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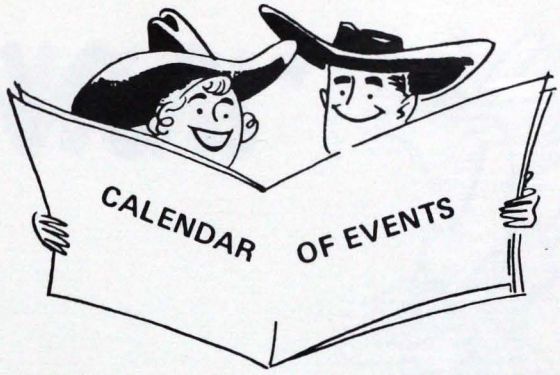


FEBRUARY 1972

AOA Midyear Meeting
February 2—4
The Arlington Hotel
Hot Springs, Arkansas

Postgraduate Seminar
February 5, 6
Statler Hilton Hotel
Dallas

District VI Meeting
February 7
Look's Sirloin Inn
Houston

TOIL Committee Meeting
February 11
San Antonio

12th Annual Surgical Conference
Texas Society of Osteopathic Surgeons
February 25—27
Sheraton-Marina Inn
Corpus Christi

APRIL 1972

District VI Meeting
April 3
Warwick Hotel
Houston

International Academy of Preventive Medicine
Spring Seminar
April 8, 9
Fairmont-Mayo Hotel
Tulsa, Oklahoma

American Osteopathic Academy of Sclerotherapy
Postgraduate Course
April 8, 9
Chicago Sheraton
Chicago, Illinois

State Board of Medical Examiners in The Basic Sciences
(Examination & Reciprocity)
April 14, 15
Dallas, Galveston, Houston & San Antonio

First Eastern Regional Osteopathic Convention
April 27—30
New York, New York

MAY 1972

District VI Meeting
May 1
Bismarck Restaurant
Houston

TOMA House of Delegates
May 10
Sheraton-Fort Worth
Fort Worth

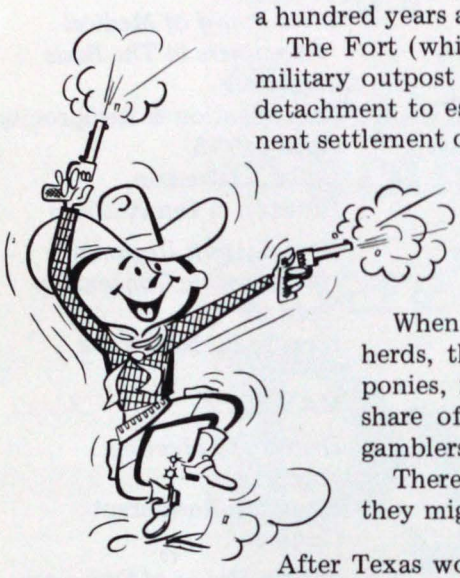
TOMA Annual Convention
May 11—13
Sheraton-Fort Worth
Fort Worth

JUNE 1972

TAOMA Convention
June 9—11
Corpus Christi

State Board of Medical Examiners
(Examination & Reciprocity)
June 12—14
Sheraton Crest
Austin

"COWTOWN"



Round 'em up—head 'em in! To Fort Worth. That was the cry more than a hundred years ago—as it will be this May.

The Fort (which actually never was a fort, but a camp) was founded as a military outpost in 1849 when Brigadier General William J. Worth ordered a detachment to establish it, and Camp Worth was created as the first permanent settlement on a bluff overlooking the Trinity River.

Its name notwithstanding, Fort Worth is better known as a major stop on the Chisholm Trail during the great cattle drives of the last century, rather than as a military post. Thus, it became known as "Cowtown".

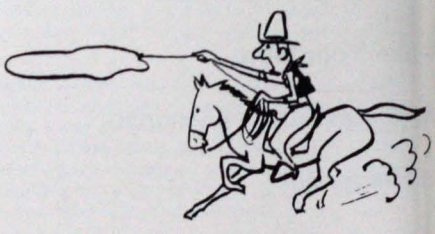
When the cowboys on the "Long Drive" reached Fort Worth with their herds, they were ready for a spree. They whooped into town on their cow ponies, rode them along the plank sidewalks, often drank more than their share of rotgut, and were slickered out of every cent they had by crooked gamblers and painted women.

There was some gunplay, some drunken brawls, some flaring tempers. And they might encounter "hostiles"!

After Texas won its independence from Mexico in 1836, Texas cowboys habitually trailed herds to Kansas and Missouri. Droving became a way of life for Texans—this in spite of the fact that after the Civil War, when they were using the old Shawnee Trail, herds clogged the road, broke farmers' fences, destroyed crops and meadows—and irate farmers ordered the Texans to go back, threatened them with flogging and strung up a few!

Then Joseph McCoy talked the railroads into building stockyards on their lines west of the settlements, and it was he who selected the frontier village of Abilene, Kansas as the place for the end of some of the cattle drives. The plains were flat here and a route southward across Indian territory to Texas had been used for some years by Indian trader, Jesse Chisholm. The ruts cut by his wagon in the prairie sod could be traced in many places.

Apparently Chisholm chose well when he established his "trail", since it is basically the route for the modern I-35.



The perils of the cattle drive were numerous. Along with the "hostiles", raging rivers took their toll, and sometimes vast herds of buffalo would threaten to engulf a herd. Stampeding was commonplace, since longhorns would panic for any reason or no reason. Drought, cloudbursts and vicious hailstorms tormented the riders. Marauding white renegades added to the trail boss's worries.

The cowboy's work was hard and dangerous, calling for courage, skill and endurance. It was said, "A cowboy is a man with guts an' a hoss."

And so the beginning of "Cowtown". A few thousand military—then the cowboys.

is "NOWTOWN"

The old Fort has changed—some!

Nearly three-quarters of a million people in the metropolitan area have access to a different sort of entertainment and culture.

The buffalo are still to be found—but only in the famous Fort Worth Zoo.

The only time the cowboys ride their ponies down the street is during parades (and then not on the sidewalks—the wooden planks having been replaced some years back).

The cowboys do return in droves once a year for the Southwestern Exposition and Fat Stock Show (and indoor rodeo), the oldest and most prestigious event of its type in America.

No doubt there are still some crooked gamblers and painted women around the town, but the modern visitor is a little more sophisticated than the cowboy of some hundred years back, and he can find whatever he is seeking in Fort Worth.

The "hostiles" come in many colors today, but there are probably as few of them in Fort Worth as you will find in any great metropolitan center.

The Longhorns still stampede on occasion, but mostly on football fields. The Cowboys have rounded up quite a few mavericks in the past several years and managed to corral them. But again, these modern-day Cowboys' work is on the football fields. And the Texas Rangers will soon be showing their prowess on baseball diamonds.

While Fort Worth is metropolitan in all respects, it has maintained the relaxed pace of easy Western living and hospitality—and the citizens haven't strung up anyone in years!

Rotgut is still available, but the old saloon has been replaced by elegant nightclubs and cocktail bars, where the finest products of the distillers' and the brewers' art may be purchased—and you aren't apt to run into a drunken brawl in these, nor into a likkered-up cowboy interested in gunplay.

The "good old days" may be gone, but the free and easy spirit of them remains in Fort Worth—where the best begins.

Truly, "Cowtown" has become "Nowtown"!

And the 1972 convention program will reflect the "Now" of the city, the State and the osteopathic profession, as well as the future of them all.

District II is hard at work on a program that will round up the doctors and their wives and head 'em in to Fort Worth come May 11.

