Texas
Osteopathic Physicians Journal

Volume XI FORT WORTH, TEXAS, DECEMBER, 1954 Number 8

Wishing You A Merry Christmas and Happy New Year

In This Issue—

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EDITORIAL PAGE

The President Speaks . . .

With the glittering symbols of this holiday season in evidence everywhere, it is ingenuous that we in our hearts capture the real true Christmas spirit of peace and good will to men by pausing in humble thankfulness for this professional year. Through your genuine love and most diligent help, strides have been made in this Osteopathic profession.

We are grateful for our completed central office, without indebtedness, and in full use by our office staff. We offer our thanksgiving for the high membership of our state organization, for the accomplishments of our district groups, and for the continued interest and progress of our hospital staffs. We thank God for your realization of the obligations to our profession, and we want you to know the real worth of your investment with us, and the service you give to humanity.

On behalf of the official family of the Texas Association of Osteopathic Physicians and Surgeons and its office staff, please know our sincere depth of our gratitude for your continued support and real friendship. May the real true Christmas Spirit of peace, good will to men be yours today, and every day until Christmas comes again.

ARCHIE L. GARRISON, D. O.
PRESIDENT

Texas Osteopathic Physicians' Journal

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VOLUME XI FORT WORTH, TEXAS, DECEMBER, 1954 NUMBER 8

A Review of the Literature Concerning Acute Cardiac Arrest During Anesthesia in Surgery

By GARRY W. TAYLOR, D. O.

This paper is a review of the recent literature concerning acute cardiac arrest taken from the recent journals and publications. At the present time, in papers and magazines, we read many articles concerning the heroic art of resuscitating and reviving patients with acute cardiac arrest by a surgeon or surgical team manipulating or massaging the heart. Many of us are prone to say that this is a heroic act for publicity and that the patient did not actually have an acute cardiac arrest. According to the review of recent literature in the busy surgery at the present day, there will be at least two cases of cardiac arrest per year, and of these, approximately 87% may be saved if the surgeon and surgical crew are informed and have the necessary skill to act quickly and skillfully.

When we speak of acute cardiac arrest, we do not mean the gradual falling of blood pressure or the gradual slowing of the heart, but we mean an acute sudden stopping of the heart diagnosed by the lack of pulsation in the heart and heart vessels and a lack of registerable blood pressure. If the large vessels are exposed, such as the Aorta, the Iliecs, the Axillary, or the Carotids, and true cardiac arrest is present, there will be no pulsation in these vessels. If thoractomy is being performed, neither will there be any visible or palpable movement of the heart. One diagnostic test that may verify visual and palpatory sense is the inserting of a needle into the heart musculature through the chest wall and observing any oscillation of the needle hub. If there is any oscillation of the hub, true cardiac arrest is not present. The inserting of this needle, in a case of true cardiac arrest, sometimes is sufficient stimulus to bring about normal cardiac physiology.

As we all know, the heart circulates or pumps the blood throughout the body. Fortunately the heart muscle itself is one of the strongest tissues in the body and is a tissue capable of functioning without oxygen, and without blood for a period of at least seventy-two hours. However, there are other vital tissues in the body that cannot stand more than brief periods of anoxia. These tissues are in the brain

centers, the medullary centers, and other vital organs. The longest that these tissues can go in a state of anoxia and return to their full physiological function is three and one-half minutes. There have been a few cases that have returned to physiological state after a period of from 5 to 8 minutes. However, some of these patients are unconscious for a considerable period of time and some never regain their full normal functions or physiological balance. This is one point that all articles dealing with the actual acute cardiac arrest stress, "That is, the rapidity of action that must occur if these patients are to live."

Acute cardiac arrest may occur under any type of anesthesia and during any type of surgery. Acute cardiac arrest could occur from simply swabbing the nose or throat of a patient with a diseased heart, without performing surgery or without an anesthetic.

There are two main etiological factors in cardiac arrest. Of these, there is a difference of opinion among authorities as to which is the most common. Some authorities claim ventricular fibrillation as a most frequent complication. This complication is due to several etiological factors including anoxia, mechanical trauma, electric shock and drugs which increase the irritability of the heart. Fibrillation apparently occurs most frequently during operations on the pericardium and heart. When ventricular fibrillation occurs, it is necessary to treat it promptly before acute cardiac arrest develops. The diagnosis of ventricular fibrillation should be made by the anesthetist by ascultation of the heart during surgery and by a gradual falling of the blood pressure. Other authorities state that the vagal reflex will cause 90% of acute cardiac arrest. Any time that you scratch, cut, or irritate an area of the body that is supplied by a vagus nerve, you may produce a vagal reflex which may produce acute cardiac arrest. The vagus nerve receptor points are distributed throughout the nose, pharynx, esophagus, mucous membrane of the gastrointestinal tract, trachea, bronchus, and pleura. When operating on these areas, cardiac arrest may occur with sudden and disastrous results.

The vagal reflex is an interesting reflex but a complicated one. The heart contains vagal fibers in the auricle which depresses the heart action. These vagal fibers are part of the autonomic nervous system. Also in the heart, starting in the aurrcle and passing toard the ventricle, is a specific tissue. There is no absolutely reliable anatomically distinguishing feature of this specific tissue, however, the tissue has a capacity to form stimuli independently and automatically. This automaticity is the outstanding feature of this specific tissue. The rhythm formation of this specific tissue decreases from the auricle down toward the ventricle. At the auricle the automaticity of the stimulation may be 80 or 90 stimulations per minute while at the ventricle, it may be as low as 10 stimulations per minute. If you will recall, I previously made the statement that the ventricles do not contain vagal fibers, but they are contained only in the auricle—but that these vagal fibers when stimulated could cause a depressing action. There are three separate pathways by which a reflex can travel to the heart from the receptor organs: these are, first, over the vagal network through the vagal center and from there by an afferent path to the heart; second, by an axon reflex in the vagal system, by passing from one branch to another without going centrally and, third, by radiation of vagal impulses in which the stimulus originates at vagal nerve endings and passes to a ganglion where it transfers to a branch of the sympathetic system and then to the heart.

Besides the actual anatomical pathways we must consider the type of stimulus applied. Some stimuli, though slight, may cause more depression than others, depending exactly upon the

trigger point affected. While working with the vagal innervated areas, we do not know where that trigger point may lie. One might ask: "If there are no vagal fibers in the ventricle, how can one get cardiac arrest from vagal stimulation?" (The point is that no healthy, normal heart can ever stop from vagal stimulation in the sense that serious symptoms will arise.) One will never see a carotid sinus syndrome in a healthy heart.

If the heart has been the site of disease in which the specific tissue in the ventricles had widespread areas of destruction and if, under these conditions, vagal stimulation depressed the stimulus formation in the auricles, the automaticity in the ventricles will have been abolished and a contraction does not occur, or occurs with insignificant rapidity to provide an adequate circulation.

Anesthetic agents have precisely the same action on the functional response of the specific tissue, and it behaves as though there were widespread areas of non-functioning tissue. In other words, a heart under anesthesia is as vulnerable to vagal stimulation as a heart with diffuse organic lesions would be without anesthesia.

There are several other factors which might be etiological agents in acute cardiac arrest. One is avitaminosis, especially of the B complex group. The B complex group is known to be important and many authors long ago described electrocardiagraphic changes in vitamin B deficiency, especially might this be true when the heart is to undergo the stresses and strains of an anesthetic. Endrocine imbalances no doubt play a large role and an important role in cardiac arrest. As we all know, menopausal women and men have various symptoms referred to the heart during the period of the climacteric. Therefore it only seems reasonable to correct endrocine imbalances as much as possible before prolonged surgical procedures.

The treatment for acute cardiac arrest may be divided into two phases—preventive and emergency. The preventive treatment for ventricular fibrillation is the intravenous injection of a weak procaine solution. During cardiac and chest surgery, some authorities recommend that a 1/10% solution of procaine-hydrochloride be given intravenously throughout the surgery. In preventing acute cardiac arrest occurring due to the vagal reflex—atropine, in an adequate dosage for the individual should be prescribed in the pre-anesthetic drugs. Atropine abolishes the vagal reflex. One dose of atropine usually reaches its maximum effect in 45 minutes and will probably keep the vagal reflex abolished for 90 minutes. During prolonged surgical procedures, atropine should be repeated.

