Texas Osteopathic Physicians Journal

VOLUME XXI FORT WORTH, TEXAS, SEPTEMBER, 1965 NUMBER 5

In This Issue—

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

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VOLUME XXII FORT WORTH, TEXAS, SEPTEMBER, 1965 NUMBER 5

'The Auxiliary Is At It Again'

MRS. DONALD E. HACKLEY
State Funds Chairman

The Auxiliary is at it again. Not content in surpassing last year's osteopathic Seal goal of $100,000, they've set their sights at raising $150,000 in 1965-66.

Any doctor who thinks it can't be done, faces an interesting argument from the ladies. Regardless of his feelings pro and con, the doctor is in for a solid selling Campaign on the importance of Seals to the profession.

The Auxiliary thinks it has the key to meeting and topping the 1965-66 goal. *More* doctor participation. Only a fourth of the profession contributed to Seals in 1964-65. That leaves nearly 9,500 D.O.'s who haven't realized that Seals mean Student Loans and Research Grants.

"In recent years Seal campaigns have stressed that more than 60 percent of the proceeds come from the public, Mrs. Henry N. Hillard of Lancaster, Pa., explained. Mrs. Hillard is the Auxiliary National Christmas Seal Chairman.

The remaining 35 percent comes from only a quarter of our D.O.'s she said. "Our $150,000 goal can be reached easily if we can impress the rest of the profession with the importance of Seal proceeds."

To do this the Auxiliary, the Guild, student Wives' groups and the doctors themselves are primarily gearing their efforts to attract the interest of these indifferent D.O.'s.

"The Auxiliary gets the job done, whenever it sets its mind to a project," Dr. True B. Eveleth said. Dr. Eveleth, AOA, executive director, is secretary to the National Osteopathic Foundation which oversees Seal Campaign activities.

"I have no doubt their efforts will lead to increased professional giving in this year's Campaign," he said. "Of course, physicians must realize they are real benefactors from Seal proceeds. Seals provide *more* D.O.'s to carry on the principles and precepts of osteopathic medicine. They also mean continued osteopathic research, something essential to continued professional growth. In a sense D.O.'s contributing to Seals are providing a legacy to the profession."

Once again the National Auxiliary Committee will supply the "Packet" Plan and Mail Clerk Service to assist those "too busy" doctors in reaching patients and other outside sources interested in supporting osteopathic student loans and research.

As for those D.O.'s who have never given a thought about Seals, they can expect to be bombarded with reminders from their wives and other Auxiliary members, Mrs. Hillard explained.

Doctors, the ladies mean business. And in this case, business, means the growth and development of the profession. Again nobody's taking bets they won't succeed.

Summary of Membership Committee Action

I. Suspensions due to non-payment of dues:

Adams, Justin
Samblanet, H. Louis
Tedford, N. L.

II. New Applications Approved:

A. Interns

Corpus Christi Osteopathic Hospital
John I. Latham
Community Hospital, Inc.
James E. Thompson
Leopold Villegas
John A. Ward
Dallas Osteopathic Hospital
Max E. Ayer
David Charles Conner
Robert Young Fong
Merlin LeRoy Shriner
Gaetano Guy Urso
East Town Osteopathic Hospital
Ernest Joel Carlson
Glen J. Holliday
Roy E. Honeywell
David F. Norris
James Royder
Harold Steinbaum
Arthur S. Wiley
Fort Worth Osteopathic Hospital
William R. Graves
Jere R. Lancaster
Donald K. Paxton
Wyman P. Sandlin
Adron C. Tenbrook
Fred R. Tepper
Mid-Cities Memorial Hospital
Richard D. Chandler
Stevens Park Osteopathic Hospital
L. D. Howlett
H. S. Hewes
M. Louis Vanderschot

B. New Residents

East Town Osteopathic Hospital
Shirley Ahlers
Graydon James Carlstrom
Mid-Cities Memorial Hospital
T. J. Tuinstra
Fort Worth Osteopathic Hospital
Joel Alter

C. New Regular Members

James H. Cason, Mesquite
Raymond Joseph Droney, Houston
Kennith Gregory, Abernathy
Myron D. Jones, Jr., Grand Prairie
Carl Vernon Mitten, Houston
Edmund F. Touma, Dallas

III. Applications now being processed:

Louis Carlos Boneta, Forney
James William Branch, Colleyville
Frank Corpaci, Grand Prairie
Wendell V. Gabier, Arlington
William T. Hamlin, Duncanville
Martin R. Kaplan, Dallas
Richard L. Lande, Irving
Richard Allen Lane, Richardson
James W. Linton, Hurst
James E. Little, Dallas
James P. Malone, Leakey
Roy C. Mathews, Wolfe City
Irvin S. Merlin, Richardson
Roy D. Mims, Jr., Comanche
George J. Naugles, Ft. Worth
Frank J. Orlowski, Hurst
Charles L. Pigneri, Farmers Branch
Ronald R. Reed, Duncanville
H. Louis Samblanet, Dallas
Bill Warren Smith, Dallas
Gordon Lee Thorn, Dallas
Edmond R. Tyska, Irving
John Ronald Wilk, Dallas
Richard Charles Wiltse, Houston
Norman Eugene Wood, Houston

Two D.O.'s Join AMDOC Mission

Dr. Ramon Villeda-Morales, former president of Honduras said: "Honduras is the land of four seventies: seventy percent illiterate, seventy percent illegitimate, seventy percent rural population, and seventy percent preventable deaths."

It was to help lower this last "seventy" that J. Warren McCorkle, D.O. and Grover Stukey, D.O., recently joined a group of 17 physicians in an AMDOC (American Doctor) mission to Honduras.

Each team of volunteers consists of an American doctor, an adult advisor and six young people. The team is trained to administer small-pox vaccinations, inoculations against diphtheria, whooping cough and tetanus and oral medicine for internal parasites. The volunteers also help in recreational programs, English language classes, projects requiring manual labor, and formal and informal entertaining.

Dr. McCorkle reports that he was assigned to San Antonio de Copan in Northern Honduras and had an 18-year-old premedical student from Houston as his only helper. There were about 5,000 people in his area with no physician. He saw over 100 patients daily, many of whom had never seen a doctor before. One boy, age 10, had broken his arm two months before with no medical care. Typhoid, goitres, intestinal worms, eye diseases, and amaebiasis were of epidemic proportions but patients responded much more quickly to antibiotics than in private practice in the States, Dr. McCorkle said.

The group was well received by local people who furnished them living quarters. "Some remarked that they thought more of our giving up vacation time to help them than for the Government to send workers," Dr. McCorkle said.

In the first three weeks there were 172,000 treatments and immunizations given. Some of the groups went on mules to coffee plantations to treat patients. These trips sometimes took ten hours one way.

The cost of the program for each individual is $150 which includes round trip air transportation from Houston, travel within Honduras, room and board, inoculations and medical expenses and insurance. This is actually about one-sixth the cost, but the balance is donated by individuals and organizations including the government of Honduras and the sponsoring organization.

There are plans for a follow-up program in 1966, but AMDOC always has opportunities throughout the world for any length of time. So far, 120 doctors haev been sent at a cost of $3,000.

This project is sponsored by River Oaks Baptist Church of Houston. Willow Meadows Baptist Church of Houston has also made significant contributions.

Further information may be obtained by writing to: Amigos de Honduras Project, c/o River Oaks Baptist Church, 2300 Willowick, Houston, Texas, 77027.

Watch for 'Fakes'

All osteopathic physicians should be on the lookout for the appearance of "doctors" who claim to be osteopathic physicians and have fake diplomas from the fictitious "University of New York Faculty of Osteopathy." The appearance of anyone holding such a "diploma" should be reported immediately to the legal counsel of the American Osteopathic Association.

From Journal of the A.O.A

SOPA Convention Held

Dr. Bobby Gene Smith stands in front of the Public Relations Committee booth at the SOPA convention showing public relations materials to Lula F. Hayes, office assistant to Dr. Jack E. Barnett.

The fourth annual convention of the Texas Osteopathic Physicians Assistants was held July 17-18 in Beaumont at the Ridgewood Motor Hotel.

