The Dallas County Medical Society and its associated Journal have been around for a long time, caring for patients and commenting to physicians about the world of medicine, respectively. The Dallas Medical Journal and its predecessor publications offer a bit of historical perspective as DCMS leaders viewed and reported on the world of Dallas medicine.

A small ad hoc committee of past-presidents — Drs. Gordon Green (chair), Fred Ciarochi and Richard Joseph — has taken the opportunity of the DCMS Anniversary to look back over written essays and commentaries, more recently named “The President’s Page,” which appeared in the Journal during the 20th century — a century of great discovery and great tribulation. Throughout 2014 we plan to publish monthly excerpts from Journal archives, offering glimpses of views from the past which reflect the interests and concerns of their day. We hope that readers will find them enjoyable and perhaps even instructive.

The first installment covers the period 1919 – 1930 … the post-WWI era, the time following the Great Influenza Pandemic, and the Great Depression.

When we reach the end of 2014, we will have published items up to the year 2000. We’ll then ask you, our readers, to rank all of the selected 20th century essays … most meaningful, important, impactful, or prescient. Please read, enjoy, and appreciate the wonderful legacy which we contemporary physicians have inherited.

Michael Darrouzet, DCMS CEO/EVP; Steven Harrell, DCMS director of communications; Drs. Fred Ciarochi, Gordon Green and Richard Joseph
Timeline of Significant Events: 1919 – 1930

Unfortunately, the Dallas Medical Journals from the years 1914–1919 have been lost to history. At that time, the DMJ was a 4- to 6-page pamphlet that was distributed at the Society’s monthly meetings. Even as early as 1935, the DMJ editors reported that those early journals had all been lost or destroyed.

Beginning in 1919, the Journal began to take its current form. Many scholarly articles were published, as well as studies on various new procedures. The minutes of each monthly meeting were published along with a roster of every member in attendance.

1913
Parkland Hospital erects first brick hospital building in Texas

1914 – 1918
World War I

1918 – 1919
Spanish flu pandemic, which killed more than 50 million people worldwide

1920 – 1933
Prohibition of alcohol in the US

1927
Dallas Methodist Hospital opens

1929
Stock Market crash, beginning of Great Depression

Excerpts from the Era

As stated several months ago, we desire to repeat here, that every member of the Dallas County Medical Society is considered an associate editor and entitled to the privilege of writing anything for publication in the Journal which he might deem of interest to our readers. We hope that during the year 1927 more of our members will take advantage of this privilege and write some good editorials from time to time for the Journal.

President George L. Carlisle, MD
January 1927

The question of free clinics is one of great importance, both from the standpoint of the profession and of the public …

To admit patients for free treatment who are able to pay for the same works a great injustice to all concerned, even to the patient himself. The institution thus has a burden imposed upon it that ought not to be. The physician is robbed of his fee, thereby working a great hardship upon him, the profession is pauperized, the public are educated to seek free treatment rather than to be self-sustaining by his own efforts, and results in a deteriorating effect upon society in general. The time has come for organized medicine to take a hand in this matter and we hope it will not shirk the responsibility.

President William D. Jones, MD
“The Free Clinic Problem,” January 1925

For a doctor to prescribe alcohol because an applicant desires alcohol is reprehensible. Such a practice is plain prostitution and a member of the medical fraternity who is not guiltless is on a lower strata than the bartender of the common bootlegger. The reputable profession, while enjoying the confidence of the government in a practical way, must resent imputations of dishonor. It must do more, it must see to it that such imputation is not justified. The medical profession is on trial.

C.M. Rosser, MD
“Medical Profession on Trial,” 1923

It has been brought to the attention of the Journal on several occasions that a patient who has the nerve can get free medical work without any questions being asked. The Journal does not want to assume the position of combating any advance in the stride of medicine, but these clinics should take steps to avoid medical treatment to people who are amply able to pay for the same, but go there with the idea of evading just medical charges.

President W.M. Young, MD
“Severely Timely Topics,” July 1922

The values of properly supervised interning is being realized more every day by men old and in the profession and by the graduates themselves. The hospital owes its internes a good training just as much as it owes its patients proper care and treatment…. One often hears that “so and so” is lazy and incompetent, and in many cases this is true, but whose fault is it that he is incompetent? This fault is about equally distributed between the interne and his attendings. … The internes are due our consideration. Encourage them rather than discourage them by doing your duty as a member of the staff. After all, they are only human. They will work and give, then when you fail to reciprocate they quite naturally lay down, and are then generally referred to as “our lazy and inefficient bunch of internes.”

“Relation of Attending Physician to Internes,” March 1927

A vintage cartoon illustrates the expenses of parenthood. Some things haven’t changed.
Best of the Decade
“Fads”

by J.M. Martin, MD, President
October 1929, Volume 15

What is a fad? The Standard dictionary defines a fad as “a passing fancy or fashion; a hobby.” From this definition it would appear that a large proportion of the people of the earth are faddists in one way or another, often without knowing it. If fads were all mere “passing fancies” of fashion they would soon become tiresome and be forgotten, but such is not the case, because there are many things innocently indulged in as “fads and fancies” that after a time become fixed habits and a menace to the health and happiness of the individual during after life.

As examples I might mention the practice of smoking, snuff dipping, a cocktail occasionally with a friend and later a regular tippler.

Many men have told me that they regularly smoke from twenty to thirty cigarettes a day. Women, not to be out done by a mere man, have, almost as by a single impulse, jumped onto the stage and from one end of the world to the other are creating a smoke screen that could be made to do a national service by hiding our entire navy during the next war. Let us hope that some valuable service may yet come from this expenditure of so much money and waste of valuable time. Let us hope. But what is the use to hope because it would be a hopeless hope for the average girl feels herself disgraced if she is unable to compete with her boy friends who are seasoned smokers. I am told by one young lady that she has no idea how many cigarettes she consumes in a day. The entire family, father, mother and children join in competition during the evening during when the smoke in the rooms becomes so dense that doors and windows must be opened for ventilation. The smokers, their clothing, the upholstering’s of the furniture and the draperies in the rooms are thoroughly impregnated with the fumes of tobacco. Smoking is no longer a fad with them, it is a habit.

Without the least hope of in any way lessening the menace that is facing thousands of our young people because of their over indulgence in the senseless habit of cigarette smoking, I am taking this space to reproduce an abstract appearing in the September number of the International Medical Digest from the pens of A. Winterstein and E. Arnson and taken from Schweizerische medizinische Wochenschrift, 59:550-552 (May 25) 1929.

The authors stress that the difference of nicotine content in cigarettes is as important as that of alcohol content in liquors. The percentage of nicotine should be marked on the cigarettes as is the percentage of alcohol in liquors. A state control is needed.

Heavy cigarettes, filled with a nicotine-rich tobacco, introduces from 3 to 7 times more nicotine into the smoker's organism than do the “light” cigarettes, filled with a nicotine-poor tobacco. In the 200 specimens of cigarettes available on the Swiss market, the nicotine content is from 0.7 to 3 per cent. On smoking, from 21 to 36 per cent of the cigarettes’ nicotine is retained in the smoker’s mouth; from 43 to 62 per cent passes into the air. From 2.5 to 4.4 per cent of the nicotine passes into the organism on smoking without inhalation, and from 8.1 to 17 per cent with inhalation.

Toasted cigarettes without a cough in the “first carload” were a fad for a time because the advertisements strongly hinted that they were safe, but never a mention was made of the amount of nicotine contained in them.

I am modern enough to believe that both men and women should be allowed to smoke if they choose to do so, but at the same time I am sensible enough to admit that neither should use tobacco in any form because, in the first place, the habit is filthy and often disgusting to others. People who must endure the fumes and the odor of stale cigar and cigarette butts strewn around on the table in private and public places where food is served. In the second place, the effect of nicotine on the mucous membrane of the smoker’s mouth is a problem to be seriously considered by every tobacco user. Hundreds of cases of destructive cancer of the lips, the tongue, the inside of the mouth and throat caused from the use of tobacco are being recorded each year. At the present time, the majority of these cases are in men. Soon we may expect to see evidence of leukoplakia and other malignant manifestations in the mouths of our women smokers. Few physicians are in a position to sound a warning to their clientele because they are smokers themselves. Advice to a young lady regarding the injurious effects of smoking by a physician who smokes is not likely to make a favorable impression. Many physicians know that they smoke a great deal more than is good for them, but being human, they take a chance and tempt fate a little further each time. Smoking in moderation might be tolerated by most people for many years without serious effects, but what of the smoker who consumes 30 or more cigarettes each day? Can he hope to escape a punishment that must surely come with advancing years? Abuse of the body is always followed by an invited punishment. Like the criminal who knows what the punishment will be if caught, we go right on and commit against our bodies with a full knowledge of the consequences, and then we look surprised when the fall comes and it is too late to undo the wrongs.

Oh! The frailties of human nature. DMJ
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi. Upon reading every President’s Page from the decade 1931 – 1940, each observed that this particular decade marks a discernable shift in focus for the Dallas County Medical Society. The decade was marked by a new interest in transitioning DCMS from primarily a social organization to a unified force in organized medicine with the ability to set policy and affect legislation.

In response to the growing bureaucracy of medicine, the DCMS presidents of the 1930s recognized the potential for DCMS to have a major influence on the city of Dallas. They sought to establish high standards for physicians and were concerned with how to best train the next generation of physicians in an uncertain climate.

