collectively, as they see fit, without let or hindrance, except as they violate the provisions of the medical practice act of the State, or commit gross breaches of ethical conduct; in which latter instance they lay themselves liable to citation before the constituted authorities of their fellows, to explain why they choose to jeopardize the scientific and ethical standards of their guild, and its capacity to adequately serve the people.

* * *

During the past year these changes affecting the California carbuncle on the body of the American Medical Association have occurred: The American Medical Association has become more lenient toward California experiments in the relation of doctor to patient; California doctors were scared away from drastic changes in ethics by Upton Sinclair's EPIC. Doctor Coffey hopes that by "playing ball" with the American Medical Association that organization will fulfill his dearest wish and agree that he has cured many a case of cancer with hypodermic injections of extracts of adrenal cortex.

"California carbuncle" must be put down as strained effort of cheap and inapt smartness, to which a number of *"Time's* editors, ablest historians of our day" (if one may refer to the radio laudations of their merits), seem obsessively addicted.

We believe that the California Medical Association, one of the largest and best organized constituent state associations of the American Medical Association, far from being a carbuncle on the body of the national organization, is a state unit of which the American Medical Association is and has just right to be proud.

The "leniency of the American Medical Association toward California experiments in the relation of doctor to patient" is a nonsensical statement, because the national organization is too busy with its own important work to meddle with a state unit's studies of the attitude of physicians to their patients.

When the "able historian" who conducts the "Medicine" department of *Time* has the presumption to print, "California doctors were scared away from drastic changes in ethics by Upton Sinclair's EPIC," his superficial and senseless twaddle are more obvious than ever.

Why Doctor Coffey should be dragged in by *Time,* as in the concluding sentence of the last quotation, is beyond our ken, and to every member of the California Medical Association who knows aught about its organization work, or that of the American Medical Association, the reference must sound like mere moonshine and balderdash.

* * *

Question Arises of Diagnosis of the Mental Condition of the Magazine's "Medical Editor." —Within a day or two after the issue of *Time* for April 20 reached California, several colleagues called our attention to the article quoted, on which these comments are now made. If *Time* were a publication of lesser circulation, it would be questionable whether any statement, in relation to the California Medical Association and several of its members, would be deserving of the space here given. When one remembers, however, the emphasis which radio announcers place on the so-termed accuracy of *"Time's* editors, the ablest historians of our day," then the declarations seemingly made in great earnestness by that magazine's contributor or editor on matters medical, must amuse California and other physicians—who actually know a good deal about the matters discussed—as being little less than farcical and laughable. We would observe also that, if we felt the statements made in other departments of that publication were as far from the truth as are those to which our remarks are directed, we should promptly cancel our own subscription, and quite as quickly cut off the broadcasted "March of Time" if, by chance, the radio brought it to our ears.

However, *Time's* "medical editor," when "up against it" for copy, may have been indisposed through illness—or, who knows, for some other cause—or may even have been absent from his desk, making it necessary for friend or office boy to "pinch-hit" and help him out; for any one of which or similar reasons, he might possibly be excused. Nevertheless, if in future the articles on "Medicine" in *Time* are such babblings as those excerpted, then we shall religiously avoid perusing the stuff, although presuming that the magazine hires the "medical editor" to portray the medical history of the day, and in far better form than that to which expression is given in the periodical's issue of April 20.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 407.

EDITORIAL COMMENT†

ARTIFICIAL FEVER AS A THERAPEUTIC PROCEDURE

The use of artificially produced fever has become an established therapeutic procedure for the treatment of certain diseases. There is a constantly growing list of conditions for which pyrotherapy has proved beneficial. It is of particular value in the treatment of syphilis of the central nervous system, especially paresis, tabo paresis, and tabes dorsalis. In other forms of neurosyphilis which fail to respond to drug therapy, artificial fever is a valuable adjunct. Fever therapy is indicated in gonorrheal arthritis, epididymitis, and resistant urethral and prostatic infections. The effects upon gonorrheal arthritis are striking, the pain and swelling responding promptly. In other types of arthritis, in multiple sclerosis and leprosy, irregular results have been noted with

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

fever therapy. The field of pyrotherapy is gradually extending, and its exact place in therapeutics should be determined by careful trial in various conditions.

