Texas Osteopathic Physicians Journal

Volume XVII FORT WORTH, TEXAS, FEBRUARY, 1961 Number 10

In This Issue—

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

PUBLICATION OFFICE: 512 BAILEY STREET, FORT WORTH 7, TEXAS

EDITOR . . . PHIL R. RUSSELL, D. O.
ASSOCIATE EDITOR: GEORGE J. LUIBEL, D. O.

ADVERTISING RATES UPON REQUEST. ALL ADVERTISING CUTS TO BE SENT WITH COPY

VOLUME XVII FORT WORTH, TEXAS, FEBRUARY, 1961 NUMBER 10

EDITORIAL PAGE

YOUR CHOICE

It's high time that every member of the osteopathic profession either declare himself an osteopathic physician and be proud of it or else leave the profession. The House of Delegates of the A.O.A. and the Texas Association has set a policy that we are and will remain a separate and distinct school of medicine—that we have much, from the philosophy of our profession, to offer to the public in health care and maintenance. We either believe it or we don't. Those members who do not, should get out of the profession and admit they have lied and cheated to the public. This will permit those who do, to continue their efforts in behalf of their profession and the public.

It has been known by some of the profession's leaders that there are a few political leaders who would sell their birthright for a mess of pottage in the hopes that they personally might profit from same. The California situation is a serious problem, led by a few politicians who would sell the profession down the river. The AOA and the loyal members of the profession have therefore revoked the Charter of the California Association and at a called meeting of the AOA House of Delegates in Miami, *have granted a charter to a new organization headed by Dr. Richard Eby, 2999 West 6th St., Los Angeles, California.* It behooves every one of us to write Dr. Eby and give him your support that he may gather together, in this new organization, the loyal members of the profession in California.

President John F. Kennedy recently made a statement that is applicable to this profession—"He who rides on the back of a tiger winds up in its belly." These disgruntled politicians who have taken control of the old California organization are indeed riding on the back of a tiger. We sincerely regret what may happen to them, but we cannot stand by and see them take the loyal members of the profession and one of our schools on this hectic ride with them.

As a loyal member of the profession, it is your duty to read carefully the letter from Paul D. Foster, M.D., President of the California Medical Association to the members of his profession and also the report of the Committee on Other Professions—Relating to Osteopathy, both of which are published in this Journal, immediately following this editorial that you may be thoroughly familiar with what may happen to you if you join this ride.

Feature Speakers At Annual Convention

Granada Hotel—San Antonio, Texas

May 4, 5, 6, 1961

ROY J. HARVEY, D.O.
Midland, Michigan
President, A.O.A.

Dr. Harvey is a general practitioner who has served the osteopathic profession at local, state and national levels for many years. He has served on the A.O.A. Board of Trustees since 1956 and as Chairman of the Committee on Firms and Corporations of the AOA Council on Development.

A 1938 graduate of the Kansas City College of Osteopathy and Surgery, Dr. Harvey has served as Board President of both the Saginaw and Clare General Hospitals in Michigan. He is a past president of the Michigan Association of Osteopathic Physicians and Surgeons; has held every office in the Saginaw Valley Osteopathic Association, has been physician for the Midland High School and has been elected coroner for Midland County continuously since 1948.

J. GORDON HATFIELD, D.O.
Los Angeles, California

Dr. Hatfield was graduated from the College of Osteopathic Physicians and Surgeons in Los Angeles and received surgical training under the guidance of Dr. W. Curtis Brigham. He has been a member of the staff of Los Angeles County Osteopathic Hospital since 1933 and is now Senior Surgeon. He is presently Professor of Surgery and Executive of the Department of Surgery at the California College; Chairman of the Department of Surgery at Doctors Hospital.

Dr. Hatfield is a past president of the California Osteopathic Association and Past President of the American College of Osteopathic Surgeons.

California Medical Association

January 5, 1961

To The Members
Of The Association

Dear Doctors:

In the past few weeks the press of California and the entire nation has carried several stories about discussions which are being held between the medical and osteopathic professions in California looking toward eventual unification of the two groups.

As you know, the California Osteopathic Association has recently had its charter revoked by the American Osteopathic Association because the California group voted at a special meeting of its House of Delegates to continue negotiations with our Association along these lines.

For your information and as background for this situation, I would like to outline for you the steps which have been taken by the C.M.A. to date and those which remain to be taken to accomplish the goal of interprofessional unification.

IN 1941, ALMOST 20 YEARS AGO, the two Associations in California reached agreement on a program which would have unified the two professions, *STOPPED FURTHER LICENSING OF OSTEOPATHS IN CALIFORNIA* and converted the *OSTEOPATHIC COLLEGE IN LOS ANGELES INTO A CLASS A MEDICAL SCHOOL.* This proposal met with the approval of both American Medical Association and medical educational authorities; unfortunately, it failed to meet some technical requirements of the state licensing boards of the country. Accordingly, it was stopped at that point.

In the intervening 20 years, educational and other leaders in both professional groups have kept alive the hope of eventual unification and the elimination of confusion in the minds of the public over the real or *IMAGINED DIFFERENCES BETWEEN THE TWO PROFESSIONS.* This hope resulted in the appointment, *ABOUT NINE YEARS AGO,* of a special committee of the C.M.A. to meet with a similar committee of the C.O.A. to probe further into such unification.

Several months ago these joint committees both acting with the approval of the governing bodies of their respective Associations, arrived at a general plan which gives every evidence of being workable, of being helpful to the public understanding of the two professions and, simultaneously, of *PROVIDING CALIFORNIA WITH AN ADDITIONAL MEDICAL SCHOOL* which is so badly needed to serve the state's growing population.

It is still too early to go into the details of this plan. As in all negotiations, however, there must be a certain amount of give and take on both sides. Our committee is working for a reasonable and mutually acceptable agreement and we are certain that the C.O.A. Committee is doing likewise.

This general plan is predicated on the understanding that *FURTHER LICENSING OF OSTEOPATHS IN CALIFORNIA WILL CEASE.* It would provide for the unification of presently practicing osteopathic physicians and surgeons with doctors of medicine. It would *ESTABLISH THE PRESENT OSTEOPATHIC COLLEGE AS A CLASS A MEDICAL SCHOOL* under thoroughly acceptable auspices. Finally, it would signal the end of many of the interprofessional differences which arise in many communities to the detriment of good public relations and good patient care.

Prior to the meeting of the 1961 House of Delegates of the California Medical Association we expect to have all these items worked out and ap-

proved by the C.M.A. Council for presentation to the House. A detailed report will be prepared for the study of the members of our House of Delegates so that each member will have a chance to study the entire proposal with his colleagues at home and to vote intelligently when proposals are put before the House.

I want to assure you that the Officers and Council of the California Medical Association are in complete agreement on the plan now being developed. Further, I believe I speak for all these individuals in expressing our approval of the concept of the plan and our hope that it may develop as now outlined. I am sure that all of us, as physicians, as well as the people in California will benefit by the implementation of the plan now in process.

Further details will be made available to all members as they may be developed and approved by our official bodies.

Fraternally yours,
PAUL D. FOSTER, M.D.
President

(Editor's Note: Caps are ours)

Report of Committee On Other Professions Relating to Osteopathy

To the Chairman and Members of the Commission on Public Agencies

Gentlemen:

Your Committee on Other Professions, pursuant to direction of the Council, has consulted with a like committee of the California Osteopathic Association, and has explored the possibilities of unification of the professions of medicine and osteopathy in California. Due to various circumstances, your Committee is now of the opinion that the time has come to submit through you to the Council a specific proposal for a contractual agreement between this Association, under the terms of which complete unification of the two professions would be accomplished. It is further proposed that in the event the Council approves this report, representatives of the Association be authorized to transmit it to the California Osteopathic Association as a framework from which a legal document, to be executed by both associations, can be developed.

We propose the following points for inclusion in an agreement for unification:

1. *Presently Practicing Osteopathic Physicians and Surgeons—Membership in This Association.* It is proposed that Article I, Section 5, of the Constitution of this Association be amended to add a new sentence at the end of the present section reading as follows:

"Notwithstanding the foregoing, one charter may be issued to a component society that is not limited as to geographical area and which overlaps the area covered by one or more existing component societies."

Further, the Chapter II, Section 3(b), of the By-Laws of this Association be amended by inserting after the second sentence of said Section 3(b) a new sentence to read:

"A physician and surgeon licensed by the State Board of Osteopathic Examiners on or before 196... who holds a degree of Doctor of Medicine issued to him by the College of Osteopathic Physicians and Surgeons (or its successor) and whose license to practice medicine and surgery is unrevoked and unsuspended, is eligible for election to active membership in a component society."

After these amendments are adopted a charter shall be issued pursuant to

Article III, Part A, Section 7, of the Constitution to an appropriately named component society that will encompass within its membership all of the present membership of the California Osteopathic Association who hold the degree of Doctor of Medicine. Eligible members of the California Osteopathic Association shall be permitted to apply for membership in one of the present forty (40) component societies if they so desire, but absent such application and acceptance such persons may, as of right, become members of the new component society.

