

The COLLEGE JOURNAL

O
S
T
E
O
P
A
T
H
Y

O
S
T
E
O
P
A
T
H
Y

WIN, PLACE OR SHOW?

* * * The race is on.

* * * The class of 1939 is in the running.

* * * If we top fifty, the race is won. If we make just fifty, we place. Less in number is for show.

* * * It is August 1st. We are in the last lap. September 11th will tell the story—whether the class runs to win, place or show.

* * * As we view the field we are placing all our bets on win. If we only place we will be satisfied. It will be an unexpected result if the class ends in show.

* * * No bets are being placed on show; but few on place. As we say, we are betting our all on win.

* * * The results of this crucial race will be announced in the October issue.

Published Bimonthly by the
Kansas City College of Osteopathy and Surgery
2105 Independence Boulevard
KANSAS CITY, MISSOURI

Vol. 23, No. 4

August, 1939

Entered as Second Class Matter, April 23, 1917, at the Postoffice at Kansas City, Missouri, under the Act of August 24, 1912, as a bi-monthly. Accepted for mailing at special rate of postage provided for in section 1103, Act of Oct. 3, 1917. Authorized August, 1918.

OUR HOBBY—Continued

June is slipping by. In a few days the convention will commence in Dallas. We will not be there in person but our prayers will be for those who are attending to our profession's business. While we won't be there we are glad to know that Our Hobby will be well represented by the Conleys, the Peaches, the Johnstons, the Jones family, and others. And quite a large number of graduates of "the aggressive college" will be among the throng.

We are writing these lines at the urgent request of our substitute editor who is holding down the job while we are spending a few months recuperating in the Ozarks, getting ready for what we hope will be the beginning of a great year in September. As matriculations gradually come in we are encouraged to believe that we will have a nice class starting then, with additions to some of the upper classes.

And now, as we often do, we are thinking of days long gone by—when we wondered if we would have any class at all; when we wondered what futurity held for us. It is needless to say, in the long ago, that we had no idea that we would one day be in our new enviable position; that the day would be reached when every member of the staff would be paid for his services. In the early day, we all worked without financial recompense; and be it known that we worked as diligently and as earnestly in those days as we do now. Possibly we worked even a bit more wholeheartedly in those days than we do now in spite of the fact that we now are doing our very best. Then, we were in rented quarters often wondering where the next month's rent was coming from. Now, we own our own magnificent building and are anxiously awaiting the day when we can erect more.

In those days we were without hospital facilities. Now, we have our own little hospital and are wondering how soon we will have to enlarge it.

In those hectic days we wondered how we were going to meet bills, although somehow we always did. Now, our friendly banker is always asking us if we don't want to borrow some money.

In those days, gone past, our college was the youngest among the osteopathic colleges—also the smallest. Now, while we are still the youngest, we are by no means the smallest, student body considered.

Then we had a small clinic. Now it is a problem to care for the scores who come to us for attention. Our reception room will not accommodate them. They sit or stand in the hallways awaiting service every clinic hour.

We then had a staff of about a baker's dozen—13. Now we are staffed with thirty or more. Then we had 30, or 40, or 50 students. Now we average around 200.

Oh, there are so many "thens" and "nows" that come to mind that we cannot possibly recount them all. But in a few years—we are now 25—we doubtless will be comparing the "now" with the "then." Time marches on.

A. A. KAISER, Secretary.

CRASHING THE GATE OF A "CLASS A" HOSPITAL

Years ago before osteopathic hospitals had their being in Kansas City the writer had the following experience.

A young married woman, the wife of an attorney-at-law and a university graduate herself, consulted me with respect to herself. She was pregnant for the second time. The first pregnancy had resulted disastrously. She was delivered at term. She had the services of a competent medical obstetrician. Her case was one of those that you read about. Labor didn't progress as normal cases should. Consultation was called and after hours of ineffectual effort the consultant called added consultation. The three applied themselves diligently and succeeded in delivering a dead foetus after a nerve-wrecking ordeal which lasted for 48 hours. They were all unanimously of the opinion that she should never become pregnant again, that she could not deliver (this was before the classic Cesarean Section had become the vogue). She wanted a family, so, disregarding the most competent medical obstetrical advice in the city, she became pregnant the second time. And she was referred to me for care.

While the history was none too promising, yet realizing the advantages of osteopathic preparatory care and the superiority of its delivery technic, I readily accepted the charge. She then said she wanted to go to the hospital for her delivery and named a standardized medical institution which was famous for its professional standards, but which was "pizen" not only to osteopathic physicians but also to all medical men not enjoying the favor of a staff membership. I explained that in times past I had worked at that hospital but when standardization was effected, I, being an osteopathic physician, was barred. I could not take my business there. She was obdurate. She intended to be confined in that institution. It was up to me to arrange my plans accordingly so I told her we would go there.

She was instructed to go out and make the acquaintance of the management and arrange for her hospitalization, but under no circumstances was she to divulge the name of her in-

tended doctor. If the question was asked, she was to parry by saying, "Whom would you recommend" and to make note then and there of the physician named. She complied with instructions. When she came back and reported her progress she was told to stay clear of the hospital until labor began when she was to call me.

A couple of months later, on a Sunday morning at 4 o'clock, she called saying she was in labor. She was instructed to call an ambulance at once to take her to the hospital; that I would notify them that she was on the way in. So I called the hospital. Sunday morning in the wee small hours was ideal for my purpose. The switchboard operator answered my call. I told her Mrs. Blank, a confinement case who had made her hospital arrangements, was in labor and was on her way in, that I would be down right away to take care of her, goodbye!

About 4:30 I was ringing the bell at the big, front door. A sleepy night supervisor let me in. I asked her if Mrs. Blank was in and, receiving an affirmative reply, asked her room number all the while making for the stairs, and about two steps in advance. I took the stairs two steps at a time, found the room, asked the patient a few questions, ascertained the time and duration of the pains and requested sterile gloves for an examination, before said night supervisor caught up with me. By that time I was in the doctor's room changing clothes. After my examination I ordered her moved to the delivery room and had an intern called to administer the anaesthetic. No one had had a chance to ask me a single question. I had the jump on them and kept it.

While I was "scrubbing up" for the delivery the patient had told the intern and the night supervisor all the gruesome details of her previous confinement. When I was properly garbed and ready to work the patient said, "Doctor, how long will I be in here?" I looked at the clock. It was just 6 A. M. by that time. I had a hunch and I rode it. My reply was, "It is now six o'clock. I expect to have you in bed and all hands at

breakfast by 7 o'clock." It was a bold assertion and one contrary to all odds as indicated by the case history. I saw the night supervisor give the intern a knowing look, elevate the eyebrows slightly and indulge in a supercilious smile. I realized that it would take a special dispensation of Providence plus all the beneficencies of the osteopathic technic to extricate me from that predicament.

I knew nothing of the routine obstetrical technic in that hospital. The nurse on duty was about as big as a "pint of cider half drunk up" but she was all nurse. Inhibition of the clitoris was used during pains and as dilation came quickly chloroform was used to deaden the heavy bearing-down pains. The intern gave it at my direction. At 6:45 I called attention to the fact that I was holding back on the head to minimize danger of a perineal laceration. At 6:55 A. M. the patient was on the cart going back to her bed with a nice healthy youngster as a souvenir of the occasion. It was an ideal delivery. With the delivery room door open one could not have heard a sound from the patient during the entire seance.

After resuming my street clothes I went in to thank the little nurse for her assistance. She made this remark (and remember this particular hospital was the bailiwick of the ne plus ultra of the obstetrical talent in Kansas City) "Doctor, I never saw you before. I don't know who you are or where you came from. This is my last case in my obstetrical service. My tour of duty expired at 7 o'clock. I want to tell you that was the cleanest, nicest delivery I ever saw," for which I was truly grateful.

No one said a word to me that would indicate anything other than that I was a staff member. I gave my patient what might be called routine osteopathic after care. A few days later the floor supervisor said to me, as I was at the chart desk perusing the chart, "Doctor, why don't you bring all your work here?" I asked why she made that remark. The reply came, "We have thirteen other cases on this floor and yours has gotten along better than any of the rest. She has had a minimum of disagreeable after symptoms and she is so easy to take care of. We girls wondered why you didn't bring all your work here." I thanked her and

said, "Maybe if I told you my name was not on your list it might be explanation enough." There was a mischievous twinkle in her eyes as she repeated, "Maybe."

My patient told me of an intern who spent considerable time in her room and she engaged him in argument as to the merits of osteopathy. His contention was that osteopathic physicians were ignorant and that when they raised their educational standards to a parity with theirs the medical school would recognize them. One evening I was treating my patient when a "probationer nurse" opened the door, stuck her head in, saw a strange man at the patient's bed doing something with her. She shut the door and her feet indicated she was running down the hall to report. Back came an intern in a great hurry. As he came in I recognized him as the doctor who had given the anaesthetic for me. I greeted him and explained what I was doing and what I expected to accomplish. The patient said to me, "Doctor, this is the intern I have been telling you about." Instantly, I changed the line of conversation, asking him casually if in his operating room experience he had ever encountered a case of "duodenal block." I was looking him squarely in the eye. The look of helplessness flashed in his eye. He hesitated, stuttered and finally said, "No, I have not." He was afraid to say "Yes" because he had no way of knowing what my next question would be. He hated to acknowledge ignorance in the presence of the patient, for of all subjects in the medical category they had mentioned, surgery was by far his favorite and the one in which he had established proficiency. It was a hard dose to swallow. I then told him why he had not contacted it, that the roentgenologists were not making their observations at the proper time or in the proper manner to visualize it. With that I went on my way leaving Mr. Intern to the tender mercies of the gleeful patient. The door had hardly closed when she was after him. "I thought you said osteopathic physicians were ignorant," she said, "yet you were caught flatfooted on purely a surgical problem. Now don't lie to me and say you had forgotten for I saw the look in your eyes that indicated ignorance." He "fessed" up—said I was very well posted and beat a hasty retreat.

My experience in said hospital was moving along without a ripple. I decided to smoke them out. Next day I called the hospital, gave them my name, asked if they had a bed for a surgical patient of mine, was referred to the room clerk, just as friendly as could be until she asked, "Who is going to do your work?" "I am," was the reply. "Wait a minute," she said. After a few moments she answered, saying, "I am very sorry but we have no beds." "Do you mean that you really have no vacant beds or couldn't you find my name on your list?" I asked. "You will have to speak to the business manager," she replied. "Let me have him for he is the very party I want conversation with," was my answer. After an interminable wait the business manager began the conversation with, "Didn't the room clerk tell you that we had no vacant beds?" "Yes," I replied, "but I was curious to know whether that was really the condition or whether it was because my name was not on your list of eligibles." "We don't have to do business that way," he replied. "No you don't," I said, "but the fact remains that you are. I was in your institution this morning and I observed numerous vacant beds." "We have no vacant beds today," he said. "A week ago Sunday morning I had no difficulty securing a bed in your hospital," I injected. "I know all about that," he said, "but we have no beds." "How about tomorrow," I asked, "in an institution as large as yours there is a normal percentage of demits so that you would have some idea," I suggested. "Our doctors don't know when their patients are going home so we have no idea as to vacancies," he stated. "Queer," I said, "I know at least twenty-four hours in advance when my patients are leaving and I make it a point to notify the management. As efficient as you are said to be I'd suggest you make such a request from your doctors." "We have no beds," came the answer. "Well, my patient is a wealthy man. He wants the best service that can be had in the hospital. If you can't accommodate him I'll go where they can. Goodbye!" With that I hung up.

On my next visit as I was leaving the hospital by the way of the big, front door I met the chief-of-staff face to face. He had been instrumental in having me barred at another

standardized institution for the reason that I was an osteopathic physician and had refused to bend the knee or to bow the head. My chin came up, my shoulders back, my demeanor that of one who had purchased 51% of the stock of the institution and with my widest grin I said, "Good morning, Doctor. How are you?" Had I kicked him in the solar plexus he would not have turned any whiter. He passed without a word, looking straight ahead. I was told later that things popped when he reached the inside of the building.

