The Bulletin

OF THE TULSA COUNTY MEDICAL SOCIETY

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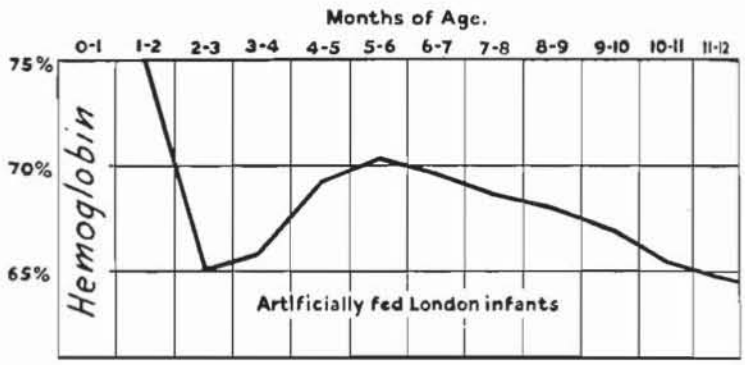
Nutritional Anemia in Infants



The accompanying chart of the hemoglobin level in the blood of infants is based on more than 1,000 clinical cases studied by Mackay. The sharp drop in hemoglobin during the early months of life has also been reported by a number of other authorities. It is noteworthy that this fall in hemoglobin has been found to parallel closely that of diminishing iron reserve in the infant's liver. The usual milk formula of infants in early life further contributes to this anemia because milk is notably low in iron. It is now possible, however, to increase significantly the iron intake of bottle-fed infants from birth by feeding Dextri-Maltose With Vitamin B in the milk formula. After the third month Pablum as the first solid food offers substantial amounts of iron for both breast- and bottle-fed babies.

Reasons for Early Pablum Feedings

1. The iron stored in the infant's liver at birth is rapidly depleted during the first months of life. (Mackay,[1] Elvehjem.[2])

2. During this period the infant's diet contains very little iron—1.44 mg. per day from the average bottle formulae of 20 ounces, or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt.[3])

For these reasons, and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Coons,[4] Galloway[5]), the pediatric trend is constantly toward the addition of iron-containing foods at an earlier age, as early as the third or fourth month. (Blatt,[6] Glazier,[7] Lynch[8]).

The Choice of the Iron-Containing Food

1. Many foods reputed to be high in iron actually add very few milligrams to the diet because much of the iron is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 gm. (Bridges.[9])

2. To be effective, food iron should be in soluble form. Some foods fairly high in total iron are low in soluble iron. (Summerfeldt.[10])

3. Pablum is high both in total iron (30 mg. per 100 gm.) and soluble iron (7.8 mg. per 100 gm.) and can be fed in significant amounts without digestive upsets as early as the third month, before the initial store of iron in the liver is depleted. Pablum also forms an iron-valuable addition to the diet of pregnant and nursing mothers.

Pablum (Mead's Cereal thoroughly cooked and dried) consists of wheatmeal, oatmeal, cornmeal, wheat embryo, brewers' yeast, alfalfa leaf, beef bone, iron salt and sodium chloride.

1-10 Bibliography on request.

"The average gain in weight of the children fed on the buffered lactic acid evaporated milk for the first ten days of life was 110.5 Gm., which surpassed that of any other group. In this period the infants fed on buffered lactic acid milk showed approximately seven times as great an increase in weight as the other artificially fed infants. This increase in weight was reflected in the excellent tissue turgor and muscle tone of these infants. Furthermore, the morbidity in the group was almost as low as that recorded for breast fed infants."—SMYTH, FRANCIS SCOTT, and HURWITZ, SAMUEL: J. A. M. A., Sept. 7, 1935.

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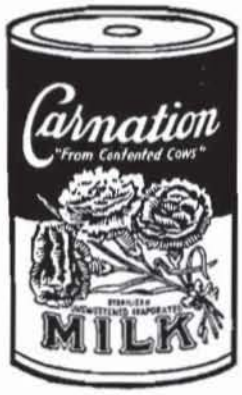