Preventive treatment of the etiological factures of avitaminosis and endrocine imbalance is self explanatory.

The treatment for acute cardiac arrest is manual massage of the heart. Intravenous procaine and occasionally epinephrine combined with artificial respiration, having the patient breathe 100% oxygen, Trendelenberg position and replacement therapy of blood or fluids lost immediately prior to the cardiac arrest. According to Cole, in a study of 350 cases of cardiac arrest, 112 recovered, 238 died with a live rate of 32% and a mortality rate of 68%. However, in valid cases, in cases where cardiac massage was started within 5 minutes, out of a total of 47 cases—40 recovered, 7 died, with a recovery rate of 85.1% and a mortality rate of 14.9%. Statistics on cases with massage within from 3 to 3½ minutes after cardiac arrest should show a higher recovery rate.

As soon as cardiac arrest has been determined by the absence of pulse beats in the larger vessels and of registerable blood pressure, a predetermined plan of action should be instituted at once. A needle, not attached to a syringe, should be introduced into the heart. Any oscillation of the needle

will show the heart to be beating and in rare instances, insertion of the needle will provide the stimulus to start the cardiac action again. Artificial respiration with 100% oxygen kept on continuously, using an anesthetic machine or an oxygen tank with a tightly closed mask. An intratrachaal tube — when available, should be applied. The general opinion is that drugs are of little, if any, benefit in resuscitating the heart; however, in the ventricular fibrillations, 5 or 10 cc's of 1% procaine solution injected intravenously will generally decrease the fibrillation and reinstate normal heart action. In the vago-vagal reflex type, this will of course not do the desired work. Most authorities agree that ½ cc of 1 to 1,000 epinephrine solution injected either into the heart or into the venous system preferably in the antecubital vein, will help in stimulating heart action. The Lahey Clinic recommends that all surgeries have ready for instant use the solution made of 9½ cc of 1% procaine solution, and ½cc of 1 to 1,000 epinephrine, making a total of 10 cc all together. According to Frank Lahey's writings, in their surgeries, this solution is kept by the anesthetist, available for immediate use at all times. When acute cardiac arrest develops, half of this solution is injected immediately while cardiac massage is being started. In many cases of prolonged surgery and chest surgery especially, an intravenous solution of 1/10 to ½% procaine is sometimes given as an intravenous infusion during the entire surgery.

I must repeat that cardiac massage is a life-saving device at this time. Cardiac massage during a thoractomy or through the chest is a much easier and a much more effective procedure than through the abdominal route. The massage or squeezing of the heart should be done at the rate of 40 to 60 contractions a minute. Every few minutes, one should stop to see if the heart will pick up by itself. Cardiac massage has been carried on for long periods and the patient began to respond and lived with a successful outcome. If cardiac arrest develops during an abdominal operation, the heart may be compressed between the hand and the anterior chest wall. Most authorities agree that this is the least effective way and that if the heart does not begin to beat instantly, a rent should be made in the diaphragm and the fist shoved through, grasping the heart and massaging. Lahey recommends that the left diaphragm be incised large enough to admit only the thumb and that the heart be massaged between the thumb and the rest of the hand on the abdominal side of the diaphragm. If cardiac arrest occurs before the surgery has commenced, the surgeon should be prepared to open the chest with the greatest of dispatch. He needs no tools other than gloves and a scalpel. Given these, he should have his hand on the heart in 10 to 15 seconds, according to T. C. Bost. Antiseptics and sterile drapes are refine-

ments to be utilized when available but their lack should be made little difference and not be allowed to cost the life of a patient. The incision should be made in the left fourth interspace from about the edge of the sternum to the posterior axillary line. In this area the bleeding is negligible and the incision can be quickly carried through the chest wall and pleura. The surgeon can readily put one hand between the 4th and 5th ribs, grasp the heart and start compressing it rhythmically. One must remember that while the surgeon is massaging the heart, Trendelenberg position should be administered, artificial respiration with 100% oxygen should be given, and intravenous procaine with epinephrine should be given, but most authorities agree with ½cc of epinephrine is the maximum dosage that should be given and Lahey recommends that no other stimulants of any type should be administered. Fluids and replacement therapy, including whole blood, should also be administered. The use of electrical equipment to stimulate the heart into responding is recommended by many authorities and should be tried if available. However, many small hospitals do not have this type of equipment available.

In conclusion, I wish to state that acute cardiac arrest may occur under any type of anesthesia and under practically any type of surgical condition whether it be major or very minor. The saving of lives in times of acute cardiac arrest depends upon the skill and the ability of not only the surgeon, but the entire surgical team.

After the diagnosis of acute cardiac arrest is made, 3½ minutes is the maximum time that should be allowed to elapse before cardiac massage is instituted. While procaine and epinephrine may be effective in some cases and helpful in all cases, most authorities agree that the life-saving device is cardiac massage, which is best done through the chest. Second choice would be through the abdominal approach with a rent in the diaphragm and, third, through the abdomen, massaging the heart between the hand and chest wall. This massage should be carried out at a rate of from 40 to 60 per minute and the contraction of the hand should be slow with a rapid release of all force. Artificial respiration with 100% oxygen should be administered. Cardiac arrest is rare, but with prompt and skillful action, you may save a life.

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Physicians Start Drive On Surgical Fee-Splitting

CHICAGO (AOA)—Physicians at Michael Reese hospital voted voluntarily to disclose their financial records in a drive against fee-spitting with surgeons, it was announced here recently.

Apology

Please accept the apology of this office for errors in the Annual Directory where, under Board of Trustees, H. H. Edwards, D. O. is listed as H. H. Peters, and B. M. Klase, D. O. is shown both as a member and nonmember. Dr. Klase is a member of this association.

Quarterly Meeting

Texas Osteopathic Radiological Society

(All Texas D. O.'s and their Technicians Invited)

Sunday, January 16, 1955

St. Anthony Hotel, San Antonio, Texas

PROGRAM

Symposium: X-Ray Diagnosis and Technic In the Small Clinic-Hospital

9:00 a.m.—Registration

CASCADE ROOM

9:30 a.m.—Radiological Equipment for the Small Hospital
Dr. Chas. D. Ogilvie, Dallas, Texas

10:00 a.m.—Genitourinary X-Rays in Small Hospital Practice
Dr. Gordon Beckwith, San Antonio, Texas

10:45 a.m.—Gastrointestinal Procedure in the Small Hospital
Dr. Ellis Miller, Talco, Texas

11:30 a.m.—Special Problems in X-Ray Technique
Dr. Malcolm E. Snell, Dallas, Texas

12:00 Noon—Dinner for Registrants, Technicians and other Guests

PEREAUX ROOM

1:30 p.m.—Business Meeting of T.O.R.S. — *Cascade Room*

2:00 p.m.—Do's and Don'ts in Processing Technique
Mr. J. E. Heath, San Antonio, Texas

2:30 p.m.—Round Table Discussion on Radiographic Technique
Dr. Chas. L. Curry, Moderator, Fort Worth, Texas

* * *

Physicians Registration Fee (Luncheon included)—$10.00
Luncheon Fee for Technicians, Wives and other Guests—$3.00
Room reservations—Mrs. Madsen of St. Anthony Hotel

SATURDAY NIGHT DINNER PARTY

All physicians and their guests are invited to a Saturday night dinner party at the Anacacho Room. Reservations should be made with Dr. I. T. Stowell, 120 West Ashby Place, San Antonio, Texas.

DR. JOE LOVE,
General Program Chairman

Doctors Stand Duty As Nurses Hold Annual Staff Dinner

Staff physicians of the Porter Clinic Hospital served as hall nurses at the hospital Wednesday night while the regular nursing staff enjoyed its annual dinner.

The event, at which J. N. Porter, hospital administrator, was toastmaster, was held at the Aztec Inn. About 20 nurses were present.

