BULLETIN

of the

Mahoning County Medical Society

"To each according to his need;
from each according to his means."

July, 1935

Volume 5 Number 7

IN FECAL PUTREFACTION PROTEOLYSIS

KARICIN

KARICIN is more than just kaolin and mineral oil. It is a ricinoleated emulsion which adds a strong detoxifying action to the adsorptive powers of the kaolin.

The nature of the ricinoleate is such that when it reaches the intestines, it is readily converted into Soricin—a detoxifying agent, effective against the toxic products of putrefactive and proteolytic organisms.

Karicin offers a valuable physico-chemical attack on diarrheas, hypermotility, colitis. It not only helps to check bacterial proteolysis, but is soothing to the inflamed bowel.

Karicin is exceptionally palatable and well tolerated by the patient.

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CINCINNATI, U. S. A.

For bland diet therapy, especially ULCER cases — PABLUM

FAR too often the bland diet prescribed for gastric ulcer, colitis, and similar gastro-intestinal disorders is a deficient diet. An analysis made by Troutt of ulcer diets used by 6 leading hospitals in different sections of the country showed them to be "well below the Sherman standard of 15 milligrams" in iron and low in the water-soluble vitamins.[1] "Vitamin B would appear to be represented at a maintenance level in most cases," writes Troutt, "but the possible relation of vitamin B to gastro-intestinal function and appetite should make one pause before accepting a low standard."

Although Pablum has a low fiber content it is 37 times richer than farina in iron and in calcium, 4 times richer in phosphorus, and 4½ times richer in copper.

Low in Fiber — High in Iron

Pablum is the only food rich in a wide variety of the accessory food factors that can be fed over long periods of time without danger of gastro-intestinal irritation. Its fiber content is only 0.9%. Yet Pablum contains 37 times more iron than farina and is an excellent source (+ + +) of vitamins B and G, in which farina is deficient. Supplying 8½ mgms. iron per ounce, Pablum is 8 times richer than spinach in iron.

Rich in Vitamin B

The high vitamin B content of Pablum assumes new importance in light of recent laboratory studies showing that avitaminosis B predisposes to certain gastro-intestinal disorders. Apropos of this, Cowgill says, "Gastric ulcer is another disorder which can conceivably be related to vitamin B deficiency. Insofar as the treatment of this condition usually involves a marked restriction of diet the occurrence of at least a moderate shortage of this vitamin is by no means unlikely. Obviously the length of the period of dietary restriction is an important determining factor. Dalldorf and Kellogg (1931) observed in rats subsisting on carefully controlled diets that the incidence of gastric ulcer was greatly increased in vitamin B deficiency. Observations of this type merit serious consideration."[2]

Requiring no further cooking, Pablum is especially valuable during the healing stage of ulcer when the patient is back at work but still requires frequent meals. Pablum can be prepared quickly and conveniently at the office or shop simply by adding milk or cream and salt and sugar to taste. Pablum has the added advantage that it can be prepared in many varied ways—in muffins, mush, puddings, junket, etc. Further, Pablum is so thoroughly cooked that its cereal-starch has been shown to be more quickly digested than that of farina, oatmeal, cornmeal, or whole wheat cooked four hours in a double boiler (studies *in vitro* by Ross and Burrill).

Pablum consists of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa, yeast, beef bone, iron salt and sodium chloride.

1-2 Bibliography on request.

MEAD JOHNSON & COMPANY, Evansville, Indiana, U. S. A.

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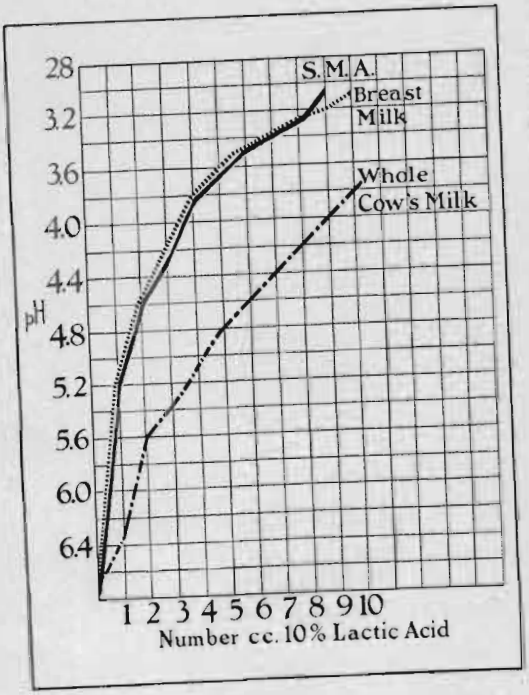
In BUFFER VALUE *too*, S.M.A. *resembles* BREAST MILK



This buffer chart shows the close similarity between the buffer value of S.M.A. and Breast Milk and the wide difference between cows' milk and Breast Milk. *This also explains why it is not necessary to add an acid to S. M. A.*

Breast Milk from the Normal Mother is the Ideal Food for the Human Infant. That is why S.M.A. is made to resemble breast milk in percentages of carbohydrate, protein, fat and total salts (ash) content, and why even the chemical and physical constants of the fat in S.M.A. are like those of breast milk fat.

This photograph shows the equipment for determining hydrogen ion concentration necessary to plot the Buffer Curve. The chemist drops a measured quantity of acid (from the tall tube in the right foreground) into solution to be tested (in the beaker below) and records the readings from the dial before him.

S.M.A. is a food for infants—derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an anti-rachitic food. When diluted according to directions, it is *essentially similar to human milk* in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

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THE MAHONING COUNTY MEDICAL SOCIETY BULLETIN

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MISCELLANEOUS ITEMS

PRESIDENT'S PAGE

MANY months ago Frank Lyons asked me to write something in the *Bulletin* about the proper way to obtain, prescribe, and dispense narcotic preparations. The subject did not appeal to me. Every doctor has a copy of the regulations sent him by the Internal Revenue Department, which he can read. But Professor Lyons said that many doctors did not seem to understand the importance of observing the regulations to the letter and that some of them might innocently get into serious trouble. Recently Ralph White told me the same thing and added that he sometimes receives prescriptions not properly made out which he could not fill because the law makes the druggist jointly responsible.

Events of the last month have borne out their predictions and, innocently or not, we find doctors in serious trouble. After sitting in Federal Court in Cleveland for two days listening to the trial of a case of violation of the Harrison Narcotic act, one is more than ever impressed with the importance of being extremely careful to live up to the letter as well as the intent of the law in the everyday practice of medicine. When you consider that your good name, your means of making a living, your savings and your liberty, may all be taken away because of a violation of this law, it assumes a place of major importance in the professional life of every doctor.

Often I have heard some of my older colleagues say, "All you need to do is practice honestly and do what is right and you will never be bothered about minor violations." I wish this were true but unfortunately it is not, and I can cite instances where a doctor's sympathy and humanitarian instincts have led him into trouble. As to minor violations—in the recent trial in Cleveland the whole thing simmered down in the closing argument of the prosecution to a *technical* violation on which conviction was obtained. That *technical* violation was this: The Government claimed that the doctor had written a prescription for an amount of a narcotic for a patient and appropriated it for his own use. The patient never got it. The prosecutor said this violated both purposes of the law—the collection of revenue and the protection of morals. The amount of revenue involved was one cent for an order form, but the moral issue was incalculable. How many of our doctors when they have needed morphine for their hypo cases have written a prescription for someone, instead of bothering with the official order form, which is a nuisance to fill out and must be kept on file for two years? An old friend of mine, now dead, *always* wrote a prescription and he was the soul of honor. My druggist friends tell me that they believe it is done very frequently just to avoid the red tape. Think of the significant implications brought out when it is found that such prescriptions were not filled by the patient! Better to endure the red tape.

Another way doctors are liable to get into trouble is by yielding to sympathy when faced with the sufferings of an addict deprived of his drug. These persons present such a miserable, abject and pitiful spectacle that no one could bear to see even an animal suffer so. The law states that narcotics can be administered to an addict who is aged and infirm to prevent death, but not in excessive amounts. The narcotic division believes that four grains a day is sufficient for any case. But all addicts are not aged and infirm. What can be done about saving their lives? Only one thing. The law permits administration of narcotics to a known addict only as part of the withdrawal treatment. This should be done in a properly equipped institution, under strict supervision, with careful records kept which show a reasonably rapid diminution in

(*Turn to Page 220*)

BULLETIN

of the

MAHONING COUNTY MEDICAL SOCIETY

JULY 1935

Pros and Cons of Relief

What about Federal-State Medical Relief? Is it working efficiently? Is it fair to both doctors and patients? Do the members of our profession approve it? Is its philosophy correct? Is it another step towards State Medicine? How does its actual administration compare with other forms of relief? If the fees agreed upon are fair and just, can pro-ration be justified as applied to the doctor's bill any more than as applied to the bills of grocers and druggists?

