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In This Issue—

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VOLUME XIX FORT WORTH, TEXAS, SEPTEMBER, 1962 NUMBER 5

EDITORIAL PAGE

A PUBLIC TRUST

Insurance Programs

As we live in this new social stage we must recognize that as physicians and hospital staff members, we must fall in line with the extension of this social control which has imposed more restrictions and duties upon the average physician and hospital. We must realize that when one pays a premium on insurance policies, that premium is put in trust with millions of other premiums paid by fellow-citizens. This trust requires the insurance company to pay settlements, defend cases and pay final judgments. Therefore it is the responsibility of the insurance company to resist unmeritorious claims as well as to pay meritorious claims.

The insurance companies do not practice medicine. Their knowledge so far as disease and modern control of same, is meagre. In turn, physicians and hospitals are not in the insurance business and they know very little about same. Therefore, to protect the public trust is the duty and obligation of both the insurance companies and the doctors and hospitals. Hence the organization of the TAOP&S Hospitals & Insurance Committee and the Texas Osteopathic-Insurance Liaison (TOIL) Committee whose function it is to bring about negotiations between the two groups involved in questionable claims. It is imperative that honesty prevails in these negotiations. Errors must be freely admitted whether they are made by the insurance companies or by the doctors and/or hospitals, regardless of who must pay the price. During their years of operation, these two committees have found considerably more errors made by the insurance companies and therefore they have adjusted more claims in favor of the doctors and hospitals. But it has been found that when our doctors or hospitals violate the public trust through over-utilization of drugs, x-rays, laboratory procedures, etc., they seem to feel that the Hospitals and Insurance Committee and the TOIL Committee are working against them, in the interest of the insurance industry, which of course is not the case.

Remember, one could purchase an insurance policy with the broadest coverage from birth to death—provided the public could and would pay the premium. We must recognize that insurance premiums are set after a thorough study is made of the coverage provided by the policy and benefits are paid according to the provisions of the policy. Otherwise, the public trust would be violated and the public, the insurance industry, doctors and hospitals would suffer as we would soon price ourselves out of the voluntary trust system of insurance.

Keep in mind that insurance programs are a two-way street. Your Committees are working in your behalf, but they must adhere to the fact that the traffic on this street must be directed honestly and sincerely.

The Chronic Discharging Ear, Its Clinical Importance and Treatment

LLOYD A. SEYFRIED, D.O. F.O.C.O.*
Detroit, Michigan

Chronic discharge from the ear, which continues constantly or intermittently for years, associated with a perforation of the ear drum, is primarily due to middle ear and mastoid disease. Such disease usually begins in early childhood or infancy by an infection which predestines it to chronicity.

Myers [1] studied 94 cases of chronic otitis media and mastoiditis and found that the average patient had a discharging ear for 37 years.

Acute otitis media and mastoiditis have largely been prevented or controlled by antibiotics. The type of problem we are considering does not usually occur from acute mastoiditis and is not prevented by antibiotics. Hence, it continues to be a major problem to health and hearing.

Chronic suppurative otitis media and mastoiditis are the number one public health problem among the native population of Alaska [2]. Fritz and Crawford [3] discovered over 3000 cases of chronic mastoiditis and with Rambo [4] developed a highly successful surgical procedure which has found wide acceptance.

One of the most interesting phases of the universal problem of chronic suppurative otitis media and mastoiditis, is its very early beginning. When infection occurs in infancy or early childhood, it may arrest the normal pneumatization and development of air cells in the mastoid and it alters the mucosa of the middle ear to render it more susceptible to recurrent infection. This can easily be proven by the fact that most patients with chronic suppurative otitis media and mastoiditis have small, undeveloped, acellular, sclerotic mastoid processes, easily demonstrated radiographically. Ordinarily, a case of acute suppurative otitis media in a normally pneumatized mastoid bone does not become chronic. Boies [5] believes that chronic suppuration in the middle ear and mastoid is due to the result of one of three developments:

1. A severe infection causing necrotic changes in the tympanum. This occurs most frequently in measles, scarlet fever, and diphtheria. The necrosis may occur in the mucosa, ossicles, or bony walls. Granulations and polyps, and invariable destruction of the tympanic membrane are common. Such an ear is destined to chronicity from the onset.

2. An acute otitis in an ear in which the development of normal tympanic mucosa has been interferred with by otitis media neonatorium, or catarrhal otitis in early infancy. These diseases render the middle ear mucosa hyperplastic and poorly able to resist infection or heal. Granulations and polypi are common.

3. Primary acquired cholesteatoma without marginal perforation.

This is a destructive epithelial mass which develops by an ingrowth of epi-

* Attending Surgeon, Detroit Osteopathic Hospital

thelium into a blind pouch formed by the invagination of Shrapnell's membrane by negative pressure. Such negative pressure occurs in two ways: First, by prolonged occlusion of the Eustachian tube by nasopharyngeal disease or obstructive lymph hyerplasia; and second, by persistent hyperplastic sub-epithelial connective tissue in the epitympanic recess. The resulting pouch is too constricted to permit the escape of desquating epithelium. When it becomes large enough to extend out of the attic or when saprophytic infection of the resulting epithelial debris causes discharge through the small opening.

Secondary acquired cholesteatoma results from the ingrowth of squamous epithelium into a marginal tympanic perforation. The accummulation of epithelium in a blind pocket results in continuing desquation, erosion by pressure, and suppuration. The presence of cholesteatoma results from the development of organic matter out of contact with oxygen.

Both primary and secondary acquired cholesteatoma are chronic diseases from onset of the otorrhea, not because of the duration of the disease, but because of the nature of the pathology which progresses unceasingly and unless destroyed surgically, will eventually destroy the host.

I. Non-dangerous Chronic Suppurative Otitis Media

Fortunately, most forms of chronic suppurative otitis media are of the non-dangerous or benign type. The disease develops from an acute necrotic otitis media, or from hyperplastic otitis media with Eustachian tube obstruction. Differentiation from dangerous or bone invasive chronic otitis media is of utmost importance. Fortunately too, this is usually not too difficult.

First, the otorrhea in benign or non-dangerous otitis media is always mucoid. When first seen there may be purulent material mixed with the mucous discharge with considerable odor, especially if seen shortly after reinfection. As soon as the ear is cleaned or treated with a mild antiseptic, or antibiotic, the discharge again becomes typically clear mucoid and odorless. This discharge may be more or less constant or intermittent with long periods of inactivity, lasting several years. It may be very thin or viscid and rubbery. When reactivated by an acute tubo tympanitis, it again becomes purulent and foul smelling.
The perforation in the tympanic membrane is also characteristic. It is always central; it may be very small or very large, and kidney shaped, but it always is in the pars tensa, never in the pars flaccida (Shrapnell's membrane). Even when very large and complete, there is a narrow margin of intact annulus and the manubrum of the malleus is either intact or only slightly shortened to give the perforation its characteristic kidney bean shape.

The tympanic wall is also typical as seen through the perforation. There is always mucous membrane lining the tympanic cavity, rather than stratified squamous epithelium. This mucous membrane may be pale and edematous or red, thick, and granular, when badly involved granulations or polypi may be found.

