Staff Meeting Bulletin
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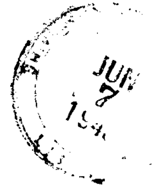

Psychiatric Problems in Children

Volume XIV | Friday, May 14, 1943 | Number 25

STAFF MEETING BULLETIN
HOSPITALS OF THE
UNIVERSITY OF MINNESOTA

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Published for the General Staff Meeting each week
during the school year, October to June, inclusive.

Financed by the Citizens Aid Society,
Alumni and Friends.

William A. O'Brien, M.D.

I. LAST WEEK

Date: May 7, 1943

Place: Recreation Room, Powell Hall

Time: 12:15 to 1:20 p.m.

Program: "Complications in Fractures of Shaft of Femur and Tibia"

Arnold G. Schwyzer

Discussion
Harry Mock, Chicago
W. D. White
Harry Hall

Attendance: 107

Gertrude Gunn,
Record Librarian

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II. MEETINGS

1. ANATOMY SEMINAR

Saturday, May 15, at 11:30 a.m., in room 226 Institue of Anatomy.

"Histology of the Gingiva"
C. H. Morningstar
"Thyroid and Blood"
Robert H. Reiff

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2. MINNESOTA STATE MEDICAL ASSOCIATION NINETIETH SESSION

Monday, May 17

Section I - Gold Room, Hotel Radisson
9:00-12:00 Fracture Symposium
2:00- 4:00 Care of the Aged
4:00- Russel D. Carman Memorial Lecture

Section II - Flame Room, Hotel Radisson
9:00-12:00 American College of Chest Physicians, Regional Meeting
2:00- 5:00 Scientific Cinema
Open House - 7:30 p.m.

Tuesday, May 18

Section I - Gold Room, Hotel Radisson
9:00-11:00 Abnormal Uterine Bleeding
11:00-12:00 Eye, Ear, Nose and Throat Diseases for the General Practitioner
2:00- 4:00 Cardiovascular Disease
4:00 Routine Blood Counts in Newborn

Section II - Flame Room, Hotel Radisson
9:00-12:00 Scientific Cinema
2:00- 5:00 Scientific Cinema
12:15 Round Table Luncheons
7:00 p.m. Annual Banquet, Minikahda Club -- Dr. Judd

Wednesday, May 19

Section I - Gold Room, Hotel Radisson
9:00-11:00 Newer Therapeutics in Surgery
11:00-12:00 Control of Tropical Diseases
2:00- 4:00 Child Health in War Time
Section II - Flame Room, Hotel Radisson
9:00-12:00 Scientific Cinema
12:15 Round Table Luncheons

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3. PROGRAM FOR CENTER FOR CONTINUATION STUDY

Course in Radiology, Friday, Saturday, and Sunday, May 14, 15, 16.

Special Conference on Silicosis, Sunday, May 16, 10:00 - 12:00 and 2:00 - 5:00. Luncheon will be served in Center dining room, $0.75. Guest leader, Dr. Leroy U. Gardner, Saranac Lake.

Course in Homes for Aged, Monday, Tuesday, Wednesday, May 17, 18, and 19, for Administrators and their associates.

Course in Obstetric and Newborn Nursing, Thursday, Friday, and Saturday, May 20, 21, and 22, for representatives of small hospitals, course arranged for Minnesota Department of Health.

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III. NEW BABY

The Flahertys are the proud parents of a baby daughter.

Congratulations!

IV. PSYCHIATRIC PROBLEMS IN CHILDREN

Eric Kent Clarke

Despite over twenty years of psychiatric work with children which began in the early 1900's it was not until after 1925 that psychiatric services to children were organized on consultation bases in University Hospitals and medical schools. Among the early services were the clinics established at the University of Rochester and at Johns Hopkins Hospital and University. Following these other medical schools developed similar programs. Of these the Psychiatric Clinic for Children at Minnesota is one. When organized in 1938, one of its several objectives was to develop a close integration between pediatrics and psychiatry. The emphasis of this program was twofold: (1) an interest in those children offering somatic complaints without demonstrable organic bases with the hope of: (2) developing a program of prevention in better understanding and management on the part of the pediatrician.

