Sweet are the uses of adversity.
—*Shakespeare*

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
VOL. XX No. 10
OCTOBER ● 1950

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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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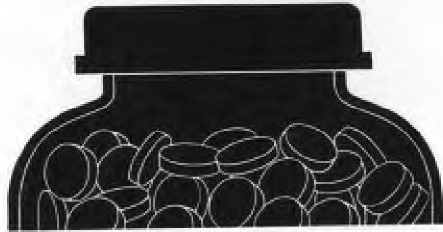

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PRESIDENT'S PAGE

The first subject taken up on this page early this year was the importance of voting. It was found that many doctors had not even registered and of course were not eligible to vote. During the months that have followed, through the medium of the press and the radio and by word of mouth the general public have been awakened to the necessity of registering and then voting.

In our Society, the Womens Auxiliary have done an outstanding piece of work in stressing to each doctor and the members of his family, the importance of taking advantage of this prized privilege. The results of the work are reflected in the daily papers that have recently reported a great rise in the number of people registering.

Now it is also important that these people who have registered should get out and vote. Each doctor should make himself a committee of one to get people out to vote.

This country is probably the only one the world over, where an individual may vote as he pleases, but it seems that we have come to treat that privilege with smug complacency. We may well heed the warnings that have come from lands across the sea because it is certainly within the realm of possibility that we may lose the right to express our wishes through the ballot box.

I cannot emphasize too strongly to you that we must get out and cast our ballot on Election Day.

Gordon G. Nelson, M. D.
President

BULLETIN of the Mahoning County Medical Society

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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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DIABETES WEEK NOV. 12-18

The Mahoning County Medical Society will again observe Diabetes Week with a Diabetic Detection Drive from Nov. 12-18, according to plans announced recently by Dr. Morris Rosenblum, chairman of the Society's Diabetes Committee.

The feature of the week will be the appearance of Dr. Howard F. Root, physician-in-chief of the New England Deaconess Hospital, Boston, Mass., and Past President of the American Diabetes Association, who will talk to the Society Nov. 14 at 8:30 p. m. in the Elks Club on the subject of "The Medical and Surgical Treatment of Diabetes." Dr. Root also is expected to talk to the hospital resident staffs during the day. Plans are being formulated to invite all interested practitioners for dinner at the Elks Club before the evening meeting. Dr. Root will present a short talk at the dinner.

Accompanying this issue of the *Bulletin* is a folder describing the activities of Diabetes Week and asking every practitioner to take part in the activities. Galatest and Clinitest material will be distributed to every physician so that he may help in the detection of new diabetics in his own office.

A number of physicians are being asked to give talks on the importance of detecting diabetes before many of the civic organizations and noon-day luncheon groups of the city.

Posters are again being placed in strategic places throughout the city informing the public of the drive to detect new diabetics and asking everyone to have his urine tested during the week. As before the Hospital laboratories will examine urine specimens for sugar free of charge and report the findings to family physicians.

One of the aims of the local committee is to see that every patient who is reported as having sugar in his urine has follow-up blood tests for sugar to determine if the patient is a diabetic.

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plus Choline, and other factors of the B-Complex present in the natural base. The Riboflavin content is derived entirely from natural sources.

BASE: Rice Bran, Corn, Liver Concentrate.

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Natural Base

formula:

Each Capsule Contains:

Thiamine Hydrochloride	10	mg.
Riboflavin	15	mg.
Niacinamide	100	mg.
Pyridoxine	1	mg.
Calcium Pantothenate	10	mg.
Choline Dihydrogen Citrate	20	mg.
Inositol	20	mg.
Folic Acid	0.[illegible]	mg.
Liver Extract (secondary)	1[illegible]	mg.
Brewers' Yeast Extract	1[illegible]	mg.

plus other factors of the B-Complex present in Whole Liver.

BASE: Liver and Yeast.

SUPPLIED: in 50's and 1000's.

1. Jolliffe, N., Special Article, Council on Foods and Nutrition: The Preventive and Therapeutic Use of Vitamins, J.A.M.A., 129:613, Oct. 27, 1945.
2. Lewey and Shay, Dietotherapy, Philadelphia, W. B. Saunders Co., 1945, p. 850.

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DR. BLANKENHORN TALKS ON SPOTTED FEVERS

By E. R. McNeal, M.D.

An interesting review with a logical classification of the "Spotted Fevers" was presented by Dr. Marion A. Blankenhorn, Professor of Medicine in the University of Cincinnati School of Medicine, before the Society at its monthly meeting September 19, 1950.

Dr. Blankenhorn illustrated his talk with colored lantern slides. He gave the following classification:

I. **EXANTHEMATOUS VIRAL DISEASES**
 a. Measles
 b. German measles
 c. Chicken pox
 d. Small pox

II. **RICKETTSIAL DISEASES**
 a. Murine typhus
 b. Rocky Mountain spotted fever
 c. Rickettsial pox

III. **PYOGENIC SEPTICEMIAS**
 a. Meningocòccemia
 b. Staphylococcemia
 c. Etc.

IV. **ULCERATIVE ENDOCARDITIS**
 a. Subacute bacterial endocarditis

V. **INFECTIONS OF UNKNOWN ETHIOLOGY**
 a. Erythema multiforme
 b. Erythema nodosum

VI. **PURPURA**

VII. **DRUG REACTIONS**

Histopathological studies are of definite value in the differential diagnosis, he pointed out. The virus exanthematous group is the only one that involves both the corium and the epidermis, the other main groups being confined to corium. The main lesions in the corium consists of capillaritis, mural thrombi, pericapillaritis and in the virus and the rickettsial groups vascular necrosis. Of definite aid is the finding of organisms in the skin lesions in (a.) rickettsial Diseases (endothelial and muscle cells), (b.) pyogenic septicemias (Typhoid Fever) and (c.) inclusion bodies in the virus group.

