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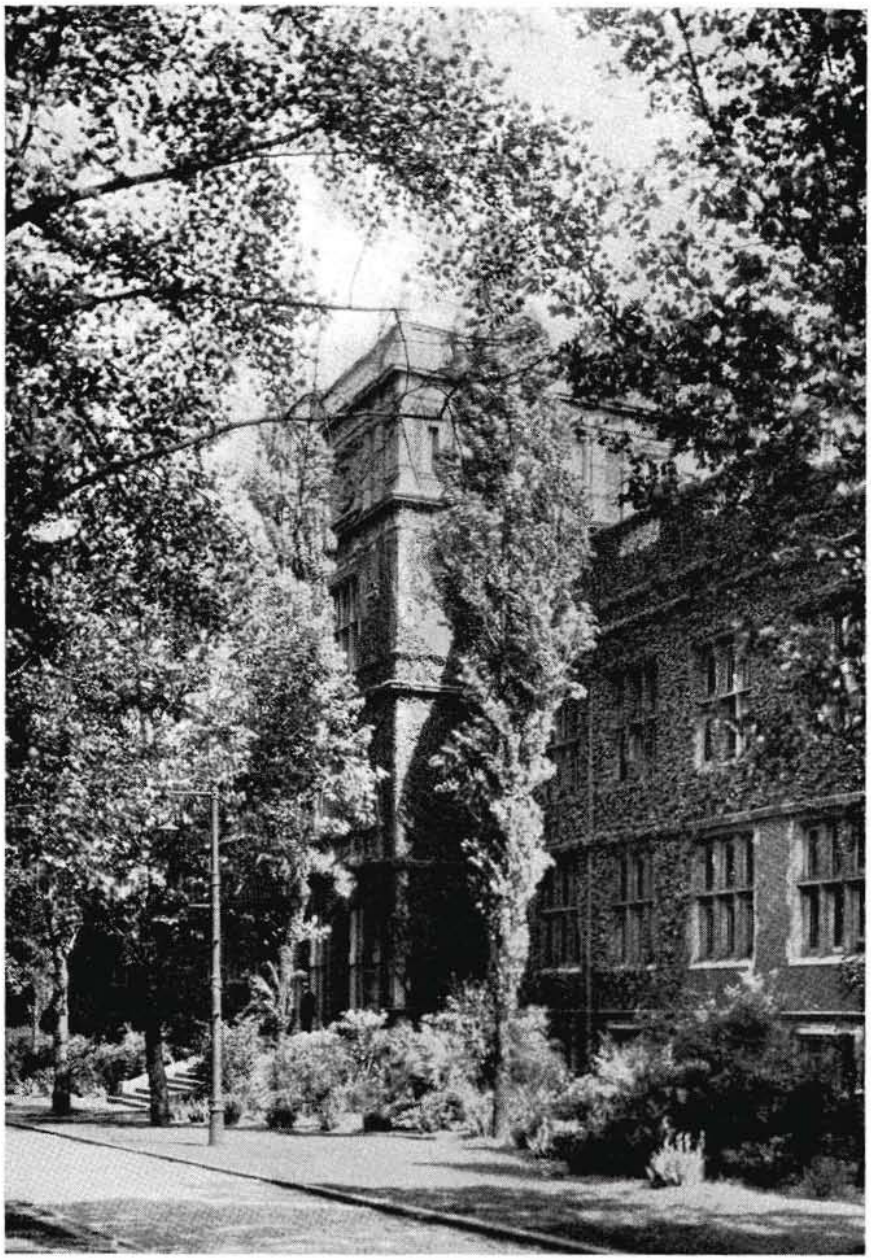

Medical Schools of the United States

1. University of Pennsylvania
School of Medicine

Guarding the Milk Supply

The medical profession's role in making the milk supply safe is told here. Doctor Rosenau is president of the American Association of Milk Commissions

by M. J. Rosenau, M.D.

Among the myriad activities of a county medical society none is more important than the certification of milk. Not only is this function a most significant professional and public service but, unlike most of the operations of the county medical society, it is conducted at no expense to it, and in some instances is even an appreciable source of revenue.

Selected milk supplies of a limited number of leading producers are certified as to purity by medical milk commissions appointed by county medical societies. There are now eighty-one such commissions whose sole object is to encourage the production of milk of the highest standards of quality; milk that may be prescribed with confidence for the delicate task of infant and child feeding, for expectant and nursing mothers, for invalids and the mal-nourished, and for all persons who desire a clean and safe milk possessing exceptional nutritive value.

Certified milk is peculiarly the product of the medical profession itself. It was originated nearly half a century ago by the late Henry L. Coit, M. D., of Newark, N. J., who, provoked by the prevailing conditions in the milk industry in 1892, devised a practical plan for dairy hygiene, which he submitted to his colleagues in the Practitioners' Club of Newark. His proposal was adopted with enthusiasm, and the first medical milk commission was appointed by the Essex County (N. J.) Medical Society in 1893.

Since 1894, when the first bottle of the new certified milk was delivered to Dr. Coit himself, this product has been the leading type of milk obtainable in America. This honor milk supply not only was the pioneer in the cause of clean milk in a period when most market milks were adulterated and contaminated and epidemics of milk-borne diseases were rife, but its advent inaugurated the present system of grading milk supplies. The seventy rigid hygienic specifications laid down by Dr. Coit served, also, as persuasive standards for subsequent requirements for the sanitary production of all milks.

"Pure, nutritive milk is as essential to medical practice as drugs," says an editorial in *New York Medical Week*, the official organ of the Medical Society of the County of New York. "Pediatric successes have multiplied, and failures diminished proportionately,—since the County Society created the Milk Commission to safeguard the quality of man's most valuable food. Certified milk has given life and strength to countless thousands of infants and invalids and has enabled the physician to prescribe diets with the certainty that a safe and dependable milk supply is available. The lessons learned in the production of certified milk have raised the quality of milk in general." (1)

Certified milk is produced today in accordance with uniform national standards which are frequently revised to conform to scientific progress. It is, in fact, the only milk that is produced under such national standards, promulgated by the medical profession and enforced by committees of physicians. Certified milk is always uniform in composition, low in bacterial content, and of superior nutritive virtues.