Child Health Clinic

Fort Worth, Texas

Texas Hotel, March 25-26, 1955

Dr. Myron D. Jones of Kansas City has accepted the invitation to serve as Pediatric Consultant for the Third Annual Child Health Clinic. Dr. Jones is certified by the American Board of Pediatrics and is a full-time member of the Department of Pediatrics of the Kansas City College of Osteopathy and Surgery. Dr. Jones has been very active in the Kansas City Child Health Clinic for a good number of years. His experience along these lines will be a decided asset to the clinic at this period of growth. We feel very fortunate to announce Dr. Jones' association with our next clinic.

Specialists are being procured at this time to serve in the various fields of specialty practice. It is the intent of the clinic to be able to offer consultants in all fields. Stress is to be made on problem cases and physicians over the state will be invited to bring cases to the clinic. Please read your JOURNAL for further announcements concerning the clinic in subsequent issues.

Public Votes Funds for Osteopathic Hospital

CHICAGO (AOA)—For the first time in the history of osteopathy, the public has voted funds for an osteopathic county hospital.

In the November 2nd general elections, the voters of Los Angeles County overwhelmingly approved a $9,220,000 bond issue to finance a new Los Angeles County General Osteopathic Hospital.

Latest unofficial tabulation, covering all of 9016 precincts, was 884,663 for the measure and 357,928 against. Some 20,000 absentee ballots had not been counted at presstime but would make no difference since the measure received 57,269 votes more than the two-thirds required for passage.

The victory at the polls is a tribute to the service rendered in the past by osteopathic physicians using the facilities of the Osteopathic Unit of the Los Angeles County Hospital. The Unit, an integral part of the Los Angeles County Hospital, has been functioning in buildings granted them by the Los Angeles County Board of Supervisors, who established the Unit in 1928, making complete osteopathic care available to county patients.

Patients are admitted to the Osteopathic Unit on the basis of their expressed preference. Popularity of the Unit has meant a tremendous expansion, which has, over the course of the years, left present buildings bursting at the seams.

Leaders of the profession point out that the high concentration of osteopathic physicians in the Los Angeles area has won approval, not only from patients whom they have served, but from the public as a whole. The measure received 72% of the total vote cast. This decision by the voters should stimulate similar activity elsewhere.

Osteopathic Physicians Ask 'Open Staff' At Proposed County Hospital

From the DALLAS TIMES HERALD, November 25, 1954

MINEOLA, Nov. 25.—The Wood County Osteopathic Doctors Association has opened a drive for an "open staff" in the proposed $500,000 Wood County Hospital.

Ardent backers of the hospital plan said the osteopath's movement has gained support as county commissioners have indicated they are not opposed to an open staff for the new hospital.

It was explained by the osteopathic group that an open staff means a hospital in which both osteopaths and doctors of medicine are admitted to practice.

The osteopathic group had asked the county commissioners court to submit the question of an open staff to the voters along with the vote on the hospital proposal Dec. 11.

One member of the osteopathic group said they had been advised that this question will not be submitted in the vote.

"Our next step will be to ask the county attorney to ask the attorney general of Texas for a ruling as to whether or not this question should be submitted to the people," a spokesman for the osteopaths said.

"We believe that the attorney general will favor our cause and we certainly hope for the sake of fairness that the people are given an opportunity to decide this matter. It is their tax money that will be spent for the hospital and we certainly hope the commissioner's court will let the voice of the people be heard."

Recently all of the osteopaths in the county called on commissioner's court to give their views on the hospital and its operations.

At that time, at least two members of the four-man court indicated they would certainly not be opposed to the "open staff policy."

The new hospital, to be named the Wood County Memorial Hospital, will be constructed only if the people vote a 15-cent increase in the county road and bridge fund on Dec. 11 and also approve a measure instructing the commissioner's court to build it.

EDITOR'S NOTE:

In this particular county there are an equal number of osteopathic physicians and MDs.

It is the editor's understanding that the osteopathic physicians serve a larger percentage of the population than do the MDs.

It would indeed be an injustice to the taxpayers of Wood County to build a hospital for the minority of the population of the countty.

To Policy Holders of the Sid Murray Agency

The Washington National Insurance Company of Evanston, Illinois, has been sending you letters informing you that Sid Murray and his representatives are no longer associated with the Washington National, and advising you not to pay your premiums to the Sid Murray Agency.

Both statements are correct. But, in these letters the Washington National fails to tell you that our entire agency force resigned in August of this year from the Washington National, nor do they tell you why we resigned.

Prior to our resignation from the Washington National, I had discussed with my agents on many occasions the length of time it took Washington National to issue a policy, and the handling of their claims. I have had considerable correspondence and discussion on these same subjects with the officials of the Washington National in the past, but they could not or did not give us the service that we felt our policyholders were entitled to. We have *not* resigned from the Metropolitan Casualty.

I have been General Agent for the Metropolitan Casualty Insurance Company of New York for sixteen years. I am still their General Agent for the State of Texas, and all of my agents are still working for the Metropolitan Casualty.

Our agents and our policyholders are satisfied with the prompt manner in which the Metropolitan Casualty issues its policies, and the authority and freedom we have to pay our claims promptly and fairly without unnecessary correspondence.

All premiums on the Metropolitan Casualty policies should continue to be paid direct to this office, and all losses will be paid promptly direct from this office. We still have facilities where we can write up to $833.00 per month for loss of time from sickness or accident, as well as hospital and surgical benefits for the members of these professional groups and their dependents.

If you desire to keep your Washington National policy, then you should pay the premium to whomever and wherever the Company directs you. However, we feel that we have an obligation to you and, if at any time you have a claim, or desire any other service in connection with your policy, and do not get prompt service from the Washington National, please write or call us immediately, and we will assist you in whatever way we can.

I had hoped it would not be necessary to write this letter, as we have many agents all over the State of Texas to give our policyholders local service, but since Washington National has sent so many letters from their Home Office, they have many of our policyholders confused. Therefore, we felt this letter was needed to clear up any confusion. If you have not already been contacted by our local agent, you will be in the near future. He will answer any of your questions and give you a written comparison of the benefits provided in the Metropolitan Casualty policy with any other sickness and accident policy.

Sincerely yours,
SID MURRAY
"Pays in a Hurry"

KCOS Clinical Review Course

Plans are shaping up for the annual Clinical Review Course at the Kirksville College of Osteopathy and Surgery June 12, 13 and 14, 1955, Dean M. D. Warner has announced. The course will follow the pattern of the symposium-type employed during the past two years and which was so highly praised by the physicians in attendance because it permits a more complete discussion of a problem and affords opportunity for audience participation. A more complete announcement will appear in the JOURNAL OF OSTEOPARHY for January, 1955, Dean Warner said.

1954-55 Directory

Your new Directory is now in your hands. We call your attention to the tremendous amount of information available in this publication. This office continually receives letters from members regarding information that is available in this Directory.

We sincerely hope that the membership will give it careful study, and maintain it, and use it for reference.

To prepare this Directory is tedious, difficult, and time consuming. There are, we feel sure, some mistakes, for which we apologize before they are discovered.

Since its publication there have been some changes in address, and the following members have paid their dues and are now members, and should be so indicated, and stricken from the nonmember list:

IRENE BORROW, D. O.

WILLIAM R. BALLARD, JR., D. O.

The membership now totals 510, and the nonmembers total 150, of which there are 60 who this office feels are eligible for membership in this Association, and we feel the district should make a concerted effort to get these men into the organization.

Good Public Relations

From the WALL STREET JOURNAL, Friday, October 29, 1954.

Some In the Black

Editor, The Wall Street Journal:

Your recent story on "Hospital Costs" Sept. 23, and the letter from Harrison G. Taylor of Worcester, Mass., regarding hospitals and doctors was most interesting.

Mr. Taylor raised the question as to why doctors and surgeons, upon graduation from their medical schools and internship, can then utilize the facilities of a large and increasingly expensive hospital and its equipment without making any contribution to the institution.

I would like to point out that there is a group of hospitals in America which generally do not operate on that basis. These are osteopathic hospitals. Oftentimes they are established solely by osteopathic physicians and surgeons. In many cases they are owned outright by those doctors. In many other places osteopathic hospitals are non-profit corporations, but usually the doctors and surgeons pay a monthly service charge

to these hospitals also. This, to a great extent, helps reduce any deficit in the annual operation of the average osteopathic hospital and makes the staff physician a contributor towards its continuance and advancement.

