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*in this issue*

- ARTHUR CONAN DOYLE
- MEDICAL CARE
- CARCINOID TUMORS
- RENAL FUNCTION

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# History of Medicine

Arthur Conan Doyle, Detective - Doctor \*

C. Frederick Kittle, M.D.†

Were you to ask your neighbor or friend to compile a list of noteworthy literary characters, it would be a comparatively short one—Romeo and Juliet, Robinson Crusoe, and James Bond perhaps. Certainly Sherlock Holmes and Doctor Watson would be present and would rank in popularity with all ages and professions. Except for the Bible no other writings have been published in as many different languages and no English author has had as many editions as the tales of Sherlock Holmes. Sherlock Holmes is not only a household word—he has become an actual person by virtue of organizations founded in his memory—the Baker Street Irregulars, the Speckled Band Club, to mention only two. In our own midwest town of Kansas City the Great Alkali Plainsmen, based on the “Sign of Four,” commemorates him and perpetuates his exploits. What manner of man was the creator of Sherlock Holmes and Doctor Watson? That Arthur Conan Doyle was a physician is fairly common knowledge, but perhaps his other talents and achievements are not as well-known.

Doyle’s ancestors were Irish and he was born in Scotland, but throughout his life Doyle was the epitome of the typical Englishman. His grandfather, John Doyle, left Dublin for London in 1850 and soon distinguished himself in the field of political caricatures. At a time when the public was smarting from bitter and pungent satirical drawings of Rowlandson and Hogarth, John Doyle’s sketches found ready acceptance. His four sons inherited this artistic ability.

The eldest, James, wrote and illustrated in color the “Chronicles of England” a comprehensive history of England from 55 B.C. to 1485 A.D.

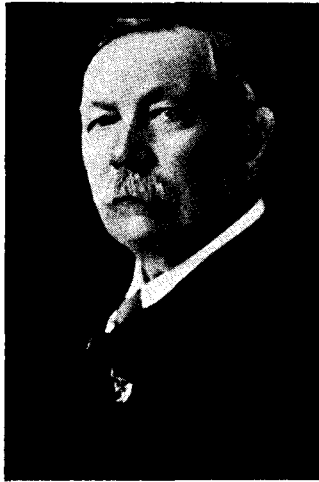
His second son, Henry, was manager of the National Art Gallery in Dublin and respected as a judge of paintings. The third, Richard, illustrated many contemporary books for Thackeray

\*Quarterly Surgical Seminar, History of Medicine Lecture Series, given December 2, 1965 at the University of Minnesota.

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and Dickens, contributed frequently to "Punch" magazine and designed the cover which until only recently was the hallmark of this journal. The fourth, and youngest son, Charles, was a government employee who occasionally painted. In 1855 Charles married Mary Foley also of Irish parentage, who traced her descent from the French Plantagenets. While living in Edinburgh, their first son, Arthur Conan Doyle, was born on May 22, 1859.

Although born in the Catholic faith and reared in Catholic schools, Doyle declined the offer of free tuition if he would become a priest, thus arousing the lifelong animosity of his uncles. Chiefly because of his mother's suggestion he decided to become a doctor. Edinburgh was a famous medical school at this time and he would have the advantage of being at home while attending there. He applied and was accepted. His master at prep school (Sandyhurst) called him up and spoke to him just before graduation in the following declaration: *"Doyle, I have known you now for seven years, and I know you thoroughly. I am going to say something which you will remember in after-life. Doyle, you will never come to any good."*



Arthur Conan Doyle (1859-1930). A photograph taken during his first trip to the United States in 1923.

With this admonition he entered medical school. It was during these formative years that a family friend, Doctor Waller, became a close friend and talked to him about the writings of Emerson on self-reliance. Undoubtedly these discussions were the basis of much of his personal philosophy in the years to come:

*"DO is a far finer word than BELIEVE, and ACTION is far better than FAITH."*

He entered the University of Edinburgh in October 1876 and received his Bachelor of Medicine degree in August 1881, only three months past his 22nd birthday.

Many of the future characters to be found in his writings resulted from contacts with professors and fellow students at

Edinburgh. It was here in the out-patient department that he met Dr. Joseph Bell, the prototype of Sherlock Holmes. The diagnostic acumen of Bell impressed the medical student Doyle tremendously. Repeatedly, Bell would demonstrate with piercing keenness his powers of observation and his lightning deduction in the solution of diagnostic problems.

Dr. Joseph Bell came from a long dynasty of surgeons. His great-grandfather, Benjamin Bell (1749-1806), was the first in Edinburgh to restrict his practice to surgery. Benjamin Bell became surgeon to the Royal Infirmary at the age of 24 and also wrote "A *System of Surgery*," a six volume work.

Joseph Bell, "Joe Bell" to his students, was born in 1837 and became assistant to Prof. James Syme, Lister's teacher and father-in-law. Like his great ancestor, Bell also was surgeon to the Royal Infirmary. Later he became surgeon to the Royal Hospital for Sick Children and president of the Royal College of Edinburgh. He excelled as a teacher and taught the students much besides surgery. As he diagnosed the disease and injury, so did he also elicit the occupation and personal characteristics of each patient. Seated in the clinic with his fingertips twisted together, he surprised both patients and students by the accuracy of his deductions.

One instance particularly impressed Doyle:

"Well, my man, you're in the Army."

"Aye, sir."

"Not long discharged?"

"No, sir."

"A Highland regiment?"

"Aye, sir."

"A non-com. officer?"

"Aye, sir."

"Stationed at Barbados?"

"Aye, sir."

"You see, gentlemen," explained Bell to his students, "The man was a respectful man but did not remove his hat. They do not in the Army, but he would have learned civilian ways had he been long discharged. He has an air of authority and he is obviously Scottish. As to Barbados, his complaint is elephantiasis, which is West Indian."

It might have been Holmes addressing Watson when "Joe Bell" taught his students the importance of the observation of trifles. The comparison ends here, however. Holmes had many habits quite foreign to Dr. Bell — his incredible untidiness, his addiction to tobacco and cocaine, music at strange hours and indoor revolver practice — all these belong to Baker Street and

were unknown at Melville Crescent, Edinburgh.

Another outstanding personality at Edinburgh was the teacher of physics, Prof. Rutherford. Short and squat, with a large, fierce, black Assyrian beard, his singular manner and booming voice impressed all the students. Many of his peculiarities were reproduced in the fictitious character of Prof. Challenger.

At the University, Doyle was an average student, stating that he was a "60% man at examinations." From the very first he was forced to supplement his meager finances by extra jobs. During five years of medical school he worked as an assistant in the poor quarters of Sheffield, the countryside of Shropshire, and lastly in the slums of Birmingham. It was in Birmingham at the urging of a friend, who perhaps recognized Doyle's literary talents, that he submitted an adventure yarn to *Chamber's Journal*. This tale, "*The Mystery of Sasassa Valley*," was based on an old South African Kaffir superstition of a demon with glowing eyes. When finally discovered by the hero the demon's eyes proved to be diamonds. The story was accepted and Doyle received 3 guineas. His first publication! When he read it in printed form he expressed only one regret — the publisher had taken out all the damns.

While still in medical school a fellow student abruptly walked into his room and asked if he would go as surgeon on a whaler to the Arctic Sea. Tempted by adventure, and particularly the financial return, Doyle found himself two weeks later on the *Hope*, a 200-ton vessel which was to be his home for the next seven weeks. His Arctic experiences made a deep impression on him and he secured a wealth of material for future writings. As a direct result of the expedition, another short story appeared, "*The Captain of the Polestar*," published in the *Templebar* magazine.

He could not forget the fascination of the sea and soon after graduation in 1881 sailed again as ship's surgeon of the *Mayumba* of the African Navigation Co. It was a spirited voyage to many ports along the west coast of Africa. He contracted tropical fever and on the return trip endured a ship's fire of eight days' duration. After four uncomfortable and miserable months he was glad to see England again.

On return he entered general practice in Birmingham, but soon left to join an old classmate in Plymouth. The next few years of his life are summarized in an autobiographical account called, "*The Stark Munro Letters*." This book tells of his experiences in practice with his classmate, a thoroughly incor-

rigible, fantastic egomaniac — half-genius, half-charlatan. This character, Cullingworth in the book, is actually George Budd in life.

