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Some Aspects of the Mutual Responsibilities of a Medical School and Its Alumni

DR. J. M. T. FINNEY

Mr. Toastmaster, Mr. Chancellor, Dr. Graham, ladies and gentlemen:

I have been asked to talk to you about a subject which is really a very important one, not only here in St. Louis, but all over the country, namely the mutual responsibilities devolving upon the medical school and the alumni body. I want to emphasize the word mutual, "the mutual responsibilities dependent upon the medical school and the alumni," individually and collectively.

Now what does "mutual" mean? I don't have to define that term to you, I am sure. It is a reciprocal relation, the relation that works both ways, giving and taking. That reminds me of my old uncle who was a country doctor who said, "it is a poor rule like a poor pill that don't work both ways." (Laughter) There is something in that. (Laughter) So this is one of the rules that works both ways, it is a matter that interests the medical school and the alumni body.

What is the relationship of the medical school to the student? There is a term which is applied in this connection, "Alma Mater." What does that mean? Translated literally, of course, it means Dear Mother, but its use in this relation dates back several centuries, when the term was first used to refer to certain goddesses who had a fostering influence over certain localities, individuals or institutions. The term was
given a wider usage after that, and by implication it was applied to colleges and schools, the Alma Mater.

The college then became, in a sense, the foster mother of the individual. Now that brings up right away the family relation. Need I say anything to this group about the sacred relationship of the family? Everybody who remembers a mother, (unfortunately I am sorry that I do not, my mother died in my early infancy), but anyone who has felt the influence of a mother knows what I mean when I say that it is really sacred. Now, the same implication applies to the medical school. What has the medical school done for you, I ask each one of you, what have you received from the medical school?

Some of you may say you did not receive much. If so, I wonder whose fault it was! On the other hand others will say they have received a great deal. As a matter of fact what they received from the medical school gave them an opportunity to go out into the world and make a living, to do something that was really worth while for humanity. To do something that is in many instances, so worth while as to reflect credit upon the Alma Mater for what she has done for you.

Now these are the points that are worth thinking of upon occasions such as this; what has the medical school done for you? Then what have you done for the medical school? What are you willing to do? What do you really owe the medical school? And then how are you going to discharge your obligation to it? These are some questions that at once suggest themselves.

I understand that you already have a liaison committee between the medical school and the alumni body. I do not know to what extent it is active, but whether small or large it is a step in the right direction. The alumni can do a lot for the medical school. Many things suggest themselves right away. The question of medical education isn’t settled yet by any means. We sometimes speak of it as if it were, with the new improvements, the great progress that has been made in recent years in medical education, the full time and so on. We speak of these things as promised panaceas, something that is going to reform the whole subject of medical education. Well is it? I wonder.
The question isn't settled by any means. Speaking from the standpoint of the trustee, I happen to be a trustee myself of several institutions of learning of one sort or another, there are continually questions coming up in the management of the institutions, real live questions that require a great deal of thought, mature judgment, and consideration. Not by one person alone, or by one group of persons, but by two groups. First, the trustees who are charged primarily with the management of the institution. I am sure every Board of Trustees will welcome carefully considered suggestions of the alumni group, who certainly are interested and who give thought to the questions that come up. There are lots of ways in which the one can benefit the other.

Any group of medical men must have ideas on the question of medical education and of the proper management of the Washington University Medical School. Ways in which it occurs to you as practicing physicians that this medical school can do even more good in this community to the practicing members of the profession, and to the community itself than it is doing now, even as much as that is.

I should like to refer to one or two questions that are debatable. Take the question of teaching. What constitutes a good teacher? There is a difference of opinion upon this very important point. As I look back over my experience, there are perhaps a half dozen men whom I studied under during my medical school days who stand out. They are men whom I look back upon with the greatest pleasure, their courses, even their didactic lectures, the much abused didactic lecture of today.

Take men like Dr. Cheever, of Harvard, or Dr. Osler and Dr. Welch of Hopkins. Dr. Welch had a way of lecturing on a subject so that when he got through two or three, hardly ever more than four points stood out very clearly. When he got through, the subject that he had been discussing had been so carefully analyzed, so thoroughly explained, that even the dumbest among his students could get the gist of what he had been talking about.

What constitutes a good teacher and who selects the good teachers? The Trustees partly, but I cannot help but feel that it is a mistake that the Board of Trustees as a rule are not
medical men. I think it is a pity that the medical school should not have a good representation of medical men on its Board of Trustees. They ought to know, and if carefully selected I am sure they do know what constitutes the kind of a man wanted as a medical teacher.

That brings up the question of preclinical teaching. Well, what is the difference? The men of the pre-clinical faculty are not doctors at all, they know very little about medical science, about practicing medicine, or about what a doctor has to do. They are pure scientists. Fine as far as it goes but the clinical man is the man who teaches the medical student what he is supposed to know about taking care of sick people.

What does Dr. Welch say about the medical schools? They always have, always should, and probably always will teach the medical student what he ought to know in taking care of sick people. Now that is the substance of Dr. Welch’s thought, I have heard him so express himself a good many times.

That brings up the question of research. You are interested, I am sure, I am interested and the trustees of the school are interested in research. The matter of the part that it should play is a debatable question. I yield to no one in my devotion to research, but I have been in a medical atmosphere for fifty-odd years, and I am convinced in my own mind that as good as research is, it isn’t enough. It helps a lot. Research by all means, yes, but not to the exclusion of the clinical side of teaching, which is the tendency in this scientific age.

You will hear some people talk as if there was not such a thing as clinical research. Well, isn’t there? When a doctor or medical student is studying a patient what is he doing? He isn’t just playing, he is studying, he is learning, he is trying to explain certain phenomena observed. The medical man, in making his diagnosis, what is he doing? He is studying, just as hard as if he had a test tube and a microscope. Different, yes, but the same idea in view, the same goal is being striven for.

Now what about treatment? Has the treatment of disease by medicine reached such a point where there is a specific remedy for each disease? It has perhaps in certain cases, sulfanilamide in streptococcus infection for instance, but there
are a lot of cases that you have to study, and try the experimental method. You know there are some few cases in the practice of medicine that diagnostically always run true to form, and there are some few that respond right away to treatment, but there are other cases that don’t. There is room here for experiment. The experimental method in the diagnosis and treatment of cases has a definite value.

Now I ask you, isn’t that research? Perhaps some of you may say “no,” I know some of my friends do, I have argued with them. I am not convinced myself that that isn’t research, for as I look back over the history of medicine, there are quite a number of ordinary doctors who have done excellent research. How about Lister’s work? Experimental? Yes. He did not have any help until Pasteur came along and furnished the explanation. But he had gone a long way before Pasteur came, and there are lots of places in the history of medicine where you will find the experimental method in use in clinical medicine.

There are so many ways in which medical men can help the alumni or the trustees if they will only get together and sit down and talk it over.

Now a thing of this sort has got to be done in a friendly spirit, just like everything else, if you want to get anywhere. When you come in with a chip on your shoulder, you never get anywhere. If you start in the spirit: “You are just as honest as I am. I will grant you all that I ask you to grant me,” you will get somewhere. Put all cards on the table, no bickering or backbiting or anything else. Now please don’t misunderstand me, I am talking general principles. I have been through a number of similar situations and I have them in mind while I am talking. Whether this applies here or not I don’t know. I hope it doesn’t, but these are the things you want to bear in mind. The spirit in which you approach a subject is what really counts.

Now, gentlemen, I am one of those who believe very strongly in human nature. I believe that the average man is ready and willing to do his “utmost” in any situation in which he happens to be, provided the other fellow does his.

I know Medical Alumni, what a matter of fact body of men and women they are, if anything I may have said here sounds
too high to any of you, let me say that I have been so tied up and busy that I owe you an apology for appearing before you without a set speech, but I wrote all this in the airplane coming from Baltimore, so if what I have said happens to be over your heads, remember it was written about two thousand feet up in the air. (Laughter)

Well, the whole question resolves itself into just one of mutual goodwill, we are all working for the same thing, we all want to accomplish the same results. You have, I know, the good of Washington University at heart, you have a pride in that fine institution, in seeing it progress as it has until it reaches the proud position of being, if not the leading medical school in the country, certainly second to none, and that is not beyond the range of possibilities, if you approach it in the right spirit. This is a case of getting together, everybody doing his part, everybody looking to any source from whence he may reasonably expect help to accomplish the result that he has in mind.

Now, I said there is a difference between colleges and medical schools, of course there is. A college boy hasn't got very much to do, in the average college; if he has he doesn't do very much of it, as he has other things on his mind. He is a gregarious kind of an animal, the average college boy, as I knew him, unless he has changed a lot in the last fifty years or so. He has a lot of other things to do. He has a lot of enthusiasm and all that sort of thing, so when he comes back to a reunion everything is lovely and there's no place like the old Alma Mater and so on. Well, that is fine, but you have your medical student, what about him?

He has a different point of view, he is older, he has his profession to think about. He has gotten to the point where it is serious business with him, he has to make a living, he cannot go fooling around with a lot of things that the college boy does. And then the average doctor, unfortunately, has mighty little money, as I know him. Maybe it is different out here, but around the east he has mighty little money, and for a few years after he gets out of the medical school he cannot do very much with justice to himself, if he has a family to support. Se he cannot do very much in the matter of alumni associations, and giving and that sort of thing. But he can do
something, he can do a little just to show his goodwill. It does not take very much, and every little helps.

When you get a group of alumni together one can do a lot in stimulating interest in the school itself. One can help for instance in the matter of scholarships for poor students who would not be able to go along. A little there would help; founding of lectureships; better active cooperation it is not beyond the range of possibility to found a professorship, and so on through the list.

Then another thing, the doctor can influence some of his patients, he occasionally has a wealthy patient, I say occasionally (Laughter), he can, at times, influence him to give something to the medical school. There are lots of ways, I don't need to enumerate them, in which the alumni body, and the individual alumnus who has the good of his Alma Mater at heart, can do a lot of good.

I could mention several instances, but I haven't the time, where something that a doctor said to a patient sometime when the patient was feeling mighty grateful to him for what he had done for him or for one of his family, that here is the thing that is very badly needed, and somebody can do a world of good with it. That little seed so dropped will, not infrequently, bear wonderful fruit in course of time.

Just a word more, something that will interest my good friend Dr. Graham here, a fellow Princetonian like myself, I think I am simply stating a fact when I say that Princeton has organized her alumni body better than any other educational institution in the country. I hear that from other colleges speaking not infrequently in a very complimentary way of what Princeton has done. I have in my hand here, I won't take time to read it, a little booklet, "National Alumni Association of Princeton University Constitution and By-Laws."

They have the whole thing organized so that every class is represented, every class graduated from that institution that has anybody still living is here, every one, so that they keep in touch with their men. They have a gentleman, the secretary of the graduate council, who is a full time man, he gives his entire time and attention to looking after this organization.

I wish I had time here just to give an illustration of this,
just something for you to shoot at, to let you know what certain other institutions are doing. Here is a report from Harvard, Yale, Dartmouth and from the University of Chicago, here is a list of what they are doing, what they have done, what they are hoping to do, and if one is interested in it at all, it would be well worth while to get this information simply by asking for it from the different colleges.

I just want to take one moment more to show what Princeton has done. From the time of the first commencement, in 1794, up to the present day the campus and the endowment funds of the university have constantly grown, through the support of alumni and friends.

In this they include “friends,” parents of boys and other interested persons. It is well worth while to get the parents, and the next friends interested. Here is a list of the buildings, the lectureships, the professorships, and grants to poor students, and how much they have benefited. It shows the various ways and opportunities for doing a thing of that sort.

Now, are you going to have a share in what your Alma Mater is doing? I have talked too long already, I want to tell you a story and then I am going to quit. Try to apply it. An old darkie was driving a mule down the road and all of a sudden the mule took it into his head to stop. The darkie knew the mule and he knew he was in for it for a while, so he got busy and he did everything he knew to get the mule started; nothing doing, could not get a rise out of the mule at all. Presently a fellow came rattling along in a Ford and said, “What is the matter?” “Oh,” he said, “Boss, this here mule has done stopped on me again.” He said, “He did?” “He sure did.” “Does he do that every now and then?” “Yas sar, every time he takes a notion in his head, I can’t do nothing wid him.” “What have you done?” He said, “I done all I could, I done put sand in his ears, I done twisted his tail, I done built a fire under him and there he is, I can’t do nothing with him.” He said, “Maybe I can help you, I happen to be a veterinary.” “Oh, you is a vetenary, is you, I am sure glad you come along about this time, I hope you can do something wid this mule, because I has to get down the road.” He said, “I will see what I can do.” He went over to his car, opened his bag, pulled out a syringe, took a stopper out of the bottle, got a big swig of
fluid in his syringe and went up to the mule, grabbed a handful of the mule's hide, jabbed in the needle and the old mule never batted an eye. He said, "Well, we will see what happens." The darkie said, "I hope it happens pretty soon, I have been here a long time."

Presently up went one ear, then another, and then up went his head, and then up went his tail, and down the road he went lickety split, it wasn't any time until all you could see was a cloud of dust, the darkie looked at him and said, "'Fo' the Lord, I never seen nothing like that." Then he looked at the fellow, went up to him and pulling up his sleeve, said, "Boss, have you got any more of them drops?" "What do you want with them?" He said, "Give me a shot, please, 'cause, 'fo' de Lord, Boss, I'se got to catch that mule." (Laughter)

Well now, I am not a veterinary, I am not dealing with a mule, don't forget that, but you know doctors have a way of offering a little free advice sometimes, it isn't always received and accepted, still they are prone to offer it. I would like to offer as a suggestion to this group that somehow or other each one of you get somebody to give him a shot of this particular prescription that I am going to suggest, composed of four ingredients; one of them Loyalty, Loyalty to the Washington University. And then Cooperation, the getting together spirit, the organization to make real the ideal that this institution is to be the best institution of its kind in this country.

You want to have an ideal that is real, you want to have an ideal that is worth fighting for, worth working for. Then the fourth ingredient, and a very important one, is enthusiasm. Enthusiasm, determination to put over the thing that you have in mind. Now if some way or other, you get the ideal, the loyalty to the institution, the organization and the enthusiasm, I venture to say that it won't be long before everyone in this room will be proud that he belongs to the Washington University. (Applause).
When, in the summer of 1914, the School moved to its new site opposite Forest Park, the quarters provided for anatomy in the North Laboratory Building were more than ample for the small class of students and limited staff of instructors. The department occupied the third and fourth floors of this large building, about one-fourth of the basement and more than half of the fifth floor. After twenty-five years, with the increase in the size of the class, growth of research activities, augmented staff and the building up of apparatus and collections this space is fully occupied and more room is becoming an urgent desideratum.

Many changes of detail have been made from the original planning of the laboratory, notably the location of the lecture room and of the animal quarters, but the general arrangement of the laboratories for instructors, students and technicians has remained about as described in "Methods and Problems of Medical Education," Series XX, published by the Rockefeller Foundation, 1932. The third floor continues to function in the activities of microscopic anatomy and includes the anatomical lecture room now situated at the eastern end. The fourth floor is dominated by the dissecting room and the collections of skeletons and museum preparations. The original animal quarters have been taken on by the Department of Surgery and new rooms and runways at the western end of the fifth floor are provided for Anatomy. The uses of the basement space have been much increased in connection with the research program in gross anatomy.

In the last number of the Medical Alumni Quarterly Professor Cowdry published a modest account of the progress and development of the teaching and research in the fields of histology and neuroanatomy since 1914, growth and achievement of which the School of Medicine can properly feel proud. It remains now to set forth a summary of the work in gross anatomy in order to complete the account of the Department
of Anatomy during the quarter century just ended. This résumé will be presented in two parts, the first concerning teaching, the second, which will appear in the next issue of the Quarterly, reviewing the research that has been published in the last twenty-five years.

TEACHING

It would not be accurate to use the term "method" with reference to the way gross anatomy has been presented in the past in laboratory and lecture room, because the term means orderly arrangement. The traditional way of leading students to a knowledge of human structure is a grotesque anomaly in contrast with the tried methods long in use in the teaching of the physical and fundamental biological sciences. My own experience, like that of other students, made a deep impression upon me. The memory of it is still vivid: dissecting the lower limb, lectures on the muscles of the arm, studying the microscopic structure of the skin, suffering in a quiz on the temporal bone—all of these diverse and complex matters to be attended to in the day's schedule. There were equally monstrous features of the old course in anatomy, other than those of lack of organization, that contributed to the confusion that drove students to despair and caused many of them to avoid as much as they dared of the laboratory and lecture room and to spend the time in committing to memory the single track descriptions of the text-book. Some features of this hodge-podge appear in Ernest Whitnall's satirical gem "Astonishing Anatomy" whose underlying truth was buried too deeply by the comic strata generally to be discovered and pondered over. I suspect that the kind of course in gross anatomy, as I found it, had been handed down almost unchanged since the time of the Monros.