**Timeline of Significant Events: 1931 – 1940**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1931</td>
<td>The Great Depression.</td>
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<td>1932</td>
<td>“Dust Bowl” decimates agriculture and many people move to Dallas for work.</td>
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<td>1933</td>
<td>Prohibition ends.</td>
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<td>1934</td>
<td>FDR signs the Social Security Act.</td>
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<td>1935</td>
<td>DCMS hosts its first Annual Dinner, then sponsored by Skillern's Drug Co., for its approximately 400 members.</td>
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<td>1936</td>
<td>Germany invades Poland, marking the beginning of World War II.</td>
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<td>1937</td>
<td>Southwestern Medical Foundation is established.</td>
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<td>1938</td>
<td>Children's Hospital of Texas and the VA Hospital open in Dallas.</td>
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<tr>
<td>1939</td>
<td>DCMS establishes the Dallas County Medical Plan.</td>
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<td>1940</td>
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Strict uniformity of opinion in medicine would be extremely detrimental to the individual, to society and to scientific advancement. Uniformity of purpose in medicine, however, is fundamental. One of the outstanding obligations to be met by the doctor is his personal reaction to the study and practice of medicine. He holds the responsibility of privileged information with the liberty of interpreting as he desires or thinks. ... But, the physician who, for his own personal gains, exploits this knowledge by misrepresentations in court or otherwise, or who allows his worthy colleagues to be dragged in the dirt by his patient, is false to his trust and quite eligible for membership in the great army of present-day crooks. Uniformity of purpose should protect from such abuse the right of individual interpretation in medicine.

President F.H. Newton, MD
“Uniformity of Purpose”
February 1934

The doctor, of course, is a necessary cog in the machinery; but only too often he gets nothing for his technical skill. But, he must pay taxes, grocery, and other bills. ... There is really something the matter with medicine, but help must come from the bonafide leaders of this great profession — leaders who will get together and take the time to successfully work out the real problems we have to face.

President H.B. Descherd, MD
“What is the Matter with Medicine?”
February 1932

Your committee believes it entirely possible and feasible that a plan may be developed whereby various groups may create a fund which, when placed under the control of an administrative board, will meet the needs of persons without income and supported by general relief. It is possible that such a board could work out a plan whereby the sum of $10 annually, per person, could be made to cover the expense of medical and hospital care of this group, provided every penny allocated was used for such care and there was no waste due to administrative expenses.

...Your committee unreservedly condemns any and all forms of Compulsory Health Insurance.

George Schenewerk, MD
Chair, Medical Economics Committee
“Recommendations for a Tentative Plan of Medical Insurance Covering the Low Income Group”
December 1938

It would appear that the time is not far distant when the County Medical Society must decide whether as an organization it shall enter into what may be termed the “business of medicine.” ... The time is opportune and we must address ourselves seriously to the interrogation that presents itself — society and the doctor. We stand at the parting of the ways from an old, outworn system to a new and better type of social organization. There are difficulties. They can be solved.

Charles Heyd, MD
“The Economic Contributions of Physicians to the Community”
August 1932

The training and professional skill of a physician is in his stock in trade in the same sense as the merchandise of the merchant or the money of a banker. The contribution of a physician’s services to the public welfare charitably rendered should, from a standpoint of value, be eligible for credit as charitable contributions in income tax returns. The public often believes physicians giving free service are paid by the local government, or by the institution, for rendering such services. They do not realize that this service is a charitable contribution of the physician.

President Elbert Dunlap, MD
“Recognition of the Physicians’ Contribution to Charity”
February 1937

Accepting membership in organized medicine brings with it many inescapable responsibilities. The profession of medicine is somewhat unique in that there is no provision made for mediocrity. Every physician, regardless of position or location, must assume full responsibility for his or her patients. There is no choice in the matter. Shirking this responsibility represents a frank failure to keep a trust. Your County Society offers you an excellent opportunity to fulfill the above-mentioned obligations. You owe it to yourself and your colleagues to attend the meetings promptly and regularly.

President F.H. Newton, MD
“Message of the President”
January 1934
With this issue of the Dallas Medical Journal, we turn a new leaf and start out with a clean sheet for the year 1939. This issue marks the beginning of Volume 25. When we consider the changes that have occurred in the practice of medicine since the Dallas Medical Journal started on its first legs, twenty-five years ago, we are reminded that the world is moving at a very rapid pace.

Twenty-five years ago, much of the modern equipment and the armamentarium now used in the practice of medicine was unknown to the profession. Great strides have been made in scientific discoveries and in the equipment that is now found in every doctor’s office and in every hospital. Twenty-five years ago, even the hospitals were very poorly equipped as compared with what they are today.

Medical education, along with other improvements, has also made many changes for the better — requirements for entrance to medical schools have been raised, teaching facilities have been greatly improved, the curricula have been made more rigid, and the attaining of the degree of medicine and preparation for the practice of the same is now far more difficult than it was even twenty-five years ago.

The young physicians have so many more advantages than the older ones had. When they are graduated from medicine and have finished their internship, they are much better prepared for the practice than all the older physicians were.

The great profession of medicine has unselfishly devoted itself to the task of helping those who are to practice the healing art to become more efficient in their work and better able to render the very best of service to the public. Never in the history of any class of men could it be said that they had better and higher standards than the medical profession has today.

Twenty-five years ago, the medical profession was looked upon with honor and respect by the public, and a physician who conducted himself as he should had little trouble in securing a lucrative practice in most any community in which he might live.

But today we find things quite different. The cults have infringed upon the real scientific practice of medicine. Many people have been deluded into thinking that they had better and higher standards than the medical profession has today.

It is our honest opinion that there are plenty of well-qualified physicians in the United States to render adequate medical service to all the people in every community, but it seems that there is something wrong with the distribution of these services.

“When we consider the changes that have occurred in the practice of medicine since the Dallas Medical Journal started on its first legs, twenty-five years ago, we are reminded that the world is moving at a very rapid pace.”
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi.

The decade of 1941 – 1950 was centrally important in the history of Dallas County medicine. After the bombing of Pearl Harbor thrust the United States into World War II, the entire nation surged to support the war effort. In several instances, DCMS presidents used their platform to encourage physicians to purchase war bonds and take on extra patients to make up for physicians who were serving overseas.

In the midst of this trying time, the M.D. Anderson Foundation invited the Baylor University College of Medicine to leave Dallas, where it was founded in 1900, and relocate to Houston. All of the approximately 200 clinical faculty implored the Southwestern Medical Foundation to move quickly to preserve medical education in North Texas. The SMF founded the nondenominational Southwestern Medical College (now UT Southwestern) that same year and all but five Baylor faculty members moved to the new school.

Drs. Green, Joseph and Ciarochi noted that this was a decade in which the quality of health care in Dallas easily could have been diminished due to the dual threats of war and the relocation of the school. Instead, DCMS leaders shepherded the organization to an even more prominent position in the state and nation. DCMS hired its first staff member in Millard J. Heath, the Dallas County Medical Plan was influential nationwide, and the foundation was laid for Dallas to pioneer polio immunization for school children.

Timeline of Significant Events: 1941 – 1950

1941
US enters World War II.

1942
DCMS boasts about 500 members, 60 of whom are enlisted in the military.

1943
Baylor University College of Medicine announces that it will move from Dallas to Houston; Southwestern Medical College is founded in Dallas.

1944
61 medical school seniors receive medical degrees from Southwestern Medical College. 38 were simultaneously commissioned as first lieutenants in the US Army Medical Corps and 15 took the oath of office as medical officers in the US Navy.

1945
World War II ends.

1946
Millard J. Heath is hired as executive secretary for Dallas County Medical Society.

1948
World Health Organization is founded.

1950
DCMS ends the decade with about 700 members. The Dallas Medical Journal establishes an editorial board and editorial consultants to expand its influence.
The Selective Service Act and the preparedness program have brought us tremendous new responsibilities. We must take care of the military forces without harm to the civilian population. Let us not permanently give up our independence and the rights guaranteed us by the Constitution to be free citizens. ... We do not want socialized medicine. The government should not practice medicine.

President Homer Donald, MD
April 1941

The determination to win the war requires that every physician be prepared to contribute to the full extent of his individual capacity. Extra responsibilities and extra duties of one kind or another have to be assumed without regard to the personal dislocations, inconveniences and sacrifices involved.

President John L. Golforth, MD
August 1942

Two or more years ago, the Dallas Southern Clinical Society and the Dallas County Medical Society promised unconditional support to the Southwestern Medical Foundation. Fortunately, the time has arrived for us to fulfill that promise. As you know, Baylor has revoked its agreement with the Foundation to permit the joint Board to administer Baylor Medical College. ... These new developments offer a real challenge to the Doctors of Dallas. We accept the challenge and will have a better Medical and Dental School than ever before.

President Davis Spangler, MD
May 1943

Perhaps at no time have greater demands been made upon the members of the Dallas County Medical Society than at present. The first consideration of all of us is to do all that we can to win the war. Our Society has made a very great contribution to this end in that a very large number of its members have entered the armed forces of our country. With the departure of so many members of the Society, the care of the civilian population becomes an increasingly heavy task which the local profession is caring for to the best of its advantage. ... The second great problem confronting the profession of the U.S. at the present time is the contemplated socialization of medical practice as proposed in the Wagner-Murray-Dingell bill now before Congress.

President D.W. Carter Jr., MD
January 1944

County medical societies, state and national organizations are frequently referred to as “organized medicine.” This is a misleading term. To the average layman, “organized medicine” is a labor union whose objectives are to obtain better working conditions, secure higher rates of pay, and procure certain privileges. ... It has become popular to look upon any “organized” group with suspicion. Public relations of the medical profession could be improved considerably if physicians would drop the expression “organized medicine” and use the term “recognized medicine,” or better still, “the medical profession.”

