Texas Osteopathic Physicians Journal

Volume VI FORT WORTH, TEXAS, AUGUST, 1949 Number 4

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LOCATIONS AND REMOVALS

Dr. Donald E. Hackley, formerly of Dumas, is now located at Spearman, Texas.

Dr. H. W. Sanders, Sanders Clinic, Morton, Texas, is looking for someone to take over his practice for a three to six months period. If interested, please contact Dr. Sanders.

DR. ROBERT E. MORGAN, TRUSTEE, A. O. A.

Texas Osteopathic Physicians' Journal

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Volume VI FORT WORTH, TEXAS, AUGUST, 1949 NUMBER 4

Outstanding Honors Accorded Dr. Morgan

Dr. Robert E. Morgan, past President of The Texas Association of Osteopathic Physicians and Surgeons and a former Board Member of this Association, who has faithfully and loyally served the profession for many years in the House of Delegates of their National Association, was this year elected to the Board of Trustees of the American Osteopathic Association.

Dr. Morgan carried off many honors at the St. Louis Convention. He was elected President of the Supreme Council of the I. T. S. Fraternity, President of the Osteopathic War Veterans Association, and also appointed a Member of the Committee on Professional Liability Insurance and Chairman of the Committee on Code of Ethics Revision.

Those who have served with Dr. Morgan in official capacity know his loyalty to the Osteopathic profession and his untiring efforts in any assignment that has been given him. We feel sure that Dr. Morgan will make Texas an outstanding representative on the Board of Trustees of the American Osteopathic Association and will fulfill the obligations of his new duties without a quibble. We congratulate both the American Osteopathic Association and Dr. Morgan. We wish you well, Bob.

Board of Trustees Meets

The Board of Trustees of the Texas Association of Osteopathic Physicians and Surgeons held a called meeting in Fort Worth, July 31, 1949, at the Texas Hotel. It convened at 10:25 A.M. and adjourned at 6:30 P.M. The meeting was attended by the following: Dr. J. R. Alexander, Dr. Joe Love, Dr. George Luibel, Dr. Wiley Rountree, Dr. J. T. Hagan, Dr. Earle Mann, Dr. Lige C. Edwards, Dr. Phil R. Russell, Dr. H. V. W. Broadbent, Dr. Merle Griffin, Dr. R. H. Peterson and Dr. Everett W. Wilson.

The meeting of the Board was for the express purpose of passing upon the contract between the Association and Dr. Phil R. Russell as Executive Secretary for the Association on a full time basis. The contract had been negotiated by President Edwards, the Committee consisting of Dr. Peterson, Dr. Roun-

tree and Dr. Brune with Mr. Zollie Steakley. The contract was unanimously accepted by the Board of Trustees.

The moving of the State Office to 1837 Hillcrest Street, Fort Worth, Texas and the induction into office of Dr. Russell on August 1st as Executive Secretary created quite an agenda dealing with the policies of the Association and many emergencies that had to be taken care of because of the entire change in the personnel of your office there.

Dr. Lige Edwards, your President, presided and Dr. Broadbent served as Executive Secretary, turning over the affairs of the office to Dr. Russell at the end of the meeting, thus winding up a successful administration as a part time Secretary for the Texas Association. Dr. Broadbent served the Association for a period of sixteen months as a part time Executive Secretary, working under a severe handicap, attempting to do a job on a part time basis for the Association that required not less than a full forty hours per week. In spite of the handicap the Association progressed and moved forward under his direction as Executive Secretary and the Association should be deeply grateful to him for the sacrifices he has made in this capacity.

Dr. Russell, as Chairman of the Public Health Committee, gave an extensive report to the Board of Trustees dealing with the Blue Cross Hospitalization Plan, the Basic Science Law and Board, the Medical Practice Act and the results of the last examination given by the Medical Board. Much discussion was given to each of these subjects.

The meeting was considered one of the most profitable Board meetings that has been held in the last year.

Openings for Osteopathic Physicians

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

Opening for Osteopathic Physician, Muleshoe, Texas. Population of town and surrounding territory approximately 12,000. For further information contact Mr. Joe Damron, Damron Drug Co., Muleshoe, Texas.

Hubbard, Texas is in need of an Osteopathic Physician. Dr. Fredeking is moving to join Dr. E. V. DeVinny in a new clinic. Hubbard has a trade territory of 5,000 people. Dr. Fredeking has had an extensive practice. Will help any man get started. Cooperation promised from the druggist. Office rent free. Hospital connections at Hillsboro, County Seat.

Osteopathic Physician needed, Itasca, Texas. Population about 2,000. Large industrial payroll, woolen mill. Only one elderly M. D. there. Real good location.

Opening in Glen Rose, Texas for Osteopathic Physician.

From S. H. Bailey, Bailey Pharmacy, Grand Saline, Texas:

"We are in need of a doctor here, preferably a D.O., as we have a D.O. who has been very successful and will stay and get the new man acquainted with the practice and turn over to him a very good general practice. Have just talked to Dr. Sam Sparks who will recommend this as a very good location . . . Office space available over drug store at very nominal figure and the building is all arranged for a doctor's office."

If you have information on openings, please contact Dr. D. D. Beyer, 1800 Vaughn Blvd., Fort Worth, Texas.

Diagnosis of Common Surgical Conditions of the Abdomen

EMMETT BINKERT, *D.O., F.A.C.O.S.*

The diagnosis of common surgical conditions of the abdomen entails the same essential steps as diagnosis of any body part or tract.

First, the history; then the physical examination; next, special diagnostic procedures; and last, the application of a trained mind to evaluate and correlate the findings.

Although modern scientific medicine places great emphasis on the special diagnostic procedures, roentgenology, laboratory tests, cystoscopy, proctoscopy, and gastroscopy, adequate and thorough history and physical examination remain the prime means of diagnosis. This is particularly true when diagnosis is sought within the limitations of the physical equipment of the general practitioner, and despite the unquestioned merits of institutional facilities.

The picture has been proposed of a general practitioner answering a call to some distant rural home. Accompanying him is a scientific team, roentgenologist, technacologist and pathologist, housed in a special trailer, fully equipped, with facilities for these specialties.

This is as idealistic as it is euphoristic.

Because this ideal is unfortunately not attainable, it remains the obligation of the general practitioner to make a diagnosis with the facilities within his means..

It is a matter of record that the diagnosis of the surgical abdomen made by careful history and physical examination alone is, in a majority of cases, verified and not contradicted by additional diagnostic procedures. This, therefore, suggests a brief review of the essential steps of hsitory taking and the physical examination.

THE HISTORY

Because an adequate history is many times the most important single diagnostic step in abdominal conditions, it should be made a matter of exacting detailed routine.

The relative value of a history is in direct proportion to the cooperation and the intelligence of the patient. The ability of the physician to secure detailed information by patient questioning, by overcoming language difficulties, or in the case of a child in securing information from a parent, for the moment overshadows his scientific training.

What is the chief complaint, or presenting symptom? This is the patient's own interpretation of the outstanding symptom.

Describe the onset and course of the present illness. Again, this is the patient's story and in the telling of it may lie an outstanding diagnostic point.

The personal history elicits the age sex, race and marital status of the patient.

Past History discloses past illnesses and operations. The family history gives clue to diseases inherited or transmitted in family strains.

The inventory of systems completes the history. This last division can often be the most informative, for it is here that the patient may tell of minor or sub-chronic conditions not classified by him as illnesses. Regarding the abdomen, specific questions, such as the following should be asked. Eating habits, appetite, belching, regurgitation, flatus, acid burning, foods that disagree, nausea, bad taste, bad breath, fulness, constipation, jaundice, itching, backache, vertigo.

The Physical Examination

Although the examination of the abdomen does not give the exact findings and results obtained in other parts of the body, and is superseded in importance by the history, it does maintain an essential place in diagnosis.

Examination is divided into four phases:

1. Inspection
2. Palpation
3. Percussion
4. Auscultation

The abdominal examination is best conducted with the patient lying on his back, on a firm surface that can be approached from either side. Illumination should be across the abdomen, rather than overhead.

For convenience the surface of the abdomen is divided into segments. There are several standard methods of division. I prefer and use the divisions of, epigastrium, umbilical and suprapubic, upper right and left, and lower right and left.