Nothing else is being more generally discussed. Since one of the purposes of the *Bulletin* is to serve as a medium through which Society members—and sometimes others—may express their views on subjects of especial interest to us as medical people, we are printing this month a sort of "symposium" on Medical Relief. Of course this does not close the subject so far as the *Bulletin* is concerned. Your views are also welcome.

The preponderance of views expressed in these papers indicates strong disapproval of the set-up as it is. Some feel that the whole thing is wrong and actually stultifying. Some make suggestions as to how to improve its administration. But all the papers are interesting and very thoughtful.

Play, work, Play

Too many medical men are passing out of the picture prematurely. Dr. Bunn, in a recent public address, gave in straight forward, easily understood language, the reasons. Over-work, worry, loss of sleep—not to mention certain other "toxic" things. Here's what Phaedrus says:

"The bow that's always bent will quickly break;
But if unstrung will serve you at your need.
So let the mind some relaxation take
To come back to its task with fresher heed."

And Shakespeare:

"Sweet recreation barr'd, what doth ensue
But moody and dull melancholy,
Kinsman to grim and comfortless despair,
And at her heels a huge infectious troop
Of pale distemperatures, and foes to life?"

SECRETARY'S REPORT

At the meeting of Council on June 7, 1935, the Public Relations Committee made the following report:

1. That we recommend the use of the Municipal Hospital on Indianola Avenue, Youngstown, Ohio, for a Psychopathic Hospital.

2. That we recommend the employment of a well-trained psychiatrist, who shall not engage in private practice of medicine except by consultation and on demand of a physician.

3. That we recommend the patient and his family have the right to employ their own physician if they so desire.

This was approved by the Council and was referred to the Society as a whole.

The Society's regular monthly meeting was held at the Youngstown Club on June 18, 1935, and the following papers were read: "Modern Treatment of Mental Diseases," by Dr. Arthur G. Hyde, and "Hallucinations and Diagnosis," by Dr. Arthur O. Gillam, both from Massillon Hospital.

Major Ewing from Fort Hayes, Columbus, Ohio, urged that the younger men of the profession join the Medical Reserve Corps because the ranks of the Reserve Corps are becoming depleted and to have a good army it is necessary to have a good medical corps. He said that the doctor is the first man in service when war is declared and the last one out after war ends. He gave some very enlightening facts to show the necessity of preparedness. Because of the essential demand for certain foreign-produced commodities, it is impossible for us to live alone.

Following the regular meeting there was a short business session when the Psychopathic Hospital was discussed and the Society endorsed the resolution of the Public Relations Committee of June 7, as approved and submitted by Council, and instructed the Secretary to inform the County Commissioners of the Society's action.

Members of the Speakers' Bureau:

Will you please allow a few moments at the end of each talk to P. T. A. and other meetings for publicity concerning our diphtheria immunization campaign in Youngstown? Besides the general information concerning diphtheria immunization which you know and can impart to parents, we wish you to give them the following special message:

That the charge for diphtheria immunization is so small that there will be very few people who will not be able to pay for it. However, for those who are unable to pay, provisions have been made so that there will be no charge to them. They will simply have to sign a card that they are unable to pay.

W. M. SKIPP, M. D.,
Secretary.

Speakers' Bureau

The following doctors made addresses over WKBN, during the month:

Dr. R. B. Poling, June 11th, on "Vacation Health."

Dr. Joseph Rosenfeld, June 18th, on "Relieving Hay Fever and Asthma."

Dr. Louis Deitchman, June 25th, on "Swimming Hazards."

Dr. J. D. Brown, July 2nd, on "The Foolish Fourth."

Dr. A. Marinelli, June 23, addressed The Agnonesi Club, on "The Agnonesi as American Citizens."

"Forever and ever it takes a pound to lift a pound."—*Emerson.*

MEDICAL FACTS

By J. G. B.

Progress in Gastro-Enterology for 1934*

Because caffeine stimulates the secretion of gastric juice, Hanke employed it for the experimental production of chronic ulcers in cats. For two months the animals were given almost daily subcutaneous injections of from 0.2 to 0.3 gm. caffeine sodiosalicylate. At the end of two months the stomachs of the cats showed chronic ulcers, the structure of which resembled closely that of human ulcers. He calls attention to the possibility that caffeine may play a part in the pathogenesis and further development of peptic ulcers in human subjects.

Various injections have been utilized in the treatment of peptic ulcer, but the reports show that all give about the same results, namely, relief from discomfort in a large proportion of the cases. Unfortunately, this improvement usually persists for less than a year.

Udaondo stresses the necessity of patients with peptic ulcer continuing the medical regime. It is now being generally recognized that our present methods of treatment are sufficient to relieve but do not cure the disease.

Jones administered from 10 to 15, sometimes 20 units of insulin subcutaneously, 15 minutes before eating, to 12 patients having recent peptic ulcers. The action was not immediate but usually in from 4 to 5 days of insulin treatment there was a decrease in pain, improvement in the subjective condition and an increase in weight.

Saralegui advocates the injection of 20 to 30 cc. of thorotrast of Heyden in the drainage tube after cholecystectomy. By use of the fluoroscopic screen he believes that the presence of hepatic stone may be satisfactorily observed.

Although hookworms are rarely seen in this part of the country, the fact that parasites can simulate the symptoms of various diseases of the intestinal tract should be kept in mind. Emery has seen one case which suffered from symptoms suggestive of duodenal ulcer and was promptly relieved after the passage of an ascaris.

The Morro treatment of diarrhea by the apple diet continues to be used in European clinics. Baumann and Forschner-Boke state that although the favorable influence of the apple and banana diet on diarrheal disturbances has been definitely established, the mode of action is still in dispute.

Goldberg and Nathanson point out that an acute mesenteric lymphadenitis may give a picture similar to that of acute appendicitis. They report the results on 16 surgical cases in which the appendix was grossly normal. Five of these cases showed fluid present in moderate quantities. Enteritis of some degree was not infrequent. They stated that the etiology is not known but suggest that the condition may be due to a streptococcic involvement coming from the throat.

Anderson and Reed discuss the untoward effects of anti-amebic drugs. They point out that emetin hydrochloride is toxic for most mammals including man, in total doses of 10 to 25 mgm. per kilogram of weight. The heart muscle bears the burden of the toxic effect. The maximal safe total dose of emetine hydrochloride is 10 mgm. per kilogram of weight in patients with an amebic hepatitis and free from heart damage. Acetarsone may exhibit toxic manifestations in one of every 6 cases treated.

*For references see Emery, N. E. J. M., Vol. 212, Nos. 15, 16, 17.

PRESIDENT'S (from p. 216)

the dose. There is no other way you can treat a known addict without incurring the suspicion of catering to his addiction. The law is strict, you have no choice, and the penalty is severe.

I do not believe that one doctor out of ten keeps proper records of narcotic preparations dispensed. The law here is ambiguous and space does not permit discussion of this phase. There is a very complete resumé of the narcotic regulations in the *Ohio State Medical Journal* of last May which everyone should read carefully. The study of this entire subject is just as important as the study of the medical side of practice and should not be neglected.

In closing let me present a very important part of the subject not covered by the law, and that is the prevention of addiction. Every addict blames his plight on the administration of a narcotic by some doctor in the treatment of previous disease. I am not willing to believe that this is true even in a small proportion of cases, but nevertheless we should be extremely careful in the treatment of patients requiring the use of such preparations. Certainly the patient with painful, incurable disease which is bound to cause death should have all the morphine necessary to render him comfortable, but modern medical treatment as a general rule does not find it necessary to administer habit forming drugs over considerable periods of time to those with curable disease, especially if the symptoms tend to be recurrent. Modern pharmacology has so augmented our armamentarium that we have a wide choice of pain-relieving remedies. Let us be scrupulously careful not to produce an appetite for narcotics in any patient. Further than that let us be careful that no narcotic preparations through us shall fall into improper hands. The intent of the Harrison Act is laudable and by complying with it to the letter we are helping to stamp out a great evil.

