Texas Osteopathic Physicians Journal

VOLUME XXIV FORT WORTH, TEXAS SEPTEMBER, 1967 NUMBER 5

In This Issue—

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

PUBLICATION OFFICE: 512 BAILEY AVE. FORT WORTH, TEXAS 76107

VOLUME XXIV FORT WORTH, TEXAS, SEPTEMBER, 1967 NUMBER 5

OFFICERS

Wiley B. Rountree, D.O., President
San Angelo

Fred E. Logan, D.O., Immediate Past
President, Corpus Christi

Robert H. Nobles, D.O., President-Elect
Denton

Frank Bradley, D.O., Vice-President
Dallas

BOARD OF TRUSTEES

Mickie G. Holcomb, D.O., El Paso
Donald E. Hackley, D.O., Spearman
Leland C. Long, D.O., Portland
Kenneth R. Watkins, D.O., Groves
Jack P. Leach, D.O., Houston
Walters R. Russell, D.O., Dallas
W. G. Millington, D.O., Nixon
Bobby G. Smith, D.O., Arlington
Clifford E. Dickey, D.O., Ft. Worth
Robert G. Haman, D.O., Irving
Robert E. Slye, D.O., Tyler
Richard L. Stratton, D.O., Cuero

HOUSE OF DELEGATES

Samuel B. Ganz, D.O., Speaker
Corpus Christi

John H. Boyd, D.O., Vice Speaker
Louise

DEPARTMENT OF PROFESSIONAL AFFAIRS

W. G. Millington, D.O., Chairman

1. Professional Education and Meetings — Kenneth Watkins, D.O., Chairman; Robert E. Slye, D.O.
2. Ethics — R. H. Peterson, D.O., Chairman; Leland Long, D.O.; Howard Coats, D.O.
3. Annual Program — Frank Bradley, D.O., Chairman; Richard M. Hall, D.O., Chairman-Elect
4. Facilities and Exhibitors — Mr. Robert B. Price, Chairman; Carl Everett, D.O.
5. Selective Service — Walters Russell, D.O.
6. Statistics and Locations — Mr. Robert B. Price, Chairman; D. D. Beyer, D.O.; Joe Suderman, D.O.; Leland Long, D.O.; John Walton, D.O.; H. Eugene Brown, D.O.
7. Membership — C. E. Dickey, D.O., Chairman; John Boyd, D.O.; Robert E. Slye, D.O.; R. D. Van Schoick, D.O.; Judy Slagle, Secretary
8. Constitution, By-Laws and Charters — Richard L. Stratton, D.O., Chairman
9. Editorial Policy and Journal Publications — H. Geo. Grainger, D.O., Chairman; M. A. Calabrese, D.O.; Virginia Ellis, D.O.; Wendell Gabier, D.O.; Mr. Robert B. Price, Editor

DEPARTMENT OF PUBLIC AFFAIRS

Robert L. Haman, D.O., Chairman

1. Public Health — Elmer Baum, D.O., Chairman; L. G. Ballard, D.O.; Gordon Beckwith, D.O.; J. Warren McCorkle, D.O.; Jack Leach, D.O.; Walters Russell, D.O.; Mickie G. Holcomb, D.O.; Everett Wilson, D.O.
2. Public Relations Committee — Richard M. Hall, D.O., Chairman; Ronald Owens, D.O., Vice-Chairman; Benjamin R. Beall, II, D.O.; Catherine Carlton, D.O.; David Norris, D.O.; B. G. Smith, D.O.
3. Osteopathic Progress Fund and National Osteopathic Foundation — Donald Hackley, D.O., Chairman; Maurice Mann, D.O.
4. Veterans Affairs — M. A. Calabrese, D.O., Chairman
5. Hospitals and Insurance — G. W. Tompson, D.O., Chairman; Clifford E. Dickey, D.O.; N. G. Palmarozzi, D.O.; Glenn Scott, D.O.
6. Disaster Medicine — B. G. Smith, D.O., Chairman; Robert Clayton, D.O.; B. R. Beall, II, D.O.; Gerald Geske, D.O.; Joe Wolpmann, D.O.

Summary of Dr. Stratton's Address to the TAOP's Assistants Convention

RICHARD L. STRATTON, D.O.

Ethical behavior antedates recorded history. The word Ethics, however, came to us from a Greek word meaning custom.

One of the Webster dictionaries gives us the following two-part definition: (a) "The branch of philosophy which deals with the moral duty of man as in his obligation to others, or *in the perfecting of himself.* (b) Moral principles of action; standards of conduct."

I think that to be ethical, one simply applies the Golden Rule. The subject at hand is related to all activities of man that are his custom—not his busineeds or social activities alone. Economic ethics have a modern connotation in that they are essentially business ethics and therefore are what we oft-times find printed by fraternal groups so that economic infringement does not occur when members behave ethically one to the other. We then say one is not ethical if he obtained an improper financial advantage by his behavior. Or we may say he is ethical to deal with—meaning he is honest and will not take from you any hidden cost.

If ethics are man's customs, they must encompass all of those customs from the way he dresses to how he eats, to his manners, to his behavior and on indefinitely until we have the whole picture of man as he lives day by day.

If we could answer in the affirmative each time we deal with fellow human beings the question: "Am I treating them as I would want to be treated?" we would be ethical in every sense.

Why, then, do we find something so purely simple to be so complex in more than random instances?

The problems arise in the shades between the extremes of right and wrong. Much like the pedestrian who becomes a changed personality when behind the wheel of an automobile, we find people who may be ethical purists in every facet of their lives except one. An example you may immediately think of is the rulthless business man who may be an excellent person in other ways. The complexity increases when we realize that he may be admired and encouraged in his ruthlessness by the people who surround him. They may say he is shrewed, or cunning, or clever and thus serve to balm any conscience there may be. Then, too, customs change. Ethics must adapt. None of us here today would consider it ethical social behavior to appear at work wearing rawhides from wild beasts as did our ancestors. Yet we do consider much dress wholly acceptable in its time period or under special conditions, for example a dramatic sketch or a costume party.

In a special article on the subject of professional ethics, a Newark, Delaware, Ph.D., Dr. Charles Wilbur wrote, in a recent A.O.A. Journal: "Ordinarily in human affairs, there seem to be three general types of acts which man can ini-

tiate. There are those which a man *ought to do;* there are those which a man *ought not to do.* Finally, there are those acts which he *may do or not do* as he wishes; it makes very little difference whether these acts are done or not done."

Based upon these three acts, man judges himself individually and collectively. He meets punishment or lauds praise dependent upon what he ought to have done—not what he has done. Ethics itself is declared by what we ought to do, ought not to do, or what is indifferent. If an action fits one of the three categories properly, it is ethical. If not, it is unethical.

Now we see why there are shades between ethical and unethical acts that can cause honest confusion or even lead to a conflict as to what to do if being ethical proves to be illegal—as it might well be, or vice versa. Harboring a fugitive might be illegal and yet be ethical. Forcing a transfusion by legal means might be viewed as being unethical since the state would over-ride the church or religious belief and even invade the right and privilege of an individual who might steadfastly refuse such treatment for himself or his family.

What is ethical for me might be unethical to someone else in this room, because to a degree ethics may vary from individual interpretation and it most ceratinly does vary from time to time and place to place, because we know that customs vary.

If being ethical can be such a beclouded and difficult proposition, perhaps we should cast such attempted behavior aside as not being feasible. Some can do this readily. You and I cannot, anymore that we can deny goodness because sinfulness is so inherent, or fail to resist because freedom is such a constant struggle, or discontinue cleanliness because it is an effort or bore. No indeed. Ethical behavior is something to be prized and therefore worth the struggle. It is a polish to gracious living, a must to the civilized state. Ethical behavior has to be acquired by practice until one adopts it into his way of living with others. When this is done, ethics takes its place with pride, honesty and other such attributes. Once this state is reached, it becomes difficult to be unethical, for to do so means a breach of one's own moral code with all the attendant guilt and other ill feeling which the individual does not well indure. Our heroes in prose and fiction are persons who will lay down their lives, if need be, before they will break with the principles they have accepted as their code.

Since you, here today, act as assistants to physicians, you assume partial responsibility for eight or more hours several days each week for your physician's ethical image. None of you would think of exposing a patient to equipment known to be faulty or unclean, nor would you knowingly permit cross infection or contaminants in the reception room, central supply, or examining rooms, nor would you fail to call to the physician's attention loose flooring tile, or a new wax which had made the floor slippery. Because I am a physician and know and deeply appreciate this, I also know you would do nothing to hurt the image. However, some acts are so akin to human nature that they may occur without realizing what we do. An assistant must like her job and believe in the ability and dedication of her employer, or she cannot be wholly effective in her work. Yet these very essentials can pose a damning drawback and reek havoc with no such intent being meant. I would cite you an instance whether at the place of business or away from it that an assistant would herald the abilities of "her doctor" so emphatically and to such an extent that it might seem to be the physician talking through her. To the casual listener the doctor would be cast in a very poor light. The reverse of the desired effect would occur. What happens if a loyal assistant makes a wry face, shrugs, or simply raises an eyebrow when a patient or prospective

patient asks her opinion of some physician other than her employer? Such automatic and understandable reactions could seriously hurt practice where you work and could conceivably end up costing your employer unnecessary days in court testifying, if the offended doctor begins to sling back arrows by insinuation or innuendo to patients. Quite often malpractice cases are indeed incited by a casual remark or shrug by someone who should be in the know, but is not in the discussion at hand at the time. Since none of us knows what we would do in a given situation, we must not be critical of others who have met a situation and reacted to it. Let the rule apply here that if we cannot say something nice then let us say nothing, not even by gesture.