Social conditions in the past played a part in determining the way anatomy was taught. In the eighteenth and early part of the nineteenth century there were factors unfavorable to the study of the human body in operation. The cemetery and the gibbet were the sources of dissecting material, the one held sacred, the other infamous, thoughts and references to which aroused the hostility of the public toward the teaching of anatomy and settled a stigma upon dissection that has lasted to the present time. There was no law in England and Amer-
ica providing cadavers for dissection, as there is today, and human dissection was involved with the law because its pursuit depended largely upon the violating of graves. There was ever the threat of a visit of the constable hanging over the dissecting room, a menace that burst forth into violent action with the exposure of the trade in dead bodies conducted by Burke and Hare in Edinburgh. The tall dissecting table about which the students stood while at work may have been an adaptation favoring a swift retreat when an alarm of the approach of the law was sounded. In those times, methods of preserving the body were very imperfect as compared with the successful use today of carbolic acid and formalin. The danger of infection from dissecting wounds haunted the student's mind. The teachers were practitioners, surgeons or surgeons-to-be, and were preoccupied with important duties and interests away from the schools. This division of time and effort was probably to the advantage of practice rather than to the cultivation of anatomy in most instances, but there were exceptions; great impetus to the progress of anatomical knowledge was given by certain practitioners whose names stand out in the history of research into human structure: the Hunters, Willis, the Bells, Cooper.

Haste to remove incriminating evidence, and to be rid of a loathsome, decaying body demanded speed in dissecting. As many as could crowd about the table worked to complete the job. Hours for lecturing and attendance in the dissecting room were probably compromises influenced by duties of practice, as they sometimes are today in the case of part time teaching. Orderly arrangement of the course in anatomy under such circumstances was hardly possible. Grave robbing, putrid bodies, part-time interest in the school were potent factors in shaping the course in human anatomy in the past.

Change from old practices in anatomical teaching has been slow. Even after dissection had been made legal, embalming methods discovered that insured good preservation and ended the dread of infection, after full time staffs were beginning to be established, tradition still ruled the way the subject of anatomy was presented. The tall table held its memorial place but students no longer stood in dissecting, being accommodated with tall stools, and janitors continued to groan over their
labors in hoisting unwieldy corpses to the heights prescribed by tradition. The absence of correlation between lectures and laboratory study continued to the confusion of students and finally to the realization by the teacher of the futility of this maladjustment. So lecturing in some instances was abandoned, in others substituted by lectures on broad biological themes which were good ammunition but were not discussions of the structure of man's body.

I early rebelled against the traditional way of teaching human anatomy, developed as it had been under conditions that had ceased to exist in America many years ago. It seemed to me both possible and highly advantageous to the student to correlate the laboratory study of anatomy and class room lectures on the subject, just as the teachers of the physical sciences were doing in their disciplines. So a plan was made and put into effect to have all the students dissect the same part at the same time and all hear lectures and attend demonstrations on that part of the body, while the dissection was in progress. This method was begun nearly forty years ago. The arrangement of the present laboratory, planned in 1910-12, is adapted to this mode of instruction. The large anatomical laboratory at Munich at about the same time was constructed so that it would provide for the correlation of laboratory work and the didactic lecture. The system has in recent years been adopted in the Harvard Medical School. It is elaborated in the School of Medicine of the University of Illinois where the student can investigate the several anatomical aspects of a given part in close correlation: gross structure, microscopic anatomy, embryology, attention to the historical growth of the knowledge of the part. Of the many advantages of the method of correlating the didactic and practical work in gross anatomy that have appeared in our laboratory, only some of the more important ones will be mentioned here.

Stated categorically: a) The confusion and discouragement resulting from our old practice of giving lectures on the systematic anatomy of one region without relation to the dissecting field of three-fourths of the class, no longer exists. The lecture is now upon the one subject of dissection with which every student is engaged. b) Concentration of work on one part of the body by the whole class promotes fruitful and stim-
ulating discussion between students and instructors. c) The laboratory at all times offers an extensive series of dissections of the same region or organ, of much value in studying by comparison, toward realizing the range of variation, in giving experience in the inductive method of investigation. d) Students learning by this system can witness with profit application of the knowledge of the anatomy of the part which they have been dissecting, by attending a clinical demonstration in medicine or by attending a surgical operation involving the part. e) The subject of dissection is the text of the lecture that follows, and the lecturer seizes the opportunity to interpret and develop the significance of the structures uncovered by the scalpel. f) The young instructor whose experience is yet too limited to justify attempts to answer questions on all parts of the body suffers no apprehension in the system here practiced, in approaching a table in the laboratory, for he has concentrated his study on the one part being dissected and can be a real and much appreciated help to a perplexed student.

The principle of correlated laboratory and didactic teaching of human anatomy was conceived forty and more years ago and was applied in gross anatomy soon after the union of the Missouri and St. Louis Medical Colleges. From 1905 to 1907, after the inclusion of histology in the department of anatomy, the method was tried with respect to all of the anatomical sciences but had to be abandoned because of the small staff. In a fully staffed department the method offers a logical way for presenting so many-sided a subject and is stimulating to both instructor and student.

Since the School moved to its present location, the method of correlation has continued to be practiced in the teaching of gross anatomy (as it is of course in microscopic teaching) and techniques permitted by the system have been added and developed. It followed that a program of weekly demonstrations and tests on the single subject of study for the week could be carried on throughout the whole dissecting period, an exercise that called from the student his best efforts in investigating the part he was to demonstrate, and knowledge of which could be broadened and strengthened by his study of the large series of the same organs or regions made available by the prepara-
tions of all the dissectors in the laboratory. It followed that such large series of preparations of a given region were made available for inspection and study to physicians who had special interest in the region, who have been kept informed by the weekly Alumni Bulletin of the day when the demonstration was to occur. The method simplifies the giving of periodic examinations, for, since the entire class has been engaged during the period in concentrating attention upon one division of the subject in laboratory and lecture room, one examination paper suffices for the whole class.

Adjusting the lectures to the dissecting program has brought up the question as to the proper relation in time of giving lectures relative to the period when the subject is under consideration in the laboratory. Time was when a daily lecture in anatomy was the prevailing custom in this School. Our curriculum now permits two lectures a week, and in timing the subjects of the lecture, it was decided that they follow the subject under study in the laboratory. This unorthodox method had its inception with the recognition of the tendency of students to study a laboratory assignment in advance, then to go to the dissecting room fortified by the text-book to confirm its faithful descriptions of the structure of the human body. The feeling held, is that the text has all the truth there is in anatomy and when the body does not agree, why then.... But it always did agree, or so it seemed to all excepting a few obstinate grinds. This false attitude has led many laboratories to discard those dissecting guides that are largely text books in their contents, and to replace them by laboratory outlines of directions for procedure which are lacking in descriptive matter. Endorsement of this step is seen in the appearance of several printed dissecting guides, of which that of Professor Lewellys Barker was, I believe, the first used in the United States. From this experience our deduction in respect to the timing of the text of the lecture, was that it should follow the subject matter of the laboratory. And so the authoritarian status of the lecture, as the expositor of the truth concerning human structure, passed away and, as such, we can say of it, Ichabod! The object of the lecture which follows the laboratory observations is no longer that of informing students of what they are expected to find just so in the dissecting room,
but something totally different, namely to review what the student has himself revealed and studied first hand and without bias, to illuminate difficult points, to emphasize the things that are now in practical application in medicine, to stimulate interest in anatomical problems, correlate the several anatomical sciences, keep function in the foreground, and in other ways, largely by deduction to draw a lesson from the students' experience in the laboratory.

Experience in teaching anatomy over a long period has shown that the purpose of objective study in the dissecting room has been submerged to a considerable extent as the result of the tendency of students to prepare in advance for the work to be done by conning text-book descriptions, and so to undertake the practical work of the laboratory under more or less bias. We have endeavored during the past twenty-five years to overcome this tendency by advising certain methods, in order that the principle of laboratory experience will prevail and its benefits given in training the student to seek knowledge first hand in nature, and inculcating confidence in knowledge so acquired. We recommend the use of a guide to procedure in dissecting, reference to texts and atlases minimized during the preparation of a part and study of descriptions and illustrations on completion of the day's work. This method of study is, in principle, the reverse of a common practice of comparing the dissection with the text-book description, and consists on the contrary in verifying the description from the basis of the dissection. This attitude of believing that in the parts revealed by dissection lies the true source of knowledge of structure and that the description and figure represent at most an earnest effort to interpret these truths, is we think a way to encourage a critical point of view. Further to impress the purposes of the laboratory, the week end quiz is a practice, not instituted as some students believe in order to assign grades, that is quite subordinate, but is primarily a method calling for demonstration of the parts prepared during the week, involving of course their identification, simple relations and correlations. The oral discipline in this procedure, is an essential part of the mechanism of learning.

These are principles on which the course in gross anatomy has been built up during the period of occupancy of the present
laboratory building. It is not pretended that these principles
are carried into practice in the case of some students or that
they are not overlooked sometimes by every student. Learning
from nature is the hard way, as we hear complained, but it
is the sound way to real knowledge. If doctors who have
studied anatomy by such methods forget many of the details
of structure and relation, they have profited by an experience
whose usefulness is ever in force in the practice of medicine.

Space does not permit a review of the experiments made in
evolving the present course since entering the new buildings in
1914, or of descriptions of the methods of studying the skele-
ton, of muscles and joints, of viscera. The brief course given
in the third year of demonstrations of regions and organs is
an effective link between the fundamental teaching and its
application in clinical teaching, and perhaps may be extended
in the future as its usefulness deserves. In the laboratory stu-
dents are constantly discovering pathological conditions, ex-
periences heightening interest in this subject and serving to
bind anatomical knowledge with another province of medicine.
Only reference can be made to the valuable adjunct of lectures
to the first year class offered by teachers of clinical branches.
Much time and thought are given to the teaching of anatomy
to the classes of nurses, including as it does, lectures, labora-
tory study and demonstrations. With regard to graduate in-
struction, attention will be devoted to this important function
of the department in a subsequent publication, dealing with
investigation pursued during the past quarter century.

Effort to improve the teaching of gross anatomy on the
principles and by methods here briefly summarized, has been
one of the major lines of endeavor in our laboratory during
the past twenty-five years. It is our belief that the continued
practice of out-moded ways in presenting the subject of gross
anatomy has exerted no slight influence in lessening interest
of both instructor and student and shares responsibility for
the unfavorable attitude of some medical school administra-
tors toward gross anatomy. We are encouraged by our experi-
ences that with better organization and improvement in meth-
ods, interest will revive and medical students will receive the
training that is so necessary in a fundamental subject. We
believe that progress has been made in our laboratory, but that
there is still much to be desired in making the teaching more effective.

Methods of teaching anatomy differ in different laboratories as is to be expected from differences in training and individual interests and concepts of the staffs that plan and conduct the teaching. This discussion of our views and methods has not been written as a tract aimed to reform the teaching of anatomy, but simply to present an account of what the Department of Anatomy has been trying to do in this field during the past quarter century. It constitutes the first part of a description of the laboratory in response to an invitation from the Editor of the Medical Alumni Quarterly.
The Pancreatic-Hepatic Syndrome

WARREN H. COLE, '20 *

For many decades pathologists have noted fatty infiltration of the liver of varying degree at the autopsy table. This finding is relatively frequent, but as yet there has been no satisfactory explanation of the mechanism of deposition of the fat, except that it occurs in hepatic damage. During recent years, however, some experimental data have been reported which explain one type of fatty infiltration.

This work was initiated by the research of Fisher and Allen and associates (1924), who discovered that pancreatectomy in dogs resulted in death of the animal in two to eight months. At autopsy the livers of these animals, which had been given insulin, were heavily infiltrated with fat. They noted that death and the fatty infiltration of the liver could be prevented by feeding raw pancreas. A short time later, Hershey and associates discovered that pancreatectomized dogs could be saved by feeding lecithin and choline. The next notable contribution to these experiments was made by Dragstedt and associates. They isolated an alcoholic extract of the pancreas, named by them lipocaic, which would prevent or cure the fatty infiltration of the liver produced by pancreatectomy.

These experimental data are so conclusive as to suggest that possibly pancreatic deficiency might be an important mechanism in the pathogenesis of fatty infiltration of the liver in a significant percentage of cases. For example, Ireneus working in this laboratory noted that animals suffering from acute pancreatitis, produced experimentally, frequently had, to a very significant degree, fatty infiltration into the liver. In his experience it was noted in the animals with a severe type of pancreatitis, and appeared to be more prominent if the animal survived several days. In his experiments he noted a rather marked acute hepatitis along with the infiltration of fat.

It is well known that the disease consisting of fatty infiltration of the liver and pancreatic fibrosis occurs only rarely in the human being. In 1937 Snell and Comfort reported three

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cases of enlargement of the liver along with pancreatic lithi-
asis. They obtained favorable results with lipocaic, in so far
as symptoms as well as enlargement of the liver decreased.
In seven cases analyzed from the literature by the author, in-
cluding one to be reported by him, gallbladder disease appeared
to be a fairly common complicating disease. It is well known
that gallbladder disease is frequently the lesion instigating
acute pancreatitis. Whether cholecystitis was the etiological
factor in development of the pancreatic lesion found in the
cases mentioned above could not be accurately determined.
It is true that fatty infiltration of the liver has not been
described as a complication of the ordinary type of acute pan-
creatitidis which is observed clinically. This feature would,
therefore, appear to cast some doubt upon the supposition that
since gallbladder disease is an important factor in the patho-
genesis of acute pancreatitis, it would likewise be an important
factor in the pathogenesis of fatty infiltration of the liver re-
sulting from pancreatic fibrosis. It would first have to be
proved that the pancreatic fibrosis encountered along with
fatty infiltration of the liver was secondary to acute pan-
creatitidis. This proof is not as yet at hand. It is the opinion
of the author, however, that as more patients with pancreatic-
hepatic syndrome are reported the incidence of gallbladder dis-
ease will be too high to be merely coincidental.

The manifestations of pancreatic-hepatic syndrome, as noted
in the various cases reported, have been slightly variable but
sufficiently similar to identify them as belonging to the same
disease group. Moderate epigastric pain along with weakness
and malaise appear to be the earliest symptoms. Distension
with dyspeptic manifestations may be encountered. Nausea
and vomiting are occasionally complained of. Steatorrhea is
common but is not a prerequisite for the diagnosis. The same
may be said regarding the absence of pancreatic enzymes in
the duodenal secretions. Early in the disease an enlarged liver
will be palpable. Two or three of the seven cases studied have
had diabetes. Presumably pancreatic disease including fibrosis
and necrosis is a prerequisite.

In a patient recently observed by the author there was a
history of a gastroenterostomy several years preceding onset
of symptoms consisting primarily of weakness, epigastric pain
and vomiting. Examination revealed an enlarged liver. At operation the liver was found to be enormously enlarged and of a pale gray yellow color. The gallbladder was filled with stones and the pancreas was indurated indicating the presence of considerable fibrosis. Not being able to undertake any operative procedure which would correct the fatty infiltration of the liver by the fatty necrosis, we directed our attention to the gallbladder which presumably must have been the cause of the pancreatic disease. Thinking, therefore, that removal of the instigating factor might prevent progress of the pancreatic disease, we removed the gallbladder with the stones. The patient made an average convalescence but on the fourteenth day when she was allowed up she developed marked signs of decompensation and in spite of cardiac therapy, died two days later. Death occurred before we could institute lipocaic therapy. At autopsy the pancreatic fibrosis and fatty infiltration of the liver were confirmed. Death was due to myocardial insufficiency produced by fatty infiltration of the ventricular wall along with atrophy of the muscle. This complicating lesion does not appear to be common in the pancreatic-hepatic syndrome.

One of the most complete observations made on the pancreatic-hepatic syndrome was that reported by Rosenberg, who proved the presence of pancreatic fibrosis and fatty infiltration of the liver and later demonstrated the disappearance of fat in the liver following administration of lipocaic.

As already intimated, there have not been more than seven or eight cases reported as occurring in adults. It is a well known fact, however, that a similar disease occurs in children. The pediatricians have long been well aware of the presence of steatorrhea accompanied by pancreatic fibrosis. This is known as congenital pancreatic steatorrhea. Weakness, anorexia, distension, pallor, anemia and steatorrhea represent the symptoms encountered in the disease. So far as is known no one has suggested that the two diseases are the same. It is the opinion of the author, however, that the two diseases are identical except that one occurs in childhood and the other in adult life.
Tropical Medicine in Puerto Rico

F. G. IRWIN, '30*

Tropical medicine has interested a growing number of doctors during the past few years. This has come about due to several well-known factors. The war in Europe has fostered more cordial relations between North and South America. Protection of the Panama Canal has produced a new interest in the West Indies. The international highway to Mexico has increased travel between the United States and her southern neighbors. Air lines bring tropical regions within twelve hours' time distance. Wealthy South Americans who formerly sought medical care in Paris, Madrid or Vienna are arriving in this country in increasing numbers. Lastly, diseases encountered in tropical regions offer an interesting and often virginal field for research.