It shall be the responsibility of the California Osteopathic Association to make arrangements with the College of Osteopathic Physicians and Surgeons for the issuance of Doctor of Medicine degree to its graduates, and the issuance of Doctor of Medicine degree to other osteopathic physicians and surgeons in California upon completion of a refresher course.

The new component society above outlined and its members shall have exactly the same rights, privileges, duties and responsibilities as the presently existing component societies and their members.

It is recognized by your Committee that only the House of Delegates can amend the Constitution or By-Laws and that a constitutional amendment must lay on the table for one year. It is therefore proposed that this report, if accepted by the Council, be presented and recommended at the next session of the House of Delegates, as well as the implementing amendments, so that the House may vote on the entire proposal before voting upon its implementing sections.

It is proposed that upon the adoption of the necessary constitutional and by-law amendments and the issuance of the charter to the new component society, the California Osteopathic Association agree to commence and in an orderly fashion complete legal dissolution.

With respect to the individual osteopathic physicians and surgeons, those eligible to do so may apply for component society membership in the society of their choice (subject to By-Law provision), but shall not be compelled to do so, so that those Doctors of Osteopathy who wish to remain in practice as such may be free to do so.

2. *College of Osteopathic Physicians and Surgeons—Future Status.* It is proposed that the name of the College be changed as soon as reasonably expedient to some suitable name that eliminates the word "Osteopathic." It is further proposed that the college thereupon commence and diligently undertake such revisions in its organization, activities and operations as are necessary to enable it within the minimum peroid of time to become a school of medicine approved by the Council on Medical Education and Hospitals of the American Medical Association, and classified "A." To this end the college shall cease granting the degree of Doctor of Osteopathy as soon as practical. To assist the college during its transition period, it is proposed that this Association appoint a special committee consisting of medical educators and that the California Osteopathic Association appoint a similar committee, and that these two special committees function under the jurisdiction of your Committee on Other Professions and appropriate committee of the California Osteopathic Association. It is proposed that these committees of medical educators be requested to advise, guide and assist the College of Osteopathic Physicians and Surgeons in its conversion process. It is the intent that all necessary precautions be taken to insure that students presently enrolled in the Los Angeles College of Osteopathic Physicians and Surgeons shall have the opportunity to complete their education and take the examination for a California physician and surgeon's license under at least one of the present examining boards.

3. *College of Osteopathic Physicians and Surgeons—Students.* Between the time that an agreement is reached and the time that the college becomes approved by the Council on Medical Education and Hospitals, there will be a period of several years during which students who are enrolled at the time of the agreement will graduate and receive the degree of Doctor of Medicine. It is proposed that the State Board of Medical Examiners be requested to approve the college on an interim basis during the conversion period, so that such graduates may be eligible for examination and licensure by the State Board of Medical Examiners. If such approval is not obtainable, it is proposed to seek temporary legislation limited to the conversion period of the college that will enable such students to become licentiates under the State Board of Medical Examiners by transfer from the State Board of Osteopathic Examiners after the college has become an approved school of Medicine. It is proposed that the California Osteopathic Association use its best efforts to cause the State Board of Osteopathic Examiners concurrently with approval of the college by the State Board of Medical Examiners to disapprove the college as an osteopathy school.

During the transition period graduating students of the college shall be assured adequate opportunity for intern training and this Association shall undertake necessary arrangements to assure eligibility of such students for intern training in one or more hospitals approved by the State Board of Medical Examiners.

4. *Hospital Staff Membership, Specialty Societies Membership, and Membership in Other Professional Societies.* It is understood by your committee that this Association has no right or power of contract with the California Osteopathic Association with respect to the granting of membership to present members of the California Osteopathic Association in other professional or scientific organizations or with respect to the granting of or continuance of staff membership in hospitals. However, your committee does propose that this Association in any contract with California Osteopathic Association agree to use its best efforts to avoid any unnecessary injury to any individual member of the California Osteopathic Association by virtue of the unification, and to issue a joint policy statement to the effect that this Association recommends that the prior holding of a Doctor of Osteopathy degree by a Doctor of Medicine should not be considered by any person as an evidence in connection with admission to membership in a society or hospital, but that any such applicant should be judged solely on the basis of his individual merit and character. In this connection, it is further understood that this Association has no right or power to control the accreditation of hospitals, but this Association should agree to use its best efforts to persuade the Joint Commission on Accreditation of Hospitals to evaluate the medical staff of hospitals in California on the basis of merit, without disqualifying or prejudicing the status of a hospital solely because one or more members of its staff may have formerly practiced under the Doctor of Osteopathy degree. Furthermore, any hospitals currently having osteopaths on their staffs shall not be encouraged to alter their requirements for staff membership because of anything pertaining to this agreement.

5. *Statutory Changes.* It is proposed that Section 2396 of the Business and Professions Code be appropriately amended to permit recipients of the Doctor of Medicine degree from the College of Osteopathic Physicians and Surgeons to practice under such degree if they so desire. It is further proposed that such changes and modifications in the osteopathy initiative be jointly undertaken by this Association and the California Osteopathic Association, as may be jointly recommended by legal

counsel for the two associations. The osteopathy initiative needs to continue in existence solely as a licensing law for existing Doctors of Osteopathy who elect to practice as such. However, it should be modified to transfer the remaining functions of the Board of Osteopathic Examiners to the Board of Medical Examiners and to eliminate the authority to issue new osteopathy licenses. In this connection, it is proposed that the Business and Professions Code be amended to add on a proportionate basis representation on the State Board of Medical Examiners to those physicians who are now members of the California Osteopathic Association.

Respectfully submitted,

WAYNE POLLOCK, M.D.
Chairman
Committee on Other Professions

MEMBERS:
William Evans, M.D.
Eugenian Hayes, M.D.
J. Philip Sampson, M.D.
Dante A. Gazzaniga
William F. Kaiser

Congenital Megacolon In the Newborn

ROBERT E. MOORE, D.O.
Mesquite, Texas
Co-Chairman, Dept. Pediatrics, Dallas Osteopathic Hospital; President, Southwestern Society Osteopathic Pediatricians; Junior Member American College of Osteopathic Pediatricians.

Congenital megacolon or Hirschsprung's disease is caused by a malformation in the pelvic parasympathetic system which results in the absence of ganglion cells in Auerbach's plexus of a segment of distal colon. Not only is there an absence of ganglion cells, but the nerve fibers are large and excessive in number, indicating that the abnormality may be more extensive than absence of ganglion cells. The parasympathetic innervation of the colon is derived proximally from vegal fibers. At a variable point on the left side, these fibers normally end and the remainder of the colon, the sigmoid, rectogigmoid, and rectum is supplied by the pelvic parasympathetic system which originates from the second, third and fourth sacral roots. This system also supplies the detrusor muscle of the bladder, so consequently patients with congenital megacolon may have a defect in bladder function with megalobladder and secondary megalounters.

The ganglion cells are a part of the myenteric system which coordinates peristalsis, and it has been shown that the aganglionic segments in Hirschsprung's disease do not exhibit progressive peristaltic waves. It is this absence of peristalsis in the aganglionic segment that explains the patients symptoms. The peristatic waves bring the intestinal contents down to the aperistaltic segment, resulting in chronic accumulation in this region with huge fecalith production, and massive dilation and hypertrophy of the bowel just proximal to the aganglionic segment.

In older infants and children, the diagnosis of megacolon is suggested by the obvious chronic abdominal distention and severe constipation. In the newborn, however, it is rare for the correct diagnosis to be made promptly.

Actually the symptoms of Hirschsprung's disease in the newborn follow such a definite, constant pattern

that the Physician who is familiar with them will have little difficulty in arriving at the correct diagnosis.

Early, accurate diagnosis and prompt treatment of Hirschsprung's disease are of major importance during the first few weeks of life, for the mortality rate is greater during the neonatal period than it is in older infants and children.

A newborn infant who has congenital megacolon will invariably have a period of obstipation, abdominal distention, and vomiting. The symptoms will vary in severity from a transient mild condition to the vomiting of bile-stained fluid, and the infants will be normal in all resepects except for the abdomen which will be distended without any palpable masses. The degree of distention will range from a slightly enlarged soft abdomen to a severe firm distention and auscultation will reveal hyperactive peristalsis of normal pitch. Digital examination of the rectum sometimes gives the impression of a mechinical obstruction, but actually there is none since little or no intestinal content has traversed this part of the colon. Diagnostically flat abdominal X-rays are of little help as they may lead to an erroneous diagnosis of small bowel obstruction. A barium enema is mandatory, for it will determine if the dilated intestine is small or large bowel and helps differentiate an ileal obstruction from a megacolon. If the colon has not had sufficient time to dilate and megacolon is suspected from X-rays findings, then a rectal biopsy will definately establish the correct diagnosis. Under anesthesia a small bit of the rectal wall can be obtained two or three cm. above the anus. On histological study, the presence or absence of ganglion cells in Auerbach's plexus rules in or out the diagnosis of megacolon.