Inspection reveals the general contour of the abdomen, and any local masses or swellings. The color and the condition of the skin are noted. Movement of the abdomen due to respiration, peristalsis of foetal life is observed. Abnormalities of the umbilicus and evidence of distended veins are noted.

Palpation is perhaps the most important phase of the physical examination. Experience alone can bring to the examiner a proper tactile sense. In general, several rules are to be followed:

1. Palpate with the cushions of the fingers, not with the tips.

2. Palpate gently and always begin palpation over the least suspected quadrant of the abdomen.

3. Do not palpate with a cold hand.

Palpation reveals areas of local tenderness and peresthesia whether superficial, deep or rebound. It determines muscle spasm and reveals masses of defects. Peristaltic movement may be felt though it may not be observed. Skin temperature and evidence of dehydration may be evaluated.

Percussion determines areas of generalized or localized gaseous distention. The presence of free fluid may be detected. Areas of abnormal dullness or decrease in areas of normal dullness are determined.

Auscultation reveals the normal sounds of peristalsis, or changes from normal, or their absence. Succussion sounds, vascular sounds, the feotal heart or uterine souffle may be heard.

Special Procedures

Only those facilities common to the general practitioner will be mentioned. Evaluation of the vast array of special procedures available to the institutional clinitian is beyond the scope and time of this paper. Properly used, they are invaluable in solving complex diagnostic problems, but only after full attention has been given to diagnosis by history and physical examination.

The blood count includes as indicated R.B.C., W.B.C., Hbg. and the Differential count, with the Schilling hemogram.

The Urine Analysis both routine chemical and microscopic.

Bedside tests for occult blood in feces and urine are accurate and practical.

Of common surgical conditions of the abdomen, I have selected the following for consideration of diagnosis.

1. Appendicitis—both acute and chronic
2. Intestinal obstruction, including intususseption
3. Perforating peptic ulcer

Acute Appendicitis

Acute appendicitis occurs with equal frequency in the sexes. It is most commonly a disease of early life, however, no person regardless of age is exempt from this disease. In some families there appears to be a familiar predisposition to acute appendicitis. The incidence of this disease does not appear to be affected by diet or race, pregnancy, acute infections or by ingestion or for-

eign bodies such as cherry pits or berry seeds.

The etiology remains disputed. Some hold that infection, that is actual invasion of the sub-mucosa by organisms is the prime etiological factor. Others believe that it is primarily due to obstruction produced by fecalith.

The diagnosis of the typical case of cute appendicitis is not difficult. The difficulty lies in the low incidence of typical cases, and the atypical case may require great diagnostic acumen.

Typically, the attack begins with epigastric or mid abdominal pain. There may be a negative history as related to previous or chronic abdominal symptoms. The pain is intermittent or colicy in nature. Nausea or vomiting follow, and rarely precede the initial pain, although anorexia may be present for several hours.

Systematically fever is of mild degree, rarely going above 100, unless gangrene develops. The pulse is usually fast and full but under a rate of 100. As the pain localizes to the lower right quadrant, it tends to become more constant and varies from dull to severe. If the pain remains colicy it may warn of complete obstruction and early perforation.

Because of the ability of acute appendicitis to mimic any acute abdominal condition, thorough questioning concerning all abdominal organs must be made. In the retro-coecal appendix the pain may be entirely in the right flank and kidney region. Irritation of the psoas muscle may give rise to pain on the anterior inner thigh. Lying on the ureter the appendix may cause pain to radiate into the bladder, the labia or the scrotum, and produce dysuria and frequent desire of urination. If the inflamed appendix is in contact with the sigmoid or rectum, it can give rise to painful defecation and backache. If relatively high under the liver with a short coecum it may simulate acute cholelethiasis, perforated ulcer or acute pancreatitis. Finally, the appendix may be left sided or may lie in the sac of an umbilical, an inguinal or a femoral hernia.

The physical examination shows tenderness on palpation localizing over McBurney's point, with muscle guarding or splinting. When there is irritation of the parietal peritoneum, rebound tenderness is elicited.

Again, however, the appendix may not be in normal position and the area of maximum tenderness may shift grossly from McBurney's point.

Rectal examination should always be made because in 50% of cases tenderness is elicited high in the right pelvic vault. Rectal examination is of particular value in children because of the shallow pelvis.

Simple laboratory procedures are benficial. In acute appendicitis the white count is usually 12 to 14 thousand. Above 14,000 suspect perforation and peritonitis, above 20,000 look for pneumonia or pyelitis. The differential count shows an increase in neutrophyls and the Schilling hemogram is an accurate check on advancement of the case. Routine urine examination should be performed.

The main conditions requiring differential diagnosis from acute appendicitis are:

1. Pyelitis of the right kidney. This disease is not uncommon in children and gives rise to the same syndrome of symptoms, namely abdominal pain, nausea and leukocytosis. However, the pain is usually greatest at the costo-vertebral margin, the white count and temperature are higher and there is little localization of pain or indication of peritoneal irritation. Microscopic urine analysis completes the differentiation.

2. Ruptured ectopic pregnancy elicits alteration in the menstrual cycle, and has a more abrupt onset with shock and internal hemorrhage. Pelvic examination reveals a boggy mass in the cul-de-sac. However, a partial rupture may demand repeated differential study.

3. Rupture of a graafian follicle usually occuring in the mid menstrual cycle and is differentiated by the absence of symptoms of constitutional infection.

4. Acute salpingitis may give all the symptoms of acute appendicitis. However, careful study will usually show that nausea and vomiting are less, fever and leukocytosis are greater, and localization is often duplicated to a degree on the left side. The history usually reveals symptoms of dysuria and an increasing vaginal discharge. Pelvic examination reveals a warm moist vaginal dome and diffuse inflammatory reaction in the adenexia.

5. Ruptured peptic ulcer presents the following differential picture. It occurs in males 25 to 1, usually between 30 and 50 years of age, and there is an associated ulcer history. Pain is constant, often unbearable, and marked prostration is present. The early temperature is sub-normal, the pulse thready. Rigidity is boardlike and movement of the diaphram is restricted.

6. Acute cholecystitis may prove very difficult to differentiate from the acute appendicitis with a high lying coecum. Differential points are: cholecystitis occurs more frequently in the female; usually past forty years of age; there is often a history of chronic upper abdominal distress; mild degree of jaundice may be noted; often a globular mass may be palpated in the right epigastrium; a positive Murphy's sign may be elicited; the pain radiates to the right scapula. Special examination such as X-ray and serum bilirubin tests may be required to differentiate.

7. Diabetic acidosis may present a picture of acute appendicitis, with nausea vomiting, pain and leukocytosis. The fruity odor of the breath, history of diabetes, and the finding of a high level of sugar in the urine are differential points.

8. Pulmonary disease, especially in children may present striking acute abdominal symptoms. Usually the patient is much too sick for appendicitis, the fever too high and the leukocyte count reaches 20,000 plus, too early in the course of the illness.

Chronic Appendicitis

This disease, if it may be called a disease, is without question, a common surgical condition of the abdomen.

Diagnosis of chronic appendicitis in its broadest application may be briefly stated. Any ill defined pain in the abdomen or any vague abdominal distress, accompanied by tenderness or palpation in the lower right quadrant may be said to be chronic appendicitis. However, can a differential diagnosis be made, ruling out such conditions as: low grade salpingitis; malpositions of the uterus or degrees of prolapse; ovarian disfunction; peptic ulcer, duodenitis, parietal and visceral neuralgias associated with degrees of scoliosis and rotation lesions; intestinal parasites; Pott's disease of the spine and psoas abscess; congenital bands and membranes about the terminal ilium, the coecum and ascending colon; intra-peritoneal adhesions; low grade lesions of the biliary and urinary tract; and the low grade chronic conditions of the small and large bowel.

It is only, when painstaking history, thorough and repeated physical examination, and exhaustive differential elimination has been conducted, utilizing special examination procedures to the minutest detail that a diagnosis of chronic appendicitis may be made.

Even then the surgeon should be prepared to deal with any eventuality at surgery.