Strictly speaking, there is no such thing as "tropical" medicine or surgery. To practice tropical medicine successfully the physician needs a thorough background of internal medicine plus the knowledge of a few disease states commonly found in the tropics. This is obvious in view of the fact that residents in the tropics have heart disease, diabetes, cancer, tuberculosis, and everything else, excepting frostbite, that his northern brother is apt to have.

The practice of medicine in Puerto Rico is comprised of run-of-the-mill diseases, plus malaria, typhoid fever, intestinal parasitic infestations, sprue, schistosomiasis mansoni, filariasis, leprosy, amebic dysentery and multiple deficiency states.

The following paragraphs are a few "off the record" observations on some of the above listed diseases as seen in the Presbyterian Hospital in Puerto Rico.

Sprue: The sprue state or syndrome is common in Puerto Rico. We agree with Hanes of Duke University that there is no distinction between tropical and "non-tropical" sprue. Incidentally, in our opinion Hanes' description of sprue in the

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Oxford system of medicine is the most satisfactory one available.

Whereas full-blown sprue with diarrhea, glossitis and anemia is easily recognized, the problem of incipient sprue constantly taxed diagnostic acumen. We have seen patients with sore tongue only, patients with diarrhea only and no sore tongue, and patients with anemia and carbohydrate intolerance. Various combinations of findings are encountered. Diagnosis rests on history, physical findings, a flat glucose tolerance curve and typical x-ray findings of hypermotility, pudding and segmentation seen in the small intestine. We felt that without a flat glucose tolerance curve or typical x-ray findings as stated above the diagnosis of sprue was wrong.

The etiology of sprue remains unknown. Castle jestingly likened the relation of sprue to pernicious anemia to a mule to horse relationship. The monilia as a causative agent has been pretty well excluded. It is found in sprue and non-sprue states with equal frequency. One of our patients had pulmonary moniliasis of fifteen years' standing, and did not develop sprue. Curiously, sprue is not seen in the Virgin Islands forty miles distant from Puerto Rico. Not uncommonly sprue is seen in the Negro race. Dr. H. P. Colmore, internist at the hospital, believes there is a strong familial tendency in sprue, but does not venture to say whether it is due to hereditary bodily characteristics or to slight contagiousness of the disease.

We had occasion to operate on two patients with full-blown sprue. In both, the ileum was pale, thickened and waterlogged in appearance. The mesenteric nodes were enlarged to 1 cm. in diameter and were pearl-like and glistening. They were left undisturbed but would have made interesting material to section and culture.

Sprue responds to liver therapy, but the "retic" rise obtained is usually from 3 to 8 per cent regardless of how or in what quantity the liver is given. Spontaneous remissions occur in sprue. Many old-timers give a history of sprue cured by Dr. Ashford's milk diet. As a rule sprue recurs when liver is stopped and tends to become chronic. Tropically grown starches are well tolerated by sprue patients, whereas potatoes, northern cereals, etc., are not. Dr. D. H. Cook at the School
of Tropical Medicine believes that this may be due to a lower "colloidization" point found in yautia, ñame, platynos, and like tropical tubers.

*Schistosomiasis mansoni* is a prevalent and fairly well-known disease. We divided its course roughly into three stages, the acute period with bloody-mucoid diarrhea, the quiescent period over months or years, and the third stage of cirrhosis, splenomegaly, anemia, leucopenia, ascites, and finally liver insufficiency. With adequate treatment by fuadin it is believed that the parasites can be killed. Patients entering the third stage are benefited by splenectomy to relieve portal hypertension. Dr. Louis Rousselot, of Whipple’s Spleen Clinic in New York, has demonstrated the mechanism of congestive splenomegaly in Banti’s syndrome. We had occasion to remove fifteen spleens in Banti’s syndrome caused by schistosomiasis, with fair results. Although results are better when cases are carefully chosen, even a small percentage of “cures” is something gained in face of the hopeless outlook of patients with increasing ascites. Schistosomal spleens are probably the toughest type to remove since there is often perisplenitis with adhesions. The veins are always very large and friable and the spleens themselves are huge.

*Malaria:* It is surprising how many general practitioners in the Middle West are unfamiliar with the League of Nations report on malaria, which appeared a few years ago, it being the first real advance in concepts of malaria and its treatment in the past thirty years. At the Presbyterian Hospital we favored the use of atabrin in simple malaria, reserving plasmochin, quinine and atabrin combinations for malignant infections, cerebral malaria, black water fever, etc.

*Lymphangitis tropicum,* elephantiasis, or filariasis has been heatedly discussed in Puerto Rico since O’Conner laid the blame for the disease solely on filaria bancrofti. The consensus of opinion now is that the filarial organisms block the lymphatics, setting the stage of lymphatic stasis for the entry of the real villain—a streptococcus. It has been proved that streptococci are responsible for the recurrent bouts of lymphangitis, that repeated attacks of lymphangitis result in the brawny edema of elephantiasis. Hence, in any climate, blockage of lymph drainage followed by entrance of streptocci will
cause lymphangitis tropicum, and ultimately produce elephan-
tiasis. This has been seen in arms following radical mastec-
tomy with mildly infected wounds. James Knott (W. U. ’28) of St. Croix has done good work in treating elephantiasis among the Negroes of St. Croix, using inexpensive pressure bandages, etc., in reducing chronic lymphedema.

Uncinariasis is an ever present problem among the poor of Puerto Rico. Patients with profound hypochromic anemia are frequently seen on the wards. Using iron therapy these pa-
tients can be brought up to 3.5 RBC and 65 to 70 percent Hb, without ridding them of the worms. Regardless of how much iron is used they will not gain beyond that point until they are rid of the parasites. Why? I do not know.

Approximately 80 percent of the admissions to children's ward have intestinal parasites, many having hook-, round-, and whipworms simultaneously. I recall one child who had hook- and roundworms, ameba histolytica, and schistosomal ova.

There are many unanswered whys in tropical diseases. I am sure that Manson-Barr’s “Myositis Tropicum” has nothing to do with filariasis as he claims, but simply illustrates the predilection of hemolytic staphylococcus aureus for muscle tis-
sue in the tropics. Puerto Rico is a hematologist’s paradise and the opportunity is likewise there for research in sprue and the deficiency states, parasitology, etc.

Students interested in tropical medicine should be well grounded in internal medicine, and should plan on spending a year or so in London for formal courses. If interested in the tropical diseases found in Puerto Rico, opportunity is avail-
able at the School of Tropical Medicine and the Presbyterian Hospital in San Juan.
The Tumor Registry of the American Urological Association

OTTO J. WILHELMII

Since most doctors have but a vague idea as to the exact significance of the cancer registry in Washington, I thought it would be worthy of comment to give a detailed explanation as to just what this registry is.

Men vitally interested in cancer study realized for a number of years that in order for the profession to progress in eradicating cancer it was essential, not only to collect a large incidence of cases, but also a large incidence of the various types of cancer therapy.

The bladder tumor registry was started in 1927 by the American Urological Association and trickled along up to 1938 when there were at that time 1500 cases reported. The kidney tumor registry was started later in New York by Russell Ferguson and had but 85 registrations when transferred to the museum in 1938. In 1938 a special committee was appointed consisting of twenty-two urologists selected from the American Urological Association and so geographically placed as to enable them to continually stimulate interest and collect material in their respective territories. At the present time the Kidney and Bladder registry is under the supervision of the committee composed of this group of urologists throughout the country headed by Dr. Archie Dean of New York, with Colonel J. E. Ash as curator. The registry has stimulated profound interest in the country and to date has registrations of 3651 bladder tumors and 408 kidney tumors.

Although the Registry is located at the Army Medical Museum in Washington, D. C., the government, as such, has nothing to do with the activity. It is sponsored and financed by the American Urological Association. The use of the museum is a tremendous asset to our organization because it permits the use not only of space, but also of equipment, supplies, and technical and clerical facilities, not mentioning the professional and administrative services which are given gratis.
The two registries of the American Urological Association are amalgamated with six other registries from other specialties into the American Registry of Pathology which is sponsored by the National Research Council. At present this includes a registry for otolaryngology, ophthalmology, dermal, dental and oral tumor, and lymphatic tumor.

Method of Registration:

All Kidney and Bladder tumors are registered in the following manner—

1) Fill in questionnaire which is sent on request from Army Medical Museum.
2) In Bladder tumors send a paraffin block or a slide from each biopsy.
3) In Kidney tumors a sagittal section where possible is requested, otherwise blocks or slides.
4) Send significant pyelograms which will be copied and returned.
5) Include address of hospital or doctor so that yearly “follow ups” can be sent.
6) Old, as well as new cases, are solicited from general surgeons as well as from urologists.

The American Urological Association soon came to realize that the above registration entailed considerable work for the average busy man, so a special fund was set aside to pay interns who are designated as registrars in different localities. They are paid a certain fee for each case that they register and in this manner many are helped to finance their education.

A paraffin block or slide is requested so that it may be filed with the case so as to permit any interested and qualified person to study these cases in the future. Requests for “follow up” information are sent out once a year in every case that is not closed. The response to this phase of the registry has been most satisfactory. Of all the registries the eye registry leads with over 9400 registrations and 7000 enucleations.

One can readily conceive the vast importance of a registry of this sort, how massing the material will lead to more accurate study not only of diagnosis but also of treatment, how centrally located and available this material is to all who are interested and wish to study same.

It is quite astounding what results are accomplished quite
often from an extensive collection of cases. The follow-up registry reveals that some tumors that formerly were thought to yield or be entirely eradicated by the application of radium did very poorly, but showed amazingly favorable results when direct x-ray was applied and that others did better with surgery and x-ray than when radium alone was used, etc. So one can see that with an intensive study of the various types of therapy with definitely differentiated types of tumors one should in time standardize a specific type of treatment for a specific type of tumor.

There is but little doubt that the cancer registry is the solution, if not of the eradication of cancer, at least to the perfection of better treatment and probably standardization of treatment.

We, as urologists, solicit your earnest cooperation and request that you communicate with the registry and enlist your cases.
The Multnomah Medical Service Bureau

GEORGE C. SAUNDERS, '27*

Portland, Oregon

The Multnomah Medical Service Bureau, operating in Portland, Oregon and surrounding territory, has arisen to answer a need and to meet a problem which is in many ways unlike conditions existing in other parts of the country. In order to understand these factors, it is necessary to review briefly the history of pre-paid medical service in this community.

Pre-paid medical service in Oregon extends back over a period of thirty-five years and came about because of problems peculiar to the industries of the State. Many logging camps, employing a large number of men, are located far from organized medical accommodations and, in certain instances, from any medical attention, and the same is true of other groups of workers in construction and similar industries. Most of these employees are in the minimum wage groups and are totally unable to meet the burden of a major illness out of their own pockets. In addition, much of this work is seasonal and the workmen are transient or subject to change from one job to another, with the result that the doctors seldom were paid even if they were available and were equipped to handle the problems.

Several business men realized that a profitable undertaking could be made by supplying medical and hospital services to these individuals on a contract basis and there arose several rapidly growing organizations which agreed for a stated sum, to be paid in advance by deductions from the workers' pay checks, to furnish necessary hospital, medical, and drug services for most illnesses. In the beginning, these organizations also covered accidents on the job but, in later years, since the formation of the State Industrial Accident Commission, many contracts exclude this service.

It cannot honestly be said that all of these services were bad, even though several major objections were made repeatedly.

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Most of the organizations employed staff physicians and the right of the patient to a free choice of physicians was markedly restricted and, in many cases, totally absent. Lay control was another objectionable feature and resulted in solicitation and under bidding, and the old proverb, “someone can always be found to do a thing for less and do it worse,” had frequent application. In spite of all this, these organizations progressed by leaps and bounds, and in 1930 in the midst of the depression, many of the doctors suddenly awoke to the realization that most job holders were under contract and that private practice was limited to a very small high income group and to those with little or no funds at all. These doctors felt that the best way to meet the situation would be to organize a pre-payment medical service which would eradicate the evils of the commercial associations and leave control in the hands of physicians and preserve the normal relation between the doctor and patient. Twenty-five members of the County Medical Society met and laid down the plan which has been the basis of the present organization. Unfortunately, the new association entered a crowded field with many established customs and it was essential to fight them on their own home ground. As a result, certain undesirable factors had to be incorporated into its early endeavors. I refer to such things as the furnishing of drugs, a practice which now apparently is ready to be discontinued by joint action of all associations furnishing pre-paid medical service. The Multnomah Service Bureau operates under the Insurance Department of the State of Oregon and, in its inception, was approved by the County Medical Society. Unfortunately, the Association and the County Society had difficulty in their relations with one another. Certain leaders in the Society were of a reactionary nature and extremely conservative in their outlook and frowned upon all forms of pre-paid medicine. This difficulty was augmented by the attitudes of the A. M. A., which apparently had a great talent for shooting holes in all pre-payment plans but, unfortunately, seemed to be unaware of problems in Oregon and incapable of offering any constructive help. To add to this, there was the inevitable clash of personalities on both sides of the question and this culminated in 1935 with the withdrawal of the approval of the Association by the County Medical Society.
After three more years of discussion, both sides began to come to a common understanding and concessions were made by all, and as a result of a vote of the Society in 1939, approval was restored.

As a result of this re-organization, the County Medical Society emerged as the virtual controller of the Association. The directors of the Association are selected from a panel of its membership named by the council of the Medical Society. The society is owned, controlled, and administered by physicians. The medical director, Dr. F. H. Dammasch, as well as his assistant, are both practicing physicians. The Association is a stock corporation and each physician owns only one share of stock, the value of these shares is $75.00 and the money was used to supply the necessary capital to make the corporation workable. Dr. Dammasch has been director of the Association through its entire history and his experience in administrative matters perhaps is the most extensive of that of anyone in the country.

Workmen are covered in groups of ten or more and when a group of employees wish to place themselves under contract, a representative of the Association explains to them the services available and if they elect to participate, their firm handles the financial transactions and makes payments monthly to the Association. Medical services include specialists and necessary hospitalization; drugs are furnished for all acute conditions and in most chronic conditions except venereal diseases, allergy and a few other conditions which have their inception before the patient comes under coverage. Coverage is limited to those whose incomes are less than $1800.00 a year. The patient who requires attention obtains a slip from the office of his employer and then makes his own choice of any physician on the panel. If specialists are required in addition, the general practitioner refers the patient to such specialist as he or the patient may select. Since each doctor is remunerated on the basis of the amount of work done, he is naturally anxious to please these patients just as he is his others, and knows full well that if the patient becomes dissatisfied he will go to someone else, which he can freely do. There are 430 members of the County Medical Society and at the present time, 293 of these are members of the Association and the
number is increasing daily. The income of the Association during its first year was $4,100.00. In this last year it has jumped to $332,081.00 and there are twenty thousand persons now under coverage.

One of the major objections to pre-paid service, namely, that patients will take undue advantage of the situation, has been surprisingly lacking. In my own experience, the percentage of “chiselers” has been very small. It is true, of course, that patients will come in for earlier treatment of illnesses and will ask medical advice rather than drug store suggestions for acute infections, but certainly this use of the service is a favorable thing for the public health. In my own specialty, I find that many people will come to me for refractions rather than go to an advertising optometrist, but again no one could say that this is an undesirable thing. Each patient who comes to my office comes freely because he has selected me as his own preference, whether at the suggestion of a friend, or his own doctor, and I welcome each of these patients because they add to my income both directly and indirectly.

The patient presents the doctor with a slip when he first comes in and if treatment lasts longer than one month, a new slip is obtained for each month. These slips in turn are used by the doctor as a bill to the Association and at the end of each month are turned in to the Association with a notation as to the services rendered and the charge for same. These charges are made according to a fixed fee schedule which has been laid down by the council of the Medical Society. At the end of each quarter, the Association, after having paid the hospital, drug, and administrative expenses, reimburses the doctors for their services with the money left. Unfortunately, it has never been possible to pay the fee schedule in full but a percentage is paid, depending on funds available for the total of the accounts rendered. In early days this was indeed a very small percentage but, at the present time, it runs between sixty and seventy percent and with the prospect of an increase in the future, particularly since the furnishing of drugs, which is now taking 15% of the gross income, is to be eliminated.

From the standpoint of the doctor, the remuneration is small but, on the other hand, it is sure and obtained from a class
of people who would otherwise be subject to charity, semi-
charity, or unwilling or unable to pay the doctor at all. It
keeps these people as well as their families in the hands of
private practitioners rather than in the hands of lay controlled
Associations, which operated successfully over a period of
years and which are here to stay whether we like it or not
unless we can offer a similar service better than theirs. It is
this last thing which the Multnomah Medical Service Bureau
is doing and the result has been disastrous for the commercial
organizations. Most of the smaller ones are practically on the
rocks now and the two largest ones have suffered severe losses
while the physician-owned Associations are growing with each
quarter. It is our hope, of course, that eventually all this ser-
vice will be rendered through the approved bureau and the
remaining small percent of the doctors who are not in the
Association will see fit to join.