"Don't just do something -- Stand there!"

The above headline is taken from an address by U.S. Congressman Omar Burleson of Texas at the concluding luncheon on Sunday, January 23, of the first South Central Osteopathic New Action Conference in Hot Springs, Arkansas.

Mr. Burleson said he had read those words on a signpost at a fishing hole in South Carolina, and in repeating them in his address, he was making the point that one of the difficulties today—not only in Congress, but in the various federal bureaus—was that they were constantly thinking up things to *do*—whether they were right or wrong—instead of just *standing* there until they had thought the problem through to a logical conclusion.

Mr. Burleson not only addressed the conference registrants, but spent Saturday evening discussing health care problems with a number of Texas D.O.s, and was a very attentive listener at the Sunday morning general session prior to his address.

Although a number of airports were socked in by fog and ground visibility was sometimes near zero, nearly 50 D.O.s from nine states still managed to get into Hot Springs for the January 22—23 New Action Conference.

The Arkansas Association of Osteopathic Physicians and Surgeons invited all D.O.s from the states surrounding Arkansas to attend this new type of meeting, which included six forums and three general sessions of a brainstorming, group dynamics type in which every individual was encouraged to participate.

Those attending were enthusiastic about the conduct of the conference because—in contrast to other meetings they attend at times—there were no politics involved, rank was eliminated, all those in attendance had voice, and structure and protocol were minimized.

The first general session opened at 11:00 a.m. Saturday, when the six panels were formed and assigned to meeting rooms.

At noon Arkansas Attorney General H. Ray Thornton, Jr., addressed the conference and showed a profound knowledge of osteopathic medicine, the profession and its problems. In explaining his ruling on licensure reciprocity for D.O.s in Arkansas (since last year's passage of a bill giving full practice rights to osteopathic physicians in that State), Mr. Thornton said his ruling that the law *does* grant reciprocity rights was not because of any special sympathy or empathy for any profession, but because, in his opinion, the intent of the law was to bring more qualified physicians to Arkansas, and he had ruled for what was *right* in the face of powerful opposition.

The six forums began their deliberations immediately following the Saturday luncheon, and went back into general session at 4:00 p.m. to report to the full conference.

Texas President, Dr. Richard M. Hall and Kansas Executive Secretary, Lloyd Hall, coordinated the panel on the osteopathic profession's fight against amalgamation with the AMA or its political subdivisions.

Dr. Paul Grayson Smith, Secretary of the Tennessee Association, and Texas' Vice Speaker, Dr. John Boyd, headed the forum on rural medicine.

Iowa's President, Dr. Kenneth Carrell, brought considerable knowledge on federal medicine to the conference and the panel he headed on this subject drew so much interest that a third of the conference registrants reconvened Saturday night to study the subject further. Texas Executive Director, Tex Roberts, was co-chairman of this panel.

Panel chairmen on the medical jurisprudence (legislation) panel, Dr. Bobby G. Smith of Texas and Missouri's Executive Secretary, Ed Borman, had done their homework prior to the meeting and engendered a lively discussion on what was being done for—and to—the osteopathic profession through state and national legislation.

Bob Jones, Executive Secretary of Oklahoma and Dr. Joel Alter, Coordinator of Clinical Instruction for TCOM, headed the panel on osteopathic medical education, but the big news to come before the conference was Oklahoma President Dr. James Routsong's announcement that, by Oklahoma legislative action, the Oklahoma College of Osteopathic Medicine expected to become a reality shortly, hopefully with its

'New Action' Popular

first class opening next fall.

Dr. Routsong and Herman Walter, Iowa's Secretary, were chairmen of the osteopathic professional public relations forum, which explored methods of educating the public through the press, the doctors' own employees, and mounting a concerted campaign to initiate positive action public relations programs in each of the states participating.

Mr. Michael Cleary of the Arkansas Health Planning Commission, spoke at dinner Saturday night and stressed particularly that it doesn't take large numbers to accomplish what is right, citing what only a handful of D.O.s had done in Arkansas to get the full licensure bill through the Arkansas legislature.

Conclusions reached at the conference include:

That more New Action Conferences of osteopathic representatives in the South Central states be held regularly;

That the states attending the Hot Springs Conference have a study made of HR1 immediately, with a pro and con analysis being forwarded to the participating states for possible action by their official bodies;

That there was less than a year left for the osteopathic profession to have any effect on national health insurance legislation;

That amalgamation was not in the public interest;

That the individual D.O.s and state osteopathic associations should intensify their efforts to know their congressmen and legislators better, and to increase the frequency and firmness of their presentations to health agencies;

That the profession should exercise greater surveillance over any questionable practices of colleagues.

Recordings of all sessions were made and every attempt will be made to boil out some of the more significant statements and conclusions for circulation among the participants.

Enthusiasm was the key to a very successful working conference and tentative plans are already underway for a second one to be held possibly in the early Fall of 1972.

Texans attending the Conference included Dr. and Mrs. Richard M. Hall, Dr. and Mrs. Bobby G. Smith, Dr. Robert G. Haman, Dr. and Mrs. Joel Alter, Dr. and Mrs. Phil Russell, Dr. Glen Kumm, Dr. John Boyd, Dr. H. H. Edwards, Dr. Robert L. Hamilton, Dr. A. Ross McKinney, Dr. and Mrs. Carter McCorkle, Dr. and Mrs. Ralph H. Peterson and Mr. and Mrs. Tex Roberts. ^

Preventive Medicine Spring Seminar in Tulsa

The International Academy of Preventive Medicine will hold its Spring Seminar at the Fairmont-Mayo Hotel in Tulsa, Oklahoma April 8 and 9. Dr. Robert McCullough, immediate past president of Lions International, will co-host this fine meeting with Dr. Harold Rosenberg of New York City.

The speakers will be Doctors of international renown and will include: Dr. Linus Pauling, Ph.D. (of the Vitamin C controversy), internationally acclaimed biochemist, Nobel prize winner.

Dr. Wilfrid Shute, M.D., of Canada, author and authority on Vitamin E.

Dr. Humphrey Osmond, Director of the Bureau of Research, New Jersey Neuro-pyschiatric Institute, noted authority on mental illness and will discuss megavitamin therapy and mental illness.

Dr. Carlton Fredericks, Ph.D., renowned radio and television nutritionist and health authority will discuss low blood sugar and common discrepancies in regard to food claims.

Paul Baerger, D.D.S., M.S.D., New York dentist, preventive dentistry, author and lecturer.

Bradford N. Craver, M.D., Ph.D., Medical Director of the Wilson Research Foundation and former co-chairman of the AMA Council of Drugs.

Dr. John Miller of Chicago, authority on biochemistry and especially concerned with minerals, vitamins, and metalic nutrients.

There will be practical panels for physicians, dentists, Ph.D.'s and allied health professionals. We invite you to attend and enjoy this carefully planned Seminar.

For further information write: Dr. V. L. Jennings, Secretary, The International Academy of Preventive Medicine, 609 N. Retta, Fort Worth, Texas 76111. ^

Sclerotherapy Postgraduate Course Scheduled April 8-9

The American Osteopathic Academy of Sclerotherapy, Inc. will hold a two day Postgraduate course April 8 and 9, 1972 in Chicago at the Chicago Sheraton. Doctors interested in sclerotherapy are invited to attend. Those interested may obtain further information by contacting the Secretary-Treasurer, David Shuman, D.O. at Suite 701 Fox Building, 1612 Market Street, Philadelphia, Pennsylvania 19103. ^

Expect Stodgy AMA to "Get With It

by Paul Harvey

In one year you mightn't recognize the old American Medical Association. Internal upheaval will be reflected in more external involvement.