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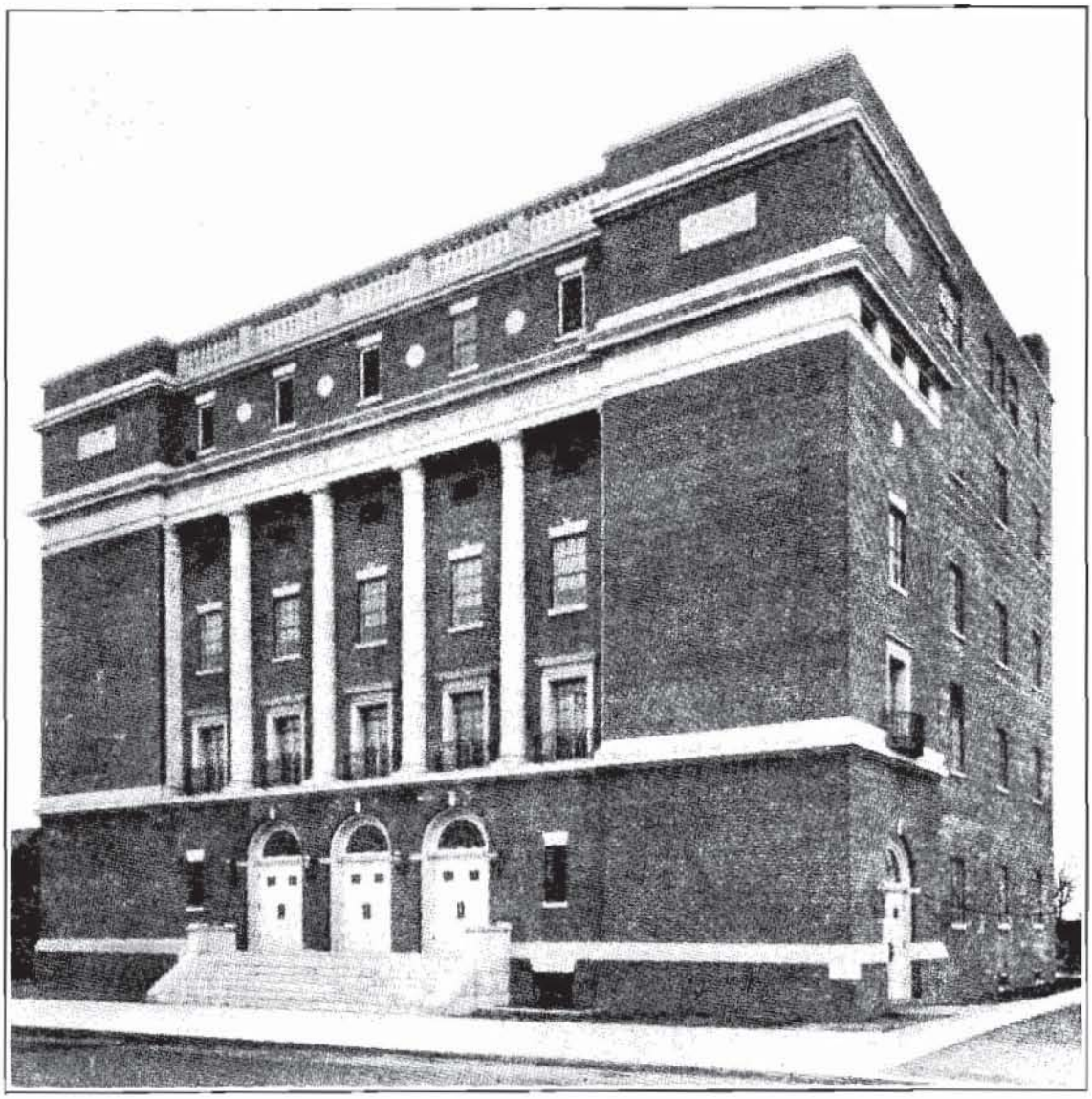

Homes of County Medical Societies

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Fielding H. Garrison

A brief biographical sketch of an American physician honored for his contributions to medical literature

by Benjamin Lieberman, M.D.

Physician, scholar, linguist, musician, soldier, critic, literateur—all these and more was Fielding H. Garrison. For in the make-up of a personality, unlike a mathematical summation, the whole is greater than its individual components.

But let us set the background for this unique figure in American medicine. On November 16, 1936, the centenary of the U. S. Army Medical Library was observed in Washington. From a modest beginning in the days of President Jackson it grew along with the youthful nation and through the viscissitudes of the century to become the largest and most valuable medical library in the world. Originally designated as the Surgeon General's Library, its first director was Dr. John Shaw Billings, a Civil War Surgeon. Under his administration it expanded rapidly, so that it now has approximately one million titles in volumes and pamphlets and the largest collection of medical incunabula extant.

Dr. Billings' greatest achievement, however, was as a bibliographer. The idea of arranging lists of the world's medical literature by both author and subject matter had a trial at his hands in 1876. The great help of this venture to physicians and medical research workers could not be over-estimated. It was ultimately launched as "The Index Catalogue of the Library of the Surgeon General's Office," and appeared as an annual volume from 1880 to 1895. So painstaking a task was this, in which Billings had the assistance of Dr. Robert Fletcher, that in all these volumes they could discover but fifty articles not listed. This was continued through subsequent series of volumes, as well as by the monthly Index Medicus, the predecessor of the present-day "Quarterly Cumulative Index to Current Medical Literature," published by the AMERICAN MEDICAL ASSOCIATION. To William H. Welch, the nestor of American Medicine, the greatest contribution of this country to medical service were these volumes of medical bibliography, to the editorship of which Garrison brought his labors and his talents for almost twenty out of the forty years during which he was associated with the Library.

The peculiar drift of Garrison's career was one of those circumstantial events that not rarely has led to greatness in other men. His early schooling was obtained in Washington where his father was an employee in the Treasury Department. His academic training followed at Johns Hopkins, with graduation in 1890 at the age of twenty. In 1891 he obtained the position of clerk in the Surgeon General's Library. His thirst for more learning now asserted itself, and in preparation for his life's work, while holding to his duties in the library, he managed to complete the three years' medical courses at Georgetown University. He received his M.D. degree without an internship, and it may be regarded as fortunate that he was not attracted to the usual type of medical service.

The following years were ones of continuous labor in the library under the expert tutelage of both Billings and Fletcher, his assistant, the former exerting his molding effect on the young Garrison for five years. His senior by many years, Billings recognized in his young protege a scholar

likely to carry on the work in which he pioneered in this country. Like Billings, Garrison had formed the practice of doing much of the bibliographic work at his home during the evening, after the day's chores at the library were completed. Of both Billings and Fletcher, Garrison has written appreciative biographies, that of the former being a volume that covers in its scope the earlier history of the army medical library.

