blood, and were somewhat congested centrally, and posteriorly. The cavities of the heart, particularly the right ventricle, contained a good deal of dark fluid blood, as did also the entire venous system. The liver was much congested, dark blood flowing copiously on section. The kidneys were much congested, but otherwise were normal. No uric acid infarction was observed on gross inspection. The stomach contained a drachm of yellowish fluid and some air. Air was seen in the intestines as far down as the transverse colon. The urinary bladder contained a few drops of fluid. The brain was much congested but otherwise was normal, and the same remark will apply to the upper two inches of the spinal cord.

It is certain that the child did not die of hæmorrhage. It is equally certain that it was a well-formed and normal child capable of carrying on its existence with ordinary care. No marks of injury to cause death were anywhere apparent. The appearances were those of death from suffocation, and an opinion was given to the proper legal officers that the child came to its death from suffocation, exposure, and neglect. At the inquest the justice of the district court held the woman to appear before the grand jury for murder of her child. Upon taking testimony, the grand jury found no bill against her.

Certain points of interest appear in this case which it may be profitable to discuss. First, as to the truth of the woman's story. It is evident from preparations made that she *did* know of approaching labor, and the caput succedaneum shows that the labor was not quite tumultuous. She could have summoned aid had she been so disposed. How came the child upon the floor and the placenta in the vessel? How was the cord ruptured? If the woman fainted immediately after extrusion of the child, she must have fallen into the surrounding filth. Nothing was found upon her clothing but a little ordinary lochial discharge. The extraordinary movement of the placenta is hardly consistent with the statement of fainting. Upon inquiry, the woman stated that at time of delivery, her buttocks were not more than a foot from the floor. The cord had a free end of fifteen inches in length, and the child weighed only seven and three-quarters pounds. With regard to the sustaining power of the cord, the only reliable statement at my hand is that of Robin, quoted by A. Flint, Jr., who puts it at ten to twelve pounds. Taylor says nothing definite about it, and Tidy refers to the experiments of Negrier and others as being inconclusive, without giving any definite views of his own. I wished to make some experiments in this direction before presenting this case, but have not been able to do enough reliable work as yet, to warrant notice. If members feel so disposed, I would suggest that a good spring-balance would occupy but little room in the obstetric bag, and any information sent me will be gratefully received and acknowledged in a subsequent paper. A broad tape might be used to attach the fetal end of the cord to the hook of the balance, and the balance being fixed, traction upon the cord to the point of rupture be made. The index of the balance could be made self-registering in many ways which readily suggest themselves. It is almost superfluous to say that such observations should be made immediately after birth of the child, as the changes going on in the cord may make delayed experimentation useless. Reports giving the length of time after delivery, the weight required to break the cord,

and the part of the cord broken, would be of value in the present uncertainty on the subject. Where possible, the effect of weight combined with falling from a known distance would, if noted, be valuable, but naturally such experiments would be more subject to error than simple ones.

How long did the child live? Tardieu, quoted by Tidy, says that the presence of air in the alimentary canal indicates an existence of ten or fifteen minutes, the length of time being in proportion to the depth to which the air has penetrated. In this case, the opinion was given that the child lived some minutes. It is not probable that in this case the child breathed in the maternal passages, as the presentation was of the vertex, and the labor was not delayed.

Could the child have been strangled by the turn of the cord about its neck? The turn was what is commonly called a half-hitch, necessarily exercising no constricting power in absence of a strong pull upon the maternal end. The cord was of unusual length (twenty-nine inches) and, as has been before noticed, the position of the mother would preclude the possibility of strangulation after birth. With regard to strangulation before birth, it is evident that the full dilatation of the lungs and the air in the alimentary canal would have been lacking. Taylor very justly says, that the term strangulation should not apply to those cases where by constriction or knotting of the cord during labor the maternal oxygen is withheld from the fetus. Though the child dies in the same manner as in strangulation, still the term is better limited to subjects which have breathed. My view of this case is that the woman knew of her approaching labor, that she ruptured the cord by pulling upon it after the child was born and before the placenta was delivered, that she removed the placenta and placed it in the chamber-vessel, and, rolling the child snugly in the shawl to avoid warning the family of what had taken place — if for no more unworthy purpose — she went to bed, leaving the child to succumb, which it soon did by suffocation. How much exposure may have favored death it is difficult to say. The temperature of the outside air was about 33° F. during the night. It is hardly reasonable to suppose that the mother was ignorant of the care necessary to be given to a neonatus, as she had had three children previously.

