SOME ETHICAL PROBLEMS CONFRONTING THE EYE, EAR, NOSE AND THROAT SPECIALIST.*

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A recent editorial in the *Saturday Evening Post*, says: "The Unremunerative Professions: From a high authority, President Pritchett of the Carnegie Foundation, we learn that the medical profession scarcely pays now and tends to pay even less. It is becoming more and more a profession to which men give themselves from ideals of public service, recognizing that the average practitioner is to obtain little more than a comfortable living, and in many cases not even that. The parent who seeks for his son a remunerative occupation should look elsewhere."

Everybody knows that teaching does not pay and preaching pays still less; while literature, if you measure the total bulk of time expended against the gross receipts represents a positive deficit.

There remains the law, in which a sufficiently agile youth may now and then overtake a fortune; but the grand prizes are very few and the average income is about equal to that of a good carpenter.

Thus, of the old professions, none pays. A diligent and skillful man may make a comfortable living and keep up the premiums on his life insurance. Why, then, do practitioners of the learned professions persist in trying to make them pay? How much they might simplify professional life by going in frankly for "ideals of public service" with a reasonable pension. Probably, as a matter of fact, there are more furtive socialists among professional men than professed ones among the workingmen.

Ethics and morality are largely chronologic and geographic. The machine politics of the past two or three decades are now censured by all good citizens. The immoral conduct of the Mormons, the Turks, or the patriarchs would soon land one in jail in the State of New Jersey. So has the ethics of medical practice changed in the past forty years, and even now there is a marked difference in the ethical standards of different localities notably in the city and country, and in the East and West.

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My preceptor maintained that there was no necessity for a code of ethics as the ethics of medical practice should be the same as that governing the relations of one gentleman with another.

The question naturally arises as to what qualities entitle one to be called a gentleman. "A gentleman is an individual whom all other gentlemen concede to be a gentleman" seems to be about as accurate a definition as we can secure. To love your neighbor as yourself and to do as you would others should do unto you is the ideal, but so far as I know, no one on earth has attained such perfection save the man of sorrows himself.

The competitive spirit and the attempt to make the practice of medicine "pay" is the principle cause of the necessity of a medical code of ethics. This is fostered by the low standard of medical education prevalent in this country.

Up to two years ago we had in this country more medical schools than were to be found on the whole continent of Europe; a large number of these were purely commercial institutions with practically no standards, sustained chiefly by clever advertising methods. As a result we have a large surplus of uneducated, ill-trained practitioners. We have four or five times as many physicians in proportion to the population as has Germany or England.

The remedy is obviously higher educational requirements. The man who possesses a college degree before entering upon the study of medicine is much more liable to be imbued with the "ideals of public service" than the one recruited from the ranks of the "butcher, the baker, and the candlestick maker."

Dispensary and hospital abuse is another of the principal reasons why the practice of medicine does not pay. After an experience of many years, I venture to say that at least one-third of the patients coming to the eye, ear, nose and throat clinics in our larger cities can afford to pay for treatment. To be sure, in many instances, they cannot afford to pay the fees of the eminent specialists at the head of the clinic whose services they expect to receive free of charge, but they can afford to pay the usual fee of the poor, struggling junior who actually does their work in the treatment or refraction rooms.

In New York State a law has been passed making it a misdemeanor to apply for free treatment when the applicant can afford to pay, but who ever heard of an attempt at its enforcement. The reason is obvious. The hospital boards are made up of laymen and eminent members of our profession whose sole interest is to make

the institution great. Patients are necessary and the fact that they are unworthy of free treatment is a matter of little moment.

After all, this is nothing more nor less than the survival of the fittest. The eminent members of our profession get most of the desirable cases in their private practice and treat the middle class and poorer work in their hospital and clinics without giving the slightest thought to the rights of their less fortunate brother.

The exclusive special societies will not permit their prospective members to designate their special practice in any public manner whatsoever, yet if Jno. D. Robafeller has a cataract removed or Helen Gold appendicitis, the attending surgeons issue bulletins at almost fifteen minute intervals.

As Lydston pertinently remarks, no one in the medical profession is permitted to advertise except quacks and eminent members of the profession. Is it any wonder that the under-dog says the code is a fence erected by the big fellows to keep the little fellows out?

