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ADDRESS OF THE PRESIDENT OF THE ONTARIO MEDICAL ASSOCIATION.

AT THE ANNUAL MEETING HELD IN TORONTO, JUNE 4TH AND 5TH, 1902.

BY DR. NEWTON A. POWELL.

GENTLEMEN,—To utter words of kindly greeting is always a grateful task, and to-day it becomes my pleasant duty to welcome you to the twenty-second annual meeting of the Ontario Medical Association. To all of you—to our guests, to old friends, and to those who are with us for the first time—I offer a greeting which is none the less sincere because it happens to be official.

The Ontario Medical Association may be fairly taken as representative of what is best and most progressive in the profession of this Province. This being so, I would be an ingrate indeed if I did not, first, before all else, thank you for the evidence of good-will shown in your having bestowed upon me for this year the office of President. Being deeply sensible of this kindness, the selection of a topic to which I might with advantage invite your attention, has weighed heavily upon me. If one could have been found, the intrinsic interest of which would more than have atoned for my own imperfect presentation of it, then indeed I should have felt a measure of contentment. I can claim no marked success in the quest for a subject such as this, but a number of topics seem to have sufficient interest to justify their discussion in your presence. The first of these has to do with the bearing of recent and of pending legislation, Dominion or Provincial, upon the welfare, the rights and the prospects of Ontario physicians. Before entering upon any consideration of these matters, it is just as

well that we should put aside the modesty with which we have for a long time been tongue-tied and claim boldly that in regard to the regulating of the study and practice of medicine by legislation, this province has been and still is in advance of any other province or state on this continent. More than this, our methods of conducting examinations by a Board representing all the interests concerned, and having the sole power to confer licenses for practice, while it has served as a model for the organization of many State Boards, is still better than any other. Our examinations have been and are more exacting and searching, and our standards are higher than those of any other state or province. The influence for good which has thus been exerted cannot easily be computed. It is quite true that upon paper examinations have been set which would appear to present greater difficulties for students, but the percentage required for a pass and the proportion of candidates rejected have uniformly been lower than has obtained with us. Numberless students who, after being graduated here, have passed some one or more of the better class of State examinations in the United States, or have taken degrees in our own mother country, testify to this fact. Their uniform report is that our examinations present greater difficulties than any other. The net result of the operation of the Ontario Medical Act of 1869 and of amendments thereto has been that there is to-day in this province a profession of which we can justly feel proud, and that scattered over the world are countless progressive and successful physicians who, having been trained here, *owe no small measure of their success to the fact that for* more than thirty years the medical colleges of this province have had to teach up to the requirements of a rigid State examination. We are proud of this record as a record, but what has been done is of importance mainly as indicating what better results may still be attained. Where we stand on any question or what we have done, is of less importance than the direction in which we are moving. We are facing a wonderful to-morrow! The measureless growth of the medical sciences within recent years imposes upon us grave responsibility for the future, and we cannot afford to "mark time" while other and even less favored states or provinces are progressing.

Claiming all that I have for the Ontario Medical Act, and for its influence upon the profession here, I am far from claiming that it is incapable of improvement, or that its provisions have always been wisely and judiciously administered. A long series of indictments could be laid against successive medical councils. If I were to undertake even an enumeration of the mistakes, the short-comings and the follies of these bodies, I

should have no time to discuss them. It is the part of wisdom to learn from the mistakes of others, and recognizing such mistakes, let us try for the future rather to avoid and correct them than to waste time in harping upon them. During the past winter a bill to amend the Ontario Medical Act was introduced into our Provincial Legislature by Dr. Jessop. In brief, this bill asked that the Medical Council should be composed entirely of the territorial representatives and that the universities, the medical colleges and the homeopathic faction should no longer have direct representation. Although without mandate from you upon the matter, I felt called upon to oppose this bill for reasons with most of which I need not trouble you just now.

Admitting, for the sake of argument that the homœpathics are over-represented, we still must remember that when our Act was passed, a direct bargain was made with these gentlemen, and that it should be carried out in good faith till changed by mutual agreement. Those who trade on the name of Hahnemann, or who, at a greater or less distance, follow his vagaries, are diminishing in number and in influence, and for us to drive them into making application for separate incorporation, and into the position of an oppressed minority, would be foolish in the extreme. As to the right of representation of the universities, actually engaged in the educational work of the country, and of the medical colleges, there can be no question. It does seem to me, however, that the members of the Medical Council who represent charters in abeyance, or universities having no direct interest in medical education, should no longer have the right to appear at the Council meetings, and that our Act should be amended so as to reduce the membership and expense to this extent.

Dr. Jessop's bill was thrown out with, I believe, a strong feeling on the part of the House Committee which dealt with it, that some such provision as this should become operative in the near future.

A measure of much greater importance to us is the one promoted in the Dominion House by Dr. Roddick, and providing for inter-Provincial registration. This measure has passed the House, been amended in the Senate and received vice-regal sanction. Members of this Association will recall the fact that Dr. Roddick strongly advocated his bill from this platform two years ago. They may not as easily recall the fact that I objected to the measure as being manifestly and disastrously unfair to Ontario. As then put forward the bill gave as large a presentation to Prince Edward Island, to Alberta and to other provinces with a few score of practitioners as to this province, with over 3,000 registered practitioners.

I am glad to say that the protest we raised was effectual, and that the Bill was redrawn with the representation arranged upon a more equitable basis.

An examination of the bill as it finally passed the Senate leads me to fear that it has been emasculated, and is now potent neither for good nor harm. I may be wrong in this estimate, and since the main object of the bill is such a desirable one, I should be glad to find myself mistaken. What we in Ontario must guard with zealous care is the standard which we now have. There must be no levelling down to meet the needs of schools in any other part of the Dominion. Pledges will not suffice, we must have the power to prevent its being done, and if we have such power and use it, I am exceedingly doubtful if we shall ever see the Act in operation.

During the session of the House of Commons just closed, the Canada Evidence Act of 1893 was amended so as to limit to five the number of expert witnesses who may be called on either side, in civil or in criminal cases when the consent of the judge for the calling of a larger number has not been asked for and obtained, before beginning the examination of the first witness to give opinion evidence. This, in my judgment, is a sensible enactment, tending to lessen but not competent to remove certain abuses which His Honor Judge Macdougall may touch upon in his address before you to-night. It will have some tendency to lessen the advantage which always goes with a long purse in litigation, but it appears to run counter to the statement which we have from the very highest of authorities that "in the multitude of counsellors there is safety."

The development and extension of cottage hospitals in very many of the cities and larger towns of Ontario, is a movement in the right direction and a natural outcome of the more complete and practical training which our students are now receiving. It has greatly increased the number of positions as house surgeon, now available, and these positions become year by year a more important factor in medical education. The status of the hospital interne in Ontario is a live subject, and in order that it may be studied from a view-point new to most of us, I have asked a gentleman who is still a hospital resident, and who is filling his position with advantage to his hospital and credit to himself, to read a paper on the subject at this meeting. I hope that he will take up the appointment of graduates in medicine, who, on account of our fifth or so-called clinical year, are still without the license to practice, that he will discuss the relation of these gentlemen to the administration of anesthetics, and most important of all that he will consider the advisability of the appointment of a certain proportion of the house surgeons of our larger institutions every six

months, with a graded service of eighteen months, instead of our present unsatisfactory plan of appointing all together once a year and for one year only. In recent visits to some of the surgical centres of the neighboring Republic, I was impressed by the fact that no surgeon whom I saw at work was doing better operative surgery than is being done here from day to day, but that the assistance given and the "team" work, if I may borrow a term from the campus, was far and away better than anything we see here. We have as good or better men to select from, but the present plans of appointment and terms of service do not give them half the chance they should have. Beside that, every operator is handicapped by having as his chief assistants men who have just been appointed, and by losing them when they are becoming trustworthy and helpful. A graded course with responsibility increased as experience is gained, and with the men who are lazy or inefficient weeded out at the end of the first six months, would be better for the residents themselves, infinitely safer for the patients and would help the surgeons who are operating to obtain the results they individually strive for. The first six months of such service would naturally be spent in performing the less responsible duties of the position, and during this time, in my opinion, the administration of anesthetics should be placed in other hands.

In another respect we appear to be falling behind the procession. While here in Toronto as I know, and in Kingston and London as I fully believe, excellent teaching is given to undergraduates in medicine, we have so far failed to make adequate provision for post-graduate instructions. As a consequence, gentlemen desiring review courses have been going in large numbers to Manhattan Island and to certain large towns in Pennsylvania, Maryland and Illinois. We have the men, the hospitals and the material to meet all needs, but they are not utilized as they might be. In the past professional jealousy was so keen and controversy so bitter that success would have been hardly a possibility. Now *laus deo* we know each other better, and out of mutual respect can come united and successful action. True, we are given to criticizing each other a good deal, but with rare exception, this is in the spirit of rivals rather than of antagonists. Old animosities are dying out and are not being replaced.

> "The teeming future
> Glorious with visions of a full success"

holds for us a grand, united and splendidly equipped school of medicine doing for the students of a coming time what in an imperfect and patchy way we are striving to accomplish now.

I have faith in that future, and in the men who shall sway

its destinies and believe that with absolute fairness to all real interests the wisest course can be found and followed.

The Reaper whose name is death has not been idle in the year that has passed since we last met. Your committee on Necrology will present the names of certain of our members who rest from their labors and whose memories we honor. Permit me to refer to two only of the number: Dr. John Coventry was President of this Association in 1899, and well and worthily did he perform the duties of his office. He died from the disease which cuts off, in the midst of their greatest usefulness, so large a number of physicians—from an acute pneumonia. Leslie M. Sweetnam, in the full tide of professional success and with an ever-widening circle of patients and of friends who appreciated his sterling worth, and who loved him for what he was as well as for what he did, fell a victim to blood poisoning received in operation,—I had almost said to a wound received in action.

In one of the songs which Homer chanted when the world was young, we hear Idomeneus crying to Nestor:

> "Worth many a life is his
> The skillful leech who knows with practiced hand
> To extract the shaft and healing drugs apply."

If this was true when men were wild and when human resources were few, how shall we estimate the value to the communities in which they practice, of wise and prudent physicians, honest to their own consciences and armed with all the aids which advancing science has placed in their hands. Looking further afield, we have to regret the death of a man who, with the possible exception of the elder Gross, did more for the development of surgical pathology, than any other surgeon in the new world. Christian Fenger was your guest three years ago, and those who met him only at that time will join with all who knew him more intimately in the belief that *he has made a lasting impression upon surgical science.* Recalling the fact that surgical pathology has progressed more rapidly than any other department of medicine—that, as has been truthfully stated, it has made more progress in the last thirty years than in the previous thirty centuries, we can appreciate the splendid work which this great investigator and teacher was able to crowd into thirty-five years of professional life. His work and the work of others like him will live. Their best knowledge will continue to be utilized for the benefit of mankind.

"Were a star quenched on high,
For ages would its light
Still travelling downward from the sky,
Shine on our mortal sight.

"So when a good man dies
For years beyond our ken,
The light he leaves behind him lies
Upon the paths of men."

The interest you have always shown in the Ontario Medical Library and the financial aid you have from year to year given towards the upbuilding of a working library for all the physicians of this province, leads me to mention that after the death of Dr. L. M. Sweetnam, his friend and our friend, Dr. Howard A. Kelly, of Baltimore, authorized me to select from Dr. Sweetnam's extensive library every book not already in the Ontario Medical Library, and these, to the number of about three hundred, he purchased and presented to us. He did this in order that the collection should be kept together and should form in some degree a memorial library. Dr. Kelly's action was a pleasant surprise to many who did not know him; all who have the pleasure of knowing him intimately recognized it as just another large-hearted, generous act such as he is continually doing. Dr. Osler's establishment of the Bovell Memorial Library in honor of an old teacher of his, was along the same line and may have prompted the later gift. I am glad to be able to tell you that through the generosity of the President of the Library Association, Dr. J. F. W. Ross, a catalogue of the principal works now upon our shelves is being printed and copies will shortly be sent to members of this Association. They will then be enabled to see what an extensive library has been accumulated and should remember that these books are at all times available to them without expense.

The continued presence of smallpox in Ontario, the large number of reported cases and their wide distribution are causes of regret, of alarm and of humiliation. Of regret on account of the loss of life, the direct expense and the indirect interruption of bread-winning involved; of alarm because the end of the outbreak does not seem to be as yet in sight and of humiliation because we appear to have taught the public less faithfully than our fathers did, the demonstrated fact that this disease can be controlled, and in times of epidemic can only be controlled by vaccination and revaccination. Two of the factors which increase the difficulty of stamping out smallpox undoubtedly are humbug vaccination, and a failure to make the differential diagnosis between this disease and chicken-pox. In regard to the first, let me cite the case of a girl exposed to so-called chicken-pox occurring in a man who had come here

from Cleveland. This man lied to his physician about his symptoms. I cannot use Browning's euphonism and say, "He fell from truth in climbing toward it." He knew that he had been exposed to smallpox, and that he had the symptoms of that disease, but to avoid being placed in quarantine he lied, and as a result his physician took smallpox and died from it. The girl referred to and one other member of a large family had certificates of vaccination, but no scars, and both took the disease. Both had been "vaccinated" by a physician who did not believe in Jenner's discovery, and who had used the uncharged ends of ivory points in performing the operation. Justice fails when a man who spreads smallpox is not made to atone, so far as he can, for his offence by serving a long term in the penitentiary. May I here raise the question of the necessity for a standard certificate of vaccination, stating the result obtained in each case, and may I in this connection also ask if the time has not arrived for placing chicken-pox on the list of diseases which must be reported to our medical health officers?

It is a matter for mutual gratulation that we have now available in our gloriously health-giving Muskoka region a hospital for the free treatment of fifty patients with incipient phthisis. If my own connection with this and with its sister institution, the Muskoka Cottage Sanitorium had been less intimate, I might have been tempted to say more regarding them. Old men are said to talk of what they have done, children of what they are doing, and fools of what they are going to do. As I am no longer a child, have not as yet begun to grow old, and cannot believe you would have placed one of the third class in the chief office of this Association, I am precluded from entering into any detailed statement at present. Instead, let me be content with extending, on behalf of the Board of Trustees of the National Sanitorium Association, and of my associates of its medical staff, a cordial invitation to each one of you to visit Gravenhurst at your earliest convenience, and to see for yourselves just what is being done. Let me assure you that the "latch-strings" there always hang outside for the members of this Association.

