of the indigent in hospitals, dispensaries, and in the patients' homes. The cost would be met by local tax funds to the utmost possible degree, but with state aid generally, and with Federal aid under certain conditions and for certain types of communities.

The third proposal is *extension of the facilities of tax-supported laboratories* to make the scientific aids to diagnosis and treatment (urinalyses, blood counts, metabolism tests, X-ray, vaccines, and so forth) available to physicians generally, and thereby to their patients at low units of cost, and free to the indigent and near-indigent.

The fourth proposal is recognition of the principle that the *medical care of the indigent and the near-indigent* (or 'medically indigent') *is a logical charge upon tax funds,* local to the greatest possible degree, with state aid, and with Federal aid under certain conditions and for certain types of communities.

Most of the public has no conception of the astounding amount of free care doctors now give to the indigent—in hospitals, where every agency in

the service except the doctor and possibly the pupil nurse is paid; in dispensaries, where young doctors devote most of their day to unpaid service; in the doctor's office, and in patients' homes to which the doctor sends no bill because he knows there is no money. Most of the world wants to end this highly illogical forced contribution of doctors' service—in order, if for no other reason, that the costs of medical services to other groups may be put upon a more even base.

Federal grants-in-aid to the states, on the basis of care for the indigent, would permit a desirable national standardization of principles and procedures in medical care, always recognizing the necessity for local variations and adaptation to local conditions.

The fifth and last recommendation in this programme of limited state medicine and private practice is *a Federal coordinating authority*, a ministry of health for this country, a Department of Health with a medical Secretary of Health in the President's Cabinet.

Medical men, however, do not like the Department of *Welfare* which the President's message on reorganization several months ago proposed, and which would include the Social Security measures, Education, the Womens' Bureau in the Department of Labor, and so forth. It is not good 'reorganization,' the medical scientist submits, to bundle the above administrative unlikes together just because they all touch in some fashion upon the 'welfare' of the individual citizen. He does not think a heterogenous new department of this kind would be a vast improvement over the present system. It would collect the now scattered health functions of the Federal Government, and to that extent would be an advance; but it would still make the critical error of assuming that the same national authorities can effectively administer vastly separate fields, which in fact require different kinds of expertness and experience, different planning, and utterly different procedures.

IX

This summary of the medical scientist's 'programme' will be only inaccurate dogma unless we add that, in a way, the medical scientist disavows *all* 'programmes,' all charts, all fixed procedures—in short, the whole commodity conception. He is constantly apprehensive lest the 'plan' submerge the work. He favors *no* scheme for extending and distributing medical care that does not recognize the changing, vital, fluid nature of medical science, and that does not provide for avoiding fixation of mediocre standards. The heart of any plan will be national standards for medical education and research—and national funds for both

To illustate: he would not establish a single new 'community hospital,' except as it is clear that trained men can be made available to staff it. He would not 'extend' the facilities of tax-supported laboratories until it is clear that every laboratory thus 'extended' has the personnel and the facilities to meet adequately the added demand for high-grade work. He would check *every* scheme for 'establishing,' 'founding,' 'extending,' 'distributing,' by the degree to which it recognizes that the thing being dealt with is not a commodity, not a constant, but a *force*, fluid, vital, ever changing, effective only as it is permitted creative growth.

Will the government call the medical scientist into counsel as well as the social scientist? Under discerning leadership they can be brought into cooperation, for their views are rather different than opposed.

But before the national administration can bring about this cooperation it must itself be clear whether, in planning for health and security, its concern is chiefly with the illness of the underprivileged or with the health of the whole population

WHEN PICNICS WERE PICNICS

The young physicians or the recent interne who allies himself with the Mahoning County Medical Society finds it a closely knit organization, and if he is of a contemplative turn of mind, he may wonder however it became so. Therein he observes old friendships which, he infers, must be of long duration, and as deep as still waters. In the staff room "bull" sessions he hears references to Jackson's Gulch, Tobey's Hole, Cornersburg, Southern Park and Brier Hill Park; all mentioned in connection with some amusing or sentimental anecdote.