Of interest is the part German measles plays in congenital anomalies and the importance of prophylaxis.

The rickettsial diseases are concentrated in the lower fourteen counties but may occur anywhere in Ohio. The incidence is much lower in Ohio than in surrounding states, but Dr. Blankenhorn feels this is due to oversight and not thinking of the disease. The fatality rate of Rocky Mountain Spotted Fever in Ohio is 28%. This he stressed should be lowered with early diagnosis and the use of specific drugs as Aureomycin, Terramycin and Chloromycetin.

Dr. Blankenhorn stated that the overall opinion of experts favored Sulfadiazine in the treatment of Meningococcemia and Meninitis without intrathecal treatment. However, intrathecal penicillin could be used if limited to

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five injections, the danger being a local reaction to the drug if used in high doses or too often.

The drug fevers with eruptions are bugaboos in differential diagnosis from the infectious spotted fevers and must always be kept in mind. The most common offender is the sulfa group, but Streptomycin and Penicillin are very often guilty.

It is too bad we can't reproduce the colored slides in this review because they illustrated the above discussion extremely well.

COUNCIL MEETING

The regular monthly meeting of the council of the Mahoning County Medical Society was held on Monday, September 11, 1950 at the office of the Society, 203 Schween-Wagner Building, Youngstown, Ohio. The following physicians were present: G. G. Nelson, President, presiding; J. N. McCann, I. C. Smith, C. A. Gustafson, W. M. Skipp, J. Noll, and G. E. DeCicco.

The following applications were acted upon favorably by council:

FOR ACTIVE MEMBERSHIP

Harold Teitelbaum, M.D., 4880 Kirk Road, Youngstown, Ohio

Francis J. Gambrel, M.D., 306 Home Savings Bldg., Youngstown, Ohio

FOR INTERNE MEMBERSHIP

Robert Fisher, M.D., 224 North Phelps St., Youngstown, Ohio

Unless objection is filed in writing with the secretary within 15 days, the above applicants become members of the society.

A motion was made, seconded, and duly passed, instructing the secretary to order 25 automobile emblems, embossed with the name of the Mahoning County Medical Society, from the A. M. A.

A motion was made, seconded, and duly passed that the society underwrite the cost of a freedom roll call advertisement to be inserted in the Boardman News the week of October 8. A similar advertisement will be inserted in the Vindicator by the A. M. A.

A motion was made, seconded, and duly passed adopting the following resolution:

WHEREAS, The Council of the Mahoning County Medical Society is aware of the responsibility of each member in rendering assistance necessary in getting every registered voter to the polls. Whereas, It is the duty of every member to see to it that his disabled patients are registered and that they obtain absentee ballots.

WHEREAS, It is the duty of every member to see that his family and friends are registered before September 27, 1950.

BE IT RESOLVED, That regular office hours will be cancelled on election day, November 7, 1950 but that each one of us will be available for emergency calls as usual.

G. E. DeCicco, M.D.
Secretary

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CLEVELAND SESSION OF A.M.A.

CHICAGO—The Fourth Clinical Session of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5-8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel. These sessions of the body elected to govern the affairs of the A.M.A. are attracting more and more non-delegate physicians each year.

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnoses, treatment and preventive measures as they fit into daily practice will receive the greatest attention.

Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

In obstetrics, difficult cases of interest will be featured. Especially stressed will be the general subjects of breach deliveries, induction of labor, indications for cesarean section, obstetric analgesia and anesthesia, and hemorrhages.

Clinical discussions featuring actual pediatrics patients have been programmed. The care of premature infants, acute diarrhea in children, rheumatic fever, preventive medical measures and psychiatric care for small children are among the interesting topics scheduled.

WILL STRESS HEART DISEASE

Because of the unusual interest displayed last year in the section devoted to management of heart cases, there will be a similar session this year. It will include discussions on hypertension, recent advances in drug therapy, including ACTH as it applies to heart disease, acute arterial occlusion and cardiac arrhythmias.

Of special interest will be discussions on Parkinsonism, the use of the electro-encephalograph, electric shock therapy and psychotherapy.

With more cases of fluid balance appearing because of the larger number of geriatric patients, there will be discussions on fluid replacement in shock, renal repairment, dehydration and other topics.

Of unusual interest will be the new studies and clinical histories involving traumatic surgery. This will include material on reconstructive surgery, emergency analgesia and emergency surgical measures.

Taken up in detail will be the management of post-operative or inoperable cancer patients. The use of analgesics and the effects of hormone and radiological treatment will be discussed.

An excellent program has been arranged covering diabetes. This will include diagnosis, vascular complications, special consideration in pregnancy and surgery, and dietary problems.

Very timely will be the panel discussions and demonstrations on the diagnosis of poliomyelitis, the treatment of respiratory failure and the man-

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agement of paralytic cases. There will be demonstrations of physical therapy and rehabilitation measures for poliomyelitis cases.

Papers covering practical problems in dermatology and syphilology will be presented. Deep fungous infections and industrial, allergic and contact dermatoses will be demonstrated and discussed. Emphasis will be put on the newest development in syphilology.

New developments and refinements of older techniques will feature the discussions on anesthesiology. Spinal anesthesia, management of the surgical case, intravenous administration and other practical problems will be reviewed.