The American Medical Association, after the outspoken Morris Fishbein era, withdrew from the world.

That's a figurative expression, of course; does not reflect disrespect. This program has guarded very zealously a longtime mutually respectful association with the medical profession, but the AMA has now diagnosed its own hardening of the arteries.

There is an internal power struggle going on of consequence by the Association and of significance to us all.

Elected officers, coming and going, have been hamstrung by the permanent administrative staff.

Recent Presidents have accepted, accomodated, lived-with this inbred inertia.

But the now President, Reno, Nevada's Dr. Wesley Hall, intends to overthrow the old guard.

Though opposed by the AMA's Board of Trustees and two AMA councils, he is asking the Association's 214,000 members to rally 'round and demand a constitutional convention to overhaul the AMA.

There hasn't been such a convention in 124 years.

It's Dr. Hall's contention that the Association has been spending too much time, effort, energy and money "politicking" and not enough on promoting scientific and medical education.

He says the practice of medicine has become in every way more complicated, entwined with red tape and government forms, and "we are not providing the practicing physician with the help and services he needs."

And as evidence he cites the fact that, despite an increasing physician population, AMA membership is slipping.

A recent dues increase was vigorously resisted by the membership; many resignations.

One state medical society threatened to disassociate itself.

As with most overgrown associations, too many programs are being perpetuated past their point of usefulness; need pruning.

And Dr. Hall adds the stinging reminder to his colleagues that "osteopaths spend more than four times as much per man toward osteopathy education as does the doctor of medicine, even though the latter has had a higher income."

Nudged off its comfortable posterior by this vigorous leader, the AMA is already showing signs of recovery.

One of its councils proposes speedup training—as the Army trains medics—for the 53 per cent of all medical school applicants who are turned down.

These could work as trainee-assistants to doctors, thus to alleviate the doctor shortage, pending reapplication to Med school.

But President Hall believes the AMA has done all it can with palliatives; he prescribes major surgery now.

[The foregoing is from a December 16, 1971, ABC telecast commentary by Paul Harvey; printed in full with the permission of Mr. Harvey.—Ed.]

Osteopathy returns to California!

by Alexander Tobin
Attorney for the Osteopathic Physicians and Surgeons of California

[from an address to the Third Annual Meeting of Californians in Support of Osteopathy September 25, 1971, in San Diego]

In 1962 Proposition 22 was passed by an overwhelming vote of the people of this State. Proposition 22 was in effect a form of "health suicide" by the very people who voted overwhelmingly for its passage. This type of health suicide is not uncommon, it occurs many times through the ignorance and passive interests that the people of this country display with respect to many things.

Why was this a form of health suicide? Because, a review of the purpose and effect of Proposition 22 clearly shows that its objects were to eliminate the practice of osteopathic medicine in the State of California and to deprive the people of the State of California of a form of health care which they had been accustomed to, had been demanding, and needed desperately. But the people did not know what they were voting on when they passed Proposition 22. They didn't know because the information that they were *fed* by the news media and by political medicine deliberately kept from the people the true purpose and effect of Proposition 22.

Effectively, this was a conspiracy of the first order entered into between one of the largest lobbying institutions in the United States—the AMA and certain political interests in California. Recently the Superior Court in and for the State of California ruled that Proposition 22 was unconstitutional. In all probability the court's judgment will be appealed and hopefully the appellate court will affirm that judgment. Our battle is not yet over and any suggestion that we can now sit back and relax is not only far from the truth but plays into the hands of political medicine, by undermining our attempts to not only return to the State of California the availability of osteopathic medicine, but also to return to California doctors of osteopathic medicine who, because of Proposition 22, have been deprived of their constitutional rights to practice in this State.

We lost osteopathy in 1962—even unconstitutionally and it can happen again. We must be ever vigilant, and must never become complacent.

The organization "Californians in Support of Osteopathy" (CSO) has done a tremendous job in bringing the facts to the people of the State. We cannot thank them enough.

Their contribution has been more than just a casual interest in returning to the people of the state Osteopathic medicine. Their efforts have been to educate the people on this subject. Their contribution has been in time, sweat and funds. Their contribution has been effectively felt.

The Board of Osteopathic Examiners and the Board of Medical Examiners are well aware of the work of Californians in Support of Osteopathy. They are also aware of the professional organization of D.O.s—Osteopathic Physicians and Surgeons of California (OPSC). That organization composed of the most dedicated and hard working people that I have ever had the pleasure of encountering, have put forth time, effort, money, sweat, blood, tears, and you name it; they have made the most magnificent effort—and successfully—to bring to the people of California their healing art.

I fortunately had the opportunity to serve as attorney to the Petitioners who brought the lawsuit which declared Proposition 22 to be unconstitutional. And again, without the help of the two organizations I have just spoken of, our efforts would have been less effective—if not impossible.

The first question that comes to mind when you hear about the work of so many dedicated people is why? Why do they make such an effort? And the answer is evident if you have any knowledge at all of osteopathic medicine. The osteopathic physician and surgeon brings to the people of the State of California a form of the healing arts that is not obtainable in any other fashion or from any other person. No matter what you call it, the training of the D.O. is something above and beyond that which the M.D. receives. Historically, even though political medicine may scream

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osteopathy returns to california

and shout something to the contrary, the D.O. has brought to the people healing in instances where his brother M.D. has been totally unsuccessful.

We are here today because we share a common view of the benefits that the osteopathic physician brings to California, and because we are willing to make every effort to assure that what happened in 1962 doesn't happen again—and don't think for one moment as I indicated before that it cannot happen again. It can, and it will—unless we are ever vigilant and unless we tell the story of osteopathy to the people. We must explain time and again exactly what it is that we are losing when we lose osteopathy, and when we voluntarily commit "health suicide" by voting on health measures which are detrimental to us or by permitting our elected representatives to do it for us. If we do not know the facts behind a particular piece of legislation, we *must* educate ourselves—*and* others.

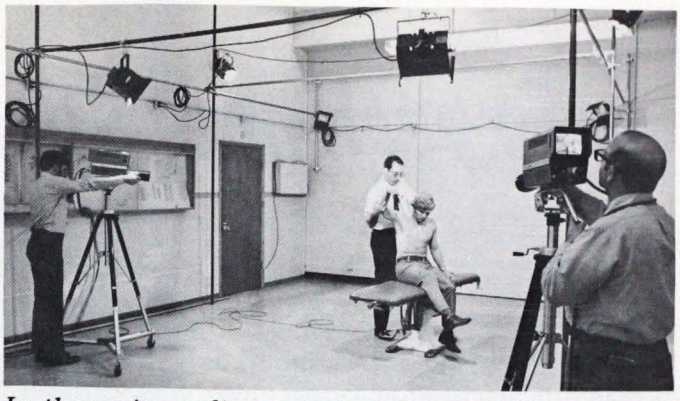
We want the world to know that osteopathy is back in California—and that its back to stay! Osteopathy was in California before 1913 when the medical practice act was passed. It was here in 1922 when the osteopathic act was passed, and in force at that time because the osteopathic act in 1922 was passed in order to *prevent* the type of thing that happened in 1962. Of course we were here in 1962 when Proposition 22 passed, and the reason Proposition 22 passed was, as I pointed out earlier, that the people of the State of California did not get *all* the facts—*and didn't seek them out!*

Therefore, when you boil it all down to what it is that Californians in Support of Osteopathy can do in order to continue the existence of osteopathy in California, and avoid a reoccurance of the 1962 Proposition 22 disaster, the answer is "*Educate The People*". How do you educate the people? You've got to tell the people the story about osteopathy—of how it was almost destroyed in 1962; of the benefits that osteopathy can give the people of the State of California; and above all, what a D.O. can do beyond that which his brother M.D. can do. Tell the people of the constitutional rights of the individual physician who is deprived of his right to enter the State of California and practice as a physician and surgeon while a physician and surgeon M.D. is given the red carpet treatment.

