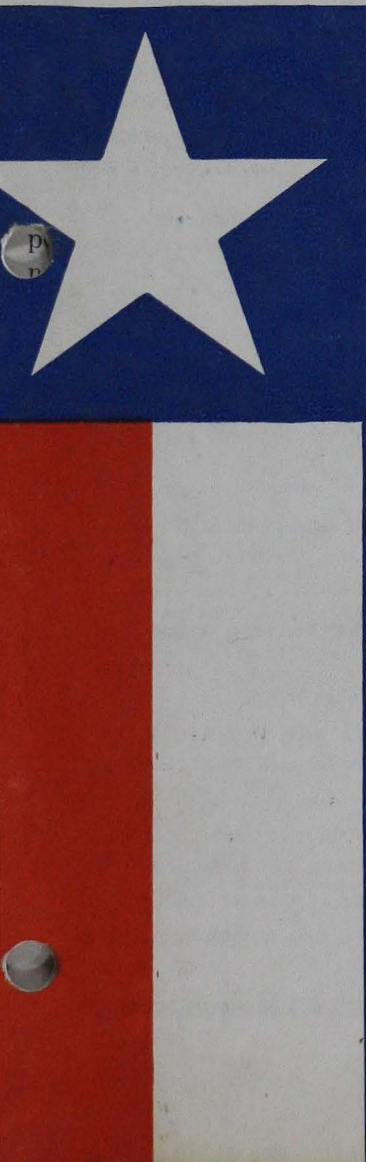


Texas **OSTEOPATHIC PHYSICIANS** *Journal*

VOLUME 2

DALLAS, TEXAS, DECEMBER, 1945

NUMBER 3



In This Issue . . .

The President's Message	3
Looking Forward	5
Glad Tidings of Great Joy	6
Shock	7
Services to Texas Physicians	11
A Forward Step	13
Some Immediate and Ultimate Effects of World War II on College Education	14
The Cranial Concept	19

Texas Association of Osteopathic Physicians and Surgeons

OFFICERS

Dr. Joseph L. Love, President,
Austin, Texas.
Dr. Robert E. Morgan, President-Elect,
Dallas, Texas.
Dr. Robert B. Beyer, First Vice-President,
Port Arthur, Texas.
Dr. Catherine K. Carlton, Second Vice-
President, Fort Worth, Texas.
Dr. J. W. McPherson, Secretary-Treasurer,
Dallas, Texas.
Dr. Mary Lou Logan, Assistant Secretary,
Dallas, Texas.

BOARD OF TRUSTEES

Dr. J. R. Alexander, Houston, Texas.
Dr. George J. Luibel, Ferris, Texas.
Dr. H. G. Gainger, Tyler, Texas.
Dr. D. B. Whitehead, Denton, Texas.
Dr. R. H. Peterson, Wichita Falls, Texas.
Dr. Keith S. Lowell, Clarendon, Texas.
Dr. Thomas M. Bailey, Corpus Christi, Texas
Dr. Louis H. Logan, Dallas, Texas.
Dr. James T. Hagan, Longview, Texas.

COMMITTEES

LEGISLATIVE

Active Members

Dr. Everett W. Wilson, Chairman, San Antonio
Dr. Phil R. Russell, Fort Worth
Dr. Sam F. Sparks, Dallas
Dr. George J. Luibel, Ferris
Dr. Louis H. Logan, Dallas

Associate Members

Dr. John B. Donovan, Austin
Dr. Wm. H. Van de Grift, Austin
Dr. E. C. Baum, Austin
Dr. Robert B. Beyer, Port Arthur
Dr. James J. Choate, Houston
Dr. Thomas M. Bailey, Corpus Christi
Dr. H. E. Roberts, Denton
Dr. J. Francis Brown, Amarillo
Dr. H. G. Grainger, Tyler
Dr. Geo. G. Smith, Dublin
Dr. J. B. Riggs, Groesbeck
Dr. Carl R. Stratton, Cuero

FEDERAL STATE COORDINATOR

Dr. Sam F. Sparks, Dallas

PARLIAMENTARIAN

Dr. H. M. Walker, Fort Worth

ANNUAL PROGRAM COMMITTEE

Dr. Louis H. Logan, Chairman, Dallas
Dr. Robert E. Morgan, Dallas
Dr. V. C. Bassett, Dallas

CONVENTION SITE COMMITTEE

Dr. R. H. Peterson, Chairman, Wichita Falls
Dr. Louis H. Logan, Dallas
Dr. Keith S. Lowell, Clarendon

VETERANS' REHABILITATION

Dr. Robert E. Morgan, Chairman
Dr. H. Willard Brown, Garland
Dr. Lloyd N. McAnally, Fort Worth

VOCATIONAL GUIDANCE

Dr. Mary Lou Logan, Dallas, Chairman
Dr. J. R. Alexander, Houston
Dr. Catherine Kenney Carlton, Fort Worth
Dr. Lester J. Vick, Amarillo

CENSORSHIP

Dr. R. H. Peterson, Wichita Falls, Chairman
Dr. Howard R. Coats, Tyler
Dr. R. R. Norwood, Mineral Wells

P & PW COMMITTEE

Dr. Sam L. Scothorn, General Chairman,
Dallas
Dr. J. F. Clark, Greenville, Fund Chairman
Dr. Reginald Platt, Houston, Radio
Dr. Thomas M. Bailey, Corpus Christi,
Speaker's Bureau
Dr. J. Francis Brown, Amarillo, Hospital
Activities
Dr. Louis H. Logan, Dallas, Legislative
Coordinator

MEMBERSHIP COMMITTEE

Dr. H. G. Grainger, Tyler, Chairman
Dr. D. Beyer, Alvarado
Dr. J. Francis Brown, Amarillo
Dr. Carl R. Stratton, Cuero
Dr. W. H. Sorenson, Port Arthur
Dr. George G. Smith, Dublin
Dr. V. A. Kelley, Waco
Dr. Lloyd W. Davis, McAllen

PUBLIC HEALTH COMMITTEE

Dr. George J. Luibel, Chairman, Ferris
Dr. Russell L. Martin, Pittsburg
Dr. J. B. Riggs, Groesbeck
Dr. Ernest P. Schwaiger, Winnsboro

WAYS AND MEANS COMMITTEE

Dr. Earle F. Waters, Corsicana, Chairman
Dr. Ted R. Krohn, Wichita Falls
Dr. A. Ross McKinney, Jr., Texarkana

PHYSICIANS' RELOCATION COMMITTEE

Dr. Phil R. Russell, Fort Worth, Chairman
Dr. Marille E. Sparks, Dallas
Dr. George J. Luibel, Ferris

INDUSTRY AND INSURANCE

Dr. Joe G. Brown, Mineral Wells, Chairman
Dr. Earl P. Stuart, Winnsboro
Dr. Irving J. Ansfield, Nocona

PUBLICATION

Dr. J. W. McPherson, Dallas, Editor-in-Chief
Dr. Reginald Platt, Houston
Dr. George J. Luibel, Ferris
Dr. H. G. Grainger, Tyler
Mrs. Margaret F. Markes, Business Manager,
Dallas

Texas Osteopathic Physicians' Journal

The official quarterly publication of the Texas Osteopathic Physicians and Surgeons

STATE OFFICE, 1234 IRWIN-KEASLER BUILDING, DALLAS 1, TEXAS

EDITOR-IN-CHIEF

DR. J. W. McPHERSON

ASSOCIATE EDITORS

DR. GEORGE J. LUIBEL

DR. REGINALD PLATT

DR. H. G. GRAINGER

MRS. MARGARET F. MARKES, *Secretary*

Advertising Rates Upon Request.

All cuts to be used in advertising must be sent in with copy

VOLUME 2

DALLAS, TEXAS, DECEMBER, 1945

NUMBER 3

The President's Message

THE YEAR 1946, the first post-war year, will challenge the osteopathic profession of Texas far more than any of the war era just closed. Increased number of doctors returning to practice and a probable decline in national income mean that the osteopathic profession is going to meet greater economic competition. The use of restrictive and repressive legislation, court actions and bureaucratic methods to limit and eventually to eliminate the osteopathic physician will be greatly intensified.

During the war period our profession made great advances in obtaining recognition from federal and other agencies concerned with public health. This progress must not fool us into thinking that the battle is about won. A new technique is being developed in medical practice which threatens us more than any development in the past fifty years. This method is to channel all medical practice into hospitals and medical centers where the general practitioner will be entirely replaced by specialists.

This tendency toward further control of medical practice offers a golden opportunity to sift out the osteopathic physician. At present this does not seem to be an imminent threat except in those Texas areas which are already building hospitals with federal aid. It is planned that federal and state aid will make hospitals and health centers available to all but the most isolated sections, even in a state as large as Texas. Office practice and private hospitals will be subjected to heavy economic and social pressure. The fashion will be to go to the hospital for every ailment.

It is the plan of those who sponsor federal aid to health centers to subject the use of funds to certain minimum standards. This supervision is, of course, necessary to insure proper expenditure of money and adequate service. Nonetheless, attempts will be made to ignore osteopathic hospitals and specialists and to rule them out whenever possible. It is further planned, as mentioned

before, to eliminate general practioners so that all ailments will be treated by specialists carefully selected by boards which would automatically refuse recognition to osteopathic specialists no matter how well trained.

It is conceivable that in the future when a patient has a cold, he will go to a hospital as a matter of course. There he will be referred to a rhinologist; if the cold goes into the throat, off he goes to the laryngologist; down goes the cold to the bronchial tubes and a lung specialist is called in, etc., etc. Finally it is decided to give the poor patient a laxative but a gastro-enterologist must be consulted first. This could proceed until all the specialists had been seen, when the case could have been handled by a general practitioner much more easily and certainly less expensively.

This intense overspecialization through the universal use of hospitals is certain to lead to state medicine by whatever name it may be called. The poorer patient, for whom most of the new hospitals are meant, could not afford the services of specialists. Federal and state aid and control are inevitable.

The question is not whether we want socialized medicine or some variation of it, but whether we will be included in the many plans, which will actually be socialized medicine though they may appear to be something else. The bills in Congress (such as S. B. 191, just passed by the U. S. Senate) leave most of the discretion to state agencies. The agency in Texas is the State Health Department. Already an unofficial body has been set up to survey hospital needs. Since this body was sponsored by the Texas Hospital Association, it was not unexpected that osteopathic hospitals would lack representation. It is hoped that the Texas Department of Health will take steps to see that all hospital facilities in Texas are properly surveyed.

The hospital survey is just one of the first post-war problems which must be faced this year. Only through group action can our objectives be reached. You individual members must do your part, not just by paying your dues but by active work for the profession and your Association.