JAMES L. FISHER.

Medical-Dental Elects

Thursday evening, June 13th, The Medical-Dental Bureau held its First Annual Meeting, at the Elks Club. It was well attended and those present were well entertained. The music was excellent, and the dinner was—excellent, too. Besides, the reports of the President, Dr. McCurdy, and others, showed that the Bureau, during its first year, had been conducted successfully.

Three members of the Board of Directors were elected, who, by the way, were re-elected, as follows: Dr. W. Howard Hayden, Dr. H. E. Hathhorn, and Dr. Robert Poling. New officers are: Dr. Sidney McCurdy, President; Dr. J. D. Chessrown, Vice President; Dr. H. E. Hathhorn, Secretary; and Dr. W. Howard Hayden, Treasurer.

OH, NURSE!

District No. 3 held its annual picnic June 25th at Slippery Rock Pavilion. Instead of the usual picnic dinner a box picnic was arranged and the proceeds from the sale of boxes was contributed to the Ohio Nurses' Relief Fund.

A son was born in June to Mr. and Mrs. Harold Ift. Mrs. Ift was the former Ruth Morrison, graduate of Youngstown Hospital class of 1932.

Miss Edith McLean of the Nursing staff, South Side Unit, Youngstown Hospital, was married June 11 to Mr. Francis Clark of Youngstown.

Mr. and Mrs. Evan Powell are the proud parents of a son born June 11th at the North Side Unit, Youngstown Hospital. Mrs. Powell was

Dorothea Williams, graduate of Youngstown Hospital class of 1932.

Miss Mary Knauf, operating room supervisor in South Side Unit of the Youngstown Hospital, left June 20th to take a similar position in New Rochelle, New York.

Miss Ruby Knauf, Youngstown Hospital graduate class of 1916, was married in May to Mr. Arthur Boley. Mr. Boley is city engineer in Sheboygan, Wisconsin, where they will reside.

The population of the United States has been growing slowly; the number of trained nurses has been growing very rapidly. The United States Census figures for the general population and for trained nurses, including student nurses, are as follows:

Year	Population (Millions)	Trained Nurses
1900	76	11,892
1910	92	82,327
1920	106	149,128
1930	123	204,189

During this 30-year period the population of the United States has increased 60% while the number of trained nurses has increased 2,374%. In the past 4 years approximately 100,000 new nurses were added to the profession.—*Nursing Schools Today and Tomorrow*, 1935.

St. Elizabeth's Library Party

Food, fun, foam, and friendliness, —these tell you that the St. Elizabeth's Library Party, held Saturday evening, June 29th, at Renner's Brewery, was a great success. Aside from the fine purpose—additions to the Hospital Library—the party just for itself was wholly worth while in that it gave another occasion when "good fellows get together."

Dr. Ivan Smith sat out front, and you simply had to greet him—he had such a "taking" manner. Then just to your right, as you enter, gentlemen, was a device that spun around and stopped on a number—always somebody else's number! This you were inveigled into dabbling with because of the "come-hitherness" of Drs. P. J. McOwen, Saul Tamarkin, Joe Nagle, M. W. Neidus, W. Z. Baker and others. Then over to your left sat, or rather stood, Mr. Jim Quinn and Dr. M. E. Hayes, with "chuck-a-luck." You generally chucked your luck all right—but you "chucked" it in the right direction—viz., where you're sure to get it all back in good "readin'." Over here towards the rear right sat Drs. Elmer Nagel, E. W. Coe, Ray Scott, and Joe Kupec, and the words "five-hundred" were uttered frequently—possibly referring to cents rather than dollars! Several seemed to make it pay, e. g., Dr. C. D. Hauser and, in particular, Dr. Joe Ranz, who possibly have had experience in the "numbers," certainly knew their way around! But now swing to the left—and what do you see? Dr. Jim Birch back of a table full (the table, not Jim) of everything it takes in the way of food—and a little further to the left—oh, boy! What delicious water Renner's use! Proceeding on to the adjoining "East" Room, hovering about a long table, were Drs. E. M. Rosenblum, Klinke, L. G. Coe, and Cafaro, sleeves rolled to elbows, "guarding the bones." Then to the north of this scene were the bridge "hounds," Drs. "Hank" Osborne, E. W. Cliffe, Jim Nelson, Louis Deitchman, and a lot more. Dr. F. W. McNamara cut an elegant figure as he "flitted" about, here, there and everywhere, trying to "help." Sitting and standing about were Mr. Clyde Campbell, Mr. Jim Hyland, Drs. Arundel, W. K. Stewart, Claude Norris, and Marvin Goldstein, smiling benign approval. There were a lot of others there, too —good fellows—but we just don't have their names!

The party was a financial success as well as a social success. Renner's, as usual, were royal hosts!

Women's Clubs Boost Park Commission

No group of citizens is more interested than the Medical Profession in any civic movement that gives promise of improved health conditions. Parks and play-grounds do that. It is doubtful if the majority of us realize what a blessing we have in that respect. Mill Creek Park is one of the "wonders" to the new citizen and to thousands who see our community only in passing. Scattered all over this city are many other lovely parks and recreation grounds.

These are too precious to be dealt with haphazardly. And here's the point: The Federation of Women's Clubs, under the extraordinary leadership of their president, Mrs. McDonnell, is leading in an effort to establish the control and administration of the parks and playgrounds under a non-partisan, non-paid (except in satisfaction) Commission. This Controlling Board is to consist of 5 citizens, as follows: one to be appointed by The Board of Education, one by City Council, one by the Mayor, and two (at least one of whom must be a woman) by the Judges of the Court of Common Pleas. The final tenure of the appointees is to be 5 years.

No politics, no "monkey-business" here. Our Profession will be back of this!

Diphtheria Our Responsibility

By J. A. A.

Prevention and Treatment of Diphtheria *H. H. Pansing.*

Ohio State Medical Journal Vol. XXXI No. 6, June 1935, Page 436

"No child in Ohio need die of Diphtheria," this slogan of the Communicable Division of the Ohio Department of Health appeared in 1923. In 1927, the diphtheria case rate was 109 per 100,000 population. In 1933, 2362 cases were reported with a case rate of 34 per 100,000 population. In 1933 there were 164 diphtheria deaths with a death rate of 2.36 per cent.

Pansing further reports the use of toxoid in the first three grades of Montgomery County schools and concludes that:

(1) Early immunization with toxoid is a distinct advantage over toxin antitoxin.

(2) To secure practically 100 per cent. immunity, two doses of the one dose alum precipitated toxoid is required, one dose conferring immunity to between 85 and 90 per cent. of cases.

(3) Until all infants are immunized by their family physician, at the very earliest age that they are found susceptible, then and not before will the slogan, "No child need die of Diphtheria" be fully realized.

The Youngstown City Board of Health reports as follows:

	Diphtheria Cases	Deaths
1932	138	10
1933	70	1
1934	30	0

The Mahoning County Board of Health reports as follows:

	Diphtheria Cases	Deaths
1932	37	5
1933	11	3
1934	9	0

The Public Health Committee of the Mahoning County Medical Society has been very active in a year-'round Diphtheria Immunization campaign. The whole matter of diphtheria immunization is a public function which we as physicians demanded and which we as a Medical Society accepted. If we are to improve the quite satisfactory record of 1933 and 1934, one hundred per cent. coöperation between each individual physician and patient is necessary.

Every physician must talk and practice Diphtheria Immunization!

OPINIONS OF OTHERS

By P. J. F.

We hear much about social and economic security. Most of it reflects the individual viewpoint as dictated by self-interest, or mere "parroting," but, now and then, opinions rest upon a philosophical basis. In the latter the following seems to belong.

Character and Economic Security

Unrest abounds, and the unrest is universal. While it is more mental than physical, it would seem to have the effect of discouraging individual lines, and appears to be marking time against the moment when a call for mass activity may be made. Everyone seems too lazy to do anything unless someone appears to drive him. Why should anyone await such a call? Why should anyone sit still and await the action of someone else, when his own welfare is a matter of his own private concern? . . .

The men and women that made this marvelous country had no such complex. They had no "Relief"! They had no social workers preying upon them, nor aiming to provide them with compulsory health insurance. They are said to have had no competition in the virgin country; hence their success. How foolish such a statement! They had the competition that comes from ignorance of conditions, ignorance of agriculture in a new locality, lack of adequate equipment, and no market for the products of their brain and brawn. . .