ON THE ABUSES CONNECTED WITH GRATUITOUS MEDICAL TREATMENT.¹

BY HASKET DERBY, M.D.

It may be taken as a maxim that gratuitous medical attendance is to be exercised with discrimination. The obtaining from their profession a means of support for themselves and their families will always be a necessity to the great majority of practitioners. The difficulties in the way of this would evidently be enhanced if they were forced to compete with those whose desire of increasing their clientele led them to reduce their fees far below the usual standard; or whose private means enabled them to practice without remuneration, for the sake either of extending their knowledge or spreading their reputation.

Every physician, therefore, owes it to his brethren to limit his gratuitous practice to certain classes of people. It is his right and duty thus to treat members

¹ Read before the Boston Society for Medical Observation.

of his own profession, unless they have reasons for desiring the contrary, and his privilege to extend his unrequited services to his immediate relatives, and perhaps even to a few most intimate friends. And, over and above this, he expects throughout his life, and especially if connected with any hospital or public clinic, to constantly prescribe for a large number of the poor.

The multitude of those classing themselves under this head, and applying for free medical attendance, is increasing at a considerable rate; and even more than keeps pace with the clinics, public and private, that now open their doors. In Boston, the Eye and Ear Infirmary alone treated 1,911 out-patients in 1852, 3,580 in 1867, 11,027 in 1884. In the same year the total number applying at this institution, the Massachusetts General Hospital, City Hospital, Carney Hospital, and Boston Dispensary was 56,908. When we add to this the number treated at their homes by medical men connected with the above charities, as well as those applying at other clinics scattered through the city, it is evident that these figures would be largely added to. And, considering the population of Boston and the surrounding country, the question naturally arises as to whether the percentage of those receiving free medical and surgical attendance is not abnormally large, and whether a greater degree of discrimination ought not to be exercised by those prescribing for the poor.

I am well aware that this is a threadbare theme on which to submit a paper to this Society, and that much has already been said and written on this subject by those more competent than myself to discuss it intelligently. I venture, however, to again bring it forward, believing as I do that it has thus far largely fallen into the wrong hands, and that it is not for the directors and trustees of our public institutions, whose management of their finances may be admirable, but whose knowledge of their medical and surgical workings might be superficial, to deal theoretically with so grave a question, and frame regulations for the government of an out-patient Utopia. It belongs to the profession, who devote their skill, energies and time to the extension of this relief, to decide on the cases to which it is applicable, as well as to adopt practical measures for the restriction of its abuse. No principle is more false than the one that a physician should be compelled, at the bidding of the lay directors of any medical institution, to treat gratuitously any patient from whom he might with justice accept a fee, had he applied at his private office rather than at the hospital.

The throng requesting medical aid at the out-door department of any public institution may ordinarily be classed as follows:—

First. There are those able and willing to pay for treatment. They are attracted to the institution by its established reputation, as well as by reports of the skill of its staff. They neither expect or desire to be treated gratuitously.

Second. Those able to pay a fee less than the ordinary one; but anxious to have what they consider the best talent brought to bear on their cases, and deterred from consulting the same privately by a fear of the expense.

Third. Those able to pay but unwilling so to do; hoping to steal an opinion and pass unnoticed among the crowd.

Fourth. The deserving poor.

The problem for solution is how to deal with these various classes; to define those really entitled to relief, as well as to arrive at a practical plan for their ready selection. My own solution I offer with all modesty. It is based on twenty years' experience at the Eye Infirmary. Here we have at present an out-patient department of over eleven thousand, recruited from all over New England, and more largely perhaps composed of our native population than would be the case among those applying from the city proper.

The first class, or those able and willing to pay, find placards hung at conspicuous points in the waiting-room, informing all comers that the institution is a public charity, that "it is designed wholly for the poor and needy, under no circumstances for those who are not proper subjects for charitable treatment." These notices prove entirely sufficient and bring about the withdrawal of such people as those above described.