Of the approximately 400 osteopathic hospitals scattered across America from Bangor, Me., to San Diego, Calif., and from Seattle, Wash., to Miami, Fla., most are able to operate in the black. Generally this is due to two things: one, good economical management consistent with the best patient care; and two, contributions of payment of service charges by the osteopathic physicians.

Because that is generally an unheard-of procedure in the average allopathic hospital and because Mr. Taylor raised the question, I wanted to present these facts for your public.

R. P. CHAPMAN

Davenport, Iowa

New Osteopathic Clinic At Honey Grove

From THE DENISON HERALD, Friday, November 12, 1954.

Honey Grove Gets Osteopath Clinic

HONEY GROVE—Dr. David D. Matthews of Throckmorton, currently a member of the staff at the *Denison General Hospital,* will open an osteopathic clinic here Dec. 1.

The clinic will be located on the east side of the plaza just south of Baker's Pharmacy in a building remodeled by Dan Baker. The building formerly housed a theatre.

Dr. Matthews has purchased a lot on West Main Street from Ray Deyhle and has let a contract to Turner and LaRoe to build a new home here for himself and family.

The renovation of the building for the clinic is expected to be completed shortly and Dr. Mathews will start equipping the clinic in the near future.

Appointed Assistant To KCOS President

The appointment of Miss Gwendolyn Selsor of Kirksville as assistant to the president of the Kirksville College of Osteopathy and Surgery was announced recently by President Morris Thompson.

Miss Selsor was graduated from the Kirksville Senior High School, attended Northeast Missouri State Teachers College and was graduated from Maher's Business College of Kalamazoo, Mich. For six years she was employed as Secretary to the District Traffic Superintendent of the Michigan Bell Telephone Company in Kalamazoo, resigning that position to return to Kirksville as secretary to the business manager of Northeast Missouri State Teachers College. Since November 1, 1948 she has been employed as secretary to the president of the KCOS and assistant secretary to the Board of Trustees since October 1952.

"Symptoms of Our Time" Radio Series Completed

"Symptoms of Our Time," a new 26-week radio series, has been completed.

Written and directed by Richard C. Thorne, assistant to the director of the Division of Public and Professional Welfare, this fresh and entirely different series, uniquely presented, is a combination of capable acting, and interesting subject material.

The 15-minute dramatic programs, nine months in the making, are of professional quality replete with sound effects and imaginative background music, all of which contribute greatly to the series' high degree of public service appeal.

Attesting to the popularity of these programs is the fact 13 states—Minnesota, Iowa, Illinois, Michigan, Missouri, Indiana, Texas, Georgia, Maine, Pennsylvania, Ohio, Idaho and Arizona—were airing these tapes before the series was completed.

Should you consider our opinions biased as to the quality of these shows, here are a few representative comments:

Earl F. Hoerner, M. D., director of the Division of Alcoholic Studies and Rehabilitation, Department of Health, State of Pennsylvania, said:

"This is one of the finest public service programs I have ever heard. Its message is both interesting and informative."

The tape Dr. Hoerner heard was titled "Alcoholism" and was aired during the recent convention of the Pennsylvania Osteopathic Association.

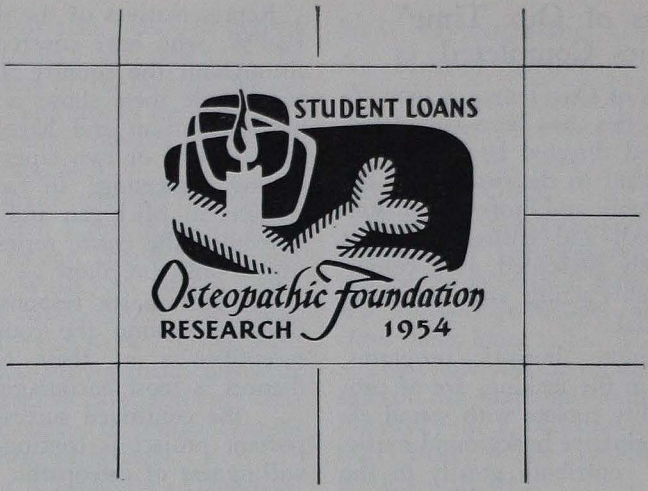
George Jennings, Director of Radio and Television, Chicago Board of Education, commented:

"One of the most sincere and well-done public service programs to which I have had the opportunity of listening. I sincerely hope that the rest of the series matches the one I heard, in quality, production, writing and over all excellence."

Representatives of the department of P&PW, who have covered conventions throughout the country this past year, have made these shows a part of their armamentarium and have never failed to have one or two tapes programmed during a meeting. In fact . . . radio stations in Michigan and Pennsylvania scheduled the entire series after listening to only one show.

The enthusiastic response of program directors around the country and the receptiveness of their respective audiences is most encouraging. However . . . the continued success of this important project is contingent upon the willingness of osteopathic physicians to contact their local radio stations.

As you have no doubt gathered by now, we here at Central Office think highly of this series. And we know you will too, IF you hear one of these shows.



SEAL APPEAL—From seal to thank-you card, the materials of the 1954 campaign are related.

The seal, in blue-green and scarlet on a white ground, sets the pattern. The poster—an elegant piece for any desk or book-shelf—is an enlarged seal. "This Is the Story," the four-page folder which goes wherever the seal goes, brings the seal to life in a series of line drawings. The thank-you cards, picking up the color and motif of the seal, sign off on a job well done.

IF YOU PLEASE!—Give attention, please, to the order form included with your Christmas seals. Use it to order seals supplies *now,* so that you, or your wife, or your secretary, can have them ready to mail to patients and friends.

1954 Founder's Day at KCOS Termed Successful

The 1954 observance of Founder's Day at the Kirksville College of Osteopathy and Surgery October 19 and 20 was one of the most successful ever held at the Home of Osteopathy.

A unique feature of this year's observance was the honoring of three members of the faculty for more than 30 years of service to the institution. Dr. A. C. Hardy, chief of staff, Dr. Grover C. Stukey, chairman of the division of pathological sciences, and Dr. Seth C. Thomas, lecturer in oral sepsis, were honored at the banquet on the evening of the 19, and Dr. Hardy and Dr. Stukey addressed the convocation the following morning on advances in osteopathic education and the osteopathic profession. Dr. Morris Thompson, president of the college, presented his annual report on the affairs of the college at the convocation.

Dr. W. F. Englehart of St. Louis, who was graduated from the college in 1903, was presented the Certificate of Merit at the banquet for outstanding service to the college and to the osteopathic profession. Representatives of the classes of 50, 25 and 10 years ago were in attendance and introduced at the banquet.

Other events on the two-day program included visits to the birthplace and grave of Andrew Taylor Still, the dedication of the bust of the late Dr. George W. Riley, widely-known alumnus, a picnic and an All-College dance.

Artificial Insemination

By WILLIAM HARRIS BELL
Legal Consultant to the Texas State Department of Health

The first one to employ artificial insemination in humans was John Hunter, 1728-1793. The case was reported by Hume in 1799. J. Marion Sims, in 1866, recorded the first such case in this country.

In 1877, by a Papal Encyclical, artificial insemination was condemned as immoral and prohibited. A recent pronouncement by the Pope holds that such insemination of women is entirely illicit and immoral and to be condemned except when practiced in wedlock in the single instance where it serves as an auxiliary to the natural act of union of the spouses and to further fecundation. In Protestant countries it is maintained that, irrespective of religious views, the doctor must ask himself only whether it is medically correct. If the answer is yes, then it is his duty to perform the procedure. (Koerner, Alfred, "Medicolegal Considerations in Artificial Insemination," La. L. Rev., 8:484-503 (1948) .)

In 1921 there appeared the first reported case in the Western Hemisphere involving artificial insemination. The wife sued for alimony; her husband counterclaimed adultery. She alleged that she was inseminated heterologously in England, because of dysparunea, while he was in Canada. The court found, however, that she had committed adultery in the normal manner of sexual intercourse; hence, any pronouncements made on the heterologous aspects of the impregnation were mere dicta. (Orford V. Orford, 49 Ont. L. Rep. 15 (1921); "Medicolegal Aspects of Artificial Insemination," J.A.M.A., 147: 250, Sept. 15, 1951.)

