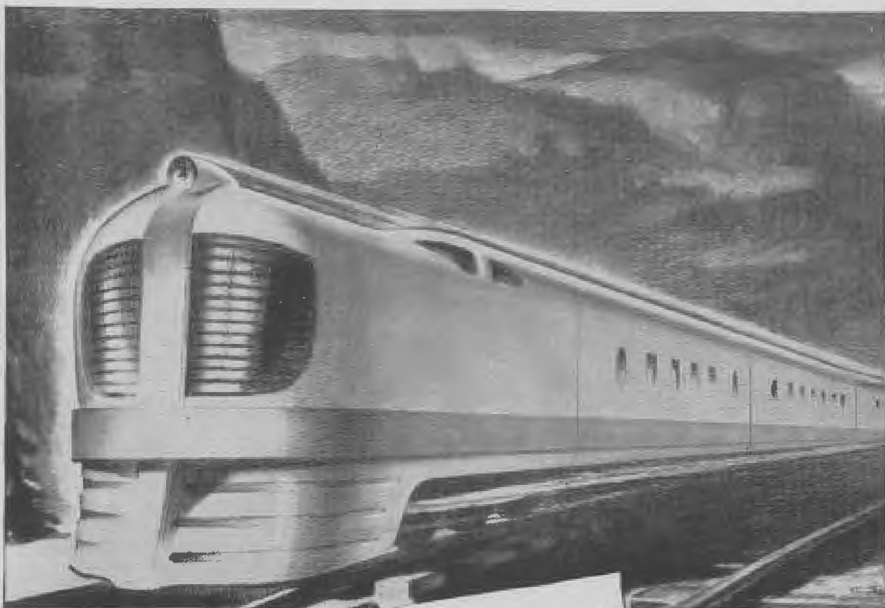
"There are three things which the public will always clamor for: (1) Novelty; (2) Novelty; and (3) Novelty."—Thomas Hood.

BULLETIN

of the

Mahoning County Medical Society

Vol. IX No. 3
March 1939



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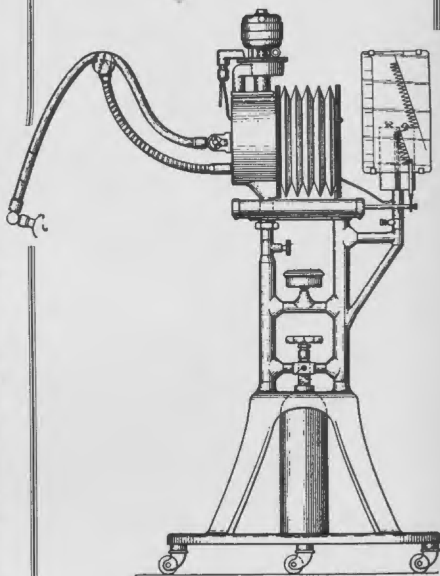

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Mahoning County Medical Society

MARCH 1939

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MEDICAL CALENDAR

March 21—Speaker, Dr. George Curtis, O. S. U. Dinner, Youngstown Club, 6:30 P. M.

April 20—Postgraduate Day—U. of P. group, Drs. Wolferth, Pendegrast, Stokes, and Kern.

May 16—Intern Competition, Youngstown Club.

June 20—Speaker, Dr. August A. Werner, Endocrinology. Dinner, Youngstown Club, 6:30 P. M.

July 20—Golf Party, So. Hills Country Club.

August 17—Golf Party, So. Hills Country Club.

September 14—Corn Roast and Clam Bake, Bert Millikin's Farm.

September 19—Speaker, Dr. Walter M. Simpson, Artificial Fever Therapy. Dinner, Youngstown Club, 6:30 P. M.

September 20—Lecture Course, continuing each Wednesday for six weeks at First Christian Church.

October 17—Dinner, Youngstown Club, 6:30 P. M. Speaker.*

October 21—Second Annual Dinner Dance.

November 21—Dinner, Youngstown Club, 6:30 P. M. Speaker.*

December 19—Annual Business Meeting, Youngstown Club.

*Speaker announced later.

RADIO TALKS

Mar. 10—Childhood Tuberculosis - - - - - - Dr. R. H. Middleton

Mar. 17—Tuberculosis—The Unsolved Problem - - - Dr. M. Belinky

Mar. 24—The Tonsil Operation - - - - - - - - - - Dr. Ray Hall

Mar. 31—Do You Take Your Hearing for Granted? - Dr. O. J. Walker

April 6—Why Pasteurize? - - - - - - - - - - Dr. Chas. Scofield

April 13—Warm Water Healing - - - - - - - - - Dr. P. J. Mahar

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PRESIDENT'S PAGE

Federalization of medicine has been pigeon-holed, so to say, by the Health Committee of the Senate, but in an address before the Electrical Workers Local No. 3 of New York on February 25th, Senator Robert F. Wagner has introduced a Health and Medical Insurance Bill which far surpasses any he has so far sponsored. The contents of this bill to date is unknown except that it does carry Health Insurance for citizens of the United States. Thus for all we have been having a feeling of relief and maybe a breathing spell, we are still in hot water, for the time is past when we can think that the public, plus the politician, is going to forget all that which the lay press has told them is coming. Doctors do not believe that patients want them to cease being their doctor but do feel there should be some way in which patients can buy their doctor's service in a manner which they can budget. We believe it is their just right to expect such a set-up or plan, and as their doctor we are going to see that they (our patients) are given the opportunity to buy such service at a reasonable cost.

We in Ohio have been more fortunate than most other states in that, through the efforts of the Medical Profession, our entire slate of County, State and National representatives were elected to office and thus in our Legislature are men working to the end we desire. There will be given each county or district or whatever number of counties wish it, a service PLAN under the supervision of the State Insurance Commissioner. This plan will sell complete medical service to the low income group at a price they can afford to pay. The plan is ready to be presented to each county by the State Medical Council as soon as it has been legalized.

This plan cannot function without the whole-hearted support of all the doctors; that will include all general practitioners, all types of specialists; and it means they all have to work together. It also means that the chiseling doctor and patient will have to be eliminated, for there are many in both giver and receiver of service.

The doctors will have to play fair with each other, cut out unfriendly relations.