A few days later my patient was ready to go home. I went down to the desk and asked for the business manager. He came out from his sanctum. I introduced myself as though he did not recognize my identity. "Room 310 will be vacated tomorrow morning at 10 A. M.," I said, "I thought you might have a request for a bed." He turned on his heel, entered his office and slammed the door so hard that he shook the building. Which act ended a delightful as well as an edifying experience.

George J. Conley, D. O.

The
"Aggressive
College"

Kansas City College
of Osteopathy and
Surgery

RESUME OF THE MEETING OF THE ASSOCIATED COLLEGES OF OSTEOPATHY, DALLAS, 1939

It was found, as the result of years of experience, that the meetings of the Associated Colleges of Osteopathy must be held several days preceding the opening of the Annual Convention of the American Osteopathic Association if the amount of work coming before the group was to be completed in a satisfactory fashion and those attending were to have their time free from other demands that accompanied the routine of the Convention proper. With that thought in mind it has been the practice to meet in the Convention city the Friday before the opening date. Members of the Associated Colleges have served in a variety of capacities in the American Osteopathic Association. In recent years two of our members have served as President of the American Osteopathic Association, others have been members of the Board of Trustees, have served in the House of Delegates and in the various Departments, Bureaus and Committees of the National organization and as Chairmen of the various sections of the program and as participants in the sectional and general program activities. In a word it was found that it is impossible for the membership of the Associated Colleges to serve their own organization and that of their various interests and responsibilities if time was not provided outside the Convention week.

The first session of the meeting was held Friday at 9:00 a. m. and was attended by full representation from all member colleges. It might be of interest to the reader to know those who make up this body and were present throughout the sessions. Drs. Arthur D. Becker, President of the A. C. of O. and O. E. Owen of the Des Moines Still College of Osteopathy. Drs. J. S. Denslow, Secretary of the A. C. of O., George M. Laughlin, Wallace M. Pearson and Mr. Carl Magee of the Kirksville College of Osteopathy. Drs. R. N. MacBain, Floyd O. Peckham and Dean L. B. Whetten of the Chicago College of Osteopathy. Drs. Edgar O. Holden, Paul T. Lloyd and C. H. Soden of the Philadelphia College of Osteopathy. Drs. P. T. Collinge and W. W. Pritchard (president elect of the A.

C. of O.) of the College of Osteopathic Physicians and Surgeons of Los Angeles. Drs. George J. Conley, Margaret H. Jones and Dean J. M. Peach of the Kansas City College of Osteopathy and Surgery. In addition to these named there was a number of the members of the faculties of each of the colleges, members of the Bureau of Professional Education and Colleges of the A. O. A., members of various State Boards of Examination and Licensure, members of the Legislative Council and other interested members of the profession who were in and out of the meetings during the session.

The first session was given over to reports of the year's activities by a representative from each of the colleges. Opportunity for discussion of each report was allowed and considerable clarity on policies of the various colleges was obtained. Following these reports work on the agenda was started. Luncheon for the group was arranged as guests of the Drs. Margaret H. and J. Leland Jones of the college staff. In the afternoon session the whole of the time was given over to the Curricular Survey of the Junior College Division presented by a committee of which Dr. R. N. MacBain of the Chicago College was chairman and the Curricular Survey of the Senior College Division presented by a committee of which Dean J. M. Peach was chairman. This work was a continuation of work started last year and the reports of both committees were adopted and the Associated Colleges of Osteopathy now have an official curriculum, approved by all member colleges which should be of considerable value to them in standardizing their educational programs and unifying their efforts.

These reports are modeled after the Survey of the Dental Curriculum which was sponsored by the Carnegie Corporation of New York. They consist of a Division of the Curriculum into the work of the first two years designated as Basic Science of Junior Division of the Curriculum and the work of the third and fourth years designated as the Clinical or Senior Division of the Curriculum.

The Junior Division is departmentalized into the Departments of Anatomy, Bacteriology, Chemistry and Pharmacology, Pathology, Physiology, and Preventive Medicine and Hygiene. In this Division of the course there is also provided certain courses as Principles of Osteopathy and Physical Diagnosis which are designed to provide practical application of the methods of the Basic Sciences to clinical problems. In each course there is a definite statement of the objectives of the individual course, the place in the curriculum, the amount of time, the division of the time to class room, demonstration and laboratory work. Following this is a detailed outline of the subject matter covered, points of special emphasis, etc.

The Senior Division is departmentalized into the Departments of Practice, Surgery, Obstetrics and Gynecology, and the Department of Clinical and Hospital training. Each department is subdivided into the usual courses and the procedure indicated above is followed in this Department of Instruction. The profession now has an official curriculum, sufficiently detailed and organized, that should be of considerable value in legal and legislative affairs.

The Saturday session was given over to the presentation of prepared papers, as follows. "Standards for Evaluation of Entrance Qualifications" prepared by Dean H. G. Swanson and delivered by Dr. Denslow. "The Correlation of the Library with the Curriculum" prepared by Miss May M. Brown of the College of Osteopathic Physicians and Surgeons and delivered by Dr. Pritchard. "Results of the Strong Vocational Test and Interpretations" by Thomas C. Schumacker. This was a most interesting and valuable paper of which more will be heard at a later date. "Student Recruiting" by Dean L. B. Whetten of the Chicago College and "A Report of the Committee for the Compilation of Material for Text Books" by Dr. Pritchard.

In the afternoon session the agenda was completed and after this the following officers were elected. President, Dr. Pritchard and for Secretary Dr. Denslow was re-elected.

Saturday evening brought forth a dinner meeting of the Associated Colleges of Osteopathy and the Bureau of Professional Education and Colleges

of the A. O. A. A stated program was followed with discussions on matters of common interest between the two groups.

During the Convention week daily meetings were held for the purpose of handling current matters and joint meetings with the Legislative Council of the A. O. A., the Association of Osteopathic Examining Boards etc., served to make the week a busy one.

One of the valuable pieces of work completed this year by our secretary was the complete indexing of the Minutes of the Associated Colleges of Osteopathy. Minutes are compiled for each year since 1898 and with this master index and the eight volumes that comprise the minutes one is now able to learn of the action taken on any given matter in short order.

The meetings of the Associated Colleges of Osteopathy are open to interested members of the profession and a better understanding of the activities of the colleges would be obtained if a greater number of the profession would arrange to attend these meetings.

In pregnancy a rising blood pressure and particularly a sudden rise of diastolic pressure, should call attention to the probability of a toxemia and should put the accoucheur on the alert for eclampsia.

"If a general practitioner knows three things about a disease condition that are really true and important, he probably would be a good diagnostician; he might still be good if he knows five things and was an exceptional man, but if he knows too many things, he is likely to become lost in the fog of the minutiae."

A. J. Ochsner, M. D.

William Withering (1741-1799), graduate from Edinburgh 1766, was unusually versatile and a keen observer. He was a great medical botanist and was designated wittily by his colleagues, "The Flower of Physicians." He learned from a country grandmother that foxglove was useful in the treatment of dropsy. This was in 1776. He began using it in heart trouble and gave digitalis to the Edinburgh Pharmacopoeia in 1783.

Descartes (1596-1650) treated the body as a material machine governed by the soul located in the Pineal Gland.

F. A. (PAT) GORDON, D. O.

President-Elect A. O. A. 1939-1940

The House of Delegates of the American Osteopathic Association, assembled in Dallas, Texas, in annual convention, gave recognition to the zealous enthusiasm, the unselfish service, the true worth and the inherent executive ability to organized osteopathy of "Pat" Gordon, by elevating him to the office of President-Elect for the year 1939-1940. It was a signal honor they rendered him; the highest gift within their power to bestow—and it was deserved!

My first contact with "Pat" in organization work was in the convention at Wichita, Kansas, where he was actively associated as Secretary, with the Legislative Council under the able direction of A. G. Chappell, D. O., Chairman. He did a good job there. The following year at Cleveland, Ohio, he was elected a Trustee of the A. O. A. and drew the Chairmanship of the Special Membership Committee—a most important assignment and one of vital importance to the national organization. It is second to none in opportunity to render selfless service to the organization. "Pat" held that job for three years, during which time approximately 1500 new members were added to the roll. This was of vital importance to the expanding demands made upon the Central Organization coupled with a decrease in revenues from advertising, sale of literature, etc.

With the elevation of Arthur E. Allen, D. O., to the presidency of the A. O. A., "Pat" was given the chairmanship of the Department of Public Affairs to which he gave the same unwavering zeal and service which has always characterized his organization efforts.

During this time he had served his state well, faithfully and energetically, first as Secretary of the Iowa State Osteopathic Association and, finally, as two-time President of the same or-

ganization. Under his able administration the association grew in numbers, more members were added to the national organization and the efficiency of the district associations was increased to a marked degree. He left an indelible imprint upon the organization affairs of his state—a mark for future executives to shoot at.

At the Chicago Convention in 1937, due to my over-zealous enthusiasm regarding his inherent abilities, and the desire to see him in a position wherein he could have a wider scope in up-building the Central Organization, he became a candidate for the office of First Vice-President. He was defeated; the House of Delegates wisely concluding that he was needed on the Special Membership Committee. "Pat" took his medicine and continued with undiminished effort to build up the rank and file of the American Osteopathic Association. If he was disappointed he did not show it. If he felt that his untiring efforts in membership getting were not appreciated by the Official Family he found surcease in added effort to increase the membership. His was a selfless service.

At Dallas, Texas, he came into his own. He was elected over his opponent by a handsome majority. His profession had learned that with him organization needs were first. He had demonstrated it. He has made good in every assignment allotted him.

He will make good in this wider field of opportunity when he assumes the Presidency of the American Osteopathic Association in St. Louis, Missouri, in 1940.

More power to you, "Pat!"

G. J. C.

"An hypodermic syringe and a stock of ampoules do not make a physician."
—*Johnsonian Memo-Grams.*

THE DALLAS CONVENTION

The Dallas Convention is now a matter of history. It was a successful meeting socially, professionally and in policy achievement. It lacked in number of doctors in attendance, the smallest since Seattle in 1931. It was woefully short on exhibitors—at least 50% off. Not only that but those hardy individuals who did take exhibit space were unfortunate in their location, only those who registered were compelled to pass through their area. So located they were off the beaten path of travel and they suffered. Such a "faux pas" must never be allowed to occur again. Exhibitors are one of the foundation stones of convention success financially. Their interests must be safeguarded in every way. They must be given the breaks. They must be given primary consideration.

The program was a successful accomplishment and credit must go to Dr. Collin Brooke for its selection, arrangement and prompt presentation. It was primarily osteopathic and the general program was particularly outstanding in the presentation of osteopathic concepts and practices. There was time given also for the strong presentation of specialty groups, legislative problems, and public welfare relations. The sectional programs were in keeping with the general program. Dr. Brooke deserves much credit and commendation for his untiring efforts in the way of getting together such a splendid, well-balanced program.

Mention must be made of the exceptional hospital accommodations provided by the "Sparks Hospital" of Dallas, Texas. The hospital is brand new, well arranged, compact and ideally adapted for the purposes intended. A very ample number of clinics, of diversified major types, were awaiting operative attention by the outstanding surgeons of the osteopathic profession. There was something doing at the Sparks Hospital at all times. Dallas should be proud of Dr. Sam Sparks' contribution to its institutional facilities—and should support him 100%!

The Board of Trustees conducted its lengthy agenda with dispatch. Its various problems were fully discussed and their decisions were marked with temperate judgment. Even "balanc-

ing the budget" was accomplished with scarcely a thought of recriminations.

The House of Delegates was unusually harmonious and tractable. Questions were discussed with an eye to a solution compatible with the greatest good to the largest number. The vital question of the change of the Central Office location from Chicago to Washington, D. C., was left to the Committee on Reorganization for preliminary report to the Executive Committee with final action delegated to the House of Delegates in 1940.

The Committee on Endowments, headed by Dr. Walter Goodfellow, made a strong presentation of its case for the proper set up of institutions; particularly our Colleges, so as to be in position to meet all exigencies when such activities are appropos. His work, his investigations and his conclusions reveal an intimate knowledge of the objectives which must underlie permanency in institutional development.