Another common breach of ethics may occur when the assistant doesn't leave knowledge where she obtained it. Carrying information home where others might come in contact with it is dangerous business for you and your employer. If the social set or neighborhood friend opens a discussion as to just how many stitches used in a given procedure in your office on a mutual acquaintance, do not get trapped into the conversation. Be mum. Listen. You cannot imagine how entertaining the conversation may become when the pseudo-expert describes the case to you. Do not attempt to correct her. If you dignify the conversation by bringing facts into it, you only succeed in embarrassing the one who was embellishing it, yourself as the one who freely dispenses personal information, and your physician as running an office where everyone's business is blatently exposed. Even the courthouse makes it more difficult to review those records which are public. If you are pressed for an answer, give only details that are generally available to the public. This is arbitrarily decided by applying the question — It is of public interest without specific invasion of the person's privacy? "Yes, Mr. & Mrs. Jennings were admitted to our clinic following an automobile accident. They were transferred to the hospital. No, I don't know if all the injuries have been determined. Their children went on to the hospital to see about them. I am certain they would like to hear from you and can tell you more than I can, now."

Then, too we often mistake questions for what they are not. People are prone to ask, "What is wrong with Mrs. Stanley?" This may be nothing more than a statement similar to a greeting such as, "How are you?" The questioner means it more than likely as a conversation opener. If you attempt a detailed answer it may shock or bore her. A simple, "I don't know," or " I really couldn't say," will porbably be enough to start the questioner off on a tangent of verbalizing his or her own complaints or some subject equally as interesting to her.

There is, to be sure, the more calculating person. The one who does pry, inveigle, and boldly insist upon details to which he or she has no right. You can be certain that *here* what you say will be used against you. Such a questioner is bound to use the information in a way you would not knowingly permit. These persons may themselves be sick. In any event, they are actually using you.

A safe yardstick is to employ ethics to any of your answers. Do not reveal one smattering of information you would not want released if the discussion were about *you*. You should be aware, too, that a questioner will usually use your name as the authoritative source of information repeated.

Handled tactfully, (and all questions can be so handled *if* there has been a little prior thought and preparation), your answers can effectively increase the stature of your employer, your place of work, and most c e r t a i n l y yourself. Wouldn't you select a personal physician or clinic only if you felt your problems would be given confidential consideration? Why, of course. In fact, this is

one of the prime considerations next to the ability of the physician. It is possibly even ranked equal to his ability in making the selection.

Unfortunately, because of third-party interest in medicine, privileged communication between physician and patient is becoming less a fact; because the law permits these other parties to have full knowledge of what service they are paying for. We also find the courts are treading into this field with much less timidity than has perviously been the custom. For example, any statement made with a third party present, (in some states even the spouse of the patient), is not privileged information. Nonetheless, ethics demands discretion.

I hope that you do not feel at this point that I have been critical of any of you as individuals or of your group. This is not my intent at all. In fact, the examples I have been pointing out are the very type of ethical quagmire that we as physicians must daily strive to avoid. I have simply applied it to you, the assistant, realizing full well we are in the situation together. The whole discussion would require no change of intent to be a suitable discussion to be directed toward your physician-employers.

TUR-BI-KAL

for nasal congestion

- mild
- long lasting relief
- for adults, children, infants

Now, I want to alter the topic and talk about a subject unique to your place of employment. It occurs nowhere else. "What is an osteopath?" Ceratinly a familiar question, isn't it? Are you familiar with an answer or answers that the public can comprehend and repeat the gist of? You see, more often than we suspect, the question is being asked by the patient who feels an urgent need to have an answer to give to people who are inquiring of him. He already has the courage of his convictions, but feels a need to explain how something works that he doesn't understand—although he is absolutely certain it does work.

Think a moment how you and I use and rely upon things day in and day out that we never question, but do not understand. I know that an airplane flies and a steel-hulled ship floats. Nonetheless, it doesn't seem logical unless one thoroughly understands the involved dynamics. Why don't we question all of the things we daily encounter One reason is that we take too much for granted. We are all spoiled by our living standards. Another reason is that we assume we know *what* a thing is because it is the only such product known to be available.

"What is an Osteopath?" the answer is neither simple nor is it a subject for light discussion. However, I feel it can be simplified. Osteopathy *is not a treatment!* It is a method of treating. It is a philosophy of *total* health care. It is the only medical theory of disease and its management to have originated in the new world. It is a product of America given through the genius of a frontier physician. In the United States it has reached full stature, but not full growth.

I believe that when one encounters the question, "What is an osteopath?" —the answer should impart the knowl-

edge that he or she is a physician trained in *all* aspects of alleviating human suffering, not limited to only a knowledge of medicine or only a knowledge of surgery or only a knowledge of manipulation. Such physician practices osteopathic medicine which means an application of the *osteopathic philosophy* to the art of medical practice. You are the public relations expert in your office and, therefore, you should be able to explain this philosophy. It is not easy. The philosophy of a church, profession, or group of people is something one would not attempt to define "in twenty-five words or less". Our most reputable dictionaries cannot do it. Much in a philosophy is metaphysical and defies short, meaningful description. The osteopathic philosophy is basically the belief that people are whole units. If any part is diseased or injured, the whole unit is affected—not just the affected part. Then too, the philosophy incorporates the belief that the inherently normal body is able to repair or bring itself back to a state of well-being which it constantly seeks, *provided* it is not overwhelmed. In his fight against illness, the osteopathic physician seeks to alleviate and/or correct the internal or external environment so that the body may have time and substance to adapt and to regain its own balance.

When we hear the phrase, "structural integrity", this *does not* mean skeletal structure alone. Skin and muscle have structure. Even blood or lymph has structure. We must remember that many modalities of treatment are basically osteopathic in nature although research from fields allied to the medical professions may be the actual developers of such treatment. I think specifically of our wonder drugs. Antibiotics keep bacteria from developing in devious and ingenious ways, thus giving the human system time to marshall its defenses and commence damage repair. There is no medicine to replace blood, or to cause sudden blood replacement in volume from within the system. Isn't a transfusion of whole blood compatible with the osteopathic philosophy? It is buying time for the body and at the same time it is aiding in restoration of balance while the cause of the blood loss is being corrected. What about surgery? Isn't it an obvious admission that we are unable to effect a cure? Diseased, damaged, or deranged tissue (as in the case of a malignancy) must be destroyed so the whole body doesn't become overwhelmed and irreparably out of balance. You can think of many more examples.

It is a sad thing for me to find good physicians who themselves are practicing the osteopathic philosophy without a full comprehension of what it is. They are fully aware that their approach is effectively different, but they somehow miss why. Within the past twelve months I have heard physicians comment, "I don't guess my scalpel is os-

CALENDAR OF EVENTS

Sept. 21-22-23—National Osteopathic Guild Association, Annual Meeting and Convention, Green Oaks Inn, Fort Worth, Texas. Mrs. T. Y. Lewis, 3725 Hamilton, Fort Worth, Texas 76107.

Oct. 7-8—Texas Association of Osteopathic Obstetricians, Gynecologists, annual meeting. Hilton Inn, Dallas. Secretary, Dr. Roy L. Fischer, 6116 North Central Expressway, Dallas 75206.

Oct. 8-12—40th Annual Clinical Assembly, Americana Hotel, Bal Harbour, Florida. Dr. C. L. Ballinger, Executive Secretary. P. O. Box 40, Coral Gables 33134.

Oct. 30-Nov. 2—American Osteopathic Association, 72nd Annual Convention and Scientific Seminar; Fairmont, Mark Hopkins, Sheraton-Palace Hotels, Del Webb's Townehouse, San Francisco. Program chairman, Dr. Dana P. Arneman, 6265 Sodum-Hutchings Road, Girard, Ohio 44420.

teopathic as opposed to some other kind," and "do you think my anesthetic machine contains osteopathic gas?" Both of these doctors should have known, and I hope now do know that the scalpel, gas machine or whatever instrument a physician uses becomes oriented by his use of it to his philosophy—no matter what that philosophy may be. Yes, the surgeon or the anesthesiologist cannot help but carry his philosophy to the surgical table just as the physician to the bedside or treatment room. Identical procedures can be carried out by physicians with different philosophies, and while they are so doing, the inanimate objects or the modalities utilized are used to serve the philosophy of the user. This seems so basically simple to me.

How do you answer the question, "How does an osteopath differ from an M.D." In our own office we parry with the question, "What do you mean by M.D.?" Nine out of ten patients do not know that eclectics, homeopaths and allopaths are all grouped under the M.D. degree. The osteopathic physician is the only licensed practitioner of medicine and surgery who pridefully declares he has an identity and philosophy of his own through his degree, D.O., Doctor of Osteopathy. As our very able A.O.A. Editor, Dr. George Northup has pointed out, to try to differentiate the D.O. & M.D. is like asking the questions, "How do robins differ from birds?" or "How are statues like art?" You see, the doctor doesn't own medicine or health, nor the musician—music, nor other artists—their art forms. These things are and forever should be in the public domain.

In our present day of enlightenment, no matter how backward we as nations seem to be, we have advanced to the point that we recognize there can be more than one approach to the same goal. Neither road will be found totally straight, true or proper, and without some limit or fault. Look at the reforms in religion that we see. As a Protestant, I cannot say that the Presbyterian Bible differs from the Baptist, Methodist, and so on. I can assure you, on the other hand, that the philosophy, interpretation and application may differ. Does one have to be right and all others wrong? I think not. Is there room for more than one? I think so. The same is true of the osteopathic philosophy of medicine. It withstands the test of time and scientific scrutiny.