The loss of hearing is moderate and conductive in type. It is also fluctuant and hearing may be considerably better when the ear is moist than when it is dry. This is due to the conductivity of the fluid aiding the impedance matching mechanism of the middle ear.

Treatment of benign chronic suppurative otitis media is directed to the local mucosal infection and any pathology or infection in the Eustachian tube or its nasopharyngeal orifice. Bacterial cultures are of little practical value except in acute reinfection or a complication from thrombophlebotic extension. Secondary invaders—staphylocci, proteus vulgaris, and pseudomonas areruginosa are in-

variably found in chronic mucoid aural discharge.

Nothing succeeds in treatment like cleanliness—chronicity is maintained by neglect. Patients are instructed not to swim or permit water or anything but prescribed medication to enter the ear. The ear is carefully cleaned with spot suction under direct vision, followed by antiseptic tiny cotton wipes on a slender wire applicator or delicate Hartmann's type ear forceps. Antiseptics used are tincture of zephiran, 1:1000, or meta-cresylacetate (cresatin). The Eustachian tube is inflated by Eustachian catheter to determine patency. The middle ear is then dusted with an antiseptic powder, Sulzberger's 10% iodine in boric acid powder, or aerosporin in boric acid is used. If discharge is profuse, cortico-sporin otic, gantrisin otic, or Neodeca-dron 0.1% otic is prescribed 3-5 drops b.i.d. This is reduced to twice a week as the ear comes under control until dry treatment with powders can be em-ployed and the ear becomes dry. Small granulations are treated with 2% gen-tian violet. Large granulations and poly-pi are removed with aural snare or cup forceps and the base treated with 2% gentian violet.

Notice of Examination

The next meeting of the Texas State Board of Medical Examin-ers when examinations will be given and reciprocity applications considered is scheduled for De-cember 6, 7, 8, 1962, at the Black-stone Hotel, Fort Worth, Texas.

Completed examination appli-cations must be filed with their office thirty days prior to the meeting date—1714 Medical Arts Bldg., Fort Worth 2, Texas.

Completed reciprocity applica-tions must be filed sixty days prior to the meeting date to be given consideration.

Lymph hyperplasia or adenoid hyper-trophy is dealt with surgically by direct vision adenoidectomy. Irradiation of the nasopharynx by radium applicator or by cross fire of the nasopharynx is no longer used because of unknown dan-gerous late sequale, including carcinoma of the thyroid.[6].

Nasal allergy is a frequent accom-paniment of the problem and it should be treated by desensitization, especially to house dust and other offending al-lergens.

Once a dry ear is obtained, closure of the tympanic perforation is of great importance. While it is true that this will not prevent reinfection by way of the Eustachian tube, it does reduce sus-ceptibility of extension from the naso-pharynx and eliminates reinfection from the external auditory meatus. In addi-tion, when successful, it greatly im-proves hearing.

There are several ways of closing the central perforation. It must first, of course, be central. No marginal perfo-ration should ever be closed. The sim-plest method of accomplishing this is by means of office treatment developed by Juers.[7]. It consists of Bonain's anesthesia to the drum, application of saturated trichloracetic to the margin of the drum, employing magnification by Zeiss loupe or otomicroscope and evert-ing the margin of the perforation with small currettes and small sharp hooks. Urea crystals, four parts and borofax ointment, six parts is applied in the middle ear under the perforation and a sterile cigarette paper patch is pressed against the outer surface of the tympanic membrane. This is repeated at 10 to 14 day intervals until the perforation closes. Posterior perforations close much more rapidly than anterior ones.

More definitive closure can be ac-complished by tympanoplasty. Tym-panoplastic surgery was originally developed by Zollner in 1951 and Wullstein in 1953. It has a two-fold

purpose—first, to remove and control morbid infection in the middle ear and mastoid; and second, reconstruct the sound conducting mechanism of the middle ear to protect or improve hearing.

Originally, ear drum perforations were closed surgically with a skin graft. Later it was found by Shea and Austin, that a more dependable and flexible tympanic closure could be accomplished with a vein graft.

Eventually an entirely new system of surgical reconstructions evolved designed to improve hearing in ears destroyed by chronic middle ear and mastoid disease or destructive mastoid surgery.

These operations are based on two important physiological principles — first, that there is 17 times greater area of the tympanic membrane than that of the foot plate of the stapes in the oval window, and with the lever action of the ossicles there is a sound pressure transformation of 22 times. Restoration or reconstruction by surgical means is necessary to obtain maximum hearing. The second is that without a tympanic membrane, sound reaches both oval and round windows in the same phase, thus cancelling the energy transmission in the fluid medium of the inner ear. By sound protecting the round window to delay the phase, there is an improvement in the energy transmission to the inner ear.

Based on these principles, four types of Tympanoplastys have been developed. In well trained hands these ingenious operations have a high degree of success.

II. Dangerous Otitis Media and Mastoiditis

Dangerous otitis media is characterized by destructive disease, chronic osteitis, or osteomyelitis of the middle ear and temporal bone or destructive cholesteatoma. It frequently destroys the inner ear by labyrinthitis, the facial nerve with permanent facial paralysis and may invade the brain to produce abscess in the temporal lobe or the cerebellum.

In Meyers [1] 94 cases of chronic suppurative otitis media and mastoiditis, 20 had evidence of intracranial invasion during the immediate preoperative period. Such patients have profuse, more or less continuous discharge which is purulent and offensive. Cleansing and antibiotic ear drops have little or no effect on the character of the discharge. The perforation is either large and kidney shaped with loss of ossicular structure and multiple granulations on the tympanic wall, or marginal erosions with ingrowth of epithelium. Large areas of canal wall and annulus may be destroyed.

The hearing loss is mixed, having both conductive and perceptive characteristics. There is apt to be vertigo and dizziness. Pressure on the canal may produce dizziness and nystagmus. This is the fistula test whic hindicates a communication with the inner ear. It is

always a dangerous sign requiring immediate surgical consideration. The x-ray findings show eburnation and sclerosis of bone with sequestum and areas of cavitation.

Surgery of the dangerous chronic suppurative otitis media and mastoiditis has undergone many changes. If dealt with by classical radical mastoidectomy or one of the modifications, such as the Heath or Bondy, the danger of intracranial infection and serious complications is usually eliminated, but the chronic suppuration often continues in spite of a technical excellent operation. Moreover, these patients require 6 weeks to 8 or 9 months of postoperative care to obtain a healed cavity. Even then, reinfection of the large cavity produced by complete mastoid exenteration occurs frequently and the cavity always requires periodic cleaning and care. The development of the endaural radical mastoidectomy improved the outlook greatly, but the problem was not solved until a technique for eliminating the mastoid bowl by a closed cavity mastoidectomy was developed. There are a number of ways in which this can be done. Guilford and Wright[8] filled the cavity with diced cartilage and employed secondary grafting.

Rambo's[4] development of a large anterior based temporalis muscle flap is probably the most important single contribution to solving the problem. Not only is the operative cavity obliterated, but it is obliterated by a viable tissue flap which has a profuse blood supply and this in itself promotes early healing. The technique is not difficult and the method has been widely adopted for not only radical mastoidectomy, but also for tympanoplasty and closed cavity fenestration.