In 1912 Dr. Garrison was commissioned a First Lieutenant in the Medical Reserve Corps. Primarily not a military man, he nevertheless acquired some of the army manner and discipline by a course of training at Plattsburg in 1916 under General Leonard Wood. At the outbreak of the World War he was commissioned a Major and assigned to the task of gathering and organizing data pertaining to the surgical and medical aspects of the army, which later became the seventeen-volume work entitled "The Medical Department of the United States Army in the World War."

Later, in conformity with army regulation, Garrison was required to spend two years away from Washington. So the years 1922 to 1924 were spent in Manila, in the Philippines. What unhappy years those were for him: detached from his books and work, and from his friends. Not many months after arriving there he intimated in a letter to Dr. Harvey Cushing that he had reached a degree of dissatisfaction where he was ready to resign, rather than continue to spend his time fruitlessly. Perhaps his self-discipline prevailed, aided by his diversion in writing poetry, playing the piano, and smoking Manila cigars. How much more productive those two years of his life might have been under happier circumstances can only be conjectured.

A survey of Garrison's literary work looks impressive even in the light of his many years of work in the field of letters. His first paper was published in 1906 and the last, shortly before his death in 1935. Dr. C. F. Mayer has listed, in the April, 1937, issue of the "Bulletin of the Institute of the History of Medicine," titles from the pen of Dr. Garrison. These cover every variety of form: texts and documents, histories, general and special, translations, editorials, biographies, and popular articles. But if he had not written another line his name would be immortal among medical historians for his opus magnum, "An Introduction to the History of Medicine." It was naturally conceived in the environment in which the man was living, thinking, and working. He felt constrained, as the years passed, to crystallize his thoughts and put them into permanent form for posterity. In his judgment, medical history is "the history of humanity itself, with its ups and downs, its brave aspirations after truth and finality, its pathetic failures."

The volume appeared in its first edition in 1913. It received merited praise from other historians and won world-wide recognition, including translation into foreign languages. For its thorough, almost encyclopedic character, its degree of saturation with factual data from cover to cover, it has been ranked by Professor Phelps as the foremost single volume of reference in the English language. His chronology of medicine should sober any sophomoric mind impressed with the literary plethora of present-day medicine and make us all humbly conscious of the debt we owe to the elders of medicine in generations past. In Appendix I., in seventy compact pages, is a parade of achievement and discovery from 7000 B. C. to the present day that is not alone an epitome of medical history but of the evolution of civilization itself. By this work he made medical history so interesting that, to use a Menckenian twist, it appealed even to doctors.

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A Graduate of 15 Years Ago Looks Back

Dr. Dixon urges the need for thorough training in general medicine before any effort is made in the direction of specialization

by Claude F. Dixon, M.D.

If one could impart to the medical student one's exact ideas after having practiced medicine for some years, doubtless some of them would prove of value, but somehow it is difficult to accept advice even when it is strongly suspected that it may be good. As I review my student days, I think I had the wrong viewpoint regarding almost everything that dealt with my teachings. It is perhaps difficult for *most* medical students to obtain the correct perspective with regard to training. I am of the impression that the average medical student spends much of his time thinking about grades and graduation. Perhaps the present system of grading employed in most universities is partially responsible for this attitude. I wonder if considerable of the anxiety about grades would not be dispensed with if it were possible to have only two grades, satisfactory and unsatisfactory. Since I know nothing about teaching, you might expect that I would make some recommendations on this subject.

During the time of undergraduate study, I think that most medical students attempt to think too far ahead, while others doubtless go to the other extreme and apparently think little or do not think at all. Osler, in addressing the medical students at Yale University, said that every man has worked out a philosophy for himself. I suppose that is true, but I am of the opinion that as students are confronted by various obstacles their philosophy changes at least once each semester. Naturally, what I say that the undergraduate student should do—call it advice if you like—is what I think I would do if I were again a medical student. I can fully sympathize with the student who not infrequently wonders just what certain parts of his medical curriculum have to do with people who are sick. . . . I can only say . . . . that knowledge of the fundamental subjects will be required and that in many instances such knowledge will be conspicuously absent.

The study of medicine is long and arduous. As Hippocrates said, "Life is short, the art is long." At the time of graduation the task will not have been completed. By that time, however, the new physician will be supposed to have acquired such knowledge and wisdom that he can make some practical application of it. It is well, I think, to remember that receipt of the diploma makes the recipient a doctor largely by title only. I make this statement not to be discouraging, but rather to encourage study. Internship is the young physician's first great opportunity to apply to clinical medicine the results of didactic teaching. I have heard students discuss, at the time of graduation, whether an internship was a complete, or only a partial, waste of time. To those students who have doubt about the value of an internship, the time is probably entirely wasted. The question of compulsory internship needs no comment, except to say that the doctor without postgraduate training wanders around more aimlessly than a ship without a rudder. The period of postgraduate training is the physician's first good chance to discover himself. By hard work, study, and observation, it affords a test of his potential wisdom.

The tool of common sense is here imperative. Some students perhaps consider an internship a rest period in which they relax for a time before retiring to their home towns, where they will gladly enlighten older contemporaries on the new theories of disease and its treatment. Such students, however, usually develop into those young doctors who change location frequently, because it is difficult for them to find a community which appreciates their talent.

The intern year should be a year of work. Promptness, seriousness, and thorough study of cases are good investments. This is the period when one can learn to evaluate the patient's story of his illness, and can develop expertness in physical examination. These two factors form parts of the equation, and ability to correlate them will be the result. Careful observation of the methods of members of the staff, whether they prove to be right or wrong, all give to the young man an invaluable perspective.