In order to supervise the production of certified milk each medical milk commission appoints certain qualified scientists, including a physician, a veterinarian, a sanitary inspector, and a laboratory technician, and it maintains a suitable laboratory where chemical and bacteriological analyses of the milk can be made weekly, or more often if necessary. In smaller communities two of these positions may be held by one competent person.

The expenses of supervision and certification of the milk are borne by the producers who are invariably the leading representatives of the local milk industry. In the original charter for the production of this outstanding milk supply Dr. Coit stated that "approved and trustworthy dairymen possessing honor, financial ability, and dairy facilities shall be induced, by reason of promised medical support and the increased price of their milk to conduct their dairies and collect and handle the product in conformity with a code of requirements made by the Medical Milk Commission and imposed by them in due legal form." Producers of certified milk have lived up to this code. They have cooperated with the medical profession by providing doctors and their patients with a dependable milk supply, but they have gone even further since they have sponsored and supported clinical and laboratory investigations, the results of which have brought about many improvements in the sanitary quality and biological attributes of certified milk.

One of the most noteworthy results of scientific research on a certified milk farm was the development of vitamin D milk, (2) a product that first appeared in 1931, following extensive animal feeding experiments at the Walker-Gordon Laboratories at Plainsboro, New Jersey, which showed that milk could be naturally enriched in vitamin D by scientific feeding of irradiated yeast to cattle. (3) These preliminary tests had been carefully checked by laboratory studies and then were subjected to expert clinical investigations conducted with a large number of infants by the late Dr. Alfred F. Hess of New York City. (4) His studies, corroborated by others and carried out over a period of several years, demonstrated that this natural vitamin D milk would protect young infants, both white and colored, against rickets at all seasons of the year, when this metabolized milk is fed in the customary dilutions prescribed by the physician.

Today, vitamin D certified milk is produced at forty different farms. It must have a vitamin D potency of at least 430 U.S.P. units, as shown by bioassays made at frequent intervals by laboratories controlled by the medical milk commissions. Since the appearance of this pioneer among the fluid vitamin D milks other efficacious processes for enhancing the vitamin D content of milk, as by direct irradiation, have been perfected, but all certified vitamin D milks are produced only by this natural method.

The content of other vitamins in milk is likewise augmented by scientific feeding of the producing cattle. Thus, vitamin A, which is essential to growth in infants and children and is believed to be a factor in increasing vital resistance, can be definitely increased in milk by using proper rations for the cow. Similarly, the content of vitamin C, the antiscorbutic factor, can be intensified in milk. (5) Adoption of these scientific methods on certified milk farms assures the physician of a milk supply of superior nutritive qualities.

Another notable event in the progress of certified milk was action favoring the pasteurization of this honor product. At the annual meeting of the American Association of Medical Milk Commissions held in Atlantic City in June, 1935, approval of permissive pasteurization of certified milk was unanimously voted. Certified milk-pasteurized had already

been on the market in Boston for several years, with the sanction of the local medical milk commission, and also had been distributed in a number of other cities. In Boston, about sixty-five per cent of all certified milk is now pasteurized in order to meet the present professional and popular demand.

The permissive pasteurization of certified milk has been hailed as a progressive step comparable only to the appearance of certified milk itself in 1894. ([6]) The process reduces the bacteria in certain milk virtually to the irreducible minimum since many samples are sterile and the average bacterial count is only 100 per cubic centimeter. The methods and standards for regular certified milk require that bacteria shall not exceed 10,000 per cubic centimeter, as shown by weekly examinations, but actually most supplies will average less than 5000. The pasteurized certified milk must contain not more than 500 bacteria after pasteurization. The process does not exert any appreciable effect upon the unsurpassed nutritive qualities of this unique milk supply.

The adoption of permissive pasteurization for certified milk does not mean that this product has entirely superseded the clean, natural, raw certified milk, which may still be generally obtained, but merely that physicians who desire the highest grade of milk with the added advantage of this final seal of safety can now prescribe it. In many instances, pasteurization will obviate the need for boiling the infant feeding formula prepared from certified milk.

From these various facts, it is apparent why certified milk, whether pasteurized or unpasteurized, deserves the active support of the medical profession. It should be prescribed and advised as the milk of choice not only because it is the physicians' own milk supply but because of its many advantages, sanitary and biological, and benefits which offer the utmost satisfaction to doctor and patient alike. ([7]) Pediatricians and other practitioners who counsel their patients to use certified milk are assured of clean milk that will not and can not cause outbreaks of disease or digestive disturbances, and which will yield the greatest return in nutritive values on a moderate investment.

Physicians will, of course, have occasion to employ various forms and grades of milk at different times since each feeding case is a law unto itself, but for general all-around advantages certified milk is unexcelled. It carries the seal of approval of the county medical society, which is the highest badge of honor that any ethical commodity could possess.

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3. Thomas, B. H. and MacLeod, F. L.: Increasing the vitamin D potency of cow's milk by the daily feeding of irradiated yeast or irradiated ergosterol. Science. 73:618, June 5, 1931.

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7. Tobey, J. A.: The advantages of certified milk in pediatrics. Cert. Milk. Oct., 1935.

Next Month

"Your Income Tax Report"

Modern Football Injuries

Are football injuries increasing? Their frequency and duration during 1934 in the Rocky Mountain Conference, as determined by Dr. Cotton, are illuminating

by George K. Cotton, M.D.

A recent survey was made in the Rocky Mountain Conference to ascertain the frequency and duration of injuries common to the college football player. Questionnaires were sent to all of the coaches in the Conference and the data was compiled in the following table. Those injuries requiring the loss of one day or more were reported.