NEWER DRUGS DISCUSSED

Outstanding speakers will discuss ulcers, jaundice, infectious hepatitis, cirrhosis and other gastro-intestinal diseases. Newest advances in medicine and the use of many newer drugs and their application to the general practice of medicine will be presented in another section. Of special interest will be the discussions on the use of antibiotics, hormones and antispasmodics.

Outstanding features of the scientific exhibits will be special demonstrations on fractures, diabetes, rheumatism and arthritis. Exhibits will be presented on cancer, pediatrics, chest diseases, surgical procedures and other subjects correlated with the clinical presentations.

Once again color television will take its place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium. It will be sponsored by Smith, Kline & French Laboratories.

The annual General Practitioner Award has come to be regarded as one of medicine's highest honors and a definite step toward increasing the recognition of the family doctor. This year's selection will be made at the Cleveland meeting.

The steadily climbing registration of general practitioners at the clinical sessions and the comments of those participating indicate these meetings are valuable means of keeping abreast of developments in medicine. It is hoped that a record number of physicians will take advantage of the opportunity in December to attend. The program has been designed with that in mind.

DR. TEITELBAUM BECOMES DIRECTOR

Dr. Harold H. Teitelbaum has been appointed Medical Director and Superintendent of the Mahoning Tuberculosis Sanatorium succeeding Dr. William Newcomer who resigned in August.

Dr. Teitelbaum's appointment was made by the trustees of the Sanatorium following the recommendation of the Medical Executive Committee of the institution.

Dr. Teitelbaum will be in complete charge of the Sanatorium with the exception of financial matters related to purchasing and disbursements which will continue to be handled by Fred M. Lloyd, business manager. Mr. Lloyd also is to become assistant superintendent.

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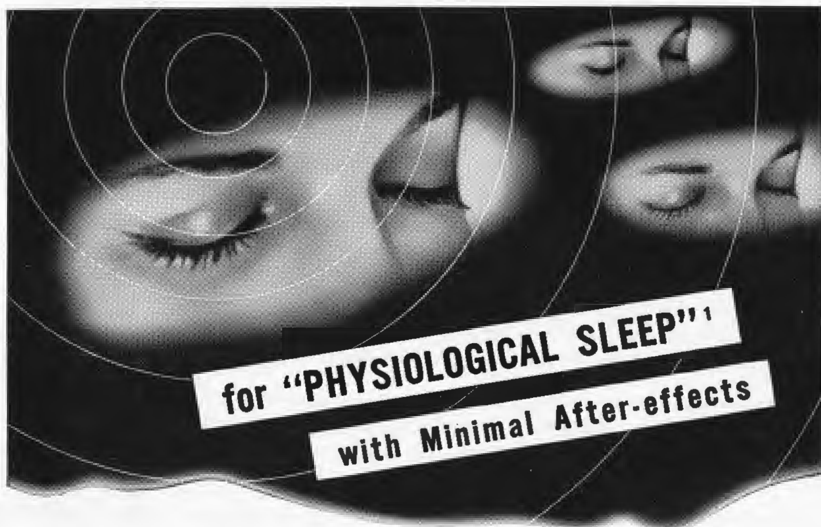

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[1]N.N.R., 1947, p.398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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THE DOCTOR IN THE ARMED SERVICES

As the *Bulletin* went to press there was still a lot of confusion about the status of many of the members of the profession concerning the recently passed national "Doctor Draft Law." Some of this confusion is beginning to clear with President Truman's announcement that former member's of the Army's A. S. T. P. and Navy V-12 were to be registered October 16.

According to the Washington office of the A.M.A. this was the plan advocated by General Hershey in order to have the doctors who would be inducted first, register first and thus get more volunteers.

There is still a great deal of confusion about the term reserve officer. The Navy definitions are clear since all physicians in World War II were in the naval reserve unless they have since resigned their commissions. In the Army and Air Force the situation remains muddled because the armed services will not make a definite statement as to whether a physician (or dentist) with only an A. U. S. commission is in the reserve.

The law mentions only "reserve components" and is not more specific. Likewise we quote from the bill (Public Law 779)" . . . where any person who served on active duty as a physician or dentist in the Armed Forces (including Public Health Service) of the United States subsequent to September 16, 1940, thereafter has been, or shall be recalled to active duty as a physician or dentist in the Armed Forces (including the Public Health Service) of the United States, such person may, under regulations prescribed by the President, be promoted to such grade or rank as may be commensurate with his medical or dental education, experience, and ability."

The words "recalled to active duty" in the paragraph above seem to indicate the A. U. S. officers are in the reserve.

It is important that this be clarified because of the $100 bonus provision. In Section 2 of Public Law 779 it is provided that reserve officers called to "active duty with or without their consent, shall, if otherwise qualified, be entitled to the benefits of section 203 of public Law 351, Eight-first Congress," which is the $100 a month bonus.

Perhaps before the veterans of World War II have to register this will be clarified.

F. S. C.

YOUNGSTOWN HOSPITAL STAFF MEETING

At the regular monthly staff meeting of the Youngstown Hospital Association September 5, 1950 Dr. Gordon Nelson presented a talk on "Use of Tantalum Mesh in Surgical Repair," showing colored lantern slides of the postoperative appearance of patients as well as of the fate of tantalum in the body.

Dr. Henry Sisek presented two unusual cases of Gall Bladder surgery and its complications, while Dr. Fred Schlecht presented an analysis of "Post-Operative Venous Thrombosis and Pulmonary Emboli" in the Hospital before and after the use of anti-coagulants.