While many of my hearers may resent these plain words, they are facts not to be gainsayed and we owe it to ourselves and our profession to give them serious consideration. I would urge every member of our profession who has "arrived," to keep fresh in his mind his early struggles and hardships, and to remember that the crumbs from his hospital "table" may be a living for some struggling young member of our profession.

The nationalization of medicine is suggested as a possible outcome of the doctors' revolt against the Lloyd-George National Insurance Act. Dr. Rentoul outlined before the British Medical Association at Liverpool, a scheme for a public medical service, organized, controlled, and worked by doctors. He said he thought that the government should make the employment of all doctors a branch of the civil service, adding that the nationalization of medicine was not as far off as some thought. The state or municipalities already appoint medical officers in the army and navy, under the Poor law in prisons, and for lunacy and other institutions. The trend of the discussion which followed was generally in favor of Dr. Rentoul's suggestion.

It naturally goes without saying that the specialist should be governed by the same code as that governing the general practitioner and the code formulated by the American Medical Association should be carefully studied by every eye, ear, nose and throat specialist. There are, however, some problems confronting the specialist with which the general practitioner does not have to deal.

The general practitioner must be licensed as such by the state before he may practice, but no such public safeguard restricts the specialist. Any person who chooses may call himself a specialist: the only restriction lies in the character of the individual.

There are so many pseudo-specialists that the first and most important ethical question every man should ask himself is, "Am I a real specialist; am I competent; am I what I represent myself to be?" If he cannot conscientiously give an affirmative answer he cannot ethically practice as a specialist, and should fit himself by further preparation.

Dr. M. M. Cullom (*Southern Medical Journal*, February, 1912) says: "There is a time-honored tradition in our profession that one shall only take up a specialty after years of general practice. With this I do not agree. The best time to take up special work is upon completion of an internship in a general hospital the year following graduation."

The best answer to the doctrine of years of preliminary general practice is given by those men one sees in every large special clinic endeavoring to master the intricacies of special work long after they have passed the age of receptivity and enthusiasm. The effort required of many of them to assimilate the simplest elementary facts is little short of pathetic.

A man should begin his life-work before he is thirty, and the sooner he can begin after the necessary preliminary training the better. Years of preliminary practice would result, generally, in one of two things. A man would become so absorbed in his work if successful, that he would have no desire to change it. If not successful he would probably find the same experience awaiting him in another line of medicine. There are, of course, notable exceptions to this rule, but generally speaking, I believe it will hold.

I am a firm believer in the most rigid preparation; the ideal preparation is a collegiate course leading to a degree, followed by four years in a medical college, a year or two years in a general hospital, and then the special line, followed with all the earnestness and enthusiasm that a well-trained mind can bring to bear upon it.

Dr. Hamilton Weir (*Northwest Medicine*, September, 1911) thus defines a specialist: "I consider a specialist to mean a graduate of a responsible medical school, a qualified, licensed practitioner who has perhaps before, but certainly after graduation, further pursued the study of a certain branch of medicine or surgery, and who limits his practice strictly to that chosen department and refuses

or refers to another, any and all practice not properly within his limited line. Further, one who refrains from prescribing outside his specialty even for patients under his care if they are referred to him by a general practitioner, and who refuses under all circumstances, except possibly in emergency or in simple humanity, and this without remuneration, calls or demands for general medical or surgical attention."

To this strict interpretation some may object, and it is probable that many who consider themselves specialists and are so accepted by the profession and laity, would fail to fulfill its requirements by a large margin, but I contend that any interpretation less strict would be unjust to the general practitioner and that its honest fulfillment is necessary to proper professional conduct, to the rights of both specialist and practitioner and in their attitude and service to the public.

I agree most emphatically with Dr. Weir in his strict interpretation of the province of the specialist, and to those who may plead for greater latitude I say not only is it right, but that it pays.

The general practitioner feels his practice is his own: his patients are the assets he has accumulated by a life-time of work and devotion.

The criticism most frequently heard of the specialist is that he oversteps himself and treats the patient for some condition outside his special field or interferes with the treatment being given by the family physician. To be sure, that is often owing to the failure of the patient to fully explain what is being done by the family physician. One or two of my gravest misunderstandings with general practitioners have been due to deliberate prevarication on the part of the patient.