After the diagnosis of megacolon has been made, the treatment of choice in the neonate is colostomy. This is made in the lower left quadrant and from the dilated sigmoid a biopsy is taken from the muscular coat, eight to ten cm. proximal to the area of narrowing the pathologist can make a frozen section and determine whether ganglion cells are present or not, as it is essential that the colostomy be made in the segment of bowel which contains ganglion cells. Most infants with a colostomy will do well, provided oral feedings are given and tolerated as early as possible after operation. During the postop period, no parenteral fluids should be given, provided an adequate oral intake is maintained. The colostomy will discharge liquid material early. However, with normal feedings, the discharge will rapidly become solid. Once the colostomy has been made there is no hurry to resect the aganglionic segment. It is usually done when the infants attain a weight of thirty to thirty-five pounds and are about one year of age. The resection is done by the abdomino-perineal pull through method of Swenson.

Post operatively parenteral fluids are supplied, and naso-gastric suction is used until there is a return of intestinal peristalsis which usually occurs in twenty to forty-eight hours. Gastric suction is then discontinued and the patient is started on oral liquids. If these are accepted, a soft diet is given and increased to a full diet as rapidly as the patient will tolerate it. Usually, the patient will have a liquid movement on the second or third day, and a few develop some abdominal distention. If this occurs, a large rectal tube is inserted and the colon is gently irrigated with saline for two or three days. The majority of children are up and around on the third or fourth postoperative day and the patients are discharged on the tenth postoperative day.

REFERENCES

1. Gross, Robert E.: The Surgery of Infancy and Childhood, W. B. Saunders Company, 1953.
2. Swenson, Orvar: Pediatric Surgery, Appleton-Century-Crofts, 1958.
3. Practice of Pediatrics, Brenneman's: W. F. Prior Company, Inc., Hagerstown, Maryland.
4. Observations of Author at Landes Kinderkrankenhaus, Linz, Austria.

American Osteopathic College of Proctology
35th Clinical Assembly

Pre-Assembly Refresher Course

Monday-Tuesday, March 20-21, 1961

Rice Hotel — Houston, Texas

This will be a complete two-day review course in Proctology conducted by Diplomates of American Osteopathic Board of Proctology.

Tuition Fee: $50.00 with A.O.C.Pr. registration mandatory for convention which follows.

ASSEMBLY PROGRAM

Subjects—Wednesday, March 22

"Anal Fissure" ..... Howard Weinstock, D.O.

"Nutrition and Protein Metabolism As Related to Proctology" Wm. M. Beemer, D.O., F.A.O.C.Pr.

"Modern Approach to Color-Proctology" ... Emery E. Ludwig, D.O., F.A.O.C.Pr.

"Why We Should Become Certified Proctologists" Carlton N. Noll, D.O., F.A.O.C.Pr.

"Factors Governing the Selection for An Anesthetic for Proctologic Surgery" ..... A. Leon Smeyne, D.O.

Subjects—Thursday, March 23

"Urological Problems As Related to Proctology" ..... Russell F. Kenaga, D.O.

"Sigmoidoscopy As An Aid to Diagnosis of Medical and Surgical Problems of the Colon" ..... Milton M. Lurie, D.O., F.A.O.C.Pr.

"How to Have A Bowel Movement" ..... Francis M. Neff, D.O., F.A.O.C.Pr.

"Observations At St. Mark's Hospital, London, England" ... A. Leon Smeyne, D.O.

"Rectal Fistula—Motion Picture" ..... John W. Orman, D.O., F.A.O.C.Pr.

"Smyposium On Hypnosis and Its Uses In Proctological Practice With Demonstrations of Its Uses" ... John J. Mahannah, D.O., F.A.O.C.Pr., V. A. Leopold, D.O., Clinton A. McKinstry, D.O., F.A.O.C.Pr.

Subjects—Friday, March 24

"Symposium On Hypnosis"—Continued

"Diagnosis and Management of Colitis and Proctitis" Lester I. Tavel, D.O., F.A.O.C.Pr.

"Audio-Visual Pictures" ..... Members of A.O.C.Pr.

Note for the Ladies: Activities for the ladies include party honoring President's wife, Mrs. Lester J. Vick, style show, tours of interesting places, luncheons with the doctors, dinner with the doctors at San Jacinto Inn, and President's Banquet.

Venereal Disease Seminar

The United States Public Health Service in cooperation with State and local Health Departments will hold its annual Venereal Disease Seminar at the Statler Hilton Hotel, Dallas, February 28-March 1, 2, 3, 1961.

Recognized authorities in the field of medicine, anthropology, sociology, sexology and writing will be contributing to the various panels. There will be thirty states represented at the Seminar along with local and regional representatives:

Tuesday, February 28

10:00 A.M. - 12 Noon—Status of Syphillis in the United States

1:30 P.M. - 5:00 P.M.—Panel: Problems in the Diagnosis and Management of Syphillis

Panel: Problems in the Diagnosis and Management of Gonorrhea

Wednesday, March 1

9:00 A.M. - 12:00 Noon—Panel: The Society We Live In (including urbanization, mobility, changing sex patters, etc.)

2:00 P.M. - 5:00 P.M.—Panel: Problems of Children and Youth (peculiar factors influencing increasing VD problems among this group)

Thursday, March 2

9:00 A.M. - 12:00 Noon—Panel With Audience Contribution: Control Techniques That Pay Off.

2:00 P.M. - 5:00 P.M.—Six Discussion Groups

Friday, March 3

9:00 A.M. - 12:00 Noon—Panel: Findings of Previous Day's Discussion Sessions

Closing Address.

Physicians are urged to attend—Advance Registration not necessary.

Centenarian Dies

JAMES L. HOLLOWAY, D.O.

Dr. James L. Holloway, 100, of 3817 Gillon Ave., Dallas, died Saturday morning, January 28. Services were held at 2 p.m. January 30 at the Central Christian Church in Dallas.

An Honorary Life Member of the Texas Association, Dr. Holloway devoted his life to humanity, Christianity and his profession. On September 15, just ten days before his 100th birthday anniversary, he was honored by the members of District 5 at a dinner held " . . . in appreciation of his distinct contribution to the advancement of the science of Osteopathy."

Dr. Holloway was graduated from the American School of Osteopathy in 1904.

Executive Secretary's Travelogue

Pictured above are seven of the 10 D.O.'s who gathered during the White House Conference on Aging in Washington, D.C. Standing, l. to r.: Dr. Charles Naylor, Ravenna, Ohio; Dr. Alexander Levitt, Brooklyn, New York; Dr. L. Raymond Hall, Kansas City, Missouri. Seated, l. to r.: Dr. J. A. Walker, Royal Oaks, Michigan; Dr. O. L. Brooker, Plymouth, Michigan; Dr. Phil R. Russell, Fort Worth, Texas; Dr. Roy J. Harvey, Midland, Michigan.

Not pictured were Drs. Vincent P. Carroll of Laguna Beach, California, Nicholas Oddo of Long Beach, California, and J. B. Rapp of Glen Riddle, Pa.

The executive secretary returned to the office on January 2 and the new year, so far as this office is concerned, started off with a tremendous bang! The January Journal had to be prepared in a hurry as it was late because of the preceding holidays so for two days there was hustle and bustle attempting to get it into printable form.

On Tuesday, January 3, the executive secretary received a call from Dallas requesting him to be present at a luncheon on Wednesday, January 4, in the private dining room of Mr. McBee,

Executive Director of Blue Cross. The invitation was accepted with no knowledge of the purpose for the meeting. When the executive secretary arrived he found the meeting presided over by Dr. Milford O. Rouse, Vice-Speaker of the House of Delegates of the A.M.A. and in attendance were the following from Dallas: Dr. James Basden, Dr. Roderic M. Bell, Dr. Ellis Carnett, Dr. Evelyn M. Carrington, Dr. W. Dudley Coursey, Dr. Milton V. Davis, Mrs. Charles Hurst, Mr. Walter McBee, Dr. Harold W. Martin of the University of Texas Southwestern Medical School, Mrs. William B. Ruggles, Mr. Herbert Shore, Mr. Eldred Thomas, Col. Charles R. Tips, and Mr. Charles E. Watson. These were Dallas delegates to the White House Conference on Aging and the only two delegates present from out of the city were Dr. May Owen of Fort Worth, President of the T.M.A. and Dr. P. R. Russell, your executive secretary. The purpose for this pre-caucus was to discuss their participation in the White House Conference on Aging.