The Committee on Public and Professional Welfare presented an ambitious and well merited program preparatory to the greater opportunities in the immediate future. The progress this committee has made since its inception has been remarkable. Even now it cannot keep pace with the demands its avenues, developed for publicity and educational purposes, compel. Radio, press, health syndicate articles, public addresses, etc., are clamoring for attention. Committee activity is circumscribed by a limited budget. Every osteopathic physician who is a non-member of the National organization profits proportionately from this publicity propaganda. Could he but realize the potentialities of this important committee's work as a business getter he would be blind indeed, who did not get behind and push its activities by Association membership.

And necessity compelled a lopping off of \$5,000.00 from its proposed 1939-1940 budget!

The social aspects of the convention were most commendable. Dallas osteopathic physicians, hotels, radios, the press and its public service clubs outdid themselves in extending the hospitalities of the city to the convention as well as to its individual at-

tendants. The southern hospitality was there to a plus degree. The Texas bunch were on hand with conspicuous "Ask Me" buttons and they meant it. Everybody had a good time.

The Convention was held in two hotels, although practically contiguous, yet this constituted a serious handicap. It prevented concentration of program activities, with the general program and many of the sectional and group activities in one location and the official bodies (Trustees and Delegates) with other sectional programs in the other. This has been of too frequent occurrence of late and should be given sober attention and thought in the future, by the Convention City Committee in making their recommendations.

St. Louis, Missouri, was chosen over Atlantic City, New Jersey, and Toronto, Canada, for the 1940 convention. St. Louis has been contender for this honor lo—these many years. Our congratulations to the profession of St. Louis for its persistent and untiring efforts in achieving the goal of its ambitions. We prophesy, with Buddy Drennan at the helm and the united St. Louis bunch plus the rest of Missouri behind him, a rip snorting, outstanding convention for 1940.

The Scientific Exhibit under the direction of Otterbein Dressler, D. O., Chairman of the Committee on Convention Scientific Exhibit, deserves especial mention and commendation. It was better than ever before, was well planned and presented a diversity of subjects and objects of interest both to the critical professional observer and to the inquiring layman. Its presentation showed much care and thought together with an unusual degree of time spent in plotting and preparing for its presentation. Our compliments to Dr. Dressler.

Dr. Arthur E. Allen, President, presided at the opening of the Convention, giving a thoughtful presentation of the professional problems now and those looming in the immediate future. He presided over the meetings of the Trustees and House of Delegates in a dignified, diplomatic, purposeful manner. This convention marked the apex of his professional organization career.

President-Elect, Frank F. Jones, D. O. of Macon, Georgia, was duly inducted into office on Friday morning,

the last day of the Convention, by President Allen. We predict for President Jones a successful and a harmonious administration.

F. A. Gordon, D. O. of Marshalltown, Iowa, was made President-Elect for the year 1939-1940 assuming the Presidency in 1940.

The mainspring behind this magnificent, smooth-running convention machine was our incomparable Executive Secretary, Russell C. McCaughan and his efficient Central Office co-workers. It is a pleasure to see such an efficient organization in action.

G. J. C.

LIBRARY ADDITIONS

Through the courtesy of Miss May M. Brown, Librarian of the College of Physicians and Surgeons, we have been able to order the following osteopathic texts to supplement those already carried in our own library.

As we desire to complete as fully as possible our line of osteopathic texts, we were very glad to avail ourselves of receiving these from the Los Angeles College library.

They are as follows:

- Basic Principles—Burns
- Clinical Osteopathy—Murray
- Diseases of Children—A. T. Still
- Research Institute
- Surgery from an Osteopathic Standpoint—Young
- Lymphatics—Millard
- Applied Anatomy of the Spine—Halliday
- Diseases of Women—Clark

Through the courtesy of Dr. Ralph S. Lickliger our library has received nicely bound examination questions of the Ohio State Medical Board from 1928 through 1938. The expense of this compilation was borne by the Ohio Osteopathic Association of which organization Dr. Lickliger is Vice-President. The questions will be issued to interested students the same as the circulating books of our library.

We also acknowledge a number of texts from our Staff Associate, A. B. Crites, D. O.

"He who has faith will always find his rent money coming in on time."—*Johnsonian Memo-Gramps.*

A TEXTBOOK ON GENERAL SURGERY

Cole and Elman
Saunders Publishing Company (2nd Ed.)

A REVIEW

My teaching experience in the Principles and Practice of Surgery began in September 1905 and has continued to the present writing. During that time many texts were consulted but only a few advised for student use. Serious objections, particularly from the student's view point, were present in all. From the teacher's standpoint the great difficulty arose in lesson assignments. The salient points in any given section of a discussion of either Principles or Practice were so shrouded in the maze of the minutiae that the student, in the endeavor to acquire the whole, failed in the acquisition of the essentials. True the lecturer could call attention to them, but the student, as a rule, tried to stick to the text with minimal results on the part of each. The whole proposition reverted to lecture work, depending on note taking by students and the assignment of collateral reading by the instructor, which left much to be desired.

The question of a satisfactory arrangement of the text, whereby one could begin with junior students, chapter one, page one with the principles underlying the practice of surgery and build upon them an ever extending knowledge of the so-called minor phases of the subject, to the end that an adequate foundation upon which to lay the corner stones of its major aspects would follow naturally and sequentially, was universally wanting.

Then came the work under discussion written by teachers of surgery, based upon outlines used in their daily work, comprised of subject matter carefully culled from the great mass of surgical literature, from personal clinical experience and designed for student consumption. With the exception of a single section, "Surgical Diseases of the Chest," the authors are responsible for the entire subject matter to be found therein, hence the same general methods of presentation prevail throughout its entirety. This is decidedly advantageous from the teacher's point of view.

Roughly the first half of the book, some 500 pages, prepares the junior students in the general principles underlying the practice of surgery and

familiarizes them with those divisions of the subject which constitute its minor phases (if such a distinction can be made). The second portion takes up in logical order the subjects generally designated as its major features, giving due consideration to the special principles necessary for the understanding of the technic to be depended upon for their correction. By such an arrangement it is not only practical but very easy to assign lessons so that each section may be covered in an equitable space of time. Outlining the year's work is simplified to a marked degree.

The designation of each chapter is followed by a concise statement of the points to be covered, each of which is then considered consecutively stressing the salient points from the practical clinical viewpoint with just enough attention to the minutia to convey the necessary information to the student (or general practitioner) and at the same time intrigues him to further outside reading. It is remarkable to what extent the authors have been able to present so much of value in an amount of space so minimal. It matters not which section is chosen—all of the essential facts are there and concisely stated.

Take chapter one for example, in eleven pages the whole subject of "Inflammation and Repair" is disposed of most adequately. The chapter on "Prophylaxis of Infection: Asepsis and Antisepsis" gives to the student all he needs to know to confer upon him proficiency in such technic, and it is covered in eleven pages. In the chapter on "Surgical Methods" the subject of "Heat and Cold" requires two pages and yet the reader has acquired a most valuable fund of information concerning their indications and uses. In it occurs a statement that has been a part of my teaching and practice for thirty-six years; i.e., "The frequent use of the ice bag in acute appendicitis is not only based on misconceptions but may actually lead to danger." The consensus of surgical opinion on that point has been lacking. It is refreshing to find such confirmation here.

It matters not what section of the book comes under consideration, one is impressed after reading it that he

is in possession of all the important facts concerning it. In this sense as a "refresher" for the general surgeon it is most valuable. Such common place subjects (to the student) as case history and physical examination receive the same careful consideration and close scrutiny of clinical aspects as do the chapters on Endocrinology, Chest Surgery, Nervous System, Alimentary Tract or what you may desire. A deep feeling of satisfaction follows their perusal.

A noticeable feature of the work is the absence of technical descriptions of operations—often times several to correct a given pathology—to be found in the average work on general surgery.

A text for student instruction is not intended as a guide for a major surgeon in his operative work. One's work with the undergraduate student is finished when that student is given a foundation knowledge of the principles underlying the practice of surgery plus a general acquaintance with

the diseased conditions requiring surgical intervention common to the area in which he may locate for practice. The high points of etiology, pathology, pathogenesis, symptoms, diagnosis and prognosis constitute the sum total of surgical instruction intended for undergraduate consumption. He should be taught to recognize surgical diseases and to give the proper advice as to treatment together with its probable outcome. Should he desire to go further to acquire proficiency as a major surgeon then he should take service under a competent surgeon and follow a well defined course of reading and instruction covering a period of years.

A too intimate knowledge of surgical technic during the undergraduate period or immediately thereafter would constitute a danger rather than an advantage.

This **General Surgery** by Cole and Elman fulfills the requirements as a general text for student use.

G. J. C.

WE are listing herewith the Accredited Colleges of Osteopathy. These colleges are approved by the American Osteopathic Association, are in good standing with the various State Examining Boards and are members of the Associated Colleges of Osteopathy.

Chicago College of Osteopathy

**College of Osteopathic Physicians and Surgeons
(Los Angeles, Calif.)**

Des Moines Still College of Osteopathy

KANSAS CITY COLLEGE OF OSTEOPATHY AND SURGERY

Kirksville College of Osteopathy and Surgery

Philadelphia College of Osteopathy

A CONTINUATION OF PERSONALITY AN AID IN DETERMINATION OF GLANDULAR FUNCTION

Annie G. Hedges, D. O. of the College Staff

In an article with the above heading in the June issue of The College Journal, a resume was given of the glands of internal secretion, with the special characteristics and functions of each gland. In this article, an attempt will be made to clarify this matter still further. Knowing the characteristic responses to each glandular secretion, it seems that it would be easy to make a diagnosis of the functioning of each gland when we have a complete history of the patient, including his disposition, habits, etc., but such is not the case. It is extremely difficult to be certain, particularly when we know how many combinations are possible.

We know that it is impossible to separate the physical, mental and spiritual, and we know that every thought, whether pleasant or unpleasant has an effect on the secretion of the glands. Due to environment or education much change is possible in the size and secreting power of the glands. According to physiological laws, normal usage tends to strengthen an organ or tissue, but overuse or abuse weakens it. So, to a large extent, our thoughts are masters of our fate. In childhood they are influenced by the things we see, hear, eat and do. These in turn depend a great deal on the actions of those about us and the circumstances under which we live. No matter what our inheritance—so long as we are average, normal beings with normal brains—the greatest factors for producing happy, healthy individuals and good citizens, are environment and education. We may be able to determine to a great extent the latent possibilities of a child, but we do not know to what extent the outlook may be changed due to changes in circumstances, to injuries or illnesses.

Dr. Louis Berman classifies types of individuals as: adrenal-centered, thyroid-centered, pituitary-centered, gonad-centered, parathyroid-centered and their combinations.

The adrenal gland may have a predominance of either cortical or medullary secretion. The former is associated with courage and fight and the latter with fear and flight. The adrenal centered type of personality

has some degree of pigmentation and probably moles and freckles. Pigmented birthmarks are common. The hair is coarse, rough and dry with low hair line and often has red hair. The canine teeth are prominent. If the thyroid and pituitary are normally co-operating this type of person will be vigorous, energetic and successful. If cortical secretion is lacking, brain power cannot properly develop. A woman with abundant cortical secretion is the type we term "masculine." They are dominating and usually successful in whatever they undertake. A man with dominating medullary secretion is a "feminine" type. If combined adrenal secretion is deficient, we have the neuroasthenic, inefficient person with cold hands and feet—lacking will power, unsuccessful and unable to cope with circumstances. At puberty, when so many glandular changes are taking place, it often happens that a transformation takes place in this, as well as other types.

In the pituitary-centered personalities, either the anterior or the posterior lobe secretion may predominate. In the feminine type, whether male or female, the post-pituitary predominates while in masculine types the anterior predominates. Due to the fact that secretions from the pituitary activate the best that is possible in humans, the pituitary dominated personality is the highest type of person. A normal post-pituitary type of woman is attractive, has strong maternal instincts, is sympathetic, tender, affectionate and understanding. The unstable pituitary type is restless, craves excitement, is fearful and unreasonable and may bear pituitary unstable children. A deficient post-pituitary person often becomes fleshy, good-natured, happy and kind, but not necessarily stupid as in the thyroid deficient.

