Texas
OSTEOPATHIC PHYSICIANS Journal

VOLUME XXIII FORT WORTH, TEXAS, JULY, 1966 NUMBER 3

In This Issue —

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

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

EDITOR: MR. ROBERT B. PRICE

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SUBSCRIPTION RATE $2.50 PER YEAR

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EDITORIAL PAGE

GUEST EDITORIALIST

A Report On The Future

By GEORGE W. NORTHUP, D.O., *A.O.A. Editor*

On April 22, 1966, President Johnson accepted for the people of the United States a little-publicized report, "Health Is a Community Affair." This was the report of the National Commission on Community Health Services, and it represented the completion of a four-year study of the nation's health services and problems. Marion B. Folsom, former Secretary of Health, Education and Welfare and chairman of the National Commission, stated that it was his wish that the objectives of this report "may prosper in communities all over the land."

The Commission has taken fourteen policy positions on what it considers to be major issues in health services today and discusses them with supportive recommendations.

The National Health Council Forum recently devoted three days to a study of the report, and the sessions proved to be both provocative and stimulating. Over 600 leaders of the "health community" gathered in New York at the Americana Hotel. The American Osteopathic Association was represented at the three-day sessions by Drs. Wallace M. Pearson, Gus S. Wetzel, Alexander Levitt, and George W. Northup.

The report is a blueprint of things to come and has strong support both within and outside of government. The recommendations of the Commission make the recently enacted Medicare program look conservative by comparison. Many will agree that a large number of the recommendations deserve implementation. Others will question, and still others will disagree violently. Regardless of opinions, physicians everywhere should be familiar with the report, know all its contents, and formulate opinions based on fact.

THE JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION, beginning in August or September, will publish a series of editorials on the fourteen policy positions and their associated recommendations. The purpose of these editorials will be to inform rather than to judge.

Few reports have been presented in recent years which will have a greater impact on the methodology of supply of health services than this one. The importance of the report seems to have escaped the attention of many who have written concerning it. No report in recent memory has had the mechanisms for implementation so well developed prior to its publication. It is an important document in the future of medicine.

Possible Relocation of C.O.M.S. Continues to Receive Top-Level Study

Proponents of the possible removal of the Des Monies-based College of Osteopathic Medicine and Surgery to a new location in north central Texas are encouraged by reports that the Corporate Board of the school has accepted for further study a survey in depth prepared by Vice President Ed Dugan under the auspices of President Merlyn McLaughlin. The regular annual meeting of the Corporate Board scheduled for July 11 has been postponed so that some aspects of the proposed solution may be developed further.

It is known that the Corporate Board feels it is not really considering an enlargement of COMS as it has existed in the past. The major challenge to be faced is establishing a completely new facility to produce osteopathic physicians, which has very little to do with what the school has now. Federal participation and present-day methods of medical education are forcing the College to follow entirely new concepts if it is to continue to exist and grow. The present institution offers, therefore, a nucleus of a faculty, a student body, and some sources of financing.

Some of the ground rules which the Federal Government has officially, or unofficially, presented are:

1. A minimum of a 4 to 1 student-faculty ratio.
2. A heavy majority of teaching beds located in an immediate geographic area to the College.
3. A minimum of 200 beds to participate in federal financing of a new teaching hospital.

This places on the College the responsibility of insuring enough community clinical material to support a new hospital of at least 200 beds or to have enough beds available from affiliated hospitals in the area. P.H.S. is virtually insisting that all teaching beds be in close proximity to the college.

To build a new Osteopathic College with our present nucleus will require realistic answers to three major areas of concern; namely, academic program and access to a wide range of specialties to participate in the teaching program. We must count on presenting a minimum of 110 full-time faculty members.

On May 5, 1966, the Texas Society of Osteopathic Physicians and Surgeons unanimously passed a resolution inviting the College to relocate in Texas and allocated $75,000 from their treasury as a token of good faith. On June 14, 1966, the Fort Worth Chamber of Commerce unanimously passed a similar resolution offering their complete cooperation and support. A charter, under the name of the Texas College of Osteopathic Medicine, has been obtained.

With two exceptions, Texas physicians contacted have expressed an enthusiastic and positive response to the idea of specific teaching responsibilities. Not one physician voiced any opposition to the proposed financial support. Ten per cent of the physicians in the state are COMS graduates.

The community leaders interviewed in Fort Worth were suggested by the Chamber of Commerce as those having the most knowledge and influence on the giving habits of the community. They were approached with the idea of the community being ready and able to support a financial program. With the understanding that the College had an obligation to present a sound program, they all felt that this goal was very reasonable and could be expected to meet

with success. Everyone who had any contact with the physicians and community leaders was impressed with the extremely enthusiastic and positive attitude they presented.

The community leaders in Des Moines expressed basically the same opinions as those in Fort Worth. They felt $1,500,000 could be raised in the community provided a strong program were possible. There were no negative comments concerning the College. There was general agreement, as there was in Fort Worth, that strong lay leadership was available if the program warranted it.

Given identical programs to support, both the Des Moines community and the Fort Worth-Dallas area have an equal potential of a minimum of $1,500,000. However, it appears that the possibility of presenting a complete, well-founded program would be much greater in Fort Worth than in Des Moines. In addition, there is a population difference of close to 500,000 persons between the two cities, plus the potential in Dallas.

The other major portion of our prospects, the alumni of the College, have generally expressed an opinion, through several state resolutions, that whatever is best for the College should be done. We do not feel their giving potential will be changed in any way other than possible increased support if the College moves, because of the ability to present a stronger program.

CLINICAL MATERIAL AND SPECIALTY AVAILABILITY

Des Moines has a metropolitan population of about 300,000 including 88 osteopathic physicians, 28 of whom are specialists.

Three osteopathic hospitals (Des Moines General, Wilden and College), totaling 160 beds, had the following statistics for 1965.

	Des Moines General	Wilden	College	Total
Beds	67	47	60	174
Admissions	2,600	2,150	1,384	6,134
Live Births	287	0	139	426
Autopsy Rate	33%	31%	32%	32%
Major Surgery	539	293	142	974
Minor Surgery	599	596	276	1,471

Fort Worth has a metropolitan population of about 750,000, including 68 osteopathic physicians, 23 of whom are specialists. The Fort Worth-Dallas area has a population of about 2,000,000, including 300 osteopathic physicians, 75 of whom are specialists. There are 14 osteopathic hospitals in the greater Fort Worth-Dallas area, 11 of which are of 35 to 50 bed capacity. Nine D.O.'s have moved to Fort Worth to establish practices within the past year. The four larger hospitals, all of which currently conduct intern and resident training programs, had the following statistics for 1965.

	Dallas Osteopathic	East Town Dallas	Stevens Park	Fort Worth	Total
Admissions	3,821	4,139	4,114	5,016	17,090
Beds	100	132	100	120	452
Live Births	397	373	317	336	1,423
Major Surgery	597	562	443	1,015	1,617
Minor Surgery	979	908	1,235	1,170	4,292
Autopsy Rate		36.5%	33.3%	28%	

Note that Fort Worth Osteopathic Hospital alone, with 120 beds, nearly equals the activity of the three Des Moines hospitals combined. (Source of Data: Directory of Intern Training Hospitals, published by American Osteopathic Hospital Association, May 15, 1966.) This hospital has a submission in under the Hill-Harris Act to expand to 160 beds and add ancillary facilities. The Board of that hospital met last month and passed a resolution to allow the College to place a Medical Education Director in the hospital to supervise the teaching program if the relocation takes place.