The trend today is more liberal. In a recent case, the wife asked the court to determine her husband's right to visit the minor child of the two parties. It was conceded that she was artificially inseminated, with his consent, and that the child was not of his blood. The court held that the child had been potentially adopted or semi-adopted by the husband and that he was entitled to the same rights of visitation as those acquired by a foster parent who has formally adopted the child, if not to the same rights a natural father would be entitled under the same circumstances. Further, that the situation was no different from that involving a child born out of wedlock who is made legitimate by the marriage of the interested parties. Accordingly, he was granted the right to visit the child at specified times. (Strnad v. Strnad, 78 N.Y.S. 2d 390.)

A child created by heterologous insemination, who has not been adopted, may not be permitted to inherit from the husband of its mother; nor will the husband be liable for its support. Conversely, the child, if possessed of means, may not be compelled to support the destitute husband of its mother.

Legislation is needed to define the rights of inheritance and legal status of such children. *Thus far, such bills introduced in state legislatures have failed of passage.*

In some localities there are special laws governing the practice of human artificial insemination. The Board of Health of the City of New York by the Sanitary Code of that city controls human artificial insemination: "No person other than a physician duly licensed to practice medicine in the State of New York shall collect, offers for sale, sell or give away human seminal fluid for the purpose of causing artificial insemination in a human being . . ."

In addition: (1) Donors "shall have a complete physical examination with particular attention to the genitalis at the time of the taking of such seminal fluid." (2) A donor "shall have a standard serological test for syphilis and a smear and culture for gonorrhea not less than one week before such seminal fluid is obtained." (3) "No person suffering from any veneral diseases, tuberculosis or infection with brucella organisms, shall be used as a donor of seminal fluid . . ." (4) "No person having any disease or defect known to be transmissible by the genes shall be used as a donor of seminal fluid . . ." (5) "Before human artificial insemination is undertaken, both "the proposed donor and the proposed recipient shall have their blood tested with respect to the Rh factor. . ."

The regulation adds that if the female recipient is negative for the Rh factor "no semen shall be used for artificial insemination other than from a donor of seminal fluid whose blood is also negative for this factor." (6) It is mandatory for the physician performing human artificial insemination to keep records that will show the name of the physician, the name and address of the donor, the name and address of the recipient, the results of the physical and serological examinations and the date of the artificial insemination. These records are confidential and not open to inspection by the public or any person other than the Commissioner of Health, an authorized representative of the Department of Health, and such persons as may be authorized by law to inspect such records. (Sec. 112, Sanitary Code of the City of New York (effective July 1, 1947).)

Other citation that might be of value on this subject are:

Greenhill, J. P., "Artificial Insemination, Its Medicolegal Implications,"

Symposium on Medicolegal Problems, p. 43, J. B. Lippincott Co., Phila. 1943.

Cason, W. J., "Custody of Children in Artificial Insemination Cases,"

Mo. L. Rev., 15:153 (1950*/

There is no State law in Texas covering artificial insemination.

KCOS Awarded $2,500 Grant

A grant for $2,500 from the Foundation for Research of the New York Academy of Osteopathy has been awarded to the Kirksville College of Osteopathy and Surgery, according to an announcement recently by President Morris Thompson.

The grant will support a study of the present plant facilities of the College toward determining methods of providing additional space for research. The study will be directed by President Thompson and will be conducted by specialists in plant use and design.

Notification of approval of the grant was received from Dr. W. Kenneth Riland of New York, president of the foundation, after unanimous action by the directors.

Osteopathic Physicians of Texas in Attendance at American College of Osteopathic Surgeons

Baker Hotel, Dallas, Texas — October 31 - November 4, 1954

Dr. Merlin F. Achor, Hereford, Texas
Dr. J. L. Adams, Houston, Texas
Dr. J. W. Axtell, Lubbock, Texas
Dr. T. M. Bailey, Corpus Christi, Texas
Dr. L. G. Ballard, Fort Worth, Texas
Dr. E. G. Beckstrom, Dallas, Texas
Dr. Harriett Beckstrom, Dallas, Texas
Dr. Gordon S. Beckwith, San Antonio, Tex.
Dr. W. D. Blackwood, Comanche, Texas
Dr. Richard O. Brennan, Houston, Texas
Dr. R. W. Briscoe, Fort Worth, Texas
Dr. J. Francis Brown, Amarillo, Texas
Dr. Lionel Burton, Dallas, Texas
Dr. E. W. Cain, Amarillo, Texas
Dr. James T. Calabria, Dallas, Texas
Dr. S. J. Candas, Dallas, Texas
Mr. Hal H. Coker, Houston, Texas
Dr. James W. Coldsnow, Pittsburg, Texas
Dr. W. L. Crews, Gonzales, Texas
Dr. Palmore Currey, Mount Pleasant, Tex.
Dr. Charles L. Curry, Fort Worth, Texas
Dr. E. S. Davidson, Lubbock, Texas
Dr. Robert C. Dean, Dallas, Texas
Dr. A. M. Duphorne, Athens, Texas
Dr. William V. Durden, Houston, Texas
Dr. J. B. Durkee, Dallas, Texas
Dr. Hal H. Edwards, San Antonio, Texas
Dr. Roy B. Fisher, Fort Worth, Texas
Dr. Milton V. Gafney, Dallas, Texas
Mr. J. Gallion, Dallas, Texas
Dr. Helen K. Gams, Houston, Texas
Dr. W. E. Gorrell, Kerrville, Texas
Dr. W. S. Gribble, Jr., Houston, Texas
Dr. H. M. Grice, Houston, Texas
Dr. Merle Griffin, Corpus Christi, Texas
Dr. Charles M. Hawes, Dallas, Texas
Dr. John G. Henery, Corpus Christi
Dr. John G. Henery, Corpus hCristi, Tex.
Mr. Tom Hilton, Denison, Texas
Dr. T. H. Hoard, Denison, Texas
Dr. Mickie G. Holcomb, El Paso, Texas
Mr. R. Lee Hopkins, Jr., Dallas, Texas
Dr. W. L. Huetson, Denison, Texas
Dr. V. L. Jennings, Fort Worth, Texas
Dr. B. W. Jones, Mineola, Texas
Dr. A. L. Karbach, Arlington, Texas
Dr. Robert I. Kerwood, Fort Worth, Texas
Dr. Burr Lacey, Quitman, Texas
Dr. L. R. Lind, Houston, Texas
Mr. E. W. Lock, Tyler, Texas
Dr. Roman J. Madzier, Dallas, Texas
Dr. Earle H. Mann, Amarillo, Texas
Dr. E. L. Miller, Talco, Texas
Dr. George E. Miller, Dallas, Texas
Dr. H. K. McDowell, Dallas, Texas
Dr. T. J. McNaughton, Houston, Texas
Dr. Charles D. Ogilvie, Dallas, Texas
Dr. Edwin L. Parker, Dallas, Texas
Dr. G. F. Pease Fort Worth, Texas
Dr. R. H. Peterson, Wichita Falls, Texas
Dr. Kenneth E. Ross, Tyler, Texas
Dr. P. R. Russell, Fort Worth, Texas
Dr. Walters R. Russell, Dallas, Texas
Dr. Glenn R. Scott, Amarillo, Texas
Mrs. Jane Siniard, Fort Worth, Texas
Dr. Malcolm Snell, Dallas, Texas
Dr. Carl J. Sohns, Cross Plains, Texas
Dr. Sam F. Sparks, Dallas, Texas
Dr. Henry A. Spivey, Dallas, Texas
Mr. G. D. Stephens, Amarillo, Texas
Dr. Paul A. Stern, Dallas, Texas
Dr. Harriette M. Stewart, Dallas, Texas
Dr. J. Natcher Stewart, Dallas, Texas
Dr. Garry W. Taylor, Mt. Pleasant, Texas
Dr. J. E. Vinn, Houston, Texas
Dr. R. L. Vinson, Fort Worth, Texas
Dr. W. A. Weathers, Fort Worth, Texas
Dr. H. M. Webb, Houston, Texas
Dr. W. E. Winslow, Dallas, Texas
Dr. John L. Witt, Groom, Texas
Dr. Victor Zima, Houston, Texas
Miss Ella Zuercher, San Antonio, Texas

Awarded Postdoctorate Research Fellowship

Dr. John A. Chace, associate in research at the Kirksville College of Osteopathy and Surgery, has been awarded a postdoctorate research fellowship by the National Institutes of Health of the United States Public Health Service, President Morris Thompson has announced. This is the first time that such an award has been made to an osteopathic physician.