TYPES OF FOOTBALL INJURIES FOR THE SEASON OF 1934

Ligamentous (Sprains)

	Right	Left	Length of Time Disabled
Number of Knees	8	9	4 weeks
Number of Ankles	11	4	2 weeks
Number of Shoulders	7	5	3 weeks
Number of Hips	3	0	3 weeks
Number of Backs	2	0	3 weeks
Other sprains (Elbow)	1	0	1 week

Bones (Fractures)

	Number	Length of Time Disabled
Number of Nose	8	10 days
Number of Jaw	0	

	Right	Left	Length of Time Disabled
Number of Fingers	3	0	1 week
Number of Arms	1	0	4 weeks
Number of Legs	2	1	6 weeks

Dislocations

	Right	Left	Length of Time Disabled
Number of Fingers	2	0	10 days
Number of Elbows	1	0	3 weeks
Number of Shoulders	2	0	4 weeks
Number of Hips	0	0	
Number of Knees	0	0	
Number of Ankles	0	0	

Muscle Injuries (Charley Horses)

Site	Number	Length of Time Disabled
Right Thigh	5	2 weeks

Skin (Lacerations Requiring Sutures)

Site	Number	Length of Time Disabled
Face	11	10 days

Infections

Site	Number	Length of Time Disabled
Right Leg	1	10 weeks
Right Elbow	1	1 week

Other surveys reveal a close similarity to the injuries occurring in the Rocky Mountain Conference. Stevens of Yale and Horan of Cranbrook School have shown in their extensive studies that football injuries are decreasing, college being less hazardous than high school and sand lot football games. A well-trained and supervised player should be able to play an entire season without receiving a serious accident.

The total number of men playing during the 1934 season was 205. Of this number 87, or 40 per cent, sustained injuries sufficiently serious to remove them from their activity for one day or more. Joint injuries, as tabulated under sprains, were the most frequent, and the left knee was the most common site. No differentiation was made to determine the extent of these sprains. Some were, no doubt, sufficiently severe to be classed as an internal derangement of the knee joint. Several of the coaches reported that some of the knee injuries had been particularly troublesome. One reports several knee injuries during the past three years which have been operated for the removal of the internal semilunar cartilage. Half of the cases responded very satisfactorily and were able to perform in football without any noticeable handicap. The others did not have the ability to play football, but did have a good functioning knee joint for ordinary purposes. Another coach stated that they had had four such operations

and all players were sufficiently sound to withstand all the impacts and strain occurring in the game of football.

Milder knee sprains, as most trainers realize, soon subside under heat, massage and rest. If there is a weakened tendency of the knee, which is usually the result of quadriceps insufficiency, then support of the joint by adhesive bandage or brace should be used; otherwise, a recurrence of the sprain is probable. Knee injuries that fail to heal in the proper length of time must be considered as being cases of internal derangement. Other joint injuries, in the order of their frequency, were ankle, shoulder, hip, back and elbow injuries. With the proper exercise, support and protection of these joints, disability should rarely occur. The amount of time lost waiting for a sprained ankle to heal is one-half as great as that lost in the case of a sprained knee. The sprained shoulder, often called the "football shoulder," when severe, represents a tearing of the acromioclavicular ligaments.

Fractures represent a smaller group of injuries than in the case of sprains, but as a rule, they require a longer period of disability. Broken noses are quite common and may be annoying, reducing the players agility and efficiency; nevertheless, proper protection could reduce this frequency. Fortunately, the length of time lost for the eight cases of broken noses was only ten days. Fingers were the next most common site of fracture, the legs and arms being next. The most common type of leg fracture was, no doubt, the ankle fracture. The incidence of fractures can be greatly reduced by adequate training and protection.

Dislocations rarely occur, and when they do the fingers and shoulders are the most frequent sites. Disability is, as a rule, for only a short period of time. It has been reported that dislocations occur more frequently in high school games than in college games. The prevention of dislocations requires proper muscle training and the avoidance of awkward, unguarded movements against the proper dislocating force.

Muscle injuries resulting from direct force on the unprotected surfaces, especially the thighs, represents a serious type of disability because of the sequelae — hematomas and myositis ossificans. However, through training and supervision this type of injury rarely occurs. The loss of time usually averages about fourteen days and is best treated by heat and a compression bandage, but no massage whatsoever is given until the muscle has healed.

Lacerations requiring suturing occurred about the face only. These wounds were quite frequent and required, on the average, a ten-day disability. The rarity of infection demonstrates the careful surveillance given all the players with the slightest abrasions. The risk of infection is, no doubt, great since all contests are held upon well fertilized fields where tetanus and gas bacilli abound. In this survey infection accounted for the greatest loss of time; therefore, it is expedient that all lacerations and abrasions be thoroughly sterilized. The wearing of fresh, clean underclothes and stockings also reduces the incidence of infection.

Conclusions

Football injuries in colleges are decreasing because of the training and supervision given to all the players.

The most frequent injuries are those involving joints, especially the knee joints. With adequate muscle training by special exercises, the muscles, inclusive of the joints, may be strengthened to alow for architecturally stronger joints. Weak joints must be sufficiently protected by strapping or bandaging to allow for all unguarded impacts.

Sprains should be immediately immobilized and no weight-bearing al-

(Continued on page xii)

The Patient's History

Experience emphasizes again and again the importance of an accurate and complete history. Dr. Tufts' comments are timely and interesting

by Millard Tufts, M.D.

Frequently patients whom we meet for the first time complain that their former physician or physicians previously seen by them, asked a lot of questions. When this happens it confirms our belief that they have seen competent medical men. From the standpoint of the physician taking the history the problem is reversed. All too often his difficulty is to control the history of a patient who needs no questioning to bring forth an unending narration of his case.

