Texas Osteopathic Physicians Journal

VOLUME XX FORT WORTH, TEXAS, JULY, 1963 Number 3

In This Issue—

Texas Osteopathic Physicians' Journal

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EDITORIAL PAGE

WARNING!

This warning is to those physicians who distribute drugs of any character, including samples, to their patients. If you do not follow the labeling requirements as set forth in the Texas Dangerous Drug Law, there is a stiff penalty attached, as follows:

> "Any person, firm, or corporation violating any of the provisions of this Act shall be fined an amount not exceeding Three Thousand Dollars ($3,000.00) or confined in jail for a period of not less than thirty (30) days nor more than two (2) years, or by such fine and imprisonment. For any second or subsequent violation of this Act, any person so violating the same shall be confined in the penitentiary not less than two (2) years nor more than ten (10) years; provided that upon any second or subsequent conviction the benefits of the suspended sentence law shall not be available to a defendant convicted for a violation of the provisions of this Act; provided further that any person convicted of any second or subsequent violation of this Act shall be entitled to the benefits of probation under the Adult Probation and Parole Law, as provided therein."

You should keep informed of the drugs covered under this Act. Dangerous Drugs are defined as "Any drug which bears the legend: *CAUTION: Federal law prohibits dispensing without a prescription.*" Most of the drugs today carry this legend, and if there is any doubt as to whether it is a legend item drug you can gain this information from the pharmacist, wholesaler or manufacturer's representative.

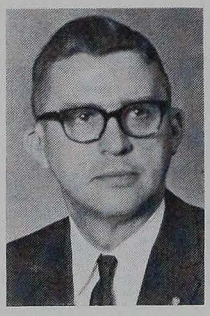
If a practitioner dispenses a legend item drug or dangerous drug whether a sample or not, it must bear the following information according to this Act:

1. The directions for the use of such a drug.
2. The name and address of the patient.
3. The name and address of the practitioner.
4. If such a drug is prescribed for an animal, a statement showing the species of the animal.

This act can and is enforced by any local, county or state police officer. The only way the officer has of knowing if an individual is entitled to possession of this dangerous drug is by the proper label on the container or sample package. Already a number of patients of the practitioners have been embarrassed and inconvenienced because the practitioner failed to properly label the medication. As you can well understand this does not bring about a good practitioner-patient relationship and subjects you to the penalty.

It is hoped that each of our physicians who are forced to distribute drugs in their office will recognize that they must act as a licensed pharmacy in doing so.

Shoulder Disabilities



IRA C. RUMNEY, D.O.*

The incident of shoulder disabilities is becoming more frequent with the aging of our population. The shoulder disabilities in the younger individual is usually due to some type of injury but as a person becomes older shoulder disability becomes an outgrowth of degenerative changes. If we look at the anatomy of the shoulder joint and note the distribution of the muscles that either insert or originate about the shoulder, we will find that disturbances in function of the musculoskeletal system anywhere from the feet to the head can cause symptoms referred to the shoulder. Muscles of the shoulder having origin from:

I. Occiput
   a. Trapezius
II. Vertebral Column
   a. Trapezius
   b. Latissimus Dorsi
   c. Levator Scapula
   d. Rhomboids, major and minor
III. Sacrum and Ilium
   a. Latissimus Dorsi
IV. Ribs
   a. Pectoralis, major and minor
   b. Serratus Anterior
   c. Subclavius
   d. Latissimus Dorsi
V. Clavicle
   a. Deltoid
   b. Pectoralis major
VI. Scapula
   a. Supraspinatus
   b. Infraspinatus
   c. Subscapularis
   d. Deltoid
   e. Teres, major and minor
   f. Long Head of Biceps
   g. Long Head of Triceps
   h. Coracobrachialis

Muscles of the shoulder having insertion into:

I. Scapula
   a. Trapezius
   b. Levator Scapula
   c. Rhomboids, major and minor
   d. Serratus anterior
   e. Pectoralis minor
II. Humerus
   a. Deltoid
   b. Supraspinatus
   c. Infraspinatus
   d. Pectoralis major
   e. Latissimus Dorsi
   f. Teres, major and minor
   g. Coracobrachialis
   h. Subscapularis
III. Clavicle
   a. Subclavius

These muscles are supplied by the 11th cranial nerve, the 8 cervical nerves, and the first thoracic. The preganglionic sympathetic nerve supply to the shoulder and the blood vessels of the arm come from T-1 to T-4. The post-ganglionic sympathetic nerve supply to the shoulder and the blood vessels of the arm come from C-4 to T-4.

The joints of the shoulder are four in number: I. The Scapulohumeral, II. The Sternoclavicular, III. The Acromioclavicular, IV. The Scapular Thoracic, and some speak of a fifth, The Suprahumeral Joint. The motions permitted in the shoulder joint are abduction, adduction, internal and external rotation, anterior flexion and posterior flexion,

*Perrin T. Wilson, Professor in Department of Osteopathic Medicine, Kirksville College of Osteopathy & Surgery.

with the many combinations of these motions. The specific motions that may be permitted, such as the thoracoscapular movement (shrugging mechanism) permits the elevating of the arm to about 65°. In the claviculohumeral mechanism we find that for the first 90° that the arm is abducted, the sternoclavicular joint has to elevate 4° for every 10° that the arm is raised. There is about 20° of motion at the acromioclavicular joint that takes place during the first 30° of abduction of the arm, and then again after 100° of abduction of the arm. The clavicle has to rotate on it's long axis, about 20° for complete abduction of the arm. If the clavicle does not rotate backward on it's long axis the arm cannot be abducted beyond 110°. During the first 30° of abduction and 60° of flexion, the scapula finds a position of stability in relation to the humerus. Beyond this point the scapula moves with the humerus on a ratio of 1:2. Therefore, loss of scapula motion decreases abduction one third.[1]

The causes of the painful shoulder are: I. Trauma, II. Poor posture and muscular weakness, III. Abnormalities in the cervical spine, (such as the osteopathic lesion of the cervical spine, cervical rib, arthritis), IV. Diseases of the lung and heart, V. Intra-abdominal diseases that produce irritation of the diaphram, VI. Tender fibrous nodules, or trigger points, in the muscles about the scapula, and VII. Reflex sympathetic dystrophy.

Many times in taking the history, on careful questioning of the patient, I will learn that they have had a vague discomfort in the shoulder for quite some time. This, the patient does not pay much attention to until the shoulder becomes quite painful. Many times the patient will state that previous to the time the shoulder became painful he noticed that it would become fatigued, or that he had a dragging or heavy feeling in the shoulder, or that the arm and hands would go to sleep easily. The patient may give a history of inability to lie on the painful shoulder. The motion in the shoulder may vary all the way from moderate restriction to complete immobility.

It has been said that the so called frozen shoulder takes six months to develop, is bad for six months, and then takes six months to correct itself. There is a certain amount of truth to this statement, pertaining to the shoulder that has degenerative changes. The shoulder can be helped by properly administered osteopathic care.

The three outstanding symptoms of the frozen shoulder are pain, lack of motion and reflex sympathetic dystrophy.

The causes of these symptoms are: I. Tendinitis of the rotary cuff. II. Shoulder injuries. III. Bicipital tenosynovitis. IV. Muscle inbalance due to inactivity, particularly of the subscapularis and the infraspinatus. (The head of the humerus must be depressed during abduction and flexion). V. Osteopathic lesions of the sternoclavicular, acromioclavicular, scapulo-humeral joints. VI. Osteopathic lesions of the lower cervical and upper thoracic vertebra. (They may be due to structural faults or viscerosomatic reflexes.)