Dr. Chace will work in the Department of Osteopathic Technic and in the Bio-mechanics Laboratory of the College under the sponsorship of Dr. J. S. Denslow, director of research affairs. His work during the period of the fellowship will be in the field of reflex and postural muscle contraction in relation to various functional disturbances and diseases.

Dr. Chace was graduated from the KCOS in 1941 and recently completed five years of service as an intern and resident at the Massachusetts Osteopathic Hospital in Boston. It was as a result of this work at the Massachusetts Osteopathic Hospital and the studies he has carried on with Dr. Denslow since coming to Kirksville in November of 1953 that Dr. Chace was awarded the fellowship.

American Dental Association Rejects Bid for Social Security

MIAMI—The House of Delegates of the American Dental Association, during its recent convention here, voted 235 to 152 against a proposal to ask Congress to include dentists in the old age and survivors program of the Social Security Act.

The House also voted, 180 to 153, against inclusion of dentists on a voluntary basis.

Kirksville Awarded Cardiovascular Training Grant

A federal grant of $25,000 has been awarded the Kirksville College of Osteopathy and Surgery for extension of training in the area of cardiovascular diseases. The college has received notification of the award from Dr. James Watt, director of the National Heart Institute. The grant extends from November 1, 1954 to October 31, 1955. This marks the third such grant to be awarded the college.

Christmas Seal Campaign Far Ahead of Last Year

CHICAGO (AOA)—Acceleration is the word for the Christmas Seal Campaign as it steadily gains momentum in its quest to break the $50,000 mark this year.

Personal contributions from the profession and the Auxiliary are up 24 per cent over last year at this time; packet orders (materials for public distribution) to date exceed by almost 10 per cent last year's TOTAL number of orders and Oklahoma, the Sooner state, lived up to its name by breaking all state convention records with 47 packet orders.

Through the offices of secretaries and presidents, 36 divisional societies now have Christmas seal chairmen and seven also have district and local chairmen.

Even more encouraging are the many letters like the one following:

"I want to share this experience. One day last week, on the back of a letter from a patient, I noticed a Sister Kenny seal. I wrote this patient and enclosed a sheet of our seals. Yesterday when she and her husband came in for their weekly visit they very happily presented me with $50.00.

This was my first attempt. I have broken the ice."

And so it goes on the road to FIFTY THOUSAND OR MORE IN FIFTY-FOUR!

Washington News Letter

Selective Service — Important

To: Administrators of Hospitals AOA-Approved for Training of Interns or Residents.

Some hospital administrators have failed or neglected to give timely assistance to the Selective Service local boards of their interns and residents.

This letter is a reminder that—a registrant is 1-A unless he or his employer, or both, shall establish his civilian essentiality, or other deferrability.

Enclosed are copies of my November 19, 1954, re-issue of Washington News Letter of February 16, 1953, regarding Selective Service procedures for occupational deferment of interns and residents. Please keep this material in your active file.

Selective Service grants occupational deferment for one year of internship, *provided* the subject registrant and the AOA-approved intern training hospital have followed the requisite Selective Service procedures and the registrant continues full-time satisfactory service as intern.

Selective Service does not look with favor upon occupational deferment of residents. Residency is not a requirement for licensure. Therefore, occupational deferment for residency can only be based on the need for and irreplaceability of registrant by the hospital. That is why it is so important that the hospital certify to the local board, as indicated in the enclosed copy of Residents and Selective Service, the "nature and

extent of hospital's dependence on registrant; his irreplaceability; number of hospital beds, number of obstetrical, medical and surgical cases, etc., handled during the past year by the hospital, thus indicating scope of necessary service to community."

Do not hesitate to write me for additional information or advice.

C. D. SWOPE, D. O., *Chairman*

* * *

Internes and Selective Service

1. Promptly notify Dr. Chester D. Swope, Farragut Medical Building, Washington 6, D. C., when an interne receives 1-A, and keep him currently informed of the developments,

2. *Hospital should expressly request deferment.* When an interne enters on his duties, the hospital should promptly inform his local board that interneship in the AOA approved training hospital has begun, and expressly request deferment in class 2-A for the duration of the interneship. By so doing, the hospital establishes its right to take an appeal if the interne is placed in 1-A.

3. *Appeal.* If an interne is placed in 1-A, the registrant, a dependent of the registrant, or any person (including the hospital) who prior to the classification appealed from filed a written request for the current occupational deferment of the registrant, may take an appeal to the *appeal board* within the allotted 10 days. The local board can extend the 10 day period if convinced that the delay was due to lack of understanding or some other cause beyond the control of the person appealing.

If registrant's local board is located in an appeal board area different from the hospital, the request for appeal should also request *transfer of the appeal* to the appeal board serving the area of the hospital.

If the appeal board, by a *divided vote,* confirms the interne in 1-A, then within 10 days from the mailing of notice of that action, the registrant, any person who claims to be a dependent of the registrant, or any person (including the hospital) who prior to the classification appealed from filed a written request for the current occupational deferment of the registrant, may appeal to the President. The local board can extend the 10 day period for cause.

If the appeal board's decision for 1-A is by *unanimous vote,* only the State Director or national Director may appeal to the President. Either can take the appeal at any time prior to induction.

A pending appeal to the appeal board or to the President stays induction.

4. *Reopening classification.* No classification is permanent. Upon the basis of new evidence, the local board can re-open a classification at any time prior to having issued an order to report for induction. The State Director or the national Director, at any time prior to induction, may require the local board to re-open a classification or may require an appeal board to reconsider.

5. *Transfer for physical or induction.* A registrant who is 1-A may be required to have a pre-induction physical notwithstanding pendency of appeal. If his local board is distant from his current place of principal employment (the hospital), he may apply to the local board which serves his principal place of employment and obtain transfer to that board for the physical. A transfer for induction may be similarly effected.

6. *Notice of private practice.* All internes, other than veterans, should be instructed by the hospital that at least 60 days before termination of the interneship the interne should advise his local board that he has made definite arrangements to enter practice on a certain date as an osteopathic physician in a particular location which currently requires the professional services of an added physician. Upon entering practice, he should inform his local board that he has done so.

Residents and Selective Service

1. Promptly notify Dr. Chester D. Swope, Farragut Medical Building, Washington 6, D. C., when a resident receives 1-A, and keep him currently informed.

2. *Hospital should expressly request deferment.* When a resident enters on his duties, the hospital should promptly inform his local board that residency in the AOA approved training hospital has begun, and expressly request deferment in class 2-A for the duration of the residency. By so doing, the hospital establishes its right to take an appeal if the resident is placed in 1-A.

3. *Appeal.* If a resident is placed in 1-A, the registrant, a dependent of the registrant, or any person (including the hospital) who prior to the classification appealed from filed a written request for the current occupational deferment of the registrant, may take an appeal to the *appeal board* within the alloted 10 days. The local board can extend the 10 day period if convinced that the delay was due to lack of understanding or some, other cause beyond the control of the person appealing. The hospital letter of appeal should state nature and extent of hospital's dependence on registrant; his irreplaceability; number of hospital beds, number of obstetrical, medical and surgical cases, etc. handled during the past year by the hospital, thus indicating scope of necessary service to community.

If registrant's local board is located in an appeal board area different from the hospital, the request for appeal should also request *transfer of the appeal* to the appeal board serving the area of the hospital.

If the appeal board, by a *divided vote*, confirms the resident in 1-A, then within 10 days from the mailing of notice of that action, the registrant, any person who claims to be a dependent of the registrant, or any person (including the hospital) who prior to the classification appealed from filed a written request for the current occupational deferment of the registrant, may appeal to the President. The local board can extend the 10 day period for cause. If the appeal board's decision for 1-A is by *unanimous vote*, only the State Director or national Director may appeal to the President . . . any time prior to induction. A pending appeal to the appeal board or to the President stays induction.