President John G. Young, MD
October 1947

Medicine isn’t alone in the fight against socialism. The sooner we quit trying to fight this battle alone and align ourselves with other people whose interests are just as great as ours, the sooner will we begin to make public opinion felt by Congress. How many times recently, Doctor, have you pointed out to someone else in casual conversation that socialization does not end with any one profession or business, but continues until its tentacles have included everything within their grasp?

President George A. Schenewerk, MD
February 1949

It’s fun to live in America! It is fun to work and play, to aspire and achieve, to know that ambition “pays off” in this great land of ours, where both a railsplitter and a farm boy became Presidents of the United States. It is also a privilege and a responsibility to live in America. Our thrift and saving enables us to have more advantages than any people on earth, yet at the same time it enables us to help others.

President Elliot Mendenhall, MD
September 1950

Excerpts from the Era
by Edward White, MD
64th President of the Dallas County Medical Society

*Can you spare three minutes, Doctor?*

A new medical organization has been proposed, and I am in favor of it. I know that there are already more organizations and more meetings than the average physician can get around to attending; however, this one is unique in that there would be no dues, and the meetings would be held right in your own office. The idea was first suggested at the Grass Roots Conference in Chicago. It has been taken up in Wichita, Kansas, and, also, in Oklahoma, and I would like to have a branch here in Dallas and call it the “Three Minute Club.” Members would agree to spend three extra minutes with each patient explaining why and how and what the doctor expects in his or her particular case.

Public relations experts have prophesied that should each medical practitioner proceed upon the theory that selling goodwill is as important as scientific fact finding, the threat of socialized medicine would disappear overnight. The truth is that during the rush of the wartime period when patients themselves did not have time to spend in any extra conversation, physicians more or less developed the habit of ending the interview promptly, and sometimes bluntly, in order that the next patient could be seen. It has been suggested that the practice of medicine has almost been placed on an assembly line basis along with other war production.

Whether it is premeditated or thoughtlessness in the rush to take care of the patient load, too many doctors have let their patients get the idea that the patient is just a case history to his doctor. It is a short step in the patient’s mind from this sort of procedure to socialized medicine. If the patient already feels that he is being personally neglected and is just a number in the case file, then he cannot see any difference between the present situation and that which would exist under socialization. In other words, if the doctor has regimented his patients, then why should not the doctor in turn be regimented himself?

The standing of the profession suffers greatly if the patient feels that he has become a part of an assembly line to line the doctor’s pockets. Would it not be well, after the examination has been made or the treatment completed, to spend an extra brief period with each patient, either in discussing his own case, his family’s health, his golf game, or just the weather?

Can you spare three minutes, Doctor?

Three minutes extra with each patient to convince him that he is not just a case history, but a human being in whom you are interested personally. It will pay big dividends. DMJ

“Three minutes extra with each patient to convince him that he is not just a case history, but a human being in whom you are interested personally.”
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi.

The decade of 1951 – 1960 represents the period of huge economic growth spurred by the global post-World War II economic boom. Prepaid health insurance plans spread rapidly, encouraged by growth of labor union membership, and many physicians warned against further government control. Dallas County Medical Society pioneered the “Blue Shield” plan, which was then copied and imitated by many other health insurance plans across the state.

DCMS presidents often encouraged the use of prepaid health insurance plans by physicians, but clearly articulated their case against government infringement on the patient-physician relationship. Although the Medicare and Medicaid Act wouldn’t pass Congress until 1965, the seeds were being planted throughout the decade of the 1950s. In 1951, the Social Security Administration first proposed a beneficiary health plan. In 1954, Representative Aime Forand introduced a bill which would legally mandate “compulsory” health insurance for all people of Social Security age. The bill failed multiple times, but its effects were felt all the way in Dallas. The DCMS presidents of this decade consistently warned against the socialization of medicine, which reflects the national bent of antisocialism as a response to the Cold War.

In 1954, Dallas was chosen to be a test center for the Salk polio vaccine. DCMS President Frank A. Selecman, MD, dedicated his April 1954 President’s Page to commend the DCMS Public Health Committee and its chair, Howard Coggeshall, MD. Because the vaccine was new and largely untested, DCMS was hesitant to approve its use on the children of Dallas. Dr. Selecman asked the Public Health Committee to review all of the available data and report their findings to him. Within two weeks, they had done so and found the data to be satisfactory. DCMS then approved the usage of the Salk vaccine, and countless children were (safely) spared from polio.

Timeline of Significant Events: 1951 – 1960

1951
The Social Security Administration annual report recommends health insurance for all beneficiaries.

1952
Jonas Salk develops the first polio vaccine

1954
Parkland Memorial Hospital moves to its current location.

1955
DCMS member Tate Miller, MD, introduces a TMA resolution to remove “white” as a requirement for membership from the TMA constitution. It passes the House of Delegates by a vote of 102 – 32.

1958
AFL and CIO labor unions merge to become the AFL-CIO, then representing nearly all unionized workers in the US.

1958
Explorer 1 is launched into orbit, the first successful American satellite.
Medical organization is a good thing. It is only through combined resources and group planning that real progress can be made in any field of endeavor. Medicine is probably one of the very few vocations which shares all of its knowledge with all of its members. There are no secret remedies or developments.

C.L. Martin, MD
May 1951

The county society is the basic unit of medical organization. This is where people live and work, this is where doctors practice, and this is where public relations are made, either good or bad.

Jack Kerr, MD
February 1953

Why doesn’t my doctor explain to me? This question is heard over and over again.... Too often though, it has become a habit to put our notes on the patient’s record, without putting much information in his mind. Most patients are fairly intelligent people. They like to be treated like grown-ups.

Ridings E. Lee, MD
July 1955

Whatever the merits of the Social Security System, it is apparent to any student of politics that the “give-away” of government benefits in an election year is a strong temptation to those who are not concerned with the long-range welfare of the country. Once medical benefits are included under the system, it is certain that pressure groups will try to expand and liberalize them, moving step by step toward government medicine.

Harold A. O’Brien, MD
February 1956

‘Where there is no vision, the people perish.’ The author of the familiar proverb would surely say that this is an era of great vision, which has given us wisdom to control many diseases which formerly caused us to perish at an early age. By expanding our vision only a little, we can see that this trend is bringing about a new pattern of social order. It is well to think about living to the age of ninety or so, but it is just a little sobering to wonder how one will spend the last quarter of a century of his life. We are living longer. It will take the wisdom of many Solomons to teach us how to be useful and productive for a longer period.

Harold A. O’Brien, MD
June 1956

What many under forty and a few over forty physicians fail to realize is that our standing in the community is affected by everything we say and do. Each physician is a public relations manager for the profession.... This relation is established by our conduct, behavior and speech in all places and at all times.

Andrew B. Small, MD
July 1958

We physicians cannot ignore the demand for a service, or indemnity-in-full, contract for the low-income groups and for the aged. And it should be unnecessary to say that we must protect major medical and catastrophic illness coverage by rendering usual and customary charges for our professional services. This is basic and unquestionably vital to any voluntary insurance program since the premium rate is based on the usual fee, and abuse must not be tolerated.

Floyd A. Norman, MD
August 1959

The truth is that the health requirements of our citizens — the elder citizens certainly included — can never be met through inflexible methods made compulsory by the Federal Government. When the Federal Government, no matter how good its intentions, attempts to solve the challenges posed by those millions of Americans over 65, it is foredoomed by the very inflexibility of its approach to certain failure.

Lester H. Quinn, MD
January 1960
Who killed Cock-robin? That's easy — every nursery book says the sparrow did. The question we will ask ourselves and each other some day is, “Who killed the goose and took away the golden egg?” The goose is the insurance business of America and the golden egg is prepaid voluntary health insurance.

There is no fundamental difference in fire insurance on my house, accident insurance on my car, and health insurance on myself and family. As long as I have no fire, accident or sickness, I am safe, but I cannot afford to take a risk. If my house burns, I am ruined. Therefore, I ask an insurance company to pool my risk with several thousand others and prorate the cost to me in terms of a premium. The insurance company sets this up on a basis that is actuarially sound and thus the cost to me is low. But what would happen to this business arrangement if people began burning their houses? Obviously, the insurance company loses money and may even be ruined financially. Their only alternative would be to discontinue fire insurance or raise the premiums to cover the loss. The same thing is happening in the field of voluntary health insurance — the liabilities are becoming greater than the assets.

There is no magic about this: the insurance company does not create money. It simply collects and administers the client’s money according to the policy contract. When the costs exceed the premiums, somebody has to pay. Somebody always has to pay!

Through abuse and ineffectual use of these “pooled risks,” physicians and patients are pricing voluntary health insurance out of existence or putting it beyond the average man. One of the most important steps we can take is to educate our patients and colleagues regarding our respective responsibilities in the proper use of health insurance.

These responsibilities lie in the correction of:
1. Unnecessary hospitalization
2. Needless tests and examinations in the hospital
3. Prolonged hospital confinement
4. Excessive fees charged to the “third party”

Voluntary health insurance helps meet the cost of medical care and is also our last bulwark against socialized medicine. We are living in a welfare state dedicated to a planned economy and if we are derelict in our duty and refuse to take a stand for traditional American Medicine then we must pay the price of government medicine.

Did I say, “pay the price?” Yes, that’s right — “pay the price” because “there is no such thing as a free lunch!”

