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OPPORTUNITIES FOR STUDY ABROAD AND AT HOME.

(Excerpts from address at the Atlas Hall, April 8, 1911.)

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I was asked to address the club on the opportunities there might be for an osteopath to practise in Europe, but that seems to me so narrow a topic to discuss, that I shall pass over it rapidly and dwell more on the opportunities for study abroad. Of course, there are only a few practitioners in Europe at present. Most of these are in the British Isles, and there are one or two in Paris. They have no legal standing there, but their position is very much the same as it was here before there were laws regulating the practice of osteopathy. That is, they can practise without being molested and have no trouble so long as they keep away from acute cases. That simply means that they are confining themselves to office practice and are refusing such cases as might die. There is usually sufficient chronic work to keep a man busy anyway, and so long as they follow this method they have no trouble whatever. In case a man was anxious to take acute cases he could arrange with a medical man to consult with him and sign death certificates if some of his patients did die. That is really a good thing to do and something that can, as a rule, be easily arranged, although a good many medical men do not want to consult with an osteopath.

But there is plenty of room for chronic work. The best chances, I should say, are in the British Isles, for there the authorities do not bother a man particularly. There would be more trouble on the continent, because there they look after other people's business more carefully. Yet, the man in France has no great amount of trouble, though in Germany there might be some difficulty. Even the medical men have trouble in Germany except when they confine their practice entirely to their own people. In Paris they confine their work to the American colony. Consequently, that explains why Dr. White has no difficulty in his practice. I don't believe the law would bother a person any if he exercised a proper amount of caution so that no patient died on his hands, and if he confined his practice to Americans. In

Great Britain there is not the least difficulty to contend with. As for a field, there is, of course, a great opening with practically no competition and a chance to practise among people who are willing to pay well for your services.

But now, what, in general, are the opportunities that an osteopath has for study during his vacations? Of course, a man does not stop studying when he gets his diploma. He must keep at work all the time in order not to lose what he has already learned and to keep up with the progress of the times. Every man feels it his duty, when he can do so, to take special courses along certain lines. What courses can you take, what can you get out of them, and of what good is the work to you? The special thing from which you can all get the most good is clinics.

The clinics in the big cities are the places where you can get at the most cases for diagnosis, and diagnosis is the thing we probably need most. You may study the textbooks faithfully, but that doesn't help you very much in your diagnosis, because the textbook and classroom work are not the same as the work at the bed-side. So it is desirable to see as many cases as possible. In that way your knowledge increases and your confidence grows. It is true that young physicians have cases that they think do not fit the texts. Of course, this is not so, but the symptoms do not seem the same at the bedside as they did in the book, and it is by seeing a large number of cases that you can fix the symptoms in your mind best. A man usually remembers his first case if he can actually see the patient and get the symptoms fixed in his mind. I remember one summer of taking one of the seniors who had finished in June into the clinics at Chicago. The case that was demonstrated was absolutely typical and the symptoms were all brought out. He was one of our good students, but when I asked him what he thought it was he guessed two or three times wrong. It was a typical case of meningitis. He had seen the opisthotonos, the Kernig's sign and all that sort of thing demonstrated, but had failed to make the diagnosis, and yet on examination I have no doubt that he could have written an excellent paper on meningitis. I have no doubt either, that he would never forget that first case, for that is what usually stays by us. Of course, you get some of this work here, a number of chronic cases and some acute cases. But with all the hard work that there is in the regular course the amount of practical work on actual cases you can get must necessarily be limited.

What in the line of clinics can we get in this country? In every large city there are clinics and in Chicago, for instance, the advantages

are unexcelled. The Cook County Hospital in Chicago is said to be the largest in the country. You are not allowed in the wards of the hospital, but can attend a system of clinics that are held every day in the year. Eight or nine cases are shown in the morning and several in the evening, and these cover the general field of practice except obstetrics, gynecology and possibly genito-urinary diseases. Practically everything else is demonstrated and discussed. These cases are demonstrated by a man who knows his work. They are discussed thoroughly and then taken aside so that anyone can go down and study the case at one side. The symptoms, differential diagnosis, prophylaxis and treatment are all given, and commonly they pass around slides of similar conditions, so that one can study the pathology of the disease. You can see there perhaps fifty different cases a week, and at that rate you would not have to be there a great many months before you would have learned a lot on diagnosis. And it is not hard work by any means, but rather a pleasant as well as profitable way to spend one's vacation. I can not imagine a better way of doing in this country. In addition to attending these clinics you can attend several other clinics. There are one or two of the medical schools that have summer clinics that you can attend, and so on. You can go to the lectures at the medical schools without expense; all you need to do is to go in, take your seat and say nothing. There is a charge at the hospital but it is very low. In regard to laboratory subjects our students here have had no trouble whatever in taking up any work they have wished. The University of Chicago is very liberal. They know there that you are serious and admit you without question. The fact that you are an osteopath has no especial weight with them. Any person can have the benefit of their facilities, and one of the great points about taking work there is the fact that so many departments are grouped under one roof. In the East, on the other hand, they are not so liberal in admitting students to the various courses, as a rule, and the various departments are more scattered, so that more time is lost in going back and forth. Then, those who want obstetrical work can get all of that they want. You can get the experience in handling the cases and all the cases anyone could possibly want.

So you see that in all of those general lines you can get a great deal in our own country, but doubtless a good many at some time will go abroad to spend your vacation and while there may want to do some studying, to do some work that will be of advantage to you when you return. So I shall discuss somewhat the conditions abroad, the advantages that are offered, and what you might

expect to gain. Of course, a person who does not speak German is at a disadvantage and cannot get nearly so much there as one who does understand the language. For the most part, the instructors do not speak English and the regular work, of course, is all done in German.

Nevertheless, private courses can be arranged to be given in English by an instructor who does speak the language. For this sort of work the instructor demands a minimum amount of money that three, four or five can split. The way this is done is about like this: you would go to an instructor who you knew spoke English and ask him to give you the particular course in English and ask him for one or two hours a day for a month. For such a course as that the price would be about ten dollars a man for six men for the month. Now suppose, for instance, you wanted some work on diseases of the heart and lungs. If you went to the man and gave him fifty dollars a month he would take you in with him half a day at a time. You could listen to every case of heart disorder in the hospital and you could get into the wards by yourself and spend as much time as you wanted, all day if you wished. Again, with two or three others the price for this work would be proportionally reduced. Or, if you wanted him to show you two heart cases a day for a month you could get them with five other persons for ten dollars. That would mean over fifty cases that you would have a chance to examine and hear discussed fully from every standpoint, and it is well worth while. Then besides this, you could put in another hour a day on lung cases, and so on, with different hours. There is no limit to the amount of work you can do. You can put in four, six or eight hours a day—just as much as you want to do. The most can be gotten with the least expenditure by understanding German because, as a rule, there are not enough men who want to take the courses in English so but that there is some expense involved, and then again, most of the men could not give instruction in English if they would. Nevertheless, one can get a great deal there at a reasonable expense without knowing the language.

In the laboratories you can get work much the same as in the medical schools in Chicago, but Vienna has the best work in pathology that can be gotten anywhere in the world. There they have five or six post mortems daily. The method of procedure is about like this: first, the clinical history of the case is given in full, the disease is discussed from the standpoint of the pathological changes that are to be expected, and then the autopsy is performed. Slides are made and examined, and the gross and minute pathology are discussed in detail. So for pathology the facilities are better and the clinical material is

gotten at better there than they are in this country. The hospitals, too, are handled quite differently. In the hospitals here you can get only at the clinics, you do not have access to the wards; but there you can get into the wards and make bedside examinations. They keep the cases in the wards just as long as any interest is shown in them. Unless some interest is shown a case may be taken out of a ward very soon after it is placed there, but if a person is watching the new cases as they are admitted he can see and examine them all. There is no chance that an osteopath cannot get all the knowledge there that there is to be gotten. He can get just the same work that a medical man can get and just as much as he wants. For clinics and the work that is of value to the general practitioner the opportunities are great here. But there anyone can attend the universities and no questions are ever asked. You don't have to have any qualifications or anything of that sort, and the only expense is that for board and lodging. Of course, you don't get any certificate for the work you may do, but that is not what you are after. And all you need is to use your ears—if you know German.

