There is no peace and quiet except that which reason has contrived.

—*Seneca*

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
VOL. XX No. 5
MAY • 1950

"In addition to the relief of hot flashes and other undesirable symptoms (of the climacteric), a feeling of well-being or tonic effect was frequently noted" after administration of "Premarin."

Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944.

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943.

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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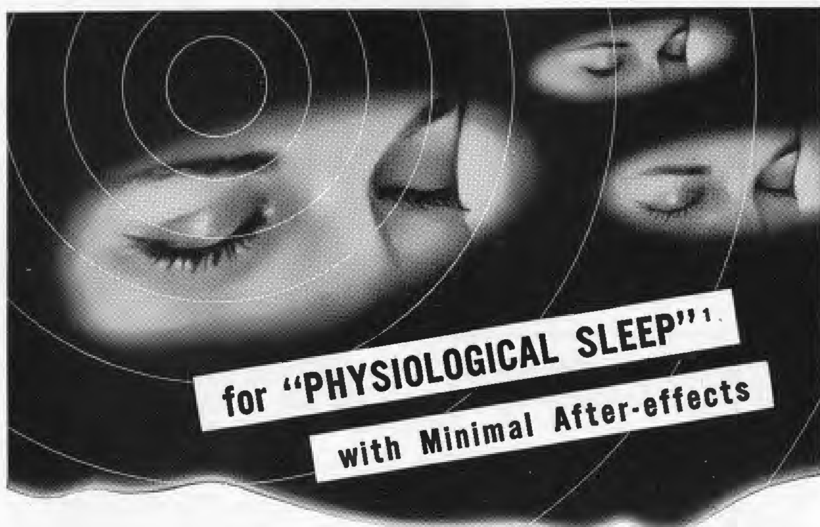

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[1]N.N.R., 1947, p.398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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MEDICAL CALENDAR

1st Tuesday 8:30 p. m.	Monthly Staff Meeting, Youngstown Hospital, Auditorium—Nurses' Home Monthly Staff Meeting, St. Elizabeth's Hospital, St. Elizabeth's School of Nursing
Sunday following 1st Tuesday 11:00 a. m.	Monthly Surgical Conference, St. Elizabeth's Hospital Library
2nd Monday 9:00 p. m.	Council Meeting—Mahoning County Medical Society—Office of the Society—Schween-Wagner Bldg.
2nd Tuesday 11:30 a. m. 8:30 p. m.	Monthly Medical Conference, Youngstown Hospital, Auditorium—Nurses' Home American Academy of General Practice, Youngstown Hospital Auditorium—Nurses' Home
3rd Tuesday 8:30 p. m.	Monthly Meeting—Mahoning County Medical Society—Elks Club, 220 W. Boardman St.
4th Tuesday 8:30 p. m.	Monthly Staff Meeting—Tuberculosis Sanitarium, Kirk Road
Every Tuesday 8:00 a. m.	Weekly Medical Conference, St. Elizabeth's Hospital Solarium
Every Tuesday 11:00 a. m.	Orthopedic Conference, St. Elizabeth's Hospital Library
Every Tuesday 3:30 p. m.	X-ray Conference, South Side Unit, Youngstown Hospital
Every Thursday 12:30 p. m.	Orthopedic Section, Library—South Side Unit, Youngstown Hospital
Every Friday 11:00 a. m.	Clinical-Pathological Conference, St. Elizabeth's Hospital Library
Every Friday 11:30 a. m.	Clinical-Pathological Conference, Auditorium Nurses' Home, South Side Unit Youngstown Hospital
Every Friday 2:00 p. m.	Conference—X-ray Dept., St. Elizabeth's Hospital
11:00 a. m. Alt. Saturdays	Obstetrical Section—North Side Unit of Youngstown Hospital

COMING MEETINGS

American Medical Association, San Francisco, Calif., June 26-30.

American Diabetes Association, San Francisco, June 24-25.

American College of Radiology, San Francisco, June 25.

American Heart Association, San Francisco, June 22-25.

PRESIDENT'S PAGE

The American Medical Association, reacting to public clamour, is starting a thorough nation-wide investigation of the complaint of overcharging. It is setting up the organizational machinery to handle such complaints against doctors. Perhaps it is better that the Doctors' own organization starts an investigation of this kind before our government sets up a similar plan.

I think we are all agreed that the matter of a fee is really something which should be settled between the doctor and his patient, and in most instances it is settled that way. In view of the sniping at the medical profession which is going on quite generally, it behooves us to take stock and see if we can do something to improve the situation.

The Board of Trustees of the American Medical Association adopted a resolution recommending the establishment of grievance committees to hear complaints of overcharging. It has also been recommended that these grievance committees be established at the county society level. This has been carried out in our society, and any complaint should be lodged with the Secretary and proper action will be taken. For reasons which should be obvious to all, the names of the members on this committee will not be published. It is to be hoped that all the members of the Society will make every effort to get together with their patients on matters involving fees. This is one field in which we can establish good public relations with the public at large.

GORDON G. NELSON,
President

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

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275 W. Federal St.

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OHIO STATE MEETING

The annual scientific and business session of the Ohio State Medical Association, a 104-year old organization of Ohio's doctors of medicine, will be held May 16, 17, and 18 in Cleveland with 2,500 physicians attending the meetings in the Cleveland Public Auditorium. The House of Delegates, governing body of the Association, will convene at the Hotel Cleveland.

Senator Robert A. Taft of Ohio, guest speaker at a general session, Wednesday morning, May 17, will discuss "Progress in Medical Care." Sharing the rostrum with Senator Taft will be Dr. George F. Lull, Chicago, Secretary and General Manager of the American Medical Association. Dr. Lull will speak on the activities of the A. M. A.

Scientific aspects of the program will include 14 instructional courses, dealing with the handling of problems arising in everyday medical practice; and panel discussions, entitled "Medical Topics of the Day," which will deal with diagnosis and treatment of diseases seen less often by the average physician. In addition, 13 physicians, five of whom are from other states, will discuss current medical advances at general sessions of the convention.

Approximately 140 exhibits showing latest developments in pharmaceuticals and medical equipment, as well as current medical findings in medical research, will be viewed by those attending the meeting.

While the physicians are attending the business and scientific sessions, their wives and daughters will be participating in the annual meeting of the Woman's Auxiliary of the Association, which will be held at the Hotel Cleveland.

Among those expected to represent Mahoning County at the meeting are the following Youngstown physicians: Dr. William M. Skipp, a past-president of the State Association, a member of the state-wide Committee on Medical Service Plans and the Sub-Committee on Legislation, Dr. V. L. Goodwin and Dr. I. C. Smith, also a member of the State-wide Committee on Medical Care of Veterans. All three are official delegates. Their alternates

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are Dr. R. E. Odom, Dr. C. A. Gustafson, and Dr. J. C. Vance (Poland). Dr. Gordon G. Nelson, president, and Dr. G. E. DeCicco, secretary, also will attend.