“There is no such thing as a free lunch!”

by Andrew B. Small, MD
President of the Dallas County Medical Society

“Through abuse and ineffectual use of these ‘pooled risks’ physicians and patients are pricing voluntary health insurance out of existence or putting it beyond the average man.”
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi.

The decade of 1961 – 1970 was a decade marked by enormous social transformation in the United States and in Dallas. Civil rights issues were a central issue, as well as the growing conflict in Vietnam and dramatic changes to government social programs. A year after the Civil Rights Act of 1964 was signed into law by President Lyndon B. Johnson, Medicaid and Medicare passed Congress and were added to the American healthcare system. Many of the DCMS presidents spoke against aspects of these programs, as they saw further governmental control over prepaid health insurance to be destructive to the physician-patient relationship. The presidents also wrote about their mistrust of any system resembling socialism, a carryover from the major theme of the 1950s, as the domestic tensions from the Cold War increased.

Although, once the implementation of Medicare and Medicaid was underway, DCMS presidents did encourage cooperation and resolved to continue to keep the quality of health care strong. Doyle Ferguson, MD, wrote in June 1966, before Medicare began in July, “It is my hope, regardless of whether you actually engage in this plan or not, that each of you will continue to see that those in need of medical care receive it and that it is the highest quality possible. This is the backbone of American Medicine. This is our greatness. Let us not falter as we enter this new era!”

Even despite the wariness of socialism and the tension of the Cold War, our DMJ Centennial Committee members noted a President’s Page from July 1968 in which Oscar Marchman, MD, described hosting a visiting delegation of Russian physicians and taking them on a tour of area hospitals. There were also mentions of DCMS members visiting Chicago, Austin, Washington, DC, New York City, and London — all researching new ways of practicing medicine that might be beneficial to Dallas County physicians.

The most tragic event was November 1963. The next President’s Page, written by 1964 President Charles Max Cole, MD, reflected a somber tone reflecting the tragedy “and aftermath” of the assassination of President John F. Kennedy. Many prominent DCMS leaders were in the emergency room of Parkland Hospital when the president was taken in, and many of the same physicians were also present when Lee Harvey Oswald was admitted two days later. DMJ


1962
Cuban Missile Crisis

1963
President John F. Kennedy is assassinated in Dallas.

1964
Paul Peters, MD, performs the first successful kidney transplant in Texas at Parkland Memorial Hospital.

1965
President Lyndon B. Johnson signs the Social Security Amendments of 1965 into law, creating Medicare and Medicaid.

1967
Christiaan Barnard, MD, performs the first human heart transplant.

1970
DCMS ends the decade with 1,649 members.
An examination of the Declaration of Independence of the United States will reveal that among the signatures are those of seven physicians. Even in modern times, at least six physicians are now serving as members of the national congress. The time has long past, if it ever truly was, when a physician can simply practice medicine and assume that the higher-ups will take care of things at the legislative levels.

“Political Doctors”
Felix L. Butte, MD
July 1961

The quacks are ever with us — more sophisticated now than in the days of the medicine show, and more difficult to recognize. … Present laws allow a person to use the title “Doctor” even though he does not have the proper education. Since many people do not distinguish one type of doctor from another, it becomes important that we, as physicians and citizens, do our part in exposing the charlatans.

“The Quacks are Still Here”
Ben A. Merrick, MD
September 1963

The series of tragic events that had its beginning on November 22 has left Dallas perplexed and uncertain as this new year begins. We shared the grief and shock of the entire nation at the loss of our President, but we were not prepared for some of the implications of guilt that have had wide circulation. Regardless of how irrational or illogical these implications be, it is clear that our city has been hurt. The hurt is there — and healing is necessary.

Charles Max Cole, MD
January 1964

Isn’t it much better to keep our local problems at the local levels? Too many physicians have not assumed their responsibility in politics. We must assume our role in this important area. The political action committee (now called PAC) was set up as the political arm of medicine and supports candidates favorable to medicine.

“Responsibility”
Doyle W. Ferguson, MD
January 1966

Peer review goes beyond the function of the medical society. It has also provided means to upgrade the quality of medical care as well as more effective utilization of medical facilities. … The more closely we can examine ourselves, the better able we are to deal with those inclined to look critically at our affairs.

“Peer Review — A Must”
James K. Peden, MD
October 1969

It is becoming increasingly evident that more and more medical care is being provided by persons other than physicians. … Evidence is that we are involved in this whole area of recruitment, training, the ultimate qualifications and proper utilization of all nonphysicians in the care of patients. We must continue this involvement, but at the same time be ever mindful that the responsibility for the care of the patient is ours.

“Who is Providing the Care?”
James K. Peden, MD
November 1969

What do you say to a student nurse — particularly one who invades your study in the evening for help with her lessons as you are pondering over the Task Force Report on Medicaid and Related Programs? … As the student nurse closes her book and prepares to leave, she says, “You Establishment Guys aren’t so bad, but you know what? We care too.”

So — what do you say to a student nurse? You say very little. You listen — and you learn.

“What Do You Say to a Student Nurse?”
C.F. Hamilton, MD
October 1970
Economic Freedom

by J.E. Miller, MD
President of the Dallas County Medical Society

All men can still breathe without paying tribute to the Federal Government. Productive men (even poor men) must pay this tribute to the Federal Government before they buy the first mouthful of food for their families and themselves. Ironically, the nonproductive man can have food, clothing, shelter and even luxuries furnished to him by various governments.

The Social Security tax until recently cost the poor man $7.25 of every hundred dollars he earned. Ten percent was considered the top on this tax. Without much hesitancy, Congress and the President enacted legislation, which will cause this tax to go to 11.2 percent in the near future. Where will it stop? ...With “Medicare” now a part of it, it will be difficult to control, even if this were desired by those who are supposed to control it. I have been opposed to both of these laws from the moment it became apparent to me they would some day take away “The Fundamental Freedom.”

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Without ECONOMIC FREEDOM all your other freedoms are in jeopardy. This means the right of private citizens to own property; to buy and sell their goods and services on the free market; and to enjoy the rewards of their economic efforts as they see fit — all without undue restraint or control by government.

As government assumes a dominant role in the economic activity of our country, it will gain the power to withhold from citizens the basic economic requirements of food, clothing and shelter.

Under socialism, communism or a dictatorship, the government can tell you what work you will do, where you will do it, and how much you will be paid. In fact, it must do so in order to implement its national economic planning. Once government has this economic control, it can control every aspect of your life. History proves that sooner or later, it does so.

No country without a reasonably free economy can have enduring freedom for the individual citizen.

It should be obvious to the rich and poor alike, that we will lose all freedoms granted by our Bill of Rights if we continue to permit our government to destroy ECONOMIC FREEDOM by unreasonable taxation.
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Modern historians increasingly portray the years from 1971 – 1980 as a “pivot of change.” The cultural revolutions that began during the 1960s were adopted by the mainstream during the 1970s, including the women’s rights movement, the opposition to the Vietnam War and national health insurance and other welfare programs. WIC and SNAP, the primary federal nutrition programs, were introduced in 1974.

While the DCMS presidents of the 1950s and 1960s focused on the potential perils of socialized medicine, the DCMS presidents during the 1970s focused on the rapidly rising costs of health care in the United States. They were chiefly concerned that the higher costs were a direct result of the Social Security Amendments of 1965, the bill that created the Medicaid and Medicare programs, and the “social experiment” of national health insurance. In 1977, Wayne H. Gossard, MD, noted that medical care was approaching the then-unfathomable number of nine percent of GDP, and discussed the challenges of balancing cost-control measures while still providing high-quality care.

This was also a decade of great advances in medical science, especially technology. MRI and CT machines were developed for commercial use, vaccines spread across the world to eliminate smallpox, and famed American inventor Dean Kamen devised a vastly-improved portable insulin pump. Continuing medical education also grew in importance, as specialty societies became more organized and sub-specialty societies were formed.

In a decade marked by difficult topics, the DMJ Centennial Committee observed that the DCMS presidents were unafraid to discuss the important, albeit potentially controversial, subjects of the day. They published pages devoted to the Roe v. Wade decision, the demise of the Southern Clinical Society, the workings of the Texas Legislature in regard to a new medical school, and even cultural concerns like violence on television and the changing nature of family life.

“This was the hardest decade, thus far, to select from,” said Dr. Green. “DCMS was blessed by great leaders — some of whom wrote to the day, some to the ages.”

### Timeline of Significant Events: 1971 – 1980

**1971**  
First patient brain-scan with computerized axial tomography completed in England, introducing CT scanner technology to healthcare

**1973**  
The U.S. Supreme Court rules 7 – 2 in Roe v. Wade, disallowing many state and federal restrictions on abortion.

**1974**  
Dallas/Fort Worth International Airport opens.

**1975**  
DCMS moves its headquarters to 3630 Noble Ave., which was also headquarters for the Dallas Southern Clinical Society and the Dallas Academy of Medicine.

**1975**  
Robert L. Heath, former DCMS assistant executive officer, replaces his father, Millard J. Heath, as DCMS’ executive officer.

**1976**  
DCMS elects its first female president, pediatrician Gladys Fashena, MD. DCMS’ membership is approximately 1,700.

**1977**  
Smallpox is eradicated worldwide

**1977**  
The Medical Arts Building on Pacific Ave. is demolished.

**1978**  
The soap opera “Dallas” debuts with a miniseries on CBS.

**1979**  
DCMS members hosts the first “fellowship banquet” for the freshman class of Southwestern Medical School. This event is now known as the Annual Student Dinner.
Certainly, the most serious problems facing doctors seems to me to be the new — and not necessarily “medical” — definitions for medical care which are being widely used and accepted as criteria for judgment of present “health standards” and as future demands for legislation and regulation of the “Health Industry.” ... We must begin to see our role as the ultimate providers of physical, and in most cases, mental health, but not as experts on all fronts having to do with the currently accepted definitions of health.