You can tell that story, and when you've told that story, tell it again, and again, and again, over and over and over—because people have a short memory. You've got to let them know and if they heard it before tell them again because they just might start telling it too!

We can keep osteopathy in California if we are willing to insist on its being here—its up to us! A

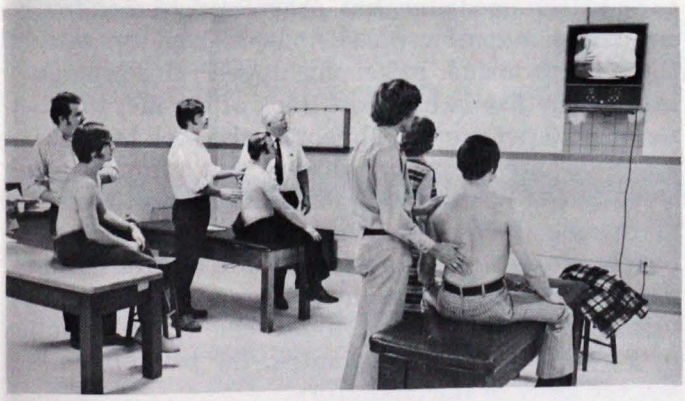
OMT by TV at KCOM



In the main studio, an instructional tape is being produced as two student cameramen focus on a technique being demonstrated by Herbert Miller, D.O., F.A.A.O. on a student volunteer.

Kirksville, Missouri—The new approach to teaching osteopathic technique at the Kirksville College of Osteopathic Medicine (KCOM) this year is television. A small closed circuit installation, some expert advice, and a little technical know-how have been combined with a hard working corps of faculty volunteers to provide a new kind of learning experience for more than 200 student physicians in classes directed by Herbert Miller, D.O., F.A.A.O. A small TV installation in the KCOM Administration Building operated by students is opening up many new teaching avenues.

Ideally, the teaching of osteopathic technique (manipulative therapy) according to Dr. Miller, should be done in groups of not more than 10 students per instructor. Even when sufficient instructor power exists to maintain this ratio, those just learning often find it difficult to understand the variation in approach and technique employed by different instructors. Television, Dr. Miller feels, offers a more uniform approach and assures that all students, initially, have the same educational experience, supplemented by discussion and actual practice under the direction of a faculty physician who views the tape with the students, comments, and provides followup instruction at the time.



In another classroom beyond the studio area, volunteer faculty, James Keller, D.O. and Louis Astell, D.O., view a lesson with a small group of students. After appropriate discussion, they will assist students with actual practice and supervise the laboratory experience.

While the demonstration lesson is being televised to students in four laboratory rooms simultaneously, it is also being recorded with a video tape recorder. Students may then arrange for repeat viewing at a later time for review purposes. The 9:00 a.m. to noon period each Saturday is also set aside for student viewing requests. Dr. Miller also points out that patient demonstrations, once available to perhaps only one class group now may be recorded and replayed for the benefit of all or future classes.

The basic teaching installation includes two cameras, video tape recording equipment, a portable TV studio control center with switcher/fader, special effects panel and audiomixer, three monitors, and grid-mounted lighting. Monitors have been placed in each of four laboratory classrooms in the Administration Building. Eventually, the college hopes to connect this studio via cable to other classrooms on other floors in the Administration Building-Memorial Hall complex. The camera and production equipment are managed by trained students with the technical assistance of Bill Casper and Ron Shriver of the college audiovisual department. Lab sessions are televised to freshmen and sophomore laboratory groups three times weekly. Volunteer faculty laboratory instructors view tapes with groups of 10 or less students in adjacent rooms and assist with individual practice instruction.

While osteopathic theory and methods faculty at the KCOM are primarily concentrating on the development of a basic instructional program, they concede that the potential future application of the medium is great. Among those possibilities are student developed teaching tapes, individual critique tapes, exchange and competition between students of osteopathic colleges.

Among the volunteer instructors working with the program are: Doctors Ira C. Rumney, F.A.A.O., W. Hadley Hoyt, Wayne English, Delores Wallin, Douglas Hagen, William Kelly, Delbert Maddox, Louise Astell, James Keller, Charles Cunnick, C. A. Rohweder, Max Gutensohn, Olwen Gutensohn, James Stookey, F.A.A.O., James Turner and Elliot Blackman. ▲

Experience Speaks

Dear Tex:

In reply to your letter sent out in December to the general membership in Texas, I have mulled it over in my mind for some time and desire to make some statements.

Dr. Hall, our President, asked me the following question in December: "What is your opinion in reference to amalgamation?" The question astonished me, for I am sure he knew my opinion in reference to this problem. The answer was that I would oppose such action as long as the good Lord allows me to live.

I believe that I have as many friends in leadership in the medical profession as any osteopathic physician in Texas. I have had it said by many of these men that I was the block in stopping amalgamation of the two professions, and yet they cooperate with me thoroughly.

There is an axiom for which I cannot give you the authority which states, "Observe, listen, remember and apply." This is an axiom that applies to success in any business or profession. Apparently our profession has lost faith and is failing to follow through in a manner that will keep it independent and successful.

We broadcast through the mails and in the journals that we will fight the medical profession, thus giving them an invitation to fight us. This is bad business for a minority school to practice, and we might as well expect the 12,000 osteopathic physicians to fight the Vietnam war. Our statement should simply be that we oppose amalgamation in every way possible. Let's not try to kick up a fight. You can pick a fight in any two blocks walking down the street if you want to. You might win the fight, but lose the war. Let us oppose amalgamation and so state, and cooperate with every health organization in the interest of public health.

In this free country of ours, the allopathic profession has every right to want to amalgamate and to destroy us as an independent group. The osteopathic profession has the right to oppose amalgamation. We know that we have a philosophy of health that is in the interest of the public that cannot be challenged if applied.

To make ourselves worthy of the trust placed in us by the people and legislative action, we must apply the principles of the osteopathic profession. Are we doing this? I remember when the osteopathic physicians in California practiced under a limited status. They took their fight to the people in a referendum and won unlimited rights to practice their profession. A number of years ago the allopathic profession took its opposition to the osteopathic profession to the public in a referendum and won its fight, and forced amalgamation with two-thirds of the osteopathic profession and destroyed the Board of Osteopathic Examiners. Those who did not amalgamate have consistently fought in the courts until the courts have issued a judgment sustaining their position and again, osteopathy as an independent school has been recognized in California.

My opinion is that the medical referendum was won because the majority of the osteopathic physicians in California was failing to apply—and to educate the public—in reference to the distinct philosophy of the osteopathic profession. Dr. Still made a statement: "Find the cause and fix it"; therefore, if you want to know what is wrong with the osteopathic profession today, it's the people in the profession—not the allopathic profession.

It behooves us to educate our own profession:

That every legislative act passed in the United States recognizing our profession has been gained through the application of the osteopathic principles, and

That, by proof, our educational institutions, through the support of the profession, have equalled or surpassed the schools of medicine, have had millions of tax dollars to support their educational programs.