During the past four years of the Clinic's existence 53% of the patients studied have been referred by the pediatric service of the hospital and the physicians of the community and state. The majority of patients came with somatic complaints which careful physical studies did not justify. Within this group of patients were found many who, inadequate constitutionally in one way or another, were incapable of competing successfully with others in the family or with their contemporaries. In other patients an emotional problem complicated the treatment of an underlying organic disorder. In this latter group fall the diabetics who refuse to accept the limitations imposed by their illness and persistently refuse to follow the diabetic regime, the choreic and cardiac cases who rebel at prolonged strict bed rest, the child with convulsive disorders, and the asthmatic whose sensitivities are exaggerated by individual or family conflict. There has been a wide variety of these patients tagged with almost every type of physical diagnosis, and involving a variety of reaction patterns. Sometimes the refusal to accept the handicap is an intense rebellion against being different from other children with a determination to act and do as others in spite of the consequences. Occasionally the child uses his symptoms as a weapon, threatening violation of restrictions in an effort to punish his parents and win concessions. A more common reaction is an exaggeration of symptoms to promote or prolong an unnecessary degree of invalidism.

Typical of this group is a nine-year-old girl, an only child, who has had recurrent choreic episodes for four years. She has been a feeding problem since infancy, with projectile vomiting that led to diagnosis of pyloric stenosis at 3 months, but which cleared without operation as a result of careful management by the age of 15 months. Any undue excitement, threat of punishment or sudden fright resulted in vomiting until recently. There has been an unstable family setting since the child's birth. The father, age 40, an unsuccessful individual still dependent upon his mother, takes but casual interest in the child. The mother, energetic and competent, has worked more or less regularly since the child's birth to bolster the shaky family finances. She was chagrined over the accidental discovery shortly after the birth of her child that she had congenital lues. This led to total estrangement from her own family with particular hostility toward her father who for years had been excessively cruel and demanding. The child's prolonged illness complicated the tense family situation, preventing the mother from working and increasing her sense of frustration and futility. On three occasions the child was hospitalized because of her excessive twitching and nervousness. Each time the symptoms receded rapidly and because of crowded conditions in the hospital she was returned home with instructions for prolonged bed rest. The emotional atmosphere of the home negated any good that was hoped would be achieved from bed rest, for each time the child returned for a monthly check the twitching was intense, in spite of lack of organic activity. The interest of the Psychiatric Clinic for

Children was directed at untangling the family problems and relieving the frustration of the mother, who felt completely caught in the net of circumstances. The child was again hospitalized for a brief period and later placed in a convalescent home, with three other girls of approximately her own age and subject to similar limitation of physical activity. During the child's absence we continued to see the mother to help her find a solution to her own sense of frustration. She secured work, bettered the family financial situation and developed a more tolerant attitude toward her husband and his mother, so that life assumed a new outlook. When the child eventually returned home the invalid period was completely passed and there has been no recurrence of symptoms or friction for the past year.

In this group of cases there is a fundamental organic disease, exaggerated by the superimposed emotional tension which in turn creates barriers that impede the medical treatment of the original condition.

Those children with convulsive disorders have been of special interest to us. In several instances children have been brought to the hospital having had a series of convulsions. In some the history of attacks dates back several years, with scattered episodes of frequent attacks separated by intervals free from seizures. There is generally an air of utter discouragement and anxiety in the child and parents. Often inquiry reveals some situation with emotional tension that directly affects the child, precedes the onset of the series of attacks, and seems to be directly related to their precipitation. This sequence has been detected in several instances, even where there is definite evidence of an organic brain lesion.