By this means, the most stubbornly discharging ear can predictably be cured in 3 weeks and often sooner. Moreover, the patient is freed from periodic trips to the otologist for cleaning and such ears will seldom reinfect even though the patient swims or otherwise abuses his ear by self cleaning with match heads, hair pins, etc.

To achieve a result of this kind, naturally, the otologic surgeon must first do a thorough exenteration of the mastoid and middle ear; not the slightest vestige of infection must remain. One cannot cover up trouble with the muscle flap. If he has carefully handled and constructed the canal wall flap, the cavity can be closed completely and healing is prompt and predictable. I have employed this method routinely for the past 3 years, in both radical mastoidectomy and tympanoplasty, and found it most dependable.

2406 David Stott Building

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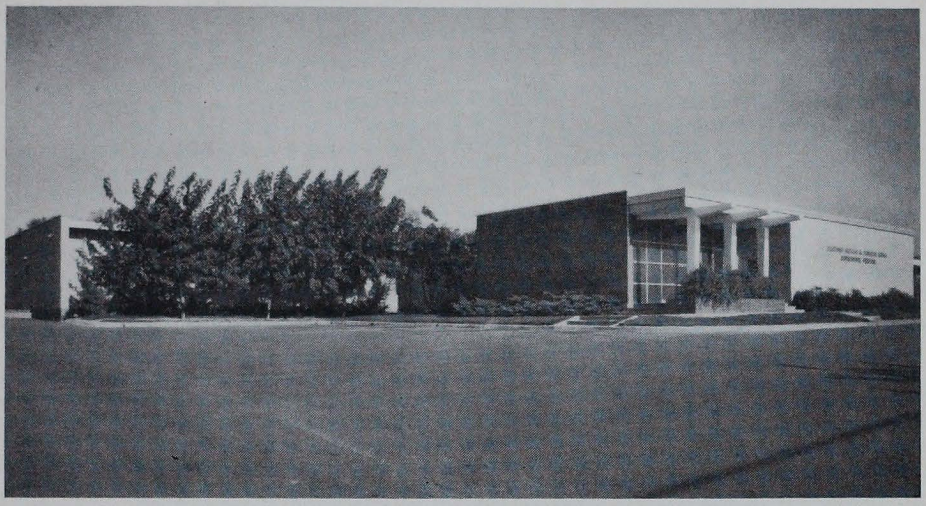
Guild Donates $1000 to FWOH

Mrs. F. R. Hunnicutt, treasurer of the Fort Worth Osteopathic Hospital Guild, presented a $1,000 check to Dr. Virginia Ellis, chairman of the department of pediatrics, for new furnishings in the hospital. The presentation received publicity through the pages of the morning Fort Worth Star-Telegram.

Hospital of the Month



Plattner Hospital and Clinic 322 N.E. 8th Street, Grand Prairie, Texas

The Texas Osteopathic Physicians' Journal is proud to salute the PLATTNER CLINIC AND HOSPITAL, 322 N. E. 8th St., Grand Prairie, Texas as THE HOSPITAL OF THE MONTH.

The hospital, owned and operated by Doctors Albert L., Donald V., Emil P. and Herman H. Plattner, was opened April 12, 1959. It has 20 beds, 6 bassinets, surgical, delivery and recovery rooms and complete x-ray and laboratory facilities.

The Plattner Hospital and Clinic actually dates back to 1941 when these four physicians opened their first hospital in a "T" shaped residence. It had six beds and one bassinet. From 1941 to 1958 the hospital was continually filled beyond capacity and surgical cases were sent to the Stevens Park Osteopathic Hospital in Dallas. Their six beds were primarily used for medical, obstetrical and emergency cases. As the bed situation became more pressing, the Plattner's built this beautiful new and modern hospital in conjunction with a new clinic in which they have offices.

Grand Prairie is a thriving city at the edge of the great Southwest industrial area developed on a 15,000 acre tract which is also the home of the new $15,000,000 Six Flags Over Texas. Grand Prairie is approximately 15 miles from Dallas and 20 miles from Fort Worth and is a fast growing community of 45,000 persons with a trade area population of some 90,000.

The City of Grand Prairie offers many opportunities for ethical and qualified physicians. If interested in locating here, contact Dr. Herman Plattner or any of our physicians in that city.

GOOD LOCATION

DARROUZETT, TEXAS — Needs well-qualified physician. This town is located in the panhandle of Texas and has a population of some 400 people and a trade territory of some 1500 people. No other physician within a radius of 30 miles. If interested contact Joe Hershey, President of the Chamber of Commerce, Darrouzett, Texas.

A Time for Meeting

By GEORGE W. NORTHUP, D.O.

Traditionally, July has been the month for the annual meetings of the officers, trustees and delegates of the American Osteopathic Association. July 1962 was no different. Yet it was unique because of a diversity of serious problems facing the osteopathic profession.

With the call to order by President Naylor to his Board of Trustees and by Speaker Haviland to the House of Delegates, the American Osteopathic Association opened the sixty-fifth annual meeting of its two governing bodies.

Members of this year's Board and House exhibited a quiet and determined realism as they approached the profession's business. They were encouraged by the report of the $4,718,000 of state funds appropriated to the Philadelphia College of Osteopathy; the 75-bed addition to the teaching hospital of the Chicago College of Osteopathy; the completion of the student dormitories at the Kirksville College; and the inauguration of the $1,500,000 public fund drive for the further development of the college in Kansas City.

They were grateful for the increasing support being given the National Osteopathic Foundation by leading pharmaceutical houses. They were particularly heartened by the $10,000 grant from the Pfizer Laboratories to the Chicago College, to be used in the establishment of a chair in osteopathic medicine. The Kansas City College received a $10,000 grant from Smith Kline & French Laboratories. This is to be used toward the establishment of a chair in pharmacology.

The trustees and delegates who met in mid-July in Chicago were disgusted with the news that the California College of Medicine had in two days issued 2,000 M.D. degrees for $65 each. They were disturbed by efforts of the Washington State Medical Association organizationally to seduce a group of osteopathic physicians in that state into professional slavery.

They were given confidence by the fact that the financial position of the American Osteopathic Association was never stronger, despite frequently repeated statements to the contrary by former osteopathic physicians of California.

The July 1962 meetings concluded, the profession moves ahead in strength and greater unity. The Chicago meetings were characterized by realism rather than by blind optimism or by negative pessimism. They were meetings of determination and strength.

They were good for the profession.

D.O.'s Attend Lectures in Victoria

Osteopathic physicians attending a Study of the Newly Born Infant in Victoria, Texas, August 10, 1962 were Drs. Richard L. Stratton, Cuero; John H. Boyd, Louise; Clark D. Tisdale, Moulton. Sponsored by the Texas State Department of Health, invitations were extended to all physicians in the area by the Victoria County Health Department.

Lecturers were Drs. Murdina Desmond and Arnold J. Rudolph, Baylor University College of Medicine, who presented the following subjects: The Apgar Scoring Method, The Clinical Behavior of the Newly Born, The Effects of Maternal Factors on the Newly Born, and Diseases of the Newly Born.

Texas Osteopathic Hospital Association Meets

The annual meeting of the Texas Osteopathic Hospital Association was held August 11-12 in the Adolphus Hotel, Dallas, Texas. It was one of the most successful meetings held by this organization.