Perhaps from a professional standpoint the most regrettable incident of the year was the simultaneous publication in all of the Toronto daily papers of advertisements of the so-called "Ramage process" for the cure of phthisis as "demonstrated" at a private hospital here. The hospital in question is conducted by two of the members of this Association, and the advertisements to which I refer appear to set at defiance the code of ethics which we have adopted, and by which we profess to be governed. I would willingly have passed over, in silence

and in sorrow, these publications if it were not for the conviction that by so doing I would have shown a cowardly dereliction of duty. The medical men to whom I have referred are engaged in active practice, and are reputed to be wealthy. By their direct connection with flagrant advertisements of this character, they appear to have established a *prima facie* case against themselves. If they are right in what they have done and are doing, they should be given an opportunity of proving it and of removing the stigma that now rests upon them. The matter is one for consideration by our Committee of Ethics, and to this body I now officially transfer it, in the full belief that it will be dealt with fairly, courageously, and in a spirit of professional self-respect.

Before closing, it is only right that I should express my deep sense of obligation to the gentlemen who have labored so earnestly to make this meeting a success. In a time of political excitement like this I may refer to them as my cabinet, Dr. Parsons being Secretary of State; Dr. Fotheringham, Minister of Education; Dr. J. M. Cotton, Minister of Public Works, and Dr. A. R. Gordon, Provincial Treasurer. How efficiently they have labored will never be known because they are far too modest to speak of it themselves, and I much too prudent to let the real facts escape lest I should lose all credit for the results attained.

I am sure, gentlemen, that we have all watched with keenest interest the movements of the armies of our empire which in Southern Africa have been making history. We have felt an honest pride in the bravery and fighting skill of the thousands who have gone from Canada to aid the mother land. Only a few days ago we were thrilled with the story of how Canadian surgeons at Hart's River for a whole day long and under a withering fire of shot and shell went on with the work of caring for the wounded. While we unite in profoundest thankfulness to Almighty God that the end of this bitter struggle has come, we exult in the part taken by our own country in conquering a peace. We have fought a good fight! we have kept the faith! What has been gained?

"Do you not see your Greater Britain's soul
Has come to birth?
Do you not hear above the sighs—the song
From all those outland hearts which peace kept dumb;
There is no fight too fierce, no trail too long
When love cries 'Come.'"

WHY SHOULD WE NOT TREAT THE GALL-BLADDER AS WE DO THE APPENDIX?*

BY ROSWELL PARK, BUFFALO, N.Y.

The object of the present paper is to invite attention to the resemblances in function between the gall-bladder and the appendix, as well as the similarities between many of the pathological conditions which I would wish to have you interpret as calling equally for radical removal of the organ in question, whichever it may be.

First of all there are resemblances in function and structure between two appendages. Both of them are hollow receptacles, both are more or less tubular in shape and arrangement, both normally contain a certain amount of secretion, and most important of all, both are essentially superfluous organs, neither of them being necessary for normal purposes of life. The gall-bladder is a reservoir lined with mucosa continuous with that of the intestine. The vermiform appendix is scarcely even to be dignified with the importance of a reservoir, is lined with the same mucosa, and whatever its function may have been it is now almost useless. So long as each of these cavities can discharge itself easily there is little likelihood of trouble. It is when occlusion, no matter whether recurring or permanent, occurs, that trouble begins. This occlusion is produced in either case by analogous processes, in which bacterial infection plays a prominent part. Both cavities contain secretion from which calcareous deposits may be precipitated; in other words, in both is there liability to formation of concretions. The amount of pain and disturbances which may be produced by these small stones is, of course, well known to you, and is entirely disproportionate to their size and apparent significance.

Much attention has of late been paid to the toxemia or stercoremia which follows retention of appendicular contents. There is a less general appreciation of a perfectly analogous toxemia which comes from retention of morbid products within the gall-bladder, although I doubt if any man can reflect upon these cases intelligently without recognizing that which has previously escaped his notice. I have had such frequent occasion to be amazed at the degree of toxemia which may be produced under these circumstances that I wonder that they did not appeal to me in this regard many years ago as they do now.

Further resemblances are seen in that each may become anchored to its surroundings by a variety of intrinsic or

* Read at the meeting of the Ontario Medical Association held in Toronto, June 4th and 5th.

extrinsic lesions, and each when so anchored produces a degree of tenderness, of pain and of disturbance of function which is not always to be measured by the mere density or number of such adhesions. Each in its place, moreover, may lead to coprostasis by interference with the motility of the colon. Each again may cause localized pain and tenderness with acute exacerbations which are a constant menace to the welfare of the individual. Sometimes this tenderness is very easily evoked, and other times it takes deep pressure to call forth the response. Sometimes the enlarged organ can be felt through the abdominal wall and sometimes it cannot. Still, in either case we may fall back on the general expression of tenderness as a safe sign of disease in the part below.

Just as the appendix, when compromised, disturbs the function of the cecum, so does the gall-bladder when involved, especially and often disturb the normal action of the stomach and of the pancreas, and numerous cases of pain, tenderness and associated dyspeptic symptoms, referred primarily to the stomach, are in effect the result of a compromised gall-bladder. Moreover, just as trouble may radiate from the appendix proper and disturb the function of the ovary, or even of the bladder, so may lesions of the gall-bladder completely upset the stomach and produce such symptoms as to be mistaken for gastritis or gastric ulcer.

This incomplete list of resemblances might be well supplemented by a further statement that in either case when the part is diseased it is a constant source of irritation, and even a menace to life itself.

Assuming then that the organs themselves and their disease so completely resemble each other, you will be quite ready for the important surgical question, "Why should we not treat them both alike?" Replying to this self-raised question, I would further say that such is not my custom and my teaching. Whether, then, the case be acute and fulminating, or chronic and growling, I would say that the diseased and troublesome gall-bladder, like the diseased and troublesome appendix, should come out, and that we should now formally include cholecystectomy as the ideal operation corresponding to appendicectomy. My past year's experience with a relatively large number of these cases has taught me that one is no more dangerous than the other, and is equally satisfactory. I now scarcely think of leaving an evidently diseased gall-bladder after exposing it any more than I would think of partial operations upon the appendix. It is in almost all cases a not difficult matter to throw a ligature around the cystic duct near its entrance into the common duct, and to extirpate the gall-bladder from the lower edge of the liver, tying off vascular

adhesions, and if necessary, opening the cyst for the purpose of emptying it in order to make this extirpation more easy. In fact, I sometimes not only open it but widely, in order that with one or more fingers in the inside I may expedite its separation from the liver or adjoining viscera. This method is now demonstrated to be vastly preferable to the old method of opening and drainage, with too frequent and almost permanent sinuses which remain thereafter.

It is fair to maintain that when the gall-bladder is occluded and contains calculi with old, more or less inspissated or altered mucus, it has ceased to functionate as a gall-bladder, and is more than useless, is a source of offence.

When it is thus removed it can no longer furnish calculi which shall cause trouble within the ducts, or which shall provoke or irritate the pancreas.

I would repeat again that it is astonishing what a degree of toxemia can proceed from the contents of an old and occluded gall-bladder. On the other hand acute gangrenous affections of the gall-bladder are much less common than those of the appendix, all of which is due largely to the variations in their blood supply and anatomical arrangement, nevertheless, even in acute cases of cholecystitis there are exceedingly strong and unmistakable resemblances to acute appendicitis.

So far as the danger of the operation is concerned, I have come to believe that operation on one is scarcely more risky than upon the other, and that there are the same reasons for prompt and early intervention in one case which we meet with in the other. Looking back upon my own experience, I am perfectly willing to record my regret that convictions to the above effect have not overcome my prejudices years ago. I have never regretted removing a gall-bladder and have more than once had cause to regret not doing so. It has now become with me as standard a procedure as removal of the appendix, and seems to me one to be practised with much greater frequency, and to be recommended in a large proportion of cases which have hitherto restrained from putting themselves under surgical management.

ROENTGEN RAYS IN RELATION TO CANCER.

By A. GROVES, M.D.,
Superintendent Royal Alexandra Hospital, Fergus, Ont.

Mrs. W. S., age 59 years, was admitted to the hospital on January 31st, complaining of vaginal discharge and falling of womb. Personal history was good, usual diseases of childhood. Had been married thirty years, giving birth to ten children. Present illness commenced about two years ago, the symptoms of which were "a dragging down sensation, accompanied by profuse discharge, with pain in top of head." Had been gradually losing strength, characteristic cachexia also present. A vaginal examination showed a large ulcerated surface with very fetid discharge, hemorrhage occurring when parts were touched. A diagnosis of epithelioma of os uteri was made, and it was decided to try the effect of Roentgen rays, the case being beyond operative interference. Treatment was commenced, lasting on an average fifteen minutes per diem, and on the fourteenth day there was no apparent result excepting a partial relief of pain, but after this, the odor decreased with lessened discharge, and the ulcerated surface showed healthy signs, granulation occurring, and, on the thirtieth day from the commencement of the treatment, there was only a very small surface not completely healed, no odor, discharge or hemorrhage, and complete absence from pain. Patient then left the hospital, and ten days afterwards I examined her and found the remaining surface had healed and her general health improved in every way. Two months afterwards I found her in perfect health, with absolutely no return of symptoms. I think this may be confidently claimed as a cure.

Mrs. E. McD., aged 55 years, married, admitted to hospital on May 14th, with diagnosis of cancer. Examination showed that whole of lower third of rectum was involved, also the posterior wall of vagina, so much so that both organs opened as one. The disease had started five years ago, but up to time of admission had never been properly examined, receiving no treatment except medication. Treatment by Roentgen rays started, and on the night of the fourth treatment the patient slept for eight hours which, when compared with the history of the preceding seven months, the average sleep for which being one and a half hours per night, was very encouraging. She left the hospital on the 18th, temporarily, and I have no doubt that on her return a complete cure can be made.

TOWN VS. ARCHER AND ARCHER

IN THE HIGH COURT OF JUSTICE. TRIED AT TORONTO NON-JURY SITTINGS

Town *v.* D. Archer and R. Archer N. F. PATERSON, K.C., and SHARPE for *Plaintiff* AYLESWORTH, K.C., J. H. MOSS and W. H. HARRIS for *Defendants*.

JUDGMENT DELIVERED BY HON. CHIEF JUSTICE FALCONBRIDGE.

This is an action brought by the plaintiff, who is the wife of a farmer residing in the County of Ontario, against the defendants, who are physicians and surgeons residing and practising in partnership at the Village of Port Perry, in the same county.

In the month of May, 1899, the plaintiff fell and sustained injuries in her left ankle and foot, and the defendants were retained as surgeons, for reward in that behalf, for the purpose of treating the plaintiff for such injuries.

The plaintiff charges that the defendants negligently, improperly and unskilfully treated the plaintiff for such injuries; in consequence whereof the plaintiff has been suffering, and still suffers pain, and her foot has become distorted and twisted so that she has been rendered permanently lame, and her health has become otherwise impaired thereby.

The defendants plead, in their statement of defence, that they are both duly registered members of the College of Physicians and Surgeons of Ontario. That the defendants were not retained to treat the plaintiff, as alleged, but that defendant D. Archer was called in after the accident to the plaintiff, as a surgeon to set the plaintiff's ankle, and with the assistance of another surgeon did set the same in a proper and skilful manner, and that said defendant D. Archer was thereupon discharged by the plaintiff from any further attendance in the case. They also plead that the injury complained of by plaintiff was not caused by any negligence of the defendants, or either of them, but is due solely to the negligent manner in which the plaintiff's injuries were treated by herself subsequently to the treatment of her ankle by the defendant D. Archer. And the defendants further set up as a defence that the plaintiff's ankle was set by defendant D. Archer more than a year before the commencement of this action, and that the plaintiff's claim, if any, is barred by R. S. O., Chap 176, sec. 41.

The case was tried before me on the 18th, 19th, 20th and 21st of February last, and argued on the 27th of the same month. I have deferred judgment until now, not because I had any doubt as to what the disposition of the issues ought to be, but because the importance of the case to the medical profession, and to the community at large, seem to require that I should make a more formal and deliberate deliverance of my opinion than would be conveyed by an off-hand judgment pronounced at the trial.

The condition of the plaintiff, who is a woman of sixty years of age, at the time of the trial, is fully set out in the report of the surgeon appointed by order of the Court to make a physical examination. It is as follows;

"Report of Physical Examination of Mrs. Narcissa A. Town, of Saintfield, Ont.:

"She states that she sustained an injury of the left ankle on May 17th, 1899. Examination by order of the Court September 28th, 1901. Condition on examination:

"Length of tibia, same on both sides.

"Length of fibula, same on both sides.

"Circumference of the left leg, one inch less in calf than that of right.

"Circumference above knee, equal.

"The distance from the external malleolus to the ground is increased, and that from the internal to the ground slightly diminished. This causes the foot to be turned inwards, so that in the erect position the left side of the sole of the foot reaches the ground, while the inner side is raised about an inch. This is more marked at the toe than at the heel.

"There is a marked prominence of bony character in front and to the outer side of the ankle-joint. This is clearly the head of the astragalus. The body of the astragalus can be felt distinctly behind this, somewhat in front, and to the outer side of its normal position.

"The patient complains of pain on pressure over this part, and also at the inner side of the foot below the malleolus. (ankle).

"There is but little thickening of the soft parts.

"No other injuries are present.

"Conclusions:

"(1) There has been, and still is, a dislocation of the astragalus, forwards and outwards.

"(2) There is no sign at present of there ever having been fracture either of the tibia or fibula.

"(3) Result: The pain will, perhaps, become less on using the foot, and the displaced parts will gradually become accustomed to their altered relations, but the deformity resulting from the dislocation will be permanent.

"(Sgd.)

"GEORGE A. PETERS, M.B., F.R.C.S., ENG."

The question, then, for trial is whether the condition of the plaintiff to-day is due to the want of care and skill of the defendants; or (2) whether the plaintiff's own want of care has resulted in the injury, or whether she has by her own conduct

aggravated her injuries; or (3) whether her present condition is a result which might reasonably be looked for, and which has come to pass, having regard to her age and to the nature of the injury, even with the best degree of care and skill of a medical attendant, and the best degree of care and obedience to the doctor's orders on the part of the patient and of those in attendance on her in her own household.