Intestinal Obstruction

In considering the diagnosis of intestinal obstruction, the division of intussuseption will be studied separately, and does not appear in the following statistics given under this heading.

Over 75% of cases of intestinal obstruction have either an external hernia or an abdominal scar, as an etiologic factor. Nearly 50% have an external hernia; umbilical, incisional, inguinal or femoral. Over 25% have an abdom-

inal scar with adhesions from previous surgery. Therefore, less than 25% of intestinal obstruction occurs from such causes as carcinoma, volvulus, gallstones or mesentenic thrombosis.

The most important consideration in intestinal obstruction is early diagnosis. It, therefore, becomes a major bedside problem.

The cardinal symptoms of intestinal obstruction are pain, vomiting and obstipation.

The pain begins as a colicy pain, due to increased peristalsis and distention of the bowel. In general, obstruction in the small bowel tends to center pain in the epigastrium or umbilical region; if in the large bowel, below the umbilicus. With each wave of peristalsis the cramp like pain appears in increasing intensity, then a period of freedom occurs until the next peristaltic wave. Later as distention increases and especially if strangulation occurs, the pain becomes more constant.

The appearance of vomiting is in direct relation to the location of the obstruction. If the lesion is high in the small bowel, vomiting occurs early and is profuse. If in the colon, vomiting occurs late in the picture, and occasionally not at all. The lesion of the low small bowel characteristically produces fecal vomiting, a term that is incorrectly used. The vomitus is not fecal but because it comes from the distal loops of the jejunum and ilium and contains numerous colon baccili, it has a foul and fecal odor.

Obstipation is always present in intestinal obstruction but it should be properly evaluated. An early enema may produce a copius stool, or peristalsis may produce an evacuation. However, when the bowel below the lesion has emptied, obstipation results.

Early in the course of obstruction the patient may not appear seriously ill. But as dehydration progresses, the patient begins to evidence prostration, with rapid toxic pulse. Distention as a rule varies with the location of the lesion. If high the vomiting may keep the bowel empty, whereas lesions of the colon usually show progressive distention.

It is rarely possible to elicit visual peristalsis, but here auscultation is of great diagnostic importance.

The ability to hear increased peristalsis or borborygmus is a constant early positive sign of obstruction. Borborygmus has been described as a sound resembling water bubbling from an inverted bottle, accompanied by sharp tinkling metallic sounds. These sounds are broken by periods of quiet. In obstruction, the crampy pain always occurs at the time of the active peristaltic wave.

Uncomplicated obstruction without strangulation may show no particular signs on palpation other than slight general distention. Tenderness and muscle guarding may be considered evidence of strangulation.

Strangulation is the most feared complication of obstruction. If it occurs early, all the symptoms are exaggerated. The pain tends to become more constant, distention occurs more rapidly and abdominal tenderness is present.

No constant laboratory findings are noted in early obstruction. An increase in leukocytes, of course, creates a suspicion of strangulation. Later changes in blood chlorides, N.P.N. and CO^2 combining power give an accurate index of the degree of dehydration and plasma loss.

The use of the X-ray as an additional means of diagnosis in intestinal obstruction has become a routine institutional measure.

Breifly stated survey films often make it possible to:

1. Determine if an obstruction is present.
2. Give the approximate location of the obstruction.
3. Define whether the obstruction is mechanical or due to inhibition ilius.
4. Determine whether strangulation or perforation has occurred.

5 Define the nature of the obstruction lesion.

Intestinal obstruction should be differentiated from:

1. Simple enterocolitis. Here diarrhea is usually present, and distention is not usually a progressive sign.

2. Perforated peptic ulcer. This condition shows an abrupt onset, the pain is constant and severe, early prostration is noted distention appears only after peritonitis sets in, and increased peristalsis is not noted.

3. Acute pancreatitis. The onset is abrupt, the pain severe and constant, there is prostration and rigidity, and peristalsis is normal or inhibited.

4. Torsion of an ovarian cyst may simulate the pain of obstruction, and vomiting and evidence of peritoneal irritation may be present. Here the findings of the cyst mass, and the absence of increased peristalsis are the differential factors.

Intussusception

This form of obstruction is considered separately because its incidence and etiology vary greatly from other forms of intestinal obstruction.

Intussusception is the prolapse of one part of the intestine into the lumen of an immediately adjacent part.

Although intussusception can occur at any age, it is primarily a disease of infancy. The peak of incidence is between 3 and 11 months of age. A slightly greater percentage of boys are affected than girls, and it most commonly develops in the plump, healthy baby.

No exact cause has been ascribed to intussusception. In a small percentage of cases diverticula, polyps and preceding enterocolitis are etiological factors.

It may occur in any portion of the bowel but is most commonly found at the iliocoecal junction.

Recurrent colicy pain is the outstanding sympton. There is associated vomiting and in 85% of cases bloody stool.

Between the bouts of cramp pain, the child may appear to be entirely normal and a false security should be guarded against. Early diagnosis is imperative.

The outstanding physical finding is the presence of an abdominal mass. This is a constant finding in some 90% of cases but it requires patient, careful, and decilate palpation. The mass is often described as sausage shaped but it may be irregularly defined.

Rectal examination may assist in making a diagnosis.

To summarize: Recurrent colicy, crampy pain in an infant, with vomiting and bloody stools, and the presence of an abdominal mass immediately suggests intussusception.

Differentiation from simple acute enterocolites and from acute appendicitis is rarely difficult.

Perforating Peptic Ulcer

Perforation is the most serious complication of the chronic ulcer. It is not uncommon although the incidence among ulcer patients under active medical treatment is low.

Perforation is 25 times as common in the male as in the female. It is comparatively rare before the age of 25 and after the age of fifty.

Most free perforations occur in the anterior wall of the stomach near the lesser curvature.

Unlike acute appendicitis which may mimic any acute abdominal condition the symptoms of acute perforation are classical in over two-thirds of the cases.

Only a small percentage of cases of perforation fail to give a history of previous stomach trouble. Previous pain of a gnawing or aching type, or exaggerated hunger or burning pain, usually in the midline, occuring anywhere from the zyphoid to the umbilicus, or dyseptic symptoms of occasional vomiting or regurgitation, gaseous indigestion and belching are usually elicited.

The onset is abrupt. The pain is suddenly there and it is of an intensity that is often unbearable. The location is in the midepigastrium and it is constant. If the spill from the stomach is great, the pain may be more widespread.

Usually within an hour or two from the onset, the pain has spread throughout the abdomen, often with greatest intensity in the lower right quadrant due to the gravitation of the caustic gastric contents down the right gutter.

Nausea and vomiting usually accompany the pain, but may be absent in a small percentage of cases.

Symptoms of shock are prominent. There is pallor and the skin is cold with clammy perspiration. Respirations are shallow and restricted because movement of the diaphram increases the pain. The temperature is subnormal and the pulse thready. The patient desires to remain in a fixed position, often with the knees drawn up and resists movement, because it increases his pain.

In many cases an apparent symptomatic improvement will occur within one to four hours. However, physical examination disproves this seeming improvement.

Physical examination reveals a board like rigidity of the upper abdomen, often extending throughout the entire abdomen. So severe is the peritoneal irritation, and so well guarded is the muscle splinting that palpation often does not elicit tenderness. Deep palpation may be required to elicit pain. Early this is in the epigastric region but after a few hours it may be found in the lower right quadrant.

Auscultation reveals the quiet abdomen of peritonitis. Absence of liver dulness is not a constant sign.

Leukocyte count shows a moderate increase of 10,000 to 15,000, with presence of toxic granules.

If X-ray is available, it will show free air in the peritoneal cavity in a large percentage of cases. Absence of this finding, however, does not rule out perforation.

Differential diagnosis must be made from acute appendicitis, acute pancreatitis and mensenteric thrombosis. The differential points between perforation and acute appendicitis have been discussed. Acute pancreatitis may be differentiated by study of the serum amylase and lipase, and in mesenteric thrombosis the differential points to consider are that the age incidence is usually later in life, the pain is less severe, and the muscle splinting is rarely boardlike and often absent.

A. O. A. Delegates Report

By Dr. Phil R. Russell

The 1949 Convention at St. Louis was truly a great meeting though the attendance was lower than expected.