With the help of Dr. Dammash, and his staff, similar
smaller organizations have developed in other regions in Ore-
gon and eight communities of this State now offer such a ser-
vice through local bureaus. The State of Washington has
sixteen bureaus while California operates as one large State
Bureau. Recently, administrative officers have been sent here
to study our methods and returned to their own organizations
in California, Michigan, Pennsylvania and elsewhere. The
fundamental test of any medical endeavor is whether it suc-
cedes in giving satisfactory medical services to its patients
and a fair consideration of the right of the private practi-
tioner, and its ability to remunerate him suitably for his
labors. It has not all been smooth sailing and many rough
spots remain to be ironed out but, fundamentally, the bureau
is accomplishing the task it has set for itself and has achieved
a permanent place as a pioneer in the field of medical eco-
nomics.
Dr. Elsworth Smith, 1864-1940

Dr. Elsworth Striker Smith died at Barnes Hospital June 6, 1940, after an illness of one month. Dr. Smith's association with the medical school began in 1890 when he was appointed Demonstrator in Anatomy and Instructor in Physical Diagnosis in the St. Louis Medical College. Thus, he had held an unbroken record of appointment for fifty years as a member of the faculty. In 1923 he was made Professor of Clinical Medicine and his title was changed in 1930 to Professor Emeritus. Through the last years he had taken but little part in clinical teaching but he continued in active attendance on his hospital patients until his last illness.

Dr. Smith was born in St. Louis January 1, 1864, the son of the late Dr. Elsworth F. Smith who, himself, was an eminent member of the St. Louis profession. He attended the St. Louis schools and received a literary collegiate course at St. Louis University. He graduated from the St. Louis Medical College in 1887. For three years he served as interne, resident and Assistant Superintendent in the St. Louis City Hospital and immediately thereafter began his long teaching career in the school in which he had been trained.

His hospital associations increased early in his professional life and for many years he was active in the management of the St. Louis Mullanphy Hospital, where he was Chief of Medicine, and in the St. Mary's Infirmary where much of his early experience was gained. He practiced with his father and the late Dr. J. B. Johnson from an office on Grand Avenue at the origin of West Pine Blvd.

When Barnes Hospital was organized and he was appointed to its staff in May, 1914, he transferred most of his private practice to this hospital. It was here and through his teaching in the Washington University School of Medicine that most of his later acquaintances were acquired.

During the first World War, Dr. Smith gave unfailingly of his time and energy in consultation work on the Draft Board and in examining recruits for service. His participation in public organization began early, and he was president of the St. Louis Medical Society in 1918. In 1923 he was president
of the American Congress of Internal Medicine. Throughout his life he held memberships in many national organizations, attended their meetings regularly and contributed scientific papers. In the earlier days of specialization in internal medicine he became a pioneer in cardiology and vascular disease and contributed to the rounding out of our knowledge of these conditions.

Dr. Smith's greatest strength probably lay in his handling of the problems of the individual patient in his private practice. In his broad knowledge of medicine and his even broader knowledge of the personal problems of sick people and of their families, those he attended found a means of adjustment to suffering and seemingly impossible situations. Thus was expressed an achievement in the art of medicine as distinguished from the pure science. He used to speak of "the integrity of his practice" by which he meant his availability at all times to rich or poor and his personal attention to all phases of their sickness. This he maintained to the last and those under his care when he finally entered the hospital received personal notes explaining his inability to attend them and expressing his best wishes.

His loss is to be keenly felt by the School of Medicine, by a host of patients and by many physicians who were trained at his elbow and befriended by him in their own adventures in practice.

Dr. Hiram S. Liggett.
William Thomas Coughlin, 1873 - 1940

On May 22 of the present year Dr. William Thomas Coughlin passed away after a brief illness, caused by coronary thrombosis. Born April 25, 1873, in the country village of Iris, Ontario, Canada, he spent his boyhood in close contact with nature, getting experience that influenced the shaping of a fine character. He prepared for the study of medicine in the Collegiate Institute of Barrie, Ontario, and spent the year 1897-98 as a beginning medical student in the school of the Medical Faculty of Trinity University, Toronto. The year 1898 found him matriculated in the Missouri Medical College, St. Louis, where he had come to continue his course in Medicine. The union of this School with the St. Louis Medical College brought William Coughlin into Washington University, and in 1901 he received the degree of doctor of medicine from that institution. As a student, interest in surgery was apparent; he excelled in the study of anatomy, winning the prize then bestowed in recognition of high attainment in that field. In 1902, Dr. Coughlin was appointed instructor in anatomy at his Alma Mater, and held the position most efficiently until 1910. Following graduation, he served an internship in the St. Louis City Hospital, after which experience he entered upon practice. His progress in surgery led to his appointment as instructor in that branch in Washington University.

The medical faculty of St. Louis University had not failed to recognize in young Coughlin, ability and promise of a fine career. The post of assistant professor of surgery was offered him in 1911 and was accepted. In the year 1916 he was promoted to the professorship of surgery and appointed head of the department of surgery in 1920, a position held to the time of his lamented death.

In the years following his fundamental medical training Dr. Coughlin pursued post graduate study abroad, in the London Hospital and at the Universities of Paris and Heidelberg. The French language, learned in his boyhood in Canada, and German acquired in collegiate days and at Heidelberg were put into practical use, as well as his knowledge and skill in
surgery during the World War. For he served in the Medical Corps of the United States Army, 1918-19, as major and lieutenant colonel.

Dr. Coughlin's inclinations made him both student and practitioner throughout his life, the one tendency yielding valuable contributions to surgical knowledge, the other involving him in a large practice and leading to appointments demanding judgment and surgical skill, and carrying much responsibility. His studious habits and acute mind, combined with a good sense of humor, were elements that contributed largely to his success as a teacher. Students honored him for his learning and loved him as a man.

Coughlin's honesty and directness in dealing established the confidence that these traits always do; his generosity and sympathetic nature made him well beloved by his patients. He practiced for many years in St. Mary's Hospital, and became surgeon-in-chief of that institution, a position he occupied at the time of his death. As a member of the national, state and local medical and surgical societies, Dr. Coughlin was very active; the loss of his energy, liability and critical judgment is already felt and deplored by his colleagues. The death of William Thomas Coughlin is the passing of an alumnus of Washington University, honored and beloved who, true to the ideals of his profession, gave himself to the welfare of his patients and to the advance of medicine; is the passing of a spirit steadfast in the faith.

Dr. R. J. Terry.
News of the School

Seventy-ninth Commencement Exercises

The seventy-ninth commencement of Washington University with its conferring of 705 degrees, 4 honorary degrees and 33 diplomas in nursing was held on June 11, 1940 in the Field House. Ninety-five of the degrees were conferred upon candidates from the School of Medicine. Honorary degrees of Doctor of Laws were conferred upon Dr. Walter B. Cannon of Harvard University Medical School, who delivered the commencement address; Dr. Herbert Spencer Gasser, director of the Rockefeller Institute; and Dr. Eugene Lindsay Opie, professor of pathology at the Cornell University Medical School. The honorary degree of Doctor of Science was awarded to Dr. Edward Adelbert Doisy, professor of biochemistry of St. Louis University School of Medicine.

Dr. Cannon, who has been connected with the Harvard University department of physiology for forty years, spoke on “Progress and Problems.” He spoke of the upbuilding of Washington University by the late Robert S. Brookings as an important part of the “marvelous transformation in medical and surgical knowledge and practice that has taken place in the United States.” He discussed the moral and scientific problems presented by the use of modern inventions for warlike and destructive purposes. “The suggestion has been offered,” he said, “that we declare a temporary halt in scientific research. That is a counsel of despair. The abominable discrepancies between the great benefit we might enjoy from the powers which natural science has placed in our hands, and the great evils which are inflicted upon us by means of those powers, result not from knowing too much, but from knowing too little.”

Final honors were awarded the following members of the class of 1940 who were graduated cum laude: Russell Jackson Crider, Leabert Robert Fernandez, James Harold Growdon, Paul Guggenheim, Margaret Orr Huntington, Mary Catherine McFayden, Leo Aaron Sachar and Horace Mann Wiley.

The Alexander Berg Prize in Bacteriology was awarded to Miss Frances Marshall Love, the George F. Gill Prize in
Anatomy was won by Gordon Musgrove Todd; David Goldring of the class of 1940 was awarded the George F. Gill Prize in Pediatrics; Leo Aaron Sachar of the Class of 1940 won the Alpha Omega Alpha Book Prize; and Martin Sanford Withers was awarded the Howard A. McCordock Book Prize in Pathology.

Mr. Chancellor:
Walter Bradford Cannon, George Higginson Professor of Physiology at the Harvard Medical School since 1906. Distinguished scientist, outstanding teacher, zealous champion of human liberty. Recipient of honorary degrees from Harvard, Yale, Liége, Strasbourg, Paris and other universities. Exchange professor at the Sorbonne and École de Médecine, Paris. Recipient of the Baly Medal of the Royal College of Physicians, London, and of the gold medal of the National Institute of Social Science. Corresponding or honorary member of scientific societies in Paris, Bologna, Buenos Aires, Brussels, Budapest, London, Barcelona, Edinburgh and other cities. His laboratory has been a Mecca to many young physiologists who have received training and inspiration there. His pioneer application of the x-ray to the study of the movements of the stomach and intestines formed the basis of the modern
accurate and satisfactory method of diagnosing abnormal conditions of those organs. He has made important studies of the effects of emotions on body processes. His work on the sympathetic nervous system has been daring in conception and brilliant in technical execution. In the last war he made important contributions to the subject of surgical or traumatic shock, and again in the preparations for another possible national emergency he has responded to the call of the medical services of the army and navy to elucidate this problem still further.

Mr. Chancellor, it is a great privilege to me to recommend Dr. Cannon to you and the Corporation of Washington University for the degree of Doctor of Laws.

Dr. Evarts A. Graham.

Mr. Chancellor:

It is my privilege to present for the honorary degree of Doctor of Laws Eugene Lindsay Opie, Professor of Pathology in the Cornell University Medical College. A member of the first graduating class of the Johns Hopkins University School of Medicine, and after a promising beginning at his alma mater and at the Rockefeller Institute for Medical Research, he was called in 1910 to become the Professor of Pathology in the Washington University School of Medicine. A disciple of
William Henry Welch, he brought to pathology in St. Louis a fresh viewpoint—the viewpoint of a brilliant investigator, a stimulating teacher and an inspiring associate. In the years after 1910, his patient and thoughtful judgment made its contribution to the mold from which this medical school was cast. We honor him today not only for his service to Washington University, but also for his manifold contributions to scientific medicine and to medical education.

Dr. Robert A. Moore.

Mr. Chancellor:
I present Herbert Spencer Gasser, Director of America’s foremost laboratories for medical research, the Rockefeller Institute, and sometime collaborator in the development of the School of Medicine of this University. The fine product of the University of Wisconsin and of the School of Medicine of the Johns Hopkins University. Trained in medicine, he has, with great talent for research, applied the self-acquired techniques of the mathematician, of the physicist and of the electrical engineer in the investigation of a wide range of physiological problems, and has shown the way in a renewed and fruitful endeavor to thin the veil which shrouds the functioning of the nervous system, that most intricate of the bodily structures. Physiologist, pharmacologist, sound and inspired leader in his field. He is presented for the honorary degree of Doctor of Laws.

Dr. Joseph Erlanger.

Mr. Chancellor:
I present for the honorary degree, Doctor of Science, Edward Adelbert Doisy.

He is a native of Illinois and a gifted son of the University of that state. In the invigorating atmosphere of that institution he early discovered within himself an abiding interest in the science of chemistry, an interest he has cultivated with enthusiasm, rare skill and with notable success—to the benefit of mankind.

With a good foundation laid at Illinois, he migrated to Harvard where under the wise influence of Otto Folin, he acquired more than a knowledge of biological chemistry; he was led to develop resourcefulness and independence of thought
and action, the best preparation for his later achievements. After service in the first World War, he was for four years a member of this University. For the past seventeen years he has added lustre to St. Louis University.

Dr. Doisy is an able representative of the modern type of iatro-chemists, those who discover, identify and make available for therapeutic use drugs of a new sort,—the physiological agents by which nature regulates orderly traffic within our bodies and controls our emotions and behavior, the hormones and vitamins. The contributions which entitle him to distinction are his isolation of several hormones and recently of two forms of a new vitamin.

He was one of a group first to isolate insulin in pure form. He is a pioneer in the isolation of sex hormones. After demonstrating with Edgar Allen the location of the ovarian hormone, he and other collaborators first isolated this potent agent in pure crystalline form, and thereby laid a cornerstone of the now large structure of sex physiology. A year ago he isolated, then identified and even synthesized the vitamin essential for normal clotting of blood and avoidance of hemorrhage.

The beginnings of the earlier of these dramatic investigations were made by Dr. Doisy in Washington University, which takes therefore a special pride in his accomplishments. As head of the department of bio-chemistry in St. Louis University since 1923 he has become a leader in that subject and in that institution. In honoring him we salute our sister University.

Dr. Philip A. Shaffer.

Alumni Banquet

The annual banquet of the Medical School Alumni Association was held at the Hotel Jefferson on Saturday night, Jan 1, 1940. Three hundred and twenty-three attended, the graduating class were guests, and Dr. Finney the principal speaker. The financial report was presented and is printed in this issue of the Quarterly. The election of officers and four members of the executive committee was made by acclamation. The officers, Becke as president, Schmidtke as secretary-treasurer, Day and Tuholske as vice-presidents were retained for another year. Woodruff, Lohr, Burman, and Arbuckle were elected to
the executive committee. Other members of the executive committee are Blair, Bagby, T. Brookes, Drewes, Harrison, Jorstad, Magness, and McNally.

Following the address by Dr. Finney it was announced by the Executive Committee that the Alumni Association is incorporating itself as a "non-profit" organization with a Corporate Trust Agreement. A Foundation of the Alumni Association is being established, the purposes of this to be "Establishment, maintenance and distribution of the Foundation for special needs of Washington University Medical School or the Alumni Association as determined by the Alumni Association."

It was emphasized that two major contacts are necessary for the proper fruition of this venture. First, the Medical Alumni must be reliably informed of specific needs of the Medical School. On the other hand, alumni advice on medical education, general and specific, is important to the Medical School. Secondly, confidence must be enhanced between the Board of Trustees, the Executive Faculty, and the Alumni so that this confidence in the program of the Medical School may be fully imparted by the Alumnus to his interested friend.

1893 Class Reunion at Banquet

The Class of 1893 celebrated its 47th anniversary at the annual banquet on June 1st. The following were present: J. N. English of Gillespie, Ill., and A. Darling, J. J. Meredith, H. M. Kinner and M. R. Horwitz all of St. Louis. Many others who were unable to be present at this time sent messages to the reunion. It is to be regretted that a number of classmembers have not acknowledged the announcement and invitation sent them each year for three consecutive years.

Dr. Hamil, class of '90, joined us at our table, and all had a good time.

On Monday evening our "A. Darling" was host to the class at a dinner at the Little Bevo. The festivities that evening were delayed 45 minutes while the group awaited the arrival of Dr. Kinner, the latter upon arriving explaining that his car developed mobile trouble and had to be removed to a clinic for diagnosis. Becoming suspicious of "nocturnal calls" after 47 years of diligent practice, Dr. Meredith brought along his chauffeur, for protection it is believed. Altogether the evening
was spent very pleasantly, and it is the wish of all of us to renew the meetings and attend the class reunions annually.  

M. R. Horwitz.

The Class of 1895, Missouri Medical College, Celebrates its Forty-fifth Anniversary

Murphysboro, Illinois, was the gathering place of those members of the class of '95, who responded in person to the cordial invitation of Henry Horstman's family to be their guests, Wednesday and Thursday, June 5, 6, 1940. Of a graduating class of sixty-three, twenty-six survive and of these twelve were present for the reunion: Charles G. Ahlbrandt, his wife and daughter, Henry G. Horstman and family, our hosts, Sandor Horwitz, Curtis C. McMachin, A. T. Quinn and Mrs. Quinn, Robert E. Schlueter and wife, W. A. Tolleson, Edmund P. Staff and family, Albert H. Thornburgh, his wife, son Frank and Miss McCallom, their guest, J. W. Winn, John and Mrs. Zahorsky, Robert J. Terry. Wednesday evening the Logan Hotel offered a bountiful banquet—a chicken for everyone. Letters, telegrams and verbal messages were received from nine classmates who were unable to come. The loss of another member, spirited, lovable, able A. C. Brown, was recorded with sorrow. John Z., the class poet, did his stunt, with Horstman the victim. Class officers were unanimously re-elected to serve a fifth term.