This plan will give service to the subscriber and fees will be paid to the doctor members. The fees paid will be established by the Society and even then there will of necessity be a pro-rata clause because all stipulated fees may not be maintained because of overload and thus lack of funds, but the contract will be your contract and it will be your duty to see that service is rendered regardless of how much money you receive.

The patient will have free choice of his physician or specialist but there will be a certain few of our own profession who will not carry on as a whole. It will be these men who by their aloftness will in some respects interfere with the proper functioning of this plan, but by the work and faithfulness of the majority may we hope to keep the Government out of our practice. This plan will be owned and operated by the Medical Society and on a non-profit basis.

The plan of the Society must succeed or we will have to admit to the Government we are lost, please take us over. If it does not succeed it will be due to our members refusing to coöperate,

So, as soon as possible, your Committee will have a plan formulated which will be suitable to this county. If and when this is completed it will be turned over to you for approval, additions or deletions as the case may be. Give this matter some serious thought as it is the only way open to give the people what they want and deserve and stop the Government from taking over the practice of medicine.

WM. M. SKIPP, M. D.

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THE USE OF X-RAY IN TUBERCULOSIS*

By DR. E. C. BAKER
Roentgenologist, South Unit, Youngstown Hospital Association

This paper will be confined to the diagnostic uses of the Roentgen ray in tuberculosis. No mention will be made of Roentgen therapy in tuberculosis. Frequent attention will be called to the part that Roentgen diagnosis plays in the therapy of tuberculosis. The use of the Roentgen examination in diagnosis and treatment of tuberculosis has become increasingly important and necessary. To those familiar with tuberculosis work it goes without saying that Roentgen examination is a fundamental part of the present-day diagnosis and an absolute necessity for many of the surgical procedures now used.

Until the start of this decade numerous places and numerous medical men could be found that had no real appreciation of the necessity for Roentgen work in connection with tuberculosis. Several things have changed this attitude. Publications by the recognized leaders in tuberculosis work, showing the value and their own dependence upon x-ray examination, have helped. The growth of an increasing number of surgical procedures in therapy has gone hand in hand with the increasing use of x-ray. Many of these procedures are dependent on the information obtained from the Roentgen examination for their proper execution. In public health work there has been increasing use and increasing recognition of the value of group chest examination by x-ray.

In some of the leading institutions the x-ray examination has proved to be the most satisfactory for the detection and diagnosis of tuberculous lesions. In numerous publications it far exceeds in value any specific physical finding. Even though a diagnosis of tuberculosis can be established by physical examination, a Roentgen ray examination to determine the full extent of the disease and to help in planning the method of attack on the disease is desired.

Surgical procedures in tuberculosis would be completely lost without the information obtained from x-ray. Even the mildest procedure, pneumothorax, is dependent on the knowledge obtained by fluoroscopy and check films. The more elaborate rib resections and collapse of part of the chest are planned with the aid of Roentgen examination. In the early diagnosis of tuberculosis the x-ray film, properly taken, is regarded in many quarters as one of the two most reliable findings. Some authorities place it at the top. Myers in a recent book regards the tuberculin test as more important in infancy and early childhood. He places the x-ray examination ahead of the tuberculin test in later childhood and in adult life. The one drawback in the use of Roentgen examination in the diagnosis of tuberculosis is usually given as the failure to determine definitely the activity of the process. This drawback is completely eradicated by the use of serial Roentgen examination. Clinicians expect to examine their patients more than once. The Roentgenologist has every bit as good a right to examine his patients more than once. The use of serial Roentgen examination is very little appreciated and still used infrequently. In tuberculosis work the men in sanatoriums expect to re-examine their patients and should expect to re-examine their suspects both clinically and by x-ray at varying intervals. Treatment of the disease necessitates serial films to follow the advance or decrease of the process. The diagnostic use of the Roentgen ray in tuberculosis work is then a fundamental part of the problem.

*Read at the regular monthly meeting of the Mahoning County Medical Society.

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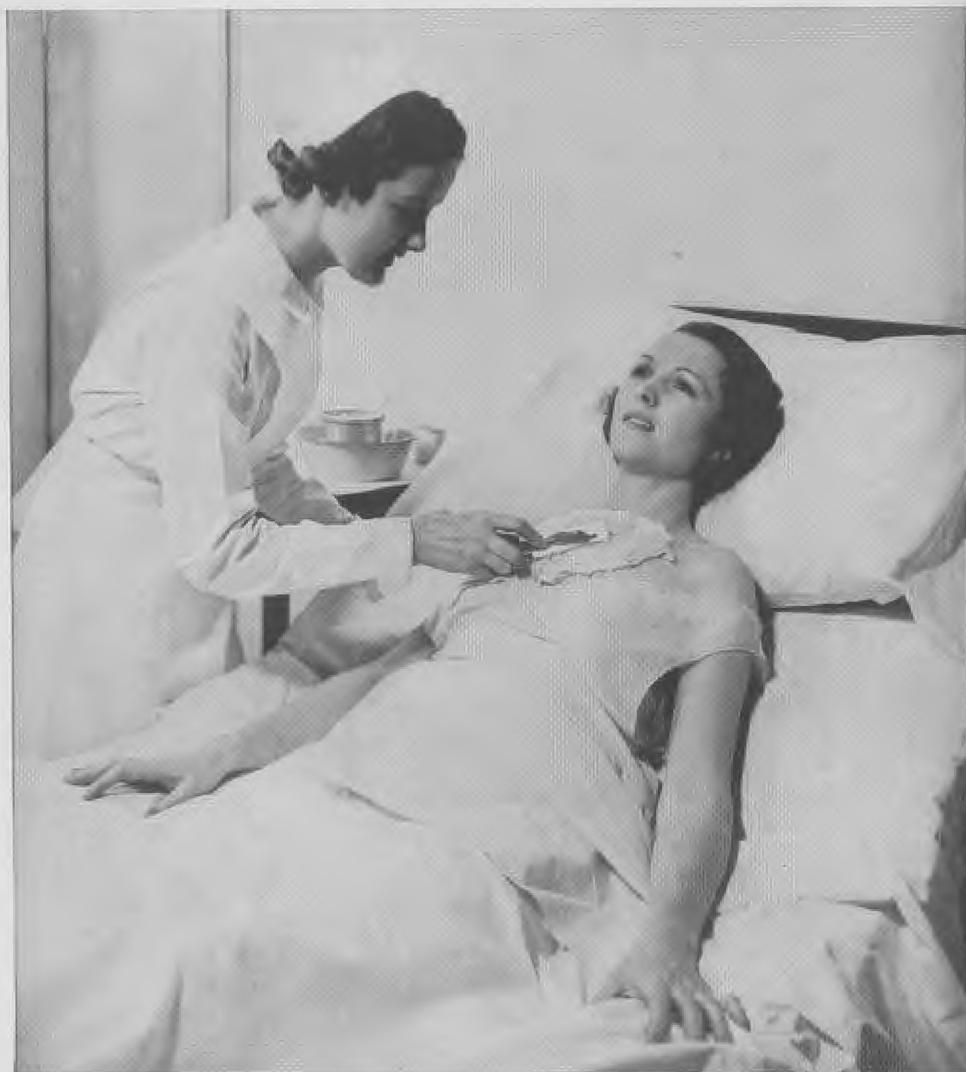
LUSTIG'S

