fairly constant, having been observed in ten out of the eleven cases of the morphin series. In the one exception, the case which received the largest dosage, and the only one in which contraction of the pupil was noted, no effect whatever was shown by the small bowel. In one of the ten positive cases, which was examined twice, a single dose produced no appreciable effect, but at the second examination when the dose was doubled, there was a noticeable delay. In another of the ten cases a hypermotility was lessened. In nine of the ten cases showing delay, there was evidence of this in the upper portion of the bowel.

Experience has shown that our method was not the ideal one for studying the effect on the large bowel, although our results were very much the same as those of others. As a rule this part of the tract was studied at the end of the examination, after the active influence of the drug had subsided partially or entirely. A more accurate method would be to administer the drug at about the time the cecum was filled and the terminal ileum nearly empty — from six to eight hours after the meal in the average case. This was the procedure followed by Arnspurger.⁶ His results were very variable, however, with different doses and with different individuals given the same doses. Stierlin and Schapiro⁷ found that morphin had no effect of any consequence on the large bowel.

In all of our cases the large bowel was studied in connection with the tract higher up. Our conclusions were based mainly on the relative position of the head of the opaque column as compared to the control. The colon was studied in ten cases, and a noticeable delay in the head of the column was observed in six, and no apparent effect in three, two of which received small early doses and the other case which received the largest dose of any. In one of the ten, delay was doubtful.

So far as we were able to judge, it made little difference whether the morphin was administered by mouth or subcutaneously. The only accurate way to determine the relative effect of varying dosage would be to examine the same individuals repeatedly with increasing doses, as small or single doses in one individual may produce the same or a more marked effect than large or repeated doses in others. Of the two sexes, females seemed to be more susceptible.

CONCLUSIONS

The Roentgen examination is a valuable method of studying certain phases of drug effects on the gastrointestinal tract, especially motility, and the knowledge it furnishes can be gained better by this method than by any other.

Our observations were made in a series of eleven cases given morphin and one heroin habitué. While we have been able to duplicate the phenomena observed by others, with one exception, there was a decided lack of uniformity in the effects produced in different individuals, in connection with both stomach and bowel.

There is no distinct uniformity in connection with dosage. Small doses in some may produce more marked effects than much larger doses in others. Females appear to be more susceptible.

In the stomach a rather high spasmodic hour-glass contraction is observed rarely, but we have not seen this near the pylorus as described by others. In some instances the stomach may show no appreciable change from normal. In most cases there is more or less

pyloric spasm, increased peristalsis and a decided prolongation of the emptying time.

In the small intestine, morphin causes decreased motility almost uniformly, apparently as a result of a lack of propulsion and not of spasm. When marked, it is most noticeable in the upper small bowel.

The effect on the large bowel is very variable and probably of little consequence.

Oral administration produces practically the same effect as subcutaneous injections.

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THE ENDOWMENT OF CHILDHOOD FROM THE OBSTETRIC STANDPOINT *

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The present era in the practice of medicine, like the preceding periods, is one of transition, and the goal, the conservation of health and the prolongation of life, is hampered by ignorance, mysticism, superstition and exploitation. The beacons of scientific investigation, clinical observation and experience, however, are steadily revealing the mysteries of Nature, and are thereby enriching our knowledge in the alleviation, prevention and cure of disease. Down through the ages each period has contributed more or less to this progress, and we are not unmindful of the rich heritage we enjoy in the possession of the accumulated knowledge and treasures of our predecessors which form the granite ground-work of the art and science of medicine.

Each era has been distinguished for some epoch-making contribution. Ours is particularly noted for the development of an aseptic technic which has revolutionized the practice of surgery and obstetrics. We were present at the christening, if not the birth, of that science, bacteriology, which has placed preventive medicine and sanitation on a rational and enduring basis. A half century ago the practice of surgery was mostly of an emergency character, caring for fractures, dislocations, gunshot wounds, etc., while today three fourths of the operations are elective and cover a wide field of application. "No cavity is now too deep and no organ too important or vital to deter from direct interrogation. By vision and tact, the gravity, density and magnitude of any, of every part, may be revealed to the sensorium and adjudicated by the unerring edict of positive knowledge."¹

The more important advancements in obstetrics as the result of these recent developments are the awakening interest in prenatal care and the prevention of infant mortality, the practical abandonment of craniotomy on the living child, and the broadened indications for cesarean section.