On June 2 and 3 Dr. McNerney and Dr. Vigorito visited the Fort Worth-Dallas area and inspected Dallas Osteopathic Hospital, East Town Osteopathic Hospital, and Fort Worth Osteopathic Hospital. Stevens Park Osteopathic Hospital was not visited due to lack of time. At each hospital visited, the Medical Director, members of the administration and professional staff and and an occasional member of the hospital's Board of Trustees were interviewed.

Net impressions of the trip are as follows:

Most D.O.'s in Fort Worth are very enthusiastic about the prospect of a College and indicated willingness to contribute financial support.

All the larger (100 beds or more) hospitals expressed a desire to participate in a formal educational porgram for the students. The concept of a College maintaining one or more clinicians at each hospital was well received by the specialists and administrators at each hospital. There is adequate hospital activity in the area to support most or all of our clinical curriculum.

ANNUAL MEETING - - - NORTH TEXAS ROENTGEN RAY SOCIETY

August 26, 27 and 28

STAGECOACH INN SALADO, TEXAS

- Film Reading Conferences by Dr. Leo Sheiner of Detroit and Texas specialists
- Solid Lung Tumors
- Mass Lesions of the Kidney
- Small Bowel Roentgenology

Open to all TAOP&S members Registration fee—$25

For information contact: Dr. Charles D. Ogilvie, Program Chairman
Stevens Park Osteopathic Hospital
1141 North Hampton
Dallas, Texas 75224

Resolutions as Passed By TAOP&S' House of Delegates

No. I (To be submitted to the Executive Director for inclusion on the Agenda of House of Delegates of A.O.A.)
SUBJECT: FEES FOR SERVICES TO PATIENTS

WHEREAS: Both physician and patients understand the 'Team-Effort' required in the modern era of health care, sometimes necessitating the knowledge of two or more physicians during a patient's illness, and

WHEREAS: Assignments of third party payments is in common usage.

THEREFORE BE IT RESOLVED: That it shall be considered unethical for any physician to participate in any fee for which he did not render a professional service to the patient.

BE IT FURTHER RESOLVED: That any one physician involved in the joint care of a patient and who accepts the assignment of monies which results in the exclusion of equitable payment to other members of the 'Physician Team' shall be guilty of an act of unethical conduct.

No. II (To be submitted through the Public Health Committee for possible consideration at state and national conferences.)

BE IT RESOLVED that the Texas Association of Osteopathic Physicians and Surgeons voice its concern for the apparent emphasis currently being placed on paramedical mechanics and personnel by examining bodies instituted by H. E.-W. with reference to all hospitals which have shown intent to participate in the Medicare Program. As minimal examples we would cite stipulations for professional medical record librarians, specified numbers of registered nurses and accounting agencies as not being absolute necessities to patient safety and quality care.

To adhere strictly to such requirements in communities and areas where such personnel and facilities are neither existent nor realistic would tend to result in non-implementation of the program for a large segment of the populace thereby denying participation in their program.

For these and similarly bona fide reasons we would be derelict in our responsibility to the public we serve to do less than stress the need for a reappraisal, by the Federal government and its pertinently associated agencies and legislative bodies, of the idealistic goals of the Medicare program and the realistic approach to their fulfillment.

Editor's note: Although not specified for publication by the House of Delegates, it is our feeling that these are affirmations of position and require to be disseminated to the profession through the JOURNAL.

R. B. PRICE.

TAOP&S' Executive Secretary Participates in Society of Divisional Secretaries Program

Title XIX of Federal Health Care To Be Discussed at National Sessions

Mr. R. B. Price

The Executive Secretary of TAOP&S will occupy an important position on the national program of the Society of Divisional Secretaries of A.O.A. according to printed programs recently distributed to the official divisional secretary of each state.

Mr. Price will present an analysis of Title 19 of the Social Security Amendments of 1965—Grants to States for Medical Assistance Programs, which is a tremendous expansion of Kerr-Mills principles that within ten years is expected to have vastly greater significance to the practicing physician than is Medicare. It is expected to involve perhaps more than twice as many individuals under its provisions and is designed to allow each individual state at its option to extend Medical Assistance to all medically indigent persons within the state. The annual meeting of the S.D.S. is held on the three days immediately preceeding the opening of the A.O.A. House of Delegates each year.

Fighting the Lure of Tobacco

from New Jersey State Department of Health

Thousands of New Jerseyans now in their 'teens will later in life die prematurely of lung cancer or cardiovascular diseases aggravated and hastened if not actually caused by cigarette smoking. The problem is how to make the satisfaction of additional years of healthful living more attractive to the teenager than what he considers to be the important approbation of his peers in his contemporary conduct. Sociologists have said that the greatest single determinant as to whether a youth smokes or not is the approval of the group with whom he associates.

These are some guidelines for parents. Teenagers are less likely to smoke if:

- their teenage friends do not smoke.
- their fathers strongly disapprove.
- their goals in education extend beyond high school.
- their dates don't smoke and their dating frequence approaches once a week.

ROSCOE P. KANDLE, M.D.
State Commissioner of Health

Mid-Cities Holds Medical Self-Help Course

Participants in the Medical Self-Help Course held recently at Mid-Cities Memorial Hospital are: (seated l to r) Dr. Lee Walker, Dr. Robert Nelson, Dr. Myron Jones; (standing l to r) Dr. Elmer Kelso; Dr. Arthur Henson; Manuel Vasquez, Civil Defense Staff; Dr. Gerald Geske, Civil Defense Medical Officer; Dr. George Kelso and Dr. Ted Tuinstra.

Staff members of Mid-Cities Memorial Hospital, Grand Prairie, have concluded their participation in the semi-annual Medical Self-Help Course which they sponsor in conjunction with the local Civil Defense Commission. The course is unique in that each lesson is instructed by a different physician with a total of seven osteopathic physicians participating.

The purpose of the course is to provide the public with knowledge and skills in treating injuries and caring for the sick in the event of nuclear attack, flood, hurricane, tornado or any other disaster. The program is held in the city civil defense fallout shelter to acquaint the public with the importance of this type of structure. Films, slides and a practice session supplement the program.

The Commission is presently attempting to obtain a Resusi-Ann maniken to better instruct artificial respiration and external cardiac massage.

The last class, which is the largest by far since the program began four years ago, will receive diplomas from the Mayor of Grand Prairie.

Medical Assistance Under Title XIX of the Social Security Act

ELLEN WINSTON

U. S. Commissioner of Welfare

Based on an address delivered before the American Hospital Association Conference, Washington, D.C., August 5, 1965.

UNLIKE THE INSURANCE provisions, the welfare and child health provisions of the "medicare" act cannot materialize into effective programs without essential action by States and localities. The decision about whether and when to develop a medical assistance program under Title XIX, for example, rests with the States and ultimately the communities.

The most important of the groups that could benefit from these provisions unquestionably, is the children in low-income families, and that means one-fourth of the children in the United States. Despite the growing emphasis which both the Children's Bureau and the Bureau of Family Services of the Welfare Administration have given to child health over a long period of years, emphasis which has included a number of Federal grants for a broad range of preventive, remedial, and treatment services, the health status of needy children remains a national disgrace.

Among the important ways in which the 1965 amendments attack this problem are the provisions for increasing Federal aid to maternal and child health and crippled children's programs and for special project grants for health services to children of school and preschool age.

Potentially the most far-reaching of all the provisions relating to child health is the authorization to include all medically needy children and young people in the new medical assistance program which is established under Title XIX of the Act. This means that, if States elect to do so, any medically needy child or youth under 21 years of age can receive whatever medical or health care he needs. His family does not need to be dependent on public assistance, or even eligible for such assistance—the family income from earnings may cover all the child's basic daily needs, but if it is not sufficient to meet his medical needs, he can be made eligible for the Title XIX program.