Those able to offer a fee less in amount than that ordinarily demanded are more difficult to deal with. They at once admit, on being questioned, that they do not care for charitable treatment, and expect to pay something. But they have been informed that they will get "the best advice" here; or they assume that professional ability depends on the length of time a man has been in practice, but fear that a private consultation with the older members of the profession will be beyond their means. It is hardly possible to lay down a hard and fast rule applying to all such cases, and yet I believe that this class should, in the great majority of instances, be refused treatment. An honest statement of their circumstances to the private practitioner will almost invariably result in an arrangement by which the fee will be proportioned to their means. And, what is of much importance, the withdrawal of this class of patients from the profession at large, works a distinct injury to the struggling beginner, whose time has not yet become sufficiently valuable to oblige him to always insist on a full honorarium and whose possible absence of private means compels his entire dependence on his professional income; an income largely recruited, during the earlier part of his practice, by the smaller fees derived from patients of relatively humble means. Wealthy hospitals and well-appointed clinics, by absorbing such cases, render the upward path of the medical beginner more difficult year by year.

This whole question of fees, large and small, is both delicate and distasteful. Its discussion lays us open to the imputation of mercenary motives; its casuistry is objected to as unworthy the disciples of a great and beneficent science. But if the laborer is worthy of his hire, if those who serve the altar are to live by the altar, the devoted physician has surely a right to a decent support from the community whose well-being is intrusted to his care, and to whose service he often sacrifices health, and sometimes life itself. Nor can he regard the matter from the airy height of disinterested benevolence, but must keep his books and collect his dues on the same business principles that govern his relations with his own creditors.

The above classes being eliminated, there remain those seeking to obtain advice or treatment by fraud, and those legitimately entitled to both. How to distinguish between them, and in the case of the latter, how to determine that precise degree of absence of worldly possessions that entitles one to free medical treatment, is the great out-patient problem.

The ingenuity of those who seek to disguise their resources must have been experienced to be credited. We were once surprised by a handsome legacy from the estate of an old lady, who had for weeks enjoyed the hospitality of the Infirmary and there been relieved of a cataract; an excellent thing for the institution itself, but not calculated to raise the spirits of the surgeon originally in charge of the case. Another free patient, treated for the same disease, was afterwards discovered to have been the mayor of a New England town, and a large real-estate owner there at the time of the operation. "I prefer to see you at your office, Doctor," said a young man to me once, "as I get more of your time. But I suppose I might go to the infirmary as uncle does." "Is your uncle a very poor man?" I asked. "O, Uncle owns a factory." "But how does he manage to pass at the infirmary?" "Uncle's sly," said the youth, with an exquisite enjoyment of the fact; "he puts on old clothes and dirties his hands, every time he comes down." A well-known lawyer of this city once emerged from the waiting-room, and sat down in the patient's chair. On being remonstrated with for attempting to impose himself on a charity, he coolly informed me that all he wanted was an examination and opinion, having obtained which he proposed to place himself under private treatment outside. He had evidently thought he would escape recognition. A well-to-do merchant, being similarly detected, informed us that he had been a tax-payer for forty years, and demanded treatment as a right. Finally, one day, a very respectable and well-dressed lady from New Hampshire presented herself for treatment, and, disclaiming poverty, was refused an examination. The next patient, evidently in good circumstances, hailed from the same place. So did the four succeeding, all unfit cases for relief. At last it transpired that we were dealing with the members of a cheap excursion, where one of the attractions offered by the enterprising agent had been a free call at the Eye Infirmary.

Various have been the expedients proposed for the sifting out of those cases justly entitled to free relief, and numerous the rules laid down for the purpose of defining them. It has been sought to draw the line at a certain sum earned weekly; all in receipt of smaller wages being accepted, the rest rejected. The absurdity of such a test is borne on its face. A weekly income, large for a single man, may mean absolute want to one with a family dependent on him; while certain occupations involve an expenditure for personal appearance that leaves very little of the modest salary for other than the most urgent wants, even to the man who has but himself to care for. Attendant circumstances are therefore as important as the gross amount of wages earned. Again, it has been sought to test the good faith of applicants by an adaptation of the detective system, employing a trained official to cross-examine them in the outset, and ultimately to investigate doubtful cases at their homes. Were the city poor alone to be considered, such a system might not be without its advantages, but it is evidently inapplicable to a clinique whose material is collected over a wide territory. But little more than half our Infirmary patients are residents of Boston, many of the remainder coming from distant parts of New England. Information might, it is true, be obtained from their town authorities, but the necessary correspondence, besides involving us in the expense of an increased

clerical force, would bring upon the really deserving poor a publicity both unpleasant and unmerited. This would be especially true in the smaller towns.