Gentlemen, those were the birthplaces of your present day Medical Society. Truly, there had been a medical society in Mahoning County since 1872, which had led a prosaic existence over the years, meeting in the offices of its members, and later on in the Elks Club. And a fine discordant society it was!

The writer attended a meeting in 1909, and before the evening was over, feared for the lives of several of its members. Dr. John McCurdy was then alive, and Montgomery; there seemed to be no agreement on anything, and the meeting seemed given over to discord.

Then about 1911 or 1912, a group at the "City" hospital concieved the idea of having an annual picnic. Fred Bunn was then rising to the Superintendency and fostered the idea. The Hospital Chef prepared the ham and beans, corn, pie and coffee, and our friend, Spitz Renner, furnished the beer and truck. Food, beer, tables and utensils were loaded on the truck just after noon and away we went. The first picnics were to the north of the Canfield Road, just beyond Cornersburg, where a creek angled across the highway. This was the place made famous by Tobey's prodigious jump, whereby he developed a ventral hernia. Tobey insisted one could use bricks to carry oneself along, but no one else agreed. So he finally surrendered his contention and proceeded to show that they weren't needed anyhow. He hurled himself into the air and come down with a pained expression on his face and his hand on his abdomen. A hasty examination by Buechner revealed a separation of the recti. Thus ended Tobey's jumping days.

Jackson's Gulch was the setting for another of these outings. If memory serves rightly, Fenton either fell in the lake or was thrown in during an argument in a poker game. For the exact details, we will refer you to Fent. An enjoyable remembrance of the Jackson Gulch outing was the presence of Mr. Lamar Jackson, whose wit and humor kept everyone in an uproar all afternoon.

No one enjoyed these occasions more than Edgar Tobey. One summer he reported early that he had discovered a better place to hold the picnic, and that there was a swimming hole available. That sounded fine, so a committee with Tobey in the lead were conducted out in the upper reaches of Mill Creek in the area now occupied by the golf course, to inspect the hole. It proved a lovely silvan retreat and it was decided to hold the picnic there. So on the appointed afternoon everyone threaded their way along the country dirt roads to Tobey's hole. It was so secluded no one thought of swimming suits and the boys were gamboling in and out of the water to their hearts delight, when two female nature fakers hove in sight. Well! Have you ever seen frogs take to water? I did that afternoon, and the worst of it was Jim Fisher, in his rush to gain the seclusion of the water, near broke his neck in a shallow dive.

About this time, Saint Elizabeth Hospital became an entity with a staff and these picnics were the occasion for friendly rivalry in baseball. There was lots of big league talent

in our midst those days. Chick Evans was a clever short stop. Joe Nagle would stop anything behind the bat, and Bill Welsh was an old O. S. U. varsity pitcher. M. P. was a beautiful outfielder, the rest of us just filled in. One outstanding remembrance was Arthur Smith's famous Casey act. St. Elizabeth was behind, the bases full and Arthur at bat. The writer enveigled Bill Welsh in to letting him pitch. First Arthur passed up a strike to show his disdain. The next was a foul tip, strike two. And then he sucked on a fade away out shoot for the third strike. Too mad for words, Arthur dared anyone to throw just one more ball!

But alas, we were growing older. The following year the picnic was held at Brier Hill Park and proved the undoing of many. Joe Ranz at bat drove one down first base way and hit Luxan on the leg. Luxan only weighed 280, and what that smash did to Luxan's internal saphenous cost him about two years of misery. M. P. tried to score from second on a scratch single and would have made it too, he always contended, if he hadn't developed a pair of Charley horses and fell between third and home plate. To cap the afternoon Kocialek, in making a throw from the outfield, forgot to hang on to his arm and sustained a spontaneous fracture of the humerus. From then on all competition was confined to African dominoes and poker.

Interesting side events were trap shooting and pistol shooting. In these events, M. P., McElhaney and Sherbondy carried off the prizes.