The main point I wish to make is that the work to be gotten over there is not better than what you can get right here from the standpoint of the general practitioner, and is more expensive for a man who is not familiar with the language. On the other hand, if one wants to become a specialist along one line, as in pathology, the advantages to be gotten in the great German universities are greater than in this country. So much for the opportunities for study.

It is always rather interesting to know what others think of us as osteopaths. The Germans don't know the word "osteopathy," and the nearest they can come to it is "a mechanical method of healing," which to them means principally Swedish movements. Many of these practitioners go to Europe from Sweden and a great many go from Europe to Sweden to study the system of practice. You find a great many of them abroad. Now the system of Swedish movements is a very limited specialty and is to be regarded as such, so that as far as a system of treating disease from the mechanical point of view is concerned, a system like osteopathy that covers the entire field of practice, they don't know anything about. I didn't tell too much about myself while I was there, for the reason that I was so closely associated with so many medical men that it would not have been to my advantage to have done so, but I can say that without exception I got favorable opinions of osteopathy from the medical men whom I met. Most of them could tell of cases in their own families or among their friends that had received ben-

efit from osteopathic treatment. They admitted this in private in almost every case. That shows the difference between the feelings the medical man displays in public and the true feelings which he discloses to his brother practitioner. So you may know that whatever your medical man in the same town with you may say about osteopathy, in his heart he does not mean it.

The professor of internal medicine at Heidelberg while discussing rheumatism one day when I was there, got started on mechanical methods of treatment, and said that this was the one method of treatment that had always been neglected, and that medical men have hunted along every possible line except this one. They have worked on sera of various kinds for a number of years, but have accomplished very little; they have worked on the X-Ray, radium and so on, along so many lines, and he urged the students to work along the line of mechanical treatment. He talked at some length on the subject, but the students took his lecture as the average medical man does—forgot it about as soon as it was over. There is an interesting bit of psychology in the way in which physicians have neglected any form of mechanical treatment. I think the reasons that it does not appeal to them are that it is hard work, manual work and, as it were, beneath the dignity of the "ideal" medical man with his silk hat and black coat. At any rate, it doesn't appeal to the medical man as a rule, and perhaps in this day of competition it is well that it does not. It is certainly a good thing for the osteopath.

VERTEBRAL LESIONS AND THEIR EFFECTS.

Second Dorsal Lateral to Right.

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The effects of a vertebral lesion should be clearly distinguished from its symptoms and signs. Each lesion is a condition of disease and is also a cause of disease. As a disease, it has symptoms and signs; as a cause, it has effects. Deviation of the spinous process of the second dorsal vertebra to the right of the spinous process of the third, is a sign of this lesion; impaired heart resistance is an effect. Symptoms and signs are integral parts of a lesion; effects are consequences of it.

Although this lesion occurs with great frequency, is readily recognized, and is one with which every osteopathic physician has had experience, yet the time is not ripe for a complete statement of its effects. Reasoning from the facts of anatomy and physiology involved, widespread disorder is inferred. Accumulating clinical experience goes far toward establishing this inference. Second dorsal lateral to the right was assumed in a former article in discussing the morbid anatomy, and is now assumed in discussing the effects. It will be recalled that the intervertebral foramen between the second and third dorsal vertebrae is narrowed in all diameters on the left side and widened on the right. The head of the right second rib is carried forward and upward; the left one is drawn downward and backward. The left second dorsal nerve and the right dorsal sympathetic ganglion are thus exposed to pressure; their fellows on the opposite side are more or less drawn upon. The blood flow to and from the spinal cord is more obstructed on the left side. The movement of the upper dorsal spine is greatly restricted, and usually a secondary lesion of the first, third or fourth vertebra is present. This increases the defect in innervation and circulation occasioned by this lesion.

The sympathetic branches (white rami) of the upper dorsal nerves are largely distributed to the involuntary cells of the thoracic cavity, neck, face, head and upper extremity. The cells are of two kinds—(a) muscle cells, (b) gland cells. The muscle cells comprise the musculature of the heart, lungs, bronchi, œsophagus, blood vessels, hairs (arrectores pili), and the involuntary musculature of the orbits and eyes. The gland cells comprise the thyroid, salivary, lachrymal, mucous, and sebaceous glands. It should be remarked, in passing, that splanchnic branches from several of the cranial nerves are distributed

to the same involuntary muscular and secretory cells that are supplied by the upper dorsal nerves. Both are essential for the normal excitation and regulation of the cells they conjointly supply, and, when either is deranged, the normal nutrition and resistance of the part is lost. The lowered resistance, which invites disease, is not the whole of the mischief caused by deranged nerve supply to a part of the body. This impairs and restrains recovery, because one of the conditions upon which repair and reproduction and removal of the products and effects of disease depends, is normal nerve supply.

Functional and organic diseases of the organs and parts enumerated in the preceding paragraph may be caused by this lesion. The evidence, establishing a causative relation between second dorsal lesions and the diseases of the central nervous system, organs of special sense, heart, lungs, thyroid gland, upper extremities, etc., is three-fold: (a) the presence of the lesion in these diseases, (b) the disappearance of the disease following the removal of the lesion, (c) the appearance of the disease following the experimental production of the lesion—experiments of McConnell and others.

In order to justly weigh the evidence, offered to establish a relation of necessary sequence—causation, between a particular lesion and process of disease—it is necessary to bear in mind certain general principles of etiology: (a) There are absolute limits to resistance, and, however normal the nutrition and health of an organ, it will be injured when exposed to influences which, in kind or degree, exceed these limits; (b) There are absolute limits to healing, and however normal the body, it does not recover from injuries exceeding these limits; (c) So long as an organ or part is normally excited, regulated, sustained and kept clean, the scope of resistance and healing is relatively wide—in other words, so long as the nerve and blood supply and work of an organ or part are normal, its capacity for resistance and recovery is so great that thereby disease is largely prevented or remedied; (d) Normal nerve supply is but one of a group of factors upon which prevention and remedy depends; (e) The excitation, regulation and nutrition of each part of the body depends upon nerves received from two or more sources, any one of which, being deranged, invites disease and restrains recovery in that part; (f) Impaired nerve supply is rarely, if ever, the total cause of a particular disease of an organ or part of the body; it may therefore exist in full perfection without the effect appearing, unless and until it is aided by some other cause or causes which forward its influence and operation; a factor is discovered as essential to the production of an effect by the disappearance of the effect on the removal

of the factor; that it requires the assistance of other factors is proved by the non-appearance of the effect when this factor exists alone; (g) The same lesion may be a cause of several different diseases; (h) The same disease may be caused by several different lesions.

Failure to give due consideration to the foregoing general principles of etiology is responsible for some of the confusion and conflicting beliefs concerning the effects of this and other vertebral lesions. The effects of second dorsal lesions are traceable, largely, to the deranged nerve supply—glandular, motor, vaso-motor—occasionally by it; less, to the direct disturbance of circulation it produces. Many physicians underestimate the injury to the body from this lesion; probably an equal number exaggerate it. To illustrate: It is argued by some that this lesion cannot be a cause of endocarditis, because it is not constantly present in this affection. The fallacy of this reason is apparent from principles (a), (d) and (e). On the other hand, it has been urged that the existence of the lesion without an endocarditis following proves that it is not a cause. This conclusion is unwarranted. See principle (f). Again, it is incorrect to assume that the correction of this lesion is not an essential factor for healing, because healing fails to occur, following its removal—(b) and (d). It is equally incorrect to assume that the correction of the lesion was the total cause of healing, because this proceeds rapidly immediately following such correction. Healing depends upon a group of factors and, if all but normal nerve supply exist, the correction of a lesion interfering with this will be followed by recovery. Too often, it is forgotten that each process of health and disease depends upon a group of antecedents; and that the problem confronting the therapist is, not that of establishing the relation of causation between one antecedent and one consequent, but rather, that of establishing a relation of causation between one factor and the effect, and the relation between a group of factors and the effect.