A delightful and humorous recollection of Doyle's trials and tribulations during this period, the account of Cullingworth's bid for notoriety to increase his medical practice is typical of the entire story. Doyle is talking with Cullingworth:

*"My eyes happened to catch the medal which I had dropped lying upon the carpet. I lifted it up and looked at it. Printed upon it was — 'Presented to James Cullingworth for gallantry in saving life. Jan. 1879.'*

*"Hullo, Cullingworth," said I. "You never told me about this!"*

*He was off in an instant in his most extravagant style.*

*"What! the medal? Haven't you got one? I thought every-one had. You prefer to be select, I suppose. It was a little boy. You've no idea the trouble I had to get him in."*

*"Get him out, you mean."*

*"My dear chap, you don't understand! Anyone could get a child out. It's getting one in that's a bother. One deserves a medal for it. Then there are the witnesses, four shillings a day I had to pay them, and a quart of beer in the evenings. You see you can't pick up a child and carry it to the edge of a pier and throw it in. You'd have all sorts of complications with the parents. You must be patient and wait until you get a legitimate chance. I caught a quinsy walking up and down Avonmouth pier before I saw my opportunity. He was a rather stolid fat boy, and he was sitting on the very edge, fishing. I got the sole of my foot on the small of his back, and shot him an incredible distance. I had some little difficulty in getting him out, for his fishing line got twice around my legs, but it all ended well, and the witnesses were as staunch as possible. The boy came up to thank me the next day, and said that he was quite uninjured save for the bruise on the back. His parents always send me a brace of fowls every Christmas."*

Doyle finally left Cullingworth (Budd in real life) and settled for independent practice in Southsea near Portsmouth. His clientele grew slowly and he spent most of his early days cleaning his house, shopping and doing other simple household tasks. As he describes it:

*"Month followed month and I picked up a patient here and a patient there until a nucleus of a little practice had been formed. Sometimes it was an accident, sometimes an emergency case, sometimes a newcomer to the town, or one who had quarreled with his doctor. I mixed with people so far as I could, but I learned that a brass plate alone will never attract,*



and people must see the human being that lies in wait behind it. Some of my tradespeople gave me their custom in return for mine, and mine was so small that I was likely to have the best of the bargain. There was a grocer that developed epileptic fits, which meant butter and tea for us. Poor fellow, he could never have realized the mixed feelings with which I received the news of a fresh outbreak . . . It was a ghoulis compact, by which a fit to him meant butter and bacon to me, while a spell of health for him sent me back to dry bread and saveloys."

Gradually his practice increased, probably because of many contacts he developed socially. He lectured to clubs on any subject, he played rugby and cricket, he bowled, debated at political meetings, publicly supported vivisection, and vociferously argued for vaccination. His practice never become really large and when he completed and sent in his first income tax report, it was returned with the terse comment: "Most unsatisfactory." Doyle promptly added, "I agree" and fired it back to the agent. An inspection of his books by the visiting officials supported both statements. These years in Southsea were the most active part of his medical career.

His only strictly medical writings appeared as brief notes in *Lancet* and *The British Medical Journal*. There were three:

The first (1879) was written while he was a student (*Brit. M.J.*, Sept. 20, 1879, p. 483). In it he describes an experiment conducted on himself in which he took increasing doses of gelsemium over a seven day period, listing his reaction and symptoms daily. The other two papers (1882 and 1884) are concerned with case reports, one suggesting a connection between malaria and leukemia (*Lancet*, March 25, 1882, p. 430), the other describing gout in three successive generations of the same family (*Lancet*, Nov. 29, 1884, pp. 978-979).

His M.D. degree was granted by Edinburgh University in 1885 upon completion of a thesis, "*The Gouty Diathesis*," and an examination.

In 1885 Doyle married and with the greater financial responsibility began to devote more time to writing. In rather rapid succession "*Habakuk Jephson's Statement*," "*The Firm of Girdlestone*," "*The Great Keinplatz Experiment*," "*A Physiologist's Wife*," and other short stories were published.

In 1886, that famous couple Sherlock Holmes and Doctor Watson were created, but it was not until the following year that the first Holmes story was published. In Beeton's *Christmas Annual* "*A Study in Scarlet*" appeared. Doyle received £25 for the complete copyright of this story. The famous detective's name is taken from Oliver Wendell Holmes, whom Doyle greatly

admired. The technique follows that of Edgar Allan Poe, another favorite of Doyle, and his astonishing sleuth, M. Dupin.

History next claimed Doyle's attention and he delved into the 17th century conflict between Catholicism and Protestantism. "*Micah Clarke*" emerged, to be followed by another historical novel, "*The White Company*," which was Doyle's favorite work and subsequently the humorous accounts of Brig. Gerard. The Napoleonic Wars fascinated Doyle and although the leading character, Gerard, is purposely absurd, this does not lessen the excitement of these narratives. They are among the best of Doyle and emerge so spontaneously that their gaiety and enthusiasm cannot fail to capture the reader. The English will accept a Frenchman as a hero as long as he is ridiculous, and Gerard instantly became popular. The following excerpt between Gerard and his commander is indicative:

*"Col. Etienne Gerard," said the commander, "I have always heard that you are a very gallant and enterprising officer."*

*It was not for me to confirm such a report, and yet it would be folly to deny it, so I clinked my spurs together and saluted.*

*"You are also an excellent rider," the commander continued.*

*I admitted it.*

*"And the best swordsman in the six brigades of light cavalry."*

*Massena was famous for the accuracy of his information.*

In October 1890 a great splash of newspaper articles announced that Dr. Robert Koch of Berlin had found a cure for tuberculosis. Doyle decided he must see for himself, though he had no particular interest in this disease. He made the journey to Berlin for a personal investigation and after careful consideration was the first to write in the English press against this alleged cure. In a letter to the *Daily Telegraph* he warned: "The whole thing is experimental and premature." On his way from Berlin he talked with Sir Malcolm Morris who suggested that he withdraw from general practice and devote himself to a specialty. He elected ophthalmology.

In 1891 he reached Vienna and spent four months attending eye lectures at the Krankenhaus. He returned to London and in Devonshire Place, amidst the fashionable physicians, set up rooms as an ophthalmologist. After long hours, weeks, and months of waiting for the first patient who never visited, he abandoned himself completely to writing.

*"My rooms in Devonshire Place," he said, "consisted of a waiting-room and a consulting-room, where I waited in the consulting-room and no one waited in the waiting-room."*

*"The only thing which came along to me was the rent collector so I left my profession . . ."*

At a dinner in London given by a representative of the American publisher Lippincott, he met another not-yet-famous young author, Oscar Wilde. Would each of them write a novel for the *Lippincott's Magazine*? Each promised, Doyle obliging with the "Sign of Four" and Wilde with "The Picture of Dorian Gray."

The Sherlock Holmes stories with their famous narrator, Doctor Watson, were now immensely popular. Doyle signed a contract with George Newnes, editor of the *Strand* magazine, for a series of these. Who could resist them?

*"In the dim light of the lamp I saw him sitting there, an old briar pipe between his lips, his eyes fixed vacantly upon the corner of the ceiling, the blue smoke curling up from him, silent, motionless, with the light shining upon his strong-set aquiline features."* (*The Man with the Twisted Lip*.)

In Doyle's Victorian Age such detective stories became popular and acceptable, just as western and spy stories have in present times. The advent of railroad travel in England increased the desire for a short interesting tale that could be read in several hours.

It is no secret that Doyle did not think highly of his Sherlock Holmes stories, preferring his historical accounts to those of the detective. He resolved to kill Sherlock Holmes and abolish the ever-increasing demand for these adventures. He did so and as he wrote to his mother:

*"All is very well down here. I am in the middle of the last Holmes story, after which the gentleman vanishes, never to return, I am WEARY of his name!" and thus, Prof. Moriarty waited, the precipitous falls of Reichenbach beckoned, and Sherlock Holmes was dead—until the public demanded a resurrection.*

The Great Plains of the United States and particularly its Indian lore fascinated Doyle. In his Sherlock Holmes tale, "The Three Garridebs," he tells of the wealthy Alexander Hamilton Garrideb and his huge farm "lying along the Arkansas River, west of Fort Dodge." In this story numerous references are made to Kansas and Topeka. In an after dinner talk during his first trip to America he won the friendship of all by his compliments regarding America:

*"I have heard even Americans say that life is too prosaic over here. That romance is wanting, I do not know what they mean. Romance is the very air they breathe. You are hedged in with*

*romance on every side . . . I love the memories of shattered castle and the crumbling abbey; of the steel-clad knight and the archer; but to me the romance of red-skin and the trapper is more vivid, as being more recent. It is so piquant also to stay in a comfortable inn, where you can have your hair dressed by a barber, at the same place where a century ago you might have been left with no hair to dress."*

Another link with the Midwest, and certainly one of which we need not be proud, is perhaps speculative. Doyle generally based his characters on real life people. One of the best-known, but disreputable, individuals to attend the University of Kansas was Frank Harris, a notorious publisher, and intimate friend of Oscar Wilde. It is generally conceded that this Jayhawker, who spent many years in London and Europe and distinguished himself by his sensational journalism and personal scandals, served as the basis for the Sherlock Holmes story "*Charles Augustus Milverton*."

