Texas Osteopathic Physicians Journal

VOLUME XXI FORT WORTH, TEXAS, OCTOBER, 1965 NUMBER 6

In This Issue—

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

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Annual Post-Graduate Seminar

The Texas State Department of Health wishes to announce the annual Post-graduate Seminar for the Osteopathic Physicians and Surgeons of Texas to be held in Dallas, Texas, December 3-4, 1965, at the Statler Hilton Hotel.

Guest speakers for this Seminar will include:

John C. Ullery, M.D. University City, Ohio	Chairman, Department of Obstetrics and Gynecology, College of Medicine, Ohio State University; Chief of Obstetrics and Gynecology, University Hospital.
C. J. Karibo, D.O. Detroit, Michigan	Chief, Department of Radiology and Chairman, Department of Radiology, Detroit Osteopathic Hospital
J. Donald Sheets, D.O. Detroit, Michigan	Senior and Consulting Surgeon, Detroit Osteopathic Hospital
Robert J. Samp, M.D. Madison, Wisconsin	Professor, Surgery and Division of Clinical Onocology, University of Wisconsin Medical Center; Clinical Cancer Coordinator, University Hospitals

We are hopeful that another speaker will be secured for the program.

We believe this will be an informative and interesting Seminar, plan to attend.

A Typical Case

T.O.I.L. Committee Activity Report

The Texas Osteopathic Insurance Liaison Committee continues actively to maintain effective communication and understanding between the insurance industry and the osteopathic profession. Occasionally, a case situation develops that clearly and concisely illustrates the high level of work being routinely carried through by the TOIL Committee. Such a case recently developed in the Dallas-Fort Worth area with respect to group policies written for one of the nation's largest employers by one of the oldest and largest of the insurance carriers.

I. Situation.

A certified osteopathic internist was called to consult for a post-surgical patient who was an in-patient of an approved osteopathic hospital. The patient was the employee and was the member of the nationally underwritten insurance plan.

II. Rejection.

The following letter was received from the main insurance offices in New York City:

"The claim submitted on behalf of the above-named patient has been received and carefully reviewed."

"We regret that we are unable to accept liability for your charges for consultation service. It has been the policy of the Company to recognize charges for consultation only from those physicians who are listed in the American Medical Association, *American Medical Directory,* as having a practice confined to one of the various medical or surgical specialties."

"Therefore, your fee must remain the responsibility of your patient."

III. Course of Action.

After supplemental information was obtained and confirmed by TAOP&S Executive Secretary, the matter was referred to the full T.O.I.L. Committee and was assigned to an industry representative who serves his own company as vice-president and claims attorney. After research, the industry representative wrote the following letter:

Dear Mr. .....:

A thermofax copy of your letter of May 26 addressed to Dr. ..... of ....., Texas, together with a copy of Dr. .....'s letter to you of June 3 in connection with this claim, was referred to this Committee for consideration at its last meeting here in San Antonio on June 25.

Dr. ....., D.O., maintains his principal offices at ..... Street, ..., Texas, and is Certified by the American Osteopathic Board of Internal Medicine on page ..... of the current directory of the American College of Osteopathic Internists. Dr. ..... is also listed on page ..... of the 1965 American Osteopathic Association Yearbook and Directory of Osteopathic Physicians.

We would like to call to your attention that in all national legislation and in most of the states, the American Osteopathic Association is designated as the evaluating and accrediting authority for licensed graduates of Osteopathic Medical Colleges, the same as the American Medical Association is recognized as the evaluating and accrediting authority for graduates of Allopathic Medical Schools.

Although Dr. .....'s office is situated in ....., he was called in consultation to see this patient at ..... Hospital in .....

Under the laws of this state as set out in *Vernon's Civil Statutes of the State of Texas,* Chapter Six, "Medicine," Art. 4510, the practice of medicine is defined as follows:

Any person shall be regarded as

practicing medicine within the meaning of this law:

(1) Who shall publicly profess to be a physician or surgeon and shall diagnose, treat, or offer to treat, any disease or disorder, mental or physical, or any physical deformity or injury, by any system or method, or to effect cures thereof; (2) or who shall diagnose, treat or offer to treat any disease or disorder, mental or physical or any physical deformity or injury by any system or method and to effect cures thereof and charge therefor, directly or indirectly, money or other compensation; provided, however, that the provisions of this Article shall be construed with and in view of Article 740, Penal Code of Texas, and Article 4504, Revised Civil Statutes of Texas as contained in this Act.

"Notes of Decisions under Art. 4510 No. 5, "Osteopathy" reads as follows: The practice of osteopathy is within the meaning of the phrase "the practice of medicine." Op. Atty. Gen. 1939, No. 1298. An osteopath was a practitioner of medicine eligible for appointment to staff of visiting physicians appointed by board of managers for county hospital within discretion of board. Op. Atty. Gen. 1950, No. V-1024.

We quote further from Attorney General's Opinion No. WW-1163: Article 4510 of Vernon's Civil Statutes provides who is to be regarded as practicing medicine in this State.

Doctors of osteopathy are licensed in this State by the Texas State Board of Medical Examiners and come within the provisions and requirements of Chapter 6 of Vernon's Civil Statutes, entitled, "Medicine."

Before Doctors of Osteopathy or Medical Doctors receive licenses to practice medicine in the State of Texas they must meet the same requirements and pass the same examinations and they receive the same license to practice medicine in this State.

It is, therefore, our opinion that a doctor of osteopathy who is duly licensed by the Texas State Board of Medical Examiners, and is a competent physician, is legally qualified to fill the office of a county health officer if he possesses in addition the necessary reputable professional standing as is required by statute.

Summary, page 5:

4. There is no change in the legal significance of a service rendered by a Doctor of Osteopathy and a Medical Doctor.

You can, therefore, see from the above and foregoing that in Texas, Doctors of Osteopathy are given the same legal recognition as Doctors of Medicine.

In your letter you stated "It has been the policy of the Company to recognize charges for consultation only from those physicians who are listed in the American Medical Association, American Medical Directory, as having a practice confined to one of the various medical or surgical specialties." We would greatly appreciate it if you would furnish us with the answers to the following questions:

1. Is this an administrative policy of your Company, or is it a formal clause in the Master Policy of the group health coverage?

2. If it is actually written in the Master Policy, was it the result of a requirement made by the Union representatives for acceptance of your group health coverage, or was it placed there at the option of the employer?

Dr. ..... is a recognized specialist in internal medicine. The very fact that he was called in consultation would bear this out.

This Committee will appreciate your further consideration of this matter.

In order to give you an idea of what this Committee does, we are enclosing a reproduction of "The TOIL Committee—A Progress Report" (Revised November, 1964).

Yours Very truly,

Dr. Verne J. Wilson (top) COMS Vice-President Edward Dugan, and President Merlyn McLaughlin (seated) look over posters which will be displayed at the College to remind D.O.'s about the COMS Fourth International Cardiovascular Conference in Hawaii. Dr. Wilson is Chairman of the Conference, which will be held in July, 1966.

COMS Plans Summer Conference

The Fourth International Cardiovascular Conference sponsored by the College of Osteopathic Medicine and Surgery will be held in Honolulu, Hawaii, in July 1966, according to an announcement made by Dr. Verne J. Wilson, Chairman. He said the theme for the postdoctoral course will be "Practical Cardiac Diagnosis," with Physical Diagnosis being considered during the first eight hours of the twenty-hour course, and Laboratory Diagnosis the second eight hours. The remainder of the time will be used for a round table discussion.