Although I consider it due to all the parties concerned, to pass upon the merits of the case, yet I am bound to give an opinion upon the defence which has been raised under the Statute of the limitation of the action by reason of the lapse of time. The Statute R. S. O., Chap. 176 (The Ontario Medical Act, section 41), is as follows: "No duly registered member of the College of Physicians and Surgeons of Ontario shall be liable to any action for negligence or malpractice by reason of professional services requested or rendered, unless such action be commenced within one year from the date when, in the matter complained of, such professional services terminated."

The writ herein was issued on the 21st day of December, 1900. If, therefore, the defendants' professional services continued up to the 21st day of December, 1899, the Statute is not a good defence. The defendants contend that their professional services terminated with the visit of the 12th June, 1899, and that any visits paid by them after that date were friendly visits and not professional ones. Plaintiff contends that she called, as a patient, on defendants at their office on the 21st December, 1899, and on the 11th January, 1900; and that the defendants' professional services did not terminate until the last-mentioned date. There is a conflict of testimony between the plaintiff and defendants as to the real date of the last visit but one; the defendants contending that it was not on the 21st December, but on the 21st November, and backing up their statement by evidence of their different professional engagements and journeys on that day, and on the day preceding. However that may be, I am decidedly of opinion that when the plaintiff went to see the defendants on the last two occasions she did not go as continuing the relation of patient and medical man, but as a person who had a grievance and who was dealing with the defendants more or less at arm's length. She had called in another doctor (Parke, of Saintfield) to look at the foot on the 13th December, 1899; and she consulted a solicitor during the same month. Consulting another surgeon, in the absence of, and without notice to or leave of the surgeon in charge, is an indication of want of confidence in the latter, and would of course be treated by him, when he came to know of it, as tantamount to a dismissal of him by the patient. I am clearly, therefore, of the opinion that the

defendants can claim the benefit of the Statute, and that on this ground alone the action fails. But, as I said before, I deem it incumbent upon me to dispose of the other issues in the case.

The defendants are practising in partnership, but David Archer was the partner who was in charge of the case, and it is his alleged negligence which is in question here. But where physicians or surgeons engage in practice as partners all are liable for malpractice by any member of the firm.

Malpractice *(mala praxis)* is bad or unskilful practice by a physician or surgeon, whereby the health of the patient is injured. Negligent malpractice means gross negligence and lack of the attention which the situation of the patient requires; as if a physician while in a state of intoxication should administer improper medicines: that is not charged here, but what is charged is ignorant malpractice, namely, a course of treatment which was calculated to do injury, which has done harm, and which a well-educated and scientific surgeon ought to know was not proper in the case.

In 1697 the Court of King's Bench (Temp. Chief Justice Holt) resolved in Doctor Groenvelt's case, which Lord Raymond reports at page 214 in the quaint language of the day, "That *mala praxis* is a great misdemeanour and offence at common law (whether it be for curiosity and experiment or by neglect), because it breaks the trust which the party has placed in the physician, tending directly to his destruction."

The burthen of proof is upon the plaintiff in an action of this character, to show that there was a want of due care, skill and diligence on the part of the defendant, and also that the injury was the result of such want of care, skill and diligence. The general rule of skill required of a medical practitioner was thus ably summed up by Chief Justice Erle, in Rich *v.* Pierpont, 1862, 3 F. & F., at page 40: "A medical man was certainly not answerable merely because some other practitioner might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined but which in the opinion of the jury was a competent degree of skill and knowledge. What that was the jury were to judge."

"It was not enough to make the defendant liable, that some medical men of far greater experience or ability might have used a greater degree of skill, nor that even he might possibly have used some greater degree of care. The question was, whether there had been a want of competent care and skill to such an extent as to lead to the bad result."

Chief Justice Tindal, in Lamphier *v.* Phipos, 1838, 8 C. & P., at page 479, charged the jury in the following clear and suc-

cinct terms: "What you will have to say is this, whether you are satisfied that the injury sustained is attributable to the want of a reasonable and proper degree of care and skill in the defendant's treatment. Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill; and you will say whether in this case the injury was occasioned by the want of such skill in the defendant."

It has been held in some American cases that the locality in which a medical man practises is to be taken into account, and that a man practising in a small village or rural district is not to be expected to exercise the high degree of skill of one having the opportunities afforded by a large city; and that he is bound to exercise the average degree of skill possessed by the profession in such localities generally. I should hesitate to lay down the law in that way: all the men practising in a given locality might be equally ignorant and behind the times, and regard must be had to the present advanced state of the profession and to the easy means of communication with, and access to, the large centres of education and science. For example: Port Perry is a two hours' journey from a city of a quarter of a million inhabitants, with three medical colleges and numerous hospitals.

There is no implied warranty on the part of a physician or surgeon that he will effect a cure. He can be treated as an insurer or guarantor of success only if there be an express agreement to that effect.

If a surgeon treat a patient improperly, he is liable to an action even though he undertook *gratis* to attend to the patient.

If a patient by his own conduct, or disobedience of orders, has aggravated his injuries to an extent that will account for the mischief complained of, he cannot recover damages from the medical man, having regard to the general law of contributory negligence. The burthen of proof to show contributory negligence is, of course, on the defendant in an action for malpractice.

The failure on the part of a medical man to give a patient proper instructions as to the care and use of an injured limb is negligence for which the medical man is liable for injury resulting therefrom.

These are the principal propositions of law involved in the consideration of the present case.

In addition to the cases cited above, I refer to Slater *v.* Baker, 1767, 2 Wilson, 359; Carpenter *v.* Blake, 60 Barbour, 488; same case 50 N. Y., 696; Beven, Negligence 2nd Ed., page 1390 *et seq.*; Smith on Negligence, Blackstone Ed., 195, *et seq.*; American and English Encyclo. of Law, 1st Ed., vol. 14, page 75 *et seq.*; Bouvier Law Dictionary, sub. tit. Physician.

Actions of this kind were, as a matter of course, formerly tried, both here and in England, by a jury; and it was the almost inevitable result that juries, perhaps innocently and unconsciously, looked more favorably upon the case presented by the patient than on that presented by the physician or surgeon. To remedy this condition of affairs, and not to leave doctors entirely at the mercy of juries, the courts in this country early became astute to lay down limitations and restrictions on the actions of the twelve; or, rather as to what matters ought to be left to them to deal with. For example, in 1869, the Court of Queen's Bench held in Jackson *v.* Hyde, 28 U. C. R. 294, that in an action against a surgeon for negligent malpractice, where the evidence is as consistent with the absence as with the existence of negligence, the case should not be left to the jury.

In Fields *v.* Rutherford, 1878, 29 C. P. 113, although there was professional evidence that a different course of treatment might preferably have been pursued, but the weight of evidence showed that the course of treatment pursued by the defendant was such as would have been adopted by medical men of competent skill and good standing in the profession, it was held that there was no evidence of negligence to be submitted to the jury, and a non-suit was entered. These cases were followed in McQuay *v.* Eastwood, 1886, 12 O. R. 402. The *ratio decidendi* of these cases was, that a medical man ought not to be placed in peril with a jury where their decision would involve the consideration of difficult questions in the region of scientific inquiry.

The next step in the practice was the suggestion by the courts that this class of cases ought more properly to be tried by a judge without a jury. This was the corollary or natural logical sequence of the cases which I have cited, and was first made in Kempffer *v.* Conerty, 1901, 2 O. L. R., page 658 (note); and the same intimation was given in McNulty *v.* Morris, 1901, 2 O. L. R. 656. In both these cases it was stated in the judgment that this intimation was not intended to fetter the discretion of the trial Judge in this regard. And so it comes about that this case is tried by me without a jury, the parties having practically consented to my so doing.

The injury which the plaintiff sustained, namely, dislocation of the astragalus, is one which is admittedly not of frequent

occurrence; difficult to diagnose, especially when there is swelling of the parts; and one in which perfect restoration is not, at the plaintiff's time of life, to be expected. I was strongly pressed by counsel in the argument, to find as a fact that David Archer and Dr. Windell did not make a correct diagnosis, or recognize the dislocation of the astragalus at all. Much stress was laid upon the somewhat different accounts given by these two, of the extent and position of the alleged fracture of the fibula. I think that the comments on this subject were somewhat hypercritical; and I fail to see their cogency in this regard. Technically speaking, the breaking or carrying away of portions of the periosteum constitutes a fracture; and I find, on the preponderance of the evidence, that such a fracture cannot be expected to be disclosed after the lapse of two years, by the aid of the X-ray or sciagraph. The sciagraph is not a photograph, it is a shadow, and it is, in the present state of the science, not an infallible guide in fractures, to this extent at least, that it will not always disclose the line of fracture; and the possibility is that the bony covering being reunited might not show at all. I therefore attach much less importance to what is now claimed to be shown by the sciagraph than the plaintiff's counsel wishes me to do. On the whole case, and having regard to the burthen of proof, I find myself unable to determine this point in plaintiff's favor.

The next point in the case is, assuming the diagnosis to have been correct, whether the treatment adopted was in accordance with good surgery. Two medical men were called to say that it was not. Having already been examined as witnesses they were recalled at the very end of the plaintiff's case to criticize the treatment that was adopted. One of them was, apparently, a very respectable country practitioner of eighteen years' standing; the other was the gentlemen who produced the sciagraph and gave evidence based thereon. These two witnesses found fault with the treatment in this respect, that in their opinion, the particular injury in question having been diagnosed a bandage should have been applied with some form of angular splint before putting the leg in a box; and they said that the treatment actually adopted, namely, the wooden box splint with cotton batting packed about the limb, and a bandage outside the box, was not good surgery. I find that this position is not sustained by the preponderance of expert evidence. Dr. George A. Bingham says that what the defendant did was good surgery, and that the treatment suggested by the two witnesses of whom I have spoken would be practically "criminal." Mr. I. H. Cameron is equally pointed and incisive in his statement; he says that the box splint is quite good practice, and that the bandage next the skin and the rest

of the treatment suggested by plaintiff's witnesses "would be the most undesirable that could be conceived." Dr. Herbert A. Bruce says that the splint box and bandaging adopted were perfectly suitable, and that the angular splint and the bandage next the skin would be very detrimental.

To what, then, if I find, as I am bound to do upon the preponderance of evidence, that the case was properly diagnosed and that the proper treatment was adopted, is the present unfortunate result to be attributed? If it came down to a question between negligence or malpractice on the part of defendants, on the one hand, and the extreme improbability, even under favorable conditions, of perfect or even approximate restoration, I think the doctor in charge ought to have the benefit of the doubt. But I am of the opinion that there is abundant evidence to show that the present unfortunate condition of the plaintiff is due to her own conduct.

I may premise by saying that it is clearly proven that it is impossible to say now whether the present dislocation is initial, or is a dislocation subsequent to the injury of the 17th May, and the setting or reduction thereof on the same day. It is further to be observed that Mr. Cameron says that the X-rays show that the astragalus is still in its mortise, *i.e.*, in place as regards the tibia and fibula, but that there is a rotation of the joint, and a displacement of the head of the astragalus outwards. I think I understood Dr. Bruce to say that that condition of affairs was evidence that there had been a reduction of the original dislocation. Be this as it may, Dr. Windell swears that having diagnosed and set and reduced the injury with David Archer on the 17th May, he visited the patient on the 19th May and found her condition satisfactory, and again on the 22nd; he paid a visit on the 3rd June alone, and found that the bandages had been disturbed, and he asked her about it and she admitted that she had had the bandages loosened and had a nice sleep. That he then found a partial dislocation of the astragalus and that he replaced it, put the limb back in the splint and repacked it; that he could not tell what was the extent of that dislocation, but that he does not think that there was any dislocation except at the head. He attributes this partial dislocation to her having fallen asleep and turned over. The three medical experts called by the defence agree in saying that there was very grave danger in a box splint if the patient relaxed the bandages; that it would be impossible to say that there was no disturbance, even if the patient lay perfectly still; that there would be room for spasmodic action of the muscles which might occur involuntarily or during sleep, and which might be attended with grave results; that it would not be possible, even with an effort, to keep the limb rigid for more

than a minute or two; and, moreover, that the result of this disturbance might not be discernible until after the patient began to use the foot, when a gradual inversion of the foot might be looked for as the patient commenced to walk.

I am asked to disbelieve the statement of Dr. Windell, upon the mere ground that while he is not a defendant in the case, his professional reputation is at stake. I find myself unable to do this, especially as his evidence is strongly corroborated. The plaintiff admits having gone to sleep once, while the bandage was loosened; this, however, was after the leg was placed in the plaster-of-Paris splint and cut open on the 12th June; but Mrs. Asling, an apparently independent and credible witness, says that she went in one time and the bandage was loose, and the plaintiff was working at the cotton batting, and witness asked plaintiff not to do it, and cited the case of a relative of her own whose tampering with bandages had been attended with disastrous results. Witness saw it loose on one other occasion afterwards. Both these times were while it was in the box splint; it was unbound when the witness came in and she helped the plaintiff to do it up. She says Mrs. Gibson was there on that last occasion. Mrs. Asling also says that she saw the plaster-of-Paris bandages taken off and the leg was laid bare, and the plaintiff wanted the witness to get it done up in a hurry before Mrs. Baird, plaintiff's daughter, should come in. Mrs. Gibson corroborates this statement, saying that she was at the plaintiff's house with Mrs. Asling one evening that the bandage was loose, and it was bound up while she was there. As far as she can remember it was while in the box splint; it was right out of the splint and that they replaced it in the splint and bound it up in the bandages.

If this evidence were much less clear and convincing than it is; in other words, if the case were much more evenly balanced, I should feel obliged to give the defendants the benefit of the doubt; but, as I have indicated before, I am decidedly of opinion that the plaintiff has failed to make out a case of negligent malpractice, and that the action must be dismissed.

(Signed) W. G. FALCONBRIDGE,
Chief Justice of the King's Bench.

KEMPFFER VS. CONERTY.

BEFORE THE HON. MR. JUSTICE MACMAHON, AT PERTH, WEDNESDAY THE 30TH DAY OF APRIL, 1902.

JUDGMENT.

This case has been very thoroughly discussed, and the points have all been elaborated with great care by counsel on either side with their usual ability. No legal questions are involved, and I have simply to deal with the facts.