And now in this wonderful age with 1,900 colleges scattered throughout the country and any number of educational clubs and philanthropies, the only devices we can think of for the restoration of prosperity comprise boosting the liquor business, developing war industries, and the destruction of farm products! . . .

The same selfishness that actuates the liquor enthusiast and the war industrialist provides the inspiration for the professional worker in the relief field. The more participants on relief the more card indexes, the more folders, the more surveys, the more confusion, the more workers, and the more salaries. Any time one of them works for nothing, she or he gets fired for inefficiency. It is a bad precedent and likely to put a crimp in the whole racket. This entire group, fostered by the favor of the Federal Administration, is expanding daily at a tremendous rate and bids fair to equal the number of recipients of the relief. Prospering on the adversity of our fellow men is not an expression of the highest type of character. . .

The three learned professions, medicine, the clergy, and the law, with medicine pre-eminently first, enjoy a type of organization which makes possible promulgation of any kind of propaganda a matter of relative ease. Some of our thinking physicians would like us to have periodic conferences with representatives of these other professions so that we might provide the several communities in which we live and work and serve, an educational forum centering around the re-establishment of individual character as the foundation stone of our social and economic security. Physicians have been devoting their lives to the saving of the lives of their fellow men. Surely this should be, as the expression goes, their line. The manner in which the medical profession has stood up under the strains and stresses of the past four years is mute testimony to its ability to head up such a movement. Certainly no class could enter such a group with hands so clean.—Editorial, *Weekly Roster & Medical Digest*, April 20, 1935.

"There are times when it is better to incur loss than to make gain—*Plautus*.

Gleanings

By S. J. T.

Dr. J. E. Hardman recuperated slowly after his tonsillectomy, but is now feeling fine again and ready to be on the job.

Dr. W. J. Colbert has finally been permitted out of bed. He has at last gotten rid of all the barium and feels fine again.

Dr. C. S. Lowendorf presented some motion picture films on "Reconstruction Operations of the Upper Extremities," at the June meeting of the Staff of St. Elizabeth's Hospital.

Dr. J. F. McGowan has departed for Chicago where he is entered at the Rush Postgraduate Medical School and the Presbyterian Hospital. He is specializing in eye, ear, nose and throat work and expects to be gone about a year and a half.

Drs. Bachman, E. C. Baker, Elsaesser, Kling, Lewis, Montgomery, Neidus, Skipp, Saul Tamarkin, O. J. Walker and H. S. Zeve attended the recent meeting of the American Medical Association in Atlantic City.

Drs. Lewis and E. C. Baker had an interesting demonstration of "Lesions of the Lower Ureter" at the A. M. A. They exhibited a large number of x-ray plates.

Health News

By H. A. K.

Just at this particular time, the Animal Industry Bureau of the United States Department of Agriculture makes available sufficient funds to attempt eradication of a little-heard-of disease endemic in this area. Undulant fever, so called because of its wave-like temperature curve, had its origin in goat countries, but as soon as goats were imported so was the disease, and now the cow and the pig are the "goat" here. As high as 25% of cattle tested show positive reactions. Efforts will center on testing all cattle possible and those found positive will be destroyed at government expense, the owner remunerated for slaughtered reactors.

In man the infection is largely contracted by drinking raw milk from infected cows, but it can also occur through handling diseased meat, especially that of swine. The incubation period may be 5 but is usually 10 or 12 days with an onset of malaise, headache, chills, fever, backache, sweating, muscular and neuralgic pains, insomnia and mental depression. Abdominal pains may even lead to diagnosis of an acute abdomen. Typhoid, malaria, T. B., rheumatism or neuritis may be similated, but serology clinches the diagnosis. The fever in typical cases is characterized by afternoon rise and forenoon fall. Loss of weight and strength with profuse night sweats is impressive. After apparent recovery, relapses occur commonly in a few weeks or several months. Since the treatment of this disease has no specific and is so prolonged, eradication from farm animals to prevent milk and dairy product contamination is imperative, or we may see more of our micrococcus melitensis billy-goat-friends.

What Can Men Mean?

By MARY MILES COLVIN

What can men mean,—
In this great day,—
In this great time,—
When God has given the key
To all His mysteries?
When earth, and sea, and sky
Respond unto man's will,
As ne'er before, since time began.
What can men mean,—
To use these powers,
Not to benefit mankind,
Nor carry out His thought of life and love,—
The Brotherhood of Man,
But to wound and kill their kind,
To devastate the land,
To break the hearts of women,
And to leave even the little children
Lonely and disconsolate?
How will they answer for this thing?
What can men mean?

July

July and August

VACATION

For the Best Good of Ourselves
and Our Patients

PLAY WORK PLAY

After Vacation

September

DR. ED. PLASS
Professor of Obstetrics, University of Iowa

October

DR. CHAS. GORDON HEYD
Professor of Surgery, Columbia University

November

DR. H. L. BACKUS
Professor of Medicine, University of Pennsylvania

December

ANNUAL MEETING

January

ANNUAL BANQUET

February

Not Ready

March

DR. ELLIOTT P. JOSLIN
Professor of Medicine, Harvard University

April

POSTGRADUATE DAY
Group from Columbia University

MEDICAL RELIEF: A SYMPOSIUM

The Council of the State Medical Association, and the Policy Committee, have had several conferences with Mr. Stillman, State Relief Administrator, with the following results:

Revised Relief Plan

Under date of May 28, Mr. Stillman wrote the State Executive Secretary, outlining his decision on certain changes that would be made as soon as practical in the medical relief program.

The revised plan, as summarized briefly in that communication, is as follows:

1. The available amount of money for medical care in any county will be the sum obtained by multiplying $1.00 by the number of current family relief cases, plus an amount represented by multiplying 25c by the number of single cases exclusive of transients. (Under the former plan, no amount was made available for medical care of singles.)

2. The amount representing the cost of medical supplies will be considered apart from the amount available for medical services. (Heretofore, the cost of medical supplies has been met out of funds made available through the $1.00 per family allocation and paid, in most instances, at 100c on the dollar before bills for professional services were paid. This was responsible for pro-rating of physicians' bills in many instances.)

3. No changes will be made in the fee schedule and pro-rating will be resorted to when necessary. (Presumably if we don't like it we can lump it!)

4. An effort will be made by the State Relief Administration to have each county relief director set up on a voluntary basis an advisory committee composed of a physician, a dentist, a nurse, a pharmacist and the relief director or his proxy. In formulating such a committee, the local relief director will be expected to secure the coöperation and assistance of the county medical society and societies representing the local dental, nursing and pharmaceutical professions. In this connection, it is planned to have the physician member of the advisory committee serve as a medical adviser to the local relief administration and assist in validating bills for professional services, supplies, etc. The idea was offered that should the physician medical adviser choose to give a designated number of hours, up to 3 or 4 a day, for field service in connection with the medical relief program, then he would be placed on a salary basis at an amount to be agreed upon by him and the local relief director.

The State Council continues:

"It is hoped that the officials of all county medical societies will immediately confer with their local relief director, offer their coöperation, and especially request him to make available for professional services the full amount allowed by the budget set up in the revised plan. Failure on the part of any local relief director to coöperate with the local medical profession should be reported to our state headquarters office so that the matter can be taken up with the proper officials at the state relief office."

By Walter King Stewart M. D.
Chairman of Economics Committee

A Frank Discussion of the Mahoning County Experiment

Whether we all approve or not, the fact remains that Mahoning County sponsored and put into effect a socio-medical program of indigent medical relief. The success or failure of the venture is still problematical, but it will serve as a basis for study and needed experience in future consideration of this economic problem. Before we get down to facts and expla-

nations, please keep in mind the Committee which has so diligently served had no criterion to follow; nothing except traditional disgust with the entire problem and a few vague rules prescribed by the Government entitled Regulation Number Seven.

Another fact never considered by the economically secure physician and often lost sight of even by the physician whose lot it is to treat the poor, is that, fundamentally, the basic effort of the Committee's work was to give financial assistance to the needy physician. It seems but a myth by today's reckoning that three city physicians were permitted more or less efficiently to treat the poor of this community at a ridiculously inadequate figure, while fifty or more physicians were leaning toward indigency. These physicians have been enormously helped over the hump of the depression by the Mahoning County experiment.