Opening day of the meeting included an insurance workshop presented by Kenneth Clingaman, a Port Arthur insurance agent and a mental health program presented by Smith, Kline & French Laboratories. A uniform style show was scheduled during the opening day luncheon.

A reception and banquet was held Saturday night to honor incoming officers, Mrs. Betty Woodall, Port Arthur; Miss Emma Jo Smith, Groves; Mrs. Mary Ann Wahoff, Fort Worth; and Mrs. Olette Warren, Houston.

Also scheduled for Saturday night was a film presented by Warner Chilcott Laboratories. State Representative Carl Parker was guest speaker.

A breakfast with installation ceremonies was held Sunday with Mrs. Paul Seifkes, Secretary of the Auxiliary, as installing officer.

Committee chairmen for the convention were: Miss Smith, convention program chairman; Mrs. Woodall, convention chairman; Mrs. Katy Holstead, registration; and Mrs. Betty Latimer, breakfast and installation.

This new group is serving a very useful purpose by exchanging information on better procedures, informing those new to the profession just what a D.O. is, operating an employment information service. It is significant that they would use their after working hours time to conceive and construct this worthwhile endeavor.

Law Course for Medical Assistants

A course in "Legal Aspects of a Medical Practice" will open the 1965-66 program for medical assistants at Texas Christian University.

The course is designed for medical assistants and secretaries. Among the topics which will be discussed are: confidential communication between physician and patient, compensation for professional services, medical professional liability, status of medical records and physician duties imposed by statute.

Instructor for the course will be Martin O. Siegmund, a graduate of the University of Texas Law School. Mr. Siegmund is a former corporation court judge and is actively interested in community health problems.

Classes will begin on October 4, 1965, at 7:30 p.m. and continue for six consecutive Monday evenings. Tuition for the sixteen hour course will be $20.00. Inquiries about the course may be made of Dennis Schick, TCU Short Course Division, WA 6-2461, ext. 288 or at the TCU Evening College.

Clinic Serves as Art Gallery

When Westside Bone and Joint Clinic opened last July, the biggest attraction wasn't the brand new building.

Persons touring the building were more interested in the paintings hanging on the walls than in the sparkling new fixtures.

They reacted to the paintings, which were done by doctors in the clinic and their families, as if they were in an art gallery. They walked through and studied each painting carefully, criticizing and complimenting.

Watching the touring critics, Mrs. Thomas R. Turner, whose husband's office is in the clinic, had an idea. Now the Westside Bone and Joint Clinic is not only a bone and joint clinic but also an art gallery of sorts.

Mrs. Turner, a high school art teacher for 10 years, has a dual purpose for turning the waiting room of the clinic into a monthly-changing art gallery. First, patients waiting to see one of the three doctors who share a common waiting room get tired of looking at the same old magazines.

"They may not like the art that's on exhibit," said Mrs. Turner, "but they certainly notice it. It helps them get their minds off their problems—gives them something to think about."

"And if they don't like what's up this month, chances are there'll be a different show up the next time they come."

Second, the waiting room gives her a place to encourage young artists to exhibit. The space is dedicated to art students of high school and college age who are not old enough or professional enough to be accepted by other galleries.

Mrs. Turner hopes to work in cooperation with schools in this area, to give students a public outlet for their works.

Mrs. Turner has already had favorable comments on her "gallery." "The patients seem to enjoy the change of scenery and they're coming to expect something different," she said.

"I heard one patient explain to her friend that she didn't mind waiting so much now, because there's always something different to look at."

The "Gallery," at 990 Montgomery, is open from 9 a.m. to 5 p.m. Monday through Friday, and from 9 a.m. to noon Saturdays.

Mrs. Turner will be remembered for the art work she did in the Journal for the Child Health Clinic.

(Editor's note: Above was taken from a story in the Forth Worth Star-Telegram by Anne Miller.)

Special Notice

Blue Cross Statewide Workshop Scheduled for October 14

A special workshop has been scheduled by Group Hospital Service (Blue Cross) to be held in Dallas on Thursday, October 14, for osteopathic hospitals of the entire state, according to A. Rex Kirkley, M.D., Director of Professional Relations for the Texas Blue Cross — Blue Shield health care organizations. The workshop will be devoted almost entirely to problems of admitting, confirming, and discharging patients who are Blue Cross members but will also explore and explain some aspects of Blue Shield that are closely related to hospital inpatient and outpatient clerical procedures. Because this is the only such workshop planned in the near future, the Hospitals and Insurance Committee of TAOP&S is very hopeful that every osteopathic hospital in Texas will be represented at the workshop, because the instructions and explanations will be invaluable for all business office persons who have never attended such a workshop and will also be of good practical benefit for anyone who has attended in past years.

Although developed primarily for the benefit of business office managers and admissions officers, any physicians or hospital administrators who care to attend will be very welcome, according to Mr. Ralph Webb of Blue Cross Professional Relations staff.

Registration will start at 9:00 a.m. in Dallas. The session will open at 9:30. Complementary luncheon will be served and the workshop will conclude at or about 2:45 p.m. Each member hospital will receive a special announcement from Blue Cross in the very near future which will specify the location of the session.

Sam Sparks Awarded Life Membership in ACOS

SAM F. SPARKS, D.O.

Dr. Samuel F. Sparks of Dallas has been awarded a Life Membership in the American College of Osteopathic Surgeons.

Court Ruling

From The Journal Oklahoma Osteopathic Association

We were all surprised to learn from the Executive Secretary of the Missouri Board of Registration for the Healing Arts, that *Mitchem and Wilson v. Missouri Board of Registration for the Healing Arts* was a "friendly suit" to determine whether the California College of Medicine's m.d. degrees were valid in Missouri. The application of one of the plaintiffs to transfer the case from the Kansas City Court of Appeals to the Supreme Court of Missouri has been denied. Therefore, the decision of the Kansas City Court of Appeals in refusing to grant the plaintiffs a Missouri license as an M.D. on the basis of their little m.d. degree is now final.

Fourteenth Annual Hospital Convention

Texas Osteopathic Hospital Association held its annual meeting July 30 through August 1 at the Robert Driscoll Hotel in Corpus Christi.

Featured speakers included Mr. Charley Reed, Texas Association of C.P.A.'s, who spoke on hospital cost accounting and related subjects.

Other speakers were Mr. John Winters from Texas Department of Welfare who spoke on Medicare as it relates to OAA and the Kerr-Mills program, and Mr. Robert Mayne from the U.S. Department of Health, Education and Welfare who continued the lecture on Medicare and OAA.

The following were nominated as officers for the year May, 1966 to April, 1967: R. J. Shields, D.O., President; H. G. Mann, President Elect; Walter J. Dolbee, Vice President; Mary Hayes, Secretary-Treasurer; Glenn R. Scott, D.O., and Gordon A. Marcom, D.O., Trustees. They were elected by unanimous vote.

Those attending the convention included:

Dr. Jim Martin, Garland
T. G. Leach, Ft. Worth
Roy D. Mims, Jr. D.O., Comanche
E. M. West, Garland
Alyne Kelly, Stanton
Mrs. Roy D. Mims, Jr. Comanche
Janie Morgan, Stanton
Zella Graves, Stanton
Lee Baker, Lubbock
Dr. R. J. Shields, Port Arthur
Dr. J. C. Calabria, Dallas
John B. Isbell, Dallas
Mrs. John B. Isbell, Dallas
J. C. Hubbard, Kennedale
Jaunita L. Brown, Kennedale
Mrs. H. R. Wicks, Klondike
Dr. Glen R. Scott, Amarillo
Clara Danner, Groom
Gene Danner, Groom
Mary Hayes, Ladonia
Dr. Gordon A. Marcom, Ladonia
Everett W. Wilson, San Antonio
Dr. G. Stuckey, Houston
Mrs. G. Stuckey, Houston
Robert Price, TAOP&S, Ft. Worth
W. L. Davis, Jr., Amarillo
Mrs. Edward J. Aycock, Houston
E. F. Cox, El Paso
Ed Aycock, Houston
Olie C. Clem, Denton
Jim J. Garrett, Tyler
Walter J. Dolbee, Hurst
G. A. Fuller, Jr., Ft. Worth
Neil Purtell, D.O., St. Jo
Mrs. Neil Purtell, St. Jo
Joseph W. Harom, Corpus Christi
Franklin E. Wells, Dallas
Martha Ann Beasley, Corpus Christi
Dean E. Wintermute, D.O., Klondike
H. G. Mann, Dallas
Charles E. Reed, Port Arthur
Mrs. Charles Reed, Port Arthur
Emma Jo Smith, Groves
Bennie Bearden, Groves
Dr. R. E. Cordes, Tyler
Mrs. Dan Hale, Tyler
Dr. R. J. Horan, Houston
Don Wenglar, Houston
Dr. S. E. Smith, Wolfe City
Grace Harrison, Dallas
Marilyn Mobley, Groves
Royce L. Ashcroft, Austin
Dr. A. N. Clanton, Tyler
James P. Malone, D.O., Corpus Christi
Fred E. Logan, Corpus Christi
R. W. Brisco, D.O., Ft. Worth
C. E. Foster, Houston
Chuck Bell, Euless
Cecile Cox, El Paso
Mrs. Lois Johnson, Garland
Mrs. Dorothy McMullen, Garland
Wm. R Harris, D.O., Kennedale
Dr. J. R. Horan, Houston
Dr. Palmore Curry, Mt. Pleasant