Among the many valid arguments against sickness insurance as it operates in European countries is the fact that physicians do not have the opportunity to make adequate examinations of their patients. Statements have been made by physicians participating in these systems that they are harassed by the great number of patients to be taken care of in a limited time. It is not surprising then that only the major ailments of those who apply to them for care are recognized. Thorough examinations are out of the question, and therefore, early signs of disease too often go unrecognized.

Since there is no time for proper examination of the patient under a sickness-insurance system, obviously there is no time for history-taking. Naturally, where this is not done good medicine cannot be practiced. If for no other reason we should be unalterably opposed to wholesale or "mass" medicine which inevitably is brought about when a "system" dispenses medical care.

The patient's history, as has been emphasized frequently, is the foundation upon which the doctor builds his diagnosis. Just as no building will stand without a foundation, so will the doctor's final decision in the matter of diagnosis be open to question if he has not gone into the patient's history very carefully. It is this art in medicine which so definitely marks success in our profession. Making a diagnosis without a history is like completing a painting without a setting. Many beautiful paintings are effective largely because of their backgrounds and surroundings.

When we first see a patient most of us have in mind a certain routine or a basic outline which guides us in history-taking. A very adequate outline was prepared by our Medical Society a few years ago, which included forms for both a physical examination and the history of the patient. Copies of these forms were sent to each member of the Society. However, in the minds of some of us there is a question as to the necessity or advisability of using a set form. The important thing is to obtain a complete history, and, of course, this should be done in the manner best suited to the needs of the individual physician.

I recall several important industrial cases to which I listened recently in which the commissioner in charge found it impossible to get clear histories from the plaintiffs' own physicians. In one instance, unfortunately, the history was the deciding factor in establishing a fair award for the injured.

A few days ago a cardiologist whom I consulted made an evaluation of a diseased heart in a case of thyrotoxicosis. His decision was an important one for the very life of the

(Continued on page xiii)

EVENTS FOR FEBRUARY

Monday, February 3rd:

Morningside Hospital Staff Meeting, Morningside Hospital, 8:00 p. m.
Luetic Lesions of the Rectum and Colon.....V. K. Allen, M. D.
Subject Unannounced.....A. Ray Wiley, M. D.

Tuesday, February 4th:

Auxiliary to the Tulsa County Medical Society with Mrs. Fred S. Clinton, 1315 S. Boulder Ave., 2:00 p. m.
Musicale
Tea

Thursday, February 6th:

Flower Hospital Staff Meeting, Flower Hospital, 8:00 p. m.
Osteomyelitis.....Ian MacKenzie, M. D.
Discussion of Cases
Refreshments by Hospital Management

Monday, February 10th:

Tulsa County Medical Society Meeting, 1207 Medical Arts Building, 8:00 p. m.
Symposium on Pneumonia:
Medical Diagnosis and Treatment.....S. C. Shepard, M. D.
Heart Conditions.....W. J. Trainor, M. D.
Bacteriology.....I. A. Nelson, M. D.
X-ray Findings.....Morris B. Lhevine, M. D.
Surgical Complications.....Fred A. Glass, M. D.
Discussion opened by.....B. L. Branley, M. D.

Wednesday, February 12th:

Tulsa General Hospital Staff Meeting, Tulsa General Hospital, 8:00 p. m.
Business Meeting
Refreshments.

Monday, February 17th:

St. Johns Hospital Staff Meeting, St. Johns Hospital, 8:00 p. m.
Recent Advances in the Study of Biliary Diseases:
Medical Aspects.....H. A. Ruprecht, M. D.
Surgical Aspects.....D. L. Garrett, M. D.
Discussion opened by.....I. A. Nelson, M. D. and C. C. Hoke, M. D.

Monday, February 24th:

Tulsa County Medical Society Meeting by Invitation at Tulsa General Hospital 8:00 p. m.
The Management of Mental Cases.....Felix Adams, M. D.
Refreshments by Hospital Management

Clinical Pathological Conference:

Room 31, St. Johns Hospital, Mondays, 7:00 p. m.
Room 219, Morningside Hospital, Wednesdays, 5:15 to 6:00 p. m.

Medical Reserve Officers School:

Medical and Dental Arts Building, Fridays, 7:30 p. m.

Annual Society Dues Payable Now $10.00.

COUNTY SOCIETY MEETINGS NORTHEAST OKLAHOMA

Monday, February 3:
Osage County Medical Society, Pawhuska Municipal Hospital, Pawhuska, 8:00 p. m.

Tuesday, February 4:
Craig County Medical Society, Library. Eastern Oklahoma Hospital, Vinita, 7:30 p. m.
Modern Methods of Anesthesia,—Doctors W. R. Marks and R. D. Gilbert.

Thursday, February 6:
Creek County Medical Society, Bristow, 7:30 p. m.
Program Unannounced.

Monday, February 10:
Muskogee County Medical Society Oklahoma Baptist Hospital, Muskogee, 8:00 p. m.
Program Unannounced.

Tuesday, February 11:
Washington County Medical Society Memorial Hospital, Bartlesville, 7:30 p. m.
Speakers Doctors L. D. Hudson and J. P. Vansant.

Monday, February 17:
Rogers County Medical Society, office of Dr. F. A. Anderson, Claremore, 8:00 p. m.
Program Unannounced.

Thursday, February 20:
Haskell County Medical Society, office of Dr. J. C. Rumley, Stigler, 7:30 p. m.
Program Unannounced.

Monday, February 24:
Muskogee County Medical Society, Oklahoma Baptist Hospital, Muskogee, 8:00 p. m.
Program Unannounced.

THE AUXILIARY

The Auxiliary to the Tulsa County Medical Society will meet in the home of Mrs. Fred S. Clinton, 1315 S. Boulder Ave., February 4th at 2 P. M.

A Musicale will be given followed by tea. There will be no business meeting.