Perhaps a concrete statement of the influence of second dorsal lesions in some particular process of disease will not be amiss. Inflammation of the lining of the heart is taken for this purpose. This lesion involves some of the augmentor fibres to the cardiac musculature, some of the vaso-motor fibres to the blood vessels of the heart, and some of the cardiac afferent fibres. The deranged nerve supply weakens the resistance of the heart to other causes of disease. It is now susceptible to injury by chemical, microbic and mechanical agencies, to which a normal heart is immune. Whether the disease that arises be inflammatory, degenerative, functional or organic will depend

upon the nature, amount and combination of causes at work. Activity, previously normal, may now be "overwork;" germs, previously resisted, may now destroy tissue and cause inflammation; deficiencies in food, water or oxygen, more readily induce degeneration; chemical substances, previously innocuous, are now hurtful.

Assume that the person having the lesion is a lad of twelve and that he develops acute rheumatic fever. Passing over the fact that the lesion may have been a partial cause of the predisposition to this infection, we go on to ask, what causes are now at work tending to produce endocarditis? The more conspicuous of these are: Deranged nerve supply, a depleted and poisoned blood stream, a specific toxin, and accelerated heart action. Will the endocarditis invariably appear? No, a few persons will escape it. The amount of these factors is variable and escape may be due to insufficiency of some of them. Let us now assume that the inflammation is limited to one or more joints and the child is allowed to be out of bed and to move about. The heart is thereby compelled to do its usual amount of work at a time when it should be rested. This factor, added to the foregoing, produces a combination from which escape is almost unknown. Let the lesion now be corrected: the resistance may be restored and the disease prevented; let the toxins be eliminated or neutralized, and the disease may be prevented. Suppose, however, that the group of causes be allowed to operate until every tissue is killed and an inflammation arises. It is now too late to think of prevention. Remedial treatment is indicated. Will the correction of the lesion further recovery? The question cannot be intelligently answered without an inquiry into the nature of the endocarditis—the inflammation assumed in this example. Tissue destruction has been produced. Many of the endothelial and connective tissue cells of the endocardium and the cells constituting the walls of the blood vessels which sustain the endocardium have been killed, more are injured; the blood vessels are dilated and the circulation slowed; the part is infiltrated with a pathological exudate from the injured vessels; tissue proliferation has begun; the cells of the blood vessel walls, the connective tissue cells, and the cells of the endothelial layer of the endocardium show the figures of karyokinesis. In a word, inflammation, the triple process of disease—tissue death, pathological exudate, tissue growth—exists. The continuity of the endocardium was destroyed by the causes at work; healing is attempting to restore continuity. Tissue resistance is yet fighting to limit destruction; healing is struggling to make good the loss. Natural recovery is attempting (a) to remove, neutralize or counteract the cause at work; (b) to re-

store anatomical soundness in the part; (c) to restore normal function. The indications for treatment are: (1) Assist the removal, neutralization, or counteraction of the cause; (2) Promote healing, i. e., aid in the restoration of structural continuity and soundness in the part; (3) Promote the removal of the effects, i. e., assist in the re-establishment of normal function, when a tissue defect remains after healing is completed. Let us now return to the immediate subject before us, and again ask the question, "Will the correction of the lesion further recovery?" This question resolves itself into the more specific one, "Will removal of the cause, healing, and removal of the effects, one or all, be furthered by the correction of the lesion?" It is sufficiently obvious that removal of the cause is effected in part, by the correction of the lesion and no more need be written on this point. That the two remaining indications for treatment equally demand the removal of the second dorsal lesion, is apparent, when the factors upon which healing and removal of effects depend, are analyzed. A paragraph will be devoted to each. It should be borne in mind that the object of this discussion is to point out the effects of second dorsal lesions and not to discuss the treatment of endocarditis.

Healing depends upon at least five essential conditions, factors, antecedents,—causes: (1) **NORMAL NERVE SUPPLY**, i. e., normal structure, organization and function of all the afferent and efferent augmentor, inhibitor, vaso-constrictor, and vaso-dilator neurons and centers. (2) **NORMAL BLOOD SUPPLY**, i. e., the quantity and quality of blood flowing through the inflamed part must be normal. The quantity depends upon heart action, peripheral resistance, blood mass, open route, and normal action of the local vaso-motor nervous mechanism. The quality depends upon the normal receipt of food, water and oxygen, and upon digestion, respiration, and elimination. (3) **CLEANLINESS**, i. e., removal of necrotic tissue, exudate, and chemical and microbic causes. (4) **A CERTAIN AMOUNT OF REST**, i. e., reduction of the activity of the body as a whole and the heart in particular. (5) **TIME**, i. e., the foregoing factors must not only be established, but must also be maintained over a certain period in order that healing may occur. Second dorsal lesions may derange both nerve and blood supply to the heart (the nerve supply directly, the blood supply indirectly, through the vaso-motor nerve involvement) and thereby restrain healing.

It frequently happens that healing fails to restore the typical structure of the part. The mass of tissue reproduced after extensive destruction is usually less than the mass destroyed. The kind of tissue reproduced is frequently not exactly like the kind destroyed. Repair occurs

and all of the events of the inflammatory process disappear with healing, but a tissue defect frequently remains. If this tissue defect impairs the function of the organ or part, the indication, to "promote the removal of the effects" prevails. A common and unfortunate defect which remains after healing is completed, in endocarditis, is a departure from the typical form and structure of the heart valves. Regurgitations and obstructions occur. The function of the heart—circulation—is impaired. "To remove the effect of the endocarditis" is synonymous with "To restore normal circulation of the blood." Let us assume that, following healing, a defect of the mitral valve remains and that this allows blood to flow back into the left auricle with each systole of the left ventricle. The aortic and systemic pressure begin to fall and the pulmonic pressure to rise. Unless these waves of decreasing pressure forward and increasing pressure backward are arrested, the circulation will be brought to a standstill and death of the organism will result. The damage to the heart valve is done, and is irreparable. How may a compensation for the defect, and the regurgitation which results from this, be established? By a dilation and hypertrophy of the chambers of the heart on each side of the lesion. Dilation provides room for the extra amount of blood which will remain in the heart; hypertrophy enables the left heart to put the increased pressure on the blood mass, which is required to maintain the circulation, under the altered conditions. The factors essential to the production of hypertrophy are: (1) Normal nerve supply, (2) Normal blood supply, (3) Accurately graduated increase in the amount of work, (4) Intervals of comparative rest between periods of work, (5) Time. In order to fulfill the first and second of these conditions, it is clear that the second dorsal lesion must be corrected.

Thus, we see that the removal of this lesion is important, alike for prevention and remedy, and that its removal is indicated at every stage of an inflammatory process. Did space permit, or were it needful in order to emphasize the influence of this and other vertebral lesions, we might similarly outline the therapeutical considerations involved in fatty degeneration, or in some one cardiac neurosis, or those involved in the various inflammatory, degenerative and nervous diseases of the lungs, eyes, etc. We would find, in passing from one to the other of these, that this lesion plays its role, as a cause of diminished resistance, tardy healing or imperfect compensation, in combination with a different group of factors in each case, but it is always the role of impaired nerve supply to the involuntary cells in the diseased part.—Cosmopolitan Osteopath.

THE NEW FAMILY PHYSICIAN.

To be able to recognize the clinical form of disease and to aid nature in its reparative endeavors, is the aim of the physician. The time was, and it is within the memory of many of us, when the family practitioner was the trusted family counselor in all matters concerning health and sickness. Before the advent of antiseptics and specialism and the acceptance of the germ theory in medicine, every mature and successful practitioner was authority for his clientele. Disease was looked upon as a visitation of Providence, the belief in drugs and medicines was absolute, and surgery was brutal and simple. * * * *

Owing to the great strides which practical and theoretical medicine have made in the past twenty-five years, the position of the general practitioner today is a peculiar one. He has found it impossible to keep abreast with the rapid progress in medicine; any young specialist feels himself his superior in his particular line, and, in our large cities, among the wealthy class, the general practitioner finds himself little more than "master of ceremonies"—the diagnosis and treatment are furnished by the various consultants and the patient is handled by the trained nurse.

