1946

1946 Clinic Yearbook

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The fateful, fighting years of nineteen hundred and forty-two to nineteen hundred and forty-six will be chronicled by many hands. Our accounting will not reach history’s archives—it is removed from the fields of our nation’s mighty battles. Although a simple one, we hope that it is still a worthy contribution. It is a story of study in the gloom and shadow of total war, study and practice to soothe and heal the wounds wrought by man upon man.

In the summer of 1942, when many of us came to Jefferson for the first time, the frontiers of freedom were pushed back by the forces of evil . . . to El Alamein, to Stalingrad, to Guadalcanal. Free men fought against terrible odds, victory lay in the dim, unforeseeable future . . .

Then it was that iniquity cast its shadow over a wounded world . . .
Such was the backdrop of our first sight of Jefferson ...
With the initial feelings of trepidation dispelled by the Dean...
Gentleman, Scientist, Teacher—The man who painted us a vivid picture of the human organism waging a ceaseless struggle against its environment—the man who taught us to scorn the dictum of post hoc, ergo propter hoc and substitute a rational, vital concept of the pathogenesis of disease—the man who gave the words "Health" and "Disease" a fuller, more profound meaning.

... we satisfied his searching appraisal.
Few teachers have brought to the dissecting room the camaraderie and zest for productive effort as Dr. Michels. These admirable attributes and mastery of his subject led to the unanimous choice of Dr. Michels as dedicatee.

In March, 1929, he established his first contact with Jefferson Medical College when he met Dr. J. Parsons Schaeffer at the 45th session of the American Association of Anatomists held at Rochester University. Impressed with the high-mindedness, scholarly attitude and gentleman-like character of Dr. Schaeffer, he accepted his invitation to come to Jefferson and was appointed Associate Professor of Anatomy in 1929.

Dr. Michels received his M.A. degree in 1918 at the University of Minnesota. Dr. Downey sponsored his major (hematology) and Dr. Lee of the Medical School sponsored his minor (microscopic technique). Further study carried him to Louvain University, Belgium, where he was awarded maxima cum laude the doctorate degree (Docteur en Sciences Naturelles) in 1922.

From Louvain Dr. Michels went to Siena University, Italy. Here with Dr. Ferrata he investigated prehepatic embryonic blood formation and with him showed the hemohistioblast to be the most primitive type of circulating blood cell. At the time of his coming to Jefferson Dr. Michels was American Editor of Ferrata's blood journal Haematologica.

In his extensive travels in Europe Dr. Michels visited twenty universities and for a time attended the University of Paris.

Upon returning to the U. S. A. he worked with Dr. Maximow at the University of Chicago on tissue cultures, in particular the explants of blood cells. Leaving Chicago, Dr. Michels went to N. Y. U. and the Bellevue Hospital Medical School. Here with Dr. Globus, prominent neuropathologist of Mt. Sinai Hospital, round cell infiltrations in diseases of the central nervous system were jointly studied.

In 1926, Dr. Michels was appointed Assistant Professor of Biology and Histology at St. Louis University Medical School.

He is the author of Section IV (Mast Cells) of Dr. Downey's Handbook of Hematology. His contributions to hematological literature are many.

Since 1936, Dr. Michels has been studying the variations in the arterial blood supply of the supramesocolic organs. At the present he is preparing a large monograph on the variations of the blood supply of the liver, gall bladder, stomach, duodenum, and pancreas.
In April, 1943, the United Nations were resurgent on all fronts... the campaigns which were destined to drive the Axis inexorably to defeat were begun, but the road to victory was long and bitter.

Against the backdrop of this titanic struggle, we returned to Jefferson to begin our studies. It was impossible for us to detach ourselves completely from the world around us... our own troubles and worries were dwarfed in the broad perspective. On not a few occasions concentration on studies was impossible, and many of us longed to take a more active role in the world conflict... but we came to realize, finally, that we were making our most valuable contribution here at Jefferson, learning the art of healing.
... that first registration line, at the desk of the indefatigable Mr. Storm ...
Robert P. Hooper, President of the Board of Trustees. A man of vision, whose love and admiration of Jefferson are as far-reaching as his plans for a greater Jefferson of tomorrow.

Joseph O. Crider, M.D., Assistant Dean and Associate Professor of Physiology, whose unobtrusive thoroughness has been a Jefferson bulwark and whose clear presentation has clarified many of our problems in physiology.
These are the men who contributed much to the classical background of Jefferson. Unyielding time withdraws them from the teaching halls, yet their fundamental principles in medicine and surgery remain to guide their successors. To them, we of '46 owe a debt yet unpaid.
Before opening our books, we became acquainted with the environs of Jefferson...
... with the places we were to know so well.
LIBRARY

At first awed by the great products of medical knowledge contained in the Samuel Parsons Scott Memorial Library, and bewildered by the multitudinous volumes and indices, we soon felt at home, thanks to our affable librarian, Mr. Joseph J. Wilson, and his capable assistants, Mrs. Marjorie Lentz and Miss Marion Fretz.
OFFICE STAFF

Mr. Storm
Miss Bremerman
Miss Wint
Miss Jay

Miss Huth
Miss Ziegler
Miss Carter
We began with a box of bones under one arm and Morris' Anatomy under the other. Advice from sophomores was plentiful, but there were as many conflicting stories as there were sophomores. We didn't know which way to turn, and we were frankly scared. Those first days we studied with a feverish energy which eventually died down, never to be rekindled. Far into the night we pondered the gentle mysteries of the first rib, the typical thoracic vertebra, and the carpus. Dr. Bancroft intoned solemn assertions on our ignorance; we didn't have to be told. We slinked around like whipped dogs. Thus, with proper humility, we commenced the study of medicine.

... withal, we could not forget the momentous events occurring in other parts of the world ...
yet realizing the master word in medicine is work.
Dr. Michels, with his ultra-blunt dissection, was the envy of all impulsive would-be surgeons. Then there were those colorful lectures and those early morning hours spent studying the microscopic appearance of different tissues under the firm but friendly guidance of Drs. Ramsay and Bates.

The anatomy of the nervous system was undertaken in the second year, after a respectable interval for recovery. With the enthusiasm and abilities of Dr. Schaeffer and Dr. Benjamin Lipshutz, an otherwise impossible maze of anatomical confusion became clear. This knowledge blossomed forth in senior neurology, giving us insight into a group of diseases.

The junior year saw a much needed light shed upon an already familiar subject from a most practical angle. Dr. Bonney and Dr. DeCarlo are responsible for the excellent clinical correlations to anatomy that were emphasized in this course. Recourse to lectures and five weeks of dissection in applied anatomy were afforded.

Such was the character of our pre-clinical training at D. B. I. Exhaustive and time-consuming? Yes, but eminently practical because it gave us a foundation without which future medical education would be merely an evanescent edifice in air.

ANATOMY

Anatomy—one of the foundations of rational medical practice, is to the novice a critical test of his stamina.

The career of the embryo anatomist has a somber beginning. Almost at once he is introduced to a cadaver, with which he will spend a considerable portion of his life during his freshman year. At first the relationship is strained but eventually this weird companionship becomes more tolerable; indeed during pre-examination season, there are additional visits to the laboratory, after and before class. Even the sleeping hours do not dissolve this companionship, for at night the weary femora, humeri, et al., recline beneath the bed of the ardent young Galenic disciple.

Dr. Schaeffer, prominent in his field and editor of Morris' Human Anatomy, was indispensable. That this was the students' regard for him is attested by his now firmly established cognomen, "Great White Father". His possession of the proper proportions of genuine human interest and objective scientific spirit has won him his pupils' respect and affection.

Dr. Bennett gave zest to his oral quizzing.
When as freshmen we entered the spacious auditorium for the opening lecture of the course in bacteriology, little did we realize that we would be the last group of medical students fortunate enough to be trained by a physician with fifty years' experience in practicing and teaching the art. For, shortly after we became sophomores we were all deeply grieved to hear that Dr. Randle C. Rosenberger, Professor of Bacteriology, had been stricken down by a disease of unknown etiology, myelogenous leukemia.

To say that we were taught bacteriology by Dr. Rosenberger and his able colleagues, Doctors Kreidler, Blundell and Meranze would be a masterpiece of understatement. Under their vigilant guidance we were introduced to such famous personalities as Streptococcus, and his brother Staphylococcus, to their first cousins Gonococcus and Pneumococcus, to their friends the Bacilli family, and even their distant relatives the Spirochaetes, Parasites and Rickettsiae. Agar slants and Petri dishes became as familiar as salt and pepper, the techniques of many stains were practiced, memorized for the examinations and soon forgotten again; the morphology of the diplococci and Neisseria were ground deeply into our cerebral cortex; parasites and viruses were convicted of mass murders, and before it was all over not a few of us were convinced that we had learned something in the way of etiology. We were given an excellent series of lectures and when our final practical and written examinations rolled around we were all convinced that we had been schooled in bacteriology as well as any group of medical students anywhere.

We have missed Dr. Rosenberger's familiar encouraging remarks during our clinical years, but we know that the bacteriology department under Dr. Kreidler, his close friend and associate, has continued to uphold the high standards of teaching and efficiency which he as Professor demanded of everyone associated with it.

Who knows, maybe some day in the not too distant future one of the members of this class may stumble upon the etiology of leukemia.
CHEMISTRY

With the retirement of Dr. George Russell Bancroft in June, 1945, a chapter in the history of chemistry at Jefferson came to an end. The encyclopedic course in Physiological Chemistry, with liberal portions of etymology, botany, mineralogy, animal husbandry, and metaphysics became a memory.

We recall Dr. Bancroft as a man of inexhaustible energy, great personal integrity, and deep sincerity. His knowledge of matters animal and vegetable and mineral was vast, and his storehouse of facts bottomless. As we look back, with as much detachment as is possible, upon the course in chemistry, we discover that we memorized an unbelievable number of complex formulae, and thereupon quickly forgot most of them. Our concepts of chemistry are inextricably entwined with the Venus fly-trap, the Dalmatian coach-hound, whale milk, and the tinkle of glassware. Faint memories of a terrible morning spent chewing paraffin and analyzing the saliva thereby generated appear before us. Friday afternoons making up back work in a lonely laboratory. Our first introduction to the business end of the Rehfuss tube.

Dr. Bancroft was succeeded by Dr. Abraham Cantarow, who had been associated with Jefferson Medical College and its Hospital for twenty years. At the time of his appointment to the chair of chemistry, he was associate professor of medicine, and biochemist to the Jefferson Hospital. Under Dr. Cantarow a new department of chemistry, different in many ways from the old, is taking shape. Dr. Cantarow brings to the department of chemistry a broad background of teaching and practice in clinical medicine, as well as wide experience in the laboratory both as teacher and investigator. He is uniquely fitted by this background to present the subject of chemistry to the student in its true relationship to medicine as a whole. The spirit of investigation, so conspicuously absent in recent years, has been revived. The prospect of a department of chemistry unsurpassed by any medical school in the country seems very bright indeed.
We, as sophomore students recently released from the ravages of our freshman year, shall never forget that first day in the laboratory of physiology on the fourth floor. We entered this domain of knowledge on this particular day wherein we were to learn the phenomena associated with life and characterized by the ability to assimilate food, to respire, to metabolize, to eliminate, and to reproduce. There we found our seats by some arithmetical equation, were handed a book of laboratory directions and told to proceed. Some of us had never pithed a frog before; most of us had never correctly "smoked" a drum before; all of us had never before been permeated by a spirit for experimentation on living animals. We sat there dazed for a few minutes not knowing what to do or how to do it. We were puzzled by the mystic indifference of the men of the department. But soon a few brave souls ventured out to do the work assigned and started the ball rolling; and with each roll of the ball, there was a gain in momentum so that by the end of that semester, we had gained invaluable knowledge of those little things which make us go. We then realized that what we thought was unconcernedness on the part of our teachers was actually an attempt to inculcate within us an exemplification of the experimental attitude.

Our laboratory sessions, directed by Dr. Crider, were three in number, two of which were conducted by the students themselves, and the other by members of the staff. In the afternoon we had excellent lectures in physiology delivered by our unassuming yet versatile professor, Dr. J. Earl Thomas. On various occasions, Dr. Paschki, Dr. Friedman, and Dr. Hart would take over and deliver lectures on subjects most dear to their hearts. Then, of course, there were those weekly lectures given by that juggler of the blood cells, Dr. Tuttle (since retired), whose distinguishing characteristics of personality and ambidexterity will always remain with us. Rounding out the program, there were those weekly recitation hours with various members of the staff.

Thus did we obtain an important link in our chain of medical education.
The laboratory during the same year was under the direction of Drs. Stasney, McGrew, and Scaricaciottoli. How well we remember those famous words of Dr. Stasney—"Tak another luk;" or those classical descriptions of microscopic slides—from necrosis to misplaced chromosomes—of Dr. McGrew in his own inimitable ways; or those silent hints and aids given to us by Dr. Scaricaciottoli both in the laboratory and recitation rooms. Further, we attended various autopsies, and had special practical examinations on pathological specimens, and became acquainted with neuropathology under the direction of members of Dr. Alpers' staff. Since "our time," Dr. McGrew has left Jefferson; and a new course in surgical pathology has been added to the sophomore year.

The course in our junior year consisted only of lectures in organ pathology presented by Dr. Stasney and afforded us an excellent review and broader concept of our sophomore pathology. Further, these dissertations were spiced by journeys to P.G.H., and high-lighted by "the Chief" on discussions in a subject dear to him and us alike—"Shock and Related Capillary Phenomena."

Thus was another rock in the foundation of Medicine laid next to those of Anatomy, Physiology, Chemistry, Bacteriology and Pharmacology.

"Gentlemen"—for that was always how our unpretentious, yet steadfast, Professor of Pathology, Dr. Virgil H. Moon, addressed us—"Gentlemen, you are now sophomores, and as such, you must know the subject of pathology; for as Sir William Osler said, 'As is our pathology, so is our practice.'" Thus were we introduced to a new field of study and a new teacher; and soon after, both in our sophomore and our junior years, we learned through hard and tedious work in an efficient and orderly manner the full import of the above quotation.

During the lecture periods in our sophomore year, Dr. Moon acquainted us with the morphological evidence and manifestations of the process of a disease, its gross and microscopic characteristics, and its cause and effect especially upon function; and he tried to show us how disease is an abnormality of structure, function, or both. Further, it was his special delight to give short and impromptu quizzes so that we might get practice in answering questions not only adequately but also concisely and to the point.
We didn’t fully appreciate our course in Pharmacology while we were taking it. We lived in perpetual fear of the day when Dr. Gruber would burst into the lecture room with a broad grin on his face and a package of blue books under his arm. We despaired of retaining one-tenth of his rapid-fire lectures. We couldn’t find Wharton’s duct, let alone put a canula in it. We struggled with prescription Latin to no avail. The terrors of the apothecary’s system and that endless list of doses haunted us. Periodic quiz sessions with Dr. Gruber did absolutely nothing to restore our equanimity and peace of mind. In a word, we were less than completely happy.