The Conference, scheduled for July 16-22, will feature the following well-known researchers and clinicians:

Aldo A. Luisada, M.D., Professor of Medicine, Chicago Medical School, Chicago, Illinois;

Joseph T. Rogers, Jr., D.O., Director, Cardiopulmonary Laboratory, Detroit Osteopathic Hospital, Detroit, Michigan;

Arthur Simon, D.O., Chairman, Department of Radiology, Youngstown Osteopathic Hospital, Youngstown, Ohio;

Robert M. Kreamer, D.O., Chairman, Department of Medicine, Wilden Osteopathic Hospital, Des Moines, Iowa;

Jay W. Adams, D.O., Chief of Pediatrics, Wilden Osteopathic Hospital, and Chairman, Department of Pediatrics at COMS;

David R. Celander, Ph.D. Chairman, Department of Biochemistry at COMS;

Evelyn F. Celander, B.A., Assistant Professor of Biochemistry at COMS; and

Donald F. M. Bunce, II, Ph.D., Research Professor of Physiology and Director of the Graduate School at COMS.

According to Dr. Wilson, the lectures will be held Monday through Friday from 9:00 a.m. until 1:00 p.m., and the remainder of the day will be free for sightseeing and relaxation. Guided tours of Honolulu are being planned for the afternoons during the Conference. Wilson stated that every alumnus and friend of the College is invited to the Conference and urged to bring his family. Northwest Orient Airlines will serve as the official airline.

The cost for the Conference, including round-trip air transportation and seven nights in the Royal Hawaiian Hotel, will be approximately $540 for those traveling from Des Moines. Meals, laundry, and other personal expenses are not included. Registration and tuition for those taking the course will be $125.

A deposit of $75 is required with each reservation. Final payment is due June 16, 1966. After that date, full payment must accompany each reservation.

A seven-day extension tour of the Outer Islands is scheduled following the Conference. The additional cost for this tour will be about $240.

Information may be obtained by writing to Dr. Verne J. Wilson, 1347 Capitol Avenue, Des Moines, Iowa, 50316.

More detailed information will follow in later COMS publications.

ARE YOU MISSING A BET?

Addendum:

(from an out-of-state D.O.).

Dear Mr. Price:

Went to surgical meeting in Mexico City the first part of August and worked and visited four hospitals.

Those four hospitals now have (or had) a good supply of "The Osteopathic Physician and Surgeon Today" put there by me.

Although we were allowed to visit and assist in surgery, I did not find one Mexican doctor who knew what a D.O. was.

Physicians Attend Obstetrical And Gynecological Meeting

The Tenth Annual Post Graduate Course of the Texas Association of Osteopathic Obstetricians and Gynecologists was held at the Cabana Motor Hotel in Dallas on October 2 and 3, 1965. The seminar was attended by physicians representing all parts of Texas. Some eighty persons enjoyed the program and the social events of this meeting.

The program was highlighted by the talks given by Dr. Lester Eisenberg of Philadelphia, Pennsylvania, President of the American College of Osteopathic Obstetricians and Gynecologists.

Other well received speakers on the program were Drs. Dan R. Barkus, Charles D. Ogilvie, J. T. Calabria, Charles Bamford, Hyman Kahn and Coleman Jacobson, all of Dallas. A panel discussion of "Management of the Infertile Couple" was presented with Dr. Dan Barkus, moderator, and other members of the panel being Dr. Lee J. Walker of Grand Prairie, Dr. Richard M. Mayer of Lubbock and Drs. Roy Lee Fischer and Daniel Slevin of Dallas.

This post graduate course has increased in value each year to all physicians and this year's program was outstanding. The American College of General Practitioners of Osteopathic Medicine and Surgery approved this year's course for fourteen hours post graduate credit.

During a business meeting following the conclusion of the program the following officers and trustee were elected:

President—Dr. Richard M. Mayer, Lubbock

Vice-President—Dr. Lee J. Walker, Grand Prairie

Secretary-Treasurer—Dr. Roy Lee Fischer, Dallas

Trustee, Term Expiring 1969—
Dr. Jerry O. Carr, Fort Worth

The following doctors and wives registered for this meeting:

PENNSYLVANIA

Upper Darby

Dr. Lester C. Eisenberg
Mr. K. C. Eisenberg

TEXAS

Alvarado
Dr. John Falk

Aransas Pass
Dr. Gladys Auten

Bedford
Dr. and Mrs. O. F. Redd

Bridge City
Dr. J. E. Barnett

Comanche
Dr. and Mrs. W. D. Blackwood

Corpus Christi
Dr. Joseph Schultz

Dallas
Dr. Max E. Ayer
Dr. C. L. Bamford
Dr. Dan R. Barkus
Dr. Donald Bernstein
Dr. Dale P. Bondurant
Dr. Frank J. Bradley
Dr. and Mrs. John Burnett
Dr. J. T. Calabria
Dr. Joseph Dubin
Dr. Roy L. Fischer
Dr. and Mrs. Coleman Jacobson
Dr. and Mrs. Hyman Kahn
Dr. Richard A. Lane
Dr. and Mrs. Charles D. Ogilvie
Dr. and Mrs. Donald M. Peterson
Dr. Merlin L. Shriner
Dr. Daniel Slevin
Dr. Louis Vanderschot
Dr. Winton L. Welsh

Deer Park
Dr. Billy J. Sealey

Denison
Dr. S. F. Kubala

Forney
Dr. Louis C. Boneta

Fort Worth
Dr. and Mrs. W. F. Baker
Dr. Catherine Carlton
Dr. Elbert Carlton
Dr. and Mrs. Jerry O. Carr
Dr. Noel G. Ellis
Dr. William R. Graves
Dr. Jere R. Lancaster

Grand Prairie
Dr. and Mrs. Gerald K. Geske
Dr. and Mrs. Albert Plattner
Dr. Emil Plattner
Dr. Lee J. Walker

Houston
Dr. and Mrs. Thomas E. Bennett
Dr. J. E. Berry
Dr. Gordon A. McClimans

Irving
Dr. and Mrs. A. Virgil Mansky

Lubbock
Dr. and Mrs. Richard M. Mayer
Dr. and Mrs. Harlan O. L. Wright

Mesquite
Dr. and Mrs. Vernon Drummond
Dr. and Mrs. Leonard C. Nystrom
Dr. David J. O'Mara

Mineola
Dr. and Mrs. B. R. Beall, II

Port Arthur
Dr. Robert J. Sheilds

Troup
Dr. C. F. List

Tyler
Dr. George Grainger

Denton Physician Dies

Dr. Marvin Thomas McDonald of Denton expired there Friday, Sept. 17, 1965 of an apparent heart attack.

Dr. McDonald, a 1937 graduate of Kansas City College of Osteopathy and Surgery, lived in Denton 16 years.

He was a 32nd degree Shriner, a member of the Moslah Temple of Fort Worth and of the Asbury Methodist Church, and was a founder and senior partner of the Denton Osteopathic Hospital. Dr. McDonald was also a member of the Texas Association of Osteopathic Obstetricians and Gynecologists.