The tuberculosis problem is twofold. The care of the individual patient and the prevention of new cases. It seems to me that we as physicians recognize these problems poorly. The two problems are bound together to some extent. We have some of the time completely forgotten the second portion of the problem, and very often dimly recognized our responsibility in the first portion. Part of this is our inherent laziness. Very largely we have been willing to delegate a problem which belongs to us as physicians to public health authorities or to communities. Because of our willingness to slide out from under this problem, the figures that Drolet gives in the American Review of Tuberculosis published in 1938 are made possible. This article is a statistical review of a large number of sanatoriums over the country. These sanatoriums do not include the few exceptional sanatoriums which are adequately staffed by competent specialists and properly trained men. It does include most of the sanatoriums of the country. For these sanatoriums the death rate per number of cases of tuberculosis has shown practically no variance for twenty years. The implications of that statement are rather terrific. Most of our sanatoriums are not institutions for the treatment of tuberculosis but are simply clearing houses, or points of isolation for people with the disease. In other words in the bulk of our tuberculosis institutions of today the treatment of tuberculosis has not appreciably improved over a period of twenty years. The reason tuberculosis deaths have decreased is because the public health authorities have by methods of isolation and discovery of hidden cases of tuberculosis protected the general public so that there is less spread of the bacilli than formerly.

There are a few institutions in this country staffed by adequately trained men, who are actively coöperating with each other, in which the death rate per number of cases has been materially reduced. Only in such institutions has therapy of the individual case improved. The remainder of our sanatoriums have been largely quarantine places. From these figures of Drolet and other statements found in the literature it is very apparent that most of the tuberculosis work in sanatoriums has been little more than isolation of the diseased patient.

There is a very definite reason for the need of trained men in several specialties coöperating in the therapy of tuberculosis. In Roentgen work it is an impossibility for the man not specializing and not trained in that field to have the necessary knowledge of the underlying physical principles. Without such knowledge the best of apparatus can and is mishandled. The use of poor apparatus means in inexperienced hands results that are terrible. A proper interplay of kilovoltage, milliampere seconds, and distance are dependent on more than a casual knowledge of buttons on a machine. A brief statement of some of the techniques needed or in use in Roentgen diagnostic work in the tuberculosis field will further prove this point. These various techniques are of use and may be necessary in different cases: antero-posterior films, postero-anterior films, oblique films, lateral films, films with the x-ray tube centered high or films with the x-ray tube centered low, films made with the tube centered obliquely from above downward through the patient or the opposite, dense exposures, double exposures of several different types, films made on inspiration and on expiration, films made with Potter Bucky diaphragm, films made with several different types of grids, films made of hemi-thorax, films made with plastic material for hemi-thorax, proper use of stereoscopic films in many of the above procedures, films made with lipiodol, films made with patient erect, bending forward or backward, supine or prone, opaque meals for esophageal position or pa-



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thology, films made with kymography; these procedures require alteration in technical factors. Such a variety of techniques, the reasons for the use of each, and a knowledge of how to use these techniques certainly demands Roentgen examination by a man trained in that specialty. Physical factors of voltage, milliampere seconds and distance as I have mentioned, are much more complicated than can be noted by a single sentence. The knowledge of buttons on machines does not mean the knowledge of kilovoltage, milliampere seconds, and distance. Only by a proper understanding of the fundamental principles involved can such a variety of techniques as mentioned be used to obtain satisfactory results.

To get back to the problem, we have then two methods of attacking it as a whole. The first method is the treatment of the individual case and in such treatment the use of x-ray is of undoubted importance. While the treatment of this individual case is still fundamentally rest and good hygiene, if we are to improve our statistical rate of cure it means that in the institutions for the care of tuberculosis adequate staffs of varied specialties and proper coöperation between these staffs must exist. The treatment of the individual case of tuberculosis is today no longer a one-man problem.

When it comes to the public health aspect of this problem, x-ray appears to be every bit as important as in the treatment of the individual case. There are several ways of attacking this problem, all of which are expensive. At the present time, it seems as though the method must be used which succeeds in discovering the greatest number of active cases of tuberculosis at the least expense. One of the first methods of doing this is to investigate contacts of known tuberculous patients. Such work is carried out in a rather hit or miss fashion in many communities. In this respect I gather from the literature and somewhat from my own experience that we as physicians are remiss in not more thoroughly following up families with known cases of tuberculosis. A second method of attacking the problem is that of the epidemologist. When an excessive number of cases of tuberculosis are found in one small area of a community then it becomes wise and necessary to investigate that cross-section of the population to discover unknown cases of tuberculosis. For further study it resolves itself not into the problem of examining the individual person but of examining large groups of individuals such as whole schools. Schools are particularly valuable, regardless of the many arguments as to whether adult infections are reinfection or flare-ups of the childhood type of disease, it is in the younger population that the tuberculosis problem is more severe. Again discovering cases amongst the school children is an excellent way of discovering families in which the disease exists. When it comes to group survey work, two methods have proven by far the most valuable. The first method, that of skin-testing with tuberculin has been widely used because of comparative lack of expense. Comparatively recently many doubts have been expressed by some of the best of the tuberculosis workers as to the accuracy of skin-testing methods. It seems probable in children that such methods are of tremendous help. The second method which has been proven to have a rather high degree of accuracy is that of Roentgen examination on a wholesale pattern by one of several different methods. Fluoroscopy has proven in the hands of certain trained observers to be quite highly accurate in picking up comparatively early lesions. A fluoroscopic screen is much more difficult to interpret than films. Extreme attention must be paid to the preparation of the examiner's eyes prior to fluoroscopy. It is a method that demands high skill on the part of the