Other members of State Association committees expected to attend are Dr. Horace K. Giffen, committee on scientific exhibits, Dr. E. J. Wenaas, committee on judical and professional relations, and Dr. O. M. Lawton, committee on mental hygiene.

Youngstown physicians who will participate in the scientific program as guest lecturers, instructors or discussants are: Dr. Frederick S. Coombs, Dr. William H. Evans, and Dr. A. J. Fisher.

COUNCIL MEETING

April 10, 1950

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, April 10, 1950, at the office of the Society, 203 Schween-Wagner Building, Youngstown, Ohio. The following doctors were present: G. G. Nelson, president, G. E. DeCicco, C. A. Gustafson, J. N. McCann, W. M. Skipp, E. J. Wenaas and R. E. Odom.

The following application was acted upon favorably by council:

FOR ASSOCIATE MEMBERSHIP

Merrill D. Evans, M.D.
Youngstown Receiving Hospital
Youngstown, Ohio

Unless objection is filed in writing with the secretary within 15 days the above applicant becomes a member of the Society.

Dr. McCann asked Council if it would be interested in piloting the study of home care for Tuberculosis patients in Mahoning County.

A motion was made, seconded, and duly passed giving Dr. McCann support and authority to preceed with such a worthwhile project.

Dr. Odom discussed the reaction of some of our members to the report of his committee that was submitted to the Co-Ordinating Council. The many discussions, especially in the staff rooms, have brought to light the fact that some of our members are not only unfamiliar with the contents of the report, but with what is actually going on with reference to Out-Patient Departments.

Council discussed, and deemed advisable, a monthly news letter to bring to the attention of our members, pertinent facts on up-to-the-minute questions.

G. E. DeCicco, M.D.
Secretary

APRIL MEETING

A new type of program was presented at the monthly meeting of the Society April 18 in the Elks' Club when four residents from local hospitals presented original papers.

The Essayists were Drs. Edward Massullo and Hugh B. Munson of St. Elizabeth's Hospital and Drs. J. G. Rogers and Frank K. Inui of the Youngstown Hospital Association.

The names of Drs. F. J. Schellhase, Hugh B. Munson, S. A. Lerro were read as applying for interne membership. Dr. Gordon G. Nelson presided.

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1. Jolliffe, N., Special Article, Council on Foods and Nutrition: The Preventive and Therapeutic Use of Vitamins, J.A.M.A., 129:618, Oct. 27, 1945.
2. Lewey and Shay, Dietotherapy, Philadelphia, W. B. Saunders Co., 1945, p. 850.

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ST. ELIZABETH'S HOSPITAL STAFF MEETING

The regular monthly staff meeting of St. Elizabeth's Hospital was held on April 4, 1950. The meeting was called to order at 8:30 p. m. by Dr. R. B. Poling, President of Staff.

The medical department presented the review of a 30-year-old white male with chronic glomerulonephritis with Dr. L. Caccamo, medical resident, relating the case history. Dr. M. M. Szucs eleborated on the pathological physiology of the disease, emphasized the differential diagnosis of glomerular and tubular damage and cited the utilization of simple laboratory procedures in such differentiation. He added that close attention should be paid to the history of acute respiratory infections in cases without a definite finding of chronic nephritis.

The surgical department presented the case history of a 75-year-old white female with a perforating carcinoma of the stomach and complicating peritonitis. After simple closure, performed shortly after admission, the patient expired on the fifth post-operative day from mesenteric thrombosis. Dr. L. Luchette, surgical resident, related the case history and clinical course and discussion was led by Dr. M. J. Kocialek.

Dr. Saul J. Tamarkin, chairman of the library committee, gave a report on library facilities and stated that cataloging and indexing had been completed. He elaborated on the new procedure in signing out texts and periodicals.

The secretary presented an analysis of hospital service for the month of March. Significant features were a bed occupancy of 90.7%, average day residence per patient 8.3, autopsy rate of 37.7% and average hospital census per day of 347.

Dr. R. V. Clifford, acting president of the Ex-Interne Association, announced that there would be a re-union of the members of the association sometime in June. Arrangements were nearly complete for an outstanding speaker to address the group following which plans for usual entertainment would be carried out. Stephen W. Ondash, M.D. Secretary

YOUNGSTOWN HOSPITAL STAFF MEETING

Members of the staff of the Youngstown Hospital Association were treated to a critique of the techniques of amputation in the application of prosthesis by Mr. Joe Spievak at the regular monthly meeting April. 4.

Mr. Spievak, a Youngstowner who has a national reputation for his work in fitting articificial limbs, outlined the conditions for proper stumps and told of the best sites of election for amputation. He pointed out that proper post-operative care with bandaging of the stump meant that the artificial leg could be fitted within three to four months, thus returning a wage earner to his work.

Exercises early would prevent flexion deformities, he pointed out. He also said that physicians should prepare patients mentally for the application of a prosthesis.

He illustrated his talk with movies showing how willow wood is cut, seasoned, and finally fashioned into the tailor-made appliances. The movies also contained glimpses of the rehabilitation measures made for various types of amputees and the progress individual amputees have made in learning to use their appliances.

Statistical report of the Hospital for the month of March showed 74 deaths and 37 autopsies for a percentage of 50.

Dr. W. K. Allsop presided at the meeting.

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MEDICAL CARE OF CIVILIAN EMPLOYEES CONSOLIDATED

A new directive by Defense Secretary Johnson puts the three Surgeons General in direct charge of supplying medical service to the armed forces' 400,000 civilian employees in the United States. A small saving will be effected, but economy is not the reason for the shift, according to the Office of Medical Services, which will have overall administrative, technical and professional control of the program.

The main objectives are to set up a uniform system of medical care for civilian employees of the three services, and to bring the program directly under control of the medical departments. The change is effective on July 1. Currently a dozen or more departments and agencies are involved in furnishing medical care to these civilian employees.

T.B. STAFF TO HOLD ANNUAL DINNER

The medical staff of the Mahoning Tuberculosis Sanatorium will hold its annual staff dinner meeting Tuesday, May 23, 1950 at the Sanatorium.

Dr. Robert Anderson, chief of the Division of Tuberculosis, Public Health Service, Washington, D. C., will be the speaker for the occasion.

Cards for reservation will be mailed to all interested physicians.

CHEST PHYSICIANS TO MEET

The Sixteenth Annual Meeting of the American College of Chest Physicians will be held at the St. Francis Hotel, San Francisco, California, June 22 through 25, 1950. An interesting scientific program has been arranged for the meeting.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in San Francisco, June 22, 1950. Candidates for Fellowship in the College who would like to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

NEWS

Four members of the county society have been patients in the local hospitals during the last month. Dr. John R. Buchanan, has been fighting a chronic affliction in the North Side Unit. At the South Side Unit were Drs. Howard C. Miller, G. A. Parillo, and W. J. Flynn.