Most of the protests and often justifiable criticism comes from the economically secure physician, but you cannot escape the fact that the physicians of this county have received during the existence of the Mahoning County Project some $100,000.00.

The Mahoning County experiment has safeguarded the confidential relationship between the patient and his family physician. There has been absolute freedom of choice on the part of the patient as to his physician. This, you will remember, is Point One of the A. M. A. House of Delegates' famous Ten Points. The Committee observes after nearly two years of experience that with a set-up freed of hampering restriction Point One is workable.

Those in favor of clinic or dispensary practice for the needy will argue that the type of service offered by Point One isn't efficient. The Committee answers this argument by calling attention to a certain foundation who spent a huge sum of money to arrive at a conclusion that 85 to 90 per cent. of the ills which mankind is subject to may be adequately treated by the general practitioner, and with the ordinary equipment he carries or has available in his office. The services of a specialist were available under the Mahoning County Plan.

The Committee looks with much anticipated interest to the Erie County Clinic Plan for their experience. With similar material, their plan is entirely the opposite from our own. One thing certain is that their plan is less expensive.

The Committee had the foresight to incorporate into its rules and regulations the rule requiring that if the indigent were to go to a specialist, they must be referred through the channel of the general practitioner. The Committee suffered much embarrassment from some of the specialists who hate this rule. But, remember, the indigent is jobless with a lot of free time on his hands. What fun it would be for them to get a slip, enter the door of a specialist's office here-to-fore closed to them—to be treated by the "big shot" when the clinic could offer only his second assistant.

II.

The Committee has always felt that the Ohio State Medical Association Council and Policy Committee could have been more helpful in the fall of 1933. We feel that their contention was wrong not to interfere with County Societies in working out a set-up. Questionaires could have been sent out then as well as in March, 1935. Demands could have been made to supersede the dollar allocation with greater State grants to include hospitalization (as Indiana did); also to get additional funds for peak expense loads of winter sickness; also to secure a better plan of payment of medical bills such as West Virginia has, so that the minimum fees of urban localities would not be jeopardized.

Adequate medical service should include, for instance, x-ray. The Committee has been forced by low

funds to limit x-ray to fractures and dislocations alone. Chronic cases, such as heart disease, have had too limited care but let it be said truthfully at this point, Mahoning County has been much more lenient to the chronic patient than any surrounding state.

The Drug Bill should never have been a part of the medical expense. This is another item which the Committee feels could have been foreseen from the start. At last, beginning July first, the Drug Bill will be excluded from the Medical expense account. It would take a volume to record the many meetings with pharmacists in an effort to get the drug expense reduced. Through the efforts of the Committee and the coöperation of the Relief Director, a pharmacist was put on the payroll as a draftsman. At once, the drug bill was reduced, but it is still averaging $2500 a month. How much more satisfactory it would have been, and the effect on pro-ration would have been tremendous, if a united effort had been made early in the game to exclude this expensive item.

III.

In July, 1934, the Committee accepted the added burden of the care of indigent venereal cases. The Committee did this because of numerous complaints that people who could pay for this service were receiving low cost care in the two hospital dispensaries at the expense of the physicians who cared for them. At once, the Committee received much criticism from the specialists who care for indigent venereals in the dispensary. Their criticism, perhaps justifiable, is that syphilis should not be treated by the general practitioner. The Committee asks: Why? Does not the general practitioner treat syphilis in private practice? Should the indigent venereal patient be entitled to more consideration in this respect than the private patient?

There are no means of checking up on the matter specifically but by hearsay. The Committee has learned that many of the venereal patients who had previously received dispensary care and could afford the minimum cost of private care were being returned to proper channels.

Venereal cases under the Mahoning County set-up are taken care of just like any other disease. There was a time, however, for two or three months from the time of the closing of the dispensaries and the acceptance of treatment by present means, when the indigent luetic received very little treatment. Though all of the former patients of the dispensary who were on relief and many in the low wage class could avail themselves of treatment, very few did so. These patients who had not taken advantage of the opportunity were reached by the nursing staff and brought in for slips and treatment by their physician.

In June, 1934, at the request of Captain James Hepburn of the Salvation Army, a weekly examination of the inmates of the Home for Homeless Men was undertaken by a group of physicians. The purpose of the examination was the detection of active venereal disease. The population of the Home during the fall and winter months was over three hundred. The Home is admirably well kept, the men are well fed and the incidence of venereal cases very low. At first about fifteen cases of tertiary skin lesions were picked up and treated. Only one primary lesion was discovered—three cases of acute gonorrhea and a few cases of chronic discharge, which proved to be a urethral discharge. The physicians were paid directly by the Salvation Army.

Having available in charge nurses of both hospital dispensaries and a staff of nurses to investigate, the Committee had a survey made of all of the old dispensary venereal cases. This survey was made early this year after some six months of operation under this plan.

Venereal Report on Patients of Both Hospitals

Patients on relief being treated	97
Patients on relief not being treated	20
Patients not on relief and wanting to be treated	14
Patients not on relief being treated	9
Patients not on relief not wanting to be treated	48
Died	5
Moved	104

IV.

When we come to the discussion of pro-ration and the factors which caused it, let us first of all keep in mind that no pro-ration occurred until July, 1934, the month after the physicians received their first check for indigent relief work. At the request of the Committee the auditing department has presented a statement for this article.

There are five factors causing pro-ration:

1. The failure of the State to grant sufficient funds.
2. The drug account.
3. The leniency of the Committee.
4. The attitude of the relief patient.
5. The attitude of the relief doctor.

Youngstown Doctors

1934	DOCTORS			1934	DENTISTS		DRUGS
Months	Gross	Pro-rating Factor	Net	Gross	Pro-rating Factor	Net	
May	$8,027.90		$8,027.90				$1,791.02
June Reg.	5,261.00		5,261.00				903.26
June Supp.	1,050.96	.633	665.31				54.30
July	5,621.53	.641	3,603.45				843.25
August	5,516.67		5,516.67				1,025.87
September	5,662.05		5,662.05				1,132.88
October	8,984.15		8,984.15				1,773.63
November	11,797.64	.863	10,181.81				1,615.72
December	11,865.65	.566	6,715.95	631.05	.566	357.28	2,639.00
1935							
January	14,273.62	.435	6,209.65	888.50	.435	386.55	2,001.47
February	11,029.25	.496	5,470.56	896.00	.496	444.44	2,178.89
March	11,360.50	.396	4,498.93	1,181.00	.396	467.68	2,576.61

Township Doctors

1934	DOCTORS			1934	DENTISTS		DRUGS
Months	Gross	Pro-rating Factor	Net	Gross	Pro-rating Factor	Net	
May	$1,910.67		$1,910.67				$ 289.02
June Reg.	1,433.60		1,433.60				163.60
June Supp.	329.85	.633	208.79				40.69
July	1,801.27	.641	1,154.61				294.10
August	1,635.25		1,635.25				190.97
September	1,504.25		1,504.25				269.19
October	3,118.75		3,118.75				249.82
November	3,344.10	.863	2,885.96				418.90
December	3,827.61	.566	2,166.43				379.87
1935							
January	4,376.65	.435	1,904.03	245.50	.435	106.82	412.65
February	3,098.50	.496	1,536.85	244.50	.496	121.27	359.41
March	4,143.50	.396	1,640.82	301.50	.396	119.39	443.93

The first and second factors of pro-ration namely, the failure of the State to grant sufficient funds and the drug account have been fully discussed so we move at once to a discussion of the third factor of pro-ration. The leniency of the Committee is a factor of pro-ration and the chief criticism of the Committee's work. At first, we had no means of keeping a check on cases. After we did have a nursing staff capable of investigation, the committee did not use them in the simplest, most efficient manner, namely—Is the patient bed-fast or ambulatory? Experience has taught the Committee a great deal. Each physician who had large bills against the relief was called in individually and collectively, their slips reviewed, and an explanation was made to them regarding the necessity of controlling their patients. Frankly, this did very little good.

There were many instances when the Committee felt the doctors were making unnecessary calls. One might expect that this situation could be corrected by a study of the diagnoses. But, the diagnosis on the slips always fits the number of calls. It wouldn't be fair under these circumstances to refuse to pay these slips and how, we ask you, are you to determine the number of calls on a pneumonia, for instance?