The major portion of the program was conducted by Mr. William S. Konold of Columbus, Ohio who spoke on (1) "The Distinction Between Staff Duties and Administration." (2) "The Responsibility of Doctor-Owned Hospitals Toward Attending and Working in the Organization." and (3) "Relationships Between Osteopathic and Medical Organizations."

Although Mr. Konold's presentations were more applicable to the larger hospitals, the educational contents were such that even hospitals with a staff membership of two could profit tremendously and gain a better understanding of hospital activities.

Another outstanding feature was the two-hour open session of Actual Case Work by the Texas Osteopathic-Insurance Liaison (TOIL) Committee. One must see this committee at work to fully appreciate the fact it is comprised of dedicated men who take their work seriously. Their job is primarily to create better understanding between the doctors, hospitals and the insurance industry, thereby protecting our voluntary system of health insurance.

Of particular interest to all hospital representatives in attendance were the presentations made by Mr. Robert S. Hawthorne of Blue Cross-Blue Shield of Texas, (1) "Cost Analysis of Osteopathic Hospitals" and (2) "Old Age Assistance Program and Its Success to Date Within Texas."

At 8 p.m. Saturday a cocktail party was held for the registrants, courtesy of Dallas-Fort Worth Osteopathic Hospital Council. It was a delightful function.

At a business session on Sunday, the following officers were elected. They will assume office April 1, 1963—

PRESIDENT ELECT—Dr. Selden E. Smith, Wolfe City Hospital

VICE PRESIDENT—Mr. Lee Baker, Administrator, Lubbock Osteopathic Hospital

SECRETARY-TREASURER — Mrs.

Mary Hayes, Business Manager, Marcom Hospital, Ladonia, Texas. (Mrs. Hayes assumed her duties immediately as she will fill the unexpired term of Mr. Weatherly TOHA Secretary who recently left Texas)

TRUSTEES—Dr. P. R. Russell, Fort Worth Osteopathic Hospital

Dr. J. C. Calabria, Stevens Park Osteopathic Hospital, Dallas

The following physicians and lay persons, representing osteopathic hospitals, were in attendance:

AMARILLO

W. L. Davis, Jr., Amarillo Osteopathic Hospital

Glenn R. Scott, D.O., Amarillo Otseopathic Hospital

ARANSAS PASS

John Gilmore, Aransas Hospital

BEAUMONT

Claude J. Hammond, D.O., Hammond Hospital

BIG SANDY

Christine Davis, Big Sandy Clinic and Hospital

Maxine Harris, Big Sandy Clinic and Hospital

COOPER

Mrs. M. C. Hornsby, Reed Memorial Hospital

Mrs. H. R. Wicks, Reed Memorial Hospital

Mrs. Dean E. Wintermute, Reed Memorial Hospital

Dean E. Wintermute, D.O., Reed Memorial Hospital

CORPUS CHRISTI

Dave Gassiot, Corpus Christi Osteopathic Hospital

DALLAS

Roberta Blaylock, Stevens Park Osteopathic Hospital

Sherrill Burba, Stevens Park Osteopathic Hospital

A. Garside, Dallas Osteopathic Hospital

Robert Hawthorne, Blue Cross-Blue Shield

Eloise Longley, Dallas Osteopathic Hospital

H. G. Mann, Dallas Osteopathic Hospital

DENTON

Mary Ellis, Elm Street Hospital and Clinic

EL PASO

John F. Holcomb, Tigua General Hospital

FORT WORTH

L. G. Ballard, D.O., President T.A.O.P.S.

Emma Bennett, Fort Worth Osteopathic Hospital

G. A. Fuller, Jr., White Settlement Hospital

Mary Hinerman, Fort Worth Osteopathic Hospital

J. E. Kirkpatrick, Lake Worth Osteopathic Hospital

P. R. Russell, D.O., Fort Worth Osteopathic Hospital

Jane Siniard, Fort Worth Osteopathic Hospital

W. M. Snow, D.O., White Settlement Hospital

D. J. Tousegnorst, Fort Worth Osteopathic Hospital

T. R. Turner, D.O., Fort Worth Osteopathic Hospital

GONZALES
Willis Crews, D.O., Crews Hospital
Sidney L. Gustafson, Crews Hospital

GROOM
Robert E. Clayton, D.O., Groom Memorial Hospital
James B. King, Groom Memorial Hospital

GROVES
Bennie Bearden, Doctors Hospital

HOUSTON
Mrs. Dorothy Almond, Homestead Hospital and Clinic
Hal H. Coker, Doctors Hospital
Ann Davis, Community Hospital, Inc.
Lee Davis, Community Hospital, Inc.
Lloyd D. Hammond, D.O., Houston Osteopathic Hospital
Mrs. Jane Mills, Houston General Hospital
Mary Stucky, Houston General Hospital
G. W. Tompson, D.O., Community Hospital, Inc.
H. Murphy Webb, D.O., Doctors Hospital

HURST
Charles H. Bragg, D.O., Hurst General Hospital
V. L. Jennings, D.O., Hurst General Hospital

LADONIA
Mary Hayes, Marcom Hospital
Gordon A. Marcom, D.O., Marcom Hospital

LUBBOCK
Lee Baker, Lubbock Osteopathic Hospital

MINEOLA
Mrs. Geleska Armour, Mineola General Hospital
J. W. McCorkle, D.O., Mineola General Hospital

MT. PLEASANT
Julia Currey, Currey Clinic and Hospital
Palmore Currey, D.O., Currey Clinic and Hospital

SAN ANTONIO
Everett W. Wilson, D.O., San Antonio Osteopathic Hospital

STANTON
J. M. Shy, D.O., Physicians Hospital and Clinic

TYLER
Golda Schultz, Coats-Brown Clinic and Hospital

WOLFE CITY
Selden E. Smith, D.O., Wolfe City Hospital

OUT OF STATE
H. B. Boughan, D.O., Fairview City Hospital, Fairview, Okla.
William S. Konold, Hospital Consultant, Columbus, Ohio

Annual Fall Seminar

Texas Association of Osteopathic Obstetricians and Gynecologists

OCTOBER 6 & 7, 1962

Holiday Inn—Central (Central Expressway) • Dallas, Texas

* * *

PROMINENT OUT OF STATE SPEAKER

RICHARD E. EBY, D.O.; F.A.C.O.O.G., Pomona, California. Certified in Obstetrics and Gynecology Member of Board of Trustees American Osteopathic Association. Past-President of Osteopathic Physicians and Surgeons of California. Past-President of American College of Osteopathic Obstetricians and Gynecologists.