“The New Environment”
H.C. Henderson Jr., MD
January 1971

Within the past month, representatives of our Society have met in five small groups with elected officials of each of the 26 incorporated municipalities of Dallas County to present to them reasons for the consideration of a consolidated, countywide health department. The growth of Dallas County has so progressed that, at present, it is almost one community with little void between municipalities. People traverse city limits daily in their work and recreation habits. Thus, the responsibilities of the Public Health Department are constantly increasing and becoming more complex. The idea of a consolidated department is not new; it was, in fact, foreseen and recommended in 1947. ... Progress on this effort will be reported to members of the Society.

“Action or Reaction?”
Jack T. Chisolm, MD
November 1972

The concern, of course, is the rising cost of medical care, now approaching 9 percent of the Gross National Product. The logic of the administration is that since the major increases have been in hospital costs, the initial efforts must be directed at hospitals — basically limiting cost increases to about 9 percent a year. This is an admirable objective although an approach which can be debated pro and con in many different directions. ... Hopefully, after bleeding from previous encounters, we can rise to prevail in the arena we know best, i.e., what constitutes good medical care professionally delivered in a high quality setting.

Wayne H. Gossard, MD
June 1977

Lay groups covet the jobs of monitoring and making decisions concerning utilization, professional standards, capital expenditures, and even the need for hospitalization. ... As one of our Society directors noted at a recent Board meeting, when one reads or listens to these expressions of desired influence [by lay groups], the patient is never mentioned. Individuals and groups seem to be more concerned with increasing power and influence than with the patient.

Wayne H. Gossard, MD
August 1977

The medical profession needs no prompting to maintain its patriotic concern and its commitment to justice. The medical profession, however, may find difficulties maintaining a balance in its roles as patient advocate, as conservator of society’s health resources, and as a responsible member of this society.

Albert F. Hendler, MD
January 1978

Our national political leaders feel compelled to search for social experiments that purport to improve health. ... National Health Insurance is such an experiment. Physicians are aware of its shortcomings, but we are concerned that large numbers of the public are so uncertain about their health care that they feel favorable to such an experiment. There are no simple answers; however, the hypothesis that altering the method of payment for health care will be all the answer, seems weak.

Albert F. Hendler, MD
March 1978

We must be willing to be an active financial supporter of the candidate of our choice, either directly or through such organizations as TEXPAC. We can be sure that those groups that hold ideas differing from ours will be actively pursuing each and every means possible to see that their views prevail in the Legislature, and Texas physicians must never lose a battle by default. Whatever the Chinese New Year is, it is not the Year of the Ostrich!

“Warning: Political Indifference is Dangerous to Your Health”
January – February 1979

John E. Eisenlohr, MD
Children and Television Violence

by Gladys Fashena, MD
President of the Dallas County Medical Society

Last week, a cyanotic, semi-conscious six-year-old with prominent rope burns and bruises about the neck was admitted to the Children’s Medical Center Intensive Care Unit. He had watched the movie “Hang ‘Em High” on television two days previously, in which the “hero” is hanged for stealing five horses. On the day of admission while playing on the monkey bars on school grounds, he placed a rope around his neck and a crossbar, proclaimed he was going to hang himself, and then either jumped or slipped from his perch, thus fulfilling the prophecy! Within five minutes he was cut down, was noted to be breathing, and was rushed to the hospital. Happily, his neck was not broken and after 12 hours of oxygen and fluid therapy he had returned to a relatively normal state. Upon questioning, he admitted that he got the hanging idea from the TV movie he had watched.

On the basis of Nielson Index figures, the average American child will view some 15,000 hours of television by the time he has graduated from high school, compared with his having been exposed to 11,000 hours of formal classroom instruction. He will have witnessed some 18,000 murders and countless other crimes including robbery, arson, bombing, hanging, beating, torture, etc. — averaging approximately one per minute in the standard television cartoon for children. One hundred forty-six articles largely in behavioral science journals, representing 50 studies involving 10,000 children and adolescents from every conceivable background, all showed that violence viewing produces increased aggressive behavior in the young. Rothenber’s excellent review of these studies points out that such behavior may be retained over a long period of time; that emotional sensitivity to violence decreases with repetition; that the original idea of “aggression catharsis” has been disproved by a number of studies; and finally, that a previously aroused subject is more likely to take his cue from film violence than one who was not previously aroused.

A five volume technical report to the Surgeon General concerning television and social behavior, prepared by his Scientific Advisory Committee and published in 1972, comes to these same conclusions. A sixth summary volume prepared by this committee, whose selection was manipulated by the television industry, concludes that there is a causal relationship between violence viewing and aggression by the young but states these conclusions in an equivocal manner which could lead to misunderstanding.

The evidence is overwhelming and immediate remedial action for improved television programming is warranted. The time is long past due for a major organized cry of protest from the medical profession against what I consider a national scandal. DMJ
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi.

The decade of the 1980s was one of great social, economic, and international change. Globalization led to the industrialization of many countries in the Global South, as the United States economic policies shifted toward laissez-faire, free market economics. US President Ronald Reagan was a key figure in many of the changes of the decade, as his election in 1980 marked a strong victory for the modern American conservative movement. President Reagan accelerated the so-called War on Drugs, which was favorably discussed by multiple DCMS presidents as drug abuse became a state-wide epidemic, and pursued a hardline policy against communism, which encouraged DCMS presidents who were concerned about the socialization of healthcare in the US.

The DMJ Centennial Committee noted that the overwhelmingly dominant healthcare event of the decade was the AIDS crisis, which significantly affected Dallas. AIDS was first clinically observed in the US in 1981. It wasn't until 1987 that AZT, the first antiretroviral drug to treat HIV, became available. By 1989, over 100,000 cases in the US had been reported. A myriad of issues surrounding AIDS was discussed by the DCMS presidents, including the question of whether or not a health care provider had a moral obligation to disclose their HIV positive status, the social and practical barriers to effective testing, the legal complications of a positive test, and the devastation of whole communities around the country.

During the 1980s, Dallas exploded onto the national economic landscape as a hub for business development and corporate relocation. By the end of the decade, Fortune magazine named Dallas/Fort Worth the number one business center in North America. The medical society also grew at an unprecedented rate during this decade, more than doubling its membership. This force of organized medicine made several changes that are still in place today. DCMS moved into its current headquarters, constructing a new building on Twelfth Street in Oak Cliff. Also, current CEO Michael Darrouzet was hired as assistant executive officer in 1988.


1981
The first vaccine for Hepatitis B is approved by the FDA.

The IBM 5150 PC is introduced, launching the personal computer industry.

1983
HIV is first identified as the virus that causes AIDS.

1984
DCMS breaks ground on a new 9,000 square-foot headquarters building in Oak Cliff.

Dallas hosts the 1984 Republican National Convention.

1985
DCMS cosponsors the first Health Check with the DCMS Alliance (formerly the DCMS Auxiliary). Together, the two organizations sponsor the new Health and Medical Exhibit at The Science Place as their Sesquicentennial project.

DCMS members Michael Stuart Brown, MD, and Joseph Leonard Goldein, MD, are awarded the Nobel Prize for Medicine for their research of low-density lipoprotein receptors at UT Southwestern Medical Center.

1987
Annette Strauss is inaugurated as the first female mayor of Dallas.

1988
Michael J. Darrouzet joins DCMS staff as assistant executive officer.

1990
DCMS ends the decade with 4,950 members.
Federal regulation is the leading growth industry today. It threatens many forms of private enterprise — including your ability to practice good medicine.

“Coping with Federal Regulation”
Joseph C. Ogle, MD
May – June 1981

Without any appreciation for the larger shifts that are restructuring our society, we act on assumptions that are out-of-date. Out of touch with the present, we are doomed to fail in the unfolding future. We must understand this new society, and the changes it brings. Change is occurring so rapidly that there is not time to react; instead, we must anticipate the future.

“Winds of Change”
B. David Vanderpool, MD
July – August 1983

Regrettably, the days of yore, when all decisions regarding patient care were processed with a two-party contract (physician and patient), are long gone. These decisions are increasingly made in legislative halls in Austin and Washington, and worse, in the bureaucratic recesses established by these same legislative bodies. A physician who fails to understand this probably would have been found rearranging the deck chairs on the Titanic, in an earlier day.

“Come Win With Us”
Harold C. Boehning, MD
July – August 1984

The term “profession” has its origin from Latin — “to make a public declaration.” A profession is a calling requiring specialized knowledge and often long and intensive training, maintaining by force of organization or concerted opinion high standards of achievement and conduct.... The responsibilities of a profession are to maintain high standards of achievement and conduct, and I believe the DCMS has one of the strongest approaches to self-discipline.

“The Responsibilities of a Profession”
Vernie A. Stembridge, MD
April 1985

When lung cancer, heart disease and fetal tobacco syndrome develop and patients cry out, “Why didn’t someone tell me?” let it not be said that we in medicine did not do our part to prevent these disorders.

“Where There’s Smoke...”
Ernest Poulos, MD
February 1986

The next time that you have completed a long and complicated operation or controlled a difficult medical crisis, instead of taking five minutes to sip a cup of coffee and discuss the case with your colleagues, remember there is a family in the waiting room who cares a lot more about the patient than your colleague. See them first. Help them through this very difficult time. You are their doctor, too. Then go and enjoy your coffee — you’ve earned it!