The programs were well attended, each paper given emphasizing to a greater extent the osteopathic concept of health. The social functions and entertainment were exceedingly good and were well received. As a Trustee and a Delegate it is my desire to pass on to you the highlights of my observation of the action taken by the Officers and House of Delegates of your Association.

Last year a change in the Code of Ethics was made requiring all members in the use of their professional name to designate themselves either by their degree or the term "osteopathic" in their practice. It was noteworthy to see the reaction of the House this year to any change in the Code as adopted last year. One Doctor Philip Morris of California, representing the Pacific Medical Association, requested of the Board, and permission was granted, to appear before the House and state their organization's position in regard to this part of the Code of Ethics as changed last year. Dr. Morris received the utmost courtesy and attention, made his presentation in the matter of an hour, giving all his arguments and evidence as to why the change in the Code as adopted last year should be revised and the requirement of designation of profession deleted.

The unanimous rising vote in opposition to any change in this provision of the Code was indeed an impressive sight. Instead of a treat, he received truly a "treatment". I prophesy that this part of the Code of Ethics will never be changed and that each member will be required to identify his profession in the use of his professional name. This is a warning that those who do not heed will soon be out of the profession without professional insurance and the protection of organized Osteopathy.

Another significant change in the Code of Ethics was adopted this year allowing, under Divisional Societies' supervision with restrictions, paid educational radio programs.

One of the most striking meetings of the House of Delegates was the five hour executive session in which a program was adopted on National Health Insurance. This program was truly an effort to adopt a method by which all the people of the United States would receive proper health care, without domination from any school of Medicine or the Government, with free choice of licensed physicians assured the public. Each and every member should study thoroughly this policy as adopted and it will be printed in this Journal.

The Board of Trustees took cognizance of the need for more and more research on the osteopathic concept and, with the approval of the House, set up plans for an expanded program on this phase of education and appropriated more money than ever before appropriated for a research program.

The Bureau of Hospitals cracked down on our hospitals, removing several of our teaching and registered hospitals from the approved list. This should be regarded as a healthy move and proof that the Officers of the Organization and the Bureau of Hospitals will not tolerate any lowering of the standards of our hospitals, demanding that the staffs and the hospitals live up to the requirements set and the Code of Ethics as adopted by your Association. Warning to the Texas Hospitals: Better read the requirements of approved hospitals and see that they are met or you will find yourselves without approval.

The Committee on College Inspection had an exceedingly good report. Our colleges are continually improving. This improvement has placed us second to none in professional education, yet there is always room for advancement and the Committee on College Inspection has indicated that each and every college must meet equal educational standards or suffer the penalty of becoming unapproved as teaching institutions for the profession. There is a strong determination on the part of every Officer and the Members of the House that osteopathic education cannot be tampered with.

Colleges, as usual, are suffering from lack of financial resources. Physical improvement is badly needed and it behooves the profession to make an all out effort to see that funds are secured for this purpose. You must realize that it costs the colleges $1250.00 a year to educate each individual student. The tuition received is $500.00. If we are to better the physical facilities of the colleges we must double our donations to the Progress Fund for we cannot afford to sacrifice teaching facilities for physical plants.

Recognized post-graduate courses were given due consideration and have been elevated in their standards. The members of the profession will be able to get the character of post-graduate training necessary for them to qualify under our Certification Program which has reached a high level. The Department of Public Relations submitted a most gratifying report. We are gradually overcoming the prejudices in our National Government that have been built up over a period of years by the dominant school of Medicine in its efforts to destroy any system of practice that does not coincide with its theory.

More and more Federal recognition has been received during the past few years.

P&PW showed a very marked improvement in its activities; in fact, the progress from this Department has been astounding each year. The proof of this is the increased understanding of Osteopathic education and the concept of Osteopathy by the magazines, newspapers, radio and the public at large.

The Budget adopted by the American Osteopathic Association this year exceeded by far that of any other year, totalling approximately $670,000.00, which means progress for your profession.

As usual Texas was well represented at the Convention by a high percentage according to the osteopathic population of the States. Texas is to be congratulated that it again has a Trustee in the National Association, Dr. Robert Morgan of Dallas, Texas being my successor. We feel sure that Dr. Morgan will carry on for Texas in national affairs.

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By ROBERT E. MORGAN, D. O.

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The 53rd Annual Convention of the American Osteopathic Association is now history and sincere thanks should be given to all of those who helped to make this one of our greatest meetings. Many things of great importance came before the House of Delegates.

The House of Delegates held their first meeting Sunday, July 10th starting with registration at 12 noon. They concluded their meeting on Friday at 11 a.m. just before the installation of the new officers. The agenda was set out for 30 hours work but due to the many important decisions to be made it was necessary to extend their meetings overtime on several occasions.

One of the matters under discussion which called for an executive session of the House of Delegates was the American Osteopathic Association attitude toward Health Insurance Plans. The House of Delegates passed a resolution and I quote part of that resolution. "The American Osteopathic Association through its House of Delegates assembled approves the principal of contributory health insurance under governmental supervision with services available to all the people on a prepayment basis and restates that it will continue to cooperate and consult with all groups or agencies toward the end of determining the essential needs of such plans." The complete resolution with the premilinary statement and Fundamental Requirements will no doubt be published in our Journal.

The House after much debate appropriated about $40,000.00 to be used in an expanded research program. This work wil be carried on in California in the laboratory of Dr. Burns and will call for additional help and equipment and I personally feel this is one of the greatest advancements that we have made and will do much to enable us to prove our theories of osteopathic principles scientifically.

The House of Delegates approved the hospitals presented by the Bureau of Hospitals as meeting the requirements. The importance of the hospital standards was discussed because if the hospitals do not meet the requirements in standard it will be impossible for our graduates to obtain the needed internships.

There were many fine reports from various committees which will be printed in the Journal and we feel that it is important that each and every member of the profession should read these reports and familiarize themselves with what the Association is doing.

Dr. Phil Russell retired from the Board of Trustees of the A.O.A. this year and with this retirement went the praise of the Association in general when they spontaneously arose at the banquet in his honor when he was introduced. The Board of Trustees and the House of Delegates adopted the following resolution:

RESOLUTION

WHEREAS the term of office as a member of the Board of Trustees of the American Osteopathic Association of Dr. Phil R. Russell does expire with this 1949 annual convention; and

WHEREAS information has been presented to the members of the Board of Trustees that Dr. Russell has accepted the responsible position of Executive Secretary of the Texas Association of Osteopathic Physicians and Surgeons; and

WHEREAS Dr. Russell has expressed his desire that his name be not presented for nomination for election to further office in the American Osteopathic Association; therefore

BE IT RESOLVED that the Board of Trustees of the American Osteopathic Association express its sentiments to Dr. Russell, and that these sentiments are:

THAT it recognizes the many years of loyal unstinted service rendered by Dr. Russell to his profession and its organizations; and

THAT this long service has been of consistent high calibre, far above the ability given most men; and

THAT devotion to the profession and to the osteopathic concept, arising from a great and faithful heart has been the foundation for the stamina, courage and determination which characterized all of Dr. Russell's endeavors; and

THAT he has guided each member of this Board with an affectionate wisdom and inherent kindness; and

THAT through these qualities he has earned the love of those who have worked with him to a degree given only to a few; and

THAT much of the growth, development, and progress of the American Osteopathic Association, as exemplified by the building of the Central Office Home, has been due to his efforts; and

THAT each member of the Board of Trustees, enriched by his inspiration and friendship, joins in saying: "Phil, we're proud to know you"; and that

IT BE FURTHER RESOLVED that this resolution be spread on the minutes of the Board, and that a copy be properly transcribed and presented to Dr. Phil R. Russell.

I appreciate again having had the opportunity of representing Texas in the House of Delegates and I assure you it was a pleasure to serve you.

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By LIGE C. EDWARDS

Twelve P.M. July 10th marked the beginning, with registration and presentation of credentials, of approximately thirty-two hours of reports, discussion, debate, argument and finally considered decision on a voluminous agenda for a Metropolitan House of Delegates. Registrations were as routine as Southern Fried Chicken in Mississippi with delegates ranging from New Zealand, Alabama, Quebec, Britain. Most conspicuous was the interest in organizational working of A.O.A. on National lend as evidenced by approximately thirty-six freshman delegates to the House of recent graduates of A.O.A. recognized colleges. Longest tenure of a delegate ranged from about twenty-six years down to two years.