A Memorial Fund has been established in honor of Dr. McDonald. The name of the Fund is the Dr. Marvin T. McDonald Student Nurse Loan Fund. A non-profit corporation is being set up to make low interest loans to individuals who need money either to start or finish their nurses training. The emphasis will be on financial need. The Board of Trustees for the Fund consists of Mr. Royce Whitten, Attorney; Mrs. Yarbrough, Director of School of Nursing at Texas Women's University and Dr. Charles Hawes, Orthopedic Surgeon from Dallas. An escrow account has been established at the First State Bank in Denton. Contributions should be sent to Mr. W. C. Orr, Escrow Agent for the Fund, who is President of the First State Bank.

A contribution to the revolving Student Loan Fund of Kansas City College of Osteopathy and Surgery by TAOP&S has also been made to establish a living memorial to Dr. McDonald.

Survivors include his widow; a daughter, Mrs. Ronald Favors of Denton; a sister and a granddaughter.

Twenty-Five Years Ago:

The President-Elect of the American Osteopathic Association was Dr. Phil R. Russell of Fort Worth, Texas, and the new President of the AOA was Dr. F. A. Gordon of Marshalltown, Iowa. Among the names of delegates to the AOA Convention the previous June were found such familiar ones as Chester D. Swope, Charles W. Sauter, P. E. Haviland, E. A. Ward, William C. Bugbee, R. McFarlane Tilley, Donald V. Hampton, J. W. Mulford, and Marion E. Coy.

Seventy-Four to Twenty-Six

By GEORGE W. NORTHUP, D.O., *A.O.A. Editor*

If 74 to 26 were a basketball score one would conclude that it was a lopsided game. Yet in the 1964-65 Osteopathic Seal Campaign, a record-breaking year, only 26 per cent of D.O.s participated in and contributed to the program.

As one writer put it, "It makes you wonder that a profession so determined to fight for its political future would be so lax about providing the means to maintain itself." This comment is devastatingly accurate, for the Osteopathic Seal Campaign that is being ignored by so large a percentage of the profession provides the means for future doctors through student loans. In fact one of every ten D.O.s practicing today owes his career in part to student loans provided by seals. In its 35 years of existence, over 1,200 students have benefited from this program. If you took 10 per cent from future osteopathic graduating classes, you might be robbing the profession of some of its most promising physicians.

The success of the Campaign is equally important for the provision of research funds. As you know, 50 per cent of the receipts support osteopathic research. And it is through medical man power and research that this profession will progress. Without them, it will grind to a lackadaisical halt.

The 1965-66 Osteopathic Seal Campaign goal of $150,000 is both realistic and attainable. But it will not be achieved with three fourths of the profession sitting back and allowing one fourth to carry the burden.

The facts of the situation are that if any reasonable percentage of D.O.s saw to it that their patients and business associates were *given an opportunity* to contribute to the Seal program, the 1965-66 goal would be met several times over.

It has been demonstrated time and time again that the public gives to the support of osteopathic medicine—*when asked.* Many times gifts have been made not only because of gratitude and acceptance, but also because the profession has manifested its faith in itself by sizable investments.

The Auxiliary to the American Osteopathic Association continues to guide the destiny of the Seal program. The members have done well. They have set high goals, and the least that we can do is to support *their effort* in *our* behalf. Let's reverse the figures for 1965-66. Let's have 74 per cent of the osteopathic profession actively participating in the program. Let's demonstrate our belief in the Seal slogan, "Stepping Stones to Better Health . . ."

Up to Twenty $1,500 Osteopathic College Scholarships

Offered By

The Auxiliary to the American Osteopathic Assn.

Available To

Students Entering Osteopathic Colleges as Freshmen, Fall 1966

The Auxiliary to the American Osteopathic Association will award up to twenty $1500 scholarships to students entering osteopathic colleges as freshmen in the fall of 1966, it was announced by Mrs. Robert N. Rawls, Jr., Granbury, Texas, AAOA scholarship chairman.

The scholarships will be awarded on the basis of scholastic standing, financial need, professional motivation and aptitude, and moral character. Winners must be citizens of the United States or Canada and must have been admitted to one of the five osteopathic colleges.

The $1500 will be paid directly to the selected college in two installments of $750 each for the freshman and sophomore year. Renewal of the scholarship for the second year is dependent on the maintenance of satisfactory work and continued financial need.

Applications Must Be In Before May 1, 1966

Send Applications to

Office of
The Scholarship Chairman
212 East Ohio Street
Chicago, Illinois 60611

For Further Information

Write to the Dean of one of the five approved osteopathic colleges or to Mr. Lawrence W. Mills, American Osteopathic Association, 212 E. Ohio Street, Chicago, Ill. 60611.

Dr. Hesse Elected to Office

W. N. HESSE, D.O.

Dr. W. N. Hesse of Dallas, a long-time member of TAOP&S, has been elected Secretary-Treasurer of the American Academy of Sclerotherapy.

Dr. Bone Expires

Dr. James DeWayne Bone, Sr., 54, of Midland died Sunday, Sept. 12, 1965, in a Lubbock hospital. He had been ill for four months.

Dr. Bone had practiced in Stanton and Henderson before moving to Midland two years ago. He was associated with Dr. B. B. Jaggers. He was a member and a ruling elder of the First Presbyterian Church of Midland. Dr. Bone was also a Mason of the Clinton Lodge 23 in Henderson and a member of the BPOE Lodge in Midland.

Services were held Wednesday, Sept. 15 at the Waldrop Funeral Home Chapel in Houston.

Survivors include his widow; four sons, Dr. Jere H. Bone of Houston, James D. Bone, Jr., of Lake Jackson, John R. Bone of Pensacola, Fla., Jack T. Bone of Midland; two brothers; a sister and three grandchildren.

A contribution to the revolving Student Loan Fund at College of Osteopathic Medicine and Surgery from which Dr. Bone was graduated in 1943 has been made by TAOP&S to establish a living memorial to him.

Photograph professionally posed.

Overtranquilized?

Drug dependency can be a serious problem with some medications. Too often, patients come to rely on a dulling sedative effect as a shield against anxiety and refuse to come to terms with reality.

Not with Stelazine® brand of trifluoperazine

In contrast to many of these agents, 'Stelazine' helps the physician normalize anxiety. On 'Stelazine', patients respond more appropriately to reality yet are unlikely to overreact to stress.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

SK&F

Smith Kline & French Laboratories
Philadelphia

Dr. Young Installed as President of A.C.G.P.

A. ROLAND YOUNG, D.O.

Dr. A. Roland Young of Dallas was installed as President of the American College of General Practitioners in Osteopathic Medicine and Surgery during the College's meeting in Philadelphia in September.

Dr. Young has also served as a member of the Board of Trustees of the College. He has been a member of TAOP&S since 1955 and has served on several committees. He is a graduate of Kansas City College of Osteopathy and Surgery.

Bentex Pharmaceutical Co. Is First Exhibitor

Even though it is some seven months until the state convention, several firms have already reserved booth space for the 1966 meeting to be held in Corpus Christi.

Bentex Pharmaceutical Company of Houston was the first exhibitor to reserve a booth.

Other concerns that have reserved space are: The George C. Tong Company, D. M. Doyle Pharmaceutical Company, Ciba Pharmaceutical Company, Parke, Davis and Company, Abbott Laboratories, Kay Pharmacal Company, Miller Pharmacal Company, Vitamin Products Company, Carnation Company and The Upjohn Company.