This was indeed a very enlightening and enjoyable meeting. Blue Cross went out of its way to provide the best luncheon the executive secretary has ever had the privilege to attend. He was also invited to return for a post conference meeting to be held at the home of Col. Tips on Thursday, January 26, but he was unable to attend as he did not arrive back in Fort Worth from the Miami convention in sufficient time to do so.

On Saturday, January 7, the executive secretary left for Washington, D.C. to attend the White House Conference on Aging as a delegate from Texas. There he found the following D. O.'s present: Dr. Roy J. Harvey, President of the A. O.A.; Dr. Alexander Levitt of Brooklyn, New York who was serving as a delegate on invitation from the White House; Dr. Charles Naylor of Ravenna, Ohio, President-Elect of the AOA, who served as a special guest replacing Dr. True B. Eveleth, AOA executive directory, which was an appointment from the Advisory Committee; Dr. Vincent P. Carroll of Lafuna Beach, California, Past President of the AOA, was a member of the Advisory Committee of the Whitehouse Conference on Aging. The following osteopathic physicians were Governor appointees to the Conference: Dr. J. A. Walker, Royal Oaks, Michigan; Dr. O. L. Brooker, Plymouth, Michigan; Dr. L. Raymond Hall, Kansas City, Missouri; Dr. J. B. Rapp, Glen Riddle, Pennsylvania; Dr. Nicholas V. Oddo, Long Beach, California; Dr. P. R. Russell, Fort Worth, Texas.

Mr. Leonard Heffel of the AOA Division of Public and Professional Service served as a member of the Conference Press.

The objectives of the White House Conference on Aging included finding answers to a vast number of questions including:

(1) What are today problems of older age persons?

(2) What is being done to serve these needs?

(3) What are the recommendations with regard to unmet needs?

(4) What are the suggestions for activities which may in the future help prevent the problems and needs of older people?

The Conference consisted of 10 groups arranged into major sections, each with about 140 voting delegates and further arranged into small Workshops.

The major sections were assigned the following topics:

Group 1—Section 1. Population trends and Social and Economic Implications.

2. Income Maintenance

3. Impact of Inflation on Retired Citizens.

4. Employment Security and Retirement.

Group II—Section 5. Health and Medical Care.

6. Rehabilitation

Group III—Section 7. Social Services.

Group IV—Section 8. Housing

Group V—Section 9. Education

Group VI—Section 10. Role and Training of Professional Personnel.

Section 11. Family Relationships and Friends.

Group VII—Section 12. Free Time Activities: Recreation, Voluntary.

Group VIII—Section 13 Religion

Group IX—Section 14 Research in Gerontology: Biological.

Section 15 Research in Gerontology: Medical.

Section 16 Research in Gerontology: Psychological and Social Sciences.

Group X—Section 17 Local Community Organization

Section 18 State Organizations

Section 19 National Voluntary Services and Service Organizations.

Section 20 Federal Organizations and Programs.

The Conference was arranged to provide Plenary and Work-group Sessions. Plenary Sessions were held on Monday morning, Wednesday night and Thursday morning. President Eisenhower spoke at the Monday morning opening session.

Section and Workgroup sessions were held Monday Afternoon, Tuesday morning and afternoon and Wesdnesday morning and afternoon.

Special meetings were held on Monday night.

The immediate objective of the White House Conference as directed by the Advisory Committee was the development of policy statements in each of the 20 subjects sections with consolidation and emphasis on major findings and recommendations.

The rules of order for the Conference as approved by the Advisory Committee, provided for voting at the Workshop and Section sessions and was instructed to report on the following:

I. An overall policy statement, including general recommendations.

II. Specific recommendations for im-

mediate action.

III. Specific recommendations for long term study and action.

Policy Statements were developed from recommendations of the Delegates at the workgroup level and must be limited to 250 words, then voted upon, revised, and coordinated by Delegates gathered into their respective major sections, and they formulate the policy statement and recommendations into a statement containing no more than 1200 words.

The official policy statements of the major sections were presented at the two final Plenary Sessions of the Conference. However, the rules of the Conference prevented voting on these policy statements at the Plenary Sessions. A proposal at the Wednesday night Plenary Session to amend the rules of the Conference to permit voting on a policy statement was rejected by a vote of the Delegates present.

Policy statements from major sections were published in the Washington News Letter, under date of January 12. This newsletter appears elsewhere in this issue of the Journal.

Cooperation at major sections and workgroups was reported by the D.O. delegates to the Conference.

The facility designated as the AOA headquarters provided for a reception of A.O.A. members and guests and served as a meeting place for Workgroup C2-"Health Maintenance and Medical Care" in which Dr. Roy J. Harvey, AOA President, was a participant. This provided an excellent opportunity to further interprofessional relations between the osteopathic and other health professions.

Your executive secretary served in C3-"Health and Medical Care" and one of its workshop sessions was held in the AMA suite at the Statler Hilton Hotel. This workshop group was indeed interesting and was the one spot in the program where he was permitted to speak his piece. The workshop group met for some eight hours in formulating its 250 word policy.

Many participating agencies at the White House Conference had good exhibits with promotional literature that explained the interests and roles of those agencies with regard to problems of the aged.

It was noted at the Conference that there are strong trends favoring and strong trends opposing third party medicine and related policies regarding health and medical care of the aged. An example is the approved policy statement of the Income Maintenance Section in favor of Social Security financing of health costs. This matter may have serious bearing on the future practice of medicine in this country. At the meeting of the overal group "Health and Medical Care" a policy statement was voted, being led by Dr. Milton V. Davis, which expressed the sentiment that it should be financed under the present plan as adopted by the last Congress which is directly opposed to the policy statement from the "Income Maintenance Section".

The executive secretary feels that the AOA should encourage all its Divisional Societies to establish and implement Committees on Aging and that the AOA Committee on Health Care of the Aging and members of similar Divisional Society Committees should be advised regarding policy statements and recommendations developed at the White House Conference on Aging. Further he feels that members of the AOA Committee on Aging should be included, if possible, in AOA delegations attending national meetings which deal with problems of the aging; and that Divisional Societies should seek similar representation in State sponsored meetings having to do with problems of aging.

The White House Conference on Aging presented a great challenge and opportunity. Its success or failure depends on our ability to correlate and communicate the thoughts and ideas of the many teams or groups, especially with regard to consideration of preventive

aspects of problems related to the aged, applied at age levels preceding old age.

It can readily be seen, from this report, that the executive secretary was a very busy man—running from one hotel to some of the larger buildings in Washington and back to the hotel again—from one section of town to another during his stay in Washington—January 8 through January 12. Indeed, he had a good brain washing but he came away thoroughly determined that they had failed to wash his brain sufficiently to keep him from opposing the socialistic trend in our government.

During the Sessions there were a few hours of relaxation for the executive secretary which he thoroughly enjoyed. One such moment was the reception for the AOA group held in the AOA suite at the Statler Hilton Hotel where he was able to mingle and visit among his old friends who were in attendance.

The second was his attendance at the reception held at the Shoreham Hotel by the Texas Society on Aging, which was attended by all of the delegates from Texas.

The third was his visit to the AMA offices in Washington, D.C. to renew his friendship with Dr. Roy T. Lester, former Medical Director of Blue Cross, who now heads the AMA office. Unfortunately, Dr. Lester was out but his secretary knew who the executive secretary was so she took him on a tour of the AMA offices, introducing him to everyone in the office—some 20 persons. He was cordially received and graciously entertained for better than an hour, receiving an explanation to the work of the AMA office in Washington.

Fourth was his visit to the AOA offices in Washington where he spent some two hours discussing some of our problems with our AOA attorney, Mr. Larry Gourley.

The executive secretary left Washington at 3 p.m., January 12, by Capitol Airlines for Philadelphia, Pennsylvania where reservations had been made for him at the Union League Club by the Philadelphia College of Osteopathy. That evening he was entertained at dinner by Dr. and Mrs. Walter Evans and Mr. Thomas M. Rowland, Administrator of the College. It was indeed an enjoyable evening during which much information was gained concerning the College.

Friday morning, January 13, the executive secretary was at the Philadelphia College of Osteopathic where he renewed acquaintances with the Dean and members of the faculty for some two hours. At noon a special meeting

of all the students was called and President Barth introduced the executive secretary to the student body. The executive secretary addressed the students for some 40 minutes. Following this he was taken to lunch by President Barth, Dean Mercer, Dr. Evans and Mr. Rowland. He returned to the college at 2:30 p.m. and met with numerous students who desired to talk with him in reference to internships and locations in Texas. At 6:30 p.m. he caught a plane for Chicago, Illinois.