The most frequent lesion that I have found in the reflex sympathetic dystrophy is the lesion of the head of the fourth rib, in which the motion of the rib is limited and the rib is held in a position of inhalation on the side of the painful shoulder. Irritation to any part of the shoulder girdle causes a reflex through the central nervous system which affects the neurocirculatory elements of that section of the body.

With increasing age I look carefully to the rotator cuff and look for evidence of degenerative changes that may be taking place. The deterioration is frequently found after the fifth decade and is observed in most shoulders after the age of 60. The tendinous fibers of the rotator muscles gradually deteriorate and are worn down by attrition between the humeral head and the coraco-acromial

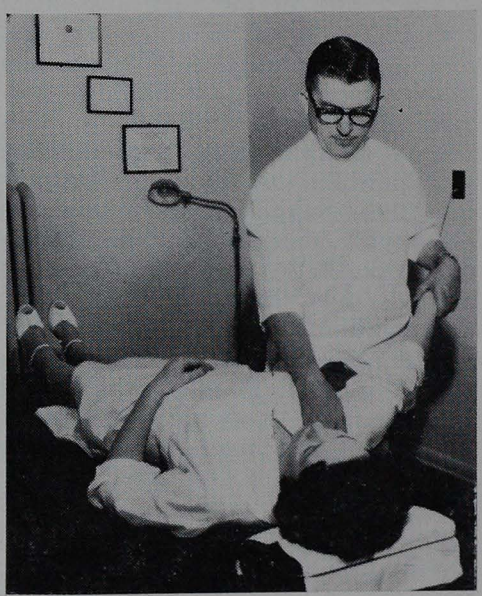
arch (this is the suprahumeral joint). The tendon of the biceps over the humeral head is likewise eroded and predisposed to rupture. As the cuff wears away the deltoid gradually takes over more function. The symptoms of this degenerative process are manifested by recurring pain and stiffness in the shoulder and down the anterior aspect of the arm aggravated by activity. The shoulder is tender over the cuff, about the greater tuberosity, and over the bicipital group.

When the patient complains of an acute pain developing in the shoulder and states that at the time it came on he heard a snap, we must suspect rupture of the rotary cuff. This rupture may be brought on by a very small amount of force, such as reaching out or passing a light object to someone. However, there is usually more force involved.

On examination the arm can be raised actively to about 45° by the deltoid and further raising of the arm is accomplished by the shrugging mechanism. The arm is most painful in the abduction between 45° and 90°, and if raised passively beyond the 90° point it can then be taken farther up with very little discomfort. After several months the ability to abduct the arm improves and eventually a full range of painless motion results but the arm remains weak. Atrophy of the supraspinatus and infraspinatus, and contracture of the abductor and internal rotator muscles is apt to occur. This must be counteracted by specific exercises.

It is important that the individual preserve all the strength possible in the shoulder before surgical repair is attempted. Even with surgical repair, the disability may last six months.

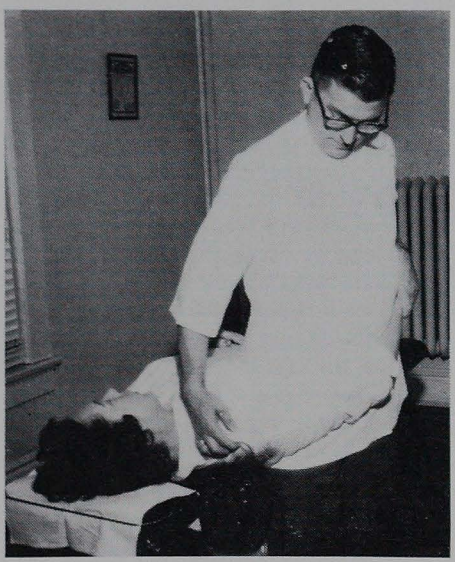
In the examination and treatment of shoulder disabilities I start by doing a gross postural analysis[2] and if I find any evidence of a short leg, vertebral or pelvic anomalies, a standing x-ray and other indicated diagnostic x-rays are ordered, such as checking for calcium in the long head of the biceps, arthritis, etc. If there is evidence of an actual short leg on x-ray findings I may or may not use a lift, depending upon the clinical findings. After completing the gross postural analysis, I inspect and palpate the shoulder. It is not unusual to see the shoulder in a position of external rotation and subluxed anteriorly. Then I check to see what shoulder motions the patient has. In checking the motions, I find out in which directions the patient can move the arm the easiest and then proceed to get tissue release by taking the arm in that direction and holding it there for half a minute to a minute. Then I take it back in the opposite direction as far as it will go without causing too much discomfort. After checking out the various ranges of motion, I look for tender nodules in the supraspinatus muscle, infraspinatus muscle, teres major and minor, and where the teres major crosses the long head of the triceps. Next I check the motion of the acromioclavicular and sternoclavicular joints. The motion at these joints will be limited. *(Fig. 1)* To re-establish motion in



the sternoclavicular joint, I stand at the side of the patient, place my knee under the shoulder joint as a fulcrum, and use the arm as a lever. I have the arm pro-

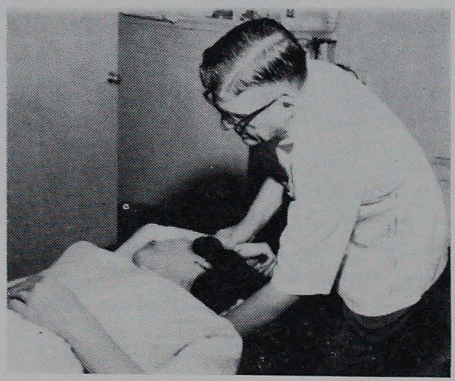
nated as I check motion at the sternoclavicular joint and supernated as I check motion at the acromioclavicular joint. Sometimes I have to take the acromioclavicular joint in the direction of strain with the hand pronated to release the tense ligaments and muscles.

At times I may need to use traction on the acromioclavicular joint and this is accomplished by having my thigh in the patient's axilla, standing facing the arm, and then hold the arm against my body as I turn my back towards the patient. *(Fig. 2)* This uses the thigh as



an effective fulcrum to put traction on the acromioclavicular joint to correct an acromioclavicular separation. The most frequent lesion that I find at the acromioclavicular joint is one in which the clavicle is rotated anteriorly and slides up and back on the acromion. In order to raise the arm above 110°, the clavicle must rotate anteriorly on it's long axis.

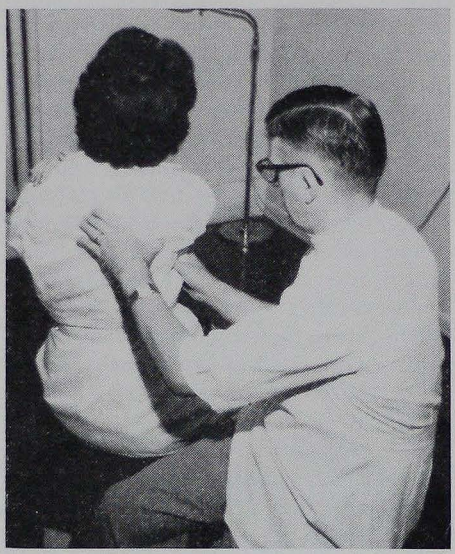
By this time the arm is usually more comfortable and the patient can move around more readily, so I now ask the patient to lie prone on the table and start checking the back for evidence of osteopathic lesions (musculoskeletal strains). I examine carefully the sacroiliac and the lumbosacral joints, the thoracolumbar area and the upper thoracic area. Now I ask the patient to lie on his back and I examine the cervical spine for evidence of osteopathic lesions (musculoskeletal strains). After I have established the diagnosis of the musculoskeletal strains, or osteopathic lesions, then, to the best of my ability, I proceed to re-establish normal motion throughout the spine at that visit. Next, I place the fingers of my left hand on the angles of the first, second, third, and fourth ribs, on the right side if I am dealing with a right shoulder problem, and with my right thumb, or heel of my right hand, spring the first, second, third, and fourth ribs. *(Fig. 3)* This is



done on the left side for left shoulder disability by applying the hands similarly on the left side.