4. *Reopening classification.* No classification is permanent. Upon the basis of new evidence, the local board can re-open a classification at any time prior to having issued an order to report for induction. The State Director or the national Director, at any time prior to induction, may require the local board to re-open a classification or may require an appeal board to reconsider.

5. *Transfer for physical or induction.* A registrant who is 1-A may be required to have a pre-induction physical notwithstanding pendency of appeal. If his local board is distant from his current place of principal employment (the hospital), he may apply to the local board which serves his principal place of employment and obtain transfer to that board for the physical. A transfer for induction may be similarly effected.

6. *Notice of private practice.* All residents, other than veterans, should be instructed by the hospital that at least 60 days before termination of the residency the resident should advise his local board that he has made definite arrangements to enter practice on a certain date in a particular location which currently requires the professional services of an added physician. Upon entering practice, he should inform his local board that he has done so.

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To: State Officers and Federal-State Coordinators.

The degree D. O. has for the first time been included in the standard fetal death certificate recommended by HEW. You may wish to check its adoption by your State Health Department.

Santa Claus Comes Early!

Mrs. J. R. Alexander, Treasurer of Auxiliary to Texas Association of Osteopathic Physicians and Surgeons, presents a check to Dr. A. L. Garrison, President, as Mrs. John L. Witt, President of Auxiliary looks on.

The check was to pay for furnishings for the reception room at the Central Office building in Fort Worth.

Members of the Auxiliary assessed themselves a fee for two years in order to make this donation to the central office.

AUXILIARY NEWS

Auxiliary Wins Award

The auxiliary to the Texas Association of Osteopathic Physicians and Surgeons won the AWARD RIBBON for the best section of the state auxiliary news in conjunction with the divisional society printed publication, the TEXAS OSTEOPATHIC PHYSICIANS JOURNAL for the year.

This is the second year that the auxiliary has won this award.

Auxiliary District Two

The Auxiliary to District Two held its regular monthly meeting at Cattleman's Cafe Tuesday, November 16, 1954, 7:30 p. m.

Guest speaker was Mrs. Elizabeth Bradley from the Council for Retarded Children, who spoke on the work being done with retarded children in this area. Mrs. Bradley is a teacher in the Special Education Department of the Fort Worth Public Schools.

Mrs. John Witt, our state president, of Groom, Texas, was present, and there were several other members who came as much as 100 miles to attend the meeting. We hope in the future to have many more, for they are always a happy sight.

Automobile accidents have taken a toll in our district this month.

Dr. George Pease lost his mother in an accident in Indiana. Our most sincere sympathy to Dr. and Mrs. Pease from the Auxiliary.

Trudy, Mrs. C. E. Everett, an Auxiliary member who by her sweet disposition and kindness had endeared herself to all, lost her life in an accident that occurred Thanksgiving Day. Trudy will be sorely missed in our group. Our sincere sympathy to her family from the members of the Auxiliary.

Victor and Carl Everett who were passengers in the car with their mother are both doing well at present. Victor had to have some repair work on his fractured jaw but came through just fine.

Dr. and Mrs. C. R. Packer report a wonderful time on their recent trip to Mexico. It seems they are going in the Burro business and bringing them back to the small fry.

Dr. and Mrs. Roy Russell are still on the sick list.

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Auxiliary District Six

The regular meeting and Christmas party of District 6 was held Sunday, December 5 in the Elk's Club. A buffet supper and our Christmas tree followed the meetings.

The small son of Dr. and Mrs. R. A. McClimans is a polio patient in the Respiratory at Jefferson Davis Hospital. He is in the iron lung.

In the Stork Dept.—Dr. and Mrs. M. F. Bennett are proud of their new daughter born in October.

Dr. and Mrs. R. S. Winegardner are showing off a new daughter who arrived in November.

The convention committee are busy with convention plans. We want every wife to make plans and come with her husband to Houston for the convention in May.

The Auxiliary enjoyed a lovely luncheon on November 9 in the home of Mrs. Reginald Platt. No business conducted, we just had fun.

We are looking forward to a visit from our state president, Mrs. John Witt early in 1955.

A merry Christmas and a happy New Year to all.

MRS. J. J. CHOATE, *Reporter.*

DEATHS

Mrs. Trudy Goodwin Everett, wife of Dr. Carl E. Everett, Fort Worth, Texas, died Friday, November 26, 1954. Mrs. Everett was fatally injured in an automobile accident which took place on Thursday, November 25, Thanksgiving Day.

Mrs. Everett was buried in Greenwood cemetery, Monday, November 29, 1954.

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David S. Harris, D. O., Dallas, Texas. Doctor Harris was a graduate of S. S. Still College of Osteopathy and Surgery, 1901. He died November 18, 1954.

MD's Involved on Several Socio-Medical Battlefronts

CHICAGO (AOA—Certain medical groups are involved on several socio-medical battlefronts. In California, the state medical association has opened its drive on closed-panel medical plans by mailing more than 1,000,000 pieces of literature.

The attack is aimed primarily at the highly successful plan sponsored by the Kaiser Foundation. A Kaiser medical spokesman stated: "We consider ourselves part and parcel of the medical profession."

Another sharp fight has broken out in Hammond, Indiana, between specialists and general practitioners. The GP's are up in arms over a proposed revision of the constitution of the city's only hospital . The revision would limit hospital activities to doctors whom a committee of specialists find competent. There have been cries of fee-splitting, ghost surgery and unnecessary operations.

One GP spokesman said: "You can't have ghost surgery just because you have a shady GP. You've got to have a shady specialist as well." Another declared: "It gives them a complete strangle-hold on your practice. What you do will depend entirely on what kind of politics you play."

An observer who noted "the long-time rivalry" between the two groups commented: "It just happens in Hammond the GP's have been making most of the money. After this maybe they won't."

An additional battle took shape earlier in Indianapolis when the most widely known of Indiana's surgeons, Dr. Karl R. Ruddell was dismissed from St. Vincent's hospital for alleged performance of unnecessary operations. The hospital administration pointed out that medical staff membership is not a right, but a privilege and that a medical society is not the hospital's accrediting body.

In Springfield, Ill., Harvey V. Higley, chief of the Veteran's Administration rapped the AMA for its stand on veteran care. Higley said: "The AMA has the right to question any program operated by the federal government, as does any citizen. But my chief gripe is that they don't come up with a better one."

Brain Sounds Heard By Physicians: Normal Purrs, Insane Breaks Rhythm

NEW ORLEANS—The normal brain purred "like an idling engine" while the two insane brains stuttered now and again and made urgent sounds, an Associated Press story revealed.

The sounds were broadcast over a public address system direct from the brains to physicians who listened in an auditorium at Tulane University medical schools here. Tulane officials said it was the first such broadcast in history.

The brain sounds were recorded by long slivers of electrical contacts submerged like pilings deep in the brains of a normal and two abnormal persons.

NEWS OF THE DISTRICTS

DISTRICT THREE

The regular meeting of District III was held November 21, 1954 at 2:00 p. m. in Henderson, Texas at the new and modern clinic building recently built by Dr. James DeWayne Bone. Dr. Bone's building also houses a modern dental office and one of those new air pressure driven abrasive blasting types of painless drills was noted with considerable interest. The meeting came to order promptly at 2:30 p. m. and the business attended to included the adoption of a new constitution.

The program consisted of the delivery of specific information by Dr. W. K. Bowden, of Cushing, Texas, in regard to the proper use of tetanus antitoxin, fluid toxoid, and alum precipitated toxoid. Mention was also made of the possible immediate and delayed reactions that may occur from the use of any of these materials.

Dr. Myron S. Magen, prominent Dallas Pediatrician then spoke on the general care of the infant through the first several years of life, and brought out many simple but specific examination procedures that, probably, most general men do not use. Just one example was the condition of premature closure of the anterior fontanel, its easy detection and—if you were there—the consequences of ignoring it and what to do by way of treatment. If you weren't there—better look it up.