One example of this type was a boy of fifteen, the oldest of 5 children born to intelligent, ambitious, aggressive parents who had high hopes for their children. This boy has a history of cerebral hemorrhage at birth, with delay of establishment of respiration, marked cyanosis, and lethargy. After an anxious ten days he developed normally, walking and talking at the usual time. He was regarded as an average child until the age of six when he had a severe head injury, following which he was dazed, vomited, and complained of dizziness for several hours. He was examined by a local physician who found no evidence of fracture nor any neurological abnormalities. The boy started school soon after this, and in spite of the earlier reports of "average behavior," he proved unable to accomplish ordinary schoolwork. In the succeeding years he failed to earn a single promotion, being passed from grade to grade on the basis of age and family pressure. On the strength of three group tests, which gave him a rating of intelligence bordering on mental defect, the teachers felt little challenge or interest in him. At ten he began to have his convulsive attacks, which invariably started with twitching of fingers of left hand, proceeding to a spasm of fingers which spread to arm and then became generalized. In addition there were numerous petit mal attacks. The majority of the major attacks occurred at night, varying from 3 to 15 episodes per month. A complete study in this hospital revealed no demonstrable neurological changes and the attacks were completely controlled for a period of three years with sedation. In the spring of his final year in Junior High School the seizures recurred with increasing severity and as frequently as 15 attacks per day. During this time he was under great pressure at home, as the family was anxious that he would make a good showing so that he could proceed to high school. The competition with three younger siblings who possessed superior intellectual endowment was great. All the family were impatient at his "dumbness." The boy was acutely aware of his inadequacy, worked hard to achieve, and was discouraged over the lack of success. When seen at the Clinic he was apathetic, despondent, and unable to make simple decisions. He was completely passive and dependent on the family. He had never been permitted normal activities such as swimming, riding a bicycle, going to movies or parties, as the family feared he might have an attack and be injured. He did not go out without

another member of the family, his sisters walking to school with him.

Physical study at this time revealed no demonstrable pathology or neurological change. Psychological study showed the earlier findings of the group test to be inaccurate. He had average intelligence with a marked reading disability that proved to be the basis of the long years of school failure. This discovery proved to be the key that opened the door to improvement. His response to individual attention, tutoring to correct the reading handicap, was startling. Encouraging his independence from family and urging the family to ease the pressure for immediate academic success gave the boy a feeling of adequacy and freedom he had never known before. In the past two years he has had only three convulsions, two of which followed excessive fatigue, excitement and dietary indiscretions. In this instance there is undoubtedly an organic basis for the attacks, arising from the cerebral hemorrhage at birth aggravated by the head injury at six. The unsatisfactory school record grew out of a specific reading disability that was unrecognized and improperly considered as mental retardation. Overprotection by the family coupled with their pressure for better academic achievement produced a sense of futility in the boy. Fear that he would not reach high school with his companions completed the net of circumstance that undoubtedly precipitated the series of convulsions after a period of freedom from attacks for three years. The cessation of seizures after the inauguration of tutoring, and the relief from family pressure does not seem to be a coincidence. Similar encouraging response has been encountered in several other patients with like histories. Our results have not always been successful, for there are numerous other youngsters for whom we were either unable to relieve the anxiety or find any channel that would bring a feeling of acceptance or adequacy. The response to these few cases leads us to believe that time devoted to the establishment of a sense of achievement is worthy of trial. While this in no way explains the underlying seizures, the salvaging of the individual so that he may live a socially acceptable life is worthwhile.

The most challenging group of patients are those with persistent organic complaints for which no satisfactory underlying pathology can be established. In this group are those with recurrent bouts of abdominal pain, headaches, visual disturbances, vague muscle pains and weakness, cardiovascular symptoms and recurrent diarrhea. These patients are referred to us through our cooperative service in pediatrics, and consultation is requested routinely in the absence of any demonstrable physical findings. In some instances the reason for the escape in physical symptoms is quite superficial and easily detectable. In others it is obscure and elusive. It has generally been our experience that the anxiety arises from a feeling of inadequacy in the child, an inability to compete with other members of the family or schoolmates, a sense of rejection by the parents, insecurity in the home or in personal relationships, psychological handicaps, such as dull normal, special disability, etc., or some fear that has been suppressed but still exists. From a medical standpoint this group is of particular importance, for it provides the confirmed neurotics that are so resistive to treatment in the adult years. In several of these youngsters, even in the pre-adolescent period, operative procedures had already been undertaken, with persistence of symptoms postoperatively. We have encountered these reactions in six-year-olds where often there has been a strong element of suggestion, growing out of discussions that are overheard. The symptoms become a successful method of evading responsibility too often encouraged by over-solicitous relatives or for securing extra concessions. This type of reaction increases in frequency with adolescence.