Scientific medicine has progressed tremendously, and the osteopathic profession has kept up with all the progress made. In keeping up with this progress, I feel certain that we have lost track of the fact that better than 70 per cent of all people who seek the help of a doctor have no organic disease, but a functional disease that, if permitted to continue, will in time result in organic disease. We should recognize that these people are as sick as those who have organic diseases. Remember, the philosophy of osteopathy is health—not disease—and preventive medicine is the objective of a good physician. Remember, the patient is sick—not the x-ray or the laboratory.

Another concern is the economics of the practice of medicine. We have allowed people to believe that they pay for treatment. We have failed to educate them that they pay for *knowledge.* Anybody can give medical treatment, and this has forced too many phy-

sicians to practice "gunshot" medicine on people suffering from functional diseases, without discovering the cause and application of the particular therapy necessary to bring them back to a state of health.

When I was honored in Austin in January of last year by the Southwest Insurance Industry, a prominent medical physician made a statement that was purely osteopathic before an audience of some 500 people—doctors, lawyers and insurance people. He said, "I never worked a miracle, I never cured anybody. No doctor ever did. He can only take the stumbling block out of nature's way, and nature cures the sick; and a doctor had better be careful that he does not put stumbling blocks in the way of nature."

Another problem of this profession is communications and division. Hospitals are divided against hospitals; divisional societies against divisional societies. Every specialist society in the profession thinks that its specialty is a gift of God. They do not recognize that the general practitioner is a man that does (or should) know the problems of his patients and should at all times be in charge of his patients, except for the advanced technical knowledge involved in specific cases.

How can we have a united front with this division? How will we be able to prevent amalgamation until this is corrected and the profession begins to apply the simple axiom of, "Observe, listen, remember and apply"?

Let's get together!

We must recognize our own faults and correct them to gain our objectives. If we are doing right, the public will support our professional independence.

Sincerely,

Phil R. Russell, D.O.

Defensive Mechanism?

Dear Sir:

I read with much interest the November Journal concerning some of the dangers facing the profession but I have not changed my mind on what we, as Osteopathic physicians, are or are not. I believe that it is a reaction on the part of the Medics as an organization to try to amalgamate the professions as they see it for the public good. Actually it is a defensive mechanism to tell the Public that their best interests lie with the Allopathic profession.

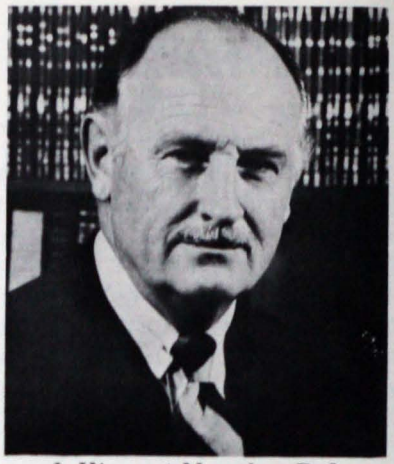
Now as I see it the public themselves must decide whether they are to be served by both professions. If we have not made sufficient inroads in the healing business in the past 40 or 50 years then we are, indeed in a bad fix. My feelings are that at a local level people have been well served by our profession and will stand and fight for our rights and their right to have the physician of their own choosing. Sometimes, not what we say, but rather what our patients think of us is more important. A point in fact was the recent fiasco in Fannin County over the County Hospital Authority issue of whether a county Hospital setup could exclude D.O.s. In a vote at the grass roots level my precinct and two others defeated the issue. However, in passing I would like to say we do need a County hospital with both M.D.s and D.O.s to give this service. Now it seems, without any further name calling or personal vendettas the people are now in the position of asking us to be Members of the Staff. We did not do this to glorify our profession alone but rather to offer our services in an effort to make this a financial success.

The present position of Health, Education and Welfare does not seem to differentiate between D.O.s and M.D.s but commands the position of being the dictator over all healing professions. This is a sad state that the professions could not decide themselves on Medical care for the American people. We, as a profession, have gone along with this system for it at least did something for the Welfare patient who prior to this time did not have adequate medical care. The cost has been astronomical but has filled a void which had not been filled by organized medicine; be it socialized medicine or whatever it is the only thing that has reached the elderly, the poor, and the totally disabled.

Practicing in a small town as I do this has helped me financially and has allowed me to give service most of which I wrote off as loss prior to Medicare. I feel that most people have not taken advantage of this program, although I admit some have. I have better equipment and do not have to be worried about the cost to the patient. I have not jacked up my fees, I have no problems with collecting just fees and I am able to do a better all around job for the patient both in the hospital and in my office.

This is not small town bigotry but I think an element of common sense so lacking in this get ahead time of history.

AOA President-Elect Murphy Is Heard In Washington



J. Vincent Murphy, D.O.

The president-elect of AOA, the president of KCOM and the president of AOHA appeared before the U. S. House Ways and Means Committee conducted by U.S. Representative (Arkansas) Wilbur Mills, chairman. The subject: National Health Insurance.

J. Vincent Murphy, D.O., AOA president-elect, presented the position paper printed herewith. Accompanying him were Dr. Morris Thompson, president of KCOM and John Rowland, president of AOHA.

A dozen other associations presented testimony on the same day and during the course of the weeks-long hearings at the end of 1971 scores of others testified.

According to reports, most health professions appealed for a middle-of-the-road bill.

Dr. Murphy's statement:

I am Doctor J. Vincent Murphy, president-elect of the American Osteopathic Association. With me are Doctor Morris Thompson, president of Kirksville College of Osteopathic Medicine in Kirksville, Missouri, representing the American Association of Colleges of Osteopathic Medicine, and Mr. John Rowland, president of the American Osteopathic Hospital Association.

We appear today on behalf of the entire osteopathic profession. We can make that statement with some assurance because all elements of our profession are represented before you at this time. We are pleased to have this opportunity to appear together before this distinguished Committee to express the views of our profession on the very important question of National Health Insurance.

In July 1970 and again in July 1971 the House of Delegates of the American Osteopathic Association, during its annual meeting, adopted resolutions endorsing the concept of National Health Insurance. In October of this year the American Osteopathic Hospital Association similarly supported the basic principle that health care is an inherent right of all individuals.

While our profession favors a program of National Health Insurance, we have consciously refrained from specifically endorsing any of the myriad health proposals now before Congress and from presuming the competence or responsibility for proposing a program of our own. Our profession's expertise lies in the delivery of quality health care not in the field of legislative drafting and advocacy.

We would, however, briefly note for the record a few general recommendations which we believe are reconcilable with any program of National Health Insurance which may be enacted and which we believe will help insure that any such system instituted will be an effective and viable one.

1. To insure continuity in the delivery of quality health care, the institution of any National Health Insurance plan should be accomplished, insofar as is practicable, through the modification of the existing delivery system rather than through the inauguration of a system which would be wholly foreign to both physician and patient.

2. In order to avoid the vice of depersonalizing the delivery of health care, any program of National Health Insurance should insure the maintenance of the free choice of physician.

3. To further promote continuity in the delivery of health care and consistent with the concept of maintaining the free choice of physician, any National Health Insurance program should be designed to encourage the fullest participation of all of our country's physician manpower.

4. Any program of National Health Insurance should be drawn so as to operate in consonance with our nation's system of free enterprise, leaving with the physician options as to his practice location, method of delivery and manner of payment for his services. We believe that by insuring such options unto the physician the concept of pluralism in the delivery of health care will be retained. Pluralism in the delivery of health care is absolutely essential to meet the varying health service requirements of our nation.