In my previous address² on "The Endowment of Motherhood," I made a plea for better obstetrics in general practice, and expressed the belief that the solution lies in more intensive training of the students in practical obstetrics and educating the public to the necessity of efficient care of woman in the most important epoch in her life.

* President's address, read at the meeting of the Washington Obstetrical and Gynecological Society, Oct. 8, 1915.

1. Miller, DeLaskie: *Tr. Ninth Internat. Med. Cong.*, ii, 302.

2. Moran, John F.: *The Endowment of Motherhood*, *THE JOURNAL A. M. A.*, Jan. 9, 1915, p. 122.

Of course, accrued benefit to the unborn child was implied in this advanced obstetric teaching and practice, but I wish now to direct attention more specifically to what has already been accomplished regarding its welfare and the prospective possibilities of the future.

The importance of the subject does not arise from the frequency with which its problems are presented but from the grave emergencies created by them—emergencies which demand early recognition and prompt decision by the physician in that they involve the lives of the mother and child, as well as points of professional honor and conscience.

The longer I practice obstetrics, the more deeply I am impressed with the difficulty which often presents itself of deciding when to interfere and what particular method of intervention to elect. In no other field of medicine is a well-balanced judgment and skill more requisite for success; and not infrequently, even then, the result is fortuitous.

"When it is realized that practically 38 per cent. of the deaths under 1 year of age are due to causes mainly dependent upon the health and condition of the mother during pregnancy and confinement; that within the registration area of the United States of 154,373

hopelessly handicapped for life's struggle, while many more perish through ignorance and neglect.

The illuminating papers of Williams,⁴ and Holt and Babbitt,⁵ on institutional infant mortality incident to childbirth and the two weeks following, show on careful analysis of 10,000 consecutive cases by each reporter how a very large percentage of the mortality could have been averted by intelligent supervision of pregnancy and competent care during labor.

TABLE 2.—STILLBIRTHS (INCLUDING ABORTIONS)

Cause	No.	Per Cent.
Unknown	342	47.4
Congenital syphilis	84	11.7
Accidents of labor (difficult and prolonged, 50; prolapsed cord, 64; cord around neck, 5; knotted cord, 4)	123	17.1
Toxemia and eclampsia	34	4.7
Asphyxia	35	4.7
Accidents (violence)	28	3.9
Monsters	6	.8
Placenta praevia	30	4.1
Accidental hemorrhage	23	3.2
Miscellaneous	11	1.5

TABLE 1.—CAUSES OF DEATH FOLLOWING CONFINEMENT

Cause	No.	Per Cent.
Prematurity	250	40
Inanition	99	15.8
Accidents of labor	34	5.4
Atelectasis	30	4.8
Asphyxia, pallida	21	3.3
Asphyxia, accidental	11	1.7
Patulous foramen ovale	11	1.7
Congenital syphilis	22	3.5
Hemorrhage of the new-born	26	4.1
Enteritis	40	6.4
Pneumonia	19	3
Toxemia	12	1.9
Convulsions	12	1.9
Malformations	9	1.3
Miscellaneous	27	4.3
	623	

infants under 1 year of age, who died in the year of 1910, 14,964, or nearly 10 per cent., lived less than one day; that 36,351, or practically 23.5 per cent., lived less than one week, it will be seen that the infant mortality problem cannot be solved adequately by any measures which leave out of their scope some attention to the care of the expectant mothers." Since the foregoing sentence was written, the mortality statistics for 1911, issued by the Bureau of the Census, show a more distressing situation than was revealed by the figures of 1910. With an increased death registration area (now covering 63 per cent. of the total population), there was a decrease in deaths of children under 1 year to 149,322 as against 154,373 in 1910. But those who lived less than one day increased not only relatively but also absolutely, that is, from 14,946 in 1910 to 40,883, or 27.4 per cent., in 1911. These figures show that the efforts made to save babies through pure milk and more intelligent care have produced results, while lack of organized effort to reach prenatal conditions for a very considerable period or over any extended area has further emphasized its need.³

These figures of the death toll of early infancy are appalling; and show that besides the unavoidable mortality incident to childbirth, many infants are born

In this connection I wish to invite attention to a summary of a review of 10,533 confinements which occurred in the obstetric service of Columbia Hospital from July 1, 1876, to June 30, 1915. They were divided as follows: stillbirths (including abortions), 716; living births, 9,817.

The hospital is open to the profession. All classes are received. More than 60 per cent. are admitted in labor, and over 70 per cent. of the confined are colored. The free patients are discharged on the eighteenth day, though in case of illness the time is extended to meet the requirements.