The National Osteopathic Foundation has announced that E. R. Squibb and Sons will renew their grant to TAOP&S as a means of underwriting the scientific program.

Eli Lilly and Company, although they do not plan to exhibit at this particular convention, have repeated their grant of $250 toward the cost of the technical lectures.

Two Texans Elected to AAOA Offices

MRS. R. N. RAWLS, JR.

MRS. GEORGE J. LUIBEL

Two Texas members of the Auxiliary to the American Osteopathic Association were elected to its slate of officers at the AOA convention in Philadelphia.

Mrs. Robert N. Rawls, Jr., of Granbury was elected First Vice President. Mrs. Rawls also serves as AOA Scholarship Chairman.

Mrs. George J. Luibel of Fort Worth was elected a trustee for a two year term.

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.

* * *

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.

* * *

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.

* * *

From Mr. Ed Isaac: The city of Bovina, located around the richest area in Texas, will help in every way possible to locate an osteopathic physician in our town.

There is no other doctor in our town of approximately 2500 people. We will provide a well-equipped facility for the doctor.

We need you, come and talk to us.

* * *

Edgewood, Texas—population 1,000. City-owned clinic available. 24 miles to hospital facility. Contact druggist in Edgewood, Mr. Humphrey, or J. Warren McCorkle, D.O., Mineola, Texas.

* * *

Grand Saline, Texas—office of deceased M.D. available with three months free rent, town of 3,000. 14 miles to registered hospital. Contact J. W. McCorkle, D.O., Mineola, Texas.

NOGA To Meet

The National Osteopathic Guild Association will hold its annual convention in Albuquerque, N.M., at the White Winrock Hotel, Nov. 4-6.

There will be many speakers of distinction including AOA President, Dr. Wesley B. Larsen; Emil Herbert, executive secretary of the American Osteopathic Hospital Association and Dr. George Luibel, member of the AOA Board of Trustees.

In addition, Norma Manson, newspaper fashion reporter for Sears, who accompanied the flying doctors of DOCARE on their expedition into Sisoguichi, Mexico, and Dr. Joseph Peterson, secretary-treasurer of DOCARE, will give the woman's and the doctor's viewpoints on the Tarahumara Indians.

Reservations for the convention are being taken by Mrs. George C. Shertenlieb, 4002 West 9th St., Trainer, Chester, Penn.

Ft. Worth Guild Gives 3,153 Hours

Summarizing their 1964-65 year, Fort Worth Osteopathic Hospital Guild noted some 3,153 hours of volunteer service had been given to the Hospital, along with 300 puppets for patients under 12. In the Junior group, 2,008 hours were given.

In addition, guild members donated 265 hours to a health clinic, 64 to addressing brochures, 100 to rummage sales. The women furnished an examining room, and purchased a new aluminum book cart. In its 10 years of existence, the guild has given $12,000 to the hospital, according to Meta Leach, recording secretary.

Publicist Mrs. Norman W. Beard adds that during the hospital's open house, the guild showed its appreciation to staff physicians by presenting each with a red carnation boutonniere.

Dialysis*

When two solutions are separated by a semi-permeable membrane, small molecules of solute will diffuse across the membrane from a higher to lower concentration until equilibrium is established. Whether equal concentration of a given substance is established on both sides of the membrane will depend basically on the time of equilibration and the nature of the membrane. The simple principle underlying the use of dialysis for the treatment of acute renal failure is that a "bathing" solution is used on one side of a semipermeable membrane in concentrations depending on which chemicals are to be added or removed from the blood or extra-cellular fluids. This basic principle can be influenced by many factors, such as the molecular size of the particles which are to be removed, the pore size of the membrane, the relative solute concentration and volumes of fluid on each side of the membrane, the flow or exchange of the "bathing" fluids, and the rate of diffusion of various substances, to name but a few.

Clinically, there are three forms of dialysis which are available: gastrointestinal lavage, hemodialysis and peritoneal dialysis. Gastrointestinal lavage may be carried out in the stomach, small bowel or colon. Lavage of the stomach and colon are the least efficient and will not be discussed further.

The general procedure used in small bowel lavage is to pass a double lumen tube (or two tubes) with the proximal opening in the duodenum and the distal opening in the lower ileum. Fluid is delivered to the duodenum and allowed to perfuse the intestinal tract to the lower ileum where an inflated balloon halts the progress, and the distal tube removes the fluid. The alternative method is to deliver the fluid into the duodenum and allow it to pass through the small and large bowel and be removed by a colon tube.

When considering intestinal lavage, it must be recognized that the intestinal mucosa is not an inert semipermeable memberane and selective absorption and excretion of sodium, chloride and potassium, as well as other electrolytes, occur independently of the osmotic gradients. Water and urea, on the other hand, are largely a matter of passive transference determined by osmotic forces. Water and urea transference can be augmented by the use of substances such as lactose, sucrose, and magnesium. Lactose and sucrose are especially helpful because they are not absorbed by the intestinal mucosa in small amounts and are not recommended for prolonged use.

The intestinal mucosa handles urea differently than uric acid, phosphate or creatinine, and this fact is of great importance if this modality is used. It has been proven that intestinal lavage may cause rapid and effective decrease in blood urea nitrogen, but only slight decrease in uric acid, phosphate and creatinine. As has been previously stated, the clinical significance of this is obvious since the clinical syndrome of uremia appears to depend more upon uric acid, phosphate and similar substances.

Evaluation: It may be surmised that intestinal lavage, when carried out under good control, may be an effective method of correction of fluid and electrolyte abnormalities. However, it must be kept in mind when attempting to remove one electrolyte, such as potassium, that other electrolytes will also be removed because of the selective excretion of intestinal mucosa. This electrolyte loss must be controlled or corrected as ac-

* *This is the fifth and final article in a series by Jerry D. Houchin, D.O., a resident at East Town Osteopathic Hospital.*

curately as possible, and gastrointestinal lavage should not be used when hemodialysis or peritoneal dialysis are available.

Hemodialysis: Since this is a very specialized and difficult procedure which is available in relatively few hospitals and requires expert teams of physicians and technicians, the discussion will be limited to possible indications, contraindications and adverse reactions.

Indications for the use of the "artificial kidney" are usually stated to be: (1) the patient showing signs and symptoms of renal failure quickly following renal injury; (2) the patient with a potentially reversible renal disease or one in a severe catabolic reaction (severe catabolic states may be defined as a rapid weight loss with a BUN increase up to 30 mg. percent per day or more); (3) the patient suffering from acute tubular necrosis due to nephrotoxins which are dialyzable, etc.; and (4) in hyperkalemia and conditions where acute trauma (such as automobile accidents) is the background for renal failure.

Contraindications for the use of hemodialysis have been stated to consist of: (1) bleeding from gastrointestinal tract or other areas, which originates from the fact that heparinization of the patient precedes the use of the machine; (2) hypotension, since the procedure almost always causes a decrease in blood pressure; (3) pre-existence of a cardiac arrhythmia, which is due to the very rapid changes in potassium concentrations; (4) overt congestive heart failure because the priming of the machine with blood may overload the circulation (with the new machines that ultrafilter water, this is not as great a hazard, and in fact has been used to treat pulmonary edema); and (5) pericarditis, because there is a possibility of pericardial hemorrhage when the patient is heparinized. In general there is little value in using this form of therapy in terminal stages of chronic renal failure, except perhaps when an acute process such as pyelonephritis causes an acute exacerbation.