Pfizer Laboratories for the fourth straight year granted $10,000 in July to the Chicago College of Osteopathy toward support of a Chair in Osteopathic Medicine. Recipient of the grant, Dr. Ward Perrin, who is chairman of the college's Department of Osteopathic Medicine, has been relieved of some routine duties through the addition of personnel, thanks to past grants, Dr. MacBain, president of CCO explained. This has given Dr. Perrin more time for student training, postgraduate instruction, program appearances and attendance at educational seminars.

How To Interview An Applicant

By: MRS. R. N. RAWLS, JR., *AOA Scholarship Chairman*

MRS. R. N. RAWLS

Qualified new students are the lifeblood of our osteopathic colleges and the osteopathic profession. In the field of osteopathic education, the matter of securing good students receives top priority; the awarding of scholarships to deserving applicants is synonymous with this theory. Much of this effort must be done in the "grass root" areas by dedicated osteopathic physicians, their wives and families.

The personal interview of a scholarship applicant is of prime importance to the Awards Committee when grants are made. District and state auxiliaries have a voice in the selection of a candidate when a letter is written to the scholarship chairman, state president or auxiliary member in the locality where the applicant resides asking for her assistance in obtaining information regarding the candidate.

Three factors for consideration when interviewing an applicant are: the AAOA member's aptitude toward the AAOA scholarship program and the osteopathic profession in general, the interview focus, and a concise report regarding the personal interview.

The National Osteopathic College Scholarships is in its thirteenth year. Up to twenty scholarships are awarded annually to students entering one of the approved osteopathic colleges.

The scholarship money is paid directly to the college in which the student matriculates; $750 for the first year and provided the student's work is satisfactory and the financial need the same, $750 is granted for the second year.

This year over 900 academic colleges and universities received the material announcing the National Osteopathic College Scholarships. In most instances, the applicant is made aware of the scholarship program through the academic college in which he is enrolled or through discussions with an osteopathic physician.

The AAOA scholarship program and the AOA student loan program are confusing to many not connected with the two. The scholarship grants are monetary gifts to students entering an osteopathic college. The AOA student loans are available to students in their third and fourth year of professional training, and are to be repaid at a specified time.

A good general knowledge of the osteopathic profession is the requisite of all osteopathic wives. It is not required that the busy doctor assist in the personal interview of an applicant, but most physicians CAN recognize immediately the qualities present for the making of another good physician.

Many interviewers invite the candidate to the home at an appointed time when the doctor can be present. This creates a relaxed setting, however, it is not imperative and the interview can be conducted successfully in the home of the applicant or another appointed place.

Due to the keen competition for the National Osteopathic College Scholarships, high scholastic standing rates

approximately 30 percent when the Awards Committee reviews the application. Good business sense requires this consideration because of the investment of the scholarship monies as well as the cost to the profession for the education of the student. In the discussions regarding grade points it is recommended that the applicant's interest in courses of study, extracurricular activities and general information concerning college life be determined.

One of the prime purposes of the scholarship program is to assist young men and women, who otherwise might not be financially able, to become osteopathic physicians. High on the priority list in the scope of financial need are such questions as: does the applicant have a long-range plan for financing his education; how has his education been taken care of thus far; what, in general, is the financial status of the applicant's family; does he own a car—if so, is it paid for.

Motivation and aptitude toward the osteopathic profession rates approximately 30 percent on the student's application. Who or what motivated his interest in osteopathic medicine? What does he know of the osteopathic concept? Does he plan a general practice or a specialty field? Does he prefer a small community to a city practice.

The applicant's moral character and personality are determining factors that will be formulated throughout the interview. To assist in creating an image of the hopeful and perhaps nervous young man or woman, the interviewer's mental pattern might pursue the following points: was he courteous; was he prompt, if not, was an apology offered; were you aware of his personal neatness; did he seem sincere in his determination for an osteopathic education; is there evidence of self-discipline and cooperation as a member of a team? A very important factor is the applicant's attitude toward his family and friends. Did he mention a church or religious affiliation? During the course of the interview the applicant will undoubtedly mention sports, a hobby, or other means of relaxation and interests that make for a sound person.

A report of the interview should be sent to the AAOA scholarship chairman in which the focal points—motivation and aptitude, financial need, scholastic standing, and personality—are stressed; bearing in mind that the awards committee and the five osteopathic colleges are dependent upon the recommendations and the personal interviews for a better return on the investments made in our doctors of tomorrow.

American Osteopathic Association
Office of
CARL E. MORRISON, D.O.
Chairman: Council on Federal Health Programs
1757 K. Street, N.W.
Washington, D.C. September 3, 1965

Washington News Letter

Medicare. H. Dale Pearson, D.O., has been named as A.O.A. representative to serve as consultant to the Department of Health, Education and Welfare on matters relating to conditions of participation for providers of services under the Social Security Health Insurance Program for the Aged. Dr. Pearson's A. O. A. experience extends from his Chairmanship of the A.O.A. Committee to Study Plans for Council on Osteopathic Education and Hospitals in 1943 through his current service as a member of the A.O.A. Bureau of Professional Education and as Chairman of the Advisory Board for Osteopathic Specialists, with an interim term of service as Chairman of the A.O.A. Bureau of Hospitals. The first meeting of consultants will be held in Baltimore on September 13-14. This meeting will concern itself mainly with the standards for participation of hospitals. The information developed will be submitted to the Health Insurance Benefits Advisory Council, which has not yet been appointed. In the meantime, the Commissioner of Social Security has written to all osteopathic hospitals in the A.O.A. registry, enclosing a 23 page leaflet of Information for Providers of Services and a 32 page leaflet including 52 questions and answers on the operation of the new program.

Osteopathic College Assistance. On September 1st, the House passed the Committee print of H.R. 3141 (see WNL of August 14th), by a vote of 340 to 47. The House made two changes. First, language was inserted to make certain that only students from low-income families are awarded scholarships. Second, the language of S. 576 which passed the Senate January 28th, was incorporated to provide for forgiveness of up to 50% of the loans of D.O.'s, M.D.'s and dentists who locate in State determined shortage area as provided in S. 576 which passed the Senate January 28th. It will be recalled that Dr. MacBain's testimony requested the forgiveness amendment. Senate Committee hearings have been scheduled for September 8th.

Regional Medical Complexes. Yesterday, the House Commerce Committee ordered favorably reported H.R. 3140, the Heart Disease, Cancer, and Stroke Amendments of 1965, relating to establishment of regional medical complexes for research and treatment. The Committee deleted all reference to regional medical complexes, and substituted regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training and continuing education and related demonstrations of patient care in the named categories and related diseases. All reference to diagnostic and treatment stations were deleted. The following limitation was added: "No patient shall at any facility be furnished hospital, medical, or other care incident to research, training, or demonstrations carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician."

Dr. Peterson Honored

R. H. PETERSON, D.O.

An unusually significant resolution was passed recently by the Texas State Board of Medical Examiners expressing appreciation to Dr. Ralph H. Peterson for his "long and distinguished service" on the Board.