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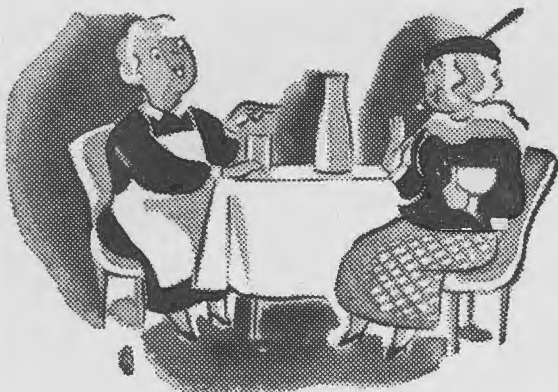
individual doing the examination. It leaves no permanent record. The second method that has been used is that of paper film. The cost of paper film is approximately half that of the ordinary acetate base film. The shadows on paper film are much more difficult to interpret. Technical factors for proper paper films work require greater power on the part of the machine. The gradations of the shadows on paper are of a much shorter scale than on film. This necessarily adds to the difficulty in interpretation. I believe practically all workers are agreed that the ideal method for group study in the Roentgen field is that of properly taken x-ray film. Here again properly taken x-ray films today demand powerful machinery and a high degree of technical excellence. In addition to that the cost in most group survey work has seemed almost prohibitive. Recently there has been developed a comparatively cheap film method which I believe has great promise for group survey work. This new method involves the use of very recent discoveries in the field of photography and in the field of radiographic technique. Essentially it is this, the patient is positioned in front of a light-proof box, approximately 4 feet long. Next to the patient, inside the box, there is a fluoroscopic screen of a particular type. At the other end of the box there is a camera with a very fast lense. The x-ray tube is positioned as is normally done in the taking of an x-ray film. The camera exposes a film 3x3 inches. Using a powerful radiographic machine, it is possible to make exposures of chests at essentially the voltage used for ordinary film work in the time of 1/10th of a second. This time is an irreducible minimum for chest film of good detail. For children the exposure time can be a 20th of a second. The resulting small film, a photograph of the image thrown on the fluoroscopic screen by the x-ray, has amazing detail and is of sufficient size to very accurately show minute lesions in the lungs. The cost of this small film is approximately 1/15th the cost of the film normally used. This means that the film expense for the single individual would be approximately 5 cents. This is enormously cheaper than paper. Its accuracy promises to be greater than that of fluoroscopy and is certainly tremendously greater than the accuracy of unskilled fluoroscopy. If suspicious lesions are found, larger films can be taken for better study. While the initial cost of such an x-ray plant would be fairly high, the saving in the examination of numerous groups of individuals would be correspondingly great.

The public health problem then resolves itself into tuberculin testing and x-ray examination of large groups of individuals. Here again, the average physician is throwing away his opportunities. More and more of this work is being taken over by governmental agencies with the unusual exceptions of cities where the physicians themselves are on their toes. For instance, at the present time in Detroit, under the direction of a Dr. Douglas, there is a large scale effort being made by the physicians as a whole to solve this tuberculosis problem. The tuberculin testing is being done by the general men after short postgraduate courses; radiological work is being done largely by the trained Roentgenologists and any films sent in not made by a trained Roentgenologist are reviewed by a board of men with such training. Remuneration has been rather low for the individual case. The work, however, has been done on a comparatively large scale. Many cases of hidden tuberculosis have been discovered and the physicians of Detroit themselves have awakened to the problem. To sum up, the use of the Roentgen ray in the diagnosis and therapy of the individual case of tuberculosis has become an indissoluble part of this work. In the public

(Continued on Page 85)

What A Record!



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Unselfishness, our heritage from years of practicing preventive medicine, dominates over thought and planning for Voluntary Health Insurance. This lower bracket group, economically speaking, can pay their own way, all things being equal. Given a job, fair continuous wages, smart budgeting, and a sufficient length of time, this lower bracket family could meet the expenses of a surgical calamity or a prolonged medical illness. Thus our attitude regarding this isn't a selfish one. Voluntary Health Insurance offers this group an opportunity to help themselves. They enjoy the economy of group-purchase when buying a car, or any home appliance. Under Group Medical Care they enjoy the benefits of the need of many for the same type of medical care on a coöperative basis. The Committee feels the desire for this need is sound.

The terms Poor Relief and Voluntary Health Insurance are often used synonymously not only by the laity but the profession as well. Really, they are separated as a Reno divorcée from her husband. The confusion arises when economic brackets are discussed. Indigent relief, so far as economic brackets are concerned, is a financial zero or as the A. M. A. puts it, "Those persons who cannot pay for food, shelter, clothing or medical care." They are the group, well defined, as taken care of at public expense. They include those persons on direct relief, widows pension, old age pension, aid to dependent children, etc., a group covered insofar as their care is concerned by taxation. Our attitude regarding this group has been largely a selfish one. We expect when the relief laws are re-written, these people will receive complete medical care including hospitalization with an equitable payment for their care at public expense. However, this point is injected only as a feature of clarity since it is not a matter of present discussion.

Certain problems face any County Medical Society which endeavors to foster Voluntary Health Insurance. The Society does not have actuarial experience, as a basis for premiums as does Group Hospitalization. You could arrive at such a figure or figures if you could get fifty or more general men to go over their books for a year to determine the need of families for ordinary care. If this isn't possible, then you must gamble at a figure, say one hundred dollars, which could be allowed as a maximum for one year's medical care. As ordinary care, I mean home and office calls.

Then there is the problem of referred care to the various specialties, and to dentists and nurses. How much should be allowed for this important care to each beneficiary?

The problem arises of combining group hospitalization with group medical care. I can see how Cleveland with a large reserve in their group hospitalization plan can set up a group medical care plan where the patient is hospitalized. But remember this is taking medical care out of our hands and putting it in the hands of a third party who may dictate the amount or type of practice to each patient. But where there is a small reserve such a plan would only tend

(Continued on Page 83)

February Meeting

Tuesday Evening, March 21st

6:30 P. M.