Typical of this group is a 15-year-old girl, the only child of mother's first marriage, who had lived in comparative security on stepfather's farm until his death one year before her coming to the Clinic. There was some jealousy over a younger half-sister, with considerable striving for the mother's affection. She

had been doing mediocre school work in the freshman year of a rural high school. Her attendance was irregular due to frequent minor illness that was overly disturbing to the mother. In the months following the stepfather's death, when there was a great deal of financial insecurity and anxiety over the future, the girl began to have frequent attacks of vague abdominal pain with occasional bouts of diarrhoea and vomiting. She was seen several times by the local doctor who suspected chronic appendicitis. On two occasions she was hospitalized in a small town where an appendectomy was considered but delayed because of absence of verifying data. Later the complaint of pain shifted from the lower abdomen to right upper quadrant, became more colicky in nature, often following meals that contained any fat. The girl became more incapacitated, lost some weight and was quite anxious. During this same period the mother had similar complaints, which ultimately led to a diagnosis of cholelithiasis with subsequent cholecystectomy. At this time the farm equipment was auctioned, and the children came to the city to stay with relatives of the stepfather. After her mother's convalescence a new home in a crowded tenement was established, with a meagre income that barely covered necessities. Complaints of pain occurred more frequently and the girl was referred to this hospital for evaluation and suggested laparotomy. Careful physical investigation was unproductive and psychiatric consultation was requested. We found this girl to be an insecure youngster, greatly concerned over her own health, and panicky lest the mother's illness prove fatal, thus depriving her of her last shred of security. She was fearful of her intellectual ability because of her poor schoolwork, below average in the rural school and markedly below the level of the large city high school. She was acutely aware of her country manners and dress. She was ill at ease in the school group as she was without any sophistication, and appalled at the living standards in the tenement which were exaggerated by the mother's warnings of the dangers that lurked for unwary youngsters. The jealousy toward the younger half-sister was aggravated by the stepfather's family, who showed more consideration and concern over the little girl. Psychological testing, which revealed a good average ability, included aptitude tests that convinced the girl she had the capacity to be self-supporting and played an important part in beginning rehabilitation. Contacts with the school, with suggestions for a school program in which she could succeed, and the interest of the girls' advisor in helping create acceptable friendships and develop recreational outlets speeded her adjustment to city life. Arrangements were made for the mother's enrolment in a training class for defense work. Eventual placement in a munitions plant produced an income that enabled the family to move to a better section of the city. Part time after school work was found for the girl that permitted her to secure more suitable clothes and finance small luxuries. With this realignment of interests and the creation of new outlets there has been an improvement in attitude, with an absence of abdominal pain over several months. The girl's fears of school failure, the financial insecurity, the mother's illness, the stepfather's death, the change to city life were sufficient threat to make some escape necessary, and complaints of abdominal pain proved an effective medium. In this instance the mechanisms were obvious, but until the environmental factors were considered and the girl given reassurance and acceptance, there was no improvement. It is our impression that this type of reaction may be the prodromal period for the major hysterical reactions where the individual, because of inability to verbalize anxiety and frustration, builds up emotional tension that overflows into physical symptoms and ultimate dysfunction.