Some graduates in medicine become general practitioners; others continue training in special fields. To determine just what branch of this vast subject one will become most interested in requires time. Things apparently of a trivial nature may influence one. Osler matriculated at Trinity College, in Ontario, because he read in one of the college bulletins that dancing and singing were taught to the senior class. It was here that he met Rev. W. A. Johnson, who, he said, was the sole influence that enabled him to become what he did become. Choice of a specialty should be determined entirely by one's interest in the subject.

Many students become disillusioned regarding specialization. I refer to the individual who selects a special field in medicine because it appears easy, a short cut to fame and possible fortune. Regardless of what branch of medicine is most intriguing, a general knowledge of the subject of medicine is necessary. A successful internist is one who has some knowledge of surgery. The surgeon who is successful must understand and know the fundamentals of diagnosis. The doctor who classifies himself as a surgeon because he cuts when and where the internist or physician instructs him to cut, is an operator only, and fortunately his type is fading into the background.

I am trying to emphasize the importance of a thorough training in medicine as a whole before any effort is expended in the direction of specialization. The eye specialist must know something of systemic disease. He must have a fundamental knowledge of neurology. He who attempts correction of vision when the cause of impaired eyesight is a tumor of the brain or nephritis is a mere fitter of glasses. The orthopedist needs more knowledge than a thorough understanding of anatomy of the skeletal system. To a degree he, too, must be an internist, a physician. He must know the effects of certain systemic diseases on the structures with which his special field is concerned. Every so-called specialty of medicine could be considered in this way, and it would be found that those who are outstanding in special fields are those who have a good knowledge of general medicine.

When should the student or young physician, who intends to specialize, decide what his specialty is to be? The majority of those who think they know this at an early period of their education doubtless will be like Saul seeking his asses. "They suddenly will come on something more important." Therefore, there is no need to occupy the mind with this problem until more has been learned than can be acquired in the classroom. Sometime during the first or second year of internship is perhaps early enough to decide. All of any given class will not become specialists, perhaps only a small percentage will specialize; the remainder will become general practitioners.

During the last decade the general practitioner, the country doctor, and the specialist have all been criticized.

What is the trend of medicine with regard to the specialist and the general practitioner? The country doctor formerly was, for the majority of the community, the authority on many subjects. Along with the minister and the lawyer, he was called on to settle all controversies of the vicinity. The family physician is now consulted only for the professional service he can render, and that professional service is more limited than it was formerly. The family doctor, who twenty-five years ago extracted teeth, fitted glasses, cared for confinement cases, treated fractures, and so forth, is finding himself more limited because of the specialist. I do not misjudge the importance of the family doctor, for I realize that he can and does treat 80 per cent of all sickness. Furthermore, I think no one deserves more praise than the general practitioner who ministers to sick and suffering humanity. He gives freely of himself; his judgment in regard to the diagnosis and treatment of many maladies is founded on experience and in many instances is irreproachable. The medical graduate just out of school cannot compete with many of the widely experienced general practitioners in the average case. Years of experience have enabled the family doctor to practice medicine by ear better than the inexperienced man can practice by note. However, the recent graduate who is fundamentally well informed and makes practical application of his information, with accumulating experience, can place himself in a superior position which will qualify him scientifically to diagnose and treat not only the usual garden varieties of diseases but the more unusual cases as well.

The trend of medicine seems to be toward specialization and group practice. It is not difficult to imagine that the patient who has an unusual condition receives better attention if all those who attend him are exceptionally well trained in one or two certain fields. Individualism in medicine can be compared to individualism in industry. Every well organized business today is operated not entirely by one individual but by groups of persons, each of whom is an expert in a particular department. It is true that the ailments of many patients are not difficult to diagnose and no more difficult to treat, but the unusual conditions which afflict roughly 20 per cent of people who seek medical advice can be managed best by a group of specialists. The trend of medicine toward specialization will answer, I think, a common question of the present time: Is the production of doctors today greater than the demand? According to the number being graduated from medical schools at present the supply will not meet the demand if specialization is taken seriously.

As I have said before, specialization is not infrequently criticized. Most of the criticism, however, is aroused by those individuals who have declared themselves to be specialists by desire rather than by extensive training. Can you imagine a physician who has done general practice for a number of years suddenly limiting himself to urology and thereby administering expertly to his clientele? He certainly cannot do so without special training and by that I do not mean a few weeks or months spent in observing someone who does things the way they should be done. The so-called specialists who are trained overnight are largely responsible for the criticisms against specialization. It is reasonable to assume, I think, that intensive training in a certain field of medicine, preceded by the acquirement of a thorough, general fundamental knowledge of the subject, qualifies one to do better work in a specialty than does the information gained through attempts to do

(Continued on page xiv)

A Patient Looks at Doctors

Some interesting views on the relationship between physician and patient, wherein the need for a better understanding is emphasized

by Frances Teplow

Perhaps some explanation is required for the appearance of a mere layman in this publication, dedicated to and for, and published by, the medical profession. The fact that such an explanation is necessary illustrates one phase of my thesis: that medicine and medical practice is not an art and science restricted to the medical profession alone: rather, medical practice is the performance of a social function, the maintenance of health and treatment of health disturbances in which the physician and the public cooperate to achieve the desired result.

I am a member of this public, a patient who while under medical treatment for several years has had the opportunity to observe medical practice in operation. This article is written with the thought that a better understanding of the patient's viewpoint may be helpful to the physician and to his patients.