The executive secretary was lost Saturday morning, January 14, just sitting in a hotel in Chicago. He went to the AOA office and found it was not open on Saturday. However he was admitted by the janitor and he sat down and read for some 1½ hours hoping that someone would just happen to drop in. No such luck! Finally, at Noon, he decided to get some fresh air so he walked from 212 East Ohio St. to Old Heidelburg to replenish his food supply with pork knuckles and sauerkraut along with some fermented "buttermilk". He then walked to Palmer House and back to his hotel, which almost proved disastrous as he had been walking in a strong wind, with temperatures of 32 degrees, wearing only a light summer suit—no hat or topcoat. However it was most vigorating and he enjoyed every minute of it even though he almost lost his voice as a result of his venture. In fact his voice has not yet entirely returned. We're sure some of the members of the profession will be disappointed to hear he did not lose it entirely.

At 3 p.m. he was at the Drake Hotel to again visit a dear old friend who has been generous to our profession to the tune of $135,000. He entertained her at dinner and had a most enjoyable evening with this 81 year old woman with a marvelous mind. She recently broke her hip but was now able to walk with a cane. The executive secretary feels she will further help our profession if we will maintain our pride in it and promote it as an independent and separate school of medicine.

He returned to the Drake Hotel on Sunday, January 15, and entertained her again at lunch, spending some three hours with her.

That evening the executive secretary entertained Miss Patricia Guinand, Secretary of the AOA Committee on Hospitals, at dinner.

On Monday, January 16, the executive secretary was at the AOA office when it opened and he had a conference with the Executive Director, Dr. True B. Eveleth for approximately an hour. At 10:30 a.m. he was at the Chicago College of Osteopathy where he met with President R. N. MacBain, Dean R. A. Kistner and other members of the faculty.

At Noon, the student body was assembled and the executive secretary spoke before this group for some 40 minutes. His talk was well received. That afternoon he met with many of the students discussing various professional problems with them.

The executive secretary arrived back in the office in Fort Worth on Tuesday afternoon, January 17—a very tired man with very little voice. For two days he was extremely busy in the office. He devoted several hours of one afternoon in a conference with our attorney, Mr. Homa Hill, over problems in connection with a lawsuit and the coming meeting of the Executive Committee. An hour was also spent with Dr. Nobles of Denton who is chairman of the TAOP&S Civilian Defense Committee. Then, some 2½ hours were spent with two students who are interested in entering one of our colleges.

On Friday, January 20, the executive secretary left Ft. Worth by plane for Miami, Florida to attend a meeting of the Society of Divisional Secretaries of which he is President and to attend a meeting of the Association of Osteopathic Publications of which he is Immediate Past President. The trip to Miami was interesting in that some 10

or 12 osteopathic physicians were on the same plane. They all arrived in Miami approximately 5 p.m., Miami time.

Most of Saturday, January 21, was devoted to the meeting of the Society of Divisional Secretaries. However there were a few breaks during which the executive secretary was able to attend about two hours of the AOA House of Delegates meeting.

Sunday morning, January 22, was again devoted to attending the Society of Divisional Secretaries meeting and at Noon the opening session of the Association of Osteopathic Publications meeting.

Much information of value to the profession was gained at both of these meetings.

The executive secretary cannot keep from complimenting the called session of the House of Delegates, at which time they voted confirmation of a new Charter to another group in California for sticking by their former decision—that regardless of what one group does, we will stand by our decision to maintain the policy that we are a separate and independent school of medicine and that we will not be sold down the river by a few political leaders who suffer from an inferiority complex and who do not have the interest of the profession at heart and who do not believe in the principles of the profession. It is our hope that every man who is a member of the Texas Association of Osteopathic Physicians and Surgeons will lend support to the parent organization and to the profession in maintaining our policy. For the enlightenment of our readers there appears in this Journal further comments on this situation.

It had been the intention of the executive secretary to return to Fort Worth from Miami on Monday, January 23, but following a consultation with President Scott and others, it was felt that the executive secretary should enter into association activities and make additional observations and comments. So the executive secretary remained in Miami

and on the morning of January 23rd met with the Gavel Club at breakfast for some two hours, where it was decided to hold another meeting of the Gavel Club during this session in order to establish a policy of holding extensive meetings each year and to add to its discussion, problems currently confronting the profession and then offer to the AOA Board of Trustees suggestions, from this group of past presidents who have been through the mill and who have a vast storehouse of experience in organizational procedures and historical knowledge, that would be of value to the Board.

During the remaining time in Miami, the executive secretary was in various conferences with many leaders of the profession and he attended meetings of the colleges, fraternity meetings, and the meeting of the General Practitioners.

On Wednesday night the Gavel Club went back into session and remained in session until one a.m. Its entire discussion was devoted to the serious problems in reference to the California situation and its school.

The executive secretary arrived back in Fort Worth on Friday, January 27—a very tired and weary man with a squeaky voice and a terribly sore throat. He can assure you however, that he could still have managed a whisper in a loud tone in defense of this profession.

That evening, Dr. and Mrs. G. W. Tompson of Houston arrived in Fort Worth by car and were entertained by the executive secretary and Mrs. Russell. Unfortunately the Executive Committee meeting was called for Saturday and Sunday, January 28-29 in the state office in Fort Worth, and there was not a room available in the city due to the Fat Stock Show opening this same day. Therefore the Tompsons had to put up with the Russells both Friday and Saturday nights.

The Executive Committee meeting was called into session at 10 a.m. Saturday, January 28. All members were present with the exception of Dr. R. L. Stratton who was unable to attend. The meeting was called for 10 a.m. in order to allow President Scott sufficient time to get in from Amarillo.

The Committee met for some three hours with our attorney, Mr. Homa S. Hill during which time he pointed out the many deficiencies in our Constitution and By-Laws and its ambiguous statements that could not be defended. The meeting recessed at 1 p.m. for lunch and reconvened at 2 p.m. for further discussion of the problem for about two hours.

Following this meeting with Mr. Hill, the Executive Committee continued its meeting discussing other business at hand. Fortunately they were able to complete their business on Saturday and so no meeting was necessary on Sunday. Dr. Scott left that night for Amarillo but Dr. and Mrs. Tompson remained over until Sunday as they were traveling by car and the countryside was well

covered with snow and ice.

Following dinner, that evening, Dr. Tompson and the executive secretary continued their discussion of the various problems concerning our profession until well after 1 a.m. and on Sunday morning, January 29, held another session for some two hours before the Tompson's left for Houston.

A busy month, yes? From all the instructions the executive secretary received, it looks like February will be equally as busy which preview makes us hope we will survive to—

See you next month!

Texas Physicians In Attendance At AOA Convention In Miami, Florida

AMARILLO
Glenn R. Scott, D.O. and wife

CUERO
C. R. Stratton, D.O.

DALLAS
Edward C. Brann, D.O.
Laura A. Lowell, D.O.
Hartley Polaskey, D.O.

EL CAMPO
Alan J. Poage, D.O. and wife

FORT WORTH
C. E. Dickey, D.O. and wife
Raymond D. Fisher, D.O. (Delegate only)
George J. Luibel, D.O. and wife
T. T. McGrath, D.O.
P. R. Russell, D.O.

GRAND PRAIRIE
A. Roland Young, D.O. (Delegate only)

GROOM
John L. Witt, D.O.

HOUSTON
Richard O. Brennan, D.O. and wife
James E. Cary, D.O.
F. A. Norris, D.O.
Lester I. Tavel, D.O.

MIDLAND
B. B. Jaggers, D.O.

OLTON
Lynn F. Fite, D.O.

SAN ANGELO
W. B. Rountree, D.O.

SOUTH HOUSTON
Donald K. Cutshall, D.O. and wife

WICHITA FALLS
R. H. Peterson, D.O.

O.P.F. Report

January started off to be another record-breaker which practically assures that 1960-61 will see osteopathic physicians and surgeons giving more for the support of their colleges than in any other fiscal year. All of this has come about because volunteer workers are educating the members of the profession that it is vitally necessary to provide funds in order to keep our schools operating. We are proud of this progress but we must not lose sight of the fact that we are still far short of raising the amount of money necessary to overcome the inroads of inflation and to enable our schools to keep pace with the ever increasing standards of education in the healing arts.

Announcement from Texas State Board of Medical Examiners

Executive Board Meeting

Fort Worth, Texas — November 29, 1960

The Texas State Board of Medical Examiners on this 29th day of November, 1960, hereby adopts the following rules and regulations pursuant to the provisions of Article 4509, Revised Civil Statutes of Texas, 1925, as amended:

INTERNS—*Approved Hospitals for Internship Program by the Texas State Board of Medical Examiners*

1. Interns must register annually and pay a fee of One Dollar ($1.00) with the Texas State Board of Medical Examiners. Article 4498a Vernon's Texas Statutes.

2. Interns may be issued an Intern Permit for one year only and must confine his internship to the hospital designated. If an intern violates Article 4505, Vernon's Texas Statutes, the permit is automatically cancelled. If an intern uses his Intern Permit to practice his profession outside the designated hospital, the permit will be automatically cancelled.

3. At the completion of one year's internship or if the internship is terminated for any reason, other than illness, the permit is void and no additional permit will be issued.