Most striking in recognition was the streamlining of the Manual of Procedure and the completely explainable wording of reports in the agenda. The original manual in 1930 of seventy-five pages had pyramided to two hundred and thirty pages, supervised by Miss Dorcas Sternberg.

Membership, June, 1949, was 7,710 with 3,555 non-members with a total of 11,265. In 1949, 171 graduates would become eligible for A.O.A. affiliation, with 370 graduates completing their work in 1950.

Most outstanding event of the year as frequent discussions arose in the House of Delegates was unanimously, the moving of A.O.A. Central office into their permanent home with a foothold in Democracy and the United States. Completion and dedication of this office was a milestone in the life of Texas' Dr. Phil Russell, who dreamed this building and has served as a permanent Chairman of the Building Committee. In addition to healthy, efficient office space for good working conditions, the new office will effect a financial saving in that the Trustees and official family can meet here in lieu of expensive suites in hotels in Chicago.

Reports showed 357 Osteopathic hospitals housing 8,089 beds. Of these hospitals 103 are on the registered and approved list. Sixty-three are approved by the committee for intern training with facilities for 313 internships.

Doctor, your National future as an association is in safe hands in your National officers, trustees and functioning committees. They are continually striving to operate an organization efficiently, promulgate and perpetuate the Osteopathic concept, and secure deserved recognition for the title D.O. in obscure and isolated communities throughout the length and breadth of this land. These three incentives occupy the minds of your National officers twenty-four hours daily.

As the adjournment time drew near, each delegate fully realized the important position in the realm of Medicine and Science that Dr. Still's concept and philosophy had developed into as a result of patient's confidence and clinical results through the years. In a public health manner and legislatively, we were united in our future to perpetuate a man's concept through clinical results.

American Osteopathic Association Attitude Toward Health Insurance Plans

Adopted by the House of Delegates July 14, 1949, St. Louis, Missouri

PRELIMINARY STATEMENT

Purchasable access to adequate health and medical services for the prevention of illness, the care and relief of sickness, and the promotion of a high level of physical, mental and social health should be available to every individual regardless of his economic status.

Despite community aid, it is recognized by most physicians regardless of school of practice, that at present adequate medical service for most individuals has been available only to those who can buy it and to the extent that they can pay for it. The principal causes for this lack of available services are scarcity and maldistribution of medically-trained personnel and the cost of modern medical care.

Contributory to the scarcity of medical care personnel is the rapid rise in the cost of medical education and the resulting inadequate increase in the number of practicing physicians. The maldistribution of medical personnel is accentuated by the diminished economic status existing in areas of low income level and the lack of adequate facilities in such areas.

During the past fifteen years the payment of medical care by means of personal contract between the patient on one hand (or someone for him), and the physician, nurse, hospital or laboratory on the other has been gradually shifting in two divergent directions, — one in which the government itself is paying out of general taxes for all or part of needed medical services (ex-President Hoover in his report estimates this at 24,000,000 individuals) and the other in which individuals themselves have been trying to cover the cost of the similar services by means of prepaid insurance in so-called voluntary non-profit plans. (Only about 6,000,000 individuals have a complete coverage in this manner.)

Neither of these methods has solved the problem. The government method has already created too much state medicine and the voluntary insurance method is finding itself unable, without government subsidies, to provide in most instances even limited health services to those individuals who need it most. Either method eventually will cause an endless drain on general tax resources of the country. In addition, as presently organized, voluntary non-profit plans have been turned into devices whereby one school of medicine seeks to nullify existing state medical practice rights and creates for itself a monopoly in the supplying of all medical services.

RESOLUTION

The American Osteopathic Association, through its House of Delegates as-

sembled, approves the principle of contributory health insurance under governmental supervision with services available to all the people on a prepayment basis, and restates that it will continue to cooperate and consult with all groups or agencies towards the end of determining the essential needs of such plans. Since such an extensive departure from the present economics of distribution of medical care will involve wide latitude in statutory enactment and can result in discrimination against existing patient-doctor relationship, the following fundamental prerequisites are offered by the osteopathic profession as being essential requirements for any plan whether it be voluntary or compulsory:

FUNDAMENTAL REQUIREMENTS

1. In order to spread the insurance costs and risks equitably among the citizenry, the over-all plan should be nationwide in scope with general administration for separate plans no lower than at state level.

2. Freedom of choice of licensed physician shall be accorded to every individual both by specific declaration in statutory law and by edicts of every administrative and regulatory body set up to administer plans at every level of government. Nothing in the plans shall act to disturb the existing confidential relationship between the patient and his physician.

3. Freedom to change physician or to refuse care shall be accorded every patient. Freedom to accept or to reject any patient shall be accorded every physician.

4. Participation in medical services shall be open to all licensed physicians without discrimination against the exponents of any school of medicine or against existing state medical practice rights.

5. The financial support provided to pay for the services shall be computed, among other factors, on the basis of present-day costs of training of medical-care personnel as well as for necessary financial support to supplement the available resources of institutions training medical-care personnel and undertaking research.

6. Basic administrative policy shall be determined at all times only after consultation with an advisory committee composed of recipients of the service and of representatives from each participating profession.

7. Problems dealing with type and frequency of service necessary to the care of patients shall be decided by committees from each participating profession.

8. Funds should also be provided in the over-all plan for the construction of necessary additional hospitals and health centers wherever there is a deficiency, but the use of such facilities shall not be a prerequisite to the eligibility to receive medical service itself.

BASIC SCIENCE BOARD

The following men were appointed by Governor Shivers to constitute the first Basic Science Board of Examiners:

Dr. Henry B. Hardt, *Chairman, Texas Christian University,* Fort Worth, Texas.

Dr. Asa C. Chandler, *Rice Institute,* Houston, Texas

Dr. W. Mayne Longnecker, *Southern Methodist University,* Dallas, Texas

Brother Raphael Wilson, *Secretary, St. Edwards University,* Austin, Texas.

Dr. Ophelia C. Wesley, *Daniel Baker College,* Brownwood, Texas

Dr. Cornelia M. Smith, *Baylor University,* Waco, Texas.

These men and women have our congratulations along with our sympathy, for I am sure they are in about the same state of confusion over this Basic Science Law as the public, the Medical Profession, the Medical Board and those graduates of Medical School seeking a license to practice one of the healing arts in the State of Texas.

The Basic Science Law is truly a monstrosity in its composition, full of unconstitutional features and failing in many ways to meet the requirements of a well rounded law or fulfill the purpose for which it was created — providing an educational screen for those seeking the right to practice the healing arts.

The members of this new Board find themselves in the ridiculous position of receiving funds from the applicant to cover the Board's expenses and salary yet the Law provides no method by which they can receive their expenses or pay for their services, thus necessitating the Members of the Board standing their expenses until a correction can be made.

The Medical Board finds itself in the position of having complied with a State Law by holding its usual scheduled examination in June and then receiving an opinion from the Attorney General to the effect that it cannot issue licenses to these prospective physicians until the examinees have a Basic Science Certificate. When the examinee will receive this Certificate and then his License, no one knows. This means that some 400 physicians, over 200 who took the examination and approximately 200 whose applications for reciprocity were before the Medical Board prior to the passing of the Basic Science Law, are being delayed in rendering professional service to a public that is badly in need of more qualified physicians.

The Osteopathic Profession should be proud of its stand before the Legislature when it opposed this Bill because it failed to comply with at least the minimum of a truly Basic Science Law which would give the public some assurance of the screening power for which purpose it is supposed to serve.

The organizational meeting of the Board of Basic Science Examiners was held in Fort Worth Saturday, July 30. The next meetings is scheduled for late in September and the first examination will be held in October. It is to be hoped that the Members of the Board at these meetings will be able by their wisdom to clear up many of the perplexing problems facing them so that Licenses may again be issued to qualified physicians.