YOUNGSTOWN CLUB

Subject:

"THE IODINE METABOLISM IN THYROID DISEASE"

•

BIOGRAPHY

Dr. George M. Curtis comes originally from Michigan. After an early education in Boston, where his father was professor at Tufts College, his family returned west, where Dr. Curtis was graduated from the University of Michigan. He subsequently took his Master's degree there, in Biology, in 1910, and later his Doctor's degree in Anatomy, in 1914. In 1913 he was called to Vanderbilt University Medical School, where he eventually became Professor of Anatomy and Director of the Department of Anatomy. This work was interrupted by the war, during which Dr. Curtis completed his medical course as a part of his Reserve Officer's training.

Dr. George M. Curtis

Upon graduation in Medicine, he spent some time in one of the Public Health Service Hospitals, and then later a period of residency in the Presbyterian Hospital of Chicago. This was followed by a National Research Council Fellowship, a part of which was spent in Europe in physiological laboratories and in the Surgical Clinic at the University of Berne.

When the University of Chicago opened up its new hospital on the Midway, Dr. Curtis was appointed to a professorship of surgery, which he held from 1925 to 1932. At this time he was appointed to the professorship of research surgery at the Ohio State University. In 1936 he was appointed chairman of this newly created department.

Dr. Curtis is a Fellow of the American College of Surgeons; of the American Surgical Association; of the Western Surgical Association; and of the Southern Surgical Association. He has long been interested in the foundations of scientific medicine, in which field he has done a considerable amount of original investigation. His present interest lies particularly in three fields—the relation of iodine to diseases of the thyroid gland; the relation of the spleen to diseases of the blood; and thoracic surgery.

Twelfth Annual

Postgraduate Assembly

of the

MAHONING COUNTY MEDICAL SOCIETY

Thursday, April 20, 1939

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POSTGRADUATE DAY — APRIL 20

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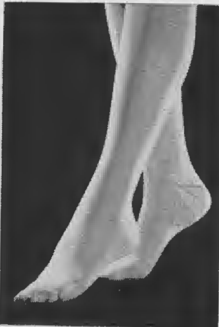

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YOUNGSTOWN, OHIO

They're Asking For It

(Continued from Page 79)

to wreck the financial status of group hospitalization for an obvious reason. Personally, it is the consensus of opinion that group hospitalization should be completely separated from group medical care, again, for a very obvious reason.

Thus, we are faced with a non-profit organization such as a Medical Society attempting to sponsor a program which requires capital to operate. So we must look forward to an assessment from each member to establish capital and to pro-ration if there isn't enough money in the "kitty" at the pay-off. It is going to be difficult to sell the members of the Medical and Dental Societies and to the Nurses Association and by the same token the rates must be low enough to be attractive to the public within the specified bracket.

The Ohio State Medical Association, through the Council, has offered a basic contract or policy, which is applicable in any county. It is unnecessary at this time to go into any detail concerning this contract, for, unless first of all, legislation is enacted to make this contract legal or we are able to fit into it the necessary monetary figures, it's merely a scrap of paper.

We must consider with all seriousness, the possibility of private interests with capital or the Government stepping in to offer a plan. This would naturally have the unfavorable stigma of dictation of policies on the one hand and the failure or confusion in payment of claims on the other hand. We had such an experience right here in this county with a private interest entering the group hospitalization field. For our patients' own welfare, we would dislike this thing repeated. From "Medicine in Modern Society," by David Riesman, M. D., I quote here his final warning to the profession: *"If it fails to lead then it will be obliged to follow those who have neither the knowledge, the wisdom, nor the incentive to preserve what is best in American Medicine."*

DR. WALTER KING STEWART,
Chairman of Public Relations
& Economics Committee.

HOME TALENT PROGRAM

The February meeting of the Society was planned by the Public Health Committee, and the committee and the essayists deserve thanks for the character and quality of the papers. Three papers were presented. Dr. Morrall's subject was Bone and Joint Tuberculosis; Dr. Keogh's was Surgical Treatment of Pulmonary Tuberculosis; Dr. Baker's, The Use of the X-Ray as a Diagnostic Measure. All were excellent and it is our intention to publish them in the *Bulletin.*

In this issue is presented Dr. Baker's paper, because it has a more general appeal in its social aspects and merits the careful thought of our Society. Dr. Baker points out that the diagnosis and treatment of tuberculosis is much more of a problem than anyone man can encompass, and that failure to put into operation the full facilities at our command merely makes of our sanitariums comfortable places for the last days of our tuberculous population.

We are all familiar with the situation existing in Mahoning County. Dr. Kirkwood is business manager, roengenologist, clinician and therapeutist all in one. That is too much of a job for any one individual. As a follow-up to this timely paper of Dr. Baker's, our Public Relations Committee should go to the County Commissioners with a well-thought-plan for the proper staffing of our institution that it may be an active agent in the prevention and cure of tuberculosis in this county.

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The Use of X-Ray In Tuberculosis

(Continued from Page 77)

health aspect of tuberculosis the use of the Roentgen ray in multiple examinations plays an equal part with skin-testing in the discoveries of unknown cases. The modern treatment of tuberculosis can no longer be confined to individual effort but demands the coöperation of trained groups of men.

SECRETARY'S REPORT

February, 1939

The regular Council meeting was held February 13, 1939. Dr. McKelvey, as chairman of the Housing and Library Committee gave a detailed report upon the project of hiring an assistant to the secretary and of having a central office. As a result of the discussion a motion was made as follows: The Council of the Mahoning County Medical Society approves the principle of the organization as outlined by Dr. McKelvey for an assistant to the secretary, the details to be worked out later, provided that an arrangement for office space shall be made by the Housing Committee and Secretary. The motion was duly seconded and passed. It was requested that the salary be paid by Dr. Patrick from the *Bulletin* fund.

The regular February meeting of the Society was held at the Youngstown Club on the twenty-first of the month. Dr. Skipp opened the meeting. The following applications for membership were read by the Secretary: Dr. M. M. Szucs of Youngstown and Dr. John Smith of Sebring.

A resolution to the memory of Mr. B. W. Stewart was read by the Secretary and motion was made, seconded and duly passed to adopt said resolution and send a copy to the family.