When there is evidence of autonomic dysfunction in the arm, such as muscular atrophy, dry skin, cold, wet hands, etc., I look very carefully for thoracic lesions, particularly involving the head of the fourth rib on the side that is involved. It has been my experience that there is frequently a lesion of the fourth rib, in which the rib is in a position of full inhalation and the head of the rib is caudad. The costotransverse joint acts as a fulcrum. I correct this lesion by having the patient seated on the table while I sit on the opposite side and cradle the entire rib in my two hands, have the patient take a fairly deep breath, then as he exhales I follow the rib down and

then hold the rib down as the patient continues to breathe deeply. *(Fig. 4)*



With a little springing of the rib, with the hand on the distal part of the shaft of the rib, I soon feel the head of the rib move back up to its normal position. With the acute arm hand syndrome I have had some very dramatic results with this type of treatment.

The frequency of patient visits depends entirely upon the stage of the condition. The more acute condition is seen more often than the chronic condition. The extremely acute condition may be seen daily and the chronic condition is usually seen twice a week.

Analgesics and specific exercises, based upon the patients condition, are prescribed. I rarely use any of the cortico-steroid hormones. I have not injected any shoulders.

There are many different strapping techniques that are used to help the shoulder, particularly a painful shoulder that has fairly good mobility. One strapping technique is to use 2″ tape, begin at the insertion of the deltoid and fan your strappings out over the shoulder, extending the tape about 8 inches medially from the tip of the shoulder. When some people strap a shoulder they extend the strappings past the midline but I have never done this.

There are several exercises that the patient can do to help loosen up the shoulder. One of them is to stand about 2 feet from a wall and, using his fingers, climb up the wall, making as large an arc as the patient can with his arm. The patient must be careful to climb up and climb back down the wall and not let the arm drop. Another exercise that can be used is to have the patient lie on his stomach on a table high enough so that the arm can hang off fully extended. In this position the patient can circumduct the arm and, as the arm begins to feel a little more comfortable, he can hold a weight in the hand to help stretch the muscles about the shoulder.

Other exercises, especially when the shoulder first begins to bother, is to externally rotate the arm with it straight, abducted at 90°, then make a motion as if the arm was going around the outside of a cone with a base of 16-18 inches. The apex at the shoulder and base at the hand. Shrugging the shoulders helps to mobilize the clavicle.

For the trigger points, one may use ultra sound or one may inject them with 1% procaine hydrochloride.

BIBLIOGRAPHY

1. Turek, Samuel L.: Orthopaedics — Principles and Their Application. Philadelphia-Montreal: J. B. Lippencott Co., 1959.
2. Rumney, Ira C.: Structural Diagnosis and Manipulative Therapy. J. O., January 1963.

Soap-suds enemas are not harmless, since rectal inflammation, troublesome urticaria and local eczema may follow their repeated use.

Good Location

VAN HORN, TEXAS, (2,000 pop.) needs and wants a D.O. One M.D. in town. Large trade territory. Offering several months free rent for anyone interested in locating there. If interested contact J. W. Berghouse, Van Horn, Texas, El Capitan Motor Inn.

TOHA Meeting Aimed At Administrators and Physicians

The Texas Osteopathic Hospital Association will hold its annual meeting, August 3-4, 1963 in the El Tropicana Motel, San Antonio, Texas.

A unique program, directed toward the physician and hospital administrator has been planned. Every osteopathic physician who owns or holds office in a hospital organization is urged to attend.

Blue Cross-Blue Shield of Texas will conduct a workshop on Saturday, August 3, at which time insurance problems will be discussed and practical solutions presented. This portion of the program has been designed to benefit every osteopathic physician, administrator and insurance clerk, regardless of the hospital's size.

Scheduled lectures include a presentation on "Early Detection of Phenylketanuria" by Mr. Rex Lynch of the Ames Company. Mr. Lee Davis, Administrator of Community Hospital Inc., Houston, will speak on "Hospital Problems—Administrative and Staff". Dr. G. W. Tompson, President of the Texas Osteopathic-Insurance Liaison (TOIL) Committee will then present, "The Viewpoint of the Hospital Staff."

The entire program has been planned with the sole objective of presenting facts that will benefit every hospital represented. The approach is new, practical, and different!

Program Chairman is Dr. Selden E. Smith, Wolfe City Hospital, Wolfe City, Texas.

Texas Osteopathic Hospital Association

Annual Meeting

El Tropicana Motel — San Antonio

August 3-4, 1963

SATURDAY

8:30- 9:15	Welcome and Introduction of Guests W. L. DAVIS, D.O., presiding, *President,* TOHA
9:15-10:15	Blue Cross Workshop
10:15-10:30	Coffee Break
10:30-11:45	Blue Cross Workshop
12:00- 1:30	Luncheon—Courtesy of Blue Cross-Blue Shield of Texas
1:30- 2:30	Blue Cross Workshop
2:30- 2:45	Coffee Break
2:45- 3:15	"Hospital Problems—Administrative and Staff" MR. LEE DAVIS, *Administrator,* Community Hospital, Inc., Houston
3:15- 3:45	"The Viewpoint of the Hospital Staff"....G. W. TOMPSON, *President* TOIL Committee
3:45- 4:00	Questions and Answers

SUNDAY

9:00- 9:45	"Early Detection of Phenylketanuria".....MR. REX LYNCH, of the Ames Company
9:45-10:00	Coffee Break
10:00-12 Noon	Business Meeting .....W. L. DAVIS, D.O., *Moderator*

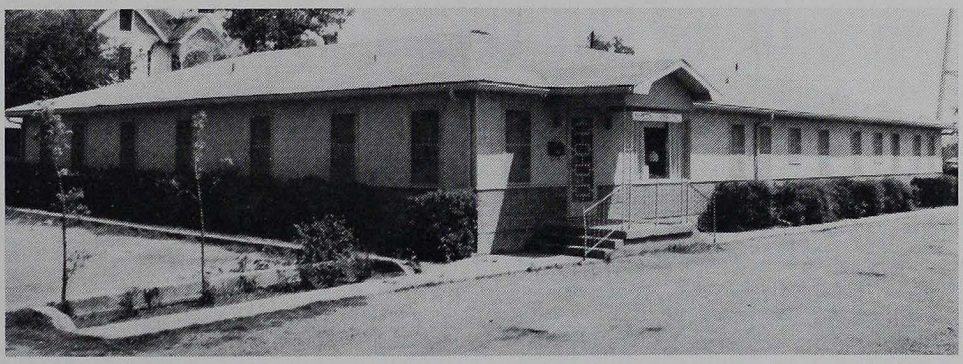
New curriculum at *WESTERN RESERVE UNIVERSITY* proposes "to teach medicine as a coherent, meaningful whole rather than as series of unrelated disciplines . . ."; starting midyear classes. New policy at *UNIVERSITY OF FLORIDA* states: ". . . the orientation of the program in medicine is toward educating family physicians. . . . If in the four years of medical school this can be attained, the Florida program will have been uniquely successful." *BOSTON UNIVERSITY, HARVARD UNIVERSITY, JOHN HOPKINS UNIVERSITY* all have adopted a six-year-from high school curriculum for M.D. degree. (Remember when our colleges were criticized for teaching "only family doctors" "without enough pre-medical training?")