But with the objectivity which comes with the passage of time, we can look back and assay the work in the Department of Pharmacology in its true light. In a considered appraisal, many facts emerge which were not formerly apparent. The essence of the course was a systematic investigation into the origin, nature, action, and dangers of a vast number of drugs. Dr. Gruber, himself an experimental scientist of first rank, presented the wide array of material, being careful that no statement was not firmly supported by experimental evidence. He cited chapter and verse, and, when workers disagreed, gave both aspects of the problem. This rigorous training was to prove invaluable to us in our later study of medicine. When mystic claims for the efficacy of this drug or that were pronounced, supported by vague “clinical experience,” we were able to look on with polite skepticism. Our firm grounding in pharmacology admirably equipped us to practice rational therapeutics.

Mornings in the Pharmacology Laboratory were among the most rewarding hours of our preclinical years. The experiments were cleverly devised and carefully planned, and generally worked out successfully, even in our inexpert hands. Dr. Ross Hart’s well-knit lectures on anesthetics proved an excellent introduction to an important subject. As for toxicology, we derived the general idea that blurred vision, nausea, vomiting, and diarrhea are the symptoms of poisoning by practically anything, but we’ll never forget to give picrotoxin one milligram per minute until recovery or facial twitching, for barbiturate poisoning.
In September, 1944, with those difficult preclinical years behind us and examinations passed, we paused for a brief vacation from study. Then we realized the great changes that had come about since that first trip to D. B. I. The second front was now an overwhelming reality, and victory in Europe seemed close at hand. Little did we realize the terrible cost yet to be paid in the Belgian bulge. Our men in the Pacific moved inexorably on. For us, the intensive fundamental studies were over.

...we moved on to the clinical years,
to the realization that medicine is, indeed, a jealous mistress...
Our course in medicine was one of extraordinary breadth and compass. One extreme was Dr. Erf's learned dissertation on the complexities of nuclear physics; on the other, Jake's literal demonstration of the technique of the soap-suds enema. Between them lay a vast potpourri of clinics, laboratories, lectures, and clerkships—the heart of our medical training at Jefferson.

We were initiated into the mysteries of medicine back in the dim shadows of sophomore year. The diagnosis of disease was approached from two points of view. Dr. Robert Charr introduced us to the patient, and we practiced the ancient art, of physical diagnosis. We came to realize that the physician's five senses still formed the cornerstone of his diagnostic armamentarium. Dr. Abraham Cantarow's course in laboratory diagnosis revealed the other side of the picture. Here disease was viewed as pathologic physiology and we studied its manifestations in the secretions, excretions, and body fluids of the patient.

Then came junior year, and the opportunity to put the principles we had learned to a trial. As we worked on the wards of the Jefferson Hospital, the realization grew that there was a world of difference between the textbook and reality. We came to understand that the practice of medicine consists not of the treatment of disease per se, but of sick people. Dr. Reimann proved to be a stern and uncompromising taskmaster. We grumbled a bit, at first, but we soon came to realize that his insistence upon correctness in speech was just one expression of his whole philosophy of exactness and precision of thought, word, and deed. Any habits of loose thinking were quickly and permanently eradicated.

During this year we took a superbly organized course dealing with the parasitic diseases, under Dr. William Sawitz. Many of us considered it a model for the teaching of medicine. Instead of the customary description and dogmatism, the subject was treated in a fashion that emphasized the application of logical and scientific principles. Dr. Karl Paschkis gave us a glimpse of a vast, new, fascinating field, filled with unsolved problems and much hope for the future—endocrinology.

The problem of the correlation of the mass of material we had accumulated remained for the final year. In the medical outpatient department we were faced with the enigma of the chronically ill patient. We were chagrined to discover that many of them lay beyond the help of rigorous scientific medicine. We cautiously probed an old field with a new name—psychosomatic medicine. Dr. Martin Rehfuss' omnibus course in therapeutics equipped us to deal with every problem from hiccup to hemorrhoids. We ventured afield to the wards of the Pennsylvania Hospital and the Philadelphia General Hospital.

And in the end we emerged, fully cognizant of the limitations of our knowledge, but with the realization that our training equalled the finest obtainable.
SURGERY

Surgery, as we know it today, represents a specialty of refined diagnostic methods and rational supportive therapy in addition to the mere mechanics of operation; finally, "good judgment" must be at the base of all these factors.

Dr. Shallow's clinics afford the neophyte an opportunity to cultivate these precepts under the direction of a renowned and capable surgeon.

Likewise Dr. Muller's contributions in this regard were memorable. Further, he exemplified the equanimity of William Osler, in his relationship with the patient.

Surgery was first presented to us as sophomores when Dr. Behrend discussed minor surgery and the principles of pre-operative and post-operative therapy. Dr. Surver taught us the principles of asepsis, burn treatment, and treatment of shock and hemorrhage.

It was in our Junior class in Operative Surgery that we were initiated into the fundamental principles of operative technique under the guidance of Dr. Rankin and Dr. Robertson.

In spite of the pressure of acceleration, the other phases of this subject were well presented through the patient efforts of the surgical staff. Special lecture series on various hernias and their complications, principles of vascular surgery, the pathology of surgical lesions, proctology, neuro-surgery, orthopedics, fractures and their treatment, principles of anesthesia, and thoracic surgery were given.

Practical experience during the senior year, studying patients from admission through operation and discharge was afforded. However, we must not forget those calls at 3 A. M. for emergencies only to arrive (2 hours later) as they wheeled the patient from the operating room. Then there were those early morning lectures in which Drs. Knowles and Wagner worked feverishly to unravel the mass of confusion compiled during our junior year.

All in all, a comprehensive, general, fully balanced foundation in surgery has been our lot. Those of us who may later turn to this specialty, as a life work, will become increasingly grateful to our surgical faculty, for this excellent background; for the rest of us, this basis in surgery will prove an essential complement to general practice or any of the other specialties.
OBSTETRICS

We live in the shadow of grand events; we walk in the footsteps of mighty men. For in our four short years we have been versed in the art and lore of such as Soranüs of Ephesus, whose hands have so often guided those of Dr. Giletto as he instructed us in the manikins; of Mariceau, whose accounts of the conduct of normal labor, the employment of version, and the management of placenta praevia must yet be uttered with fervor to us, the embryo obstetricians of today, by his far-remote yet no less glorious pupils, the Doctors Clifford Lull, Mario Castallo, and Bernard Bernstine; we have also seen the advent of Caudal Analgesia, that newest obstetrical colossus, whose giant shadow towers over the pain of childbirth—almost obscuring it; and with this advancement, too, the names of those in Jefferson stand out.

As the sun rises each day so with no less regularity does each senior Thursday obstetrical clinic and Monday junior clinic roll back the veil of obstetrical blackness which had almost claimed us, as it did those in the dark ages of the world. In these clinics—to us another routine lecture—stands one of the clearing houses for American obstetrical information—Dr. Norris Wistar Vaux. For his duty it is to sort the facts originating from a William Hunter, a Smellie, a Baudelocque, a Chamberlen, an Oliver Wendell Holmes, a Semmelweis, a Tarnier, a Credé, a Porro, a Von Graefe, a Potter, a Sanger, a Dewees, a Waters, or a DeLee from those of some up-to-date mountebank, and present that knowledge to us through the media of his weekly obstetrical triplex.

With our coupled services in the O.P.D. and ward, we learned the normal, the warning signals, and the abnormal—knowing that often alone to our hands, to those of the classes we have followed, and who will follow us have been entrusted the souls of generations yet unborn.

The inspiration of their teaching has become ours, our future progress will be their reward.
ORTHOPEDICS

It was on a late Friday afternoon at the beginning of our Junior year that we first were exposed to the subject of Orthopedics under the able tutorage of our professor, Dr. Martin. In his didactic lectures, he first introduced us to the scope of orthopedic surgery by delineating the subject of the prevention and correction of deformities and the treatment of the diseases of the joints in general. Thereupon there followed concise and descriptive accounts of the individual congenital and acquired diseases and deformities. As rheumatic infection is to Dr. Bauer, so diseases of the hip joint are to Dr. Martin such as Legg-Calvé-Perthes’ Disease with its musically sounding synonym, Osteochondritis Deformans Coxae Juvenilis. We labored to learn the differential definitions of Osgood-Schlatter’s Disease, Köhler’s Disease, Scheuermann’s Disease, Kienböck’s Disease and Kümmel’s Disease.

In our senior clinic, we were exposed to patients exhibiting various orthopedic problems from Torticollis to Colles’ Fracture. Our section work consisted in being present at and assisting in various surgical operations and in the actual applying of casts, etc., under the direction of Drs. Martin, Davidson, and Hand. Thus we received ample instruction in a very important field.

PEDIATRICS

“Gentlemen, the necessity of the use of the five senses and not laboratory test tubes is imperative in the study of children’s diseases.” Such was the essence of the lectures in the “Bauer Hour” on Thursdays at Four in our Junior year. Yes, we were taught the diagnosis and management of the various diseases of childhood; but we were further exposed to humorous anecdotes of worldly knowledge from acrid statements of a political nature to the “erection to resurrection” of socialized medicine. In addition we obtained actual pediatric experience under the capable Dr. Mac Neill and assistants. How well we remember such statements as: “Bring me a baby, Miss Bieber,” “What are the contraindications to breast feeding?” “Did you inspect the ear drums?” and “These Juniors will never make physicians.” It was also during this year that we took our sundry trips to Municipal Hospital.

In our Senior clinic on Saturdays at Twelve under the guidance of our resolute professor, we were shown cases of clinical interest. But we were more impressed by Dr. Bauer’s dissertations on Rheumatic Infection than any of the other topics of discussion. Also during the year we received further practical experience in the pediatrics ward.

Thus we obtained a well-diversified knowledge of medicine in general, as it pertained to children, in particular.
UROLOGY

Dr. Davis, urologist and teacher ever stimulated us with “God gave you a brain didn’t he—he—well use it” or “Doctor, take your hot little hands out of your pockets and examine the patient.” To know the man was a rare privilege.

We first met in our Junior year at a series of lectures on male and female plumbing and rusty pipes. The drawings were beautifully done. By the end of the year we could clean the trap in the kitchen sink or pass a soft rubber catheter.

Drs. Baker, Bogaev and Fetter in the O.P.D. (and a female at the desk) caught our interest and we immediately took to massaging prostates.

As Seniors, ward rounds and clinics were either horrible or delightful (depending on whether you presented your patient or not). Later with forewarnings from Miss Kutz and help from Dr. Lubin we caught the idea and sounded off like experts.

The day a Negro tried to walk off with a lost filiform in his bladder will not be forgotten by doctor, students or patient. Cystoscopes nos. 20, 22, 24 and 26 were used to retrieve it. Dilatation? Yas! Suh!

DERMATOLOGY

Fridays from two to three Drs. Knowles and Decker introduced us to scabies and tabes, fifty per cent of our Junior year the Seniors said, since it consisted of scabies, tabes, rabies and babies.

By the end of the first hour we were experts on split peas and the anatomy of the epidermis. Three little words, liquor carbonis detergens, given us the second hour made us all big skin men. Lectures were well illustrated, and so we rested after lunch.

Individually, Drs. Corson and Wilson amazed us in the clinic by diagnosing and treating not less than fifty patients in a single morning. Precipitated sulfur, salicylic acid and lanolin will do the trick.

Dr. Decker’s talks on syphilology, his ready wit and philosophy were excellent. Was it Columbus or the Indians still remains a question. The Nina, Pinta and Santa Maria brought men to a new land. Here in Dermatology are lands awaiting a new Columbus.
We were introduced to the highly specialized science of ophthalmology in the clinical amphitheatre on Friday afternoons of our senior year. Little time elapsed before Professor Charles E. G. Shannon won the hearts of all seniors with his ever pleasant personality and thorough knowledge of the subject. His informal quizzes never failed to bring out the highlights of the previous lectures. No one feared them because Dr. Shannon had an uncanny knack of making one feel completely at home, even in the Pit. His lectures on conjunctivitis, sympathetic ophthalmia, keratitis, and iritis were models of conciseness.

Dr. Carroll R. Mullen caught and held our attention like magic with his sterling presentation of glaucoma. Those lessons will, indeed, be well remembered. The intricate physiology of the eye was explained to us by Drs. Olsho and Hunt.

Those afternoons in the O.P.D. were remarkable for the number of patients seen in one short hour. It was the firm purpose of Dr. Hunt to see that we would not be ignorant of, nor fail to recognize, any eye lesion apt to be met in practice.

It has been a rare opportunity indeed, to be fortunate enough to have been taught in so excellent a gynecological clinic as ours, and to have received instruction under such a distinguished clinician as Dr. Lewis C. Schefley. As Juniors we recognized early that his Monday evening lectures embodied everything sound and progressive in gynecology; the principles he taught arising from the best in such men as our own Marion Sims, Tait, Simpson, McDowell, Sampson, Kelly, Anspach, Curtis, Goodell, Graves, Taussig, and those many other "voices" in gynecology. He has organized a department steeped in unanimity and cooperation; as Seniors, Doctors Montgomery Mohler, Thudium, MacCarroll, and Lynch helped him to verse us in the Wards, the O.P.D., and in the Thursday afternoon Pathology sessions. Here we were permitted to see our teachings applied and watch the unending struggle against malignancy.

Recognizing that knowledge of facts, however numerous they may be, is not education, they tried to teach us to observe and to think; the need of work and how to work; to instinctively coordinate our observations and reading; to have ideas, ideals, hopes, and enthusiasms—voices instead of echoes—springs instead of wells.
Probably one of the most important things in medicine is detail, a knowledge and observation of particulars. Although this is true of most specialties, it finds its greatest application in radiology for here one cannot depend on auxiliary measures in diagnosis. It is imperative, therefore, that an accomplished and competent man be entrusted with the teaching of this subject. In this respect, we were fortunate in being associated with Dr. Paul C. Swenson, who is considered an outstanding man in the field of Roentgenology. It was through his efforts that we, as Juniors, learned how to observe accurately and how to interpret our observations in differentiating the roentgenological appearance of many diseases. The proper method of "internal inspection" and a careful correlation of the shadowgraph with the clinical findings were stressed. This instruction was carried over into the Senior year, when opportunity was afforded for individual attempts at interpretation under the critical eyes of Dr. Swenson.
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Hartford, Conn.
Trinity College, B.S.
ΛΩΛ ΛΚΚ
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
DWIGHT
RANSFORD
ASHBEY, JR.
Chestnut Hill, Pa.
Franklin & Marshall College,
B.A.
ΘΚΨ
Bryn Mawr Hospital, Bryn Mawr,
Pa.; 1st Lieutenant, M.C., A.U.S.