Before a State is ready to adopt this broad a program for its children, however, it must give priority attention to the medical needs of certain children and certain other needy groups whose medical needs are not now being adequately met. The first priority must go to persons who are receiving financial assistance under the federally aided public assistance programs: aid to families with dependent children, old-age assistance, aid to the blind, and aid to the disabled. These groups represent the minimum coverage called for under the new program, and, if States want to continue to receive Federal funds for medical care for these recipients of public assistance, they must set up the new medical care program by January 1, 1970. Since States are now spending more than a billion dollars a year in vendor payments for medical care for recipients of public assistance, it is easy to appreciate how important it is, from a purely fiscal standpoint, for a number of them to begin to move rapidly toward the establishment of the new program.

Not only must the new program include all of these dependent people, but it must also provide more services. At present, States can receive Federal aid for vendor payments no matter how limited their medical care programs may

be. But under the new program, five specific services must be included after June 30, 1967: inpatient hospital services; outpatient services; other laboratory and X-ray services; skilled nursing home care (this is required for adults only); and physicians' services.

States that have the Kerr-Mills program of medical assistance for the aged —and 46 jurisdictions now have this program—will have to include this group also in the new program. Even with the basic hospital insurance in Title XVIII, many elderly people will need to have their deductibles paid for under the new Title XIX program, so this group will continue to constitute an important population served under the Title XIX program. However, the more liberal eligibility requirements that now apply only to the MAA group must be extended to other groups. Specifically this means that, if States are to pay for medical care for elderly people who are not dependent upon financial assistance for their day-by-day needs but do need help with medical expenses not covered by the social insurance programs, they must also pay for medical care for blind and disabled people who are not receiving financial assistance and for children in families that are not receiving financial assistance. But it does not mean that all medically indigent adults and children must be included; coverage can be limited to those who would meet all eligibility requirements that would entitle them to financial assistance except for the one requirement of not having enough income to meet their daily needs. For example, a 60-year-old man would not need to be included even though he had no income at all because, unless he happened also to be blind or disabled or had dependent children, he would not be eligible for any type of aid under any of the federally aided public assistance programs.

Naturally, we would hope and expect that, at least gradually, with the increased Federal aid for medical care under Title XIX and with the basic hospitalization for all elderly under Title XVIII, States and communities would find that they could afford a plan to meet the medical needs of such persons, through their general assistance or other State or local programs, even though no Federal assistance is provided in the new law. In fact, by 1975, they must make some provision for such people if they wish to continue to get Federal support for the Title XIX program.

Therefore it seems apparent that, if States take full advantage of the new legislation, they can go a long way toward assuring that people who need but cannot afford health and medical care will receive it. They can do so in four stages: covering first all the people—and there are over 7 million of them in the nation—who depend upon the public assistance programs for all or some of their basic income; covering next the people in the same general categories who do not need financial assistance for daily maintenance but do need assistance with health and medical bills; then covering all children under 21 in any family with an income too low to allow for medical expenses, and finally picking up, at the States' own expense, any remaining medically needy persons aged 21-64. The scope and quality of medical care for all these groups must be the same with two exceptions: The programs for children need not include nursing home care, and provisions for aged persons in mental and tuberculosis institutions do not require the program to include care in these institutions for persons under 65.

To develop the facilities and services for these broadened programs and to see that they are carried out along sound and practical lines constitute a real challenge. We have been doing a great deal of work on this in the Welfare Administration for many months, and we have consulted with a number of

distinguished public health and medical authorities.

We hope soon to issue some general guidelines for the States which will reflect the results of these consultations and will help them to move forward with plans that will assure that needy people receive as high quality care and as considerate service as any other segment of our population.

Although these guidelines are still in draft stage, they are sufficiently advanced so that some of the basic areas they will cover can be mentioned. For one thing, they will call for medical care units in every State public welfare agency. This will be needed even in States in which another agency might administer the new program, because the law requires that eligibility be determined by the public welfare agency. The size and makeup of the staff of the medical care unit will be affected by the extent of responsibilities of the welfare agency. In any event, however, medical personnel as well as social work personnel will be needed, and they must be well qualified since the effectiveness of any program is primarily dependent on the competency of its staff. The new amendments provide 75 percent Federal participation for the training and employment of medical and supporting staff.

We also believe that it will be highly important for the public welfare agency to have a medical advisory committee representative of both the providers and the consumers of health and medical services.

The guidelines will also cover the items that will need to be spelled out in a State's plan to indicate progressive development in scope and coverage as well as methods the State will employ to see that high standards are observed and that funds are used economically and efficiently.

States will vary widely in terms of how far and how fast they can move toward the development of their programs. Some will need new State legislation; policy changes will almost certainly be required; fiscal capacities will be another factor in the variation in State progress. It is important that States assess all these as well as a number of other highly complex administrative factors promptly so that they can begin to make realistic plans.

For States that are not ready for a Title XIX program, all possible emphasis must be placed on improving the current vendor payment programs under the public assistance titles, including MAA programs.

The interest, support, and help of professional groups, voluntary organizations, and other interested citizens are needed both in building up the public climate which will enable States and communities to use this increased Federal aid to maximum advantage in meeting their needs and also in assisting State and local public welfare agencies in developing and implementing sound and effective programs.

Smoking Drew Fire Even in 1799

From MEDICAL WORLD NEWS

Current studies linking tobacco with a variety of chronic illnesses have their roots in some very early medical papers. One of the first American physicians who had reservations about the smoking habit was Dr. Benjamin Waterhouse, who taught at Harvard in the early 19th century.

In a series of lectures he delivered in 1804, Dr. Waterhouse noted that tobacco might have some value as a diuretic, an emetic, and a purgative, but that he was against smoking because it debilitated the body. Then, as now, people would not listen.

"With what caution should a man proceed in attacking a favorite of the people," Dr. Waterhouse wondered. "A prudent man, one who wishes to sail quietly down the popular stream, would be disposed rather to flatter and applaud the object of their affections."

The doctor chose to be a pioneer rather than a prudent man, and he published this theory about tobacco: "I am entirely convinced that smoking and chewing injures ultimately the hearing, smell, taste, and teeth."

Dr. Edward W. Brailsford in Philadelphia in 1799, conducted a series of experiments on the chemical and medical properties of tobacco. He reports in one paper that three hours after breakfast he took 40 drops of a liquid made from tobacco leaves boiled in water.

"My pulse beat 70 strokes a minute. For the first five minutes afterward, there was an aromatic warmth diffused all over my throat, which soon extended itself to my stomach and continued thus for the first quarter of an hour. In 15 minutes I experienced nausea, which was promoted on the 25th minute. On the 30th minute, my pulse was greatly increased, both in tension and frequency. On the 45th minute, the symptoms abated. My pulse was diminished in both fullness and frequency. At the expiration of the hour, I felt a kind of languor, and my pulse was reduced to its natural standard. Soon after, every inconvenience disappeared, and I dined with my usual appetite."

In an 1805 dissertation presented for an M.D. degree at the University of Pennsylvania, Daniel Legare, "an honorary member of the Philadelphia Medical Society," describes the effects on his own body when tobacco fumes were injected anally. His observations included a more rapid pulse rate and dyspepsia.

In an essay on tobacco written in the 1850s, Dr. Henry Gibbons of San Francisco advised the smoker not to flatter himself that he is healthy because he feels no ill effects. "The deadliest maladies often take silent possession of the vital organs without disturbing the general health."

Texas Osteopathic Hospital Association

1966 Convention

August 6-7, 1966

El Tropicana Motor Hotel

San Antonio, Texas

5 August, 1966

Hospitality Room — 6 P.M.-9 P.M.

