mental jejunostomy following or concurrent with an operation. His idea is that gas pains are caused by the meeting of the reverse and forward peristalsis and he used this complemental jejunostomy instead of proctoclysis or hypodermoclysis. I tried this a few times when patients were in extremis and found that I got instant relief.

One hesitates, however, to resort to a complemental jejunostomy which increases the hazards of surgery. (See Journal A.M.A., Volume 90, No. 4, pages 257 to 258.) Yet when we take into account the fact that distention is a potent factor in causing gangrene, jejunostomy in well selected cases may be a life saving precaution.

Dr. T. Edward Jones, resident assistant surgeon, Freedmen's Hospital, Washington, D.C., reported to me a case of strangulated hernia that gave all the outward symptoms of obstruction. On operation, nothing was found but an enlarged mesenteric gland. Operation was completed but the patient died. On autopsy, two loops of gangrenous gut were found; but no evidence of strangulation could be determined. This was a plain case of gangrene from undue distention. This fact cannot be too strongly emphasized. Post-operative distention should be dreaded and avoided as much as any other complication and prophylactic treatment observed before operation. Systematic pre-operative purgation is justly falling into disuse.

Summary

Neither morphine nor purgative should be given to a person suffering from abdominal pain. Early diagnosis and early relief by operation within twelve to twenty-four hours should be the aim of the surgeon. The contents of the bowels above the obstruction should be removed. Pain, vomiting, inability to secure bowel movement, visible peristalsis (especially when not attended by fever) are the cardinal symptoms in intestinal obstruction.

Sodium chloride solution tends to prolong life. Gaseous distention of the bowels alone may exert sufficient pressure to produce gangrene by occlusion of the circulation in the bowel wall.

Alkalies should not be given, because in these cases we have an alkalosis and not an acidosis. Death is due to toxemia, low blood chlorides, dehydration, starvation, and alkolosis.

Obstruction is a curable disease when promptly recognized and treated. Too much emphasis has been placed on the establishment of the lumen and too little on the condition caused by the obstructed bowels.

PROVISION FOR TRAINING COLORED MEDICAL STUDENTS*

By B. C. H. HARVEY, M.D.

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There are 10,463,000 Negroes in the United States, nearly one-tenth of the population. Over 1,500,000 (fifteen per cent) of them are in northern states. It is a startling and pathetic fact that there is twice as much disease among the colored as among the white. The mortality of Negroes in the cities of the United States is 187 per cent of the mortality among whites; in the rural areas it is 149 per cent. (United States Public Health Bulletin 174, 1928.) In Chicago the mortality among Negroes in 1928 was 26.25 per thousand among whites it was 12:53 per thousand. Thus their mortality was 209 per cent of the mortality among whites (Chicago Health Department figures). Morbidity among them was correspondingly excessive. In the whole state of Illinois their death rate was double that of their white neighbors. The proportion is shown by the Public Health Bulletin to be still higher in Michigan and Ohio. According to the United States Life Tables 1920, the expectation of life for whites in the registration states was fifty-five years, for Negroes forty-one years. The difference is fourteen years; one-third might be added to the Negro life time.

The condition is lamentable because it involves needless suffering, death, and economic loss among the Negroes. But that is not the whole story for they cannot keep their diseases to themselves. The whites catch them from the Negroes. Disease in the entire population is more prevalent than it need be because of the relative ease with which it spreads among them and through them to others. We all live together. Contacts are innumerable and intimate . . in houses and offices, Pullman cars and street cars . . everywhere. We share our communicable diseases in full communism. All men are equal before the bacteria.

But there are certain diseases from which Negroes die in greater numbers than do their white neighbors. As compared with the death rate

* This article has appeared in the proceedings of the Annual Congress on Medical Education, Medical Licensure and Hospitals published in the Bulletin of the American Hospital Association.

for the white population that of the Negroes from malaria is 344 per cent, pellagra 327 per cent, tuberculosis 236 per cent, typhoid 174 per cent, puerperal sepsis 170 per cent, lobar pneumonia 166 per cent, whooping cough 162 per cent, and gastric ulcer 154 per cent

These are the diseases which swell the Negro death rate, and these are diseases which can for the most part be prevented or cured. Their great prevalence among Negroes indicates a deplorable lack of medical and sanitary care and education.

It is clear that any attempt to cure disease or prevent its spread must take account of the Negro. It must do more; it must be directed more toward Negro sanitation and education than toward white sanitation and education, because it is through this part of the population that disease spreads most easily and extensively. The conditions show plainly that the United States needs better medical care of the sick Negroes and more effective sanitary education of Negroes. This need of the country imposes certain obligations definitely on the medical schools and hospitals. The hospitals have sought to meet theirs through the investigation requested by the National Medical and Hospital Associations and conducted by Dr. Jackson under the auspices of the American Medical Association, the American College of Surgeons, and the American Hospital Association. The report published last April in the Journal of the American Medical Association stresses the need of facilities for training an adequate supply of Negro physicians and nurses, and hospital executives and administrators. It may be thought that white doctors and nurses could do this work better. But the truth is, they cannot do it as well, because the doctor needs to understand his patient mentally and environmentally, and in sanitary education of the Negro people, the colored doctor and colored nurse can be much more effective.