“Have You Ever Been a Patient?”
Robert M. Tenery, Jr., MD
October 1988

Watching and waiting in the corridors of the Capitol are many other types of non-physician practitioners interested in how this legislative session shapes that nature of hospitals.... In summary, if there is an ever-expanding number of practitioners mandated by the Legislature with a broader scope of practice, practicing independently and providing for more mandated, specific illnesses or treatments or levels of treatment, we will have a medical Tower of Babel that is beyond what we can afford.

Byron L. Howard, MD
March – April 1989

I do know I feel my best in the doctor-patient relationship when I treat other folks exactly like I would want to be treated. What a privilege each of us has every day to be entrusted with making decisions about something as precious as someone’s health.

“What Have We Done for Them Lately?”
Phil H. Berry Jr., MD
January – February 1990

It is clear that only two groups exist as far as politics are concerned: PLAYERS and VICTIMS. If we are not actively in the arena, on the court, on the field participating and playing, we are victims of decisions made by other players.

“Are You a Player or a Victim?”
Phil H. Berry Jr., MD
March – April 1990

Excerpts from the Era
Issues of AIDS

by Maurice E. Herring, MD
President of the Dallas County Medical Society

If the epidemiological predictions are anywhere near accurate, civilization is being threatened with the most devastating — in terms of number of people involved — and unusual epidemic in recorded history. As you read this article, there are an estimated 1.5 million people in the United States alone who carry the human immunodeficiency virus (HIV) in their blood. Of this number, probably 100 percent will develop the immunodeficiency phase of the disease within the next six to eight years. Unless a treatment breakthrough intervenes, 100 percent of the luckless people in this phase will die. These numbers do not include the people who will acquire the virus after today nor the untold millions of infected people in other countries.

Both the virus and its diseases have several peculiar characteristics that make them unique. It is a retrovirus, i.e., by encoding the host cell chromosomal material to replicate the virus, the virus can increase the number of infected cells on the host body without ever leaving the protective environment of the host cells and exposing itself to the host immune system. Somewhere in the initial infestation, the virus does expose itself to the host immune system long enough to stimulate the development of antibodies. But for some reason, the antibodies take up to six months to develop; meanwhile, the virus passes from the parent cell to an ever-increasing population of offspring cells which are unmolested by the antibodies just outside of the cell wall.

In this phase of the disease, the host is not clinically ill; but, through body fluids containing infected lymphocytes, can pass the disease to another person. This infected but not clinically ill phase (better known as the incubation phase) may last six to eight years before the host loses enough of his T lymphocytes to become immune deficient and subject to opportunistic infections!

It is unfortunate that only the last phase of the disease was labeled AIDS in the early literature, giving the impression that the viral phase and the incubation phase are not the disease. If a patient has no clinical illness but has evidence of the virus, such as a positive antibody test, then he actually has AIDS in the incubation phase and should be so managed medically.

This disease, like no other before it, has raised very difficult issues of civil rights, social behavior, law, and morals. Because in this country it happened to start in the gay community, AIDS has been considered “divine retribution for the amoral” and therefore not a disease of the majority, who are presumably moral.

It was “their disease” — not “our disease.” The associations of AIDS with homosexuality, sexual promiscuity and IV drug abuse in the public mind have produced a social stigma around anything connected with AIDS and in large part accounts for the delay in recognition of the severity of the epidemic. The HIV antibody-positive patient, and even the person who feels the need to be tested, is automatically stigmatized. This stigma is powerful enough to cause serious discrimination in the work place, public facilities, housing, and social interactions unless the possible exposure is explained through blood transfusion, a more socially acceptable means of exposure.

The obvious impact on health and life expectancy brings about economic discrimination for HIV-infected patients who apply for health and life insurance, credit, loans, or any form of contract. They have a predictably shorter life expectancy and are thereby seen as an unacceptable risk. However, this form of discrimination is shared by others with a proven fatal disease. The insurance companies, creditors, lenders, and others entering a contract have a right and a duty to appraise the risks of such an endeavor. If there is any indicator of poor risk, such as a positive HIV antibody, high blood pressure or high blood sugar, they have the right to refuse the relationship or adjust the rate to offset the potential loss. As a society, we will help bear the risk by paying higher interest and premium rates and by paying higher taxes to support the care of indigent AIDS victims.

Traditional public health measures will be of little help in quelling the disease. The virus is probably transferred from one person to another within the protective envelope of the lymphocyte; therefore, it must travel in media hospitable to the lymphocyte, such as blood, semen or tissues. It cannot survive for even short periods at room temperature or in open air.

Population screening develops statistics, but it does little to reduce the spread of the virus. We still have no treatment. We cannot quarantine or even police the sexual activity of 1 million people, and we would probably have a hard time enforcing the wearing of ID markers.

The social and legal issues raised by AIDS revolve around a conflict between the rights of the infected individuals and the rights of society.

Unfortunately, this problem is sure to get worse before it gets better. DMJ
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The 1990s were a decade of sharp advancement in medicine, when many issues that lingered for decades came quickly to the surface. Our committee members described it as the “access to care” decade, when many of the DCMS presidents were concerned about patients ability to actually see a physician. During the 1990s, DCMS and other organized medicine groups fought back the HMOs that took over many markets, and laid the ground for tort reform that would pass the Texas legislature in the early part of the next decade.

There were also huge advances in technology and information sharing, thanks to the internet. As early as 1996, DCMS presidents were considering the possibilities of health information sharing that the World Wide Web could offer. DCMS also continued their mission to educate the public.

In 1991, thanks to DCMS fundraising, the Cecil and Ida Green Medical and Health Sciences Exhibition opened at The Science Place. This new addition featured the popular hands-on exhibit, BODYTECH. Throughout the decade, DCMS had a member representative on The Science Place’s board of directors.

The committee members admit they looked at this decade differently than others, because these years represent each of their own time serving as president of DCMS. “We may not have given these a totally objective reading,” joked Dr. Green.

They also reminisced about the difficulty of producing their own President’s Pages. “I knew it was coming during my year as president-elect,” Dr. Joseph recalls. “I had made some plans, but some months, writing was just plain hard.”

**Timeline of Significant Events: 1991 – 2000**

1991
The first servers to host the World Wide Web are turned on.

1983
The World Health Organization declares tuberculosis to be a global health emergency.

1994
President Bill Clinton signs the North American Free Trade Agreement.

Dallas hosts several games of the 1994 World Cup.

1995
DCMS elects its first African-American president, James L. Sweatt III, MD.

The FDA approves the first vaccine for Hepatitis A.

1997
DCMS hosts MedExplore, a unique information technology expo for physicians. DCMS also launches its website, www.dallas-cms.org, in October.

Michael J. Darrouzet is named executive officer of DCMS upon the retirement of Robert Heath.

1999
The Dow Jones Industrial Average closes above the 10,000 mark for the first time.

2000
DCMS begins the new millenium with a membership of nearly 6,000.
Excerpts from the Era

Are you doing your share? Are some appointments available to the needy? Are you willing to work in that last patient who needs you today? Do you get out of bed to come to the aid of the emergency patient? Yes, yes, yes, and yes. We respond on a daily basis, and that is as it should be. Dallas doctors respond thousands of times because Dallas doctors care.

“Access”
Richard J. Joseph, MD
January 1991

Federal fiat requires that medical schools train primary-care residents in a nonhospital setting. Unfortunately, this means encroaching on the turf of their former trainees: private practitioners.

... Spread of these clashes is our future predicament as more “providers” chase a static, or shrinking, number of dollars. One can only wonder what form our erstwhile noble and esteemed profession will take as more of these “efficiencies” are institutionalized.

“Efficiencies”
James L. Sweatt III, MD
August 1995

Residents of Dallas and Tarrant counties benefit from the recent merger of the blood banks in these communities. The result is Carter BloodCare, which serves 21 North Texas counties and 198 medical facilities. The board of directors of the Dallas and Tarrant county medical societies and the Dallas-Fort Worth Hospital Council support this merger.

This merger is a win-win situation for our entire area and deserves our continued support: “Where There’s Smoke...”

“Who Cares? BloodCare”
Roland E. Black, MD
December 1997

In medicine, we have been critically wounded by our own success and now we face dealing with a near-terminal illness: apathy. In the past, most of us have had job satisfaction, respect, financial security, and a fierce sense of independence. Today, all of those are being eroded. How did we let this happen? ... The future of medicine will be only as good as you make it.

“Apathy — A Terminal Illness?”
Robert T. Gunby Jr., MD
January 1998

Public health is not the same as publicly funded health care. Public health is not poverty medicine. Public health is the health of the public. That means all of us. ... Please support your local health department — politically and in your clinical interactions — so we may have stronger, more vital community public health agencies.

“Improving the Public’s Health”
Gordon Green, MD
August 1999

The easiest way to be a good physician is to be a good patient first, and view life from that perspective. When was your last physical exam, personal assessment, or period of personal reflection? Are you using tobacco or are you overweight? Do you exercise regularly? Is your family a priority in your life? Can you name your children without picture IDs? We must have a balance in our lives so that we are effective, interactive humans. Then we are prepared to be better physicians.

“Render Unto Caesar: A Time for Renewal”
Fred F. Ciarochi, MD
August 2000

It is clear that clinical data collection is too burdensome on physicians unless it is electronic and is gathered using standard office routines. Therefore, DCMS has joined with the TMA to choose one or more computer companies to develop a software package and an electronic medical record to collect and compile office data. The offices of volunteer DCMS members will be involved in this data collection.