Dr. Peterson served on the Board for twenty-four years and was its Vice President for seven and one-half years.

Dr. Peterson was first appointed to the Board by Governor James V. Allred on March 5, 1935, and served a term or six years. He was again appointed on June 2, 1947, by Governor Beauford Jester and served continuously from that date until this year.

House To Make Study

From The Journal Oklahoma Osteopathic Association

Because the AMA has under study a proposal that allopathic teaching hospitals open their intern and resident training programs to osteopathic physicians, the House adopted an amended form of a resolution submitted by the Ohio Osteopathic Association of Physicians and Surgeons that the AOA complete the study on the feasibility of requiring osteopathic college students to complete a one-year internship at an approved osteopathic hospital prior to the issuance of the D.O. degree. This matter has been presented on more than one previous occasion without having been adopted. There are many ramifications and complications to this procedure.

Dr. Stratton Named

RICHARD L. STRATTON, D.O.

Dr. Richard L. Stratton of Cuero has been reappointed to the Governor's Hospital Licensing Advisory Council.

The Council was set up by Governor Price Daniel in 1959. It is a nine member group of three hospital administrators, three lay people and three physicians.

The Council drafts rules, recommendations and regulations regarding licensure which are then passed on to the Board of Health.

TENTH ANNUAL FALL SEMINAR

Texas Association of Osteopathic Obstetricians and Gynecologists

October 2 and 3, 1965

Cabana Motor Hotel — Dallas, Texas

The Tenth Annual Fall Seminar of the Texas Association of Osteopathic Obstetricians and Gynecologists will be held on October 2 and 3, 1965, at the Cabana Motor Hotel in Dallas, Texas.

Presiding at the meeting will be the Association President, Dr. Richard M. Mayer of Lubbock. An excellent program has been arranged by the Vice-President and Program Chairman, Dr. Daniel R. Barkus of Dallas. The program, dealing primarily with gynecology, includes subjects of interest to both the specialist and general practitioner. The speakers are from both the state and national level with each being an authority in his field. The program has been approved for 14 hrs. credit by the American College of General Practice in Osteopathic Medicine and Surgery. A special hospitality room will be available for the ladies' pleasure.

An invitation is extended to all osteopathic physicians and wives to attend this week-end of study and relaxation in Dallas. The program is as follows:

NATIONAL SPEAKER

LESTER EISENBERG, D.O., FACOOG, Cherry Hill, New Jersey. President of A.C.O.O.G. Chief of Obstetrical - Gynecological Dept., Cherry Hill Hospital, Cherry Hill, New Jersey and Member of the Faculty of the Philadelphia College of Osteopathy.

Saturday, October 2, 1965

1:00 P.M. REGISTRATION

1:30 P.M. "HERPETIC VULVO-VAGANITIS AND TERM PREGNANCY"
D. R. Barkus, D.O., Dallas, Texas

2:00 P.M. "DISEASES OF THE CERVIX"
Lester Eisenberg, D.O., F.A.C.O.O.G., Philadelphia, Pennsylvania

2:45 P.M. RECESS

3:00 P.M. "ISOTOPE MEASUREMENT OF BLOOD VOLUME IN GYNECOLOGY"
Charles D. Ogilvie, D.O., Dallas, Texas

3:45 P.M. "HYSTERECTOMY—TECHNIQUE AND INDICATIONS"
J. T. Calabria, D.O., Dallas, Texas

4:30 P.M. QUESTIONS AND ANSWERS SESSION
Today's Speakers

7:00 P.M. COCKTAIL HOUR (For doctors and wives—Courtesy of Ross Laboratories)

Sunday, October 3, 1965

9:30 A.M. "VAGINAL CYTOLOGY IN GYNECOLOGY"
Charles L. Bamford, D.O., Dallas, Texas

10:15 A.M. "THE CULPOSCOPE AND ITS USE IN GYNECOLOGY"
Lester Eisenberg, D.O., F.A.C.O.O.G., Philadelphia, Pennsylvania

11:00 A.M. RECESS

11:10 A.M. "DERMATALOGIC DIFFICULTIES IN THE GYN PATIENT"
Coleman Jacobson, M.D., Dallas, Texas

12:00 A.M. LUNCHEON—"EVOLUTION-REVOLUTION IN PROBLEMS OF GYNETOKOLOGY" (For doctors and wives)
Lester Eisenberg, D.O., F.A.C.O.O.G., Philadelphia, Pennsylvania

1:30 P.M. "ANESTHESIA FOR GYNECOLOGICAL SURGERY"
Hyman Kahn, D.O., Dallas, Texas

2:15 P.M. "MANAGEMENT OF THE INFERTILE COUPLE"
Moderator: D. R. Barkus, D.O., Dallas, Texas
Panel: Roy Fischer, D.O., Dallas, Texas
Lee Walker, D.O., Grand Prairie, Texas
Daniel Slevin, D.O., Dallas, Texas
R. M. Mayer, D.O., Lubbock, Texas

3:15 P.M. BUSINESS MEETING—TEXAS ASSOCIATION OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS

REGISTRATION FEE—(Including Luncheon and Cocktail Party) Members of T.A.O.O.G. $15.00, Non-Members $18.00, Ladies $5.00.

MEETING OPEN TO ALL D.O.'s

Members of State or National

MAKE THIS A WEEKEND VACATION

Approved by the American College of General Practitioners in Osteopathic Medicine and Surgary for fourteen hours post-graduate credit.

"Business In The Hospital"

By EMMA JO SMITH

Editor's note: Miss Smith is the newly elected President of the Texas Association of Osteopathic Physicians Assistants and is head of the bookkeeping department of Doctor's Hospital in Groves, Texas.

This article was featured in the Texas Retail Credit News, Hospital Section.

A hospital, much like a clock, must run smoothly, efficiently and constantly twenty-four hours a day. The primary responsibility of any hospital is to furnish care to the sick and injured. However, financial return and other interest, although a secondary consideration, are most essential and must be carried out by a carefully chosen clerical group led by a qualified administrator.

It should be remembered by each and every person in the business office that the "human side" of medicine must never be second to the "business side." The physical well-being and mental tranquility of the patient are of transcending importance. A warm heart and a cool head are very essential in this kind of relationship and go a long way in building the personality of a hospital.

Generally a patient in need of hospital care will be concerned mainly with the doctors, nurses, and other members of the professional staff with whom he will come in contact each day. I wonder if this patient wouldn't be amazed to know just how important he is and how many behind-the-scenes people go to work the minute he is admitted and never stop until his complete case is finished. Even after this patient is dismissed, work continues on him in the medical records, insurance and accounting offices.

The minute he is admitted, he immediately becomes the responsibility and concern of personnel in admitting, credit, insurance, medical records and finally dismissal. The personalities of the admitting clerk and credit officer are of first importance. The patient's impression of the entire hospital will very often be based on the treatment received in the business offices. Also when good patient relations are developed, we are creating a desire in the patient to pay his account. Above all, the patient should be assured that his welfare is of utmost importance and that the purpose of these people in the office is to relieve him of financial worry.

Important to the entire medical staff as well as to the patient, are those responsible for the medical records since this is the complete story of the patient's condition and treatment on paper and cannot be inaccurate in any way. These medical records must be available to the doctors at all times. It is not only necessary for the personnel of this office to maintain and safeguard adequate records; they must also make certain that these records are confidential and only authorized personnel be allowed to see them.

The accounting department compiles the charges of all the other departments in the hospital, checks them to be sure the patient is charged only for the treatment and medication that he received. The charges are posted daily to the patient's ledger so that at the time of dismissal he can see for what he was charged. This office takes care of not only the patient accounting but also the hospital accounting. The supplies and medication used by a patient, the supplies used by the entire staff of the hospital . . . all these bills are paid by the accounting offices.

The personnel of the dismissal office also play a very important part, since the most expert medical care and ten-

der thoughtfulness of the nursing staff can be almost completely erased from the patients' memory by thoughtless or rude treatment by the business office at the time of discharge.