The boy, Thomas Kempffer, on the 11th day of September, 1896, being then ten years old, fell from a tree and sustained a fracture of the radius, commonly known as a Colles fracture. The height from which he fell is unknown, and he was unconscious when brought to his father's house. Dr. Bell, who occupies a distinguished position amongst the surgeons of the Dominion, and is connected with the principal hospitals in Montreal, says that in the production of a Colles fracture the force is almost always on the palm of the hand and the ball of the thumb. When the boy was brought home the defendant was called to see him, and after examining the arm returned to his surgery to get the necessary splints to be used after the fracture was reduced. He then returned to the Kempffer house and after washing the boy's hands, he, with the assistance of the two men, Jacobs and Hill, reduced the fracture and then proceeded to put the arm in splints. A question has arisen as to the size of the splints, and it has been urged that I should rely on the evidence of Jacobs and Hill as to their size in preference to the evidence of the attending surgeon. During Mr. Watson's argument I pointed out to him how often the man Jacobs said he did not recollect what took place, and since then I have procured from the stenographer a statement, taken from his evidence as to what he did not know. He said, "Before the doctor came I looked at the hand or wrist I suppose, I did not take much notice to it. Did not notice marks on hand. Did not notice where the material for bandages came from. Did not notice whether the splint differed in width throughout its length. Did not notice whether the doctor had other splints there. Did not notice whether much or little batting was put under splint. Could not tell whether anything was put between the thumb and the hand. Could not tell if springs were put around the bandage. Did not know anything about the boy's color; did not watch to see if it changed. Supposed the boy was unconscious, does not know. Does not know whether the arm was washed before the boy became conscious or not. Did not see where the splints came from. Could not tell where the batting came from. Did not

notice whether a wad of batting was put in the hand. Could not tell whether the batting covered the whole hand before the splint was put on. Thinks the bandage was opened up once, but did not notice whether more batting was put in. Did not notice the width of padding placed in the hand."

It struck me at the time he was giving evidence that either he was not an observant man, or that he was occupied in the duties assigned to him by the doctor, of looking after the chloroforming of the patient, so that when one comes to consider the position occupied by the defendant as a surgeon in attendance on a patient with an injury of the nature described, and feeling that his reputation as a physician and surgeon was at stake, and that the greatest care and skill that he possessed should be given in dealing with the injured arm, I could not come to the conclusion that these men, who were not interested in the kind or size of splints that were required for the purpose for which the doctor was called upon to use them, are likely to be correct in the evidence they give, either as to the size or the material. The doctor says that he had a number of splints in his office, some of which he made himself, and others that he had purchased. He states that the splints were about two and a half inches wide, and they were both of wood. The witnesses, Jacobs and Hill, stated that the splint that was put on the back of the arm was of pasteboard, and that the one placed on the front of the arm and palm of the hand was of wood, and only an inch and a half wide at its widest part. Mr. Hill is connected with the family of the plaintiff by reason of his having married Kempffer's sister, and while I do not say that he is not desiring to state exactly what is true, he has no doubt heard the subject discussed from Kempffer sources, and I do not regard his statement under the circumstances as being entitled to the credit that I give to the evidence of Dr. Conerty, and I find that the two splints were of at least the width of two and a half inches. With regard to the course adopted by Dr. Conerty in putting on the splints, I think the evidence of Hill strongly supports the statements made by the defendant, that every precaution was taken, as far as the hand was concerned, to give it sufficient padding to prevent any injurious results arising from the use of the splints. Dr. Conerty said that the splint was padded with batting, and that he put a ball of wadding in addition to that padding, in the palm of the hand, and that the splint covered the whole of the palm down to the metacarpal bones, and that the hand was well filled with padding. As I say, he is confirmed in that statement by Hill, who says, "There was batting on the palm of the hand under the splint, and a little under the splint on the front of the arm. He made a change and loosened the

bandages and put some cotton batting under the splint." This shows that after bandaging had proceeded to a certain extent, the doctor, thinking it advisable to add some additional padding, opened it up and put in an additional quantity of batting in the palm of the hand. It was urged that the splint went down to the end of the fingers. I think Mr. Watson properly abandoned that, as Hill himself said, and Jacobs said that the splint only went as far as, I think he stated, the end of the palm.

A question has arisen as to the manner in which the bandage was put on the arm. Most of the surgeons say that the proper course is to commence at the bottom and bandage upwards, but they all say that it is immaterial in which way it is done, so long as there is no undue pressure of the bandage on the splint, so long as there is no pressure that would prevent free venous circulation. Dr. Conerty says that he did not adopt either of these methods. He commenced in the middle of the splint with the bandaging and proceeded to the top of the splint and then down to the middle of the hand. There was a good deal of evidence given by Jacobs and Hill as to what position in which the thumb was when the hand was bandaged. They say that it was bent in on the palm of the hand, and that that was the position in which the surgeon bandaged it. Dr. Conerty stated that he adopted the course sometimes adopted in cases of this kind, and bandaged the thumb on a line with the index finger. Most of the surgeons who were called, both on behalf of the plaintiff and for the defendant, say that it is an unobjectionable course, but the majority of them prefer the other method. I think one of them, Dr. Sheppard, said he had heard of it, and he knows that the system is spoken of in the books on surgery. However, they all concur in stating that unless the bandage was so tight as to cause pressure on the thumb and bring it in, that no evil results were likely to follow or should follow from the treatment.

The splints were allowed to remain on the arm for some twenty-three or twenty-four days. When the splints were removed it was found that there was a complete knitting of the bones of the arm, and that with one exception no trouble expected to arise from the condition of the hand. The plaintiff, or his mother or father, do not complain of the condition in which the arm which was fractured was found when the splints were removed. The result was all that could be desired. It is as to the condition of the palm of the hand at the ball of the thumb. The doctor says that when he saw the boy first there was, according to his observation, a slight swelling, and some redness in the vicinity of the ball of the

thumb, about the size of a twenty-five cent piece, and it was stated that the injury was situated in a place where it was likely to have been the result of the impact when the boy fell. That is the place likely to be injured when a Colles fracture takes place. Dr. Conerty did not apparently regard it as at all serious. Perhaps there was no indication that there was any great injury to the hand, and with that idea he treated the hand as if no serious result was likely to follow from bandaging it in the manner stated. When the splints were removed it was found that in the region of the ball of the thumb, where the injury was caused, there was a deadening of the tissue and a cicatrix has formed, and the doctor finding that took upon himself, as he was obliged, I think, to do under the circumstances, the treatment of the thumb so as to bring it back, if possible, to its normal condition. He thought that the necessity for an operation might be avoided by a massage treatment. Dr. Sheppard, Dr. Bell, and I think most of the surgeons, with the exception of Dr. King, say that while that condition of the thumb existed it would be improper to perform an operation, and Dr. Bell pointed out that one of the serious objections to operating at that time was the probable existence of micro-organisms, and if the operation was conducted while these were in existence in the hand, that it might result disastrously to the patient. He considered that the hand should be thoroughly healed before an operation was attempted, and I find from the evidence before me that that would have been the proper course to pursue. Now the healing was effected by the last of December or first of January, and the doctor thought that by constant massage the necessity for an operation might be obviated. The mother of the boy says that the defendant endeavored to move the thumb, and did move it slightly, that the motion caused pain, but notwithstanding that Dr. Conerty thought that by continuous use of the massage treatment the thumb would come all right and a perfect cure effected within six or twelve months' time at the latest. On the 4th of October, 1896, the doctor removed the splints, and he saw the boy again three days afterwards, on the seventh of the month. Between the 7th of October and the 16th of November, although he had been asking the mother of the boy to bring him every day, or every other day, to his surgery, she neglected to carry out his instructions. After that he only saw the boy twice during December, on the 2nd and the 7th, and then in January he saw him five times, on the 16th, 17th, 20th, 28th and 30th, and four times between the 2nd and 9th of February. He saw nothing of the boy at all until June, when he supplied him with a plaster cast for use on his hand. The cast was produced here, and from its appearance, if the boy had been using it,

the thumb would, when placed in the cast, be some distance from the index finger, and he (the boy) said he had been using it from time to time until he brought it back to the doctor's office in August and left it there, stating to the person in attendance that he used it as a paddle when he was out swimming.

Now, having regard to the treatment Dr. Conerty had prescribed, which, as he told Mrs. Kempffer, could only be carried out by the boy being brought to his surgery for treatment, one cannot say that the present condition of the thumb is owing to any want of skill on the doctor's part. Whatever neglect there was was not his neglect, and from the evidence of Mrs. Kempffer herself it is quite apparent that the doctor was finding fault with her for not making the boy keep his appointments in going to the surgery for treatment. That is borne out also by the evidence of the housekeeper, Mrs. Hunter, who says that she was present on one occasion when Mrs. Kempffer brought the boy there, and that the doctor was much dissatisfied with the condition in which the boy's hand was, and told Mrs. Kempffer that no progress towards a cure could be expected, owing to the neglect of the father and mother in seeing that the boy came regularly for treatment. The findings I have made exonerates the defendant from the charge of a want of skill or care. The reduction of the fracture was perfect, and the condition in which the thumb is now found arises from want of care and attention on the part of the parents of the boy, and of the boy himself, in not submitting to and following out the defendant's instructions.

The action will be dismissed.

Selected Article.

ABSTRACT NOTE ON GASTROSTOMY

By F. TERRIER,
Professor of the Surgical Clinic of the Medical Faculty of Paris,
AND
A. GOSSETT,
Fellow of the Faculty of Paris.

(*Revue de Chirurgie, 10 Fevrier, 1902.*)

We have had occasion to operate during the last year upon eight cases affected with cancerous constriction of the esophagus.

The operative technique is as follows: A lateral vertical incision is made, commencing at the level of the left costal margin and ending at the level of a line passing transversely through the umbilicus. This incision must be made parallel with the median line, and about over the centre of the rectus. After dividing the skin and superficial fascia, the anterior sheath of the rectus is exposed. This is divided vertically for the whole length of the wound, thus disclosing the vertical muscular fibres of the rectus with the aponeurotic transverse striæ. Continuing directly from before backwards, the fibres of the rectus muscle are separated by means of the probe director, the muscular fibres are drawn to the right and left, disclosing the posterior sheath of the rectus, which is now divided between two pair of forceps which catch it up on either side, causing a small transverse fold. In dividing the posterior sheath of the rectus one divides the peritoneum also, as the two are intimately connected.

This incision through the rectus muscle was proposed in 1888 by Von Hacker.

An important point to remember is to preserve the vessels and nerves which are seen forming two groups, one above and the other below, running along the posterior sheath of the rectus.

In cases where the vertical space between the two nervous roots is sufficient to permit a large enough opening in the peritoneum, it is better not to divide them, and thus preserve intact the innervation of the rectus, thereby obtaining more surely a contractile sphincter around the projected fistula.

The abdomen being opened, the peritoneum is drawn back by means of forceps, the left side of the wound is retracted

with a retractor, and guided exclusively by view the stomach is located. As soon as the organ is recognized it is seized with a pair of forceps and drawn forcibly out of the wound, forming thus a gastric cone which projects outside the two lips of the incision.

It is necessary to seize the stomach at a point as high up as possible, that is, near to the cardiac end, but not too high, else the gastric cone will not be of sufficient length. The stomach has a tendency during the operation to retract into the abdomen, and unless one takes care this cone will not be of sufficient length, and the suture of the mucus membrane to the skin is rendered difficult and the result functionally compromised. The forceps prevent the retraction of the stomach into the abdomen. The stomach being thus seized and (we insist again upon this point) sufficiently drawn out, the retractors are removed, and the organ is fixed to the abdominal wall by three layers of sutures. The first suture attaches the stomach to the posterior sheath of the rectus, the second to the anterior sheath of the rectus, and the third to the skin.

We use fine silk and small curved needles, and make a suture separated at two points and U shaped. The first layer of sutures unites the stomach to the posterior sheath of the rectus, four only are required, and are placed at the four cardinal points, the first one is placed near the upper end of the wound and goes successively through the outer half of the posterior sheath of the rectus, sero-muscular coats of the stomach and then the inner edge of posterior sheath, and tied above, thus completing the U. The other three sutures are then inserted in a similar manner, one at either side and the other below, after which the rest of the posterior sheath is closed in the usual way. The second layer of sutures, similar to the first, attaches the stomach to the anterior sheath of the rectus, and the rest of the anterior sheath closed. Nothing more is required to complete the operation, except the opening of the stomach and suture of the skin.

We always complete the operation at one sitting. In order to get an orifice as small as possible, the apex of the stomach cone is caught between two pair of Kocher's forceps, and in such a way as to produce a vertical fold of the sero-muscular coat, we transfix the base of that fold with a very small bladed bistoury, and cut outwards. The sero-muscular coat only is divided, and a very small opening is made if care has been taken, as very little tissue is grasped between the forceps. The mucus coat now bulges out from this opening in the sero-muscular coat, it is caught in a like manner, transfixed and opened, great care being taken that a very small opening is made. The mucus membrane is now attached to the skin by means of

a few fine silk sutures, and the rest of the skin wound closed by means of horse hair.

Theoretically, this procedure has the following advantages: First, a relatively long canal, since it reaches from the posterior sheath of the rectus to the skin surface, perhaps 1.5 cm. to 2 cm. in length, this canal goes directly from behind forwards, from the cavity of the stomach to the exterior. This may appear a defect, but the gastric mucus membrane being drawn forcibly outside forms an ectropion of the mucosa, which constitutes in itself a sort of natural obdurator. It is in order to obtain a bulging out of the mucosa as large as possible that we advise incising the walls of the stomach separately, first the muscular coat which retracts upon itself, then the mucus coat which retracts upon itself, then the mucus coat which has been carefully drawn forward from the opening; and lastly, the canal thus obtained is surrounded by a double muscular sphincter. The fibres of the rectus which have been carefully separated without cutting them, and preserving their nervous supply, which form to the right and left of the fistula a solid muscular collar which can only serve to obliterate the fistula, and prevent it from leaking, and perhaps assisting in that work also, to a certain measure is the muscular coat of the stomach, which is retracted and bulged up at the base of the protruding mucus membrane, in which is the external orifice.

Results.—The execution of this operation is as simple as possible, and it lasts from fifteen to twenty minutes.

In our eight cases we had one death in the first twenty-four hours, the patient, during two months preceding the operation, while in the medical service, had been submitted regularly to a series of dilatation, and for eight days before the operation had not been able to absorb any nourishment, subcutaneous injections of artificial serum had been omitted, and the patient was in such an extreme state that we had to operate without an anesthetic, general or local. The operation was done rapidly and very simply. The patient died at eleven in the evening; he had been operated on at ten in the morning.