These matters have been discussed at various times and from divers standpoints, but no definite and precise advice has been formulated for the guidance of the student, or prospective student, or young practitioner, who in his enthusiasm for the study of medicine fails to take into consideration the great difficulties which beset him in the practice of his chosen profession.

* * * * To judge from the large number of medical men who are yearly let loose upon the public, it would appear that medicine is looked upon as a very promising field for reward, in fame and riches. Such an assumption is, however, not warranted by existing conditions. The law of supply and demand is inexorable, and we have an overstocked profession just we may have an overstocked market in flour or cheese.

Owing to the fact that many have entered the medical profession from impulse or fancy, the production of medical practitioners has been far ahead of the demand, and although an increase in population and the dropping out of old members of our profession will make room for newcomers, there will certainly not be room for all who are clamoring for admission to its ranks. To my mind, no one should ever attempt to enter upon such a career without a good physical constitution, a sound mind, a tactful disposition, and a thorough appreciation of the situation which confronts him, a full understanding of the difficulties

to be overcome, and the hard work and drudgery to be endured by the general practitioner, be he successful or not. Competition is a stern master; it elevates and degrades, and the position of the medical man who in the battle of life has lowered his standard of honesty and loses his self-respect by reason of practices unworthy of a gentleman and a true physician is a deplorable one, be the money reward small or great.* *

I believe that the family practitioner is not doomed to become extinct and that in due time the people will again elevate him to the position of trusted family counselor, and this opinion I hold for two reasons principally.

In the first place, many intelligent people who are fortunate enough to have the services of a thoroughly good family practitioner have refused to give him up and have upheld the dignity of his position on every occasion where the counsel and services of a specialist were in demand; and in the second place, the public has already experienced the many and serious drawbacks of an indiscriminate consultation with immature specialists whose advice, if followed, has in many instances been bought more dearly than by dollars and cents.

Much of the specialist work of today is worthy of the highest praise; on the other hand, a large percentage of operative work is ill-advised, superfluous, and harmful, and as soon as the more intelligent people of the community realize that such is the case they will again turn for advice to the intelligent family practitioner; they will admit him again to the inner family council and trust to him to shield them from the meddling treatment of our times and deliver them into safe and conservative hands. And if the future family practitioner is to regain lost ground, again aspire to reach that plane in the practice of general medicine which is properly his, and again enjoy the full confidence of his clientele, it must be THROUGH HIS OWN INDIVIDUAL EFFORTS by educating himself to become a DIAGNOSTICIAN. * * * * I am convinced that all medical men who are fitted by nature and proper education for their work, will in reasonable time become competent diagnosticians and will be capable of formulating precise indications for treatment, provided ample opportunity for laboratory work and bedside instruction be offered and sought, and provided that no time be wasted experimenting with thousands of old and new and useless drugs in the endeavor to adapt a complex, cumbersome and largely superfluous materia medica to the various symptoms of acute and chronic illness.

The general practitioner must be: 1. Master of physical diagnosis. 2. He must have some laboratory training, particularly if he practises far away from laboratory facilities. 3. He must be able to

make a local or regional examination, employing such methods of specialists which have become general property. 4. He must have a good knowledge of hygiene and dietetics. 5. He must be able to practise minor surgery and be able to perform emergency operations. 6. Whenever feasible, obstetrical cases should not be handled by the general practitioner.

A thorough training in physical diagnosis is the basis of a successful medical career. Once properly learned, it is never forgotten, and as long as we are in active practice, auscultation and percussion are and should be our daily routine work. * * * *

Under all circumstances the general practitioner should direct his energies TO MAKING A DIAGNOSIS HIMSELF AND FORMULATING PRECISE INDICATIONS FOR TREATMENT. His patients will understand that he cannot be a Jack of all trades and perform everything, but they will expect him to make a diagnosis and suggest proper treatment. * * * *

* * * * Minor surgery, in my opinion, belongs to the general practitioner. The practice of minor surgery is easy and it is more impressive to the laity than the writing of a prescription for a lot of useless and superfluous drugs. A GENERAL PRACTITIONER WITHOUT SURGICAL TRAINING AND TENDENCIES IS HANDICAPPED FROM THE VERY START. As he is brought into early contact with cases requiring surgical aid, his timely recognition of the case and the use of the knife will be of the greatest importance and value in cases which, if seen at a later stage by a special surgeon, frequently necessitate extensive surgical interference. The knife in conservative hands aids nature and frequently gives prompt relief from pain and dangerous symptoms, and it is for this reason that surgeons get large fees for small operations and the timid general practitioner gets little or nothing. * * * * Thus the Simon-pure prescription-writer has no future in the modern practice of medicine, and the medical man or woman who does not care to handle the knife should drift into a mild, bloodless specialty. * * * *

We cannot with good grace dismiss the general practitioner and his requirements without speaking in plain language in condemnation of the drugging habit of which he is still guilty to a remarkable degree. Cabalistic prescriptions are as thick as flies in summer, and the majority of our patients pay willingly and handsomely for our wisdom transmitted to them in the shape of nauseating mixtures from the time-honored shelves of the apothecary shop.

I know from personal experience that our cousins across the water do not prescribe or swallow one quarter as much medicine as we do in our country. With but few exceptions the entire vegetable and min-

eral kingdoms have given us little of specific value, but still up to the present day the bulk of our books on materia medica is made up of many valueless drugs and preparations.

Is it not to be deplored that valuable time should be wasted in our student days by cramming into our heads a lot of therapeutic ballast, and is it not true that such teaching is to a large degree responsible for the desire on the part of many practitioners to prescribe frequently and without good cause an unnecessary quantity of useless drugs?

Every few weeks new drugs and combinations of medicaments are forced upon physicians with the claim that they are specifics in the treatment of disease, and the physician in his anxiety to alleviate his patients' sufferings, because the simpler and more reliable have failed him, is gulled into trying the newly extolled remedy, only to find that it is still less efficacious than the old one.

The common sense practitioner knows by experience that the constant frequent prescribing of innumerable drugs only ends in detriment to his patients. A working knowledge of hygiene and dietetics, climate, hydro- and mechano-therapeutics, simple medication and a few drugs are the successful agents in internal medicine, and THE SOONER THE PHYSICIAN WILL CONDENSE HIS PHARMACOPEIA AND MATERIA MEDICA TO A VEST POCKET EDITION THE SOONER WILL HIS EFFORTS MEET WITH SUCCESS IN THE PRACTICE OF HIS PROFESSION. * * * *

I would venture to express the opinion that all medical men should start as general practitioners. If for any reason whatever they find it advisable to practise a specialty, they will be more generously informed and better equipped in every way by reason of years of general practice and experience. I predict that the successful general practitioner of the future will be a diagnostician, sanitarian, and minor surgeon, and after years of active practice such a general practitioner will develop into a valuable and conservative general consultant.

Just as the old temple of Æsculapius, held together by a cement of superstition and ignorance, has fallen, and a new temple is being erected, decorated with the magnificent works indicative of the progress of our times, so the old general practitioner with his obsolete methods and drugs is bound to go—and in his place will arise the modern family practitioner, the diagnostician and sanitarian, who will find his way along the trails and paths blazed for him by the master minds of the past, right into the hearts and confidence of the people.—From the Introduction to "Differential Diagnosis and Treatment of Disease," by Augustus Caille, M. D.

CASE REPORTS.

EUGENE F. PELLETTE, D. O., LIBERAL, KANS.

I.—A man about thirty-five years old who had had chronic diarrhœa for one year, with from three to six watery stools each day, came to me for treatment. There were lesions as follows: 9th and 10th dorsal posterior, 4th and 5th lumbar anterior, left innominate anterior, and 1st cervical rotated. McConnell and Teall states that it sometimes took six to nine months to cure chronic diarrhœa, but this case was cured in just one month.