Classified Ad

AUXILIARY NEWS

As reported by MRS. L. C. EDWARDS *President,* Auxiliary Texas Osteopathic Physicians and Surgeons, and MRS. ROBERT E. MORGAN, *Member,* National Executive Board

The Fifty-Third Annual Convention of the American Osteopathic Physicians and Surgeons and the Ninth Annual Convention of the Auxiliary to the American Osteopathic Physicians and Surgeons was held July 11-14, headquarters Kiel Auditorium and Jefferson Hotel, St. Louis, Missouri.

The Convention opened with a tea honoring Mrs. Stephen M. Pugh, wife of the President of the A.O.A., and Mrs. Robert M. Homan, President A. A.O.A. followed by a reception and dance honoring the National President, Dr. Stephen M. Pugh. Tuesday, July 12th, before the afternoon session of the House of Delegates, two members from the cast of the Opera "The Chocolate Soldier" entertained. In the evening, Kathryn Turney Garten gave a book review, the proceeds from which were to benefit the A.A.O.A. Scholarship Fund. Wednesday, July 13th, the House of Delegates was entertained with a Radio Quiz Play, written by Mrs. D. D. Waitley, President A.A.O.A. Thursday, July 14th, the Installation Luncheon was held in the Crystal Room, Jefferson Hotel, with Anne Hayes, Director of Women's Activities, Radio Station KCMO Kansas City, Missouri, as Toastmistress, and Dr. George S. Benson, President Hardin College, Searcy, Arkanses, speaker. In the evening, a banquet, entertainment and dance were held at the Jefferson Hotel.

One of the most important sessions of the House of Delegates was the Revision of the Constitution, whereby the A.A.O.A. dues were raised to five dollars. The new revision stands as follows:

SECTION 1. Auxiliaries shall pay annual dues of

(a) five dollars per capita for all members who are of the immediate family of a practicing Osteopathic physician, wives of lay faculty members of Osteopathic colleges, and wives of laymen who hold official positions with divisional societies of the A.O.A. for active membership.

(b) twenty-five cents per lay member in organizations with a total lay membership of less than 20.

(c) a flat sum of five dollars in organizations with a total lay membership between 20 and 50.

(d) a flat sum of ten dollars in organizations with a total lay membership of more than 50

(e) ten cents per capita for organizations composed of students' wives

(f) lay members or students' wives may become associate members by payment of annual dues of one dollar, including a subscription to the official publication.

(g) wives of interns and resident physicians and wives of whose husbands are in first year practice shall be given active membership for the sum of one dollar.

SECTION 3. The official publication shall be sent to all members paying annual dues of five dollars or one dollar and to the officers of all affiliated organizations who would not otherwise receive it.

It is the intention of the A.A.O.A., with this raise in dues to hire a full-time secretary and to sponsor five National Osteopathic Scholarships. The amount of each Scholarship shall be

four hundred dollars. The purpose of these Scholarships is to bring outstanding young men and women into the Osteopathic profession, who need financial aid in completing their education, to increase public interest in the profession and to train more young doctors for the betterment of public health.

The new National A.A.O.A officers are as follows:

President ..... MRS. D. D. WAITLEY

President-Elect ..... MRS. T. H. LACEY

First Vice-Pres. .. MRS. J. G. WAGGENSELLER

Second Vice-President
MRS. M. A. BRANDON

Recording Secretary
MRS. R. C. ROGERS

Treasurer
MRS. HENRY WATCHPOCKET

New Directors
MRS. MORRIS P. BRILEY
MRS. SAM LEIBOV
MRS. HENRY MCDOUWELL

The Delegates from Texas were as follows: Mrs. George Luibel, Ft. Worth, Texas; Mrs. Robert E. Morgan, Dallas, Texas; Mrs. Lester Vick and Mrs. John H. Chandler, Amarillo, Texas; Mrs. Lewis N. Pittman, Borger, Texas, and Mrs. L. C. Edwards, *President Auxiliary Texas Osteopathic Physicians and Surgeons.*

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By MRS. ROBERT E. MORGAN

The Auxiliary to the American Osteopathic Association has grown from a small group of auxiliaries to a large organization of 31 State Auxiliaries, 115 District or Local Auxiliaries, making a total of 146 organizations with a total membership of 3,017. $22,454.78 passed thru our treasury this past year. We are still growing and this is as it should be for there is much to be done.

With such a large membership the need of a central headquarters was felt and arrangements were completed with the American Osteopathic Association for desk space in their spacious new office at 212 East Ohio Street, Chicago, Ill. A headquarters secretary was hired to carry on the work of the organization under the direction of the executive board.

In the Scholarship Fund we now have $7,631.28 so it is now possible to start in 1950 thru 1955 offering five National Osteopathic Scholarships for freshmen entering one of the accredited Osteopathic Colleges. The amount of each Scholarship shall be $400.00. In order to insure the success of this Fund $2.00 of our dues will go into this Scholarship Fund.

Our A.A.O.A. Record is indeed a magazine to be proud of and as everything is advancing in price so is the cost of publishing this magazine. The cost of printing and mailing the Record for the past year has been $2,455.97, this also from our dues.

These are the three main reasons for placing the dues for 1949-50 at $5.00 per member. Few National Organizations have accomplished anything like we attempt with dues this low. Please let's everyone get behind this organization and help them on to still greater heights. May I quote from the President's message (Mrs. Dorothy Homan):

"The theme of this convention is 'Widening Horizons'. I would like to leave this theme, and all it implies and embraces, with you. We have gone far in nine years but we still have far to go. At the close of this convention I sincerely hope that each of you will return home with new determination to keep your eyes on the far horizons and with new vistas before you, continually strive toward the ultimate in service. Let us put first things first and each do our part to keep the auxiliary wheel of activity continually turning."

NEWS OF THE DISTRICTS

DISTRICT NUMBER ONE

G. G. Porter, D.O., owner of the Porter Clinic-Hospital, Lubbock, Texas, and who has been away from his office since January, 1949, due to illness, is expected to return to Lubbock around August 15th, after going through Ochner Clinic, New Orleans, and being hospitalized in Foundation Hospital in New Orleans for several weeks.

The South Plains Chapter of the Panhandle Osteopathic Physicians and Surgeons Society will meet Friday night at Silverton, Texas.

G. G. Porter, D.O., owner of the Porter Clinic-Hospital, Lubbock, Texas, has announced another addition to his clinic and hospital. The staff has been enlarged, and additional rooms have been added to the hospital. The business office of the Porter Clinic-Hospital, advises that July, 1949, was the largest month in the history of the clinic and hospital.

H. W. Porter, brother of Dr. Porter, is now managing his hospital during the absence of Dr. Porter. H. W. Porter has wide experience in managing hospitals, but has never worked with Osteopaths. His experience has been with Alleopaths, but says he can see no difference in the practice, except that the Osteopaths he is working with are probably more thorough than some Alleopaths he has worked with.

The Porter Clinic-Hospital, Lubbock, has on its staff E. S. Davidson, D.O., Surgery and General Practice; L. J. Lauf, D.O., Obstetrics and General Practice; R. M. Mayer, D.O., Surgery and General Practice; W. D. Danks, Jr., D.O., Obstetrics and General Practice. Henry A. Spivey, D.O., does his surgery and hospitalization at the Porter Clinic-Hospital. There are twelve Osteopaths in the Lubbock area, each of whom uses Porter Clinic-Hospital, for their hospital cases.

The Porter Clinic-Hospital, Lubbock, has advised that a number of towns around Lubbock are needing doctors very badly, and that when doctors in good standing wish to use their hospital, arrangements are always made whereby their cases may be hospitalized in Porter Hospital. Any doctor wishing to make a change in location might get in touch with the Porter Clinic-Hospital, Lubock, Texas, for further information.

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DISTRICT NUMBER TWO

Mrs. A. V. Sharpe who made her home with her daughter, Mrs. Robert E. Morgan, was laid to rest July 30 in Restland Memorial Park, Dallas. She was an ardent follower of Osteopathy for over fifty-five years. In her early life she had what was then called a "floating cartilage" in her knee which the Allopaths failed entirely to help and which the Osteopathic Physicians corrected in one treatment. She was a patient of the late Dr. Covert of Neodesha, Kansas, in the early 1900's and of the late Dr. Gerardy in Dallas. Besides Mrs. Morgan she is survived by a son, A. V. Sharpe, Jr., of Highlands, Texas; a daughter, Mrs. Fred Hancock, of Dallas; four grandchildren and one great granddaughter.