Four of our patients have lived, one for twenty-two days, another for thirty days, and the other for forty-one days, the other three are still living, one after nine and a half months, second after four months, third after three months. The four cases that have succumbed so rapidly could not have survived longer, the one had a tracheo-esophageal fistula, and a localized pulmonary gangrene. Another had the pneumogastric nerves involved in the tumor, the third was operated on one year previously for a tumor of the tongue, there was a large recurrence with compression of the trachea and esophagus. Three days before the gastrostomy he had undergone an urgent

tracheotomy, and he died at the end of thirty days from hemorrhage, having its source in a neoplastic ulceration of the floor of the mouth.

Our other operative cases are living yet, and one has survived one and a half months.

The criterion of a good procedure for gastrostomy is the success of the sphincter, and absence of leakage from the fistula. We have always, except in two cases, obtained perfect retention of the stomach contents; in one of the cases, where there was incontinence, we had made a faulty technique, not having drawn out a sufficiently long gastric cone; and the mucosa, instead of making a pad by bulging forwards, had retracted towards the abdomen, and in a way invaginated the neighboring skin. In place of having a canal we had nothing more than a simple orifice.

As to the second patient who had incontinence, it only appeared after four weeks and was temporary. The patient was seen at the time of writing, three months afterwards, and the sphincter action of the muscle was perfect.

We think that it is necessary, in speaking of the patulous condition of the fistula, to consider not only the method employed but also the condition of the patient, as the incontinence is observed sometimes in cases some days preceding death, who formerly had had good sphincters.

Conclusions.—It is granted at this time that in order to obtain an opening into the stomach which will not permit the escape of its contents, the opening should be made as small as possible and placed as high up as possible. It is also necessary to obtain, not a simple opening, but a canal as long as possible, with mucus folds capable of acting as a plug and a contractile sphincter to keep the walls of the canal in apposition.

The procedure which we now employ, and the one already described, fulfils these conditions. It consists essentially in a vertical left lateral laparotomy, drawing a gastric cone through the wound and attaching it by means of three layers of sutures, a double layer which unites the sero-muscular coat to the posterior and anterior sheaths of the rectus and a superficial layer which unites the mucus membrane to the skin. The opening, practically isolated, of the sero-muscular layer and of the mucosa, permits a bulging out of the mucosa, which forms a plug to the opening. The muscular layer, after retracting on the mucosa and the two halves of the right rectus, play the role of a sphincter.—*Abstracted by Ingersoll Olmsted.*

Society Reports.

TORONTO CLINICAL SOCIETY.

STATED MEETING, May 7th, 1902.

Dr. J. F. W. Ross, President, in the chair.

The following Fellows were present: Small, Orr, Ross, Baines, Pepler, Cotton, Rudolf, Goldie, McCollum, Hamilton Harrington, McIlwraith, Fenton, Hastings, Silverthorn, Bingham, Nevitt, Lehman, Fotheringham, Stark, Garrett and Elliott.

The minutes of the preceding meeting were read and confirmed.

Membranous Glossitis.

Dr. A. J. Harrington reported this case, which occurred in a child of eleven months. The child had had measles in March, 1902. There was a history of injury, and five days later Dr. Harrington was called to see the child. The temperature was 103, and the respiration 36. On April 3th the whole cast of the tongue exfoliated. The whole system was thoroughly saturated with sepsis. Death resulted. Specimens and cultures were exhibited.

Dr. Baines discussed this interesting case, stating that the condition was a new one to him.

Dr. Baines reported a case of metorrhagia which occurred in a young girl aged sixteen, following an attack of mumps.

Dr. Rudolf referred to a case of mumps in the submaxilliary glands, expressing his belief that mumps had always been confined to the parotid glands.

Dr. Pepler spoke of having observed mumps in the different salivary glands.

Notes on Urotropin.

Three cases were reported by Dr. Fenton to which he had administered this drug. Most marked results had been obtained from the employment of it in an old man with enlarged prostate and residual urine. Drs. King and Baines spoke favorably of the drug.

Myxomatous Degeneration of the Villi of the Chorion.

Dr. C. J. C. O. Hastings reported three cases of this condition which he had observed in his own practice, two of which recovered. Drs. Silverthorn, McIlwraith and Ross discussed this paper.

Dr. Fotheringham referred to a case which was reported to the Society by himself and Dr. Bingham, some months previously, a case of exophthalmic goitre, in which loss of voice occurred after operation. The loss of voice had extended over eight months when the patient awoke one morning with her voice restored, proving that the condition had been due to hysteria.

The following officers were elected for the ensuing year: President, Dr. E. E. King; Vice-President, Dr. G. R. McDonagh; Corresponding Secretary, Dr. W. J. McCollum; Recording Secretary, Dr. George Elliott; Treasurer, Dr. Geoffry Boyd; Executive Committee, Drs. J. F. W. Ross, J. Orlando Orr, J. T. Fotheringham, H. C. Parsons and H. A. Bruce.

GEORGE ELLIOTT,
Recording Secretary.

CANADIAN MEDICAL ASSOCIATION.

Below will be found a list of papers already promised for the annual meeting at Montreal, September 16th, 17th and 18th next. Members and others contemplating contributing to the success of this meeting should notify the General Secretary at an early date of their intention. Arrangements as to railroad and steamship rates, entertainments, clinics, etc., will be announced in due time.

Address in Medicine—Professor William Osler, Baltimore. Address in Surgery—Dr. John Stewart, Halifax, N.S. Lantern Demonstration on the Exanthalmata—Dr. Corlett, Cleveland. Paper by Dr. D. Campbell Meyer, Toronto. Paper by Geo. S. Ryerson, Toronto; subject not yet decided on. Paper by A. Lapthorn Smith, Montreal, also card specimen. Paper by F. A. L. Lockhart, Montreal. "On some points in Cerebral Localization, illustrated by a series of Morbid Specimens and some Living Cases"—James Stewart, Montreal. Paper and Specimens, by Dr. Geo. A. Peters, Toronto. The Country Practitioner of to-day—J. R. Clouston, Huntingdon. Paper by Dr. P. Coote, Quebec. The Pathologic Prostate and its removal through the Perineum—A. H. Ferguson, Chicago. Paper by Geo. E. Armstrong, Montreal. Paper by Ingersoll Olmsted, Hamilton. Paper by Dr. Casey A. Wood, Chicago—"Empyema of the Frontal Sinus." On Tuberculosis—J. F. Macdonald, Hopewell, N.S. X-Ray in Cancer—A. H. Robinson, New York. On Degeneration of the Spinal Cord, Anemia, Mal-nutrition, with Microscopic Specimens—David A. Shirres, Montreal.

GEORGE ELLIOTT,
General Secretary.

129 JOHN STREET, TORONTO.

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, T. M. McMAHON, H. J. HAMILTON, AND INGERSOLL OLMSTED.

The Heart in Chronic Articular Rheumatism.

In violent acute articular rheumatism the co-existence of an endocarditis, of a pericarditis or of an endo-pericarditis is the rule and the absence of such is the exception. On the contrary, in subacute articular rheumatism, limited in character and apyretic, the lesions of the pericardium and endocardium are only exceptionally met with. Since 1840, when Bouilland formulated this proposition, most authorities have too absolutely denied the relations which exist between organic affections of the heart and chronic articular rheumatism. In recent years this subject has occupied the attention of several medical men, and within a short period not a few works have been published, among which is a very interesting one by Barié. In 1846 Romberg, Todd, Charcot and Trastour published the first cases of cardiac lesions in chronic rheumatism. In 1864 Bean related the case of a young woman suffering from chronic arthritis, in whom were discovered the physical signs of a stenosis of the aorta. Subsequently Ollivier, in a young man, 20 years old, afflicted with chronic polyarthritis deformans, found changes in the aortic valves. Barthez, in a boy of 10 years, whom he was treating for chronic articular rheumatism, discovered pericardial friction sounds in the praecardial region, and this dry pericarditis coincided with an exacerbation of the rheumatism. Cornil, out of nine cases of chronic articular rheumatism followed by autopsy, found pericarditis four times. In two of these the pericarditis was acute, developed during the rheumatism. In the other two the pericarditis has existed for some time, and had produced adhesions with obliteration of the pericardium, complete in one case, partial in the other.

In 1866 Ball published two important cases. The first was that of a woman 60 years old, suffering from rheumatism of the right hand. At the autopsy there was found a recent general adhesion of the pericardium, the heart was enormously dilated and vegetations existed on the mitral valve and on the aortic valves. In the second case the patient was a woman 84 years old, with chronic rheumatism in the shoulders, elbows

and knees, who died of cancer of the stomach and liver. The heart was flaccid, large, loaded with fat, and on the aortic valves there were clear traces of an old endocarditis. Mauriac reports a case in a woman, 71 years old, with chronic rheumatism and bronchial catarrh, who was suddenly seized with intense dyspnea. Percussion showed increase of cardiac dulness, and auscultation revealed a rough pericardial sound, throughout the whole of the lower half of the sternal region. Charcot, too, in one of his lectures in 1867, as a result of observations in his hospital, came to the conclusion that endocarditis and pericarditis are certainly found in some cases, of chronic articular rheumatism. In later years similar cases of no less interest than these, have been reported by Charpentier, Stoicesco and Dally.

Besnier admits a particular frequency of cardiopathies in that form of chronic rheumatism, called by Iaccoud, fibrous, which is characterized by superficial articular lesions with chronic changes in the periarticular tissues, producing deformities, anchyloses, etc.

The co-existence of cardiac lesions, with chronic articular rheumatism, is far less frequent than is observed in acute articular rheumatism. Lancereaux, making a comparison between the latter and chronic arthritis, recognized that in acute rheumatism the dangers are in the frequency of the mitral lesions, whilst in chronic rheumatism the danger is in the arterio-sclerosis, either with or without lesions of the aortic orifice. Iaccoud says: "Usually in chronic rheumatism we do not find valvular lesions, but pericarditis, atheroma, and, as a consequence, hypertrophy of the heart."

These lesions have been observed oftener in women than in men, which is not strange, inasmuch as chronic rheumatism is most frequent in the former. They have been seen at all ages. In chronic arthritis deformans the most frequent cardiac lesion, according to Jaccond, is pericarditis. Then come endocarditis, hypertrophy of the heart, degenerative changes of the myocardium, and finally cardio-sclerosis. The pericarditis is sometimes dry (Barthez), sometimes with exudation, all varieties of the former are found, from the simple pseudo-membranous, to that characterized by universal adhesions with complete obliteration of the sac. In the latter we often find the hemorrhagic form. In one case the endocarditis was at the same time parietal and valvular. Insufficiency is the most frequent form of aortic lesion. These lesions and the degenerations bring on, after a certain time, insufficiency of the myocardium and asystole.

As for the pathogenesis of lesions of the heart in chronic articular rheumatism we cannot compare it with that of acute rheumatism, because, at the present time, although the microbic

origin of the latter has not been incontestably proven, yet it is admitted by most pathologists.

Those who suffer from chronic rheumatism with cardiac complications can be classified in three groups: (1) In the first group the cardiac affection, which has existed for a long time, seems to run a course parallel with that of the rheumatism, but without direct connection with it, since in the previous history of the patient are discovered pathological conditions, such as typhoid fever, syphilis, etc., to which we must refer the cardio-aortic lesion; or scarlet fever, diphtheria, erysipelas, of the lesion is mitral.

(2) In the second group, when we study the evolution of the cardiopathy, we find that it has arisen during an acute or subacute rheumatic attack, which has developed upon a chronic arthritis.

(3) In the third group are gathered the cases, much more rare, in which the chronic arthritis has arisen without being preceded or complicated by any acute or subacute manifestation.

Even if we admit that acute articular rheumatism can in some cases leave articular or peri-articular changes, yet, at the present time, it is generally held that it differs completely, in its nature, from chronic rheumatism.

Dèbove observes that the articular and muscular lesions of chronic rheumatism can be attributed to changes in the central and peripheral nervous system. Likewise Lancereaux says that the lesions of chronic rheumatism are similar to those observed in locomotor ataxia and in general paralysis, and that they originate from some disturbance in the trophic innervation.

Until pathological anatomy can confirm the hypothesis of Dèbove and Lancereaux, chronic rheumatism may be placed in the list of diseases due to retarded nutrition, among which gout and diabetes, as well as chronic rheumatism, may be complicated with organic heart lesions. These complications are produced by the pathological changes peculiar to these three diseases of nutrition.

Bocker found, in the urine of a person with chronic rheumatism, marked diminution of calcium phosphate, while in the blood this salt was four times as plentiful as in the normal state; as always in such cases, uric acid was not found in the blood. The study of the blood and other humors in chronic rheumatism has still to be completed. We, however, in the present state of our knowledge, accept the above theory of the relation between chronic rheumatism and organic heart lesions. —Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

OPHTHALMOLOGY AND OTOLOGY.

IN CHARGE OF J. T. DUNCAN AND J. O. ORR.

Refractive Errors as a Cause of Mental Dulness in Children.—*St. Paul Medical Journal.*

It would hardly seem necessary at this late day to call the attention of the general practitioner to the importance of a careful examination of the eyes in children who show either persistent headaches or inaptitude in their studies, and yet the number of children who are brought to oculists, not upon the advice of their family physicians, but through other influences, would tend to show that the medical profession, as a whole, is not as yet fully alive to the important influence which refractive errors have upon the physical and mental development of this class of the community.

Dr. Charles Stedman Bull, in the February number of *Pediatrics*, calls attention to the frequency with which apparent dulness at school is the result of poor sight.

The presence of adenoids and various other afflictions have long been recognized as important causes for this apparent dulness, but few practitioners seem to realize that an uncorrected refractive error is far more frequently at the bottom of the trouble than these rarer afflictions.

Persistent headaches will frequently suggest to the family physician the possible need of glasses, but dulness and inattention to studies is set down to deficient mental power, or to laziness, and the child is either taken out of school as too dull to acquire an education, or, if he pursues his studies, does so at the expense of an infinite amount of labor, and when his defective sight becomes so manifest that it can no longer be ignored, discovers that the eyes have been permanently injured by the excessive strain put upon them.

An examination by a competent oculist, not by a so-called "graduate optician," will often save years of suffering, both mental and physical, and convert a backward, dull child into a bright scholar who excels his schoolmates in the very studies in which he formerly failed most signally.

This is a subject which should receive careful consideration from the family physician.