CLAUDE
LIDDELL
AUSTIN
Winona, Miss.
University of Mississippi,
B.A., B.S.
ΦΧ
Shreveport Charity Hospital,
Shreveport, La.
EDWARD
BLAKE
BABCOCK
Bangor, Me.
Bowdoin College, B.S.
N S N K B F
Jersey City Medical Center, Jersey City, N. J.; 1st Lieutenant, M.C., A.U.S.

1946

HERBERT
JOSEPH
BACHARACH, JR.
Clearfield, Pa.
Gettysburg College, A.B.
K K K
Mercy Hospital, Pittsburgh, Pa.
CLIFFORD
ASHTON
Baldwin, Jr.
Merchantville, N. J.
Dartmouth College, A.B.
A K K
Cooper Hospital, Camden, N. J.;
1st Lieutenant, M.C., A.U.S.

1 9 4 6

WILLIAM
HEWSON
BALTZELL
Chestnut Hill, Pa.
University of Pennsylvania, B.A.
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
AARON DAVID BANNETT
La Salle College, B.A.
Φ Δ Ε
Jewish Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

CHARLES CLIFFORD BARRINGER
Chapel Hill, N. C.
University of North Carolina, B.A.
ΑΚΚ
U. S. Naval Hospital; Lieutenant (j.g.), M.C., U.S.N.R.
MYRON BASH
Trenton, N. J.
Franklin & Marshall College,
B.S.
Φ Δ E
Mercer Hospital, Trenton, N. J.;
1st Lieutenant, M.C., A.U.S.

CHARLES EDWARD BICKHAM, JR.
Camden, Ala.
University of Alabama, A.B.
Φ B Π
U. S. Naval Hospital; Lieutenant
(j.g.), M.C., U.S.N.R.
MAHLON
ZWINGLI
BIERLY, JR.
Drexel Hill, Pa.
Franklin & Marshall College, B.S.
ΘΚΨ
Bryn Mawr Hospital, Bryn Mawr, Pa.; Lieutenant (j.g.), M.C., U.S.N.R.

AL
BLAKE
Spartanburg, S. C.
The Citadel, B.S.
ΑΚΚ
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
JOHN ALOYSIUS BONGIOVANNI
Drexel Hill, Pa.
Villanova College, B.S.
Pennsylvania Hospital, Philadelphia, Pa.; Lieutenant (j.g.), M.C., U.S.N.R.

HOMER WILSON BOYSEN
Egg Harbor City, N. J.
Ursinus College, B.S.
Jefferson Hospital, Philadelphia,
WILLIAM DOUGLAS BRANDON
Lancaster, Pa.
Franklin & Marshall College, B.S.
Φχ
Bryn Mawr Hospital, Bryn Mawr, Pa.; 1st Lieutenant, M.C., A.U.S.

1946

I. RALPH BURBRIDGE
McKeesport, Pa.
Bethany College, B.S.
ΛΩΑ ΛΚΚ
Sacred Heart Hospital, Allentown, Pa.; 1st Lieutenant, M.C., A.U.S.
RALPH
ANTHONY
CARABASI
Bala-Cynwyd, Pa.
University of Notre Dame, B.S.
ΦΑΣ
Fitzgerald-Mercy Hospital, Darby, Pa.; 1st Lieutenant, M.C., A.U.S.

A. JOSEPH
CAPPELLETTI
Waterbury, Conn.
Providence College, B.S.
ΦΑΣ
ΚΒΦ
Waterbury Hospital, Waterbury, Conn.

1946
1946

GEORGE AUGUST CARBERRY
Gary, Ind.
University of Notre Dame, B.S.
Φ Λ Σ
Nazareth Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

SALVATORE RICHARD CARRABBA
Hartford, Conn.
Trinity College, B.S.
Α Κ Κ
St. Francis Hospital, Hartford, Conn.; 1st Lieutenant, M.C., A.U.S.
WILLIAM STANLEY CARTER, JR.  
Hazleton, Pa.  
Wesleyan University, B.A.  
Α Κ Κ  
Jefferson Hospital, Philadelphia Pa.; Lieutenant (j.g.), M.C., U.S.N.R.

CHARLES CATANZARO  
Norristown, Pa.  
Pennsylvania State College, B.S.  
Bryn Mawr Hospital, Bryn Mawr, Pa.; 1st Lieutenant, M.C., A.U.S.
ANTHONY
EDWARD
CHMELEWSKI
Wilkes-Barre, Pa.
University of Scranton, B.S.
ΛΩΛ ΦΔΣ
Wilkes-Barre General Hospital.
Wilkes-Barre, Pa.; 1st Lieutenant,
M.C., A.U.S.

1946

ABRAHAM
LINCOLN
COHEN
University of Pennsylvania, A.B.
Φ ΔΚ
Mt. Sinai Hospital, Philadelphia,
Pa.; 1st Lieutenant, M.C., A.U.S.
THEODORE STROUD CONE

Tuscaloosa, Ala.

University of Alabama, B.S.

U. S. Naval Hospital; Lieutenant (j.g.), M.C., U.S.N.R.

HARRY LEE COLLINS, JR.

Umatilla, Fla.

University of Florida, B.S.

St. Luke’s Hospital, Jacksonville, Fla.; 1st Lieutenant, M.C., A.U.S.
BERNARD
STEPHEN
CRAMER
St. Joseph's College, B.S.
Mt. Sinai Hospital, Philadelphia,
Pa.; 1st Lieutenant, M.C., A.U.S.

VITO
LOUIS
COPPA
Providence, R. I.
Providence College, B.S.
Φ Λ Ζ
KBΦ
New York City Hospital, New
York, N. Y.; Lieutenant (j.g.).
M.C., U.S.N.R.
WILLIAM OLIVER CURRY, JR.
Ashland, Pa.
Susquehanna University, A.B.
Φ X
Geisinger Memorial Hospital,
Danville, Pa.; 1st Lieutenant,
M.C., A.U.S.

THOMAS WILLIAM DALY
Providence, R. I.
Providence College, B.S.
Φ Λ Σ
U. S. Naval Hospital; Lieutenant
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JOHN WOODROW DAVIS
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Davidson College, B.S.  
Φ Χ
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Charlotte, N. C.; 1st Lieutenant,
M. C., A.U.S.

JOHN PAUL DECKER
Spokane, Wash.
Gonzaga University, B.S.  
Α Ω Α   Φ Α Σ
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phia, Pa.; 1st Lieutenant, M.C.,
A.U.S.
ROBERT CHARLES DIETEL
South Hadley Falls, Mass.
Massachusetts State College, B.S.
A K K
Rochester General Hospital,
Rochester, N. Y.

JOSEPH F. DEVENNEY
St. Joseph's College, B.S.
Fitzgerald-Mercy Hospital, Darby, Pa.; 1st Lieutenant, M.C., A.U.S.

1946
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Wilkes-Barre, Pa.
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William-Barre Mercy Hospital,
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M.C., A.U.S.

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Bucknell University, B.S.
Robert Packer Hospital, Sayre,
Pa.; Lieutenant (j.g.), M.C.,
U.S.N.R.
CHARLES CLARK DUGAN
Harrisburg, Pa.
Cornell University, A.B.
Harrisburg General Hospital.
Harrisburg, Pa.; 1st Lieutenant, M.C., A.U.S.

1946

GEORGE NORTON ERIKSEN, JR.
Wilmington, Del.
Villanova College, B.S.
Φ Λ Σ Κ Β Φ
Delaware Hospital, Wilmington, Delaware
HARRY EARL FIDLER
Hooversville, Pa.
Dickinson College, B.S.
NΣΝ ΚΒΦ
Jersey City Medical Center, Jersey City, N. J.; 1st Lieutenant, M. C., A. U.S.

1946

JAMES JOSEPH FIEDLER
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ΦΛΣ
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CAMILLE THOMAS FLOTTE
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Franklin & Marshall College, B.S.
Jefferson Hospital, Philadelphia, Pa.; Lieutenant (j.g.), M.C., U.S.N.R.

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ANDREW WEBSTER GAUDIELLE
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Harvard University, B.S.
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Jersey City Medical Center, Jersey City, N. J.; Lieutenant (j.g.), M.C., U.S.N.R

1946

JACK GELB
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JAMES BRYSON GILBERT
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Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

EDWARD FRANK GLIWA
Elizabeth, Pa.
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RUDOLPH EDWARD GOSZTONYI, JR.
Bethlehem, Pa.
*Lehigh University, B.A.*
\[\Lambda \Omega A \backslash \Lambda K K \backslash K B F\]
St. Luke's Hospital, Bethlehem, Pa.; 1st Lieutenant, M.C., A.U.S.

EDWIN ST. JOHN GREBLE, 3RD
*Leland Stanford, Jr. University, A.B.*
\[\Lambda \Omega A\]
U.S. Naval Hospital; Lieutenant (j.g.), M.C., U.S.N.R.
JOHN RICHARD GRIFFITH
Monessen, Pa.
Tulane University and University of Pittsburgh, B.S.

Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

ROBERT AUSTIN GRUGAN
Lock Haven, Pa.
Dickinson College, B.S.

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ROBERT WILLIAM HAINES
Audubon, N. J.
University of Pennsylvania, A.B.
Johns Hopkins Hospital, Baltimore, Md.; 1st Lieutenant, M.C., A.U.S.

ROBERT ALVIN HAINES
Woodstown, N. J.
Lafayette College, A.B. ΦΧ
Cooper Hospital, Camden, N. J.; 1st Lieutenant, M.C., A.U.S.

1946
JOHN 
JOSEPH
HANLON, JR.
Harrisburg, Pa.
Franklin & Marshall College, B.S.
Harrisburg General Hospital,
Harrisburg, Pa.

CHARLES E.
HANNAN, JR.
Johnstown, Pa.
Pennsylvania State College, A.B.
Philadelphia General Hospital,
WILLIAM JAMES HARGREAVES
Johnstown, Pa.
Gettysburg College, A.B.
ΑΩΑ ΑΚΚ
Conemaugh Valley Memorial Hospital, Johnstown, Pa.

1946

DANIEL S. HARROP, JR.
West Warwick, R. I.
Providence College, B.S.
Φ Λ Σ
Rhode Island Hospital, Providence, R. I.; 1st Lieutenant, M.C., A.U.S.
JAMES

HUBERT

HAWKINS

Marion, N. C.
University of North Carolina, A.B.
U. S. Naval Hospital; Lieutenant (j.g.), M.C., U.S.N.R.

FRANK

WILLIAM

HENDERSON

Plymouth, Pa.
Maryville College, B.A.
ΦΧ
Germantown Hospital,
Germantown, Pa.
PAUL
BALABANOFF
HEUSTON
Tacoma, Wash.
College of Puget Sound, B.S.
Φ Β Π
Lenox Hill Hospital, New York,
N. Y.; Lieutenant (j.g.), M.C.,
U.S.N.R.

HENRY
WILLIAM
HOGAN, JR.
Canton, Ohio
Ohio State University, B.A.
Φ X
Mercy Hospital, Canton, Ohio

1946
HOWARD ISAACSON
Freehold, N. J.
Rutgers University, B.S.
Φ Δ Σ
Philadelphia General Hospital,
Philadelphia, Pa.; 1st Lieutenant,
M.C., A.U.S.

1946

JOHN RICHARD JENKINS, JR.
Albany, N. Y.
Duke University, A.B.
Albany Hospital, Albany, N. Y.
JAMES
JOSEPH
JOHNSON
Freeland, Pa.
Villanova College, B.S.
Φ Ρ Ξ
Misericordia Hospital, Philadelphia, Pa., 1st Lieutenant, M.C., A.U.S.

ALLEN
WILLIAM
JONES
Erie, Pa.
Juniata College, B.S.
Φ X
Allegheny General Hospital, Pittsburgh, Pa.; 1st Lieutenant, M.C., A.U.S.
HERBERT
VICTOR
JORDAN, JR.
Hanover, Pa.
Bucknell University, B.S.
Harrisburg General Hospital,
Harrisburg, Pa.; 1st Lieutenant,
M.C., A.U.S.

JOHN
ALFRED
JORDAN, JR.
Mount Pleasant, Pa.
Pennsylvania State College, B.S.
Jefferson Hospital, Philadelphia,
Pa.; 1st Lieutenant, M.C., A.U.S.
WILLIAM MARTIN KANE
Wilkes-Barre, Pa.
University of Scranton, B.S.
Φ Β Π
Misericordia Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

JOHN M. KELLER
West Virginia University, A.B.
Φ Α Σ
Fitzgerald-Mercy Hospital, Darby, Pa.; 1st Lieutenant, M.C., A.U.S.
THOMAS
JOSEPH
KENNEDY
St. Joseph's College, A.B.
Φ B II
Fitzgerald-Mercy Hospital, Darby, Pa.; 1st Lieutenant, M.C., A.U.S.

CHARLES A. KNOWLES
West Pittston, Pa.
University of Scranton, B.S.
Φ B II
Misericordia Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
KENNETH
RAVEN
KNOX
Parkersburg, W. Va.
West Virginia Wesleyan College,
B.S.
φχ
Pennsylvania Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C.,
A.U.S.

1946

CHARLES
WILLIAM
KORBONITS
Asbury Park, N. J.
Rutgers University, B.S.
ϕ B II
Fitkin Memorial Hospital,
Neptune, N. J.
SIDNEY  KORETSKY
Chelsea, Mass.
Harvard University, A.B.
Φ Λ Κ
Springfield Hospital, Springfield,
Mass.; 1st Lieutenant, M.C.,
A.U.S.

SEYMOUR  KREVSKY
Allentown, Pa.
Lehigh University, B.A.
Φ Λ Ε
Allentown Hospital, Allentown,
Pa.; 1st Lieutenant, M.C., A.U.S.
JOSEPH
BENEDICT
KRISANDA
Jessup, Pa.
University of Scranton, B.S.
Scranton State Hospital, Scranton, Pa.; 1st Lieutenant, M.C., A.U.S.

DOMINIC
ANTHONY
KUJDA
Dickson City, Pa.
University of Scranton, B.S.
Scranton State Hospital, Scranton, Pa.; 1st Lieutenant, M.C., A.U.S.
ROBERT REED LACOCK
Pittsburgh, Pa.
University of Virginia, B.A.
Delaware Hospital, Wilmington, Del.; 1st Lieutenant, M.C., A.U.S.