The following members attended the meetings of the American College of Physicians in Boston, April 17-21: W. S. Curtis, H. E. Hathhorn, J. P. Harvey, R. M. Kiskaddon, J. D. Miller, M. S. Rosenblum, and F. S. Coombs.

Dr. J. P. Keogh attended the meetings of the American Association for Thoracic Surgery, Denver, Colo., April 15-19.

Drs. William Newcomer and H. H. Teitelbaum attended the National Tuberculosis Association meetings in Washington, D. C., April 25-27.

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ANNUAL MEETING OF TUBERCULOSIS ASSOCIATION

Two hundred fifty members and guests of the Mahoning County Tuberculosis and Health Association attended the Annual Meeting of the Association held Tuesday, March 28, at the Poland Memorial Methodist Church. Representatives from the Public Health Nursing Staffs and Health Departments attended from Summit, Stark, Columbiana, Lawrence, Mercer and Trumbull Counties as guests of the Association.

Three awards to Mahoning County students were made for their participation in the 13th Annual Scholastic Press Contest sponsored jointly by the National Tuberculosis Association and the Columbia Scholastic Press Association. Miss Nancy Luce of Struthers won first prize of $25 in the state for her article in the *Struthers Student Prints*, Miss Barbara Ann Webster of Youngstown won first prize of $10 in the Junior High Cartoon entries for her cartoon in the *Hayes Hi-Lite*, and Miss Judith Chimielewski, of Poland, won third prize of $5 for third place in the Elementary School contest for her article in the *Poland Union School Chatterbox*. National Awards of Merit were presented to O. J. Gabriel, Supt. of Struthers School, from the National Tuberculosis Association and the Columbia Scholastic Press Association for national recognition of the *Struthers Student Prints* and a similar award was presented to G. M. Barton, Supt. of the Poland Schools, for the *Poland Union Chatterbox*.

Dr. Harry A. Wilmer, author of "Huber the Tuber" and speaker of international reputation, spoke on the "Psychological Aspect of Tuberculosis as It Affects People of Our Community as well as the Patients." Dr. Wilmer, who is no orator, spoke with feeling and conviction from his own experience as a tuberculosis patient and from subsequent observation. Dr. Wilmer is a psychiatrist and is now head of the Neurology-Psychiatry Department of the Palo Alto, California, Clinic. Dr. Wilmer is a graduate of University of Minnesota Medical School. He completed graduate study in pathology at the University of Minnesota and Johns Hopkins University and was associated with the Mayo Clinic before going to California.

Dr. Wilmer emphasized the psychological aspects of illness in general and of tuberculosis in particular because of the frequent long bed rest required and limited activity even when recovered. He stated that breakdowns and re-admissions were all too often caused by a complete indifference to the patient's personal problems by the medical authorities rather than lack of adequate medical care. He pleaded for a more personal approach on the part of doctors and nurses and highly commended Dr. Newcomer for his development of the extra-medical services at the Mahoning Sanatorium to help relieve the monotony and to direct the patient's activity toward his eventual rehibilitation, both physical and vocational. Dr. Wilmer advocated kindly explanation of all phases of treatment so that the patient could cooperate and understand what was being done for him.

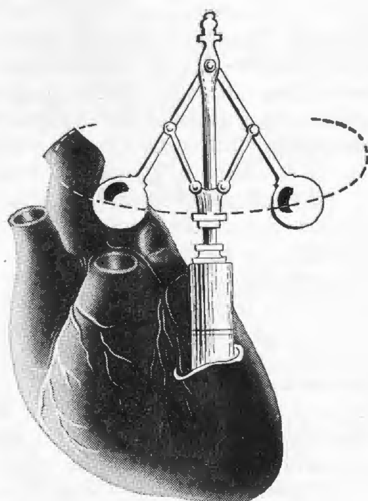
Whitney H. Herr, Sec'y
Tuberculosis and Health Ass'n

SUMMIT SOCIETY TO HOLD ARTHRITIS SYMPOSIUM

The Summit County Medical Society will present a symposium on "Rheumatoid Arthritis" at its monthly meeting Tuesday, June 6, 1950, at nine p. m. in the auditorium of the Nurses' Home, Akron City Hospital.

Speakers for the meeting will be Dr. Howard P. Doub, radiologist-in-chief, and Dr. Dwight C. Ensign, director of the arthritis clinic, both of the Henry Ford Hospital, Detroit, Mich.

For governed maintenance...



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TUBERCULOSIS CONTROL IN MAHONING COUNTY (PART II)

By William Newcomer, M.D.

The heart of the tuberculosis control program is the Central Case Register which is a complete file of all known or suspected cases of Tuberculosis in Mahoning County. The Central Registry is operated in connection with the Chest X-Ray Center at 100 Dollar Bank under the supervision of Miss Peggy O'Neill, Registrar.

Every patient or suspect is followed by the Controller through the family doctor or the Public Health Nurse until a diagnosis indicates or eliminates tuberculosis. Ex-TB patients are followed through the case register at periodic intervals to determine their current physical condition. This procedure frequently necessitates a report from the family doctor. Every effort is made to simplify the reporting procedure and all physicians are urged to check the reports concerning their patients and return them promptly.

The Case Register is a valuable tool in following the progress of each individaul case of tuberculosis. It is an invaluable asset in securing a statistical picture of tuberculosis control procedures and evaluating the effectiveness of current control methods. Too frequently after a patient learns that he has pulmonary Tuberculosis he will not return to his family doctor but will consult another and with-hold the fact that he has pulmonary disease. If this patient is not listed on the Case Register the fact that he has pulmonary Tuberculosis will often be lost and he will go along infecting others. In the case of inactive pulmonary Tuberculosis not checked at frequent intervals, reactivation may occur without the patient's knowledge, and by the time he is aware of this the disease maybe too far advanced to receive much help.

Every case of known pulmonary Tuberculosis should be x-rayed at least once a year; many patients may require shorter intervals.

Your cooperation in returning inquiries is earnestly requested and greatly appreciated.

OHIO TB AND HEALTH ASSOCIATION

The Ohio Tuberculosis and Health Association will hold its 32nd annual meeting at the Neil House, Columbus, June 1, and 2. Azel Ames, M.D., Hamilton, president of the Association, will preside.

The two-day program will center around the voluntary health agency and ways and means by which it can stimulate the provision of better public health service in the county and state.

Thomas D. Dublin, M.D., Executive Director of the National Health Council, Dr. Robert Bloch, Professor of Medicine, University of Chicago, and Gerald G. Gross, editor of the "Washington Report on the Medical Sciences," will be featured speakers.

Joseph B. Stocklen, M.D., Cleveland, is first vice president of the Association, and Charles A. Doan, M.D., Columbus, is secretary.

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OHIO TRUDEAU SOCIETY FORMED

A group of interested physicians have formed an Ohio Section of the American Trudeau Society. The decision to form this section grew out of a desire on the part of lay workers in the tuberculosis field and physicians interested in tuberculosis and allied chest diseases to work together in greater harmony through a better understanding of the problems of each.