Interest in artificial fever therapy was stimulated by the brilliant results obtained by Von Juaregg in 1918 in the treatment of general paresis with artificially induced malaria. Many other methods of producing an artificial fever have been introduced since that time, including inoculation with the parasites of relapsing fever and rat-bite fever, injections of vaccines and foreign proteins; injections of sulphur in oil, diathermy and radiothermy; electric blankets and heat cabinets; hot baths and the blanket method. As comparable therapeutic results can be obtained with any method which produces an adequate fever, it is generally agreed that the fever is the essential factor in the procedure rather than the way in which it is produced.

The exact manner in which artificial fever exerts a favorable influence is not known. In syphilis there is a direct effect upon the Treponema pallidum. Other factors which are not wholly understood may also play a part.

Hyperpyrexia can be produced by preventing radiation of body heat through simply wrapping the patient in blankets and adding heat from an external source. The body temperature rises to the desired height of 40 degrees centigrade (104 degrees Fahrenheit) within two hours. It can be maintained in this way as long as desired. This method has been described in a recent issue of the *Journal of the American Medical Association*.[1] In the treatment of syphilis of the central nervous system, five hours of fever of 40 degrees centigrade (104 degrees Fahrenheit) is regarded as one treatment. This is repeated weekly for ten weeks, a course of fever consisting in fifty hours of temperature at 40 degrees centigrade (104 degrees Fahrenheit).

While artificial fever can be produced easily in this way, it must be fully realized that fever therapy has certain dangers. The patient selected for the treatment should be in good physical condition. Any serious physical defect is a contraindication to fever therapy, such as advanced age, debility from any cause, hypertension, cardiac disease, tuberculosis, obesity, etc. The candidate for artificial fever should be physically able to stand a major abdominal operation.

Artificial fever therapy should be given only by nurses and physicians trained in this work, and only in properly equipped hospitals. This treatment is a hospital procedure, requiring twenty-four hours' hospitalization. With careful selection of patients, and under conditions as suggested above, artificial fever, for therapeutic purposes, can be induced with safety.

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1 Epstein, N. N., and Cohen, M.: The Effects of Hyperpyrexia Produced by Radiant Heat in Early Syphilis, J. A. M. A., 104:883 (March 16), 1935.

PULMONARY TUBERCULOSIS: THE NEED OF EDUCATION FOR THE GENERAL PRACTITIONER IN ITS DIAGNOSIS AND TREATMENT

That the general practitioner needs further training in the diagnosis of pulmonary tuberculosis is very apparent to those working in a general tuberculosis hospital. We see here the incorrect diagnosis of patients referred either to the hospital wards directly or to the chest clinic. At the San Francisco Hospital on the University of California tuberculosis service during the month of October, 1935, fifteen new patients were sent in to the chest clinic diagnosed by their private physicians as having pulmonary tuberculosis. Of these patients, only five actually had pulmonary tuberculosis. In other words, ten patients (60 2/3 per cent) were incorrectly diagnosed.

Too frequently the following happens: The patient comes to us with a history of long-standing cough and sputum. After making the diagnosis of advanced pulmonary tuberculosis, comes the natural inquiry, had he never before consulted a physician? Oh, yes, he had consulted several physicians, who had diagnosed bronchitis and who had given him various prescriptions for his cough. Indeed, there are many patients who state that no examination of the chest was made at all. In some of these "bronchitis" cases, not until the patient has hemoptysis does the physician suspect tuberculosis. Even with hemoptysis as the onset of the disease, many patients, in the absence of physical signs in the chest, are told to go home and "forget it"; that the hemorrhage was due to the "rupture of a delicate vein in the throat." We sometimes see patients with a gastro-intestinal onset treated as "dyspeptics," or the fatigue and nervousness of the tuberculous patient are regarded as symptoms of neurasthenia. Vomiting after cough, a symptom emphasized as almost pathognomonic of a lung lesion to the third-year medical student, is treated as "gastritis." The underlying disease is overlooked.

Hazardous as is the failure to diagnose tuberculosis, equally hazardous is the tendency to diagnose every suspect as active tuberculosis. Almost daily we find patients with pulmonary symptoms or unexplained loss of weight, due to other diseases, branded as tuberculous. Often physicians, because of a suspicious symptom, have sent patients to warm climates or other meccas for the tuberculous; families have been broken up and patients have lost their positions unnecessarily. How often, after having spent months in sanatoria, have patients been found to be nontuberculous! But too much blame should not go to the general practitioner. Consider the large proportion of the nontuberculous patients who are admitted and kept in sanatoria, as well as the large number of patients who are "cured" after only two or three months in these institutions. This applies especially to the patients with negative or no sputum. The general practitioner can point out that the specialist himself is not infallible.

But even in the correctly diagnosed cases, results are sometimes tragic. No effort is made to