A resolution to the memory of Dr. E. W. Cliffe was also read and a motion made, seconded and duly passed to adopt said resolution and send a copy to the family.

Dr. Skipp then spoke of two important questions which must be decided by the delegates to the Ohio State Medical Meeting in May. He advised the membership of the Society to think about the business and be ready at a later date to instruct the Mahoning County Medical Society delegates concerning the type of vote to be cast. The two matters were as follows:

(1) *Redistricting of the State.*

There is a proposed plan to add another District to the State, making eleven instead of ten. This will make it possible for each Councillor to have to travel only 50 to 55 miles in order to see each Society in his District. This will simplify the management of the Districts and make for more efficient Councillor help. The delegates are to be instructed to vote *yes* or *no* on this question.

(2) *Increase of State Dues.*

The proposed increase of State dues from $5.00 to $7.00 is to be submitted to the House of Delegates in May. Dr. Skipp explained, this increase is due to the fact that the program set-up for the State has become necessarily more complex in order to become more useful to the medical profession. The examples of this are the increased activity of the Public Relations Committee, the increased cost of managing the Central office including committee meetings, and the State Journal. The delegates are to be instructed whether to vote *yes* or *no* on this question.

Dr. W. K. Stewart reported on the Voluntary Health Insurance Plans and stressed the difference between medical relief and voluntary health insurance.

Dr. E. J. Reilly announced the coming program for our Annual Postgraduate Day to be held at the Ohio Hotel, Thursday, April 20.

Pamphlets from the State Association for distribution to patients con-

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cerning Socialized Medicine were offered to the members.

The Scientific Section of the meeting followed.

Dr. Ralph Morrall presented a very fine paper on "Tuberculosis of Joints," in which he stressed the necessary steps for an accurate diagnosis, then showed the difference between radical and conservative treatment.

Dr. Joseph Keogh then presented an interesting paper, illustrated with lantern slides, entitled "Surgical Treatment of Tuberculosis." He discussed the various operations used in the chest surgery of tuberculosis and emphasized the improvement of technique and results during the last few years.

Dr. Ed. Baker then gave the third and last paper of the Symposium. He used as a subject "The Use of X-ray in Tuberculosis," and handled the subject as a plea for more accurate work in the diagnosing and treating of Pulmonary Tuberculosis. This requires the close coöperation of all doctors concerned, including a well trained Roentgenologist. He cited some recent figures to show that in many of our sanitariums the results are as poor as they were 20 years ago due to a lack of such coöperation.

All papers were well coöordinated and showed that such a local program can be as interesting as an out-of-town speaker.

Following the meeting a three-reel movie on "Sterility" was presented by the Winthrop Chemical Company.

Council has approved the application for membership in Mahoning County Medical Society of the following:

Active Membership:
Michael Joseph Sunday
John A. Rogers
Asher Randell
Stanley Allen Myers
James K. Herald
William Franklin Hatcher

Class D Membership:
Elmer Troy McCune

Non-Resident Membership:
Howard Ellsworth Mathay.

Unless objection in writing to any of these applicants is filed with the Secretary within fifteen days, they will become members of the Society.

JOHN NOLL, M.D., *Secretary.*

Obstetrical Definitions

(Formulated by The American Public Health Association and Endorsed by The Committee on Neonatal Morbidity and Mortality of The American Pediatric Society.)

1. Complete birth. A birth is complete the very instant of complete separation of the body of the infant from the body of its mother (regardless of whether or not the cord is cut, or the placenta detached).

2. Live birth. An infant exhibiting life after a "complete birth." The three evidences of life are (a) breathing, (b) heart action or (c) movements of a voluntary muscle.

3. Still birth. An infant which does not exhibit evidence of life after a "complete birth": (no breathing, no heart action or no movement of a voluntary muscle).

4. Abortion. Any product of conception less than 28 weeks duration, measuring 35 cm. or less, and weighing less than 1,500 grams (3¼ lbs.).

5. Premature infant. An infant with a birth weight of 2,500 grams (5½ lb.) or less, with a "crown-heel" length of 47 cm. or less and a gestation of 37 weeks or less: the birth weight being the most important factor.

6. Neonatal period. The first 30 days of the infant's life. It is during these first 30 days that the mortality of all infant deaths under one year is the greatest (67 per cent). The usual causes, usually preventable, are pre-maturity, birth injuries and sepsis.

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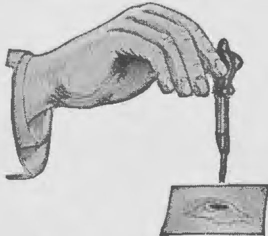

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NON VI SED ARTE

L. JAY GOLDBLATT, M.D., LL.B.

In each delivery room in the Chicago Lying-In Hospital a bronze plaque bearing the inscription, "*Non vi sed arte,*" has been conspicuously placed on the wall facing the obstetrician as he stands at the foot of the delivery table.

Dr. DeLee has wisely had them situated thusly so that the operator is constantly confronted with this admonition.

These words made a deeper impression on the writer than any other item observed during a stay of several weeks at this renowned institution. This is not to intimate that one does not gain considerable valuable instruction from the courteous and willing members of the attending staff. These men are at all times disposed and even anxious to demonstrate and discuss procedures and the theories and mechanics upon which they are based.

In the course of every operative maneuver the avoidance of force is stressed and the concomitant employment of skill is apparent.

If there is any one thing in the practise of obstetrics that should be emphasized above all others it should be the futility and peril of the use of force. It may be accepted as a truism that what cannot be accomplished by skill certainly cannot be performed by force. In fact the resort to force is, per se, a tacit confession of lack of skill.

It must constantly be borne in mind that every obstetric case involves at least two lives. Also that there is a very close proportion between passenger and passage. And finally that the structures and tissues involved in each are extremely delicate and very susceptible to trauma.

A careless, rough, or too rapid delivery may, and generally does, produce irreparable injuries which permanently affect mother or child or both. The high morbidity and mortality rates, fetal and maternal, serve as unpleasant reminders of bungling obstetric practise.

If one would constantly remember the disastrous sequellae that are so prone to result from the injudicious use of unnecessary force, the temptation to unduly hasten the course of a delivery or to employe violent procedures would be abhorred.

