The college journal

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.

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OUR HOBBY—Continued

June is slipping by. In a few days the convention will commence in Dallas and 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 earnestly on 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—15. 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 technique, 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 “pious” not only to osteopathic physicians but 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. It would be obstructed. 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 intended doctor. If the question was asked, she was to parry by saying, "Whom would you recommend" and to make note that the 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 and 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 if found.

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 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 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. While 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 then gesture in a relaxing manner. I realized that it would take a special dispensation of Providence plus all the beneficences 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 truck and "bunk up" but she was all nurse. Inhibition of the clinia was used during pains and as dilatation occurred the porter 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 session.

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 baillwick of the one plus ultra of the obstetrical field in Kansas City) "Doctor, I never saw you before. I don't know who you are or where you come 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 pursing the chart, "Doctor, don't you bring all your work to me?" 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 several hours 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. He is the one in your office." I asked a few questions 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. He is the one in your office." I asked a few questions and explained what I was doing and what I expected to accomplish.

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 one 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 sorry very much but we have no beds." "Do you mean that you really have no vacant beds or could I possibly be 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 unterminable 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 denials 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. "Quiet," I said, "I know at least twenty-four hours in advance when my patients are leaving the hospital," I said. "Are you ready," he replied, "as to their 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. He wants the best service that can be had. 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 peaked 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.

Kansas City College of Osteopathy and Surgery
It was found, as the result of years of experience, that the meetings of the Associated Colleges of Osteopathy must be held at least 3 days in advance of the opening of the Annual Convention of the American Osteopathic Association if the amount of work coming before them is to be completed in a satisfactory fashion, and that those attending were to have their minds free from other demands that accompanied the routine of the Convention proper. With that thought in mind it has been the practice to make the week a busy one.

From all member colleges.

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 Department there is a definite statement of the objectives of the individual course, the place in the whole program, and 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 subsided into usual courses under which the procedure indicated above is followed in this Department of Instruction. The profession now has an approved, 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. Fitchard. "The Statistical Analysis of the Vocational Test and Interpretations" by Thomas C. Schumacker. This was a most interesting and valuable paper and one of which more will be heard at a later date.

"Student Recruiting" by Dean L. B. Whitten of the Chicago College and "A Report of the Committee for the Compilation of Material for Text Books" by Dr. Fitchard.

In the afternoon session the agenda was given over to that portion of the work which was 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 House of Delegates of the American Osteopathic Association, assembled in Dallas, Texas, in annual convention, gave recognition to the zeal of 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 organizational 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 organization. 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-zenuous enthusiasm regarding his inherent abilities, and the desire to see him in a position where 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!"
the last day of the Convention, by President Allen. We
President Johnson a successful and a
harmonious administration.
F. A. Gordon, D. O. of Marshall-
town, Iowa, was made President-Elect
for the year 1939-40 assuming the
Presidency in 1940.

The mainstring behind this magnifi-
cent, smooth-running convention
machine was the capable Executive
Secretary, Russell C. Mc-
Caugham and his efficient Central Of-
fice 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. 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 library.

As we desire to complete as fully
as possible our line of osteopathic
texts, we were glad to avail our-
selves 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 Stand-
point—Young
Lymphatics—Millard
Applied Anatomy of the Spine—
Halliday
Diseases of Women—Clark

Through the courtesy of Dr. Ralph
S. Licklider our library has received
nicely bound examination questions
of the Ohio State Medical Board from
1928 through 1938. The execution
of this compilation was borne by the
Ohio Osteopathic Association of which
organization Dr. Licklider is Vice-
President. The questions will be
sued 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."—
Johnstonian Memo-Grants.

KANSAS CITY COLLEGE OF OSTEOPATHY AND SURGERY

A TEXTBOOK ON GENERAL SURGERY

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

My teaching experience in the
Principles and Practice of Surgery be-
egan in September 1905 and has con-
tinued to the present writing. Dur-
ing that time many plates were con-
sulted but only a few advised for
student use. Serious objections, par-
ticularly from the student's view-
point, were presented all. From the
teacher's standpoint the great diffi-
culty arose in lesson assignments.
The salient points in any given sec-
tion of a discussion of either Principles
or Practice were so shrouded in the
mazes of the minutiae that the stu-
dent, 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 assign-
ment of collateral reading by the in-
structor, which left much to be des-
ered.