The first meeting of the group was held May 19, 1949, at the Neil House in Columbus. It was decided that the Ohio Section should be formed and that the American Trudeau Society should be petitioned for permission to so form.

John A. Prior, M.D., The Ohio State University, Columbus, was elected temporary chairman. Approval of the petition was given by the American Trudeau Society on December 9, 1949.

The full support of the finances and staff of the Ohio Tuberculosis and Health Association was offered the new group. It was decided that the Ohio Trudeau Society should act as the medical section of the Ohio Tuberculosis and Health Association in much the same relation the American Trudeau Society is to the National Tuberculosis Association.

The first regular meeting since the application for charter was approved will be held at the Neil House in Columbus on June 1, 1950 at the same time as the annual meeting of the Ohio Tuberculosis and Health Association. Interested physicians are invited to submit short papers on tuberculosis and allied diseases of the chest.

All physicians are invited to attend. Communications relative to the meeting may be directed to the Ohio Tuberculosis and Health Association, 1575 Neil Avenue, Columbus 1, Ohio.

T.B. IN MAHONING COUNTY

"In 1948 Mahoning County had 90 deaths from tuberculosis for a rate of 33.8 per 100,000 which was 3.8 above the national average. 189 new cases were discovered and reported in 1948, or a ratio of 2.10 per death. The discovery of new cases in Ohio was 4.3 per death. One third of tuberculosis deaths in 1948 were not known to be caused by tuberculosis until the death certificate was filed. Two thirds of the persons being admitted to the Tuberculosis Sanatorium are still far advanced tuberculosis. We have not yet begun to find tuberculosis in its early or minimal stages in Mahoning County." — E. J. Reilly, M.D., President, Tuberculosis Association.

SHORT - SHORT STORY

The Charlotte (N. C.) News tells the story. A Charlotte doctor invited one of his friends, a real estate man, to a public meeting on socialized medicine. The friend said he couldn't make it.

"Why, aren't you alarmed at the threat of socialized medicine?" asked the doctor. "Sure," said his friend, "but where were you doctors all these years the real estate men have been fighting socialized housing?"

The doctor had no answer for that.

Everybody lets every interest fight its fight alone. The doctors fight socialized medicine, the real estate men fight public housing, each business or industry fights its own battle against government encroachment. But never together.

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MAY MEETING

★ ★ ★ ★

There will be a joint meeting of the Mahoning County Medical Society and the Youngstown Area Heart Association

TUESDAY, MAY 23, 1950

ELKS CLUB

Starting Time

4:45 P. M.

Speaker:

David D. Rutstein, M.D.
Professor of Preventive Medicine
Harvard University School of Medicine

Subject:

"Preventive Aspects of Heart Disease"

ALSO SAME DAY

ANNUAL DINNER MEETING

Mahoning Tuberculosis Sanatorium

6:30 P. M.

Speaker:

Robert J. Anderson, M.D.
Chairman of Division of Tuberculosis
U. S. Public Health Service

Dr. Anderson's address will cover several phases of Tuberculosis

ALL OF US

Here all of us are, facing the last February of the first half of the twentieth century. A few days after you receive this issue of Farm Journal I shall be observing another birthday. Since I was born in the nineteenth century, before another twenty-five years roll by I may be old enough to write reminiscences. So this month let me be old and cantankerous and pessimistic, and imagine that I am already twenty-five years older. Would I, perhaps, be writing notes like these?

★ ★ ★

February, 1975: I can remember clearly how, back in 1950, nearly every family had an automobile. People were putting television sets in their homes. New houses were being built by individual families. No one used ration coupons for anything, although some had been used during the second World War, and people knew what they were. All meat and grocery stores were then owned and operated by private individuals and companies, who competed with each other on price and quality.

★ ★ ★

March, 1975: My neighbor was arrested today and they say he will be sent to jail for two years. His sow raised a litter of nine pigs, but he reported only eight to the Meat Administration. He had managed to hide the other one from the farm inspectors, but some one found it out when he butchered the pig. He had hoped to give his four youngsters a little home-grown meat. The Meat Administration says that not nearly enough meat can be produced or imported, and that the ration must be reduced to a half-pound per week.

★ ★ ★

April, 1975: Our hens, encouraged by spring, laid an extra egg today. It would be nice to have two for breakfast again some morning, but it has become too dangerous to try to dodge the law. Besides, for many years now one egg a week has been the allowance, and we have got used to getting along. We never appreciated our good fortune when it was possible to have two eggs and bacon, too, every morning for breakfast, and even cream for our coffee. I remember how sorry I felt for the English, back in 1949, when they had only one egg a week.

★ ★ ★

May, 1975: I went down to the Lumber Administration today to apply for three two-by-fours to brace up the barn. Had to fill out three sets of application blanks, six copies of each, and to draw a diagram to show just where the pieces would be used.

June 1975: This morning I stood in line until noon before the Health Administration offices. Wanted to get the tooth pulled that has kept me awake most of three nights. I couldn't get in to see the clerk. Long ago, before we had this "free" medicine for everybody, one could generally find a doctor or dentist fairly quickly. They took a personal interest in our troubles. Now they just jot our number down in the book and hurry us through, if we get to see them at all.

★ ★ ★

July, 1975: The Fourth of July reminds an old fellow of his younger days, when we celebrated or not, according to how we felt. Today, as is usual now, everybody had to appear in town to listen to the official program, and watch and hear the President make his speech on the municipal television.

He ranted about freedom, like his father used to do, but what he says and what he does are two different things.

★ ★ ★

August, 1975: The Lumber Administration refused my application for the three two-by-fours. They said it was improperly made out.

★ ★ ★

September, 1975: I have been trying to figure out in my own mind just when these present conditions had their beginning. Some say it was when the government bought all the railroads. Next they took the coal mines, then the steel mills, then the truck hauling business, then the whole petroleum industry. They said they had to have the mines and the oil business to get fuel for the trains and trucks, and the steel mills to get enough steel for everybody. Just try to buy some now! Now the government runs nearly every kind of business, just as Russia did when I was a young fellow. Then production started going on down, and the country has been getting poorer ever since.

★ ★ ★

October, 1975: I think the beginning was further back. It might have been about 1936, when the politicians discovered they really could buy votes in quantities with borrowed public money, through the W.P.A. and other things. Some of the younger people now can't even remember when we used to have elections.

★ ★ ★

November, 1975: I've got it now. Our freedom began to be lost in 1913. That was the year the income tax amendment was ratified, The idea would have been all right, probably, if it had contained a provision that no more than one-fourth of any ordinary man's earnings could be taken in taxes, and no more than half of the biggest incomes. Since there were no limits on taxes the politicians eventually discovered that there were no limits on the amounts they could spend. They kept taking more and more from everybody to give more free help, until no one could save. Then there had to be still bigger pensions for us old people, and more government services of every kind. No one could save up for investment, so the government said it would have to take over business.