Miss Muriel Dunlap, new Directress of Nurses, was introduced and welcomed. Miss Dunlap responded with a short talk.

Dr. John Noll reported on the training program for internes and residents.

The autopsy percentage for August was 54% for the South Unit and 52% for the North Unit.

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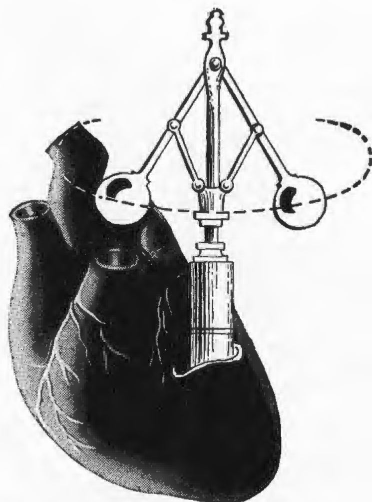

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RAPID DIGITALIZATION: 1.2 mg. in equally divided doses of 0.6 mg. each at three-hour intervals.

DR. GIFFEN RESIGNS

Dr. Horace K. Giffen, pathologist at the Youngstown Hospital, in charge at the South Side Unit, has submitted his resignation to become effective January 1, 1951.

Dr. Giffen came to Youngstown in early 1945 after having been pathologist at Lakewood, Ohio, Hospital. While in Youngstown Dr. Giffen served as a member of the committee which revised Gould's Medical Dictionary and also was a charter member of the American College of Pathologists.

He early became interested in the cytological study of vaginal, gastric, and bronchial secretions and took the course given by Papanicalou several years ago in order that such studies might be carried out in Youngstown.

After graduation from Western Reserve University, Dr. Giffen interned in Cleveland and spent his early years as a medical missionary. In 1942 he completed several years residency in pathology under Dr. Howard T. Karsner at the Institute of Pathology at Western Reserve University. He is a diplomate of the American Board of Pathology in pathologic anatomy and a member of the American Society of Clinical Pathologists.

ARMY TO REOPEN THREE GENERAL HOSPITALS

Representative Carl Vinson, chairman of the House Armed Services Committee, has announced that Army will reopen three general hospitals ordered closed last spring and enlarge the capacity of nine station hospitals. It was an Armed Services subcommittee, under chairmanship of Representative L. Mendel Rivers, which opposed the original closing orders, but was overruled by defense department.

General hospitals affected are Valley Forge, Pa.; Murphy General, Waltham, Mass.; and Percy Jones General, Battle Creek, Mich. Bed capacity of the three will total almost 5,000. According to Mr. Vinson, action was taken in view of an increase in the rate of casualties to be flown back from Korea. To date slightly more than 3,000 have been returned; by December 1 it is estimated the total will reach about 11,500.

Shortly after Mr. Vinson made the above announcement, Defense Department's Office of Medical Services (Dr. Meiling) issued a fact sheet, reviewing the military hospital situation from the start of the Korean war. It noted that between July 1 and October 1 operating capacity had been increased by 12,416 beds for a total of 49,408 (not including capacity of the hospitals to be reopened). According to the fact sheet, 20,908 operating beds were vacant at the time Mr. Vinson announced the hospital expansion program. Dr. Meiling's report also said that hospitals already activated could provide an additional 62,592 mobilization beds "as the need arises and personnel to staff them becomes available."—*Capitol Clinics.*

T. B. SANATORIUM MEETING

The regular staff meeting of the Mahoning Tuberculosis Sanatorium will be held Tuesday, October 31, 1950, in the Nurses Auditorium of St. Elizabeth's Hospital. Dr. Harold H. Teitelbaum, medical director of the Sanatorium, will present a clinical program illustrating different phases of the treatment of Tuberculosis and report the end results.

BE SURE YOU VOTE NOVEMBER 7

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NOVEMBER MEETING

•

Speaker:

DR. HOWARD F. ROOT

Physician-in-Chief, Deaconess Hospital,
Boston, Mass.
Past President of American Diabetes Association

•

Subject:

"Medical and Surgical Treatment of Diabetes."

•

Time:

NOVEMBER 14, 1950

8:30 P. M.

(Note Change of Date)

•

Place:

ELKS CLUB

220 W. Boardman St.

WHITAKER HITS AT POLITICIANS

Chicago—Administration supporters of President Truman's compulsory health insurance program, who have recently attacked the American Medical Association's decision to conduct a nation-wide advertising campaign against the program, early this month were accused by the A.M.A. of "political cowardice" and of "headlong retreat from public discussion of this public issue."

The charge was made by Clem Whitaker, director of the A.M.A.'s national education campaign, in a speech delivered this month before the National Association of Insurance Agents, meeting at the Stevens Hotel.

Attacks on the A.M.A. program have been made during the past few days by Federal Security Administrator Oscar Ewing, Congressmen Biemiller and Dingell and by Mrs. India Edwards, vice-chairman of the Democratic National Committee.

"The jittery advocates of compulsory health insurance, even though they claim public support for it, and even though they have spent millions of dollars of federal funds propagandizing for it, are now bitterly berating doctors for carrying their side of the case to the public," said Whitaker.

"It is quite apparent that they are in headlong retreat from public discussion of this public issue and their bitter attacks on the A.M.A.'s advertising program are eloquent evidence of abject political cowardice.