VENEREAL DISEASE EXPLOSION REPORTS compiled from M.D. and D.O. sources last summer will startle and sober even your members! Watch for official American Social Health Association statistics this month. Someone at each health level, whether physician or teacher or parent is apparently *guilty of neglecting* a dismal problem. Over 1 million new cases of V.D. last year—mostly in teenagers, and only 5% from prostitutes. Unless your members will honestly report V.D. cases, little hope for control is possible!

* * *

NEW TRENDS AT MEDICAL COLLEGES mimic osteopathic goals proposed *60 years ago:* note "osteopathic" trends being adopted as something new in 1963:

Hospital of the Month



Marcom Hospital (Osteopathic) 100 Bonham Street — Ladonia, Texas

The Texas Osteopathic Physicians' Journal is proud to salute MARCOM HOSPITAL as the Hospital of the Month.

Marcom Osteopathic Hospital observes its tenth year since its establishment in Ladonia, Texas in 1953 by Gordon A. Marcom, D.O. The original hospital was a six-bed institution located in a converted business house of the town plaza. These quarters were soon outgrown and the present hospital of 10 beds and 4 bassinets was completed in 1956.

The hospital has again outgrown the physical plant and plans are underway to double the bed capacity. Construction is expected to begin later this year on an addition that will house remodeled surgical, obstetrical, and enlarged x-ray and laboratory facilities. It is also planned to include facilities for two additional doctors and a dentist.

Dr. Gordon A. Marcom is chief of staff and Walters Russell, D.O. of Dallas, Texas, heads the surgical staff. Other staff members in the area are Dr. Dean Wintermute of Cooper and Drs. K. G. White and Patrick Martin of Commerce.

Mrs. Theona Cantrell, R.N. is supervisor of nurses and also instructor for the hospital's School of Vocational Nursing. Mrs. Mary Hayes, RMS, who began her duties as administrator of the hospital in 1953 during construction of the original facility, now heads the employed staff of sixteen.

Any physician interested in this practice location may contact Dr. Gordon A. Marcom or Mrs. Mary Hayes, Marcom Hospital, Ladonia, Texas.

Accomplishments of the Regular Session Of the 58th Legislature, 1963

ELMER C. BAUM, D.O., *Chairman* Public Health Committee, TAOPS

At the close of the first Regular Session of the Texas Legislature in at least 30 years to finish its work before the expiration of the constitutional limit set for such sessions, it seems appropriate to review and evaluate what was accomplished before adjournment on May 24, three days in advance of the 140-day deadline prescribed by the Texas Constitution.

As has been the case in most regular sessions in recent years, about 1,600 bills were introduced in the two houses. Considering also resolutions introduced in both houses, about 1,900 separate proposals were before the Regular Session of the 58th Legislature. About one-third—or 33 per cent—of the bills introduced were finally passed.

One of the notable characteristics of the Regular Session of the 58th Legislature was harmony and cooperation, not only among the members and presiding officers in the individual operation of the two houses, but among the House, the Senate and the Governor. The business of the state was conducted in an atmosphere of good will and mutual cooperation and understanding.

The following bills relating to medicine, insurance and public welfare have been passed by the Legislature and will soon become law. It is of utmost importance that we familiarize ourselves with this current legislation.

S.J.R. 10—Proposing an Amendment to Section 51a of Article III of the Constitution of the State of Texas by adding a new Subsection to be known as 51a-2; giving the Legislature the power to provide, under such limitations and restrictions as may be deemed by the Legislature expedient, for direct or vendor payments for medical care on behalf of individuals sixty-five (65) years of age or over who are not recipients of Old Age Assistance and who are unable to pay for needed medical services; providing for the acceptance of financial aid from the Government of the United States for such medical payments.

This is a constitutional amendment which will implement the second phase of the Kerr-Mills Law.

H. B. 418—An act relating to public health and welfare; to provide for confidential information received by the State Department of Health, medical organizations, hospitals, hospital committees, or other organizations in the course of a medical study for the purpose of reducing morbidity or mortality; to provide that such information and material so furnished may be used only for the purpose of advancing medical research, medical education, statistical and other studies; to provide for general publication of a summary of said studies; to provide an exemption from legal liability for those furnishing such information and for those studying and publishing the results and summaries of such studies; and to provide that such material and information and any findings or conclusions of such groups shall be privileged.

H.B. 266—An Act amending Section 1 of House Bill No. 245, Chapter 231, Acts, 1961, Fifty-seventh Legislature, Regular Session, codified as Article 3174b-5, Vernon's Civil Statutes of the State of Texas, authorizing the Board for Texas State Hospitals and Special Schools to contract for medical care and treatment.

"Section 1. The Board for Texas State Hospitals and Special Schools may contract for the support, maintenance,

care and treatment of mentally ill and tubercular patients committed to its jurisdiction or for whom the Board is legally responsible. Such contracts may be made between the Board and city, county, and state hospitals, private physicians, licensed nursing homes and hospitals and hospital districts."

H.B. 1006—Amending Article 4476-5, V.A.C.S., requiring registration for wholesalers and distributors of drugs and medicines with Commissioner of Health.

H.B. 162—Amending Article 725b, Penal Code, Uniform Narcotic Drug Act, to place paregoric per Se. on list of narcotic drugs to be sold by prescription only.

Physicians shall keep a record of such drugs received by him and a record of all such drugs administered, dispensed, or professionally used by him otherwise than by prescription.

H.B. 552—Amending Sec. 17, Ch. 107 41st Legis. requiring permits for stores and distributors of drugs to be issued by State Board of Pharmacy.

H.B. 717—Enabling each county to create a County Hospital Authority without taxing power.

S.B. 401—An act authorizing the State of Texas to enter into the Interstate Compact on Mental Health with other states; and declaring an emergency.

H.B. 634—An act amending the Texas Mental Health Code by adding four (4) new Sections numbered Section 39a, Section 39b, Section 39c and Section 39d, providing for the right of appeal from Orders of Temporary Hospitalization, Observation and Treatment; and amending Sections 36 and 49 respectively, providing for closed hearings on the Application for Temporary Hospitalization, Observation and Treatment of a proposed patient and/or on the Petition for Indefinite Commitment of a person to a mental hospital, only when the consent of the proposed patient or person first shall have been obtained.

H.B. 334—Amending Article 4570, Chap. 11, Title 71, R.C.S. relating to eligibility to take examinations for license to practice chiropody. Requirements: 30 semester hours of college courses acceptable for credit on a Bachelor's Degree at the University of Texas, graduation from a bona fide reputable school of chiropody or podiatry, course of instruction shall embrace at least four terms of 8 months each.

S.B. 383—authorizes the Board for Texas State Hospitals and Special Schools to enter into contracts for research on mental illness.

H.B. 156—Amending Article 3871b, T.C.S. authorizing the Board for Texas State Hospitals and Special Schools to use its facilities for research in mental retardation.

S.B. 477—Authorizes creation of a committee to study treatment of sociopathic personalities.

S.B. 419—Amending Ch. 3, Insurance Code by adding a new Article 3.71, authorizing association of insurance companies regarding medical plan to residents 65 or older.

H.B. 500—Directing the University of Texas to establish a graduate school of bio-medical sciences in Houston.

H.B. 538—Relating to per diem for members of the Texas State Board of Medical Examiners.

A Productive Expression

By GEORGE W. NORTHUP, D.O.

Recently the Editorial Department of the AOA held an Editorial Conference with representatives of the departments of osteopathic principles and practice of our five colleges.

This conference was held "to develop and implement methods by which the publications of the American Osteopathic Association can supply teaching material for our colleges and equally valuable and practical material for practicing physicians." In this initial meeting, the group limited its attention to the "distinctive" areas of osteopathic theory and osteopathic methods.