The medical profession is a conservative one, as are, indeed, all the professions. The lawyer has a very good reason for being conservative. Previous decisions determine the law, and a lawyer is therefore justified in regarding prior decisions as his guide in future conduct. The doctor, too, has excellent reasons for being conservative so far as concerns the substance of his practice. Human life and health are too precious to experiment with with untried remedies when known cures or treatments are at hand. The medical profession is justly circumspect,—perhaps I should say wary—, about applying new remedies until their claim to consideration has been carefully tested. But this desirable conservatism in the substance of medical practice, unfortunately, has been carried over into the application of medical knowledge to the patient. In other words, the traditional relationship between doctor and patient has been permitted to remain fixed in a world of constantly changing values and ideas.

What, from the patient's viewpoint, is this traditional relationship? It has certain desirable characteristics: the patient's reliance on his doctor, the doctor's high code of ethics, his regard for the patient's confidence. But it has limitations which the conservatism of the profession makes difficult to eliminate.

Perhaps the most important limitation of the doctor of the old school is his attitude of paternal superiority to his patient. The patient is made to feel that he or she is merely the subject of an inquiry, a problem which it is up to the physician to solve. The doctor makes his investigations and issues instructions.

There is a certain professional pride in the doctor of the old school which disdains sharing his highly specialized knowledge with any of the uninitiated. The attitude is expressed by "I'm the authority. You've come to me for treatment; this is what I prescribe."

This is not a healthy attitude. The patient of today no longer takes instructions on faith alone. If he has faith in his doctor it is because the doctor has given him good reason for such faith. Usually it is because the doctor has removed his mantle of esoteric mystery, and has explained to the patient

1. Why his symptoms indicate some particular illness;

2. Why it has been concluded that the disturbance is not some related or similar illness;
3. How the particular illness diagnosed has caused a derangement in the patient's system; and, most important
4. How the treatment recommended will cure or alleviate the illness, and what the patient can do to cooperate with the doctor in expediting the treatment.

This is a far cry from the old-fashioned doctor. But it is necessitated by the modern patient's healthy skepticism, by the modern enlightened attitude respecting the body and its functions, and by the fact that, it being a physical impossibility for the doctor to be with his patient at all times, the patient must know enough about his illness to be able to cooperate fully with the doctor in the doctor's absence. Life is not as static as it was fifty years ago when a doctor could keep a fatherly eye on his patient's actions. The speed of modern transportation, increasingly-large centers of population, and more frequent changes of residence have made it impossible for such a relationship to continue.

It is hardly my place to point out to the medical profession the tremendous psychological advantages which result from the patient's understanding of his illness. The patient no longer feels that he is at the mercy of strange and inexplicable forces. An understanding of his illness results in a much more wholesome attitude toward life in general and toward the treatment of his illness in particular. Moreover, the patient is more likely to cooperate with the doctor when an explanation has convinced him that the doctor is on the right track. Many persons have a certain distrust for those who know so much more than they do. A careful explanation of cause and effect and the reasons for a certain course of treatment constitutes the most certain manner of overcoming this inherent distrust.

Besides the need for a greater degree of cooperation between doctor and patient, I feel that there is a need, also, for a greater cooperation between doctors specializing in the various branches of medicine and between general practitioners and specialists. A doctor should know exactly where to send a patient suffering from some specific ailment in which the doctor himself does not specialize. He should not only know when to advise the patient to have his teeth examined or when an oculist should be consulted, but he should be not at all backward about recommending such assistance. Not only that, but the doctor should be prepared to recommend a specialist if the patient does not know to whom to go.

Another phase of the relationship between doctor and patient which the medical practitioner should carefully consider is the scope of medical service. It is no longer enough to successfully diagnose and treat an ailment. When a doctor undertakes to treat a patient he should be ready to give complete medical service. He should not only treat ailments which have developed; he should also detect incipient ailments, and warn the patient as to the weaknesses of his particular system.

The above thoughts are offered as suggestions from the point of view of the patient, with the hope that the sincere and competent efforts of the medical profession may be more effective and helpful to the public they strive to serve.

Today's successful physician is the one who refuses to be blinded by too much theory and ultra-scientific methods.

The Ohio State Medical Journal

Timely Brevities

On Capital Punishment Does capital punishment hinder crime? Statistics say, No! Studies made of states having capital punishment and those where it has been abolished cannot show the former group to have any advantage over the latter. As a matter of fact, the homicide rate is usually less in states not having capital punishment.

In the administration of the law there has been a gradual lessening in the severity of the penalties. For one thing the nature of the punishment has changed. Execution today is by the speediest, the most reliable, and the most humane methods. In the past capital punishment was inflicted by every conceivable method of cruelty, such as boiling, burning, breaking on the wheel, and drawing and quartering. Furthermore, the number of crimes for which capital punishment is reserved has lessened, whereas years ago the theft of as little as a loaf of bread meant punishment by death.

Since juries are showing a disinclination to inflict the death penalty, the public is entitled to some substitute. Warden L. E. Lawes has suggested that the parole laws be strengthened and that no prisoner serving a life sentence shall be pardoned or his sentence commuted until he has served at least twenty years. This would end the present farce whereby professional killers can be released from a life sentence at the end of a year or two.

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American Meddling The world today is closer to war than it was in 1914. This realization brings to mind a timely story. Perhaps you have already heard it. But it bears repeating.