Dr. Ross Carmichael and his bride, the former Mrs. Juanita Stell, are on a trip to Washington, D. C., following their marriage Saturday, July 30.

Three Dallas doctors received recognition at the Convention in St. Louis. Dr. Mary Lou Logan was elected First Vice President of the Axis Sorority, also

Vocational Guidance Chairman for O. W.N.A. Dr. Rollin E. Becker was elected President-Elect of the Osteopathic Cranial Association and also elected to the Board of Governors of the Academy of Applied Osteopathy. Dr. Robert E. Morgan was elected Trustee of the American Osteopathic Association, President of the Veterans Osteopathic Association and President of the Iota Tau Sigma Fraternity Supreme Council. Mrs. Morgan is Auxiliary Chairman for the Progress Fund for the coming year.

Among the Dallasites attending the St. Louis convention were Dr. and Mrs. Fred Freeland, Dr. and Mrs. Wilbur Baldwin, Dr. Sam Scothorn, Dr. Mary Lou Logan, Dr. Louis Logan, Dr. Charles Still, Dr. Rollin Becker, Dr. and Mrs. Robert E. Morgan and Dr. Patrick Philben.

Malcolm Sherwood Snell, son of Dr. and Mrs. Malcolm E. Snell, who has been quite ill with polio is improving. Dr. Snell reports that he is now doing some walking.

Mrs. Jack Crawford became ill in Clovis, New Mexico, on the way to the Ute Trail Ranch in Lake City, Colorado, where Dr. Jack Crawford is Medical Director of the Boys Camp. She was rushed to the Amarillo Osteopathic Hospital where Dr. Mann took over. She is convalescing at home and doing nicely. Dr. John Drew and his wife who were in charge at the camp just before the Crawfords were due, stayed an extra week.

Dallas now has six osteopathic physicians in the Rotary Clubs. Dr. Sam Scothorn and Dr. Robert E. Morgan in the downtown club. Dr. Frank Moon and Dr. Robert Lorenz in the Oak Cliff club. Dr. Sam Sparks in the East Dallas Rotary and Dr. Walters Russell is a charter member in the newly organized South Dallas Rotary Club.

The following Fort Worth members attended the A.O.A. Convention in St. Louis:

Dr. and Mrs. George Luibel, Dr. and Mrs. Phil R. Russell, Dr. Geo. F. Pease, Dr. and Mrs. Tom Ray and Dr. Vergil Jennings.

It is rumored that within a week the Fort Worth Hospital Association will start construction on a new modern 25 bed hospital. The Board of Trustees will consist of Mrs. Katrine Deakins, Mr. G. S. Coffin, Dr. Phil R. Russell, Dr. Roy Fisher, Dr. Geo. F. Pease, Dr. H. J. Ranelle and Dr. Lester L. Hamilton.

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DISTRICT NUMBER THREE

Dr. M. S. Gafford of Sulphur Springs had a severe cut on his right thumb while on a picnic at the Tyler State

Park. A "coke" bottle broke while he was opening it. Dr. Gafford was at the time chaperoning a group of young people from Sulphur Springs. His wound was repaired at the Gafney Clinic in Tyler. He was out of his office for three weeks following the injury.

Liberty Broadcasting Company which, of course, carries daily baseball games, cooperated in locating Dr. M. L. Kline of Mount Pleasant who was on vacation somewhere in Colorado or New Mexico at the time Dr. R. L. Martin became acutely and severely stricken. The broadcast, coast to coast, requested that Dr. Kline contact Mount Pleasant immediately and gave a description of his car and the license number. He was finally contacted by the Ranger station in Estes National Park, Colorado.

Dr. R. L. Martin is reported as being improved and is now recuperating at his home in Mount Pleasant.

Dr. and Mrs. W. L. Huetson, Tyler, are the parents of a new daughter, born June 26, 1949 at the Gafney Hospital. The baby's name is Debra Ann. Mother and infant are doing nicely; as is Pappy.

Dr. William Brown of Naples has moved to Hemphill, Texas.

The July Clinical Conference of the Gafney Clinic & Hospital was held on July 7, 1949. The synopsysm covered diseases of the Gall Bladder and Biliary system. Dr. M. V. Gafney served as chairman and moderator. Of particular interest to the program was the presence of Dr. Grover Stukey, Pathologist of the K.C.O.S. and Laughlin Hospitals. Dr. Stukey discussed the pathology found in diseases of the Gall Bladder and Bile ducts. Round table discussion followed the formal part of the program.

Dr. P. Alan Filkill has left Tyler and moved to a new location in Michigan. *(Exact town not known by me. MVG.)*

Dr. Paul Needham who recently completed a residency in E.E.N.&T. at Kansas City under Dr. A. B. Crites, was a recent visitor to Texas.

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DISTRICT NUMBER FOUR

Dr. M. G. Holcomb, KC '45, who finished a surgical residency at Tulsa Osteopathic Hospital in December, has located at Eldorado, 45 miles south of San Angelo. Dr. Holcomb occupies the offices of the late Dr. Henry Wiedenmann who served the extensive ranching country of that area for more than 25 years. Mrs. Holcomb and their daughter, Sandra Sue, have recently joined him.

Dr. W. D. Blackwood and family of

Comanche and Dr. W. B. Rountree of San Angelo attended the National Convention in St. Louis July 11 to 17.

DISTRICT NUMBER SIX

Dr. and Mrs. W. H. Sorenson and the twins have returned from a visit to Dr. Sorenson's old home, Kennedy, near the Canadian border, where his mother still resides. While there they enjoyed an outing and pike fishing at the Lake of the Woods.

Next District meeting will be held in September. Notices will be mailed near the date.

Dr. Chester Sumers is planning a trip over the district soon. He is 'taking it to the people.'

An X-ray has been installed in Dr. Rogers' office in Galveston and he is making it work right.

Drs. W. M. Hall and Alexander are still referring many patients to other D. O.'s or those that are more strategically located 'to the suffering public'.

Dr. Durden does taxidermy at odd moments. He purchased a new home among the ultra ultra.

For new and better office space see Dr. Jaffe. He is building a large business building in the northern part of Houston. More young D.O.'s are needed and welcome in this city.

Drs. Hardy and Rohr are doing a land office practice at the start, their offices are 7112 Lyons Ave.

That yellow Buick behind the hospital is Dr. Choate's. It isn't new now, it is 30 days old.

The weather is quite cool in Wisconsin. Frost is expected about the 20th inst.

Dr. Badger is happy and attending to 'his own business.'

Vacationing in New Mexico — the Cunninghams of the Farquharson Clinic.

The Ladies of the Auxiliary of the 6th District and Harris county donated $200.00 to the Progress Fund recently. Some $50.00 was raised for other funds.

Houston Osteopathic Hospital is keeping busy at contributing a tremendous quota of young Houstonians. Four D.O.'s are in the major surgery section.

Staff meetings are being held at weekly intervals at the Roehr Clinic on Montrose Blvd.

DISTRICT NUMBER SEVEN

Our deepest sympathy to Mrs. H. A. Beckwith on the recent loss of her father in Kirksville, Missouri.

Dr. and Mrs. G. S. Beckwith attended the A.O.A. Convention in St. Louis.

Dr. H. H. Edwards reports fishing good at the Red Snapper Banks, 45 miles off the coast Port Aransas, with a recent catch of 325 pounds of red snapper. (Seasickness was enjoyed by all.)

Dr. Rex Aten was busy on July 28th supervising moving into his new Clinic on Broadway. Open house and pictures will be expected at a later date.

Dr. and Mrs. Richard Wascher and family are visiting relatives in Cleveland, Ohio.

Dr. Everett Wilson busy editing Rotary film on Gonzales Warm Springs Foundation, soon to be released in all theatres throughout the State.

Dr. H. A. Beckwith advises for the tired doctor Tetanus Antitoxin following fish hook cut, with a four day sojourn in the nearest hospital for an allergic skin test reaction.