Dr. Logan Clendenning was an avid reader of Sherlock Holmes and no less addicted than millions of others. Clendenning, who for many years was professor of Medicine at the University of Kansas and the founder of the well-known History of Medicine Library there, testified to his interest by the following account of Sherlock Holmes arriving in Heaven:

*"Sherlock Holmes is dead. At the age of eighty he passed away quietly in his sleep. And at once he ascended to Heaven.*

*The arrival of few recent immigrants to the celestial streets has caused so much excitement. Only Napoleon's appearance in Hell is said to have equaled the great detective's appearance. In spite of the heavy fog which rolled in from the Jordan, Holmes was immediately bowled in a hansom to audience with the Divine Presence. After the customary exchange of amenities, Jehovah said:*

*'Mr. Holmes, we, too, have our problems. Adam and Eve are missing. Have been, 's a matter of fact, for nearly aeons. They used to be quite an attraction to visitors and we would like to commission you to discover them.'*

*Holmes looked thoughtful for a moment.*

*'We fear that their appearance when last seen would furnish no clue,' continued Jehovah. 'A man is bound to change in two aeons.'*

*Holmes held up his long, thin hand. 'Good old Watson,' he replied. 'Surely they must differ from the rest of the race.'*

*'Well,' mused God, 'it was given out that they were Jews. I don't want to hurt Prof. Einstein's feelings, but 's a matter of fact they were polyglots. Their children resembled them very closely, however.'*

*'A moment,' interrupted Holmes. 'With luck — could you make a pretty general announcement that a contest between an immovable body and an irresistible force would be staged in that large field at the end of the street — Lord's I presume it is?'*

*The announcement was made and soon the streets were filled with a slowly moving crowd. Holmes stood by idly in the divine portico watching them.*

*Suddenly he darted out into the crowd and seized a patriarch and his whimpering old mate; he brought them to the Divine Presence.*

*'It is,' asserted Deity. 'Adam, you have been giving us a great deal of anxiety. But, Mr. Holmes, tell me how you found them.'*

*'Elementary, my dear God,' said Sherlock Holmes, 'they have no navels.'*"

Doyle's medical education and his medical experiences are soon appreciated by even the briefest perusal of his writings, particularly the Sherlock Holmes stories. A few examples will indicate the depth and accuracy of this knowledge. There are many illusions to heart disease:

In the "Sign of Four" Maj. Sholto is dying in heart failure — left ventricular failure, secondary to hypertension, and orthopnea is rightly emphasized as a leading symptom:

*"When we entered his room he was propped up with pillows and breathing heavily . . . grasping our hands he made a remarkable statement in a voice broken as much by emotion as by pain . . . at this instant a horrible change came over his expression . . . his eyes stared wildly, his jaw dropped . . . his pulse ceased to beat."*

Another is the graphic account of an aortic aneurysm. As Jefferson Hope is arrested ("Sign of Four") he remarked that he might not live for the trial:

*"It isn't suicide I am thinking of; put your hand on my chest," he said. Watson did so, and at once became conscious of an extraordinary throbbing and commotion inside. The walls of his chest seemed to quiver as a frail building would when some powerful engine was at work. In the silence of the room he could hear a dull humming and buzzing noise which proceeded from the same source.*

*"Why," cried Watson, "You have an aortic aneurysm."*

*"That's what they call it," he said frankly. "I went to the doctor last week, and he told me it was bound to burst before many days passed."*

Similar examples could be cited about other types of heart disease, and it is doubtful if the works of any other novelist

contain descriptions of extrasystoles, of edema, of angina pectoris, of aneurysm, of rheumatic valvular disease, and of hypertension with such careful adherence to medical detail. Diseases of the lungs, the nervous system, tropical diseases, anatomy, chemistry, and pharmacology — all are intermingled in an unusually accurate manner to enhance the reader's interest.

At least 20 medical men flit across the stage of the 60 Sherlock Holmes stories. Doctor Watson is generally conceded to be Doyle himself. Holmes is always in the center of the picture, however, and perhaps that is why Watson did not appear to advantage, and why other doctors made only such temporary appearances.

In 1889 the Boer War claimed Doyle's attention and he tried to enlist. Before his application could be reviewed he was asked to go as a doctor and supervisor of a hospital unit to South Africa. The unit consisted of 50 men and 50 beds and as was customary in those days all expenses were paid by a private sponsor, John Langman. Doyle received nothing for his services. One of his first actions after landing at Capetown was to distribute money to the Boer prisoners for their welfare. His hospital was soon overcrowded, the accommodations for 50 actually caring for 120 patients. Dysentery was the greatest problem and deaths were common. After the capture of Pretoria he considered his work done and elected to write a history of the Boer War. His numerous pamphlets "*The Crime of the Congo*," "*The Cause and Conduct of the War in South Africa*," etc., helped to acquaint the rest of Europe with the actual circumstances in South Africa. Returning to England, Doyle exposed the propaganda about English brutalities and through his publications did much to influence European opinion favorably. Chiefly for these efforts he was made a knight in 1902. The profits from his writings about South Africa were given to the University of Edinburgh to establish a scholarship fund for needy students.

In the early 1900's in Staffordshire, an epidemic of anonymous, menacing letters occurred concomitantly with numerous incidents of horses being cut or stabbed. The police after many months linked the writer of the anonymous letters with the maimer of horses and arrested the vicar's son, George Edalji, who was tried and condemned to seven years' imprisonment. All the evidence had been contrived by the police and the verdict was obviously unjust. Three years after the trial, Conan Doyle, attracted by this miscarriage of justice, gave his whole attention to the matter, studying reports of the trial, inter-

viewing the Edalji family, and examining the scene of the crime. Among other things he discovered that George Edalji held an unblemished record throughout school, was a total abstainer, and had won numerous high honors. He had done commendable work for a Birmingham lawyer, had never shown the least sign of cruelty, and was so blind that he could scarcely see more than 20 feet away. This last point was significant because in order to commit the crimes of which he had been accused, the young man would have had to have crossed numerous railroads, fence rows and other obstacles all in the dark. In addition, he slept in a bedroom with his father, who was a light sleeper and always locked the door.

Doyle wrote a series of articles about this case which were published and caused such a sensation that the government appointed a committee to review the evidence. The committee, true to usual form, cleared Edalji of the crime, but refused him compensation for his three years in prison. As a result of Doyle's effort and detective work, Edalji was freed and re-admitted to the law society.

As one author expresses it: "Doyle thought that the home office bureaucrats were insane to ignore the evidence he had placed in their hands; but in expecting reason and justice from bureaucrats Doyle's own sanity was open to doubts."

Two years later he was involved in another mystery. Having been successful with the Edalji case he was immediately besieged with many requests to prove other condemned men innocent. Accordingly, he went to the Oscar Slater case with much reluctance, but finally came to the conclusion that it was a more monstrous perversion of justice than the Edalji affair.

In 1908 a man entered the Glasgow flat of an elderly woman, murdered her and stole a diamond brooch. A German-Jew named Oscar Slater left Glasgow for New York a few days after the crime. By a combination of contrivances, Slater was arrested when he arrived in New York, identified by witnesses who had been coached previously, tried and condemned to death, although this penalty was subsequently commuted to life imprisonment. After 18 years in prison, Oscar Slater's case was finally reviewed due to the efforts of Arthur Conan Doyle and his writings in behalf of Slater. Slater was awarded £6000 compensation for 18 years' imprisonment. The government, however, refused to bear the expense of the trial and since Doyle had engineered the appeal he made himself legally responsible for hundreds of pounds of expense. He, of course, considered that Oscar Slater would refund this from the money that he

received. Slater on the other hand thought the government was responsible and considerable friction ensued between Doyle and Slater as to which of them should pay. As it was finally settled, Doyle bore the expenses not only for the trial, but for all his personal efforts in freeing Oscar Slater. These incidents are worth noting because they illustrate the sporting instinct of Doyle to defend the underdog and the practical application of detecting methods for which Sherlock Holmes was now a pattern.