★ ★ ★

December, 1975: Kind of hard to be cheerful at holiday time. Can't help remembering the great days when every American out of jail was free and full of hope for the future.

★ ★ ★

July, 1976: Just two centuries ago the Declaration of Independence was adopted. Two hundred years! Years that saw the United States produce the highest standard of living that ever has been! And years that saw us, in my time, fritter away our freedom until all of us once proud Americans are no better off than serfs! Except the government crowd, of course.

★ ★ ★

August, 1976: They'll shoot me if I print these paragraphs. And suppress Farm Journal. After all, this isn't 1950 any more, when one could still say what he believed . . . All right, let 'em shoot!

★ ★ ★

Are my "reminiscences" exaggerated? I hope so. But I have mentioned nothing that doesn't happen today in England or Russia. And the U. S. A. has been faithfully following the English route. (By Wheeler McMillen, Editor-in-Chief, *Farm Journal,* Feb. 1950).

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A TECHNIQUE FOR CLOSURE OF POST-OPERATIVE BRONCHO-PLEURAL FISTULA

*Frank K. Inui, M.D., and P. A. Dobson, M.D.**

Pulmonary resection has become a fairly common procedure in the field of surgery in contrast to twenty years ago. Yet we are still faced with the problem of the post-operative broncho-pleural fistula, particularly following pneumonectomies for tuberculous lesions. Rienhoff in 1942 gave 27.7% as his incidence of post-operative broncho-pleural fistulas. Overholt reported in 1949 an incidence of less than 5%, thus demonstrating the marked improvement in the surgical technique of pulmonary resections.

Some of these broncho-pleural fistulas will close spontaneously, but others must be attacked surgically. Three major methods are used, either singly or in combination:

1. Secondary suturing of the open bronchus,
2. Open drainage followed by a thoracoplasty,
3. Skeletal muscle grafts in a saucerized thoracic cavity.

None of these procedures are entirely successful in every instance, and frequently the problem becomes very chronic or even fatal.

In an attempt to circumvent this complication, numerous methods for the primary closure of the bronchus have been proposed, and most of them discarded. The most extensive experimental and clinical study in this respect was that of Rienhoff's in 1942. It was then that the importance of a pleural flap was demonstrated very forcefully. He found that the mediastinal pleura alone without sutures in the bronchus of a dog was sufficient to close the open bronchus per primum. Taking our lead from this, we are now proposing the use of a living, pedicle flap of the diaphragm to close a post-operative broncho-pleural fistula without attempting secondarily to resuture a friable, open bronchus.

In order to approach this problem, it was necessary to show that a pedicle flap of the diaphragm would suffice when used per primum in closing an unsutured, open bronchus following a pneumonectomy in an experimental animal. If this could be done, one could attempt this maneuver in a simulated post-operative broncho-pleural fistula in the same experimental animal. The feasibility of this procedure in the human being would have to be studied carefully before application could be attempted. Our present paper is a preliminary report of the first phase of this study.

MATERIAL AND METHOD:

Three young adult mongrel dogs were used, and anesthesia was intravenous pentobarbital sodium. Oxygenation was maintained by endotracheal catheterization with manually controlled positive pressure. A left pneumonectomy was performed in the usual manner, and the bronchus held closed by a wide Allis type clamp, while the diaphragmatic flap was developed. The flap, generally 5 to 7 cm. long and twice as wide at the base as at the apex, was a crescent shaped wedge of muscle taken from the anterior half of the left leaf of the diaphragm with the base lying medially and the flap extending laterally. The vascular supply included the phrenic vessels and branches from the esophageal hiatus. The anterior incision of the flap in the diaphragm was extended posteriorly, creating a second wedge which could be swung medically and anteriorly in order to close the defect in the diaphragm without constricting the circulation of the

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flap at its base. Bleeding points in the diaphragm and the flap were carefully ligated with fine silk, which was used throughout the entire procedure.

Sutures which did not penetrate the bronchial wall, were placed 2 to 3 mm. apart around the circumference of the bronchus, approximately 2 mm. proximal to the crushed portion of the bronchus. Both ends of these sutures were then transfixed through the apex of the pedicle flap, forming a circular attachment corresponding to, and slightly larger than the open end of the bronchus. Having placed all the necessary sutures, the crushed portion of the bronchus was then cut away, leaving a patent bronchus. The pedicle flap of the diaphragm was then tied in place over this bronchus with the previously inserted sutures. The closure was never air-tight to pressures greater than those necessary to inflate the contralateral lung.

The chest wall was closed in the usual fashion with the anesthesiologist giving positive pressure until closure of the thoracic cage was complete. Subsequent to this, the animals were allowed to breath normally. No special post-operative measures were taken and the animals were allowed to regulate their own activity, fluid and food intake. The animals were sacrificed on the 11th, 14th, and 18th, post-operative days, and studied grossly and microscopically.

RESULTS:

In our three operations, the animals survived without complications. The diaphragmatic flap was viable even 18 days post-operatively. There was considerable scarring of this flap, particularly along its margins. The bronchi closed by this procedure were grossly intact and free from any evidence of fistulas. Microscopic sections showed that the bronchial aspect of the diaphragm was lined by bronchial mucosa. The scarring which occurred around the end of the bronchus tended to constrict the lumen at this point. There was considerable inflammatory reaction around the peribronchial sutures which were used to hold the diaphragmatic flap in place.

CONCLUSIONS:

The unsutured, main bronchus created by a pneumonectomy can be successfully closed by a diaphragmatic pedicle flap. The healing process is similar to that described by Rienhoff, et al (1942) following the use of mediastinal pleura and by Hanlon (1942) who used a gelatin sponge for the closure. There is every indication to believe that the diaphragmatic flap as used in these experiments is feasible in a secondary closure of a post-resection broncho-pleural fistula. Further experimentation is planned to establish this point.

N. B. Sincere thanks are extended to all who have aided in this problem, and especially to Drs. G. and C. Crago of Youngstown for their generosity in the use of their facilities.

* From the Departments of Surgery and Anesthesiology, Youngstown Hospital Association, Youngstown, Ohio.

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PRELIMINARY REPORT ON A NEW PROTHROMBINASE AND FIBRINOGEN INHIBITOR

by

J. G. Rogers, M.D., R. G. Thomas, M.D., A. E. Rappoport, M.D.

Plasmin has been shown to produce coagulation of oxalated plasma with fibrinolysis (1, 2,). During a study of plasmin activity in ether-treated plasma, an active coagulant was found that does not produce fibrinolysis. In high concentration this same "coagulant" functions as a fibrinogen inhibitor and prevents coagulation. The coagulation mechanism is not dependent upon the presence of calcium ions, or thromboplastin.

Ether-plasma (3) is known to contain a minute amount of prothrombin. Ether-plasma does not contain fibrinogen, thrombin, thromboplastin or calcium ions in sufficient quantities to be of any significance in clot formation by the usual mechanism.