It will be observed from the tables that the "unknown" forms the largest contingent of fetal

TABLE 3.—GENERAL MORTALITY

Cause	No.	Per Cent.
Unknown	342	24
Prematurity	250	18.5
Accidents of labor	157	11.7
Syphilis	106	7.9
Inanition	99	7.9
Asphyxia, pallida	56	4.1
Asphyxia, accidental	11	.8
Patulous foramen ovale	11	.8
Toxemia and eclampsia	46	3.4
Enteritis	40	2.9
Placenta praevia	30	2
Accident (violent)	28	2
Hemorrhage of the new-born	26	1.9
Atelectasis	30	2
Accidental hemorrhage	23	1.7
Pneumonia	19	1.4
Malformation and monsters	15	1
Convulsions	12	0.8
Miscellaneous	38	2.8

deaths—nearly 50 per cent. of the stillbirths and 24 per cent. of the total infant mortality. This is because diagnosis was usually based on clinical data and often incomplete history, and frequently because a satisfactory explanation was wanting. Routine Wassermann, other laboratory tests and necropsies would surely have proved many of this group to have been due to syphilis. Bearing on this point, the following data furnished me by Mr. Peter, the pharmacist, is of much

3. Baby Saving Campaigns, p. 381, Infant Mortality Series, No. 1, Publication 3, Children's Bureau, U. S. Dept. of Labor.

4. Williams, J. Whitridge: The Limitations and Possibilities of Prenatal Care, THE JOURNAL A. M. A., Jan. 9, 1915, p. 95.
5. Holt, L. Emmett, and Babbitt, Ellen C.: Institutional Mortality of the New-Born, THE JOURNAL A. M. A., Jan. 23, 1915, p. 287.

significance. Of 171 Wassermanns done in the past four years in the obstetric department, 113 were positive, and out of this number thirty-five, or 30+ per cent., were stillbirths. Out of the fifty-eight negative reactions there was only one stillbirth. It would probably be a safe estimate to say that at least 40 per cent. of the unknown stillbirths was caused by syphilis.

Prematurity, syphilis, inanition, atelectasis and toxemia constitute nearly 70 per cent. of the total mortality, and are independent of labor. These factors influence pregnancy disastrously, and yet are largely preventable and amenable to well-directed treatment.

The causes intimately connected with intrapartum mortality are malpresentation, forceps operations (asphyxia and intercranial hemorrhage), placenta praevia, ablatio placentae, rupture of the uterus, eclampsia, tetanic uterine contractions, etc., and were responsible for 18 per cent. of the fetal deaths.

It is difficult to estimate the probable percentage of this group that might have been saved, because many operators officiated and naturally the judgment and skill varied accordingly. I know, however, from personal experience and observation, extending over a number of years, as intern and member of the visiting staff, that I and others were responsible for some of the mortality because of errors of judgment and execution.

Pneumonia and enteritis were the most frequent mortality factors after confinement, and with the miscellaneous and accident groups made up 9 per cent. of the total, while hemorrhages of the new-born and malformations and monsters yielded 3 per cent.

This summary emphasizes the indubitable fact that there is a needless sacrifice of infants because of the neglect of prenatal care, and that early recognition of abnormal conditions and timely intervention would have averted many of the intrapartum disasters.

The public should be taught that the risks attending parturition can be, for the most part, avoided by intelligent oversight of the parturient; by preparedness for rendering aid when needed no less than by masterly inactivity when normal.

Much good is being accomplished by the various organizations engaged in the welfare of motherhood and childhood, by stimulating general interest in the cause and securing lay and professional cooperation; but if this much to be desired beneficence is to become nation-wide, the checking and follow up system can be satisfactorily done only under state subsidy and control.

For some inscrutable reason, the life of the child has been held to be of unequal value compared with that of the mother, and in complicated childbirth, when both lives are in jeopardy, the child is to be sacrificed. This is contrary to natural law, according to which all lives are equal; and furthermore, science has shown that this dictum is untenable in that there is no conflict between the life of the mother and the life of the child, and the direct sacrifice of either in the interest of the other can be defended, if at all, only on the ground of expediency and not on the claim of justifiability.

Expediency is a subterfuge used to subordinate right and justice to might and convenience, whether it be in the stifling of a human life in its inception by that heinous crime of convenience, criminal abortion, or the deliberate taking of a life in the fulness of its development and when ready for external existence by a destructive operation.