A group of distinguished scientists were gathered together on shipboard, returning from an exploring expedition into darkest Africa. They were of different nationalities. One evening their discussion brought up the subject of the elephant, and it was decided to hold a symposium on that large behemoth several nights later. On the designated evening the Englishman presented a paper on "The Elephant and How To Hunt Him;" the Frenchman, a paper entitled "The Elephant and His Sex Life;" the German contributed a paper on "The Elephant and the Anatomy of the Right Hind Leg," and the American discoursed on "The Elephant and How To Reform Him."

This story well illustrates the well known American propensity for meddling. This tendency to meddle in European affairs may be due, perhaps, to the cosmopolitan character of our population. Pressure groups, banded together by a common belief, advocate or protest according to their motives. But our concern should not be with the internal affairs of another nation. Meddling can only bring back the reply, "Clean up your own back yard!"

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Man and His Diet Man and his diet have been notoriously exploited by advertisers and pseudo-scientists with respect to certain foods. The gullibility of the average individual in matters of health has made him an easy victim. He is told he must eat this or that food and under no circumstances must any of two other foods be eaten at the same time. However, although many causes may be assigned to the alleged deterioration of the human race, the unwise choice of foods is not one of the most important factors. If left alone man will generally choose a variety and sufficient quantity of foods, and because of this

variety and quantity his diet will contain all of the essential food elements.

The pet bugaboo of many food faddists, especially the vegetarians, is meat. To them meat is the arch-enemy of mankind. But some interesting facts have been brought to light. (At this point we must pause to deny we are subsidized by the meat packing industry.) About a year ago Dr. Weston A. Price, writing in "The Journal of the American Dental Association," made some observations on tooth decay after a study of various tribes in Africa. An excerpt from his article reads as follows:

"We will consider first the Masai, a people of Nilotic origin, who live now, as in the past, largely on milk, blood, and meat. The cows are milked morning and evening, and from time to time the steers are bled, usually, at intervals of from 30 to 40 days, in regular sequence. The blood is defibrinated by whipping in the gourd with a stick, which collects the fibrin into a mass. A few ounces of this blood is given to each child daily, the quantity depending on special needs. Pregnant women receive their ration regularly. The fibrin is cut into slices and fried. Animals are slaughtered sufficiently to provide meat. The blood of slaughtered animals is carefully collected and used for food. Every edible part of the animal is utilized. Great emphasis is placed on the organs. A study of 2,516 teeth in 88 of these people, distributed over a wide area, showed only four persons with caries. The natives of Chewya, who belong to the Marigoli tribe, are very strong and physically well developed. They live within easy reach of Lake Victoria, from which they obtain large quantities of fish which, together with cereals and sweet potatoes, constitutes an important part of their diet. Here, out of the 552 teeth belonging to 19 persons which were examined, only one tooth was found with dental caries.

"In contrast with the Masai, the members of the Kikuyu tribe, which inhabits a district to the west and north of the Masai, are primarily an agricultural people. Their chief articles of diet are sweet potatoes, corn, beans, and bananas. An examination of 1,041 teeth in 33 Kaikuyus showed 57 teeth with caries.

"The Muhima tribe resides in southern Uganda. They, like the Masai, are primarily a cattle raising people and live on milk, blood, and meat. They constitute one of the very primitive and undisturbed groups. In a study of 1,040 teeth in 37 persons, not a single tooth was found with dental caries.

"At the Bogora mission, located west of Lake Albert, where the diet of the natives consists chiefly of cereals, sweet potatoes, and bananas, 53 per cent of the group had caries."

Thus it is apparent that all groups successful in maintaining a high immunity to dental caries were using animal products in their diets. All of which is good news to those who enjoy a thick, juicy steak!

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A Thought on Socialized Medicine

During the recent unsuccessful drive for the socialization of medicine in Wisconsin, one of the newspapers in favor of the program commented as follows:

"Under the present method—which might be called commercialized or capitalized medicine as contrasted with socialized medicine—the patient knows it is to the doctor's financial interest to make more calls than necessary. The doctor may be too high-minded to do these things, but there is always a lurking suspicion in the mind of the patient. Socialization does away with these unfortunate incentives. Then the doctor and patient can be real friends. . . . In every way socialized medicine is desirable—for both doctor and patient."

After reading this editorial the thought came to mind that if it is to the financial interest of the doctor to make too many calls on a patient under "commercialized medicine," then it ought be to his financial interest, also, to make too few calls under "socialized medicine." That is the chief complaint we have heard directed against the free medical care dispensed by various fraternal organizations.

Now this is in no way intended to be a criticism of those doctors engaged in this type of practice. But it is an indictment against any scheme in which bureaucratic red tape will take precedence over human lives.

A. C. HANSEN, M.D.

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Fielding H. Garrison

(Continued from page iv)

His other writings were, for the most part, shorter excursions into special fields or biographical accounts. For several years he wrote editorials in the "Military Surgeon." In 1925 he became consulting librarian to the New York Academy of Medicine, and in the course of the following ten years contributed seventy-seven papers to its "Bulletin." Their titles show his wide range of interests. Many of them were purely biographical, others more in the nature of philosophical discourses, as for example, "Life as an Occupational Disease." He employed a classical style, with frequent allusions and references, often in foreign languages, several of which he knew. It was his belief that in studying medical history the best approach is the biographical, and he expressed praise for the seminary plan of Dr. William Snow Miller of the University of Wisconsin.