Ably assisting Dr. Magen, Dr. Charles Dean Ogilvie, Roentgenologist at the Stevens Park Hospital, Dallas, Texas, illustrated with X-ray portraits, many of the conditions about which Dr. Magen spoke. This part of the program was so interesting and productive of questions, discussion and general comment that more time was consumed than usual. The social get together at Dr. and Mrs. Bone's house after the meeting was almost threatened—and definitely delayed. After the meeting, however, the doctors adjourned to Dr. Bone's house and rejoined their wives—everyone appeared to be happy with the entire meeting. Dr. Kinzie is to be congratulated on his selection of speakers and the success of their delivery of the material presented.

Dr. Charles Collins Rahm attended this meeting, being District III president and handled the meeting in his usual impeccable manner.

Out of the district guests at the meeting included Drs. Helfrey, Young, and as always, Dr. Robert Morgan. Dr. Phil Russell was unable to be there but don't think for a minute he was forgotten.

Dr. Kennedy of Mount Pleasant, Texas has faithfully promised to write an article for the JOURNAL soon on Sarcoidosis and its usual companion pathoses, periarteritis and tuberculosis. To avoid further reports in regard to just why Dr. K. E. Ross hasn't secured five articles for the JOURNAL: Everyone in the district, physically able to lift a pen, is hereby invited, begged, cajoled and threatened—just write it. If you think you need practice first—practice on sending me some news items.

Coats-Brown Hospital, Tyler, Texas, has been having an epidemic of acute cholecystitis cases—this time of the year should be perforated ulcers—just goes to show that it isn't necessarily the incidence of diseases that change. Must be the incidence of patients.

Next District III meeting will be the famous one—Longview, Texas—at Curleys, with the peerless Tom Hagen as host. Hope to see you there.

K. E. Ross

DISTRICT SIX

Dr. Edward Vinn, Houston, Texas, has been appointed a Major in the Medical Corps, Texas State Guards, Third Battalion, Houston, Texas. Congratulations to Dr. Vinn!

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DISTRICT SEVEN

The AUSTIN STATESMAN carried a three column story and picture of Dr. Bowden Beaty and Mrs. Lucille Chustz, administering gamma globulin in mass innoculation to 150 Lockhart elementary school students at the Lockhart Hospital, Lockhart, Texas.

The hospital served the staff a big Christmas dinner at their regular monthly meeting. Although it was a little early, we all enjoyed it.

Christina Schaefer was home for the Thanksgiving holidays. She is a student at the University of Houston College of Nursing. She has nothing but praise for University of Houston, Rice and the Medical Center. It would indeed be wonderful if there was an Osteopathic Medical School a part of that Medical Center.

Dr. I. T. Stowell sold his huge home and moved into an apartment. Said it was just too large for two people.

The Waschers also sold their large home and took a smaller one. "Democrat" Wascher swears that the Republicans are heading us for a depression, and he doesn't want to get caught with a big house; would feel safer if he had the money instead of land. Truthfully, he just wants to build a larger home with more land.

Patricia Edwards, Hal's daughter, is counting the days till Christmas. She is attending Stephens College at Columbia, Mo.

The Beckwith boys are indeed happy. Their mother and stepfather are here for their annual Christmastime visit. This is an event they look forward to each year.

The deer hunters were lucky this year. Dr. Schoch got 2, Dr. L. C. Edwards 2, Dr. Harold Beckwith 1, and Hal just said "call me 'No Deer Edwards' ".

Dr. and Mrs. F. M. Crawford are motoring to Des Moines, Iowa, for the Christmas holidays. It is Christmas at home for them.

Dr. Schaefer and daughter are also going home for Christmas. They go to Reading, Penna., where the doctor's parents live; Philadelphia to see relatives and visit the college; also New York State to spend a day or two with his brother and family. It never fails—they are always glad to get back to warm, sunny Texas.

Dr. Dan Tobin had the monthly party. A good time was had by all. Considerable time was spent in discussing the proposed new hospital and good public relations.

We want everyone to think of San Antonio as a place where all of us are ready and willing to help new doctors improve their skills and get ahead. Ask us about our plan.

Mrs. Norma Lowe, our former supervisor of nurses, is back with us—this time as surgical nurse. Bill and Norma are glad to get back to Texas after the Pro-Football season in Canada —too cold up there.

Many of the doctors are planning to attend the Post-graduate Seminar in Dallas. Wish I could make it.

Now that they have their deer, the boys are talking about another type of dear. Many plans are being made to attend the men's style shows at Seven Oaks Country Club and St. Anthony Hotel. I believe they prefer the latter dears.

Merry Christmas and a Happy New Year to you all.

WALDEMAR D. SCHAEFER, D. O.

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DISTRICT EIGHT

Dr. A. B. Tibbetts, Jr., in a three-column story and picture of himself, received a great deal of publicity under the title "Swindler Squelched"

This is an interesting story in an old racket that has been practiced through-

out the country and in which Dr. Tibbetts was on his toes and from which he received a good deal of publicity and public relations for the osteopathic profession.

Dr. Earl Elsea returned triumphant from Wyoming with near world record kill of bull elk, an 18 point mule deer, and two antelope. No bear this trip. He also caught brook trout. Hence he came back to Corpus loaded.

A number of the local doctors are packing up for the coming Dallas meeting. Doctors Merle Griffin, R. J. Brune, Joe Schultz, Sam Ganz, and B. A. Burton are planning to make the trip. Dr. Ganz will make it for sure if Mrs. G. delivers as scheduled.

The physicians in the Aransas Pass area are to start building their new hospital in the very near future. It is my understanding that everything is now ready to go. These fellows have been doing an excellent job in their area and are most certainly a credit to our profession.

R. E. BENNETT, D. O.
Secretary District 8.

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DISTRICT TEN

Doctor L. J. Lauf of Lubbock has a high obstetrical record for 1954. From January to the first part of December, Doctor Lauf delivered 573 babies, 80 being delivered in November.

Surgeon Says Medical Students Need Better First Aid Training

ATLANTIC CITY—A New York surgeon, addressing the annual clinical congress of the American College of Surgeons here, said many lives could be saved among the 95,000 who now die annually as the result of accidents.

Dr. Robert Kennedy, surgical director of the Beekman Downtown hospital, pointed out that application of recently developed methods for the treatment of accidental injuries and better training of medical students in first aid would bring about this result.

Physicians Need Faith in God, AMA President-elect Says

ST. LOUIS—At a recent meeting of the Southern Medical Association here, Dr. Elmer Hess, President-elect of the American Medical Association said that "any doctor who lacks faith in the Supreme Being has no right to practice medicine."

The Erie, Pa., urology specialist assailed those practitioners who are seeking only money, saying that, "a physician who walks into a sick room is not alone. He can only minister to the ailing person with the material tools of scientific medicine—his faith in a higher power does the rest."

Dr. Hess pointed out that medical schools are doing a magnificent job teaching the fundamentals of scientific medicine but the teaching of spiritual values is almost neglected.

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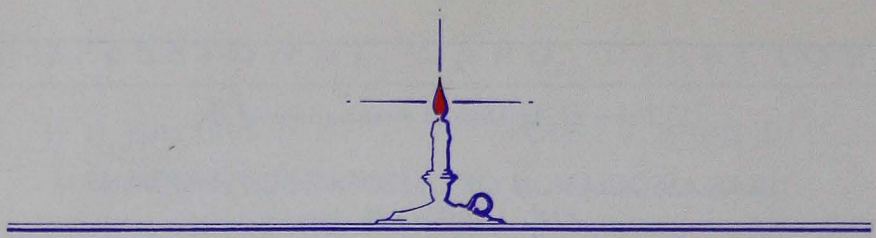

The Shining Light of Christmas

The star that guided the Wise Men of the East on the first of all the Christmases is symbolized by the Christmas Candle.

The mellow rays of this Christmas symbol help to dispel the darkness of despair, the gloom of doubt, the murk of uncertainty, and it becomes a beacon of joy and hope for all within the circle of its cheerful radiance.

To all our Doctor friends, it is our heart-felt wish that the radiance of your Chritsmas candle will glow merrily upon a scene of Christmas happiness and that it will foretell for you a new year of good health, contentment and prosperity.

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