Thursday, middle-western hot, turned out a glorious day with sight seeing of the fine city park and play grounds, visit to the Horstman farm, strolls in a beautiful piece of woods, presenting a rich variety of the native flora and a population of too much gar in Beaucoup Creek. Festivities reached a climax with dinner under the trees at the Horstman home. One piece of business followed: the adoption of a resolution to mark the grave of Dr. Joseph Nash McDowell. The location of the family burial lot in Bellefontaine Cemetery is known, but there is nothing to indicate the last resting place of the founder of the Missouri Medical College. A committee was named and charged with the duty of circulating the proposal among the Missouri Medical Alumni with request for subscriptions to cover the cost of erecting a simple marker on the McDowell lot.

Robert J. Terry, ’95.
Notes on the Class of 1900

The Class of 1900 of the Medical Department of Washington University was unique in several respects. It was the first "four year class." It was the first to be graduated under the instruction of the combined faculties of the St. Louis and Missouri Medical Colleges whose independence and individuality, not to mention antagonism toward each other, constituted a part of the medical history of St. Louis for more than half of a century prior to their amalgamation in 1899.

Because the full-sized regular class, having completed its first two years, now became "Juniors" instead of Seniors, the actual Senior Class of 1899-1900 was made up of only a few irregulars. Hence, the Class of 1900, numbering only 10 members, was probably the smallest to be graduated within forty years either before or after the date of their commencement.

Typhoid fever had delayed the graduation of two members of the Class of 1899—one being contracted while in military service in Cuba during the Spanish War. Two were repeating their senior work. Three had registered before the four year
requirement was put into effect at the old Missouri Medical College so that they were actually “three year men” in a “four year class.” One, a veterinary surgeon, was allowed one year for this qualification at the St. Louis Medical College. Two members of the class had a credit of three years work at other medical colleges—one at Beirut, Syria. With a faculty greatly outnumbering the senior students, there were no failures to be recorded when final examinations were taken by this puny class.

Six of the class became interns in St. Louis City institutions, while the remainder entered private practice or private hospitals. One-half of the class remain in active practice at this date. Distance and illness in the family prevented all but two from attending the 1940 Medical Reunion. Two were killed by accident, one died of coronary disease, one of chronic nephritis and one of pulmonary tuberculosis which apparently was first contracted during internship at the ramshackle temporary City Hospital at 17th & Pine Streets, which was used for some years after the cyclone of 1896 had destroyed the City Hospital.

A dramatic detail in the story of this latter classmate, John D. Hess, may be noted here. In spite of his pulmonary disease, he had maintained a good physique by living out of doors in New Mexico and later in southern lumber camps. He never married. When this country entered the World War, he was among the earliest medical volunteers. A recent attack of influenza had activated his pulmonary disease. A valvular murmur indicated cardiac deficiency. Confronted by the probability of his rejection for service, Dr. Hess produced a letter he had not referred to before. It was a personal appreciation
from the Colonel who commanded the regiment of U. S. regulars in which Dr. Hess and his brother had served at Santiago, Cuba, during the Spanish War. The frank sincerity of his commanding officer’s praise won a Captain’s commission for Dr. Hess in spite of the unavoidable adverse report on his physical condition. He was assigned to active duty at Jefferson Barracks, Mo., but after several months it became evident that he was no longer able to withstand the ravages of his pulmonary disease. Captain Hess was transferred to Fort Bliss, New Mexico. The end of his courageous and honorable career of medical service came in 1918 while he was wearing the uniform of his country which he had served daringly while a student at the Missouri Medical College.

William H. Luedde, ’00.

Class of 1915 — Twenty-fifth Reunion

The class of 1915 moved with the University in December of 1914 to the Kingshighway location. On Saturdays and other leisure days we watched the University Buildings, Barns and St. Louis Children’s built and spent considerable time roaming about the unfinished corridors. When the partitions were half completed, we wondered how all the small rooms, particularly those off the wards, were going to be used. We watched it finally take shape, the small rooms we now well know. The dedication occurred. We were graduated, the first class to go out from the Medical School in its present location; therefore, our Twenty-fifth Reunion celebrates its twenty-fifth anniversary.

The celebration consisted chiefly of a luncheon offered by our new and able Barnes Hospital Superintendent Dr. Frank R. Bradley, at which gathered Wilkening, Langsdorf, Cramb, Bock, Bechtold, Rose, and Hugh McCulloch, who was Resident in Medicine, when WE graduated and OUR Professors P. A. Shaffer, R. J. Terry and Jos. Erlanger. The absent members were remembered and freely discussed. It would be well to attend the next reunion!

Bald heads, gray hairs, head and even eyebrows, together with some increase in avoirdupois, localized and otherwise, were noted. All were well, prosperous, happy, and send you their very best wishes.

Dr. D. K. Rose.
The Class of 1925

The Class of 1925 held a very enjoyable fifteen year reunion in conjunction with the general Alumni Reunion. The program extended from Friday through Sunday afternoon. The outstanding features of the program which included clinical meetings and social events were the dinner dance at Hotel Chase, Friday evening, attended by some thirty members and their wives, The Alumni Banquet on Saturday evening, and the Barbecue on Sunday afternoon. The clinics this year for the General Alumni body were sponsored and in considerable detail worked out by local members of the class. Among the out of town guests were Charlie Beasley, Jerry Levy, Gersh Thompson, Walter Campbell, George Drennan, Ralph Stickler, “Hub” Denny, and George Bailey.

The fifteen year interim has added a few gray hairs, a certain degree of localized rotundity, but the gay irrepressible spirit and close comradeship have only been brightened by the passing years. Those of you who missed out this time, better come next time. The local resident group of our Class remain your ever ready hosts at any time you may chance to come back to the old stand.

Dr. Myron Davis.

Alumni Dinner in New York

The Medical School Alumni Dinner during the annual session of the American Medical Association was held at Sherry’s, in New York City, at 8 P. M., June 12, 1940. Nineteen attended the dinner, a few more dropping by for cocktails previously. The small attendance was disappointing, particularly in that it had been well publicized by Dr. Scott Johnson, president of our New York City Alumni.

An excellent dinner was provided. Each gave a short resume of his or her activities since graduation. This proved particularly interesting in that different specialties in medicine as well as different locales were represented; this most assuredly made up for the small attendance.

Celebration of Dr. Dock’s 80th Birthday

At a dinner at the headquarters of the Los Angeles County Medical Association April 2, Dr. George Dock, surrounded by seventy of his friends, colleagues, and former students, cele-
brated his eightieth birthday. Although his birthday falls on April 1, a happy conjunction of events led to its celebration on April 2, namely: the founding of the George Dock Lecture-ship by the newly-formed Walter Jarvis Barlow Society of the History of Medicine, and its initiation by Dr. Dock himself as the first lecturer.

Messages of congratulations came from friends and colleagues in all parts of the United States and Canada.

Following the reading of these messages, Dr. Dock spoke on the subject he had chosen for the first George Dock Lecture: The History of Medical Encyclopedias, and illustrated his talk with some of the many gifts he has made to the Library of the Los Angeles County Medical Association. It is planned to publish this lecture and other contributions to the occasion in a commemorative volume.

Of particular interest to faculty and alumni of Washington University is this celebration. Dr. Dock is the well-remembered teacher of many who have graduated from Washington University Medical School, having been Professor of Internal Medicine here for many years.

**Dr. Evarts A. Graham to Head Advisory Committee on Medical Work**

Dr. Evarts A. Graham of Washington University, president of the American College of Surgeons, has been made chairman of a surgical advisory committee on national defense, set up this month by the National Research Council in collaboration with Surgeon-General James Carre Magee of the Army and Surgeon-General Ross T. McIntire of the Navy.

Make-up of the committee, explained Dr. Graham, is planned to represent the profession through its various scientific groups as well as to cover the field of problems peculiar to war injuries. The plan developed from a consultation of the surgeons-general with the National Research Council on recent advances in the treatment of wound infections, formidable in the last war, and surgical shock, in which great steps have been made particularly in variants of the "best" treatment, blood transfusion.

Dr. Alton Ochsner, '20, professor of surgery at Tulane Uni-
versity, and Dr. Warren H. Cole, ’20, professor of surgery at the University of Illinois, are also members of this committee.

Dr. Cori Elected to the National Academy of Sciences

Among the scientists honored by election to the National Academy of Sciences at its annual meeting in Washington, D. C. on April 24 was Dr. Carl F. Cori, Professor of Pharmacology in Washington University School of Medicine. This honor comes to Dr. Cori in recognition of his investigations in the field of pharmacology, especially of his elucidation of the physiological mechanisms by which the hormones, insulin and epinephrine, act in maintaining the normal regulation of blood sugar concentration.

Among Dr. Cori’s recent achievements is his isolation of the enzymes present in animal tissues which break down glycogen or animal starch in the liver and muscles, thereby maintaining a constant amount of sugar in the circulating blood. By the action of these same enzymes he has demonstrated the conversion of sugar into glycogen outside the animal body, a notable achievement.

Dr. Cori is the fourth member of the faculty of Washington University School of Medicine to be elected to membership in the National Academy of Sciences.

Central Clinical Research Club

The Central Clinical Research Club, an organization of the younger men from the medical centers of St. Louis, Chicago, Ann Arbor, Minneapolis, Rochester, Minnesota, Iowa City and Madison, Wisconsin, held their semi-annual meeting in St. Louis on April 20, 1940. About thirty out of town doctors attended the scientific sessions which were also open to the profession in St. Louis.

After the morning meeting, which was held at St. Louis University School of Medicine, the members and speakers were
guests of the St. Louis group at a luncheon held in the cafeteria of the St. Louis University School of Medicine.

The afternoon session was held at Barnes Hospital.

**Society of Clinical Surgery**

The seventieth meeting of the Society of Clinical Surgery was held at the Washington University School of Medicine and Barnes Hospital April 29 and 30. This organization is composed of forty active members, of which the local members are Glover Copher and Nathan A. Womack, and forty-three senior members including the local members Malvern B. Clopton, E. A. Graham and Willard Bartlett, Sr. Among the charter members of this society were Harvery Cushing, George Crile, William and Charles Mayo.

Local members performed surgical operation both mornings for the thirty-odd registered members. Luncheons were held on the eighth floor of Maternity Hospital. Presentation of papers and demonstrations were made in the afternoons.

The annual dinner was held Monday night at the Deer Creek Club following a reception at the Log Cabin Club. After the conclusion of the program Tuesday afternoon, Dr. and Mrs. Graham had a reception for the members and their guests at their home on Upper Ladue Road. This reception was followed by a buffet supper at the home of Dr. and Mrs. Willard Bartlett.

**American Surgical Association**

The American Surgical Association held its annual meeting under the presidency of Dr. A. O. Whipple, New York, at the George Warren Brown Hall of Washington University on May 1, 2 and 3. Dr. M. B. Clopton was chairman of the local Committee of Arrangements.

The first day of the program was given to a symposium on the fluid and electrolyte needs of the surgical patient. Various other surgical subjects were considered the last two days.

The annual dinner was held at the St. Louis Country Club.

**G. C.**

The practical part of the examination for the American Board of Surgery was held at the Barnes, St. Louis City and
Desloge Hospitals on April 27. Approximately forty members took the examination to qualify as specialists in Surgery.

The National Board of Medical Examiners held their annual examination in St. Louis at Barnes Hospital June 25, 26 and 27, 1940 for twelve candidates. Dr. A. B. Day is the local secretary.

**Barnes Hospital Society Elects Officers**

At the annual spring meeting of the Barnes Hospital Society, held April 4, the following officers were elected for the 1940-41 terms: President, Dr. Warren Rainey; Vice-president, Dr. Charles Duden; Secretary-treasurer, Dr. T. K. Brown (re-elected); Advisory Councillors, Dr. Drew Luten, Dr. Charles H. Eyermann. Already in office: Dr. J. Albert Key, Dr. D. K. Rose, Dr. J. B. Brown.

Dr. James B. Costen, '22, addressed the Northern Tri-State Medical Association, meeting at Battle Creek, Michigan, on April 9th, 1940. His subject was “Neuralgias and Trismus Resulting from Mandibular Joint Disturbance.” He will give a series of talks before the Post Graduate Medical Assembly of South Texas, meeting at Houston, Texas, December 3, 4, 5.

**Alpha Omega Alpha**

At a recent meeting of the Alpha Chapter of Missouri of Alpha Omega Alpha the following members of the class of 1940 were elected to membership: Mary McFayden, Russell J. Crider, Horace M. Wiley, Paul Guggenheim, Benjamin Strehlman, Seymour Brown, Wallace Rindskopf, Llewellyn Sale, Jr., Richard L. Landau, Robert E. Buck, Perry C. Gillette, and Leabert Fernandez. At the same meeting the following members of the class of 1941 were elected to membership: Earl W. Sutherland, Leon Kahn and Henry S. Guterman.
# The Medical Alumni Association

## FINANCIAL STATEMENT

**April 30, 1939 - April 30, 1940**

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| | **$3,107.98** |

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*Edwin C. Schmidtke, Treas.*
DEPARTMENTAL CONFERENCES

The following articles present some of the material discussed at various Departmental Conferences during the past quarter. It is hoped that such presentations can be a permanent feature of the Alumni Quarterly.

Department of Pathology

PANCREATIC STEATORRHEA IN A CHILD

History No. P-1975. A white female infant, was admitted to St. Louis Children's Hospital, at 18 months of age, because of loss of weight, an enlarged abdomen, and a chronic cough. She was born at term, weighing 7½ pounds, and was adequately fed with breast feeding supplemented by lactic acid formula. She developed normally until the age of 7½ months, at which time she weighed 14 pounds. Shortly thereafter, she began to lose weight and her abdomen increased in size. The stools became large, numbering one to three per day. Various diets were tried, and in spite of the fact that her appetite was good, she failed to gain weight normally. About the same time that she began to lose weight, she developed a severe upper respiratory infection and a cough which persisted.

On entry to the hospital, she was found to be pale and undernourished. The abdomen was distended. She had a chronic cough, and examination of the chest revealed a few dry rales. The stools were large, soft, yellow in color, and contained a large amount of undigested fat.

The child continued to lose weight, and two months after entry to the hospital she developed an acute upper respiratory infection and a bilateral otitis media. A hemolytic streptococcus was cultured from the ears. Three days later there was evidence of bilateral mastoiditis. Her course was progressively downhill. There was marked distention of the abdomen, and in the last ten days of life, the respirations became rapid and the cough more severe. She died three months after entry to the hospital.

Postmortem No. 8482. At autopsy, the abnormal findings were as follows: The body was that of an emaciated white female infant. The abdomen was markedly distended and tense. There was a moderate edema of the hands, ankles, and feet, and a slight edema of the face, most marked about the eyes. A thin, yellow, serous fluid was present in both external auditory canals. The stomach and intestines were greatly distended. On the left, there was thick, yellowish gray exudate covering the visceral and parietal pleura. Both lungs showed scattered reddish gray, firm, non-crepitant areas, most numerous in the upper lobe of the left lung. The intervening lung tissue was crepitant.

Microscopically, the pancreas showed marked inter- and intra-lobular fibrosis which had replaced most of the acinar tissue, leaving only scattered acini and the islands of Langerhans. Some of the islands also contained a moderate increase in connective tissue. In the connective tissue, there was a slight infiltration of mononuclear cells. The small pancreatic ducts were moderately distended, lined by cuboidal epithelium, and contained a granular secretion.

Sections from the left lung showed a thin layer of fibrin over the pleural surface and areas of acute bronchopneumonia with beginning abscess formation. In addition, about most of the bronchi and large vessels, there was an increase of connective tissue and a striking infiltration of mononuclear cells which were chiefly plasma cells. Many of the bronchi also showed polymorphonuclear leukocytes infiltrating the lining epithelium, and the lumina of some were filled with mucus and polymorphonuclear leukocytes. Sections from the right lung showed less alveolar exudate and no abscesses, but the same peribronchial infiltration of mononuclear cells was present. The bronchial epithelium in both lungs was of the normal columnar type.

Sections from the kidneys showed occasional glomeruli containing crescents of proliferated epithelium without any exudation of cells.

Discussion. This case belongs to a group with similar findings which we have studied within the past few years. The outstanding clinical symptoms in these cases have been a chronic cough, failure to gain weight, and in some instances—
as in this child—changes in the stools, indicating a pancreatic insufficiency. At autopsy, a characteristic change in the pancreas and a bronchopneumonia with a chronic peribronchial inflammation have been found. The pancreatic change consists of an interstitial fibrosis with varying degrees of active inflammation and a dilatation of the small pancreatic ducts with retained secretion. No squamous cell metaplasia of the ducts has been observed. In a number of these patients, there has been an infection with the salivary gland virus, as indicated by the occurrence of the characteristic intranuclear inclusions in the cells of the salivary gland, and at times, in cells of other organs, including the pancreas. Similar cases have been reported, especially by Blackfan and his associates at the Boston Children’s Hospital. They have shown that some of these children are deficient in vitamin A. However, this characteristic pancreatic change is not found in all cases of vitamin A deficiency in children, and it seems probable that vitamin A deficiency may be the result of the pancreatic change rather than its cause. It is possible that the vitamin A deficiency predisposes to the chronic lung infection, although in our cases, changes in the bronchial epithelium, characteristic of vitamin A deficiency, have rarely been observed. At present, the etiology and pathogenesis of this interesting clinical and pathological entity have not been determined.