These people in the business office can give the patient his first and final impression of the hospital. So from the first contact with the business office to the last, special efforts must be made to overwhelm the patient with kindness . . . and all it takes is a warm and happy smile of greeting and a friendly goodbye.

Openings for Osteopathic Physicians

(For information write to Dr. D. D. Beyer, Chairman, Physicians Relocation Committee, 1800 Vaughn Blvd., Fort Worth, Texas)

If you have information on openings, please contact Dr. D. D. Beyer, 1800 Vaughn Blvd., Fort Worth, Texas.

The following location sent in by Jim Smothers, Mgr. Chamber of Commerce, Cisco, Texas.

Cisco is in dire need of an Osteopathic physician for permanent location. Sites and facilities are available. It would be most advantageous to a doctor and to the city to locate here. Contact Jim Smothers, Mgr. Chamber of Commerce, Cisco, Texas.

* * *

Ideal practice location. Doctor recently deceased in Midlothian, Texas, 30 miles from Fort Worth in expanding industrial and agricultural area. Contact Chairman, Statistics & Locations Committee, State Office; or Dan D. Beyer, D.O.

* * *

The following information was sent to Dr. Beyer by Mr. Gid Bryan of Sherman, Texas. There is a group of six businessmen in Sherman who want to build a clinic-hospital combination according to doctors' specifications for two or three D.O.s.

There is definitely a shortage of hospital beds and physicians.

Contact Gid Bryan, Dixie Drug Store, 220 N. Travis, Sherman, Texas.

* * *

Doctor in large Texas city leaving due to poor health. Has nice eight room clinic that can be leased or purchased with or without equipment. Nine year established general practice. Contact State Office.

* * *

Sent in by George M. Lowe of Idalou: Our present doctor is moving his office to Lubbock as of Sept. 1. We feel that Idalou, which is located ten miles east of Lubbock, offers an excellent opportunity for any physician desiring to locate in West Texas. Contact Mr. George Lowe, Western Drug Company, Idalou, Texas.

* * *

Stonewall Memorial Hospital, a new 24 bed hospital in Aspermont, Texas, needs a D.O. Contact Mr. Kirk Brunson, Administrator, in Aspermont.

LOCATIONS IN ALL-AMERICA CITY

Eight excellent locations for general practitioners in metropolitan Fort Worth, Texas. One available because of recent death of M.D. Investigate LOOK MAGAZINE'S "ALL-AMERICA" CITY. 120 bed general hospital with expansion in progress. Contact Tom W. Whittle, D.O., Chairman, Locations Committee, 1305 East Seminary Drive.

Therapy of Renal Failure

By JERRY HOUCHIN, D.O.

The therapy of renal failure for this discussion will be divided into conservative and dialysis. The conservative management of acute and chronic renal failure overlap in many aspects and will be discussed as one. The discussion will be directed to the direct goals of therapy with emphasis on specific complicated problems. A flexible guide to therapy will be set up for the physician to use as an overall procedure, not as a specific outline of therapy.

First it must be realized that each uremic patient is a completely new biochemical system with different causes and effects. No set program can be outlined for all patients in uremia and each patient must be followed from day to day with appropriate changes in therapy.

The main goals of management of renal failure should be: (1) reduce the metabolic load of the patient through dietary methods: (2) improve body chemistry being aware of and using the body's compensatory mechanisms; (3) maintain body fluid and electrolyte volume as closely as possible to a physiological state; (4) improve renal function if possible; (5) manage symptoms without disrupting compensatory mechanisms; (6) obtain cooperation by explaining to the patient the necessity of the treatment; and (7) use artificial means for removal of waste products without delay when conservative management fails. These must be performed with discretion and with the individual patient in mind. Therapy cannot be conducted on laboratory results alone or at the expense of producing another complication.

In therapy of renal failure, it has been proven experimentally and clinically that the protein catabolism must be reduced. A battle still rages between the physicians who advocate high protein and the ones who employ a low protein intake. The basic theories of the high protein advocates are that protein is used in the healing and rebuilding process and should be used because of this fact. It is also stated that edema may be decreased by increasing circulating proteins, but this can usually be controlled by restriction of fluid and salt intake. The low protein advocate has as his main stay the clinical response and the fact that although catabolism is taking place, protein is being synthesized through the urea cycle for basic body processes. This, of course, may not be adequate when protein is being lost through the glomeruli or into the body cavities. However, in my experience when a patient is placed on a normal or high protein diet, his condition deteriorates and the giving of protein does not appear valid if it increases the patient's azotemia and reduces clinical response.

The protein intake in moderate uremia should be limited to 0.5 gram per Kg. per day; in advanced uremia it should be reduced to as near zero as possible. Protein catabolism may be reduced by: (1) using a high carbohydrate intake orally or intravenously covered with insulin if necessary, (2) the use of anabolic agents, (3) avoiding catabolic agents such as cortical steriods if possible, (4) avoiding infection and hyperthermia which increases protein catabolism, and (5) avoiding unnecessary surgery and blood transfusions except when indicated.

Management of Fluid, Electrolyte and Calorie Balance

The management of water balance is a delicate procedure and must be undertaken with many factors in mind. The first factor is the patient's total fluid

output via the gastrointestinal and urinary tract. This may be replaced in toto if the patient is not edemous or has not had a gain in weight. The patient in acute uremia will lose 0.5 to 1 lb. per day, whereas chronic uremia patients will lose weight more slowly, but should have a steady loss. The insensible water loss may be calculated in many ways. A convenient method is daily water requirements equal 15 ml. per pound of body weight per day, but many aspects enter into this calculation. If a patient is sweating or is breathing fast and/or deeply, more fluid is going to be lost. This is a very common occurrence in uremic patients due to acidosis and fluctuations of body temperature. In children this loss will be much higher and produces a more acute problem. The humidity and external temperature will also affect the rate of insensible loss as will emotions and activity. If the uremic patient develops pneumonia or other infections, this will not only produce a metabolic stress, but the temperature elevation and increased respiratory rate will cause a great deal of body water loss each day.

Water may be gained by the body in the process of caloric oxidation. It has been calculated that one gram of protein will yield 0.41 cc. of water, one gram of fat 1.07 cc., and one gram of carbohydrate 0.55 cc. These calculations were made on normal subjects under normal conditions. It appears, however, that the acutely ill or traumatized patient, such as the patient in renal failure, may produce a far greater amount of endogenous water. These factors must all be taken into account when administration of fluid is undertaken.

It is felt by most clinicians that the best solution for replacement is glucose in water. A solution which is frequently used at our hospital is 1000 cc. of 10% glucose in water with 50 cc. of 50% glucose added which is usually covered by ten to twenty units of insulin. This solution serves several purposes: (1) to replace water; (2) to supply calories without nitrogenous residue; (3) to decrease protein catabolism by acting as a protein sparer; (4) to drive potassium back into the cells; (5) to decrease and/or prevent accumulation of ketone acids which results from incomplete oxidation of fat in the presence of inadequate carbohydrates; and (6) to act as an osmotic diuretic.

This brings forth the problem of how to supply the patient with sufficient calories to sustain him. It has been stated that protein cannot be used, and this leaves carbohydrates and fats with which to work. The glucose solution discussed above may be used, but usually the most fluid which can be given per day is around 2000 cc. Using 2000 cc. of 10% with 50% glucose added provides about 400 Gm. of glucose per day which is equal to about 1600 calories. This amount would not be sufficient because a normal adult male at rest requires about 2000 calories per day. The danger of thrombophlebitis occurring with this high glucose concentration can be minimized by: (1) using a different vein every day which has its limitation; (2) using small amounts of heparin in the solution; (3) using a polyvinyl catheter and threading it into the vena cava brachial or iliac veins. If this method is used, heparin should be added to the solution to prevent thrombosis at the catheter tip. Should thrombosis occur, it is usually well organized and usually does not create major embolic phenomenon.