Peritoneal Dialysis: Peritoneal dialysis will be discussed in more detail because of its simplicity and availability to any physician or hospital which chooses to use it.

The major advantages and disadvantages of peritoneal dialysis as compared with hemodialysis may be stated as follows:

(1) The equipment required for peritoneal dialysis is much simpler, less expensive and it may be performed in almost every hospital. This is very important because patients who benefit most from dialysis are frequently too ill to be transported to a center where an artificial kidney is available. Also peritoneal dialysis may so improve the patient's condition that he can be transferred if desired.

(2) Abrupt changes in blood pressure and volume can be avoided because the patient does not have to be "primed" and the fluid exchange is not as rapid.

(3) During peritoneal dialysis the exchange of fluid and electrolytes is not as fast as with hemodialysis and gives the physician ample time to change the composition of the irrigation fluids when required. The slower exchange will almost eliminate the abrupt changes in serum potassium levels with the resultant cardiac arrhythmias.

(4) Peritoneal dialysis can be used in patients with bleeding tendencies because heparinization is not required.

(5) Peritoneal dialysis can be continued for a longer period of time and may be used to tide the patient over

several days of anuria. With the artificial kidney, it may be necessary to perform a second dialysis a few days following the initial therapy, and if this continues, the patient may well run out of arteries which can be used.

Additional disadvantages of hemodialysis are:

(1) Urea diffuses more slowly from the brain into the blood, and when hemodialysis is used, the blood urea concentration may fall too quickly. This may create a hypertonic state within the cerebral intra-cellular fluid in relationship to the blood, and fluid will enter the neurocells causing cerebral edema with convulsions and/or coma. This is less likely to occur when peritoneal dialysis is used because of the slower rate of urea removed.

(2) The use of blood from several donors to prime the artificial kidney increases the hazard of transfusion reactions and hepatitis.

(3) There is danger of air embolism.

The following may be considered as disadvantages of peritoneal dialysis:

(1) Water cannot be removed as rapidly, although this can be overcome by using high glucose concentrations in the irrigation fluids.

(2) There is danger of infection during dialysis which may be overcome by the use of sterile technique and being sure that there is no leakage around the catheter.

(3) There is a possibility of perforating the intestines when the catheter is placed in the abdomen, but this is minimal if appropriate measures are taken.

(4) If dialysis is prolonged, protein loss may be troublesome.

(5) Abdominal pain occurs in some patients which may be overcome by using warm solutions and novacaine.

(6) Peritoneal dialysis cannot be performed when there has been recent injury to abdominal organs or when severe peritonitis is present, although it has been used in these conditions and used successfully.

(7) Peritoneal dialysis requires sterile irrigation fluids which are not required in hemodialysis.

(8) The dialyzing surface of the artificial kidney is larger than the peritoneum.

(9) In the artificial kidney the blood flow through the "bath" can be regulated by pumps, whereas in peritoneal dialysis the flow is controlled by gravity and can be quite variable.

The contraindications for the use of peritoneal dialysis are: (1) peritonitis, (2) massive abdominal adhesions because of danger of perforating the bowel, and (3) recent injury to the abdominal organs, surgery not included. There have been many cases of peritoneal dialysis used without complications following major surgical procedures.

There are two methods of performing peritoneal dialysis. The intermittent method is a process in which a single tube is placed in the abdominal cavity,

through which the irrigation fluid is admitted. After a time interval for diffusion to occur, the fluid is siphoned back through the same tube. The second method is the continuous method in which two catheters are placed in the peritoneal cavity and the irrigation fluid flows continually through one catheter and out the other.

Technique: The patient is placed in a supine position and checked to see if the bladder is empty. The skin is then prepared and local anesthesia infiltrated. A small lengthwise incision is made at a point about one-third the distance from the umbilicus to the pubic bone in the midline. Bleeding which usually is not troublesome may be stopped by suture or a gauze soaked in dilute epinephrine solution. The tissues are then cleaved until the peritoneum is reached and the Oschner gall bladder trocar is used to enter the peritoneum. (This is used because it is large enough to admit the largest peritoneal catheter). The catheter is then inserted through the trocar into the right or left pelvic gutter to the lowest possible point. The trocar is then removed and a purse-string closure is used to prevent leakage. When a large trocar is not available, the catheter may be placed directly into the abdomen.

The dialyzing material used at this hospital is Abbott's Impersol. Other fluids may be used or the physician may make a solution to suit the occasion. If water is to be removed, a five to seven percent solution should be used, and if fast removal is contemplated, seven percent is more efficient. If fluid is to be removed slowly, we have found the combination of 1000 cc. of 1.5 percent and 1000 cc. of Impersol seven percent useful. It must be remembered that the failure of peritoneal dialysis is frequently due to the inadequate quantity of dialyzing fluid used.

We have used two methods in dialyzing patients: (1) the patient may be dialyzed enough each day to keep the BUN, potassium, etc., at static levels awaiting the return of adequate renal function which will usually take eight to twelve dialysis per day of 2000 cc. each; or (2) dialysis may be carried out until the BUN and electrolytes are adequately removed which will take as much as fifteen to thirty dialysis per day.

The time in which the irrigating material stays in the abdominal cavity is variable and is gauged by the amount of fluid which is to be used per day. Many experts have stated that ninety percent of the diffusion with a heated dialyzing fluid will occur in thirty minutes and should be maximum at forty-five minutes to an hour.

The method we have used is to allow the fluid to run ten minutes, leave in the abdomen for thirty minutes, drain for twenty minutes, or until the amount placed in the abdomen has drained and the flow has stopped. In all dialysis periods, an effort is made to remove all the fluid which was placed in the

abdomen, or all excess fluid if dehydration is the object. This may be accomplished by moving the patient from side to side or by gentle palpation of the abdomen. If all the fluid is not returned and the above procedures are carried out, the fault may lie in a blocked catheter because clotting of the fluid in the abdomen may occur around the catheter, or peristaltic action of the bowel may displace the catheter into the upper abdomen. Slightly twisting the catheter may correct this situation, but if difficulty still arises, a 50 cc. syringe may be used to blow air through the catheter, thus dislodging a clot. Many times none of the above procedures are effective, and the catheter must be replaced. The physician must strive to obtain a sufficient outflow with each dialysis, or the remaining fluid may be reabsorbed with resultant edema.

Whether substances are added or removed from the irrigating fluid is determined by blood chemistry. This need not be checked following each dialysis because studies have revealed that after a rapid fall in serum potassium from 7mEq. to 5mEq., the decrease was gradual until a concentration of 3.75 mEq. was reached. At this point the serum potassium remained stable in spite of further dialysis.

It has been stated that in this hospital we use commercial solutions. Heparin in amounts of 0.1 to 0.2 cc. are used in the first two to four series of irrigations and is not used again unless the patient is dialyzed through the day, but not at night. If this method is used, a slow drip of dialysis fluid with heparin added is allowed to run through the night to prevent the clotting which may occur in a dormant catheter. Antibiotics are used in the irrigation fluids per se, and a small amount of antibiotic-containing fluid is left in the bottles and tubes between dialysis. Potassium is added or subtracted from the fluid depending on the serum potassium levels. A useful guide which we use is if the potassium is below 6 mEq., potassium is reduced or omitted depending on the serum levels. Some patients experience discomfort during the inflow and toward the end of the outflow, and this can be relieved by warming the solution to body temperature (which will also increase the permeability of the peritoneal capillaries and increase diffusion), or by adding 5 cc. of two percent novacaine to the solution.