In a day and a half of concentrated effort, the consultants worked out a long range, broad program for the assembling and classification of existing osteopathic literature to serve as a bibliographic supply for the production of articles, monographs, and books so needed in osteopathic teaching programs.

The conference was distinctive in that it was not a "talkathon." It has started a program which will involve close cooperation among the five colleges and the AOA Editorial Department. Its accomplishments will be reflected in the writings, the teachings, and the development of osteopathic education and osteopathic literature.

It is a new, different, and integrated attempt to set the pace for a more productive expression of the goals, the teaching, and the practices of osteopathic medicine.

It deserves the interest and support of the entire profession.

NOTICE OF EXAMINATION

The next meeting of the Texas State Board of Medical Examiners when examinations will be given and reciprocity applications considered is scheduled for December 5, 6, 7, 1963 at the Blackstone Hotel, Fort Worth, Texas.

Completed examination applications for graduates from United States medical schools must be filed with the Medical Board thirty days prior to the meeting date.

Completed examination applications for graduates of foreign medical schools must be filed sixty days prior to the meeting date.

Completed reciprocity applications must be filed sixty days prior to the meeting date to be given consideration.

(Texas State Board of Medical Examiners, 1714 Medical Arts Bldg., Fort Worth 2, Texas)

The Vagus nerves do not carry pain sensations from the abdominal viscera.

Men are four with regard to knowledge:

He who knows, and knows that he knows, he is a wise man—follow him;
He who knows, and knows not that he knows, he is asleep—wake him;
He who knows not, and knows he knows not, he is a child—teach him;
He who knows not, and knows not he knows not, he is a fool—shun him.

Unexplained amenorrhea calls for X-ray study of the skull for pituitary tumor.

Patients with edema are generally brine-logged, not water-logged.

Male breast cancer shows striking improvement after castration.

No clinical test can think for the clinician.

Three New Hospitals

Pictured at Doctors Hospital, Tyler, Texas are Dr. John S. Turner of Canton (left), and Dr. Phil R. Russell, executive secretary for the TAOP&S.

Park Center Hospital (Osteopathic)

On May 21, the executive secretary as official representative of the Hospitals & Insurance Committee inspected the new osteopathic hospital at Euless, Texas, *Park Center Hospital.* It is a proprietary institution of 16 adult beds in semi-private rooms and four-bed wards. There are no private rooms. The hospital has sufficient x-ray and laboratory facilities and maintains all the required records.

Park Center Hospital is owned by Dr. Joseph W. Burke, Jr. and two dentists. It is built around Dr. Burke's office and is operated by him with the assistance of Dr. Ernest J. Sachse of Fort Worth and courtesy staff doctors. This is a nice, small institution located in a fast growing community some five miles from Hurst General Hospital and approximately six miles from Mid-Cities Memorial Hospital in Grand Prairie, both of which are osteopathic institutions. Park Center Hospital has received a temporary permit from the State which we feel will be made permanent with very few changes.

Garland General Hospital (Osteopathic)

On June 8, the executive secretary inspected the Garland General Hospital, Garland, Texas. It is a two-story proprietary institution owned and operated by Dr. C. J. Martin. There are 19 adult beds in semi-private and ward rooms. There are no private rooms. All facilities such as laboratory, x-ray, records room, kitchen, etc. are on the first floor as is Dr. Martin's office. The equipment is most adequate and all required records are maintained.

At the present time Dr. Martin is operating the Garland General Hospital by himself with the exception of some courtesy staff members. The hospital is permanently licensed by the State. Garland is a fast growing community 18 miles from Dallas and has one other hospital which is operated by M.D.'s.

Doctors Hospital (Osteopathic)

On the evening of June 8, the executive secretary inspected the Doctors Hos-

pital in Tyler, Texas, a completely new 25-bed osteopathic hospital built some five miles from the center of Tyler, on the loop. It is beautifully constructed and well arranged, having four private rooms and semi-private and ward rooms with connecting half-baths.

Doctors Hospital is a proprietary institution owned and operated by Doctors Brady K. Fleming, John S. Turner, William H. Clark and Anton Lester. The facilities are more than adequate for a hospital of this size and all the necessary records are maintained. The active staff consists of the hospital owners and Dr. J. Warren McCorkle of Mineola.

The executive secretary on each of these inspections spent some four hours with the administrators and staff, going over requirements for A.O.A. Registration, instructions as to the handling of insurance matters and the policies of the TAOP&S in reference to osteopathic hospitals in Texas.

Hospital Expansion Planned at Comanche

We have received notice that the Comanche Hospital, Inc., owned and operated by Dr. Blackwood and Flannery, started work on an expansion program June 1.

Eight private rooms, so designed as to serve as isolation units should the occasion arise, are to be equipped with toilet facility, piped in Oxygen, telephone and television plugs and two-way inter-communication. In addition there will be storage rooms and mechanical rooms, properly insulated so that noise will not be passed into the hospital proper.

Additional rooms will also be added to the clinic wing of the structure, allowing for larger business offices, new private offices for doctors, library, work room for the clinic nurses and an additional treatment room.

The plans have been submitted and approved by the Department of Health in Austin.

THIA Meets

The ninth annual state convention of the Texas Health Insurance Association was held at the Inn of the Six Flags, Arlington, Texas, June 12-14, 1963. Each and every member of the Texas Osteopathic-Insurance Liaison (TOIL) Committee who represents the osteopathic profession and the osteopathic hospitals was invited to attend. It was truly unfortunate that some of the TOIL Committee members were unable to attend. However, the executive secretary was in constant attendance. The facts are, this meeting would have been a wonderful show for the entire osteopathic profession and would have given many of our doctors a different opinion in regard to the insurance industry and its objectives.

The lectures were primarily devoted to impressing the group that health in-

surance was written for the protection and for the benefit of the public. It was emphasized that the insurance industry would soon be destroyed unless they realized that they were a public trust and that all just claims should and must be paid; but under no circumstances should they permit abuse of the funds set up for the protection of the policyholders in sickness. It was admitted that the program of hospitalization and sickness insurance was not a profitable venture, but a responsibility of the insurance industry to keep Uncle Sam from forcing us into government controlled medicine.

The main speeches were delivered by Harry L. Triece, Agency Director for Mutual of Omaha whose topic was "Claims from An Agency Viewpoint"; James A. Williams, Attorney at Law, Dallas, Texas spoke on "Has Insurance Missed Valhalla?"; Mr. C. M. Kara, Director of Southern Zone Benefits, Mutual of Omaha discussed the development and use of the unit value surgical schedule.

There were several workshop sessions during which actual claims were evaluated by the entire group of some 300 insurance representatives. Another topic discussed was, "Claim Hootenanney".

Twice during the program did such men as Mr. Triece and Mr. Kara make mention of the osteopathic professions contributions toward better insurance programs and the defeat of government control, through its Insurance Committee and TOIL Committee. Indeed, you would have been proud to hear the many remarks made regarding your profession.

Several speeches brought out the fact that poor communications in the insurance industry between the underwriters, agents, and salesmen was the cause of more trouble than anything else and it was one of the problems that must be corrected and this will be the avowed purpose of this organization within the coming year . . . to make the salesmen who work on a commission and the agent better understand their responsibility to the public in handling and explaining the benefits of the policy, that they might properly carry out the objectives of the underwriters.

On the night of June 12, the executive secretary attended the opening which was an open house cocktail party for the entire group. He was indeed flattered that so many insurance people knew him and recognized him . . . people he himself did not know. There was hardly a person in the crowd who did not comment on the activities of your Hospital & Insurance Committee and the TOIL Committee.

DEATH

Dr. George E. Hurt, 62, of Dallas, Texas died of Heart failure, June 7, 1963, while visiting in Port Arthur.