5. To promote economy in National Health Insurance the services offered under any such program should be specific to actual health needs.

'Insure the free choice of physician'

6. In the interest of maintaining the general good health of our population and to reduce the cost of the program, by reducing the number of in-patient hospital claims, we believe that any National Health Insurance legislation enacted should include a sophisticated mechanism for the comprehensive delivery of preventive medical care.

7. To the end that the American people may enjoy the highest calibre health care, any National Health Insurance program should provide that responsibility for the establishment and enforcement of standards for continuing education of health personnel, the certification of medical personnel to specialty bodies and professional standards review be vested in the various health professions, who are best equipped to make enlightened decisions in those areas.

8. Because of our nation's existing health manpower crises, it is imperative that any program of National Health Insurance concomitantly provide the necessary support to health education to insure that the promise of comprehensive health care for all Americans can be fulfilled.

It is our hope that the foregoing recommendations will be considered by this Committee in its evaluation of the various health proposals before it, and in forwarding a program of National Health Insurance to Congress.

We would conclude by assuring the Committee that our profession, as represented before you this morning, stands ready to cooperate in the execution of any National Health Insurance program which realistically responds to the needs of the people to make high quality health care accessible to all who require it.

Here is the list of associations giving general testimony for nursing, medical and groups representing specific problems:

L. B. Knecht, executive vice president, Communications Workers of America.

Joint presentation: Honorable Samuel L. Devine, M.C. (Ohio) and Dr. James L. Henry, Ohio State Medical Association.

Eileen M. Jacobi, executive director, American Nurses Association.

Maxine Taylor, president, Professional Nurses Bureau.

Dr. Ernest M. Weiner, president, American Podiatry Association; accompanied by Dr. Seward P. Nyman, executive director and Werner Stropp, general counsel.

Shep Glazer, vice president, National Association of Patients on Hemodialysis.

Dr. Stanley J. Brody, member, social policy and action committee, National Association of Social Workers, accompanied by Dr. Elizabeth Watkins.

Jane D. Keeler, on behalf of National League for Nursing and Council on Home Health Agencies and Community Health Services.

O. L. Frost, Jr., member, federal affairs committee, Los Angeles Area Chamber of Commerce.

A. P. Mynders, chairman, public health committee, National Hearing Aid Society, and Anthony DiRocco, executive secretary.

Ednajane Truax, chairman, committee to study National health care, of the District of Columbia Nurses Association, District of Columbia League of Nursing and District of Columbia Student Nurses Association.

Arthur Bockstahler, president, Southern California Occupational Therapy Association. ▲

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OPPORTUNITIES FOR OSTEOPATHIC PHYSICIANS IN TEXAS

BROWNSBORO—Immediate opportunity for a D.O. who wants a busy practice in a location where a D.O. clinic has been successfully operating for 20 years. Brick building, owner will equip to suit, if desired. Location is 14 miles from Tyler and excellent osteopathic general hospital. Gross will easily exceed $5,000 monthly. Call Olie Clem, Administrator, Doctors Memorial Hospital, Tyler 214—597-3771, or Mrs. Sue Porter, 214—849-6424.

NEW CLINIC—To be completed by January 1 needs another G.P. to help two doctors with well-established practice. Guaranteed income with no overhead makes this an ideal situation for new D.O. Contact Samuel B. Ganz, D.O., 3914 Leopard, Corpus Christi 78408; Phone 512—883-3433.

SPRINGTOWN—Will pay a young agressive D.O. who wants to go into family medicine $1,000 a month to get started. Plans are to open a new clinic in Weatherford. Parker County is deficient in the number of doctors and therefore affords a great opportunity for a D.O. Contact Keith G. Winterowd, D.O. and Associates, Box 215, Springtown, Texas 76082.

DALLAS—Will build to suit tenant. Leases being accepted in new professional building in north Dallas near Richardson, across from developing $150 million Park Central Complex. Contact Ronald Regis Stegman, D.O., 214—233-9222 or 214—369-2233 or Coit-Central Bldg. Suite 119, 12011 Coit Road, Dallas, Texas 75230.

LUBBOCK—Need three general practitioners for West Texas area as members of a 9 to 12 man group. Guaranteed salary. All the benefits of a corporation. Complete general practice including OB, hospital, minor surgery. Send resume to V. Wayne Ramsey, D.O., 1702 Parkway Drive, Lubbock, 79403.

ARANSAS PASS — Excellent opportunity for D.O. to operate, lease, rent or purchase large 25-year general practice location. Very nice clinic building and up to date equipment. Warm climate, good schools and hospital in thriving Gulf Coast community of approximately ten thousand. For more information contact Tex Roberts, Executive Director, TOMA Locations Committee, 512 Bailey, Fort Worth, Texas 76107, 817—336-0549.

FORT WORTH—Excellent opportunity for D.O. to develop local and regional practice in already successful clinic. Guaranteed minimum. Office space provided on hospital property. Many alternative arrangements. Tailored to individual needs. Contact Tom Banowetz, Administrator, White Settlement Hospital, P. O. Box 5128, Fort Worth 76108, phone 817—246-2491.

MARLIN—Has outstanding opportunity for D.O. to develop local, regional and national practice. One of world's finest treatment centers for arthritis and related diseases. Natural hot springs, clinic and treatment center. Contact J. M. Leath, First State Bank of Marlin, Box 720, Marlin, Texas 76661.

DALLAS SUBURB—D.O.-G.P. associate needed. Busy G.P. in S.E. Dallas Community desires an active associate in Family Medical Clinic. Must be well trained, mature, stable and happily married. Every other weekend off, 8 to 12 weeks off per year, as desired. Practice will provide ample time off, total coverage, and excellent income. This is an excellent practice location for now and future. Fine schools and living facilities. Partnership after one year, if desired. Please send resume to Jack Royder, D.O., Drawer AG, Hutchins, Texas 75141.

AMARILLO — Room for two D.O.s in large, brick clinic building that has housed long-time successful practices. Lots of room for ancillary facilities, offices, treatment rooms, finished basement work areas. Buy, lease or associate. The location is minutes from the modern, expanding Southwest Osteopathic Hospital. Contact E. W. Cain, D.O., 1608 Washington Street, Amarillo, 79102, phone 806—374-5213.

CALVERT—Excellent opportunity for D.O. who is tired of the city and its problems. Small town practice can be adjusted to your pace. Large clinic available for sale or lease with or without equipment. Large acute general practice with gross receipts excess $50,000. Contact Billy Hall, President of Citizens Bank and Trust, Calvert, Texas. Phone 713—364-2896.

(For information call or write Mr. Tex Roberts, Executive Director, TOMA Locations Committee, 512 Bailey, Fort Worth, Texas 76107, 817-336-0549.)