Garrison personified an individuality in which was combined the greatest profession and the finest of the arts. Music was his life's sustenance, to him "the noblest and most spiritual of all fine arts." He enjoyed music as one in communion with it; it had for him not a sentimental but a profoundly intellectual interest. His understanding of a Beethoven or Brahms work would do credit to an erudite music critic. He himself was an excellent pianist, and whiled away many of the sultry Manila hours in mastering Chopin. At least two of his papers bear medico-musical interest: "Medical Men Who Have Loved Music" and "Medical History of Robert Schumann and His Family." His favorite composer was Brahms, and he was conversant with every creation of that genius. He mentions the composer in his "History" in reference to the life-long friendship between Billroth and Brahms, and thus, we surmise, Garrison pays his debt to a composer through a famous surgeon—a man he never met but to whom he was grateful for the many hours of his music he could play or enjoy in hearing others perform.

According to his acquaintances he was personally shy, highly sensitive, at times melancholy and even despondent. But these attributes must be allowed to one who was culturally a giant and creatively a genius. He was not, like the prophet, without honor in his own country. In 1917 he received an honorary degree from Georgetown University and in 1932, the degree of Doctor of Letters from Yale.

When the definitive history of American Medicine is written the name of Fielding H. Garrison will be as strongly eponymic of medical belles-lettres as others will be of purely technical accomplishments. And any complete anthology of American prose must rank him among the most representative of American literature, in a special field in which he was first a pioneer, then a peer.

How Did They Vote?

by An Observer

Doctors need only to review public discussions and legislative debates for the past year to convince themselves that it behooves the medical profession to keep a watchful eye on public affairs. Anything may happen in these uncertain days, and the price of free and unfettered medical practice is vigilance.

There are a number of well-meaning persons and some who cannot be so designated who have become inoculated with the idea that change is synonymous with progress. If permitted to do so, the more enthusiastic would run the gamut of experimentation. They are impatient with delay and announce themselves loudly in favor of the trial-and-error method. Intolerant with those who would take cognizance of what has been learned by past experience, they brand their opponents as obstructionists whose sole concern is their own interests. History might as well have been unrecorded so far as they are concerned, for all that is important is "where do we go from here?"

Despite the extremes to which the "disciples of change" have gone, it is true, nevertheless, that advances have been made, due to well-directed efforts of clear, progressive thinkers. In the field of health, however, even honest and intelligent individuals are treading on dangerous ground. Prevention of disease and care of the sick is a highly-specialized field which does not lend itself so readily to experimentation. Because of its personal nature medicine always will be the most individualistic of professions.

Laymen as a rule have little conception of the scientific factors involved in delivering good medical service and of the heavy obligations resting upon the medical profession. Nor do they understand the true significance of the proposed changes which relate to medical practice. Yet one hears on many sides of persons without medical training posing as authorities on the care of the sick, incongruous as that certainly is.

Politicians must, of necessity, give consideration to the opinions of those who elect them. If they desire to remain in office,—and most of them do,—votes are all-important. It is, therefore, essential to the public official's welfare that he diagnose public opinion correctly. A perfectly natural reaction is to throw support to the group whose opinion seems most representative. If he is the exception, he may be sufficiently independent to exercise his best judgment, or he may seek expert advice. Too often this goes for naught because the official does not find its acceptance to his own interest.

It is easy to become cynical about public officials, particularly those in our legislative bodies. Their situation, however, is a difficult one. On the one hand they are expected to hold lofty ideals of service; on the other, to meet the demands of various groups who, by implication, threaten a reprisal at the next election if they do not respond to their wishes. Criticism of them is not warranted, however, unless encouragement is given to honest and courageous representatives by the more intelligent voters.

It is an obligation of the physician to inform legislators on all matters pertaining to medicine, for it is a field about which they have little knowledge. If such assistance is refused, or, if accepted, ignored for political reasons, that is another matter. Then the physician is justified in bringing to the attention of his patients, friends, and others, the issues in-

volved, at the same time lending his cooperation to medical organizations which are usually actively interested in such matters.

How did the legislators from your district vote on medical bills which were introduced during the past year? If they voted for compulsory sickness insurance you should become acquainted with them. Learn their views before the next election. Let them know that how they vote speaks more eloquently than what they say.

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A Graduate of 15 Years Ago Looks Back

(Continued from page vii)

everything. It requires time to become a true specialist; therefore, those who choose this type of practice will not be worthy of the designation until a considerable period has elapsed following their graduation from medical school.

The public is becoming educated regarding professional requirements. Charlatans are being discovered earlier in their activities and are being punished. When those who patronize quacks decide to secure the services of doctors, more of the latter will be required. The various mediums for education of the public will have the desired effect, and "cure-alls" will fade into oblivion, where they have always belonged.

Regardless of how well trained a physician becomes, he will make mistakes of which he will not be proud, but if he is properly prepared to practice scientific medicine his "batting average" will be high and his results commendable.

. . . . I cannot refrain from emphasizing some ideals which I think are worth considering seriously. The physician should be interested in medicine to such an extent that commercialism does not enter his mind. If he works hard and takes advantage of his opportunities for training, remuneration for his efforts will be sufficient to furnish more than the necessities of life.

Even while a medical student it is well to acquire what some may term "useless knowledge." I refer to the reading of worthwhile literature. This must not be done at the expense of school work, but it can be done at the cost of a few hours of sleep, and it will broaden the view and increase the appreciation of all that is good. It is delightful, if possible, to be well informed on subjects other than medicine.

Time spent in ridiculing a competitor is wasted. Osler said never to believe what a patient tells about another doctor even though there is reason to suspect that it is true.