The passing of craniotomy on the living child is one of the greatest triumphs of modern obstetrics—a veritable turning of defeat into victory. Practiced almost from the dawn of civilization, down through the centuries, this mutilating operation is happily being supplanted by humane methods of intervention that have for their purpose the saving of both lives.

In this connection, I quote from the recent interesting paper of Dr. Wall.⁶

It cannot be charged against us, as it was in the earlier days of medicine, that the interests of the child are entirely subservient to those of the mother. The abandonment of craniotomy on the living child was an acknowledgment of infantile rights, which, thanks to modern advancement in medical science, have attained a station hitherto unknown, so that the mortality of the child is mentioned in the same breath with that of the mother in almost all obstetrical conditions and procedures.

I am of opinion that there is still room for improvement in judging the rights of the unborn child, and there are certainly enormous opportunities for advancement in the consideration and attention bestowed on the little individual after birth.

It is to the honor of this society, dedicated to the cause of motherhood and childhood, that its first anniversary (1883) was made memorable in the defense of the rights of the unborn child. The president, Dr. Busey, in a trenchant and forcible address, challenged craniotomy on the living child as being unethical and unscientific, and, in the light of medical progress, should be abandoned in favor of cesarean section and other conservative measures.

Until less than twenty-five years ago, cesarean section was rarely performed save for contracted pelvis, obstruction of the birth canal by tumors and in the case of sudden death of the mother, while today it embraces in its broadened scope not only deformities of the pelvis but also some cases of placenta praevia, eclampsia, disproportion between the size of the child and the pelvis, heart disease, ventrifixation, stenosis of the cervix and vagina, edema of the vulva and accidental hemorrhage; and a member of this society, Dr. Bowen, has recently advocated it for certain breech cases, particularly, in aged primiparas after a test labor, even though the pelvic measurements are normal.

I am in accord with this recommendation, for the usual methods of practice in this class of cases are attended with an infant mortality of from 10 to 20 per cent. In discussing the case reported by Dr. Bowen, I said:

Under the conditions mentioned with the patient showing signs of fatigue, evidenced by increased pulse rate, uterine inertia, etc., cesarean section was not only justifiable but a rational method of procedure, even though the pelvic measurements be normal. If the bag of waters were intact and condition of mother and child favorable, some would advocate further trial aided with sedatives. Instead of putting forth "the desire for a live child," I would make it stronger by substituting "the inherent moral and legal right of the child to be born alive." I had two somewhat similar cases recently in consultation, in one of which I resorted to slow extraction, against the better judgment of the attending physician, who suggested the advisability of cesarean section, lost the baby and got severe perineal laceration and colon infection. In the other case, classical cesarean section was done with happy results to mother and child.

6. Wall: The Status of the Child in Obstetric Practice, read before the Washington Obstetrical and Gynecological Society.

In the complications that confront the obstetrician, there is none that is fraught with more danger or attended with greater anxiety than placenta praevia, save perhaps eclampsia. Its sudden manifestation, often alarming hemorrhage and consequent anemia, shock and possible infection present a formidable array of difficulties that even in the hands of the most skilled has been attended with a high maternal mortality. It is true that in recent years, with more definite method of treatment and advances of antisepsis and sepsis, the maternal death rate has been greatly lessened, but the extraordinarily high proportion of infants lost remains unchanged.

If we analyze the statistics, we cannot fail to recognize that it is the lateral and marginal varieties that have contributed largely to this improved showing by directly sacrificing the life of the child by using it as a plug to control the hemorrhage. In central implantation, modern methods have not materially affected the death rate. It was quite natural, then, that other measures would be evolved with the hope of reducing the frightful infant mortality, while still not increasing, if not improving the chances of the mother. Hence for more than two decades, from time to time, the justifiability of cesarean section in certain cases of placenta praevia, in the interest of the child as well as the mother, has claimed the attention of the profession. Some have recommended it on theoretical grounds, with the conclusion that it is not only justifiable, but also indicated in central implantation of the placenta. On the other hand, there are those who are equally positive in their belief that cesarean section has no legitimate field in placenta praevia, contending that the mother's life is of paramount importance; and further, that many of the infants will of necessity be born prematurely and likely to succumb at birth. The physician has no moral right to decide between the value of two lives, nor is he in conscience capable of determining whether the child will survive or not. Both are his patients, entitled to his best skill, and he is in honor bound not to deliberately sacrifice the life of one to save the other.

The induction of premature labor, though offering little danger to the mother, is opposed on the ground of fetal mortality. Besides, it is not an easy matter to determine the time for intervention, and the widest experience and most painstaking study and keenest mechanical sense are requisite for successful issue of this operation.

