A distinguished lawyer said to me the other day, that however well prepared he might be, yet he would not, as the law at present stands, *dare* to practice medicine, and he thought he had about as much courage as most people.

Section 200 of the Penal Code, says:

Liability of Physicians.—A physician or surgeon who being in a state of intoxication administers a poisonous drug or does any other act as a physician or surgeon to another person which produces the death of the latter is guilty of manslaughter in the second degree.

But according to Judge Bartlett's ruling, "Physicians are also liable under Section 193 of the Penal Code in connection with the proceeding provisions." Subdivision 3 of Section 193 says: "By any act of procurement or culpable negligence." This comprehends a great deal and can be made to mean anything. A physician or surgeon though he may have the best preparation, yet by any act of procurement as administration of medicine or surgical operation, if the patient dies he may be found guilty of culpable negligence. There will always be found physicians who would have used different procedures, or advised another course as preferable.

If a surgeon for the welfare of a patient deems it best for him or her to perform abdominal section and death ensues, malice can, under subdivision 3 of Section 193, have him indicted for manslaughter in the second degree.

If a surgeon neglects to perform abdominal section, when in the estimation of another it should have been performed, and the patient dies in consequence of the pelvic conditions, that surgeon under Subdivision 3 of Section 193, of the Penal Code, can be found guilty of culpable neglect, and indicted for manslaughter in the second degree.

Judge Bartlett says further: "If a person assumes a certain amount of skill, and does not develop that amount of skill, his act is guilty of culpable negligence." How largely malice or blackmail may misjudge this skill and use the law for direct persecution, or as the *New York Medical Journal* puts it, for "Roasting Physicians."

Notwithstanding the strong points she presents, I am of the opinion that the courts have ruled in justice to all concerned in these cases. It is necessary that the public have proper protection, that while we must advance in our profession only by experience and accumulated skill in the doing of untried operations, yet in their performance great caution and the careful study of cases becomes a necessity. It will be observed that, while it has been a great hardship and required much resolution for the surgeons who have been attacked to defend themselves, yet they have in the end triumphed.

What I would like to see as the result of this discussion is, the betterment of our laws in this, that surgeons may have better protection in the recovery for loss of time, for expenses they have been put to, when it is proven that the case was urged by some disreputable lawyer, or by those personally malignant, within or without the profession.

My conclusions would then be:

1. That we should exercise the greatest care in the examination of our cases of doubtful diagnosis.

2. That when in doubt we should lay great stress upon the necessity of an exploratory incision, and make a very proper explanation of what this means to the patient and friends.

3. That in the cases thus far brought to trial, we have reason to believe that the judges in their rulings have treated our profession with great fairness, the strong points being, that the public good is not subserved by undue and wilful persecution of the surgeon who has shown the proper amount of intelligence in his profession.

4. That we should seek still to have the law so made in our favor as to eliminate the cases of wilful prosecution.

5. That in the careful study of these cases we have presented the lamentable condition of expert testimony. Men absolutely ignorant upon the subject, men who have never done an operation of any merit in surgery, being allowed to come upon the witness stand and testify as experts.

THE MEDICO-LEGAL ASPECT OF EXPLORATORY LAPAROTOMY.

Read in the Section of Medical Jurisprudence at the Forty-first Annual Meeting of the American Medical Association, held in Nashville, Tenn., May, 1890.

BY W. C. WILE, A.M., M.D.,
OF DANBURY, CONN.

All abdominal operations which involve section of the peritoneum are in a measure exploratory. The parts we seek are out of sight, and it is only from the signs, symptoms and history of the case that we can make a diagnosis; and the diagnosis warranting it, we are justified in entering the cavity. We are justified in entering the abdominal cavity, I say, for in the present light of antiseptic surgery, and with the statistics which we have to-day of successful laparotomies, hesitation on the part of the surgeon to attempt *e. g.* to free an obstructed intestine when the symptoms pointing to it are manifest; or to proceed to surgical interference in a case of appendicitis when the indications for such interference are clear; or to explore in cases of abdominal tumors where diagnosis is probable and the life of the patient is endangered; or even to explore where, in cases of profound shock proceeding from some internal source which points to lesion of the abdominal viscera or pelvic contents—hesitation to proceed to surgical relief in such cases is negligence on