The first week, I treated to correct lesions, gave inhibitory treatment in lumbar and lower dorsal, and kept him on a diet devoid of starchy foods of any kind. Stools were still watery, but never more than three per day. Then I put patient on a fast with nothing but water to drink, and an enema twice each day, to thoroughly wash out the bowels. This resulted after four and one-half days, in one slight movement per day, after which I put him on original diet of no foods at all of a starchy nature, and very little nitrogenous foods. I followed this fast by orange juice for the first two meals, hot milk next meal, chicken broth next meal, and so on, till he gradually came to his original diet, or fruits, raw vegetables, greens, etc. At first, right after the fast, patient was constipated, but good treatment of the liver, stimulating it, and treating the mid-dorsal region, resulted in good free action of the bowels once each day from then on, with no further occurrence of the trouble; and besides, there was a feeling of exhilaration and strength which had not been felt before.

The reason of the fast was to give a chance to get rid of all irritating fermented food in the bowels, and wash it all out, so that the proper food least liable to create fermentation, would digest properly. Starchy foods are most liable to cause fermentation of any foods; and fruits and vegetables of a non-starchy nature are least liable to ferment in the bowels. By lessening the intake of food, giving the digestive organs less food to take care of, and of a character easier to digest, and by stimulating digestion by osteopathic treatments to the splanchnic area, and correcting lesions in that area, cure was accomplished. I might add that I cut out all tea or coffee, and forbade drinking anything at meals or for a couple of hours after meals. The cure has remained permanent, so far.

II.—At the same time when there was an epidemic of scarlet fever in town, a patient called on me to treat a supposed case of tonsilitis.

Patient was about 18, and showed symptoms of very sore throat, temperature of 103 3-5, pulse of 108, with vomiting and diarrhoea, a very coated tongue which was bright red around the edges, scanty high colored urine; headache, etc. Gave her a treatment, and ordered all food proscribed.

The second day, she was feeling worse than ever, and so sick she couldn't take a treatment, and wouldn't see me in the morning, and when I came in the afternoon, there was a bright red scarlet rash out all over her neck and chest and arms, consisting of fine closely set red points. She was feeling better. She showed all the symptoms of scarlatina. I treated her twice each day, and with enemas to wash out the bowels every day, and absolutely nothing to eat, although she begged for different things. She commenced to get better, the rash was gone at the end of the fifth day from its appearance, and by the end of a week, she was feeling so well that she went back to work. No doubt if this case had been fed just a little milk or broth or egg albumin, she would have developed a typical long-standing case of scarlet fever. Why feed anything at all in this disease?

PROGRAM OF THE NEW ENGLAND OSTEOPATHIC ASSOCIATION.

The annual meeting of the State Association will be held at Worcester, Mass., May 19th and 20th. The following program will be carried out:

FRIDAY P. M.—2:00—Opening Exercises. 2:15—Dr. George W. Reid, Worcester, Physiological Exercise. 2:40—Dr. Frederick W. Gottschalk, Boston, Peritonitis. 2:50—Dr. Effie L. Rogers, Boston, Bronchitis. 3:00—Dr. Ralph K. Smith, Boston, Orthopedic Surgery and Osteopathy, Their Relations and Their Vital Divergencies. 3:30—Dr. Florence A. Covey, Portland, Statistics. 3:45—Dr. Martin W. Peck, Lynn, The Place of the Bony Lesion in Osteopathic Therapeutics. 4:00—Dr. J. H. Corbin, Westfield, N. J., Herpes Zoster. 4:15—Dr. E. F. M. Wendelstadt, New York, Hernia. 5:00—Dr. Albert Fisher, Syracuse, Subject to be announced. 5:30—Dr. Harry W. Conant, Cambridge, Treatment. 8:00—Dr. E. E. Tucker, New York, Fourth Dimension. 8:30—Dr. Joseph Ferguson, Brooklyn, Emergencies. 9:00—Dr. William H. Jones, Marlboro, Correction of Lateral Curvature.

SATURDAY A. M.—9:00—Dr. Charles C. Teall, Fulton, N. Y., Conservation, Patient and Operator. 9:30—Dr. George W. McPherson, Claremont, N. H., Treatment. 9:45—Dr. John J. Howard, Franklin, publicity. 10:00—Dr. Kendall L. Achorn, Boston, Arthritis. 10:15—Dr. Sidney A. Ellis, Boston, Subject to be announced. 10:45—Dr. E. M. Downing, York, Pa., Subject to be announced. 11:15—Dr. Helen G. Sheehan, Boston, Treatment of the Liver. 11:30—Dr. Robert H. Nichols, Boston, Bright's Disease. 1:30—Dr. H. L. Chiles, New York, Secretary A. O. A., Problems Outside the Operating Room. 2:00—Dr. Arthur M. Lane, Boston, Why? 2:15—Dr. George W. Riley, New York, Intestinal Disorders. 2:45—Dr. A. F. McWilliams, Boston, Rib Lesions and Their Adjustment. 3:00—Dr. Guy Wendell Burns, New York, Subject to be announced. 3:30—Dr. L. Van Horn Gerdine, A. S. O. Faculty, Kirksville, Mo. 4:30—Dr. Wilfred E. Harris, President Massachusetts College of Osteopathy, Cambridge, Subject to be announced. 5:00—Dr. A. H. Gleason, Worcester, Lesions and Spinal Cord Diseases. 5:30—Business Meeting. 7:45—Banquet.

OSTEOPATHIC GLEANINGS.**Medical Men's Attitude.**

It is extremely interesting, and from some points of view almost amusing, to note the wild struggle which the political doctors are making to win the favor of the people and to make possible the passage of the Owen Bill or some similar bill. If any one with even a moderate sense of humor reads how Mr. Spenlow in Dickens' David Copperfield believed that the whole honor and prosperity of England was bound up in the doctors' commons, and should then read some of these addresses and articles written by our allopathic friends, we believe he would discover a striking similarity between the aforesaid Mr. Spenlow and the allopathic physicians. In other words, they are really trying to convince the public that they are the sole repositories of medical and hygienic wisdom and that any blow which is struck at them or at their system is a blow which is aimed straight at the health and prosperity of the country. They are not the only physicians who make the mistake of supposing that the interests of the people at large are identical with their individual interests. Many of them seem to seriously believe that there is some express charm in an allopathic medical college and that it is an absolute impossibility for one to acquire a knowledge of the treatment of the human body in disease and intelligent methods of preventing disease without getting the information and training from one of their colleges. They seem also to believe that there is some particular charm in the exceeding artificial entrance requirements required by the American Medical Association.

Now, just as a matter of fact, there is no magic in medicine and medical education is no more mysterious than is an equal education along any other line. The same preliminary training which fits a student to become an accomplished historian, a successful chemist or civil engineer fits him for the study of medicine. It would be well for them to remember that if history teaches us anything it teaches us that improvement has been forced upon corporations from the outside rather than to have developed from the inside. Had the church been left free from the external pressure the stake, the rack and the thumb screw would form a part of the paraphernalia of each municipality. It was extreme pressure and not internal development which did away with these things, and had the old school of medicine been left entirely untrammelled by pressure from the outside, there is no reason to suppose that we would not be dosed today as people were dosed when the profession was vituperating against Oliver Wendell Holmes for his criticism of their methods and dosings. It might be well for some of them to ponder upon the fact that love and care for the welfare of the people is not only sometimes one of the first delusions of the simpleton, but frequently forms the last refuge for the knave.—The Western Osteopath.

THE BULLETIN

OF THE ATLAS AND AXIS CLUBS.

E. R. HUMPHRIES, A. B., EDITOR. E. G. CAREL, A. B., BUSINESS MANAGER

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Entered as second class matter, October 12, 1903, at the post office at Kirksville, Mo., under act of Congress of March 3, 1879,

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KIRKSVILLE, MO., APRIL, 1911.



New England We wish to call attention to a part of a letter from Dr. W. C. Brown, Atlas 1908, in the March Bulletin, in which, speaking of the defeat of the bill asking for an independent board of registration in Maine, he says, "One of the strongest arguments against us was that there were only eighteen of us, which is true. So you see there is plenty of room for osteopaths here, and particularly for men, as we number only five." Eighteen osteopaths in the entire state! Of this number two of the five men are Atlas men, and eight of the thirteen women are members of the Axis club.