Because of restrictions on holding conventions, your officers and board of trustees had to serve an extra year. The board of trustees, the officers, the legislative and other committees and individual groups of volunteer workers have had to carry on the business of the Association. A great amount of time and money has been spent working for the good of the profession.

Not all objectives have been reached. When we have succeeded, it has been because of the cooperation of the membership at large. When we have failed, it has been because we did not receive that cooperation. The hospital bill in the last legislature failed at one time by one vote because there was practically no real cooperation from the field from those doctors who could have made the difference by their influence.

The Association and the state office must no longer be considered as minor affairs but are approaching the proportions of big business establishments. We can not protect and promote our means of livelihood on a peanut stand basis. Fortunately there is a growing movement among the membership to increase the annual dues, search for other sources of income and make our state office into the big business that it must be if we are to continue to progress.

The present administration has by necessity been held over an extra year. I hope that the principal criticism will be one richly deserved, that we did not do enough, rather than that we did too much. If there is any apology necessary, it is that we did not have the vision necessary to see how great our profession could become, not that we were too ambitious for our limited means.

As members of our Association you should be looking for officers and trustees who have more vision than those of the past, not for men who will want to retrench. We can not stop, we can only go forward or back to oblivion. Where is homeopathy? Where is eclecticism? They stopped for a breather and now they are all but forgotten. God grant that this does not happen to osteopathy!

Joseph L. Love, D.O.

Looking Forward

THE KIRKSVILLE COLLEGE of Osteopathy and Surgery faces 1946 with a feeling of stirring anticipation. More must be done by the College, more must be done for the College, than in any year before in history.

But the past two years have given your "hired-hands" in the College a faith and confidence to face that year with an assurance that it will be marked with accomplishment. You in Texas have a lot to do with that feeling.

You have told us what we must do and you have helped provide the funds to start doing it. The beginnings of expansion and improvement in Kirksville which have been accomplished the past two years demonstrate that the big things ahead in 1946 can also be accomplished—and they will be accomplished with your help.

In 1945, the Kirksville College helped spearhead approval of osteopathic education under the new legislation in Massachusetts. Kirksville and Philadelphia are now approved in that State. The College was also successful in securing New York approval in '45, after more than ten years. Many other successes have been chalked up—steady advances in research, an ever-stronger basic science and clinical faculty, an expanding clinical traffic that now taxes existing facilities, the establishment of recognized budgeting, accounting and control methods in business operation, etc., etc.

These have all been accomplishments that are basic and pre-requisite to the needed physical expansion of the College. This New Year sees Kirksville ready to go on that expansion, with a record of accomplishment to date that justifies the need for expansion, that assures the maximum use of expanded facilities in better osteopathic education.

It will take more than \$400,000.00 to do the job that must be largely done in 1946. Most of that must come from the profession. And, of course, when the profession has a job to do, Texas does a large part of it.

Knowing Texas, knowing Texas Osteopathic Physicians, knowing your interest in your College and your Profession, Kirksville faces 1946 and its challenges with faith and good cheer.

MORRIS THOMPSON, *Exec. Vice. Pres. KCOS*

Glad Tidings of Great Joy

POSITIVELY! There is going to be a Texas Association of Osteopathic Physicians and Surgeons Post-Graduate Conference this year! Place—The Dazzling and Far-Flung Metropolis of Dallas—Time April 25th, 26th and 27th; program modern, stream-lined, and one of the finest; exhibitors—plenty of them and eager to serve you.

The exhibits and lectures will be held in the Baker Hotel and the banquets and luncheons will be held at the Adolphus and Baker Hotels.

An interesting sidelight on the enthusiasm that has been encountered in the announcements of the forth-coming conference is that there were over thirty requests for exhibitor's space within forty-eight hours after the announcement there was to be a meeting in 1946.

The meeting is scheduled for April 25th, 26th and 27th, 1946, and plans are rapidly maturing; the time is ripe; the Convention Committee is expecting the greatest crowd ever, and it is preparing the best that can be offered for your approval. Hotel reservations are extremely limited and if you desire accommodations, do not procrastinate, but attend to this matter at an early date. Remember; the Association was successful in booking one of the few conventions held in Dallas during 1946; after May 1st, there will be no more conventions in Dallas until 1947.

This issue of the Journal and the April issue will contain all the pre-convention material that it is possible to give you before the meeting. Read them carefully and be ready to leave for Good Ol' Dallas the last week in April by scratching those dates off your appointment book right now.

We'll be seein' ya!

The Program Committee consisting of Drs. Louis H. Logan, Chairman, Dr. Robert E. Morgan, and Dr. Vernon C. Bassett, promises that the program for the 1946 convention will be better than ever before. Letters have already been sent to numerous persons but at this time there has not been time for replies. All phases of techniques will be featured. The April issue will contain the complete program.

The osteopathic profession of Texas is most happy to welcome Dr. John W. Drew, POC '39, who has taken over the office and practice of Dr. Felix Spector, 1203 South Hampton Road, Dallas. Dr. Drew has but recently resumed the practice of osteopathic medicine after four

years as a Captain in the First Armored Division, United States Army, and has seen service in Ireland, England, North Africa and Italy. Dr. Drew is the son of Dr. Ira Walton Drew Ex-Congressman from Pennsylvania one of the outstanding members of the profession.

Shock

WILLIAM S. GRIBBLE, D.O.

IT IS MY PURPOSE in this discussion to present some of the more modern concepts of shock, as reviewed by numerous investigators in this field. The general practitioners' concept of shock, particularly its mechanism, is more or less vague, and consequently, at times it is unrecognized before it reaches the advanced state. Hemorrhage and shock are often spoken of in such a manner that one would think they were synonymous terms—the end result of hemorrhage, of course, is shock, but true shock may be due to a variety of causes. The Committee on Medical Research of the AMA, realizing the importance of this problem, allocated funds for a careful investigation of the bodily response to shock and the end results of these investigations are contained herein.

The end result of a local injury, when it becomes large enough to cause systemic symptoms, is shock. The process is by drawing water and electrolytes into the tissue spaces from the blood, and possibly from the blood cells. This may be attributed to an increased avidity of the tissues, an alteration in the capillary endothelium or a shift of osmotic balance due to metabolic products, either of the original injury or of suboxidation. Most workers agree that circulatory failure or true shock is the end result of an uncompensated disparity between the blood itself and the volume capacity of the vascular system. Meyler explains that this disparity is caused by a decrease of the blood volume due to loss of blood dehydration, exudation of plasma, and increase in vascular capacity, or a combination of their factors. When shock threatens, there are certain normal compensatory mechanisms which tend to restore the blood volume by a discharge of blood from the normal reservoirs, like the spleen and liver, or through absorption of fluids from other sources and still other mechanisms which tend to decrease the volume capacities of the vascular system by constricting certain parts. As long as these inborn compensative mechanisms are at work, there is no marked fall in blood pressure, but when they fail to compensate to a sufficient degree, the blood pressure falls rapidly and progressively. This proves to us that shock is not a static condition due to one cause, but that it is a process which may be instituted by one of many factors. It makes no difference whether shock is primarily due to a histamine-like substance liberated at the site of a large injury causing increased permeability of the capillary walls, whether it is due to fear or pain, reflexly causing vasodilation and capillary atony, anesthetics paralyzing the vasoconstrictor nerves, lack of venous return, etc.—the important thing is that if inadequately compensated any one of these factors may lead to one or more of the conditions that are part of the vicious cycle which produces a disparity between the effective blood volume and the available capacity of the vascular system. This expresses itself in the clinical picture of shock, which for all practical purposes, is in part, defined by Moon as follows: "Shock is a disparity of fluid balance resulting in a peripheral circulatory deficiency mani-

fested by reduced volume and flow, and increased concentration of the blood, with anoxia."

When a hemorrhage occurs there is a loss of the whole blood and all of its component parts, followed by a secondary lowering of the blood pressure. If the hemorrhage is profuse, there is an almost immediate lowering of blood pressure, which occurs before the natural compensatory mechanisms of the body are able to exert their stabilizing effect. If the hemorrhage is one which consumes a reasonable length of time in discharging a large amount of blood, the lowering of blood pressure is not immediately apparent. In either condition, however, there eventually occurs a decrease in the osmotic tension of the blood vessels, and a secondary change of the permeability of the capillaries. This phenomenon leads to an actual decrease in the oxygenation of the body tissues, causing anoxia.

Any delayed prostration or death from hemorrhage can rightfully be called hemorrhage shock. And there are many factors that make this condition variable, depending on the percentage of body weight lost due to the hemorrhage, and the time consumed. There are still other factors which cause the patients to respond to treatment in varying manners, especially in a condition in which anoxia is pre-eminent.

From a practical standpoint, therefore, there is no treatment for hemorrhage except transfusion with whole blood or its equivalent.

TREATMENT.

The mechanics and treatment of shock until the last few years have been, more or less, considered on the basis of the information compiled during the treatment of the casualties in World War I. The loss of blood colloids in shock and the harmfulness of large crystalloid injections in the treatment of shock have been challenged only in recent years, and also hypoproteinemia was unquestioned as a prime factor in the hemoconcentration encountered. The first consideration to treatment was therefore the replacement of plasma protein. Modern investigations disprove these erroneous ideas, and in doing so, bring to light an entirely new concept in the treatment of shock.

Sodium chloride solution dilutes the blood in shock and increases the velocity of circulation. This decreases the generalized vasoconstriction, and increases the elimination of potassium through the kidneys and relieves anoxia. In other words, life is saved either temporarily or permanently, by changing the hemoconcentration of the blood to a hypoproteinemia. The use of other solutions do not give the favorable results obtained with plain physiological saline. Glucose and water solutions have obvious value for dehydration, but this must be differentiated from shock and the untoward results encountered following the administration of 5% glucose and water solution when given for severe shock, is explained by the need of the blood for electrolytes, principally sodium chloride. Potassium has no specific role in shock, and its substitution for any considerable part of the sodium is dangerous.

In both hemorrhage and shock, most authors have agreed that the infusion of salt solution is temporarily beneficial, but that it leaves the circulation very quickly. This being so, one would naturally feel that there must be more room

in the circulation for more salt solution. But knowing that the excretion through the urine is limited, there has, heretofore, been a fear that massive edema and collapse would be the end result of large saline injections, and also a fear of washing protein out of the circulation. Allen makes three noteworthy observations in this regard. (1) Sustained elevation of blood pressure, which many authors have failed to obtain in hemorrhagic shock with transfusion or with inadequate saline injections, is usually obtainable with a sufficient volume of salt solution, furnishing a definite illustration of the specific relation of sodium chloride to blood pressure. (2) In hemorrhage, both plasma and corpuscles are hopelessly lost. Exudate in a severely traumatized area coagulates and can only be slowly resolved, but the serum is free with its proteins; and in a less injured area or around the peripheral of severe injury, the coagulable exudate does not clot, so that there can be practical benefit in the rapid recovery of these materials through the lymphatics. Theoretically, as well as practically, the equilibrium between the exudate and the circulating blood has a great influence, but this, of course, is lacking in hemorrhage. (3) In the absence of local damage, there is an absence of increased capillary permeability with hemorrhage, as shown by the very slight gain of body weight with large saline injections. The longest and severest anoxia makes no such change in the capillaries. The tendency to exudation in special areas, such as the lungs, must be classed along with the phenomenon of circulatory failure.