In 1912 at the age of 53, Doyle broke fresh ground and entered the realm of science fiction. His first effort was "*The Lost World*." This was a captivating account of the Mato Grosso in Brazil with pterodactyls, dinosaurs, iguanodons and other prehistoric fauna and flora. It was in "*The Lost World*" that Prof. Challenger first appeared, with Prof. Rutherford as the model. Although Challenger delineates many of Rutherford's physical characteristics — his originality, idiosyncrasies, fiery energy and uncertain temper — many of the features of Doyle's old friend Dr. Budd are also present. Perhaps most entertaining of all the Prof. Challenger series is "*The Poison Belt*" which appeared in 1913. In this tale the inhabitants of the world are destroyed by a malignant gas in the atmosphere.

Doyle's science fiction is unforgettable and ranks on a comparable basis with H. G. Wells or any other author in this field.

With the onset of World War I, he quickly organized one of the first volunteer forces and this eventually numbered more than 200,000 people. It was the forerunner of the Home Guard in World War II. He remained a private in his local company from 1914-1918 — drilling, marching, camping, rifle practicing and thoroughly enjoyed all of it even at his age of 60.

Meanwhile he was making all sorts of suggestions about warfare and its conduct to the newspapers. He suggested body armor and shields for the infantry, collapsible boats and rubber collars for the sailors. Many of these ideas were subsequently adopted. In addition, he wrote numerous pamphlets during the war, made frequent trips to the front, and began an official history at the request of the government. This is a very readable and detailed six volume account of World War I entitled "*The British Campaign in France and Flanders*."

An intriguing wartime novel, "*Danger*," written early in World War I related how Great Britain was defeated by an imaginary, small and weak, but craftier nation. The smaller country with eight submarines systematically sank all food-ships supplying Great Britain. In a short time England was forced to capitulate. The analogy was clear and by this story Doyle called



attention of the British, in particular the war office — who was forced to admit the tactical possibility of such a maneuver — to the great danger of submarines. A solution? — One possibility would be a tunnel across the English Channel between Dover and Calais, an idea that Doyle championed and is now gradually being realized.

Throughout life Doyle was interested in many sports and by his enthusiastic support did much to promote several of them. He became interested in boxing at the University of Edinburgh and maintained this interest for years. His mention of boxing in the Sherlock Holmes stories and in two novels, "*Rodney Stone*" and "*The Croxley Master*," helped to popularize this sport which until his time was held in little esteem by the public. His novels about boxing provide a panoramic view of the sporting and social world in London during the Regency.

With his 74-inch height and 220 pounds Doyle did well in soccer and cricket, playing these until almost 50. He had great skill at billiards and was also an enthusiastic and early participant in motoring and ballooning.

In 1895 while vacationing at Davos in Switzerland he planned a golf course there and like many prominent citizens today enjoyed golfing in his numerous travels. Also at Davos in 1895, having just read Nansen's account of crossing Greenland on skies, he interested two businessmen named Branger in the idea of introducing skiing to Switzerland. They caught his enthusiasm, sent to Norway for skis, and within a short time skiing was firmly established.

He was asked to be president of the Olympic Games to be held in Sweden in 1916.

For the last ten years of his life he devoted himself to the greatest mystery of all. Doyle's nature demanded a religion. The Jesuits had disgusted him with their hell-fire nonsense and he was too rational to accept any ready-made creeds available at that time. He looked long and hard for a faith that would harmonize with his temperament. Doyle wanted to believe in a future life and he gradually adopted spiritualism.

As with everything he undertook, from the writing of historical novels to the exposure of British justice, he was thorough, leaving no source of information untapped, and when his studies were completed he possessed one of the largest libraries of spiritualistic literature (over 2,000 volumes) in the world. Haunted houses, sepulchral voices, moving tables, automatic lighting, materialization of limbs, levitation of bodies, mysterious sounds, lights and touches — everything was present to stimulate and satisfy his love of the weird.

The reasons Doyle gave for future life were essentially materialistic:

*"If there is no afterlife, why should man strive to improve himself? It is a waste if all of his efforts end in annihilation."*

This materialism like that of many others compelled him to make converts to his faith, and he began a crusade for spiritualism with all his vigor. Pamphlets and books flowed almost ceaselessly from his facile pen. Talks and travels followed in rapid succession and even when his son was dying he refused to cancel a speaking engagement at Nottingham.

The most highly paid writer of his time (at the rate of 10 shillings per word) he abandoned fiction at the age of 60 and devoted himself exclusively to an exhausting campaign in behalf of his psychic religion. "*The New Revelation*" in 1918, "*The Vital Message*" in 1919, "*The Land of Mist*," "*The Mystery of Spiritualism*," "*The Coming of the Fairies*," "*Phineas Speaks*," "*The Edge of the Unknown*," pamphlets, countless letters, speeches, and debates — all on the subject of spiritualism. As he wrote:

*"Spiritualism does prove survival of the personality, but it cannot give growth to the eternal man. One has to live in accordance with spiritual law in order to grow. The Christian Bible gives these laws. It is for the Church to interpret them as facts and advise men how to proceed in order to live nobly and eternally. The seance room proves life after death; God alone can give that life, when man has created the cup within himself to hold and receive it."*

He toured Great Britain, Australia, America, South Africa, America again, and Europe — an estimated 50,000 miles to promote his cause. In the midst of his efforts he developed angina and after several months of illness quietly died.

Arthur Conan Doyle cannot be pictured as a single person. He was an unusual and remarkable combination of many different entities blended into one: The physician, the sportsman, the champion of the undertrod, the historian, the orator, and the author. A man of amazing versatility and boundless energy, he died on July 7, 1930.

He was buried in the garden outside his home in Windlesham beneath a simple tombstone of British Oak. Engraved are his name, his birthdate, and four words:

STEEL TRUE, BLADE STRAIGHT

Let no man write his epitaph. He is not dead.

## Staff Meeting Report

### The Poverty Programs and Medical Care \*

Annie Laurie Bakert

The President, Lyndon B. Johnson, in his first address to Congress stated:

"There are millions of Americans, one-fifth of our people, who have not shared in the abundance which has been granted to most of us, and on whom the gates of opportunity have been closed."

The concern of the President and others resulted in the passage of the Anti-Poverty Bill, known as the Economic Opportunity Act. Since the passage of the act, much has been written and people have become interested. State agencies, county welfare departments and city governments have begun to plan programs and to apply for financial grants to implement the provisions of the act. The level of poverty has arbitrarily been set at an annual income of \$3,000 or less for a family of four. The figures were obtained from the 1960 Census Report and may be understood more easily if related to food costs. An income of \$3,000 allows \$5.00 per week per person, 72 cents per day, 24 cents per meal. Of the families surveyed, 30 million people have an income of less than \$3,000; 45% had \$1,500; 10% had \$1,000 or less. The education of the head of the household was less than eight years. Of this group, one-fourth of the households were headed by women. A surprising fact was that two-thirds of the families had at least one person employed. The number of families representing minority groups was five times as high as among the white, and less than one-half, 48%, resided in the southern states. The tragic fact is that one-half of these 30 million people living in poverty are children under 15 years of age.

Material from the 1960 Census Report gives the following information on poverty in Minnesota:

\*From a Report to the Staff Meeting of University Hospitals on April 2, 1965

†Professor and Director, Social Service Department, University Hospitals

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Total Number of Families .....	836,723
Income below \$3,000 for family of four ...	178,766
\$2,000-\$3,000 .....	71,854
\$1,000-\$2,000 .....	64,352
Below \$1,000 .....	42,560

One-third of the patients who come to the University Hospitals have their medical expenses paid through authorizations from their home county. A portion of those whose expenses are met through insurance have an annual income of less than \$3,000 for a family of four. Since many patients have incomes below the poverty level, it is essential that the staff understand the provisions of the Economic Opportunity Act. The importance of knowing the provisions is so they can use the additional resources which will be made available and to help patients take advantage of the new programs.

The Economic Opportunity Act contains nothing affecting medical care, but has five provisions of interest to doctors and others who work with patients: (1) Funds made available to stimulate community projects directed toward the elimination of poverty. (2) Education and vocational training for young adults, 16 to 21 years of age. (3) Vocational guidance and work experience for unemployed fathers. (4) Financial resources to assist farmers and operators of small businesses. (5) The American Volunteer Corps.

The Act is directed toward prevention and is not concerned with the material needs of the poor of today. The responsibility of providing relief to hungry people remains with the public assistance programs — Old Age Assistance, Aid to Dependent Children, Aid to the Disabled and general relief. The new programs are designed to modify the elements in our present day society that perpetuate the vicious circle of poverty; lack of education, of job opportunity and economic resources.