The Existing Facilities

For training colored medical students there are now in the United States only two medical schools, Howard and Meharry, both in the South. Both have been given "A" ratings by the Council on Education. They had, in 1928, 444 students and 101 graduates. Negro students are not admitted to the other schools in the South. In the North there were in Class A schools in that year, 53 Negro students and 13 Negro graduates. Chicago schools had 17 Negro students and 7 graduates. The schools which admitted them were:

University of Chicago	14
University of Michigan	7
University of Indiana	6
Harvard University	4
Columbia University	3
Tufts University	3
Northwestern University	2
Boston University	2
Ohio State University	2
Western Reserve University	2
Medical Evangelists	2
Loyola University	1
Nebraska University	1
Long Island	1
Syracuse University	1
Temple University	1
Women's Medical School	1*

The fifty-three colored students were good. They had to be good to secure admission to these schools. Most of them came from northern states and were unwilling to go to southern schools. The Negro born and educated in the north prefers to stay here, and the southern schools naturally do not want him if he does not want them. Negro medical students are few in proportion to the colored population of the north, being about 1 in 30,000, whereas 1 in 6,000 of the total population was enrolled in the medical schools. That is, there are five times as many white doctors for the white people as there are colored doctors for the colored people. These few colored students should be trained as well as possible because there will be great need for their services as colored doctors. But the facilities are lacking. We have long been able to carry them through the first two preclinical years without difficulty. But difficulties that are almost insuperable appear at once when they begin the work of the third year, and the difficulties continue through the fourth and the fifth or interne year.

Clerkships provide an exceedingly valuable part of the students' training and it is not practicable to assign colored students to clerkships in white hospitals in a routine way. We have tried it in the Billings Hospital in a small experimental way with one or two tactful colored students. It can be done perhaps to a small extent but it creates an embarrassing situation and cannot be the real solution of the problem. Since hospital clerkships in white hospitals cannot be given regularly to colored students, they have to fall back on the dispensary service, which affords valuable training but not in itself enough.

Interneships for colored students can be served only in colored hospitals or general hospitals

*These figures are from the report of the Council on Medical Education and Hospitals for 1928. Some medical schools did not report their Negro students to the Council, so the list is incomplete and the total too small. It is estimated at 65.

with many colored patients. In the entire United States only thirteen colored hospitals are approved for interneships by the Council on Medical Education and Hospitals. They provide ninety-four interneships. In the northern states only five are approved providing forty-three interneships. These are not enough. There are 120 colored graduates each year, and former graduates also seek such training. President Mullowney of Meharry says the existing facilities are scarcely sufficient to provide one-half the number of good interneships required. There are 183 Negro hospitals in the United States. If only thirteen are now approved for interneships, could not others be added? It is apparent that others must be added if the distressingly high death rate is to be reduced. Others can be approved only as they are improved. The report of the official investigation shows that only sixteen of the 120 Negro hospitals visited could be put in Class A. Some were so bad as to be menaces; the investigator feared to take a drink of water in them.

Many ought to be improved and added to the list. The country plainly needs more Negro hospitals connected with good schools, hospitals where the sick get well and learn to keep well, hospitals where the staff can teach clerks and internes sound medicine and good hospital administration, hospitals where Negro graduates can improve themselves, hospitals where everyone concerned sees how he should improve himself and is encouraged and helped to keep doing it. Such hospitals are likely to be connected with schools. They are schools. Every good hospital is necessarily a medical school for clerks and internes, a nurses' training school, and a school of public health and sanitation through its outpatient department.

What we are Doing in Chicago

The trustees of the Provident Hospital in cooperation with the University of Chicago are establishing such a hospital in this city. The Rosenwald Fund and the General Education Board have helped them. Many others have helped through the campaign just conducted under the leadership of Mr. Rosenwald, Dr. Frank Billings, and Mr. A. A. Sprague. The devoted efforts of these three men have conferred on the Negro population a great and lasting benefit. It is fitting that this hospital should be in Chicago. The death rate among Negroes here is much higher than in the nation as a whole. We have more colored medical students than any other northern city, and at least two of our medical schools have colored doctors on the faculty.

The new hospital be will housed in the building now occupied by the Chicago Lying-In Hospital at the north end of Washington Park. It will have 100 beds, a Nurses' Training School, and an outpatient department. The objects which the hospital trustees and the university have in common are better care of the sick, better training of Negro students and practitioners, better Negro nurses and better medical social service workers. The university assumes in general the professional and educational part of the enterprise. It will nominate the consulting and attending staff, and it will pay them. It nominates also the hospital superintendent and superintendent of nurses. All the resident staff will be colored and the attending staff will be colored as far as possible, but the first consideration is quality. The consulting and directing staff will be from the staff of the University Clinics which thus assumes the duty of teaching colored medical students, clerks, and internes, making the teaching work of this hospital an integral part of the work of the University Medical School. The University assumes the conduct and expense of all the purely teaching and research activities of the hospital.