Given amounts of oxalated plasma were added to increasing amounts of ether-plasma. It was found that coagulation of the oxalated plasma occurred, and the coagulation time was shortened with the increase in concentration of the ether-plasma until a coagulation time of 5½ minutes was reached. In the presence of higher concentrations of ether-plasma, the coagulation time was increasingly prolonged until a concentration was reached when coagulation did not occur. This last concentration could not be made to clot after the addition of active thrombin. This indicates one of three processes: the absence of fibrinogen from enzymatic digestion, the inhibition of fibrinogen, or neutralization of thrombin thereby preventing its enzymatic conversion of fibrinogen to fibrin.

We have shown (3, 4,) there isn't any release of non-protein nitrogen which refutes the possibility of fibrinogen digestion. Ether-plasma is not anti-thrombic in nature as shown by the ability of thrombin, which has been treated by ether-plasma, to coagulate oxalated plasma.

All fibrin clots were incubated at 37° C. for 48 hours and no fibrinolysis occured. Fibrinolysis was checked by non-protein nitrogen determination at intervals for 22 hours, and there was no evidence of lysis.

Ether-plasma prepared from deprothrombinized plasma does not exhibit coagulation properties. However in high concentrations a point is reached where inhibition of fibrinogen occurs. This shows the active enzyme is still present even though coagulation does not occur in the absence of prothrombin.

The active protein was found to be a globulin, with an iso-electric point of 6.0. The globulin, when separated from plasma, produced clotting of oxalated plasma in 2 minutes.

The mechanism of coagulation is thought to be due to conversion of prothrombin complex into thrombin by the active globulin of ether-treated plasma. The thrombin thus produced then converts fibrinogen into fibrin. This entire process is not dependent on calcium ions, or thromboplastin. In high concentrations of the active globulin, fibrinogen is inhibited so thrombic action is no longer effective in converting this fibrinogen into fibrin. This is not a result of digestion of fibrinogen, or an anti-thrombic action of the active globulin.

It is our belief that this active globulin is normally present in plasma as a precursor. This precursor is held inactive by an inhibitor. This inhi-

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bitor is removed by treating plasma with ether, and the precursor then becomes active spontaneously.

The clinical application of this prothrombinase and fibrinogen inhibitor remains to be clarified. However, the presence of a globulin in circulating plasma, that has the potential ability to release large quantities of thrombin into the circulating blood, is of tremendous importance. We suggest that this substance may play a part in the etiology of phlebothrombosis, coronary thrombosis, and cerebral thrombosis. It is possible that this substance may account for the increased coagulation ability of blood in a patient receiving sulfa drugs or digitalis.

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MANAGEMENT OF ACUTE HEAD INJURIES

(Editor's Note:—The following article is one of several articles being distributed by the Committee on Trauma of the American College of Surgeons. This article was prepared by a special committee of the Harvey Cushing Neurological Society composed of F. H. Mayfield, M.D., Spencer Braden, M.D., Dean H. Echols, M.D., and the late Cobb Pilcher, M.D.)

Head injuries may be classified as (A) open and (B) closed. Open injuries incur the risks of (1) hemorrhage and (2) wound infection. Closed injuries involve the risks associated with (1) immediate destruction of brain tissue (contusion, laceration, etc.) and (2) progressive damage secondary to (a) cerebral compression due to intracranial hemorrhage or edema, and (b) anoxia resulting from an inadequate airway.

For clarity, the treatment of open and closed wounds will be considered separately in this bulletin, but it is to be emphasized that both often are seen in the same patient and require consideration jointly.

TREATMENT OF OPEN WOUNDS

The proper treatment of *lacerations of the scalp* consists of thorough cleansing, debridement and snug closure. As a first aid measure, a compression bandage should be applied to control bleeding. Externally protruding foreign bodies should not be manipulated. When the patient's general condition permits and adequate equipment is available, the following procedure should be undertaken:

(1) Shave scalp widely about the wound.

(2) Cleanse wound with soap and water and irrigate thoroughly with copious amounts of solution (saline or water).

(3) Infiltrate margins of scalp wound with procaine.

(4) Remove dirt and excise devitalized portion of scalp.

(5) Explore skull for fracture.

(6) If no fracture, close wound snugly in one or two layers with interrupted sutures of nonabsorbable material.

(7) Give antitetanic serum or tetanus toxoid.

Simple lacerations may be closed in the Emergency Room by a single

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operator, but it is more satisfactory if the operator has an assistant to compress the margins of the wound to control bleeding.

Where the *laceration overlies a fracture*, surgical correction should be undertaken only in the Operating Room, for it may be necessary to remove dirt, hair, or debris from the fracture line or to remove bone fragments. One should be prepared to deal with bleeding from the dura and brain.

If the *brain is lacerated* or *foreign bodies are retained* within the brain substance, all macerated brain tissue should be removed, the foreign bodies removed if possible, particularly if they are nonmetallic, all bleeding controlled and the dura and scalp closed snugly. Surgical treatment of these wounds requires experience in brain surgery and special equipment (suction, lighting, electrocoagulation, etc.). With the use of chemotherapeutic and antibiotic agents, it is permissible to defer operative closure of wounds for many hours pending improvement in the patient's general condition and analysis of his neurologic status.

Leakage of cerebrospinal fluid from the nose or ear constitutes a special problem. Any cerebrospinal fluid fistula invites the risk of meningitis. Now, with an adequate screen of antibiotic and chemotherapeutic agents, one is justified in waiting ten to twelve days pending spontaneous closure. If the leak persists longer than this, surgical closure of the fistula should be considered. Some feel that lowering of the spinal fluid pressure to 90 mm. of water by spinal drainage every twelve hours promotes spontaneous closure. Fortunately most fistulas do close spontaneously.

CLOSED WOUNDS

One of the most frequent causes of death after head injury is progressive cerebral damage due to anoxia. Many factors contribute to this:

(1) The capacity of the contused brain to utilize oxygen is diminished.

(2) The cerebral blood flow is reduced, even though blood pressure may be elevated.

(3) The oxygen concentration of the blood is diminished as the result of a disturbed respiratory center and obstruction of the respiratory tract (tongue, mucus, pneumonitis).

The treatment in such cases is the maintenance of an adequate airway and the administration of oxygen. Patients frequently improve remarkably after clearing the airway and administering oxygen. The most satisfactory way of giving oxygen is by nasal catheter. Oxygen tents and masks interfere with attempts to keep the airway patent. Constant nursing attention, with a suction apparatus for the removal of mucus, is necessary. This may be supplemented by postural drainage (head down on face). Tracheotomy is indicated in certain cases.

The *differential diagnosis* between surgical and nonsurgical lesions is of primary importance in the management of acute head injuries and usually depends upon the patient's course. Hence, a carefully taken history, particularly as relates to the onset and duration of unconsciousness, and frequent and repeated neurological examinations are necessary.