Just at this time state board examinations and place for location are the things that are taking up most of the seniors' thoughts, and while considering the latter it would be well to consider such a state as Maine, which certainly is not overcrowded and offers some enticing advantages.

What is true of Maine is for the most part true of the other New England states. Vermont was the first state to recognize osteopathy;

yet there, in New Hampshire, in Connecticut and in Rhode Island there are but few osteopaths. In Massachusetts there are more, though there they are centered in Boston and the suburbs. New England needs osteopaths and needs the RIGHT KIND OF OSTEOPATHS. The field there is as good as in any part of the country.

* * *

Convention Three months remain before the National Convention at Chicago. In the past month arrangements have been made for additional meetings of other osteopathic organizations and societies and plans, in general, have been more nearly perfected. One of the most important announcements is that regarding reduced rates that are offered, one fare and a half to Chicago and return to the Eastern points. All railroads have adopted these rates, we are informed, that are such that the trip should be within the reach of practically every practitioner.

* * *

Amendments The club has published the amendments that have been made to the constitution and by-laws since May, 1909. These are just off the press and are now ready for distribution. In case you do not receive a copy you can do so by applying to the Pylorus.

* * *

It has often been assumed that the fever occurring in infectious diseases is a protective process favoring the destruction of bacteria; and it is not impossible that in individual cases it may exert such a favorable influence. Thus, for example, it is conceivable that a parasitic micro-organism, growing well at a temperature of 37-38° C., will not thrive at a temperature of 40-41° C., so that high fever temperature may hinder its power or production. The conclusion should not, however, be drawn from this that fever is a useful phenomenon which always favors the counter-balancing of pathological disturbances. Even in those cases in which the metabolic processes occurring during the fever exert an injurious influence upon the bacteria, this is not to be taken as proving the usefulness of fever. We can only say that a part of the morbid processes occurring during an infectious fever leads to a formation of decomposition-products which may possess anti-bacterial or anti-toxic properties.—Zeigler.



ATLAS NOTES.

Dr. Gerdine was the speaker for the open meeting, Saturday evening, April 8, and addressed the club members and their guests on "Opportunities for Study Abroad and At Home," with special reference to what the osteopath might expect to be able to obtain along the lines of graduate work in the medical schools here and in Germany. Another feature of the program was a piano solo by Mr. Stanton of the June, 1913, class, one of several blind students at the A. S. O. The program:

Selection	Atlas Club Orchestra
Piano Solo	Mr. Stanton
Address	Dr. Gerdine
Vocal Solo	H. H. Howard
Selection	Atlas Club Orchestra

* * *

Several times members of the faculty of the Kirksville State Normal School have consented to come before the club either to address the club or, as in the case of Prof. Gebhart, to furnish a part of the musical program. Saturday evening, April 22, Prof. Wilson, of the Normal School faculty, spoke to the club, taking as his subject "The Relations of Mind and Body," touching upon the many sides of the subject briefly but comprehensively, and opening up the subject of psychotherapy and its place in the field of therapeutics. Prof. Wilson's was one of the most valuable addresses that have been delivered at the club meetings since September, and we regret that we are unable to quote from it.

* * *

Word was received last month, too late for correction of the March Bulletin, of the death of Wm. Edward Plant, father of Ernest A. Plant, Jan., 1905, though the last Bulletin reported him as being "on the road to recovery." In his last letter Dr. Plant stated, "Death occurred March 27, in St. Louis, Mo., where he had spent most of his life; was 66, and death was due to sapremia, following operation for gangrenous appendicitis, performed three weeks previously."

Several of the club members went to Chicago early in the month to take the Illinois State Board examinations. No returns have been received as yet, but all the club members who took the same set of examinations last year were successful, and it is hoped that this year's number passed the same way. The Atlas men who tried the board this year are: Park A. Morse, Don C. Nye, Edward H. Parker, and F. L. McGonigle, 1911; H. W. Hancock and H. J. Wise, 1912. Noble Skull Ingram, who passed the board last year, was present and took the mid-wife examinations.

* * *

We are indebted to Dr. Eugene F. Pellette, Atlas 1909, for some case reports which appear in this number and others that will appear next month. "Wish I could visit old Kirksville this spring," he writes, "and give you a gist of some of my experiences in the field."

* * *

Dr. W. H. Elmore, Atlas 1905, of Elk City, Oklahoma, was re-elected Councilman of the Fourth Ward on the Democratic ticket, in his home town recently.

* * *

On March 13th, Dr. J. W. Bennett, Atlas, 1904, of Augusta, Ga., met an untimely death while driving in a buggy in response to a call from a patient. While crossing a bridge the horse became startled, and turning sharply to one side threw Dr. Bennett out of the buggy and against an iron girder of the bridge, causing a fracture of the skull from which death resulted soon after. Dr. Bennett is survived by his wife, Dr. Fannie C. Bennett, who was associated with him in practice, and a brother, T. L. Bennett, of the present Senior class.

* * *

Dr. J. O. Smith, Atlas, 1905, formerly of Waseca, Minn., has recently removed to Menominee, Wisconsin, and reports a good opening for an osteopath at Waseca. If any one is interested he may write to Dr. Smith at Menominee, and he will be glad to give further information in regard to the place.

* * *

Dr. E. Randolph, Atlas 1905, of Garden City, Kans., has changed his office from the New Warden building to rooms over Carter & Fant's grocery store.

* * *

Dr. Chas. J. Muttart, of Philadelphia, is the recipient of a very nice little appreciation in The Forecast for March, under the title "Glimpses of Progressive People."

Dr. W. A. Cole, Atlas 1902, formerly of Iowa and Illinois, moved to Oklahoma some time ago, under the assurance that a license would be granted to him by reciprocity on his Iowa and Illinois certificates. However, when he had settled himself in an office for practice he found that under the new ruling of the State Examining Board, all reciprocal relations had been discontinued, and so it was up to him to take the examination or go elsewhere for practice. He finally concluded to submit to the inevitable and take the examination, and he has recently received notice that he successfully passed. Dr. Cole, in spite of the fact that he has been out of school since June, 1902, passed the entire fourteen studies given by the board.

* * *

Dr. J. W. Murphy, Atlas, 1907, formerly of Sedro-Wooley, Wash., will spend the summer at Katalla, Alaska, where he is under contract to treat a well-to-do man and his wife, who have made Dr. Murphy a proposition that he considers excellent. Katalla is in the coal and oil region near the Copper River.

* * *

Dr. J. E. Matson, Atlas 1903, of Minneapolis, formerly of Eau Claire, Wisconsin, was in Kirksville recently, for a short time, and was impressed with the splendid progress made by the school here in all departments.

* * *

Dr. E. C. Link, Atlas 1902, who has been practicing at Elizabeth, N. J., has removed to 339 Atlantic Street, Stamford, Conn.

* * *

Dr. C. W. Proctor, Atlas 1900, 897 Ellicott Square, Buffalo, N. Y., wishes to receive reports of cases of constipation, stomach and intestinal indigestion, in which a special diet was used in connection with the osteopathic treatment. These reports should be definite as to the character of the diet, and frequency of eating, with the results obtained, as they are for the use of the committee on research in dietetics, and are to be included in a report at the Chicago meeting and should be sent at the earliest convenience.

* * *

The A. T. Still Osteopathic Association, of Massachusetts, held a special meeting in Boston, April 6. Dr. Frederic E. Moore, of Portland, Ore., was the speaker of the evening and he discussed the advantages of a separate osteopathic board in each state, and said emphatically that he was against the composite boards, being a member of one in Oregon. He related several of his experiences as a member of the

Oregon board, and then gave some hot shot from Kirksville. Following his discourse Dr. Moore demonstrated some fine points in technique of the A. T. Still kind. Dr. Moore was loudly applauded for his efforts, and after the meeting was tendered a banquet at the Hotel Lenox.