Therefore, it is shown that a new equilibrium can finally be reached between the blood and tissue fluids by administration of saline solution which provides a sufficient volume of circulation with a hypoproteinemia to maintain life for a certain length of time. In hemorrhage, if the original bleeding has been stopped, this new equilibrium can maintain life to such a time that

Sympathy is extended to Dr. John S. Crawford over the loss of his wife, Caddie Caroline on January 6, 1946. Mrs. Crawford was born in Dallas County sixty-four years ago and lived here all of her life with the exception of nineteen years which were spent in Denton. Mrs. Crawford married in 1902 and two children were born, Dr. Jack Crawford of Dallas and the late Ruth Jones of Kirksville, Missouri. Mrs. Crawford was very interested in several organizations, namely the Light House for the Blind and the Wednesday Morning Choral Club. While president of the Wednesday Morning Choral Club, she inaugurated the scholarships for underprivileged talented musicians, and since that time over 400 of these have been given. The Wednesday Morning Choral Club gave a memorial service honoring Mrs. Crawford on Wednesday the 8th and at this time, many of the philanthropic interests were brought to light some of which were news to her own family.

She is survived by her husband, Dr. Crawford; a son, Dr. Jack W. Crawford; a sister, Mrs. H. H. Loggins; and three grandchildren, all of Dallas.

whole blood can be given to correct the hemorrhage factor. There is a zone of safety, therefore, between fatal hemorrhage on one hand and pulmonary edema on the other.

BODY TEMPERATURE

Animal experiments show that lowering of temperature, rather than elevation of temperature, as was formerly believed, exerts a definite reduction in the incidence of shock. This is brought about by reducing capillary permeability and slight constriction of the superficial vessels. These experiments should not, at this early time, completely change the treatment in human beings, but the works of Blalock, Mason, and Chambers suggest that we should alter treatment to the extent that, in the emergencies of shock and hemorrhage, the temporary survival of the patient until he can obtain further treatment, is favored by lower rather than higher temperatures.

There are obvious common sense reasons why severe exposure calls for reasonable treatment by warming. Extremes in all temperatures should be avoided by practitioners until the uncertainties have been settled by the experts. There is an abundance of good reason for believing that a slight sub-normal temperature in a shocked or bleeding patient is a harmless and beneficial reaction. The patient's covering should not be excessively warm, and in particular, artificial heating is injurious, both theoretically and according to actual practice.

CONCLUSIONS

1. A modern conception of the mechanism of shock is described, and any one of many exciting causes may start the vicious cycle leading to shock.
2. The replacement of blood proteins is a secondary consideration in the treatment of shock, being unrelated to the problem of immediate fatality encountered. The failure of plasma injections in advance shock is recognized, simple saline solutions being more effectual.
3. The old conception that extreme shock is irreversible is erroneous, as the process is reversible at all stages, up to the instant of death.
4. In hemorrhage, the immediate treatment of choice is physiological salt solution in massive quantities, followed later by transfusion of whole blood.
5. Treatment of true shock by physiological salt solution in doses up to 1/8 or more of body weight causes a reversal of the shock cycle, (a) hemodilution and increased blood volume, (b) correction of anoxemia, (c) sustaining elevation of blood pressure for as much as 24 to 48 hours, (d) promoting diuresis.
6. An equilibrium can be reached between the blood and tissue fluids by the administration of physiological salt solution, which provides a sufficient volume of circulation to maintain life.
7. Pulmonary edema is recognized to be pre-eminent, whether the solutions used are saline, plasma, or serum—but a definite zone of safety is obtainable.
8. Extremes of temperature should be avoided but slight chilling is more

beneficial than heat, in that it reduces the capillary permeability, constricts superficial vessels, and decreases edema.

Vidor, Texas

REFERENCES:

- Abott, W. E. and Mellors, R. C., *Arch. Surg.*, 46: 277-288, 1943
Allen, F. M., *Am. J. Surg.*, 335-347, June, 1943
Blalock, A., *Surg., Goiner., and Obst.*, 58: 551-566, 1934.
Fredericks, Lillian E., *Am. J. Surg.*, 438-444, May, 1942
Mahoney, E. B., *Am. J. Surg.*, 108: 177-193, 1938

Services to Texas Physicians

GEO W. COX, *State Health Officer*

THE TEXAS State Department of Health has the duty of protecting the citizens of Texas against communicable and preventable diseases. In this connection there are numerous activities that result in benefit to the practicing physicians of the State.

The Bureau of Laboratories prepares and distributes various vaccines, through city and county health officers, for use by physicians with their indigent patients. The items distributed are rabies vaccine (14 day), typhoid vaccine, smallpox vaccine points, pertussis vaccine, pertussis vaccine (combined), diphtheria toxoid, Schick material, old tuberculin, silver nitrate and plasma.

The laboratory will also assist in the diagnosis of diseases that require laboratory work, including biopsies for cancer and arthropod identification. Assistance will also be given in diagnosing rare or ill defined diseases.

A mobile TB. X-ray clinic is available upon request of any County Medical Society. The local physicians send their patients and contacts to this clinic and assist the tuberculosis nurse in making arrangements for the clinic. The diagnosis, together with a chest film, is sent to the physician recommending the patient for his guidance. Plans are now being made for mass X-raying and this method is expected to uncover many unsuspected early cases that will be amendable to treatment.

The Division of Public Health Nursing assists in immunization programs, through educational work and recommending that such service be secured from family physician.

Conferences for doctors on obstetrics and care of children have been held as a direct service to Texas physicians in cooperation with the University of Texas School of Medicine. Last year more than 150 doctors attended such a conference in Galveston.

The State Health Department has had charge of administering the funds for E. M. I. C. which funds have taken care of the prescribed doctors' fee for those physicians who participated. It also made it possible for the doctor to

handle such cases in approved hospitals, instead of home deliveries, as would have been the case in thousands of instances.

Arsenicals are available to physicians for the treatment of those with syphilis. Five rapid treatment centers are maintained for the intensive treatment of syphilis and gonorrhea and doctors can send patients there if they so desire.

Phamphlets and health motion pictures are available upon request. The professional films on syphilis and childbirth have had wide distribution.

The services of a trained epidemiologist are available to make studies on the spread of diseases and make recommendations to suppress threatened epidemics of communicable disease. At present an intensive study is being conducted in the Rio Grande Valley to reduce the occurrence of diarrhea and enteritis which is too prevalent in Texas.

Housing Shortage Blamed For Sinus Increase

"Doubling-up during the current housing shortage is resulting in a radical increase of sinus infection," Dr. C. M. Mayberry, East Liverpool, Ohio declared in writing for a recent issue of the Journal of the American Osteopathic Association.

People who never had "sinus trouble" have fallen victims to the infection and those who had already suffered from it, have experienced more frequent and violent attacks, Dr. Mayberry says.

He explains that in hot rooms overcrowded with people the humidity is usually low which results in a depletion of the nasal mucosa. The lining membrane of the nose is the first line of defense and to function properly it must have moisture. Add to the drying affect of overheated and overcrowded rooms, the exchange of showers of bacteria that are bound to occur among people and in many instances clouds of smoke and "you

have a natural breeding place for sinus infection which often is preceded by a head cold."

For these reasons, people who are forced to live under such conditions must observe the following basic health rules if they wish to offset the hazards of such crowded living; Dr. Mayberry points out. They are: Adequate ventilation and humidity, proper rest and correct diet. If a head cold starts, don't neglect it. Seek the advice of a physician.

▲ ▲ ▲

Between thirty and forty osteopathic physicians were present at the District meeting of the Southeast Texas Osteopathic Physicians and Surgeons at the Mirror Room of the Hotel Beaumont, Beaumont, to listen to lectures and indulge in a round table discussion of problems of vital interest to the profession. Dr. Robert B. Beyer of Port Arthur was the principal speaker delivering a lecture on "Cranial Technique." Dr. Claude E. Hammond of Beaumont was program chairman.

RESOLUTION NO. 10

Published in the Texas Legion News for November 1945 on page 6, under Legislative Resolutions Passed.

RESOLVED by the American Legion, Department of Texas, in convention assembled at Fort Worth, Texas, September 24-25, 1945, That we advocate that Osteopathic and Chiropractic Health Services be included in the treatment of veterans in the Facilities of the Veterans' Administration, where patients desire such treatment.

A Forward Step

THE BOARD of Trustees of the American Osteopathic Association have decided that the American Osteopathic Association should acquire its own building for permanent headquarters chiefly to obviate future moves, reduce rental and maintenance costs and provide more desirable working conditions for the staff. Other outstanding factors influencing this decision were:

1. An investment into real estate property materially increases the assets and worth of the Association.
2. A properly planned building will permit the enhancement and expansion of services from time to time.
3. Continuity of same address over a period of years tends to give strength and stability to an organization.
4. Professional loyalty and pride in ownership on the part of the members of the American Osteopathic Association help to promote professional pride and unity.
5. Owning a national headquarters lends prestige to the Association and is of incalculable public relation value.

In order not to add to the financial burden of the Association or jeopardize its moderate reserve for emergencies, The Board of Trustees believes that the profession and its friends will consider it a privilege to participate in the financing of a building for permanent headquarters. The income of the Association is carefully budgeted to give a maximum of service to the profession. Each department has a schedule of work which must go on and even increase in volume and in quality. It is not conceivable that the profession would want any of the services which are now provided to be diminished or eliminated in order to save money for the building of an American Osteopathic Association headquarters. For the first time the Association now asks its members to participate in providing it a home.

In 1947 the American Osteopathic Association will have been organized 50 years. What could be a more fitting recognition of progress, stability, and prestige than to build its own permanent headquarters at this half-century anniversary time?

We trust that the profession in Texas will respond generously to this splendid project.

OSTEOPATHIC HOSPITALS EXPANDING

There are 260 osteopathic hospitals in the United States with many more in the building or planning stage. In addition, a number already existing hospitals are adding to their plant and other facilities to increase accommodations. More than \$1,000,000 has either been spent or appropriated for new construction this year.

COURT PRO-CONTRA

The U. S. District Court in Washington, D. C., has issued a permanent injunction barring the Postmaster General from interfering with the mailing of the Consumer's Union "Report on Contraceptives." This final decision, according to some authorities, says *Time* magazine, "may well uncheck the rein hitherto held on contraceptive advertising."