In younger children many instances of tics and habit spasms have been encountered on similar patterns of insecurity and doubt as to the emotional acceptance by parents or in the face of competition with other siblings. The frequency with which these are combined with enuresis and occasionally encopresis has been intriguing. Often the recurrence of enuresis after long periods of dryness is almost as reliable an indicator of

emotional discomfort as elevation of temperature is of physical illness. This finding has been the most frequently observed symptom in children in England, who have been removed from their homes to areas of comparative safety because of the "Blitz." In the average stable well-adjusted child this is ordinarily of short duration, but in the highstrung neurotic youngster it is often prolonged and recurrent. In some of the children studied the tics and enuresis have been combined with phobias and night terrors. It is difficult to get these youngsters to verbalize their anxieties, either because of immaturity or lack of the child's appreciation of his conscious fears. The use of play therapy and spontaneous drawings is often an effective method of evincing hostilities and anxieties that the child cannot or will not express verbally.

Gross deviations from the average rate of growth constitute another important group of patients that have come to us. Youth generally craves standardization of size and rate of development. Any departure from the average occasions concern. The fat child may superficially accept his fate philosophically, but under the surface be acutely unhappy. Often the appeals to adhere to a rigid diet result in negativistic indulgence, particularly where the obesity is a source of embarrassment to others in the family, thus becoming a masked form of retaliation. The obese child according to our experience is not always the cheerful, phlegmatic individual of the traditional Dickens type. The asthenic child, with long, thin bones and straplike muscles, probably suffers more over his physical structure than does the obese. So much of our national advertising has as its ideal the Greek god figure, that there is often chagrin over the physique which no amount of eating or exercise seems to alter. There is a great sense of shame and a feeling of inferiority that leads the child to lead a solitary existence. Sports such as swimming or athletics that expose the body to public view are avoided. Acute explosions are encountered in adolescents of both sexes when the educational law makes gymnasium classes compulsory at the junior high level. Great sensitivity and fear of ridicule coupled with inferior skill that results from lack of practice or participation may create anxieties that seek expression in physical complaints and in at least one instance led to threats of suicide. The attitudes growing out of chagrin in the preadolescent over his asthenic build may influence the entire future course of life, by encouraging activities that lead to a solitary existence devoid of close companions and normal gregarious interts.

One of our most perplexing problems growing out of abnormal physical development is a boy who came to the Clinic at the age of six for psychological evaluation. He is a case of puertas praecox, who had at this time the average physique of a 12-year-old, and already showed signs of puberty with beginning sexual maturity. His intellectual capacity was average for his chronological age, but he felt quite out of place with his contemporaries in first grade. The situation was further complicated through the amputation of both legs in the middle thigh as a result of thrombosis following chicken pox at the age of three. The boy's physical handicaps and difficulty in maneuvering the artificial legs restricted his activities, but his craving for companionship and good sportsmanship won him the friendship of older boys. It has been difficult to find a satisfactory level on which he could function. Intellectually and emotionally he reacts at his chronological level with which he is dissatisfied. Now at nine he has the stature and physical maturity of a 15-year-old, has reached the biological stage of puppy love, but lacks the emotional experience to make sound judgments and has recently been skirting the edge of disaster by sexual advances to an adolescent mentally defective girl in the neighborhood. The problem is aggravated by a difficult family situation. The mother, an emotionally immature person, rejects the boy and shows little toleration for his reactions. The father's working schedule has permitted little opportunity to spend time with the boy. His school progress has been disappointing for he has continued to resent placement with

his contemporaries and disrupts the classroom by his antics. Even the informality of the special school for crippled children has not overcome these characteristics, although there has been some modification. Although the period of rapid growth is levelling recently, the wide variation between intellectual and emotional experience and his social and biological desires make a hazardous future.

The evaluation of intellectual capacity constitutes another area of activity. Anxious parents come seeking assurance that their child who is slow in developing is of normal intelligence. Personally I feel it more distressing to be called upon to inform parents that their child will be a low grade mental defective than to have to tell them the child will die in a few months from an incurable disease. In the latter the inevitable happens and nature and time do their best to obliterate the tragedy. We have become most hesitant in making a positive final diagnosis of subnormality without a sufficient period of observation. We have encountered many patients penalized by incorrect diagnoses made on insufficient data. It is more constructive, in my opinion, to help the parents accept the child's limitations gradually than to be brutally and abruptly frank. It must always be borne in mind that parents of a retarded child often have a large sense of guilt about their responsibility in producing such a child. It is more constructive to help the parents develop to their limit any potentialities which the child may have.