Calendar of Events

August 2-6, 1963 — MEMORIAL CARDIOVASCULAR FOUNDATION, annual convention, Hotel Colorado, Glenwood Springs, Colo. George F. Pease, D.O., 1001 Montgomery St., Fort Worth 7, Texas.

August 3-4 — TEXAS OSTEOPATHIC HOSPITAL ASSOCIATION, annual meeting, El Tropicana Motel, San Antonio, Texas. Secretary, Mrs. Mary Hayes, Marcom Osteopathic Hospital, Ladonia, Texas.

August 1-31 — Begin to think support of Student Loans and Research thru Seals. Select names for Packet mailing list — add new patients, friends, tradesmen and family. Check for current addresses.

September 30-Oct. 3 — AMERICAN OSTEOPATHIC ASSOCIATION, 68th Annual Convention and Scientific Seminar, Jung Hotel, New Orleans, La., Program Chairman, W. Clemens Andreen, D.O., 1475 Ford Avenue, Wyandotte, Michigan.

September 30-Oct. 3 — Specialty Group meetings, Jung Hotel and the Royal Orleans Hotel, New Orleans, Louisiana:

OSTEOPATHIC COLLEGE OF OPHTHALMOLOGY AND OTORHINOLARYNGOLOGY. Program Chairman, Ralph M. Connell, D.O., 5101 Ross Avenue, Dallas 6, Texas.

ACADEMY OF APPLIED OSTEOPATHY, annual meeting. Secretary Margaret W. Barnes, D.O., P.O. Box 1050, Carmel, California.

AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY, annual meeting. Secretary, Daniel Koprince, D.O., 713 N. Main St., Royal Oak, Michigan.

AMERICAN COLLEGE OF GENERAL PRACTITIONERS IN OSTEOPATHIC MEDICINE AND SURGERY, annual meeting. Secretary, Mr. Jack Hank, 13942 So. Clark, Riverdale, Michigan.

AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, annual meeting. Secretary, Myron S. Magen, D.O., 1475 Ford Ave., Wyandotte, Mich.

AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, annual meeting, Secretary, George E. Himes, D.O., 3921 Beecher Rd., Flint 4, Michigan.

AMERICAN OSTEOPATHIC COLLEGE OF PHYSICAL MEDICINE AND REHABILITATION, annual meeting. Secretary, Joseph C. Snyder, D.O., 2225 Spring Garden Street, Philadelphia 30, Pennsylvania.

AMERICAN OSTEOPATHIC COLLEGE OF PROCTOLOGY, annual meeting, Secretary, Earle F. Waters, D.O., 24 M St., Salt Lake City 3, Utah.

October 24-26, 1963 — AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS annual meeting, Statler-Hilton Hotel, St. Louis, Mo., Secretary, Stuart F. Harkness, D.O., 1626 63rd St., Des Moines 22, Iowa.

October 27-30 — AMERICAN COLLEGE OF OSTEOPATHIC SURGEONS, 36th Annual Clinical Assembly, in cooperation with American Osteopathic Hospital Association, American Osteopathic College of Anesthesiologists, American Osteopathic College of Radiology, American Osteopathic Academy of Orthopedics and American College of Hospital Administrators.—Chase Park Plaza Hotel, St. Louis, Missouri. Convention Executive, Charles L. Ballinger, D.O., Box 40, Coral Gables 34, Florida.

November 2-3 — TEXAS OSTEOPATHIC OBSTETRICAL AND GYNECOLOGICAL SOCIETY, Annual Meeting, Cabana Motor Hotel, Dallas, Texas. Secretary, J. O. Carr, D.O., 2715 Hemphill, Fort Worth 10, Texas.

A Boy and His Dog to Graduate

By GEORGE H. GRAINGER, D.O.

Sometime early in July a special kind of graduation ceremony will be held. Special, because a boy and his dog will graduate together after having studied the same courses together for some 18 months. The boy is Richard Bruce of Gladewater, a student in Junior High. The dog is an alert, attentive little bright-eyed Collie, about three-and-a-half years old. Richard Bruce is fifteen, and he is blind.

Burr Lacey is an osteopathic physician. He practices medicine in Quitman, assisted by his secretary-wife. Together, they train seeing-eye dogs for sightless children, and young Richard Bruce's dog is one they helped train.

Richard Bruce and his companion will be the first young Texans to receive their "seeing-eye-degree" from the school, [illegible]rivate Dogs, Incorporated, Dayton, [illegible]Ohio.

Sightless children need a different kind of dog companion than do grown-ups, for one thing because of their age and size. A Shepherd dog for a ten-year-old would be too big and strong. Dr. and Mrs. Lacey work only with little Collies, "Smooth Collies" the breed is called. They train them individually; that is one at a time. They get them shortly after puppyhood and put them through a course of basic training, an intensive course of love and discipline that takes as long as a year and a half. When they are finished, the Collie is ready to meet his child companion-to be; and the two are trained together by someone else for another year and a half. Then comes graduation day.

There has always been "something special" about the relationship between a boy and his dog. To those who witness Richard Bruce and his companion receive their diplomas on graduation day, that "something special" will become more meaningful, more poignantly clear.

In the meantime, the Burr Laceys have taken on another smooth Collie and begin their long and loving task of training it for another sightless youngster. The Laceys have given basic obedience training to seven small seeing-eye-dogs.

The Emergency Examination of the Severely Injured Patient

By JOSEPH J. MUELLER, M.D.

The emergency examination of the acutely and severely injured individual is one of the most important techniques which we must strive to develop. The chief problem being that in time of disaster the individual doing the examining may be confused and upset by the sight of the severely injured cases. Therefore, we must attempt to develop a technique which will become second nature to us and which will not be easily forgotten in time of disaster. It is very distressing to an observer to watch an examiner jumping from patient to patient in a confused and excited manner not being able to readily come to some type of diagnosis and appropriate treatment.

Upon arriving at the disaster scene, whether it be a roadside accident, the emergency treatment station during wartime, a tornado devastated area or whatever the case may be, there are three prime considerations which must be evaluated immediately. It is imperative that we instantly make a quick survey for evidence of hemorrhage, obstructed airway and shock. It will do no good to start to examine a patient completely and have him bleed to death from a large vessel or artery which has been torn and which can readily be stopped by simple compression of the area. By the same criteria, a patient whose airway is obstructed either by position or by injury must have this airway immediately reestablished or we will shortly be examining a dead individual. If the patient is in shock, which can readily be determined by the palpable pulse, or rather the lack of a palpable pulse, the condition of shock must be remedied immediately or you will again be examining a dead person within a short period of time.

Therefore, when entering a disaster area, look for three important things. Number 1, evidence of hemorrhage from a readily accessible site, 2. airway obstruction and 3. shock.

In examining acutely injured individuals probably one of the best methods is to begin at the head and progress in an orderly fashion on down to the lower extremities. In this we will establish a routine which even in time of stress, will not easily be forgotten.

Initially, in the examination, the examiner should slip his hand under the region of the neck, that is, the cervical spine, and palpate for any evidence of injury or tenderness. If there is evidence of tenderness or any degree of pain whatsoever in this area when palpated,

then it is best if the head be immobilized in its position so that no further damage to the spinal cord in this area might occur. Immobilization can easily be brought about by using sandbags, rocks, pieces of wood or whatever else might be available, placing any one of these objects on either side of the patients head.

Then the scalp should be carefully examined for evidence of lacerations, depressed wounds of the skull or areas of ecchymosis behind either ear, all of which are indications of possible intercranial damage. A quick glance at the patients eyes and the dilation position of the pupils will suffice for this portion of the examination.

Next, look in both ear canals and the nose for evidence of a discharge of clear watery fluid which will probably be spinal fluid indicating intercranial damage.