"Let's Get Acquainted"

6 August, 1966

8 A.M.-9 A.M.	— Registering
9 A.M.-10:20 A.M.	— Blue Cross "Medicare"
10:20 A.M.-10:40 A.M.	— Coffee Break
10:40 A.M.-12 Noon	— Blue Cross "Medicare"
12 Noon-1:30 P.M.	— Lunch
1:30 P.M.-2:30 P.M.	— Guest Speaker
2:30 P.M.-2:45 P.M.	— Coffee Break
2:45 P.M.-4 P.M.	— Blue Cross "Workshop"
4 P.M.-4:30 P.M.	— Introduction of proposed Code of Ethics

7 August, 1966

8:30 A.M.-9:00 A.M.	— Wake-up Coffee
9 A.M.-10 A.M.	— Discussion & possible adoption of Code of Ethics
10 A.M.-10:15 A.M.	— Coffee Break
10:15 A.M.-10:45 A.M.	— Texas Social Welfare
10:45 A.M.-12 Noon	— Business Meeting

Digital Surgery of The Naso-Pharynx

(One of the interesting and different papers presented at the Canadian Osteopathic Association meeting at Niagara Falls, Ont. in September 1965 was the following one by Robert M. Marshall, D.O. of Montreal. It describes a different approach to some ENT problems.)

History

The early history of finger surgery of the naso-pharynx is rather sketchy to my knowledge, but the American Osteopathic Association headquarters in Chicago has quite a few accounts in its archives, according to Dr. George W. Northup, Editor of the A.O.A. Journal.

Among the earlier doctors who practised this type of finger surgery can be included Dr. T. J. Ruddy of Los Angeles, now eighty years of age but still going strong; Dr. Edwards of St. Louis; and a Dr. Snyder from Kansas City who, in 1924, together with a group of doctors from Kansas City, visited Kirksville College to demonstrate the technique to students there. It is said that a Dr. Disson of St. Louis was already practising the technique in 1914. Dr. Muney had clinics in New York and Florida and really perfected this finger surgery; in fact he was reported as performing "miracles" in very many cases of deafness. It would seem to be almost a lost art, for certainly as far as I can remember of my student days at Kirksville we were barely aware of it. I, myself, studied it under H. J. Pettapiece, D.O., in Portland, Maine. He was a specialist in EENT and used this technique on all T & A cases, of which he did some five or six cases, plus three to four submucous resections daily. He used to marvel at the number of adhesions of this type in children of three to four years of age.

Until recently, the only doctor I knew of who practised this type of surgery was Dr. Harryette Evans, now retired, but at our recent Convention in Niagara Falls I was most interested and pleased to learn that many D.O.s know of the technique and indeed, a few, like myself, are using it.

Diagnosis and Pathology

The pathology consists of cicatricial tissue of infectious or irritative origin in the naso-pharynx. These binding, rubber band-like adhesions, attach the soft palate to the hard palate and destroy the continuity of normal muscular layers of the throat. Pockets are formed where sinus secretions and nasal secretions will pool and ferment causing increased bacterial inflammation and chronic pathology. Many times the condition may start from a severe "strep throat" but it usually starts from chronic tonsil and adenoid infection. In general such adhesions build up gradually from the cradle to the grave.

Pathology that may be treated by this method.

1. Loss of hearing. . . Eustachian tube blockage.
2. Chronic sniffing and snuffing in adolescents and adults.
3. Chronic tonsillitis and adenoiditis after 11 years of age.
4. Some cases of Meniere's Syndrome.
5. Chronic sinusitis.
6. Post-nasal drip. . . upper respiratory chronic congestion.
7. Inability to breathe well through nose.
8. Ears "plugging up" easily in plane or up in mountains.
9. Ears "plugging up" following slight cold in head (patient usually thinks trouble is wax).
10. Ears "plugging up" not due to wax.
11. Uvula-Asymetrical.
12. Sino-bronchial syndrome.
13. Swimmers' otitis media.

Methods of Treatment

With patient sitting. (Wash hands thoroughly of course.) Gain patient's confidence first by explaining technique and tell him that he may bleed a little. Technique is to sweep right index finger cleanly and quickly between the medial and lateral edges of posterior tonsillar fossa and post-phanygeal wall, using the tip of index finger. Do both sides quickly. Have patient expectorate to show him you have broken adhesions. Explain that you do not remove all adhesions at once but that it is necessary to work on one layer at a time so that it usually requires about six treatments, treating patient once every two weeks. It is best to treat patients before meals because of gag reflex and possibility of vomiting.

With patient lying down. This way is easier with children. The same basic procedure is followed as for the first method but with the patient lying down on his back on the table. The doctor must

take care not to tear the tissues otherwise patient's nose will bleed.

Long, thin, "gynacological" fingers are most suited to this type of surgery and doctors, like myself, with short, broad fingers may find the technique somewhat difficult.

Results

One usually obtains good results in cases of severe adhesions but it is impossible to tell just what adhesions are present until this finger surgery is attempted on the patient. You will find often that patients have had antibiotics sprayed in their throats or air blown in under pressure, but both of these treatments usually irritate and worsen the condition. I would be so bold as to say that we D.O.s cannot consider that we are giving a good treatment in head and neck pathology cases if we do not check the posterior nasopharyngeal area along with our osteopathic treatments and traction. One can obtain eighty per cent successful results if the surgery is followed through with four to six regular treatments. In the deafness category, cases that will not respond are usually cases of nerve deafness or thickened drums.

This technique is essentially an osteopathic technique well within the realm of manipulation and is essentially a drainage for the posterior nasopharynx. It is a fine technique which can normally be used by anyone and is similar to the cardiovascular surgeons' finger dilation of bicuspid and tricuspid valves. It requires a little explanation to the patient to prepare him and I usually show him diagrams and pictures.* Postsurgically I have the patient gargle TID with Lavoris, which is pleasant tasting. I also get the patient to chew gum as the muscles of the lower throat sometimes ache due to constriction following surgery. The chewing of gum helps relieve tension in these muscles too.

I might add in closing that, because of the nature of the procedure and the possibility of being bit by younger patients the physician would do well to keep his own anti-Tetanus levels high.

* DoHo Chemical Company, makers of AURALGIN, an ear preparation, put out an excellent little brochure with diagrams of ear, nose and throat.

COMS Department Head Relocates in Houston

E. Lynn Baldwin has left his position as Chairman of the Department of Medical Illustration after 15 years with College of Osteopathic Medicine and Surgery. He has been named Supervisor of the Visual Production Laboratory at the M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston.

During Baldwin's 15 years with COMS he built up a medical illustration department that has become a much relied on center of audiovisual equipment, knowledge and skills.

Reflecting on his years at COMS, Baldwin said, "It's been a fine experience. I've become very attached to the school and to the many fine people I've worked with. In fact, I've had the opportunity to work for the whole profession through the AOA."

Highly regarded in his field, Baldwin is a member of the Board of Directors of the Biological Photographic Association.

KIRKSVILLE COLLEGE OF OSTEOPATHY AND SURGERY
KIRKSVILLE, MISSOURI 63501

July 8, 1966

Mr. Robert B. Price, Executive Secretary
The Texas Association of Osteopathic
Physicians and Surgeons
513 Bailey Avenue
Fort Worth, Texas 76107

Dear Mr. Bob

Please extend to your Officers and membership the very great great gratitude of all of us in this College for the generous dues support transmittal received here on June 22. Our further appreciation to you and your office force for the extra-special effort involved in getting this help to the College prior to the end of our fiscal year on June 30. We deeply appreciate this concern and interest and hope you will pass this appreciation along to your co-workers.