Syphilitic Ulcer of the Eyelid.—W. C. POSEY, in the *Ophthalmic Record.*

The patient was a female, aged 52 years. She was the mother of seven children, five of whom were living, the youngest being 17 years old. She never had a miscarriage,

and no information was obtained in regard to a primary sore. The diagnosis was made first, from the fact that she had a running sore upon the skull due to necrosis of the bone, and second, from the nature of the ulcer. The ulcer extended from a point about 4 mm from the external commissure of the lids to the junction of the outer and middle third of the lid. It had entirely destroyed the margin of the lid, cutting one or two deep notches into it. The edges of the ulcer were clean cut but indurated, and its bed was filled in with white necrotic tissue. The ulcer had at first appeared as a small lump like a stye upon the outer margin of the lid, it gradually enlarged, and after three weeks a small open sore appeared on the inner part of the lid. This area spread rapidly.

The patient had been under antisyphillitic treatment for some months in ordinary doses; but these doses had to be doubled, and an iodoform ointment used twice daily before the ulcer was healed. Posey is of opinion that the lump resembling a stye by which this ulcer began was a gumma.

Operation for Corneal Complications of Gonorrheal Ophthalmia.—H. C. PARKER (*Ophthalmic Record for April.*)

Saemisch's incision (the passing of a Graefe knife from clear cornea to clear cornea, and dividing the ulcer) is usually recommended in the books, but no series of cases has been published known to the author. Parker operated on twelve cases, in all of them the ulcer had been spreading rapidly over the cornea, the spreading ceasing, however, after the operation was done. The following results are noted: Out of the twelve cases but one resulted in loss of the eye, in the other eleven there was a useful eye in each case. In most cases the operation should be done early, but it also should be done if the ulcer is extensive and accompanied by bulging of Descemet's membrane. It is necessary to keep the wound open and draining well. The wound should be opened once, or even twice, daily. After the operation the discharge and œdema have rapidly subsided and the patient quickly becomes more comfortable.

Tendon Tucking in Strabismus.

J. E. Colburn (*Ophthalmic Record*) objects to tendon tucking, first on account of the danger of non-adhesion between the tendon and the ocular wall; second, the persistency of the thickening resulting from the folded tendon. The thickening may be very disfiguring. He prefers a combined operation of section and tucking, which is really a shortening of the tendon, and not an advancement.

Cerumen as a Cause of Cough.

Breitung, in the *Wiener Klin. Woch.*, reports the case of a boy who had coughed a long time in paroxysms, with a tickling sensation in the larynx. The cough was very severe; and no cause for it could be found. Finally the author discovered cerumen impacted in his ear, which was softened and removed by syringing. While doing this he caused severe attacks of coughing. After the ear treatment was stopped, the cough disappeared, nor has it returned in the three years which have passed since. Breitung believes that this is a frequently undiagnosed cause of reflex coughing.

Cerumen as an Indirect Cause of Somnolence.

W. G. B. Harland (*St. Louis Medical and Surgical Journal*) gives the history of a boy of 13 years who was brought to the hospital complaining of a tendency to sleep constantly Careful examination was made by Dr. Talley, as well as by the author, and the only abnormal condition discovered was a small impaction of cerumen in the left ear. This was removed by syringing, and a few drops of very fetid pus escaped. The drum was perforated. The sleepiness disappeared the following day. So long as the passage is kept clear there is no return of the somnolence; but, if the wax be allowed to block the passage even slightly, there is a tendency to recurrence of the symptom. The exact cause of the somnolence has not been determined, but the case is an interesting one, and shows the importance of keeping the meatus clear. J. T. D.

Editorials.

THE MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

The recent meeting of the Ontario Medical Association was successful, and it is generally conceded that the success was due chiefly to the ability and zeal of the President, Dr. Powell, and his two lieutenants, Drs. Fotheringham and Milton Cotton, and the committees working with them.

The meetings of the last few years have not attracted as many members as those of ten or twelve years ago. We believe that the reason for this is the fact that some of our meetings have been poor, if not solid failures. The attendance at the recent meeting was the largest for some years. The character of the papers and discussions, and the work done by lantern demonstrations, and in a clinical way, were much above the average. This ought to make it easier to work up enthusiasm for the meeting next year. It was a foregone conclusion that Dr. Mitchell would be President. No man in the association, be he from the east, west or north, better deserves the honor. There are some unwritten laws, such as, the President shall be elected from Toronto every second year, and from the east and west every four years, respectively. No member shall be elected President unless he has previously attended a few meetings. We have no desire to complain of the east, which is furnishing us such a good President for next year; but we think it is generally understood that we have got sadly poor support as to numbers from that section in recent years.

There seems to be a very decided objection to the division into sections for certain portions of the programme. To those who hope that the association will be progressive in character it is difficult to see how it can be avoided. We know of no prosperous general medical society in any part of the world that is able to manage without it. The deadest and flattest meetings we have known are those in which the amount of work offered was so small that there was plenty of time to hear in general session the papers and discussions, with some

to spare for the cranks with their grievances and their amendments to the constitution.

Why is it that there seems to be no proper announcement made respecting the election of the Nominating Committee? The gross carelessness shown in this regard during the last few years has been deplorable.

UNIVERSITY OF TORONTO.

The proceedings at the recent Convocation were, in some respects, more than usually interesting, although somewhat tedious. We desire to congratulate Dr. Reeve, the Dean of the Medical Faculty, on his LL.D. degree, which he well deserves on his own merits, apart from the position he holds in his Faculty.

One of the most interesting features of the programme was the unveiling of the portrait of Hon. Wm. Mulock, ex-Vice-Chancellor. Principal Caven, in presenting it, laid particular stress on Mr. Mulock's support of the re-establishment of the Medical Faculty in 1887, and on his pre-eminent services in connection with confederation, which, without him, could not have been brought about. Vice-Chancellor Moss, on behalf of the University, was glad to receive the portrait of Mr. Mulock, who had greatly distinguished himself both as a University man and a statesman.

Everyone was pleased to again see our good friend, Dr. W. H. Drummond present, and honored as he was. He has captured our University, graduates and undergraduates alike. The other recipients of the LL.D. degree were all well received, especially by the students. The speeches connected with this ceremony occupied so much time that the audience grew very weary, and long before the programme was completed the gymnasium was practically empty.

The Alumni dinner was fairly successful although the number of graduates present was not so great as it should have been. We can hardly expect many from a distance to come to the dinners and meetings when no serious issues affecting the welfare of the university are in evidence. It is sometimes difficult for busy men living in Toronto to attend both the Commencement proceedings in the afternoon and the dinner in the evening.

The officers of the Alumni Association have done exceedingly good work during the last three years, and we are glad to know that this is generally appreciated. Some think, however, that honors should "pass round." All right! pass them round, but don't replace good workers with inane figureheads. Judging from our experience in the past we are inclined to think that when we get zealous and faithful officers we had better *hang on* to them as long as we can.

BATHING IN FRESH AND SALT WATER.

Many people have greatly exaggerated ideas as to the benefits to be derived from bathing, especially in salt water, such as that found on the shores of the Atlantic or the Lower St. Lawrence. Those who visit the resorts in those regions have noticed that a large proportion of the visitors do little or no sea-bathing after the first two or three days. The latter are often greatly disappointed, and think, as the result of their unfortunate experience, that sea bathing does "no good."

Such people are generally quite correct in thinking that their sea baths or swims have been weakening rather than invigorating, but they do not understand the reason. The bad results have been due to injudicious methods of bathing. They have "overdone" it during the early days of their visit, and have thus spoiled it altogether.

We quite agree with the following, taken from the address of Dr. John Grannis, President of the Connecticut Medical Association, delivered at the recent meeting:

"I am accustomed to saying that for the average child or adult the maximum of benefit is obtained by not more than one half hour a week, five minutes every day or ten minutes on alternate days; and, further, if after thorough rubbing there remains a feeling of lassitude, an inclination to lie down, or the desire for a stimulant, the time must be shortened to that point at which, after the bath, the bather exhibits a full reaction and a desire to resume his play or occupation immediately."

We think it would be well for physicians to take more pains and explain to their patients the good or evil which may result from judicious or injudicious methods of bathing.

TOWN VS. ARCHER AND ARCHER.

We are pleased to have the opportunity of publishing in this issue the full text of the judgment recently delivered by Chief Justice Falconbridge in the recent case of alleged malpractice tried in the High Court of Justice, Toronto. The lawyers for the defendants, Drs. D. Archer and R. Archer, practising in partnership in Port Perry, claimed that the action should be voided under the Statute of Limitation by reason of the lapse of time. According to this statute no surgeon "shall be liable to any action for negligence or malpractice by reason of professional services requested or rendered unless such action be commenced within one year from the date, when, in the matter complained of, such professional services terminated." The claim of the defendants in this regard was allowed by the Judge.

We are very glad the judgment did not depend altogether on this technicality. The Chief Justice considered it due to all the parties concerned to pass upon the merits of the case. Malpractice and negligent malpractice are clearly defined, and it is further pointed out that "if a surgeon treat a patient improperly he is liable to an action even though he undertook *gratis* to attend to the patient."

Actions for malpractice were formerly tried by jury, but generally juries favored the patient at the expense of the surgeon. Consequently the courts laid down limitations and restrictions on the action of the jury, or, rather, as to what matters ought to be left to them to deal with. Finally, it was decided that this class of cases be tried by a Judge without a jury. Hence this case was tried by Chief Justice Falconbridge without a jury.

We desire to congratulate Drs. Archer on their complete vindication. The closing words of this remarkably clear and able judgment are as follows: "If the evidence were much less clear and convincing than it is, in other words if the case were much more evenly balanced, I should feel obliged to give the defendants the benefit of the doubt; but, as I have indicated before, I am decidedly of opinion that the plaintiff has failed to make out a case of negligent malpractice, and that the action must be dismissed."

KEMPFFER VS. CONERTY.

Since commenting on Chief Justice Falconbridge's judgment we have received the judgment of Mr. Justice McMahon *re* suit of Kempffer *vs.* Conerty, which we are glad to publish this month. The judgment of the latter like that of the former, is clear and fair, we think, to all parties.

There was a serious difference between the evidence of the witnesses of the plaintiff and that of the defendant as to the shape and size of the splints applied to the boy's arm for the Colles fracture. The Judge considered that Dr. Conerty was likely to have a more correct idea in this regard than the other witnesses, and so ruled. He also considered that all the evidence showed that every precaution was taken, as far as the hand was concerned, to use sufficient padding. Dr. Conerty bandaged the thumb on a line with the index finger. Most of the expert surgeons, giving evidence, pronounced this an unobjectionable course, but the majority preferred the other method.

The splints were left on the arm twenty-three or twenty-four days. When removed there was bony union; but the condition of the palm of the hand and ball of the thumb was not satisfactory, and Dr. Conerty thought further treatment was necessary, and used massage instead of operating. Most of the surgeons considered that immediate operation would have been dangerous on account of the presence of micro-organisms on the hand. A question arose as to carelessness or neglect. The boy should have received more frequent treatment. The defendant ordered the boy to be brought to his surgery every day or every second day. The Judge ruled finally that the reduction of the fracture was perfect, and that the condition of the thumb was due to the neglect of the father and mother and boy in not following out instructions. The action was dismissed. Congratulations to Dr. Conerty!

British Columbia Medical Association.

The third annual meeting will be held in Vancouver, on Friday and Saturday, August 29th and 30th. Members desirous of presenting papers will kindly notify the Secretary, J. M. Pearson, as soon as possible.

Personals.

Dr. E. Lelia Skinner has removed to 40 Carlton Street.

Dr. Price Brown, of Toronto, visited Boston early in June.

Dr. Arthur Small, of Toronto, returned to his home with his bride, June 7th.

Dr. Shaw Webster, of Toronto, visited New York during the first week in June.

Dr. Fred. J. Hart, of Barrie, was married, June 5th, to Miss Bain, Winnipeg.

Dr. Graham Chambers, of Toronto, spent a week, June 7th to 14th, in New York.

Dr. J. W. Rutherford, of Chatham, was married to Miss Jessie Taylor, June 11th.

Dr. J. Franklin Dawson, of Toronto, was married to Miss Hilda Richardson, June 11th.

Dr. Frank C. Trebilcock, of Enniskillen, was married, June 18th, to Miss Sparling, Toronto.

Dr. James Stewart, of Montreal, was elected President of the Association of American Physicians at the May meeting.

Dr. Alex. Stewart has decided to remain in Fort William, where he took over the practice of Dr. Dean about six months ago.

Dr. G. S. Beck, after travelling in Great Britain and Europe for about six months, has returned to Port Arthur, and resumed practice.

Dr. Walter H. McKeown, of Toronto, has removed from McCaul Street to the residence of the late Dr. James H. Burns, College Street.

Dr. W. J. Wilson, of Toronto, left for Atlantic City, June 16th. After remaining there a few days he intended to visit the hospitals in Philadelphia and Baltimore.

Dr. Alexander Munroe, of Victoria, B.C., spent a few days in Toronto in the second week of June. He then went on to Baltimore, where he will engage in post-graduate work in Johns Hopkins Hospital.

Dr. T. Shaw Webster, of Toronto, spent a month visiting hospitals in Baltimore, Philadelphia and New York. He worked two weeks at operative gynecology under Dr. W. R. Bryon, of New York polyclinic.

Professor Wm. Osler, of Baltimore, will spend a portion of the summer at Point-au-Pic, Murray Bay, Quebec.

Dr. Beattie Nesbitt has retired from the presidency of the Simcoe Old Boys' Association. Dr. Wylie was elected President and Dr. Todd Vice-President, at a recent meeting.

Mr. Macdougall King and Mr. George E. Mackenzie, of the final year in medicine, University of Toronto, who went out to South Africa with the Canadian Field Hospital Corps last January, have been allowed their examination, and will be formally admitted to the degree of M.B. on their return to Canada.

Dr. Chas. O'Reilly, of Toronto, went to New York, June 8th. On his journey he injured his leg in attempting to board a morning train at Niagara Falls. After resting a few days in New York he went to Pittsburg on a trip arranged for him by some of his friends in the American Association of Hospital Superintendents.

Col. Neilson, Medical Director-General of Canada, attended the meeting of naval and military surgeons of the United States in Washington during the first week in June. There were present many delegates from Europe. Col. Neilson says all the visitors were treated in a most hospitable way; but more especially those from Great Britain and Canada.

Dr. Marshall Dean, after leaving Fort William, took charge of Dr. Beck's practice in Port Arthur for six months. He passed through Toronto, June 12th, on his way to Brighton, where he will spend a few weeks at his father's residence. In the latter part of July he will go to London, England, where he expects to spend a couple of years at post-graduate work.

Results of Final Examinations, Medical Faculty, University of Toronto.

M.D.—E. S. Hicks.