Some Immediate and Ultimate Effects of World War II on College Education

By H. L. TURNER, *President Hillsdale College*

THE WORLD shaking events of World War II have disturbed the complacency and smugness of college education to a degree unequaled since the Renaissance gave Western Europe its historic revival of learning. Most of us who are engaged in the administration and direction of instruction in our colleges are fully aware that a tremendous impact has been made upon us. We somehow feel that a major operation may be necessary to give us a new lease on life. Some of the immediate effects of this war on the colleges are quite apparent to us all. The ultimate effects are not quite so apparent and yet we are striving to comprehend what may be the lasting effect of this war on the program of college education in America. There are some among us who yearn for the return of the status quo enjoyed before the war, but most of us realize that such can never be in college education or any other realm of life in the future.

The first and most pronounced effect of the war upon the colleges was the rapid decline of enrollments. The calling of men to the colors cut totals by half or even more in our co-educational institutions and practically closed the boys' colleges except for those securing military units. In colleges like Hillsdale where normal enrollment is approximately evenly divided between boys and girls, the school year of 1942-43 saw practically all the boys called to active military service. Of 150 boys enrolled there in the fall of 1942, almost 100 of them were gone by March 15, '43 and the rest left on July 1, 1943. They have not yet returned in noticeable numbers and few of those under 18 years of age have enrolled. It should be noted also that when the boys left us, some of the girls went too, either into service, into war plant jobs, or as war brides.

Then came the avalanche of military and naval units on some campuses, but these were mostly to the larger universities or the smaller technical and engineering colleges. This meant for most of the colleges to which they were assigned a new kind of student body. These men were in the army, navy or marine corps. It meant that dual programs of instruction had to be operated—one for the civilian students and another for the military units in most cases. Such dual programs were not essential where naval units were involved, but even here there was considerable cleavage between the military and the civilian programs. Calendars had to be changed, schedules modified, and offerings exaggerated in the fields of science, mathematics, and related fields. Yes, the coming to the campus of military units has had marked effect upon the enrollments in most colleges of the country.

Now the trend is again upward so far as enrollment goes. In most of the small colleges in Michigan this fall actual percentages of increase are from 10% to 30% or better. Evidently girls are going to college as never before. As more and more of the service personnel are discharged and come back to college the mixed nature of the student body will become more perplexing. The mixture of young boys and girls just out of high school with the more mature men with military service, and with older young men and women who have worked at war plants for the duration, will create many problems—social, academic and moral. All of us are expecting greatly increased enrollments if not a literal stampeded to college campuses when the present war ends. Several factors seem to us to make this certain. First, the cumulated savings by families who were never able to afford college education for their children will send many of them to college. Ex-service personnel will have seen the advantages of education by their observations of promotions in rank by their buddies and the encouragement of the Federal Government to help finance education for all those who have served in the military. Yes, the war has certainly had its effect upon college enrollments and will likely affect them for several years to come, I would guess at least three to five years ahead, even if the war should end in 1945.

College finances have been materially reduced by several factors directly related to the prosecution of the war. Decreased enrollments have caused income from tuitions to drop. Government spending and war loans have greatly reduced interest rates and consequently the college income from endowments. The necessity of heavy purchases of War Bonds and marked increases in taxes have almost stopped the giving of large sums by men of large income. Even tax supported colleges and universities have found the competition for tax revenues more pressing than ever before. Then, there are those who fear that recent amendment of the income tax law to allow \$500 for gifts by small income tax payers regardless of whether or not they actually give anything

VICTORY

"With malice toward none; with charity for all; with firmness in the right as God gives us to see the right—let us strive on to finish the work we are in; to bind up the Nation's wounds; to care for him who shall have borne the battle, and for his widow and orphans; to do all which may achieve and cherish a just and lasting peace among ourselves, and with all nations."

March 4, 1865

ABRAHAM LINCOLN

Send for the "VITAMINERALS MANUAL"
VITAMINERALS CO.

3636 BEVERLY BLVD., LOS ANGELES 4, CALIF.

Distributors

Sidney E. Dennis, 1010 S. Rosemont, Dallas 11, Texas

Ira C. Seymour, 8327 Findley, Parkplace, Houston 12, Texas

R. S. Ingersoll, 514 National Bank of Commerce Bldg., San Antonio 5, Texas

may even prevent this as a major source of funds for our colleges that must depend upon voluntary contributions for support. Thus the large income group from which funds were derived in the past are now unable to continue their support of college education and the small income group get tax exemption credit up to \$500 per year whether they actually give or not. So the colleges are caught between the two and find their financial problems extremely acute now and with little hope of remedy in the near future.

College instruction has never played the part in war that it has in the present conflict, but it has suffered severe casualties and the scare of war may long remain. The urgency of the situation has forced acceleration of learning at a maddening pace. Most colleges have felt it necessary to operate the year round and try to complete four years of college work in three calendar years. This has meant tremendous pressure on administration, faculty and students. Perhaps it has been necessary in the war emergency, but there are some who will contend that college instruction after the war should continue at this pace. But to me this seems exceedingly unwise, if not impossible, and certainly undesirable.

The educational process is one of growth and maturity that takes time for proper maturation. I know we sometimes break sprigs of pussy willow, forsythia, and red bud, bring them into the warmer temperatures of the house and force them to bloom ahead of season. This is what we have had to do in the college program in the haste necessary to win the war for our side. But this is an unnatural situation which has succeeded only because of the impelling motives that have prompted speedy action to save lives and the very life of our nation. The speed-up program has undoubtedly revealed some of the dead wood in the past content of college education but in the post war era there will be much new knowledge to take the place of any we can afford to discard. Just think what will have been added to medical science, to engineering, to scientific fields, to the need for larger social understandings and most other fields of human knowledge and learnings. Yes, it will take longer to give youth a fair chance to begin even with the world and college programs of instruction may have to be lengthened rather than shortened in the post war period.

This will be true not only of general college education but of the technical and professional colleges in particular. You in the profession of the healing arts realize this fully, I am sure. Your own organization of osteopathic physicians and surgeons is thriving valiantly to raise the standards of preparation for your profession. Over the years you have gradually lengthened the time necessary for certification in this field. The artificial stimulus of the war emergency may have caused you temporarily to reduce the time but I am sure you are looking forward to more normal conditions when ample time can be given to more thorough and more normal programs of instruction. This is what we in the colleges desire and it is what I am sure will happen.

The administration of college education has been affected in various ways by the impact of war. The extra burdens administrators have had to bear as a result of declining enrollments, decreasing revenues, turn-over and shortages

in staff, restrictions on equipment and maintenance supplies—all these have tested the patience and taxed the ingenuity of college administrators. But there is another impact of the war and its accompanying attitudes that have given major concern to some college administrators. Gradually over the years some of our leading colleges had been developing democratic procedures in the conduct of campus affairs through increasing participation by faculty and students in their management. The presence of military units on campuses and the popular appeal of the militaristic point of view and its efficiency in the present emergency have turned backward this movement. It is also true, however, that the development of more democratic administrative practices in our schools and colleges has been felt in military circles as well. So while we regret the loss of some of these things on the civilian side of college education, we are pleased to observe some evidences of more democratic practices in military administration. These we hope are to be lasting effects rather than merely immediate because there is perhaps much to be gained in the middle ground between the extremes of traditional military discipline and the developing progressive practices in some of our more liberal schools and colleges.

All these immediate effects of the war on college education have had one tremendously significant result for the life of our nation and its future place in the family of nations. The war has created a huge deficit in educated manpower that will be so urgently needed for the reconstruction of the world and our nation in particular. We have poured millions, if not billions, into the

FINE PHARMACEUTICALS FOR THE PHYSICIAN

SINCE 1900

Featuring a complete line of

Tablets, Friable Pills, Ointments, Elixirs, Syrups, Suppositories,
Children's Tablets, Vitamins, Powders.

EVERY AMPUL TREATED AS A SPECIALTY

Chicago Pharmacal Co.

CHIMEDIC

5547 Ravens Wood Ave.

Chicago 40, Ill.

training of young men and young women for the technical services of war. But while we were busy at this we have neglected sadly education for leadership in more constructive pursuits of peace. The war has produced for us vast resources of man power in technical lines but tremendous shortages in most of the professions such as dentistry, law, medicine and teaching. You are fully aware of the critical situation in your own field, I am sure. The situation in the medical field as described in the July 8, 1944 "Journal of the American Medical Association" and quoted in the October 1944 number of the Association of American Colleges Bulletin is somewhat disturbing if not actually alarming. In essence it is pointed out by facts in this article that we now face an annual deficit of at least 2,000 doctors unless immediate and drastic efforts are made to remedy a rapidly deteriorating situation. The cumulative effects of this and similar situations in all our constructive professions make apparent the need for speedy action to remedy the situation. This huge educational deficit in America is one of the reasons why Congress enacted so speedily and so unanimously the so-called G-I Bill. It is your job and mine to see to it that the same distorted emphasis on merely the vocational and the technical that has overwhelmed higher education since the outbreak of the war not be continued but that the real deficit in liberal and professional education be given its proper attention.

There are, however, some ultimate effects of the present war on college education that seem fairly clear on the horizon even now. And they are not all bad! It seems to me I discern at least three significant impacts on college education that should give us all heart.

First, is the improvements that have come to college instructional procedures as a result of the war. We hear much about the wonderful teaching techniques of the Army and Navy and Marine Corps. They have merely appropriated and tested by fire, teaching procedures long advocated and considerably practiced in most elementary and high schools and a few colleges and professional schools. The extensive use of visual and auditory aids, the teaching on campus or in camp followed by testing in the field and then bringing back to the campus the experience, and the wide use of objective, laboratory techniques,—all these will bring lasting improvements in college teaching. The war emergency, therefore, has perhaps unwittingly done a great service toward the improvement of teaching practices on the college level.

Second, there is increasing evidence that the masses of our people believe in the value of college education perhaps as a result of the impact of this war. The extensive use of colleges and universities in preparing men and women for military services and the effective job they are doing as a result has impressed us all with the value of college and university training. The men and women in service have seen the value of college education for their comrades in arms. As a result many of them will come back to civilian life with a determination to secure its benefits for themselves. The Federal aid for education of ex-service personnel will likewise encourage many who might not otherwise consider it, or who would not have been financially able to

afford a college education. So, the war will mean ultimately that a much larger proportion of our population will secure benefits of college education.

Third, this greater appreciation of the value of college education by the masses of our people will mean more adequate financial support for our colleges. Immediately and in the near future, those of us in college administration, and especially those of us in small church-related or private colleges, feel the pinch of poverty. But somehow I still have confidence to believe that when the American people are thoroughly convinced of the value of anything they will pay the price for it. If we in the smaller colleges can prove our worth, we will enjoy the financial support sufficient to continue our service.