Dr. and Mrs. Moore and Miss Judith Snodgrass sailed from Boston on April eight, for England. Dr. Moore will take a post-graduate course in noted schools of medicine in London, and the party will also visit various European centers before returning to the home in this country.

* * *

BORN—To Dr. and Mrs. L. van H. Gerdine, at Kirksville, Mo., April 14, a daughter.

* * *

BORN—To Dr. and Mrs. Irving Colby, of New London, Conn., February 28, a son.

* * *

DIED—Mrs. Hattie Shipman, wife of Dr. K. W. Shipman, at Janesville, Wis., March 27. Funeral and burial at Manawa, Wis.

* * *

DIED—Herman Millay, age 3 1-2 years, son of Dr. E. O. Millay, of Detroit, Michigan, of tubercular meningitis. Burial at Kirksville, Mo.

* * *

DIED—Mr. William E. Plant, father of Dr. Ernest A. Plant, at St. Louis, Mo., March 27, from sapremia, following an operation for gangrenous appendicitis.

DIED—On March 13, at Augusta, Ga., Dr. J. W. Bennett. Burial at Owensboro, Kentucky.



Edward K. Clark, Jr., comes from Marion, O., and is a member of the January, 1914, class. He was assistant collection manager with The Huber Manufacturing Co., of Marion, and was influenced to take up the study of osteopathy through Dr. R. C. Dugan, who has been family physician for about twelve years, and through his brother, Fred W. Clark, of the June, 1912, class.

* * *

Charles S. Smith, June, 1913, was formerly a photo-engraver at Battle Creek, Mich. Mr. Smith is a graduate of the University of Michigan, from which he received the B. S. degree in 1898. He was influenced to come to Kirksville by Dr. A. S. Harris of Battle Creek.

* * *

Frank B. F. Hardison was induced to study osteopathy by Dr. Frank C. Martin, Atlas 1907, and Dr. R. D. Heist, both of Geneva, N. Y. He was graduated from the Geneva high school in 1904, and spent one year at Hobart College and three years at Princeton. Mr. Hardison is in the January, 1914, class.



OFFICERS OF THE AXIS CLUB.

President—Mrs. Mabel Willis Payne.
 First Vice-President—Miss Anna C. Myles.
 Second Vice-President—Miss Annette M. Alexander.
 Recording Secretary—Mrs. L. M. Kerrigan.
 Financial Secretary—Miss Sarah L. Balfe.
 Corresponding Secretary—Miss Mary E. Emery.
 Treasurer—Miss Grace M. Bales.
 Chaplain—Miss Anna M. Mills.
 Escort—Miss Edyth M. Carel.
 Librarian—Miss Elizabeth E. Smith.
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COMMITTEES.

FINANCE.—Miss Grace M. Bales, Miss Elizabeth Brewster, Miss Franzisca Nickenig, Miss Veva Chalfant.
COURTESY.—Miss Mai Branner, Miss Ethel Priseler, Miss Althea L. Taylor, Miss Emily Malcolmson, Miss Mary M. Meleski, Miss Julia J. Chase.
PRACTICAL WORK.—Mrs. Edyth M. Carel, Mrs. Anna R. Murphy, Mrs. Ruth McBeath, Mrs. Elizabeth K. Crain.
PROGRAMME.—Miss Mary G. Crossman, Miss Mary E. Emery, Miss Esther M. Bebout, Mrs. Iva M. McAnelly.
NOMINATING.—Miss Council E. Faddis, Mrs. Jennie Beckler, Miss Elizabeth J. Sharp, Miss Julia A. Larmoyeux.
AUDITING.—Mrs. Lucy M. Hull, Miss Caroline I. Griffin, Miss Mary Faires.

Dr. Eliza M. Culbertson writes that her correct address is Post Building, Appleton, Wisconsin, instead of Indiana, as published in the directory. Dr. Culbertson was in Europe last summer and so missed the convention at San Francisco, but says she is looking forward to the meeting of many familiar faces in Chicago. She closes with best wishes for the club.

* * *

Dr. Sylvia R. Overton of Tuscola, Ill., in a letter to the Financial Secretary, says in part: "Just now a little son two months old requires most of my time, but even so important an event as that does not cause me to lose interest in the Axis Club, and am always glad to hear from the club, even if it is only a statement for dues neglected." The Doctor closes wishing the club an enjoyable and prosperous year.

Dr. Grace C. Learner writes that she and her husband, Dr. H. N. Learner, passed the New York state board examination, and have changed their residence to 111 Bidwell Parkway, Buffalo, N. Y.

* * *

Word comes from Drs. Pauline and Harriet Sears, of Ontario, Oregon, that they are doing well in their new location and would like very much to meet again with the Axis girls.

* * *

Such a good friendly letter comes from Dr. Lydia H. Holmes, of Pekin, Ill., that we want to pass it on to her friends through The Bulletin. She says:

"Just received The Bulletin, and although had patients in the office, had to take a little time and peep between the covers to find out what you were doing. How often I think of you and how I long to see you. How I would have enjoyed the second degree.

"Had a few hours' visit with Drs. Gross and Loring last Sunday at Joliet. My, how precious the time was, but all too short. See you have had your installation of officers, and how proud I am to look over the list of names, those who have given their time and effort and those who take up the new burden. You do not now realize what the club work means to you as you will when you get away from school, and you can refer back to the profitable hours spent in the acquirement of professional work and the sweet memories of the friends and social gatherings. Osteopathy is just as fine as ever. Sometimes when you want to get discouraged, something happens which makes you more enthusiastic than ever."

Dr. Holmes promises us some case reports some time (we hope it will be soon) and closes with best wishes to the club for its success and good luck to every member.

* * *

Following is a short history of those who have recently become members of the local chapter of the Axis Club:

Miss Vera E. Derr came here from her home in Fostoria, Ohio. She was formerly a teacher, and received her education in the Fostoria schools, being a graduate of the high school. She was influenced to take up the work here by the good results of treatment given her sister by Dr. T. M. Westfall of Fostoria, and entered the A. S. O. with the 1911 class.

* * *

Miss Emma A. Heberd came here from her home in Brooklyn, N. Y. She received her education in the Girls' High School of Brook-

lyn, and did work in Barnard College, Columbia University. She took up the work here with the intention of doing settlement work in New York City, and entered the school with the January, 1913, class.

* * *

Miss Grace Whallon, also a member of the January, 1913, class, received her education in the high school of Tuscola, Illinois, which is her home town. She also did work in the St. Mary's College of Music at Elgin, Illinois. She took up the study of osteopathy because of her health and the good work done by the osteopaths of her home town.

* * *

Mrs. Elizabeth L. Gilchrest was formerly a teacher in Detroit, Michigan, holding a life certificate. She came to Kirksville because of her rapidly failing health, the only help for which she found in osteopathy. While here she took up the study of the science, and entered the A. S. O. with the June, 1913, class.

* * *

Miss Muriel H. Staver came here from her home in Bluffton, Indiana. She received her education in the Bluffton High School, De Pauw University, at Greencastle, Indiana, and Winona College at Winona Lake, Indiana. She was influenced to take up the work by Dr. Blackmann of Bluffton, and entered the school with the June, 1913, class.

* * *

Miss Laura O. Jackson is also a member of the June, 1913, class, coming here from Lawrence, Massachusetts. She is a graduate of the Lawrence high school, and was influenced to take up the study of osteopathy by Dr. Charles G. Hatch of Lawrence.

* * *

Wednesday evening, March 22, the following were given the second degree:

Miss Vera E. Derr, 1911; Miss Mary M. Meleski, Mrs. Cora Pipping, Mrs. Iva M. McAnally, June, 1912; Miss Elizabeth J. Sharp, Miss Frieda F. Allabach, Miss Grace Whallon, Miss Emma Heberd, January, 1913; Miss Ruth Watson, Miss Alletta Herrold, Miss Dot Dillon, Miss Carolyn B. Chance, Miss Edith Muhleman, Miss Muriel H. Staver, Miss Laura O. Jackson, Mrs. Elizabeth L. Gilchrest, June, 1913.