The staff of the University Hospitals has made a significant contribution to the prevention and alleviation of poverty in Minnesota. Good medical care supported by sound social planning helps patients achieve and maintain maximum health and to function creatively in the affairs of daily life. The partnership which exists between the Hospitals and community agencies is a positive force in the prevention of poverty.

Many members of the medical, administrative and other staff have contributed to the initiation and promotion of laws to meet specific needs of the patients they served. Others have

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taken positions of leadership on commissions, organizations and committees concerned with medical, education and welfare programs.

The national assault on poverty should make the public more aware of medical problems and disabling conditions. The positive emphasis on prevention should result in sounder comprehensive plans for people. This tremendous concentration on the problems of one-fifth of the nation's population should produce a dynamic atmosphere which should spark more positive attitudes toward people and encourage and motivate patients in their hard fight to regain health.

People in the helping professions will need to accept certain responsibilities if they are to become a part of this interesting crusade. Those working in the health fields have an obligation to keep the public informed of the importance of providing adequate medical services for people if poverty is to be prevented. Increased effort needs to be exerted to interpret the requirements of medical care and the limitations imposed by illness. Patients need to be encouraged to take advantage of the new opportunities created for them. Others must be protected from going beyond their limitations. In evaluating tests, physical findings, etc., a new dimension needs to be added to include an assessment of the patient's potentials for life, for work, participation in school and capabilities in the general areas of daily activities. Volunteers in Service to America (VISTA), part of the Act, offers a new opportunity for people to live and work with those in poverty. Everyone involved in the medical care of people qualifies as a member of that corps.



## Staff Meeting Report

### Carcinoid Tumors of the Rectum\*

William C. Bernstein, M.D.† and F. Gary Lewis, M.D.‡

The term carcinoid, meaning cancer-like, was introduced by Oberndorfer in 1907 to distinguish it from carcinoma. Carcinoid tumors are of small size and slow growth, but their potential for local invasion and widespread metastases is not to be overlooked. Carcinoid tumors may occur anywhere in the gastrointestinal tract and are most common in the appendix and ileum. As the practice of proctosigmoidoscopic examinations is increased and the public becomes more cognizant of its importance, larger numbers of rectal carcinoids are being found. At the present time more than 400 cases have been reported in the literature and, certainly, at least an equal number of unreported cases exist.

#### *Incidence*

Twenty-seven records were available for review. Eight cases were first noted at the University of Minnesota Cancer Detection Center. The remaining 19 records were obtained from eight hospitals in the Minneapolis-St. Paul area. All are histologically proven carcinoid tumors of the rectum. Over the last 17 years 59,012 proctosigmoidoscopic examinations have been performed on 12,620 patients at the Cancer Detection Center. Eight carcinoids and 29 adenocarcinomas of the rectum were discovered for an incidence of 0.063% and 0.23%, respectively, in this group of patients.

#### *Age and Sex*

Sixty-nine per cent of patients are between the ages of 40 and 59 years. The mean age is 49, which is nine years younger than the mean age of those patients with adenocarcinoma of the colon. The one patient in this series with metastases was 53 years old. The women with carcinoid tumors tended to be younger

\*From a Report to the Staff Meeting of University Hospitals on March 26, 1965

†Professor and Director, Division of Proctology, Department of Surgery

‡Medical Fellow Specialist, Division of Proctology

than the men. The sex distribution is essentially equal with 14 women and 13 men.

### *Histogenesis*

The carcinoid tumor originates from the Kultschitsky cell which is located in the base of the crypts of Lieberkühn. The ability of the intracellular granules to reduce metallic salts has led to the use of the terms *argentaffin*, *chromaffin* or *enterochrome* cell, all of which are synonymous with the Kultschitsky cell. Not all carcinoid cells have the ability to reduce metallic salts and are said to exist in a pre-enterochrome state. It is postulated that the granules produce serotonin (5-hydroxytryptamine) which is a smooth muscle stimulant. Serotonin is found in high levels in the blood of patients with carcinoid liver metastases. This may result in a syndrome characterized by patchy sporadic flushing cyanosis, frequent watery stools, asthma and sclerosis of the tricuspid and pulmonary valves. This syndrome has not been reported with carcinoid of the rectum, however.

### *Symptoms*

Seldom are the presenting symptoms attributed to the tumor. Eleven of the 27 patients in our series had no symptoms. The tumors were incidental findings on routine examinations. Eight patients presented with rectal bleeding. Two of these could be definitely attributed to the tumor. The remaining six were associated with hemorrhoids. The one patient with metastases had a 6-month history of rectal bleeding as well as decrease in stool caliber. The common complaints of left colon tumors — cramping abdominal pain, constipation, diarrhea, rectal itching and vaginal bleeding — did not appear in connection with carcinoid tumors.

### *Physical Examination*

The diagnosis of carcinoid tumor should be considered when a small, smooth, firm, flat submucosal polyp is palpated on digital examination. On proctosigmoidoscopy a flat or sessile polyp may be seen. It is rarely pedunculated, often has a pale yellow hue, and is covered by smooth intact mucosa, differentiating it from an adenomatous polyp. The exact position was not recorded in all cases, but half were located on the anterior wall and half in the remaining three quadrants. The majority were less than one cm. in greatest dimension (16 of 23 recorded). Five were between one and two cm., and two were greater than two cm. Twenty-one tumors were located between

five and ten cm. and six were between 11 and 15 cm. above the pectinate line.

### *Histology*

The cells are round, polygonal or columnar with an indistinct cellular membrane. The cytoplasmic vacuoles are filled with lipid material which is no doubt responsible for the yellow color. The nuclei are hyperchromatic and mitotic figures are seldom seen. The cells lie in nests, clumps or sheets and may show ribboning. Pseudoglandular structure has occasionally led to confusion with adenocarcinoma but mucin stains are negative. The cell groups lie in varying amounts of stroma, often with marked desmoplasia accounting for the firmness. The rectal carcinoid will occasionally take up silver stains but the majority do not. It is difficult for the pathologist to determine the virulence of the individual tumor as there is no histological pattern that is not associated with at least occasional metastases. The metastasizing tumors tend to grow in larger cell masses and have more hyperchromatic nuclei.

### *Treatment*

Clinical evaluation and size, particularly, have been the most valuable criteria for determining treatment. Those lesions one cm. or less are adequately treated by forceps biopsy and fulguration. Those between one and two cm. are widely excised and either closed primarily or fulgurated, depending on their level. Those over two cm. require proctosigmoidectomy.

In two instances, following biopsy and fulguration, the scar was excised and no residual tumor was found. The largest lesion was fungating, bleeding, and measured  $3.5 \times 3 \times 3$  cm.. This patient was treated by proctosigmoidectomy. The liver was grossly free of metastases as were the regional nodes but the ischial rectal fat contained three separate nodules composed entirely of tumor cells. Local excision would have failed. The other proctosigmoidectomy was performed following excision of a 1.5 cm. lesion in which microscopic section revealed invasion of the muscularis mucosa. No residual tumor was found. Local excision would have been adequate.



## Staff Meeting Report

### Incidence and Course of Psychiatric Patients in the Comprehensive Clinic \*

Sherod L. Miller, M.S.W.,† Adeline U. Mandel, M.S.W.,†  
and Floyd K. Garetz, M.D.§

The research described in this paper grew out of an interest of the staff of the Psychiatry Outpatient Clinic in the incidence of patients with psychiatric problems in New Medicine Clinic, and in the nature of the evaluation of such patients. Our goal was to learn something of the percentage of patients in a general medical setting who indicate that they have psychiatric problems and to learn also something of the way in which such patients are evaluated.

#### *Data*

The data of this research were derived from two main sources. First, all patients in the study were asked to complete a simple, short questionnaire during their first visit to New Medicine Clinic. The completed questionnaire was then sealed in an envelope and was not available to the examiners conducting the regular clinical evaluation of the patient.

The questionnaire consisted of these 11 questions: (1) Have you been ill for a long time? (2) Did you have treatment for your illness before coming here? (3) Do you tend to worry a lot about your health or other matters? (4) Do you have trouble eating or sleeping? (5) Do you feel you have psychological problems? (6) Do you tend to cry a great deal? (7) Are you satisfied with your life? (8) Do you quarrel with others easily? (9) Have you been in trouble during the past year? (10) Are you very unhappy about anything which concerns your family, your job, or relationships with people? (11) Do you want to discuss these problems with someone in the University Hospitals, namely a social worker, psychologist or psychiatrist?