“Health Care Value Initiative is Underway”
Jerry Friend Sudderth, MD
April 1996

The recent contractual problems that Aetna US Health Care has experienced with some Dallas County physicians has attracted broad interest. ... Our patients are not getting what they pay for and, for some reason, the physician looks bad. If various managed care companies are going to Wal-Mart-ize medical care, let them be the ones to take the heat.

“Aetna, I’m Sorry I Met Ya”
Roland E. Black, MD
November 1997
Dear Doctor in the Year 2040

by Barry W. Uhr, MD
President of the Dallas County Medical Society

Economic forces are changing the delivery of medical care. It will never be the same as we have known it. Those changes started many years ago when a third party assumed the player role, placing itself between the patient and the physicians.

Those who have known medicine the way it was are going through a grieving process. You have heard more on that topic than you probably want to. I do not intend to add to your anxieties. Medicine will survive, but I wish to take you on a brief journey to help us through our grieving.

Here I am, a medical romantic with dreams of what medicine should be and memories of what it has been, just another in a long line of physicians to whom our profession is special and one who is concerned about the changing image which touches us all.

See if you agree with a physician's letter to the future.

Dear Doctor in Year 2040:
I am writing you this letter in 1992 because I will not be around in your time. I may be one of your guardian angels. Yes, all physicians have them. No, you cannot dismiss them. The lineage of medicine goes back thousands of years, and all ethical physicians are angels on our shoulders and will be on yours.

I am sending you this letter so that you may have a better understanding of your past. Then, perhaps, you will be able to put things into a better perspective. If I have predicted correctly, your system of medical care delivery will be less personal than mine, and that concerns me.

In my early years, we doctors had very personal relationships with our patients. They selected us as individuals, not because we were members of a particular provider group. We enjoyed a one-to-one, trusting relationship. Can you even imagine what that individual relationship meant to us? It was more rewarding than any monetary gain. That relationship is changing even as I write this letter. The changes are being driven by economics and technology.

The government probably pays you a salary now, and the patient's allegiance to the payer, not his physician.

In my time, we have seen a change in the public's perception of medicine. Advertising and promotion changed the image of the physician. People became fascinated with technology and began to trust in it more than in the physician. The loss of that trust was difficult for us to accept because of our basic commitment as advocates for our patients.

I suspect you have a much less intense role in taking care of patients than I. Technicians probably deliver most medical care, diminishing your role as a physician. That is the nature of technology.

Because you have not been without them, I'll bet you do not even realize that the classic role of a diagnostician has been usurped by technological advances, such as computerized diagnostic analysis and treatment programs, robotic imaging scanners, and automated laboratories.

Surgical procedures using computer directed lasers and the implantation of artificial organs and limbs should be commonplace. Genetic engineering probably has eliminated many physical defects and diseases which I could only ameliorate. Those technologies, born in my lifetime, are undeniable scientific wonders.

But where do they leave you as a physician? What is it that you can offer to validate your profession?

Perhaps you have feelings of being a part of something larger than yourself. Those are feelings we all share. They emanate from the spirits of gentle giants of medicine coursing through our veins.

They are what we have always been about — the touching of a hand, the gazing into eyes, and the comforting voice of a physician saying, “I dream your dreams; I perceive your pain; I share your mortality; therefore, I understand.” Thus, the domain of the physician is not restricted to the physical being as is technology. You are allowed beyond that temporary temple. You have access to the spirit.

As a healer of the body, you have been superbly trained. As caretaker of the spirit, you must preserve a personal relationship with patients. To touch another body with healing hands may be your job, but to instill hope is to continue the heritage of our profession.

We are counting on you.

DMJ
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi.

The committee members were especially challenged by the decade of the 2000s, as these years are so recent that putting them into a fully realized historical context is impossible. Even still, they were struck by the content of the President’s Pages that discuss issues arising in medicine which would, unbeknownst to the authors, eventually lead to the passage of the Patient Protection and Affordable Care Act. The committee members recalled that many presidents of the 1950s devoted their pages to issues of health insurance for the elderly and poor, signaling shortcomings in the health care system that would be addressed by landmark health care legislation in the next decade — the Social Security Amendments of 1965, which created the Medicare and Medicaid programs. Similarly, during the 2000s, many of the presidents used their platform to discuss the need to ensure patients’ access to care against the backdrop of a growing uninsured population. These are the issues that the landmark health care legislation of our current decade attempts to correct.

Dallas County Medical Society leaders didn’t just talk about the problems of access to medical care; they also proposed and implemented many important initiatives to create new avenues for patients to see physicians. The most important of these programs, Project Access Dallas, launched in 2002 and enrolled thousands of patients throughout the decade. Don Read, MD, wrote in May 2002 that Project Access Dallas was intended to be “a collaborative effort among DCMS, physicians, clinics, hospitals, and business” to provide uninsured patients with access to specialty care and services. Project Access Dallas was extremely successful over the course of ten years and became known as a signature achievement of DCMS physicians.

The most defining moment of the 2000s came at the beginning of the decade — the events of Sept. 11, 2001. This began a series of preparations for medical emergencies, including terrorist attacks with conventional weapons as well as biological and chemical weapons, especially anthrax. In September 2004, Warren Lichliter, MD, described DCMS’ role in the formation of the Medical Reserve Corp, a system for local physicians to respond to local emergencies. Hurricanes Katrina and Rita gave DCMS the opportunity to show the importance of physicians responding to immediate, large-scale medical needs in an organized way.

Throughout the 20th and at the beginning of the 21st century, Dallas County Medical Society leaders have written words that light the path toward the a brighter future of health care, always emphasizing the importance and sanctity of the physician-patient relationship. Now, it’s up to the next generation of physicians to carry on their mission with the words that will be written during the next 100 years of organized medicine in Dallas County. DMJ

### Timeline of Significant Events: 2001 – 2010

**2001**
DCMS boasts a membership of nearly 6,000 physicians as DCMS’ second female and African-American president, Carolyn Evans, MD, takes office.

On September 11, 2001, terrorists coordinate a series of four attacks on targets in New York City and Washington D.C., killing nearly 3,000 people.

**2002**
Project Access Dallas begins its pilot program.

**2003**
The United States and other allied forces begin the occupation of Iraq.

The first nasal influenza vaccine is approved for use in the United States.

**2005**
Hurricane Katrina, one of the five deadliest hurricanes in the history of the United States, devestates the Gulf Coast and sends thousands of new patients to Dallas. Shortly thereafter, Hurricane Rita hits Houston and displaces thousands more people.

**2008**
Failures of several major financial institutions rapidly devolve into a crisis of bank failures, marking the beginning of a long global recession.

**2009**
H1N1 flu pandemic occurs in the United States and in Mexico. By October, “swine flu” was declared to be a national emergency.
The next entering class of medical students might contain someone who will revolutionize the way that we practice medicine. And if I could give some advice, it would be to make yourself into the best possible physician you can be because your gift will have little to do with you and everything to do with your patients.

“A Message to New Medical Students”
Carolyn Evans, MD
August 2001

The attacks on the World Trade Center and the anthrax attacks that followed have made it clear that our lives have changed forever. The responsibility of recognizing and responding to future threats lies squarely on the shoulders of the public health system. ... We need a strong, coordinated regional public health system to ensure our protection.

“Public Health: A Victim of Its Own Success”
Don R. Read, MD
November 2002

My most important advice to parents and athletes is what my mother has preached to two generations of athletes, “Don’t count on sports for your happiness.” After all, few teams will win all the time, few athletes play as well as they dream, most kids spend their share of time on the bench, injuries happen at the worst time, referees and umpires really are blind, coaches are unfair, all athletic careers end. Teaching children (and their parents) to recall this aphorism at the low moments helps maintain the right perspective.

“It’s Only A Game”
Robert W. Haley, MD
April 2003

The Medical Reserve Corps has been created by the health department as a first-responder system to integrate the county’s health agencies in response to bioterrorism. Initial meetings have seen a good response from our membership. ... We hope to develop a coordinated model of integration with the health department and DCMS that will serve as an example across the country.

“DCMS & Health Department Working Together for Dallas”
Warren E. Lichliter, MD
September 2004

Where health care was and where it probably still is: We still have a cottage industry mentality; we are totally reliant on professional/individual responsibility, individual perfection, train, and blame; and we have little understanding of systems. ... Without a change in the medical culture, it is impossible to attain the most basic objective of medicine — to first do no harm.

“Near Misses”
David M. Bookout, MD
June 2006

What has organized medicine done for me? ... Hmm. If there were no DCMS or TMA, you would pay higher liability premiums and more taxes, see sicker patients, have no allies in your battles with managed care, be stuck with paper documentation, watch the government shrink your revenues, and have to come up with your own physician directory. I contend that the dues are a bargain.

“It’s All About Me! Isn’t It?”
Tim Norwood, MD
April 2007

If we align ourselves with patients, we will benefit, too. I recognize that incrementalism is the norm with our nearly paralyzed political system; with each increment of added care, the profiteers and money changers have a chance to corrupt the system. We need a Teddy Roosevelt to take on the moneyed interests for the benefit of our patients and our profession. Remember that the real experts in health care are you and I — not the economists or politicians. Speak up and be heard!

“Healthcare System Reform”
William J. Walton, MD
September 2008

All these great [medical society] leaders remind us how important it is for us to give of ourselves beyond the practice of medicine. We must work together to advance the ideals of health and medicine as well. Whether it be taking our message to the legislators to increase access to health care or volunteering our time to care for the uninsured, we are all here to do more than just our jobs.