The Hostesses: Mesdames Fred S. Clinton, George R. Osborn, Emry H. Hyatt, Leon H. Stuart, Arthur H. Davis, assisted by the Social Committee.

At our last meeting, which was held in the home of Mrs. P. P. Nesbitt, Dr. R. M. Shepard gave a splendid talk on Health Insurance and State Health. There was a very good attendance.

James Stevenson, M. D.
President-Elect
Tulsa County Medical Society

Born 1893 at Chicago, Ill. Graduated from the University of Illinois College of Medicine 1917. Located in Cherokee Okla. in 1920. Took post-graduate study at Harvard Medical School and came to Tulsa in 1925. Dr. Stevenson limits his practice to Dermatology.

GUEST SPEAKER

Felix M. Adams, M. D.

Graduated from Barnes Medical College. St. Louis in 1909 and has limited his practice to Neuro-Psychiatry. Dr. Adams is Superintendent of the Eastern Oklahoma Hospital, Vinita and a member of the American Psychiatric Association. He speaks Fedbuary 24th on the very subject you wanted to look up, "The Management of Mental Cases".

American College of Surgeons

The southwestern sectional meeting of the American College of Surgeons will be held in Dallas, Texas, on Wednesday, Thursday and Friday, March 4, 5, and 6. Headquarters will be at the Baker Hotel.

TULSA COUNTY MEDICAL SOCIETY COMMITTEES FOR 1936

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TULSA COUNTY MEDICAL LIBRARY JOURNALS FOR 1936

The American Journal of Cancer.
The American Journal of Digestive Diseases and Nutrition.
American Journal of the Diseases of Children.
The American Journal of the Medical Sciences.
American Journal of Obstetrics and Gynecology.
American Journal of Syphilis and Neurology.
Annals of Internal Medicine.
Annals of Surgery
Archives of Dermatology and Syphilology.
Archives of Internal Medicine.
Archives of Neurology and Psychiatry.
Archives of Pediatrics
Archives of Ophthalmology.
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Archives of Pathology.
Archives of Surgery.
Bulletin of the Johns Hopkins Hospital.
Chinese Medical Journal.
Endocrinology
The Journal of Allergy.
The Journal of the American Medical Association.
The Journal of Clinical Investigation.
The Journal of Experimental Medicine
The Journal of the Oklahoma State Medical Association.
The Journal of Bone and Joint Surgery.
The Journal of Immunology.
The Journal of Urology.
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New England Journal of Medicine.
Physiological Reviews
Psychiatric Quarterly
Southern Medical Journal
Surgery, Gynecology and Obstetrics
Quarterly Cumulative Index Medicus
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Surgery—Carl Hotz, M. D.
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X-Ray, Radium, and Pathology—M. B. Lhevine, M. D.

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Professional Directory

Timely Brevities

The subject of euthanasia has been given much prominence lately in the daily press. This is largely due to the formation of a group in England to promote legislation to render legal the termination of life in painful and incurable disease. In favor of this right to die, the argument has been advanced, that if the hopelessly diseased or crippled animal can be mercifully destroyed, the same privilege should be accorded to man.

Needless to say, this subject has provoked a storm of discussion. "Murder by Request" is an article written by Anthony Turans in *American Mercury*. In it he says, "It appears that, aside from the surviving prejudices of a bigoted age, no plausible reason exists against enabling physicians to extend to human beings the ordinary kindness accorded to glandered mules and moribund cats. After all, until the state finds a means of officially assuming the deathbed agonies of hopelessly afflicted citizens, it cannot logically deny the private right to die."

Naturally physicians have followed the arguments with interest, since upon them would fall the role of executioner. Aside from the doctrines of immortality involved there is to be considered, also, the question of ethics. It would be entirely foreign to our code for the doctor to enter the sick room with any purpose other than the preservation of life. Further, there is a strong possibility that the physician might be placed in the same category with the hangman, and throughout the ages the hangman, however his occupation be legalized, has felt the ostracism of mankind.

One exponent of euthanasia was questioned regarding his willingness to administer the merciful death. His reply was, "No!"

Medical defense companies long have been able to trace the origin of many unmerited malpractice suits to the uncautious remarks of some physician. The attendant publicity which follows even the most ridiculous of such cases harms the entire profession by impairing confidence.

There is a proverb in all languages which has come down from the remotest times: "The wise correct their own by studying the faults of others." In equal truth may we say that the wise also temper their criticism with charity. This should be especially applicable to physicians.

•

We are surprised now and then to find clergymen of various denominations urging "state medicine." It seems to us that inner mission work is one of the essentials of practical Christianity; that "faith must express itself in work, especially in works of love and charity." For the State to take over arbitrarily the practice of medicine and enter into an elaborate scheme of social service work is to deprive the church of its one great opportunity of applying its teachings. In those countries where dictators hold sway the state has become an absolute power, and the church, if it is tolerated at all, has been reduced to the status of a mere puppet, rendering lip worship only.

•

Some of the blackest pages in human history are found in the story of man's treatment of the insane. These unfortunates were starved, beaten, tortured, and burned at the stake on the theory they were demonically possessed. Even the Church waged war on her weaker members on the ground that they were agents of the devil. The evolution in the care

of the insane was slow, and it is only within the last twenty-five years that great headway has been made.

In a recent issue of *Scribner's* Inis Weed Jones relates an incident which was typical of the past: "One day, years ago, an ox-cart drew up before the Worcester State Hospital in Massachusetts bearing a heavy wooden box bored with barely enough holes to enable the madman within to breathe. The doctor came out to the wagon. "Open that box," he told the countrymen who had brought the patient. "That's no way to treat a sick man!" "Oh, but Doctor, he's dangerous," one of them replied. "He's been chained to a tree for three years. His family died, and we neighbors knew something had to be done. We got him in, but we're afraid to let him out." "Open up that box!" the indignant physician demanded. Tremblingly they did so, and revealed an old and broken man who for the first time in three years was hearing sympathetic and understanding words. He got to his knees, clasped his hands, and with tears raining down his withered cheeks exclaimed in his strange bewilderment, "Oh, Doctor . . . . . you must be God!"