Carbohydrate solutions such as alcohol and fructose may also be used. Infusions of ethyl alcohol yields five to six calories per cc. and up to 2100 calories may be given in a twenty-four hour period. The infusion must be below 15 cc. per hour or intoxication will occur. The obvious disadvantage of this form of caloric intake over a long period of time is the possibility of liver disease. This is especially true of the malnourished, acutely ill uremic patients. Fruc-

tose theoretically has three advantages over dextrose: (1) fructose can be metabolized in the absence of insulin and therefore can be utilized more rapidly than dextrose; (2) it can be given at a fast rate without spilling into the urine; and (3) fructose can be metabolized in the presence of acidosis. Other methods of caloric intake are intravenous or oral feeding of fat, multiple small feedings, and tube feedings. However, when multiple feedings or tube feedings are used, the constant threat of potassium intake is always present.

The electrolyte management may be outlined as follows. Hypernatremia is usually due to dehydration and may be corrected by its reversal. Most patients in chronic or acute renal failure probably should be on a low sodium intake regimen if they are not losing large amounts in the urine. Hyponatremia occurs frequently in the so-called "salt-losing nephritis" and the diuretic phase of renal failure. Restricting salt under these circumstances would not be rational and may result in aggravation of renal failure. It should be remembered in the above conditions that the repair solution should contain sodium and chloride in a physiologic ratio because the patient with renal failure is unable to selectively retain sodium when administered with excess anion. Therefore, in the absence of hypertension or congestive heart failure, the patient with renal failure may require a greater salt intake than normal. When hypertension is present, severe salt restriction usually will have little effect on the reduction of blood pressure and may aggravate the renal failure. If congestive failure occurs, the physician is caught in a real dilemna. He must avoid precipitating pulmonary edema by excessive salt administration, yet must not be too drastic in salt restriction as to increase renal failure or precipitate adrenal insufficiency.

Calcium and Phosphorus: The administration of calcium in renal disease must be carefully weighed because hypocalcemia is seldom the result of inadequate intake and the administration of calcium in early renal disease may be harmful. The administration of three grams of calcium may help balance the gastrointestinal losses, but will not prevent hypocalcemia. Infusions of calcium for the treatment of twitching or convulsions which may occur are usually only temporarily successful. The cause of these symptoms appears to be more frequently in the general metabolic disturbances rather than hypocalcemia. Despite low serum calcium levels, most uremic patients do not need calcium therapy unless symptoms occur. Nevertheless, it may be tried when doubt exists and can do little harm if not used in massive quantities over long periods of time or given too rapidly to a degitalized patient.

Hypercalcemia is usually not seen in renal failure. When it is seen, the mechanisms causing the elevation is probably

the etiological factor underlying the renal failure.

The excretion of phosphorus demonstrates the importance of maintaining adequate filtration rate because as the glomerular filtration decreases, the tubular reabsorption of phosphate also decreases. Due to diet and protein catabolism, the phosphorus intake is continuous and exceeds the excretion causing the phosphate values to increase when there is tubular damage. The data presented in Part III suggests that the effect of increased water and sodium intake may improve urine volume by expanding the extracellular fluid. This will increase the glomerular filtration rate which in turn will increase phosphate excretion. Water and sodium loading alone will create a decrease in plasma phosphate concentration by hemodilution, but this procedure can only be carried out when the patient's urinary output is above oliguric levels.

Phosphate in the diet may be decreased by eliminating high phosphate and protein - containing foods (milk, etc.). While it is possible in chronic renal failure to promote intestinal excretion of phosphate by binding it with aluminum hydroxide gels, its long-range usage in acute failure is impractical and usually impossible due to the vomiting and/or ileus which is present. The importance of minimizing protein catabolism in phosphate, sulfate and potassium retention must again be reemphasized.

One of the most important complications of acute renal failure is the development of potassium intoxication. Its particular importance is in the fact that its onset is often insidious and frequently overlooked. This syndrome is completely reversible and if overlooked, may cause death. However, it is not simply a matter of hyperkalemia. In other words, the serum potassium is not the sole factor involved, rather it is the interplay between many factors which initiate the final common pathway of a disturbance in myocardial conduction. For instance, a given low potassium concentration may be aggravated by hyponatremia or hypocalcemia. Similarly, the profound acidosis and metabolic disturbances seen in uremia may create an inadequate energy supply to maintain the gradient of potassium across the cell membrane. It is then possible to have a high extracellular concentration with a low intracellular content.

The successful reduction of extracellular potassium may be performed by: (1) the reduction of protein catabolism; (2) minimizing glycogenolysis by administration of glucose and insulin; (3) inducing diarrhea with substances such as sorbatol; (4) elevating pH, sodium and calcium; (5) decreasing dietary intake; (6) using potassium-releasing drugs only when necessary, i.e., digitalis, etc.; (7) using chlorothiazides or similar blocking agents (in chronic uremia only); (8) using gastro-intestinal drainage; (9) the use of dialysis or intestinal

lavage; and (10) the use of cation exchange resins. These resins, when exposed to intestinal secretions, will selectively pick up cations from this fluid and are capable of removing one to two mEq. of cation per gram of resin. The oral administration of these resins is complicated by the fact that most uremic patients are nauseated and cannot take substances by mouth. An alternate method is to give them by enema, but this as well as the oral administration has the serious complication of impaction with obstruction. In addition when 50 Gm. of resin (which is the recommended dosage) is given a day, a large amount of water must also be given which may cause excessive hydration. If resins are to be used, it is recommended that the ammonium ion exchange be used because the ammonia is converted to urea by the liver and the resultant increase in blood urea nitrogen is probably not harmful.

In chronic renal failure with adequate urinary output, the syndrome of acute potassium intoxication rarely occurs. However, these patients are unable to excrete large amounts of potassium and the judicious use of protein and potassium in the diet must be continued. These patients will frequently show a chronic elevation of potassium to 6 or 7 mEq., but this need not cause alarm if there is no change in the electrocardiogram. Occasionally patients with early renal failure may lose an excessive amount of potassium in the urine which appears to be due to the same mechanism as "salt-losing nephritis" and has in many cases caused symptomatology of hypokalemia.

Acidosis: The major factor to be remembered in treating acidosis is not to disrupt the compensatory mechanisms. A rise in fixed acids requires a decrease in serum bicarbonate in order to maintain normal pH. This is accomplished by the respiratory regulation of carbon dioxide. Thus, a low CO_2 combining power, which to many signifies acidosis, is in essence a compensatory mechanism and because of this the CO_2 combining power should never be used as a guide for therapy. If the lowered serum bicarbonate is the result of fixed acid retention, there is doubt if any useful purpose is obtained by administering sodium bicarbonate. There is danger in this form of therapy when the ionized calcium is low because a sudden infusion of an alkaline salt may precipitate more calcium causing tetany. When sodium loss is combined with acid retention, it is logical to replace this with sodium bicarbonate. This will create a rise in serum bicarbonate, sodium and pH.

Anemia: Anemia in renal failure should be treated only when it is symptomatic. Hematocrits of twenty to twenty-five percent are often well tolerated by these patients, and it is well known that anemia of this type is refractory to any form of therapy short of transfusions. When transfusions are used, the response is only temporary because of the short red blood cell survival time

in uremic patients. Transfusions should be fresh-packed cells to eliminate as much as possible the increase in potassium and nitrogenous products therein. The physician must also be cognizant of the possibility of vascular overloading and reactions which may prove fatal. It is felt, however, that if the hematocrit falls much below twenty percent, say fifteen percent, transfusions should be used. The rationale for this is in the fact that the low hematocrit may so reduce oxygenation of the tissues (kidney) as to be a deterrent to healing processes or cause further damage.

Congestive Heart Failure: Management of congestive heart failure should be similar to patients without renal disease. When congestive heart failure occurs in chronic renal failure, the digitilazing dosage should theoretically be less because of decreased excretion. However, this is not always the case, and in fact the dosage may be quite variable. Digoxin is probably the most satisfactory agent to use because of its short toxic effects. These patients, as any other patient, will have to be titrated as to heart rate and clinical response to find the proper dosage.

Diuretics may be used and there appears to be no valid evidence for the contraindication of mercurical diuretics if the following criteria are used: (1) mercurial diuretics should be given intramuscularly in divided doses four to six hours apart; (2) injections should be given into an edema-free area; (3) aminophyllin may be used to enhance the diuretic effect; and (4) serum chloride should be normal. If these criteria are met and there is no diuretic response, mercurial diuretics should be considered ineffective and discontinued, and an osmotic diuretic such as mannitol should be used.