We can thus continue to admit capable and carefully selected colored students, and to give them every facility and opportunity available to any students in the first two years. And we can do it hereafter with much more satisfaction than heretofore, because we have had to tell them in the past that we would be unable to give them adequate training in the third and fourth years, and have had to advise them to seek their clinical training elsewhere. Right here I should like to say that some of the colored students whom we have had in the first two years have shown unusual ability and admirable qualities of character and it is a great satisfaction to me personally to know that hereafter they can look forward to unrestricted opportunity within the university in the work of the third, fourth and fifth years.

Through this co-operation it is hoped—it is assured that there will be provided:

1. Skill, science, and adequate clinical and laboratory equipment for the treatment of the Negro sick.
2. Thorough clinical training of colored medical students and internes,
3. Opportunity for post-graduate training of colored physicians.
4. Further research in diseases to which Negroes are especially susceptible.

5. Training of Negro superintendents and administrators of hospitals, of Negro nurses, technicians, public health workers, and social workers, and

6. An atmosphere and environment in which capable Negro medical men will find incentive and encouragement to the highest development and achievement.

It is hoped that this enterprise may help to improve health conditions among the Negroes by giving them physicians and public health workers of the best quality, and of their own race, who will teach them to help themselves. It cannot increase very much the total number of Negro physicians, but it does provide incentive and opportunity for them to attain the highest professional levels. The road to these higher levels has not been wide open to Negro physicians heretofore: it has been a discouragingly difficult road. But some of them seek to qualify nevertheless. They do not desire a second class standard. Dr. Murray, trustee of Howard says, "We are concerned with improving the quality of our graduates rather than increasing the quantity", and "We want the Negro to accept no second rate standard." Not every colored applicant and not every white applicant can be admitted to the school. Selection will be made on the basis of scholarship, personal honor, and intellectual promise, just as heretofore. No favor can be shown to either black or white. But to all admitted we can hereafter offer full and equal opportunity.

This will have a greater effect in promoting social co-operation and security than is commonly realized.

THE SURGICAL CLEARING HOUSE*

By C. WAYMOND REEVES, M.D., C.M., Atlanta, Ga.

At Baltimore, when elected chairman of this Surgical Section of our beloved National Medical Association, I desired to find a subject that would be at least interesting to our group. After visiting hospitals in my section and other sections of the country and conferring with my colleagues, I am constrained to sound a note of warning to our group in regard to the indiscriminate practice of surgery by many untrained, who do not possess the experience sufficiently to justify the undertaking of problems which may arise in the course of an operation. The following is not intended to appear as pendantic and certainly not boastful—far from that.

The desire to operate has taken some men from the possibilities of making excellent internists and made bad surgeons. There are some who may have been actuated by the prospect of a fee which they were loathe to see go to someone else, even though he possesses a higher degree of skill and training to cope with such possibilities.

Observing the number of patients who come to our operating table with one or more scars of previous operations, causes me to consider the oft repeated statement of the laity that one operation calls for others, followed ultimately by chronic invalidism or a tragic end, after a dramatic effort to remove the entire offending pathology.

Often we find a beautiful scar over McBurney's point, an appendix removed, no relief following and when a larger incision and a more complete exposure is made, a small ovarian cyst, a septic kidney, ureteral stone or stricture, a diseased gall-bladder, or other pathology, manifests itself which has previously been overlooked.

The overlooked pathology or the incomplete or too extreme effort at surgical relief, has ultimately led to the so-called surgical clearing house.

The poor surgical risks, consisting of a large number of diabetics, syphilitics, tuberculars, nephritics, hepatics, so-called blood dyscrasias, endocrinological disfunctions, thyroids—all comprise a class requiring most painstaking care before being subjected to surgical procedures. On the other hand though, many of these patients requiring operations may be so prepared to undergo the necessary operation. How easy it is to incise the skin and go in. How difficult it is to take care of all offending pathology and come out feeling justified and safe to approximate that skin again. How much surgical judgment is required to know when to operate, how to operate and when to stop. When one administers the estate of a deceased, the courts do not accept his statement that he has done it honestly and well; the records are checked to the last dollar. How much more important when a life, not an estate, is at stake!

I have had patients to consult me for an operation and after a painstaking examination, going through the history, the physical and the laboratory findings, advised that they were not good surgical risks and that any life was better

*Read before the National Medical Association Convention, at Newark, N.J., August, 1929. At the time of the reading of this paper, Dr. Reeves was chairman of the Surgical Section of the National Medical Association.