Gentlemen, those *were* picnics, occasions that knit together the warp upon which the woof of your society of today was erected. I am sure that without the close intimacies and friendship there engendered your society would never have progressed as it has. Do you wonder that we olders look askance at the present day Medical outings that resolve themselves into foursomes which separate for the afternoon, and afford no opportunity to mingle and commingle? Oh! for an old time picnic!

THE MEDICAL CRIER

A Page of Sidelights, News and Views in the Medical World

• Did you enjoy Post-Graduate Day? Do you know that the University of Michigan in conjunction with the Wayne University College of Medicine and the Michigan State Medical Society is offering a series of short, intensive post-graduate courses during May? There will also be summer courses available to graduates in medicine at the University of Michigan Medical School. For complete information write to the Director of Post-Graduate Medicine, University of Michigan at Ann Arbor.

• We missed the usual Pittsburgh crowd at our Assembly. They were having a big affair of their own, their annual meeting with T. Wingate Tod of Cleveland and General Hugh S. Johnson. We were looking for Milton Cohen of Cleveland who always comes down for our meeting, and found him on the program at Pittsburgh. Tough spot for Tod and Cohen trying to match adjectives with the General. Wonder if he called anyone a "bombastic buzzard" or an "Inimitable ignoramus"?

• Our old friend Dean Boylan was with us as usual for the big day. Representing the third generation of medical men in his family, he has very pronounced views on medical matters. He believes for instance that the profession should assume the leadership in public health matters. He was rather disappointed to hear that we had to turn over our diphtheria campaign to a welfare organization, and had endorsed the estab-

lishment of a venereal clinic. Seemed to think these things signs of decay. Maybe he was right.

• The old Crier would like to say a good word for the Frank E. Bunts Educational Institute of the Cleveland Clinic. Their programs are always interesting to everyone and Ruedemann deserves a great deal of credit for the manner in which the courses are conducted.

• The Mahoning County Bar Association had a great time lampooning the doctors at their gridiron dinner on April 17. The Medical-Dental Ensemble played for their show and it was the first time the lawyers ever had to dance to the tune the doctors played, although they have made us step lively many times.

• After the manner of "Are You Sure" in *Judge*, we present a short medical questionnaire for your entertainment. Score yourself one plus for each one you get right and two minus for each one wrong and see if you can stay on the plus side. Answers will be found on the last page. If you like it, maybe we can think up some more next month.

1. If a German mentioned Die Magenstrasse he would be talking about (a) Cheese straws with his beer, (b) The channel where the beer goes through his stomach, (c) a famous street in Berlin.

2. If you observed carphology you would be (a) studying the effect of strong drink, (b) watching your patient pick cotton, (c) interested in the habits of certain fish.

3. When you are afflicted with singultus you (a) have a deep bass voice, (b) can't carry a tune, (c) need a carminative (d) or an antispasmodic.

4. He was the father of Anatomy, (a) Andreas Vesalius, (b) Galen, (c) Hippocrates, (d) Harvey, (e) Paracelsus.

5. One of these authors was *not* a physician (a) Rabelais, (b) Oliver Goldsmith, (c) Wier Mitchell, (d) Wilfred Grenfell, (e) Conan Doyle, (f) Swinburne, (g) Deeping, (h) Maugham.

6. If you suffered from achor you would be bothered with (a) aches and pains, (b) a bad heart, (c) pimples on your head, (d) gas on the stomach.

7. "The American Sydenham" was a name given to (a) Sir William Osler, (b) Benjamin Rush, (c) Hahnemann, (d) Oliver Wendell Holmes.

8. The celebrated work of the Yellow Fever Commission was performed in (a) Panama, (b) Porto Rico, (c) Cuba, (d) Jamaica, (e) San Salvador.

9. The phrase "Primum non nocere" over the portal of the Chicago Lying-In Hospital should be translated (a) No harm in just once, (b) First, do no harm, (c) Don't do wrong in the first place.

10. The American Medical Association was organized in Philadelphia in 1847. Its formation was opposed chiefly by (a) the State Societies, (b) the Medical Colleges, (c) the medical journals, (d) the Hospitals.