The question of a satisfactory ar-
rangeent of the text, whereby one
chapter, page one with the princi-
iples underlying the practice of sur-
gery, and page one of an ever extend-
ing knowledge of the so-called minor
phases of the subject, to the end that
an adequate foundation upon which
to build and an adequate fund of
major concepts which would form natu-
ally and sequentially, was universally
wanting.

Then came the work under discus-
sion. Two criteria of surgery, based
upon outlines used in their daily
work, comprised of subject matter
stating the symptom of the disease
in question, as a foundation stone,
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 presenta-
tion prevail throughout its entirety.
This is dictatedcs advantageous from
the teacher's point of few.

Roughly the first half of the book,
some 500 pages, prepares the junior
students in the general principles un-
derlying 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 fea-
tures, giving due consideration to
the special problems of the under-
standing of the technic to be
be depended upon for their correc-
tion. 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 stress-
ing the salient points from the practi-
cal 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 intrigue him to
further outside reading. It is
marvelous to watch the number of
readers have been able to present so
much of value in an amount of space so
minimal. The text is then chosen—all of
the essential facts are there and consetly
read.

Take chapter one for example, in
eleven pages the subject of "In-
flammation and Repair" is disposed
of most adequately. The chapter on
"Prophylaxis of Acute and An-
sepsia" gives to the student
all he needs to know to confer upon
him proficiency in such technic, and
it is covered in two pages. In the
chapter on "Surgical Methods" the
subject of "Heat and Cold" requires
two pages and yet the reader has
possessed of this subject, to the end that
an adequate foundation upon which
to build and an adequate fund of
major concepts which would form natu-
ally and sequentially, was universally
wanting.

Then came the work under discus-
sion. Two criteria of surgery, based
upon outlines used in their daily
work, comprised of subject matter
stating the symptom of the disease
in question, as a foundation stone,
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 presenta-
tion prevail throughout its entirety.
This is dictatedcs advantageous from
the teacher's point of few.

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

KANSAS CITY COLLEGE OF OSTEOPATHY AND SURGERY
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.

Kansas City College of Osteopathy and Surgery

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, Dr. Louis Berman classifies types of 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 ascertain, 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 environmental 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 and their combinations.

The adrenal gland may have a predominance of either cortical or medullary secretion. The former is associated with courage and flight and the latter with fear and flight. The adrenal centered type of personality has some degree of pigment and probably moles and freckles. Pigmentation of the skin is usually marked at birth. The hair is coarse, rough and dry with low hair line and often has red hair. The canine teeth are prominent. If the thyroid glands are normally co-operating this type of person will be vigorous, energetic and successful. The thyroid centered type 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 neurasthenic, 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 flabby, good-natured 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 uncoordinated. He represents the class of thinkers, educators, philosophers, inventors, engineers and leaders. A post-pituitary...
A parathyroid-dominant person is highly excitabie 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 the body functions.

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 deficiency of pohtation, 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 childlike 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, and laugh easily, anger easily and are unreasonable. The gonad-excessive type are sexually unstable.

NOTES ON ETIOLOGY OF PEPTIC ULCERS

Peptic ulcer, so designated to include both gastroduodenal and peptic types (95% of them occur within ⅓ of an inch of the pyloric vein) continues to be the diagnostician's most difficult and a mooted proposition to the clinician. Its etiology is shrouded in mystery. Its symptomatology is subject to mystery by structures extraneous to the digestive tube. Its treatment has run the gamut from early surgery to empirical methods of the extremes of massive surgical interference and is now trending back to a non-conventional palliation or to mutating treatment when the above supplies of other structures for symptomatic relief. Etiologically it occupies a disputable position and is its therapy claimed alike by surgeons and by equally proficient 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 lower resistance in the gastric or duodenal mucosa. It is advanced to account for the development of peptic ulcer, be it infection, spastic, circulatory, or mechanical, that is, the pyloric zone tautly stretched, hemorrhagic mucosal erosions, whereas in the mucosa of the fundus the folds lie irregularly against one another loosely piled.