the part of the surgeon, as much so as delay to open a knee-joint filled with pus, or to tie a severed femoral artery. Abdominal surgery to-day is a recognized proceeding, and given a case, with diagnosis as clearly defined as is possible, where prolonged suffering or death is imminent from a continuation of affairs, nothing short of exploration to ascertain exactly what the matter may be and with a view to affording relief, is warranted. How true is the affirmation of A. W. Mayo Robson, F.R.C.S., that an exploratory operation has frequently proved curative when apparently nothing beyond incision and exploration by the fingers has been effective. The following case probably explains the nature of these cures. In the Hospitals ("Tidende," 1889), Dr. Howitz describes a case of strongly adherent omentum, with displacement of the stomach and intestines. The patient had been treated for gastric ulcer, also for "the womb;" pessaries had been applied, and douching and massage of the hypogastrium practiced in vain. Dr. Howitz carefully liberated the omental adhesions, so that the displaced viscera returned to their normal positions. All the pain and discomfort from which the patient had so long suffered rapidly disappeared.

How much assurance can we obtain from the successful statistics of Mr. Lawson Tait, who is reported to have performed 135 consecutive laparotomies without a death! Successful abdominal operations with different degrees of extensiveness have been performed upon every abdominal organ. The progress of surgery in this direction is truly marvelous, and as we review in our minds the list of operations which have been successfully performed for gastrotomy, pylorectomy, gastro-enterostomy, gunshot wounds of the stomach and intestines, gunshot wounds of the stomach and liver, resection of the intestines, intestinal obstruction, typhlitis, perityphlitis and appendicitis, colotomy, extraperitoneal hepatotomy, hepatorraphy, hydatid cysts of the liver, cholecystotomy with ligature of the cystic duct, cholecystenterostomy, cyst of the pancreas, abscess of the spleen, splenectomy, hydatid cysts, wandering or floating spleen, rupture of the kidney, nephrorraphy, nephrectomy, diaphragmatic hernia, and the operations for inguinal hernia, we cannot stop short of wonder at the scientific perfection of surgery at the present day.

Now, in the light of all these attainments in abdominal surgery, what shall we do when we are consulted in reference to some condition existing within the abdominal cavity which we recognize as probably jeopardizing the patient's life? Shall we mask the only possibilities of relief through interference, by simple palliation? Shall we put our trust off, assuming ignorance as to any further relief than simply the relief from pain, and keeping the vital machine in motion, until the wheels become clogged, or some pipe bursts? Shall we, because the operation is attended with some danger, deprive the patient of the only possible chance of escape? And shall the reward be awaiting us, that if the condition of that man or woman is in whatever manner made worse from the attempt, we shall have to suffer the penalty of the law for our efforts? How grand, on the one hand, the idea; on the other how small! But it is with all possible care and precaution that any such surgical step should be undertaken. The first great step to be considered before proposing, or consenting to operate, is *diagnosis*. The symptoms of obstructed intestine or of ruptured extra-uterine pregnancy are fairly well defined, and, placed in one side of the balance, operative interference; what can be found to counterbalance the other side, when on the one hand the obstruction has remained for three days, if forsooth so long; or on the other hand, our ruptured tube has been recognized?

It was my sad lot during the past year, to be obliged to stand by, and witness the life-blood ebb away from a ruptured pregnant tube, because the family would not consent to an operation. Slowly and surely the lamp of life grew dim, until in eight hours from the time I was called to the patient, she had breathed her last.

In this case the diagnosis was absolute: Profound shock, dulness, gradually increasing in the left hypogastric region, the os uteri tilted forwards and high up, irregular menstruation, and the onset of the rupture, caused by a strain from lifting. Here a young life was lost, through what? The consent of the Church had been obtained (the patient was a Catholic)—through ignorance of the family and their friends, who preferred letting her die, rather than submit to a simple (comparatively so) operation which offered the only possible chance of recovery.

In this case, had the operation not saved the patient's life, of course the surgeon would not have been blamed, and no legal question would have arisen; but let us suppose a case where the symptoms are not so clearly defined. We are summoned in the night to see a woman suffering with intense pain in the left ovarian region. No tenderness can be found upon vaginal examination, the pain and tenderness are limited to the one spot over the ovary, no tumor can be felt.