The Committee did, however, receive some very valuable suggestions from the visits of relief doctors to the regular meetings.

The Committee was severely criticised in March, 1935, because we advised against going on strike as Trumbull and Columbiana counties did. Time has proved that the conservatism of the Committee was justifiable. No one seems to realize, except the Committee, that there is only a certain specified amount of money available to us for medical expense and how we spend it depends upon the physicians of Mahoning County. Who is to blame? We have explained this before in this article.

Recently the Committee is attempting a new experiment and as this article goes to press we have verbal sanction of it from the Relief Director. The experiment is to cut the amount of each physician's bill to $100.00, plus his special fees, such as Obstetrics and Fractures. Now, we will show you how this plan will work out in the payment of the April bills. The pro-ration for April is 44.3%. By reducing the bills to $100.00 plus fees, pro-ration will be lessened by 10% for those who have bills less than $100.00. May pro-ration is now 59%, but it will be decreased by the above procedure.

Starting July first, the Drug account will be excluded from the Medical expense, and the State will add to our account an amount for each single person. These factors cut pro-ration at least 25%, so it may not be necessary after July to restrict the amount of any bill.

The fourth factor of pro-ration is a problem more for a psychologist than a physician. Why, Mrs. X. at 245 Blank Street, cannot without jealously allow Mrs. Y. next door, to go to the Relief Office and get a slip without her having one at the same time or the next day, is a psychological problem. From the Committee's experience this condition cannot be remedied, because it is apparently no disgrace to be on relief, but a sense of self injustice not to get everything possible from the relief office.

By James B. Nelson M. D.

Somewhat more than a year has passed since a plan of Federal Relief was accepted and instituted in Mahoning County. This plan was to have been set up without red tape, as far as physicians were concerned, and certain benefits were to be gained by the patient and his physician. It is time to check up and learn if either party has profited by the arrangement.

At the time this plan was accepted by the physicians of Mahoning County, they were carrying the full burden of the care of the indigent who were ill. The argument in favor of accepting the plan was that half a loaf was better than no bread, and the consensus of opinion was that the offer so kindly made by the government should be taken. This offer was the more readily accepted because it was accompanied by a threat. The threat was that federal physicians would be sent into this County to assume charge of things unless the plan be adopted. It was accepted, too, with the belief that, later on, the fees designated for service would be raised to a more equitable figure. The demand for an increase in fees was met later, and on paper they were even doubled. So far so good, but along with this increase came that beautiful little joker of "pro-rating." With this factor at work the physician does not even receive as much for his service as in the original agreement. The system was not set up without red tape and the fees agreed upon have not been paid. A contract with the government should be as binding as any other contract and this contract has not been kept with the physicians of this county.

Many physicians were not interested in this federal plan and, perhaps wisely, refused to have anything to do with it. There were others, however, to whom this seemed a means of salvation. Their status would be improved were it not for this pro-rating factor. But this factor will eventually mean the ruin of the men who do a great amount of relief work. This factor is claimed to be in force because of the greed and dishonesty of some men doing relief work. This I do not believe, neither do I believe that there is any intentional dishonesty in this line of work, except in the very rare instance. Even if here and there a supposedly dishonest act occurs it is of small consequence and the investigation and proof of such a charge would be more costly than the payment of the fee in question. Certain it is that no physician in this county could buy many votes with any of his ill-gotten gains. The industrial commission has conducted its affairs for years with little red tape and with no noise about dishonesty.

We have allowed the politician to come into our community and establish a minimum fee schedule for us. The 9% of our people who pay their medical bills know this and have a perfect right to feel resentful that they are asked to pay more as a private patient than the government pays for the care of their wards. These people have been the true friends of the Medical Profession, but one wonders just how long they will continue to stand for this sort of thing.

For the first time in our memory, an agency has been developed that has accepted the responsibility for the care of the poor and needy. No longer do physicians need feel that theirs is the responsibility. But because this agency has accepted the responsibility does not constitute a reason for the acceptance of their every idea. Full well does this agency recognize the high ideals of the Profession relative to the care of the needy and they have not hesitated to make capital of this. They will not hesitate to accept any praise that the agency might receive, nor will they hesitate to pass the faults of the system to the physician where possible. The physician has been discriminated against in an unjust manner, a manner hardly in keeping with American ideas of fair dealing. For while he pays taxes toward the support of this system just as any one else, he alone of all the people who render service to this agency is asked to do so at a prescribed rate which in many instances amounts to a definite loss.

The patient is not receiving proper

and adequate attention under this system. Admit it or not, you know this to be true. I do not know how the patient with an imaginary ailment is to be handled, but I do know that those who are really sick are entitled to a different kind of treatment from that fostered by this relief agency. When we reach the point where an untrained social worker (many of whom have been employed by this agency), or even a trained social worker (with their ideas of state medicine), or even nurses, shall decide when a person is sick enough to require the services of a physician; and having decided in the affirmative, shall designate just how many calls the physician may make, and on what days they are to be made—we have arrived at the last milestone in the practice of an ancient and honorable profession. This is not my idea of caring for sick people.

Further, under this system, the patient was to have the free choice of his attendant physician. Since many physicians are not registered at the relief office this is an impossibility. This lack of registration plainly shows disapproval of the system.

In short, this agency is bunking the public and the patient. The physician is being cut to hold together this great vote-producing system. The longer that definite action on this question is postponed, the harder it will be to handle. Well does your politician know this. If for a time he can hold the system together against a few feeble protests, it will soon be accepted as the inevitable and thus become permanent. Should this system break down, it would not be surprising if the unpaid bills met the same fate as the unpaid C. W. A. bills.

No agency, even if governmental, has any right to regulate the character of service and the fees that are to be paid for medical service. It is high time that the physicians in every county get together and arrange a minimum fee schedule that will be fair to all. We should not permit the federal relief or the industrial commission or an insurance company or any other agency to attempt to tell us what is to be done in the way of fees. We are facing a deliberate attempt to take away the privileges that have been ours since the beginning of the Profession, and so far we have accepted the challenge by putting off until tomorrow what we should have done yesterday.

By Sidney M. McCurdy, M. D.

Medical Relief at the Cross Roads

Is the conduct of Medical Relief on a sound footing? Those who have formulated this activity, both physicians and laymen, do not seem to have analyzed this problem. Perhaps they could not foresee its difficulties; or maybe they were unable to work out a system adapted to and correlating with medical and lay needs.

Possibly the present methods were arrived at without thought of group psychology or medical economics. I believe that due to this omission there is not a proper control of the medical needs of those people applying for free medical and dental services. Certainly the system is not comparable to that carried out when material relief is dispensed. It is quite a simple matter to budget food, rent, and shelter, but a very difficult one to estimate the cost of fine medical care. Who shall say that a chronic case does not need aid if the patient is to be returned to normal earning capacity? Who can deny care for the mentally unfit, worried because of minor illness or imagined sickness? Who has the right to refuse any one the services of a physician if such a person thinks that he needs them? Who shall condemn the needy to the use of home remedies to cure their indispositions? By what stretch of imagination did anyone think that one dollar per month per family would furnish the physician a living wage? I say that one dollar is in-

sufficient or prorating would not be necessary. This dole to physicians, in many localities, has paid doctors less than taxi service. This proration in some places has not paid for the cost of medicines prescribed and dressings applied. The price has too often prohibited the use of necessary and desirable medication. The retort that physicians receive money for services from a class of patients who formerly could not pay is true, but worthless. Service is rendered in too many instances, and for the privilege more is paid out than received. Physicians are worthy of their hire, even though the payee is their government, which has little right to ask for charity.

A universal desire is inbred to protect the health of ourselves and our families—a wish that, in a country of plenty, should be satisfied. For this reason people of means consult physicians twice as often as those within the poorer income brackets. There can be no monetary class distinctions in medicine. Before the bar of medical opinion, all should receive the same careful consideration. Indigency has increased for many reasons, some of which are well stated by Mr. Walter Lippman. Medical phases are no exception to this rule.

1. Indigency has increased, because as time goes on, more and more people have exhausted their savings.

2. Increased efficiency of relief organizations uncover more and more people in distress.

3. Governmental liberality raises the standard of admission to the indigent class.

4. There is a constant decrease in shame at being obliged to seek relief. (Particularly is this true as it pertains to medical aid.)