The blood urea nitrogen and serum potassium are the substances which are usually used to determine the efficiency of the dialysis and will be the only two discussed because the other dialyzable materials will diffuse in a similar manner.

Generally speaking, the higher the BUN concentrations and formation, the larger the amount that can be removed. If, for instance, the BUN is kept at a constant level of 100 mg. percent during the dialysis period, this would indicate that the urea is being formed at the same rate as it is being removed. The clearance for blood urea nitrogen

at 2000 cc. per hour is about 23 to 25 ml. per minute. With the above statement, the physician can calculate after several hours of dialysis the approximate amount of blood urea formation and the most efficient rate of dialysis.

If a BUN is performed on the blood before dialysis and on the irrigation fluid following drainage, it will be found that after about twenty minutes diffusion time, the two determinations will be equal. It is felt that the irrigation fluid should stay in the abdomen for at least twenty minutes to obtain the maximum results.

Potassium is one of the substances released during protein catabolism and approximately 1.5 mEq. is set free with each gram of urea produced. This potassium is readily removed from the body by peritoneal dialysis, and in our experience removal and regulation are quite simple. Experiments have shown that blood concentrations of urea, creatinine and uric acid continue to decrease as long as a sufficient amount remains. However, with potassium this is not the case. Following an initial rapid fall in serum potassium to a level of about 4 mEq., the serum concentration will usually become stable despite further dialysis. The explanation of this is in the fact that potassium concentration in muscle and bone is about 170 mEq./L of water. The shift of this potassium into the extra-cellular fluid prevents the occurrence of severe hypokalemia during peritoneal dialysis. Most authorities feel that dialysis can be performed with potassium-free solutions for eighteen to twenty-four hours without danger or potassium determinations. If potassium determinations are not or cannot be used, it is advantageous to follow the effects of dialysis with the EKG, and after twenty-four hours add 2.5 to 3.5 mEq. of potassium to each liter of irrigation fluid. If serum potassium concentrations are available, removal of potassium should continue until the level is 4 mEq. or slightly below. This will prevent a rapid rise of the potassium to dangerous concentrations when dialysis is discontinued. The rise in serum potassium is probably attributable to the storage of glycogen during dialysis and its breakdown with potassium release following dialysis, and occurs frequently, illustrating the need for repeated blood sugar determinations during peritoneal dialysis, especially in diabetic patients.

In closing, it should be stated that practically all the serum proten fractions are found in the peritoneal fluids, and if dialysis is to be continued for a long period of time, a watchful eye should be kept on the serum proteins to prevent hypoproteinemia.

Case History

A twenty-five year old Negro male was admitted to the hospital with chief complaints of cephalalgia, scotoma of the right eye and dyspnea which had been present for about two weeks. Hy-

pertension was known to be present for one month prior to admission.

Past History: Tetanus six years previous with complete recovery. Physical examination on first hospital day revealed the patient to be very restless, disoriented and dyspneic. Heart rate 100 with a diastolic gallop and a grade 3 systolic murmur were present. BP 270/180, plus 2 pitting edema of lower extremities, and grade 4 retinopathy.

Laboratory: L. E. slide and prep. negative. Eloctrophoretic analysis of proteins normal, Bence Jones protein negative, sickle cell prep. negative, BUN 75, NPN 148, Na 140, K5.0, C1 106, CO_2 combining power 19, erythrocyte count 3.0, Hb 8.5 Gm., hematocrit 25%, W. B. C. 6400, U. A. specific gravity 1.012, protein 3 plus, R.B.C. 25-30, W.B.C. 6-10, course and fine gramular cast. Alkaline phosphatose 3.0 Bd units, microscopic examination of urine by pathologist nonconclusive, urine culture streptococcus faecalis. Chest x-ray revealed acute pulmonary edema and generalized cardiac enlargement.

Therapy was started on second hospital day with a solution of 25 mg. of apresoline in 100 cc. of five percent dextrose given slowly intravenously. There was no change in blood pressure during or after this procedure. The patient was then placed on apresoline 20 mg. I.M. every six hours, aldomet 250 mg. P.O. every four hours, and choral hydrate 0.25 Gm. every four hours. Patient's blood pressure was 160/100 on the fourth hospital day. The urine culture was reported on this date, and the patient was started on antibiotics. 500 cc. of packed red blood cells were also given on this date. Patient's condition was stable through day five and six with blood pressure being 160/100. The seventh and eighth hospital days the patient suffered severe nasal hemorrhages. Laboratory reports on day eight were Hb 9.1, U.A. specific gravity 1.006, protein 2 plus, occ. R. B. C., 10-12 W. B. C., Reticulocyte count 1.5 percent, BUN 75 before hemorrhage and 94 after. Na 137, K5.6 blood was given again following the nasal hemorrhage. Blood pressure was stable on day nine and ten at 180/100, but the BUN became elevated to 134 mg. percent. Following this elevation the patient's clinical symptoms (neurological and cardiovascular for the most part) became aggravated. Nasal hemorrhage once again occurred on day eleven with a blood pressure elevation of 300 plus/160. Patient was given Unitensen 1 cc. in 250 mg. dextrose in water, and blood pressure fell to 150/90. The patient had been digitalized on the second hospital day with reversal of congestive failure. Physical signs and x-ray of chest revealed return of congestive failure. Peritoneal dialysis was started on day eleven. Potassium 6.5, creatinine 5.13, blood pressure 220/140 when dialysis was started. Dialysis was carried out for the next fourteen days with complete control of the potassium. The patient went into

a coma with grade 4 body edema on the sixteenth hospital day and dialysis with seven percent solution was used to remove 10,000 cc. of fluid. Following this fluid removal, the patient began to improve. The neurological response decreased, emerged from coma, crepitant rales in lungs disappeared, grade 4 systolic murmur decreased to grade 1. The antihypertensive agent used to control the patient following fluid removal was unilensen 1 cc. every two hours which held the blood pressure at 150/90.

Steriods were started on the twenty-fourth hospital day because urine output had decreased to 100 cc. per day, and because a diagnosis had not been made. The only way a diagnosis could be made in a case like this would be through renal biopsy which was refused.

The patient was transferred to the city hospital on the twenty-seventh day, and died nineteen hours later. The autopsy report of the kidneys revealed malignant nephrosclerosis.

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S.O.P.A. NEWS

District No. Two

The Fort Worth Osteopathic Assistants met at the State Office Building Oct. 5 at 8 p.m.

Taylor Smith of Winthrop Laboratories presented the film "The Face of An Addict." Doctors and their wives were guests. There were 18 present.

The next meeting will be the first Tuesday in November at 8 p.m. in the State Office Building.

A film, "The Recognition and Management of Anxiety," will be presented by Tom Abbott of Wyeth Laboratories. All doctors, assistants and visitors are invited to attend.