"The doctors didn't raise this issue. The advocates of socialized medicine raised the issue. But in the final analysis, the people will decide what is to be done on the issue—and the present statements emanating from Washington are a vicious attack on legitimate advertising as a medium for public discussion of public issues.

"The A.M.A. advertising, which will present the merits of voluntary health insurance as opposed to government—run compulsory health insurance, will ask the question: 'Who Runs America?—The Congress?—The President?—Or You and the Man Next Door?' It is clear that the administration supporters of this socialistic program don't want the people to consider that question—and for one reason only—because they fear the people's answer."

Whitaker also charged Federal Security Administrator Oscar Ewing and other administration supporters of socialized medicine's program with "deliberate and gross misrepresentation of the amount to be spent in the A.M.A. advertising program."

"The A.M.A. advertising program," said Whitaker, "will cost slightly in excess of $1,000,000.00. Tie-in advertising, sponsored by other groups which believe with doctors that 'the voluntary way is the American way,' may equal or double the amount spent by the American Medical Association. We think that is a great tribute to the principles espoused by the doctors, but Mr. Ewing's figure of $20,000,000, which he announces will be spent, is as unreliable as most of the statistics which have emanated from his office on this issue."

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JOHN L. KELLY, M. D.
Diplomate in Psychiatry

PHYSICAL MEDICINE

By Ivan C. Smith, M.D.

(Editor's Note—The first half of Dr. Smith's article was printed last month. The second half and conclusion follows)

ELECTROTHERAPY

In electrotherapy, two types of electric current are used. First is the galvanic or direct current which constantly flows in one direction. The other is the Faradic, or alternating current, which flows alternately in each direction, changing a certain number of times a second, according to its frequency. It is possible to produce many variations of these currents. For ordinary use, apparatus usually is provided which produces both currents from different switches.

The chief indications for the use of the constant current are:

1. Iontophoresis of chemicals and drugs into the skin or body orifices.
2. Depilation.
3. Stimulation of denervated muscle, to maintain its contractility until the nerve can regenerate.
4. Testing for the reaction of degeneration.

The reaction of degeneration is highly important in the determination of the status of peripheral nerves in injuries which may sever these nerves. It is dependent upon the fact that in paralysis due to lower motor neurone lesions, the muscle loses its power to react to alternating currents. However, it still will react to the direct or constant current. A review of the physiology of muscle-nerve preparations recalls muscle contraction only on the make, and again on the break of the circuit. While the current if flowing, there is no action. Since alternating current reverses direction as many times per second as its frequency, there are twice as many makes and breaks as the number of cycles, resulting in a tetanic contraction of the muscle. When the nerve is degenerated, the muscle no longer responds to the alternating current because the chronaxie of a nerve is much less than that of muscle tissue itself. By chronaxie is meant the length of time a certain predetermined current must flow to produce a stimulus. In the case of intact nerves, it varies from 1/1500 to 1/2000 of a second. In the case of healthy muscle, it is somewhat longer than 1/100 of a second in advanced degeneration it is as long as 1/20 of a second. Since the usual alternating current is 60 cycles, which means that there are 120 makes and breaks in a second, and since only the makes and breaks supply a stimulus, it is obvious that the duration of the stimulus is shorter than the chronaxie of the denervated muscle.

In a typical complete lesion of the peripheral nerve, the usual sequence, of events is that for a few hours after the onset of paralysis, there is no change in electrical reaction. After about 24 hours, the affected muscles begin to respond less and less to the alternating current. By the end of 10 to 14 days, there is no longer any response to the alternating current. There is some chance for error in this test due to occasional difficulty in locating the motor points of the individual muscles and to the variation in

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skin resistance, etc. Repeated tests usually reveal the true nature of the lesion. In surgical case with the nerve exposed this test is practically infallible in determining the condition of the peripheral nerve.

In the case of upper motor neurone lesions, there is no variation from normal in the electrical reaction, since the peripheral reflex arcs are intact. In cerebral hemorrhage there is normal response to the electric currents. Since alternating current is more effective in stimulating muscle, its use in therapy is recommended in these upper motor neurone lesions.

DIATHERMY DEFINED

There seems to be considerable confusion regarding the nature of diathermy. This is merely an alternating current of extremely high frequency. About 1890 it was discovered that alternating currents of above 10,000 oscillations per second produced no muscular response when passed through the body, and no sensation of shock. However, when the voltage and amperage of this type of current is increased, its passage through the body produces heat.

When the frequency of the current is between 1 and 3 million, the current is spoken of as "old" or "long wave," or better, "conventional diathermy." This requires no metal contacts, only the placing of the part to be treated within the field of the cable of the machine.

Since the World War II a third type of diathermy has been introduced. This is called "micro-wave," and has a frequency about 100 times greater than the familiar short wave diathermy. The short wave diathermy is in effect a short wave radion generator while the micro-wave is a radar generator.

Conventional diathermy is considered to be superior to the short wave in certain conditions. For example, in bursitis, it seems to give better results. This is probably because the output of the machine can be better controlled, and the inflamed bursa seems to react unfavorably to too great a concentration of heat. Certainly, in surgical diathermy, the conventional machines are the only ones that are practical.