* * *

SATURDAY, OCTOBER 6, 1962

1:00 P.M. REGISTRATION
1:30 P.M. "TWENTY-FOUR HOUR OBSTETRICAL ANESTHESIA COVERAGE"
Paul A. Stern, D.O., Dallas, Texas
2:00 P.M. "USE OF MALMSTROM'S VACUUM-EXTRACTOR"
Richard E. Eby, D.O.; F.A.C.O.O.G., Pomona, California
2:45 P.M. RECESS
3:00 P.M. "THE ANEMIAS OF PREGNANCY"....Joe D. Whittemore, D.O., Dallas, Texas
3:30 P.M. "MENSTRUAL DISORDERS, DIAGNOSIS AND TREATMENT"
Lee J. Walker, D.O., Grand Prairie, Texas
4:00 P.M. QUESTION AND ANSWER SESSION .....Today's Speakers
5:30 P.M. COCKTAIL HOUR (For Doctors and Wives)—(Courtesy of Ross Laboratories)

SUNDAY, OCTOBER 7, 1962

9:30 A.M. "HEMOLYTIC DISEASES OF THE NEONATE"
Robert B. Moore, D.O., Mesquite, Texas
10:15 A.M. "X-RAY AS AN AID IN OBSTETRICS AND GYNECOLOGICAL DIAGNOSIS"
Raymond N. Dott, D.O., Dallas, Texas
11:00 A.M. RECESS
11:10 A.M. "GYNECOLOGIC ENDOCRINOLOGIC DISORDERS—GUIDES ON THERAPY"
Richard E. Eby, D.O.; F.A.C.O.O.G., Pomona, California
12:00 P.M LUNCHEON—"HEALTH OF OSTEOPATHY IN CALIFORNIA AND U.S. TODAY" (For D.O.s and Wives)
Richard E. Eby, D.O.; F.A.C.O.O.G., Pomona, California
1:45 P.M. "CURRENT TREATMENT OF CARCINOMA OF THE CERVIX"
G. Leroy Howe, D.O., Dallas, Texas
2:15 P.M. QUESTION AND ANSWER SESSION .....Today's Speakers
3:00 P.M. BUSINESS MEETING—Texas Association of Osteopathic Obstetricians and Gynecologists

REGISTRATION FEE—(Including Luncheon and Cocktail Party) Members of T.A.O.O.G. $15.00—Non-Members $18.00—Ladies $5.00

* * *

MEETING OPEN TO ALL D. O.s

(Members of State or National)

* * *

NOTE: Dr. Eby will discuss the status of Osteopathy in California and the United States as of today at his luncheon address. Plan to learn about your professional affairs together with knowledge in obstetrics and gynecology.

MAKE THIS A WEEKEND VACATION

Attendants of this meeting will be given guest privileges at one of Dallas' best private clubs. Remember football too.

Executive Secretary's Travelogue

In reading the Travelogue, this month, you may wonder if the headline writer is not "off base" and that it should be called "Troublelogue," "Goodalogue" or "Reportalogue" because there has not been too much travel during the past month.

Trouble! As you know dues were payable April 1st and by far the biggest percentage of our members pay their dues in full during April and May and you also recognize that the Constitution and Bylaws provides that if dues are not paid in full by July 1st the state office must suspend those delinquent in their dues. But they further provide that we can automatically reinstate those who pay up in full during the month of July, but after August 1st, those delinquent in their dues must be dropped from the membership. From this, we are sure you can recognize the trouble these delinquent members gave us during the months of June and July, writing letters explaining why and attempting to get them to recognize their responsibilities to the profession. It has been an endless task. This situation comes about because the membership does not read the Constitution and By-Laws and does not recognize that the Board of Trustees instructed the state office to follow the Constitution and Bylaws to the letter with regard to membership dues.

The "Goodalogue" part of this story is that we only had to permanently drop four members—Doctors: Earl C. Davis of Brownfield; Larry A. Giffen of Corpus Christi; J. C. Montgomery of Port Neches; and Lowell L. Schupback of Houston who did send in his money (too late—After August 1st) but he reapplied for membership and his application has since been approved by his district society and our Membership Committee. Our total membership to date is 601.

More Trouble! You remember the executive secretary reported last month that a scheduled meeting of the Hospitals and Insurance Committee had to be moved from the state office because the air conditioner broke down . . . the pump and motor burned out and the state office had no air conditioning for two days. Well, on Monday, August 6, we again walked into an oven. The air conditioner again! This time the fan motor was burned out. 90° in the office and no air. All work had to be suspended until it was repaired that afternoon, with the exception that the Bratt (Miss Jean Bratt) and your "Janitor" moved outside under the shade trees where their was a little air, for 1½ hours of dictation.

The "Janitor" got wise that day and with no consent from the Board of

Trustees has purchased a large oscillating fan for future emergencies, such as this. About all that's left to go bad now, in the air conditioner, is the compressor, but we can't complain because these two motors have burned out. They have run consistently 24 hours a day for eight years, forcing either cold or hot air into the office—which isn't bad service for two poor little motors. It makes your "hired hand" realize that he has been travelling at the rate of approximately 16 hours per day, 7 days a week for some 12 years with only two vacations (one for four weeks and the other for two weeks) so he has decided to take it a little slower during this extremely hot weather before he blows his fuse. He's been coming into the office a little later in the mornings.

We are in hopes the compressor goes out before the "hired hand" does. This may not be the sentiment of some of the membership, particularly those he has had to "ding-dong" about dues.

Let's change to the "Goodalogue" for a minute! The state office has received a report concerning our 1962 convention, that is so good, he wants to pass it on to you—"Evaluation Report" from Medical Exhibitors Association Inc. This report is the result of a survey made of 39 of our 40 exhibitors and is as follows:

Suitability of City: Excellent — 21; Good—16; Fair 4.

Suitability of Exhibit Hall: Excellent—14; Good—21; Fair—6; Poor—1.

Hotel Accommodations: Excellent—9; Good—22; Fair—2.

Physicians' Interest in Exhibit: Excellent—2; Good—22; Fair—10; Poor—7.

Circulation of Physicians in Exhibit Hall: Excellent—1; Good—17; Fair—13; Poor—10.

How do you Classify this Meeting: Excellent—5; Good—15; Fair—13; Poor—6.

Would Your Experience at This Meeting Lead You To Recommend that Your Firm Exhibit Next Year? Yes—33; No—6.

General Comments: "That different colored badges be used for doctors and exhibitors"

It is our feeling that the recommendation regarding badges at our conventions is an excellent one. We are also satisfied with the report, particularly since 33 of our exhibitors plan to be with us again in 1963. However, the membership can improve next year's report considerably by giving more of their attention to our exhibitors and thereby raise the grading regarding

TEXAS STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

1012 STATE OFFICE BUILDING
201 EAST 14TH STREET
AUSTIN, TEXAS

August 2, 1962

NOTICE OF EXAMINATION:

The next examination of the Texas State Board of Examiners in the Basic Sciences has been set for Monday and Tuesday, October 15-16, 1962 in Austin only.

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

Applications for the October examinations must be complete and in this office by September 30, 1962, and all necessary information and documents required by the Board of examinees must be completed and in the applicant's file by that date. Those interested in participating in this examination should act immediately.

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

physicians' interest and circulation in the exhibit hall which were the two worst gradings we received. A copy of this report was furnished to the Hotel and Chamber of Commerce.

Another Good Report! We have, as of this date, appropriated $49,600.00 to our osteopathic colleges and hope to have possibly another $400.00 to send them later in the year. The schools are grateful for this money and our profession should be proud of this accomplishment, in that the public is certain to recognize that we are sincere in our efforts toward osteopathic education and are willing to give so that the public might have better educated and qualified physicians.