Lacerations, rupture, hemorrhage, shock, infection, mutilation, deformity, and death are but a few of the unfortunate penalties of unskillful manipulation and immature judgment.

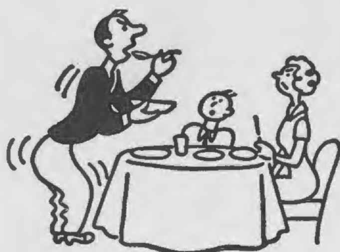
While it is generally true that lack of skill and recourse to thoughtless and useless roughness are most apt to be exhibited in instrumental and operative deliveries, it is no less so that the careless obstetrician will, by force of habit and want of consideration, exercise the same lamentable tactics in the uncomplicated spontaneous birth. Habit feeds upon itself and in so doing grows stronger.

It is well to remember that in any given case the duration of labor must depend upon certain definite factors, viz., the relative proportion between fetus and passage, the strength of the expelling forces, the resiliency of the tissues making up the birth canal, and the coöperation of the patient.

Thus a consideration of these factors brings the instant realization that the use of any method to hasten the natural forces, other than such as has been approved by sound judgment and ripe experience, is to be unreservedly condemned.

Too early rupture of the membranes, too rapid extraction of the presenting head or breech, as the case may be, too much haste in delivering the after-coming shoulders, too little patience in the third stage—these are but a few of the common faults frequently displayed during the conduct of a normal delivery.

ARROW



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Forceps Delivery

In forceps extraction there is too frequently an undesirable inordinate anxiety to get the blades into position and articulated. As a result there is insufficient regard for and care in application.

Successful forceps delivery requires careful attention to certain essential details. Complete anesthesia with ether, ethylene, or nitrous oxide (preference in the order named) is usually necessary. Assurance of the complete dilatation and effacement of the cervix is now ascertained. If the membranes are not yet ruptured this must be done at this time. Then having determined that the proportions are satisfactory, an accurate survey of the position of the head and fontanelles is painstakingly made. The bladder is catheterized. Each blade, well lubricated, is then gently introduced at the posterior commissure, and not along the lateral walls of the vagina, rotated into proper position, carefully fitted and locked. Before beginning traction a re-examination of the application is always advisable.

Traction should be made with the hands, wrists, and arms only. The use of the weight of the body is both unnecessary and undesirable, and when brought into play it is usually because of faulty position of the presenting part or inaccurate application of the blades.

Traction should not be continuous but intermittent and for not more than 12 to 15 seconds for each effort. It should not be a quick violent jerk but a slow, firm and gradual pull. After each effort the forceps are slowly released and the blades slightly separated. Thus imitating the natural expulsive forces.

If no progress has been made after repeated attempts it is good practise to remove the forceps and again examine and determine the position. With the presence of a pronounced caput it may be quite difficult, if not impossible, to distinguish fontanelles. In such case insertion of the hand into the vagina to palpate and identify an ear may be of great assistance in establishing a decision.

The fetal heart should be auscultated frequently in the course of forceps extraction, first, to make certain that the cord is not being compressed by the blades, and second, to serve as a guide as to the condition of the child so that delivery may be accelerated if required.

To aid the obstetrician to properly time his traction efforts and to facilitate the counting of the fetal heart impulses during this operation, a large clock with a prominent second-hand should be part of the regular equipment in each delivery room.

Version

Version is a serious procedure, fraught with grave possibilities, and should be performed only by the experienced accoucheur and only after careful consideration of the indication therefor. Complete detailed examination of mother and child and mature deliberation of probable effect on each should precede the decision to proceed with this operation.

Again, during the performance of this important maneuver, the admonition, *"Non vi sed arte,"* must be constantly borne in mind. The observance of extreme gentleness and the exercise of the greatest skill are required to avoid disaster.

An intimate knowledge of the contraindications for version is, at least, as important as familiarity with the modus operandi itself. The existence of any of the following conditions should serve as a stop-signal when contemplating version: Pelvic deformity sufficient to interfere with passage of the after-coming head; disproportionately large child; too early rupture of the membranes (so-called "dry labor"); incompletely dilated cervix; tetanic contraction of the uterus; contraction ring; exhaustion of the mother; fetal head im-

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pacted in the pelvic inlet; macerated or dead fetus.

Duration of Labor

What is the limit of safety in a prolonged labor? This is a perplexing problem which frequently arises during the conduct of obstetric cases, especially in cases of occiput posterior. After having waited what seems like an interminable period, the urge to intervene, to do something, harasses the mind of the operator.

That the prolongation of labor beyond safe limits is of itself the cause of subsequent trouble is well known. But to lay down exact rules as to the time which may be allowed to elapse before interference is manifestly impossible. The circumstances of each individual case must, in the final analysis, decide the issue.

The criteria to be considered in determining this important question include the condition of the mother, the condition of the child, the progress of the presenting part, and the strength of the uterine contractions. These factors must be weighed collectively as well as individually.

A progressive, though gradual, upcurve in the maternal temperature and/or pulse levels, or in the fetal heart rate are indications for intervention. Powerful uterine contractions continuing beyond the normal average duration of the first stage with no advance, or a cessation of advance, of the presenting part, or conversely, rapidly weakening nonproductive contractions are usually indicia that help is required.

The writer has recently had two cases, both primipara, one of whom was permitted, under careful observation, to continue 54 hours and the other, 76 hours without interference. In each of these cases though progress was slow it was steady and the natural forces were competent to bring down the head sufficiently to permit median forceps extraction.

It is particularly in the management of this type of case that one is required to exercise the highest degree of judgment and to maintain a watchful expectancy but not to yield to a blind unreasoning trust in the processes and powers of nature. When once it has been determined that assistance is necessary, action must replace inaction without hesitancy.

Repetition is considered monotonous. At the risk of appearing tautologic, may it again be urged in concluding that each and every obstetric procedure is an individual problem and must be unremittingly attended with the deepest concern, the utmost gentleness, and unflagging patience. Indeed, if every obstetrician would carry a mental image of the aforementioned bronze plaque into the delivery room it would be of vast benefit to himself as well as to the practise of obstetrics.