Final Rites Held For Cpl. Calabria

Rosary was recited for Lance Cpl. David M. Calabria, Sunday, August 27, 1967 in Campbell Funeral Chapel, Dallas, Texas.

Lance Cpl. Calabria, 20, was a native of Dallas. He attended St. Cecilia's School and was graduated from Sunset High School.

He had been in the Marine Corps about 14 months when he was killed in action in Vietnam on August 17, 1967.

He is survived by his father, Dr. Julius C. Calabria of Dallas, his mother, Mrs. Rosemary Calabria of Miami Beach, Florida, two brothers, Stephen Calabria of Dallas and Danny Calabria of Miami Beach; a sister, Miss Ann E. Calabria of Dallas.

Requiem Mass was celebrated at St. Cecilia Catholic Church Monday, where he was a member. Interment followed full military rites at Calvary Hill Cemetery.

The entire profession offers its condolences to the family of Cpl. Calabria.

Remember . . .

N E W S

From your district for the Journal must be in this office by the 20th of preceding month.

Please give us your cooperation.
THANKS!

Academy of Applied Osteopathy Seminar

In the picture from left to right back row: Drs. M. J. Schwartz, of Oklahoma City, Evelyn Hall Kennedy of Beeville, J. R. Cunningham of Houston, George Luibel, E. P. Carlton and M. S. Miller of Ft. Worth, John Donovan and Ralph Farnsworth of Austin, C. R. Stratton of Cuero, Frank McLamb of Houston, Burr Lacey of Quitman, front row: Laura Lowell of Dallas, Auldine Hammond of Beaumont, Catherine Carlton of Ft. Worth, State President Wiley Rountree of San Angelo, Rollin Becker of Dallas, Reg Platt of Houston. Not in the picture is Dr. Katherine Patterson of Austin.

The Texas Academy of Applied Osteopathy held a day and a half seminar in Austin August 5 and 6, 1967 at the Gondolier Hotel. The program was presented by members of the state group. Dr. Rollin Becker spoke on Whiplash Injuries, Dr. George Luibel on the low back, Dr. J. R. Cunningham on knee injuries, Dr. Auldine Hammond on cervical area, and Dr. Catherine Carlton on rib lesions.

Dr. Ralph Farnsworth of Austin was general chairman of the seminar and host to the eighteen physicians and their families who attended.

Take Advantage of Your Membership in Your State Association by Enrolling in one or all of these Special Plans

- Up to $1,000 Monthly Indemnity Disability Income Plan
  Lifetime Accident—90 months Sickness
- Life Insurance at low, low premiums
- $100,000 Accident Policy—Death-Dismemberment-Total Disablement

Each Plan Approved by the Texas Association of Osteopathic Physicians and Surgeons for its members.

SID MURRAY "Pays In A Hurry"

1733 Brownlee Blvd. Corpus Christi, Texas

FOR

MUTUAL LIFE OF NEW YORK

The Edwards Myo-Flex
A General Practice Electronic Modality

RALPH I. McRAE, D.O.

This unique, broad spectrum electronic modality has been widely used by general practitioners over the past fifteen years, with an ever widening and deepening scope of application in difficult clinical problems.

The Myo-Flex generates a fine quality of electronic energy that is easily tolerated and often gratefully accepted by patients.

A PHYSIOLOGICAL ENERGY

The electronic circuitry is designed to generate in the frequency of the alpha and beta range of the electroencephalogram and in the frequency modulations in the electro myographic range. Thus the Myo-Flex has an input that specifically activates by direct physiological stimulation; both cerebral and peripheral sensory, motor and autonomic components of man's nervous system. As a result, the energies have access to somatic, visceral, vascular, endocrine, and connective tissue systems of the body.

Physicians practicing in a wide range of medical specialty disciplines have found successful clinical application of this modality, ranging from the proctologist, gynecologist, cardiologist, to the neurologist and the psychiatrist.

As I have reported previously, it has been an invaluable tool in regaining motor strength and muscle volume in residual polio defects, cerebral palsy deficits, and peripheral neuropathy problems such as facial paralysis and traumatic nerve injury problems. Certain specific technics also are useful to clear up endogenous depressive reactions when electro-shock therapy and anti-depressive drugs have been ineffective.

FLEXIBILITY OF APPLICATION

The full range unit of the Myo-Flex has six separate patient treatment frequency ranges on a gradient scale from low audio to high audio frequencies. These six channels of physiological energy have remarkably consistent clinical applications on a broad basis of therapeutic value. The higher frequencies are useful to reduce inflammation and swelling, as well as to promote healing in injured tissue and bone fracture, and for initial treatment of sensitive areas.

The Median Range shows marked trophic effects on wasted tissues and on central neuron pathways, as well as on peripheral nerve fibres.

The Lower Frequency Range is useful in moving large muscle masses, lifting viscera and to reach certain resistant problems. Due to its active effects on somatic muscles both superficially and deep, it is an excellent pre-manipulative procedure, and quite a few physicians go on to the point of using the well localized energy to specifically mobilize a difficult spinal segment.

Direct adrenal, pancreatic and thyroid stimulation, as well as application over the liver, spleen, and intestines are definitively effective with a n o r m a l physiological range.

Visceral stimulation may also be autonomically stimulated through spinal segmental applications at appropriate levels at the sympathetic lateral chain and by sacral cervical stimulation for the parasympathetic outflow. The energy is acceptable to the acute coronary spasm

or to bitemporal stimulation of the pituitary and fronto-hypothalamic visceral systems. The arthritic and degenerative rheumatoid inflammations can be reduced and some trophic changes achieved on long term care with planned management of the application of the frequency spectrum.

CONSTRUCTIVE THERAPY

The wide scope of application of the Myo-Flex energy is based upon its fundamental physiological characteristics. Widespread clinical gains are logical and predictable in experienced hands. The clinician who is constructive in his approach to therapeutics will find this modality to be a constant source of satisfaction in caring for a wide range of patients who are not responding satisfactorily on other regimes.

In addition to the six frequency treatment settings there are five correlating power settings as well as a Dual Potentiometer hand control of power for direct treatment variation. The modality output is also enriched by a built in circuit which provides an intermittent surge out-put that varies both by surge peak and time interval between pulses on a selective variable basis. Such pulsing out-put is particularly useful in treating muscles and for stimulating nerve pathways to avoid fatigue and to flush out waste metabolites. This is therefore an instrument which provides a controlled but highly variable treatment potential. In the hands of an imaginative general clinician, its application to the every day run of difficult cases in his practice is truly remarkable. To the specialist, it has specific application on a safe and physiologically sound basis.

Recently there has been a widespread enthusiasm in the use of the Myo-Flex in the treatment of athletic injuries, especially in the hands of trainers working with national professional athletic clubs. Athletic Departments of Universities and Colleges are also showing keen interest in this particular application of the modality.

These trainers are finding that players are put back into play a great deal sooner than was previously possible.

PRACTICAL CONSIDERATIONS

Many general clinicians have found it necessary to install several units in their offices to cover the patient load and to supply scheduled care of an increasing volume of patients. Many chronic cases are able to learn to handle their treatment on their own, once their regime is established.

There are also available, small units, which have only one or two frequency ranges for use on specfic problems and to cut down the cost for prescribed units and for specialistic types of application.

SUMMARY

The Myo-Flex energy is a richly modulated physiological electronic audio frequency treatment modality. It has a wide range of tissue acceptance for both

PROFESSIONAL LIABILITY INSURANCE

Serving the Profession Nation-Wide Since 1925

EXCLUSIVELY ENDORSED BY THE A.O.A. SINCE 1934

Experienced claims handling protects the doctor's professional reputation; broad policy provisions backed by millions in assets protect his financial position—present and future.

THE NETTLESHIP COMPANY

1210 West Fourth Street Los Angeles, Calif. 90017

somatic visceral and cerebral nervous system tissues. It physiologically reaches tissue of the body through direct penetration or through nerve pathway stimulation. It therefore has a wide range of clinical application to many common but resistant problems of every day general practice and specific applications in many specialty fields. It has a history of over fifteen years of sound growth and demonstrable effectiveness in an ever widening and deepening scope of clinical problems on a safe physiologically acceptable basis. It helps reinforcement, and re-directing along normal, functional, and structural patterns. It is an instrument which like many musical instruments challenges the imagination to creatively utilize its full range of harmonic variations. It is an electronic replica of the physiological energies throughout the body which arise by alteration of electro-potentials across tissue membranes. It is quite unique, quite effective, and therefore quite useful.

BIBLIOGRAPHY:

1. Brazier, Mary A. B.: The Electrical Activity of the Nervous System, Sir Isaac Pittman & Sons, Ltd., London.
2. McRae, Ralph I.: Myo-Flex, A new Neurotherapy Modality, Journal, T.A.O.P. & S., Vol. XIV, No. 2, June 1957.
3. Selye Hans: Textbook of Endocrinology; Stress, Acts Endocrinologica, Inc., Iniv. of Montreal, Canada.
4. Walter, W. G.: The Living Brain: 1953, Norton Co.
5. Windle, Wm. F.: Regeneration in the Central Nervous System, 1955 Chas. C. Thomas.
6. Weiss, Paul, Genetic Neurology, Sponsored by UNESCO: Univ. of Chicago, Chicago Press.
7. R. Wyburn-Mason; Trophic Nerves; Henry Kimpton, London.
8. Unpublished Case Records from Physicians.

NOTICE OF EXAMINATION:

The next examination of the Texas State Board of Examiners in the Basic Sciences has been set for Monday and Tuesday, October 16-17, 1967 in Austin, Texas.