The immediate effects of the present war on college education have been severe and trying. But college education has been tested as by fire and it has stood the test. Ultimately, if intelligence and foresight govern our conduct, college education will move forward and attain a place of service never before achieved.

The Cranial Concept

KENNETH E. LITTLE, D.O.

DR. WILLIAM G. SUTHERLAND, the originator of the Cranial Concept, has followed the custom at the beginning of his Cranial Lectures of asking the audience to rise for a MINUTE OF SILENCE in respect to the memory of Dr. A. T. Still, the founder of our profession. I would like to continue the custom, including Dr. Sutherland along with Dr. Still in our thoughts.

It is my opinion that Dr. Sutherland has given to Osteopathy, and through Osteopathy to the scientific world, a new physiological concept—that of the Primary Respiratory Mechanism. This concept, which is the subject of my paper, is revolutionary. Its application to the treatment of human ills is so productive of outstanding results even in the relatively inexperienced hands of those of us who are studying and applying it, that we become humble in the realization of the power for good that is at our disposal. The more we study the more we realize the possibilities inherent in the intelligent application of this concept.

It is beyond the scope of my time to do more than give a brief background of the development of this idea, an outline of its main principles and an indication of its therapeutic potentialities.

At the beginnings of the Cranial Concept, Dr. Sutherland relates that while a student in A. S. O. in 1899, he was one day observing a disarticulated skull belonging to Dr. Still, when a thought forcibly struck him. "The articulations of the temporal bone are beveled and serrated like the gills of a fish, for respiratory mobility."

This thought became almost an obsession to the young Osteopathic mind and he began studying the articular surfaces of the disarticulated cranial

bones, with the conclusion that they were truly designed for motion. This was indeed a revolutionary idea. The standard anatomy books then as they do yet today, described two types of joints, Synarthrodial and Diarthrodial. A. Synarthrodial—characterized by (1) continuous and direct union of the opposing surfaces, (2) no trace of joint cavity, and (3) an entire absence of movement! The sutures and other cranial articulations are thus classified. B. Diarthrodial, characterized by joint cavity and motion.

Once the Osteopathic mind had satisfied itself that the bones of the skull formed a functional mechanism designed for motion, the correlative thought that such a mechanism would be subject to lesion production, was natural.

Through the years Dr. Sutherland continued to study, experiment, and observe. In the beginning most of his experiments were on his own head. He would produce various types of lesions in his own cranium and study their effects. I have heard Mrs. Sutherland tell that more than once she was very much worried for fear he would be unable to correct the lesions produced. Often with lesion production his personality and attitudes would be definitely altered, and you can well imagine her concern, for there was no one other than Dr. Sutherland who knew how to reduce the lesions! The full story of those years would indeed be fascinating reading!

In due time, Dr. Sutherland began applying to patients the technics he had developed with, as he says, "results which suggested that the idea was worth passing on to a few of the profession." He made several talks and wrote numerous articles, but as with most true pioneers, his ideas were, in the beginning, ridiculed and definitely pronounced as unscientific and impossible. Several leaders in our profession, with typical omniscience and forgetful of the Allopathic derision of Sacro-Iliac mobility a few years earlier, dogmatically stated that cranial mobility was an impossibility.

Finally, however, some began to see the light and since 1940 there has been an ever increasing demand for instruction in this phase of Osteopathy. The reason, of course, is the results obtained by those applying the concept. Over three hundred D. O.'s have had some instruction from Dr. Sutherland, or under his direction.

While not desiring to favor any particular Osteopathic school, I do want to say that at the present time the only places where one may secure adequate Cranial instruction are at Dr. Sutherland's home in St. Peter, Minn., or at the Des Moines College, where classes are held in April and October.

Briefly the Cranial Concept states that the following components

1. The brain and its coverings, the intra cranial membranes
2. The Spinal Cord and its coverings, the intraspinal membranes
3. The Cerebro Spinal Fluid
4. The Articular mobility of the Cranial bony mechanism, and
5. The Articular mobility of the Sacrum between the Iliia, form a functional, physiological unit which Dr. Sutherland has termed the Primary Respiratory Mechanism.

Before describing some of the functional phases in the operation of this

mechanism, I'd like to point out a few anatomical and physiological facts which are answered or interpreted by the Cranial Concept.

FIRST: As has been mentioned, the design of the articular surfaces indicates adaption for motion.

SECOND: Sutures are articulations in skulls of all ages can be defined and usually disarticulated, if no pathological changes have taken place.

THIRD: The only factor physiologically capable of maintaining a joint surface is mobility. If there is no mobility, ankylosis occurs. In this connection, it is interesting to note the method used to disarticulate skulls. The cleaned specimens are filled with dried peas or beans, and the opening partially closed. They are then immersed in water and the internal pressure produced by the expansion of the peas or beans as they absorb water lessens the sutures sufficiently to allow disarticulation.

FOURTH: We all know that the nasal accessory sinuses are air cells in the bony structure of the skull, but no explanation is offered as to the mechanism that keeps the air in these sinuses fresh and renewed. The accessory sinuses are like closed rooms opening into a hallway. Air moving along the hallway would not adequately aerate the inner rooms. Basically what is so-called sinusitis, and why is it so prevalent?

FIFTH: The motive power for returning the venous blood of the extremities and trunk to the heart is of course muscular contraction. What about the

THIOPENTARSON

For The Chemotherapy of Syphilis

Since the introduction of THIOPENTARSON to the medical profession eight and one-half years ago, over three-quarters of a million doses have been produced, sold, and used. This total represents treatment of approximately 30,000 patients of both sexes, in all stages of the disease.

Among its chief advantages over all other anti-luetic preparations are the following: *It produces no toxic reactions . . . It penetrates into the spinal*

fluid through the brain barrier shortly after its administration . . . it sterilizes the lymphatic glands, thus overcoming the most stubborn, unyielding cases . . . Its administration is painless and well tolerated . . . thus its efficacy in the treatment of children, female and obese patients . . . absorption is rapid and complete . . . AND IMPORTANT . . . no mixing is necessary on the part of the physician, because it is already prepared in a sterile, stabilized, aqueous solution.

HOW SUPPLIED

2 C. C. AMPULES		RUBBER STOPPERED VIALS	
Box of 12.....	\$ 5.00	30 c. c.	\$ 4.50
Box of 24.....	9.50	100 c. c.	12.00
Box of 100.....	35.00		

Additional information upon request . . .

MEDCALF & THOMAS

Physicians', Hospital & Laboratory Supplies
Medical Arts Building
Fort Worth, Texas

venous channels of the head? There are no muscular agencies in the head to assist venous circulation. The main venous channels of the Cranium are membranous, formed by the Dural walls of the Falx Cerebri and Tentorium Cerebelli, which in turn are attached to the bony skull. Then, too, it is a fact worthy of note, that the main veins leaving the skull find their exit through openings in the articulations—that is between two bones, while the arterial supply to the skull enters through openings in the body of the bones.

There are many other interesting anatomical and physiological facts which are adequately explained only by this concept, but the above will suffice to indicate the possibilities.

Returning to our Primary Respiratory Mechanism, its main activity is alternate expansion and contraction for the purpose of maintaining adequate circulation of the body fluids, including the extremely important Cebro-Spinal Fluid, to and from the vital centers of the brain and spinal cord.

The expansion and contraction of the diaphragmatic respiratory mechanism is secondary to, and usually coincident with the expansion and contraction of the Primary Mechanism—thus at the period of Costal Inhalation we have an expansion of the whole Primary Mechanism, and contraction with the Costal Exhalation.

Among the changes occurring with EXPANSION OR INHALATION are these:

- (1) A relatively increased lateral diameter of the skull with a relatively decreased anterior posterior diameter.

- (2) A relative flexion of the Spheno Basilar symphysis, with elevation of the sella turica and pituitary gland.

- (3) There is a relative expansion of the cerebral hemispheres together with an expansion of the cerebral ventricles, which in turn affects the movement of the cerebro-spinal fluid within the ventricles, and in the sub-arachnoid cisterns and in the spinal cord.

- (4) The spinal dural membranes are attached directly to the bony skull around the foramen magnum and the first two or three cervical vertebrae, and then hang relatively free within the spinal canal until they reach the sacrum where they again gain bony attachment within the sacral canal. Because of this, flexion of the sphe-no-basilar junction produces a pull on the intra-spinal dura which is transmitted down to the sacrum producing a relative backward motion of the base of the sacrum and a relative forward movement of the apex.

- (5) In addition to flexion of the sphe-no-basilar symphysis and motion of the sacrum with inhalation, the relative position of each of the other cranial bones during expansion of the mechanism can be described. I'll not take time to do this now, but will mention one or two further points.

- (6) With inhalation, all the accessory air sinuses expand allowing fresh air to enter. Also at the same time there is a relative widening of the orbital cavities and a more prominent position of the eyeballs. The orbital cavity, by the way, is made up of parts of seven different cranial bones!

The above will suffice, perhaps, to indicate a few of the complicated

changes in the Primary Respiratory Mechanism that occur with inhalation or expansion. The opposite effects occur with exhalation or contraction. No doubt many questions will be brought to mind by the foregoing, very brief outline of the normal mechanics of this Primary Respiratory Mechanism.

As we have indicated, this mechanism is subject to functional disturbances from a variety of traumatic and developmental factors. Changes in the relationships and the mobility of the various bones of the mechanism are termed Cranial Osteopathic lesions and may be productive of a wide variety of pathological conditions depending on the location and the extent of functional interference.

I'll mention just a few to indicate the possibilities. Think first of all of the suffering and misery resulting from sinusitis due to a lack of adequate mobility of the facial and frontal bones with a consequent lack of adequate venous drainage from the mucous linings of the accessory air sinuses. Here indeed is a fertile field for real Osteopathic therapy.

Then consider the eyes—what causes the increased intraocular tension in glaucoma, what about trauma to the orbital cavity resulting in abnormal and unequal tension on the ocular muscles producing crossing of the eyes? What about cataracts?

Then think of the delicate hearing mechanism and the equilibrium apparatus which are housed in the temporal bone and the train of symptomatology resulting from disturbances to these mechanisms. Why not specialize, if you will, in the Osteopathic management of ear problems?

Or, if you prefer, you may give attention to the so-called migraine syndromes, and the personality as well as other changes due to concussion and

ANNOUNCEMENT

BIOLOGICALS

PHARMACEUTICALS

M. L. Claytor & Company

203-204 Gibbs Building

San Antonio 5, Texas

Garfield-7423

DISTRIBUTOR FOR: Sherman Laboratories, George A. Breon & Co.,
W. F. Straub & Co., Estro Chemical Co.

Write for Special Prices

Ampoules & Vials

Testosterone
Vitamins

Estrogens
/B-Complex

trauma. In this connection, think of the tremendous numbers of war casualties needing real help.