B. Lynch, *Reporter*

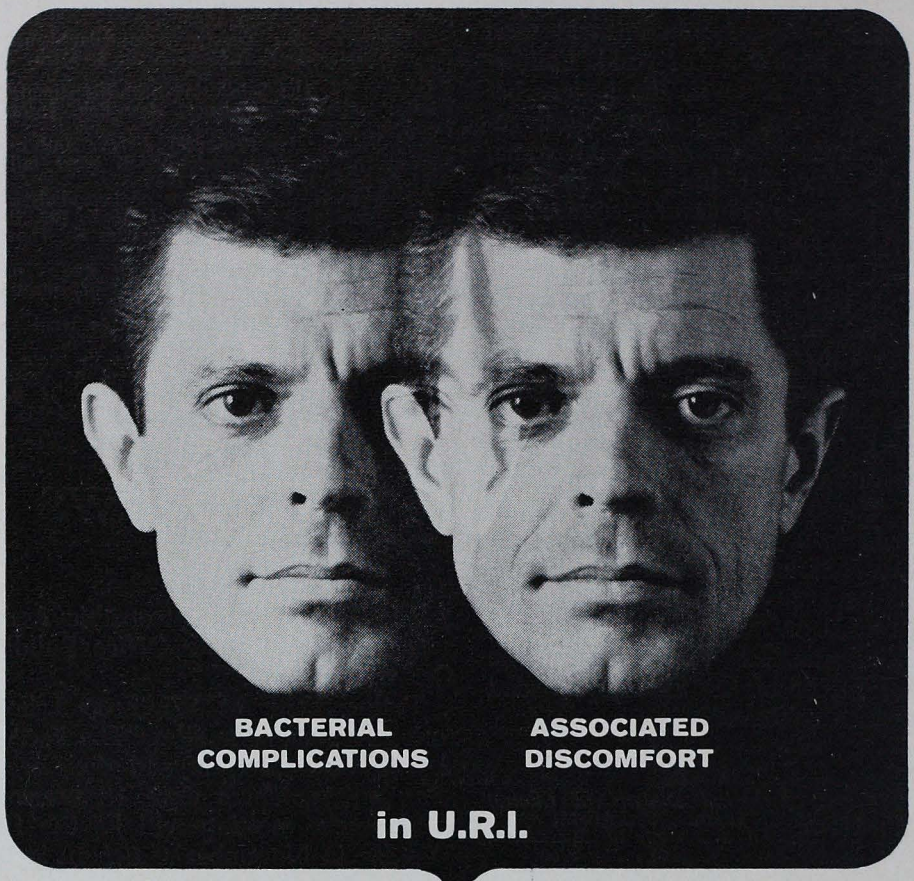
* * *

District No. Six

Armilda Interrarity, Dorothy Russo, Oletta Warren, Odell Mackin and Estelle Ochoa attended the State Convention in Beaumont in July. All of them came back excited and full of plans for another good year for our Association.

District Six is planning an all-out membership drive. A dance was given Sept. 25 at Atascocita Country Club.

LaRita Zgarba, *Reporter*



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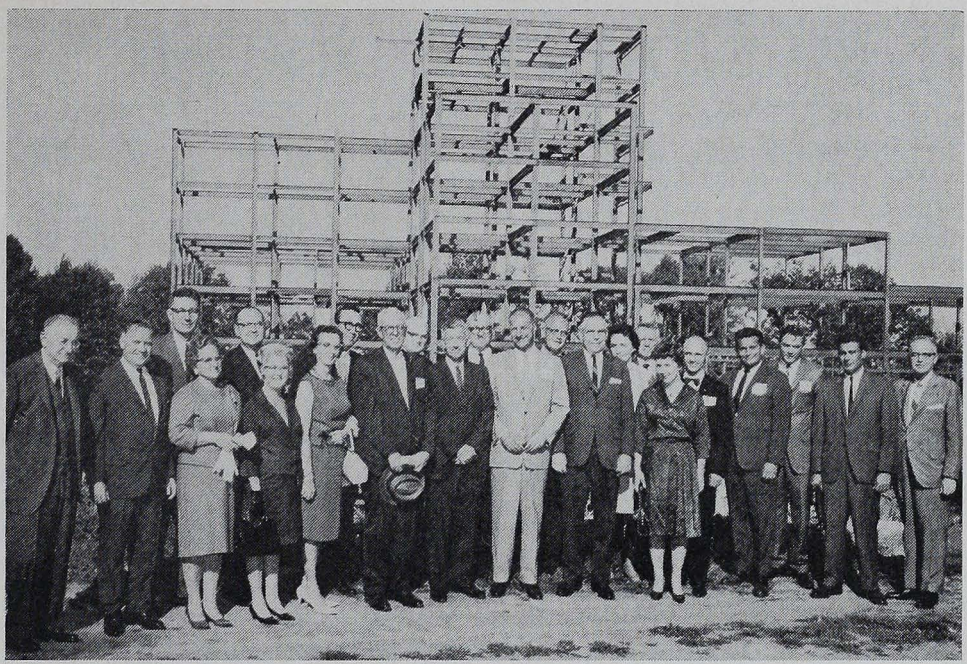

Divisional Society Secretaries See P.C.O.'s Research Hospital under Construction. (Left to right:) Dr. Frederic H. Barth, President, P.C.O., Roswell P. Bates, D.O., Bangor, Maine; Paul Grayson Smith, D.O., Pikeville, Tenn.; Mrs. Bates; Leslie C. Thelleman, Harrisburg, Pa., Mrs. P. G. Smith; Irene F. Key, D.O., Louisville, Ky.; Paul D. Adams, Jefferson City, Mo.; Walter L. Gray, Oklahoma City, Okla.; M. Sidney Hedeen, D.O., St. Paul, Minn.; Herman Walter, Des Moines, Iowa; C. Robert Starks, D.O., Denver, Colo.; Lloyd L. Hall, Topeka, Kansas; Tex Roberts, Albuquerque, N.M.; Robert P. Chapman, Trenton, N.J.; Mrs. Roberts; Stanley Schultz, Phoenix, Arizona; Mrs. Bailes; O. J. Bailes, D.O., Princeton, W. Va.; Robert Price, Fort Worth, Texas; B. J. Davis, D.O., Albuquerque, N.M.; George Abdilla, Farmington, Mich.; and Dean Sherwood Mercer.

Summary of Membership Committee Action

New Applications Approved:

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

NEWS OF THE DISTRICTS

District No. One

Dr. Richard E. Wetzel of Amarillo returned to the school hospital in Kansas City October 1, 1965.

District No. Two

Dr. George J. Luibel of Fort Worth gave the Annual Academy Lecture to the Academy of Applied Osteopathy at the A.O.A. Annual Convention in Philadelphia.

Dr. B. G. Smith of Arlington, A. F. Rollins, the City Manager of Arlington and Bob Stevens, Personnel Director of Great Southwest Corporation, were the guests of Dr. Roy Mims, Jr., who was an intern at Mid-Cities Hospital in Grand Prairie last year, but is now practicing in Comanche. The occasion was a Dove Hunt in that area. It was satisfactory to all. They came home with 46 birds.

Dr. Dan Beyer and his son, made a trip to Kirksville so that Bryce could look over the school. He was very much impressed with the school, especially the new six-story science building and its facilities. With Bryce in an osteopathic college, and David Beyer, son of Dr. R. B. Beyer, a sophomore at K.C.O.S., it looks as if there will be some Beyers in the profession for quite some time.