Mental diseases have been the last to be attacked by research methods. Although dementia praecox fills over half of our hospital beds and costs the staggering sum of $350,000,000 annually, up to five years ago there were only thirty-one books and articles on this most common mental illness. At the same time we had over 1,400 articles and books on tuberculosis.

We hope the remarkable decrease in the incidence of tuberculosis may be duplicated by a like decline in insanity.

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The Life Extension Institute is an organization of more than forty life insurance companies. In 1929, this institution published the results of the physical examinatoins given to 100,000 young men who were applicants for insurance policies. Of these 27% had defective vision; 37%, defective hearing; 45%, diseased tonsils; 78%, defective teeth; 71%, digestive trouble, and 44%, defects of the heart or circulatory system. These figures, mind you, were compiled in a pre-depression year. Now life insurance companies are primarily interested in persons who are capable of buying insurance; in other words, persons with reasonably high incomes. Surely it is only by the wildest flight of imagination that the present medical system can be blamed for the conditions of poor health in these cases, since the men examined were able to buy insurance and ought, therefore, to be wholly able to pay for whatever medical attention they required.

•

A reporter on the *Daily Cardinal*, University of Wisconsin student publication, recently cajoled a number of co-eds to press rouge coated lips to a piece of graph paper — graph paper because it facilitated measurements. The average lip coverage, .83 square inches;—the maximum was 1.06 square inches—, was multiplied by the average frequency of lipstick application per week, 32 times. The weekly frequency varied from 15 to 60 times.

The number was multiplied by 52,—the number of weeks in a year. The reporter found that the average co-ed paints 9.68 square feet of lips per year, and that the 2,875 Wisconsin co-eds cover 27,800 square feet annually, or enough "to cover four barns."

Our answer to this statement of fact might be "So What?" However, let us not overlook genius. This young man is assured of a brilliant future can he but affiliate himself with either a propagandist foundation or one of the numerous useless bureaus at Washington. —A. C. H.

At Our Own Risk

by An Observer

One of our routine tasks is to read all the material of a general nature which appears in medical publications throughout the country. We are no new hand at the job, having gone through hundreds of publications during the last several years. This may account for the skepticism which has grown upon us in recent months. It may be true that this feeling on our part has been due to a too steady diet of the same thing. At any rate, much of the material which we read affects us in the same manner that too much repetition always does. Statements which impressed us when originally made have become mere platitudes.

We agree that repetition is often needed to drive home a point. Especially is this true when writing about a subject such as medical economics for the consumption of physicians, many of whom apparently have a strong aversion to the subject anyway. It is, however, hard on the reader who is familiar with the subject. Much of the material which is now published has become so commonplace that the informed reader can usually tell from the opening paragraph what the remainder is about.

Despite these reactions to the material now published on medical economics, we believe editors should keep emphasizing the need for a better understanding of our economic affairs. Times are too critical to ignore a subject so vital to the public and the medical profession.

Not many doctors are as frank as one to whom we had occasion to talk the other evening. He said, "You know to tell you the truth, most of us doctors do not know what this thing is all about. I start to read an article on medical economics and I get all mixed up. The other day I met a doctor I know and I asked him what he got out of the stuff which we get from our medical society on economics. He said he was in the same position I was,—that he knew little about it and understood less."

Now this doctor is an intelligent fellow. Although he really felt he should understand the subject and especially wished to know what an informed physician should about socialized medicine, he apparently had not cared to apply himself to study or the subject had not been properly presented to him. This would indicate an opportunity for editors of medical journals to do a much needed job, that is to find a way to stimulate the curiosity of doctors who apparently are not interested in medical economics by presenting it in such a manner that they will read about the subject in spite of themselves.

It would be rather interesting were statistics available on how many of our physicians are really informed on the subject of medical economics. These figures could possibly be obtained by ambitious editors from their readers and incidentally would reveal to a degree how well the material published is being edited.

The point of these comments is that despite headaches which much of the material on medical economics gives us there is still a great need for such information to be disseminated among physicians generally. Those who are familiar with the subject must not be too impatient when an old, old story is retold for the thousandth time and not very well at that.

It was emphasized recently at the meeting of secretaries of state medical societies at Chicago that if we are to withstand the onslaught of

propaganda for sickness insurance the rank and file of physicians must be well informed. That being true, and knowing that they have a long way to go to achieve this goal, editors should be urged not only to disseminate information to the profession in an interesting manner but should improve themselves in the meanwhile.

We have not taken cognizance so far of the growing group of physicians who are well informed on medical economics. To them we owe a debt of gratitude. They will by their efforts help to inform the public and incidentally lead their less informed brethren into paths which they should follow.

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Modern Football Injuries

(Continued from page vii)

lowed. They must also be differentiated from fractures and dislocations.

Fractures and dislocations rarely occur in college football, and when they do the nose is the most common site.

All football injuries should receive careful attention, and if there is any doubt as to the extent and nature of the injury, nothing whatever should be denied the player.

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Reprinted from Colorado Medicine

Today the last refuge of the human being who wants to be an individual is when he is sick. If this refuge and sanctuary are also to be taken from him, what has he remaining? If so, then truly we shall become a nation of automatons, moving, breathing, living, suffering and dying at the will of politicians and political masters.

Morris Fishbein, M.D.

(Continued from page viii)

patient. It was to decide whether surgery should be done with the cardiac disability. The decision was made after the physical examination was completed. The evaluation was competent and was based largely upon the history of the case.