5. Governmental increase of monthly allowances. (Not for physicians and dentists.)

Mr. Lippman's final conclusion was well founded: "My belief is, that here as in other moral questions, the absolutists are almost surely wrong, and that the only course is to make a constant effort to strike a balance between sympathy for distress and prudence in giving relief."

It is a cardinal mistake to permit medical sympathy to run away with the necessary medical cost. The cost of relief in November, 1933, was $18.31 per month per family. The cost in November, 1934, was $28.66. Yet the medical dollar remained the same. During this year medical work markedly increased, however, so that the physicians were in many instances drastically prorated.

I wish to call attention to some figures credited to Edgar Sydenstriker, in April, 1934.

1. In 1929 people making $1,800 yearly or over numbered 37%;
   In 1934 people making $1,800 yearly or over numbered 9.5%;
   This class may be considered good medical pay.
2. In 1929 people earning $600 or less were 13.3%;
   In 1934 people earning $600 or less were 51.4%.
   This class couldn't pay anything or were paid for by the FERA.

I think it fair to say, without statistical proof, that the Medical Profession receives its total remuneration from not more than 25% of the people plus the contribution made by government. The percentage of people now paying and the amount paid is far too little for the profession to maintain its standard of service, and, therefore, payment for relief illness and accident becomes an acute problem.

A normal increase in the amount of medical work should be expected irrespective of the average incidence of disease. It is usual for the applicant to feel shame when called upon to seek relief of any sort but there is no such deterrent when medical relief is once granted. He receives an order for this service when he is found worthy, and from then on is relieved from all social stigma.

The medical certificate entitles a patient to free medical attention and from then on he is treated as a private case, either in the office or in the home. Social shame at once ceases. Free choice of physician is granted from a list of those who have agreed to work for the FERA. The qualifications for free service are that a physician is wanted, the case is not chronic, and that the case is receiving other material aid. He awaits his turn in an office designed for pay patients on a basis of equality with all other patients, too often ignorant that others are paying regular fees when perhaps his case will not pay the cost of care. He expects and gets a private pay service, whether in the home or office.

A second factor further lessens the already shrinking medical dollar. A professional person is dependent upon the good will of the people for his success. Disgruntled charity patients often hold a physician's reputation in the hollow of their hand. Everyone must be pleased and given beneficial treatment. This often occasions more visits than are necessary, and the temptation to extra costs. A private patient may discharge himself when well enough, to save further fees, but an FERA case has nothing to save.

Will not damage to medical ideals result from treating people according to this plan? I fear that time will say "yes." There is the real danger that the ethics and morale of the medical and dental professions will be undermined. Symptoms already indicate to me that *quantity* of patients rather than *quality* of service is being emphasized. Two standards of service, one for those who pay and the other for those who don't are unconsciously being developed. Hitherto, only one grade existed and that was the best each physician was capable of rendering. There is a grave likelihood that low fees will result—fees that do not permit time for a useful civic life, nor finances sufficient to keep one medically informed. I am afraid if the expected results happen, the public will not approve the products of its handiwork and its beneficence.

No destructive criticism is worth while unless constructive ideas are offered to replace it. I shall attempt to make some suggestions that I believe will control medical cost, increase the value of the service, and assist in upholding medical standards. A better balance between sympathy and prudence have influenced me in arriving at my conclusions. A change must be made to obtain the ends sought, therefore, I would suggest the following:

1. I do not believe the best and most economical service for indigents can be rendered in the average physician's office.

2. I do not think it good business to turn a private office into an indigent clinic. This method is very damaging to a private pay business. It creates a condition similar to a first class hotel filled with people of low income and the inevitable loss of good will and good paying patronage. This does not apply to those families one cares to carry through the depression and who have previously been loyal patients.

3. I believe it right and proper to care for indigent patients in the home and insure the right of free choice of physician.

4. These people need free access to hospital ward beds because of poor home environment. The free choice of physician can here be kept if hospitals will consent. Many a person, to his detriment, is now being treated at home because the hospital does not allow free choice of physician.

I would offer to the ambulatory patient the use of hospital dispensaries under the financial control of the FERA, and either supervised medically by the hospital staff or a dispensary committee selected by the local county society. All cases should

be checked by the FERA for their eligibility. All expenses should be paid by the FERA, and this includes physicians' fees. By this arrangement the indigents will receive the kind of care they need and the grade of service that physicians wish to give. Only at a hospital or other dispensary can the necessary equipment be assembled. Here attendants will be properly trained, and here control can be maintained. Smaller communities can organize dispensaries to suit their needs. The ambulatory patient can receive, by this means, adequate medical attention at the smallest cost consistent with the best of service.

By J. C. Vance, M. D.

Where Do We Go—From Here?

Time and experience have been guiding sticks for many ages past. Would it not be a rather refreshing experiment for the Medical Profession of Mahoning County to take cognizance of those events which are daily besetting our busy trails and see if perchance we might be able to correct some wrongs which are being thrust upon us?

All of us are familiar with the contract which we signed for the relief of the Emergency Relief Commission. Is there any part of that contract which has been strictly adhered to? Yes, there is. It is that pertaining to the party of the second part, who has fulfilled his every obligation by administering to those unfortunates who were unable to provide for themselves. And what has he received in return for his service? He has received the most inequitable disposition of funds that has been granted to anyone as payment of a bona-fide contract for services rendered.

And why? First, because the allotment of funds for medical care is inadequate. In a year this amounts to the staggering total of $12.00 per family. Simply ridiculous!

And secondly, discrimination. Is there any reason why grocers, butchers, dry goods dealers, etc., who serve relief families, should be paid their own prices while the Medical Profession should be called upon at all hours of the day and night to serve these same people for a fee that may run from 38 cents to 76 cents? Isn't it a grand and glorious feeling? Hold 'em, Lehigh! It was just a fluke—but they scored on us just the same!

The problem confronting us now is not what injustices we have received. What are we going to do about it? The Economics Committee was formulated to act as a sort of liaison between the Relief agencies and the physician. For a time their efforts were fruitful as well as pleasant. However, at present their suggestions, pleadings, and demands go over the heads of the relief agencies like a skyrocket. This seems certainly to be not the policy of a progressive Medical Society such as ours. But we have not offered a constructive program for our own relief and that very thing must be done now or we pass into retrogression which will seal our fates.

I would like to suggest first that we settle this matter of fees. If we are willing to be paid $1.00 for office calls and $2.00 for house calls we should declare ourselves as being willing to continue on that basis. We should say we never agreed to prorating and we don't intend to do so any longer. If our representatives and relief agencies are not able to cope with a situation that permits $800.00 to $900.00 fees to be submitted each month, by those whom they call "chiselers," then we had better not be any part of it. If these same groups can not keep all fees under $200.00, as they now are attempting, we are still no better off. Unless we can start again on a contract with definitely defined terms we should resume our sensible ways once more.

What is to become of the relief patients? Let us take care of them in our own way as we have in times

past. It's a practical certainty that we shall receive at least 37 cents worth of gratitude if we never get anything else.

And this paper detail. Now, I expect that there should be a certain amount of detail and red tape in paper work. But to heap seven individual sheets of paper on each call is just, to say the least, quite unnecessary.

Secondly, let us consider the items which should rightly be ours to consider. This is the matter of calls on patients and the investigation of cases. We must have some one or some group in charge whose authority to regulate this matter of calls *is based on medical knowledge and experience.* It must also be remembered that the "rule of thumb" is not to be resorted to in determining the number of calls. They are never the same and it is first and last a matter of judgment which the Physician should be and is capable of determining. This matter must be by all means in the hands of medically trained people, who can forego favoritism. If the "budget" will not permit the proper care of cases then the budget *must* be increased to meet the required needs as it is for food, for clothes, for coal and other products which are not now being questioned.

Next is the matter of investigators. It need be said simply that *medical* investigators *must* be trained. *There are plenty of trained nurses available who can and will do this work.* How can you expect a person who never saw a varicose ulcer to know it isn't eczema? That is what they are asked to do. Imagine the untrained investigator proceeding to the extent that the Doctor's dressing is removed from an extremity to see if there is disease or injury and then trying to replace that same dressing! Imagine a bull in a china shop!

In summary, let me repeat these suggestions.

First, our fee-schedule must be fixed, maximum or minimum, but it must be fixed and rigidly adhered to.

Second, investigators must be medically trained and able to recognize conditions as they exist — at least trained nurses.

Third, the relief patient must still be cared for to the best of our abilities whether we do it *gratis* or for 37 cents.