Relief is obtained by the use of anodynes and counter-irritants, and in a day or two the patient is quite improved. A week or so passes and the doctor is summoned again. The pain is returned with all its vigor. The patient is once more relieved from pain, and continues so for two weeks, when she decides to visit New York City for a pleasure trip. While there the pain again returns and a specialist is called in, who diagnoses ovarian, or tubal disease, and proposes that she be removed to the hospital for the purpose of an exploratory operation, with the view of removing

the diseased parts if such be found. Thus far this case is actual, and occurred in the writer's practice. But she did no go to the hospital, neither did she have an exploratory incision made; but dismissing the specialist and returning to the family doctor of the friends in the city, and finally consulting two other physicians after her return home, she was finally cured by the last doctor, who rubbed on some smarting liniment, for the rheumatism which he said she had in the *end of the spine*, and which he said was the cause of her trouble. Now, laparotomy is not often advised for rheumatism in the end of the spine; but had she been operated on and recovered, all would have been well and good. But suppose (and here is the question of the paper) an exploratory laparotomy had been made and she did not recover, having succumbed, *e. g.*, from the shock of the operation, and the husband brings suit against the surgeon for damages, *what defensive argument can the doctor present in answer to the charges made against him?* This is what is meant by the title of this paper: "The Medico-legal Aspect of Exploratory Laparotomy." It seems to me that the answer as to the responsibility on the part of the surgeon resolves itself into the following: Laparotomy to-day is in skilful hands a recognized operation. There are certain conditions of disease or accident which can be reached only through abdominal section. The surgeon must be certain as far as possible from his diagnosis, that a given condition, or conditions warranting exploration exist. He ought to be accurately informed as to the correct method of reaching the parts through operative interference. He should know just when the operation ought to be performed in order to obtain the best, or safe results. Beyond this the responsibility lies with the patient, or the patient's friends. They should be informed of the danger of the disease as it exists unrelieved; they should be informed as to the gravity of the operation, and its risks, and they should be warned that in the event of unfavorable result, either through failure of the vital powers to stand the shock, or from a too great extent of diseased parts to permit successful manipulation; or even in the case of a possible mistaken diagnosis after sufficient consultation has been held, the doctor shall not be blamed.

Gentlemen, this is not too great precaution when undertaking such operations. We may be skilful operators; there may be money in the operation; it may bring us fame if we succeed—but the operation of opening the abdominal cavity and handling its contents is no child's play, it is a dangerous proceeding at its best, notwithstanding 135 successful consecutive operations; and a failure might bring the hands of the law heavily down upon the head of the would-be benefactor. But, bringing our best and cautious efforts to bear in a case where we are firm in our conviction that the only salvation lies in operative procedure, we should not hesitate to give the patient every advantage of the enlightenment which is ours, the outcome of skilful experience.

TWO CASES OF HYPERTROPHY OF THE ADENOID TISSUE OF THE BASE OF THE TONGUE, ONE OF THEM PRODUCING "SERIOUS SYMPTOMS."

Read in the Section of Laryngology and Otology at the Forty-first Annual Meeting of the American Medical Association, at Nashville, Tenn., May, 1890.

BY J. E. BOYLAN, M.D.,
OF CINCINNATI.

The pathological importance of the denser layer of lymphatic tissue which has been considered by various observers since Henle's time, and which Waldeyer has shown to exist, normally in an unbroken circle from the base of the tongue around the arcus glosso-palatinus to the tonsil of the fauces, from it to the tube lip and thence to the posterior upper pharyngeal wall on either side, was called into general notice some thirteen years ago by Meyer in his celebrated paper on "Adenoid Vegetations." Since Meyer's communication, repeated investigation of the structure and dimensions of this "lymphatic ring" by Lenschker, Waldeyer, Gerlach, Schwartz, Trautman and others, has demonstrated that besides at the fauces, principally in two well defined regions, is this tissue massed in a similar manner to that between the pillars. In the vault of the pharnyx it exists no longer as a denser layer, but as a circumscribed and systematically arranged mass, comprising almost the whole thickness of the structure and attached by loose connective tissue to the fibro-cartilage basilares, no muscular fibres existing behind it. (1). It is further characterized by a grouping of the follicular glands containing their closed follicles and deep seated asinus glands, the ducts of which open upon the free surface and are filled with the usual gray mucoid substance.

Next important in point of quantity to the pharyngeal tonsil is the similar aggregation of this tissue at the base of the tongue; here it exists in the form of a denser layer extending usually across the whole dorsum and though varying in its dimensions is present in sufficient quantities to have induced Waldeyer to look upon it as nothing less than a flattened tonsil which he designates "tonsilla lingues."

Gerlach, who has traced this tissue upon the tube lip, has seen fit to speak also of a tonsil of the tube, though the strata is here much less dense, and according to Trautmann,[1] rarely, if

[1] Trautmann's work on Adenoid Vegetations with report of 192 autopsies.