SHOULD WE DO IT DIFFERENTLY?

By CLAUDE B. NORRIS, M. D.

The "American Foundation Studies in Government," as expressed in the March Bulletin (Page 76), wishes "to summarize the replies we receive from selected men" as to whether those to whom the inquiry is sent "feel that any essential change in the present organization of medical service is needed." The summary is to be sent "confidentially to the persons that contribute to it." The communication continues: "If you do think some essential change is needed, in what direction do you think it should be—in any form of insurance, voluntary or compulsory?" Following this, the "Foundation" asks several more questions.

The subject is timely, as, indeed, it has been for several years. It is not a pleasant one, because, as the communication well says, "Our general feeling is that more heat than light may have been developed" in previous discussions. So, one who does not pretend "to know all the answers," nor even any of them very well, probably does himself and others a disservice in attempting to write about it. The excuse, as well as the explanation, is an inadvertent promise, made at an unguarded moment, to do so.

Is any essential change in the organization of medical service needed? Perhaps a counter-question may help to answer it. Is everything essentially right as the service is now being rendered? Those who believe affirmatively of the second question must hold negatively as to the first. It seems difficult however to except the pleasant thought that "all is well" or even that "all is as well as can be expected."

Are the defects of our service essential defects? If so, is it possible to correct them without essential change in the "organization of the service," —a phrase which I take to refer to the manner and efficiency of delivering the service.

The Service is the main thing: that it shall be good service and that all people who need it shall get it. That is to say, it is a question of quality and of distribution. But the best of food kept in the original containers does nobody any good. On the other hand, bad service, widely distributed, may do much harm. The more widely one distributes stale meat the greater the damage from ptomaine poisoning.

The chief danger of "Socialized Medicine," and the basis of my own consistent opposition to it, is that the quality of the service is likely to be lowered. Experience in other countries seems to justify that fear completely. There is no question that the distribution of the service is wider, but the benefits to those who are sick are open to question.

However, studies so far made appear to confirm three points: (a) That the total sum paid to doctors for professional service is not excessive and can not be materially lessened; but (b) that the incidence of the financial burden is in a very large number of instances very severe; and (c) that a considerable unfilled need exists for medical service by those whose incomes make adequate payment therefor impossible. Points (b) and (c), while not "essential" defects in the sense that they are inevitable without essential changes in the principles under which we now work, are, nevertheless "important" defects.

May they be remedied without "essential" change in our traditional methods? I believe so.

Just what is "Socialized Medicine"? The sense in which the term is generally used and feared is that the relations between the physician and the patient will no longer be

within their own control; that the physician will cease to render his service at the direct and voluntary call of his patient,—and the patient, in turn will cease to pay directly to the physician the fee incident to the service; but that governmental "Bureaucrats," mostly non-medical people, will seize this control, and even say what service shall or shall not be performed, when and who shall perform it, how, and for whom. The expense of all this would be paid by the government.

No such "essential" change of our methods is necessary to remedy existing defects of distribution of our service. To think otherwise is to place "the cart before the horse," unless we are prepared to go all the way into socialism.

After all, we must not get too far away from the time-tested tradition that "Each tub must sit on it's own bottom." But the "bottom" should be afforded something solid upon which to rest. Of what should that solid "something" consist?

First, useful work for every one who is able to work. Remember, education for the young is useful work; also, that the housewife who keeps a happy home for her family does useful work. But those who should be income-earners should have that *continuous* opportunity. And, second, the pay should be fair, simply just—no more and no less. To some of us these favorable conditions may be regarded as already existing. Others who do not agree that they do exist may ask, "How do you expect to bring them about?" At the beginning I admitted that I do not "know all the answers." That problem is not confined to medical service. Let the labor leaders, the financiers, the industrialists, the columnists, the economists, particularly the columnists and the economists, since they seem to think they "know all the answers," let these people answer us. (For those who are interested in this phase of the discussion I commend "A Test for American Business," by James Truslow Adams, abstracted in the March, 1937, Reader's Digest.)