Expediency rather than fitness is often the determining factor in choosing the method of intervention in obstetric practice. The physician without surgical bent or training relies on such measures which, while usually safeguarding the mother's welfare, are often inimical to the interests of the child. How often do we see cases of delivery by forceps or version in which the child is sacrificed at birth or dies within a few days afterward of cranial hemorrhage? It is with the borderline cases that we have so much difficulty, and they require the most exacting care in deciding how best to act in the interests of both lives. The great mistake that many make is to apply forceps in cephalic presentations regardless of position and whether the head is engaged or not. The cardinal rule is that forceps should never be applied to a head that has failed to enter the brim of the pelvis, for in a very large percentage of cases disaster will be almost sure to follow.

I do not wish to be understood as in any way underestimating the value of forceps, version and the induc-

tion of premature labor, as they have their field of usefulness; nor am I unmindful of the fact that in the majority of cases the children would deliver themselves unaided; but what I do advocate is that more attention be given to the patient during pregnancy and that at the appropriate time a careful and thorough examination be made so as to be prepared to intervene at the proper time in the interest of both mother and child.

During the past year considerable attention has been given to *Dämmerschlaf* or "twilight sleep" in the medical and lay press. The Freiburg method was tried out in this country nearly a decade ago and practically discarded. Through the restatement of the method by one of the proponents, reiterating its claims for producing amnesia in labor, and the prompt exploitation of the address in a lay magazine article, the interest in the treatment has been reawakened, and the method is again being given a trial in several hospitals and by others. It matters little whether the lay propaganda is due to the alluring euphony of "twilight" or to commercial cupidity, when compared with the duty of the profession to settle definitely whether the method possesses the value claimed for it. This the searchlight of experience will determine, and the profession will before long be able to decide if it is to fill a much desired want in obstetric practice or share the fate of spinal analgesia.

With a view of learning of the status of *Dämmerschlaf* in Germany and elsewhere in Europe, I wrote to Professor von Heff, director of the Frauenspital, Basel, Switzerland. He replied as follows:

I do not employ *Dämmerschlaf* (twilight sleep) because it requires constant supervision, also because it excites a number of the patients, and in my judgment the infants are likewise endangered. Years ago I made experiments which did not satisfy me. The results are given by von Dietschy, whose article I send you. In a large maternity like this where the lying-in women cannot be isolated, the treatment is, according to Krönig, contraindicated. So far as I can see, *Dämmerschlaf* is little used in Switzerland. If used at all it is by physicians who have private clinics, hence "painless labor" is to them a valuable advertisement. In Germany also one does not enthuse greatly, and I believe the majority of my colleagues decline this method, for example Fehling. In isolated cases, quite naturally, it is of service.

This criticism, from the knowledge I have gathered from the current literature, is very fair. That scopolamin will produce amnesia is conceded, but its utility and freedom from danger are not generally accepted. Reports of its indications and limitations are accumulating, and the almost universal discordant note is that it is not without danger to the child. Dr. Mundell has kindly placed at my disposal the replies of eight of the leading obstetricians in this country to whom he wrote asking advice regarding the use of the Freiburg treatment. Those who favor its use restrict it to the first stage, and all but one emphasized its danger to the infant.

There has been much undeserved criticism of those investigators who insist that the treatment should be given only by an expert. The fact that it should be administered only by one who has had experience and that it is not feasible in general practice will, if for no other reason, operate against its general adoption.

The field of obstetric practice has rarely been invaded by the quack, the work being too arduous and unremunerative; but the physicians who for mercenary considerations are imposing on the credulity of their

insistent patients for the Freiburg treatment, by giving them "near" twilight sleep, are courting charlatanry.

Obstetrics appears, as it passes before the mental vision, like a panorama of light and shade. Supposed discoveries in the science and improvements in the art illuminate the scene, till the crucial light of experience casts a shadow of disappointment over the factitious light. We seek the truth. Physicians know too well that the search is surrounded with difficulties, for we advance along the asymptote of the hyperbola; though we have not attained the absolute, we are approaching the object of our quest.¹

There are still many problems in obstetrics to be solved, including a remedy that will produce amnesia in labor or preferably eutocia, at will—*tuto, cito, jucunde*, safely, quickly, pleasantly. Meanwhile let us continue to mitigate the pangs of labor with the measures which in succoring the mother do not jeopardize the life of her child.