The gifts are being acknowledged individually to those from which they originated, but I do hope that the opportunity will occur for you to thank the Officers and the Association for this important support to professional development.

Very best personal regards.

Yours sincerely

Morris Thompson
President

MT vk

Kansas City College of Osteopathy and Surgery · 2105 Independence Avenue · Kansas City, Missouri · GRand 1-1626

Office of the President

July 13, 1966

R. B. Price, Executive Secretary
The Texas Association of Osteopathic Physicians and Surgeons
512 Bailey Avenue
Fort Worth, Texas, 76107

Dear Mr. Price:

Thank you for your letter of June 29 forwarding your first appropriation check under the support-through-dues program for the current fiscal year.

As you suggested, the list of contributors has been checked and we can now verify that all are graduates of this College with the two exceptions noted in your letter.

The attached letter of acknowledgement and appreciation has been sent each physician involved.

Again let me express our appreciation to the Texas Association for making this portion of their dues available to us under the support-through-dues program, and to you for the efficient and timely manner in which these funds are collected and transmitted to us.

Sincerely yours,

Eugene P. Powers

Eugene P. Powers

M

Enclosure

Vital Statistics

1. *Number of Doctors of Osteopathic* —13,061 (This does not include 3,537 physicians on record whose mail has been returned and who may or may not, be deceased, but death has not been reported.)

a. In private practice—10,027
b. Not in private practice, but active —1,016 (In training programs, those with full-time hospital or college faculty positions, etc.)
c. No information on practice—766 (May, or may not, be in private practice)
d. Inactive-Retired—4,789

2. *Number of D.O.s who are members of the American Osteopathic Association*—9,611

a. Number of Student Members of the American Osteopathic Association—1,034
b. Associated Members of the AOA —42

3. *Types of practice*—60.2 per cent are G.P.s; 17.0 percent are G.P.s with special emphasis upon a specialty; 12.0 per cent limit their practice to a specialty, such as surgery, obstetrics, internal medicine, etc.; 10.8 per cent limit their practice to manipulative therapy and clinical conditions amenable to it.

4. *Practice locations*

a. Communities with 50,000 and over population—49.5 per cent
b. Communities with 5,000 to 50,000 population—29.9 per cent
c. Communities with less than 5,000 population—23.6 per cent.

Osteopathic Education

1. *Number of colleges and their location*—There are five osteopathic colleges: Chicago College of Osteopathy (5250 Ellis Avenue, Chicago, Illinois 60615), College of Osteopathic Medicine and Surgery (720-722 Sixth Avenue, Des Moines, Iowa 50309), Kansas City College of Osteopathy and Surgery (2105 Independence Avenue, Kansas City, Missouri 64124), Kirksville College of Osteopathy and Surgery (Kirksville, Missouri 63501), and Philadelphia College of Osteopathy (48th & Spruce Street, Philadelphia, Pennsylvania 19139).

2. *Colleges in development and/or proposed*—The Michigan College of Osteopathic Medicine is actively being developed and the land has been acquired in Pontiac, Michigan; other colleges are being discussed in other areas of the country such as New York and New Jersey.

3. *Preprofessional requirements*—Admission to these colleges requires three years of preprofessional training in college or university accredited by a re-

gional educational association. On the average, present entrants have earned 117 of 120 hours usually required for graduation; 75 per cent hold a bachelor's degree. Preprofessional study is almost evenly divided between science and the humanities.

An entering student must have credit for at least 6 semester hours in English, with 12 recommended; 6 to 8 hours (a full year's work each) in physics and biology; 8 in inorganic and 4 to 8 in organic chemistry; and elective courses reflecting a broad cultural background.

4. *Professional requirements*—The degree Doctor of Osteopathy requires 4 academic years of study; 2 years devoted to anatomy, physiology, chemistry, pathology, bacteriology, and immunology; and 2 years to clinical subjects. Inherent in all osteopathic study is the role of the musculoskeletal system as a reciprocal factor in health and disease. Structural factors in disease processes are stressed, and students are trained in osteopathic manipulative therapy and in medical, obstetrical, and surgical procedures.

5. *1965-66 total undergraduate students in the five osteopathic colleges—1,683*

6. *1966 graduates from the five osteopathic colleges—375*

7. *Postgraduate training*—Of osteopathic graduates, 99 per cent complete internships in osteopathic teaching hospitals. Residency and other postgraduate training are offered by the colleges, hospitals, and specialty groups, and are part of the educational program leading to certification in the various medical specialties.

8. *Number of internships available 504*

9. *Number of residencies available—452*

Specialty Practice

1. *Specialties certified by certifying boards of the AOA*—Anesthesiology, dermatology, internal medicine, neurological surgery, neurology and psychiatry, obstetrics and gynecology, ophthalmology and otorhinolaryngology, pathology, pediatrics, physical medicine and rehabilitation, Proctology, radiology, surgery, urological surgery, and orthopedic surgery.

2. *Number of active certified specialists—1,201*

3. *D.O.s devoting full or part time to specialty practice—2,909*

a. Full-time specialists—1,201
b. Part-time specialists—1,708

Osteopathic Hospitals

1. *Number of osteopathic hospitals*—308 with a total of 17,464 available beds

a. Hospital admissions for the year 1964 exceeded 662,000.
b. In 1964 over 275,000 surgeries were performed in osteopathic hospitals.
c. In 1964, 70,770 babies were born in osteopathic hospitals.

2. *Hospitals accredited, approved for intern and/or residency training, or listed* by the American Osteopathic Association.

a. Accredited hospitals—100
b. Hospitals accredited and approved for intern and/or residency training—88
c. Listed hospitals—28

3. *Under the Hill-Burton program,* as of Dec. 31, 1964, 70 osteopathic projects (general hospitals, chronic disease facilities, rehabilitation facilities, nursing homes, and diagnostic and treatment centers), costing more than $57 million, have received federal support of more than $19 million for construction.

Licensure

There are 40 states and the District of Columbia that provide for the unlimited practice of medicine and surgery by osteopathic physicians. In 23 states and the District of Columbia, osteopathic physicians and M.D.s must pass a basic science examination prior to taking state boards for unlimited practice rights. In the states of Colorado,

Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Virginia, Wisconsin, and Wyoming, and the District of Columbia, the licensing board is a composite one, made up of both M.D.s and D.O.s

Doctors of osteopathy are engaged in the legalized practice of their profession in all the states.

The Grass Roots Speak

Ever since it has become apparent that organized medicine has desired to absorb the osteopathic profession into oblivion, one question has persisted. The officers and officials of the American Osteopathic Association oppose merger; the House of Delegates of the AOA oppose merger; the AOA Board of Trustees opposes merger; but what about the grass roots?

It has been implied by people both within and without the profession that a poll of the grass roots of osteopathic medicine would tell a different story.

This became the focus of an attack launched by the Michigan State Medical Society against the proposed Michigan College of Osteopathic Medicine. Their leaders dogmatically stated that "at least 75 per cent" of the practicing osteopathic physicians and surgeons wish merger with allopathic medicine, and ". . . the vast majority of the D. O.'s are not in favor of the proposed osteopathic school."

The answer to these erroneous statements, given by the grass roots of the osteopathic profession in Michigan, is now a matter of history, a glorious segment of history. The Michigan poll revealed that instead of more than 75 per cent of the D.O.'s in Michigan prefering merger, 87.3 per cent *were opposed to any merger.* Instead of the M. D. prediction that a vast majority of D.O.s would be found to be not in favor of the proposed osteopathic school, a resounding 93.3 per cent of the D.Os *were in favor* of the proposed Michigan College.