While the use of diathermy is of great value in heating of body tissues, it seems to me that each year, the real contra-indications to its use and the conditions in which I believe it to be inferior to other forms of heat, increase. It has been said that it tends to increase muscle spasm. Certainly this is true if the heating is too intense. In acute low back strain, both from personal experience and experience with patients, I find it less satisfactory than certain forms of radiant heat. Muscle spasm seems to increase. In the acutely inflamed para-nasal sinus, unless adequate drainage is first provided, diathermy tends to increase the pain. In the presence of metallic foreign bodies in the area to be treated, this form of heat should not be used. This contra-indication should be constantly borne in mind, because the number of individuals with various metallic shell fragments, bone plates and metallic sutures imbedded in their tissues, has increased markedly during the last war. Many nerve lesions have been sutured with vitallim wire, and although I have never seen it happen, I believe that one diathermy treatment might permanently damage these nerves. The danger in these cases is due to the fact that the metallic bodies are better conductors and therefore heat

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more intensely than the surrounding tissue, resulting in some coagulation of body tissues. In the case of nerve tissue, only slight increase in heat is necessary to cause permanent damage.

On the other hand, certain fields of possible usefullness have been insufficiently explored. Schmidt of Northwestern University reported a considerable series of pneumonia patients, where the results were as good using short wave diathermy for 20 minutes of each hour, day and night, as with serum or sulfonamide. I of course, do not recommend its use in those cases of pneumonia which respond to the simpler procedure of using sulfonamides or penicillin. However, it seems to me it might well be tried in atypical or virus pneumonia for which there is no known specific therapy. (The vicissitude of military medicine prevented my ever being able to try it, in spite of an abundance of clinical material).

Using the same technique in a few cases of un-united fracture, Schmidt was able to bring about union in a comparatively short time. An interesting observation was made in this connection. In a case of un-united fracture of the leg, a patient observed that the nails of the foot had to be trimmed very infrequently. By painting one nail of the injured foot, and one of the well foot with a water proof polish, at the time of the injury, orthopedic surgeons associated with Schmidt were able to predict in a few instances that non-union would occur by observing the lack of nail growth in the injured part. They assumed that poor circulation, due to vaso-spasm, was responsible for both phenomena.

OCCUPATIONAL THERAPY

As previously mentioned, exercise as a physical agent may best be given as occupational therapy. While occupational therapy is in effect, physical therapy, it is such a specialized field that it requires special mention. In a well organized rehabiliation service, there must be close co-operation between physical and occupational therapy. As soon as a patient progresses sufficiently, he should be turned over to the occupational therapist for exercise. This does not imply that the occupational therapy waits until the physical therapy is completed. It is important that both be given concurrently. Thus, the two departments should be situated in close proximity. Before the patient is turned over to the occupational therapist, he received preliminary heating of an appropriate type and perhaps massage from the physical therapist. Immediately, he starts his exercise in the occupational therapy shop.

It may be explained here that there are, generally speaking, two kind of occupational therapy and functional therapy. So far we are only discussing functional therapy which is of the greater importance in this type hospital. The diversional program will be mentioned later.

Returning to the patient who has recovered sufficiently to go to the occupational therapy shop, he will continue to receive treatment from the physical therapist as long as it is needed. The occupational therapist devises an exercise which will be of interest to the patient and which will assist in increasing the power and function desired to be developed.

This type of therapy has two distant advantages over the exercises usually employed in the physical therapy department. In the first place, the therapist is able to accurately and progressively increase the resistance

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a patient must over come, so that there is continued increase in strength of the affected parts. Most important however, is the opportunity to encourage co-ordinated movement on the part of the patient. This is vital in a good exercise as there are no simple isolated movements in the normal person. Every contraction by a muscle requires relaxation of its antagonist. This is not a voluntary function but occurs automatically through the reciprocal innervation of opposing muscles. If this example of the function of one pair of opposing muscles is complicated by the addition of many more pairs of muscles acting together, it is clear that such a simple act as writing one's name would be a slow and laborious procedure if it were not for some automatic arrangement. Thus it is plain that the usual pattern of muscular action is that of co-ordinated movement. As previously mentioned, injury and disease often disrupt this co-ordination. Therefore, some interesting form of occupational therapy will tend to divert the patient's mind from his injuries and encourage the play of the physiological mechanism of co-ordination. Thus a more rapid return to the semblance of normal function results through correct occupational therapy.

It is well to mention here that the patient, when first undertaking occupational therapy may not be able physically to handle the conventional tools necessary for the work. Thus a patient with a hand injury might need to operate a screw driver but his fingers will not flex sufficiently to enable him to grasp the handle. The therapist compensates for this by supplying a screw driver with a handle perhaps twice the usual size. This enables the patient to do the work. As his function improves, gradually smaller handles are supplied until the conventional tools can be used. In the same category, it may be necessary for the therapist to suspend the upper extremity in a sling in order to bring the patient's hands to work and to protect insufficiently healed parts.

This is a good time to mention that the occupational therapist has ample educational background to be trusted to exercise proper precautions against re-injury. Some of us have the impression that the occupational therapist is merely trained in the teaching of various handicrafts. Such is not the case. Like the physical therapist, she receives a thorough training in such subjects as anatomy, physiology, kinesiology, etc. Before graduating, they also receive adequate supervised training with patients. I have never seen a patient refractured in any physical or occupational therapy department.

SKILL NOT FORCE DEVELOPED

Another common error is that occupational therapy is a form of vocational training. This is not true as vocational guidance is a separate field. The only possible application of occupational therapy is that, if a patient is so injured that he must change his occupation, he may get some inkling of the kind of work he will wan to do after being exposed to it in the occupational therapy shop. I know of one patient in a military hospital who became interested in working with plastics in this way. He has since started his own business in this field.