A man with a dominant anterior pituitary is the highest type of an individual. He is the large, well-developed, successful type with high ideals and aspirations. He is tall unless he has been sexually precocious. He represents the class of thinkers, educators, philosophers, inventors, engineers and leaders. A post-pitui-

lary type of man tends to have a feminine personality, with instincts similar to a woman and this type often develops into great poets, musicians or artists. In general a normally active pituitary produces the independent, self-controlled, reasonable person with a love of higher education. His frame is bony and large, as a rule, large unspaced teeth, large sex organs, eyes wide apart.

A pituitary-inferior person is small, delicate, tends to adiposity, has prominent upper jaw, dry, flabby skin, abnormal desire for sweets, loses self-control easily. The thyroid-dominated personalities differ according to whether they are sub-thyroid, normal or slightly hyperthyroid. The sub-thyroid is short in stature, tends to obesity later in life, has sallow skin, dry hair with high hair line, irregular and improperly calcified teeth, poor circulation, are sluggish and stupid. They vary greatly in intellectual ability depending on the cooperation of the pituitary gland. The normal or slightly hyperthyroid are the healthy, active thin types, bright and quick, constantly "keyed up." If the thymus gland is very active in such children, they fly into uncontrollable rages and show other evidence of emotional instability.

The thymus gland dominates all children up to the age of puberty and its influence may continue on into adult life. If it is overactive it causes a delicacy of constitution, fragility of blood vessels, and low resistance. These are the types most frequently afflicted with tuberculosis and other childhood diseases. If the thymus continues to be dominant after puberty, a person retains many child-like characteristics. These are the people who have "inferiority complexes." The thymus-centered often become criminals and degenerates. If the pituitary gland becomes sufficiently activated in these people these traits are modified or counteracted.

The gonad-centered people may be either the excessive or deficient type with great variations in characteristics, depending largely on the cooperation of other glands. The deficient type usually have full, rounded faces with protruding lips and small noses. They tend to be childish in actions and may be light-hearted, timid, cry and laugh easily, anger easily and are unreasonable. The gonad-excessive type are sexually unstable.

A parathyroid-dominant person is highly excitable with unstable nervous system. These are the people who are likely to be afflicted with what we term "visceral neuroses." They are constantly complaining of imaginary ailments, heart, stomach, liver or other disease. Premature birth is often responsible for this condition. People of this type have difficulty in adjusting themselves to their environment and are emotionally unstable.

It is needless to repeat that all kinds of variations of these types are possible, and when we see how many of the characteristics attributed to the glands overlap, it is small wonder that it is so difficult to make an accurate diagnosis. Even those who have made extensive study of this subject are cautious about the administration of glandular extracts for fear of upsetting the glandular equilibrium in some other direction if the wrong thing be given or the quantity too great. Until one becomes extremely proficient in this study, he **SHOULD NOT ADMINISTER ANY GLANDULAR** product without consultation of an expert. We can always safely and many times with excellent results, give the osteopathic spinal manipulations which tend to normalize all of the body functions.

Kansas City College of Osteopathy and Surgery



The
"Aggressive College"

NOTES ON ETIOLOGY OF PEPTIC ULCERS

George J. Conley, D. O., of the College Staff

Peptic ulcer, so designated to include both gastric and duodenal types (95% of them occur within $\frac{3}{4}$ of an inch of the pyloric vein) continues to be a problem to the diagnostician and a mooted proposition to the clinician. Its etiology still is shrouded in mystery. Its symptomatology is subject to mimicry by structures extraneous to the digestive tube. Its treatment has run the gamut from early gross empiricism to the extremes of massive surgical interference and is now trending back to a saner conservative palliation or to mutilating attacks upon the nerve supplies of other structures for symptomatic relief. Etiologically it occupies a disputable position and its therapy is claimed alike by surgeons and by equally prominent and positive internists. As diagnostic acumen increases the number of postulated ulcers decreases proportionately until now, taking into consideration the vast range of stomach disorders, the appearance of a frank ulcer condition is a comparative rarity.

The etiology of ulcer hinges upon the why of the point of lowered resistance in the gastric or duodenal mucosa. Every theory advanced to account for the development of peptic ulcer, be it infection, spastic, circulatory, nervous or mechanical, is confront with it. Boyd in his Surgical Pathology, expresses it thusly: "We may say with assurance that the ordinary peptic ulcer is the result of the continued action of the gastric juice on an area of lowered resistance in the stomach wall. This simple statement does not, however, carry us very far, for we are in ignorance of the exciting cause responsible for this area of lowered resistance, nor do we know why in some cases the result is a simple erosion which quickly heals, whilst in others it is a penetrating ulcer which refuses to heal."

Just now the exciting cause of ulcer development is laid at the door of over activity of the adrenal glands; but the why of the lowered point of resistance in the gastric or upper duodenal mucosae remains inexplicable. Unless the hidden factor is recognized and relieved, the effect of treatment whether it be surgical or palliative, must of necessity be temporary or incomplete for the reason

that the primary factor continuing active tends to produce a second one. That this is true requires no argument for it is a clinical fact.

Without going too much into the minutia of the various theories relative to its etiology let me cite first a distinction of importance relative to the arrangement of the stomach mucosa stressed by Aschoff. Roughly for our purposes the mucosa may be divided into that comprising the "magenstrasse" or gastric pathway, formed by the oblique fibres of the muscular coat which constitutes an incomplete sphincter separating the gastric groove from the fundus portion of the stomach. In this region the mucosa is arranged in four longitudinal folds extending from the cardia to the pyloric zone tautly stretched, whereas in the mucosa of the fundus the folds lie irregularly against one another loosely piled.

Hemorrhagic mucosal erosions, fresh in character, are comparatively common in the fundus area of the stomach of all ages but more particularly in the very young, and may be ascribed to spastic contractions of the gastric musculature. They may be thickly scattered throughout the fundus mucosa and are about the size of a pin head. In the gastric pathway they occur in smaller numbers, are of the size of lentils, and are limited to the folds of the gastric pathway and their projections into the pyloric canal. Nervous arterial vascular spasms have been held responsible for these mucosal necroses. Aschoff states that "von Lichtenbild described a spastic contraction of the muscularis mucosae as the cause of the arterial blocking and the anemic necrosis." Aschoff further states in this same connection that "erosions due to emboli are extremely rare" while the age incident of ulcer generally precludes the possibility of arterio-sclerosis as being a contributing factor. He concludes with the statement that "we must agree that the spastic condition in the gastric wall or the gastric vessels acquire an especial role in the origin of erosions of the gastric pathway, but in neither fundus or gastric pathway erosions do infections, toxic infections or mechanical factors play a prominent role. Circulatory disturbances however represent the most important source."

The fundus mucosa is thicker and

tends to a rapid epithelization due to looseness of tissue and the presence of a thin mucus which forms a protective covering over the area of erosion. Whereas in the gastric pathway the stretching of the mucosa which is thinner and deficient in the production of protective mucus tends to hold the erosion widespread subject to the action of the gastric juice. Hence it is that the predilection of gastric ulcers is near the lesser curvature and along the region of the Magenstrasse.

Durante⁵ states that "disturbed innervation, without any additional trauma or infection, will suffice to create in animals lesions presenting all the essential characteristics of acute and chronic ulcer in man. Resection of the major splanchnic nerve, although causing temporary paralysis of the gastric vessels, is not in itself sufficient to produce permanently destructive lesions. The lesions obtained can only be compared with those resulting from resection of the median nerve. At first sight this diversity of action seems contradictory. This apparent contradiction is easily explained by the fact that the median splanchnic innervates the adrenals; stimulation results in an increased secretion of adrenalin and, as the adrenal secretion has a physiologic as well as a selective action, it is one of the most powerful means by which contraction of blood vessels can be produced. Overstimulation, rather than insufficient innervation, seems to be the principle cause, for it must be remembered that intravenous injection of adrenalin has proved conclusively that, by increasing the adrenal content of the blood, hemorrhage can be produced in the gastric mucosa. The peripheral or anatomic factor must be taken into special account, since toxic stimuli—whether due to bacterial, to chemical or to biochemic agents—are capable of producing irritations in the sympathetic system, entirely comparable with those I obtained by means of surgical interference."

Mann⁶ quoting Durante says: "section of either the median or minor splanchnic nerve on either side always produced necrosis and ulceration of the gastric mucosa. The ulcers produced by section of the nerves on the right always healed rapidly and the spleen remained normal; section of the nerves on the left produced changes in the spleen and ulcers in the stomach which tended to become

chronic. He attributed the formation of ulcers after adrenalectomy to incidental injury to the minor splanchnic nerves which are buried in the posterior edge of the adrenal." (This statement is pregnant with osteopathic interpretive possibilities).

Crile⁷ says "the pathologic physiology of the adrenal sympathetic nervous system will cause a thyroid to become hyperplastic so that exophthalmic goitre develops; in another case with an equal drive there will be such an interference with the control of the stomach and with the pyloric sphincter that a peptic ulcer will develop."

Eusterman and Balfour⁸ say: "Since 1918 von Bergmana has considered derangement of the nervous system as the most significant factor in etiologic consideration of peptic ulcer. He expresses the belief that disharmony between the vagus and splanchnic systems produced localized or generalized spasm in the muscles of the stomach, duodenal or terminal blood vessels. As a result of such dysfunction areas of submucosal ischemia or of decreased resistance developed, and resulted eventually in the formation of mucosal erosions through action of the gastric juices."

Burns quoted by Downing⁹ says: "since gastric ulcers occurred only in guinea pigs and rabbits with 5th or 5th and 6th thoracic lesions, and since all animals who had these lesions present for half a year or more had gastric ulcers, it may safely be concluded that such lesions were the essential cause of gastric ulcer in the animals mentioned."

The unknown, exciting cause mentioned by Boyd, the arterial spasms and circulatory disturbances of Aschoff, the findings of Durante, the conclusions of Mann and the postulations of Crile all resolve themselves into orderly sequence etiologically when viewed in the light of the osteopathic concept of the lesion as evidenced by the researches of our own Dr. Louisa Burns. A rich field of endeavor awaits the physician of an investigative turn of mind endowed with a knowledge of the osteopathic concept of the lesion and who is in touch with a sufficient volume of ulcer cases to give weight to his observations and conclusions. Suffice it is to say that in every case of frank peptic ulcer which has come under my observation lesions involving the median and minor splanchnic nerves on the left, together with pain and

muscular contraction have been present. May not this one fact alone be the clue to the explanation of the well-known tendency to recurrence of ulcers successfully treated by surgical or palliative medical measures? And may it not explain Crile's pathologic physiology of the adrenal sympathetic system as a factor in gastric ulcer production? Does it reconcile and coordinate the nervous and circulatory theories as well as the "locus minoris resistentiae" so necessary for the postulate of the selective affinity of bacteria? These are questions pregnant with therapeutic possibilities?

The day will come when the therapeutic system of the future will take cognizance of the baleful effects of the osteopathic lesion and will, by manipulative measures, relieve the nerve irritation responsible for the pathologic physiology instead of depending upon mutilating nerve resections as at present.

Bibliography

1. Surgical Pathology, Boyd, Page 297.

2. 1932 Interstate Post-graduate Medical Association North America—Operations on the Adrenal Gland, Crile, Page 390-391.
3. Lectures on Pathology—Relation of Mucosal Erosions to Ulcers of the Stomach, Aschoff.
4. Aschoff, Ibid.
5. Trophic Element in Origin of Gastric Ulcer—Collected Papers Mayo Clinic, Vol. VII, 1915, Page 81-82, Luigi Durante.
6. Gastric Ulcers Following Removal of the Adrenals—Collected Papers Mayo Clinic, Vol. VII, 1915, Page 88, Frank C. Mann, M. D.
7. Diseases of Civilization—1933 Proceedings Interstate Post-Graduate Medical Association, George W. Crile, M. D., Page 372.
8. The Stomach and Duodenum, Eusterman and Balfour, Saunders, 1935, Page 14.
9. Osteopathic Principles in Disease, Page 498, Downing.

THE LOWER BRACKET INCOME PROBLEM

Forty million people in the United States have incomes of less than \$800.00 per year, according to Thurman Arnold, Assistant United States Attorney General, that cannot pay for medical care.