The treatment of congestive heart failure in acute renal disease is somewhat different. These patients appear to need more digitalis because of hyperkalemia, but on the other hand less because of the decreased excretion. Again the dosage depends on the patient and should be planned carefully.

It has been mentioned before (Part III) that the digitalis effect is decreased in patients with acute renal failure because of the metabolic derangements which are present. The fluctuations in serum potassium may also have their effect on the digitalis response and must be watched carefully when therapy is directed toward reduction of potassium concentrations. The use of diuretics are contraindicated in acute renal failure and probably would have no effect if used. Timely pleural taps may be life saving and should be performed without hesitation.

Hemorrhage is a frequent complication of renal failure and may be due to: (1) circulating heparin-like substances; (2) hepatic congestion or deterioration; (3) decreased platelet formation; (4) disturbance of the normal flora of the bowel; (5) increased capillary frigidity; and (6) increase in cit-

rates and oxalates. The treatment of this condition should include prevention by minimizing trauma, vomiting, surgery and anti-coagulants. When bleeding does occur, the use of protamine sulfate, fresh blood or plasma transfusions, vitamin K, and other vitamins have proven helpful.

Case History

History: Chief complaint started approximately one month before hospital admission. The patient visited his physician for irritability, fatigue, a mild sore throat and mild paralumbar ache. Urine analysis at that time revealed red and white blood cells. The patient gave a negative history of dysuria, frequency, nocturia or difficulty in initiating the urine flow. Treatment was instituted with antibiotics for about two weeks at which time the patient was symptom free and the urine clear. The symptoms on admission to the hospital were general malaise, lumbar backache, nausea, vomiting and diarrhea.

Past History: Four years previous the patient was struck in the low back with a heavy electrical cable and received an electrical shock. Evaluation at that time revealed the right kidney to be displaced low in the pelvis, but functioning well. The patient has not had any urinary symptoms to his knowledge until the present time.

Physical Examination: Examination presented a white male, age 27, height 5'10", weight 195 lbs. General appearance presented pallor, moist skin, lethargy and prostration. Lungs: no dyspnea, Kussmaul breathing present, rate 20, no rales or friction rubs. Heart rate 80 regular, no murmurs or friction rubs, blood pressure 120/80. The abdomen was distended, no organ enlargement could be palpated. The lower abdominal quadrants were rigid with tenderness in the paraumbilical area. The tongue had a blackish furry growth on the superior aspect which suggested a mycotic infection. Mucous membranes of the mouth were pale and revealed poor dental hygiene. Funduscopic examination revealed a hazy outline of the structures which suggested edema. The extremities were edema free and appeared normal. This examination was performed on the eighth hospital day. Initial laboratory work: erythocyte count 4.7, Hb 15.5 Gm., hematocrit 40%, WBC 5.400 no shift. Urine specific gravity 1.025, chemistry negative, pH 7, 5-9 WBC's, 0-3 lyalin cast and no bacteria. Intravenous urogram was performed on the second hospital day. The radiologist reported dye excretion on the left, but no visualization on the right. A retrograde was performed the following day, and the report revealed a distorted right kidney which was lower in the pelvis than ordinarily seen. Urine taken at the time of retrograde revealed protein 4 plus, gross blood, WBC 2-3 from the left kidney, and protein 3 plus, gross blood and 1-2 WBC's from the right. Cultures from both kidneys revealed E. Coli. The clinical impression recorded

on the tenth hospital day was displacement of right kidney due to congenital abnormalities or trauma, with acute pyelonephritis, renal insufficiency and metabolic acidosis.

Further Course and Discussions: Following retrograde on the third hospital day, the urine output fell progressively to 526 cc. per twenty-four hours on the eighth hospital day. Intensive therapy began on the ninth hospital day with 2000 cc. of invert sugar, 1000 cc. of ringers lactate with 100 cc. of 50% dextrose and 100 cc. of mannitol. The BUN was 97, serum potassium 4.0 mEq., sodium 141 mEq., chlorides 103 mEq., and CO_2 combining power 15 mEq. For the next eighteen days the patient was given from 2000 to 5000 cc. of fluid per day intravenously and orally which consisted of dextrose in water, electrolytes, 50% dextrose, mannitol, water and fruit juices. The output ranged from 625 on the ninth hospital day to as high as 6455 ten days later, and averaged about 2500 cc. Calcium was given frequently because of low serum calcium and central nervous system irritability. Anabolic agents were given to reduce the negative nitrogen balance. The antibiotic agent used was chloromycetin, nausea and vomiting were controlled by thorazine, and a low protein diet was used throughout the hospital stay. On the tenth hospital day the patient developed jaundice. This was felt to be due to either hemolysis or toxic effects on the liver. On the twenty-first hospital day the hemaglobin and hematocrit had fallen to 9.1 Gm. and 27 percent respectively. The BUN at this time was 10 mg. percent, serum sodium was 152 mEq., chlorides 110 mEq., potassium 5.7 mEq., and calcium 4.9 mEq. Because of the anemia and in the light of normal BUN and electrolytes, two units of packed cells were given. Following this the patient showed a rapid gain in strength and was dismissed on the twenty-seventh hospital day.

The follow-up revealed the patient to be symptom free one year later.

(See references listed at end of Part V).

President's District Visitations

(Tentative Schedule)

September 11, 1965	District 13 — Greenville
September 30, 1965	District 8 — Corpus Christi
October 10, 1965	District 9 — Cuero
October 19, 1965	District 2 — Fort Worth
November 14, 1965	District 1 — Amarillo
November 15, 1965	District 10 — Lubbock
November 16, 1965	District 4 — Midland or San Angelo
November 17, 1965	District 11 — El Paso
January 16, 1966	District 3 — Tyler
January 20, 1966	District 5 — Dallas
February 6, 1966	District 7 — San Antonio
February 7, 1966	District 6 — Houston
February 17, 1966	District 12 — Port Arthur
March 17, 1966	District 14

(Editor's note: Tentative schedule for Dr. Burnett's visitations is not completely confirmed as yet, and may be subject to change. However, it is published at this time in this form so that each member of TAOP&S will know approximately when the President will visit his district and may plan well in advance, to insure unusually fine attendance in the district meetings. R. B. Price)

The Rejected Student

By GEORGE W. NORTHUP, D.O.

Success has its problems, as does failure. As the advantages of osteopathic medicine become better known, there are increasing numbers of applications for admission into our five colleges. This is as it should be. The greater the number of applicants, the higher can be the quality of the selection. Parallel with this, however, the number of rejected candidates increases—with disappointment, misunderstanding, and sometimes strained relations. Behind every candidate there usually stands an osteopathic physician, often the family physician, who has a personal interest in the young person who chooses osteopathic medicine as a career. The physician sponsor sometimes fails to understand that even good, acceptable students cannot always find entry into our colleges. Quite the contrary: many are turned down each year simply because there is no room.

If this situation develops and affects a student that you support, understanding, patience, and good will must overcome your disappointment. The demand is greater than the supply of places in osteopathic colleges.

There can be only one answer: enlargement of our existing osteopathic colleges and creation of new ones. The impetus for this must come from the profession itself. It can be brought forth by a renewed zeal on the part of the profession to make the necessary sacrifices of time, interest, and money in support of our educational system.

The osteopathic profession stands at an all-time high in its acceptance, respect, and understanding. Our educational institutions have contributed mightily to this. Our gratitude to them must not be expressed in strained relations because our favorite student could not be accepted this year.

CIBA Pharmaceutical Co. and Wm. H. Rorer, Inc.

Additional Information Concerning National Advertising Policies

Widespread interest having been aroused by the report of delegates last month concerning the A.O.A. meetings in July, the following communication from the A.O.A. Business Office is printed for the information of TAOP&S membership:

Supplemental Report of Business Manager

Gentlemen:
During the 1965 annual business meetings of the American Osteopathic Association I reported to you that CIBA PHARMACEUTICAL COMPANY and WM. H. RORER, INC. were not participating in the official publications.
We are now happy to report that CIBA will begin their 1965-1966 advertising schedule in the month of October and RORER started their advertising with the August 1965 issue.
We are sending you this information to keep you informed.