“Giants in Texas Medicine”
Phillip J. Huber Jr., MD
July 2009

We don’t have to give up and “conform.” Rather, we can work for change and apply our dreams and energies to today’s challenges. Would you like to have it your way? Why not be more involved? If you are not used to doing that, it would now be the radical thing to do!

Stephen Ozanne, MD
June 2010
DCMS Physicians Team Up to Help Katrina Evacuees

by Leslie H. Secrest, MD
President of the Dallas County Medical Society

Little did we know how much Hurricane Katrina would affect us as it developed into a Category 5 hurricane and took aim at New Orleans and the Mississippi coast. What followed occurred in waves of people and activities. First came all the people who could leave the area by car or by air to stay with friends, relatives, or in hotels. Next came those who could get here with their own transportation but had nowhere to stay. Dallas responded by opening Reunion Arena. The medical needs of these first 500 people were easily met by using Dallas County resources of Parkland Hospital and the Dallas County Health Department. Next the wave of buses came, requiring the opening of the Dallas Convention Center. With the announcement that evacuees would be bused to Dallas, it became clear that a much larger and more diverse medical team would be required.

Dallas County Medical Society began mobilizing its membership less than 48 hours after Hurricane Katrina made landfall. When Reunion Arena was designated as an evacuation site, the DCMS leadership met with David Buhner, MD, medical director of the Dallas County Health Department, to offer assistance. With the opening of the convention center, the medical society’s assistance was clearly needed. This initiated a public and private medical cooperative never previously assembled and activated. Within minutes, the flow of physician volunteers began and quickly numbered 1000. DCMS staff worked with the Dallas County Medical Reserve Corps to schedule these physicians for shifts at the main shelters.

Ron Anderson, MD, Parkland Hospital CEO, designated Ray Fowler, MD, to lead the deployment and operation of its resources and Dr. Buhner designated the county’s chief epidemiologist, John Carlo, MD, to lead the deployment of the county Health Department resources. These two physicians teamed up to create an emergency department that started with only the cement floor of the convention center’s enclosed garage. Cloth walls were hung to accommodate the clinical areas, from primary care to pediatrics to surgery to obstetrics and gynecology to behavioral health. Soon, physicians arrived, who, Dr. Fowler pointed out, “checked their egos at the door and provided their expertise.” Unexpectedly, Tom Nobel, Parkland’s vice president of Patient Care Services, arrived and developed a schedule for personnel to staff this emergency department, and suddenly there was now an orderly flow of physicians, nurses, and all the other personnel who are necessary to make an emergency department operational 24 hours a day.

The convention center emergency department soon was having more patient visits in 24 hours than typically would be seen at the Parkland Emergency Department. People were able to get their medications filled at the convention center, thanks to the opening of pharmacy services by Walgreens and CVS. The effectiveness of the team of volunteers and Parkland staff kept local emergency departments from being overwhelmed by the evacuees’ medical needs. An outbreak of diarrhea was quickly recognized and contained. A number of patients seriously ill were stabilized and transported to area hospitals without any mortalities.

With the closing of the convention center and Reunion Arena as emergency shelters, a new phase for supplying medical care to a population that is now distributed throughout Dallas County is required. The public sector and private volunteers will need to continue to work together to provide care so as not to overwhelm our acute care facilities. It seems that creation of a Project Katrina is what is required to meet this temporary need. This would take the organizational processes and the electronic capabilities of Project Access Dallas and develop a new volunteer force of physicians, psychiatrists, and allied behavioral health providers.

Dallas’ ability to effectively and efficiently combine the medical skills and resources in public and private settings makes us proud to be physicians, to be DCMS members, and to be residents of Dallas County. The ability is based on the support and sustenance of our community’s public institutions, such as the Dallas County Health Department, Parkland Hospital, and UT Southwestern, which step forward and provide leadership and coordinate public and private resources to serve its residents.

Thanks again to the members and staff of the Dallas County Medical Society.
2014 marks the 100th anniversary of the Dallas Medical Journal. Three former DCMS presidents make up the DMJ Centennial Committee — Drs. Gordon Green (chair), Richard Joseph and Fred Ciarochi.

The committee members were especially challenged by the decade of the 2000s and the first several years of the 2010s, as these years are so recent that putting them into a fully realized historical context is impossible. Even still, they were struck by the content of the President's Pages in the first decade of the 21st century that discuss issues arising in medicine which would, unbeknownst to the authors, eventually lead to the passage of the Patient Protection and Affordable Care Act in 2010. The committee members recalled that many presidents of the 1950s devoted their pages to issues of health insurance for the elderly and poor, signaling shortcomings in the healthcare system that would be addressed by landmark health care legislation in the next decade — the Social Security Amendments of 1965, which created the Medicare and Medicaid programs.

From 2011 to 2014, the presidents wrote their reactions and interpretations of the Affordable Care Act, as the implementation was delayed and all of the effects were — and still are — somewhat nebulous.

DCMS was also faced with two unique public health emergencies — West Nile Virus in 2012 and Ebola in 2014. In both instances, members of the Society stepped into the public arena and fought for the health of all patients. In both cases, DCMS' work was commended by local and state leaders.

Throughout the 20th and at the beginning of the 21st century, Dallas County Medical Society leaders have written words that light the path toward a brighter future of health care, always emphasizing the importance and sanctity of the physician-patient relationship. Now, it's up to the next generation of physicians to carry on their mission with the words that will be written during the next 100 years of organized medicine in Dallas County. DMJ

**Timeline of Significant Events: 2011 – 2014**

**2011**

The first reforms of the Affordable Care Act take effect, including free preventive services for patients with Medicare.

The world population exceeds seven billion for the first time.

**2012**

Texas Governor Rick Perry sends a letter to Health and Human Services Secretary Kathleen Sebelius announcing that Texas will not implement the Affordable Care Act or expand Medicaid.

President Barack Obama is re-elected President of the United States.

West Nile Virus hits North Texas. Out of nearly 2,000 reported cases in Texas, 48% of patients resided in Dallas County and three surrounding counties.

**2013**

Open enrollment in the Health Insurance Marketplace begins on Oct. 1, though many patients have trouble accessing the website until several weeks later.

**2014**

On Sept. 28, Texas DHHS announces that the first patient outside of Africa to be diagnosed with Ebola Virus Disease is being treated at Presbyterian Hospital.

DCMS ends the year with a total membership over 7,000 for the first time in its history.
The one thing we know for sure is that change is inevitable. But it is not inexorable. Change can be channeled and guided. Therefore, because we are responsible members of our medical community, we must accept that change is upon us so we can nudge it in the best direction. We always are aware of this at our DCMS and our TMA. ... We must each consider, discuss and then reconsider the primary care and specialist physician shortage/maldistribution. Over it all must be the concern for our patients, both ours individually and as a class.

“Whither the TMA”
Shelton Hopkins, MD
September 2011

This crisis [West Nile Virus] has taught us that the ideal of the physician advocate is alive and well in Dallas County. Remember, regarding the health care our patients receive, we physicians have as much impact in legislative chambers and board rooms (and, in this case, a Commissioners Court) as in exam rooms and operating rooms. As clinicians we treat one patient at a time, but as physician advocates, we have the opportunity to treat everyone, even a whole county, at once!

“Anatomy of a Crisis”
Richard W. Snyder II, MD
October 2012

The billions I am focusing on are the more than $4 billion in supplemental federal and local money that Dallas hospitals are set to receive over the next four years to care for the county’s uninsured and Medicaid populations, while the physicians, the ones who actually provide the care for the patients, will receive next to nothing. ... My primary question is worth repeating: how can you ask the physicians to continue to subsidize hospital systems by seeing low-income patients at a loss, just to preserve the hospitals’ draw-down of supplemental governmental payments estimated in the eye-popping range of $4 billion to $5 billion over the next four years?

“B as in Billions”
Richard W. Snyder II, MD
December 2012

To best understand today’s healthcare dilemma, we need only look to the past. Today’s situation is a direct consequence of decisions made during the JFK and LBJ eras. And indeed, the Affordable Care Act calls the question onto the table today. Unfortunately, it is the same question of yesteryear — how do we as a nation finance and provide adequate health care for the needy in America today? ... It’s lamentable that physicians of today seem to have no more of a voice than they had in 1962. But, as long as the Affordable Care Act remains in effect and details of implementing the law are being shaped, we can marshal our efforts to influence the legal modifications to convert this law into something that will work — something that fills the fundamental healthcare needs of the underserved while allowing and promoting the American healthcare industry to thrive.

“JFK’s Forgotten Healthcare Legacy”
Cynthia Sherry, MD
October 2013

April is National Donate Life month. You can take just a few simple actions and make a critical difference in so many lives. Take the time to register or confirm your registration. Have that difficult conversation with your family, and educate your friends and patients. Todd Storch compares organ donation to life insurance. The contemplation and purchase of life insurance is difficult, but you buy it — not for yourself, but for the benefit of your survivors. Like life insurance, organ donation provides for your survivors, but there are no premiums.

“Organ Donation: Plan to Give the Gift of Life”
Todd Pollock, MD
April 2014

The first patient to develop Ebola in the United States walked into a Dallas hospital. A little over two weeks later, that index patient, Thomas Eric Duncan, has died and two nurses who cared for him were diagnosed with the disease. I feel compelled to put aside the essay I was working on and discuss this crisis. ...

Public officials and trusted community leaders should be committed to comforting the public through fact-based comments. This is not a time for these trusted individuals to advance speculation, fear mongering or politics.

“Ebola Hits Home”
Todd Pollock, MD
November 2014