M.B.—Miss E. L. Anderson, Miss E. Connor, Miss K. McLaren, A. E. Archer, G. H. L. Armstrong, G. M. Atkin, W. J. Bell, A. Brown, J. L. Campbell, W. J. Chambers, W. S. Dakin, E. J. Davey, G. C. Draescke, H. R. Elliott, J. Esler, A. Fisher, G. W. Fletcher, J. J. Fraser, E. E. Fry, J. E. Godfrey, J. A. S. Graham, J. N. Gunn, V. E. Henderson, E. T. Hoidge, J. L. Huffman, J. R. Irwin, E. P. James, W. T. Kergin, O. Klotz, R. W. Leader, H. Logan, D. McBane, H. N. McCordic, A. D. McEachern, N. T. Maclaurin, W. A. R. Mitchell, A. Moir, C. H. Montgomery, W. G. Montgomery, R. H. Mullin, A. Murdock, H. E. Roaf, R.

W. Rutherford, P. W. Saunders, F. Short, D. Smith, A. E. Snell, L. L. Stauffer, H. J. Sullivan, W. T. Wallace, O. C. Withrow, A. B. Wright.

Medals.—Faculty Gold Medal, H. E. Roaf, P. W. Saunders, equal; First Faculty Silver Medal, G. W. Fletcher; Second Faculty Silver Medal, A. Moir; Third Faculty Silver Medal, A. E. Archer.

Scholarships.—First Year, 1. W. S. Lemon; 2. R. L. Clark. Second Year, 1. A. Kinghorn; 2. S. B. Walker.

Post Graduate Scholarship.—The George Brown Memorial Scholarship in Medical Science. For this Scholarship J. E. Davey, G. W. Fletcher, H. E. Roaf, P. W. Saunders, A. E. Archer, and A. Moir ranked in the order named.

Results of Final Examinations University of Trinity College.

M.D., C.M.: W. F. Adams, E. W. Allin, S. G. Allwood, A. H Anderson, M. R. Blake, W. B. Boyce, E. Brandon, J. D. Burns, T. C. Campbell, J. R. C. Carter, Mabel A. Cassidy, R. W. Clancy, Annie Davis, F. O. Gilbart, W. J. Harris, J. Henderson, H. B. Hutton, G. T. Imrie, R. N. Irving, W. A. McCauley, C. H. McDougall, H. McKay, Elizabeth McMaster, J. R. Morrison, J. H. O'Neill, F. A. Ritchie, W. Robertson, Annie Ross, H. E. Service, T. F. Seymour, W. A. Smith, O. Sternberg, Isabella M. Thomson, John Thomson, John J. Thomson, J. M. Waters, R. Waugh, W. T. Williams, Isabella S. Wood.

Medical Council.

The following candidates have passed the final examination, and are now qualified to practice in Ontario: H. C. Arnott, T. D. Archibald, J. W. Atkinson, W. J. Brown, H. A. Bowie, C. W. Brand, J. G. Bogart, J. B. Coleridge, F. J. Colling, John Collison, H. M. Collison, J. D. Chisholm, J. Corcoran, F. P. Coates, J. A. Campbell, T. V. Curtin, J. E. Drury, W. C. Doyle, H. C. De St. Remy, H. E. Day, G. F. Dalton, F. J. Doherty, G. Davis, C. R. Elliott, J. S. Genge, A. J. Grant, W. S. Grimshaw, V. E. Henderson, O. S. Haist, D. E. Hodgson, J. T. Hope, W. T. Hamilton, J. Herod, G. F. Jackson, S. Johnston, G. B. Jamieson, R. J. Kee, T. H. Leggett, R. W. Leader, C. P. Lusk, W. H. Lowry, R. H. Mullin, J. J. Morrow, J. W. Merrill, J. J. Mason, J. W. Moak, E. A. Martin, A. D. MacIntyre, D. G. McIlwraith, J. A. McCollum, J. M. McCormack, J. McCulloch, G. R. Pirie, S. E. Porter, R. Parsons, H. R. Parent, W. C. Redmond, J. Rogers, C. G. Robertson, D. M. Robertson, J. F. S. Riches, A. E. Rannay, C. M. Reason, A. B. Rutherford, E. Richardson, P. W. Saunders, J. Smillie, J. A. Smith, G. W. M. Smith, A. Turner, Isabella Wood, C. S. Wainwright, Jean M. Willson, L. N. Whitley, D. G. Whealey, W. D. Young.

Obituary.

FRANCIS OAKLEY, M.D.

Dr. Oakley, of Toronto, died May 7th, aged 72. He graduated M.D. Victoria University, in 1862.

THOMAS SMITH WALTON, M.D.

Dr. Walton, for many years a practitioner of Parry Sound, died June 13th. He graduated M.D. University of St. Andrew's, Scotland, 1862.

JAMES HAYES, M.D.

Dr. Hayes, of Simcoe, died suddenly, May 31st, aged 58. He graduated from McGill, where he had as fellow students Drs. Temple and O'Rielly, of Toronto, in 1866, and soon after settled in Simcoe, where he practiced until a short time before his death.

THOMAS WILLIAM REYNOLDS, M.D.

Dr. Reynolds died in Baltimore, June 9th. He graduated from McGill in 1881, and was for many years Assistant Medical Superintendent of Hamilton Asylum for Insane. After having two or three hemorrhages from the lungs last winter, he went to Ashville, N.C., where he spent a few months. He started for his home in Hamilton in the latter part of May, but stopped on his way at Baltimore. He grew rapidly worse until death came. The remains were brought to Brockville, and buried June 12th.

LORENZO BACHUS, M.D.

Dr. Lorenzo Backus, of Chatham, died suddenly June 13th, aged 45. He graduated from Trinity University in 1883, and went at once to England, where he soon passed the examination of the Royal College of Physicians, London. He had been ailing

for some weeks but was only confined to bed about two days. He was unmarried and had his surgery and living rooms in the Backus block. The janitress found him dead in his bed on the morning of June 13th.

WILLIAM MILLER ORD, M.D., F.R.C.P. Lond.

The death of Dr. William Miller Ord took place on the 14th May, marks the termination of a very successful and laborious career.

Dr. Ord was the eldest son of Mr. Ord, who had a large practice at Streatham. He was educated at King's College and took the degree of M.B. London in 1857, after a brilliant career at St. Thomas's Hospital, to which institution he became house surgeon and subsequently surgical registrar. Circumstances at that time obliged him to go into general practice and for some years he assisted his father at Streatham, an experience which he always asserted proved of the greatest possible service to him. After some years he was appointed lecturer on zoology at St. Thomas's Hospital. In 1869 he was admitted to the membership of the Royal College of Physicians, and two years subsequently, the hospital having meanwhile been removed to its present site, he was elected assistant physician. He occupied successively the lectureship on physiology and that of medicine, succeeding the famed Dr. Murchison.

Dr. Ord's name will perhaps be best remembered in connection with the important work which he carried out in elucidating the clinical future of the then new disease, myxedema. He was secretary to the Committee of the Clinical Society appointed to investigate the disease, and his researches were conducted with such care and completeness that his writings on the subject really left little to be added. It is to Dr. Ord, indeed, that we owe the designation "myxedema," which has been universally accepted. Another remarkable series of investigations bore fruit in a paper on "The Influence of Colloids on Crystalline Forms and Cohesions," which fully explained the varying forms of crystals which fall in urinary sediments. Dr. Ord also devoted an immense amount of labor to the compilation of the "Nomenclature of Diseases"—a task assumed by the Royal College of Physicians. This work will remain as a lasting monument of skill and comprehensiveness in classification.

Dr. Ord's health began to fail three years ago, after repeated attacks of influenza, but he continued to practice. His health, however, steadily declined, until about two years ago, when he

relinquished active work and retired to Hurstbourne Tarrant, near Andover. He led a quiet, enjoyable existence amid his books and the attractions of a country life, but a few weeks ago brain failure began to manifest itself, and he was taken to the residence of his son at Salisbury, where he died.—*Medical Press and Circular.*

WYATT GALT JOHNSTON, M.D.

Dr. Wyatt Johnston, of Montreal, died suddenly in the General Hospital of that city, June 19th, aged 39. The cause of death was pulmonary embolism following phlebitis, for which he had been treated for some weeks. Deceased was educated at Bishop's College, Lennoxville, and graduated, M.D., McGill University in 1885. He became resident medical officer at the Montreal General Hospital, and was also appointed demonstrator in pathology in McGill University in 1885. In 1894 he became lecturer in bacteriology, and a year later lectured in medico-legal pathology, as well. In 1897 he was appointed assistant professor of public health, and lectured in medico-legal pathology. He was recently appointed professor of hygiene. He was also pathologist to the Montreal General Hospital, bacteriologist to the Provincial Board of Health, and medico-legal expert for the Coroners' Court.

Correspondence.

TRANSPOSITION OF ORGANS.

To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

SIR,—I wish to report a case of situs inversus, or transposition of organs. On the 19th of March, 1902, I was called to see a young woman 15 years old, suffering with inflammatory rheumatism. On examination I found a pleuritic friction rub on both sides with considerable dulness on the left. On examining the heart I could not find the apex in the normal position, but in the corresponding position on the right side. I at first thought that there was sufficient pleuritic effusion on the left side to crowd the heart to the right, but I could distinctly detect the pleuritic friction and there was no bulging of the side, which I might have expected in such an extensive effusion, and there was no difficulty in the breathing and but little cough. In a few days the rheumatism seemed better, but endocarditis and pericarditis set up, and I called in Dr. T. Farncombe, of Trenton, to see the case, and we came to the conclusion that it was a case of transposition of the organs. She died April 10th, and I asked for and was granted permission to hold a *post mortem*. I invited two or three neighboring M.D.'s but something preventing their attendance, I asked two young ladies who were present to assist me. I found the organs just as we had suspected. The heart in the corresponding position on the right side, that it normally is in on the left. The liver on the left side. Fundus of stomach to the right and pyloric ending in the duodenum, surrounding the head of the pancreas, on the left, spleen on right side. I forgot to notice whether the colon and the lungs were transposed. There was but little pleuritic effusion, I being deceived by the liver dulness on the left side. There was extensive pericarditis, the surface of the heart being shaggy, with the inflammatory exudate. I noticed a case reported in the March number of the *Medical World* of an old soldier, but it did not state whether an autopsy was held to verify it. Are they rare ? or are such abnormal conditions frequently found ?

G. H. WADE, M.D.

WOOLER, ONT.

Book Reviews.

Diphtheria. By WM. P. NORTHRUP, M.D., of New York. **Measles, Scarlet Fever and German Measles.** By PROFESSOR DR. TH. VON JURGENSEN, Professor of Medicine in the University of Tubingen. Edited, with additions, by William P. Northrup, M.D., Professor of Pediatrics in the University and Bellevue Medical College, New York. Handsome octavo, 672 pages, illustrated, including 24 full-page plates, 3 of them in colors. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, $5.00 net; half morocco, $6.00 net. Canadian Agents: J. A. Carveth & Co., Toronto.

This volume, the third in the series of English translations of the "Nothnagel System of Practical Medicine," needs no recommendation. Professor Jurgensen and Dr. Northrup are too well known for us to expect anything but the best. The article on diphtheria, entirely original with the editor, is fully in keeping with the high standard set by the other German articles which comprise the work. Dr. Northrup, having been associated with Dr. O'Dwyer at every step in the perfection of intubation tubes, is particularly fitted to describe this aspect of the treatment of diphtheria. Professor Jurgensen's monograph on measles unquestionably is the most comprehensive contribution on that infection that has appeared, bringing out so fully the valuable Danish records of the Faroe Islands epidemic. His exposition of scarlatina is unrivalled both for richness of clinical detail and exactness and clearness of statement. "Fourth Disease" and German measles have been accorded spaces consistent with their importance. The editor has shown judicious decision in his extensive additions, making the work far and away the best and most up-to-date treatise of the subjects extant. The book is profusely illustrated, containing, besides a large number of text cuts, twenty-four full-page plates, three of which are in colors.

Progressive Medicine, Vol. I, 1902. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 452 pages, 5 illustrations. Per volume $2.50, by express prepaid to any address. Per annum, in four cloth-bound volumes, $10.00. Philadelphia and New York: Lea Brothers & Co.

In volume I for 1902 the surgery of the head, neck and chest is considered by C. H. Frazier. The account of recent wonderful progress in the surgery of the gasserian ganglion, and of the heart, will at once attract the attention of all thoughtful men. There is no physician who can afford to overlook the immense value of the knowledge that a wound of the heart may be operated upon with as little hesitation as a wound of the brain, and that in pericarditis with effusion, tapping the heart is entirely practicable. The section on infectious diseases, by F. A. Packard, deals with typhoid fever, tuberculosis, and the various eruptive diseases, the constant progress in the study of which is revolutionizing all our pre-

vious ideas regarding their diagnosis and treatment. Floyd M. Crandall writes of the diseases of children; the importance of pediatrics to the general practitioner is daily emphasized and a knowledge of the recent advances in the science of infant feeding has been rendered absolutely necessary. The section on pathology by Ludvig Hektoen is a summary of the work being done in a science which underlies every department of medicine, and yet with which it is impossible for the clinician to familiarize himself unless studied through some such medium as the present. Laryngology and Rhinology are written of by St. Clair Thomson, their relation to general diseases coming in for special consideration. R. L. Randolph's section on otology concludes the volume, discussing various problems of otology which bring it into relation with the general practice of medicine. The very complete index which accompanies the book renders it easy to consult. These quarterly volumes may be regarded as a progressive text-book of medicine, containing as they do contributions which cover every field of medicine and surgery, and written by men who know exactly what is of the greatest value to the practitioners for whom they write.

The Diagnosis of Surgical Diseases. By DR. E. ALBERT, late Director and Professor of the Surgical Clinic at the University of Vienna. Authorized translation from the eighth enlarged and revised edition, by Robert T. Frank, A.M., M.D., with fifty-three illustrations. New York: D. Appleton & Co. Toronto: Geo. N. Morang & Co.