Gentle palpation about the bones of the forehead and the cheekbones will readily establish whether or not they have been injured to any great degree. By gentle palpation we can ascertain if there is tenderness along the jawbone. Having the patient bite his teeth together will usually cause severe pain in an individual with a fractured jaw.

Proceeding down in an orderly fashion next examine the anterior and lateral surfaces of the neck for evidence of lacerations and evidence of displacement of the trachea to either one side or the other. Palpate and examine gently for evidence of gross hemorrhage into the neck areas which should be manifested by a large hemotoma formation.

Continuing down to the shoulder region and gently examining both clavicales or collarbones throughout their entire length from the medial to the lateral, we can determine whether or not there is a fracture of the clavicle. Observing the anatomy of the shoulder joint and comparing one side with the other for gross disproportion it can be determined if the patient has a fracture or a dislocated shoulder.

Proceed to one or the other of the upper extremities and by palpating the long bone of the upper arm look for evidence of contusion, abrasion, large hematoma formations and evidence of fracture, the last being manifested by pain and deformity of the extremity. Proceed in this manner to the region of the elbow joints, forearm and hand. This examination can be accomplished without too great a degree of discomfort to the severely injured patient. Exami-

nation of the hand should be carried out even though it may seem to be a minor consideration in the overall condition of the patient. Look for severe fractures, laceration of the tendon and possible involvement of the nerve supply to the hand. The hand is an important functioning structure of the body and should not be neglected in an emergency examination.

Examination of the chest, abdomen and back can be carried out and considered as one unit. By gentle palpation of the ribs with the finger tips we can easily determine if there are fractures. If palpation of the rib cage reveals no indication of fractures then gentle compression with the palms of the hands may reveal tenderness. Then, using a stethoscope, and listening to the breath sounds on both sides, we can determine if lungs are functioning on either one side or the other. In addition, look for evidence of penetrating wounds of the chest.

In examining the abdomen we look for gross evidence of missile penetration due to flying glass, bullets, shrapnel, knives and other types of penetrating injury. Also, look for abdominal injuries which might indicate that there has been injury to underlying organs. Then pass the hand around to the flank region on either side and palpate the area of the kidney for evidence of tenderness. Palpate the area of the spine for injury or tenderness. Proceed to the lower abdomen and palpate gently over the area of the pubic bones. Tenderness there may indicate a possible injury to the bladder. Compress the iliac crests inwardly and if tenderness is noted there is a possibility of bladder damage due to a fractured pelvis.

Examine the lower extremities in the same manner used for the upper extremities by palpating with the finger tips along the surfaces of the great bones looking for evidence of disproportion, swelling, hematoma formation, abrasion, etc. Carry the examination down the anterior surface of the knee, tibial region, ankle and foot looking again for gross disproportion, fractures, lacerations and compounding injuries of the joint. Without unduly disturbing the patient, it is an excellent idea to see if he can move all of his extremities. This will indicate whether or not there has been injury to the motor or sensory function of the nerves involved.

Using this method of examining the patient from head to foot in an orderly fashion it should be possible to complete the examination in about three minutes time and it should allow the examination of several patients within the space of fifteen minutes. It should be pointed out that in this type of examination it is wise to cut away the patients clothing rather than making the attempt to remove them and in so doing move the patient unnecessarily.

It should be pointed out that his examination does not take the place of a more complete and thorough examina-

tion which, conditions permiting, should be carried out at a later time. This technique of examining is to be used in the sorting stations to enable the sorting team to determine priority for immediate treatment of one type of injury or another.

In summary it should be pointed out that initially and most importantly conditions of shock, obstructed airway or hemorrhage must be recognized immediately and treated promptly before the patient is examined from head to toe in the manner outlined.

S.O.P.A. News

STATE CONVENTION

August 3-4, 1963

Houston, Texas

The Texas Association of Osteopathic Physicians Assistants will hold its annual convention August 3-4 in the Sheraton-Lincoln Hotel, Houston. Every osteopathic physician's assistant has been sent a hotel registration card, for use during the convention, and an application for membership in our state organization. We urge all of you to attend. An excellent program and varied social activities promise education and fun for all.

The Convention will open Saturday morning, August 3, with a "Get Acquainted Coffee", followed by installation of officers for the 1963-64 fiscal year.

At the Noon luncheon there will be a drawing for a lovely silver bowl, compliments of Haltom's Jewelers, Fort Worth. The bowl, functional in design, has many uses and will blend with any decor.

Every osteopathic physician and his wife in the Houston area has been invited to attend the President's Reception and Banquet, the evening of August 3 in the Sheraton Lincoln Hotel. Guest speaker will be Dr. Loren R. Rohr, President of the Texas Association of Osteopathic Physicians and Surgeons. It is hoped that many will attend. Reluctantly we add that there will be a charge of $5.00 per person, which is the cost of the meal. Complimentary tickets are limited to clergymen, installing officer and guest speakers and their wives.

A SONY T.V. will be raffled off during the banquet, so be sure to bring your ticket. It may be the winning number.

Program participants include leaders in both the Texas Osteopathic Association and its Auxiliary.

The convention will close on Sunday, August 4, with a breakfast and business meeting at which our new president will preside and make her committee appointments. Objectives for the 1963-64 year will be clearly outlined. SEE YOU AT THE CONVENTION!

(Tarrant County)

Fort Worth, Houston and Port Arthur societies have started fund raising campaigns to help defray the expenses

of our state convention. The remainder of the money will go into our Osteopathic Scholarship Fund which was set up during the past year. Our Society is selling raffle tickets on a SONY T.V. to be given away during our convention.

This fund raising campaign is the highlight of the year, so members, get on your toes and reach high!

With all sincerity, the members of the S.O.P.A. want to express their gratitude to Mrs. Rita Neal, Executive Assistant of the TAOP&S, for her cooperation during the past year, by making her an Honorary Member of our Society and the Texas Association of Osteopathic Physicians Assistants.

Our meetings, held in the various doctors offices, are proving to be very successful, with the help of S.O.P.A. members giving practical demonstrations in different procedures we encounter in our daily office routine.

To the non-members in Fort Worth —Why don't we all work together by attending these educational meetings which broaden our knowledge and skill in the proper handling of patients, and in turn benefits our physician-employers?

EDDIE LYNVILLE
Reporter

(Jefferson County)

The Society of Osteopathic Physicians Assistants of District 12 met on June 13, 1963, at 7:30 P.M. at the Port Arthur Subcourt House. Speaker for the evening was Justice of the Peace, Judge Fulton Lee, whose topic was "Court Room Procedures and Small Claims Court." It was a very interesting meeting.

On June 15, 1963, a rummage sale was held in Port Arthur and the proceeds will be contributed to the National Osteopathic Scholarship Fund.

BETTY WOODALL
Reporter

IN THE CHICAGO AREA free cytology kits are available to dentists thru the Chicago Board of Health, the Univ. of Ill., and the Chicago Dental Assn. The importance of early detection of *oral malignancy* through the simple Pap smear technique is being emphasized to the dental groups.

Comment: it may be worth checking in your area on the possibility of such kits being available (through the U.S. Public Health) to D.O.'s doing general examinations including oral inspection.

Death

Milton V. Gafney (KCOS '33), 54, of Dallas, Texas, died July 8, of a heart attack. He was a native of Winfield, Kansas. Dr. Gafney was past president of the American College of Osteopathic Surgeons. Funeral services were held at 10 a.m. July 10.

NEWS OF THE DISTRICTS

District No. 1

Dr. Lewis Pittman reports an excellent week of advanced postgraduate work in Kansas City, recently, in Techniques of Manipulative Therapy. Harold I. McGoun, D.O. of Denver was one of the featured instructors.