The “Aggressive College”
tends to a rapid epithelization due to looseness of tissue and the presence of a thin mucous 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 the lesser curvature and along the region of the Magenstrasse.

Durante states that “disturbed innervation, without any additional trauma or infection, will suffice to create in animals lesions presenting a great resemblance of acute and chronic ulcer in man. Resection of the major splanchic 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 splanchic innervates the adrenals; stimulation results in an increased secretion of adrenalin and, as the adrenal secretion has a physiological action, it is one of the most powerful means by which contraction of blood vessels can be obtained. Overstimulation rather than insufficient innervation, seems to be the principle cause, for it must be remembered that intravascular adrenalin has proved conclusively that, by increasing the adrenal content of the blood, hemorrhage can be produced in the stomach. The peripheral or anatomic factor must be taken into special account, since toxic stimulation, whether to chemical or to biochemic agencies—are capable of producing irritations in the sympathy comparable to those obtained by means of surgical interference.”

Mann quoting Durante says, “section of the median or minor splanchic 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 ulcers in the spleen and ulcers in the stomach which tended to become chronic. He attributed the formation of ulcers after sectioned splanchnic nerves which are buried in the posterior edge of the adrenal.” (This statement is pregnant with osteopathic interpretation.)

Crile says “the pathologic physiology of the adrenal sympathetic nervous system will become hyperplastic so that exophalmitic gastre develops; in another case with an equal adrenal there would be such an interference of control of the stomach with the pyloric sphincter that a peptic ulcer will develop.”

Eusterman and Balfour say: “Since 1918 von Bergman has considered derangement of the nervous system as the most significant factor in etiologic consideration of peptic ulcer. He expresses the belief that dysharmony between the vagus and splanchnic systems produces localized or generalized spasm in the muscles of the stomach, duodenal or terminal blood vessels. As a result of such dysfunctions 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 Downing says: “since gastric ulcers occurred only in rabbits with 6th or 5th and 6th thoracic lesions, and since all animals who had these lesions presented 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 which he observed only in the small intestine, are also comparable to those obtained by means of surgical interference.”

The lower bracket income problem

Fifty million people in the United States have incomes of less than $500.00 per year, and 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 devices in the household that make housework easier. But to narrow the inquiry let it be limited to the auto, the gas and electric refrigeration. All of these may be classed comparably among the luxuries. And yet no one seems to be too poor that he feels he cannot afford a automobile that is needed to get the family started home properly. A man came my way who had been hurt in a fall while at work in a large industrial plant. He went on compensation automatically until he could get them started home properly. He received $12.00 per week. His case was stubborn. His medical advisors were at loss to determine the cause of his ailment. Months elapsed and he was still on compensation. In relating to me the case history he spoke of the difficulties that he had to encounter in getting his chicken 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 panoramic 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 "rush and carry" plan: 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 touch their abilities 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 unattainable chattels by the daily credit system. Our forefathers, who did not have any part of 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 so far 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 said 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 and a real chance to live in a 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 at rare intervals. Although this is true they pick on the doctors as the experimental Guinea pigs in the social order. Why not get back to the fundamentals and make such provisions as will insure the education in the habits which 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 commissions 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. their graduates, distributable by eliminating the daily credit system and concentrating upon the essentials of bedside practice so that the graduates will minimize time spent in school and curtail the expense thereof to a point where a reasonable fee can be charged. In this way 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 by the present generation; from the nihilistic philosophy that as they were not consulted as to their entrance into the world said world owes them a living; from the idea of acquisition and greed with the be-littlement 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.

We have pathologists, chemists, allopaths, homeopaths, electropaths, waterpaths until you listen to the "paths, and all have proven to be lamentable failures. We have listened to their request and received their通过对 the following findings:

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

- The number examined was 48, with the following findings:
  - Overweight: 1
  - 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 head, chest or the extremities; the grandular system; nerve system; abdomen; spinal examinations the following the facts were revealed:

- Specific spinal lesions: 1
- Infected tonsils or ears: 1
- Nervous system involvement: 1
- Hernia: 1
- Heart: 1

The outstanding facts from this group is the early development of throat conditions and the spinal lesions. Of this group 44% had normal weight, 20% were overweight and
It would take volumes to adequately express what the glands of the internal secretions 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 cannot 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 in the same gland or glands disturbed in the offspring, but invariably, the trend of the disturbance, 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, the child begins its fetal life with a clean slate as regards endocrine disturbance. This is sufficient evidence in itself to prove that the glands were impaired some time prior to the time of conception. On the other hand, prolonged convalescence may be evidence of severe adrenal depression and damage. Infections such as whooping cough, mumps or influenza 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. In the normal organism, growth depends upon the thyroid. Mental and physical shock can disturb the glands by disrupting the autonomic nervous system.