1946

OSCAR KENNETH LANICH
St. Joseph's College, B.S.
Fitzgerald-Mercy Hospital, Darby, Pa.; 1st Lieutenant, M.C., A.U.S.
LOUIS FRANK
LA NOCE
University of Pennsylvania, A.B.
φ Λ Ξ
St. Mary's Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

FREDERIC C. LECHNER, JR.
Montoursville, Pa.
Franklin & Marshall College, B.S.
Θ Κ Ψ
Williamsport Hospital, Williamsport, Pa.; 1st Lieutenant, M.C., A.U.S.
ALLEN H. LEE
Dunn, N. C.
Wake Forest College, B.S.
ΦΡΣ
Watts Hospital, Durham, N. C.;
1st Lieutenant, M.C., A.U.S.

GAMEWELL ALEXANDER LEMMON
Sumter, S. C.
University of North Carolina, A.B.
ΝΣΝ ΚΒΦ
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
LEONARD JORDAN LEVICK
Pennsylvania State College, B.S.
Φ Δ Κ
Jewish Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

LEON LEVINTOW
Haverford College, A.B.
Λ Ω Α Φ Δ Κ
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
MARVIN OWEN LEWIS
Erie, Pa.
Pennsylvania State College, B.S.
and Rutgers University, M.S.
U. S. Marine Hospital; 1st Lieutenant, M.C., A.U.S.

DeARMOND LINDES
University of Pennsylvania, B.S.
Frankford Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
FORREST
EDWARD LUMPKIN, JR.
Terrell, Tex.
University of Texas, B.A.
St. Vincent's Hospital, New York City, N. Y.; 1st Lieutenant, M.C., A.U.S.

JOHN PAUL LUHR
Buffalo, N. Y.
Canisius College, A.B.
St. Vincent's Hospital, New York City, N. Y.; Lieutenant (j.g.), M.C., U.S.N.R.

1946
JAMES VALENTINE MACKELL
St. Joseph's College, B.S.
A O A
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

1946

WALTER VINCENT MATTEUCCI
St. Joseph's College, B.S.
Φ Ρ Σ
Philadelphia General Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
JOSEPH MAZMANIAN
Medford, Mass.
Tufts College; B.S.
ΘΚΨ ΚΒΦ
Cooper Hospital, Camden, N. J.;
1st Lieutenant, M.C., A.U.S.

MICHAEL JOHN McANDREW, JR.
Clarksburg, W. Va.
University of West Virginia, A.B.
ΝΣΝ ΚΒΦ
U. S. Naval Hospital; Lieutenant (j.g.), M.C., U.S.N.R.
JOHN

LAWRENCE

McCORMICK

Carlisle, Pa.

Dickinson College, A.B.

N Ξ N

Jefferson Hospital, Philadelphia,
Pa.; 1st Lieutenant, M.C., A.U.S.

EDWIN

ANDREW

McGOVERN

Newport, R. I.

Providence College, B.S.

Φ Λ Σ

Kings County Hospital, Brooklyn,
N. Y.; 1st Lieutenant, M.C.,
A.U.S.
JOSEPH
LIONEL
MELNICK
University of Pennsylvania, A.B.
Jewish Hospital, Philadelphia,
Pa.; 1st Lieutenant, M.C., A.U.S.

RANDALL M.
McLAUGHLIN
Delta, Pa.
Pennsylvania State College, B.S.
AKK
Cooper Hospital, Camden, N. J.
HAROLD MEYER
University of Pennsylvania, A.B.
Φ Δ Σ
Jewish Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

1946

CLARENCE MASON MILLER, JR.
Wallace, N. C.
University of North Carolina, A.B.
ΑΚΚ ΚΒΦ
Jersey City Medical Center, Jersey City, N. J.; 1st Lieutenant, M.C., A.U.S.
GEORGE FRANCIS MINDE
Summit, N. J.
Lehigh University, A.B.
Φ B II
Gorgas Hospital, Ancon, Canal Zone; 1st Lieutenant, M.C., A.U.S.

JOSEPH PAUL MUDD, JR.
Birmingham, Ala.
University of Alabama, B.S.
Jefferson-Hillman Hospital,
Birmingham, Ala.; Lieutenant (j.g.), M.C., U.S.N.R.

1946
WILLIAM O.
MUEHLHAUSER
Quakertown, Pa.
Muhlenberg College, B.S.
ΦΧΚΒΦ
Allentown General Hospital,
Allentown, Pa.; Lieutenant (j.g.).
M.C., U.S.N.R.

ROBERT
AUGUSTUS
MURPHY
Florence, N. J.
St. Joseph's College, B.S.
ΦΡΣ
U. S. Naval Hospital; Lieutenant
(j.g.). M.C., U.S.N.R.
WILLIAM ALOYSIUS O'CONNELL
Wyomissing Park, Pa.
University of Notre Dame, B.S.
φ α ς
Reading Hospital, Reading, Pa.;
1st Lieutenant, M.C., A.U.S.

ROBERT NELSON
Jersey City, New Jersey
Upsala College, A.B.
φ x
Jefferson Hospital, Philadelphia, Pa.

1946
JAMES M. O'LEARY
Altoona, Pa.
Pennsylvania State College, B.S.
Φ A Σ
Mercy Hospital, Altoona, Pa.;
Lieutenant (j.g.), M.C., U.S.N.R.

SIDNEY HERBERT ORR
La Salle College, B.S.
Φ A Σ
Jewish Hospital, Philadelphia, Pa.
FRANK CAMERON PALMER
Johnstown, Pa.
Princeton University, A.B.
A K K  K B F
Conemaugh Valley Memorial Hospital, Johnstown, Pa.; 1st Lieutenant, M.C., A.U.S.

THOMAS PASTRAS
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A Ω Α
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THOMAS
EUGENE
PATRICK
Scranton, Pa.
University of Scranton, B.A.
Φ A Σ
Scranton State Hospital, Scranton, Pa.; 1st Lieutenant, M.C., A.U.S.

BENJAMIN
STRAWBRIDGE
PERKINS
Conshohocken, Pa.
Ursinus College, B.S.
Ν Σ Ν
Pennsylvania Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
JOSEPH
SALVATORE
PULEO
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Villanova College, B.S.
Φ Ρ Σ
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JOHN H.
PETRE, JR.
Erie, Pa.
Allegheny College, B.S.
Ν Σ Ν
St. Vincent’s Hospital, Erie, Pa.;
1st Lieutenant, M.C., A.U.S.

1946
REGINALD JAMES RABAN
Audubon, N. J.
Ursinus College, B.S.
Cooper Hospital, Camden, N. J.;
Lieutenant (j.g.), M.C., U.S.N.R.

GEORGE KANTER REBERDY
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University of Notre Dame, B.S.
Φ Λ Σ
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JOHN L. REDMOND
New Rochelle, N. Y.
University of Notre Dame, B.S.
Φ Α Σ
New Rochelle Hospital, New Rochelle, N. Y.

MELVIN LEWIS REITZ
Leck Kill, Pa.
Pennsylvania State College, B.S.
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SAMUEL DUNHAM ROWLEY
West Hartford, Conn.
Hamilton College, B.S.
Φ Δ Ε
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M.C., U.S.N.R.

ISADORE ROSE
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University of Scranton, B.S.
Φ Δ Ε
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ROBERT HOWELL ROY

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Pennsylvania State College, B.S.
A K K

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JOSEPH CHARLES RUHT

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Pennsylvania State College, B.S.
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
RICHARD G. 
SALEEBY
Wilson, N. C.
Wake Forest College, B.S.
ΦχΚβΦ
Germantown Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.

1946

ROBERT 
EUGENE 
SASS
Boswell, Pa.
Franklin & Marshall College, B.S.
ΑΚΚΚβΦ
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CHARLES
FOSTER
SCARBOROUGH, JR.
Mt. Gilead, N. C.
University of North Carolina,
A.B., B.S.
A K K ΚΒΦ
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FRANK
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Moravian College, B.S.
Φ Ρ Σ
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NORMAN McLEAN SCOTT, JR.
Harwich Port, Mass.
Colgate University, A.B.
Roosevelt Hospital, New York, N.Y.; 1st Lieutenant, M.C., A.U.S.

HENRY SEIDENBERG
University of Pennsylvania, B.A.
Jefferson Hospital, Philadelphia, Pa.; 1st Lieutenant, M.C., A.U.S.
GEORGE ROBERT SENITA
Patton, Pa.
Franklin & Marshall College, B.S.
ΘΚΨ
Mercy Hospital, Pittsburgh, Pa.;
1st Lieutenant, M.C., A.U.S.

FRANK J. SHANNON, JR.
St. Joseph's College, B.S.
ΦΡΣΚΒΦ
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1946
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1946

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1946
At a senior class meeting in September, 1945, there was an unanimous vote to present a portrait of Dr. George P. Muller to the college.

Dr. Muller was born June 29, 1877, in Philadelphia, Pa. He received his preliminary and pre-medical education at the Central High School, Philadelphia, from which he received his A.B. degree in 1895. He received his M.D. degree from the University of Pennsylvania four years later.

After serving his internship and residency in Lankenau Hospital from 1899 to 1902, Dr. Muller successively became assistant instructor, instructor, associate and Professor of Clinical Surgery, in the Medical School of the University of Pennsylvania until July 1, 1933.

At present Dr. Muller is Professor of Surgery, Jefferson Medical College, and Surgeon to the Jefferson Hospital.
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CLASS OF NINETEEN FORTY NINE
One day, while on a long train trip, Dr. Bernard J. Alpers wrote down some ideas on diagnosis which had been germinating in his head for a long time. The following paper is the result. It was delivered before a student meeting in May, 1945, and it impressed all who heard it then with its logic, clarity, and good sense. The editors of The Clinic are proud to publish it for the first time.
THE METAPHYSICS OF DIAGNOSIS
or
CAN YOU BELIEVE YOUR SENSES?

BERNARD J. ALPERS, M.D.

Address delivered before the Alpers Neurological Society, May 15, 1945.

By this time, gentlemen, having reached the hallowed and revered position of fourth year men, you have not only seen diagnoses made, but you yourselves have been responsible for establishing them. You must on such an occasion realize that feeling of gratification and power which comes with the consummation of a responsibility, experienced by you alone, a responsibility for which yourselves must answer. With it comes that glow which we must all have experienced on first learning to walk, but unlike the process of walking, this is a conscious, reasoned act and therefore one which you should be able to analyze step by step in order that you may understand not only the tools of which you make use in the process, but the process itself. Unfortunately, if your experience has been like mine—and I am sure it has—you have probably never been enlightened on how diagnoses are made; what the mental processes are by which you reach them; and how you may avoid the pitfalls of diagnosis. You and I have been taught in great abundance the symptoms and signs of disease; we have been shown how to piece them together more or less mechanically; and when mechanical processes have failed we have been nurtured by the instinctual vitamin, by which we are led to believe that diagnosis often depends upon the uncanny capacity to arrive at a logical conclusion by means of some unconscious process which we cannot fathom and should not attempt to analyze if we could.

My contention is simple: I believe that the process of the diagnosis of disease is logical and rational; that it is dependent upon solid methods of approach and study; and that we ought to be aware of these methods early rather than late in our clinical careers. Logic is the North Star of our preclinical firmament; for some unaccountable reason it fails to shine in our clinical firmament. Once we have left our preclinical years we are without logic, without a guiding star, without even a sextant to sight our courses. I propose to furnish you with a sextant and with a few guiding stars in the world of diagnosis. I confess without further argument that this is a most egotistical attempt; that it infers that I have the capacity and the accomplishment to provide you with what we all lack. But I shall disregard the inference in order to recite what I have long wanted to say. Possibly something may be gained by the endeavor even if it falls far short of its goal.

Meaning of Diagnosis. Since logic is to be our guide I think it is advisable to inquire first into the meaning of diagnosis. We mean by the term an orderly process of reasoning by means of which, after the careful accumulation of data from all sources, clinical and laboratory, it is then possible to sift and discard, and finally to regather all the material which is capable of explaining adequately all the symptoms and signs in a clinical problem. This process must always be logical, not dependent on unsupported inferences or prejudices, and must be capable of orderly analysis. Our problem obviously becomes one of asking therefore whether this definition can be maintained in every clinical problem, and if so, how it can be done. It is my contention that it not only can be done, but that the training necessary to accomplish it should begin early in our medical careers.

1. Accumulation of Data. It seems clear, if our definition is correct, that the first step upon presentation of a clinical problem consists of the accumulation of data. This must mean all data, clinical and laboratory. In many cases only clinical data are necessary; in many others
intricate laboratory data are required. Regardless of the amount of data necessary, the gathering of facts is the first step in a logical deduction and no diagnosis can be regarded as logical which does not wait for the gathering and analysis of the facts before a deduction in the form of a diagnosis is made.

Your fact gathering begins with the history, and here I must confess that I abandon reason for a moment, for it has been my disappointing experience with too many internes, to find that history taking consists often of a glorified list of chief complaints. All histories should be detailed; the more detail the better. No examination is complete without a history, and no history can be too complete. Your efforts in this direction will be rewarded in many ways.

The time will come when you are so pressed that you will be unable to seek all the details you wish; a full grounding in details when you are young will pay you dividends by permitting short cuts through leading questions, possible only because of your nose for details early in your careers. For some diseases such as epilepsy the history constitutes the most important part of the examination. On your analysis of whether there is loss of consciousness will depend your decision whether epilepsy is present. Only care and time can elicit this data. Similarly, only the virtues of patience and care can reward you in working out the progressive history of a case of brain tumor; the remission in multiple sclerosis; the nature of the muscle weakness in myasthenia gravis; the personality changes in a case of general paresis; the determination in a problem of dizziness as to whether true vertigo is present or not. These require time and patience, but the road of the scientist is hard and if you wish to be accurate you must gather your facts carefully and conscientiously or you must be content with mediocre performance.

The taking of a history is at times a contest of wits and at times a clash of personalities. Patients almost never enjoy seeing the doctor and the anxiety attendant upon their visits to you will result often in repressions and inhibitions which cause the hiding of pertinent data. Under these circumstances the problem arises as to how aggressive and vigorous you can permit yourselves to be in obtaining the facts of a history. Under most circumstances you can be as aggressive as the patient will permit you to be, but there are some situations in which it is best not to force the facts by asking leading questions—as for example in obtaining the data concerning vertigo.