Travel? A wee bit, the past month. On Friday, August 10, the executive secretary spent the day in Dallas, driving in 106° temperature which sweat some of the mean-ness out of him. His first stop was at Texas Employers Insurance Assn. where he visited with Mr. Dick Hastings, Claims adjustor for the Dallas area. From where he drove 10 miles to the office of Dr. Dale P. Bondurant for a conference with him that lasted some two hours. Also he was able to visit with Dr. Robert Lorenz for a few moments. By 1:00 P.M., Dr. Bondurant was starving and the executive secretary was growing a little weak, so Dr. Bondurant entertained him at lunch. At 3 P.M. he was across the city of Dallas, at the office of Dr. Carolyn Roberts where he had a 2½ hour visit with her. He then returned to the Adolphus Hotel where he hoped to contact Mr. William S. Konold of Columbus, Ohio who was scheduled to appear on the program for the Texas Osteopathic Hospital Association meeting.

August 11-12th the executive secretary was in attendance at the entire TOHA meeting and states very frankly that Mr. Konold's three separate presentations each followed by a question and answer period) were outstanding and of extreme value to every doctor and hospital administrator who heard them.

The Texas Osteopathic-Insurance Liaison Committee meeting, attracted a good deal of attention during its 2 hour open session before these groups. You never recognize how valuable and sincere the efforts of this Committee are until you see them at work.

Another important presentation made during the TOHA meeting was by Mr. Robert S. Hawthorne of Blue Cross who spoke on 1) "Cost Analysis of Osteo-

pathic Hospitals" and (2) "Old Age Assistance Program — Its success to Date."

There were many interesting happenings during this meeting which made the executive secretary extremely proud that he was in a position representing our Association.

On August 16, the executive secretary was happy to participate in a surprise House-Warming Party for a member of our Board of Trustees—Dr. Charles H. Bragg—who recently moved into a new home in Hurst and also into a new clinic building. Practically all the staff members of the Hurst General Hospital attended the party, as did other professional men and lay persons. This gave the executive secretary a wonderful opportunity to visit not only with osteopathic physicians, but with other professional people as well.

This housewarming gave the executive secretary some difficulty a week earlier as he had been invited to Dr. Bragg's home for dinner that evening. The hospital staff learned of this invitation and called the executive secretary, told him what had been planned and that they expected him to be there, but to please call Dr. Bragg and tell them it would be impossible for him to come to dinner. The executive secretary called Mrs. Bragg on Tuesday night . . . expressed his regrets, and stated he had an unexpected call and would be out of the city and therefore could not come to dinner on Thursday night. When the executive secretary hung up the phone, Mrs. Russell who had heard the conversation, said, "You told such a convincing lie that I won't believe anything you tell me from now on."

On the afternoon of August 21, the executive secretary was visited in the State Office by Mr. Jim Andrews, Assistant to the President of Reserve Life Insurance Company, Dallas, for the purpose of discussing hospitalization insurance. Through this conference both Mr. Andrews and the executive secretary were able to develop much information to the benefit of our profession and the insurance industry.

The Executive Secretary left for Dallas, Saturday, August 25, where on Sunday the Sub-Committee of the Public Health Committee—Drs. Elmer C. Baum and P. R. Russell, conducted an all day hearing in reference to malpractice. Also present, for the hearing were Mr. Timothy Kelley, attorney; Mrs. DuBoise, attorney; and Doctors: Milton V. Gafney, Paul A. Stern, Samuel Sparks, Walters Russell, Winton Welsh, Joe DePetris, and Leon R. Lind.

The hearing, which began at 9 a.m., was adjourned at 3 p.m. after which Doctors Baum and Russell conferred to review the findings of the consultants for the hearing.

Later, the executive secretary drove out to Dallas Osteopathic Hospital to review the progress on the new addition now under construction. They were in the process of pouring the concrete for the third floor. This will be a beautiful addition to the hospital.

On Monday evening, August 27, President L. G. Ballard and the executive secretary met at the state office until 11 P.M. discussing the progress of our profession to date.

The afternoon of August 28 was devoted to a 2½ hour conference with Mrs. Virgil R. Linville of Fort Worth, President of the newly formed Texas Association of Osteopathic Assistants. They discussed the help this new organization can be to the TAOP&S, what its objectives should be, their limitations and proper organizational procedure. We appreciate the fact Mrs. Linville came to us for help.

That evening the executive secretary attended the wedding of Mr. Gregg Ellis and Miss Susan Ann Bethea in Fort Worth and the reception which followed. Gregg is the son of Doctors

Noel and Virginia Ellis. It was indeed a beautiful ceremony.

On Wednesday, August 29, the executive secretary again met with Mr. Jim Andrews of Reserve Life and Mr. Ted Smith, their Chief Claims Adjustor. Mr. Andrews brought back to the executive secretary additional information at the request of Mr. E. H. Barry, President of the Company. Mr. Barry also sent our association the book, "Best's Life Insurance Reports" 1962 edition which is a valuable asset to our library. This is a volume the executive secretary has been wanting for a long time as it gives a breakdown on every insurance company in the United States. It will be extremely useful to this office and we express our sincere appreciation to Mr. Barry for this gift.

This same day, the executive secretary recorded a 30 minute telephone conversation with the Regional Vice Director of the Boy Scouts of America — Mr. W. C. Youngblood of Dallas and another conversation with the Regional Director, Mr. Biesenhurst of San Antonio, in refusing to accept physical examinations signed by osteopathic physicians. The entire matter was brought to a happy conclusion and we are promised that all Boy Scout troops in Texas will be officially notified of the rights of osteopathic physicians to examine Boy Scouts. They stated further that they expect to change their examination forms by deleting the term "M.D." from the signature line and inserting in its place "licensed physician" which of course includes both D.O.'s and M.D.'s. Apologies were extended to our organization by these Boy Scout officials.

See you next month!

Academy Seminar September 29-30

The Texas Academy of Applied Osteopathy will hold its Fall Seminar, September 29-30 in the Villa Capri, Austin, Texas.

The program will be presented by Dr. Angus Cathie of the Philadelphia College of Osteopathy who will speak on "Tissue Changes in the Aging Process" and Sinobronchial Syndrome." This will be followed by a panel discussion on "Organic vs. Somatic Pain."

Registration fee of $25.00 includes two luncheons. Mail your check to Dr. Catherine Carlton, 815 West Magnolia, Fort Worth, Texas.

Room reservations should be made directly with the Villa Capri. Make your reservations early!

Assistants To Osteopaths Form Group

From FORT WORTH STAR-TELEGRAM
Sunday, August 26, 1962

The Texas Osteopathic Medical Assistants Association was organized Saturday at Hotel Texas by 35 delegates, who elected officers and adopted a constitution.

Mrs. Virgil R. Linville of Fort Worth was elected president.

Others elected were Mrs. Leslie R. Woodall of Port Arthur, vice president; Mrs. Judy Mitchell of Fort Worth, recording secretary; Mrs. David McCoy of Denton, corresponding secretary, and Mrs. Bernie F. Wahoff of Fort Worth, treasurer.

Sponsoring the organization of a state group were members of the Tarrant County Osteopathic Assistants Society, with aid from Mrs. Charles A. Neal, executive assistant for the Texas Association of Osteopathic Physicians and Surgeons.

Chairman of the organizational group was Mrs. Stephen F. Synnett of Fort Worth.

Objectives of the state association are promotion of interest for patients' welfare, better understanding of osteopathic medicine, maintenance of high standards of service and the organization of more assistants societies.