We have seen some backward children who proved later to be deaf and capable of considerable development. Some non-talkers have delayed learning to talk because they were overprotected to the point where securing things by pantomime was entirely satisfactory. So many factors operate in this realm that great caution is urged in making a positive diagnosis, except in the most obvious poorly endowed patients, until there has been a fair period of observation.

The child with superior intellectual endowment doing failing work in school is often referred for evaluation. In some of these instances special disabilities in one subject have been found which have responded to corrective tutoring permitting the child to progress normall[y]. Reading disabilities are frequently encountered. These often account for the disappointing marks acquired by students who work hard and obviously possess a good endowment. Some youngsters with superior intelligence, badly misplaced in school, are bored with the program an[d] develop the habit of daydreaming leading into failure. Often the school authorities feel such a pupil should be forced to repeat the grade when a promotion would challenge his superior ability.

Our studies have brought us the conviction that emotional maturity and stability is just as important as intellectual endowment which for so many years has been used as the criterion. Evaluations in this area are difficult, for the decision reached may change the whole course of the child's life. For instance, a professional man consulted us about a 6-year-old boy who had lived with the family and was being considered for adoption. The time had come to complete the legal proceedings. The boy, an illegitimate child of presumably good inheritance, was very bright, but persisted in lying without reason, pilfered, was upset by criticism, was enuretic, and failing in school. Prior to placement in this home the boy had never known any security in an orphanage and several boarding homes. Though the boy showed great affection for the man, his wife, and their son, who was a well-adjusted adolescent doing outstanding schoolwork, he has continued his outbursts periodically and their toublres recur for no apparent reason. The famil[y] have tried to give him the affection and security he so obviously craves, but misdemeanors continue which disturb the peace of the entire family. The standards of this home are high, above anything this youngster has known previously. He is proud of everything, but still reverts to misbehavior.

At the end of two years' trial, the foster parents have decided it is unfair to their own son and to themselves to

adopt this boy, although they are insistent that he be given a chance to make something of his life. It is not easy to formulate plans for this youngster who has failed to find security or adjust adequately despite being surrounded by all the advantages of a superior home for two years. Removal will indubitably increase his insecurity and his instability. One hesitates to place this boy for adoption in a home of lower standards because of the instability. Care in the orphanage type of institution seems to offer little and there seems no place in society for this child, whose intellect is superior but emotional stability questionable.

For older children approaching adolescence the Minnesota Multiphasic Test and the Rorschach Test have been valuable aids in estimating emotional maturity. We have been attempting some modification that will be applicable to the pre-adolescent group. Spontaneous drawings have been found useful in getting at conflicts and hostilities that the child is unable to verbalize. Play therapy, using dolls that represent other members of the family will often bring to light jealousies and anxieties that could not be consciously expressed.

These foregoing are but a few samples of the types of problems which have been referred to the Psychiatric Clinic for Children for evaluation. It is often frustrating to deal with patients at a symptomatic level, for symptoms do not always indicate the nature of the conflict which prevents the child from making an adequate adjustment to his environment. However, it is frequently possible to get at the source of the conflict and eliminate it by dealing with it on a conscious level. Environmental pressures may form a prominent part in the problem. Here it is essential to carry through carefully planned teamwork in which the psychiatrist, psychologist and social worker all play an effective part.

The complaint is often heard that our studies are unduly lengthy and time consuming. I know of no way of overcoming this. There is no inflamed appendix that can be removed by a simple operation, nor any serum that can be utilized to create immunity. We have to deal with basic personality patterns that have been gradually evolved throughout the individual's life which can only change slowly, once the pressures that cause the distortions of personality become apparent.