A growth hormone has been isolated from the anterior lobe of the hypophysis, and it plays a very important 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 is the master gland in gross development.

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time when the epiphyseal close. Gigantism occurs frequently in childhood, the limbs being excessively long and the individual very tall. The pituitary hormone stimulates the bone growth only if present in the proper form. Dwarfism is caused by an insufficient supply of anterior lobe growth hormone. The true dwarfs are normal mentally and well proportioned.

While we are speaking of pituitary lesions it might be well to mention the effect of the basophilic cells of the anterior lobe described by Cush­ting and the syndrome bearing his name. Cush­ting’s disease is characterized by an obesity which is almost exclu­sive to the abdomen. The face may be affected but the limbs are corres­pondingly slender. The age incidence ranges from about five to twenty-five years of age. The face and hands may have a livid color and the hair is commonly coarse. The odontalgia is a disturbing symptom. A syndrome known as Laurence Moon-Beistle’s disease is characterized by adenoma basophilic cells disturbing the bone growth and function, these processes are inter­fered with. Hypercorticism, polyostitis, acromegaly and hypertension may ensue. A patient described by Cush­ting in this year’s clinic may be mentioned. The patient was an adult woman of about 50. In this class. Tumor of the adrenals is quite common. The small children with this condition are not severe. The mild symptoms persist almost constantly. The symptoms of sub­clinical illness being excessively long and the individual very tall. The pituitary hormone stimulates the bone growth only if present in the proper form. Dwarfism is caused by an insufficient supply of anterior lobe growth hormone. The true dwarfs are normal mentally and well proportioned.

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

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

The sub-putitary and sub-thyroid state by far should be our chief concern in our care of the child. There are many 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 then we did twenty years ago, but what percentage of the proper treatment and much 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 in little time spent in true evaluation of each case. Endocrinology plays a role in every disease in every phase of human activity deals with the endocrines. What the child eats, what vitamins he ingests and the minerals he utilizes play an vital role in sustaining his endocrine activity. I have seen glandular substances prescribed in too full a measure. Good food might have or 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 all after, 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 sub-putitary and free up the circulation to the cranial vault, we are aiding Nature's own replacement? Does it seem reasonable to 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 do with which our profession sorely lacks. The endocrinopathies all need Osteopathic treatment. The thyroid child needs particular attention. Osteopathic treatment distributes blood through all of the endocrine glands, bettering the nutrition to these organs, thus 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 therapy in infancy and childhood. This hormone has a powerful inhibiting influence on the anterior pituitary and has great possibilities of preventing adequate anterior lobe of its use in the treatment of gonorrheal vaginitis in the child is permissible. Another hormone is used in anterior like hormone of pregnancy urine. This potent substance has been used for undeserved testicles and there is little evidence to the thought that the promiscuous use of this hormone inhibits growth. We have used the true 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 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 American unit or the British unit is one-fourth of the American unit. One must use the British standard of measurement when administering these substances. The thyroid 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 substance 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 oftimes 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 that not every child need for adequate food intake, vitamin consumption, and mineral utilization in the child if we are to expect the utmost from the child's endocrine. 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 endocrine system should make one aware of the states of ill-health, alterations in body configuration, disturbances in mental and physical development and growth and that all great national benefit. Children who just do not seem to be able to adapt themselves to environmental changes and 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 preparation of a preparatory nature that the choice of a life's work should be one where the benefit of that earlier training will be the greatest. One may 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 trial college in which 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 make a living and see millions of his aid. His services are in demand among the multitudes who have failed to find relief from their ailments 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 helper. He serves the people as no other calling can serve them. He teaches them; aids them; fathoms them. There is a deal of 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