THE MEDICAL CRIER

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

• To our mind, some of the propaganda material against Socialized Medicine put out by our State Association could be greatly improved. The pamphlets given us to place on our waiting room tables are a conspicuous example. The reasoning is far fetched and obviously intended to frighten gullible and ignorant people. For instance, a man sitting in a doctor's waiting room was reading one of the pamphlets when a friend of his walked in and sat down. Pointing to the pamphlet, the first one said, "You ought to read that, there's something funny!"

• Child psychology can often be applied to adults. It is a well known principle in child psychology that when a child cries for some expensive toy which is not good for him to have, he can be pacified by substituting some new thing which is more useful. The New Deal shopkeepers

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have displayed in their windows the new, shiny and highly enticing article known as Socialized Medicine. We can see under its gaudy paint the shoddy construction, but the lure is there and many of our patients are standing with noses pressed upon the glass while their eyes are fixed upon its gleaming exterior. No use for us to try to get them home to play with the old toy called Family Doctor—they want something new and the best we can do is to substitute something more practical. The State Medical Association is now working on a plan for medical care which will avoid the costly bureaucracy and political management of State Controlled Medicine. We believe the people will be satisfied with such a plan. They want medical care with the costs pro-rated over a large group so that the great burden of devastating illness does not fall on one family. They want good treatment, and they are not keen to have medicine mixed with politics. Maybe the substitute will fill the bill.

• We predict that when the State Association's plan is presented to the Medical Society it will meet with considerable opposition from the doctors themselves, for the following reasons: 1) It will change the old system. 2) It will necessitate certain sacrifices and concessions. 3) It is not yet realized by many in the profession what an urgent need there is for such a plan to forestall a politically-controlled system.

• The new Editor of the Jackson County Bulletin (Kansas City, Mo.) pops off with the following: "Editors are funny little men with shiny pants and eye shades who scuttle about with ink-stained fingers, issuing Clarion Calls announcing, denouncing, pronouncing, pointing with pride and viewing with alarm.

"It is alleged that with miraculous fingers they mould that liquid figure called public opinion.

"If their scribblings are agreeable in emotional tone to the majority of their readers they are called staunch, loyal, wise and honest men. If their utterances are disagreeable they are called rebels, fools or stooges.

"They are called all of these at the same time, most of the time, for of course there is never unanimity of opinion.

"Though usually good chaps, editors are frequently horse-whipped and occasionally shot!"

• We agree with Stephen Leacock who says that education is taking too long. By the time a doctor goes through high school, college and medical school, takes his internship and a residency, then starts to struggle getting established; he is ten years late making a living, ten years late getting married and ten years late having children. He doesn't get to enjoy his grandchildren which is the rosiest prospect in life. He doesn't get to enjoy old age, it's all over before it's scarcely started.

J. L. F.

NEWS

At the February Staff Meeting of St. Elizabeth's Hospital a scientific program was presented by the Internes. Papers were read by Drs. Phillips, Sovik, Parker and Hardman. Dr. Ambrecht presided.

Dr. and Mrs. Bierkamp and Dr. and Mrs. McNamara have returned from a thoroughly enjoyed vacation at Miami, Florida.

Dr. Samuel H. Sedwitz addressed the Academy of Medicine, Muncie, Ind., February 14th, on the subject of Peripheral Vascular Diseases.

Dr. and Mrs. P. J. McOwen and son have returned from Florida.

Dr. P. H. Mahar has resumed his practice after a long illness.

Dr. and Mrs. V. A. Neel, son Richard and daughter Verne have

returned after a month's vacation at Miami.

Dr. and Mrs. Howard C. Miller are among the missing, having left last week for Florida.

Dr. and Mrs. D. M. Rothrock have been enjoying a three week's stay in Florida. The trouble is they didn't stay in Florida, but took to the air from Miami to Havana.

Dr. and Mrs. A. E. Brant are among the Fort Lauderdale visitors.

Dr. W. H. Evans has returned from a South American cruise.

Dr. Wm. E. Maine spent a few days the guest of Dr. Haller, Cleveland.

INTERESTING PROGRAMS

Stark County Medical Society

April 13th—Symposium on Fractures. Program being arranged by the Local Committee on Fractures of the American College of Surgeons. Speakers to be announced later.

Meetings to be held at the Elks' Club, corner West Tusc. & DeWalt, on the second Thursday evening of the month, at 8:30 p. m.

Allegheny County Medical Society

Scientific Program March 21st

Newer Concepts in the Management of Peripheral Vascular Diseases, by Dr. Harry I. Miller.

Hematemesis: Problems in Diagnosis and Medical Treatment, by Dr. Lawrence Wechsler.

Spontaneous Subcutaneous Rupture of the Stomach, by Dr. Herbert Frankenstein.

Exhibits, Miscellaneous, by various members of the Staff from several departments of the Montefiore Hospital.

Program April 18th

Recent Therapeutic Advances in Neuropsychiatry, by Dr. Max H. Weinberg.

Protrusions of Lumbar Intervertebral Discs as a Cause of Low Back and Sciatic Pain, by Dr. H. M. Margolis.

Coronary Heart Disease, by Dr. L. H. Landay.

Diagnostic Value of Occult Hematuria: Based on a Study of 3,000 Urinary Sediments, by Drs. J. H. Barach and L. Lewis Pennock.

Annual Scientific Assembly at Washington, D. C.

"The eyes of the medical world are on Washington," according to an announcement just received from The Medical Society of the District of Columbia which states that the Annual Scientific Assembly will be held April 25, 26, and 27, 1939, in the Mayflower Hotel in Washington.

Gastroenterology in all its phases will be the subject covered in the three-day postgraduate course, offering about fifty-two papers, panels and round tables on the subject. The program lists in addition to many prominent physicians of the faculties in Washington the following from elsewhere: Dr. Lewellys L. Barker, Baltimore; Dr. Fred Rankin, Lexington, Kentucky; Dr. L. M. Hurxthal of Lahey Clinic, Boston; Dr. R. J. Coffey, formerly of Mayo Clinic; Dr. B. B. Vincent Lyon, Philadelphia; Dr. E. H. Gaither, Baltimore; Dr. P. P. Vinson, Richmond; Dr. Eloise B. Cram, National Health Institute.

Luncheons, stag meeting, banquet, and entertainment for visiting wives are provided by the Society.

Reservations are being taken by Theodore Wiprud, Secretary of the Society, 1718 M St., N. W., who will forward full information on request.

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