Intracranial clot, such as extradural, subdural or intracerebral hematoma, usually is incompatible with life and requires surgical removal. Most patients with these lesions show progressive stupor, convulsions, focal paralyses and disturbance of the vital signs, such as alteration in pulse, respirations, etc. If the patient has been conscious and then loses consciousness, an expanding intracranial lesion is probably present. The lucid interval may be prolonged (days or weeks) with subdural hematoma. If the patient

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has remained continuously unconscious from the moment of impact, the coma may be due in part to contusion of the brain and in part to an expanding lesion. In such instances, it may be impossible to make a differential diagnosis clinically, and cranial exploration then is necessary if the patient's condition is growing worse.

The surgical management of these lesions is not within the scope of this paper.

SPECIAL EXAMINATIONS AND TREATMENTS

(1) X-rays of the skull rarely influence the course of treatment, yet the procedure of taking films involves considerable manipulation and wastes time, both of which are detrimental to the ill patient. Hence, it is advisable that X-ray examination of the skull be deferred until such time as the patient is co-operative and his condition stabilized. Attention should always be given to the possibility of injury elsewhere, particularly to the cervical spine.

(2) The position of election is with the head elevated, since this reduces venous congestion. The advantages of this position, however, are far, outweighed by the disadvantages which might accrue from an obstructed airway, and if the patient's airway cannot be kept completely open with the head elevated, this position should be changed to one which best promotes an adequate airway.

(3) Surgical shock (peripheral vascular collapse) is rare in head injuries per se, but, when present, the usual measures (Trendelenburg position, intravenous fluids, heat, etc.) should be employed. Shock usually indicates associated injuries and demands primary consideration.

(4) In an effort to reduce or limit cerebral swelling after head trauma, certain writers have advocated rigid dehydration by withholding fluids, administration of hypertonic solutions intravenously, the use of magnesium sulphate enemas, etc. Rigid dehydration does harm rather than good to an ill patient, as the other vital body functions are interfered with. Fifteen hundred to 2000 cc. daily are necessary to keep the patient in fluid balance.

It is necessary in this connection to keep close watch upon the protein metabolism. Coma, stupor and prolonged confusion often result from protein depletion and can be prevented or corrected by the administration of protein hydrolysates, plasma or whole blood. If coma is prolonged, gastric feedings by nasal catheter are indicated, using a high protein diet.

(5) Considerable controversy prevails concerning the indications for and the merit of spinal puncture in the diagnosis and treatment of head injuries. Some advocate daily spinal punctures as routine in the treatment of head injuries, but this is not generally accepted. The authors of this bulletin consider the indiscriminate use of spinal puncture dangerous. The following are considered proper indications for spinal puncture.

(A) Diagnostic:
- (a) To determine pressure where intracranial clot is suspected.
- (b) To determine the presence and/or degree of bleeding.

(B) Therapeutic:
- (a) To lessen intracranial pressure by withdrawing fluid as a temporary expedient pending measures that provide more lasting control of increased intracranial tension, such as surgical evacuation of clot.
- (b) Evacuation of bloody fluid when signs of meningisimus appear, usually four to eight days. Evacuation of fluid at this time usually relieves headache and speeds recovery.

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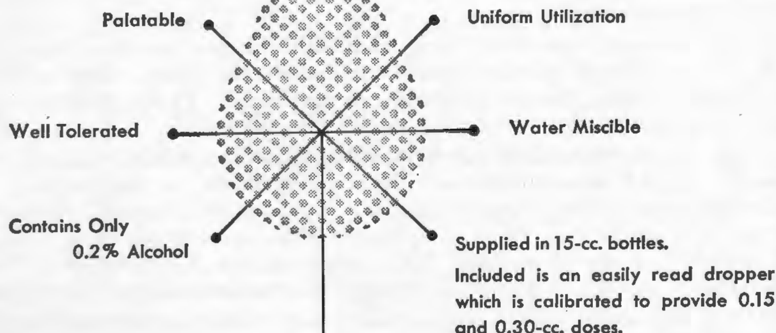

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TECHNIQUE OF SPINAL PUNCTURE

When indicated, a spinal puncture should be done with the patient in the lateral recumbent position, using a standard spinal puncture needle. The operator should make the following determinations: color of the fluid, initial pressure, final pressure and the amount withdrawn.

Jugular compression tests should not be carried out unless one suspects injury to the spinal column. These tests give no information of value with reference to the brain, and the sudden rise in spinal fluid pressure which follows jugular compression may be harmful after head injury.

Spinal puncture should not be attempted if the patient is unco-operative, for the information obtained is unreliable, and struggling against resistance may be harmful.

Patients who are restless and confused constitute a difficult nursing problem, and sedative medication may be necessary. Paraldehyde administered rectally or barbiturates—sodium amytal, sodium luminal—intramuscularly or intravenously are satisfactory. The latter are particularly indicated for the control of convulsions. Morphine and codeine are contraindicated because of depression of respirations, edema of the larynx, and alteration of pupils (diagnostic).

Early ambulation is recommended after head injury. The patient should receive physical therapy in the form of active and passive exercises early and should be gotten out of bed into a chair as soon as he is able and willing to co-operate. Prolonged bedrest is conducive to traumatic neurosis.

Lacerations of the brain, such as are associated with depressed fractures and penetrating wounds, are frequently followed by a convulsive disorder. These patients should be given anticonvulsive medication for a period of several months after injury. The drug of choice is Dilantin Sodium gr. 1½ three times daily.

Many patients complain of residual headache, particularly in the posterior part of the head, and of dizziness. These symptoms generally are classified as posttraumatic neuroses. Recent observations indicate that they may result from trauma to the cervical roots and at times are relieved by cervical traction.

BLACK INK PREFERRED

The Federal Government is running in the red at the rate of $16,000,000 a day. Oppositely, the A.M.A. has made drastic reductions in its budget "with a view to bringing the total amount of the requests made (by the various councils, bureaus, departments and committees, into line with the anticipated income of the Association for the year 1950" (J.A.M.A.).

The Federal Government, instead of harassing the A.M.A. with its gestapo-like investigations, would do much better to imitate the A.M.A.'s business-like methods.—*Norfolk Medical News.*

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NATIONAL CONFERENCE OF SOCIETY OFFICERS

The seventh national conference of County Medical Society Officers will be held before the opening of the American Medical Association Convention session on Sunday, June 25, 1950, in the Palace Hotel, San Francisco, Calif.

The program for these sessions is as follows:

MORNING SESSION

9:30 A. M.: *What do you know for sure?*
A true and false questionnaire on socialized medicine to be given to everyone in the audience with 20 minutes allowed for answering. At the end of this period the papers will be collected and corrected during the remainder of the program. Results will be announced at the end of the morning session.