The initiates came dressed for the occasion, and everything went off ALMOST as planned. After everyone had done all her stunts light refreshments were served, and sixteen new full-fledged Axis girls went home, having successfully taken the second degree.

Wednesday evening, April 12, the Local Chapter had an open meeting. After the regular business session, the few guests and members who had braved one of Kirksville's good, hard thunder-storms, were treated to a very interesting lecture by Dr. McDonald, who said in part:

"I should like to talk to you a while on one little point, i.e., the value of careful and systematic interrogation of patients. We may divide the examination of patients into three parts: (1) The interrogation of the patient, in which you get his symptoms; (2) the physical examination, in which you find out the state of every organ; and (3) the osteopathic examination, in which you determine what shall be the treatment.

"I want to take up just one point in this examination. In the subjective examination you ask questions; in the objective you look, listen and feel of the patient. I want to talk only about the subjective.

"When a patient comes into the office the physician is apt to ask, 'What is your complaint?' Don't use that word. I hate it. It is a hard, cold word. You might as well ask, 'What are you whining about?' Better say, 'What can I do for you?' or 'What is troubling you?' This may be a little thing, but it counts for a good deal. Even from a financial point of view it is bad policy, for it is cold and hard, and the patient is apt to resent it. You must use words that show that you are sorry that he needs help, sorry that he has to come to you, but glad that when he does come you probably can help him.

"Having gotten his complaint, though you haven't used the word, get the duration. This, too, is a cold, hard word. Better ask, 'How long have you been sick?' It is customary to get the name, age, occupation and home address, the latter for obvious reasons. Then pass on to general interrogation of the patient. Irrespective of the trouble, you should ask certain questions. What you want to get at is a useful routine method. You want to know his present illness, but you want to know more than that; you want to know his personal history, surroundings at home, work, habits, etc., although these must be kept absolutely separate from the history of the illness. You also want to get at his family history. To my mind, though, it is not satisfactory to ask too blunt questions. Don't ask the names, ages, complaints, habits, of all the sisters, brothers, cousins and aunts the first thing. When the patient comes in, what is he anxious to tell you? Not of his aunt's trouble or his cousin's death, but he wants to tell you of his own illness. Don't get the family history first, but the personal troubles.

It is true that you will get the most out of the patient if you get him to tell his story in his own words. Don't ask leading questions. For instance, don't ask if he has certain symptoms. He will be sure to have

them. At the same time, you must not allow him to tell the story absolutely as he wishes, for he doesn't have any capacity for judging the value of symptoms. How are you going to, as they say here, 'butt in'? Don't allow him to give a mass of information served up as he wishes. When a patient says he has had trouble, say, for several years, you should find out just what he means by several years. For instance, help him out by asking if he has had it twenty years. If he says, 'O no,' ask if for ten or five years, and so narrow it down to years or months, if possible.

"Again, you will find that patients are apt to jump huge spaces of time. Most of them dread coming to a doctor and get excited. When they tend to jump time, bring them back. Get a good chronological order of symptoms. Pain and vomiting have a different significance from vomiting and pain. Chronic bronchitis may be characterized by cough and shortness of breath; chronic heart trouble by shortness of breath and cough.

"Next, let us take up the actual method of getting at the family history. Ask about the father, mother, brothers and sisters. If any are dead find out what they died of, and how old they were at death. For instance, death in child-bed in a family with tuberculosis almost always means tuberculosis. Thus you may find from the family history that there is a tendency to a disease. Remember to inquire about past illnesses, but don't mix them up with the present illness. Don't ask if he has ever had any other disease, but ask about specific diseases, as measles, scarlet fever, and so on. Don't be content with his statement that he has always been healthy. He will probably overlook the very thing that you wish to know. Any mistake in the interrogation is your own fault. Be sure to make your systematic interrogation complete.

"Having a good account of present illness, family history and former illnesses, go on to social history. It is very important. You want to get what light you can from this, get at what part it plays in the illness. It is not so important to know whether or not he is a total abstainer or a mild drinker, but it is important to know whether or not he is a mild drinker or a drunkard. Don't ask if he has a good appetite. Different people have such different ideas of a moderate appetite. There, again, have an absolute understanding with the patient. Ask what he eats and how much. Get at his food and times of eating. Find out what he eats between meals. The fault is not the patient's if he does not tell the things he is not asked about. Ask when he takes his last meal. More than half the cases of palpitation of the heart are due

to a full stomach on retiring. Thus food, tobacco, alcohol, are all important to you. Get at the actual amounts and when they are taken. A glass of wine with a full meal will have less bad effect than a cup of strong tea on an empty stomach before going to bed.

"Ask what he actually does in the way of exercise. You want to get at his conditions at home. There is no greater diversity than between two patients and their ideals of comfort. You must also get at his condition at work or you will miss out. They won't tell you many of these things unless you ask, but you must get at these details. These points seem trivial, but they count for a good deal and you shouldn't overlook them.

"The osteopath misses out in this great healing art because he has the tendency to overlook these fine points. Is it any wonder that the M. D. prides himself on his diagnosis, for this is the one thing he can do, although after he gets it he can do little more than give palliative treatment. The osteopath has the advantage of a curative treatment. He should be able to diagnose as well as treat. When the patient comes to you remember that first of all you are a physician, after than an osteopath. Be prouder to be a physician than anything. After that be proud to be an osteopath. Are you going to be an osteopath and an osteopath only, or are you going to be an osteopathic physician. I would rather dig ditches than be a mere osteopath. Do you resent that? No, I know you don't, for there is no greater word in the English language than the word physician. Man is a machine, but he is more than a machine, and if you miss out in that human touch with your patients, that which is more than a routine osteopathic treatment, you will not be the most successful kind of osteopathic physician."

LOCATIONS AND REMOVALS



- Allen, Dr. Lewis W., from Rutland, Vt., to Westport.
Bennett, Dr. M. G. E., from Lincoln to Superior, Nebr.
Brown, Dr. A. F., 3-4 Chambers & Stewart Bldg., Mt. Clemens, Mich.
Bruce, Dr. J. O., from McCook to Maywood, Nebr.
Dandy, Dr. Helen Agnes, from Princeton, Mo., to First Natl. Bank Bldg., Brush, Colo.
Dilley, Dr. Sarah L., from Hoxie to Lyons, Kans.
Frey, Dr. Julia V., from 1210 to 1645 E. Sixteenth Ave., Denver, Colo.
Getty, Dr. Blanche M., from Pagosa Springs to Fowler, Colo.
Hay, Dr. G. W., from Chicago to Geneva, Ill.
Kerr, Dr. Frank Austin, from 27 S. 12th Street, to 518 McIntyre Bldg., Salt Lake City, Utah.
Kingsbury, Dr. L. C., Ballerstein Bldg., 904 Main St., Hartford, Conn.
Larmoyeux, Dr. Helene, Laredo, Texas.
Learner, Dr. G. C., from Freehold, N. J., to 111 Bidwell Parkway, Buffalo, N. Y.
Link, Dr. E. C., from Elizabeth, N. J., to 339 Atlantic St., Stamford, Conn.
Lynn, Dr. Olivia A., from Stamford, Conn., to 1150 Chapel St., New Haven, Conn.
Murphy, Dr. J. W., from Sedro-Wolley, Wash., to Katalla, Alaska.
Nichols, Dr. Paul S., from 11 N. Franklin to 23 1-2 N. Sandusky St., Delaware, Ohio.
Shupe, Dr. Grace, Suite 7, Gertrude Apts., Monongahela, Pa.
Smith, Dr. E. Randolph, from New Warden Block, to over Carter & Fantis, Garden City, Kans.
Smith, Dr. J. O., from Waseca, Minn., to Menominee, Wis.
Snare, Dr. W. P., 1950 Dahlia St., Denver, Colo.
Stryker, Dr. Anna K., 201 W. 105th St., New York City.
Tuttle, Dr. Eva M., at 528-29 Marquam Bldg., Sixth and Morrison Sts., Portland, Ore.
Wheeler, Dr. Jenness D., from Sarasota, Fla., to 37 Earl St., Malden, Mass.