Details as to time and place may be obtained by writing to the Executive Secretary at this address: State Basic Science Board, Room 1012, Sam Houston State Office Bldg., Austin, Texas 78701.

Applications for the October examinations must be complete and in this office by September 18, 1967, 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.

Advances in Chemical Analysis Made By Kriksville Instructor

Horst Kehl, organic chemist and instructor in the Department of Pharmacology at the Kirksville College of Osteopathy and Surgery, is the author of a research paper published in the June, 1967 issue of the *Journal of Clinical Chemistry.*

"Hippuric Acid Analysis of Urine using the Hofmann Rearrangement" is descriptive of a new method of chemical analysis for Hippuric Acid in body fluids which was developed in the course of studies of biochemical synthesis in the transplanted kidney.

In addition to its research uses, the new method of analysis is expected to aid significantly clinical diagnostic studies of kidney and liver diseases. Mr. Kehl's research, the first real advancement in this particular analytical procedure since 1926, reduces the time required to process samples from three days to three hours for the same number of samples. The faster, less laborious method greatly expedites analytical procedures.

Interested in the molecular structure of drugs as it is related to the action of drugs in clinical medicine and experimental pharmacology, Mr. Kehl has recently synthesized a number of new drugs (Hydroxamic acids and their esters) which have demonstrated a marked ability to lower blood pressure.

In the future, he hopes to demonstrate that one or more of his synthetic compounds may prove to be useful in the treatment of high blood pressure. Mr. Kehl's research is supported by the American Osteopathic Association and research grants from the National Institutes of Health to Dr. Elliott Lee Hix, Chairman of the Department of Pharmacology, with whom his research efforts are closely integrated.

Mr. Kehl holds the Bachelor of Science degree from the Northeast Missouri State Teachers College (Kirksville) and was awarded the Master of Science degree from the University of Idaho in 1963. He is a member of the American Chemical Society, the American Association for the Advancement of Science and the Coblentic Society for Infra Red Spectroscopy.

Doors Opened For Training Nurses At AOA-Approved Hospitals

Osteopathic teaching hospitals may now be considered for clinical training facilities for the associate degree in nursing as the result of a policy change by the National League for Nursing. The League has been designated as the accrediting agency for the Nurse Training Act of 1964 by the U. S. Commissioner of Education and is recognized by the HEW Dept. as official accrediting agency for nursing schools in colleges, junior colleges and hospitals.

In a lengthy correspondence beginning November 1965, with the National League for Nursing, the American Osteopathic Association documented its rigid professional standards in accrediting hospitals. Most recently it reported recognition of AOA by the U. S. Department of Health, Education and Welfare as accrediting agency for osteopathic hospitals under Medicare and by the National Commission on Accrediting, for osteopathic education.

The director of the NLN Department of Associate Degree Programs, Gerald J. Griffin, April 20 advised the AOA of a favorable revision in the League's criteria, which opens the way for AOA-approved hospitals to participate in accredited nurse training. The new paragraph reads: "The college arranges for a variety of facilities to be used in the teaching of nursing in hospitals and other health and community agencies which are approved by the appropriate authorities." This appears on Page 8 of the newly revised CRITERIA FOR THE EVALUATION OF EDUCATIONAL PROGRAMS IN NURSING LEADING TO AN ASSOCIATE DEGREE.

The previous version restricted hospitals in the program to those approved by the Joint Commission on Accreditation of Hospitals.

X-Ray Equipment & Supplies

X-RAY SALES & SERVICE CO.

2530 Mansfield Hwy.

JE 5-3251 Fort Worth, Texas

Dr. Haman Appointed

The T.O.I.L. Committee — A Progress Report

ROBERT L. HAMAN, D.O.

With the appointment of a new professional representative, Dr. Robert G. Haman, the Texas Osteopathic-Insurance Liaison (T.O.I.L.) Committee recently moved toward its tenth consecutive year of service to the osteopathic profession, the health insurance industry and the general public. Dr. Haman has maintained active general practice since 1954 in Irving, Texas, and is a member of the medical staff of Dallas Osteopathic Hospital. He has served two terms on the TAOP&S Board of Trustees and in addition he is presently the Chairman, Department of Public Affairs, and a member of the Executive Committee of the Board. According to the announcement by President Wiley B. Rountree, D.O., Dr. Haman assumes the duty post recently resigned by Dr. A. Roland Young because of the press of personal and professional affairs.

The new member joins an organization which has earned state and national recognition by its unique approach to the administrative processing of prepaid medical, surgical and hospitalization matters to the benefit of the insuring public and the participating groups, without charge remuneration, fees or financial gain to the committee or any officer, director, component group of representative thereof. National recognition was extended to the TOIL Committee in 1964 by the Health Insurance Council by its inclusion of the Committee in its Manual of Currently Active Review Committees in the Nation, a first for the osteopathic profession according to information received.

Throughout its service life, the Committee has been noted for the high calibre of representatives from the industry and the profession and its hospitals, who have contributed substantial amounts of time and energy toward the objectives of this group. At a recent meeting of the TOIL Committee, it was noted that the past three presidents and every current officer of the Texas Health Insurance Association were present. Included were past presidents: Mr. Truman Ferguson, Austin Life Insurance Company, Mr. John V. Borden, American Hospital and Life Insurance Company, Mr. W. L. Wallace, Jr., Statesman Life Insurance Company, and current officers of THIA: Prsident John E. Mayo, Praetorian Mutual Life Insurance Company, Vice president Nelson Barrow, Tennessee Life Insurance Company, Secretary-Treasurer Frank Pyles, American Hospital and Life Insurance Company.

Other recognition at the state level includes a separate page in the annual directory of the Texas Association of Health Underwriters given over to a description of the TOIL Committee organization.

The object and purposes of the committee are:

To discuss and consider in open meetings problems which affect the administrative functions of the participating groups in those cases where they over-lap, where they infringe on the rights or privileges of another or where the administrative functions of one group may cause needless or unnecessary economic distress to another or impair its prestige.

Through joint counsel to prevent the commencement or devlopment of practices which might impair the proper functions of the participating groups, and to foster harmony within all groups.

To function as a public relations committee between the groups comprising the committee and the public in general and as a united voice against governmental encroachment or interference in or upon our business or professional prerogatives.

To function as a grievance body in cases in which violations by members of one group impair the harmony of all or actions of members of one group do anything to bring about public resentment or disapproval.

Regular meetings of the committee have been held in Fort Worth, Dallas, San Antonio, Houston, Austin, and Galveston every month since its organization. These meetings have been in the form of open and closed meetings. At the open meetings invitations to attend have been extended to osteopathic physicians and surgeons, hospital personnel and representatives of insurance companies in the particular locality where the meetings were held.

At first the open meetings were confind to opening remarks by the president or some other member of the committee on the objects and purposes of the group, a general discussion and questions from guests. The committee or directors would then go into a closed session to discuss the cases or complaints which had been referred to the committee. As time progressed, it was found that the meetings could be more successfully conducted on an open basis with the guests actually participating in the discussion of the cases or questions under consideration. Now open meetings are held on the most part, in the different cities previously listed, but occasionally the committee still holds strictly closed sessions.

Governmental contact also forms a significant area of involvement for the TOIL Committee, whose representatives have at times met with the State Board of Insurance and the excutive staff of the Board. Services of the Toil Committee have currently been offered to the Joint Investigating Committee of the Texas Senate and House on Health Insurance Matters being chaired by Senator H. J. "Doc" Blanchard in its efforts to identify and correct fraudulent and unethical sales and claims practices directed toward the elderly citizens of Texas.

With the advent of Medicare, Medicade, and the importance of the nonduplication principles, membership on the TOIL Committee was recently extended to the Texas Blue Cross — Blue Shield organization which responded by naming two of its top men to assume permanent posts among the members. Mr. Jack G. Ponder of the Blue Shield legal department, and Mr. Eugene Aune, Assistant Administrative Director. Mr. Tracy W. Putnam, Assistant to the President, Empire Life, is the most recent appointee of Dallas Chapter, Texas Health Insurance Association.

President of the TOIL Committee since its inception has been Dr. G. W. Tompson, of Houston, a founding member who also serves as TAOP&S' Chairman of Hospitals and Insurance. The vice president and secretary-treasurer offices are traditionally served by lay members and those recently elected were Mr. Allan Ruesch, of Southland Life Insurance Company, and Mr. John E. Mayo of Praetorian Mutual.

This committee has successfully solved many of the problems which, prior to its existence, plagued osteopathic physicians, administrators and insurance claims personnel in the osteopathic hospitals; and the insurance industry. Many claims have been resolved to the satisfaction of all parties concerned and to the benefit of the public.

In speaking of the committee, an area representative to the national H.I.C. said in part, "In our association together on this committee, we have found that most

(Continued on Page 26)

Bamadex® Sequels®

Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

First aid for a button popper

Second aid for a button popper

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.) Sustained Release Capsules

By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients makes possible convenient one-capsule-a-day dosage.

Lederle

LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, N.Y.

6655

L' Arte Medica

MICHAEL A. CALABRESE, D.O.

For the past three months after each article of "L' Arte Medica" appeared in the Journal I would hurry to the local hospital waiting for comments on my profound and earth shaking remarks, but never a whisper from my colleagues of my work bathed in sweat. Each time after two or three days when I was unable to stand the apparent disinterest any longer I would say "Hey, you guys see my article in the Journal?". Of course I would try to make it sound like I didn't care whether they saw it or not-you know, like I just happened to think about it. Always the answers would be like "Oh yeah, sure.", like *they* just thought of it. Of course if there just happened to be someone who hadn't read it, I had a copy ready in my coat pocket for his perusal.