Lester J. Vick was a featured instructor at the Five States Convention held in Scottsdale, Arizona two weeks ago. Dr. Vick appeared on the program in five spots and reports a program of excellence. This can be understood when we know that the Program Chairman was Dr. H. E. Donovan of Scottsdale, Arizona, formerly of Raton, New Mexico. The five states represented in this convention were New Mexico, Arizona, Colorado, Utah and Nevada.

Summer vacations are coming up and Dr. Maurice Mann has just returned from Georgia where he and his family sojourned for ten days. This is the only vacationer we know of at this time. The trout are running at Red River, Eagle Nest and Seretta Lake and will catch the plugs of J. Paul Price and family very soon.

Dr. Ben Rodamar hit the Apaloosa circuit of sales and we understand he invested in one of those beautiful "oat burners". Don't let anybody kid you, they are not just quarter horses, they are whole horses, believe me.

Maybe next month we can tell you where others in our district have gone or plan to go. Have a nice vacation folks!

PITTMAN-SCOTT
Reporters, Dist. No. 1

District No. 3

District Three welcomes Dr. William H. Hanna into the ETex fold. Dr. Hanna, Kirksville, '60 has just opened offices in Tyler for the conduct of general practice. Dr. Hanna interned at Laughlin Hospital along with another District 3 member, Dr. Anton Lester, but upon completion of his training located in Edgewater, Florida before coming to Texas.

Bill is a family man with son Dan (17) and daughter Sandra (12). The Missus, whom he affectionately calls "Bitsy", remained in Florida with the children until school was out and they should now be re-united in their new Tyler home.

Dr. Hanna was with the State Fish and Game Commission offices in Tyler before entering Kirksville. He holds a B.S. degree from Southwestern University and has done advanced study in Bacteriology at Texas U. No, Bill's chief recreation is not fishing or hunting; it's golf!

* * *

Have you heard of what the Burr Lacey's of Quitman are doing? These fine, modest people are humanitarians of the first order. Dr. and Mrs. Lacey train Seeing-Eye Dogs for blind children. They have been doing this for years. We interviewed them via phone and you will find more about this in an article entitled "A Boy and His Dog To Graduate", which appears elsewhere in the Journal.

* * *

Dr. and Mrs. Jack Woodrow, Nacagdoches, left for Ottumwa, Iowa, June 8 to be with Mrs. Woodrow's mother, Mrs. George Wehr, whom we understand at this writing is seriously ill. They were expected to return June 24th.

* * *

Dr. and Mrs. Kenneth E. Ross and entourage have been spending late May-early June in the East (Boston, Cape Cod, Maine) and are long gone as of this writing. Entourage consisted of Dr.

Ross' long time girl Friday, Mrs. Grace Taylor, and her husband.

* * *

We are sorry to report the death of Mr. Charles List, June 2, at Coats-Brown Hospital. Mr. List is the father of Dr. Carl F. List of Troup, Texas. Our sympathy and great respect go with Carl and his sweet wife Voncelle who so lovingly attended Mr. List throughout his lingering illness. Burial was in the family plot in Baltimore.

GEORGE GRAINGER, D.O.
Reporter, Dist No. 3

District No. 8

Several newsworthy events have occurred in the past few months.

We were pleased to learn that the Texas alumni of the Kansas City College elected Dr. Fred Logan as president and that he was reelected to the Board of Trustees of T.A.O.P.S. It appears that he has a busy year ahead of him.

Dr. Hause reports a very informative program was presented at the A.C.O.S. post graduate meeting at Six Flags.

The Corpus Christi Osteopathic Hospital received some television and newspaper publicity when it became the first hospital in South Texas to install a hypothermia machine for gastric freezing. Much interest has been created in this new therapy for peptic ulcers.

As the completion of the intern year arrives we welcome Dr. David Bruce into practice in Corpus Christi, and bid farewell to Dr. Roy Farneman who is leaving to begin a residency in radiology in Pennsylvania.

We learned with mixed emotion that the south part of District 8 has been authorized to form a new distirct. We will miss seeing our friends in the valley but we realize that such a move will strengthen the profession in their area.

D. H. HAUSE, D.O.
Reporter

PROFESSIONAL CARD DIRECTORY

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

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Dr. Benjamin W. Rodamar, Amarillo ..... President-Elect
Dr. Robert E. Clayton, Groom ..... Vice President
Dr. Richard E. Wetzel, Amarillo ..... Secretary-Treasurer

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DISTRICT 11

Dr. John E. Holcomb, El Paso ..... President
Dr. Daniel Leong, El Paso ..... Vice President
Dr. R. C. Valdivia, El Paso ..... Secretary-Treasurer

DISTRICT 12

Dr. A. L. Garrison, Port Arthur ..... President
Dr. Auldine Hammond, Beaumont ..... President-Elect
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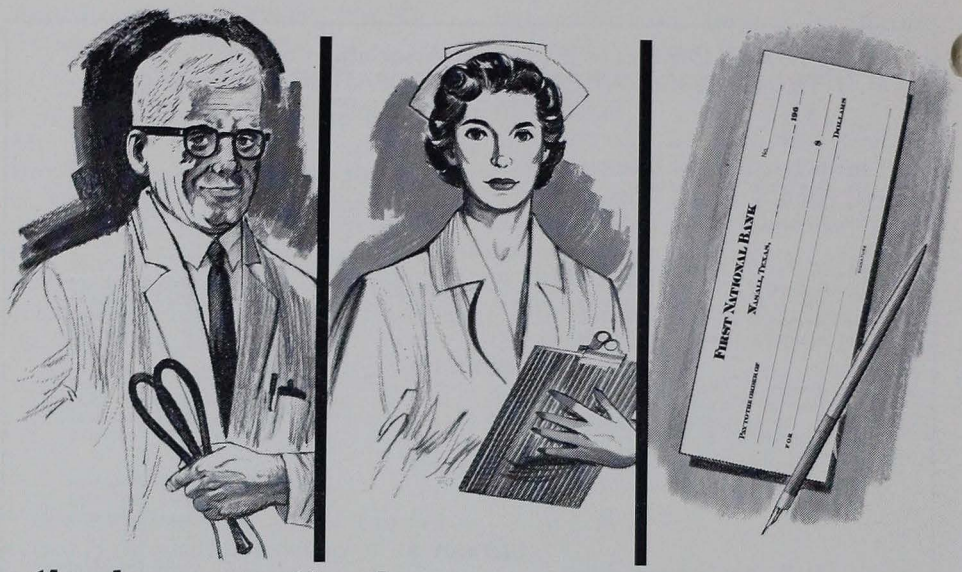
Dr. Mabel F. Martin, Weslaco ..... President
Dr. George W. Diver, Elsa ..... Vice President
Dr. Joe Suderman, Pharr ..... Secretary-Treasurer



Let's be practical...

It Takes All Three!

The hospital-ill patient must have the doctor.

He must have the modern hospital, with its trained and dedicated people.

But he must have one thing more — ability to pay.

In this day of living on the installment plan, how many really have it, without Blue Cross-Blue Shield?

With Blue Cross-Blue Shield, he shows his I. D. card at the admissions desk, and from then on gets the actual services of the hospital served up to him like hot apple pie. Worry-free. But what about the patient who has no protection? Or a limited cash coverage, so often far too small?

And — can you think of anything better for the future of Osteopathy, than wider and wider ability-to-pay, through wider and ever wider enrollment in Blue Cross-Blue Shield?

Is it time to "look at all three"?

MAIN AT NORTH CENTRAL EXPRESSWAY
DALLAS 22, TEXAS

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GROUP HOSPITAL SERVICE, INC.

BLUE SHIELD®
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