However, with the requirements as to work and pay met, still more may reasonably be done. The people involved may be encouraged to participate in the prepayment of sickness-hazards. Governmental agencies, similar to that of the Veterans' Bureau, could work out the problem on an actuarial basis. Private profits and large salaries eliminated, the costs should be greatly cut. Participation should be voluntary, but through education and sincerity of management, the advantages could be made so obvious that only a few congentially irresponsibles will fail to avail themselves of it. No compensation for loss of time should be involved in the contract. The "policy" should belong to the patient exactly as does the privately-purchased health policy, which most of us deem it wise to carry. The patient should be as free in the choice of his physician as if the policy were purchased from a private underwriting concern. Proper and fair total time limits for illness during a given period, and the total amounts of money available to pay the physician, should be set out in the contract. No government subsidies, except for education and administration, are necessary.

As to the particular governmental agency, the problem is so obviously national in its scope as to compel the conclusion that these functions belong properly to the Federal Government. Responsibilities of government, national in their nature, such as the post office or the army, if they are to be effectively handled must be handled by the National Government.

So far we have discussed the means by which self-sustaining, and reasonably prudent, people may protect themselves by prepayment of at least a large part of their probable sickness-hazards. It remains to deal with

the class of citizens whose incomes are perpetually inadequate. The burden of medical care for these people has consistently fallen upon the shoulders of the Medical Profession. This is as illogical as that the butcher should supply their meat, the clothier their wearing apparel, the barber their tonsorial needs. For these a frank recourse to the public treasury is necessary. The mode of administering the work will be variable. To the extent necessary for teaching purposes there can be little objection to public clinics. Beyond that, however, these patients should be treated individually by physicians of their own choice, and these physicians should receive directly from the government adequate compensation for their services.

The official public health services, I believe should include education, sanitation, the control of contagious diseases, and such other activities as may clearly be more effectively handled by public agencies. Public health nursing, properly regulated, could well be extended. But control should be more largely by members of the Medical Profession. The service of these nurses should always be subject to, and under the direction of, the physician in charge of the individual patient. Nurses in such service should act as assistants to the physicians, and should assume none of the functions of the latter except those delegated to them by the physicians themselves.

Group clinics, properly conducted, ought to conduce to the improvement of our service. The work could be better integrated; needless duplications and other expenses could be lessened, and these savings could be passed on to the public. But there is always the possibility of such groups becoming "commercially minded."

Is it desirable that the Medical Profession should control standards, public health appointments, etc.? To a very great extent, yes. This end, however, should be sought through our influence upon medical teaching institutions, hospitals, and public medical boards, official and unofficial. All agencies vested with authority and responsibility in connection with the health of the people should consist very largely of medical men.

EDUCATORS ENDORSE OPHTHALMOLOGISTS

Resolution Adopted by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association

February, 1937

Whereas, The eyes and the sight of the school child are of the most vital importance for satisfactory school work, and their preservation for future health and efficiency depends upon their wise conservation during childhood; and

Whereas, The school has a grave responsibility for the conservation of eyesight among school children; and

Whereas, School administrators in many parts of the United States are frequently besieged with demands for admission into their school systems of eye examinations and eye-glass prescriptions by practitioners other than qualified doctors of medicine; and

Whereas, The eye, as an organ of vital necessity, requires careful conservation and deserves treatment only at the hands of trained and competent persons; and

Whereas, Teachers and nurses properly may and often do make rough tests of visual acuity in the classroom, but diagnosis of diseases of the eye and of disturbances of vision requires more extensive examination and often involves treatment other than the mere fitting of glasses; and

Whereas, Even the fitting of glasses often requires the paralysis of accommodation through the use of

drugs popularly known as "drops"; now therefore be it

Resolved, That it is the sense of the Joint Committee on Health Problems in Education of the National Medical Association and the American Medical Association, in meeting assembled at New Orleans, February 23, 1937, that the safety of the eyes of school children, the adequate diagnosis of disease and the correct fitting of glasses require examination of children's eyes (beyond rough visual tests performed by teachers or nurses) by a licensed doctor of medicine and, upon his recommendation, by a medical specialist in diseases of the eye, properly known as an oculist or ophthalmologist

VITAL STATISTICS

The following statistical data is vital only as it pertains to the year of graduation and licensure of the members of the Mahoning County Medical Society. For this purpose, the membership list was broken up into the year of graduation from Medical School and after each name is affixed the year in which license was issued, all derived from the 1934 A. M. A. directory.