The work before us is a very lucid translation of Albert's much appreciated German work. There exists at the present time in the English language very few books that deal with surgical diagnosis, while those dealing with medical diagnosis exist in profusion. This volume is written in the free conversational style that is characteristic to German authors; has not treated the subject as is usually done, by dividing surgical diseases under classical headings, but has looked upon them rather from their clinical aspects, and makes his diagnosis by comparison and elimination. The chapters which deal with appendicitis rather surprises one on account of its brevity; it is quite evident that the distinguished German surgeon does not appreciate the appendiceal condition as we meet it in America; however, that may be or may not be a good thing for the patient, undoubtedly cases are operated upon that need not be, and we are sorry to say some are left that should not be. Considerable attention is devoted to abdominal tumors, largely of a cystic nature; these conditions are comparatively rarely met with now, and authors are tending to eliminate them from their treatises. We are very glad to see this reference in Albert's work, as it is a valuable method of keeping the practitioner in touch with a subject that he does not meet with

in the usual run of cases, and is apt to overlook when met with. The work can be highly recommended and will be of great value to all practitioners. The publishers have spared no effort to present the volume in a most attractive form.

Atlas and Epitome of Otology. By GUSTAV BRUHL, M.D., of Berlin, with the collaboration of Professor Dr. A. Politzer, of Vienna. Edited, with additions, by S. MacCuen Smith, M.D., Clinical Professor of Otology Jefferson Medical College, Philadelphia. With 244 colored figures on 39 lithographic plates, 99 text illustrations, and 292 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, $3.00 net.

The first portion of the book is the atlas. In this we have thirty-nine plates, and in each plate one or more figures. Taking them at random we find in plate No. 1 ten figures, in No. 12 one, and in No. 39 there are twenty-four figures. These plates are colored to the life, thereby giving the anatomy of the parts most clearly. By far the greater number of figures, however, are for the purpose of illustrating pathologic changes, both macroscopic and microscopic. And it must be confessed that no illustrations, even in the higher priced books, are superior to these admirable representations. They reproduce the conditions so exactly that not only are they of the greatest value to the student, but enabling the practitioner to see almost every change which takes place, thus aid in their recognition most materially. The remaining portion of the book, the "epitome," was written to contain "everything of importance in the elementary study of otology." In this the author has been successful. Beginning with the anatomy, and devoting thereto sixty pages, he has given us one of the best accounts of this subject at present available. His descriptions (and diagrams) are clear, sufficiently full, and contain the results of the latest investigations. The course of the auditory nerve fibres is stated most clearly. Sections upon the physiology, methods of examination, pathology and treatment complete a book which should be in the hands of every medical man interested in the organ of hearing. J. T. D.

American Gynecology is to be the title of a new journal which is announced to begin publication in July. It will be devoted to gynecology, abdominal surgery and obstetrics. The journal will be owned and controlled by a stock company, consisting solely of members of the profession interested in its special field. It will be conducted under the editorial management of J. Wesley Bovee, M.D., of Washington, D.C.; Charles Jewett, M.D., of New York; Charles P. Noble, M.D., of Philadelphia; Reuben Peterson, M.D., of Ann Arbor, Mich., and J. Whitridge Williams, M.D., of Baltimore. Mr. E. W. Reynolds will be the business manager. The office of publication will be No. 1 Madison Avenue, New York, N. Y.

Selections.

SURGICAL HINTS.

After suturing a wound of the bladder always fill the viscus with sterile salt solution, to observe whether there is any leakage, and place additional sutures if needed.

If possible, never allow a patient who has been operated on, and who requires dressings, catheterization or any other steady attention, to be placed in a wide bed. It is harder to keep a patient still in such a bed, and very difficult to attend to them properly.

Young children hardly ever suffer from hemorrhoids, and bleeding at stool, in the absence of symptoms of dysentery, is nearly always caused by the presence of a polypus. This may often be discovered upon digital examination, and must then be removed by tying off through a speculum.

In cases of paroxysmal pains in women, recurring at intervals, and giving no very marked symptoms of any distinct affection, and particularly if there is no evidence of inflammatory disturbance, it is always well to think of the possibility of hysteria. This disease has been known to simulate appendicitis, renal and hepatic colic, and many other surgical affections. In many cases operations have needlessly been performed when the trouble was entirely hysterical.

Whenever a foreign body has been swallowed, it may be removed by an emetic, or by gastrotomy, or it may be allowed to pass through the intestinal canal. If the body is of such size and form that it may be vomited, it is always safest to cause the patient to eat some pultaceous food, like oatmeal, before causing him to vomit. If the body, though small enough to pass readily through the esophagus, is sharp, such as a pin or other small sharp article, give plenty of bulky food and trust that it may be passed. Large bodies must be removed through the stomach walls.—*International Journal of Surgery.*

A Note on the Bacteriology of One Form of Eczema.

Whitfield has pursued special researches into the bacteriology of dry eczema, dry seborrhea, etc., of the face of children. Clinically the eruptions studied are characterized by small, well-defined discs of varying size, seated chiefly upon the cheeks, chin and neck, with a special predilection for the skin about the mouth. In the latter locality the horny layer becomes fissured

by the movements of the skin, and the scales which form are firmly adherent. The patches on the face show no tendency to symmetry of arrangement. While there may be extension at their periphery there is no tendency to head in the centre. Although several cases may be seen in one family we have no evidence that this form of eruption is contagious. On the other hand, it is certainly seen more commonly after cold winds than at other times.

A patch of eruption was curetted and bouillon cultures obtained from the scrapings. A coccus was recovered in specimens from every individual examined, which grew freely upon gelatin without liquefaction. This germ was non-pathogenic to guinea-pigs, and was unable to produce any eruption when inoculated into the human arm. Nevertheless the author believes it to be a form of staphylococcus, and, further, identical with the germ claimed by Merrill as the cause of seborrheic eczema. This micro-organism was the only one constantly present in these cases.—*British Journal of Dermatology.*

Report of a Case of Dementia Praecox.

William Rush Dutton, Jr., states that the majority of authors agree that this disease is a degenerative psychosis. He describes the case of a Norwegian woman, thirty-one years of age, and sums up the symptoms of the case, which he reports as follows: Mental depression, exaggerated tendon reflexes, a weakening of the heart's action, cyanosis, and a decrease of weight while taking nourishment well. Simple perception of external ideas was not interfered with, but there was fallacious sense perception. Negativism was present, but not very marked. Disturbance of the emotional life was shown by periods of depression and attacks of boisterousness. Stereotypy and verbigeration were shown on several occasions. Katatonic rigidity was present. This case seems to illustrate the katatonic form of dementia præcox.—*Amer. Jour. of Med. Sci.*

For Epididymitis.

Chevillot (*Médecine Orientale*) recommends friction of the scrotum every three days with the following ointment:

℞ Methyl salicylate, 150 grains.
Extract of belladonna, 45 grains.
Lard, 450 grains.
M. ft. ungt.

After friction the scrotum should be enveloped in cotton wool and a suspensory bandage applied. At the end of some hours the pains are said to cease and the patients can get about at their occupations in two or three days. Cure is effected in from eight to twelve days.

Miscellaneous.

The Income of Physicians.

Recently one of the best-known physicians in New York died, a man with a reputation on two continents, who reached the acme of his fame early and had far more than the average years of prosperity. Yet, when his estate was computed, great surprise was expressed on every hand at finding that he had managed to save during a long and busy life only the earnings of two or three years. The same occurrence can be noted every day. A supposedly prosperous physician dies, leaving nothing, while his son gives up his college education and his daughters are compelled to eke out an uncongenial existence as teachers or stenographers.

No doubt the incomes of most physicians are greatly exaggerated. The average income of the well-established city physicians is probably nearer twenty-five hundred than five thousand dollars, while the general average is said to be far below one thousand. But physicians apparently leave much less behind them than other men with similar incomes.

The business training of physicians is to quite an extent responsible for this. Each one does a vast amount of charity work for which he gets little credit, and this is especially true of the men who have an appearance of prosperity from the relative size of the fees they do collect. He is a poor collector, sending out his accounts at infrequent and irregular intervals and creating the not unnatural impression that he does not need the money. Small wonder, then, that the family medical bill is paid only after all other reasonable family desires have been satisfied.

We do not suppose it is possible to suggest any satisfactory fee-scale, but it is self evident that the scale which taxes the clerk a day's wages for consultation, while his employer escapes with the income of a minute, is, to say the least, not an equitable one. Neither can the system be defended as business-like by which the physician treats for nothing a multitude of patients who would willingly pay a small fee for the same service if the fee were in proportion to their means. And if the fees at one end of the scale are too high, those at the other end are certainly too low, as compared to other professions. The man who does not begrudge his pastor a handsome fee for a ten minutes' wedding ceremony, very often thinks the same fee too much for as many hours' work in facilitating the advent of his first-born. The business man pays his attorney a large fee for drawing his will in an emergency and then disputes the account of the surgeon who obviated the immediate necessity of that will.

This inferior business instinct also shows itself in a false professional pride. The laity generally rank a physician according to the location and beauty of his office and the size of his consultation fee, and very many members of the profession are unable to get rid of the same pernicious idea. As a consequence the aspirant invests his income in an expensive office, charges an exclusive fee, and fritters away hours in idleness rather than accept the smaller sums which he might have. Such a policy is good business for a few, but there are not rich patients enough for all, and if one adopts the plan he should do it with the clear understanding that the chances are distinctly against him. After all, the ones who lead the busiest, happiest professional lives, who do the most good in the world, and who leave the most behind, are the ones who have the least of this false professional pride.

While it may be good business policy to have an office in an exclusive neighborhood, by it insuring larger fees and a more exclusive practice, the same reasoning does not apply to a residence in the same neighborhood unless it be amply within one's means. Of course the physician likes to have his family live well and enjoy the society of many of the people who are his patients, but when, on an income of five thousand, he tries to live next to and like the banker on a hundred thousand, he pays a ruinous price.

Certain portions of our large cities are crowded with physicians attempting just this thing. They have the superficial appearance of prosperity; their families are apparently perfectly secured against want and live in style only justified by quadruple the income. After the funeral it transpires that the utmost endeavor has paid the rent or kept up the interest, while the family living has been made from the renting of furnished rooms.—*N. Y. State Journal of Medicine.*

Poisoned to Save Expense.

A Chinese boy was brought into the Pekin Hospital terribly injured by a heavy log falling upon him. The doctors, to save his life, cut off his leg. The mother came, apparently to help nurse the lad. The patient, however, almost immediately afterwards died, and expert examination showed that his mother had given him arsenic. Her reason, it is supposed (says the *Indian Medical Gazette*) was to prevent her son from the disgrace of reaching the next world in a maimed condition. This is a very strong point with the Chinese, who always pickle an amputated member to have it buried with them when they eventually die. In this instance, the family being poor and a whole leg being difficult to pickle, the simpler course was taken of poisoning the boy, so that he and his leg might go together. —*British and Colonial Druggist.*

Senator Vest's Tribute to the Dog.

One of the most eloquent tributes ever paid to the dog was delivered by Senator Vest, of Missouri, some years ago. He was attending court in a country town, and while waiting for the trial of a case in which he was interested, was urged by the attorneys in a dog case to help them. Voluminous evidence was introduced to show that the defendant had shot the dog in malice, while other evidence went to show that the dog had attacked defendant. Vest took no part in the trial and was not disposed to speak. The attorneys, however, urged him to speak. Being thus urged he arose, scanned the face of each juryman for a moment, and said:

"Gentlemen of the jury: The best friend a man has in the world may turn against him and become his enemy. His son or daughter that he has reared with loving care may prove ungrateful. Those who are nearest and dearest to us, those whom we trust with our happiness and good name, may become traitors to their faith. The money that a man has he may lose. It flies away from him, perhaps when he needs it most. A man's reputation may be sacrificed in a moment of ill-considered action. The people who are prone to fall on their knees to do us honor when success is with us may be the first to throw the stone of malice when failure settles its cloud upon our heads. The one absolutely unselfish friend that man can have in this selfish world, the one that never deserts him, the one that never proves ungrateful or treacherous, is his dog. A man's dog stands by him in prosperity and in poverty, in health and in sickness. He will sleep on the cold ground, where the wintry winds blow and the snow drives fiercely, if only he may be near his master's side. He will kiss the hand that has no food to offer; he will lick the sores and wounds that come in encounter with the roughness of the world. He guards the sleep of his pauper master as if he were a prince. When all other friends desert he remains. When riches take wings and reputation falls to pieces, he is as constant in his love as the sun in its journey through the heavens. If fortune drives the master forth an outcast in the world, friendless and homeless, the faithful dog asks no higher privilege than that of accompanying him, to guard against danger, to fight against his enemies. And when the last scene of all comes, and death takes the master in its embrace, and his body is laid away in the cold ground, no matter if all other friends pursue their way, there by the grave side will the noble dog be found, his head between his paws, his eyes sad, but open in alert watchfulness, faithful and true even in death."

Then Vest sat down. He had spoken in a low voice, without a gesture. He made no reference to the evidence or the merits of the case. When he finished, judge and jury were wiping their eyes. The jury filed out but soon entered with a verdict of $500 for the plaintiff, whose dog was shot; and it was said that some of the jurors wanted to hang the defendant. —*Nashville American.*

Verdict for Death Caused by Automobile.

On May 22nd Frank E. Thies recovered a verdict of $3,125 against Edward R. Thomas in the Supreme Court, in a suit for $25,000 damages for the death of his son, seven years old, who, in February last, was run over and fatally injured by Mr. Thomas's automobile. This is the first case of the kind that has been decided in New York, and the charge of the presiding justice to the jury has attracted considerable attention as defining the statutes regarding the liability for personal injuries in such cases. In the course of it he said: Being or playing upon a street is not of itself contributory negligence in such a child. If the automobile in question came upon the deceased under circumstances to produce fright or terror, and such fright or terror caused an error of judgment by which the boy ran in front of the automobile, the error was not contributory negligence. The mere rate of speed, whether high or low, lawful or unlawful, is immaterial, unless it entered into the cause of the accident. An automobile has the same duties to perform when meeting pedestrians or vehicles in the streets that other vehicles are subjected to. No owner or operator is exempt from liability by simply showing that at the time of the accident he did not run at a rate of speed exceeding the limit allowed by the law or the ordinances. On the contrary, no matter how great the rate of speed permitted by the latter, he still remains bound to anticipate that he may meet persons at any point in a public street, and he must keep a proper outlook for them and keep his machine under such control as will enable him to avoid a collision with another person, also using proper care and caution. If necessary, he must slow up and even stop. No blowing of a horn or whistle nor the ringing of a bell or gong, without an attempt to lower speed, is sufficient if the circumstances at a given point demand that the speed be slackened or the machine stopped, and such a course is practicable. On the other hand, every such operator of an automobile has the right to assume that every person he meets will also exercise ordinary care and caution according to the circumstances, and will not negligently or recklessly expose himself to danger.—*Boston Medical and Surgical Journal.*