There are many significant things relative to this poll. Not only is it important to the future success of the College and to the future of osteopathic medicine in that state; it is also of major significance throughout the nation. Michigan has the largest osteopathic population of any state. It has many splendid hospitals, a good law, and a strong state organization. There are large numbers of general practitioners and a sizable number of specialists. Nearly every generation of osteopathic physicians is represented as well as nearly every type of general or specialty practice. It is a truly representative cross-section of osteopathic medicine as it exists throughout the country. Therefore the poll is representative of the voice of the grass roots of osteopathic medicine all over America. It demonstrates a unanimity of opinion on major issues which our opposition will never understand. It is a unity formed out of belief, conviction, and determination.

It is hoped that organized medicine will accept the significance of the Michigan poll for what it is. The osteopathic profession does not want to merge with organized medicine, but it does desire to cooperate with it for the common good. The osteopathic profession is only beginning to realize its full potential. And it will not be destroyed by false statements, false predictions, or false promises.

The grass roots of osteopathic medicine have spoken. And the voice is one of victory.

GEORGE W. NORTHUP, D.O.
A. O. A. Editor

Journalism Student $750 Award Winner

TOP JOURNALISTS—Prize winners at the TCU journalism awards banquet included, left to right, Kay Crosby, Bill Lace, Sandra Major and Lucinda Long.

Lucinda Long, a junior journalism student from Fort Worth, received two scholarships totaling $750 at the TCU journalism awards banquet Thursday night at Green Oaks Inn.

Miss Long, of 3900 Springbranch Road, won the first $450 Thomas L. Yates Memorial Scholarship awarded by the Advertising Club of Fort Worth and the $300 Theta Sigma Phi scholarship.

. . . . *from the* FORT WORTH STAR-TELEGRAM

(Editor's note: In addition to being an honor student at Texas Christian University, Miss Lucinda Long is employed part-time in the state office and assists with the Texas Osteopathic Physicans JOURNAL)

Membership Committee Action

Applications pending:

Burton Benjamin Aber, D.O.
Robert A. Bowling, D.O.
Richard D. Chandler, D.O.
Darwin Lee Cole, D.O.
C. D. Farrow, D.O.
Robert Barton Gold, D.O.
Stuart G. Mackenzie, D.O.
K. Patrick McCaffery, D.O.
Ronnie Ray Merwin, D.O.
Richard Thomas Oliver, D.O.
Ronald R. Stegman, D.O.
James E. Thompson, D.O.
Leopold Villegas, Jr., D.O.
John A. Ward, D.O.
Paul Warren, D.O.
Thomas A. Williams, D.O.

Audio-Visual Aids Available Through TAOP & S State Office

FILMS

DOCTORS TO THE STONE AGE —A 16mm. motion picture—28 minutes. Black and white, sound. This is the story of a primitive people and the year-round medical missions flown by physician-pilots of DOCARE (Doctors of Osteopathy Care). The film shows how osteopathic physicians are aiding the cave-dwelling Tarahumaras who live in the mountains of northern Mexico. The startling existence of these Indians, their superstitions and customs are memorably documented by the camera. Filmed at the Indian settlement of Sisoguichi in Chihuahua, Mexico. Presented by the American Osteopathic Association in recognition of the humane services performed by its member physicians.

THE FITNESS CHALLENGE — A 16 mm. motion picture — 28 minutes. Color and sound. This film, made in support of and with the cooperation of the President's Council on Physical Fitness, stresses that the chief aim of adult fitness is developing increased heart and lung capacity through proper diet, exercise and physical recreation. Muscle-building is not the goal. The film also points out the need for a physician's advice before undertaking any kind of fitness program. "The Fitness Challenge" is a challenge to better physical health and mental alertness. It opens with remarks by President John F. Kennedy and closes with comments by Clarence "Bud" Wilkinson, head football coach at University of Oklahoma and Special Consultant to the President's Council.

PHYSICIAN AND SURGEON, D.O. — A 16 mm. motion picture — 14 minutes. Color and sound. This film, recommended for use by state osteopathic associations, begins with an explanation of the letters which follow the doctor's name and the significance of the degree D.O. The film moves swiftly into a visualization of the education of an osteopathic physician, beginning with his pre-osteopathic college training and following through until graduation, internship, and practice in the community. "Physician and Surgeon, D.O." is designed particularly for vocational guidance in schools or college; for vocational programs of service clubs and for other special groups.

AMERICAN DOCTOR—A 16 mm. motion picture — 28½ minutes. Color and sound. This film tells the story of the birth, growth, and future goals of oseopathic medicine. It traces the growth of medicine through the centuries and establishes osteopathic medicine as a part of the continuing development of the healing arts. Flash-backs depict the contributions of such great men as Hippocrates, Andreas Vesalius and Thomas Sydenham. Before taking up the profession as it is today, "American Doctor" utilizes the live action screenplay technique to tell the story of Dr. Still's boyhood, his study of medicine under his father and the founding of the first osteopathic college. This is considered one of the best public relations tools currently available to tell the story of osteopathy to the general public.

FOR A BETTER TOMORROW — A 16 mm. motion picture. 22 minutes. Color and sound. This is the story of one of America's most controversial problems, the doctor shortage. The film highlights the inadequate number of students in training to be doctors as a major cause of the shortage and uses the educational program in osteopathic colleges to illustrate that the training of a physician is the longest, costliest, and most complex educational program in America. "For a Better Tomorrow" is an excellent presentation on the training, requirements

and opportunities for the osteopathic physician. It is recommended for showings before lay groups, career-day programs, and pre-osteopathic students.

SYMPTOMS OF OUR TIME—A series of six 16 mm. films. Black and white, sound. Each 14½ minutes:

(1) DRUG ADDICT — Teen agers "hooked by the habit" and their effect on society.

(2) ACCIDENT PLAGUE — Examples with impact. See accidents which happen at home, play, and work — which could have been prevented.

(3) MEDICAL EMERGENCY — A girl — appendicitis — an operation — shows why no one need fear surgery.

(4) ARTHRITIS — Aptly termed the "king of misery," this is the story of a man afflicted with the oldest disease known.

(5) ALCOHOLISM—A man "takes to drink" to escape pressures of today's living and finds alcohol cannot be used as a crutch.

(6) THE DEMOCRATIC COLD—Humorous "do's and don'ts" of home remedies for colds . . . America's most common ailment.

Produced as a Public Service by the American Osteopathic Association, these films are utilized mostly for teaching of health programs in the high schools. They are highly in demand.

RADIO TAPES

EMPHASIS ON HEALTH — Produced by the American Osteopathic Association in cooperation with the U.S. Public Health Service. Two tapes I PS Speed 7½ minutes each:

PAMPHLETS

THE OSTEOPATHIC PHYSICIAN AND SURGEON TODAY — Outlines how he is trained and how he serves the people. Excellent public relations material for use in the physician's office, hospital waiting room, and for distribution at vocational guidance programs, career days, etc. Available at a cost of 1½¢ each.

BOOKS

OPPORTUNITIES IN OSTEOPATHIC MEDICINE by Lawrence W. Mills, Educational Director, American Osteopathic Association. This is a book you will be proud to give away or to place in your reception rooms. It is ideal for vocational counselors and premedical advisors. Paperback copies are $1.00 each and the clothbound copies are $1.65.

Texas Academy Holds Study Session

Texas Academy of Applied Osteopathy had a very successful day of study in Houston on June 26, according to Catherine Carlton, D.O., president of the Academy. Sixteen D.O.'s were in session from 9 a.m. until 4 p.m. to hear the four speakers.