The keynote to decreasing the appalling infant mortality is good obstetrics, and the watchword is efficiency—efficiency in prenatal care—so that at the time of birth, mother and child shall be in the best possible condition, and efficiency in the conduct of labor, whether it be in the rôle of "watchful waiting" or masterly activity, in order that the child shall be assured its inalienable right to be born alive and healthy, and the mother safeguarded to a successful and happy fruition of her noblest mission in life—maternity.

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WHERE CHIROPRACTORS ARE MADE

THOMAS F. DUHIGG, M.D.

DES MOINES, IOWA

As the season for legislation approaches, I feel that the information I have concerning chiropractors should be put at the disposal of those interested in guarding the public health and maintaining respectable educational standards. The chiropractor's machine-made bills will be introduced into the legislature of every state where they have not received recognition.

Iowa schools of chiropractic probably graduate more than the schools of any other three states. Davenport is called the home of this sect; but Iowa does not recognize chiropractors, and they are liable to a fine of \$300 if they practice here. Obviously they swarm to other states, in some of which they are permitted by law to practice, and in others they are merely tolerated. It strikes us as peculiar that other states, some with high educational standards, should take large consignments of our "graduate" chiropractors who have graduated from schools which require no preliminary qualifications and which have no libraries or hospitals—graduates of schools without any standing, inspected by no one, regulated by no one and conforming only to their own low estimate, which refers entirely to financial and not at all to scientific standards.

After reading the reports of the inspector of the state of Pennsylvania, I believe the forty-seven other states will exclude the graduates of the Iowa schools of chiropractic the same as Pennsylvania has done. This report is remarkable in that it was made by one outside Iowa and in the interest of the health of the people of a far distant state. It is a testimonial to the care and judgment exercised by the officials of the

great commonwealth of Pennsylvania in safeguarding the lives and health of those they are sworn to protect. Likewise it is an indictment of the officials in all those states which have accepted these graduates without first having made a careful inspection and ascertained the extreme wretchedness of the physical equipment of the schools and the mental equipment of their graduates.

The accompanying tabulation gives the reports on the three schools of chiropractic at Davenport, Iowa, made by the inspector of the Pennsylvania Bureau of Medical Education and Licensure.

CHIROPRACTIC COLLEGES OF IOWA

A TABULATION FROM REPORTS OF THE INSPECTOR OF THE
PENNSYLVANIA BUREAU OF MEDICAL EDUCATION
AND LICENSURE

	Davenport College	Universal College	Palmer School
Buildings	One, an old church.	One fair size	Four (crowded)
Access to hospitals...	None	None	None.
Dispensary facilities..	Saw no evidence of	Ample *	
Admission requirements.	None	Common school	Common school.
Anatomy, dissecting...	Not taught.	Dissect a few dogs	Only dogs dissected.
Histology	No equipment	Didactic only	Very incomplete.
Embryology	Not taught.	Not taught.	Not taught.
Surgical anatomy.....	Not taught.	Not taught.	Not taught.
Physiology	Didactic only	Lectures only	Lectures only.
Physiologic chemistry.	Not taught.	Lectures only	No equipment.
Chemistry, inorganic and organic.	Not taught.	No practical work done by students	No equipment for teaching.
Pathology	*	*	*
Bacteriology	Not taught.	Not taught.	No equipment.
Pharmacology	Not taught.	Not taught.	Not taught.
Microscopic diagnosis.	Not taught.	Not taught.	Not taught.
Medicine	Not taught.	Not taught.	Not taught.
Pediatrics	Not taught.	*	*
Nervous and mental diseases.	*	*	*
Surgery	Not taught.	Not taught.	Not taught.
Anesthesia	Not taught.	Not taught.	Not taught.
Gynecology	Not taught.	Not taught.	*
Eye, ear, nose and throat diseases.	Not taught.	*	*
Dermatology and genito-urinary diseases.	*	*	*
Class rooms	One	Two	Four.
Clinical amphitheater.	One large room		Two.
Medical library.....	None	Small	None.
Microscopes	None	Two	Twelve
Having oil immersion.		One	One.
Reflectoscopes	None	Yes	Yes.
Stereopticons	None	Yes	Yes.
Obstetric manikin.....	Part of one	Yes	Yes.
Maternity work.....	Not taught.	Not taught.	Lectures only.
Charts	A few.....	Large supply	Large supply.
Models	None seen.	Yes	Yes.

* This subject is taught only from the chiropractic standpoint, as it is related to certain spinal "lesions."