Then, if you like children, consider the numbers of birth injury cases, the mongolians, the spastics, etc. that might be immeasurably helped by early molding of the skull with restoration of free functioning of this Primary Mechanism. Dr. Beryl Arbuckle of the Philadelphia College hospital is doing just this.

Now it may seem that I have been envisioning a panacea, that application of cranial technic will cure everything from an ingrown toe nail to falling hair. That would, of course, be a wrong impression. The Cranial Concept is no more than the application of Dr. A. T. Still's Osteopathic Concept to the cranial mechanism. It does not obviate the need for correction of spinal lesions, but it does greatly assist their correction. Cranial lesions can maintain spinal lesions and vice versa. Dr. Sutherland's Cranial Concept does, however, broaden immeasurably our Osteopathic armamentarium, and in my opinion should at least be understood by every practicing D. O. whether or not he becomes skilled in the application of Cranial Technic.

Alton, Illinois.

Delivered at the 47th Annual Convention of the Michigan Association of Osteopathic Physicians and Surgeons, Grand Rapids, Michigan, October 30, 1945.

Arthritis Is Flourishing As An Aftermath of War, Says Osteopathic Doctor

"Arthritis rapidly is becoming a national health problem as a result of the war," Dr. Stephen B. Gibbs, osteopathic physician of Coral Gables, Fla., writes in the December issue of Osteopathic Magazine.

"The combination of the spine-jolting war machines such as jeeps and tanks as well as undue exposure to the elements, nervous strain, and shock has caused a comparatively high per cent of the military personnel to return to civilian life with some form of arthritis," Dr. Gibbs points out.

We writes that civilians too are suffering from the disease in greater numbers than before, because of the long, irregular work hours in war industry and the mental strain of the war.

Other contributory factors to the spread and growth of arthritis among the civilian population include: poorly balanced diets lacking important minerals, particularly calcium and vitamins, and long-continued occupational strains.

Dr. Gibbs warns that the national population as a whole has experienced a lowering of body resistance which will tend to "encourage arthritis to flourish."

In Convention Dissembled

The wise and scholarly doctor, exceedingly learned in economics, echatology, entomology and ersatz, rose to speak to the delegates from many lands, representing the greatest financial and commercial interests of their respective nations. The speaker had been a rebellious Marxian in his younger days, but his wild and reckless youth was now "put behind him long ago and far away," and he was now a pale gray conservative hallowed with economic lore. "When the delegates have presented their most pressing needs and economic sentiments," he said, "I will make my tri-annual report."

"Durante de los primeros siglos despues del siglo de hierro . . ." said the representative from the Argentine.

"Die Hosen sind lange, und kurz ist unser Gewinn," lamented the erstwhile clothing magnate from Germany.

"Mais il y en a ici!" interposed the munition manufacturer from France, in evident agitation. And "La donna propone ed il marito indispono," added he from Italy. "Ishkabibble!" said the man from Greece, cryptically. The delegates from N'Yawk was stammering. Finding his tongue he said "Six bits says I make a seven the next throw."

Marriage, Man-Sized Pay Achieved in Osteopathy by Women, Survey Shows

Happy marriages and an equal earning power with men are achieved by women osteopathic physicians, a survey conducted by the Delta Omega sorority, professional osteopathic society, discloses.

One of the questions asked in the survey was: Do women osteopathic physicians, busy with professional life, have time for marriage and a home?

"The answer was unanimously in the affirmative," Miss Marcheta Field, student at the Kidsville College of Osteopathy and Surgery, Kirksville, Mo., of the Alpha chapter of Delta Omega which was responsible for the survey, said, "with even further proof of its workability shown in the survey's figures that 58 per cent of women osteopathic physicians are married, 14 per cent are widows, and only three per cent have been divorced, a small rate in comparison with the overall divorce rate in this country."

Of the 58 per cent who are married, 47 per cent married doctors. Not only do women osteopathic physicians marry, but 40 per cent of them have families, with the average at two children for each doctor. While rearing their children, 95 per cent continue in practice, the survey reveals.

The average annual gross income for both men and women osteopathic physicians is the same, and is comparable to that of the other professions.

Miss Field said, "The survey's figures give concrete evidence that contrary to popular opinion that women osteopathic physicians must be 'Amazons', in reality they only average five feet five inches in height. Of the total women in practice, 62 per cent are of average build, 22 per cent are slender, and 16 per cent are of heavy build."

▲ ▲ ▲

Dr. E. E. Blackwood of Comanche expects to occupy the hospital now under construction at 201 East Grand that city, shortly after January 1st. The hospital is thoroughly modern in very detail and when completed will contain twenty beds and six bassinets. Dr. Blackwood has been operating a six bed, three bassinet hospital at 508 West Central Avenue, Comanche, for the past several years. Dr. Blackwood is to be commended upon the splendid service he has rendered his community, and we congratulate him on this public spirited enterprise.

We extend congratulations to the following osteopathic physicians and surgeons who received licenses from the Texas State Board of Medical Examiners, October 15, 1945.

Dr. Leland Anderson, Junior, College of Osteopathic Physicians and Surgeons '45. Serving an internship with the Amarillo Osteopathic Hospital.

Dr. Robert Edwin Bennett, Kansas City College of Osteopathy and Surgery, '45. Now located at 1622 Hayden Street, Amarillo, Texas.

Dr. Thomas Berry Brazelton, Junior, College Osteopathic Physicians and Surgeons, '43. Now located at Palm Court, Waco, Texas.

Dr. John Walton Drew, Philadelphia College of Osteopathy and Surgery, '39. Sparks Clinic and Hospital, Dallas, Tex.

Dr. Garnett Algerine Lober, Kirksville College of Osteopathy and Surgery, '45.

▲ ▲ ▲

Dr. Horace Emery, Lubbock, Texas, a recent graduate from the Kirksville College of Osteopathy and Surgery, has accepted an internship in the Amarillo Osteopathic Hospital.

SPARKS

CLINIC AND HOSPITAL



Offering

Good Diagnostic
and Hospital Service



5003 ROSS

Dallas

To The Women:—

Let's attend our next State Convention in Dallas the last of April, Start planning now to get someone to stay with your children so that you may go with your husband. It is your duty to encourage him in his professional contacts and by attending conventions he will keep abreast of the progress of the Osteopathic Profession.

You will also be benefited. You will meet other women who enjoy the privilege of being doctor's wives. You will learn what other Auxiliaries are doing. There is to be a Luncheon just for the women at this Convention, not to mention other entertainment in your behalf.

Do plan to come. We'll see you the last of April in Dallas.

Mrs. J. Francis Brown, Pres. Texas A.A.O.A.

1228 Bowie
Amarillo, Texas

Eating to Grow Thin

After age 25, one slice of bread extra per day may, in 20 years, make the difference between serious obesity or physical fitness.

Obesity is caused by the consumption of more food than the body uses for its current activity. The unused food is converted into fat.

The average fat person becomes that way because he ignores the first ten pounds, excuses the next few, and then reaches the point where he does not care and will not admit the cause of the weight increase.

Patients are usually prone enough to give excuses, but the obese patient does this more readily than any other. He resists all ideas of diet control, but nevertheless he is very grateful and happy after weight has been lost.

Most fat people unfortunately like fattening foods. They do not necessarily eat more than other people, but they eat fattening foods. They are synonymous with the cigarette smoker.

The balance of weight control is a matter of simple arithmetic. The patient who eats more food than the body needs, gains weight; the patient who eats less, loses weight.

Bread is the chief offender in the line of fattening foods. This is true of bread in all its forms. Most fat people like bread and eat lots of it. Bread is over 50% starch, and one slice represents 75 calories. Whole wheat, rye, toast, rolls, crackers, and similar items are as fattening as white bread. For example, at age 25, most people are of normal weight. But if they eat only one extra slice per day for 20 years, at age 45 they are much overweight.

One of the simplest methods of weight reduction is to start with the first excess pound and omit one slice of bread daily. When this start is made, the diet must be stricter. Other starchy foods, such as potatoes, macaroni, spaghetti, noodles, cake, puddings and pastries, rice, corn, and cereals should be omitted entirely.

Sweets are also a weakness with other overweight persons. Sugar, candy, honey, molasses, syrups, preserves, jams and jellies—are all worth their weight in fat. Saccharin may be used instead of sugar for sweetening.

Fats and oils, too, are fattening. Butter, fried foods, fat meat, heavy cream, and mayonnaise should be reduced to a minimum.

Most fruits and vegetables are not fattening. Pineapple and bananas contain

E. H. McCLURE CO.

1909-11 Pacific

DALLAS, TEXAS



SERVING TEXAS PHYSICIANS, CLINICS AND HOSPITALS

44 YEARS



At Your Service Day and Night



Complete Line Surgical and Medical Supplies
and Equipment

about 20% sugar and should be eaten only in limited quantity. Raisins, canned and fresh prunes, pears, grapes, and apples may also be considered fattening as well as peaches, preserved figs, and grape juice bottled with sugar added.

Rice and corn are considered cereals and are quite fattening. Potatoes, peas, and beans (except string beans) contain 20 to 25% starch, and should be eaten only in limited quantities. Other fruits and vegetables may be eaten freely.