It would be interesting as well as illuminating to have information from this group as to the number that are maintaining automobiles, who have expensive radio outfits, up-to-date electric refrigeration and that are possessed of the various electric-driven gadgets designed to make housework easier. But to narrow the inquiry let it be limited to the auto, the radio and electric refrigeration. All of these may be classed properly among the luxuries. And yet no one seems to be too poor that he feels he cannot afford an auto. He rides to work in his auto to save street car fare and to save time, disregarding or ignoring the fact that no car can make a mileage average under five cents when all expenses are calculated. To the average member of this low income bracket group the time saved in transportation is dissipated in non-productive effort or in diversions demanding a modicum at least of expenses. No one drawing \$200.00 per month or less can afford an auto unless he can increase his efficiency

to justify the expense of maintenance. And yet there are day laborers, washer women and the like who must needs maintain an auto to furnish transportation to and from work. Take any W.P.A. project and the autos parked in the vicinity almost compel the presence of a traffic cop to get them started home properly.

A man came my way who had been hurt by a fall while at work in a large industrial plant. He went on compensation automatically until he could return to work. The sum was \$12.00 per week. His case was stubborn. His medical advisors were at loss to determine the seat of his ailment. Months elapsed and he was still on compensation. In relating to me the case history he spoke of the fact that he could not live on \$12.00 per week. He had a little patch of ground and his residence in a suburban community. He told me how he had to eat his chickens because he couldn't afford to feed them; he had to sell his hog and finally he had to let his cow go. "Literally taking the milk out of my babies throats," as he said. By that time I was almost ready to cry and to make sacrifices to help him when he finished his panegyric with "and now, by God, they are going to take my automobile."

It takes gas, oil and tires to make the wheels of an auto turn. These things are all on a "cash and carry" plan. They take all the available money (encroaching on the monthly payments on the car even) the owner has at his disposal; hence the butcher, the baker, the grocer, et al, are not paid, and being not paid—they cannot meet their obligations and we have all the makings of an economic depression.

The same holds true with the rest of household luxuries, converted into necessities by over-zealous salesmen and transformed into unsurmountable liabilities by a too lax credit system on the part of far too many business houses.

It is not intended here to decry the use of labor-saving devices in the home. They are fine and should be encouraged but only insofar as the budget of the family will permit. Everybody should balance his own budget and his own being in a state of stability, the family, the community, the country and the State will automatically come into adjustment. With these in a condition of equilibrium it can be seen that the Nation will likewise fall in line. This simply paraphrases the philosophy of life as outlined by Confucius some six hundred years before Christ.

And it all hinges upon that time honored virtue of "living within one's means."

The government is greatly distressed about the medical care received by these 40,000,000 low-income people. To be sure they should have adequate medical attention as an economic prerequisite. Sickness is very frequently preventable. Given a nourishing diet, a warm, dry place to live and sufficient clothing to keep one warm, the natural adaptive functions of the body will furnish sufficient protection to the individual to keep him in an average state of health—one that will need the attention of a physician only at rare intervals. Although this is true they pick on the doctors as the experimental guinea pigs in the social security plans. Why not get back to the fundamentals and make such provisions as will insure the conditions that will make for health automatically? Why not see to it that food, clothing, warmth and housing with such labor-saving devices as are legitimate, are insured to an individual at cost plus a reasonable profit? Minimize the number of com-

missions between producer and consumer so that the product is easily purchasable. Then if the health condition is beyond the reach of the average run of people, take some steps to make the product of medical schools i.e. its graduates, distributable by eliminating the dead wood in the curriculum of its schools and concentrating upon the essentials of bedside practice so that the graduates will minimize time spent in school and curtail the expense there-of to a point where a reasonable fee can be charged, one that a patient in the lower income bracket can afford to pay when occasion demands. This problem constitutes more than the actual regimentation of the physicians of the country willy-nilly to care for their physical ailments. It is one of the many results accruing from departure from the path of economic rectitude; from the junking of the fundamental virtues so vital to the success of our forefathers; from the deliberate attempt to shirk individual responsibility for self-preservation; from the nihilistic philosophy that as they were not consulted as to their entrance into the world said world owes them a living; from glorifying acquisition and greed with the belittlement of the small returns accruing from legitimate vocations involving physical labor and self-sacrifice.

It all resolves itself within the homely proposition of living within one's means which constitutes a balanced budget.

G. J. C.

We have pathologists, chemists, allopathis, homeopaths, electropaths, waterpaths until it would make you tired to listen to the 'paths, and all have proven to be lamentable failures. We have listened to their request and advice for thousands of years and the promises they have made have been abortions. From them we have nothing to hope. Our road is straight through the woods. Old trees must fall, stumps must be taken out, trees of life and hope must be planted to declare the intelligence of the Architect of Life. The osteopaths are the army all ready to combat. Our captain is the God of Nature who has never failed in any of His plans or specifications, and His promise is, be thou faithful unto the end and the reward shall be good health every day, and He says, hope thou and Me.—A. T. Still.

STATISTICAL RESUME OF THE CHILD'S HEALTH CONFERENCE OF 1939

M. E. Johnston, D. O., of the College Staff

Again we are presenting the statistics of the Child's Health Conference which is conducted yearly by the Kansas City Society of Osteopathic Physicians and Surgeons. The report this year is compiled from reports of 258 records of the children examined at the 7th Annual Conference. Each child was given a very complete and thorough examination. The examinations were conducted by various specialists in the different fields of pediatrics. They consisted of a general history, weights and measures, general examination of the entire body, structural and developmental conditions, the glandular system, spinal examination, eye, ear, nose and throat, the nervous system, genito-urinary, rectal, heart and lungs; and the teeth were examined by a dentist.

In this resume the children are classified into four age groups, namely: Birth up to one year; one year to two years; two years to five years; and five years to ten years.

Group 1. Children from birth to one year of age.

The number examined was 45, with the following findings:

Overweight	7
Underweight	7
Normal	31

(In this group normal weight was based upon age only.)

The following infectious diseases were recorded:

Whooping Cough	1
Mumps	1
Chicken Pox	1

(Only one had been given any form of artificial immunization.)

Rickets	5
---------------	---

The general examinations for abnormalities, structural, developmental, of the head, chest, abdomen, extremities; spinal examination; glandular and nervous systems; ear, nose and throat; genito-urinary and rectal revealed the following:

Specific spinal lesions.....	1
Infected tonsils or ears....	15
Dental conditions	2
Nervous system involvement	1
Rectal abnormalities	2
Genito-Urinary	13
Hernia	1
Heart	1

Lungs	1
Glands	5

To summarize: 68% showed normal weight, 16% were overweight and 16% were underweight.

Only 2% were artificially immunized and only 6% had had any of the infectious diseases of childhood. Their natural immunity is here shown. 33% had diseased throats, and 8% showed glandular enlargement, while 32% had involvement of the genito-urinary tract.

Group 2. This group comprised children between the ages of one and two years.

Number examined

The following findings are recorded:

Overweight	9
Underweight	6
Normal	36

(In this group also, normal weight was based upon age.)

In this group the following infectious diseases were noted:

Whooping Cough	4
Mumps	2
Measles	7
Pneumonia	5
Chicken Pox	2

Only 12 of this group had been immunized against any of the acute infections, therefore the largest majority were naturally immune at this period of life.

In this group only two had rickets, and one scurvy.

The general examinations for abnormalities in the development, structurally of the head, chest or the extremities; the glandular system; nervous system; abdomen; spinal examinations the following facts were revealed:

Specific spinal lesions.....	12
Ear, Nose and Throat.....	29
Nervous system	3
Dental conditions	9
Rectal abnormalities	1
Genito-urinary	8
Heart	3
Lungs	3
Glands involved	16

The outstanding facts from this group is the early development of throat conditions and the spinal lesions. Of this group 74% had normal weight, 20% were overweight and

only 16% were underweight. While 20% had been immunized against the infectious diseases only 40% had contracted any of the so-called children's diseases. 30% had glandular involvement.

Group 3. Children from two to five years of age.

The number examined was 117.

The following findings were noted:

Overweight	31
Underweight	8
Normal	78

(In this group the weight to height was considered as well as the age.)

6 showed evidence of Rickets.

The following diseases had occurred:

Acute Rheumatism	2
Mumps	9
Scarlet Fever	2
Diphtheria	1
Pertussis	17
Measles	28
Pneumonia	4
Chicken Pox	2
Immunization	21

In this group 17% had been immunized and 57% had had some of the acute diseases of childhood.

Abnormalities of the head, chest, extremities, glands.

Ear, Nose and Throat Conditions	67
Spinal Lesions	38
Dental defects	10
Nervous system	7
Genito-urinary	16
Rectal	3
Heart	11
Lungs	8

In this group 68% were normal weight, 26% were overweight, and only 6% were underweight. There were 33% who had definite spinal lesions and 50% had diseases of the tonsils. Some 15% showed trouble in the genito-urinary tract.

Group 4. Children from five to ten years of age.

Number examined was 45.

The following findings were noted:

Overweight	10
Underweight	10
Normal	25

(In this group weight as com-

pared to height was used to determine the normal.)

The acute infectious diseases had been present in the following order:

Measles	39
Whooping Cough	24
Chicken Pox	7
Pneumonia	7
Scarlet Fever	8
Mumps	12
Immunized: Smallpox.....	10
Diphtheria	9

Evidence of Rickets were noted in 9 and Scurvy in 1.

Definite spinal lesions were present in 39.

Glandular involvement	13
Dental defects	20
Ear, nose, throat conditions...	40
Nervous system	10
Genito-urinary	16
Rectal	6
Glandular disturbances	5
Hernia	2

To summarize, it is to be noted that 68% of these children had normal weight and that 16% were overweight and 16% underweight. May we call to your attention the fact that 80% of these children had definite spinal lesions. There was also a large increase in the throat conditions showing 80% involvement. Enlarged glands were noted in 32% of the children.

General Summary:

The general examination of the 258 children revealed abnormalities mostly of the chest and extremities in 61 children or 23%.

Enlarged Lymph Glands in 34, or	13%
Ear, nose and throat conditions, chiefly enlarged tonsils in 151 or	68%
Spinal lesions found in 90 or 30%	
Genito-urinary conditions in 53 or	20%
Rectal conditions in 12 or.....	5%

Of these 258 children examined this year, 191 came from Osteopathic Physicians. Sixty-six had never had any contact with osteopathy before. Only one gave a chiropractor as their doctor.

Fifty of these children had previously been examined in our Child's Health Conferences. Forty-seven of these were return osteopathic patients. Two medical physician's patients, and one chiropractor's.

ENDOCRINOPATHIES IN CHILDREN

Ray E. McFarland, D. O., Wichita, Kansas.

(Delivered at the Child's Health Conference—April, 1939)

It would take volumes to adequately express the influences the glands of internal secretion have upon the mental and physical growth and development of the child. In an abbreviated review of this subject one can only point out the endocrine syndromes seen and discuss the clinical and laboratory symptoms presented in each case. Even though time and space would permit us to attempt to do so, this subject could not be presented in its entirety for there are as yet many undiscovered facts in endocrinology. We do not know all that we should regarding the correlation of the glands and then too constitutional variations enter in to confuse us and distort our lines of thought.

Endocrinopathies are such for several reasons. Heredity plays a great role and for this reason endocrine disturbances in the ancestors, or parents may present their telltale symptoms in the descendants. Not necessarily is the same gland or glands disturbed in the offspring, but invariably, the trouble, though non-obvious, is there. In other words the chromosomes apparently transport the endocrine set-up, so to speak, as we know they transport the color of the eyes, hair, skin, and facial characteristics. Even though the family history may be negative and the child begins its fetal life with a clean slate as regards endocrine disturbances, there are several things which may happen during fetal life which may disturb the glandular integrity of the fetus.

These are acquired and the acquired causes are many. Malnutrition of the mother as regards adequate vitamin, mineral, and food intake is one. Insufficient iodine content in the maternal organism is another cause; Mechanical (Osteopathic) deviations in the maternal organism interfering with proper blood flow, resulting in hormonal stasis, and toxic states further detrimental to the maternal glands and consequently depriving the fetus of adequate quantities of those hormones necessary to normal fetal development; Infections in the mother during pregnancy cause a drag on her endocrines and deprive the fetus; and lastly infections in the fetus itself may disrupt the normal function of the fetal endocrines.