The more recent years are presented first. Each year of the 20th century is represented by at least one member. Solly Hartzell stands alone in the 1901 trench. We continue unfalteringly down to 1894, then too, 1892, '91, have no representatives. There is a group of three from 1888, one 1887, one 1885 and one 1880. Who they are is revealed in the tabulation.

This month we are publishing the last ten years' classes.

1933

Cafaro, S. R. L34
Belinkey, M. H. L34
Kauffman, H. B. L33
Mahar, P. J. L33
McReynolds, C. A. L34

1932

Rosenblum, M. L32
Schwebel, S. L32
Tims, W. J. L32

1931

Couchman, L. L31
Dulick, J. F. L32
Hall, Jos. C. L32
Hall, Raymond L31
Kling, H. L31
Kupec, J. B. L32
Miglets, A. W. L31

1930

Axelson, O. A. ..... L?
Odom, R. E. ..... L?
Sisek, H. M. L30
Warnock, Charles L30

1929

Altdoerffer, J. A. L33
Brandt, A. J. L29
Klatman, S. J. L29
Moyer, L. H. L29
McElroy, W. D. L29
Noll, John L30
Scarnecchia, J. L. L30

1928

Banninga, H. S. L29
Brown, J. D. L29
Golden, T. K. L28
Malock, L. J. L30
Mermis, W. O. L29
Nardacci, N. J. L29
Russell, J. M. L29
Young, W. P. L30

1927

Birch, J. E. L30
Boyle, P. L. L30
Fusco, P. H. L27
Lowendorf, C. S. L31
McConnell, P. R. L28
McCann, J. N. L29
Neidus, M. W. L27
Nelson, G. G. L27
Tamarkin, Saul J. L27
Vance, J. A. L27
Weidermier, C. H. L28

1926

Hathhorn, H. E. L26
Lawton, O. M. L26
McOwen, P. J. L26
Weller, L. W. L30

1925

Buchanan, J. R. L27
Cavanaugh, J. M. L25
Colla, Jos. L26
Curtis, W. S. L30
Deitchman, M. L25
Montani, A. C. L25
Tamarkin, Sam L25
Smith, I. C. L25

1924

Berkson, M. I. L25
Goldstein, M. B. L24
Kaufman, P. M. L24
Marinelli, A. ..... L?
Stewart, W. K. L24
Wenaas, E. J. L24

SECRETARY'S REPORT

The Post Graduate Day has been experienced again. The Post Graduate Day Committee with Dr. Gordon Nelson as its chairman are greatly commended by the society for the successful management of this event. Much effort and planning is necessary to bring an event of that proportion to a successful conclusion. The displays at the booths show evidence of the confidence that business houses have in us. It is fitting that we should plan our buying of supplies that those who support us will be enhanced by our purchases.

The program was given by a group of authorities. It is certain that the various attending physicians added to their store of knowledge and technique by having listened to these lecturers. Problems are made clearer by explanation from masters. These men are truly masters of their respective fields of work. To this entire group of speakers from the University of Michigan, namely Dr. A. C. Furstenberg, Dr. Frank N. Wilson, Dr. Frederick A. Coller, Dr. Cameron Haight, and Dr. John Sheldon, the membership of Mahoning County Medical Society extends sincere thanks for their efforts to make the day complete.