The manner in which the patients answered the questionnaire led to classification of patients into several groups. A

\*From a Report to the Staff Meeting of University Hospitals on April 23, 1965

†Senior Social Worker, Department of Social Service, University of Minnesota

‡Supervisor, Psychiatric Social Work, Department of Social Service

§Assistant Professor, Department of Psychiatry and Neurology

patient was considered to have indicated that he had psychiatric problems if he answered affirmatively any two of the questions which specifically referred to mental, emotional or psychological concerns. A patient was considered to have asked for psychiatric help if he answered affirmatively the question regarding his wish to see a social worker, psychologist or psychiatrist for help with his problems.

One sample of 147 patients was accumulated in June and July, 1964. This sample was characterized by the fact that these patients were seen by medical students who were just beginning their experience in Comprehensive Clinic. A second sample of 71 patients was accumulated in September and October, 1964, after the students had passed the half way mark in their experience in Comprehensive Clinic.

The second kind of data collected for this research came from the medical records of the patients. The records of each patient in the study were reviewed carefully by one of the authors. Special attention was paid to (1) whether or not there was any mention in the current record of mental, emotional, family or psychological problems; and (2) whether or not there was a psychiatric referral or consultation and/or treatment in the psychiatric clinic. Review of the charts was begun approximately four weeks after the patient's initial visit in New Medicine Clinic.

From the information gathered from the clinical records, a classification of patient groups was made. If anywhere in the current New Medicine work-up there was mention of a psychiatric problem, it was considered that the examiner in that case had recognized the presence of a psychiatric problem in the patient. If referral or consultation occurred, either through the facilities in our own hospital or facilities elsewhere in the community, it was considered that this patient had been referred for psychiatric evaluation.

*Results*

Following is a summary of tabulations of 218 patients in the study:

- A. Patients indicated they had psychiatric problems . . . . . 54%
- B. Patients indicated they had psychiatric problems and asked for help with these problems . . . . . 26%
- C. Examiner recognized presence of psychiatric problems . 32%
- D. Examiner referred patient to psychiatry . . . . . 17%

The following is a summary of data comparing how patients answered the questionnaire and the clinical course of the

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patients' evaluations. "Inexperienced" refers to patients seen by "inexperienced" medical students (those in the first two months of experience in Comprehensive Clinic). "Experienced" refers to patients seen by "experienced" medical students (those past the half way mark in their experience in Comprehensive Clinic).

<i>Patients indicated they had psychiatric problems</i>	<i>Recognized by examiner</i>	<i>Referred to psychiatry</i>
Inexperienced .....	49%	25%
Experienced .....	60%	37%
<i>Patients who asked for help</i>		
Inexperienced .....	63%	39%
Experienced .....	76%	52%

*Conclusions*

The following conclusions appear warranted from the data of this research: (1) Previously reported clinical observations are confirmed in that a significant percentage of patients in New Medicine Clinic report or are perceived as having psychiatric problems. (2) There is a difference in the percentage of patients who report psychiatric problems on a questionnaire as compared to the percentage of patients in the same sample perceived by the medical student examiner to have psychiatric problems.\* This is thought by the authors to reflect difficulties of communication between students and their patients about psychiatric problems. Not all patients who asked for help with psychiatric problems were referred for psychiatric evaluation. The two major factors in this occurrence are thought by the authors to be the lack of recognition by student examiners of psychiatric problems and the lack of awareness of appropriate ways of dealing with such problems, even if they are recognized. (3) It appears that experience and training increase the medical student's ability to communicate with his patients regarding psychiatric problems and also to better cope with such problems when recognized. Both the percentages of recognition and referral increase with experience.\*\*

These data suggest a need for more critical evaluation of the methods and effectiveness in teaching psychiatry to medical students. It may be that we are not teaching students adequately the importance of exploring social, family and the personal aspects of a patient's life in the general medical evaluation.

\*This difference was significant at the 1% level of confidence.

\*\*This difference was not significant at the 5% level of confidence.

## Staff Meeting Report

### Renal Function in Patients with Spinal Cord Injuries\*

Mary Price, M.D.,† John A. Tobin, M.D.,‡  
Milton Reiser, M.D.,§ Mildred E. Olson, B.S.,¶  
William G. Kubicek, Ph.D.,\*\* Frederic J. Kottle, M.D.,††  
and James Boen, Ph.D.‡‡

*A* study of 56 patients with spinal cord injuries and nine normal control subjects indicates that injury to the spinal cord does not reduce kidney function after the stage of spinal shock if infection and decubiti can be minimized.

For many years it has been generally accepted as a fact that 90% of all patients with spinal cord injury die from renal failure. Misinterpretation of a paper published by Dietrich and Russi in 1958 has helped to perpetuate this fallacy. Barber and Cross in 1952 reviewed histories of 361 paraplegic patients and found a mortality rate of 14.4/1000 per year. Uremia was the cause of death in 57.8%. In 1956 Morales evaluated kidney function of 62 paraplegic patients and found that 37.5% showed glomerular filtration rates which deviated more than 25% from normal and 47.9% had depression of renal plasma flow.

In the Department of Physical Medicine and Rehabilitation of the University of Minnesota Hospitals, a study has been undertaken for evaluation of the current status of renal function of patients with traumatic spinal cord lesions. Fifty-six paraplegic and quadriplegic patients and nine normal control subjects were studied.

Glomerular filtration rates, renal plasma flows, and tubular maximal excretory capacities were estimated using inulin and

\*From a Report to the Staff Meeting of University Hospitals on April 30, 1965

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‡Assistant Professor, Department of Radiology

§Clinical Assistant Professor, Division of Urology

¶Assistant Scientist, Department of Physical Medicine and Rehabilitation

\*\*Professor, Department of Physical Medicine and Rehabilitation

††Professor and Head, Department of Physical Medicine and Rehabilitation

‡‡Assistant Professor, School of Public Health and Department of Physical Medicine and Rehabilitation

sodium hippurate as testing agents. From these values, renal blood flows and filtration fractions were calculated. Complete blood counts, urinalysis, urine culture, fasting blood glucose, blood urea nitrogen, serum creatinine, and total serum protein with albumin/globulin ratio were the other laboratory studies made. Intravenous pyelography, slow-fill cystometry, and cine voiding cysto-urethrography were also utilized.

Patients were limited to those whose spinal cord injury was due to trauma. For purpose of statistical analysis, subjects were divided into three groups according to the duration of their spinal cord lesion. The first group consisted of 10 paraplegic and eight quadriplegic patients with lesions of less than one year's duration. In the second group, there were seven paraplegics and 10 quadriplegics with lesions of one to five years' duration, and in the third group there were 11 paraplegics and 10 quadriplegics who had sustained lesions more than five years previously. In addition, a fourth group of nine normal controls consisted of five subjects under 30 years of age and four over 30.

In all groups of patients in this series, values for renal function were found to be within the range of our normal control group and also within the range established by Homer Smith and his co-workers. Only three patients exhibited severely depressed renal function.

Time does not appear to produce any trend in the values of glomerular filtration in either paraplegics or quadriplegics or in values for tubular function in paraplegics. In the quadriplegic patients in the group having lesions of longest duration, however, values for tubular function are somewhat lower than in the other groups. Study of mean values for renal plasma flow in the three groups strongly suggests a trend toward lower renal plasma flow in quadriplegics with passage of time. This is not statistically significant in this series but merits further investigation.

Thirty-three patients had positive urine cultures at the time of these studies. None had symptoms of pyelonephritis at the time of testing. Of these patients four showed depressed renal function in one or more tests. Only five were catheter free. Of eight patients with proven vesicoureteral reflux, six had bacteriuria and three showed some abnormality of function. Two were catheter free.

Little correlation was found in this series between severity of renal involvement and elevation of blood urea nitrogen or serum creatinine. No relationship was found between degree of completeness of spinal cord lesion and level of renal function.

Only three patients in this series showed markedly depressed renal function. All three were young men who had acquired their lesions more than five years previously. One was paraplegic and two were quadriplegic. All had had recurrent decubiti and repeated infections, urinary and otherwise, both in days of early care and following discharge from the hospital. All three were psychologically immature, neglectful of their own care and resistant to attempts to provide reasonable management of their medical problems. All three young men were rejected by their parents. Two are now living in nursing homes, the third was set up in business in another country by his father.