DISSEMINATED LUPUS ERYTHEMATOSUS WITHOUT LESIONS OF THE SKIN

History No. 79927. A 45-year old white, married woman was admitted to the Barnes Hospital on January 25, 1940, because of a subacute upper respiratory infection of five days duration. During the last three months she had not been well and had seen her private physician on numerous occasions because of pain and edema in the lower extremities. One day before admission, she had noticed purpuric spots over her entire body. She had developed extreme dyspnea on the morning of admission. Physical examination revealed an acutely ill woman with a temperature of 40°, pulse 120, and respiration 24. The pharynx and larynx were covered with a thick yellow exudate. The respirations were noisy but there was no
retraction of the interspaces. There was slight cyanosis of the skin and mucous membranes. Otolaryngologic consultation revealed moderate edema of the larynx. Four hours after admission she became extremely cyanotic and her pulse became irregular. An emergency tracheotomy was performed but gave only temporary relief and death occurred five hours after admission.

Postmortem No. 8506. The gross findings in this case were inconspicuous. All of the lymph nodes were slightly to moderately enlarged and on section revealed a finely granular grayish pink bulging cut surface. The kidneys weighed 100 grams and 85 grams each. Throughout the cortex there were numerous pale yellowish gray nodules measuring up to \( \frac{1}{2} \) mm. in diameter. The cortical striations were irregular and distorted. The mucosa of the urinary bladder was reddish purple in color and thickened. There were firm areas of consolidation in all lobes of the lungs. The heart was essentially normal.

Microscopically, there were characteristic lesions in the small blood vessels of the kidneys, adrenals and urinary bladder. These lesions consisted of necrosis in the walls of the arterioles and infiltration of the wall and surrounding tissue with polymorphonuclear leukocytes. In many vessels there were recent thrombi. The lymph nodes showed non-specific hyperplasia and the areas of consolidation in the lungs were foci of bronchopneumonia.

Discussion. Histopathologically, this case is a typical example of disseminated lupus erythematosus. The clinical history was not sufficiently characteristic to make the correct diagnosis. The necrosis, thrombosis and inflammation of the arterioles in numerous organs are pathognomonic of the disease. The case illustrates the fact that disseminated lupus erythematosus is a generalized disease and is not always associated with skin lesions. It is of interest that there was no evidence of tuberculosis, because in about one-half of the reported cases there is an active tuberculous process, usually in the lymph nodes. The characteristic lesion in the kidney (the wire loop lesion of the glomerulus) was present but was not a conspicuous feature (Tr. Assn. Amer. Physicians, 50: 139, 1935). This patient was a woman, which bears out the findings in the literature that disseminated lupus erythematosus is extremely
rare in men. The not infrequently associated lesion of atypical verrucous endocarditis as described by Libman and Sachs was not present. (Tr. Assn. Amer. Physicians, 38: 46, 1923).

LIPOID NEPHROSIS

History No. Q-832. A 4 year old white boy was admitted to the Children’s Hospital on May 3, 1940 because of a severe sore throat and cough which had been present for 6 days before entry. For 1½ years he had had intermittent edema of the entire body with occasional sore throats. During the past 6 days the edema had increased and involved the face, extremities and trunk. Physical examination revealed a listless almost moribund white boy with a temperature of 37.5. There was edema of the face, eyelids, back and lower extremities. The skin was pale. There was slight dullness to percussion over the left posterior half of the thorax with numerous rales both posteriorly and anteriorly. The heart was normal and the blood pressure was 110/70. The abdomen was distended and a fluid wave could be demonstrated. Abdominal paracentesis yielded 1200 cc. of yellow cloudy fluid in which there were many gram positive diplococci. Treatment with sulfapyridine was instituted but he died within 12 hours of admission to the hospital.

Postmortem No. 8652. The right kidney weighed 110 grams and the left kidney 120 grams. The capsules stripped with ease, leaving a smooth light yellow surface. The parenchyma was soft in consistency and the cortices were thickened. All of the vessels on the surface and in the substance of the kidneys were dilated. The pelves, ureters and bladder were normal. The peritoneal cavity contained 1000 cc. of cloudy light yellow fluid, the pleural cavities 500 cc. each of similar fluid and the pericardial cavity 150 cc. of similar fluid. There was edema of all of the subcutaneous tissue of the body. In all lobes of the lungs there were foci of bronchopneumonia. Microscopically, in the kidneys, the tubules were dilated and the renal epithelium in the proximal convoluted tubules was finely vacuolated. Frozen sections showed that this vacuolization was due to anisotropic fat. The basement membrane of the glomerular capillaries was slightly thickened. In one glomerulus in 4 sections, there was a typical crescent. Cultures of the
heart's blood, lung, and fluid in the pericardial cavity and peritoneal cavity revealed pneumococci.

Discussion. This patient illustrates many of the characteristic features of lipoid nephrosis; hypoproteinemia, reversal of the albumin-globulin ratio in the plasma, hypercholesterolemia, massive edema with periods of remission, marked albuminuria, no hypertension and death from pneumococcal peritonitis.

Since the original description of lipoid nephrosis there has been discussion among pathologists as to whether or not there are histological alterations in the glomeruli. In other words, is lipoid nephrosis an early stage or special type of glomerulonephritis? A positive answer can not be given to this question at the present time. Bell (Am. J. Path. 5:587, 1929) described thickening of the basement membrane of the glomeruli, a change which was present in this case. Others have described proliferation of the glomerular epithelium and endothelium as was found in one glomerulus in this case. Careful follow-up studies of patients with lipoid nephrosis may throw light on this problem.

The recent finding by Farr and MacFayden (Am. J. Dis. Child., 59: 782, 1940) of hypoaminoacidemia in children with the nephrotic syndrome has opened a new field of investigation.

BANTI DISEASE WITH OBLITERATION OF THE PORTAL AND SPLENIC VEIN

History No. 42412. A 36 year old white man was first admitted to Barnes Hospital on March 7, 1934. At that time he had a pansinusitis from which he recovered in 7 days. Four years previously, he had had a splenectomy for Banti's disease. Following the operation he made an uneventful recovery and the only abnormal sign found in the abdomen in 1934 was a slight enlargement and firmness of the liver.

He was admitted to the Barnes Hospital for the second time in November, 1939 because of a sore throat, rhinitis, a constant epigastric pain, diarrhea and increasing jaundice. These symptoms had been present for four days. Physical examination revealed an acutely ill man with a temperature of 39°, pulse 100 and respirations 20. There was slight jaundice. The lungs and heart were normal. The liver was moderately en-
larged and was soft and tender. The significant laboratory findings were: white blood cells 22,150 with 50% stab forms; and icteric index—80. After a course of one month in the hospital, the patient was discharged improved.

On January 4, 1940, he was readmitted to the hospital and an intravenous cholecystogram showed a pathologic gall bladder. The prothrombin time was normal and the bleeding time was 10½ minutes. A liver function test showed 21 percent retention. There was still a slight icteric tint to the skin and the liver was firm but not tender. At operation, the liver was found to be large and nodular. There was extensive collateral venous circulation about the hilum of the liver. A cholecystectomy was performed and the post-operative course was stormy with eventual improvement and discharge from the hospital on February 15, 1940.

After his return home, he began to have chills and fever, at first every two or three days and later every day. The urine was bloody and he began to vomit. Physical examination on the last admission to Barnes Hospital on March 12 revealed an acutely ill man with a temperature of 40°. The liver was palpable 6 cm. below the costal margin. There was questionable shifting dullness in the abdomen. The significant laboratory data were: red blood cells, 3,230,000; hemoglobin, 68 percent; white blood cells, 47,100; total protein 5.1 with an albumin-globulin ration of 1:1. The urine was grossly bloody with albumin and casts; an intravenous P. S. P. gave only a faint trace of the dye in the urine at 60 minutes; and the blood N. P. N. was 85 mg. percent.

During a period of about one month in the hospital the N. P. N. gradually rose to 200 mg. percent and the red blood cell count fell. There were an increasing tendency toward coma and occasional muscular twitchings, and the patient died on April 10, 1940.

Portmortem No. 8623. The liver was large and weighed 2300 grams. It was firm in consistency and the parenchyma was composed of nodules of brown tissue varying from 2 to 4 mm. in diameter. The portal and splenic veins were completely obliterated and represented by a fibrous cord with foci of calcification. The hepatic artery was at least twice as large as normal and the branches of the hepatic artery in the liver
were conspicuous. All of the veins in the wall of the esophagus and stomach and in the omenta, diaphragm and capsule of the liver were dilated. In the common bile duct adjacent to the obliterated portal vein there was a scar which caused moderate stenosis of the bile duct. The kidneys were greatly enlarged and each weighed 420 grams (normal-150 grams). The cortices were red with numerous small petechiae on the surface and on the cut section. There were foci of bronchopneumonia with abscess formation in the left lower lobe.

Microscopically, the liver was the seat of a cirrhosis of the usual nodular or Laennec type. The portal vein was a mass of dense fibrous tissue with small foci of calcification. The kidneys showed the typical picture of subacute diffuse glomerulonephritis.

Discussion. There are two apparently independent diseases in this patient. The immediate cause of death was the subacute glomerulonephritis possibly related to the respiratory infection. The obliteration of the portal and splenic vein and the history of a splenectomy for Banti’s disease raise problems which can not be settled with certainty. The surgeon who removed the spleen made no observations on the splenic or portal vein at the time of the operation. Although the lesion in the veins is old, it is impossible to say that it was present 10 years ago. The relationship of so called cavernous transformation of the splenic vein and Banti’s disease is becoming more evident. More observations of this type would serve to elucidate at least in part the obscure nature of Banti’s disease.

This case further demonstrates that complete occlusion of the portal vein is entirely compatible with life, especially if it be brought about slowly.

CARCINOMA OF THE ESOPHAGUS WITH JAUNDICE

History No. 80185. A 65 year old white man was admitted to the Barnes Hospital February 7, 1940. Ten months before admission he had first noticed difficulty in swallowing. There was no pain. For a period of 8 months only liquid food could be taken. Three days before admission complete obstruction of the esophagus developed and the patient had noted a gradually increasing jaundice for the last few weeks. There had been a loss of 65 lbs. in weight in the last year. Two brothers
died of cancer. Physical examination revealed an emaciated and dehydrated man with marked jaundice. One lymph node in the right supraclavicular fossa was enlarged. The lungs and heart were essentially normal. The liver extended 1 cm. below the right costal border and there was slight tenderness in the right upper quadrant of the abdomen. Esophagoscopy revealed a polypoid growth filling the lumen 39 cm. from the upper incisor teeth. The histological diagnosis of a biopsy of the tumor was epidermoid carcinoma. Intravenous fluids and blood transfusions were of little avail and the patient died 10 days after admission.

Postmortem No. 8547. On an anterior wall of the esophagus at the level of the bifurcation of the trachea there was an irregular ulcerated tumor mass measuring 3.5 by 2 cm. The adjacent lymph nodes were enlarged and composed of firm white tissue. There was similar enlargement of the periaortic, peripancreatic and portal hepatic lymph nodes. There were small tumor nodules in the liver, right adrenal, skin, pleurae and in the wall of the stomach. One of the lymph nodes adjacent to the common bile duct had extended into the lumen of the duct and produced advanced stenosis. The bile ducts above this point were dilated and the liver showed the typical appearance of obstructive biliary cirrhosis. There were small foci of bronchopneumonia in all lobes of the lungs. Microscopically all tumor nodules were composed of irregular masses of cells typical of epidermoid carcinoma.

Discussion. The gross and microscopic appearance of the primary tumor of the esophagus in this case is typical. However, the metastasis to a lymph node about the common bile duct with stenosis of the duct and the resulting jaundice is distinctly unusual. The immediate cause of death was bronchopneumonia.

Carcinoma of the esophagus is typically a disease of older men as illustrated in this patient. It is of interest that two brothers of the patient died of cancer.
Department of Pediatrics

At the Clinical Conference held at the St. Louis Children’s Hospital amphitheatre on April 11, 1940 two cases of peritonitis who had recovered following the use of some of the chemotherapeutic agents of the sulfonamido group of drugs, with surgical drainage when localization developed, were presented.

From one case a non-hemolytic streptococcus was isolated and from the other a pneumococcus type I. The first patient was a white male, 16 months of age, who was first seen in the hospital in May, 1939, with what appeared to be a generalized peritonitis. He was treated conservatively, given parenteral fluids and sulfapyridine, at first intravenously as the sodium salt and later by mouth. This was followed by gradual improvement in the patient’s condition. Gradually, however, he developed a mass in the left lower quadrant and this had to be incised. A large amount of pus was obtained and a non-hemolytic strep. cultured. The patient returned about 3 months later because of the development of a mass in his right flank. At this time he was once more treated with sulfapyridine and the abscess incised. Once more a non-hemolytic strep. was isolated. The mass in the right lower quadrant has recurred several times associated with high fever and each time that this happens the abscess spontaneously discharges through a fistula in the incision in the right loin and promptly the symptoms disappear. At the time of admission, just such a train of events had transpired. At the conference it was decided that, in this instance, a rather prolonged course of chemotherapy should be instituted in an attempt to eradicate the infection completely. During the present admittance the patient was given sulfathiazol.

Carmel G, age 3 years was admitted in February, 1940 following an illness of 12 days which was thought to be a pneumonia, by the attending physician. The pneumonia cleared up but following it the patient again began running a septic temperature and she was admitted to the hospital. At this time she was found to have a mass in the right lower quadrant which appeared quite tender. It was palpable per rectum. The temperature rapidly subsided following institution of sulfathiazol.
methylthiazol. The fever recurred, however, and incision and drainage of the mass was performed. Pus was obtained. Prior to operation, aspiration of the mass was undertaken. Pus was aspirated and type I pneumococcus isolated from this material. Following operation the mass in the right lower quadrant disappeared and the temperature became normal. However, very soon after this she began developing a mass suprapubically in the left lower quadrant, associated with a septic temperature course. At this time the sulfamethylthiazol was discontinued and sulfathiazol instituted. This was followed by rather prompt fall in the temperature course, associated with marked clinical improvement, and disappearance of the mass. At the time of presentation the patient’s temperature had been normal for a period of two weeks and she was ready to be discharged.

James O., age 14 years, was a white boy, who on admittance, had a history of increasing pain in his neck for 10 days. At the time of admission his head was held deviated to the right side and there was extreme tenderness on palpation of that side of the neck. In the pharynx there were redness and fullness on the right side. X-rays showed fullness in the retropharyngeal space, along with a rotary subluxation of the first cervical on the second cervical vertebra. The infection in the pharynx, from which we isolated streptococcus hemolyticus, subsided under sulfathiazol and this was associated with marked clinical improvement. Movement of the head and neck returned to normal and the fullness in the retropharyngeal space disappeared. The question arose as to whether the mass in the retropharyngeal space was infection, or merely edema and spasm of the retropharyngeal muscles.

**Department of Neuropsychiatry**

**“THREATENED NERVOUS BREAKDOWN”**

Case presented by a fourth-year medical student, who had been following the patient in the Neuropsychiatric Outpatient Clinic.

The patient was a 23-year old woman who had first come to the Clinic about six weeks previously with the complaint of having had, during the past six years, feelings of fatigue, ex-
haustion, and lethargy, accompanied by feelings that she is
dying or dissolving into nothing and by fearfulness and emo-
tional instability. During the past ten months there had been
periods of vomiting with weight loss.

Her illness had started in 1934 when her mother had refused
to allow her to continue in school. At this time she had told
her mother that she would have a nervous breakdown if she
did not go to school. Her symptoms have been persistent since
that time. She remained at home, at times was very fearful,
with many anxieties and much emotional instability, and would
remain in bed for long periods. She did little about the home
and had few contacts or activities outside the home, spending
her time reading or sitting, preoccupied with her own thoughts.
About a year ago she had improved temporarily while she was
ill with mumps, but in June, 1939, she had recurrence of in-
tense anxiety and fears, while her mother was ill in a hospital.
She feared that her mother would die. To reassure the mother,
she visited her daily and brought verses. The self-centered
nature of her concern is indicated by one of these poems:

Saturday, July 1, 1939

Dearest Mommie,

1. If I could pave a road into your mind,
   I know just what I would discover
   My loneliness is echoed there
   Your love for me I'd find.