Since the subject had been so subtly brought up (by me) I would pursue my inquisition, I'd ask "Well, what did you think of it?" And always the answer was universal, "When the hell are you going to change that picture?". Now if I get this kind of thunderous reverberation from my dear close friends with whom I work every day, I can well imagine the deep inroad I have made into the psyche of my many acquaintances throughout the state who are waiting impatiently each month to read what great words of wisdom I may have to impart to the world.

During the performance of a surgery for an acute appendicitis on a young boy of about 8 or 9 years old I witnessed what I thought was an interesting phenomenon. After the surgeon had performed the appendectomy, he routinely began to examine the small gut for a Meckel's diverticulum. At about 8 or 10 inches from the ileocecal valve instead of a Meckel's he encountered an intussusception which he reduced simply enough and continued his exploration of the small gut. Surprisingly enough within another 6 or 8 inches there was another intussusception and a few inches beyond that lo and behold still a third. None were inflammatory, all of the intussusceptions were invaginated about an inch or more and all were reduced by traction. Checking my limited library, I find no mention of such occurences with the exception of Boyd's Pathology who says "Multiple agonal intussusceptions are often seen in the small intestine of children at autopsy. They are probably caused by irregular spasmodic con-

PORTER CLINIC HOSPITAL
LUBBOCK, TEXAS

•

G. G. PORTER, D.O.
L. J. LAUF, D.O.
J. W. AXTELL, D.O.
HARLAN O. L. WRIGHT, D.O.
F. O. HARROLD, D.O.
ALFRED A. REDWINE, D.O.

•

COMPLETE HOSPITAL AND CLINICAL SERVICE

An Osteopathic Institution

tractions at the time of death. There is no inflammation nor adhesions, so that the intussusception is readily undone by traction." This patient had a very uneventful recovery and the surgery was very normal and routine. I'd be interested to learn if some of you have had similar experiences.

Ever since the California debacle, or capitulation, or sell out, or call it what you will, I have wondered how such a thing could come about if Osteopathic physicians believed and had faith in their profession. Let us analyze. As the statement stands, it would have been impossible for such a thing to happen—delete the last phrase and the answer is equally obvious—because the D.O.s (most of them) wanted it so.

It's rather asinine that one day 2000 men are quacks, charlatans, cultists, and the next day they change their "coats" and have become ethical practicing M.D.s. I like to think that it would be very unethical for me to consult with an organization that would take 2000 quacks into its profession without batting an eye lash. Now the A.M.A. has come out openly and has blandedly set up a fund to help take over our colleges! For heaven sakes, why? They say because of a shortage of doctors and medical schools. Would taking us over cause more people to receive medical care? Would taking over our colleges produce more doctors? When you add the total D.O.s to the total of M.D.s that still makes a sum total of so many doctors to practice medicine whether it's done under the M.D. degree or the D.O. degree. There must be a better answer. I think it's the closest solution they could come to and save face without admitting they could have been wrong.

DOCARE

Flying and non-flying D.O.s and lay friends are all invited to join DOCARE International and to be watching for the DOCARE closed circuit half-hour show at the San Francisco AOA Convention.

This word comes from Dr. B. J. Davis of Albuquerque, DOCARE Trustee.

Mercy medical missions of DOCARE are flown frequently into the stone age society of the Tarajumara and Baborigame Indians of Old Mexico. DOCARE gets its name from the fact that Doctors of Osteopathy do care about suffering in areas of disaster or primitive medical conditions.

Bob Klobnak of AOA is secretary of DOCARE and would be glad to sign you up as a member at $10 a year; or send you more information on DOCARE. Let him know if you are a pilot or not.

TO: Bob Klobnak, Secretary
DOCARE International
212 East Ohio Street
Chicago, Illinois 60611

1. Enclosed is $10 for my membership ____
2. Send more information ____
3. I am____am not____a pilot

Name_____

Address_____

Trauma to the Kidney and Ureters

Editor's Note: This is the first part of Dr. Bragg's article on Trauma Therapy. The second part will be published in the October Journal.

CHARLES H. BRAGG, D.O., ACOS

The physician caring for the victims of trauma must view the patient as a whole while simultaneously diagnosing and treating the individual injuries. Such possibly associated disorders as shock, hemorrhage, severe head injury, open thoracotomy and cardiac tamponade nearly always take immediate precedence over the damage to the genitourinary tract — for the reason that the former are likely to be more immediately life threatening. On the other hand, the patient's genitourinary damages frequently do not receive proper attention largely because the associated injuries are more readily evident, more common, or more generally publicized. Early and late disasters are not rare following injury to the urinary tract, but many can be avoided and nearly all mitigated. Patients have been dramatically saved from acutely near-fatal injury, only to become urinary cripples because damage in that out of the way tract was overlooked and the therapy, too little and, especially, too late.

Renal Injuries

The simplest renal injury is a minor contusion, and complete recovery may be expected clinically. In fact, many subtle contusions go unnoticed. A little flank pain and some red cells temporarily in the urine are usually the only indications of a mild contusion, and pyelography is nearly always normal. It is important, however, to know that a previously abnormal kidney can be seriously damaged by forces otherwise considered quite minor. For example, significant gross hemorrhage or dangerously aggravated infection may follow a relatively light blow to a hydronephrotic kidney. Major contusions commonly with some slight rupture or laceration, nearly always present clinical evidence. Patients with a major renal contusion have flank pain, hematuria, and at least a tendency to shock. A capsular tear may permit a small or moderate perineal hematoma. Spasm and tenderness in the flank are usually found, but if these signs seem particularly notable anteriorly, the possibility of intraperitoneal damage may also be considered. In fact, renal injuries from violence such as occurs in war time have been associated with intraperitoneal lesions of significance so frequently as to demand, consideration in every case. When the injury has been thoracoabdominal, multiple sites of serious damage in addition to the renal lesion can nearly always be anticipated. Renal ruptures and lacerations are prone to cause serious difficulties. When such a lesion extends into the collecting portion of the urinary tract as well as through the renal capsule, urinary extravasation is probable. However, the clinical evidences of extravasation are commonly delayed because renal function is often in abeyance at least temporarily, and during this time considerable sealing by clot formation and inflammation may take place. Some time later, infection may break down this seal, so that it is advisable to observe the patient almost continuously for about two weeks and to use antibacterial drugs prophylactically. A clearly minor extravasation may be treated expectantly but major extra

vasations are best drained surgically within a day or so. An intravenous pyelogram and careful following often suffice in the cases of lesser damage, but if all does not progress well or information is not adequate, retrograde pyelography may be indicated. It is valuable to realize that the damage is usually more extensive than the clinical and pyelographic findings portray. Serious hemorrhage from the traumatized kidney is the most obvious immediate concern, although it is not the most common result of renal trauma. The signs of major and continuing bleeding are the clearest indications for immediate or very early operative intervention — increasing mass in the flank, increasing shock, etc. In these circumstances, it is of the utmost importance to have information about the opposite kidney because removal of the involved one is often the most direct way to avert the threat to life. A flat film of the abdomen may not only provide useful information concerning the traumatized side but may also reveal the size and position of the supposedly good kidney. Unless the blood pressure remains very low or the emergency is extreme, an intravenous pyelogram is nearly always in order — even more to reveal the opposite kidney than to study the injured one. Such pyelography can be made in bed using portable radiographic equipment. In some circumstances, retrograde pyelography may be required to gain the necessary information. At operation, the supposedly good kidney can be palpated transperitoneally if necessity demands, but under no circumstances should a nephrectomy be done in the absence of reasonable information concerning the mate of the traumatized kidney. If the patient has only one reliable kidney and operation is indicated, it is mandatory to perform repair only. On occasions, the blood loss may be from an open wound in the kidney or down the ureter. A tear across the renal pedicle is a rare event, but prompt surgical control has prevented some fatalities (many exanguinate before reaching a hospital).

Ureteral Injuries

Ureteral injury from external violence is rare and likely to be associated with extensive damage in the area. Obviously the ureteral damage must be recognized and then controlled, or urinary infection and extravasation will add serious hazard both immediately and later. If there is good reason to believe that the continuity of the ureter has been interrupted by the external force, at the least, a simple surgical drainage is in order. Intravenous injection of indigo carmine at the start of operation may facilitate this diagnosis at exploration and aid in the localization of the injury. As with renal injuries, knowledge of the opposite side is of the greatest value. Only rarely is nephrectomy permissable immediately following a ureteral injury. This holds even when the status of the opposite upper urinary tract is known to have been normal some time earlier, because patients thus greatly traumatized are likely to need all available renal function for convalescence. If a ureteral repair with external drainage is not feasible, transplantation of the ureter to the skin at any convenient level or nephrostomy above a ureteral ligation can be the method of choice. Prophylactic antimicrobial drug therapy is a great aid, though not the fundamental correction. Follow-up examinations including intravenous pyelography and urinalysis should be made at least a few months later and preferably for a year or two even if all appears highly satisfactory. Late hydronephrotic atrophy, infection, chronic uremia and hypertension are well known sequelae of renal or ureteral damage.