Since intensive psychotherapy is such a long process, our best line of attack is prevention, one of the original objectives as earlier stated. As the pediatrician recognizes psychiatric problems in their incipiency and learns to deal with them at that time the number of patients requiring long, intensive service will be materially reduced. In the process not only will the patients and their families be better served but the practice of medicine will become more stimulating and satisfying.

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V. GOSSIP

Last Saturday - the great day - arrived when the interns and fellows after months of preparation finally gave the staff a view of themselves as others see them. To the credit of all it must be said no advance information slipped out which prevented anyone from attending. The program started by getting the audience in the proper mood. The master of ceremonies gave the signal to go ahead when he noted reactions which he desired. An elaborate stage had been erected at one end of the room leading to a large room filled with properties of every sort. As the story unfolded one soon realized we are very dependent on properties in this place. After prolonged suspense the show got underway. A 3-act affair with songs between. Never for one minute was the audience allowed to forget it was the real stage. Sly glances from time to time indicated the fellows and interns were watching us as much as they watched the stage. As soon as the performance was over one heard expressions on every hand demanding this should be made an annual event. The more one studied the question the more it was realized this particular group of actors will probably not be replaced in the immediate future. The cleverness with which the play was assembled was so much above average it would be too much to ask of any future group that they should duplicate it. In Act I we were given a preview of what goes on in the admission department. The admitting physician must be the busiest man in the institution for he demonstrated he could do six jobs at one time. His greatest skill was demonstrated in the selection of a choice case for diagnostic study. This patient had an unusual appearance, strongly resembling the color of persons who have a metabolic fault involving porphyrin. Act II demonstrated the staff at work trying to unravel the mystery of what was wrong with the patient. In Act III the surgeons had their way and the patient had the operation. If Acts I and II stretched us in the aisles Act III caused complete paralysis. It has never been my good fortune to see such excellent acting as the finale of the two extraordinary performances in Act I and Act II. During the entire evening photographers roamed through the audience taking pictures of the victims and the players. Many of these will be made the objects of serious study for days to come. The F.B.I. never studied its victims with greater care and accuracy than did the young men who portrayed the daily lives of internists, surgeons, dermatologists, radiologists, and obstetricians. To those staff members who could not be included in the play there was plenty of opportunity to take care of them in the songs which rounded out the evening. The guests departed at a late hour feeling our staff of interns and fellows had given us one of the most enjoyable evenings of our lives. As one man expressed it he would not have missed it for anything. He said he would have made it if he had to come in an ambulance. It is difficult to give individual credit to those responsible for the affair. The only word of criticism heard was that the lines contained so many laughs that one missed the next point laughing at the one preceding it. So far as one could determine not a single faculty man or department was neglected. When the young men who took part in the performance are old and grey, let us hope if someone must point out their special characteristics to them that it shall be done as artistically as it was done for us. All credit to Mrs. Campbell, George Heffingwell, Lena Johnson, John Doe, Geo. Quakefield, Ray Amberg, patients of Dr. Creevy, Richard the confused, Porphyria Jones, Lyman Stowe, Hazel, Richard Haines, Wesley Spink, John L. McKelvey, Henry Michelson, Drs. Strakosch, Fredericks, Madden, Laymen, Cumming, Rusten, Winer, Kendall, Lynch, Cecil J. Watson, Bill Bernstein, Dick Varco, Surgical Gremlin, Ralph Knight and a Bevy of Babes, Dr. Sargent, Dr. Tongen, William Fleeson, Wolf Sjoding, Clarence Dennis, Owen Wangensteen interns, nurses and all others who contributed to the success of the evening. Several entertainments were given before the show including one sponsored by a certain alleged gentleman of this staff said to have a connection with neurosurgery. He invited a group to his home for refreshments and a light repast. The latter consisted of a plate of crackers almost obscured by sickly strands of lettuce. On the crackers were posed small pieces of meat which the guests ate with gusto. Afterwards they learned it was horse meat, referred to as horses ouveres when served. At this late date the alleged gentleman is still at large.....