Mrs. Linville will announce her appointments at a breakfast Sunday.

Dr. L. G. Ballard of Fort Worth, president of Texas Osteopathic Physicians and Surgeons, spoke at a banquet Saturday night.

ACOS 35th Assembly Set Oct. 28- Nov. 1

The thirty-fitfh annual Clinical Assembly of the American College of Osteopathic Surgeons will be held October 28-November 1, 1962, at the Americana Hotel, Bal Harbour, Miami Beach, Florida. Members or candidates of ACOS or the other participating organiaztions are invited to the assembly.

Theme of this year's Clinical Assembly will be "Neoplasia." In addition to a variety of other subjects, the diagnosis, treatment and management of malignancies will be featured.

Registration fees for the Assembly are $40 for physicians and $25 for lady guests, entitling each to a ticket for the organiaztional banquet and a ticket for the Wednesday night banquet, entertainment and dancing, and admissions to all the didactic programs, industrial and scientific exhibits. Ladies' registration also includes a ticket for the Ladies Luncheon and entertainment.

Advance registration should be directed to Charles L. Ballinger, D. O., American College of Osteopathic Surgeons, P. O. Box 40, Coral Gables, Florida.

Academy Seminar September 29-30

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The Medical Records Department

From: "THE OSTEOPATHIC HOSPITAL"
September 1962

(Editor's Note: This article is reprinted here because your Hospitals and Insurance Committee and Public Health Committee are concerned over medical regards. They urge your review of this concise and noteworthy article.)

Before describing what constitutes a good record an dits evaluation, the record itself should be defined.

Definition. A medical record is the story of the patient's illness, treatment and progress. Across the ages, the history of the written word traces the story of medical care.

Qualifications of record. In order to be considered a *good record,* each record must be complete within itself—the last installment having been completed within 10 days after discharge of the patient.

It states facts. In other words, a *good record* contains sufficient data to substantiate the diagnosis, justify the treatment gievn, and warrant the end results. Essential facts entered in a concise, orderly and consecutive manner are of considerable more value than a disorderly and voluminous collection of positive and negative findings.

It is only natural when speaking of medical records to think of them as a whole, but emphasis must be placed on the importance of the completion of each and every chart. It goes without saying that each record pertains to a single individual—and a poor chart would jeopardize his future welfare—but for statistical purposes, let us use as an example:

One chart out of 50 discharges a day is laid aside, because the data are glaringly missing. The 2% it represents is relatively small when the csaes are used collectively—but should that one chart represent the only case of a certain doctor—the Medical Audit would report his work 100% poor. Consequently, no chart should be allowed to be filed until processing has proved it to be an acceptable chart.

Various phases have been used to describe the medical record department: The nucleus of the hospital; the orbit around which the hospital revolves; the conscience of the hospital.

Evaluation of record usefulness. A record must be capable of serving the hospital before it can serve the patient, doctor, community and research. Therefore, the appraisal values to follow have been limited to those phases and activities within the hospital which utilize this document as the basis on which they originate and function.

General hospital statistics. Report of averages and percentages of those items listed as the "danger signals": 1) more than 12% normal tissue removed in surgery; 2) more than 4% or 5% caesarean sections; 3) high death rate; 4) more than ¼ of 1% maternal death rate for obstetrical patients; 5) more than 2% infant mortality; 6) high rate of disagreement between pre-operative and post-operative diagnosis; 7) more than 1% post-operative infections; 8) low percentage of consultations (below 15% or 20%); 9) more than 1% post-operative death rate for surgical patients, and 10) post-anesthesia complications.

Service analysis. Indicating the number of patients according to each specialty service—showing the consultations, complications, infections, deaths and autopsies in each category.

Report of each doctor's work. Should reveal more than just the number of patients and types of cases—if the following committees are functioning properly:

Medical record committee. It is one of the four basic standing committees of the medical staff, working directly and constantly with the other three re-

porting irregularities and interesting results of its surveys, furnishing program material and serving as a bridge between the medical record librarian and the attending staff. This committee is as old as the medical record itself. As the name implies, without the medical record, there would be no need for this important committee.

Medical audit. This committee's sole purpose is to analyze each record to evaluate the professional work (keeping a score card for each doctor on the staff), in order to improve the quality of the care and treatment of the patient.

Tissue committee. The most valuable research project in the field of surgery, within the hospital, is the tissue committee. It reevals and controls the unnecessary removal of normal organs and tissues.

Legal aspect. In case of a lawsuit the medical record may be the only source of information to prove or disprove a point, and a good, complete record may shorten the (otherwise long and tedious) court session. It may also eliminate the worry and unnecessarily wasted valuable time of the busy hospital administrator, doctor or nurse in testifying. *It is to be kept in mind that each and every medical record is a potential court case.*

Medical research. Federal, state and local governmental agencies as well as private parties depend a great deal upon the medical case history as an aid in proving or ruling out their theories. The U.S. Public Health Service uses the data for committee planning to meet its health needs; the Vital Statistic Department places upon the hospital the responsibility of recording a birth and completing a death certificate.

Numerous screening processes or sample reports (perhaps only tabulated once, if the results are satisfactory) are compiled from the record, for instance, to determine whether or not smog is a health problem. The demands for this research material are so apparent that further elucidation is unnecessary.

Teaching hospital. The medical record becomes a part of the student nurse, intern and resident training programs— as well as background material for the physicians' contributions to medical literature.

Major disaster. The governing bodies, radio and press demand a quick but accurate account of the casualty victims, the extent of their injuries, treatment received and disposition. The medical record librarian's training has particularly qualified her to give this service.

Hospital inspection. Quoting an unknown author — "Adequate clinical records are so much a part of good medicine that they are the keystone of the standards for approval of the hospital." From the medical record librarian's observation: the inspector from the hospital approval organizations, in rating the hospital, both for teaching and non-teaching institutions, will come into the medical record departmental set-up. He will examine her methods of arriving at the "danger signal" statistics— then, by checking a selected assortment of medical records, he will:

1) Determine if any of the statistics are false; 2) check the quality of the work of the attending medical staff; 3) check the quality of the work of the special diagnostic departments.

To assist him in determining the scientific spirit of the hospital, he will ask to see the minutes of the monthly meetings of the attending staff and the clinical-pathological conferences, to be assured case record material is used in the discussions.

In any *audit* of the *professional work* of a hospital, major stress is placed upon the quality of the medical record. This is true not only because the medical record is concrete evidence which can be accurately judged, but also because the medical record is one of the best known methods for the crystalization of the thoughts and judgments of the physician.

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

August 9, 1962

Washington News Letters

New Drug Testing.

Evidence that thalidomide sleeping pills taken during pregnancy has resulted in births of deformed children in Germany and England, and that the pills have been under new drug clinical testing in the United States since 1959, lead HEW Secretary Anthony J. Celebrezze to anounce today the issuance of proposed regulations strengthening control over testing of new drugs.

Although the proposed regulations would not require advance Government approval of the preclinical investigation, the qualifications of the investigators, or the plan of the clinical investigation, they do require: that the Food and Drug Administration be put on notice and given the full details about the distribution of drugs for investigational use; that clinical investigations be based on adequate preclinical studies to assure safety; that the clinical investigations themselves be properly planned, executed by qualified investigators, and that the Food and Drug Administration be kept fully informed during the progress of the investigations.