When the child is born and begins

its singular existence, a great physiological struggle takes place. In an endeavor to cope with the sudden change in environment all of the physiological forces of the child are necessarily brought into play to meet the demands placed upon it. The first two years of life present many obstacles to normal development and there are many chances for impairment of the glandular system. Gastro-intestinal disturbances may so interfere with nutrition that the glands are damaged. The acute infectious diseases force the glands to their utmost and produce Osteopathic lesions of the cervical spine which, if not corrected, so disturb the circulation to the pituitary body and surrounding neural tissue that an endocrinopathy may result. Too frequently we see obesity in the child dating to an upper respiratory infection. This is sufficient evidence in itself to prove that the glands were impaired by that acute process. On the other hand, prolonged convalescence may be evidence of severe adrenal depression and damage. Injuries such as those brought about by falls may produce Osteopathic lesions which in turn disable normal function of the child's endocrines. Mental and physical shock can disturb the glands by disrupting the autonomic nervous system.

The most important function of the endocrine glands during infancy and childhood is their influence on growth. The two glands chiefly concerned in this process are the hypophysis and the thyroid, although the thymus, pineal, and suprarenals all play a role. It is probable that all the glands concerned in growth depend directly or indirectly upon the hypophysis for their stimulation to activity and we draw the conclusion that the pituitary body remains the master gland in gross development.

A growth hormone has been isolated from the anterior lobe of the pituitary body and it deals with skeletal development. Gigantism, dwarfism, and acromegaly are all evidence of disturbances of the growth process and their presence denotes pituitary disturbance. Acromegaly rarely occurs in childhood but when it does it is evidence of over-activity of the hypophysis caused by neoplasm. Height will of course increase only to the

time when the epiphyses close. Gigantism occurs frequently in childhood, the limbs being excessively long and the individual very tall. The pituitary lesion simulates the one usually seen in acromegaly. The acidophilic cells of the anterior lobe are at fault in the above two syndromes. Dwarfism is caused by an insufficient supply of anterior lobe growth hormone. The true dwarfs are normal mentally and well developed.

While we are speaking of pituitary lesions it might be well to mention the disturbance of the basophilic cells of the anterior lobe described by Cushing and the syndrome bearing his name. Cushing's disease is characterized by an obesity which is almost exclusive to the abdomen. The face may be affected but the limbs are correspondingly thin. The ageincidence ranges from about five to twenty-five years of age. The face and hands may have a livid color and ordinarily the abdomen is striated simulating the striae of the pregnant state. Due to the fact that disturbances of the basophilic cells disturb sexual development and function, these processes are interfered with. Hyperglycemia, polycythemia, glycosuria, and hypertension may ensue. A syndrome known as Laurence Moon-Beidle's disease cannot be passed up in a consideration of the endocrinopathies. This latter disturbance is familial, in other words, it has the tendency to occur in several children in the same family. The mentality is low and the patients obese. Polydactylism is present and sexual development is retarded. Optic atrophy and rhinitis pigmentosa may occur. The hypothalamic area is undoubtedly affected in this disease. Occasionally we see a case of extreme cachexia known as Simmond's disease. This is due to hypo-function of the pituitary body and asthenia and emaciation are the characteristic symptoms. The only remaining pituitary deficiency syndrome is Frolich's, which is characterized by girde obesity and gonadal underdevelopment. The above symptoms of pituitary disease are specific to the type and all of the types are due to depression or overstimulation of the pituitary. The great majority of childhood pituitary endocrinopathies cannot, however, be discussed as syndromes. Many children present symptoms of pituitary hypo-function and go undiagnosed because the symptoms are not severe. The mild symptoms persist until some undue strain on the child's system brings the deficiency to

light or adolescence calls attention to abnormal function. The following are some of the symptoms which may be presented by the hypopituitary child: Easy fatigability, weakness, obesity of the girde type with a tendency to gain weight on the abdomen, hips and lower extremities, emotional changes, alterations in intelligence, headache (dull and oppressive and almost constant), pain in the extremities, dizziness (tumor), hyposphyia (chilliness), vomiting (tumor), excessive thirst (diabetes insipidus), polyuria (diabetes insipidus), amennorrhea (Frolich's or pseudo-Frolich's only diagnosed by genital mal-development including bi-lateral cryptorchids in adolescence), somnolence or drowsiness, convulsions (tumor), failure of vision (tumor), heart weakness, and the dyspnea seen in central disturbance due to pituitary tumor. In addition to the above clinical symptoms the following information may be of value; The blood pressure is usually low. Most of these patients run a sub-normal temperature. Oftimes a bradycardia exists. The BMR is lowered in most cases and the specific dynamic action of proteins is usually absent. Blood chemistry studies are of value and we invariably find a lowered blood sugar. There is a high chloride content of the blood and the cholersterol values are lowered particularly when the thyroid is involved. An increase in uric acid is also noted. There is a tendency to an increased sugar tolerance. We always measure these patients and close scrutiny discloses a short stature with small hands, feet and head. The height is greater than the span and the lower measurement is shorter than the upper. X-ray studies are oftimes valuable in that some of these patients show a delay in appearance of the ossification centers and in closure of the epiphyses although they are not as marked as in sub-thyroid cases. We also do the Volhard water retention test on suspected cases of pituitary disease. We have said very little regarding the posterior pituitary but as the only apparent positive symptom connected with disturbance of this lobe is Diabetes Insipidus, no further elaboration seems necessary.

The hormone of the THYROID acts as a catalyst in human body economy. It stimulates growth and body metabolism. Without this hormone the organism exists in a state of decreased neuro-muscular excitability. There are two forms of hypo-thyroidism, namely cretinism, and acquired sub-

thyroidism. We generally consider cretinism as being congenital in origin for it has its beginning in fetal life. Early in the first year of life one notices in these cases of marked thyroid deficiency, a chain of symptoms which should not confuse the clinician. There is a marked delay in sitting up, walking, dentition, and talking. Deafness and deaf mutism are common. The tongue is thick and large, fills the entire mouth and very often protrudes constantly. The fontanels close late and the head, large for the size of the body is particularly noticeable. There is an increase in tissue, so to speak, but in reality it consists of swelling of the tissues over the shoulders and neck and the feet and hands may become swollen. The bridge of the nose is flattened due to retarded sphenoidal development and the hair on the vertex and eyebrows is usually scant. The hair is dry, as is the skin. There is a pot-belly, and constipation is one of the marked symptoms. The teeth tend to decay early when they do erupt, and the voice is husky and hoarse. There is a sub-normal temperature, the BMR is low and blood cholesterol is high. These children are definitely very dull. MILD hypothyroidism may occur in children to the extent that they become dull, apathetic, and obese. Here again is the evidence of lowered metabolism and I am personally of the opinion that mild sub-thyroidism is fairly common and frequently overlooked. Children in this latter group have a bad appetite, disturbed sleep, and a surprising degree of emotional instability. X-ray studies of carpal bone development is the best means of diagnosis. Mild degrees of HYPERTHYROIDISM are probably seen in childhood but by far our greatest thyroid problem in the child is with deficiencies in the hormone of this gland.

The ADRENALS are the emergency glands of the body. Any physical or mental shock brings pressure to bear on these glands and depletion may occur. The same may happen in the acute and chronic infections. We then have a state of hypo-adrenia with sub-normal temperature, weak pulse, and general lowered resistance. The child who fails to recover satisfactorily from environmental emergencies or illness of infectious nature, falls in this class. Tumor of the adrenals may evidence itself in childhood and produce a state of HYPER-FUNCTION of the adrenals. These children are quite hairy. With this hairiness

usually there is an increase of subcutaneous fat and enlargement of the sweat glands. The muscle development is increased and the stature is large and the same holds true with the teeth. When the adrenals are overstimulated, the child is mentally very alert and somewhat precocious. The female child shows premature development of the breasts, excessive growth of hair, and menstruation begins early. The male child may have sexual organs of adult proportions with marked development of the secondary sex characteristics.

The THYMUS gland gives us some trouble in children oftimes remaining persistently large after birth. We have had several cases in which the babies came in for a feeding problem when in reality the enlarged thymus was at fault and the child improved markedly after adequate calcium, viosterol treatment and irradiation of the gland. It is well to remember that apparently the thymus is concerned also in the growth processes of the body and thus profuse irradiation should not be attempted.

The PINEAL gland has been presumed to also affect growth, but as so little is known regarding this gland we will only mention this gland on this occasion.

The PARATHYROIDIS are chiefly concerned with the utilization and mobilization of calcium. Hypo-parathyroidism results in tetany and tetany may be active or latent. We are concerned here with only the tetany which results from a lack of parathyroid hormone. Tetany may occur of course, when the parathyroid are damaged in thyroid surgery, or from injury in any way to the glands through trauma or disease. We also see however, tetany occurring in states when the parathyroid do not appear to be damaged and we are forced to believe that undoubtedly other factors besides withdrawal of the parathyroid hormone enter in to bring about the convulsive states. Also, we have alleviated the symptoms of childhood tetany with administrations of large amounts of calcium and vitamin D without resorting to the administration of parathormone and this, it seems, would be additional evidence that the parathyroids are not alone concerned. The discussion of infantile tetany and the treatment of this disturbance belongs elsewhere and we will not go into it. HYPERTHYROIDISM occurs in tumor of the glands. There are several clinical

types of this disturbance and we will do no more than mention them. They are: Osteitis Fibrosa Cystica, Hyperparathyroidism with Nephro-lithiasis, Hyperthyroidism with kidney disease other than stone, Acute hyperparathyroidism, and Osteopetrosis.

The PANCREAS in the child could not be discussed without a dissertation on diabetes.

The sub-pituitary and sub-thyroid state by far should be our chief concern in our care of the child. There are many diagnostic pitfalls in evaluation of endocrine symptoms of the human of immature years. Too many patients are suffering today directly or indirectly due to the ignorance of the physician of yesteryear. One wonders how much pelvic surgery of today could have been prevented if the adult female of today could have had adequate endocrine treatment when a child or an adolescent. This is only one question about a small phase of endocrinology that might be asked. True it is, that we feel at least that we know more about the endocrine glands today than we did twenty years ago, but what percentage of the profession takes time to know more about the diagnosis of glandular conditions in the child. I am afraid that there has been too much so-called shot gun therapy used, and too little time spent in true evaluation of each case. Endocrinology plays a role in every disease but in turn every phase of human activity deals with the endocrines. What the child eats, what vitamins he ingests and the minerals he utilizes play a vital role in sustaining his endocrine activity. I have seen glandular substances prescribed in cases of avitaminosis. Good food might have been the better route to take, especially when we recall that replacement therapy cannot be given artificially without that substance given affecting several of the glands. I say artificially for after all, where does replacement begin and where does it end? Does it seem possible that a pituitary body deprived of its proper blood has the facilities to secrete its hormones in needed amounts? Doesn't it seem plausible that if we correct Osteopathic lesions of the cervical spine and free up the circulation to the cranial vault, we are aiding Nature's own replacement? Do I need ask you, who have or should have been reading Osteopathic literature of the past years, what effect spinal derangements have upon the autonomies? So closely are the autonomies to the endocrine system

that they are considered by some as a member of the endocrines. Needless to say, we have in our profession something to offer which the other profession sorely lacks. The endocrinopathies all need Osteopathic treatment. The thyroid child needs general attention and Osteopathic treatment distributes blood through all of the endocrine glands, bettering the nutrition to these organs, thus increasing the hormonal output as well as increasing the volume of the vehicle charged with the transportation of the hormones to the other glands and to the organism as a whole.