At the end of the days session a telegram from the executive secretary of the State Association, Charles Nelson, was read to the audience. He explained that the Osteopathic Bill would be voted on the following day. At this point the Legislative Committee Headed by Dr. O. J. Walker drew up a resolution to send to Senators Seidner and Lipscher. The resolution reads as follows:

"Be it Resolved that the physicians assembled at the Tenth Annual Post Graduate Medical Assembly of the Mahoning County Medical Society, comprising some 400 physicians practicing in the eastern portion of Ohio, go on record opposing the passage of the osteopathic bill by the Ohio Senate."

This we respectfully present to you and ask that you vote against this bill.

This Osteopathic Bill has caused a great deal of fight in the Ohio General Assembly during this session. It is known as Senate Bill 132.

The sponsors of this proposal counted noses and discovered they did not have enough votes to pass the bill. By skillful maneuvering and playing on the sympathy of some members of the senate who were on the spot sponsors of the bill succeeded in having it recommitted to the Senate Health Committee. The impression was left with many members of the Senate that this would be virtually "Death" for the bill. Overnight the Substitute Senate Bill 132 was drafted and presented to the Senate Health Committee. Before those who had opposed the original bill had an opportunity to even see a copy of the Substitute Bill, a motion to report out the Substitute Bill was made and adopted by the committee.

The Substitute Bill has several objectionable features and assemblymen should be informed of them at once.

The entire membership of the Mahoning County Medical Society deeply regret the passing of Dr. James A. Sherbondy. Dr. Sherbondy had made an enviable record in the field of surgery. His skill and mastery of his work at the operating table was rarely surpassed. He had many admirable characteristics and his loss to the community is keenly felt.

ROBERT B. POLING.

Answers to the Medical Crier's Questionnaire

1. Refers to passage through the stomach.
2. Plucking at the covers. Cotton picking, unless they are wool.
3. You need an antispasmodic for hiccups.
4. Vesalius.
5. Swinburne.
6. Old term for herpes of the scalp.
7. Benjamin Rush.
8. Cuba.
9. First, do no harm. We were only kidding about the others.
10. The Medical Schools.

PROGRAM COMMITTEE REPORT

For the June fifteenth meeting, the regular monthly meeting of the county society, the program committee has invited the internes of the hospitals of the city to put on a program. This is in place of the local talent meeting.

The internes have been asked to present a protocol of a case which has been well worked up and in which the diagnosis has been ascertained. The time for each presentation has been sharply limited.

The case presentations are to be judged solely on the basis of presentation and not on the basis of rarity of the pathology presented.

In order to arouse slightly more interest, the society, through the president, has authorized the presentation of two prizes for the best and next-best protocol presented.

This program is organized with the distinct feeling by the committee that too little effort is being paid in encouraging our younger men to do work of a scientific nature. We expect the society to loyally support this venture and we are counting on the internes for a most excellent meeting.

Application for Membership

The following application for associate membership to Mahoning County Medical Society was acted upon favorably by Council:

C. W. Sears, M. D., 3027 Market St., Youngstown, Ohio.

Should there be any objection to this applicant, present same in writing to the Secretary of the Society within 15 days.

NEWS NOTES

The Bunscombe County Medical Society, Asheville, N. C., proposes an Institute in Tuberculosis this summer, probably in July, to consist of a week of practical demonstrations and discussion of the many phases of the Disease.