RESIDENTS—*Teaching Hospitals:*

1. Residents must registar annually and pay a fee of One Dollar ($1.00) with the Texas State Board of Medical Examiners. Article 4498a Vernon's Texas Statutes.

2. *Hospitals with an approved residency program, approved by the Texas State Board of Medical Examiners:*

The resident may be issued a Resident Permit for three (3) to five (5) years, dependent on the requirements of his specialty, and must confine his residency to the hospital designated. If a resident violates Article 4505, Vernon's Texas Statutes, the permit is automatically cancelled. If a resident uses his permit to practice his profession outside the designated hospital, the permit is automatically cancelled.

3. At the completion of the residency or if terminated for any reason, other than illness, the permit is void and no additional permit shall be issued.

4. *Non-Teaching Hospitals — Approved by the Texas State Board of Medical Examiners*

The resident may be issued a resident permit for two (2) years only and must confine his residency to the hospital designated. If a resident violates Article 4505, Vernon's Texas State Statutes, the permit is automatically cancelled. If a resident uses his permit to practice his profession outside the designated hospital, the permit will be automatically cancelled.

5. At the completion of the residency or if terminated for any reason, other than illness, the permit is void and no additional permit shall be issued.

FOREIGN GRADUATES:

(a) Foreign Graduates applying for either internship or residency in this state who have *permanent E.C.F.M.G.* certification must comply with the above regulations.

(b) Foreign Graduates with only a

temporary E.C.F.M.G. certificate may serve only two (2) years in a residency or one (1) year internship and one (1) year residency and must comply with above regulations.

(c) Foreign Graduates *without E.C.F.M.G.* certification are not permitted to serve an internship or residency.

THESE RULES AND REGULATIONS SHALL BECOME EFFECTIVE JULY 1, 1961.

Good Public Relations

From January 27, 1961 Lubbock Avalanche-Journal

IN CITY

Two Sets Twins In 30 Minutes

Officials at Lauf Clinic-Hospital believe a record for Lubbock was set at the hospital Thursday afternoon when two sets of twins were born within a span of 30 minutes.

The unusual incident started at 2:30 p.m. when the first of twin sons was born to Mr. and Mrs. Claudio DeLeon, Levelland. The second baby arrived five minutes later.

At 2:52 p.m. the first of twin girls was born to Mr. and Mrs. Fernando Romo of Shallowater. The second girl was born at 3 p.m. to complete the 30-minute cycle.

Both mothers were reported in good condition by hospital attendants.

Excellent Location

Physician needed in this small town located 45 miles from Dallas. Office furnished. If interested, contact Mr. T. A. Miller, Kemp, Texas.

Notice of Examination

THE TEXAS STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES
201 East 14th Street
Austin, Texas

The next examination of the Texas State Board of Examiners in the Basic Sciences has been set for Friday and Saturday, April 14-15, 1961, in Austin, Galveston, Houston and Dallas.

Details as to time and place may be obtained by writing to the Executive Secretary at the above address.

Applications for the October examinations will not be accepted after April 1, 1961 and all necessary information and documents required by the Board of examinees must be completed and in the applicant's file by that date. Those interested in participating in this examination should act immediately.

Very truly yours,
Henry B. Hardt, Ph. D.
President of the Board
HBH:vs

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

January 12, 1961

Washington News Letters

White House Conference On Aging.

The Conference was held in Washington, January 9-12, and was officially attended by four DOs on the part of the AOA and six as State delegates.

As the press has widely reported, speeches by former HEW Secretary Marion B. Folsom and Arthur Larson, former Under Secretary of Labor, turned the tide in the Income Maintenance Section in favor of Social Security financing of health costs. A supporting recommendation by the Section on Federal Organizations and Programs and a contrary recommendation by the Section on Health and Medical Care were ruled out-of-order on jurisdictional grounds. A policy statement by the Health and Medical Care Section that "Compulsory health care inevitably results in poor quality health care" was allowed to stand.

Other recommendations of the Section on Health and Medical care were a voluntary accreditation program for institutional facilities, such as The Commission on Accreditation of Hospitals; that existing Federal-State matching programs will provide effective, economic, dignified, medical care for the elderly who need help; that physicians' services are essential to care at home and he should be the coordinator of services provided to the individual; that both the aging group and the health professions must be cognizant of the importance of the value of periodic health appraisals.

The Section on Rehabilitation recommended enactment of Federal grant-in-aid legislation to help communities establish rehabilitation facilities and workshops meeting acceptable standards to provide diagnostic and therapeutic services; that well structered units should be established or expanded in schools of medicine, dentistry, nursing and other related disciplines both on the graduate and under-graduate level; that rehabilitation services could well be a condition of accreditation for hospitals, particularly those with approved intern training programs; that volunteer and other health insurance plans should provide in-patient as well as out-patient coverage for rehabilitation services in hospitals and in rehabilitation centers; that consideration be given to the establishment of a National Institute of Rehabilitation.

The Section on Research in Gerontology recommended early establishment of a National Institute of Gerontology; full Federal support without matching funds for construction of laboratories and special animal facilities (with long term support) for research programs in aging, in universities, medical schools and other appropriate institutions; and Federal support for establishing graduate scholarships in aging research, and assisting universities and medical schools to establish academic chairs in gerontology.

February 1, 1961

Hospitals

Resident (as well as intern) housing loans are available to nonprofit osteopathic hospitals from the Community Facilities Administration (Housing and Home Finance Agency). Applicants and project descriptions should distinguish clearly the number of "interns"

and "residents" which will be housed in the project facilities: Interships and residences must be approved by the AOA. Most loans run for forty years. Current interest rate is 3½ percent.

Nonprofit hospitals in or near urban renewal project areas would be eligible for urban renewal grants under a bill, H. R. 665, by Congressman Jacob H. Gilbert of New York.

Osteopathic participation under the Hill-Burton program has been diversified. As of November, 1960, osteopathic institutions that had received or were receiving Hill-Burton allocations included 32 genera lhospitals, 1 chronic disease hospital, 1 rehabilitation center, 4 diagnostic or treatment centers, and 1 nursing home. The Federal share was matched in varying degrees by private funds, equal to one-third to one-half the cost.

Nonprofit hospitals in urban areas would be eligible for Hill-Burton assistance for medernization under a bill introduced by Senator Jacob K. Javits of New York which would liberalize the priorities system. The bill defines modernization to include "alteration, major repair (to the extent permitted in regulations), remodeling, replacement, and renovation." See page 2 of this Washington News Letter for January 3-4, 1961 Hill-Burton Conference recommendations including modernization.

Honored

A. ROLAND YOUNG, D.O.

Dr. A. Roland Young of Grand Prairie, Texas was elected to the Board of Trustees of the American College of General Practitioners in Osteopathic Medicine and Surgery, at its recent meeting in Miami, Florida.

Senator Lister Hill of Alabama has introduced a bill, S. 278, to extend the program of Federal assistance to the States for the training of practical nurses for another five years.

Nonprofit hospitals would be exempt from communications and transportation taxes under a bill, H. R. 2317, introduced by Congressman Frank E. Smith of Mississippi.

The January, 1961 HEW Indicators shows per capita private expenditure for hospital services in 1959 was $32. In 1958, it was $30.

Congestive Heart Failure

By LAWRENCE A. WILLS, D.O.
Fort Worth, Texas

Congestive heart failure is the inability of the heart to pump a sufficient volume of blood to satisfy the demands of the periphery.

Some factors producing heart failure are: 1) States demanding an increased blood flow as in thyrotoxicosis, severe anemia, fever, prolonged infections, arteriovenous fistula, Paget's disease of bone, etc. These examples illustrate "high output failure" wherein the cardiac output is increased. The peripheral resistence is somewhat dimished not as a result of the heart failure but due to the abnormality of the peripheral resistence. 2) Increased work on the heart as in hypertension, arteriosclerosis, aortic stenosis, pulmonary hypertension. 3) Acquired or congenital lesions interfering with the blood thru the heart itself as in constrictive pericarditis, rheumatic valvulitis, syphillis and others. 4) Damage to the heart muscle itself as in rheumatic fever, collagen diseases, coronary artery diseases, viruses, etc.

Contributory causes of Heart Failure may be, 1) Undiagnosed heart disease 2) Untreated heart disease, 3) Unusual demands placed upon the heart as physical effort which may be excessive for a given heart depending on the state of health of that heart, excessive sodium intake, numerous pregnancies, overloading the circulatory system with intravenous fluids, 4) Chronic constitutional diseases as malnutrition with avitaminosis, such as Beri-Beri, senility, severe anemia, endocrinopathies, infections, stress, obesity, metabolic diseases and others.