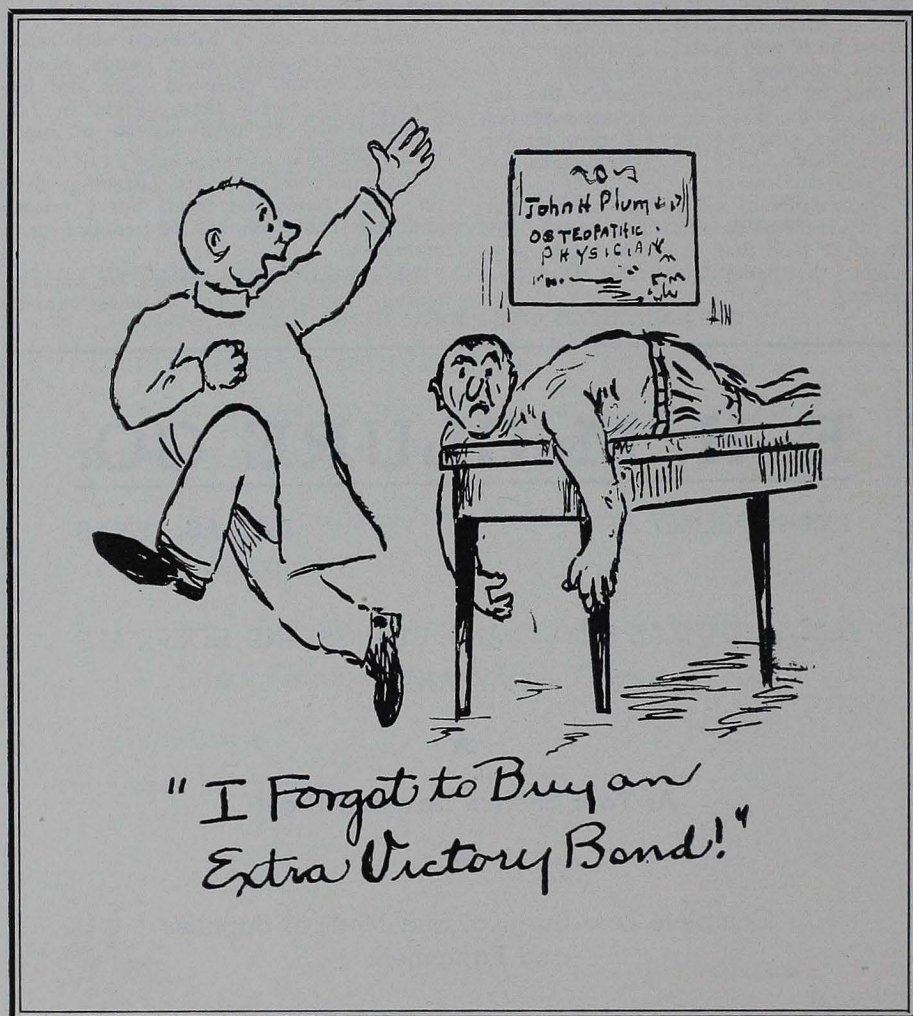
The patient dieting should lose about two pounds per week. If there is no weight reduction in a month it indicates either a failure to keep to the diet or an unsatisfactory diet.

Other factors concerned in weight reduction are sleep and rest, exercise, digestion, and health. A patient sleeping and digesting well, and resting a lot, tends to gain weight. An active person, having poor digestion, or emotionally disturbed, loses weight. Wasting illness also a loss in weight.

No surgical operation causes a gain in weight except insofar as it tends to restore the patient to good health, with a resultant increase in appetite.

Thyroid and other glandular products should not be given for weight reduction unless the patient has some other definite indication for the preparation.

Water has nothing to do with weight



unless there is a heart or kidney ailment.

Exercise will reduce weight, but a great deal vigorous exercise is required to work off a single pound.

Obesity can be both prevented and corrected. Diet is the most important factor. Following is a list of foodstuffs that should be in every obesity diet.

FOODS HIGHLY RECOMMENDED

Thin soups, lean meat, including poultry and fish (not fried), eggs, cheese (except cream cheese), skimmed milk or buttermilk, vegetables (except grains and potatoes), peas and beans (should be limited, except string beans), fruits (except pineapple, raisins, canned and fresh prunes, pears, apples, peaches, preserved figs and grapes), and gelatine desserts without sugar. Use saccharin for sweetening.

FOODS NOT RECOMMENDED

Rich soups and gravies, creamed foods, bread (all kinds including whole wheat, rye, crackers, Rye Crisp, zwiebach, rolls, biscuits), pancakes, macaroni, spaghetti, noodles, rice, corn, wheat, oats and their flours and products, fats and oils, butter, cream, mayonnaise, fat meat, fried foods, sugar, candy, syrup, molasses, preserves, jams, jellies, honey, fountain drinks, cake, pudding, pastry, pie, tapioca, ice cream and gelatine desserts such as jello.

BORDER-LINE FOODSTUFFS

Pineapple, banana, and fruits canned

with sugar; potatoes, peas, beans (except string beans); coffee, tea, without sugar or cream; salads with french dressing.

▲ ▲ ▲

The Panhandle Society of Osteopathic Physicians and Surgeons held their last meeting of the year 1945, Sunday, November 11th, at the Capitol Hotel in Amarillo. Report of Committees and other routine business engaged the attention of the Society, and many subjects were discussed and disposed of. Dr. Kirby J. Clements of Plainview was elected to a Life Membership in the Society.

The following officers were elected for the ensuing year:

President, Dr. E. D. Thompson, Lubbock; President-Elect, Dr. L. V. Cradit, Amarillo; Vice-President, Dr. W. R. Ballard, Pampa; Secretary-Treasurer, Dr. G. W. Gress, Amarillo.

Dr. Reginald Platt, Houston, was guest speaker and gave a most interesting lecture on Cranial Technique."

A banquet was held in the evening, attending by the physicians and their wives. Forty-four persons were present at this pleasant function.

▲ ▲ ▲

Dr. James E. Fite, Canyon, Texas, a recent graduate of the Kirksville College of Osteopathy and Surgery has accepted an internship in the Amarillo Osteopathic Hospital.

J. EDWARDS CO.

Surgical and Hospital Supplies

513 N. 14th Street

• Waco, Texas

Phone 2678



Shipments made same day as order received

Sacro-Iliac Belts, Supports and Trusses

Sharpen Scissors, Replate and Repair Surgical Supplies

THE RH FACTOR

By ELIZABETH C. JORDON, M. T.

To Macacus rhesus monkeys, rabbits, guinea pigs, or wild jackasses the Rh factor may be meaningless, but for homo sapiens it may hold tragic significance.

Just what is the Rh factor? According to the research of Landsteiner and Wiener, it was demonstrated that agglutinins, developed in rabbits or guinea pigs against the red blood corpuscles of the Macacus rhesus monkey, would also agglutinate corpuscles of 85% of human individuals regardless of blood type; therefore, the agglutinin in human corpuscles responsible for the reaction has been termed the Rh factor. The other 15% of individuals lack this factor.

Why is this of importance? Until Rh was discovered, it was a mystery why some patients receiving transfusions of blood from their own group sometimes had hemolytic transfusion reactions. We know that in at least 90% of such cases the patients are Rh-negative individuals who have become sensitized to the Rh factor as a result of a previous transfusion or pregnancy, and dangerous reactions can now be prevented by transfusing these individuals with Rh-negative blood of a compatible blood group.

The discovery of the Rh factor has also led to the solution of a second medical mystery; namely, it has served to explain why certain women had infants with hemolytic diseases (erythroblastosis) and/or unexplained stillbirths, and/or successive miscarriages in some cases. In the usual case, the mother is Rh-negative and the father Rh-positive; the fetus is Rh-positive because the Rh agglutinin is inherited and is a dominant characteristic. Because the mother is Rh-negative, anti-Rh antibodies are produced in response to a pregnancy with an Rh-positive fetus, on the theory that there is a leakage of agglutinogens through the fetal circulation into the mother's circulation. These antibodies, in turn pass through the placenta and hemolyze the infant's blood, giving rise to one or another of the manifestations of erythroblastosis.

Thus, it follows that every Rh-negative patient should be given only Rh-negative blood; however, due to the scarcity of sufficient potent anti-Rh typing serum and Rh-negative donors, it is sometimes possible to forego the determination of the Rh factor, as in the case of a male patient who has never been transfused previously, and who, if Rh-negative, has not developed anti-Rh antibodies. In an

Rh-negative female, nevertheless, although a reaction may not result at this time, it is better to give only Rh-negative blood, because a transfusion with Rh-positive blood, might ruin the patient's chances of having a normal child. Even though the patient's husband be Rh-negative, thereby producing an Rh-negative fetus, the antibodies in the blood of the Rh-negative mother produced by the Rh-positive blood from the transfusion, would tend to work to the disadvantage of the infant.

In patients who have had previous transfusions or pregnancies, Rh tests should be carried out before transfusion, particularly if any of the transfusions or pregnancies have been followed by complications; but the chance of a reaction at the first transfusion, or of an abnormal infant at a first pregnancy, is almost nil.

How is the Rh factor determined? There are at least three methods available for this test, the first two being similar. One of these uses a liquid serum; the other a dried product. Both require from 30 minutes to one hour incubation, which make these methods both time-consuming unsuitable for the doctor who might like to utilize this test in his office. The third method, however, can easily be adapted for office use, if instructions are followed exactly.

It has been our experience that the Lederle product works out most satisfactorily, although there may be others equally as good that employ this technic.

INSTRUCTIONS

A suspension is prepared by dropping two full drops of blood from finger or ear into 0.5 c.c. of physiological saline containing 1% sodium citrate. This suspension represents about a 10% suspension of cell sediment. In cases of severe anemia, the suspension should be prepared with this in mind by adding a bit more blood.

One drop of cell suspension is placed on a clean glass slide with a dropper provided in the package. Next to this is placed one drop of Anti-Rh serum, if the vial package is used, or the contents of one capillary tube, in which manner the serum is also dispensed. The two drops are mixed over an area of about three-quarters of an inch, with the rounded end of a small test tube such as that in which the capillary tubes are contained, or the rounded end of a glass rod. Tip the slide back and forth once and place on damp filter paper or blotter, covering with a Petri dish cover or some other suitable cover; even a pasteboard box will serve the purpose. This is to prevent evaporation. Let it remain undisturbed for three

minutes. At the end of this period, pick up the slide and give it two or three gentle turns. While continuing to hold the slide with a very slight motion, observe the mixture closely until a six minute period is ended. This is calculated from the time the serum and cell suspension was first mixed. In a positive test, clumping similar to that of a blood typing test, is always clearly visible at that time. All observations must be terminated in six minutes.

The positive reaction may be likened in appearance to red pepper, sprinkled rather thickly into clear water; while the negative reaction will appear homogenous, or simply as blood suspended in saline.

A few points of caution are to be noted in doing this test. At no time should the slide be vigorously twisted or rolled, since this tends to break up the clumps and might make a positive test appear negative.

The test must be macroscopic. Do not examine the negative mixtures microscopically. If the latter is done, a suggestion of initial clumping may be visible which might raise doubt in the mind of an inexperienced observer.

If possible, it is desirable to test a known Rh-negative and a known Rh-positive blood as controls with each unknown blood.

Although the Anti-Rh Serum contains a preservative, it is advisable to store it in a refrigerator.

Anti-Rh Serum of animal origin should no be used to type the blood of newborn infants, since all such bloods react positively, and in view of the fact that the Rh factor is hereditary, with Rh-positive being dominant, test of the parent's blood is all that is necessary.

If all the above directions are followed exactly, this procedure should be done very easily in any office with very little difficulty and but single equipment.

Dr. and Mrs. Felix Spector contemplate an early departure for New York, Philadelphia, and eastern clinics, as it is Dr. Spector's intention to devote some time to post-graduate study in diagnosis and surgery. Dr. Spector has conducted a practice in Texas with great success and we trust that the Dr. and Mrs. Spector will again cast their lot with the Texans.

Dr. W. D. Maxwell, KC '42, after serving an internship at the Amarillo Osteopathic Hospital has opened offices in the Midway Building, Dalhart, Texas. Dr. and Mrs. Maxwell are at home at 911 Omaha Street, Dalhart.