District No. Five

The osteopathic hospitals in the Dallas area are blessed with a considerable number of interns and residents this year. East Town Osteopathic Hospital has a total of six interns; one medical, one orthopedic and two general surgical residents. This is thought to be the highest number of trainees in an osteopathic hospital in this area to date. The Dallas Osteopathic Hospital has five interns and one medical resident with Stevens Park Osteopathic Hospital having three interns and two residents.

To greet these new and continued trainees, the Dallas Osteopathic Hospital sponsored a dinner and cocktail party at the home of Dr. George E. Miller in August for the entire training staff of the Dallas-Fort Worth area. A total of 70 interns and wives were present at this function. This number included some externs as well as new members of the staff physicians. Reports are that it was a very successful affair. The food was especially excellent this year.

We understand that all of the hospitals in the area have increased their staff, including the Mesquite General Hospital. The largest number of new applicants and remaining interns was thought to be at the Dallas Osteopathic Hospital with a total of five interns setting up practice in the area.

We hope that all the hospitals are as successful upon graduation of our present interns and residents as we see the Fifith District continuing to grow.

Two Dallas physicians spoke to their specialty groups at the A.O.A. Convention in Philadelphia. Dr. Rollin E. Becker spoke to the Academy of Applied Osteopathy on "Bioenergy Factors in Low-Back Problems." Dr. Ralph I. McRae spoke to the American College of Neuropsychiatrists on "Convulsive Therapy in Psychiatry."

RAYMOND N. DOTT, D.O., *Reporter*

District No. Nine

District Nine met Sept. 12 at Crews Hospital in Gonzales. Following the formal meeting, the doctors and wives enjoyed a buffet dinner served by Dr. and Mrs. Willis Crews at their home.

Dr. Norbert Todd, KCOS '52, has moved from Toledo, Ohio, and is now associated with the Crews Hospital in

Gonzales. His wife, Lucille, and three children are also becoming Texans.

Dr. John Boyd of Louise has been in New York visiting John, Jr., at West Point.

Dr. T. D. Crews has opened a new office in Gonzales. His son, Nickey, is enrolling at Trinity College in San Antonio.

Dr. R. L. Stratton reports that his younger daughter, Debbie, has just returned from Camp Arrowhead at Hunt, Texas, where she spent the summer, and his older daughter, Chris, is enrolling at Victoria College.

During the summer Miss Carmen Crews and Mr. Bo Price were married at Gonzales. The groom is a graduate of Texas University where he played football and the bride is a graduate of S.M.U. They recently went deep sea fishing with Dr. Willis and Mary Crews at Port Aransas and reported a good catch. They are now in New York City where Bo is preparing for the investment banking field.

Dr. J.V. Money and Ann of Schulenburg look very rested after a quiet three weeks vacation at lower Padre Island.

Dr. H. F. Elliott of Rockport was honored recently when he was awarded the Vigil Honor of the Order of the Arrow. This is the highest award of the organization of honor campers devoted to service to Scouting. His son, Denny, was elected Chief of the Copane Chapter, Karankawa Lodge. Denny, a high school senior, spent the summer working at the Aransas Hospital. Mrs. Willie Mae Elliott and Rose Ann vacationed in North Carolina and toured the Smokies.

Dr. John Fredericks of Schulenburg reports that the only item of news in his household is a new miniature shetland pony for daughter, Michele.

The next District meeting is scheduled Oct. 10 with Dr. R. L. Stratton in Cuero. Dr. John Burnett, State President, will be present for the meeting.

H. F. ELLIOT, D.O., *Reporter*

District No. Fourteen

Dr. and Mrs. E. L. Suderman of Pharr "saw America first" on their vacation going to the Dakotas, Montana, Washington, Oregon, Utah and Colorado.

Dr. and Mrs. Joe Suderman, also of Pharr, visited relatives in Oklahoma and friends in the Texas Panhandle. They also visited a medical school friend in Oaxaca, in South Mexico. A final week was spent moving into their new home.

The Rio Grande Valley is a good place to be from in the summer. But after the heat and humidity of the summer is over, this is a very comfortable place to stay. If some of you need to take a winter vacation, spend a week or month in the Rio Grande Valley. Pick your own grapefruit and oranges just six spaces from a small furnished house I have kept for you. Write me if you are interested.

JOE SUDERMAN, *Reporter*

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

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.

Dec. 3-4 — STATE DEPARTMENT OF HEALTH Post-Graduate Seminar, Dallas, Texas.

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.

Officers of the District Associations of the
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, INC.

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Dr. J. Paul Price, Jr., Dumas ..... President-Elect
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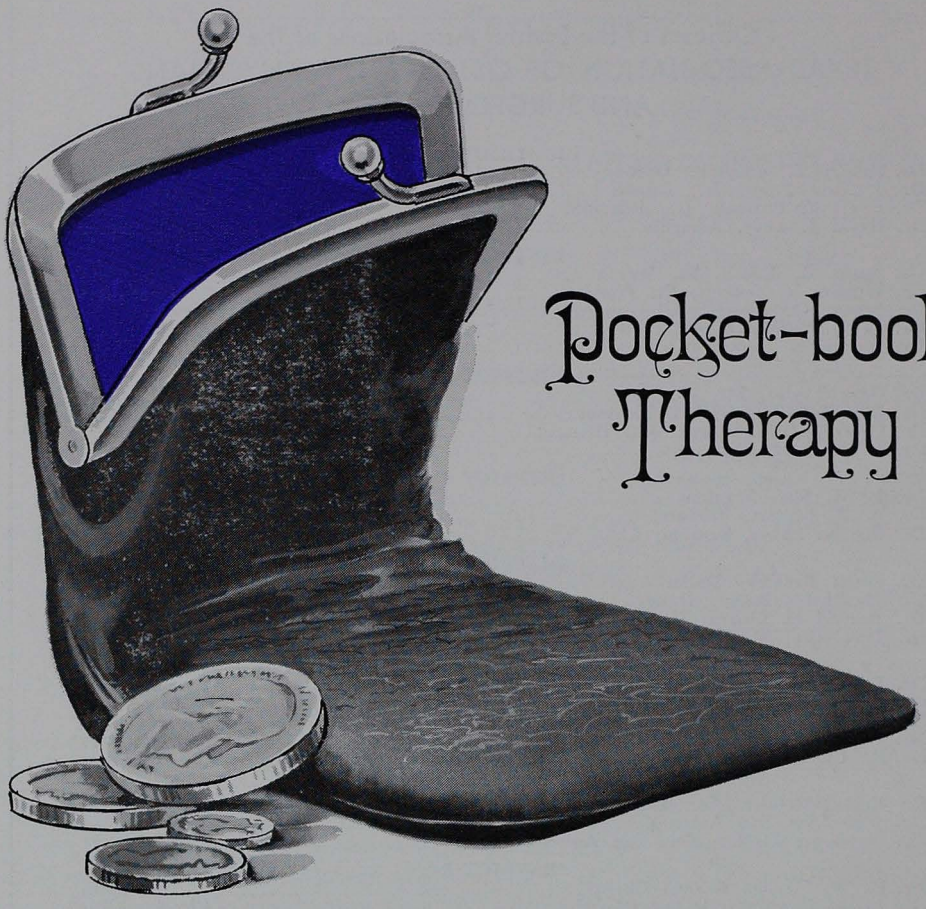

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