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A TROUBLE MAKER IS A GU WHO ROCKS THE BOAT, THE PERSUADES EVERYONE ELS THERE IS A STORM AT SE

12th Annual Surgical Conference

of the

TEXAS SOCIETY of OSTEOPATHIC SURGEONS

FEBRUARY 25–27, 1972

Sheraton-Marina Inn – Corpus Christi

FRIDAY—FEBRUARY 25

7:45 a.m.	Cervical Injuries T. T. McGrath, D.O.
8:30 a.m.	Common Roentgenographic Lesions of the Upper Gastrointestinal Tract John Kemplin, D.O.
9:15 a.m.	Metabolic Considerations in Gastrointestinal Disease Stevan Cordas, D.O.
10:00 a.m.	Coffee Break
10:30 a.m.	Obstructive Lesions of the Gastrointestinal Tract Dwight Hause, D.O.
11:15 a.m.	Surgical Treatment of Gastric and Duodenal Ulcer Robert Crawford, D.O.
12:00	Luncheon

SATURDAY—FEBRUARY 26

7:45 a.m.	Fractures of Upper Extremities Floyd Hardimon, D.O.
8:30 a.m.	Common Roentgenographic Lesions of the Colon John Kemplin, D.O.
9:15 a.m.	Hyperalimentation Stevan Cordas, D.O.
10:00 a.m.	Coffee Break
10:30 a.m.	Gastrointestinal Endoscopic Procedures Jack Leach, D.O.
11:15 a.m.	Surgical Treatment of Diverticular Disease of the Sigmoid Colon Raymond Mann, D.O.
7:30 p.m.	Banquet

SUNDAY—FEBRUARY 27

8:30 a.m.	Business Meeting

It Happened!

DISTRICT III

by H. George Grainger, D.O.

* * * * * *

Charles D. Buckholtz was installed president of the professional staff of Broadway-Memorial Hospital January 11. Others taking office were David Norris, vice president, and Neal Pock secretary. Dr. Buckholtz succeeds George Grainger, who held the office since 1969.

* * * * * *

Earl Kinzie has been appointed a member of the Smith County Board of Health. Charles Buckholtz has become a member of the consulting staff of the East Texas Chest Hospital. George Grainger has been promoted to associate professor of clinical osteopathy at the Texas College of Osteopathic Medicine. And, Drs. Norris, Buckholtz and Kinzie have been named members representing the osteopathic profession, of the Tyler-Smith County Area County Area Health Council.

* * * * * *

Anything happen in Mineola or Mt. Pleasant or anywhere else in Etex?

Basic Science Exam Date Announced

The next examination of the Texas Board of Examiners in the Basic Sciences has been set for Friday and Saturday, April 14—15, 1972 in Dallas, Galveston, Houston and San Antonio.

Details as to time and place may be obtained by writing to the Executive Secretary at 1012 Sam Houston State Office Building, 201 East 14th Street, Austin, Texas 78701.

Applications for the April examination must be complete and in this office by March 20, 1972 and all necessary information and documents required of examinees by the Board must be completed and in the applicant's file by that date. Those interested in participating in this examination should act immediately.

It should be noted that the certificate which is acquired by examination is the only one which is valid for reciprocity with other state basic science boards. The Texas Basic Science Board has reciprocity with the following states: Alabama, Alaska, Arizona, Arkansas, Colorado, Iowa, Kansas, Michigan, Minnesota, Nebraska, Nevada, New Mexico, Oklahoma, Oregon, South Dakota, Tennessee, Washington, Rhode Island, and Wisconsin.

The most widely used diuretic in cardiac edema

This technique of unwrapping a sphere to make a flat map was invented by Johann Werner, a mathematician who lived at the time of Columbus, long before the exact shape of the New World continents was known. To achieve such an equal-area projection, he kept the central meridian a straight line and intersected it at true distances with parallel lines.

Lasix®
(furosemide) Tablets and Injection

Please see prescribing information which follows.

In a wide range of cardiac edemas— the response you want by selecting the dosage your patient needs

Lasix®

furosemide Tablets/Injection

WARNING—Lasix (furosemide) is a potent diuretic which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "DOSAGE AND ADMINISTRATION.")

DESCRIPTION—Lasix is a diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by:

- a high degree of efficacy;
- a rapid onset of action;
- a comparatively short duration of action;
- a ratio of minimum to maximum effective dose higher than 1:10;
- the fact that it acts not only at the proximal and distal tubules but also at the ascending limb of Henle's loop.

Lasix (furosemide) is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid.

INDICATIONS—Lasix (furosemide) is indicated for the treatment of the edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix is particularly useful when an agent with greater diuretic potential than that of those commonly employed is desired.

If the gastrointestinal absorption is impaired or oral medication is not practicable for any reason, Lasix is indicated by the intramuscular or intravenous route. The intravenous administration of Lasix is indicated when a rapid onset of the diuresis is desired, e.g., acute pulmonary edema.

Parenteral administration should be reserved for patients where oral medication of Lasix (furosemide) is not practical.

Hypertension—Lasix Tablets may be used for the treatment of hypertension alone or in combination with other antihypertensive drugs. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controllable with Lasix (furosemide) alone.

CONTRAINDICATIONS—Because animal reproductive studies have shown that Lasix (furosemide) may cause fetal abnormalities, the drug is contraindicated in women who are or may become pregnant.

Lasix is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix is contraindicated in patients with a history of hypersensitivity to this compound.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

WARNINGS—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium-depleting steroids.

Frequent serum electrolyte, CO_2 and BUN determinations should be performed during the first few months of therapy and periodically thereafter, and abnormalities corrected or the drug temporarily withdrawn.

In patients with hepatic cirrhosis and ascites, initiation of therapy with Lasix (furosemide) is best carried out in the hospital. Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical.

There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics.

These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred.

Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Patients with known sulfonamide sensitivity may show allergic reactions to Lasix (furosemide).

PRECAUTIONS—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix, especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion. In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix is administered, since Lasix potentiates the hypotensive effect of antihypertensive medications.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration, which should be avoided, particularly in patients with renal insufficiency.

Cases of reversible deafness and tinnitus have been reported following the injection of Lasix. These adverse reactions occurred when Lasix was injected at doses exceeding several times the usual therapeutic injection dose of 1 to 2 ampules (20 to 40 mg.). Transient deafness is more likely to occur in patients with severe impairment of renal function and in patients who are also receiving drugs known to be ototoxic. Periodic checks on urine and blood glucose should be made in diabetics and even those suspected of latent diabetes when receiving Lasix. Increases in blood glucose and alterations in glucose tolerance tests with abnormalities of the fasting and two-hour postprandial sugar have been observed, and rare cases of precipitation of diabetes mellitus have been reported.

Lasix (furosemide) may lower serum calcium levels, and rare cases of tetany have been reported. Accordingly, periodic serum calcium levels should be obtained.

Patients receiving high doses of salicylates, as in rheumatic diseases, in conjunction with Lasix may experience salicylate toxicity at lower doses because of competitive renal excretory sites.

Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix, and it is advisable to discontinue oral Lasix for one week and parenteral Lasix two days prior to any elective surgery.

ADVERSE REACTIONS—Various forms of dermatitis, including urticaria and rare cases of exfoliative dermatitis, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea, may occur.

Anemia, leukopenia, aplastic anemia, and thrombocytopenia (with purpura) may occur. Rare cases of agranulocytosis have occurred which responded to treatment.

Cases of reversible deafness and tinnitus have been reported. These adverse reactions occurred when Lasix Injection was given at doses exceeding several times the usual therapeutic dose of 1 to 2 ampules (20 to 40 mg.). (See "PRECAUTIONS.")

In addition, the following rare adverse reactions have been reported; however, relationship to the drug has not been established with certainty: sweet taste, oral and gastric burning, paradoxical swelling, headache, jaundice, thrombophlebitis and emboli (see "WARNINGS"), and acute pancreatitis.

Lasix induced diuresis may be accompanied by weakness, fatigue, lightheadedness or dizziness, muscle cramps, thirst, increased perspiration, urinary bladder spasm and symptoms of urinary frequency.

As far as hyperglycemia is concerned, see "PRECAUTIONS."