No one dedicates his life more assiduously to humanity and its suffering than does the honest, painstaking, sympathetic physician who spends no small share of his life in arduous toil of preparation only to give freely of his knowledge and skill. I recite from Stephen Paget's "Confessio Medici," quoted by Cushing: "Every year, young men enter the medical profession who neither are born doctors, nor have any great love of science, nor are helped by name or influence. Without welcome, without money, without prospects, they fight their way into practice, and in practice they find it hard work, ill-thanked, ill-paid; there are times when they say, 'What call had I to be a doctor? I should have done better for myself and my wife and the children in some other calling.' But they stick to it, and that not only from necessity, but from pride, honor, conviction; and Heaven, sooner or later, lets them know what it thinks of them. The information

comes quite as a surprise to them, being the first received from any source, that they were indeed *called* to be doctors: and they hesitate to give the name of vocation to work paid by the job, and shamefully underpaid at that. Calls, they imagine, should master men, beating down on them: surely a diploma, obtained by hard examination and hard cash, and signed and sealed by earthly examiners, cannot be a summons from Heaven. But it may be. For, if a doctor's life may not be a divine vocation, then no life is a vocation, and nothing is divine."

Reprinted from The Journal of the Michigan State Medical Society.

The medical profession as a whole depends upon the highways as a means of travel. It would follow, therefore, that as a body we should try to lead all other classes in endeavoring to make our thoroughfares more safe.

The automobile manufacturer will continue to make new cars, and these cars are going to be sold. It takes a long time to wear out the modern car, yet the ever increasing automobile graveyards we see in every city and town are evidence of what is really happening—our highways are becoming more congested each year.

We are apt to take driving too much for granted, an inherited trait as it were, an evidence of our advancing racial ability.

In spite of the painstaking and continual teaching of careful driving, we see the death rate and number of injured increasing each year.

The estimated loss of life this year will be near forty thousand with a million and a quarter disabling accidents. At this rate, it means that one out of every twenty in the United States will be killed or injured in an automobile accident in the next five years. It is from these statistics that it ought to be our personal problem, because it means one out of twenty in our family or relatives, one out of twenty of our social associates, or one out of twenty of our colleagues will meet death or will be injured within this time by an automobile.

As a professional problem, this condition ought to be included in our program of preventive medicine.

—*The Wisconsin Medical Journal*

Sunny Side Up

THE EYES HAVE IT

"I've broken my glasses," said the attractive young lady to the Oculist's assistant. "Will I have to be examined all over again?"

"Oh, no," said the O. A. "Only your eyes."

•

MISFIT

Teacher: "Johnny, use the word 'paralysis' in a sentence."

Johnny: "Alice and I were in swimming, someone stole my trousers, so I had to borrow a paralysis."

•

IT'S AN ILL WIND . . .

Mary: "So you bought a new fur coat after all. I thought you said your husband could not afford it this year."

Joan: "So I did, but we had a stroke of luck. My husband broke his leg, and the insurance company paid him $100."

•

PRESCRIPTION

"What do you take for your insomnia?"

"A glass of wine at regular intervals."

"Does that make you sleep?"

"No, but it makes me satisfied to stay awake."

—*Telephone Topics.*

•

W. P. A. PROJECT

One of the men spoke: "I dug this hole where I was told to and began to put the dirt back like I was supposed to. But all the dirt won't go back in. What'll I do?"

For a long while the supervisor pondered the problem. Then: "I have it. There's only one thing to do. You'll have to dig the hole deeper."

•

NOLLE CONTENDRE

Down in the South a buxom young negress, in a very short dress, came before a Municipal Judge. His Honor, having noticed her scanty clothing, suggested she go home and put on some clothes.

"Judge, Ah spects Ah kin dress like Ah wants."

"You are fined $5 for contempt of court."

Going to the clerk to pay the fine, he inquired what it was for. She said:

"The Judge says Ah has to pay $5 for 'temptin' de Co't."

SAFE RETREAT

"I read in a book that Apollo was chasing a nymph and she turned into a tree."

"He was lucky. The one I'm chasing always turns into a jewelry shop or a restaurant."

•

FIXED FOR LIFE

Husband—"I've insured my life for $15,000, so that if anything happens to me you will be provided for."

Wife—"How nice and thoughtful. Now you won't have to see a doctor every time you feel sick, will you?"

•

FRANKLY SPEAKING

"I'll be frank with you," said the young man when the embrace was over. "You're not the first girl I ever kissed."

"I'll be frank with you," she answered. "You've got a lot to learn."

•

TAKING NO CHANCES

Mother: "When that naughty boy threw stones at you, why did you not come and tell me, instead of throwing them back at him?"

Willie: "What good would it do to tell you? You couldn't hit the side of a barn."

•

A SURE PREVENTIVE

Scotchman: "Doctor, what can I do to prevent seasickness?"

Doctor: "Have you a dime?"

Scotchman: "Yes, sir."

Doctor: "Well, hold it between your teeth."

•

—*Bee Hive*

GOES ROUND AND ROUND

Two aristocratic looking gentlemen were discussing their family affairs one day. One was worried about the conduct of his son, saying: "I don't know what to do with him. He went out with a girl about a month ago and caught trench mouth from her."

"That's nothing. Likely to happen to any young man," said the other.

"But it is something. He gave it to our hired girl—and then I got it and gave it to my wife!"

"Say! You'd better do something about him. Good lord, maybe I've got it now!"

—*The Chaser.*