2. I'd find a garden where the flowers
   Are sprayed with your undying love
   I'd find a shrine where all your pray'rs
   Are written there for one above.

3. I'd find pictures of your loved ones
   Your sweet loyalty I'd find
   And all your love and sweet caresses
   If I could pave a road into your mind.

   All my love,
   Blanche

After her mother's recovery, however, she continued in this
anxious, unstable emotional state. She states that because of
vomiting she was treated for gall bladder trouble and because of nervousness she was treated for ovarian cyst. At this time she felt that she was about to dissolve into nothingness or to slip off the world, which she illustrated by drawings.

Because she showed no improvement she was taken to New York City by her uncle, where she continued to be fearful, particularly of the tall buildings, and where she was very unstable emotionally. She was seen in a psychiatric clinic there, where it was felt that she showed a great many anxiety symptoms with hysterical features. Treatment by physicians near her home was recommended. Since she felt no better on her return home, she followed their suggestion and came to the Clinic.

The following information about her family and past history was obtained from the patient and her mother and aunt:

The patient is the oldest of three siblings. Her father and mother were both born in Mexico. Little is known about the father’s family. He became a fairly successful exporter, but came to this country in 1924 to work with a manufacturing company. He returned to his business in Mexico two years ago. Although separated from his wife since the patient was ten years old, he has continued to send money, in diminishing amounts, toward the support of the wife and children.

The mother came from a socially and economically prominent family of French and Spanish extraction. This family was a clannish and closely knit group. The mother was the oldest of the family and has always been very dependent on and devoted to her relatives, particularly since separation from her husband. She has been a dependent, inadequate individual all her life.

The patient’s family group is now made up of the patient, her mother, a devoted aunt, who makes large contributions to the maintenance of the home, and a 20-year old brother, who is described as very obese, listless, and dependent. A second brother, two years younger than the patient, died 7 years ago. Neither patient nor mother have ever recovered from the grief over his death.

The patient was born when her mother was very unhappy because of marital discord. Her birth and early development are said to have been normal. Her early home life was marked
by parental disagreement and frequent separations, which finally became permanent when the patient was 10. At this time she first was observed to be fearful and emotionally tense and unstable. From early childhood, she was constantly protected by mother and aunt, never sleeping alone and never being given the opportunity to do even little things for herself. She was devoted to her father while he was in the home and to the younger brother who died. She has been completely dependent on her mother and has been jealous of her mother’s affection for her aunt.

She attained the second year of high school, doing only fair work and developing few activities or social contacts except for a short time at the age of 15 when she became active in sports. After her brother’s death, however, she became very fearful and apprehensive and remained in bed all summer. She wanted to return to school the following year, but her mother would not allow it and she has been ill since that time.

On her first visit to the clinic she was pale, apprehensive, withdrawn and uncommunicative, expressing a hopeless attitude about her illness. Physical and neurological examinations were essentially negative, except for a slight systolic cardiac murmur. It was considered advisable to follow her for study and treatment in the Neuropsychiatric Clinic.

During her bi-weekly visits to the clinic she was encouraged to talk about her symptoms, about her family and her feelings toward its different members, and about her interests. She became more friendly and less withdrawn and more willing to talk about her interests and activities. At times she became rather resentful toward her physician, saying that she was not feeling better and blaming the physician for not doing anything for her. On several occasions she expressed the desire to be in a hospital. She expressed considerable resentment against her mother and aunt, and to a lesser degree against her father.

Much of the time was spent talking about her interests and activities. She had vague ambitions to be a physician or an artist. She could do rather good needlework and crocheting and brought in samples of her drawing and of her handiwork. (Some of these were exhibited in the conference.) During this time she seemed to improve considerably. She began to take
more interest in activities, going to movies, occasionally, playing cards, etc. She took considerable interest in telling her physician how to make Mexican tortillas and on several occasions brought some of these in for him.

Discussion. Dr. Whitehorn asked what had been the principal change in her condition, to which the student replied that she could become interested in things outside herself and her symptoms and could carry on an animated conversation about her interests.

Dr. Whitehorn asked if the patient had forced the student to commit himself as to what he expected to do for her. He replied that he had tried to answer her questions by giving her scientific explanations for her symptoms, but whenever these were inadequate she would comment, "I must be crazy because I feel this way."

Dr. Schwab inquired about the details of the patient's blaming the student for her illness, but there seemed to be no indication of an unduly suspicious attitude on her part.

Dr. Whitehorn inquired concerning the periods when the patient has felt better. The student indicated that she never admits feeling better, but on her better days does not mention her symptoms.

Mrs. Beckmann expressed the opinion that the mother is an even more difficult person than the patient.

Dr. Schwab emphasized the point that the patient by her illness controlled the organization of the home. He and Dr. Whitehorn discussed the importance of the girl's hostility against her mother, conflicting with her emotional dependence on the mother.

Dr. Whitehorn suggested that in such cases it becomes advantageous to the therapist to make clear to the patient that he is not working toward curing her of her distress, but to help her to a way of living which is more satisfactory and that in such a course her distress may become less. This may divert the conversation away from symptoms and avoid accusations that nothing is being done. The possibility of the patient's feeling worse during treatment may also be pointed out to her. It was indicated that this had already been done. The advisability, but the impracticability, of separating mother and daughter was pointed out.
The student asked what should be done to help the mother, and Dr. Whitehorn suggested that, because of her own neurotic problems she be treated by another physician.

Department of Otolaryngology

The final session of the 1939-40 series of Clinical Conferences, in the Department of Otolaryngology, was held Thursday, May 16th.

These conferences were held in the Medical Amphitheatre in Barnes Hospital each Thursday morning.

In addition to the presentation of clinical cases by members of the staff and reports and demonstrations of the research problems being investigated by the department, the privilege was enjoyed of listening to the following members of other departments of the school:

- Doctor Robert Moore opened the series on January 11th.
- Doctor David P. Barr spoke on March 14th on the subject of “Arthritis.”
- Doctor Bronfenbrenner spoke on March 21st and March 28th on the subject of “Immunology.”
- Doctor Evarts Graham spoke on April 4th on the subject of “Bronchiectasis and Lung Abscess.”
- Doctor Hugh McCulloch spoke on April 11th on the subject of “The Relationship of Nose and Throat Foci to Joint and Heart Involvement in Rheumatic Fever.”
- Doctor E. V. Cowdry spoke on April 18th on the subject of “Virus Diseases.”
- Doctor Alexis F. Hartmann spoke on April 25th on the subject of “The Theory and Practice of Supportive Fluid Administration in the Treatment of Severe Infections.”
- Doctor Joseph Erlanger spoke on May 2nd on the subject of “Sound Production in Fluid-filled Elastic Tubes.”
- Doctor Hartmann spoke on May 9th on the subject of “Chemotherapy of the More Severe Nose and Throat Infections, Including Lateral Sinus Phlebitis and Otitic Meningitis.”
- Doctor Lawrence Post and Doctor Adolph Conrad both spoke on May 16th. Doctor Post spoke on the subject of “Retrobulbar Neuritis” and Doctor Conrad spoke on “Oral Manifestations of Skin Diseases.”
The Medical Library

The following alumni were recent visitors in the library:
Dr. W. D. Balfour of Kealia, Hawaii.
Dr. H. M. Chandler of Waipahu, Hawaii.
Dr. W. E. Patton, of Little Rock, Arkansas.
Dr. L. A. Scarpellino of Kansas City, Missouri.
Dr. V. T. Williams of Kansas City, Missouri.

Recent book additions are as follows:
Goldzieher, M. A. The Endocrine Glands. N. Y. & Lond., 1939.
Rashevsky, N. Advances and Applications of Mathematical Biology. Chicago, 1940.
Sulzberger, M. B. Dermatologic Allergy. Springfield, 1940.

The library is the recipient of the following gifts:
Dr. Daniel Drake's Letters on Slavery, to Dr. John C. Warren, of Boston. Reprinted from the National Intelligencer, April 3, 5 and 7, 1851. N. Y., 1940. Gift of Dr. M. B. Clopton.
342 bound volumes of periodicals, the gift of Dr. Clopton.
10 books, the gift of Dr. M. H. Post.
Book Reviews

Modern Medical Therapy in General Practice

By David P. Barr, M.D., Professor of Medicine, Washington University School of Medicine. 3562 pages, three volumes, cloth, $35.00. The Williams and Wilkins Company, Baltimore, Maryland.

Knowledge in medicine has been progressing steadily during the present century, with a continued effort and advance along the entire line of attack, but nevertheless with thrusts first on one front and then another.

Pathology, physiology, the study of the natural history of disease, diagnostic methods, and the discoveries in etiology have all enjoyed their thrusts in this attack on disease. The present generation is witnessing remarkable gains in treatment, largely the fruit of previous advances in other lines.

"Modern Medical Therapy in General Practice" is a very complete compilation of the present knowledge of treatment. It fills a long felt want of the practicing physician. He has too often been disappointed when he has hopefully referred, for help and details in treatment, to his text-books and various loose-leaf systems of medicine. These very naturally leave treatment to the end of the chapter, and there always seems to be a let down when this is reached, as though the tremendous efforts in detailing etiology, symptoms, and diagnosis allowed treatment—if any—to take care of itself, or possibly to be left in the hands of the family physician.

Well, both the old family physician and the internist can find just what they want in "Modern Medical Therapy in General Practice." Dr. Barr has seen to it that we can find out not only what to do, but how; and on the best authority.

Inevitably the work is long. It comprises three good sized volumes. It is this which permits space for the very details of treatment for which we have been searching. But it is good reading, even when one is not looking for (and finding) the solution of a specific problem of treatment.

Dr. Barr has with great success accomplished a monumental work, which will further spread the name and fame of the Department of Medicine of Washington University.

S. B. G.
Doc’s Wife


Many a girl who is considering marrying a doctor would do well to read “Doc’s Wife.” It is not a novel, rather it is the recollections of one who, a medical school graduate herself, married a “country doctor” and learned to adapt herself successfully, often simultaneously, to the roles of wife, mother, office secretary, and (on rare occasions) pinch hitter for the doctor when circumstances required his presence in two places at once.

Mrs. Lewis had worked for a year after graduation under Dr. Arthur E. Hertzler, of whom she speaks with the greatest admiration. Marrying “P. B.” (her name for her husband) she went to live in the small Iowa town where he had already started to practice. They learned to like the town and its people. Their children were born there. But five years later, having “arrived,” the Lewises, according to their prearranged plan, bravely moved to a nearby larger town where the field was larger and the competition much keener. They managed to survive and thank their stars for their decision.

Rambling, but very well written, Mrs. Lewis’ narrative moves along easily, enlivened by deft accounts of the impact of small-town life on the city-bred Lewises, and of themselves on the small town; of the humorous, oftentimes irritating situations the doctor was frequently confronted with, which as a professional person his wife could thoroughly understand; and of the constant conflict between practice and social life (which sometimes caused her to forget all professional understanding).

One judges from Mrs. Lewis’ book that there have been few dull moments, and that theirs has been a happier and more satisfactory life than most, and had they to do it all over, they would make the same choice.

Faye Cashatt (the author’s maiden name) was the first woman to matriculate at the Washington University School of Medicine, the second one to be graduated from the School. Her husband is Dr. William Benjamin Lewis, also of the class of ’21 of this school. They live in Webster City, Iowa.
Alumni News

Dr. Amand Ravold, St. L. '81, has been elected permanent president of the "Chef's Cap" a cooking class (for men only) conducted by the Adult Study Center of Washington University.

Charles S. Huffman, Mo. '90, who is celebrating this year his fiftieth anniversary of graduation, has had a full life. He served in the Philippines as captain and assistant surgeon of the 20th Kansas U. S. volunteers during the Spanish American War. Elected Kansas State Senator in 1904, he served continuously in that capacity until 1918 when he was elected Lieutenant-Governor of the State. He was re-elected in 1922 and served as Adjutant General of Kansas during the World War. He served for six years on the Kansas State Board of Administration.

H. G. Horstman, Mo. '95, 1003 Chestnut Street, Murphysboro, Illinois, is in general practice with a special emphasis on tuberculosis. He is a member of the Jackson County, the American Medical and the Illinois State Medical Associations, is a councilor of the Tenth Council District for the latter organization.

H. Franklin Moore, '98, writes that he is by choice a general practitioner in a town of 4,500, Bethel, Connecticut, in the Southern Berkshires, and that he has never regretted his choice. He specializes to some extent in ophthalmology and for many years has held the offices of Coroner, Medical Examiner, and Health Officer, and until recently was a member of the School Board. He has one son, a student in the dental department at Temple University.

Charles A. George, '03, Springfield, Missouri, recently retired from the office of Health Commissioner of that town.

The late Joseph Mayes, '04, St. Louis, is the father of one of the members of the 100 piece orchestra chosen by Leopold Stokowski to go on a South American orchestra tour this summer. His name is Samuel Mayes and he has just completed his fourth season with the Philadelphia Symphony Orchestra of which he is first cellist.

C. F. DeGaris, '12, is Professor of Anatomy at the University of Oklahoma School of Medicine. He was elected a Fellow of the American College of Physicians at the April meeting of the College.

Leith H. Slocumb, '13, recently opened an office at 448 South Hill Street, Los Angeles, California, for the practice of proctology and gastroenterology.

H. H. Jones, '15, Winfield, Kansas, with Mrs. Jones recently spent a day visiting the School and renewing acquaintances. Dr. Jones is in the practice of internal medicine.

E. R. Kellersberger, '15, of Biauga, Belgian Congo, Africa, writes that he hopes to be in the United States towards the end of this year and expects to be in St. Louis. Many will look forward to the home coming of this far-wanderer and we hope that recent events in Europe will not alter his plans.

Lee D. Cady, '22, St. Louis, is President, and Scott Johnson, '24,
New York, is Vice-President of the Associated Diplomates of the National Board of Medical Examiners. Earl C. Padgett, '18, Kansas City, has been appointed a member of the recently organized committee for Missouri.

Walter B. Hoover, '22, Boston, writes: "I don't believe there is any real news about me. We are all working at the Lahey Clinic, struggling to keep up with medical progress."

George V. Feist, '23, of Kansas City, major in the Medical Reserve Corps, was elected Surgeon General of the Reserve Officers' Association of Missouri at the annual convention held at Columbia, May 17.

Ben May Bull, '23, Ironton, Missouri, was married to Miss Ann Rogers of St. Louis April 23.

Joseph W. Gale, '24, associate professor of surgery at the University of Wisconsin Medical School, and member of the American Board of Surgery, was one of the distinguished out-of-state guests at the Missouri State Medical Association meeting held in Joplin, April 29-May 1.

Clinton K. Higgins, '27, is Chief Executive of the Fly Casting Association of America.

Sidney O. Levinson, '27, is the Director of the Samuel Deutsch Convalescent Serum of the Michael Reese Hospital, Chicago.

The class of '27 is well represented in the Olney Sanitarium. Paul Weber devotes most of his time to clinical surgery and H. N. Fisher is the chief of the eye clinic.

Eleanora Schmidt, '27, is the Director of the Student Health Service of the University of Oklahoma.

Justin J. Cordonnier, '28, and Mrs. Cordonnier are receiving congratulations on the birth of twins, a boy and a girl, April 18. This is the first increase in their family.

J. Lester Henderson, '29, 595 East Colorado Street, Pasadena, California, is specializing in psychiatry and is a member of the American Psychiatric Association as well the Los Angeles County, California State and American Medical Association. He recently published "Alcoholism: Its Psychiatric Treatment," California and West Medicine, 52; No. 1, 1940.

Donald T. Chamberlain, '30, writes that he enjoys his work in the gastroenterology department of Lahey Clinic, Boston, and that he and Mrs. Chamberlain like their part of the world. Spent their spare time riding, golfing and skating in winter.

Mary Schmeckebier, '34, owing to an attack of brucellosis, has for the past few months had to suspend her clinical activities and has been making St. Louis her locale. However, she expects to return soon to San Francisco where she has an appointment on the visiting staff of Children's Hospital and on the staff of Cooper Foundation for Medical Research. Her special interests are in pediatrics, medical research and public health. From 1936 to 1939 she worked as a Fleischner Fellow in the field of bacteriology and pathology and also did research in diphtheria immunity.

Richard Sutter, '35, St. Louis, is division surgeon and examiner for the Burlington Railroad. The Sutters have two children, John Otto, who is three, and a baby girl, seven and one-half months old.

Paul U. Hartman, '35, after an 18 months' senior residence in orthopedics at Milwaukee County Hos-
hospital, moved in December to Seattle, Washington, and has opened an office, 1319 Medical Building, in association with Dr. Roger Anderson. Sometime this summer he expects to establish an orthopedic practice in Southern California, probably in San Diego.

C. G. Porter, '35, Centerville, Michigan, writes: "Doing fine. Sixteen room house, office on the village square, and driving 20,000 miles a year in the country. Plenty of fishin' too."