But, let us return to our major problem—the construction of a diagnosis. You have begun the accumulation of data by the recording of a detailed history. You may now proceed to the gathering of those facts made possible by the examination of the patient himself. I do not propose to bore you with details concerning this feature of the problem, except to point out that you must train yourselves zealously in the art of observation. By so doing you become enabled to make accurate studies of your patient's symptoms and you come to respect your own recordings. Observations hastily made or inadequately studied form no foundation for your future experience, for your subconscious will reject what your conscious accepts, and you will distrust your own studies. I think it must require no emphasis on my part that you must learn to use all your senses, to be accurate in your observations—neither of which is possible except by determined application. There will come a time when you will be busy with many patients. You will do well by most of them, but you will make mistakes. As Osler said, The doctor who claims he never made a mistake, never had a patient. It is natural for humans to err. It is impossible for us always to be correct in our analyses or judgments. When we err however, there must be no consolation for ourselves if our errors result from faulty observations or from carelessness. There can be no excuse for carelessness since the nature of our responsibilities is such that we must, regardless of circumstances, take time to be accurate. Mistakes of judgment, however, may permit us the consolation that it may not always be possible for us to read correctly the facts in a case. It may be a blow to one's pride to find that a diagnosis has not been confirmed by operation or necropsy. The failure may have resulted from ignorance or faulty reasoning. For both or either of these we can console ourselves with the thought that it is not possible to know everything and that there are times when one's judgment is not as sharp as it should be. If, however, one has been diligent in obtaining all the facts of a case, one has performed his duty creditably, and one has at least avoided the sin of carelessness.

Finally, the accumulation of data is completed by Laboratory studies which of course
must differ from case to case depending on the problem under consideration.

You have now reached the point at which it is possible to express an opinion concerning your problem in diagnosis. How do you proceed now to arrive at a logical conclusion?

Arrival at Diagnosis. At this point I believe it is only fair on my part to indicate that from now on the views which I shall express are decidedly personal. Obviously there are many ways of arriving at a diagnosis, and the means of doing so differ with the doctor in charge. What I shall have to say reflects my approach to the problem of diagnosis. I shall ask you therefore to accept it only on this basis, to serve as a means of discussion of the entire problem which I have attempted to outline.

There are two methods prevalent in the approach to a diagnosis. I assume in the first place that the data have been gathered, that they have been sorted, and that after sorting them, we are ready to reach some sort of conclusion. Here we are faced by two possibilities: (1) arrival at a diagnosis from the particular to the general, or (2) arrival at a diagnosis from the general to the specific. I believe I can make my point clear by further elaboration. My contention is that it is best in the formulation of a diagnosis to proceed from the specific or particular to the general rather than from the general to the specific. By this means a diagnosis becomes a problem in inductive reasoning, using all the available data to fit into the specific problem presented. Let us take a problem in headache as an example. In the problem in question you find that headache has been present for two years, that it has been associated with an increasing weakness of the right side of the body, that it is associated with choked disc and with signs of a right hemiparesis. Here the data point definitely to a lesion causing increased intracranial pressure. It is possible therefore to assert that the specific cause of the headache in this instance is increased intracranial pressure. It is not possible to assert its cause—it may be tumor, abscess, hematoma, tuberculoma, gumma, or a number of other conditions. The point is that by means of the evidence at hand you and I have arrived at a diagnosis of headache due to increased intracranial pressure, supported by all the available facts. This is diagnosis by means of inductive reasoning; from this point the problem becomes one of specific cause of the headache by a consideration of the various causes capable of causing increased pressure. My corollary to this contention is that it is necessary in the majority of instances to consider only those possibilities supported by the facts at hand. It serves no useful purpose for example to consider in the hypothetical case which I have mentioned all the causes of headache or all the causes of hemiparesis. The result of such a procedure is an exercise in dialectics in which reason is sacrificed to feats of memory. No one could possibly remember all the causes of headaches, or for that matter hemiparesis, and diagnosis made in this fashion becomes mechanical and diagnosis by exclusion. If the facts warrant the consideration of unusual cause of headache, such causes must be considered—but not until then.

You may by this time have gathered that I believe that discussion of diagnosis from the general to the particular is neither logical nor sensible. Take for example, the instance of headache which I have hypothesized. If we were to approach the problem by argument from the general to the specific, we should then ask ourselves all the causes of headache and exclude one by one the various conditions which could cause headache. Mental exercise of this sort becomes dangerous because diagnosis becomes mechanical and an exercise in rote memory. It can serve no useful purpose to consider all the causes of headache or coma or convulsions in a problem concerning one of these symptoms. In the first place, it is ridiculous to remember all the causes of these intricate and complex symptoms—books are written so that we may refer to them for matters which it is useless for us to remember or in which we have had no experience. In the second place, it is impossible to be logical in diagnosis by this means. I call attention also to the fallacious habit of lining up causes of symptoms in the order of their frequency. Here, too, I raise my voice in protest. What does it matter whether one thinks first of vascular causes or of periarteritis nodosa in a case of hemiplegia, so long as one considers all the possibilities? And what earthly use is it to consider let us say periarteritis nodosa if the facts do not call for a consideration of the condition? It is safer and more logical by far to gather data and to reason from all the available facts than it is to list causes in an effort to pigeon hole and simplify.
To recapitulate, diagnosis must be built up by the accumulation of data, by building up of the facts to lead to a logical analysis and by the exclusion of extraneous and unessential material. This I contend is impossible by the oft-used method of listing causes of symptoms in order of preference.

It is inevitable in my estimation that there should be orientation along definite lines in the gathering of the data in a clinical problem. As one takes the history and performs the examination the facts appear to fashion themselves into a definite whole and one or more possibilities loom largest as the explanation for the problem. This we may refer to as the leading possibility or possibilities. Almost invariably, however, there are facts which fail to satisfy a single possibility; for these definite explanations must be found, and it is these which lead to the consideration of other possibilities in diagnosis. I believe that the other possibilities which must be weighed are also those pertinent to the facts of the clinical problem. Some conditions explain some facts better than others, and a consideration of these conditions follows along the lines established by the facts. In other words, clinical problems deal entirely with pertinent possibilities and not with all possibilities. In the vast majority of cases clinical problems can be settled by means of this method of approach; in some it is necessary to consider rare causes of disease, but only as I say because the facts warrant such consideration. You do not stop to consider the possibility of actinomycotic abscess of the brain as a routine procedure in brain abscess unless there are some facts obtained from the history which require a consideration of this possibility. Rare causes of disease will usually be considered because the facts warrant their consideration. They should not be considered as part of a serial list of causes of symptoms.

There are of course times when one considers lists of possibilities, but here too only in response to the demand of the facts and only because in some instances a specific causal diagnosis is impossible in some problems. Consider the problem of lymphocytic meningitis. The history of headache, the fever, the signs of meningeal irritation and the lymphocytic formula in the spinal fluid point to a lymphocytic meningitis for which only general causes can be considered until the specific cause is established by laboratory tests or clinical observations. One thinks of course of poliomyelitis, lymphocytic choriomeningitis, syphilitic meningitis and tuberculous meningitis. If rarer causes are to be considered it will be because none of the common conditions can be established or because there are data in the problem which force consideration of rare causes.

In the formulation of a diagnosis it is inevitable that there should be encountered pitfalls which beset the path of the unwary—and even that of the experienced. It is impossible of course to keep one's guard up constantly, but if one is forewarned, the possibility of error may be minimized. There are certain fallacies in the approach to a diagnosis which I should like to call to your attention.

1. Fallacy of the Obvious. The first pitfall against which I must warn you is that of accepting the obvious in medicine, or what may be termed the fallacy of the obvious. Nothing will bring you greater grief than tacit acceptance of the obvious. It is as if nature, with sadistic pleasure, lures one on into a sense of false security, only to deal a knock-out punch when it may be too late to do any good. A few experiences of this sort and you will become wary. Possibly if you are forewarned you may escape the grief which the rest of us have experienced.

Let me give you a few examples. The first is that of a little girl who was studied on the neurological service. She came to us with the story that she had been bitten a few weeks previously by an insect over the left eye, following which her eye was badly swollen. She had not been well in the meantime; she was peppy, had a little fever. When she came to the hospital her eye was not swollen but she had fever, signs of meningeal irritation and an increase of lymphocytes in the spinal fluid. She seemed to be a case of tuberculous meningitis, but the history of the insect bite and the description of the swollen eye by the parents led to the suspicion that she might have had some sort of virus infection with a cavernous sinus thrombosis and a secondary meningitis by retrograde thrombophlebitis. Fortunately this obvious conclusion was discarded because the facts demanded a diagnosis of tuberculous meningitis. Necropsy confirmed the diagnosis.

Or, take the example of an elderly man of 66 who entered the hospital in stupor with the
story that he had suffered a head injury a few weeks previously, that following this he had developed a personality change, that he suffered lapses of consciousness and severe intermittent headache. He was found on examination to have choked disc and a slight degree of weakness of the left leg. Here was an open and shut case of subdural hematoma, with a typical history and characteristic findings. Fortunately, a history was obtained by direct questioning of the family of a cough over recent months and the diagnosis of a possible bronchogenic carcinoma was made with metastasis to the brain. X-ray of the chest revealed a bronchogenic carcinoma, confirmed by necropsy, as was the metastatic lesion to the brain.

The relationship of trauma to brain disease is an old and intricate problem; one which is full of pitfalls but one on which I cannot expound at length at the present time. Another example, however, will help. This concerns a little boy of 12 who was struck on the head by a hard green apple thrown playfully by one of his companions. Save for momentary stunning he suffered no ill effects. In a few weeks he began to complain of headaches which became increasingly constant and persistent—nothing more. After a few months of this he was brought to the hospital where examination revealed choked disc and a slight left hemiparesis. Nothing could be clearer than a diagnosis of subdural hematoma in this case so without further ado trephine openings were made bilaterally without, however, revealing the suspected lesion. A ventriculogram was then performed on the assumption that a brain tumor must be present, unrelated to the history of injury. The air studies revealed a right frontal lobe tumor. Craniotomy was performed but no tumor was found. Instead we were rewarded by the discovery of a brain abscess, though at no time were we able to obtain a history of sinus or mastoid disease.

Or, take the example of a young man of 32 who gives a history of failing memory and personality change over a period of six months, with headache prominent in recent months. Examination revealed choked disc and a left facio-brachial weakness indicating a right frontal lobe lesion. In addition there were signs of extensive sinus disease. Here then with signs of increased pressure and a background of sinus disease one would seem to be entitled to diagnose brain abscess. Two factors belied the diagnosis: first, the clear mentality of the patient and second, the absence of bradycardia. A diagnosis of tumor was made despite the infection, and at operation a tumor was found.

One more example. This concerns a man of 35 years with a story that four years previously he had been studied on my service in the Jefferson Hospital with all the features of a subarachnoid hemorrhage, from which he had made a good recovery. Four months prior to his second admission he developed convulsions, aphasia, and a hemiplegia—all of which persisted. He was found to have hypertension, a right hemiplegia and aphasia. In a hypertensive with a history of a previous vascular accident and what appeared to be another vascular episode, one would be entitled to dismiss the problem as one of essential hypertension with hypertensive encephalopathy. Only one feature made the diagnosis difficult to accept—the occurrence of repeated convulsions, an unusual feature of vascular disease. On this basis a ventriculogram was performed, a brain tumor revealed, and a meningioma removed from the brain.

I could give many more examples all of which would only belabor my point. I think it must be clear that one must evaluate all the facts in constructing a diagnosis, and that one must not too heavily accentuate the obvious.

2. Fallacy of Diagnosis by Elimination. The second fallacy against which I must warn you is that of diagnosis by elimination. This mental exercise is practiced unfortunately much too frequently. If making a diagnosis is a logical procedure, then arrived at a conclusion by elimination is illogical and hazardous. Disease is present because, not unless. The diagnosis of encephalitis is frequently made by exclusion. So too is the diagnosis of a psychogenic disorder. Arrival at a diagnosis of either of these disorders by exclusion is dangerous. I shall not labor this fallacy further. It requires no more mention because it is obviously wrong, and I shall have occasion to return to it.

3. Fallacy of Diagnosis by Erudition. My next fallacy I choose to term the fallacy of diagnosis by erudition. The need for this arises invariably as the result of difficult problems in diagnosis. The facts fail to fit the seemingly logical diagnosis: hence one is led to burrow into the recesses and cellars of one's mind or in the medical literature in order to find an esoteric
explanation of the facts. When such a search leads one to the correct solution, you will find nothing to give you greater satisfaction. But let me warn you that enthusiasm must be tempered with caution lest you come to grief. More often your diligence in such instances will lead you to force the facts—and remember that there are times when erudition is dangerous. There are those of us who like to find rare causes for common conditions, a state of mind which leads too often to the exercise of dialectics for its own sake. But of course erudition is not in itself bad. There are times when it is extremely helpful and times when one is grateful for its possessor. Take the example of a young man of 29 who entered the hospital with a perfectly obvious story and picture of an incomplete occlusion of the posterior-inferior cerebellar artery. The anatomical diagnosis was simple, as it always is in this condition, but there appeared to be no cause for the occlusion—no arteriosclerosis, no syphilitic vascular disease, no hypertension. In a search for an unusual cause a few glands were found in the neck and a diagnosis of Hodgkin’s disease was made, confirmed by biopsy and later by necropsy.

Or, take the example of brain tumor suspected of being metastatic in nature, but without a source for the carcinoma to be found. Deep in the recesses of one’s mind comes the knowledge that carcinoma of the nasopharynx is frequently overlooked in such cases—and one finds in an instance which I have in mind, a minute granulomatous mass at the opening of the eustachian tube found on biopsy to be a carcinoma.

But let us look at the other side of the wall paper. Take the case of an elderly lady of 62 who complains of severe headache, who is known to have polycythemia vera and who is found on examination to have choked disc and a suggestive enlargement of the sella turcica. Erudition tells us that choked disc occurs not infrequently in polycythemia vera, that the experience of many competent investigators teaches us that ventriculography and exploration have never revealed either tumor or hematoma to explain such cases—and the conclusion is reached that in the case in point the polycythemia is responsible for the symptoms. That was my conclusion in this case, but the patient, not content with my erudition, consulted a neurosurgeon in another hospital who was more skeptical that I was, and who did not put too much stock in erudition. He performed a ventriculogram, found a very slight but suggestive deformity, operated, and found a subdural hematoma which relieved completely the lady’s symptoms.

My next example could equally as well be categorized as the fallacy of not emphasizing common sense but it involves the lesson of erudition and I insert it here. This has to do with a middle-aged lady who complained of headache and increasing weakness of one side of the body, I believe the left. She had a lump on her head which appeared to be a hyperostosis and she had signs which seemed to indicate the presence of a brain tumor. X-ray studies revealed a hyperostosis with typical spicule formation such as one sees in a meningioma and the diagnosis appeared to be established. Unfortunately diligence outran common sense for in this instance we went looking for trouble. Because of the patient’s age and a history of cough, an x-ray of the lungs was made and a bronchogenic carcinoma revealed. Still skeptical, x-ray studies were made of the spine and a destructive lesion of one of the vertebrae disclosed. There could be no doubt now that the lady had a bronchogenic carcinoma with metastases, and since erudition revealed that a hyperostosis in the skull similar in all respects to that of meningioma could be produced by carcinoma, all the facts in the case appeared to be satisfied and the patient was discharged without operation, having had the benefit of radiological and neurosurgical consultations. Unfortunately she came to necropsy. No bronchogenic carcinoma was found and the brain tumor, as originally suspected, was found to be a meningioma.