Santa Comes Once a Year, Mailman's Bag Ever Here

Santa's pack doesn't hurt his back because he only totes it once a year, but pity the poor mailman who carries his bag every day.

Christmas to the mailman just means that much more strain to an already overworked spine, Dr. C. R. Nelson, osteopathic physician, Chicago, declared.

He explained, "The carrying of weight constantly on one shoulder often results in curvature of the spine. In attempting to balance the weight of the pouch, the mailman hitches up his shoulder. The muscles attached to the shoulder and spine then contract and pull the spine out of normal alignment."

The added burden of Christmas packages and mail aggravates this condition considerably, Dr. Nelson pointed out and advised the mailman "to shift his pack to the opposite shoulder every other day so as to lessen the chances of acquiring a spinal curvature."

▲ ▲ ▲

Medicine is the only profession that labors incessantly to destroy the reason for its own existence.—Bryce, 1914.

HEDGECOCK
A TEXAS INSTITUTION

HEDGECOCK ARTIFICIAL LIMB & BRACE MFG. CO.
2827 COMMERCE ST. DALLAS
OUT WHERE YOU CAN PARK

MEDICAL CORPS OFFICER ON TERMINAL LEAVE

Lt. Col. Leonard B. Hurt, on terminal leave from the Army after serving over three years in the Medical Corps, has returned to his home 3917 Miramar Drive, Dallas, after serving in the Pacific area as commanding officer of a medical unit assigned to the Sixth Army and attached to combat forces. He received his Army training with the 30th Medical Regiment at Camp Barkley, and served at Camp Bowie Regional Hospital and McClosky General Hospital after returning to the United States. He expects to re-enter the practice of medicine in Dallas.

The Osteopathic profession in Texas suffered the loss of one of its most promising young surgeons in Paul William Sistrand. Dr. Sistrand died in Dallas November 11, 1945, following an automobile accident.

Dr. Sistrand was born in Bridgeport, Conn., on August 16, 1914. Following his graduation from Bridgeport High School in 1931 he entered Upsala College in East Orange, New Jersey, where he completed two years work before enrolling in K. C. O. S. Dr. Sistrand received his D. O. degree from Kirksville in 1939 and interned at Laughlin Hospital and at General Hospital at Algona, Iowa.

Dr. Sistrand first practiced in Texas in Tyler with Dr. Howard Coats. In 1940 he opened his own clinic in Lubbock and was associated with Dr. Glen G. Porter for the next four years. During the past eighteen months, Dr. Sistrand had resided in Dallas and had practiced in that city as an associate of the Sparks Clinic and Hospital. At the time of his death he had completed the necessary training to qualify for certification by the American Board of Surgery and was waiting such certification.

Dr. Sistrand was a member of the A. O. A. the Texas Association of Osteopathic Physicians and Surgeons, the Alpha Tau Sigma Fraternity and the Sigma Sigma Phi honorary scholastic fraternity.

Dr. Sistrand is survived by his wife, the former Mary F. Knox of Lubbock and his sister Mrs. Charles Waehler of Bridgeport, Conn.

NEW OSTEOPATHIC HOSPITAL

The Houston Osteopathic Hospital was opened January 17th, with a two day Clinical Assembly; guest surgeons present at the opening were Drs. Sam F., and Marille E. Sparks of Dallas, Dr. Ralph P. Baker of Lancaster, Pennsylvania and Dr. J. Gordon Hatfield of Los Angeles, California. Dr. Reginald Platt was in charge of the opening program.

The Hospital is governed by a Board of Trustees, comprising members of the osteopathic profession of Houston together with several prominent laymen. The present officers of the Board of Trustees are:

President, Dr. W. S. Gribble, Jr.; Vice President, Dr. J. R. Alexander; Secretary, Dr. William H. Badger; Treasurer, Mr. O. C. Castle.

Dr. William F. Hall is President of the Medical and Surgical Staff, with the following heads of Departments:

Surgery, Dr. W. S. Gribble, Jr.; Anesthesia, Dr. Esther M. Roehr; Pathology, Dr. Morris Goldman; X-Ray, Dr. H. M. Grice; Osteopathic Medicine, Dr. David Jaffe; Obstetrics, Dr. William F. Hall.

The Hospital has an average capacity of 26 adult beds, with a maximum capacity of 35 adults, and 10 bassinets, with major and minor operating rooms, obstetrical delivery room, emergency room, X-ray room, interns quarters, etc. The Hospital is located at 5115 Montrose Boulevard, in one of the best sections of Houston, one block south of the Plaza Hotel on Montrose Boulevard, and one block from the junction of Montrose Boulevard with Main Street at the Garden Circle; and is of all brick and masonry construction completely air-conditioned and is thoroughly modern throughout.

All of the osteopathic physicians of Houston have either donated or pledged \$1,000 to the project, some considerably more, together with hospital equipment, furnishing for private rooms, etc. Two most generous and substantial contributions were made by osteopathic physicians outside of Houston; Drs. Claude and Auldine Hammond of Beaumont \$1,000; and Drs. Sam F. and Marillo E. Sparks of Dallas \$1,000; certainly a splendid expression of good will and encouragement.

Great credit is due Dr. W. S. Gribble Jr., of Vidor for his magnificent and untiring efforts in making this hospital a reality. For many years there has been an overwhelming need for an osteopathic in Houston and many efforts were made to promote the same. Early in January of 1945, Dr. Gribble became interested

in the project, and decided to build such a hospital. He appeared before the War Production Board and secured a priority rating suitable for the immediate construction of such a hospital; and bought a suitable site, located on Montrose Blvd. and Berthea Street, and engaged the service of James L. Keith, Architect, of Houston to draw the plans for such a structure. After all data was completed Dr. Gribble called a meeting of the osteopathic physicians of Houston, March 14th, 1945, presented the proposal for their consideration and sought their aid and advice in the formation of a medical and surgical staff. At this meeting over \$20,000 was pledged and it was decided to form a non-profit association and erect the hospital with funds to be donated by the osteopathic physicians of Houston and their patients. The plan met with instantaneous success; the entire osteopathic profession of Houston rallied to the support of the institution, articles of incorporation were drawn and a charter issued. The priorities previously granted to Dr. Gribble were transferred to the new Association, together with the building site, and the architect's plans; and the

institution came into being, a tribute to the vision and initiative of Dr. Gribble and the generous support of the osteopathic profession in the Houston area.

▲ ▲ ▲

A Modern Metropolis Is Born

TRUMAN, TEXAS, U. S. A.

'Mid the loud huzzas of the assembled gentry and yeomanry, who had gathered from near and far to witness this historic and sublime event; down came the old sign reading "Mesquite Tap," and up went the new one "Truman, Texas." Mrs. E. H. Hopkins christened the new sign by breaking a quart bottle of Grade A. Milk across its bow, and the crossroads town of 200, seven miles east of Dallas, became the first United States community to bear the name of the 32nd President.

The entire event was the idea of Dr. Sam L. Scothorn who encountered no serious opposition in obtaining the sanction and approval of the Mesquite Tap village elders. The President acknowledged the honor in a timely telegram.

A COMPLETE X-RAY & PHYSICAL THERAPY SERVICE TO
THE PROFESSION

Johnson X-Ray & Electro Therapy Co.

920 Liberty Bank Building

Phone C-2844

DALLAS, TEXAS

Offers to
THE OSTEOPATHIC PROFESSION
MATTERN X-RAY EQUIPMENT

Shockproof

Fluoroscopic

Radiographic

Portable and Mobile
15 MA up to and including 200 MA

"Service When You Need It"

Zenith of All Therapeutic Measures

PROTOZIDIN

BACTERICIDE

FUNGICIDE

PROTOZOACIDE

HELMINTHICIDE

(smaller species)

... and in addition these virtues

Prolonged anaesthetic effect

Non-escharotic

Non-Cumulative

Non-toxic

Inflammation reducing

... when applied to mucous membranes and exposed tissues, incisions, abrasions, burns, etc.

Now available through the Drug Trade

BASIC PHARMACEUTICALS, INC.
 Dallas 1 P. O. Box 863 Texas



Farquharson Sacro-Iliac Clinic

OSTEOPATHIC PHYSICIANS

Chester L. Farquharson, D. O.

R. A. Smith, D. O.

Lester M. Farquharson, D. O.

Esther Roehr, D. O.

J. Ralph Cunningham, D. O.

Helen Allen, Technician

Marguerite Burghard, Business Manager

HOUSTON, TEXAS

1016 Louisiana St.

Officers of the District Associations of the Texas Association of Osteopathic Physicians and Surgeons

DISTRICT 1

Dr. E. D. Thompson, Lubbock.....	President
Dr. L. V. Cradit, Amarillo.....	President-Elect
Dr. W. R. Ballard, Pampa.....	Vice-President
Dr. G. Welton Gress, Amarillo.....	Secretary-Treasurer

DISTRICT 2

Dr. Katherine Kenney Carlton, Ft. Worth.....	President
Dr. R. H. Peterson, Wichita Falls.....	Vice-President
Dr. H. L. Betzner, Dallas.....	Secretary-Treasurer

DISTRICT 3

Dr. Ernest P. Schwaiger, Winnsboro.....	President
Dr. H. G. Grainger, Tyler.....	Vice-President
Dr. Burr Lacey, Rusk.....	Secretary-Treasurer

DISTRICT 4

Dr. J. M. Peterson, San Angelo.....	President
Dr. George G. Smith, Dublin.....	Vice-President
Dr. Wiley Rountree, San Angelo.....	Secretary

DISTRICT 5

Dr. J. B. Riggs, Groesbeck.....	President
Dr. Ira Kerwood, McGregor.....	Vice-President
Dr. Nelson E. Dunn, Bloomingrove.....	Second Vice-President
Dr. V. A. Kelley, Waco.....	Secretary

DISTRICT 6

Dr. Edward S. Gardiner, Houston.....	President
Dr. Julius McBede, Houston.....	Vice-President
Dr. J. Edward Vinn, Velasco.....	Secretary

DISTRICT 7

Dr. H. H. Edwards, Jr., San Antonio.....	President
Dr. W. H. Van de Grift, Austin.....	Vice-President
Dr. T. T. Stovall, San Antonio.....	Secretary

DISTRICT 8

Dr. Merle Griffin, Corpus Christi.....	President
Dr. William Seydler, Corpus Christi.....	Vice-President
Dr. Neiland Hines, Corpus Christi.....	Secretary

DISTRICT 9

Dr. Joseph V. Money, Schulenburg.....	President
Dr. Paul E. Pinkston, Victoria.....	Vice-President
Dr. D. M. Mills, Victoria.....	Secretary-Treasurer



Make Arrangements
to Attend
Your
46th Annual
CONVENTION

April 25, 26 and 27



Headquarters:

BAKER HOTEL
Dallas, Texas