SUPPORT YOUR ADVERTISERS

Report From The Art Johnsons

A. W. JOHNSON, D.O.

May, 1967

Dearest ones — all of you:

Please forgive our not sending out a March or April newsletter . . . we have literally had each hour filled since March . . . many times, no sleep at all, other times two or three hours sleep per night. Both March and April brought more than their share of severe illness, tragedy and heartache. Jackie, our other RN here at St. Luke's nearly lost her life, and is still recuperating after a severe illness and the loss of her darling baby girl. Please remember Jackie and Ralph Filkins in your prayers, for this has been a doubly tragic experience, since this was their first child, and Jackie and I had made so many plans about how our two babies, only weeks apart, would grow up together, as well as how we would take turns working isolation wards, so that we would be able to care for both babies, yet keep them from dangers of contagious diseases. May God somehow ease their sorrow and bring good health back to our wonderful Jackie.

Our little Estajean Rosemarie Johnson, born March 7th, has also suffered much during her short time on earth. Several times we almost lost her, and we are even now praying for her safe recovery from Typhoid. (Note—Nan and Art adopted a European baby who was born in Salisbury, Rhodesia. They took her when she was just about a week old. My son tells me that she now appears to be well, but I have had no news from Nan about her since this letter)

Here comes a good place to tell you about our family, since it has grown somewhat. Since the first of the year, we have had a charming home, for the new additions have really made life wonderful. We have told you about little Mercy Faith—our adorable 19 month old. She is the most beautiful little African baby girl, and has developed into a bundle of charm and intelligence. Her parents are in Zambia going to the University, so she is ours for a year. Sometime I'd like to have the time to tell you about the difference proper food, rest, clothing, books, toys and care, can make in an African child. When she came to us, she spoke not a word, was content to just sit, and was rather dull in temperament. Now, Mercy speaks beautiful English, can properly use an education toy, seems more advanced than some of the European children her age, and fairly bubbles with joy. She is forever smiling or laughing, loves books, and is the most entertaining little companion. In fact we wonder how we can bear to part with her. We will have photos to show you soon.

Our next addition was 15 year old Francis — the most wonderful African teen-ager, whose family turned him out, after he had been in prison for stealing a pair of old shoes. We adore Dennis, and he returns the feeling sevenfold, and although a Moslem, he is now seriously considering becoming a Christian. He goes to Church with us, when possible, and a more honorable child could not be found. A little love has so easily brought out all that is the best in him, and we are justly proud of our little Dennis. His one ambition in life is to go to the States, and God willing, we shall have the money someday to see

his wish fulfilled. Dennis is not outstandingly bright — he has absolutely no formal education and no training for a life's work except houseboy, but these are the ones who need love and understanding the most. He is so willing to learn, to serve, and to work as long as he can stand, for those he loves, and it is hard to know what will happen to dear Dennis when we return to USA. The others are bright children with much promise for the future — so there are many who are ready to help. It is a pity that those of Dennis' status never catch the imagination of those who can help, for they can make wonderful, useful citizens and contribute to a country's growth, or they can serve a prison sentence.

Our other addition is really not an addition to the family, but a young girl who helps care for the two babies while I am at the hospital. She lives with us, though, and feels we are mother and father, so we call her ours, also. As you can see, when Dottie, Becky and Chuck are home, we now number 10. Truly life has never been more interesting . . . or hectic! ! ! Everyone pitches in to do his share, and it is a happy place to be. Others must really feel the same, for it is always like Grand Central Station at the Johnsons.

April also brought us showers of visitors from abroad . . . some who came to inspect the hospital and diocesan medical work. We are always so very happy to receive visitors from out of the country. This month, however, so many came near the same time, that we hardly had time to visit as much as we wanted. For those who came to see the medical work, life became very hectic, and all of them admitted to being happy to return to their nice calm offices back home. Lord and Lady Biet of the Biet Trust, who gave most of the money for our buildings, were amazed at the amount of work done in the small space of our hospital, and wondered how we cope. Dr. Wright, head of the Anglican Medical Work in Missions, from England, went back home with a thorough appreciation of our work here. The head of Lepra, also made her visit to our leprasarium. Several other VIPs from Europe, and then Canon McDonald from the USA — a returning friend — spent some time with us. We get so homesick and Canon Mac is a wonderful cure! Then our long awaited arrival of a very special friend from Elgin, Ill., Eve Schmitt, came and was here an entire week before we had a chance to visit, for Dr. and I had to take little Rosemarie to Salisbury, Rhodesia, to the specialist there, because she was so ill that nothing else could be done for her in Malawi. We arrived back, and are now looking forward to a luncheon date with Eve and Father Jeff. We have visited a short time, already, but had not near enough time to find out all about our beloved friends in Elgin.

Our cook-houseboy left for a better job, so I have had the extra job of cooking for the private hospital patients, as well as the family cooking.

In the hospital, we have had no less than 68 patients for the last two months. As you remember, we are set up for only 44 patients, so we have them in the laundry, the shower vestibule, on the porches etc. Very seldom does one reach the saturation point, but I must admit, that there are now no extra hours in the day, and I hope that things will level off soon. If we can replace the cook, if Rosemarie and Jackie regain their health, we can continue to cope, but one does need a bit more rest than our present pace permits. Of course, the worry does not help, but every day seems brighter . . . and certainly has been made bearable and cheerful by our most welcome visitors.

Thank all of you for your letters and may God bless you all.

signed
The ten Johnsons

The Low-ly Back

GEORGE W. NORTHUP, D.O.,
Editor, American Osteopathic Association

A lead article in a recent issue of *The Wall Street Journal* was headlined, "*Medical Puzzle* — Back Ailments' Causes and Cures Continue to Elude Researchers." Nowhere in the article is mentioned the structural problems diagnosed and successfully treated by osteopathic physicians. In fact, little mention is made of the most common cause of backache: functional mechanical problems.

The article does point out that the National Safety Council estimates that "back injuries causing lost work time total more than 500,000 a year and cost employers about $1 billion in sick pay to laid-up workers and in wages for their replacements. And these figures don't include chronic ailments that can't be traced to a specific injury but nonetheless result in loss of working days." For instance, "in California alone, 20,000 workmen's compensation awards amounting to over $60 million are made each year for back complaints. Such awards have quadrupled in 10 years, while the ratio of back problems to total cases has doubled. Back troubles now account for a third of all compensation awards in the state."

Sometimes it would seem that some osteopathic physicians hide both their talent and their training "under a bushel" for fear that they might be known just as a "back doctor." Yet it seems ironical that a problem of such magnitude—one with which our profession has had enough success to gain public acclaim, if not recognition — should frequently be played down.

The osteopathic physician, completely trained as he is and recognizing the importance of articular joint derangements, is in a better position than any physician to handle the problem. It is inexcusable for an osteopathic physician to approach the low-ly back problem with the same pessimistic resignation as expressed by the writer in *The Wall Street Journal.* We know that there is more to the management of the low-back problem than "traction, surgery, and aspirin."

We may complain, but unless we use *all* of our knowledge in the management of this costly and painful health problem, the public does not receive what it has every reason to expect from an osteopathic physician.

The late President Kennedy, from personal experience, is quoted as saying that there was no such thing as a medical back expert. Perhaps as far as he was concerned this was true. But there is no reason why every practicing osteopathic physician should not be expert in this field, because of knowledge and training received which is not given in medical schools. But to be expert, one must bring to full play *all* of his knowledge and technique.

The osteopathic profession has a major responsibility to provide continuing and more aggressive leadership in the diagnosis and management of the low-ly back. And having provided that leadership, it must be publicized, not hidden from the world.

The Louisiana Association of Osteopathic Physicians

ANNOUNCES

Annual State Convention

October 5-6-7, 1967 • Monteleone Hotel

New Orleans, Louisiana

Members will convene October 5, 4:00 p.m. for reports, old and new business. This will be followed by cocktails at the famous "Top of the Mart" overlooking New Orleans and the Mississippi River.

The Scientific Session will start at 9:00 a.m. on October 6th for members and D.O.'s from neighboring states who would like to come, register and enjoy the program — which features Rollin E. Becker, D.O.

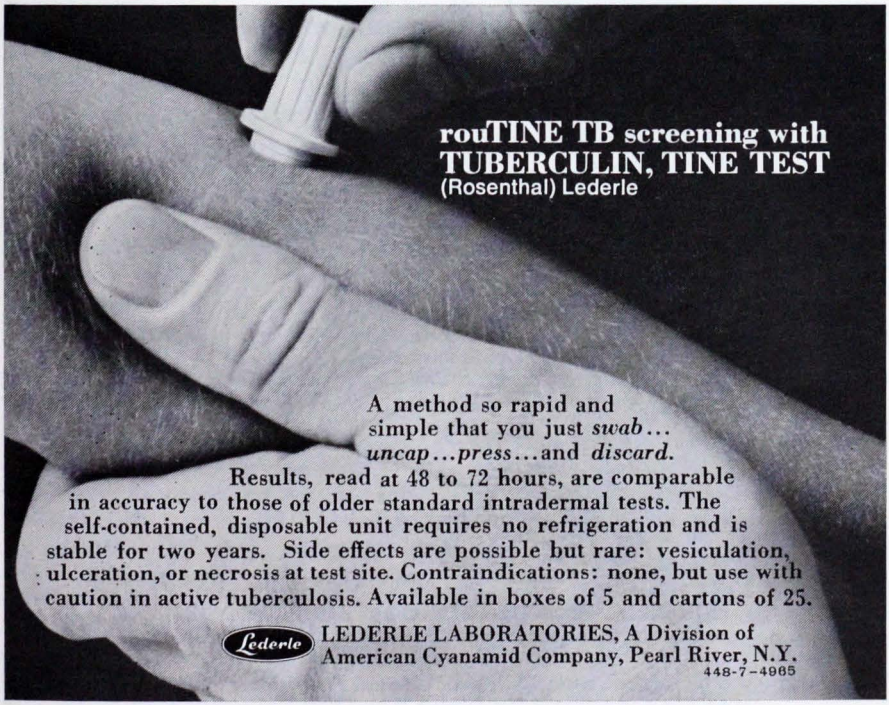
Dr. Becker is an outstanding member of the Academy of Applied Osteopathy. He has lectured extensively and has written many scientific articles for our publications.