At this point, perhaps it would be benificial to clarify three terms. 1) Cardiac Reserve which refers to the reserve energy of the heart to meet the increased demands of the tissues for blood due to physiological functions. Clinically, it may be theorized as the difference in length of the myocardial fibers at rest and when their physioligical limit of stretch has been reached. We see the application of cardiac reserve to fiber length by an increase venous return causing stretching of the fibers which results in a more forceful contraction and thus an enhancement of cardiac output. 2) Compensation (complete) where the heart is said to undergo complete compensation when the strain of the disease is overcome and sufficient cardiac reserve remains to adequately meet the diverse demands of the active life. 3) Decompensation (incomplete), and this denotes that there has been a substantial expenditure of cardiac reserve so that unpleasant symptoms develop with slight or moderate activity, although the strain of the disease may have been met.

There are two main mechanisms of congestive heart failure. 1) Forward failure, in which the symptoms arise primarily because of the heart's inability to pump out enough blood. The sequence of events are cardiac failure . . . ➧ low output from the left ventricle . . . ➧ reduced renal blood flow . . . ➧ retention of Na (+), water and Cl (-) . . . ➧ increased extracellular fluid and increased blood volume. 2) Backward failure, in which the symptoms are due to daming back of blood. Therefore, congestion in the systemic veins and vena capillary tributaries throughtout the organs and tissues of the body. The sequence of events are cardiac failure . . . ➧ elevated venous pressure and venous congestion . . . ➧ compensatory arteriolar vasco-constriction . . . ➧ anoxia of bone marrow . . . ➧ increased blood volume. There is evidence to deny and support both of these hypothesis. There can be no backward failure without

forward failure in a continuous circulatory system.

The symptoms represent the difficulties imposed by the compensatory mechanisms, which are: 1) tachycardia and cardiac enlargment (this occurs in order to increase the cardiac output). 2) arteriolar, vasco-consriction takes place in an attempt to get a sufficient amount of blood to the vital organs. 3) Increased venous return by, A) increasing the speed of the circulating blood, and B) by increasing the circulating blood volume. This is accomplished by the mechanisms that produce Na (+), water and Cl(-) retention, which are, A) increased renal venous pressure by passive congestion in the kidneys. B) dimished glomerular filteration due to decreased cardiac output. C) increased tubular reabsorption of Na, water and Cl via Pitression, the antidiuretic; (therefore, don't use during postpartum bleeding in a patient with heart disease and adrenal steroids because of the stress mechanism of congestive heart failure (especially aldosterone).

Types of congestive heart failure according to the primarily affected chamber are: 1) left heart failure (left ventricular failure or pulmonary edema) may present itself by a) hypertensive vascular disease, b) arteriosclerotic heart disease, c) aortic valvular disease, d) mitral regurgitation, e) congenital lesions affecting the left side of the heart (eg., coarctation of the aorta and of thyrotoxicosis. Since the left ventricle fails and the augmented blood volume accumulates in the pulmonary vascular bed, there are initially and primarily pulmonary symptoms. This is a heart failure with a short physiopathology. (There is a short distance between the left heart and lungs via the pulmonary veins, which take up the slack of the failure).

2) Right Heart Failure may present itself by, a) prolonged or recurrent left heart failure. (when the pulmonary veins can no longer support the failure, it is taken up through the capillaries to the pulmonary arteries to the right ventricle.) b) chronic lung disease (chronic corpulmonale), eg., emphysema. c) mitral stenosis, d) valvular leisons on the right side of the heart, e) constrictive pericarditis, and f) acute corpulmonale due to pulmonary embolism. Sypmptoms in right heart failure are more general than in left heart failure, since the slack of the failure is taken up by the vast systemic network of veins. (thus, it is also a more gradual procedure to the long physio-pathology) In this type of failure, there is an increase in the peripheral venous pressure, which results in congestion. With the early venous engorgement, there is liver enlargement and pedal and pre-tibial pitting, edema. Later, anasarca (subcutaneous edema cavities of the body). Throughout the entire course of the disease, there are varying types of edema (eg. hydrothorax.) 3) Combined heart failure results when the before-mentioned two get together; if they don't die of acute pulmonary edema first.
heart failure are: 1)

Signs and symptoms of congestive heart failure are: 1) signs and symptoms of pre-existing heart disease, whatever it may be. 2) dyspnea on exertion which is always an early sign in left heart failure. This is due to the pulmonary congestion which renders the lung rigid, lowers the vital capacity and

thus increases the rate of respiration. The degree of dyspnea is proportinate to the degree of pulmonary congestion. The dyspnea of right heart failure is usually present on the basis of pre-existent left heart failure. 3) dyspnea at rest is a late sign 4) orthopenea which is dyspnea in a recumbent position, 5) paroxysmal nocturnal dyspnea which is believed to be produced on the basis of congestion as in orthopenea, since the patient is in a recumbent position. Theoretical precipitating factors for paroxysmal nocturnal dyspnea may be cough, dimished muscular activity during sleep. (decreased milking action), terrifying dreams, change in position to more dyspenic side), slipping off of pillow and hence more recumbent and abdominal distention. 6) acute pulmonary edema is the epitony of left heart failure. Clinically, the patient presents dusky cyanosis, restlessness and apprehension, frothy hemoptysis due to transudation of blood into the alveoli and rales are audible with the naked ear. Death is near and treatment must be instituted immediately. This is very common and may be caused by left ventriclular failure due to coronary artery disease, hypertension, aortic valvulitis, mitral stenosis, pregancy, labor, exertion, intercourse, tachycardia, pneumonitis, etc. 7) cardiac edema which is characterized by increasing weight gain, tissues are over-hydrated, pretibial and ankle edema usually occur first, edema is bilaterally symmetrical and pits, and a bedrest patient may have post sacral edema first. 8) hydrothorax or fluid in the pleural cavity is more frequent and/or more severe, on the right side and is usually associated with combined left and right failure. If there is a sinus rhythum early, hydrothorax usually occurs first on the right side whereas in artial fibrillation, it is seen on the left side first. 9) Ascites, which is particularly seen due to right heart failure may be due to portal hypertension and preceeded byenlarged tender liver. Cardiac cirrhosis may take place in those individuals with protracted right heart failure. 10) Cyanosis due to an excessixe concentration of reduced hemoglobin in the blood by reason of venous congestion. 11) Jaundice occurs in 2-5% of patients with right heart failure. 12) Murmurs and tachycardia on auscultation may be heard. Ominous signs of heart failure are, a diastolic gallop rhythum, pulsus alternans, blood pressure may be elevated in previously normatensive, the heart is enlarged and may have murmurs and impaired resonance. 13) In the abdomen, the liver is enlarged and tender. The tenderness is the more important of the two. The spleen may be enlarged in advanced cases. Ascites may be present with its signs, such as, succussion splash, dullness on percussion, etc. 14) The extremeties may be cyanotic due to suboxygenation. The rail beds may be dusky. There is varying amounts of pitting edema. 15) Laboratory findings are: increased blood volume, and a reduced hematocrit, unless secondary polycythemia is present. There is a diminished output of urine per 24 hours, pre-renal azotemia with an elevated B.U.N. There is a slight bilirubinemia on the basis of hepatic dysfunction. Bromsulphalein excretion test is abnormal in rith heart failure.

An E.K.G. is 100% valueless in the diagnosis of congestive heart failure. It doesn't reflect congestive heart failure. It only reflects the basic heart disease and the tachycardia. An E.K.G. should be done if one doesn't know the cardiac status of the patient or if he is having arrythmias.

Fluoroscopy and X-ray of the lungs may reveal impaired pulmonary ventilation, prominent pulmonary v a s c u l a r pattern, interstitial and alveolar edema and the cardiac contour and rhythum.

The lung vitl capacity is reduced This is vital in following a patient with lung or heart disease or following the patient's progress under therapy.

Circulatory tests such as venous pres-

sure is elevated early in right heart failure. Later it is elevated in left heart failure. This test is valuable in prognosis and in determining if heart failure is present in doubtful cases. It returns to normal with a favorable response. One should do a venous pressure on all patients with congestive heart failure. If a patient in right heart failure is treated and responds nicely symptomatically but his venous pressure remains high, look for pericarditis.

Circulation times are often performed which are the arm to tongue time which measures the systemic circulation and this will be prolonged in right or left heart failure. Arm to lung time measures the circulation through the right heart and this is prolonged in right heart failure. The lung to tongue time which is measured by the difference between arm to lung and arm to tongue time measures the pulmonary venous circuit, but this is only of secondary interest.

In the treatment of congestive heart failure there are two prime ideas and they are: 1) Improve cardiac output, as with bedrest and digitalis and 2) limit intake of sodium and improve excretion thereby preventting water retention. Also, remember to treat the underlying cause, such as arrythmia, rheumatic fever, hyperthyroidism, etc. Prophylactic measures in those cases should be employed such as limit activity, limit sodium intake, limit diet, treat infections promptly and to control acute episodes of bleeding which result in myocardial ischemia resulting in decreased cardiac efficience.