Dr. George Luibel appeared first on the program with Friettes Laws of Physiological Motion. Dr. R. E. Farnsworth read one of Dr. Angus Cathey's award winning lectures and Dr. Catherine Carlton gave Dr. T. J. Ruddy's Rapid Rhymic Resistive Technique. The day ended with Dr. Reginald Platt on Travels Trigger Points.

Those attending were: Drs. John-Donovan and R. E. Farnsworth, Austin; Drs. Auldine and Claude Hammond, Beaumont; Drs. Laura Lowell and James Royder, Dallas; Drs. George Luibel, Catherine and Elbert Carlton, Fort Worth; Drs. R. E. Cunningham, Reginald Platt, Lloyd Hammond, Esther Roehr and F. A. McLamb, Houston; and Dr. J. V. Money, Schulenburg.

More Doctors Come Over to Nonsmokers Side

From MEDICAL WORLD NEWS

The percentage of U.S. physicians who are still smoking cigarettes today is half as great as it was in the early 50s, and the vast majority of doctors have no doubt that smoking is a serious health hazard, says Surgeon General William H. Stewart. Under Public Health Service grants, researchers throughout the country are seeking more definitive information on the exact effects of smoking.

"We cannot say with certainty how much of the excess illness among smokers represents a cause-and-effect relationship, but it is probable that there would be tremendous reductions in coronary attacks, chronic bronchitis or emphysema, sinusitis, peptic ulcers, and days of restricted activity if smoking were reduced."

The belief that it is useless to stop smoking because the damage is already done is a misconception. Studies have shown that death rates from cancer and coronary heart disease are lower among persons who have stopped smoking than they are among those who continue.

The PHS has pledged that there will be more public education "on the health hazard of smoking for both adults and children." It has established the National Clearinghouse for Smoking and Health to collect, evaluate, and disseminate available facts about smoking and to support research. The clearinghouse is part of the National Interagency Council on Smoking and Health, an association of professional, voluntary, and governmental organizations that was formed in July 1964. Similar councils have since been organized on state and local levels.

This month, representatives from these groups will meet in College Park Md., for a three-day national conference, to discuss problems and needs and to develop guidelines for future action against smoking.

"Answers are urgently needed to such questions as how to motivate adults to stop smoking, and how to present the facts on the health hazards of smoking to children in such a way as to discourage them from taking up the habit. The clearinghouse is currently supporting 20 research projects across the country in schools, universities, and health departments, to find workable answers," says Dr. Stewart. "Here are the beginnings of a grass roots movement in smoking control that gives us great hope for the future."

The Surgeon General feels that passage of the PHS-backed bill requiring health hazard warnings on cigarette packages was a step forward. The labeling law and government-sponsored educational programs are evidence of concern, but they should be followed by stricter legislation.

Meanwhile, research supported by federal funds is being expanded. The National Cancer Institute and National Heart Institute have intensified their research related to smoking since publication of the Surgeon General's report in January 1964. The NHI is currently supporting 63 grants at a cost of $5,332,350 to further illuminate the relationship between smoking and cardiovascular disease. Its program has been expanded to survey the smoking habits of nearly 400,000 men in the U.S., Israel, Norway, England, and Yugoslavia. Dr. Stewart insists that data from these studies not be locked up out of sight, because achievement of positive results within the population depend ultimately on informed individual choice.

Openings for Osteopathic Physicians

(For information write to Dr. D. D. Beyer, Chairman, Physicians Relocation Committee, 1800 Vaughn Blvd., Fort Worth, Texas)

Cisco, Texas—in dire need of an osteopathic physician for permanent location. Sites and facilities available. Contact Jim Smothers, Manager, Chamber of Commerce, Cisco.

* * *

Sherman, Texas—six businessmen want to build a clinic-hospital combination for two or three D.O.'s according to doctors' specifications. There is definitely a shortage of hospital beds and physicians. Contact Gid Bryan, Dixie Drug Store, 220 N. Travis, Sherman.

* * *

Idalou Texas—located ten miles east of Lubbock, offers an excellent opportunity for any physician desiring to locate in West Texas. Contact George Lowe, Western Drug Company, Idalou.

* * *

Fine general practice of deceased D.O. for sale at extremely moderate figure, including Accounts Receivable, urological and minor surgical equipment, moderate repeat weight patronage. Centrally located in progressive West Texas city. Correspond with: Mrs. H. M. Gorrie, 4406 Jennie, Amarillo.

* * *

Kemp, Texas—no physician presently in the town. Due to a great deal of building in progress, there will probably be a substantial population increase. Contact T. A. Miller, The City Pharmacy, Kemp.

* * *

Earth, Texas—near Littlefield, Texas. D.O. wanted to take over new, well-equipped clinic. Contact Neal Pounds, Secretary, Earth Chamber of Commerce.

* * *

Sole Practitioner in good, 34-bed acute general hospital needs good quality working partner. One or two doctors for good locations. Opportunity to share ownership of hospital.

Should have some experience in minor surgical procedures.

Please correspond to: Box S-J, c/o the JOURNAL.

* * *

Junction, Texas — 18-bed modern hospital closed. One M.D. in town. Need D.O. who is capable of surgery. Population 2,500. Beautiful country. An excellent location. Contact: James M. Shy, D.O., 201 N. St. Peter Street, Stanton, Texas.

* * *

Midlothian, Texas — Doctor recently deceased. 30 miles from Fort Worth in expanding industrial and agricultural area. Contact State Office or D. D. Beyer, D.O.

* * *

Spur, Texas — including surrounding area with population of between 8,000 and 10,000. Up-to-date practically new brick clinic with ample space for two doctors is available adjoining a twenty bed hospital. It is felt two doctors could easily earn $15,000 to $20,000 each annually. Contact O. L. Kelley, Chairman, Hospital Committee, City of Spur.

* * *

Modern, fully-equipped 12-bed hospital is now available to capable doctor. Ownership and partnership if desired. Excellent, progressive town. Prefer doctor capable of anesthesia and/or surgery. Lucrative. Reply Box MG c/o of the JOURNAL.

* * *

Normangee, Texas—Take over practice of physician leaving for research grant. Desires to sell all equipment and clinic. Will consider terms or cash arrangement. Gross income approximately $66,000. Investment not over $10,000. Contact State Office.

From Executive Director's Report

DR. TRUE B. EVELETH

The Department of Health, Education and Welfare is distributing several documents describing the Medicare program, including the medical insurance program, all of which set forth very clearly the procedures and general outline of the plans. Excerpts from these publications, which are distributed separately, are excellent PR materials for the osteopathic school of medicine. As an example they state, "The term physician includes: Doctors of medicine and doctors of osteopathy authorized under State law to practice medicine and surgery." Under services not covered by the program are listed: chiropractors, naturopaths, chiropodists or podiatrists, optometrists and Christian Science practitioners. It is all too infrequent that we find osteopathy, osteopathic physicians and osteopathic hospitals placed in the proper category and definitely separated from the chiropractors, etc.

These documents set forth clearly that doctors of osteopathy may participate within the scope of their practice as defined by State law. This clarifies one issue, that being, that all D.O.'s can participate, limited only by the State law and the license under which they practice.

* * *

June 6, 1966, issue of *The Journal of the American Medical Association* is the "State Board Number", which is published annually. Among the statistics set forth it states that in 1965, 32 state boards of examiners granted 1,250 licenses to osteopathic physicians; 594 by examination and 656 on the basis of reciprocity and endorsement. Twenty medical examining boards, which include composite boards, examined 360 D.O. candidates with a *failure rate of zero percent;* 2.3% graduates of AMA schools, 5.8% of Canadian Schools and 32.1% of foreign medical schools *failed.* We repeat, the failure rate for osteopathic physicians was zero. For M.D. candidates, Illinois had a failure rate of 58.4% and New York had 52.0%.