Transient pain after intramuscular injection has been reported at the injection site.

DOSAGE AND ADMINISTRATION

Oral Administration—The usual dose of Lasix is 1 to 2 tablets (40 to 80 mg.) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours l... This dosage and dosage schedule can then be m... tained or even reduced. If the diuretic response ... a single dose of 1 to 2 tablets (40 to 80 mg.) is ... satisfactory, e.g., in a patient with congestive h... failure refractory to maximal doses of thiazides, ... following schedule should be used: Increase ... dose by increments of 1 tablet (40 mg.) not so ... than 6 to 8 hours after the previous dose until ... desired diuretic effect has been obtained. This ... vidually determined single dose should then be g... once or twice daily (e.g., at 8:00 a.m. and 2:00 p... The dose of Lasix may be carefully titrated up to ... mg. per day in those patients with severe clin... edematous states. Higher doses are currently u... investigation.

The mobilization of edema may be most efficie... and safely accomplished by utilizing an intermi... dosage schedule in which the diuretic is given ... to 4 consecutive days each week. With doses exc... ing 80 mg./day and given for prolonged peri... careful clinical and laboratory observations are ... ticularly advisable.

Hypertension—The usual dose of Lasix (furosem...) is one tablet (40 mg.) twice daily both for initi... of therapy and for maintenance. Careful observat... for changes in blood pressure must be made w... this compound is used with other antihyperter... drugs, especially during initial therapy.

The dosage of other agents must be reduced b... least 50 per cent as soon as Lasix is added to ... regimen to prevent excessive drop in blood pres... As the blood pressure falls under the potentia... effect of Lasix, a further reduction in dosage, or ... discontinuation, of other antihypertensive drugs ... be necessary. It is further recommended, if one ... let (40 mg.) twice daily does not lead to a c... cally satisfactory response, to add other hypoter... agents, e.g., reserpine, rather than to increase ... dose of Lasix.

Until more experience is accumulated in the pedi... use of Lasix (furosemide), children should no... treated with the drug.

Parenteral Administration—The usual dose of L... is 1 to 2 ampules (20 to 40 mg.) given as a si... dose, injected intramuscularly or intravenously. ... intravenous injection should be given slowly (... 2 minutes). Ordinarily, a prompt diuresis ens... Depending on the patient's response a second ... can be administered two hours after the first ... or later.

If the diuretic response with a single dose of 1 ... 2 ampules (20 to 40 mg.) is not satisfactory, e.g., ... patient refractory to maximal doses of thiazides, ... following schedule should be used under ca... medical supervision: Increase this dose by ir... ments of 1 ampule (20 mg.) not sooner than ... hours after the previous dose until the desired diu... effect has been obtained. This individually d... mined single dose should then be given once or t... daily. Parenteral administration should be rese... for patients where oral medication is not pract... Parenteral therapy with Lasix can be replace... treatment with Lasix Tablets as soon as this is p... tical for continued mobilization of edema.

Acute Pulmonary Edema—Since the diuresis ev... by Lasix given intravenously commences within ... minutes and leads to an intensive diuresis, the t... ment of patients with acute pulmonary edema ... Lasix (furosemide) intravenously has proven ... ticularly valuable.

The following schedule is recommended: 2 amp... (40 mg.) of Lasix are to be slowly injected i... venously immediately. Then this dose should be ... lowed by another 2 ampules (40 mg.) one to one ... one-half hours later if that is indicated by the ... tient's condition.

If deemed necessary, additional therapy (e.g., ... talis, oxygen) can be administered concomitantly.

Until more experience is accumulated in the pedi... use of Lasix (furosemide), children should no... treated with the drug.

HOW SUPPLIED—Lasix Tablets are supplied in w... monogrammed, scored tablets of 40 mg. in a... bottles of 100 (FSN 6505-062-3336), 500, and ... Dose 100's (20 strips of 5). **Lasix Injection,** bra... furosemide, is supplied as a sterile solution in 2 ... amber ampules; boxes of 5 (FSN 6505-435-0377) ... 50. Each ml. contains 10 mg. furosemide (with so... chloride for isotonicity and sodium hydroxide to m... the solution slightly alkaline).

Note: Exposure to light may cause slight discol... ation which, however, does not alter potency.

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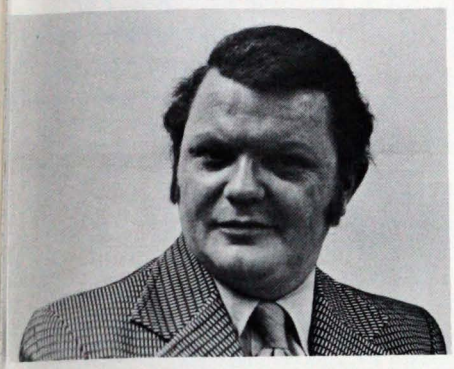
Dr. O'Shea Heads Lab at FWOH



Dr. J. Thomas O'Shea assumed his duties as Pathologist and Director of Laboratories at Fort Worth Osteopathic Hospital on January 3, 1972.

A native of Garden City, Michigan, Dr. O'Shea recently completed a three-year residency in pathology at the Garden City Osteopathic Hospital. He is a 1965 graduate of the Kirksville College of Osteopathic Medicine and served a one-year internship at Garden City Osteopathic Hospital. After completion of his internship, Dr. O'Shea was in private practice in Milwaukee, Wisconsin before entering residency training.

Dr. O'Shea is a member of the American Osteopathic College of Pathologists, Inc., the American Osteopathic Association, and the Michigan Association of Osteopathic Physicians and Surgeons, Inc.

He is married to the former Nancy Garland, also of Garden City, and they are the parents of two children: John, 3½ and Heather, 1½. ▲

D.O. Appreciated in Silverton

In the March, 1971 *Journal* there was a story about Dr. John Boyd's move to Silverton and how the community rolled out the red carpet to welcome the first doctor it had had since 1965.

At that time it was reported how the townspeople "worked like Trojans" to repaint the clinic building, install new tile on the floor and hang new curtains.

Apparently the town's appreciation of their doctor has increased over the past year, since recently Mr. and Mrs. Billy Cogdell of Silverton announced a donation of $90,000 would be presented to the Briscoe County Clinic Association and to the Silverton Ambulance Service.

Mr. Cogdell said that no strings were attached to the gift, but requested that a new clinic building be constructed and equipped and a new ambulance purchased.

The Briscoe County News reported that "It is Mr. Cogdell's hope that the new facilities and equipment will help to insure that Silverton will always have a resident doctor."

The Cogdells had already announced plans to retire the $2,000 debt on the clinic x-ray machine before the decision was made to increase the size of the gift.

The money was given out of a hospital trust fund that was established by the late D. M. Cogdell, Sr. ▲

Promises, Promises - They Can Cost You

In a precedent setting decision, the Michigan Court of Appeals upheld a $50,000 judgment to a patient who sued his physicians for breach of contract when a surgical procedure didn't turn out as represented.

The patient testified that the physician told him the operation (a gastric resection) would allay his problems and he could eat and drink as he pleased. Complications after the surgical procedure resulted in three subsequent operations and the patient became physically weak and socially inactive. As a result he brought suit alleging both malpractice and breach of contract.

The jury found the surgeons were not guilty of malpractice, but awarded the patient $50,000 for breach of contract.

The Supreme Court of Michigan affirmed the decision ruling that the jury must have found that the doctors made a promise to cure or effect a specific result.

MORAL: Always inform the patient of any and all possible outcomes and never promise to effect a cure.

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