Results of the study of the renal function of the 56 patients with spinal cord injury and the nine normal control subjects in this series indicates that in humans, as in animals, spinal cord injury does not depress renal function after the period of spinal shock. The great majority of patients in this series had good renal function. In those patients exhibiting reduced renal function, however, the consistent presence of recurrent infection and decubiti convinces us that good urologic management and meticulous nursing care must be instituted early and be maintained conscientiously throughout the lifetime of the patient. This is dependent upon the adequate training and unflinching cooperation of the patient and his family as well as of the medical and nursing staff.

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This research supported in part by Vocational Rehabilitation Administration Research and Training Grant No. 2.

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*The authors acknowledge with gratitude the technical assistance provided by Marian McColgin and Jill Jensen of the Department of Physical Medicine and Rehabilitation*

## *Student News*

Three students at the Medical School have recently won significant awards.

**Gaylan L. Rockswold**, a junior, won a fellowship from Smith, Kline, and French Laboratories for study and practice next summer in a mission hospital in the African nation of Malawi. His wife, a graduate nurse, will accompany him. Their \$3,025 fellowship was among approximately 30 awarded for 1965 to outstanding students at U.S. medical schools through the Association of American Medical Colleges.

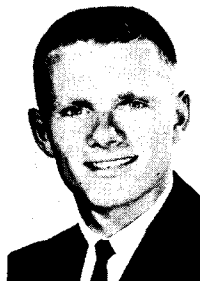
**Theodore J. Buselmeier**, junior medical student from Buffalo, Minn., is one of 142 students from 28 nations to be awarded Rotary International Foundation Fellowships for study abroad during the 1965-66 academic year. Ted will study at the University of Birmingham, England.

**David A. Pope**, freshman, has been named winner of the 1964-65 Rural Medical Scholarship of the Minnesota State Medical Association. He will receive \$1,000.00 per year to cover educational expenses during Medical School, and in return, promises to practice medicine for at least five years in a Minnesota community needing a doctor.

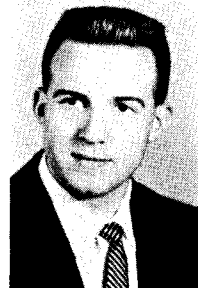
A native of Delavan, Minn., David is the 14th student to receive the MSMA award. Among those recipients still attending the Medical School are **Charles I. Benjamin**, Hutchinson; **Elton Wing**, Jackson; **Roland R. Larter**, Lancaster; and **William J. Norberg**, Barnum.



G. L. ROCKSWOLD



T. J. BUSELMEIER



DAVID A. POPE

## Letters

The Editor:

*I have noticed in the Alumni Notes that the class of 1940 will have its 25th anniversary at the time of the Homecoming Weekend Reunion and notice that Dr. Beck and Dr. Lannin who are members of my class are co-chairmen. Further, I noted some months back that in the class of 1940 there were people who were included that also graduated in 1941 and some who got their Doctor of Medicine Degree in 1941.*

*At that time as you well know, we received a Bachelor of Medicine Degree in 1940 and our Doctor of Medicine Degree in 1941 upon the completion of a year's internship.*

*My question is with the respect to the actual classification of those alumni. Am I a member of the class of 1940 or am I a member of the class of 1941?*

*Very sincerely,*

CURTIS M. HANSON, M.D.  
403 Bronson Medical Clinic  
Kalamazoo, Mich.

*Dear Doctor Hanson:*

*Members of the Class of 1940 (MB's) will observe their 25th anniversary reunion next Oct. 22-23 here in Minneapolis. I am sure you will be getting full details on this from your classmates, Beck and Lannin.*

*The confusion over "MB-MD" persists and deserves another explanation. The Medical School, from 1918 through 1952, awarded the MB degree upon graduation, with the MD degree granted after a year of internship. (In some cases, even later.) This system caused hardships for graduates, and was discontinued by the Medical School in 1953. Alumni record keepers were left with a kind of permanent headache, however.*



*To cope with the matter, editors of the MEDICAL BULLETIN now classify all alumni by the year in which they completed the normal four year curriculum of the Medical School. Thus: Curtis M. Hanson (Med. '40).*

*The Minnesota Medical Alumni Association, which sponsors all alumni reunions, invites you and all other MB's of 1940 to attend the 25th anniversary reunion here at the Medical School on Oct. 22-23, 1965. Tickets for the Michigan-Minnesota football game on the afternoon of the 23rd will be available.*

*Sincerely,*

EIVIND HOFF, JR.  
*Managing Editor*

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#### ALUMNI DONATE RECORD AMOUNT TO 1964 COMBINED APPEAL

Graduates of the Medical School broke all records in contributing a total of \$12,105.00 to the 1964 Combined Appeal to Medical Alumni. The amount given was 22% more than the \$9,954.61 given in 1963, and greater than the response to any previous combined appeal.

The Minnesota Medical Foundation, which conducts the drive annually in behalf of the Medical School, announced these final results of the 5th annual campaign which ended March 31, 1965:

A total of 557 gifts were given, an increase of nearly 49% over the 375 given in 1963. Of the record sum given, \$9,027.50 was donated to the unrestricted use of the Minnesota Medical Foundation. Another \$3,077.50 was earmarked for various medical projects at the University of Minnesota.

The Minnesota Medical Foundation is wholly dedicated to the advancement of medical education and research at the University of Minnesota. It conducts the annual Combined Appeal each Fall to stimulate alumni interest and support of approximately 40 special medical funds at the University.

The 6th annual Combined Appeal to Medical Alumni will be carried out in October, 1965.

## *Alumni Notes*

### ◆ 1920

**J. Arthur Myers**, emeritus professor of public health at the University of Minnesota, spoke on "Is Tuberculosis Still a Factor" at the 18th annual Medical Symposium of the Lorain County Medical Society in Oberlin, Ohio, on April 14th. Dr. Myers is still active in practice and appears daily at the University of Minnesota Medical Center where he continues his research in tuberculosis. Dr. Myers is presently engaged in compiling a History of Medical School, which is to be published in commemoration of the 75th anniversary observance during 1965.



J. ARTHUR MYERS

### ◆ 1940

**Elizabeth Mussey**, a consultant in Obstetrics and Gynecology in the Mayo Clinic, has been appointed an assistant professor in the Mayo Graduate School.

### ◆ 1944

**G. H. Nadeau** has spent 16 years in general practice in Riegelsville, Pa. He lives at 302 Ash Lane, with his wife, Nancy Riley of Easton, Pa., and their children, David, 12, and Michele, 10.

**Robert G. B. Bjornson** amends an out-of-date listing which appeared in the February MEDICAL BULLETIN: He is chief of radiology and director of medical education at Bethesda Lutheran Hospital, St. Paul. "For the record, I'm married to Dr. Ann-Marie Winberg of the University of Lund, Sweden, and our six children are Staffan, 11; Rolf, 9; Hans, 8; Arnulf, 6; Leif, 5; and Kirsten, 3," he writes.

### ◆ 1952

**H. Wayne Johnston**, who has practiced in Virginia, Minn. for the last 12 years, has recently become associated in practice with the East Range Clinic of that city.

### ◆ 1957

**Richard D. Cunningham** received the M.S. degree in Ophthalmology from the University of Minnesota in December, 1964, and is now practicing in Temple, Texas.

**Curtis C. Reemsnyder** is practicing radiology in Corpus Christi, Texas, and is affiliated with Memorial and Parkview Hospitals there. He recently completed a residency in the Mayo Graduate School, Rochester, Minn.

**Jerome L. Harty** reports he has begun a pathology residency at Hennepin County General Hospital, following 4½ years of general practice in Minneapolis. He and his wife live at 3128 Edwards St. N.E., Minneapolis 55418.

◆ 1958

Receiving M.S. degrees from the University of Minnesota in December, 1964, were **Richard W. Fardal** (dermatology), **Walter E. Miller** (radiology), and **William D. Backer** (ophthalmology). Dr. Fardal is now in Bismarck, N.D.; Dr. Miller is at the Mayo Clinic; and Dr. Backer is in San Luis Obispo, Calif.

◆ 1959

**Philip Bloom** has accepted a post as instructor of internal medicine at Baylor University School of Medicine, Houston, Texas, where he will be director of the Dialysis Unit of the V.A. Hospital in the Texas Medical Center. Phil completed a 2½ year residency in nephrology at the University of Washington, Seattle.

◆ 1960

**Richard E. Olson** has become a partner in practice at the Valley Medical Clinic, Jordan, Minn., with **Dr. Gerald E. Nelson** (Med. '58) and **Dr. George T. Schimelpfenig** (Med. '28). He has practiced with them as an associate for the last year.