I recall a third case which indicates the importance of history-taking. Last July I treated a man who had been stung by an insect. There had been a severe local reaction and the area involved had become infected and suppurated. The man was very ill, of course, and was completely disabled for a period of three weeks. I had recorded and reported the accident as occurring on July the fourth, a few days before my first visit. The man, however, held that he was stung while at work on July the third and was, therefore, covered by a certain insurance. My history was damaging and, if inaccurate, unfortunate for my patient.

My purpose in referring to these cases is to emphasize the need of recording an accurate history, not alone because it is essential to proper diagnosis, but so that justice will be done the person examined and those who may be interested in his illness. Where this is not done the physician must rely upon his memory or upon physical or laboratory tests, any one of which may not be entirely reliable. As a matter of fact, in many situations we might be better off with a good history alone if we had to make a choice between such a record and a physical examination.

I have often heard it intimated that it is the older man in practice who fails to record a full and accurate history. In my experience this has not been true. I have observed that during the early period of their work interns take careful histories. Later on in their service there is frequently a let-down, and when they first enter private practice their evaluation of histories is quite inadequate. However, after four or five years of practice their history-taking stock is back to par. This is, of course, merely a personal observation.

The question in the mind of a busy practitioner is "How can I see ten or fifteen new patients a day and make and record histories for each one?" I think the answer is to develop one's own system to meet his particular need. I have conferred with physicians in the various specialities and find that generally their opinion coincides with mine on this point. An actual written or typed record of any history should be made in each case.

Some years ago I purchased from a commercial concern a system for keeping history and financial records. It seemed adequate in cases where a simple note was all that was necessary and where the person was seen only once, and then for some minor ailment. In some specialties, of course, set forms might be practical, but where one's practice takes in general diagnosis more often than not they are unsuitable. Where history-taking is to be done in detail I use plain, unruled, manila cards, five by eight inches in size. Such cards permit flexibility in taking the history, and they can be filed easily and conveniently in index containers. Space should be left, of course, for the addition of subsequent important history.

Skill in recognizing the need for a detailed history is acquired with practice. In certain types of specialties, as, for example, neurology, a detailed record is often essential because of the very nature of the case. A history frequently may become too long if the physician does not manage the procedure because some patients respond readily to suggestions, thereby distorting the facts. Sometimes, too, they are prone to misrepresent or misquote the statements of physicians to whom they had gone previously. The

physician needs only to appear to be entertained by such statements to have, in many cases, a long-drawn-out, unreliable, untruthful history meant to belittle some other practitioner who undoubtedly has not been paid for his services.

Because histories are needed immediately at the time of treating the patient whatever system is used should be readily available for reference at each visit. I find that the card system which I have adopted makes this possible, and that it is especially useful where the history is to be used for testimony given outside the office.

Whatever system the physician employs it should provide a means of securing the essential facts. For example: it may be possible for the office assistant to take part of the history at her desk, but it is always best for the doctor to do this himself. Often the patient is hesitant about giving the facts requested. Frequently this is due to the presence of friends or relatives or to the fact that others in an adjacent room may overhear both the questions and answers.

To many of my readers the facts as set forth here are repetition of an important procedure in the practice of medicine. However, it is hoped that some of the experiences mentioned here may be a means,—especially to the young men just beginning the practice of medicine,—of keeping to the front the all-important need for a practical, useful system of history-taking developed to meet each physician's own particular need.

The general public has little realization of the tremendous amount of effort expended annually by individual physicians and by organized medicine in combating pernicious legislative measures, sponsored by misguided enthusiasts and by those with ulterior motives. There isn't a legislature in America which does not annually have bills presented for consideration which would, if enacted, destroy health protection. Bills to lower the standards of medical education to force the recognition of untrained cultists by health boards and hospitals, to prohibit animal experimentation, are common dangers which must be fought constantly. The opposition of medicine to such measures is based on its obligation to protect the public health, and to protect scientific and clinical investigation into the nature of disease.

In its opposition to measures that threaten the public welfare medicine employs no lobby; it makes no threats; it offers no political support. To accomplish its purpose, it must depend in the future as it has in the past, on the influence of enlightened public opinion. American facilities for medical care are unsurpassed but much remains to be accomplished before the ideals of medicine are realized. In their realization, society has obligations no less than those of medicine.

William H. Holmes, M.D.
Associate Professor of Medicine,
Northwestern University
Medical School

Sunny Side Up

A DOCTOR'S TROUBLE

"My dear fellow," said my doctor to me, "you have no idea what we have to put up with. If I call to see a patient frequently, I am 'trying to run up a bill'; if I don't, 'it is shameful neglect.' If I manage to get to church, and am called out, I hear afterward, 'Working the Bob Sawyer dodge on Sundays, eh, Doctor?' If I am so busy that I can not go, I am sure to be asked, 'How is it that you doctors are all atheists?' If my wife calls on people, it is 'because she is trying to get patients for me,' but if she doesn't, it is because she is 'too stuck up.' If I cure a patient quickly—get credit, you say? Oh, dear no!—the patient 'wasn't half as bad as the doctor tried to make out'; but, on the other hand, should the case develop serious complications, 'Ah! the doctor never understood the malady; in fact, he was worse when he had been taking the medicine a week than when we called him in.' If I suggest a consultation, it is only because I don't know what is the matter; if I pooh-pooh the idea as unnecessary, I am 'afraid of showing my ignorance.' I am expected to, so to speak, cast a horoscope on a baby's life, and tell its mother what its ailments will be. If I can't do that, I 'can not possibly know very much.' I am expected to forsee all the 'ills that flesh is heir to,' six months before they come. I once lost a patient whom I had treated for influenza, because I did not foretell an attack of rheumatism which came on three months later. In all cases, if they get worse, the fault lies in the medicine. If I send in my bill, they say, 'He is in a terrible hurry for his money'; if I don't, it is 'so unbusiness-like.' 'But we get well paid?' do you say. My dear sir, if I received payment for one-half I do, I should die from shock."