The greatest usefulness of occupational therapy is in those functions which require a great amount of skill and co-ordination rather than brute strength. Thus, it has greater application in the hands and upper extremeties than the lower extremeties, but more in the lower extremeties than the trunk. However, all these functions will improve either with or without design, when

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any type of work is undertaken. For example, sitting or standing at some machine improves other functions. Bunnell is most enthusiastic about occupational therapy for crippled hands and devotes considerable space to this field in his book.

While diversional therapy is of less importance in this type of hospital, it never-the-less does have a place. In this community of heavy industry, multiple and complex injuries are not uncommon. Long periods of hospitalization are frequently needed. In most instances, this becomes a psychologic problem sooner or later. Add to this the fact that the patient is frequently the head of the family and worried about financial matters brought on by loss of earning power. None of these problems is conductive to a favorable atmosphere for improvement. If the patient's mind can be diverted from his problems for only a part of the time, it will have a favorable influence on his recovery. However, the purely diversional work could best be carried on by volunteer workers, reserving the skill and training of the registered therapist for the more important fields.

In this rather disjointed and rambling paper, I have attempted to cover some of the high lights of these important fields of medicine. I realize that many things were omitted or passed over too lightly, but I hope that I have aroused new interest and that we will be able to expand the departments, so that adequate service can be offered the citizens of this community. I am sure that intelligent use of these agents will be beneficial to everyone concerned

DRAFTEE PHYSICAL REJECTIONS SHOW DECREASE

Draftee rejections for physical reasons in August were about 20 per cent lower than in July, Selective Service Director Hershey has reported to the House Armed Services Committee. General Hershey also noted that dental standards, which accounted for the biggest share of July and August physical rejections, have been drastically reduced, insuring that the rejection rate from now on will be substantially lower.

In August, according to General Hershey, a total of 204,000 men were examined, and in July, 12,757. Rejections for all reasons totaled 101,000 in August, or 49.4 per cent of those examined. Corresponding figures for July were 7,563 or 69.4 per cent. Physical rejections totaled 45,863 in August, or 22.5 per cent of the total examined. This was a drop from 29 per cent in July. Mental and educational rejections totaled 44,777 (21.9 per cent) in August and 2,660 (20 per cent) in July

General Hershey, who has been urging an easing of physical and mental-educational standards by the Armed Forces, pointed out that the World War II rejection rate was between 34 and 35 per cent, in contrast with the August rate of 49.4 per cent. The Selective Service chief also told the Committee that deferment of a certain percentage of premedical students, as provided in the doctor-draft law, would mean serious administrative difficulties. He said one of the greatest problems is created by the fact that less than a third of the men who take pre-medical training actually enroll in medical school.—*Capitol Clinics*

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"WHY WE SHOULD PRESERVE THE VOLUNTARY SYSTEM OF MEDICAL CARE IN THE UNITED STATES."

By Michael D. Orlando

In seventeen hundred and seventy-six the United States of America was born. In its first conception, it was born a democracy; a *democracy* that was to be a nation of free men. Since that day that spark has grown into a blaze seen round the world. Now this great fire of democracy has hanging over it a dark indolent cloud, the cloud of socialism and communism. The first drops from this cloud would be socialized medicine. If we allow such a storm to start it will develop into the greatest storm of all times. It will flood out democracy and human justice. Socialized medicine may not establish socialism in the United States, *but it sure will give it a big boost.*

The advocates of compulsory health insurance claim that such a program would bring health security into American homes. Sure Americans want security, but not security at the price of democracy. One of the principal rules of democratic government is to do for its people what they cannot do well for themselves. The government should not interfere and disrupt whatever people, as individuals, can do for themselves. American people, the true American people can and should always preserve this hereditary right of individualism without government interference.

America, one of the healthiest nations in the world, should not risk that status upon an experiment already proven inefficient and corrupt. True, the result of such an experiment here in America would not exactly conform to the results produced in Great Britain. But it would be similar *and that is bad enough!*

Under socialized medicine, our doctors would no longer push ahead on their own initiative. Their hearts, their willpower, their very beings would be shaken. The present-day relation between doctor and patient would be marred by government politics. The doctor would lose his familiarity with his patients. His patients would become meaningless numbers. It would not be "John" or "Mary" anymore, but No. 684759 and No. 746397.

Socialized medicine would discourage medical students. Why should they slave through ten years of study just to become government employees? Our most intelligent students, who today focus their eyes upon medicine as their goal, would divert their attention to other fields, and professions. Medical colleges would be forced to accept students of lower and lower quality. Doctors of inferior quality would be the inevitable end-products. *Is this what we want?*

The present day health situation is not perfect. It has faults, yes, but they will not be amended by socialized medicine. The doctors are not perfect; they make mistakes. After all they are not Gods, but only human beings themselves. Yes, the people who spend more money each year for alcoholic beverages than medical care are at fault.

The answer is not socialism. No, the answer is education. Teach the people. *Teach the people to help themselves!*

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CIVIL DEFENSE PROGRAM OUTLINED

A comprehensive plan of operations for civil defense has been prepared by National Security Resources Board for presentatioin to states and cities. At the same time, President Truman called on Congress to enact legislation to get the plan under way, including creation of a Federal Civil Defense Administration, with "power and authority to plan, review and coordinate the civil defense activities of the federal government and to coordinate the same with the civil defense activities of the states . . ."

It is the hope that states and cities will work out mutual assistance plans; if they don't, the CD Administration would be empowered to require such assistance in time of emergency. It places full medical and other responsibilities on existing civilian agencies and individuals.

An NSRB spokesman said the President has sufficient executive funds to start the program without new appropriations, and sufficient authority to change NSRB from a planning to an operating agency. If it receives this power, NSRB could administer the program while awaiting creation of the new administration.