(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 or lack of physical growth. These reactions do not have a physical cause a great many physicians make little or no effort to understand them. Consequently they are sometimes at a loss as to whom to consult for advice and the conditions frequently are not properly treated even when the parents check up to exist. Therefore throughout this discussion you will constantly remember that I am referring to 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 thumb? "Of course," 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 placed too much emphasis upon an inconsequential habit as your desire to overcome the habit you center the child's attention upon it and developed in him an antagonistic attitude. You were determined over the one time the habit and he became determined to continue the habit. It became a battle of wits and a greater misfortune is a quite normal and natural occurrence in infants. For years mothers had been erroneous and 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 shapen and jaws. Naturally, the mother did not want this beautiful creature to grow up with a sense of pride in his personal appearance. How many adults do you know that have crooked thumbs or bite their nails? And yet the majority of them did these very things when they were younger.

This pettie 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, behavior problem must be considered as a possible cause. Here again, then, the problem reverts back to the parents and not the child. Had the mother been less disturbed the habit of thumb sucking would not have become 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 calm the child and arrange the situation so that the hand away from the mouth. If the baby is around the toy holding age five to six months allow him to play with the toy or stick. For the older child around two or three years of age, the same principle applies, give him some object to hold or play with. Instead of distracting 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. 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 habit have better results. Mortification in curbing it will do more than anything else. They will terminate naturally as the child grows out of these habits. In a sense of pride in his personal appearance. How many adults do you know that have crooked thumbs or bite their nails? And yet the majority of them did these very things when they were younger.
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 is cross because his steak is overdone or his coffee is cold. Mother retaliates with the fact that he had been on time it would not have been overdone. Daddy sours another child for spilling her milk or for forgetting to wash her hands before sitting at 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 child is placed in the background. He soon learned however, that by refusing to eat, he can get more attention. Mother, daddy, and grandmother coax him, plead with him, and urge him constantly to eat. They may even force him at times because the center of conversation. Mother doesn't know what she will do to get him to eat, she considers as his loss of appetite not only with her husband but her neighbors. Skippy, Oompah, Cocomalt, etc. ad infinitum and still he refuses to eat. She is worried and takes him to the doctor's, maybe two or three times in order to get him to eat. Nothing brings a hungry stomach. Candy and ice cream should be given immediately after a meal if he does not eat then 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 him feel that there is a meal issue by centering attention upon it. Rather praise, compliment and reward good appetite. Let the child learn to eat an alarm clock be gotten by eating well and not otherwise. Ignore refusal to eat but stress good appetite.

Bed-wetting is another complaint upon which too much concern is placed. Like habitual loss of appetite, bed-wetting may have a physical abnormality beneath it, but here I am again assuming that there has of the baby. He has no 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 instead of allowing him to urinate only when fully conscious. A sautéed salt fish before the light is turned out for the night sometimes is helpful. This sauté may be composed of bacon, cheese, smoked fish or meat without a 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, or at least recognize that he is trying. This is an infantile habit and he is a big boy, let him shoulder most of the responsibility of overcoming it.

Lack of family observation will not only worries his parents, but all who come in contact with him. This is the child who is disobedient who has never been taught to obey. The child is denied the right to make the application of punishment or all this undue attention being paid to his "weakness" it will be the child's undoing. He should be punished immediately regardless of where he is or who is around. In this way he knows your words, do you say and will respect your wishes.

Don't whip the child for every little misdemeanor. Corporal punishment helps to teach him that it that jeopardize the child's health or life—for serious things only. Make that threat, "I'll spank you" mean something. In other words, do not mete out severe punishment for minor offenses. Be fair in your application of punishment, otherwise you accentuate the weakness. The child being fearful of severe punishment for the minor misdemeanor will have a much stronger fear of the big boys and girls that jeopardize the child's health or life. He will try to avoid the teacher and lost or broken it. A lecture on property rights of others, plus returning the stolen objects or its re- turn in the future, will probably be sufficient. The act is usually sufficient. The embarrassment associated with this during the moment is often helpful. The teacher should look the habit, ignore that entire-
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 misdemeanor 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 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.
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.