10:00 A. M.: *How to set up a County Medical Society Record System*

10:40 A. M.: *How to Organize a Community Health Council*

11:40 A. M.: *Providing Special Benefits Through County Medical Society Membership* (such as Group—A & H, Malpractice, Medical and Hospital, and Life)

12:20 P. M.: *Results of Quiz*

EVENING SESSION

8:00 P. M.: *The Third Party in the Practice of Medicine*
(This refers to insurance companies, hospital and medical care plans, etc.)

8:40 P. M.: *Hospitals and the Practice of Medicine*

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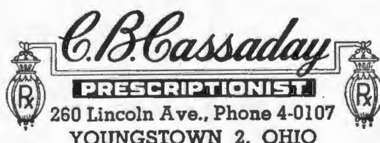

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LAY EDUCATION AND SPEAKERS' CALENDAR

April 3, 1950: Dr. J. J. McDonough; Women's Auxiliary, St. Elizabeth Hospital: "Carcinoma of the Cervix."

April 4, 1950: Dr. E. J. Reilly; WBBW; member of panel discussion: "The Problem of Cancerophobia."

April 6, 1950: Dr. A. A. Detesco; WFMJ: "Cancer Risks in Industry."

April 8, 1950: Dr. J. J. McDonough; WKBN; member of panel discussion: "Cancer on Trial."

April 11, 1950: Dr. W. M. Skipp; Bennett Chautauqua Study Club, Y.M.C.A.: "Socialized Medicine."

April 17, 1950: Dr. W. J. Tims; Social Service Group of Youngstown: "Health Problem."

April 18, 1950: Dr. W. M. Skipp; Women's Auxiliary, Women's City Club; Question and answer period following Dr. Rutledge's talk on, "Socialized Medicine."

April 18, 1950: Dr. J. J. McDonough; Business and Professional Women's Club: "Proposed National Health Legislation."

April 20, 1950: Dr. H. S. Banninga; WFMJ; "Cortisone and ACTH."

April 20, 1950: Dr. C. E. Pichette; Biology Section of Youngstown College: "Urology-General Aspects."

April 21, 1950: Dr. E. A. Shorten; Kiwanis Club of Youngstown: "Public Health in Youngstown."

Health Department Bulletin

REPORT FOR MARCH, 1950

	1950	Male	Female	1949	Male	Female
Deaths Recorded	207	119	88	225	132	93
Births Recorded	517	252	265	530	278	252

CONTAGIOUS DISEASES:

	1950 Cases	1950 Deaths	1949 Cases	1949 Deaths
Chicken Pox	78	0	287	0
Measles	206	0	95	0
German Measles	3	0	15	0
Ep. Spinal Meningitis	1	1	0	0
Scarlet Fever	7	0	22	0
Tuberculosis	9	3	1	2
Typhoid	1	0	0	0
Whooping Cough	22	0	49	0
Mumps	53	0	9	0
G. C.	30	0	19	0
Syphilis	40	0	50	0

VENEREAL DISEASES:

New Cases: 45

	Male	Female
Syphilis	10	6
G. C.	19	10

Total Patients ....

Total Visits to Clinic (Patients) 413

W. J. TIMS, M. D.
Commissioner of Health

THE ROLL OF GOVERNMENT IN MEDICINE

The Adult Activities Committee of the Jewish Community Center, as a part of their program for informative meetings on various up-to-date subjects, chose the subject of "The Place of the Government in Medicine" for a discussion held March 30, 1950 at Rodef Sholem Temple. Mr. Eddie Weygant, Secretary of the C. I. O., presented the viewpoint of the advocates of so called "Socialized Medicine." Dr. J. K. Herald spoke for the physicians. Both speakers seemed moderate in their statements and tried sincerely to serve the purposes of the forum.

FROM THE BULLETIN

By J. L. Fisher, M.D.

15 YEARS AGO (MAY, 1935)

The results of the monumental study on heat cramps made by members of the Harvard Fatigue Laboratory were reported to the Youngstown Hospital Staff by Dr. John H. Talbott (now professor of medicine at University of Buffalo). As a result of this study sodium chloride has been used in the treatment and prevention of heat cramps.

The Public Health Committee under Dr. H. E. Hathhorn was busy running an immunization campaign.

The Medical-Dental Bureau was promoting a luncheon meeting every Thursday with a free meal, a speaker and music by the Medical-Dental Ensemble.

Dr. James A. Sherbondy was taken seriously ill.

Dr. Altdoerffer was running a monthly column on the material in hospital libraries and J. G. Brody had one entitled "Medical Facts". Paul Fuzy's column was called "Opinions of Others" and some anonymous doctor ran one called "Flatus". Claude Norris was the editor.

Dr. Karl Allison died May 22.

★ ★ ★

10 YEARS AGO (MAY, 1940)

Dr. William Skipp was installed as President of the Ohio State Medical Society at the convention in Cincinnati. Everybody who could get away went down there.

On May 8, Dr. Skipp was honored at a testimonial dinner at the Youngstown Club when members of the local Medical Society presented him with a gold watch.

The Medical Society Auxiliary was formed this month.

Marjorie Rauch and Dr. Robert Lee Piercy were married in Rochester, N. Y. Martha Morris and Dr. Raymond Lupse were married May 15.

HOLDS OPEN HOUSE

The Youngstown Receiving Hospital held an open house for members of the profession and interested persons on Tuesday, April 25. Dr. Eugene E. Elder, superintendent of the hospital, extended the invitation.

ARE DOCTORS CITIZENS?

There has been plenty of evidence in recent years to suggest that some people in this country are not altogether certain of the answer to the question: "Are doctors citizens?"

The astonishing demand from several political sources, that payment for doctors' services be made by government paymasters, is compelling indication that some people think the doctor is different from other citizens, with a different sort of civic obligation and a different sort of individual rights.

No other professional man in America—no businessman, no butcher, no plumber, no baker, no clergyman, no grocer, so far as we know—has to date been nominated to share with the doctor the dubious distinction of having his income paid by government and his product or service made "free" to all comers. It is conceivable such suggestions may come later. Certainly in the logic of socialism, a case could be argued for making the work of all these essential people a function of Government.

Perhaps some day such a case will be argued. We have an idea that when it is, it will split wide open on the plumber. There is a hard core of common sense in the American people and a blunt insistence of the individual freedom of every man. There are a good many things American citizens won't stand still for—and don't expect other citizens to stand still for either. Which brings us back to the question, "Are doctors citizens?"

We'll know more about the answer after next November. The coming Congressional elections will give the whole country a good yardstick with which to measure the citizenship of the medical profession.

Is it a citizenship that influences government? A citizenship that is informed about candidates? A citizenship that means registration, voting, and working for the candidate chosen? Or is it negative and passive when faced with the vital issues of an urgent time? Is it too busy to be concerned with the public business of democratic government?

The answer is up to every doctor. And the testing time will be the coming elections—the primaries as well as the final races in November.

This is the time for doctors to demonstrate in action what their citizenship means in America. Conceivably, it may be the last time.

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Thiamine	1.0 mg.
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Each 0.6 cc. supplies:

Vitamin A	5000 USP units
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