Fourth, the amount of paper detail must be reduced to practical limits.

Fifth, the "budget" must be increased to permit proper care of the indigent sick.

If these or similar plans are not acceptable to the relief agencies it is my sincere opinion that we, as well as our patients, would be better off and relieved of a great burden by the immediate cancellation of our contracts. I feel sure that the time to act is now. Submit our plans immediately and definitely that they may be accepted or rejected and we can all enjoy the 4th!

By J. M. Cavanaugh, M. D.

It is not my intention to criticize those who have earnestly worked with the complicated problem of medical service. Furthermore, I realize it is easy to sit at the ringside and tell the fighter how to conduct himself in the ring. But risking the possibility of being completely misunderstood, I am going to tell you how the problem appears to one who is an interested spectator.

In this discussion, I am not concerned with the indigent, except to acknowledge them as representing a social and economic blunder. As long as society gives birth to them, society must care for them. As physicians the economic or political status of the patient should *not* be our concern. How medical service of a high standard can be made available to all the people constituting society *is* our concern.

Recent developments have demonstrated that the difficulties arising incident to this problem are simply those of trying to fit a square peg into a round hole. The corners of this peg are made up of four divergent elements concerned in medical care; namely, (1) the average doctor of modest income who takes care of at least 75% of the people; (2) the teaching, or University groups, and physicians whose incomes are in the higher brackets, who are satisfied with the status quo; (3) the hierarchy of organized medicine; and (4) the welfare or political group. These groups have different ends in view.

How much longer are we to cooperate in a system which presumes to restore sick bodies while its very operation nauseates the soul? How much longer are we going to bury our heads in the sand of rugged individualism, while our tail feathers are plucked by political appointees, industrial serfs, and petty philanthropists? How much longer are doctors —guardians of the public health, but nevertheless servants of society—to pose as tin gods, smugly clinging to the ragged robe of professional dignity? How much longer are the spokesmen of organized medicine to pursue the red monster of socialized medicine with a volume of literary garbage in one hand, and a weak, sometimes futile plan of Emergency Relief in the other? Emergency, mind you, when the problem is old enough to have tradition. How long are we to struggle for this "rugged individualism" in medicine, which has undermined practically every important branch of political and social life? If it must pass in industry, it must pass in medicine.

All about us we see public health service, city doctors, county doctors, school doctors, industrial doctors, commission visiting nurses, insurance health service, all definitely socialized forms of medicine, which overlap in confusion and out of which evolves a medical service which is not 50% efficient.

Isn't it a travesty on intelligence when we contemplate the facts? At no time have the means of preserving the public health been so entirely under the control of physicians, still, relatively speaking, society as a whole was never more poorly served. In the past the doctor had little scientific help to offer, but he gave generously of what he had; today, having much to offer, he gives little, because of the economic restrictions of a decrepit, politico-financial structure.

Think of free American citizens, men and women who have contributed of their brawn—and brain—to the vast wealth of our country, standing in lines by the hour, under the stern glare of a policeman, to obtain the privilege of presenting themselves to the doctor. Nor is that all. Having seen the doctor, this free American citizen (whose liberty and freedom are so dear to all political speakers), again stands in line wearily awaiting an O. K. for his box of pills or jar of salve. How frequently the doctor would like to have had x-ray or laboratory services, perhaps consultation, but realizing the red tape and possible futility of it all, he steps into line and becomes a part of one of the most degrading un-American, social blunders since the burning of witches.

Price levels are determined by quality in the merchandizing of shoes and overcoats, making it possible for everyone to have some kind of shoes, and some kind of overcoat. But in medical service there is justly only the best—and practically every physician is able to render that quality service. Furthermore, the people have a right to that best service, by virtue of the fact that they have contributed to contemporary wealth in proportion to their means and ability.

How much longer are we to "hoard" medical service, as the millionaire hoards the buying power of the people? The doctor is the serv-

ant of society, and service he must render. Nor shall he determine how it shall be rendered. Society makes medical schools possible, grants the doctor his license to practice, and places certain restrictions on his performance in conducting his practice. Society is what physicians practice on, and has a right to say how medical service shall be dispensed.

This, of course, suggests some kind of intelligent socialized medicine. And any socialized service must presume a professional veracity of high degree, honesty in government, and an enlightened, socially-conscious public. Is the very idea of social honesty fantastic? If so, then let us close our schools and universities, our churches, Y. M. C. A., civic-uplift and better business clubs, and devote the vast wealth and power involved in these institutions to policing our country!

We're Too Rich!

President Elliott of Harvard University once said that when you take personal incentive away and level all the people, progress ceases. It seems to me that everything depends on whether we accept the communist dogma that all men are equal, and therefore deserving of equal rewards from the state; whether they are idle or industrious, extravagant or thrifty, intellectually dull or alert. Once that primary axiom is accepted, all the rest follows as a matter of course. But some of us cannot swallow this fundamental principle. For the fact is that from birth all equality ceases until the Grim Reaper levels us off again.

This is a capitalistic nation. With a population of approximately 135,000,000 people, we have in our commercial banks some 800,000 depositors with a total of $16,000,000,000 on deposit. There are 39,000,000 accounts in the savings banks of the United States, with $22,000,000,000 on deposit. At the present time there are in force in this country 67,000,000 life insurance policies, representing an investment of $21,000,000,000. A country such as ours will never become socialistic as long as there remains such a percentage of investors, and while there remain the advantages of pooling resources.

—NUNZIO A. RINI, M. D., in *Bulletin of Des Moines Academy of Medicine.*

Youngstown Hospital Staff Activities

Drs. E. H. Jones and J. M. Cavanaugh shared the responsibility for the June program of the Staff. Dr. Jones discussed "Dermatoses of Fungous Origin" and Dr. Cavanaugh read an interesting paper on "Ananga Ranga"—meaning "Stages of Love."

"It is necessary," said Dr. Jones, "in every case of so-called ringworm that the patient shall receive a very careful check-up. Diabetes is to be suspected, and this along with other possible factors should be investigated."

Dr. Jones showed a large number of slides, including microscopic and culture photographs and a complete collection of clinical photographs. Dr. Clark, presiding, suggested that the clinician finds it difficult to determine how to treat effectively the conditions caused by these various types of fungous infections. The discussion brought out that as yet there has been developed no specific and selective fungicide. Much work is being done along this line, however, and the long-sought selective agent may be in the offing.

Dr. Cavanaugh's subject dealt with certain basic psychological phenomena, as they were viewed by writers long ago. His presentation was most interesting and constituted a thought-provoking interlude from the routine things to which doctors perhaps are inclined to devote their time too exclusively.

In the absence of Dr. Patrick, Dr. Herman Zeve acted as secretary of the meeting.

POSITION WANTED — Graduate Nurse with business training wants position in physician's or dentist's office. Call 2-4323.

"How a minority,
Reaching majority,
Seizing authority,
Hates a minority!"

—*Leonard H. Robbins.*

From Executive Secretary Nelson

"The July issue of the *Ohio State Medical Journal* contains much information of special interest to every Ohio physician. It is suggested you call this to the attention of your members. Encourage them to devote an evening or two to its contents. To mention a few of the articles:

NEW REGULATIONS ON MEDICAL POOR RELIEF; MORE FUNDS FOR PHYSICIANS—A detailed summary of the revised regulations governing the FERA medical relief program will be found on page 534, in addition to the discussion by and action of The Council on this question, published in the minutes of the June Council meeting, page 528. The revised regulations will go into effect July 1. Have your medical advisory committee contact your local relief director immediately so that you can secure immediate benefits from this improved program.

WORKMEN'S COMPENSATION FEE SCHEDULE—The Council (page 528) has requested the State Industrial Commission to eliminate the 20% reduction in medical and surgical fees and pay physicians in accordance with the uniform fee schedule. Data showing the improved financial status of the state insurance fund will be found in the statement adopted by The Council.

PROVISIONS OF NEW UNIFORM STATE NARCOTIC DRUG ACT—The narcotic control act enacted at the regular session of the General Assembly will become effective September 5. Its provisions are analyzed on page 539. Every physician should familiarize himself with this law.

HIGHLIGHTS OF THE RECENT A. M. A. MEETING—Ohio physicians, as usual, took an important part in the recent A. M. A. meeting. An account of the meeting and a list of those from Ohio who registered will be found on page 537."