Robert H. Swinney, '35, announces the opening of an office at 805 Stevens Building, Portland, Oregon, for the practice of general surgery.

A. J. Steiner, '35, writes: "Jerry Junior was born May 31. In spite of all I can say, he insists on going to Washington University for his M.D." Dr. Steiner has an office in the University Club Building, St. Louis, for the practice of general medicine.

Max Goldenberg, '35, and Miss Fanny Kingsbacker of St. Louis, were married November 12, 1939. Dr. Goldenberg has an office in the Murphy Building, East St. Louis, Illinois.

David Rothman, '35, Pasteur Medical Building, St. Louis, is engaged in the practice of obstetrics and gynecology. He was married in 1934 to Miss Frances Strauss and they have two girls, one four and one-half, and the other born February 22.

Alfred M. Harris, '35, Dallas, Texas, is in the Department of Medicine, Baylor University Medical School. Also, he is Assistant Physician at the Portland Hospital.

J. A. Wrenn, '35, 418 Kirkpatrick Building, St. Joseph, Missouri, is specializing in diseases of the chest. He and Mrs. Wrenn are announcing the birth of their daughter, Diane, on June 3.

Albert H. Krause, '35, S. B. A. Hospital, Topeka, Kansas, and Mrs. Krause are the parents of a son born January 11, 1940. They have one other child, a girl, two.

Announcement was made on June 1 of the engagement of Arthur B. Bortnick, '35, and Miss Pauline Quicksilver. No date has been set for the marriage.

Emmett J. Senn, '35, is in general practice in Herculaneum, Missouri. He and Mrs. Senn are the parents of a son, their first child, born April 20, 1940.

Bert M. Bullington, '35, is instructor in internal medicine at University Hospital, Ann Arbor, Michigan. He also has had for the past year and will have for the coming year a Fellowship in Medical Education with the W. K. Kellogg Foundation.

Arthur P. Echternecht, '35, I. U. Medical Center, Indianapolis, Indiana, sends regards to all "the old gang." He was married in 1938 and he and Mrs. Echternecht are now the proud possessors of their first child, a boy.

Jacob Katzzeff, '35, and Miss Ruth Breiterman of Brooklyn, New York, were married June 30. They will reside at 879 Lenox Road, Brooklyn.

R. H. McIlroy, '35, Pueblo, Colorado, and his wife became parents for the second time with the birth of a son January 30. Their other child, also a boy, is two years old.

Noland W. White, '36, is in general practice at 516 City National Bank Building, Centralia, Illinois. In February he received an ap-
appointment as Civil Aeronautics Examiner.

Charles A. Leech, '36, is assistant physician for Student Health Service at Missouri University. He is also in private practice specializing in internal medicine. He gives his address as 508 High Street, Columbia, Missouri.

Robert T. Tidrick, '36, is assistant resident at the University Hospitals, Iowa City, Iowa. He is married and has one son, Ralph Lawrence, nine months old.

Alexander Silverglade, '36, gives as his address Arroyo Del Valle, Livermore, California.

C. H. Epps, '36, has accepted a pathology residency with the State University Hospital, Oklahoma City, Oklahoma.

William H. Jacobson, '36, has received an appointment to the medical staff at Aultman Hospital, Canton, Ohio.

Stephen S. Ellis, '36, recently received an appointment to the plastic surgery service of the University of Oklahoma School of Medicine.

William R. Young, '36, will conduct a children's heart survey in the State of Utah for the State Board of Health during the next year.

Lawrence Breslow, '36, gives his address at 6748 North Ashland Avenue, Chicago, Illinois, and writes that all visitors are welcome.

Heinz Haffner, '36, has completed his year as resident surgeon at Barnes Hospital, St. Louis, and is going to open an office for the practice of general surgery at El Paso, Texas. He will be succeeded at Barnes Hospital by Dr. Samuel Harbison.

Jay L. Plymale, '36, recently took over the practice and offices of the late Dr. B. H. Taylor, 196 S. Main Street, Marion, Ohio, and is engaged in the practice of surgery and internal diagnosis.

F. Richard Crouch, '36, who is associated in practice with Dr. G. L. Watkins, '12, of Farmington, Missouri, is a frequent visitor to Barnes Hospital for the Friday morning Conference. The Crouch has a daughter, Virginia Ann, born February 24.

Lawrence Aronberg, '36, has chosen urology as his field of work and is now filling a two year appointment, which began in January, as resident in urology at Michael Reese Hospital, Chicago. He is a member of the St. Louis Medical Society.

Marshall W. Kelly, '36, who for the past year has been resident surgeon at St. Louis City Hospital, was married in June to Miss Frances Wolf of St. Louis. After a trip in the South, the Kellys will make their home in Jefferson City.

Ralph C. Peterson, '37, announces the opening of offices in the Fourth and Pike Building, Seattle, Washington, for the practice of general medicine.

William C. Pratt, '38, is resident in surgery at the Geisinger Memorial Hospital, Danville, Pennsylvania.

Aloysius J. Mullen, '39, has a surgical appointment at Fordham Hospital, New York, beginning this July.

Miles E. Foster, '39, has accepted a residency in pathology at Barnes Hospital, St. Louis, after completing a year's internship at Geisinger Memorial Hospital, Danville, Pennsylvania.
## 1940 Graduates and Internships

<table>
<thead>
<tr>
<th>Name</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>Ackerman, Albert A.</td>
<td>Jewish Hospital of St. Louis, St. Louis</td>
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<tr>
<td>Adams, George W.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<tr>
<td>Anscheutz, Robert R.</td>
<td>Department of Pathology, Washington University, St. Louis</td>
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<tr>
<td>Barton, Wesley, A.</td>
<td>Barnes Hospital, St. Louis</td>
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<tr>
<td>Biggs, Fred J., Jr.</td>
<td>St. Luke's Hospital, St. Louis</td>
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<td>Bishop, Marion Dale</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Bottom, Donald S.</td>
<td>Evangelical Deaconess Hospital, St. Louis</td>
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<tr>
<td>Bowen, Mary E.</td>
<td>St. Louis County Hospital, Clayton, Mo.</td>
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<tr>
<td>Brown, Seymour</td>
<td>Department of Pathology, Washington University Medical School, St. Louis</td>
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<tr>
<td>Budke, Harold</td>
<td>St. Louis City Hospital, St. Louis</td>
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<tr>
<td>Buehler, Carl T., Jr.</td>
<td>St. Luke's Hospital, Kansas City, Mo.</td>
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<td>Burns, Francis R.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Cayce, Lee F.</td>
<td>Nashville General Hospital, Nashville</td>
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<td>Clarke, Harvel B.</td>
<td>Huntington Memorial Hospital, Pasadena</td>
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<td>Crider, Russell J.</td>
<td>Barnes Hospital, St. Louis</td>
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<td>Cross, Roland</td>
<td>Research and Educational Hospital, Chicago</td>
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<tr>
<td>Crowell, Thomas</td>
<td>Virginia Mason Clinic, Seattle, Wash.</td>
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<td>Curtis, William S.</td>
<td>St. Luke's Hospital, St. Louis</td>
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<td>Davis, Frank L., Jr.</td>
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<tr>
<td>Delano, James G.</td>
<td>St. Luke's Hospital, St. Louis</td>
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<td>Dominick, Thomas B.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Dowling, Judson</td>
<td>Cincinnati General Hospital, Cincinnati</td>
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<td>Edwards, David R.</td>
<td>St. Luke's Hospital, Kansas City</td>
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<td>Esslingler, Arthur</td>
<td>St. Mary's Group of Hospitals, St. Louis</td>
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<td>Fernandez, Leabort R.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<tr>
<td>Fleming, Albert E.</td>
<td>General Hospital of Fresno County, Fresno</td>
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<td>Foerster, James M.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Friedman, Henry</td>
<td>Sinai Hospital, Baltimore, Md.</td>
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<td>Gallagher, John E.</td>
<td>St. Vincent's Hospital, Toledo, Ohio</td>
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<td>Galt, Charles E. J.</td>
<td>De Paul Hospital, St. Louis</td>
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<td>Garrett, Robert L.</td>
<td>Charity Hospital of Louisana, New Orleans</td>
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<td>Gillette, Perry C.</td>
<td>William J. Seymour Memorial Hospital, Eloise, Mich.</td>
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<td>Georger, Verne F.</td>
<td>Gorgas Hospital, Ancon, Canal Zone</td>
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<td>Goldring, David</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Gottschalk, Roger</td>
<td>Evangelical Deaconess Hospital, St. Louis</td>
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<td>Greaves, Fern</td>
<td>Hospital for Children, San Francisco, Cal.</td>
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<td>Gregory, Kendall</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Grindell, George A.</td>
<td>DePaul Hospital, St. Louis</td>
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<td>Growdon, James H.</td>
<td>Barnes Hospital, St. Louis</td>
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<td>Grunow, Otto H.</td>
<td>St. Luke's Hospital, St. Louis</td>
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<td>Guggenheim, Paul</td>
<td>Los Angeles County Hospital, Los Angeles</td>
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<td>Harris, Joseph B.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<tr>
<td>Hirst, Russell</td>
<td>Thomas D. Dee Memorial Hospital, Ogden, Utah</td>
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<td>Name</td>
<td>Hospital</td>
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<tr>
<td>Huntington, Margaret O.</td>
<td>Boston Children's Hospital, Boston, Mass. — Barnes Hospital, St. Louis</td>
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<tr>
<td>Iknayan, Herbert A.</td>
<td>Iowa Methodist Hospital, Des Moines, Iowa</td>
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<tr>
<td>Johnson, Charles</td>
<td>Medical Center, Jersey City, New Jersey</td>
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<tr>
<td>Johnson, Mary B.</td>
<td>Medical Center, Jersey City, N. J.</td>
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<td>Johnson, Robert H.</td>
<td>De Paul Hospital, St. Louis</td>
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<td>Jolly, Benjamin</td>
<td>Ohio Valley General Hospital, Wheeling, W. Va.</td>
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<td>Kallenbach, Glen P.</td>
<td>St. Luke's Hospital, St. Louis</td>
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<td>Kettenbach, Floralou</td>
<td>Charity Hospital of Louisiana, New Orleans</td>
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<tr>
<td>Kingsley, Sumner B.</td>
<td>Union Memorial Hospital, Baltimore, Md.</td>
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<td>Kinman, Lindell M.</td>
<td>St. Louis County Hospital, Clayton, Mo.</td>
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<td>Kitchen, Burton E.</td>
<td>San Francisco City and County Hospital, San Francisco, Cal.</td>
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<tr>
<td>Koch, Robert</td>
<td>St. Louis City Hospital, St. Louis</td>
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<tr>
<td>Landau, Richard L.</td>
<td>University of Chicago Clinic, Chicago</td>
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<td>Lindley, E. Herbert</td>
<td>St. Luke's Hospital, St. Louis</td>
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<tr>
<td>Long, Thomas S.</td>
<td>Missouri Baptist Hospital, St. Louis</td>
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<td>Love, William</td>
<td>Vancouver General Hospital, Vancouver, British Columbia, Canada</td>
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<tr>
<td>MacDonald, William C.</td>
<td>St. Mary's Group of Hospitals, St. Louis</td>
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<tr>
<td>Mann, James</td>
<td>Beth David Hospital, New York</td>
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<td>McCullough, Jerome</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>McFayden, Mary</td>
<td>Department of Pathology, Washington University, St. Louis</td>
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<td>Merrill, Robert L.</td>
<td>St. Luke's Hospital, St. Louis</td>
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<td>Mira, Joseph J.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Moore, Gordon</td>
<td>Barnes Hospital, St. Louis</td>
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<td>Obermeyer, Charles G.</td>
<td>Baltimore City Hospital, Baltimore, Md.</td>
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<td>Park, Oakley K.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Pearce, Lee J.</td>
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<td>Read, William T.</td>
<td>St. Anthony's Hospital, Oklahoma City, Okla.</td>
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<td>Rindskopf, Wallace, Jr.</td>
<td>Jewish Hospital of St. Louis, St. Louis</td>
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<td>Robertson, Howard T.</td>
<td>Denver General Hospital, Denver, Colo.</td>
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<td>Robinson, Leo D.</td>
<td>St. Louis City Hospital, St. Louis</td>
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<td>Rowland, Willard</td>
<td>Barnes Hospital, St. Louis</td>
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<tr>
<td>Sachar, Leo</td>
<td>Department of Surgery, Washington University Medical School, St. Louis</td>
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<td>Sale, Llewellyn, Jr.</td>
<td>Barnes Hospital, St. Louis</td>
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<tr>
<td>Savory, John H.</td>
<td>Hurley Hospital, Flint, Mich.</td>
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<tr>
<td>Sawyer, Harry W., Jr.</td>
<td>Southern Pacific Hospital, San Francisco</td>
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<tr>
<td>Schoen, Frederic L.</td>
<td>Jewish Hospital of St. Louis, St. Louis</td>
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<tr>
<td>Skinner, Ben</td>
<td>North Carolina Sanatorium, Sanatorium, N. C. — Duke University Hospital, Durham, N. C.</td>
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<tr>
<td>Skinner, John S.</td>
<td>Kansas City General Hospital, Kansas City</td>
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<tr>
<td>Slind, Ole</td>
<td>Providence Hospital, Seattle, Wash.</td>
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<tr>
<td>Smith, Joseph J.</td>
<td>Duval County Hospital, Jacksonville, Fla.</td>
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</tbody>
</table>
Name | Hospital
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Smith, Robert M., Jr.—New Haven Hospital, New Haven, Conn.
Strauchen, Gilbert W.—University Hospital, Minneapolis, Minn.
Strehlman, Benjamin G.—St. Louis County Hospital, Clayton, Mo.
Summers, Joseph S.—St. Louis City Hospital, St. Louis
Tomlinson, William L., Jr.—Cleveland City Hospital, Cleveland, Ohio
Wall, Walton—Wisconsin General Hospital, Madison, Wis.
Wathen, C. Barbaur—Charity Hospital of Louisiana, New Orleans
Wiley, Horace M.—St. Louis City Hospital, St. Louis
Wootten, Betsy
Wright, Sydney T.—Barnes Hospital, St. Louis
Young, Robert H.—St. Louis City Hospital, St. Louis

In Memoriam

Garnett S. Cannon, Mo. '94, Fornfelt, Missouri, died June 13, 1938, of angina pectoris.
William T. Coughlin, Mo. '01, St. Louis, Missouri, died May 22.
William D. Halliburton, Mo. '77, Moberly, Missouri, died February 22, 1939, of senility.
Moses Haynes, Mo. '77, Bingham, Illinois, died March 16, aged 90.
James Washington Helton, Mo. '97, Colony, Kansas, died July 24, 1938.
Thomas Guy Hetherlin, Mo. '93, Louisiana, Missouri, died September 4, 1939, of coronary thrombosis.
Andrew Kissel, Mo. '81, Belleville, Illinois, died in 1938.
Ottis Like, '11, Monroe City, Indiana, aged 58; died February 21, of cardiovascular renal disease.

John A. Mann, Mo. '76, Wellington, Missouri, died April 20, of hemorrhage of the bladder.
William Mardorf, Mo. '88, St. Louis, Missouri, aged 73; died May 5.
Joseph F. Mayes, '04; St. Louis, Missouri, aged 63; died June 27.
Ulvus L. Russell, '93, Los Angeles, California, died March 13, of myocarditis.
Elsworth S. Smith, Mo. '87, St. Louis, Missouri, died June 6.
Marvel Thomas, Mo. '84, Gillespie, Illinois, aged 84; died February 16, of cerebral hemorrhage.
Ira William, Mo. '96, Maitland, Missouri, died May 2, 1938.
Caleb Edwin Witt, Mo. '89, Little Rock, Arkansas, died April 23, aged 77.
James L. W. Young, Mo. '71, Portland, Oregon, aged 91; died April 29, of myocarditis.
Locations for Practice

Granfield, Oklahoma. Population 1500, adjacent to oil field. Has small, privately owned hospital. Doctor wants assistant who will eventually take over entire practice. Inquire of Dr. W. A. Fuqua, Box 267, Granfield.


Iberia, Missouri. Population 600. Community is without a doctor. Inquire of Mr. Chas. L. Brison.

Louisiana, Missouri. Inquire of Mr. J. S. Hickerson.


Kirksville, Missouri. Population 10,000. Inquire of Dr. F. B. Farrington, Kirksville.

Maitland, Missouri. Inquire of Mr. Ira Williams, Jr.

Norborne, Missouri. Take over practice of deceased doctor. Inquire of Mrs. A. E. Adkins, 601 S. Elm St., Norborne.

Opening for physician or surgeon. Inquire of Mr. W. R. Kessler, Hermann, Missouri.

Monroe, Wisconsin. Inquire of Mr. Albert D. Geigel, 1623 10th St., Monroe.


Hickman, Kentucky. Population 5,000. Inquire of Mr. C. P. Mabry, Hickman.