Charles D. Ogilvie, D.O., Chief of Radiology, Stevens Park Osteopathic Hospital, an outstanding speaker and a fine medical historian.

On Friday evening, October 6, our banquet for members and guest will be held at the fabulous Royal Orleans Hotel.

Make your reservations *now* directly with the Monteleone Hotel.

CHARLES S. WYCKOFF, D.O.
Program Chairman



TWELFTH ANNUAL FALL SEMINAR

Texas Association of Osteopathic Obstetricians and Gynecologists

October 7 & 8, 1967

Hilton Inn — 5600 N. Central Expressway — Dallas, Texas

PROMINENT OUT OF STATE SPEAKER

Carl Waterbury, D.O., F.A.C.O.O.G., Des Moines, Iowa.
Certified in Obstetrics and Gynecological Surgery.
Senior Member of A.C.O.O.G., Past Member Certifying Board.
Obstetrics and Gynecology, Chairman Department of Obstetrics and Gynecology, Des Moines General Hospital. Member of Faculty College of Osteopathic Medicine and Surgery, Des Moines, Iowa.

Saturday, October 7, 1967

12:00 P.M. REGISTRATION
1:30 P.M. *"Dysfunctional Uterine Bleeding Treatment with Progestins."*
Carl Waterbury, D.O., Des Moines, Iowa
2:15 P.M. *"Menopausal Syndrome — Current Therapy"*
Carl Waterbury, D.O., Des Moines, Iowa
3:00 P.M. RECESS
3:15 P.M. *"Cold Cone Cervical Biopsy"*
R. N. Fong, Dallas, Texas
4:00 P.M. *"Induction of Labor"*
Carl Waterbury, D.O., Des Moines, Iowa
4:45 P.M. QUESTIONS AND ANSWERS OF TODAY'S SPEAKERS
7:00 P.M. COCKTAIL HOUR (For doctors and wives-courtesy of Ross Laboratories)

Sunday, October 8, 1967

9:00 A.M. *"Congenital Absence of the Vagina — Surgical Correction"*
Slide and sound presentation.
"Bulbocavernosus Fat — Pad Transplant"
Sound film courtesy Ortho Labs.
Daniel Slevin, D.O., Dallas, Texas
10:00 A.M. *"Peri-Natal Therapeutics as Applied to Fetal Preservation"*
R. B. Helfrey, D.O., Dallas, Texas
10:45 A.M. *Recess*
11:00 A.M. *"Common Gynecological Office Procedures"*
Carl Waterbury, D.O., Des Moines, Iowa
12:00 Noon *Luncheon — "C.O.M.S."* (for doctors and wives)
Carl Waterbury, D.O., Des Moines, Iowa
1:45 P.M. *Panel — "Common Obstetrical Problems in the Delivery Room"* — Moderator — Lee Walker, D.O., C. Waterbury, D.O., R. R. Fischer, D.O., R. Mayer, D.O., D. Slevin, D.O.
3:30 P.M. *Questions and Answers of Today's Speakers*
4:00 P.M. *Business Meeting — Texas Association of Osteopathic Obstetricians and Gynecologists*

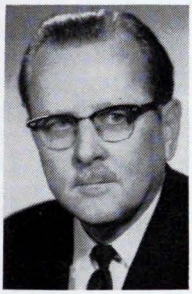
REGISTRATION FEE — Members of T.A.O.O.G. $15.00
Non Members 20.00
Wives 5.00

PLEASE NOTE — HOTEL ROOM REGISTRANTS —
Mention Seminar when registering.
Meeting Open to All D.O.'s

Approved by the American College of General Practitioners in Osteopathic Medicine and Surgery for Twelve Hours Post-Graduate Credit

NEWS OF THE DISTRICTS

District No. Two



D. D. BEYER, D.O., FACGP

The Fort Worth Osteopathic Hospital is crowded for bed space and ancillary facilities. A Hill-Burton grant of $600,000 has been approved and with matching funds the expansion program for 65 beds and new or extended ancillary facilities should run $1,200,000 but with inflationary prices the total could run between $1,500,000 and $1,600,000. The building plans call for an extension on the South of the building and a four-story wing on the West of the building. Several houses have been moved for more parking space. This will bring the hospital bed capacity close to 200 which will probably be the largest osteopathic hospital in Texas.

Fort Worth Osteopathic Hospital and District Two welcome our new interns, Thomas Newell, PCO, B. R. Haley, KCOS, Gary Cooper, KCOS, Richard Gayle, KCOS and Darrell L. Dean, KCCOS.

Dr. and Mrs. Roy Fisher and son visited their daughter and her husband, Dr. McCaleb, in Iowa City last month. The occasion was for the arrival of a new grandchild born to Susan, Dr. Fisher's daughter — the first time for Dr. Roy to be a grandfather. The Fishers also made a trip to Michigan and Ohio.

Drs. Browning, Turner and Glickfeld will attend the ACOS meeting at Bal Harbour, Florida, in October.

Dr. and Mrs. Lloyd Hardeman visited in the home of Dr. and Mrs. Hugo Ranelle. Mrs. Hardeman (Betty) is their daughter. The Hardemans made a trip to Acapulco, Mexico, and were accompanied by Betty's two brothers, Bryan and Barry Ranelle. I'll bet it took a long time for Barry and Bryan to save up their nickels and dimes to make this trip! Dr. Hardeman is serving his second year of residency in Orthopedic Surgery at Detroit Osteopathic Hospital.

Mike Merrill entered the Des Moines College of Osteopathic Medicine and Surgery in September. He was one of our surgical technicians at Fort Worth Osteopathic Hospital.

Dr. and Mrs. Joel Alter vacationed in Colorado Springs.

Dr. George Luibel has two different meetings in Chicago this month — one is the meeting of the Ethics Committee of the AOA and the other is the meeting of the Academy of Applied Osteopathy.

When your reporter's clinic was robbed the 5th time, he put in a burglar alarm!

District No. Thirteen

R. D. VAN SCHOICK, D.O.

District No. 13 was saddened to learn of the death of Dr. Kubala's mother recently.

The picnic of the District and families was held at the Cooper Country Club, August 25; all who came enjoyed the arrangements of Betty Martin and Dr. Martin. Fine food was really appreciated.

Dr. and Mrs. Pat Martin, Commerce were proud parents of a son, Todd, born May 23. Congratulations.

Dr. and Mrs. Stephen Kubala and family enjoyed a European tour this summer.

Dr. Jack Vinson reports that someone should interpret highway regulations to pilot Dr. Max Ayer; it seems the doves were expensive this year at Matador.

Guests at the September meeting of the district were:

Dr. and Mrs. Wiley Rountree, San Angelo, Texas, Dr. and Mrs. Hugo Ranelle, Fort Worth, Texas, Dr. and Mrs. Floyd Hardiman, Detroit, Michigan, (Dr. and Mrs. Hardiman are the daughter and son-in-law of the Ranelles), Dr. and Mrs. George Luibel, Fort Worth, Texas.

Dr. Bobby Waldrop was endorsed by the District for Membership to the State Association. He is now practicing in Denison, Texas.

After a discussion by Dr. Luibel on A.O.A. Hospital inspection, Dr. Rountree, President of the Texas Association gave a fine talk on rededication of all members to the task at hand of State organization. He told the District that he felt that all problems can be worked out with a cooperation of the local districts and each doctor in his own town and location. He explained that he did not have all the answers to problems of Medicare and its regulations nor to accreditation of our own national organization but felt that we could face these problems as a growing and powerful organization to care for health of people.

See you next month!

R. D. Van Schoick, D.O.
Reporter

W. R. McBee of Blue Cross Dies

Mr. Walter R. McBee, 64, president of Blue Cross-Blue Shield of Texas, expired August 30 in a Dallas hospital as the result of a short illness. Mr. McBee came to Dallas in 1941 and has been an officer of the Texas Blue Plans since that time. Prior to coming to Dallas, Mr. McBee had organized the Bue Plans in Missouri and Oklahoma.

Mr. McBee was instrumental in working out with Dr. Phil R. Russell the participation of osteopathic physicians and surgeons and hospitals in the Blue Plans, through the auspices of TAOP&S. Under policies established by McBee, the executive staff and other personnel exhibited the utmost in courtesy and cooperation in working with the osteopathic profession to achieve their mutual goal, a superior level of health care for Blue Cross-Blue Shield subscribers.

Dr. Phil R. Russell and Mr. Robert B. Price represented the profession at the funeral services and interment in Dallas on September 1. Mr. Tom L. Beauchamp, Jr., has assumed the duties of acting president for Blue Cross-Blue Shield of Texas.

T.O.I.L. Committee

(Continued from Page 13)

of our problems were due to misunderstandings, lack of information or our failure to recognize and appreciate the other fellow's position. We have also formed some very close bonds of professional friendship and fellowship and our-esteem and regard for one another increases with our participation in this worthwhile cause."

Suggestions, questions or complaints can be referred to the TOIL Committee for consideration through any of its officers or members, but first these matters should be referred for screening and handling to the Insurance Committee of the TAOP&S, through Mr. R. B. Price, Executive Secretary, 512 Bailey, Fort Worth 76107.

Here — And There

(Tour of Europe 1967)

Editor's Note: Dr. T. T. McGrath, who attended the A.O.A. Postgraduate Training Program or European Tour in June of this year, sent this poem to us written by Mrs. Helen Witt, wife of one of the participants, Dr. John L. Witt of Groom, Texas.