Each investigator in the clinical trial would be required to supply the sponsor with a full statement of his education and experience, a description of the hospital, institutional, and laboratory facilities available to him, and an outline of the plan that he intends to follow. He must fully inform himself about all the preclinical investigations before giving the drug to any patient, maintain complete records of his disposition of the drug and case histories of the patients to whom it is administered, and furnish adequate reports to the sponsor promptly after the completion of the clinical trials. These records must be open to inspection by the Food and Drug Administration on request.

The proposed regulations, all of which are presumably authorized by existing law, will be open for comment by interested parties for 60 days, after which amendments may be adopted and an effective date set.

The Kefauver drug control bill, S. 1552, already on the Senate calendar, is expected to be tightened during floor debate, and similar legislation, H.R. 11581, is due for public hearings before the House Commerce Committee August 20-24.

Medical Education Aid.

H.R. 4999, the bill for construction aid for schools of medicine, osteopathy, etc., is stymied in the House Rules Committee. The Committee is waiting for House and Senate conferees to come to some agreement on the general college construction aid bill, H.R. 8900, which seems remote.

August 14, 1962

State Osteopathic Programs on Aging.

Donald P. Kent, Special Assistant for Aging, Department of Health, Education and Welfare, has written AOA that a new program of field services of his Special Staff on Aging will make it possible to give more information and assistance to voluntary organizations, including State and local osteopathic societies and special committees on aging. "In turn," said Mr. Kent, "we want very much to hear of your plans, your activities, and your problems, so that we may be better able to promote and encourage work for older people throughout the country." As a result, the AOA Council on Federal Health Programs, in cooperation with the AOA Committee on Health Care for the Aging, has been charged with assembling that information, with your help, and passing it on to HEW. Please send us dates and programs of meetings at which activities for older people will be discussed, and suggestions as to how HEW can help. Follow with any copies of proceedings or original articles.

Mental Health Regional Conferences.

The National Association for Mental Health will hold five Regional Leadership Conferences this Fall, and is inviting State osteopathic association presidents to attend and participate. Places and dates are: Boston, October 23-24; Tucson, October 29-30; Chicago, November 26-27; Miami, December 4-5; Dallas, December 11-12. Delegtaes from the AOA and the Auxiliary to the AOA attended the National Leadership Conference in Washington, D.C. last March, and we recommend that our State presidents or their delegates attend these regional conferences for their respective areas.

F.A.A.

Dr. James L. Goddard, FAA Civil Air Surgeon, will take up his duties as Chief, Communicable Disease Center, at Atlanta, in September, with the rank of Assitant Surgeon General. Dr. H. D. Estes, formerly Special Assitsant for Technical Staff, has been appointed FAA Acting Civil Air Surgeon. As of July 1, 1962 there were 162 DOs serving as Aviation Medical Examiners.

Medicare (ODMC).

As of July 30, Colonel Bryan C. T. Fenton succeeded Brigadier General W. D. Graham as Executive Director, Office for Dependents' Medical Care. According to the Fifth Annual Report of ODMC, 98 percent of Medicare users (spouses and children of active duty uniformed services personnel) continue to endorse the program and are well satisfied with the care they receive from civilian medical sources.

NEWS OF THE DISTRICTS

DISTRICT 3

Ellen, daughter of the Dr. and Mrs. Earl Kinzie is now studying in Germany as an exchange student. Ellen has been writing some interesting letters to "the folks" back home, telling of her introduction to the German folkways, and her attempts toward mastery of the gutteral German tongue.

The Kinzies, in exchange, are the American hosts to a pretty fraulien, named Gisela, who is attending Lindale High School.

From Ellen's letters' her "Onkle Fritz" und "Tante Gertrude" sound like the kind of folks it would be good to know.

Dr. Robert E. Slye, who has been associated with the Coats-Brown Hospital group for the past several months, and left in August to practice in Brownsboro. Dr. Slye emphasized x-ray interpretation while in Tyler. He is located in the modern, new clinic building which Dr. Charles Rahm vacated when he moved to Lubbock.

We welcome to District 3 Dr. William A. Wagner and family. Dr. Wagner practiced internal medicine in Grand Rapids before moving to Tyler to be asosciated with the Coats-Brown Hospital, September 1.

Dr. George Grainger, Tyler, had the lead article in the new JOURNAL of the AMERICAN COLLEGE OF NEUROPSYCHIATRISTS, which came out last month. A copy of the first issue was sent to every member of the national association. Has anybody read it? or better, has anybody tried? We will admit, it is hard going.

Born: to Dr. and Mrs. George Grainger, August 28, a grandson. Name: George Richard Grainger (alias "Rickey") Jr.

Dr. Burr Lacey, Quitman, was last month installed President of the Quitman Rotary Club, for 1962-1963. Congratulations Burr—a fine conscientious citizen.

* * *

DISTRICT 11

The district had its monthly meeting in conjunction with the auxiliary, on the 23rd of August, 1962, at Billy Crew's Steakhouse.

The educational program consisted of a film entitled "Neurological Examination & Diagnosis" produced by Smith, Kline, & French Laboratories of Philadelphia, Pennsylvania. This was a most interesting film in that it emphasized much of the basic anatomy and physical examination in diagnosing neurological diseases. Many of these basic elements such as function and inneration of the 12 cranial nerves, which we learned in basic science and are prone to forget once we start practice, were put into practical application. We heartily recommend this film to be shown in all the districts.

Our district was honored by the presence of the State Auxiliary President, Mrs. John Boyd from Louise, Texas. She was accompanied by her husband, Dr. John Boyd. They were house-guests of Dr. and Mrs. M. G. Holcomb. The auxiliary held a luncheon at the Gay 90's Club in honor of their State President.

Dr. R. C. Valdivia of this district recently returned from a 6-weeks tour and post-graduate study throughout Europe. He also stated that he wouldn't mind putting up with the socialized medicine if he could spend more time in Paris, Rome, Naples, and Madrid.

M. A. CALABRESE, D.O.
Reporter

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Vitaminerals announces with pride—and with full guaranty certification—NEW VM 41.

VM 41 is the first *CHEWABLE* C and Bioflavonoid product of its kind, containing fully labeled high potency amounts of the citrus Bioflavonoids. Each chewable 41 tablet contains 150 mg. of the citrus Bioflavonoid Complex and 150 mg. of Vitamin C. Thus, with the recommended daily supply of three tablets, your patient gets 450 mg. of each. This is the *first* time such a Complex is available in *chewable* form.

The taste is excellent. VM 41 offers a most pleasant flavor. The texture of the tablet is excellent. It literally melts in your mouth.

Since VM 41 is chewable (and requires no water for swallowing), dosage can be conveniently spaced. Optimum blood levels can be maintained at all times, since ease of administration permits prolonged blood levels of Vitamin C & Bioflavonoid.

New VM 41 chewables are the first complete potent Bioflavonoid and Vitamin C tablets for the patient "who can't swallow tablets," as well as for the youngster who really can't.

Bottles of 50 tablets $3.00
Bottles of 100 tablets $5.00

VITAMINERALS INC.
GLENDALE 1, CALIFORNIA

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