Dr. G. S. Beckwith motored to Gonzales to perform a partial Gastrectomy recently.

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DISTRICT NUMBER EIGHT

The regular staff meeting of the Corpus Christi Osteopathic Hospital was held July 5, 1949 at which time Dr. T. M. Bailey was re-elected Chief-of-Staff. Dr. F. H. Summers was elected Chief-of-Surgery and Dr. Bailey was elected to continue to act as Chief of Obstetrics and Gynecology. Dr. James M. Tyree was elected as Chief-of-Osteopathic Medicine. Dr. R. J. Brune presented a very interesting program on "An Atypical Case of Rheumatic Fever." Staff meetings are held regularly on the first Tuesday of every month.

Dr. Russell Land is serving a year's internship beginning July 1, 1949 at the Corpus Christi Osteopathic Hospital.

Dr. Rosetta Claypool completed her internship on July 1, 1949 and returned to Kansas City to continue her work in Obstretrics and Gynecology as a resi-

dent of the Osteopathic Hospital there.

The regular meeting of District Eight was held at the Robert Driscoll Hotel Terrace Annex, Corpus Christi, on August 7, 1949 at which time the professional program was presented by Dr. R. J. Brune. His subject was "Urological Problems of the General Practitioner". The State President, Dr. Lige C. Edwards was present at this meeting.

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DISTRICT NUMBER NINE

Officers recently elected for this District are as follows: Dr. T. D. Crews, of Gonzales, President; Dr. Don Mills of Victoria, Vice President; Dr. Harry Tannen of Weimar, Secretary-Treasurer.

The June meeting was held by Dr. Alan Poage of El Campo.

Dr. Poage had the Ninth District for a week end of fishing at the San Bernard River camp. Fishing was fair and the food excellent. Everyone had a good time.

The July meeting was omitted because of the National Convention in St. Louis which was attended by Dr. Alan Poage and also by Dr. and Mrs. T. D. Crews.

Prior to their attendance at the National Convention in July, Dr. T. D. Crews and famliy visited in Iowa.

Mrs. Alan Poage made trips to Arkansas and Chicago during July.

Dr. Harry Tannen, of Weimar, opened his hospital the latter part of June. He has a modern, air-conditioned building. The hospital is to be operated by Dr. Tannen and Dr. J. V. Money of Schulenberg.

The next meeting of the Ninth District will be held in Gonzales on August 10. Dr. L. C. Edwards, of San Antonio, will be on the program and his topic will be the National Convention.

It is rumored that representatives of the Federal Government, U. S. Public Health Department, are investigating Kock Cancer Treatment in connection with the Pure Food and Drug Act.

EDITORIAL PAGE

Patience, please!

Your State Office was moved Monday, July 25, to 1837 Hillcrest, Fort Worth, Texas. You now have a new full time Secretary-Treasurer and Editor, a new assistant to the Secretary — two entirely new people. The files and equipment are strange. It is impossible to find necessary references. Some that have been found are unacceptable to us. There are few manuscripts for publication on hand. The advertising list was low. The equipment had to be worked over. Two stenographers put in four full days of hard work attempting to catch up on much delayed correspondence. New contracts for publications had to be let, stationery printed, permits secured. Detail work has handicapped every move. Sixty-eight hours were spent by your Secretary the first week in an effort to straighten out your office. There will be no let-up until every detail is handled. Your staff would have to be doubled to take care of the "musts" in two months time. We pledge you that we will do it and do it well but we must request your help and indulgence until such time as we can catch up with information needed with the many details and bring this office to the high standards you should require of it.

We know that the loyal members of the profession will understand and lend us a helping hand. We invite your constructive criticism. Good manuscripts for publication along with news items of interest to the profession will be welcomed.

PHIL R. RUSSELL, D. O.
Executive Secretary.

Officers of the District Associations of the

TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, Inc.

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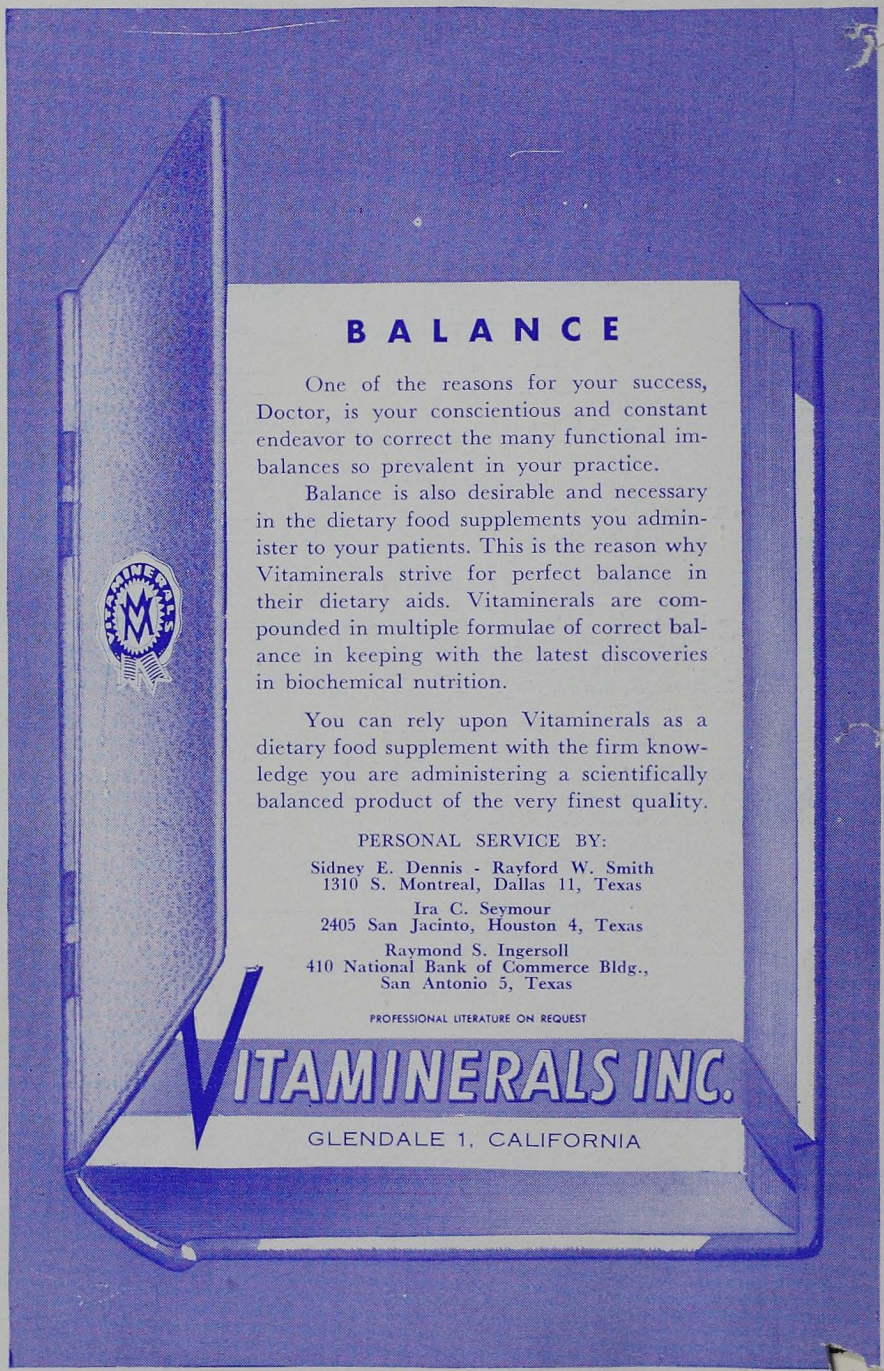
Dr. Don Mills, Victoria ..... Vice-President
Dr. Harry Tannen, Weimar ..... Secretary-Treasurer


BALANCE
One of the reasons for your success, Doctor, is your conscientious and constant endeavor to correct the many functional imbalances so prevalent in your practice.
Balance is also desirable and necessary in the dietary food supplements you administer to your patients. This is the reason why Vitaminerals strive for perfect balance in their dietary aids. Vitaminerals are compounded in multiple formulae of correct balance in keeping with the latest discoveries in biochemical nutrition.
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