The flight was most confusing,
The sun, a fiery ball,
Rose soon after setting,
With scarcely a night at all.
(Up there, we entered another day.
At home 'twas still six hours away.)
We saw the Tower of London,
The Palace, the Abbey, Big Ben,
The Palladium and ancient castles,
And places Shakespearean.
(Their downy beds, though very nice,
Did not as well as mine suffice.)
Vienna was so enchanting,
With great music all around,
And palaces with fabulous art,
Where beautiful gardens abound.
(I hoped that it had rained on ours,
Though we have only skimpy flowers.)
Rome, with its towering cathedrals,
Its great art and eternal flame,
Seemed a teeming commercial turmoil
'Midst ruins of past glory and fame.
(We heard so much of the history of Rome,
But enjoyed most hearing from home.)
We fell in love with Switzerland,
From its mountains to blue Lake Lucerne,
Its grandeur and air of welcome
Made us vow some day we'd return.
(All it lacked being perfect to me
Was sharing it with my family.)
We admired the Rhine Falls so lovely,
And the Black Forest's stately trees,
Past German farms and bustling towns
Rushed our bus in search of a breeze.
(Oh, that our air conditioner's bliss
Could have been transferred to this!)
Our air base made us nostalgic
As in Weisbaden we arrived with the rain.
And we loved steaming down the Rhine River,
But the impact of boarding their train!
(Had the Rhine flowed water from home,
I think,
Half of its contents I could drink.)
Briefly we stopped in Brussels,
And found it a most pleasant place,
But quickly we took off for Paris —
We felt we were running a race.
(We all began to look bedraggled,
At home my hair is not so straggled.)
We saw Paris in new splendor,
The vast Louvre and the Eiffel Tower,
Notre Dame and the Arc de Triomphe,
Versailles with its palace and flowers.
(My foreign accent was not so hot,
Unasked for things I always got.)
We bacame a sort of family
Sharing adventures so many days,
But now our home ties beckoned,
We prepared to go separate ways.
(Dr. Thomas again too far did roam,
We hoped to see that he got home.)
We parted quite reluctantly
From Gordon, our excellent guide,
We felt almost helpless and bereft
When he was gone from our side.
(But 'twill be nice to need no guide
In our own "castle" where we reside.)
Looking back, as we soar upward,
Where we visited the places of fame,
We realize, as has God all along,
From up high they all seem the same.

— Helen Witt

Grant For Instruction In Osteopathy Made

Chicago (UPI) — The New York State Department of Health has granted $600,000 "to enable all physicians to learn more about osteopathic theories and manipulative medicine," the American Osteopathic Association said today.

The grant was made to the postgraduate Institute of Osteopathic Medicine and Surgery, Ney York, City.

The answer to all your Printing problems is
PHONE NUMBER
ED 5-1481
FORT WORTH
F. L. MOTHERAL CO.
"The Good Printers & Lithographers"
510 SOUTH MAIN STREET

PROFESSIONAL CARD DIRECTORY

GEORGE E. MILLER, D.O.
PATHOLOGIST
5003 Ross Avenue -:- TA 4-0445
DALLAS, TEXAS 75206

GILBERT COGBURN, D.O.
ANESTHESIOLOGY
8001 Fulton OX 4-1425
HOUSTON, TEXAS 77022

GERALD D. BENNETT, D.O.
PATHOLOGIST
Fort Worth Osteopathic Hospital
1000 Montgomery PE 8-5431
Fort Worth, Texas 76107

"The OSTEOPATHIC PHYSICIAN and SURGEON Today"
How He Is Trained
How He Serves the People
($2.00 per hundred, postpaid)
ORDER FROM TAOP&S

CONSULTANT STAFF
DALLAS OSTEOPATHIC HOSPITAL
5003 Ross Avenue
Dallas, Texas 75206
TA 4-3071 Area Code 214

Internal Medicine
A. A. Acosta, D.O.
C. D. Brashier, D.O.
L. T. Cannon, D.O.
Roentgenology & Nuclear Medicine
R. N. Dott, D.O.
General Surgery
E. G. Beckstrom, D.O.
W. R. Russell, D.O.
Proctology & Urology
K. S. Wooliscroft, D.O.
Orthopedics
M. Glickfield, D.O.
T. R. Turner, D.O.
Opthalmology & Otorhinolaryngology
R. M. Connell, D.O.
Thoracic & Cardiovascular Surgery
C. D. Farrow, Jr., D.O.
Obstetrics & Gynecologic Surgery
R. L. Fischer, D.O.
Pathology
G. E. Miller, D.O.
Medical & Surgical Anesthesiology
H. M. Beckstrom, D.O.
S. S. Kebabjian, D.O.
P. A. Stern, D.O.
Pediatrics
R. J. Madziar, D.O.

Direct inquiries to: Paul A. Stern, D.O., Medical Director

HERE'S MY $4.00 for a dozen copies of the new VOCATIONAL GUIDANCE MANUAL

NAME_____

ADDRESS_____

CITY and STATE_____

or else please send_____copies at 40¢ each. Please enclose check with order.

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

DISTRICT 1

Dr. Lewis N. Pittman, Jr., Amarillo ..... President
Dr. Bradford E. Cobb, Amarillo ..... President-Elect
Dr. Gerald K. Nash, Amarillo ..... Vice-President
Dr. Royce Eugene Skaggs, Amarillo ..... Secretary-Treasurer

DISTRICT 2

Dr. Bobby Gene Smith, Arlington ..... President
Dr. Phillip P. Saperstein, Fort Worth ..... Vice-President
Dr. James W. Linton, Hurst ..... Secretary
Dr. O. F. Redd, Jr., Nocona ..... Treasurer

DISTRICT 3

Dr. George Chambers, Mt. Pleasant ..... President
Dr. Robert E. Slye, Tyler ..... President-Elect
Dr. Robert L. Hamilton, Mabank ..... Vice-President
Dr. Benjamin R. Beall, II, Mineola ..... Secretary-Treasurer

DISTRICT 4

Dr. Jack Wilhelm, San Angelo ..... President
Dr. Norman B. Leopold, Odessa ..... Vice-President
Dr. Allen M. Fisher, Stanton ..... Secretary-Treasurer

DISTRICT 5

Dr. David B. Greene, Dallas ..... President
Dr. Ronald Owens, Dallas ..... President-Elect
Dr. Jack W. Rice, Mesquite ..... Secretary
Dr. Robert H. Lambert, Mesquite ..... Treasurer

DISTRICT 6

Dr. Billy Sealey, Deer Park ..... President
Dr. Jerry Smith, Houston ..... President-Elect
Dr. Robert S. McClimans, Houston ..... Vice-President
Dr. David Armbruster, Pearland ..... Secretary
Dr. Ralph Cunningham, Houston ..... Treasurer

DISTRICT 7

Dr. William Mosheim, San Antonio ..... President
Dr. John B. Donovan, Austin ..... Vice-President
Dr. Waldemar Schaefer, San Antonio ..... Secretary-Treasurer

DISTRICT 8

Dr. Jack H. Dawkins, Corpus Christi ..... President
Dr. James W. Lively, Corpus Christi ..... Vice-President
Dr. Dwight H. Hause, Corpus Christi ..... Secretary-Treasurer

DISTRICT 9

Dr. W. L. Crews, Gonzales ..... President
Dr. N. W. Todd, Gonzales ..... President-Elect
Dr. C. R. Stratton, Cuero ..... Vice-President
Dr. C. D. Tisdale, Victoria ..... Secretary-Treasurer

DISTRICT 10

Dr. H. Eugene Brown, Lubbock ..... President
Dr. Leland B. Nelson, Lubbock ..... President-Elect
Dr. John L. McMillion, Lubbock ..... Secretary-Treasurer

DISTRICT 11

Dr. Porfirio Lozano, Jr., El Paso ..... President
Dr. R. C. Valdivia, El Paso ..... Vice-President
Dr. Luz A. Candelaria, El Paso ..... Secretary-Treasurer

DISTRICT 12

Dr. Robert Shields, Port Arthur ..... President
Dr. Robert A. Bowling, Port Arthur ..... Vice-President
Dr. Ronnie R. Merwin, Groves ..... Secretary-Treasurer

DISTRICT 13

Dr. Kenneth G. White, Commerce ..... President
Dr. Roy Mathews, Wolfe City ..... President-Elect
Dr. Max Ayer, Bonham ..... Vice-President
Dr. Robert D. Van Schoick, Leonard ..... Secretary-Treasurer

DISTRICT 14

Dr. Joe Suderman, Pharr ..... President
Dr. E. L. Suderman, Pharr ..... Vice-President
Dr. Ralph Moore, McAllen ..... Secretary-Treasurer

Why not just treat your heart attack at home?

We don't really believe anyone will, as long as the hospital doors stay open. But in this month's Blue Cross/Blue Shield messages to leaders of community thought, and to the general public, we are asking this obviously ironic question, to bring straight home to them some vital facts of life:

1) Today's hospital-medical care is the greatest bargain on earth.

2) It will cost the patient more money because the hospital's costs are rising, period.

We don't really believe anybody seriously wants the "good old days," even if the price is higher, today — everyone seems to want to have *his* life saved.

BLUE CROSS® BLUE SHIELD®
GROUP HOSPITAL SERVICE, INC. GROUP LIFE & HEALTH INSURANCE COMPANY
OF TEXAS
MAIN AT NORTH CENTRAL EXPRESSWAY • DALLAS, TEXAS 75222