4. Fallacy of Illogical Emphasis of the Psychogenic. The next fallacy is one which lies very close to my heart. I refer to it as the fallacy of illogical emphasis of the psychogenic. These are days of emphasis of the personality and emotional factors in disease, and rightfully so. I should be a fool to quarrel with this concept, constituting as it does one of the great advances of medicine in the last 25 years. My quarrel is with the illogical method in which we use this knowledge. It is a common experience with us all to find that where the facts do not fit snugly into a definite formula, to assert that the problem is of psychogenic origin or that there is a
psychogenic overlay. Both these approaches are filled with danger and may rightfully be referred to as the Scylla and Charybdis of the diagnosis channel.

In the first place, psychogenic disorders if diagnosed must be established on the basis of facts consisting of the specific features of the disorder and their proper motivations. Neuroses and psychoses have specific symptoms and require no diagnosis by exclusion for their detection. Moreover, though motivations are important they are not always what they seem. All of us will rattle if shaken hard enough, and even a cursory search will reveal skeletons in all our closets. Therefore, though motivation is important it must be considered in its proper place. What is more, you will find many psychogenic disorders for which you will be unable to reveal any motivation whatever, no matter how much you muddy up the waters of the unconscious. Moreover your patients will often get well without detection of the motivating factors behind a neurosis. Conversely, the motives may be perfectly clear but the symptoms remain.

The second aspect of the psychogenic fallacy is equally important; namely, the assertion that a patient has structural disease with a psychogenic overlay. This is almost always a euphemism by means of which one confesses that he is unable to fit all the facts to explain the clinical problem. If you suspect a psychogenic disorder, do not dispose of your problem with a sweep of the hand by asserting that there is a psychogenic overlay. By this gesture you may dispose of your facts into the basket while you yourself become lulled into a false sense of security and carelessness. Approach your problem by a study of the social history and personality and then see whether your patient's symptoms fit the personality and emotional structure.

I could go on to give endless examples of the psychogenic fallacy, but before I pass to a few let me call your attention to the fact that so-called psychogenic disease often covers up structural or organic disorders, or to put it differently, structural disorders often masquerade in psychogenic garments. The symptoms of hyperinsulinism are a case in point, for they are often first regarded as psychogenic in origin until they are finally spotted for what they are.

Take the case of a lady of 45 who suffered for several years from what was diagnosed as migraine. She had received all sorts of treatment, none of it effectual, as is often the case in migraine. Since her doctors could not explain the persistence of her symptom she was suspected of being neurotic and a maze of material was disclosed indicating that she was frustrated and inhibited. I was asked to see her for her neurosis, but on questioning her I became convinced that she had not only very severe headaches but that she had in addition an organic syndrome with memory loss and personality change. Fortunately the diagnosis was easy, for she was found to have choked disc and operation revealed a brain tumor.

The following example will illustrate my point. The patient was a lady of 33 who complained of numerous somatic symptoms referable to all parts of the body but particularly of weakness of one side. She had ample motivation for the psychogenic disorder which I decided she had. She was a Dutch lady who had had a most unhappy home life, and had left home in order to seek an operatic career, an ambition which was frustrated early in life. She was childless and married to a Greek who was volatile and intolerant, and her home life was most unhappy. Here was ample background for hysterical symptoms which she was presumed to have. She was treated for several years on this basis. It was not until I had observed her for two years that I realized that the lady was developing a hemiparesis under my eyes. Pneumogram revealed a suspected brain tumor. Dr. Jaeger removed a meningioma and the lady is no longer a neurotic.

Consider the problem of a lady of 63 who came to me because she was psychotic. The story which she and her family gave indicated that she had a psychosis, with memory loss, personality change, episodes of confusion, and a paranoid trend. She gave a history, however, of loss of vision in the right eye 10 years previously and of failing vision in the left eye for 3 months. The entire complexion of the problem was changed thereby. Examination revealed optic atrophy of the right eye, beginning atrophy of the left eye, and a temporal hemianopsia of the left eye. A diagnosis of pituitary tumor was made, confirmed by x-ray which revealed a typical ballooned out sella turcica. The mental symptoms were attributed to compression of the orbital surfaces of the frontal lobes. Operation
relieved the psychotic symptoms and restored vision in the failing eye—that of the blind eye was hopelessly gone.

There are two points of interest in this case. One is that for years this lady’s symptoms were disposed of as neurotic and later as psychotic—an obvious error. The second point of interest is that the personality trends in organic brain disease have no specific significance. They reflect the basic personality freed of its inhibitions. Therefore, if I were to know the personality of everyone in this audience I could predict the type of trends which would appear with organic brain disease—predominantly paranoid, depressed, manic, etc.

5. Fallacy of Diagnosis by Laboratory Tests. A few words are in order I believe concerning the fallacy of diagnosis by laboratory tests when such tests fail adequately to explain the clinical problem. This has many facets, all of which require that you and I maintain that balance and that degree of skepticism which is essential for good diagnosis. If a surprise positive Wassermann test when syphilis is not suspected fails to satisfy the logical demands of the clinical problem, it must be repeated until you are satisfied that it is correct. If a BMR fails to conform to the facts you must stand by your clinical facts and forget about the elevated or decreased BMR. The same holds true of other laboratory tests. You and I must judge of their value for we are the final arbiters of the problem.

I can give you a pertinent example which concerned a lady of 45 years. She was well until she suddenly developed weakness of the right side of the body, while talking on the telephone where she received news of the death of a neighbor’s son whom she had known all her life. She was put to bed and within a few days began to recover the power of her limbs. After about 5 days she developed a right sided convolution at which point I was asked to see her. She had a right hemiparesis, and a little headache, but she was mentally dull. She had no signs of increased pressure. Despite this a diagnosis of a left frontal lobe tumor was offered and she was put through a series of studies. All were normal including the spinal fluid pressure which, far from being high, was unusually low—100 to 110 mm. of water. She continued to have right sided fits, however, an unusual feature of vascular disease, and on this basis a pneumogram was done which revealed in the eyes of some no deformity of the ventricles and in the eyes of others a questionable defect. So slight was the defect, however, that on the whole the finding was not considered important.

All the studies were normal, but they failed to conform to the facts. Consequently, after much pondering it was decided to explore and a very malignant glioma was found, confirmed by biopsy.

Here then is an example of the fact that when the laboratory studies fail to conform to the data, you must stand by your clinical impressions.

6. Fallacy of Diagnosis by Unitary Disease. Finally, let me briefly point out that while the habit of explaining the clinical problem on the basis of a single cause is praiseworthy, there will be instances in your experience in which more than one cause is operative. In doubtful cases therefore, you are entitled to think of multiple causes.

The following is a case in point: The subject was a lady of 62 years who was diagnosed hysteria by her doctor. She was sick when seen and had a perfectly obvious hemiparesis, without signs of increased pressure. She had had a granulosa cell tumor removed from her pelvis 20 years previously and had had a recurrence removed 5 years ago. She had signs of chest involvement which were assumed to be due to a pneumonitis. The possibility of a metastatic lesion appeared to be very good but the dissemination of a granulosa cell tumor did not sit well. I made so bold therefore as to suggest that the patient had a granulosa cell tumor but that she might also have a bronchogenic carcinoma with metastasis to the brain, quite independent of the granulosa cell tumor. Necropsy revealed precisely this.

Last of all, do not hesitate to confess that you do not know the diagnosis in a specific instance. There are problems which defy diagnosis, even where the necropsy material is available, and you will do both yourselves and your patients more good by confessing that you cannot make a diagnosis, than you will by forcing the facts or by establishing for yourselves a false sense of security when the data fail to warrant it.

My message is simple—diagnosis by logic and reasoning, and where these are impossible, no diagnosis.
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I had just awakened from a short nap. Contemplating my roommate's return from military class, I lay back to reminisce of the past three years. We began school as civilians, but the army wielded much influence in these turbulent times.

Early in June, 1943, we visited the Custom House to be sworn into the army. On June 20th and 21st, we made the memorable journey to New Cumberland. Here we discovered we were just another bunch of rookies; hurry to wait, needle-bait, new clothes, the PX, waiting for orders, K.P. or goldbricking. Then there was a train ride to Philly where milk, mail, and country gentry got off and on, but the 3311th stayed, hot, dry and dirty. We met our beloved Colonel, everyone's pal, much to our chaperone lieutenant's confusion and chagrin with, "Hi, Colonel, your boys are back. How's Philly?" Then we were dismissed with orders to report to school in the morning. What bar was your first stop? Or was it the Stage Door Canteen?

The routine of school resumed, accompanied by the confusion of organization. How odd it was to receive and obey commands and to need a pass to go to the shore or to go home. The ROTC graduates educated many a left foot as drill masters—a job well done. Soon Friday afternoon echoed the sounds of
cadence, from D.B.I. to Walnut Street. Segar Field has seen its share of tears, sweat, toil, and bitching. Brisk chill mornings saw many a sleepy eye shaded by an upturned collar. Yet, each time the boys passed in review, no flaw was apparent. Perhaps it was due to our inspiring band.

There were the hours spent in the auditorium—"Your Day!", bond rallies, "Why We Fight," "Articles of War," "V.D.," "Hans Muller," azimuth, military courtesy and discipline, morning reports, let alone exams and The Battle of Trenton, with Lieutenants Fontaine, Blake and Olsen presiding. Who will ever forget the Sergeants, each different: Krall, Isen, Webster, Starliper, Sheetz, Behmer, et al.

Many will remember June, 1945 (when we presented Colonel Mills' splendid portrait to the school. He was soon to leave us for his well-earned retirement. There was also the short contact with Wac Captain ("You are men?") Lyons. At this time, not a few of us left the unit to become civilians again. Oh, that pay check!

They were good days, a transition with its fun and trials, from which many a gentleman and medical officer will emerge.
Now hear this!

Inducted July 1, 1943, and released to inactive duty November 3, 1945, we are the "saltiest" group ever to leave Jefferson.

From those first forms and physicals in the Widener Building, through the "shots" and drill at Penn, the Wednesday cocktail hour and Saturday happy hour (on those rare occasions that found a Navy man cutting class), the lectures on Navy customs and traditions, the monthly rush to the auditorium for those pretty little slips of green, right on to the "Lost Weekend" at Bainbridge, we have always felt secure in the knowledge that if one can't be one's own "C.O.", the Navy can fill in as second best.

Of course, we couldn't escape entirely Navy red tape and regulations but those unpleasantries were kept at a minimum and, except for an occasional trek to the U. of P. for a "shot" or a physical, we were allowed to pursue our studies as we would. Hats off to Uncle Sam for recognizing the incompatibility of medical student and guard duty!

Between school years we did put in a couple of hours a day mastering the intricacies (?) of close order drill and dozing through unvarying dull and boring lectures on various phases of Navy life. Time was left, also, for a 14-day leave each year, even if we never knew in advance when it would be.

Since there was a war and we therefore had to be connected with the service I think we're all glad it was the great and proud Navy of the United States.

Many of us will intern in Navy hospitals and probably all of us will serve some time in the Navy post-internship.

We are all cognizant of the great trust placed in us and realize that great responsibilities lie ahead. We will do our best to come as near as possible to fulfilling the ideal that is a doctor.

May we not fall too far short!
THE Black & Blue BALL
AS THE CARTOONIST
A GALLERY OF

KNOWLES

D. M. DAVIS

SHALLOW

CASTALLO

MOON
SEES THEM . . .

JEFFERSON CELEBRITIES
ALBUM

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THE ORUGANS
Unofficial excerpts from a discourse by Dr. Alison H. Price on the life, habits, and classification of interns.

You're all dressed up in your white suit, your shoes are shined for the first and last time, you've won your M.D.; your mother is proud of you, your father is penniless.

You come through the revolving door, but there's no one there to meet you, no one to greet you. You find your room; it has one window; the shower's two blocks away. The dining room sounds like a boiler works, but now you get your stew sitting down rather than standing up.

You hear a nurse comment, "He don't look so good," and the elevator man grins and shouts, "Hi, sucker!"

You're an outsider and you've got to prove yourself. You may fall into one of the following categories:

1. THE PERSONALITY KID: He's well dressed, always has a bottle of good liquor, always a broad smile, and he drives a 16 cylinder sports model.

2. THE GRABBER: He's gonna get there and no one can stop him. You're doing your 952nd sternal puncture; the boss and all his friends are watching. You're having a little trouble, whereupon the grabber dives in for the kill, jams the stylet through the sternum into the pulmonary artery and the patient makes an exit.

3. THE HOMING PIGEON: He has a frightful disease of married men; every time he sees a revolving door he wants to rush home to the wife and hide.

4. THE REFORMER: He should have been a missionary. His roommate is

5. THE ORGANIZER: His father belongs to the C.I.O.; his mother belongs to the A. F. of L. The Reformer and the Organizer work through

6. THE SUCKER: They make him the president of the Reformation Association. He'd like to be a resident—but no residency and he wonders why.

7. THE ARTESIAN: The Surgeon says, "I'm the greatest surgeon in the world," and he says, "You bet you are, Chief." The Surgeon cuts the abdominal aorta; blood hits the ceiling; they work fast and suture it. "Beautiful job, Chief, beautiful." The patient dies.

8. THE HOOKER: He has ten histories and eight physicals to do; he notes that a patient's P = 150. R = 40, and T = 108, so he calls you and asks you to take over—he wants to go to a party. Ten minutes before you arrive on the ward the patient dies. There you are; now you can call the relatives, get the post, fill out the forms, and call the chief—and you never saw the patient!

9. THE CHAMPION: You study one of his patients carefully, and quietly suggest that this may be infectious hepatitis. He runs to the chief screaming "It's infectious hepatitis, infectious hepatitis, it's infectious hepatitis, Chief!" The Chief agrees and decorates him with a silver star.

10. THE SCIENTIST: He wears suspenders to keep his belt up and garters attached to his belt to keep his socks up. He springs and snaps into position when he moves. An old dowager is concerned about her anemia. "Am I anemic, Doctor, oh Doctor, am I anemic?" He stabs her, holds his hemoglobinometer up to the light, reads 45%, and says, "Madame, you are anemic." Then he sprays out of the room.

11. THE EFFICIENCY EXPERT: The Chief is holding a bedside clinic, the Efficiency Expert needs 10 cc. of blood from the patient. He pushes the chief aside, hops up on the bed, starts a conversation with the patient, draws blood, and then pushes his way back through the crowd.

12. THE TALKER: He's like the fellow who wrote to the biological supply house: "I can send you all the frog skins you want." Supply house replies: "Send 100,000 immediately." He sends one with the explanation that all the noise out in the swamp fooled him.