Maps showing 140 critical target areas have been prepared and will be sent to governors. U. S. probably will purchase all regional medical stockpile supplies. Minimum state and local obligations are spelled out in such activities as first aid and ambulance services, emergency hospital systems, casualty services, health supplies, laboratory services, sanitation services, medical services, morgue services, records, etc. — *Capitol Clinics*

Health Department Bulletin

REPORT FOR AUGUST, 1950

	1950	Male	Female	1949	Male	Female
Deaths Recorded	174	97	77	169	88	81
Births Recorded	569	300	269	578	295	283

	1950		1949	
CONTAGIOUS DISEASES:	Cases	Deaths	Cases	Deaths
Chicken Pox	2	0	3	0
Measles	1	0	3	0
German Measles	1	0	0	0
Polio	3	0	11	0
Whooping Cough	8	0	32	0
Tuberculosis	7	6	2	3
Mumps	1	0	0	0
Typhoid Fever	1	0	0	0
Gonorrhea	36	0	39	0
Syphilis	35	0	35	0

VENEREAL DISEASES:

New Cases:	Male	Female
Syphilis	8	8
Gonorrhea	30	6

Total Patients 52

Total Visits to Clinic (Patients) 433

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

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RED CROSS GETS NEW JOBS

Red Cross has been given two more major civil defense responsibilities. In addition to supervising the nationwide blood program, it will coordinate first aid courses and courses for home nursing training and nurses' aide training. It is estimated that 20,000,000 persons may eventually participate in first aid courses, and that 100,000 women may receive home nursing or nurses' aide training.

FROM THE BULLETIN

By J. L. Fisher, M.D.

FIFTEEN YEARS AGO (OCTOBER, 1935)

Dr. Robert Odom and Dr. Elmer Wenaas came to town to be associated with Dr. W. H. Evans in E. E. N. T.

Dr. Carl Arthur Gustafson opened his office at 101 Lincoln Ave. for the practice of medicine.

Dr. Chas. Gordon Heyd, Professor of Surgery at Columbia University, addressed the Society on "The Role Occupied by the Liver in Abdominal Surgery.

Dr. Clarence Sears became associated wi h Dr. H. E. McClenahan in the practice of gynecology and obstetrics.

Dr. Claude Norris addressed members of the Y. W. C. A. on "How One May Have a Beautiful Skin."

TEN YEARS AGO (OCTOBER, 1940)

Dr. Edgar V. Allen of the Mayo Clinic addressed the Society on "Peripheral Circulation" and showed an interesting film on "Orthostatic Hypertension."

The Annual Dinner Dance held at the Youngstown Country Club was a gala affair.

Dr. Barclay Brandmiller and his bride, the former Jean Richards, returned from their honeymoon. They were married September 19th.

Dr. S. H. Davidow became a member of the Society.

Strouss-Hirshberg's advertised Tuxedos for $30.00.

Mrs. R. M. Morrison was elected President of the Auxiliary.

NEWS

Dr. William H. Bunn, Chief of the Medical Services of the Youngstown Hospital, will serve on the faculty of the Chicago Medical Society Post Graduate Course in Disease of the Heart, Kidney, and Blood Vessels to be given in Chicago, Oct. 30 - Nov. 3. Dr. Bunn will present a clinic on Pulmonary Complications of Heart Disease and will serve on a panel discussion of presentation of patients with various aspects of heart disease.

Dr. Morris Rosenblum has enrolled in the University of Pennsylvania Post Graduate School for course in Internal Medicine during the coming year. Dr. Rosenblum expects to make frequent week-end trips to Youngstown to maintain some of his professional contacts here.

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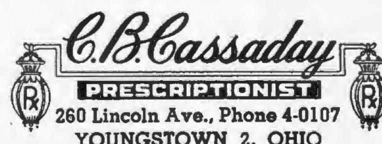

SURGICAL DRESSINGS SICK ROOM SUPPLIES

BLUE CROSS ENROLLMENT

The Associated Hospital Service reported a total Blue Cross enrollment of 212, 521 as of July 31, 1950. The Service covers Mahoning, Trumbull, Columbiana, Jefferson, Belmont, Washington, Monroe, and Noble Counties. In addition enrollment in Blue Shield is now at 47,644 members.

Veterans Administration hospitals handled 31,428 service-connected and 63,232 non-service-connected cases in August 1950.

SPEAK NOW

In every human undertaking, there comes a time for action, a time for decision. You can describe it in the language of the marriage service or — if you prefer-of the poker table, "Put up or shut up." No matter how you phrase it, the alternative of such a time cannot be denied.

This is a time of decision that requires positive action on the part of the medical profession. If this action is not forthcoming doctors cannot reasonably complain of the consequences.

This is a year in which the American people elect Senators and Congressmen to represent them in Washington. Under our system of Government, it is up to every citizen to work for the success of the candidates in whose views he believes. Only through active effort can we have good government.

This responsibility is now squarely before all doctors. If they are to be well represented they must work, and they must start now. Doctors, their families, their friends, all they can influence must be contacted. On election day in November it is up to the doctors to help turn out the vote, close their offices and offer their cars for transportation of voters to the polls.

There is only one way to preserve American freedom-medical freedom-under our democratic process. That way is the voting way-the electioneering way. It is the best way ever devised, but it poses responsibilities. But they are responsibilities no doctor can afford to sidestep. They are responsibilities that need meeting—now—today. Speak now.

C. A. G.

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