◆ 1963

**John H. Sargent** is serving in the Navy as a physician at the U.S. Naval Training Center, San Diego, Calif. He lives at 1185 Barcelona Dr.

**John D. Farr** writes from Shaw AFB, Sumter, S.C., where he is serving with the Air Force: "Living in the South is a new experience in a different world." John is presently in pediatrics, but hopes to take an OB-GYN residency after military service. He and his wife are parents of a son, born during John's internship at Cook County Hospital in Chicago, and a new baby girl, born in South Carolina.

## *Alumni Deaths*

◆ 1896

**Dr. Louis Allan Nelson**, St. Paul, Minn. Died March 10, 1965 in retirement after more than 50 years of practice, specializing in ophthalmology. Among survivors are Dr. Louis A. Nelson, Jr. of St. Paul.

◆ 1902

**Dr. Adolph G. Liedloff**, Mankato, Minn. Died March 20, 1965 at the age of 87 years.

◆ 1904

**Dr. Eugene F. Warner**, St. Paul, Minn. Died November 7, 1964, at the age of 85 years.

◆ 1906

**Dr. Carl Witham**, Minneapolis, Minn. Died March 10, 1965 at the age of 83 years. A pioneer Minneapolis physician, he was a staff member of Lutheran Deaconess Hospital, Minneapolis, for 46 years and had made rounds there only two hours before he died. He practiced from offices at Bloomington and Lake St. in Minneapolis for 58 years.

◆ 1916

**Dr. Horace S. Villars**, Hot Springs, Ark. Died February 8, 1965. He had retired in 1952 after a 39-year medical career with the U.S. Army Medical Corps. A member of Phi Beta Pi fraternity, he is survived by his wife, Mrs. Carolyn Villars, 116 Roberts Rd., Hot Springs, and a son and daughter.

◆ 1920

**Dr. Burton Rosenholtz**, Minneapolis, Minn. Died April 23, 1965. He was 68 years old and lifelong resident of the Twin Cities area. He began the practice of pediatrics in 1925, and served in the Navy during World War II.

**Dr. David Siperstein**, Minneapolis, Minn. Died March 11, 1965 at the age of 67 years. He was a clinical associate professor at the Medical School and chief of pediatrics at Mt. Sinai Hospital in Minneapolis. A member of Alpha Omega Alpha, Dr. Siperstein is survived by his wife, Helen, and two sons; one of whom is Dr. Marvin Siperstein (Med. '47), Dallas, Texas.

◆ 1921

**Dr. Gundu R. Kokatnur**, Miraj, India. Died April 4, 1965 of a cerebral hemorrhage. He had a special interest in tuberculosis, and was well known in his nation as a chest surgeon. Dr. Kokatnur did postgraduate studies at the University of Minnesota under Dr. J. A. Myers.

◆ 1924

**Dr. Roland E. Nutting**, Duluth, Minn. Died March 26, 1965 at the age of 66 years. He had practiced pediatrics in Duluth since 1937, following a residency at the Mayo Graduate School of Medicine. He was a member of Alpha Kappa Kappa medical fraternity.

◆ 1925

**Dr. Carl G. Burton**, St. Paul, Minn. Died January 18, 1965, aged 70, after 32 years of practice in St. Paul. He had retired in 1958, and was a veteran of World War I. Survivors include Dr. J. Richard Burton (Med. '58), of St. Paul.

◆ 1926

**Dr. J. Anthony Malerich**, South St. Paul, Minn. Died January 16, 1965 at the age of 73 years. He retired in 1958 after 15 years of practice in West St. Paul. Among survivors is Dr. J. Anthony Malerich, Jr. (Med. '52), who practices in West St. Paul.

◆ 1928

**Dr. Frank X. McCreane**, Calistoga, Calif. Died December 18, 1964, aged 61, of cancer. He was former mayor of his city.

◆ 1930

**Dr. John Bernard Eneboe**, San Diego, Calif. Died March 14, 1965.

**Dr. John W. Chenault**, Bradenton, Fla. Died recently at the age of 55 years, apparently by his own hand. He was an orthopedic surgeon and well known for his work in poliomyelitis. He had practiced at the Tuskegee Institute; Florida A. and M. College; and in Sarasota, Fla.

◆ 1947

**Dr. Richard F. Kline**, St. Cloud, Minn. Died December 24, 1964 of a brain tumor. He was 40 years old and had been ill three weeks. Dr. Kline was a practicing internist, and served in both World War II and the Korean conflict. He had practiced in Wayzata and Montgomery, Minn., and had been in St. Cloud since 1958. Survivors include his widow, Margaret, three daughters and one son.

◆ 1953

**Dr. Winthrop R. Rockwell**, Mill Valley, Calif. Died December 21, 1964 of injuries received in an automobile accident. He was 35 years old and was serving in the U.S. Army Medical Corps.

◆ 1962

**Dr. Lawrence B. Pearson, Jr.**, Minneapolis, Minn. Died April 6, 1965 at the age of 27 years. He had been recovering slowly from encephalitis which he contracted while in military service. After completing two years of Army service in 1964, he returned to the University and took a temporary position with the medical staff of the University Students Health Service. Larry is survived by his wife and two children, who live at 5317 First Ave. S., Minneapolis. An outstanding student, he won a Minnesota Medical Foundation Scholarship in 1961, and was planning a residency in neurology to begin in 1965.

## Memorial Gifts

The Minnesota Medical Foundation acknowledges with gratitude recent contributions made in memory of:

**Mrs. Clara Cochrane**  
St. Paul, Minn.

**James Deming**  
Edina, Minn.

**Morris Brickman**  
St. Louis Park, Minn.

**Brenson Lepowsky**  
Wayzata, Minn.

**Mrs. Clarence Benson**  
Minneapolis, Minn.

**Cal V. Olson**  
Minneapolis, Minn.

**Mrs. Gail H. Luther**  
Excelsior, Minn.

**Sam Romer**  
Minneapolis, Minn.

**Lawrence D. Pearson, Jr., M.D.**  
Minneapolis, Minn.

Memorial gifts are a thoughtful means of honoring the memory of a relative, friend, or colleague. They serve the living by strengthening medical education and research at the University of Minnesota Medical School. Gifts may be designated for specific purposes. The Minnesota Medical Foundation acknowledges all gifts to both donor and next of kin.

# COMING EVENTS

*University of Minnesota Medical School*

## CONTINUATION COURSES FOR PHYSICIANS

University of Minnesota  
Center for Continuation Study

1965

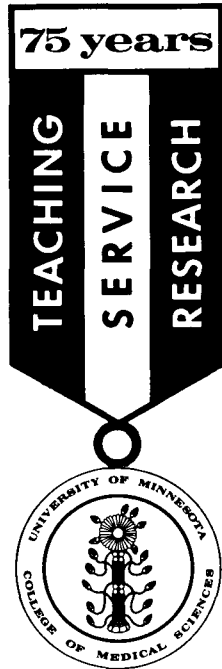
- April 2 - 3 ..... Trauma
- April 22 - 24 ..... Obstetrics
- May 3 - 5 ..... Ophthalmology
- May 20 - 22 ..... Surgery

The University of Minnesota reserves the right to change this schedule without notification.

Courses are held at the Center for Continuation Study or the Mayo Memorial Auditorium on the campus of the University of Minnesota. Usual tuition fees are \$50 for a two-day course, \$60 for a 2½-day course, \$70 for a three-day course, and \$100 for a one-week course.

Specific announcements are sent out about two months prior to each course to all members of the Minnesota State Medical Association and to any physicians who request information for a specific course. For further information write to:

DIRECTOR  
DEPARTMENT OF CONTINUATION MEDICAL EDUCATION  
THE MEDICAL CENTER (Box 193)  
UNIVERSITY OF MINNESOTA  
MINNEAPOLIS, MINNESOTA 55455



## COLLEGE OF MEDICAL SCIENCES NOTES 75th ANNIVERSARY

*A year-long program commemorating the 75th Anniversary of the College of Medical Sciences of the University of Minnesota is being observed in 1965. Although the history of the Colleges reaches back into the 1880's, University officials have designated 1965 as the official year of observance. The emblem shown at the left, symbolizing the Tree of Life from ancient Eastern culture, has been adopted as the official seal of the observance.*

*Among the first anniversary activities at the Medical Center was a "roof-raising" ceremony at the Masonic Memorial Hospital on March 17th. Two new floors are to be added this year. In April, a Claude Bernard Memorial Symposium was held by the Department of Physiology.*

*Next Fall, a formal Symposium will be held as the major event of the celebration.*