I find it to the advantage of the specialist, the family physician, and the patient, to have most cases complicated by syphilis, rheumatism, cardiac and renal diseases, arterio-sclerosis, etc., treated by family physician, with the specialist seeing the case as frequently as is necessary in the capacity of a consultant.

While the specialist is occasionally guilty of infringing on the general practitioner's field, the general practitioner is more often guilty of attempting to get on without the aid of the specialist. In this particular instance the patient is the greatest sufferer. We often see otitis media from failure to recognize and remove adenoids, mastoiditis from neglected otitis media, glaucoma treated for two weeks with atropin, and posterior synechia following iritis in which no mydriatic was used.

We also see a constant procession of cases in which adenoids and tonsils have "returned" after their removal. When these cases occur in the practices of our friends and confrères who are daily sending us patients it often requires the greatest diplomacy to serve the best interests of the patients and keep the good-will and friendship of the delinquent. The opinion prevails among general practitioners that the removal of adenoids and tonsils is a simple procedure. Thus it may be readily seen that whether the specialist or the general practitioner infringes it is the specialist who suffers.

To keep the good will of both the patient and the family doctor, the specialist must certainly be as wise as a serpent and as harmless as a dove. The general practitioner is quite independent of the specialist; so he can easily take the risk of offending him, whereas the specialist must be most careful not to offend the family physician.

A child with catarrhal otitis due to adenoids is sent by the general practitioner who does his own adenoid and tonsil operations. If the specialist is unwise enough after making the diagnosis, to go ahead and arrange for the operation, he may find this man sending his subsequent consultation work elsewhere. On the contrary, if a family who brings an adenoid case to you of their own volition, ask to have the family physician give the anesthetic, and you consent and arrange for the operation, what is your chagrin a few days later to learn that he is to, or has already performed the operation.

How do you retaliate? By smiling and looking pleasant: you cannot afford to do otherwise. I, of course, understand that these conditions obtain more in the smaller cities such as the one in which I practice, and that in the larger cities the specialist is more of a free-lance and considers everything that comes under his observation fair game with less consideration for the family doctor unless the case is a referred one:

Many specialists are very careless in reporting on referred cases. This is a courtesy to which the family physician is entitled. I have a space on my record cards for the name of the physician by whom the patient is referred and when a written report is made it is checked the same as in posting accounts. Many physicians have expressed gratification at this practice and one man told me recently: "If I send a patient to you and I do not hear from you I know he has not followed my advice."

Patients often fail to state by whom they are sent unless explicitly asked if they are sent by some physician.

In special as in general practice we are sometimes justified in deceiving a patient. In cases of incipient cataract in the aged it would often be positive cruelty to tell the patient that they have cataract. It is, however, wise to protect yourself by informing some member of the patient's family, and even then one sometimes comes to grief and is rated as incompetent, when the patient goes somewhere else and is told the truth.

In rare instances one is justified in "lying like a gentleman" and assuring the patient they are not suffering from the malady which is present.

It seems scarcely proper that I should close my paper without a word on the subject of accepting or giving commissions. This subject has been so thoroughly discussed that words seem almost superfluous. It would seem that every honest and fair-minded man would appreciate the chain of possible evils that might follow this most reprehensible practice, but I blush to say that it exists to a considerable degree. It is but another way of attempting to make the practice of medicine pay, disregarding the patient's welfare.

The specialist is accused of being narrow and seeing the world through a tube. The oculist gives everybody glasses, the rhinologist cuts or saws at your nose, and the otologist is over-hasty in performing a mastoid operation.

Let us be conservative, putting ourselves in the patient's place and asking what we would have done to ourselves or our loved ones under similar conditions, and making the patient's best interest the paramount issue at all times.

Metropolitan Building.

Malformations of the Olfactory Apparatus in Man. PERNA, Jubilee Book of PROF. AUGUSTO MURRI, 1912.

The author describes a malformation which consisted in a congenital bilateral absence of the entire olfactory tract in a twin of 11 months who died of broncho-pneumonia and who, during life, had had a facial paralysis and atrophy of the left ocular orbit. The author considers this malformation the result of an incomplete development of the cerebral portion of the olfactory apparatus.

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