13. THE WORKER: He looks at the resident and says to himself, "If I can just last this month out, that's the kind of a job I need."

What Should an Intern Be?
1. A diplomat. It's not what you say, it's the way you say it.
2. Complete your histories and physicals before going to bed. It's not what the patient thinks of you. It's: "Is your work done?"
3. Be prompt.
4. Admit your mistakes. (At least to yourself.)
5. Obey orders.
6. Remember, you're a Doc. Don't be a football to nurses, elevator boys, etc.
7. Control your temper. The nurses will give you hell—take it even if it galls you—by God it will. Learn everything you can from them—then as soon as you know it—then's your chance!
Dear Fellow Graduates:

This day marks the end of your formal education—medical and otherwise. From this date on, you write your own curriculum, choose your own teachers and examine yourselves.

Your future education will be acquired the hard way. It is our hope that the habits of thought, critical examination of alleged facts, and intellectual honesty that were your constant examples while at Jefferson have become your way of life.

If this is true you will surely be the good "perennial scholar" that every physician should be.

Most sincerely,

Wm. Harvey Perkins, M. D.,
Dean.
THE OATH

I SWEAR, by Apollo the physician and
Aesculapius the Healer, and all the gods and goddesses
that according to my ability and judgment
I WILL KEEP THIS OATH

And this stipulation to reckon him who taught me this Art
as equally dear to me as my parents to share my substance
with him, and relieve his necessities if required to look upon
his offspring in the same footing as my own brothers, to teach them this Art
if they shall wish to learn it.

WITHOUT FEE OR STIPULATION

That of present lecture or every other mode of instruction, I will impart a knowledge of the Art, to my own sons and those of my
teachers, and teach them free, if they shall wish to learn it.

ACCORDING TO THE LAW OF MEDICINE

But to none others, I will follow the system of regimen which
according to my ability and judgment I consider

FOR THE BENEFIT OF MY PATIENTS

Substan from whatever is deleterious or mischievous. I will give
no deadly medicine to any one if asked, nor suggest any such
counsel. On the contrary, I will give that which is good and will
prescribe only a remedy.

WITH PURITY AND HOLINESS I WILL

PASS MY LIFE AND PRACTICE MY ART

I will not cut persons laboring under the stone, but will leave this to be
done by men who are practitioners of this work. Into whatever houses
I enter, I will go into them for the benefit of the sick, and will abstain
from every voluntary act of mischief and corruption, and further
from the seduction of females or males or of free-born slaves.

Whatever in connection with my professional practice or not in connection with it, I see or hear
in the life of men, which ought not to be spoken of abroad.

I WILL NOT DIVULGE

as reckoning that all such should be kept secret.

While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice
of the Art respected by all men in all times.

But should I trespass or violate this Oath,
may the reverse be my lot!
WILLIAM HARVEY PERKINS, M.D.,
Dean and Professor of Preventive Medicine,
Jefferson Medical College, 1941; M.D., Jefferson Medical College, 1917; Intern, Jefferson Medical College Hospital, 1917; 1st Lieutenant, Medical Corps, U. S. Army, Base Hospital No. 120, Tours, France, 1918-19; Medical Missionary, Presbyterian Board of Foreign Missions to Siam, 1919-23; Fellowship in Medical Education, Rockefeller Foundation, 1924-26; Professor of Medicine and Director of Clinics, Chulalongkarnara University, Siam, 1926-30; Instructor in Medicine, Tulane University, 1930-31; Professor of Preventive Medicine, 1931-41; Dean and Professor of Preventive Medicine at Jefferson Medical College since 1941; awarded Order of White Elephant, Siam, 1930; American Medical Association; American Society of Tropical Medicine; American Public Health Association; National Tuberculosis Association; (Regional Director) Philadelphia Tuberculosis and Health Association; Theta Kappa Psi; Alpha Omega Alpha; author of “Cause and Prevention of Disease,” 1938.

J. PARSONS SCHAEFFER, A.M., M.D.,
Ph.D., Sc.D., Professor of Anatomy and Director of the Daniel Baugh Institute of Anatomy, 1914; M.D., University of Pennsylvania, 1907; A.M., Ph.D., Cornell University, 1908-10; M.A., Yale, 1913; Instructor of Anatomy, Assistant Professor of Anatomy, Cornell University, 1907-11; Assistant Professor of Anatomy, 1911-12; Professor of Anatomy at Yale University, 1912-14; Alpha Omega Alpha; Sigma Xi; Fellow of American Association for Advancement of Science; American Anatomiasts; American Genetic Society; Academy of Natural Sciences; American Medical Association; College of Physicians; American Philosophical Society; Corresponding Fellow of American Laryngological Association; President, Pennsylvania State Anatomical Board; President, American Association of Anatomists; author of “The Nose and Olfactory Organ”; co-author of “The Head and Neck in Roentgen Diagnosis”; contributor to a number of scientific publications; editor of Morris’ “Anatomy”; and author of a large number of papers in anatomy and embryology dealing especially with the respiratory system, the nose and accessory sinuses, and the occlusion of blood-vessels.

FRANK CROZER KNOWLES, M.D.,
Professor of Dermatology, 1919; M.D., University of Pennsylvania, 1902; Dermatologist, Jefferson Medical College, Pennsylvania Hospital; Colonel, Medical Reserve Corps, U. S. Army; author of “Diseases of the Skin”; American Academy of Dermatologists and Syphilitologists; American Dermatological Association; American Medical Association.

EDWARD L. BAUER, M.D., Professor of Pediatrics, 1926; M.D., Jefferson Medical College, 1914; Intern, Germantown Dispensary and Hospital, 1915; Assistant Resident, Children's Seashore House, 1914; Assistant Resident, Philadelphia Hospital for Contagious Diseases, 1914-15; Resident, Children's Hospital of the Mary J. Drexel Home, 1916-17; Advisory Committee on Maternal and Child Health, Pennsylvania State Department of Health; Fellow of the American Academy of Pediatrics; Fellow of the American Medical Association; Fellow of the College of Physicians of Philadelphia; Diplomate of the American Board of Pediatric Specialists; Honorary Fellow of the Pediatric Society of Uruguay.

J. EARL THOMAS, M.S., M.D., Professor of Physiology, 1927; M.D., St. Louis University School of Medicine, 1918; M.S., 1927; American Physiological Society; Society for Pharmacology and Experimental Therapeutics; American Association for the Advancement of Science; American Medical Association; Society for Experimental Biology and Medicine; Philadelphia College of Physicians; Philadelphia County Medical Society; Physiological Society of Philadelphia; American Gastroenterological Association; Alpha Omega Alpha; Sigma Xi.

VIRGIL HOLLAND MOON, A.B., M.Sc., M.D.,
Professor of Pathology, 1927; M.D., Rush Medical College, 1915; Intern, Kansas City General Hospital, 1915; Professor of Pathology and Bacteriology, Indiana University School of Medicine, 1914-27; Pathologist, Indianapolis City Hospital, 1914-24; Director of Laboratories and Pathologist, Jefferson Medical College Hospital; Visiting Chief Pathologist, Philadelphia General Hospital; American Association Pathologists and Bacteriologists; American Human Serum Association; American Medical Association of American Society for Experimental Pathology; International Association for Geographic Pathology; American Academy of Political and Social Sciences; A. A. A.; Sigma Xi; Alpha Omega Alpha.

CHARLES E. G. SHANNON, A.B.,
M.D., Professor of Ophthalmology, 1927; M.D., Jefferson Medical College, 1902; Intern, Pottsville Hospital, 1902-03; additional training.
LOUIS H. CLERF, M.D., L.L.D., Professor of Laryngology and Bronchoscopy, 1930; M.D., Jefferson Medical College, 1912; Intern, Jefferson Medical College Hospital, 1912-14; Chief Resident Physician, 1914-16; Laryngologist with U. S. Navy, 1917-22; Captain Medical Corps, U. S. N. R.; American Association of Thoracic Surgery; Fellow of American College of Physicians; Fellow of American College of Surgeons; American Broncho-esophaelogical Association (Past President and Secretary, Editor at present time); Philadelphia County Medical Society (Past President); Pennsylvania State Medical Society; American Laryngology, Rhinology and Otolaryngology Association; American Medical Association; American Laryngological Association; American Academy of Ophthalmology and Otolaryngology; College of Physicians of Philadelphia; American Therapeutic Society; New York Laryngological Society; American Trudeau Society; Pennsylvania Tuberculosis Association (Director); Association of Military Surgeons; Pan-American Medical Society.

THOMAS A. SHALLOW, M.D., Samuel D. Gross Professor of Surgery, Jefferson Medical College, 1939; Professor of Surgery, Jefferson Medical College, 1951-59; M.D., Jefferson Medical College, 1911; Intern, Jefferson Medical College Hospital, 1911-15; Chief Resident Physician, Jefferson Medical College Hospital, 1915-14; Assistant to Dr. J. Chalmers Da Costa, and Chief of Surgical Clinic, 1914-50; Assistant Surgeon to Philadelphia General Hospital, 1915-21; Surgeon to Philadelphia General Hospital, 1924-50; Neurosurgeon to Philadelphia General Hospital, 1920-54; Active Consulting Surgeon to Philadelphia General Hospital, 1934-44; Assistant Surgeon to St. Joseph's Hospital, Philadelphia, 1914-17; Captain, U. S. Army Medical Corps, A. E. F., 1918-19; Director of Surgery, Delaware County Hospital; Consulting Surgeon, Montgomery Hospital, Norristown; Sacred Heart Hospital, Norristown; Grand View Hospital, Sellersville; Shriners' Hospitals for Crippled Children; Fellow of Philadelphia Academy of Surgery; College of Physicians of Philadelphia; American College of Surgeons; International College of Surgeons; Founder Member of American Board of Surgery; Member of American Medical Association; Pennsylvania State Medical Society; Alpha Omega Alpha; Nu Sigma Nu; Member of Board of Directors of City Trusts; Chairman of Medical Advisory Board of Municipal Court; Member of Board of Managers of House of Detention, Philadelphia; Chairman, Advisory Committee on Surgery to Philadelphia Department of Public Health.

CHARLES M. GRUBER, A.B., A.M., Ph.D., M.D., Professor of Pharmacology, 1952; Ph.D., Harvard University, 1914; M.D., Washington University School of Medicine, St. Louis, 1917; Intern, Barnes Hospital, St. Louis; Instructor in Physiology, University of Pennsylvania, 1914-15; Professor of Physiology and Pharmacology, Albany Medical College, 1915-17; Professor of Physiology and Pharmacology, University of Colorado, 1917-20; Associate in Physiology, Washington University Medical School, St. Louis, 1920-21; Associate Professor of Pharmacology, Washington University Medical School, St. Louis, 1921-22; American Physiological Society; American Society for Pharmacology and Experimental Therapeutics; American Association for the Advancement of Science; Society for Experimental Biology and Medicine; Philadelphia Physiological Society; College of Physicians of Philadelphia County; Medical Society; American Medical Association; Pennsylvania State Medical Society; Alpha Omega Alpha; Sigma Xi.

DAVID M. DAVIS, M.D., Professor of Urology, 1955; B.S., Princeton University, 1907; M.D., Johns Hopkins Medical School, 1911; Intern, Baltimore City Hospital, 1911-12; Assistant in Pathology, Johns Hopkins Medical School, 1912-14; Pathologist and Director of Research, James Buchanan Brady Urological Institute, Johns Hopkins Hospital, 1914-20; Bacteriologist, American Ambulance Hospital, Paris (summer), 1915; Assistant Resident and Resident Urologist, Johns Hopkins Hospital, 1920-22; Associate in Urology, Johns Hopkins Medical School, 1917-24 and 1928-30; Assistant Professor of Urological Surgery (in charge of department), University of Rochester Medical School, 1924-38; Urologist in Chief, Strong Memorial Hospital, 1924-28; Visiting Urologist, Desert Sanitarium, Tucson, 1950-55; American Medical Association; American Urological Association (Mid-Atlantic Section President, 1941-42); Southwestern Medical Association; American Association of Genitourinary Surgeons; College of Physicians of Philadelphia; Academy of Surgery; Physiological Society of Philadelphia; Halsted Club; Phi Beta Kappa; Alpha Omega Alpha; Lieutenant, Captain, and Major, Medical Reserve Corps, U. S. Army, 1917-19.

HOBART A. REIMANN, M.D., Magee Professor of Medicine and Acting Head of the Department of Experimental Medicine, Jeffer-
son Hospital, 1936; M.D., University of Buffalo, 1921; Intern and Resident Physician, Buffalo General Hospital, 1921-23; Assistant, Hospital of the Rockefeller Institute, 1923-26; Fellow in Pathology, National Research Council in Prague, 1926-27; Associate Professor of Medicine, Peking Union Medical College in Peking. 1926-30; Associate Professor of Medicine, University of Minnesota, 1930-36; Professor of Medicine, University of Minnesota, 1936; Assistant, Hospital of Clinical Medicine, University of Minnesota, 1936; Associate Professor of Medicine, University of Minnesota, 1936; Professor of Medical Association; Society of Experimental Pathology; American Medical Association; Philadelphia County Medical Society: Alpha Omega Alpha; Nu Sigma Nu; author of "The Pneumonias."

MARTIN E. REHFUSS, M.D., Professor of Clinical Medicine, 1956; Sutherland M. Prevost Lectures in Therapeutics, 1941; M.D., University of Pennsylvania, 1909; Intern, University of Pennsylvania Hospital, 1910-11; American Hospital; Paris, 1911-12; Pasteur Institute, Paris, 1911; further studies in Germany and Austria, 1912-13; Captain, U. S. Army, World War I; American Gastroenterological Association; American College of Physicians; American Medical Association; Fellow of the College of Physicians of Philadelphia; Philadelphia County Medical Society; author of "Diagnosis and Treatment of the Disease of the Stomach," "Medical Treatment of Gall Bladder Disease," "Indigestion," inventor of Rehfuss Stomach Tube; inventor of the Fractional Method of Gastric Analysis; Sigma Xi; Phi Chi.

GEORGE P. MULLER, Sc.D., M.S., M.D., Grace Revere Osler Professor of Surgery, 1957; M.D., University of Pennsylvania, 1899; Intern, Lankenau Hospital, 1899-1903; Clinical Professor of Surgery, University of Pennsylvania, 1922; Fellow of American College of Surgeons; American Association of Thoracic Surgeons; American Medical Association; American Surgical Association; College of Physicians, Philadelphia; Society of Clinical Surgery; Major, U. S. Army, during World War I.