Calendar of Events

August 6-7 — TEXAS OSTEOPATHIC HOSPITAL ASSOCIATION ANNUAL CONVENTION, El Tropicano Hotel, San Antonio, Texas. Walter Dolbee, Hurst General Hospital, 837 Brown Trail, Hurst, Texas 76053.

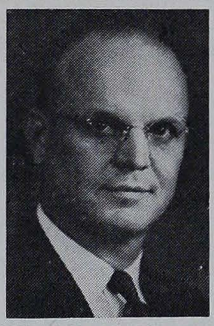
August 11-12—SOUTHERN OREGON SOCIETY of OSTEOPATHIC PHYSICIANS and SURGEONS, Second Annual Summer Post Graduate Course, North's Chuck Wagon Restaurant, Medford, Oregon. Subject, "Office Orthopedics." Oregon Shakespearean Festival will be at the same time. Cleatis D. Lemley, D.O., 3850 N. Pacific Hwy., Central Point, Oregon.

October 23-27—THIRTY-NINTH ANNUAL CLINICAL ASSEMBLY, Washington Hilton Hotel, Washington, D. C. C. L. Ballinger, D.O., P.O. Box 40, Coral Gables, Florida 33134.

November 14-17—AMERICAN OSTEOPATHIC ASSOCIATION, 71st ANNUAL CONVENTION AND SCIENTIFIC SEMINAR, Royal Orleans and Jung Hotels, New Orleans. Program Chairman, Dr. George T. Caleel, 4308 W. 67th St., Chicago, Illinois 60629.

NEWS OF THE DISTRICTS

District No. One



GLENN R. SCOTT, D.O.

District I held its recent meeting at Rice's Dining Room. The doctors and auxiliary each had their regular business meeting following a delicious dinner.

Dr. J. Paul Price was installed as President of the District and we wish him a most successful tenure of office. His district officers offer all encouragement and help in making his year a most successful one.

Dr. John L. and Helen Witt attended graduation for their son, Dan, at Kirksville. Your reporter joins with members of the District in offering congratulations. Dan will intern at Tulsa Osteopathic Hospital.

Dr. Richard Hall also attended the graduation at Kirksville.

Dr. Don Hackley presented a most interesting and informative report of the meeting of the trustees at the state convention. We are most proud of our representative at the state level. There is so much sincerity and enthusiasm seen following each meeting. Without this enthusiasm and interest we would have nothing. Good work, Don.

We wish Dr. Ben Rodamar all the luck he deserves in his residency in radiology in Detroit. Prior to Dr. Ben's departure he had the good fortune to have Dr. Royce Skaggs arrive to take over his practice. We welcome Dr. Skaggs and his family to our District.

Dr. Lester and Ruby Vick are enjoying a visit of their son, George, who is an instructor at U.C.L.A.

Dr. Don Eakin was a visitor the other day. Don is nearing the end of his residency in internal medicine at Kansas City at which time we hope he will return to our area.

Dr. Brad (Sport) Cobb is making quite a name for himself and his sports car at the driving handicap meetings. We shall expect a plaque to hang in the foyer of our new hospital.

LEWIS N. PITTMAN, JR., D.O.
GLENN R. SCOTT, D.O., *Reporters*

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, 1966, at Hotel Texas, Fort Worth, Texas.

Completed examination applications for graduates from United States medical schools must be filed with this office 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 Building
Fort Worth, Texas 76102

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PATHOLOGIST
Fort Worth Osteopathic Hospital
1000 Montgomery PE 8-5431
Fort Worth, Texas 76107

Medical space available in new modern clinic for one physician. 1460 sq. ft., private office, reception and examining rooms.
For information call or write
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San Antonio, Texas
GE 4-4321

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DALLAS OSTEOPATHIC HOSPITAL

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Dallas, Texas 75206
TA 4-3071 Area Code 214

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

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

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

DISTRICT 1

Dr. J. Paul Price, Dumas ..... President
Dr. Lewis N. Pittman, Jr., Amarillo ..... President-Elect
Dr. Bradford E. Cobb, Amarillo ..... Vice-President
Dr. P. Harlan Wilson, Amarillo ..... Secretary-Treasurer

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Dr. Bobby G. Smith, Arlington ..... President-Elect
Dr. Virginia Ellis, Fort Worth ..... Vice-President
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Dr. John C. Kemplin, Fort Worth ..... Treasurer

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Dr. David Greene, Dallas ..... President-Elect
Dr. Ronald Owens, Hutchins ..... Secretary
Dr. Jack Rice, Mesquite ..... Treasurer

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Dr. Morris Bennett, Houston ..... Secretary
Dr. Ralph Cunningham, Houston ..... Treasurer

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Dr. Waldemar D. Schaefer, San Antonio ..... Secretary-Treasurer

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Dr. Kenneth G. White, Commerce ..... President-Elect
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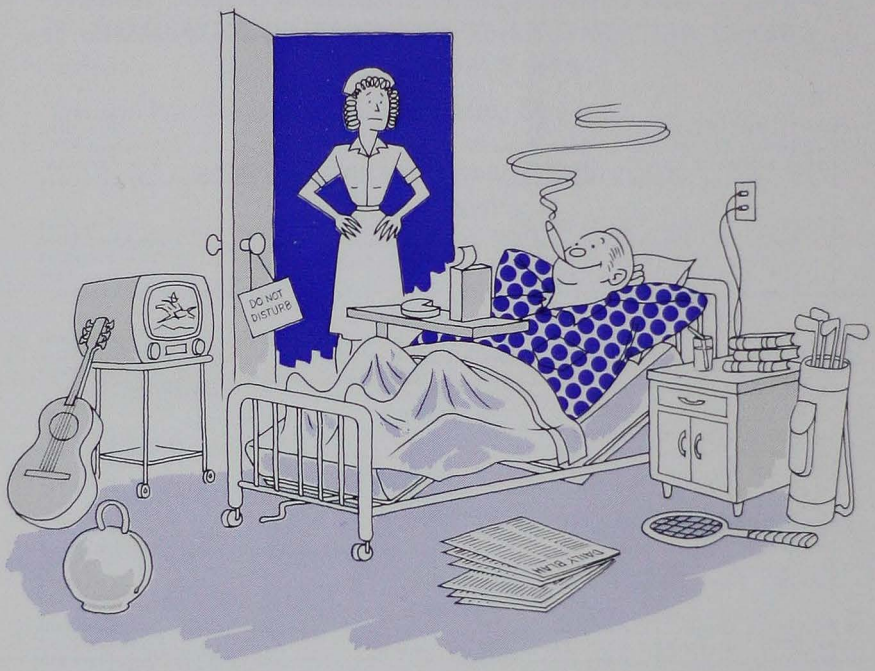
Dr. R. D. Van Schoick, Leonard ..... Secretary-Treasurer

DISTRICT 14

Dr. Ralph H. Moore, McAllen ..... President
Dr. C. A. Hess, Alamo ..... Vice-President
Dr. Joe Suderman, Pharr ..... Secretary-Treasurer



Prognosis: Bad

Every unnecessary day a patient spends in the hospital, if he is insured, inevitably finds its way into insurance rates. This is true whether the carrier is Blue Cross-Blue Shield, or anyone else.

To some, a hospital is a place of peace and comfort. A refuge. But can others enrolled in Blue Cross-Blue Shield, for example, afford to give him this comfort when he no longer needs hospital care?

The lower Blue Cross-Blue Shield membership fees, and other insurance rates, can be held, the stronger is the structure of independence and freedom in the world of health care. It's worth a little effort, isn't it?