Many of the specific hormones are on the market today in very potent form. With the advent of the introduction of the potent preparations of the estrogenic hormones to the commercial market promiscuous use of them was sure to follow. The administration of the estrogenic hormone has no place in endocrine therapeutics in infancy and childhood. This hormone has a powerful inhibiting influence on the anterior pituitary and has great possibilities of preventing adequate anterior lobe function. Its use in the treatment of gonorrheal vaginitis in the child is permissible. Another potent preparation is the anterior like hormone of pregnancy urine. This potent substance has been used for undescended testicles and there is literature to support the thought that the promiscuous use of this hormone inhibits growth. We have used the true extract of the anterior lobe (gonad-stimulating) to better results but even then its use must be kept within reasonable bounds. With only a limited experience at hand and with less knowledge the general practitioner is better off to use the extracts of the glands in an unmodified form. For example, in cryptorchidism, use whole anterior lobe extract. The growth hormone, however, is on the market and may be used for true dwarfism.

The sub-thyroid child may need thyroid extract. If such is the case, nothing to date excels or equals desiccated thyroid U. S. P. One must remember that the British unit is one-fifth of the international unit or the U. S. standard of measurement when administering these substances. The thyro-tropic hormone of the anterior lobe has been isolated but it has no place in thyroid therapy as yet. Its administration purges the thyroid of colloid but the gland return to its substate in a short time.

Adrenal cortex therapy, of course, is specific in Addison's disease, but in hypoadrenia states, its use remains empirical in character. We have felt that we have had some good results from its use in supporting the child in acute infections. It also helps in allergic states oftentimes by controlling the water in the tissues and preventing anaphylaxis and accumulation of areas of water in the subcutaneous tissues.

Much can be done for the childhood endocrinopathies if the case is given adequate study and an accurate diagnosis is obtained. One must keep in mind at all times the vital need for adequate food intake, vitamin consumption, and mineral utilization in

the child if we are to expect the utmost from the child's endocrines. To a great extent, the state of the glands during childhood determine the health and character of that individual in adult life. An involvement of the endocrines should be suspected in all states of ill-health, alterations in body configuration, disturbances in mental and physical development and growth and most of all, in those unfortunate children who just do not seem to be able to adapt themselves to environmental changes. All behavior problems need endocrine study and, due to the fact that these small but vital organs are charged with developing the child to maturity, they most certainly deserve all of the attention we can intelligently give them.

LOOKING FORWARD

Even in boyhood my ambition was to be a physician. In my high school days when the distasteful task came to prepare a senior oration, the only subject I felt capable of expatiating on was "The Physician's Opportunity." To the task, with this subject, I was able successfully to apply myself. The years passed and I drifted, as young men often do, from one vocation to another and it was not until I found several very disagreeable things to which one might devote one's life that I actually entered upon my boyhood choice. Many years have flown but as I think back on that oratorical effort I feel that my high school notion of the physician and his opportunities was anything but fancy.

It seems when one has spent a good portion of young manhood or womanhood in education of a preparatory nature that the choice of a life's work should be one where the benefits of that earlier training will count the most. It may be that some will find that sphere in the counting room; others in the great variety of clerkships; still others in commerce. Whether in commerce or labor; professional or mechanical field, the high school and college course will never come amiss. To my mind, however, this preparation fits particularly for the professional career. And yet, when one considers the various professions they are found crowded, and entrance into them is fraught with great dangers. There is no easy road to success and the way is becoming harder and more difficult.

There is at least one exception and that is Osteopathy. Here we have a young yet tried calling. Here he who would wish to serve can find opportunity and its consequent rewards. It is the only recognized profession of today wherein there is an actual demand for practitioners. Its graduates find a field of plenty awaiting them. He always has a job right in the profession for which he trained. There are thousands of communities wherein he can select his abode. There are millions of ailing awaiting his aid. His services are in demand among the multitudes who have failed to find relief from their ailment in the older schools of practice. He steps into an immediate practice; he becomes a factor and a benefactor in the community; he is rewarded commensurately with his importance. He becomes the friend of the friendless; the help of the helpless. He serves the people as no other calling can serve them. He teaches them; aids them; fathers them. There is a deal of satisfaction in making money by one's own efforts; there is a vastly greater satisfaction in realizing that along with the money one is making, service to humanity is being contributed in more than measurable quantity.

Does this appeal to you? It did to me when I was a school boy. It still does. In Osteopathy I find the opportunity to live out my high school oration: "The Physician's Opportunity."

—A. A. KAISER.

BEHAVIOR PROBLEMS IN CHILDREN

Leo. C. Wagner, D. O.—Lansdowne, Pa.

(Delivered at the 1939 Child's Health Conference)

By behavior problems we mean those reactions observed in children that are not due to any physical abnormality. Because these reactions do not have a physical cause a great many physicians make little or no effort to understand them. Consequently the parents are sometimes at a loss as to whom to consult for advice and the conditions frequently are not properly treated early enough to check the abnormality. It is only when the condition has become very annoying or pronounced that, in desperation, the parents consult their family physician and, then, when he observes the great concern that the parents feel about their child's behavior, he makes some weak attempt at treatment. However, treatment should be instituted early before the problem has really become a problem.

As in other phases of the healing art, prevention is better than cure. In fact, prevention is simpler in behavior problems than is cure. Once a habit has been established it is very difficult to eradicate and only by many hours of persistent patient efforts can the habit be eliminated. If your three or four-year-old child has the habit of biting his nails, sucking his thumb, lies, steals, wets the bed every night or any one of the many annoying habits, then it is your fault and not the child's. The responsibility of the development of these many little traits into well established habits lies entirely with the parents and not with the child. In the great majority of instances these traits become fixed habits because of the wrong attitude or improper approach of the parents to the problem in its very beginning.

Before going further into this discussion I should like to point out that there are abnormal physical conditions that frequently are the cause of these complaints; for example a child may have some abnormal state of the bladder or kidneys that results in bed wetting, or he may have some physical abnormality such as diseased tonsils or adenoids, or decayed teeth or some chronic infection like tuberculosis or rheumatic fever that would cause a loss of appetite or he may have some mental retardation that would explain his tendency to fail to obey or to lie or to steal. Naturally, what I have to say does not apply to these children.

In this discussion I am referring to those children who have been thoroughly examined and in whom no physical abnormality can be found to exist. Therefore throughout this discussion you will constantly remember that I am referring only to those children who are sound of mind and body.

Earlier in this paper it was mentioned that the formation of these habits was the fault of the parents and not the child. Then how does this apply to the child who sucks his thumbs constantly? "Surely," you say, "it isn't my fault. I've done everything possible to stop it. I knew it was an injurious habit and I tried everything to stop it." And that is just the reason, you "tried everything to stop it." In other words you did too much. You over did. You placed too much emphasis upon an inconsequential habit. In your great desire to overcome the habit you center the child's attention upon it and developed in him an antagonistic attitude. You were determined to overcome the habit and he became determined to continue the habit. It became a battle of wits and *he won*. Thumb sucking is quite a normal and natural occurrence in infants. For years mothers have been erroneously told that thumb sucking was harmful to the baby, that it caused malformations of the jaws and teeth. Consequently, the minute the mother noticed her baby sucking his thumb she pictured her child with grotesquely shaped and protruding teeth and horribly shaped mouth and jaws. Naturally, the mother did not want this beautiful creature to grow and have hideously distorted features, so she covered the hands by tying the gown over the baby's hands. But this didn't seem to be sufficient for as soon as the hands were uncovered the thumb went into the mouth. So more strenuous methods were resorted to, such as, painting bitter solutions on the thumbs, taping them with adhesive. These measures met with the same success as the first. The child either pulled the adhesive off or sucked it off as well as the bitter applications and went on sucking his thumb as unconcernedly as though nothing had happened, winning round two. By this time, the mother was getting a bit more worried about the habit and determined to stop it if it were the last thing she would ever do.

So, splints were applied over the elbow so that the child couldn't bend his arm and get his hand to his face. This is a cruel and barbarous arrangement and belongs to the days of the Spanish Inquisition and not the Twentieth Century because it interfered with the child getting his hands up to his face at all and any annoyance or discomfort of the face could not be soothed by the gentle brushing of the hands over the face. Fortunately, however, it did not take the baby long to learn how to wiggle out of these shackles and again the thumb found the mouth. By this time the mother probably decided that she was not very competent in the construction of home made appliances, so, maybe she had better buy some of these commercial objects such as metal thumb guards or even aluminum mittens. But these objects are injurious also. They retard the development of the sense of touch. A baby with aluminum mittens can not hold objects in his hands and so he is retarded in his ability to learn the difference between round, square, hard and soft objects. Again, as in the case of the splints the baby soon learns how to squirm out of these hand cuffs and round four goes to the baby. By this time the mother is vexed. Her egotism has received a severe jolt when she realized that this little thing a year or a year and a half old has thwarted her at every turn so she scolds or even slaps the little hands every time they go into the mouth. For soon the mother realizes that the thumb sucking is continuing just as it had before, except that now it is being done surreptitiously and is being confined to the seclusion of the child's own room or crib. *But the habit is still continued* and by now has become quite definitely fixed.

I have gone into the subject of thumb sucking in quite some detail to try to point out what I meant earlier when I said these habits result from improper approach on the part of the parent. Had the mother been less determined to end the habit once and for all it would not have become a problem. In her zealous efforts to stop the habit she centered too much attention to it and it became an emotional conflict and a battle of wits between mother and child with the child coming out the victor.

As a matter of fact thumb sucking as mentioned previously is a natural and normal occurrence in infants and if disregarded usually stops spontaneously. It does *not* distort the mouth,

jaws or teeth unless the habit persists until fourth or sixth year. The only treatment necessary is to *calmly* and *unemotionally* and quietly take the hand away from the mouth. If the baby is around the toy holding age—five to six months old, give it a rattle or toy to play with instead. For the older child around two or three years of age, the same principle applies, give him some object to hold or play with to distract his attention but under no circumstances should he be punished or scolded for it.

What has been said about thumb sucking and causing an emotional conflict is equally as applicable to nail biting, and nose picking. The habits of nail biting and nose picking are only habits and not symptoms of worms. Painting bitter substances on the nails, scolding or punishing the child for indulging in the habit will not cure him. A calm and unemotional attitude on the part of the parents toward the habit with encouragement to the child to overcome his infantile habit plus rewards for success in curbing it will do more than anything else. They will terminate naturally as the child grows older and develops a sense of pride in his personal appearance. How many adults do you know that suck their thumbs or bite their nails? And yet the greater majority of them did these very things when they were younger.

Habitual loss of appetite is another problem that gives parents considerable concern. Of course, there are many abnormal physical conditions associated with loss of appetite but in this discussion I am assuming that your child has been thoroughly examined by a physician and no abnormal physical state has been found to explain the loss of appetite. If that is the case, a behavior problem must be considered as a possible cause. Here again, then, the problem reverts back to the parents and the development of the condition into one of a problem is the fault of the parents and not of the child. For example, if the mother will not eat strawberries, oranges or tomatoes because "they cause too much acid" and the father refuses to eat spinach and cauliflower it will only be a short time before the child refuses to eat strawberries, oranges, tomatoes, spinach and cauliflower. Children imitate their parents in speech, posture, mannerisms and habits and many other factors and so they quite naturally adopt their parents' eating habits. If parents

won't eat certain things, the child feels he, too, may refuse to eat them—and this is a fair deduction.

Confusion at meal time is another factor which detracts and distracts an appetite. For example, daddy is late for dinner, he complains because his steak is overdone or his coffee is cold. Mother retaliates with the fact that had he been on time it would not have happened. Daddy storms because the boy won't eat his carrots, while mother scolds another child for spilling her milk or for forgetting to wash her hands before coming to the table and the entire meal is one of confusion. Maybe this situation occurs frequently so there is no wonder the child loses his appetite. Such confusion is certainly not conducive to an enjoyable meal.

Possibly the refusal to eat is merely an attempt to get some attention from a busy father or mother. Up to the time the new baby arrived this child was the center of the stage. He was the one and only thought in the minds of his parents, but now that the new baby has come the older child is placed in the background. He soon learned however, that by refusing to eat he got more than his share of attention. Mother, daddy, and grandmother coax him, plead with him, and urge him constantly to eat. They may even feed him. He becomes the center of conversation. Mother doesn't know what she will do to get him to eat, she cooks special things for him, she discusses his loss of appetite not only with her husband but her neighbors. She buys Bosco, Ovaltine, Cocomalt, etc. etc., ad infinitum and still he refuses to eat. She is worried and takes him to the doctor's, maybe two or three doctors. And still no appetite. The child is having a grand time, why should he eat. He is the center of conversation—the world revolves about him. It will take more than five or six bottles of tonic to make him eat.