In the treatment of congestive heart failure with acute pulmonary edema, bedrest with high Fowler will reduce dyspnea and increased surface area of the lung. It also increases excretion of water by increasing cardias and thus renal function. It lowers the blood pressure by diminishing the load on the heart. The disadvantage of bedrest is that it predisposes to thrombophlebtis and therefore pulmonary or cerebral embolism, but this may be prevented by rolling the patient from side to side. Sodium restriction is important and Friedberg advocates diet of milk and nothing else for 3-4 days. Must remember however, to supply chlorides, therefore give ammonium chloride tabs. Diet should consist of small but frequent meals. Vitamins should be used because they were probably undernourished due to anorexia before the acute episode. Digitalis, as it increases the strength of the systolic contraction of the failing heart since digitalis increases the cellular potassium concentration in small doses. Potassium depletion may allow the myocardium to become over distended. It also depresses conduction of the atrial musculature by its direct effect and its vagal ef ect. It reduces the refractory period of the musculature and prolongs the refractory period of the A-V node. Therefore, digitalis increases the cardiac output due to the above mentioned, causes a decrease in the size of the heart due to shortening of the fibers, produces a fall in diastolic pressure of the left ventricle, produces a fall in the right atrial pressure not dependent on blood volume and a decline in the atrioventricular oxygen differences. Diuretics, such as Mercurhydrin, diamox, aminophylline (beware of hypotension) and 50cc of 50% glucose solution may be employed. But don't use immediately with acute pulmonary edema, as it may mobilize too much fluid to further embarras the cardio-pulmonary system and also increase the chance of digitalis intoxication due to its mobilization along with the body fluid. Also may use morphine for pain, codeine to depress unproductive cough, oxygen by catheter, mask or tent and with alevair if desired. A bloodless phlebotomy as dropping legs off of bed and using tourniquets to extremities, retention catheter to record intake and output, restrict sodium and E.K.G. Maintain digitalization as determined by the cardiac rate, E.K.G. and blood pressure.

NEWS OF THE DISTRICTS

DISTRICT THREE

The regular meeting of District 3 was held in Longview on January 15 at 2:30 p.m. at the Eastwood Motel. Dr. Tom Hagen was host. The following physicians were presents: K. E. Ross, William H. Clark, Earl C. Kinzie, Palmore Currey, A. M. Duphorne, Ellis L. Miller, Wayne M. Smith, S. E. Jones, R. B. Bunn, Sue K. Fisher, C. Bowden Beaty, Brady K. Fleming, Lester D. Lynch, H. G. Grainger, Carl F. List, Allen M. Fisher, Charles C. Rahm, J. W. McCorkle, Tom Hagen and C. D. Ogilvie.

During the business session, Dr. Howard R. Coats of Tyler was unanimously recommended by District 3 to be a representative on the Texas State Board of Medical Examiners and a letter will be forwarded to the Governor of Texas through our Committee of Public Relations to that effect. Dr. Coats was also recommended by the physicians of District 3 to be given an Honorary Life Membership in the TAOP&S at the 1961 state convention.

Our delegates elected for the state convention were Doctors J. W. McCorkle, Henry Hensley, Carl F. List and C. Bowden Beaty. Alternates are Doctors Robert L. Hamilton, Lester D. Lynch, Dan A. Wolfe and Kenneth E. Ross.

It was decided to hold the March meeting of District 3 at Mt. Pleasant, Texas.

Dr. Beaty, the program chairman then introduced Dr. Charles D. Ogilvie of Dallas who gave a concise, clear and well-received lecture on the radiologist's view point concerning common lung pathologies with accompanying slides illustrating his lecture.

Those in charge of the meeting and Dr. Ogilvie are to be complimented on this well planned meeting—with a minimum of "chit-chat" and a maximum of professional benefit.

ALLEN M. FISHER, D.O.
District 3 Reporter

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

DISTRICT 1

Dr. John L. Witt, Groom ..... President
Donald L. Eakin, Amarillo ..... Secretary-Treasurer

DISTRICT 2

Dr. Elbert P. Carlton, Fort Worth ..... President
Dr. Jack H. Gramer, Fort Worth ..... President-Elect
Dr. William A. Griffith, Fort Worth ..... Vice-President
Dr. Myron G. Skinner, Fort Worth ..... Secretary-Treasurer

DISTRICT 3

Dr. J. Warren McCorkle, Mineola ..... President
Dr. C. Bowden Beaty, Tyler ..... President-Elect
Dr. Carl F. List, Troup ..... Vice-President
Dr. Charles C. Rahm, Brownsboro ..... Secretary-Treasurer

DISTRICT 4

DISTRICT 5

Dr. James C. Williamson, Seagoville ..... President
Dr. John H. Burnett, Dallas ..... President-Elect
Dr. Raymond E. Liverman, Duncanville ..... Acting Secretary and Treasurer

DISTRICT 6

Dr. George G. Clark, Houston ..... President
Dr. J. Edward Vinn, Houston ..... President-Elect
Dr. Robert R. Ling, Houston ..... Secretary
Dr. J. Ralph Cunningham, Houston ..... Treasurer

DISTRICT 7

Dr. Gordon S. Beckwith, San Antonio ..... President
Dr. Roy D. Kirkland, Austin ..... Vice-President
Dr. Waldemar D. Schaefer, San Antonio ..... Secretary-Treasurer

DISTRICT 8

Dr. Joseph Schultz, Corpus Christi ..... President
Dr. Mable Martin, Weslaco ..... President-Elect
Dr. Samuel B. Ganz, Corpus Christi ..... Vice-President
Dr. Arthur Myers, Corpus Christi ..... Secretary-Treasurer

DISTRICT 9

Dr. H. Freeman Elliot, Rockport ..... President
Dr. Willis L. Crews, Gonzales ..... President-Elect
Dr. Donald M. Mills, Victoria ..... Vice-President
Dr. John H. Boyd, Louise ..... Secretary-Treasurer

DISTRICT 10

Dr. Raymond E. Mann, Lubbock ..... President
Dr. Harlan O. L. Wright, Lubbock ..... President-Elect
Dr. M. L. Wisby, Lorenzo ..... Secretary-Treasurer

DISTRICT 11

Dr. R. C. Valdivia, El Paso ..... President
Dr. Roger R. Delgado, El Paso ..... President-Elect
Dr. John E. Holcomb, El Paso ..... Secretary-Treasurer

DISTRICT 12

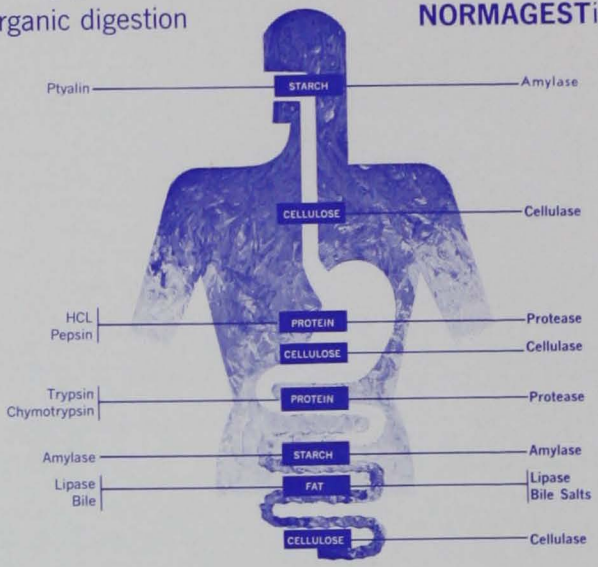
Dr. John B. Eitel, Port Neches ..... President
Dr. Jack K. Taylor, Port Arthur ..... Vice-President
Dr. Ralph C. Merwin, West Orange ..... Secretary-Treasurer

DISTRICT 13

Dr. Selden E. Smith, Wolfe City ..... President
Dr. David D. Matthews, Honey Grove ..... President-Elect
Dr. Dean E. Wintermute, Cooper ..... Treasurer
Dr. Henry B. Peters, Royse City ..... Secretary

this is ...
organic digestion

this is ...
NORMAGESTion



this is the new VM 61

NORMAGEST

The complete natural digestant that handles cellulose too!
The digestant with standardized enzyme activity.

EACH TABLET CONTAINS:	
Standardized a-Amylase	30 mgs.
Standardized Protease	6 mgs.
Standardized Lipase	2 Willstatter Units
Standardized Cellulase	2 mgs.
Standardized Pancreatin (equivalent Pancreatin N.F. 300 mgs.)	100 mgs.
Ox Bile Salts Iron Complexed	50 mgs.

50 Tablets 4.00
100 Tablets 7.50

VITAMINERALS INC.

GLENDALE 1, CALIFORNIA

PERSONAL SERVICE BY:

DENNIS & SMITH:
1905 S. EDGEFIELD ST., DALLAS • WH 8-6318

RAYMOND S. INGERSOLL:
367 REXFORD DRIVE, SAN ANTONIO 10 • TA 6-1444

WILSON WOMACK:
3930 PURDUE, HOUSTON • MA 3-9911