Respectfully yours,
Walter A. Suberg
Business Manager

The Heart of the Matter

(*extracts from* TICKER TAPE)

Oklahoma University's Board of Regents voted June 10 to permit D.O.'s to attend postgraduate seminars at the University Medical Center, reported Dr. A. W. Janzen, president, Oklahoma Osteopathic Association. He credited Dr. Thomas C. Reed, past president of AOA and his committee "who served so diligently and who worked hard toward getting results from the Board of Regents." He adds, "Certainly we were assisted by the Chancellor of Higher Education, Dr. E.T. Dunlap, who felt that such recognition was long past due. We are also deeply indebted to Dr. Mark Johnson, the representative of the Oklahoma Medical Association, on the Board of Regents, who carried on a determined effort to bring about this result." Details of the arrangement are still to be spelled out.

* * *

Ecumenical Medicine is subject of the lead editorial in the July issue of the *Journal of the AOA*. "Recent statements by the AMA have indicated that its desire to effect amalgamation between medicine and osteopathic medicine is based on the theory that 'a majority and a minority system of medicine' cannot be justified today, a pronouncement supported by pointing out that there is but one world of medicine. This proposal that the osteopathic profession be absorbed into the AMA world of medicine is a far cry from the basic tenets of ecumenicalism. Ecumenicalism in no way implies the elimination of independent action, or monolithic control. It does imply the development of a common ground for meeting and discussion and implementation of objectives for groups and organizations whose broad objectives are compatible."

NEWS OF THE DISTRICTS

District No. Two

The dinner and meeting of District II will be September 21, 1965, at 7:30 p.m. at the Worth Hotel in Golden Room B.

The doctors' program on angiography will be presented by Dr. Robert L. Nelson and Dr. Arthur N. Henson.

The wives' program will include a film on the Child Health Clinic.

District No. Nine

Dr. and Mrs. Richard L. Stratton will host the October meeting of District IX in Cuero. It is scheduled for 3:00 p.m., Sunday, October 10.

Dr. John Burnett will make his Presidential Visitation at this meeting.

District No. Thirteen

Dr. and Mrs. John Burnett paid the District their annual visit at the Cadillac Hotel in Greenville, Texas, September 11, 1965. After the introduction by President Gordon Marcom, Dr. Burnett made a short address on public relations and opportunities for advancing osteopathy.

Dr. and Mrs. Roy Mathews have returned to our District from Colorado where he practiced for a year. We are all glad to have them both back in Wolfe City.

Drs. Dean Wintermute, James Fite and Selden E. Smith attended the Annual Post-Graduate Course of the American Academy of Surgeons in Mexico City. Dr. Smith was awarded his Certificate from the Academy. His sponsor was Dr. Fite.

Ralph Marcom and wife were guests at the monthly meeting in Greenville. This is Ralph's senior year at K.C.C.O.S.

Dr. Stephen Kubala, Denison, brought his son, Stephen, Jr., as his guest to the District meeting in Greenville.

Dr. Fred Banfield, Whitesboro, will be host at the next District meeting in October.

R. D. VAN SCHOICK, D.O., *Reporter*

Remember, NEWS from your district for the Journal must be in this office by the 20th of preceding month. Please give us your cooperation. THANKS!

NOTICE OF EXAMINATION

The next meeting of the Texas State Board of Medical Examiners when examinations will be given and reciprocity applications considered is scheduled for December 6, 7, 8, 1965, at the Blackstone Hotel, Fort Worth, Texas.

Completed examination applications for graduates from United States medical schools must be filed with this office thirty days prior to the meeting date.

Completed examination applications for graduates of foreign medical schools must be filed sixty days prior to the meeting date.

Completed reciprocity applications must be filed sixty days prior to the meeting date to be given consideration.

TEXAS STATE BOARD OF MEDICAL EXAMINERS
1714 MEDICAL ARTS BUILDING
FT. WORTH, TEXAS 76102

Calendar of Events

Sept. 30-Oct. 2. — AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS, annual meeting, Philadelphia. Secretary-Treasurer, Dr. Stuart F. Harkness, 3820 Grand Ave., Des Moines, Iowa.

October 2-3 — TEXAS OSTEOPATHIC OBSTETRICAL AND GYNECOLOGICAL SOCIETY, Dallas, Texas.

Oct. 31-Nov. 4. — AMERICAN COLLEGE OF OSTEOPATHIC SURGEONS 38th ANNUAL CLINICAL ASSEMBLY, with American Osteopathic Hospital Association, American Osteopathic College of Anesthesiologists, American Osteopathic College of Radiology, American Osteopathic Academy of Orthopedics, and American College of Osteopathic Hospital Administrators. Shamrock Hilton Hotel, Houston, Texas. C. L. Ballinger, D.O., Convention Manager, P.O. Box 40, Coral Gables, Florida 33134.

March 5-10, 1966 — THE INTERNATIONAL ACADEMY OF PROCTOLOGY, Miami Beach, Florida.

May 2-3 — BOARD OF TRUSTEES, TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, annual meeting, Robert Driscoll Hotel, Corpus Christi, Texas. President, John H. Burnett, D.O., 7716 Lake June Road, Dallas, Texas.

May 4 — HOUSE OF DELEGATES, TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, annual meeting, Robert Driscoll Hotel, Corpus Christi, Texas. Speaker of the House, Wiley B. Rountree, D.O., 19 North Irving, San Angelo, Texas.

May 5-7 — TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, Annual Convention. Robert Driscoll Hotel, Corpus Christi, Texas. Program Chairman, T. Robert Sharp, D.O., 4224 Gus Thomasson Road, Mesquite, Texas. Executive Secretary, Mr. R. B. Price, 512 Bailey Ave., Fort Worth, Texas.

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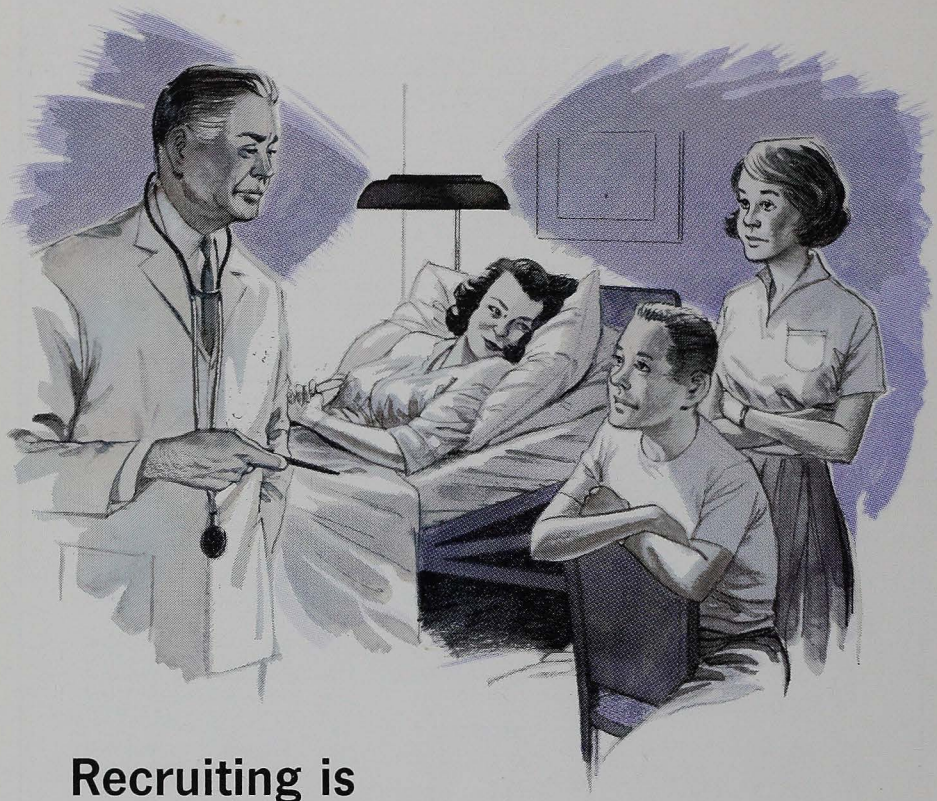

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