NORRIS W. VAUX, M.D., Professor of Obstetrics, 1957; M.D., University of Pennsylvania, 1905; Intern, Pennsylvania Hospital, 1905-07; Special Course, Rotunda Hospital, Dublin, Ireland; Director, Division of Obstetrics and Gynecology, Pennsylvania Hospital; Fellow of the College of Physicians of Philadelphia; Honorary Fellow of the Washington Gynecological Society; American Medical Association; American Gynecological Society; Philadelphia County Medical Society; Past President of Section of Obstetrics and Gynecology of Pennsylvania State Medical Society; Past President of the Philadelphia Obstetricical Society; Vice-President, American Gynecological Society, 1944-45; Honorary President, Barton Cooke Hirst Obstetrical Society; Director of Board, American Board of Obstetrics and Gynecology; Chairman of Obstetrics and Gynecology, National Board of Medical Examiners; Chairman of Medical Advisory Board of the Visiting Nurse Society; Alpha Kappa Kappa.

HORACE J. WILLIAMS, M.D., Professor of Oto-logy, 1957; M.D., Jefferson Medical College, 1912; Intern, Children's Hospital, Germantown Hospital, Jefferson Hospital, Pennsylvania Hospital; Otolaryngologist, Germantown Dispensary and Hospital, Memorial Hospital of Roxborough, Philadelphia Hospital for Contagious Diseases, Jefferson Hospital; American Academy of Ophthalmology and Oto-logy; American Medical Association; Fellow of American College of Surgeons; Philadelphia College of Physicians; American Laryngological Society; American Laryngological, Rhinological and Otological Society; Philadelphia Laryngological Society: American Otological Society.

BERNARD J. ALPERS, M.D., Sc.D., (Med.), Professor of Neurology, 1938; M.D., Harvard Medical School, 1925; Sc.D. in Medicine, University of Pennsylvania, 1930; Neurologist, Jefferson Medical College Hospital, Pennsylvania Hospital, Wills Eye Hospital; American Association of Neuropathologists; American Medical Association; American Neurological Association; Association for Research in Nervous and Mental Diseases.

JAMES R. MARTIN, M.D., James Edwards Professor of Orthopedic Surgery, 1939; M.D., Jefferson Medical College, 1910; Intern, Jefferson Medical College Hospital, 1910-12; Chief Resident, Jefferson Medical College Hospital, 1912-13; Medical Corps, U. S. Army, 1917-19; Pottsville Hospital; State Hospital for Crippled Children (Elizabethtown); Chambersburg Hospital; Delaware County Hospital (Drexel Hill); American Academy of Orthopedic Surgery; American Medical Association; Philadelphia County Medical Society; Diplomat of the American Board of Orthopedic Surgery.

LEWIS C. SCHEFFEY, Sc.D., M.D., Professor of Gynecology, 1940; M.D., Jefferson Medical College, 1920; Resident Physician, Rotating Service, 1920-22; Acting Chief Resident, 1922; Personal Assistant to Dr. Brooke M. Anschach, Chief of the Department of Gynecology, 1925-28; American Gynecological Society; Fellow of American College of Surgeons; Diplomate of American Board of Obstetrics and Gynecology; American Medical Association; Founder of Jefferson Society for Clinical Investigation; President-elect of Philadelphia
County Medical Society; Pennsylvania State Medical Society; President of Alumni Association of Jefferson Medical College; College of Physicians of Philadelphia; Obstetrical Society of Philadelphia; Pathological Society of Philadelphia; North American Obstetrical and Gynecological Travel Club; Sydenham Medical Coterie of Philadelphia; American Cancer Society; American Association for Cancer Research; American Radium Society.

BALDWIN LONGSTRETH KEYES, M.D., Professor of Psychiatry, 1941; M.D., Jefferson Medical College, 1917; Intern, Misericordia Hospital, 1919-20; Santa Casa Hospital, Rio de Janeiro, Brazil, 1920-21; Resident Physician, Pennsylvania Hospital, 1921-25; Chief of Psychiatry Service at Philadelphia General Hospital; Corresponding Psychiatrist for U. S. Federal Court (Philadelphia District); Lieutenant Colonel in the Medical Reserve Corps of the U. S. Army; Unit Director of the 36th General Hospital, Jefferson Hospital Unit; Medical Advisory Board of Philadelphia Municipal Court; American Medical Association; Fellow of American College of Physicians; American Neurologic Association; American Psychiatric Association; American Society for Research in Nervous and Mental Diseases.

HAROLD W. JONES, M.D., Sc.D., Thomas Drake Cardeza Professor of Clinical Medicine and Hematology, 1941; M.D., Jefferson Medical College, 1917; Intern, Jefferson Medical College Hospital, 1917-19; Chief Resident Physician, 1919-21; Director of Clinical Laboratory, 1919-28; Assistant Physician, Philadelphia General Hospital, 1921-29; Hematologist, Beebe Hospital; Association of American Physicians; Intermural Clinical Club; Physician to Jefferson Hospital; Hematologist to Jefferson Hospital; Fellow of American College of Physicians; American Board of Internal Medicine; Alpha Omega Alpha.

PAUL CHRISTIAN SWENSON, M.D., Professor of Radiology, 1945; M.D., University of Michigan, 1926; Intern, Gillette Orthopedic Hospital, St. Paul, Minn., 1925; Ancker City and County Hospital, 1926; Resident in Radiology, University of Michigan Hospital, 1928-30; Instructor in Medicine, 1930-34; Assistant Professor of Radiology, 1934-39; Associate Professor of Radiology, Columbia University College of Physicians and Surgeons, 1939-43; Fellow of the American College of Radiology; American Roentgen Ray Society; North American Radiology Society; Fellow of the American Medical Association; Diplomate of the American Board of Radiology; Philadelphia County Medical Society; Philadelphia Roentgen Ray Society; Fellow of the Philadelphia College of Physicians; Fellow of the New York Academy of Medicine; American Trudeau Society; Harvey Society; Alpha Omega Alpha; Phi Rho Sigma.

ABRAHAM CANTAROW, M.D., Professor of Biochemistry, 1945; M.D., Jefferson Medical College, 1924; Resident Physician, Jefferson Medical College Hospital, 1924-27; Research Fellow, 1927-29; Biochemist, 1931-45; Instructor in Medicine, Jefferson Medical College, 1930-34, Associate, 1934-37, Assistant Professor, 1937-39, Associate Professor, 1936-45; Member: American Physiological Society, American Society for Pharmacology and Experimental Therapeutics, American Association for the Advancement of Science, American Society for the Study of Internal Secretions, Society for Experimental Biology and Medicine, College of Physicians of Philadelphia, Philadelphia Physiological Society, Philadelphia Pathological Society, and Endocrine Society of Philadelphia; Alpha Omega Alpha; Author: Calcium Metabolism and Calcium Therapy, 1931; Clinical Biochemistry, 1932, 1939, and 1945; Lead Poisoning, 1945; Contributor to Piersol's Cyclopedia of Medicine, Kolmer and Boerner's Approved Laboratory Technique, and Duncan's Diseases of Metabolism.

FACULTY*

EDWIN E. GRAHAM, M.D., Emeritus Professor of Diseases of Children.

SOLOMON SOLIS-COHEN, M.D., Sc.D., Emeritus Professor of Clinical Medicine.

JOHN H. GIBBON, M.D., Emeritus Professor of Surgery and Clinical Surgery.

E. QUIN THORNTON, M.D., Emeritus Professor of Therapeutics.

FIELDING O. LEWIS, M.D., Emeritus Professor of Laryngology.

BROOKE M. ANSPACH, M.D., Sc.D., Emeritus Professor of Gynecology.

WILLIAM HARVEY PERKINS, M.D., Sc.D., Dean and Professor of Preventive Medicine.

J. PARSONS SCHAEFFER, A.M., M.D., Ph.D., Sc.D., Professor of Anatomy and Director of the Daniel Baugh Institute of Anatomy.

FRANK CROZER KNOWLES, M.D., Emeritus Professor of Dermatology.

EDWARD L. BAUER, M.D., Professor of Pediatrics.

J. EARL THOMAS, M.S., M.D., Professor of Physiology.

VIRGIL HOLLAND MOON, A.B., M.Sc., M.D., Professor of Pathology.

* Names in the Faculty list, with the exception of the Emeritus Professors and the Dean, are arranged on the basis of seniority of appointment.

‡ Died, January 16, 1945.
CHARLES E. G. SHANNON, A.B., M.D.,
Professor of Ophthalmology.
LOUIS H. CLERF, M.D., LL.D., Professor
of Laryngology and Bronchoscopy.
THOMAS A. SHALLOW, M.D., Samuel D.
Gross Professor of Surgery.
CHARLES M. GRUBER, A.B., A.M., Ph.D.,
M.D., Professor of Pharmacology.
DAVID M. DAVIS, M.D., Professor of
Urology.
HOBDART A. REIMANN, M.D., Magee Pro-
fessor of Medicine and Acting Head of the
Department of Experimental Medicine.
MARTIN E. REHFUSS, M.D., Professor of
Clinical Medicine and Sutherland M. Preist
Lecturer in Therapeutics.
GEORGE P. MULLER, Sc.D., M.S., M.D.,
Grace Revere Osler Professor of Surgery.
NORRIS W. VAUX, M.D., Professor of
Obstetrics.
HORACE J. WILLIAMS, M.D., Professor
of Otolaryngology.
BERNARD J. ALPERS, M.D., Sc.D., (Med.),
Professor of Neurology.
JAMES R. MARTIN, M.D., James Edwards
Professor of Orthopedic Surgery.
LEWIS C. SCHEFFEY, Sc.D., M.D., Pro-
fessor of Gynecology.
BALKWLD L. KEYES, M.D., Professor of
Psychiatry.
HAROLD W. JONES, M.D., Sc.D., Thomas
Drake Martinez Cardeza Professor of Clinical
Medicine and Hematology.
PAUL C. SWENSON, M.D., Professor of
Radiology.
ABRAHAM CANTAROW, M.D., Professor of
Biochemistry.

RESERVE OFFICERS' TRAINING
CORPS
FREDERICK H. MILLS, Lieutenant Colonel,
Medical Corps, U. S. Army. Professor of
Military Science and Tactics.

CLINICAL PROFESSORS
CHARLES R. HEED, M.D., Ophthalmology.
ARTHUR E. BILLINGS, M.D., Surgery.
†GEORGE A. ULRICH, M.D., Obstetrics.
WARREN B. DAVIS, M.D., Sc.D., Plastic
and Reconstructive Surgery.
SAMUEL A. LOEWENBERG, M.D., Medi-
cine.
JOHN B. FICK, M.D., Surgery.
ARTHUR J. DAVISON, M.D., Orthopedic
Surgery.
EDWARD F. CORSON, M.D., Dermatology.
JOHN B. MONTGOMERY, M.D., Gynecology.
BURGESS L. GORDON, M.D., Medicine.
J. RUDOLPH JAEGE, M.D., Neurosurgery.
† Died, July 18, 1944.

‡B. B. VINCENT LYON, M.D., Medicine.
CLIFFORD B. LULL, M.D., Obstetrics.
GARFIELD G. DUNCAN, M.D., Medicine.

ASSOCIATE PROFESSORS
JOSEPH O. CRIDER, M.D., Physiology, and
Assistant Dean.
BENJAMIN P. WEISS, M.D., Neurology.
WILLIAM A. KREIDLER, B.S., M.S., Ph.D.,
Bacteriology and Immunology, and Acting
Head of the Department.
A. SPENCER KAUFMAN, M.D., Otolaryngology.
CREIGHTON H. TURNER, M.D., Medicine.
NORMAN M. MACNEILL, M.D., Pediatrics.
LORENZ P. HANSEN, Ph.D., Physiological
Chemistry.
LEANDRO M. TOCANTINS, M.D., Medi-
cine.
FRANKLIN R. MILLER, M.D., Medicine.
AUSTIN T. SMITH, M.D., Laryngology.
ANDREW J. RAMSEY, A.B., Ph.D., His-
tology and Embryology.
WILLIAM J. HARRISON, M.D., Ophthal-
molology.
WILLIAM H. SCHMIDT, M.D., Physical
Therapy.
DAVID R. MORGAN, M.S., M.D., D.P.H.,
Pathology, and Curator of the Museum.
ROBERT A. MATTHEWS, M.D., Psychiatry.
GEORGE ALLEN BENNETT, A.B., M.D.,
Anatomy.
J. BERNARD BERNSTINE, M.D., Obstetrics.
HENRY B. DECKER, M.D., Dermatology.
ARTHUR J. WAGERS, M.D., Laryngology.
MARIO A. CASTALLO, M.D., Obstetrics.

ASSISTANT PROFESSORS
CHARLES W. BONNEY, A.B., M.D., Topo-
graphic and Applied Anatomy.
H. H. LOTT, M.D., Laryngology.
DAVID W. KRAMER, M.D., Medicine.
BENJAMIN LIPSHUTZ, M.D., Neuro-
anatomy.
ROBERT M. LUKENS, M.D., Bronchoscopy
and Esophagology.
HARRY STUCKERT, M.D., Obstetrics.
ADOLPH A. WALKLING, M.D., Surgery.
J. HALL ALLEN, M.D., Proctology.
SIDNEY L. OLSHO, M.D., Ophthalmology.
WILLIAM P. HEARN, M.D., Surgery.
JOHN WILLIAMS HOLMES, M.D., Pedia-
trics.
JOHN T. EADS, M.D., Medicine.
WILLIAM T. LEMMON, M.D., Surgery.
C. CALVIN FOX, M.D., Laryngology.
I. CHARLES LINTGEN, M.D., Gynecology.
REYNOLD S. GRIFFITH, M.D., Medicine.
ARTHUR FIRST, M.D., Obstetrics.
‡ Leave of Absence.
ROBERT A. GROFF, M.D., Neurosurgery.
KENNETH E. FRY, M.D., Surgery.
MARTHA L. LIEBER, M.D., Pathology.
J. SCOTT FRITICH, M.D., Ophthalmology.
CARROLL R. MULLEN, A.B., M.D., Ophthalmology.
E. ROSS HART, Ph.D., Pharmacology.
FRANCIS M. FORSTER, M.D., Neurology.
JOSEPH STASKEY, M.D., Pathology.
JOHN F. COPPOLINO, M.D., Pediatrics.
GUY M. NELSON, M.D., Medicine.
M. H. F. FRIEDMAN, M.A., Ph.D., Physiology.
WILLIAM GEORGE SAWITZ, M.D., Parasitology.
JOSEPH WALDMAN, M.D., Ophthalmology.
MARTIN J. SOKOLOFF, M.D., Medicine.
SHERMAN A. EGER, M.D., Surgery.

ASSOCIATES

ABRAM STRAUSS, M.D., Dermatology.
JOHN B. LOWNES, M.D., Urology.
JAMES L. RICHARDS, M.D., Gynecology.
CHENEY M. STIMSON, M.D., Gynecology.
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