—*Medical Record.*

•

FRESH EGGS

Customer: "Are those eggs strictly fresh?"

Grocer (to his clerk): "Feel of those eggs. George, and see if they're cool enough to sell yet."

•

WHICH FOOT

An Arkansas backwoods woman, the soles of whose feet had been toughened by a lifetime of shoelessness, was standing in front of her cabin fireplace one day when her husband addressed her.

"You'd better move your foot a mite, maw; you're standing on a live coal."

Said she, nonchalantly: "Which foot, paw?"

SALARY VS. LOVE

During an intense love scene in the movies, when the hero was doing his stuff, wifie nudged hubby and said:

"Why is it that you never make love to me like that?"

"Say," he replied, "do you know the salary that guy gets for doing that?"

•

UNPREPARED

The golfer had lost his ball, and, not unnaturally, was inclined to be annoyed with his caddie.

"Why the deuce didn't you watch where it went?" he asked angrily.

"Well, sir," said the boy, "it don't usually go anywhere, and so it took me unprepared like."

•

LYING ON A FEATHER

"I shall have to put you fellows in the same room," said the host.

"That's all right," the guests replied.

"Well, I think," said the host, "you'll have a comfortable night. It's a feather bed."

At two o'clock in the morning one of the guests awoke his companion.

"Change places with me, Dick," he groaned. "It's my turn to lie on the feather."

—*Grit.*

•

FIGURES

A census taker asked the woman at the door:

"How many in your family?"

"Five," snapped the answer, "me, the old man, kid, cow and cat."

"And the politics of your family?"

"Mixed. I'm a Republican, the old man's a Democrat, the kid's wet, the cow's dry and the cat's a populist."—*Page.*

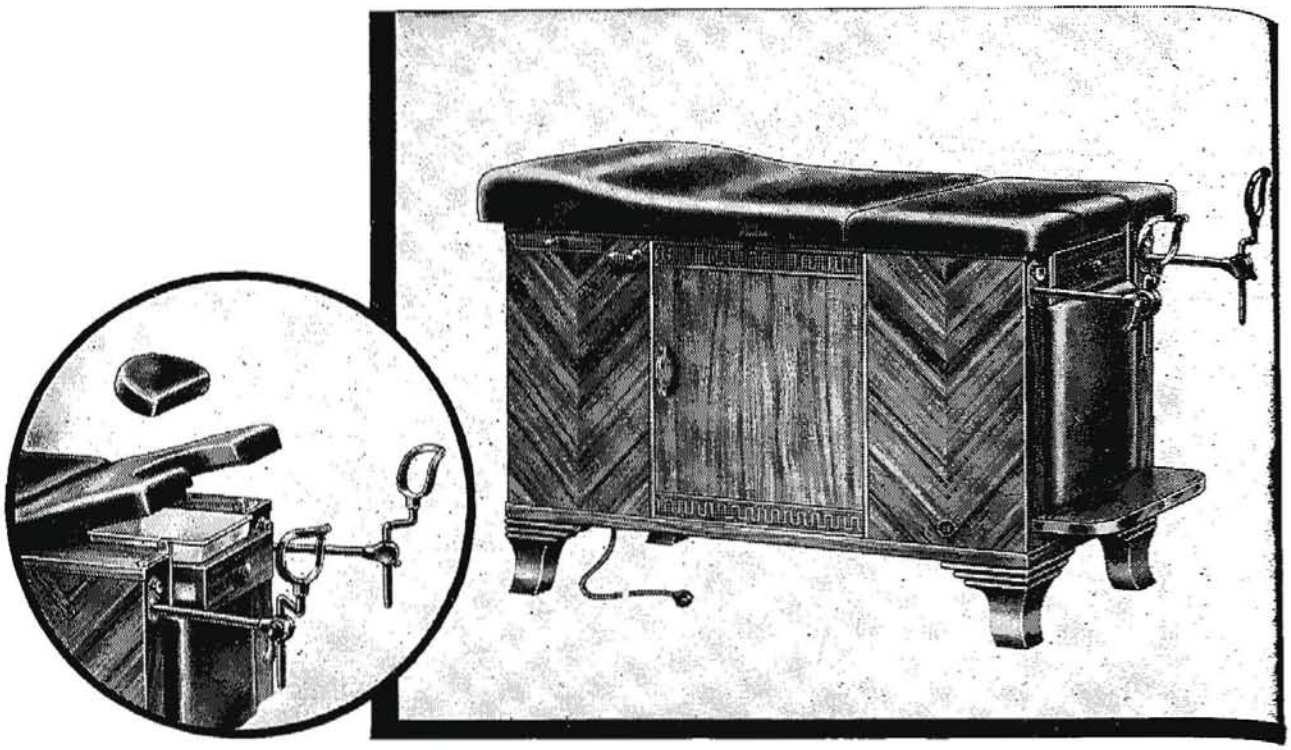
•

WHAT'S THAT

A Scotsman on a visit to Canada noticed the mounted head of a bull moose hanging in the hall of the house where he was staying. He asked his host what kind of animal it was.

"Oh, that's a moose," said his host.

"A moose!" exclaimed the Scot. "Eh, mon, what like are your rats over here?"



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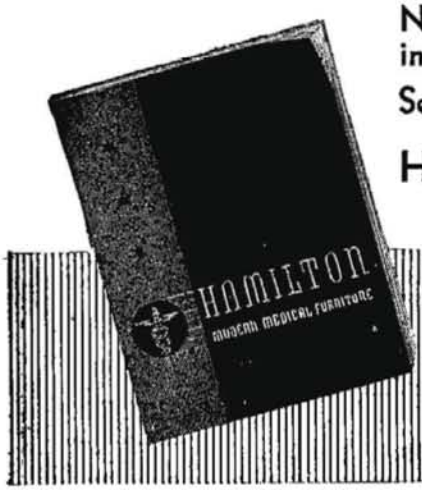

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