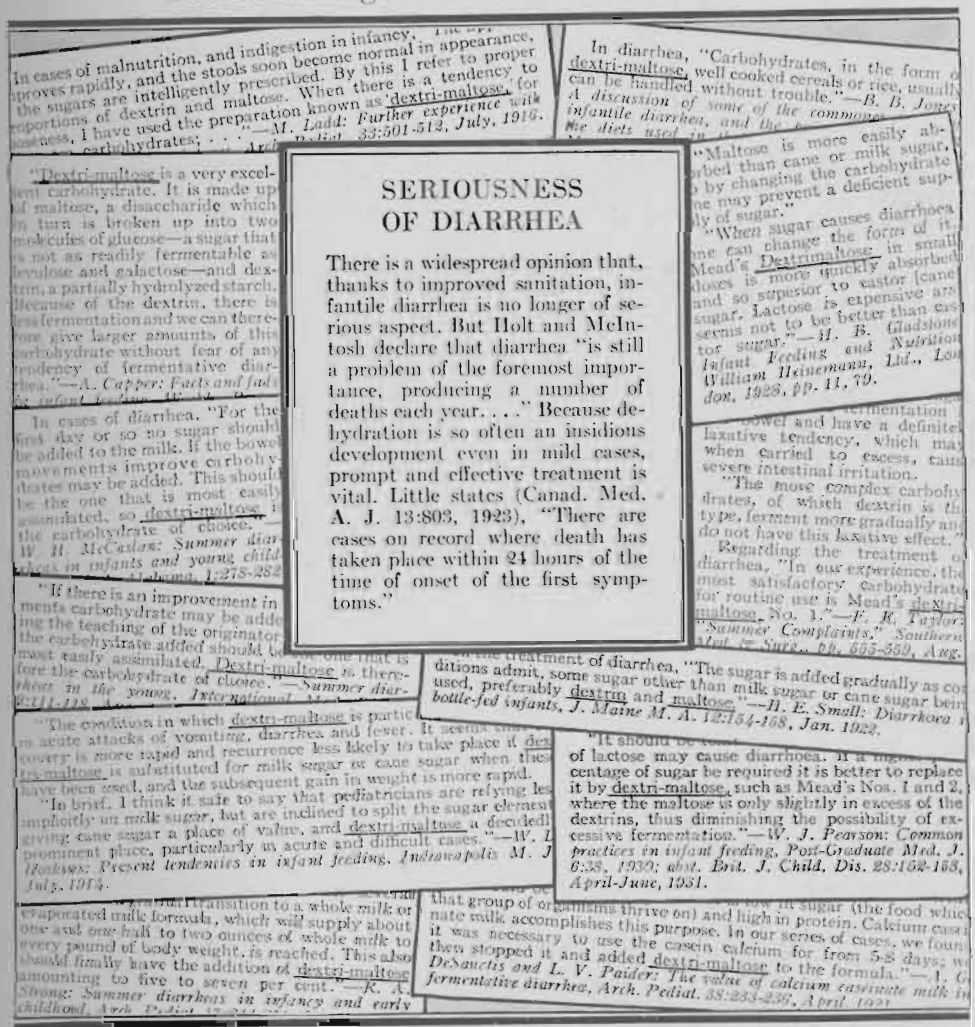
Anyone interested, may obtain further details by addressing the secretary, Dr. G. W. Kutscher.

DIARRHEA

"the commonest ailment of infants in the summer months"

(HOLT AND McINTOSH: HOLT'S DISEASES OF INFANCY AND CHILDHOOD, 1933)

One of the outstanding features of DEXTRI-MALTOSE is that it is almost unanimously preferred as the carbohydrate in the management of infantile diarrhea.



Just as DEXTRI-MALTOSE is a carbohydrate modifier of choice, so is CASEC (calcium caseinate) an accepted protein modifier. Casec is of special value for (1) colic and loose green stools in breast-fed infants, (2) fermentative diarrhea in bottle-fed infants, (3) prematures, (4) marasmus, (5) celiac disease.

When requesting samples of Dextri-Maltose, please enclose professional card to cooperate in preventing their reaching unauthorized persons. Mead Johnson & Company, Evansville, Indiana, U. S. A.

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BREAST MILK from the Normal Mother is the IDEAL FOOD for the HUMAN INFANT . . . That is Why S. M. A. is Made to RESEMBLE BREAST MILK

in percentages of carbohydrate, protein, fat and total salts (ash) content, and why even the chemical and physical constants of the fat in S. M. A. are like those of breast milk fat. This resemblance makes it easy to start the infant on supplementary feedings of S. M. A., gradually shifting over to complete feedings of S. M. A. The physician finds S.M.A. simple to prescribe and the mother gratefully finds it simple to prepare. Physicians are invited to write for samples and literature.

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