Eating between meals will naturally take the keenness of the appetite away at meal time. Occasionally a mother tells me in a most forlorn manner she can't get her child to eat. Upon examination the child is well nourished and may even be over weight. When asked whether he eats between meals the mother will say, "Well, I can't get him to eat a thing and then an hour or so after meals he asks for bread or crackers or cake." "Do you give it to him?" "Oh, yes," the mother says, "I am so glad to have him eat I gladly

give it to him." Why should this child eat vegetables and things he doesn't like when he knows that if he will hold out he will shortly be given those things he is particularly fond of?

Candy and ice cream given at any time between meals will take the edge off an appetite and consequently should not be given.

Lack of fresh air and exercise will cause loss of appetite as in the case of a child for one reason or another who has been kept in doors for a long period of time or the "book-worm" who would rather read a book than go out and play, thus robbing the child of his outdoor activity with its deleterious effect upon his appetite.

These are but a few of the factors entering into a possible cause for habitual loss of appetite. In short, may I suggest the following: 1. See that your child gets plenty of outdoor activity and exercise. 2. Nothing between meals, except fruit juice. Fruit juice leaves the stomach rapidly and therefore will not detract from his appetite because an empty stomach is a hungry stomach. Candy and ice cream should be given immediately after a meal, provided the meal were eaten and never otherwise nor at any time between meals. 3. Avoid all confusion at meal time such as arguments, scolding or constantly nagging because of poor table manners. Make meal time an enjoyable affair. 4. Avoid making the refusal of food an issue by centering attention upon it. Rather praise, compliment and reward good appetite. Let the child learn that attention and "center stage" is gotten by eating well and not otherwise. Ignore refusal to eat but stress good appetite.

Bed-wetting is another complaint upon which too much *wrong* stress is placed. Like habitual loss of appetite, bed-wetting may have a physical abnormal state beneath it, but here I am again assuming that there has been found no physical cause for it. The habit of bed-wetting is most annoying particularly to the mother, because it necessitates much extra work in the way of extra washing of night clothes and bed linen. It is generally conceded that control of the bladder during the night should be established by the third year and any time after this that the child wets the bed some attention should be placed upon the condition to eradicate it.

Quite frequently a child has had control of his bladder during the night for a year or more and then suddenly

following the arrival of a new baby starts wetting the bed. The mental reaction here is similar to that in loss of appetite. He resents being pushed out of the limelight by the new baby and soon finds that by wetting the bed he again gets his share and more of the attention. Or the habit may be dated from some specific illness. Here the reaction is the same, he enjoyed exceedingly the attention he was receiving during his illness but resented the lack of attention following his recovery. It did not take him long to learn that by wetting the bed each night he soon became the main topic of his mother's conversation with her husband, her neighbors and all visitors to the house. He was taken from doctor to doctor for his complaint. He was given special diets—in short the entire life of the household revolved around him and his "weakness." Why should he stop? Making him wash out his bed clothes, putting diapers on him, scolding him, punishing him, threatening him are all useless. They serve only to center his attention upon the fact that he is somebody different—some one important. Instead of punishment or all this undue attention being paid to his "weakness" it is better to ignore his wet nights entirely. Pass them by with "Well, tomorrow will be dry." Praise him for each dry night. Make much over the dry nights. Award a prize for so many dry night a week (but always set the goal low to encourage success). Rigidly avoid discussing his failures in his presence. Learn at what hours he is dry and at what hours he is wet. Then give him an alarm clock and set it for a half hour or so before his wetting time. Let him arouse himself and go to the bath room to empty his bladder. In other words, let him shoulder the responsibility of overcoming the habit. At all times he should be wide awake when he urinates. It matters little from the standpoint of overcoming the habit whether he empties his bladder in bed or in the bath room if he does it in a subconscious state of mind. You are trying to teach subconscious bladder control. Therefore he should learn to urinate only when fully conscious. A salty sandwich just before the light is turned out for the night sometimes is helpful. This sandwich may be composed of bacon, cheese, smoked fish or meat with a generous sprinkling of salt, preferably no fluids at this time, but if absolutely necessary, just small sips of water. In short, the approach to this problem is very much like that

of habitual loss of appetite, avoid stressing the habit, ignore that entirely and, consequently, punishment is strictly to be avoided. Instead praise and commendation for dry nights, prizes and awards for certain goals. This is an infantile habit and he is a big boy, let him shoulder most of the responsibility of overcoming it.

There is another child who not only worries his parents, but all who come in contact with him. This is the child who is disobedient who has never learned to obey. In offering an excuse for this type of child the mother will often say, "he comes by it honestly. His father was just like him when he was a boy." This is just a poor attempt on the part of the mother to excuse her own weakness in handling the child. Disobedience is *not* inherited, it is acquired. And it is the fault of the parents entirely. If you threaten to punish your child over and over again but never carry out your threat, how can you expect him to obey? He knows your threats are all talk so why should he bother himself to pay any attention to you. If you threaten to punish him for a certain misdemeanor and he does it then he should be punished immediately regardless of where he is or who is around. In this way he knows you mean what you say and will respect your wishes.

Don't whip the child for every little misdemeanor. Corporal punishment should be reserved for those things that jeopardize the child's health or life—for serious things only. Make punishment fit the crime. In other words, do not mete out severe punishment for minor offenses. Be fair in your application of punishment, otherwise, you will be encouraging lying. The child being fearful of severe punishment for the minor misdemeanor will attempt to lie out of it and if he "gets away with it" will *encourage him to try again*. Suppose he has purloined some small object from his teacher and lost or broken it. A lecture on property rights of others, plus returning the stolen objects or its replacement to the loser with an apology for the act is usually sufficient. The embarrassment associated with this is severe enough in most instances. Or if he is quarreling and the instigator of the quarrel in a group, he need not be deprived of his supper or a proposed trip. It is usually sufficient just to take him out of the group and make him stand by and watch the rest having a good time. These are

but a couple of examples, there are many many different situations, but possibly it gives you an idea of what is meant by fitting the punishment to the crime.

Never send the child to bed for punishment nor ever lock him in a closet. Don't threaten to send for the doctor or policeman if he disobeys. The child should think of the doctor and policeman as his friends and fear of them should not be instilled in the mind of the child.

Punishment should be consistent. If jumping up and down on the furniture was funny yesterday, it should not be punishable today.

If a child should perform a misdeed he should be punished for it immediately and not when daddy comes home, by this time the child has forgotten details of the affair and the effect of the punishment is lost. Also it makes daddy's home coming not a pleasant thought and also creates in the child's mind the thought that daddy is mean and unfair. He does all the punishing when it's none of his business.

If the child performed some misdemeanor on Monday or Tuesday, do not forbid him going to the movies the following Saturday as punishment. This form of punishment is too far removed from the misdeed to be helpful.

Briefly if your punishment is fair and honest and if you will occasionally discuss the rights of an individual in society, the reasons for punishment and why you as a parent must teach the child obedience and respect for rules and laws even as you the parent must obey laws, then your problem of obedience will be easier. But you must be just and firm in all of your judgments.

These are but a few of the many problems of abnormal behavior that are met with in the handling of children. Time and space does not permit of a more complete or detailed account of all of them or even completely covering those mentioned above. It is hoped, however, that in what has been said some information may be gleaned therefrom to make worth while the time spent by you in listening.

Whether he realizes it or not, the doctor in the small town is an ever-present example for the youth of the community. He must be well qualified morally as well as professionally, otherwise his light dims prematurely.—A. C. Johnson, D. O.

ANNOUNCEMENT

Dr. L. R. Livingston and Dr. A. B. Crites, both of the College Staff, are offering a two weeks' course in Ear, Nose and Throat. Operative, clinical and didactic work will be presented during the two weeks, August 14th to August 26th, when clinical material is most abundant. Each matriculant will be instructed and supervised in the operative technique of tonsillectomy, the operations being performed in the Conley Clinical Hospital. The various techniques will be taught, but with special emphasis placed upon the Sluder enucleation method, with both general and local anesthesia. It is expected that each member of the class will operate a sufficient number of cases to acquire proficiency as did the class last summer.

The clinical work will be done in conjunction with the school clinic and should thoroughly drill the student in the methods of examination for abnormalities and diseases of the ear, nose and throat. Differential diagnosis, general management and the treatment of the local condition will be discussed. Pre-operative and post-operative care will be fully explained. Didactic lectures, while discussing the essential fundamentals, accidents and complications will be held to the least possible time.

This course should be of interest to the man in general practice who wishes to make himself a better physician through an improved knowledge of ear, nose and throat conditions. To the man who is doing some specialty work, the course should be an interesting review, should fix the anatomy firmly in mind, enabling him to gain valuable points in diagnosis and management as well as smooth up and speed up his surgical technique.

A moderate fee of \$100.00 has been decided. The number of students must, of necessity be limited, first applicants given preference. To insure your place send one-fourth the fee to either Dr. Livingston or Dr. Crites at their offices or in care of the College.

IT HAPPENED IN 1922

Wherein . . .

Dr. George J. Conley, President of the Board of Control Is the Chief Actor

The President: It is regularly moved and seconded that we pay off in full the mortgage on the lot at Admiral and Highland, known as Lot 41, Ransom Place. Are you ready for the question?

The President, continuing: Those in favor, say aye.

The President, still continuing: Those opposed, the same sign.

The president, finishing: The motion is carried unanimously.

Cheers; then more cheers. (In the cheering, the President doesn't make any MORE noise than the common members of the Board.)

“The Aggressive College”

THE A. O. A. MEMBERSHIP CAMPAIGN

1939-1940

As the College Journal goes to press before the conclusion of the Dallas Convention it will be impossible to summarize the activities and the results accruing in membership due to the efforts of Frank MacCracken, D. O., chairman of the special membership committee during the fiscal year, 1938-1939. But whatever the outcome the work must be carried on. It is the most essential factor to insure the continued activity and amplification of the Central Organization's program. It is the foundation for our present and future security.

Frank MacCracken has done a good job. It has taken of his time, his energy and of his mental initiative. He has given of these freely and without stint. He has been actuated by the importance of the job as the safety factor in osteopathic progress and perpetuation. It is to be hoped that he will be continued for another year in this key position. The College Journal extends to him not only its thanks but the thanks of the entire osteopathic organization as well.

The following is a paragraph taken from my presidential address delivered in Cleveland, Ohio, at the opening of the 1935 Convention of the American Osteopathic Association. It was in a discussion concerning the activity of the chairman of the Bureau of Legislation under the direction of A. G. Chappell, D. O., i.e.: "This assignment has reached the dignity and the importance of a full time job for a competent man. If its efficacy is to be utilized to its fullest extent it should be a Central Office activity under the immediate direction of the Executive Secretary. It will be difficult, probably, to find the proper man to fill this important assignment. This, however, is a detail. The big thing is to incorporate this department intimately into the Central Office activity."

Just now this recommendation is assuming the proportions of a business necessity. The demands upon the time of the Legislative Counselor is far beyond the power of any doctor in private practice to assume. The technical problems presented demands one trained in legal matters. He must have also a flair for legislative technic. He must have the time to master thoroughly each problem presented to him.

Walter Bailey has done a good job but at the expense of his private practice. It is beyond reason for the profession to wish such an important time-exacting responsibility upon any man in private practice. As a result Drs. McCaughan and Hulbert with the assistance of Mr. Caylor have gone to the rescue in times of great need before state legislatures, etc., in pushing or protecting osteopathic practice necessities. It has taken time which was needed by them in the prosecution of other important duties. To ease the burden and to increase efficiency this full time legislative advisor is a pressing necessity. Where will the funds be found to meet the demand? Two hundred fifty non-members brought back into organization responsibilities will solve the problem and will at the same time increase osteopathic solidarity. Surely in this great organization of ours two hundred fifty men and women would volunteer and make it their business to bring in a non-member! It is a most worthy activity! And it will solve simply a serious problem!!

P. S. Frank E. McCracken, D. O., was drafted again and appointed Chairman of the Special Membership Committee.

G. J. C.