Passing over other plans, the solution of the whole matter seems to me so simple that I mention it with diffidence. It is but to accept the principle that the out-patient department is for the benefit of those whose lack of means would prevent their obtaining relief elsewhere, and to leave the application of this principle to the physician in attendance. He alone has the responsibility of examination and treatment, he alone should have the privilege of deciding whether his services are well bestowed. If charged with the direction of an important clinique, he is ordinarily an older man than any of his subordinates, has a larger experience of human nature, and, from previous work among the poor, has acquired a more intimate knowledge of their modes of thought and action. Bound by no arbitrary and inflexible rule, he will be able to judge humanely and act promptly. We shall at once be met by the objection that police work of this description is not only distasteful, but no part of the duty of a medical man. A little reflection will, however, show that it can never be very onerous. About the great majority of patients that throng the waiting-rooms of our hospitals, there can be no manner of doubt. And when anything in the dress, manner, or statement of the individual causes hesitancy to be felt, a few questions, put with tact and kindness, will readily resolve the matter; or if doubt should still be felt, the applicant for aid should certainly receive its benefit. It is not pretended that the medical examiner will be infallible, but we claim that fewer mistakes will be made by him than by any other to whom this task may be delegated, and that he should not be hampered by a set of arbitrary rules, in the framing of which he has had no voice, and from the principle of which he may even dissent.

We would not, however, give him unlimited powers. The claim is sometimes made that, for purposes of medical instruction, all should be fish that comes to the net, that valuable material for demonstration is on no account to be thrown away, and that a rare and interesting form of disease may be retained and treated, even though the patient belongs to the better classes. But the end justifies the means as little in medicine as in theology. Such a patient has no claim whatever on an institution endowed for the benefit of the poor. His withdrawal from the ranks of those on whom the profession at large depends for support, works a distinct wrong to the private practitioner, into whose hands he would otherwise fall. If the chief of the clinique elects to utilize in that way his own material, if he conscientiously diverts patients from his office to the hospital, and forgoes his just remuneration for the benefit of his class, all honor to him who thus immolates himself on the altar of science. But he has no right to assume that his professional brethren are equally disinterested, or to aid the individual who is in fraudulent search of gratuitous treatment.

This abuse, however, sinks into insignificance by the side of one to which I wish, in closing, to call particular attention. It is the requirement, on the part of the lay-governing board of a hospital, that their professional staff shall attend and, if required, operate free of charge on any patient, whatever his means, who may choose to occupy a private room at the institution, and pay the rate of board demanded for the same. The charging a fee is, under these circumstances,

strictly prohibited; the invalid pays his twenty-five or fifty dollars a week, and receives in return the free attendance of the best medical and surgical talent that can be found in the community.

A case in point will show the practical working of this state of things. And I would call attention to the fact that what follows is a simple narrative of an actual occurrence. In a New England city, a surgeon, eminent for his skill, was consulted by a woman from the country, who had a tumor of the breast requiring removal. She was accompanied by her clergyman, who proceeded to make the necessary arrangements on her behalf, for the operation. After some inquiry into the patient's circumstances, a fee was named that she declared herself quite able to pay. A boarding-house was engaged, and the day fixed upon. The two left the office, congratulating themselves on having obtained the desired professional skill on terms that met with no objection. Two days later the clergyman appeared alone.

"Doctor," said he, "I am come to tell you that we will not have you perform the operation. You are not, however, to infer that we doubt your skill, or are dissatisfied with your fee of one hundred dollars, but Sister Blank has visited the So-and-So Hospital, and there learned that, by taking a room at twenty-five dollars a week, she can have the operation performed for nothing. She can readily find other uses for the money she would have paid you, and feels it to be her duty to save the amount."

So the matter ended. The surgeon lost his fee, the hospital got its board, and Sister Blank swindled the profession. Comment is here superfluous. We see the reputation, wealth and influence of a powerful institution pitted against the private practitioner, who naturally goes to the wall. And this state of things will continue until the profession takes a firm stand in its own defence, and enacts that its members, who serve a public charity without emolument, shall deny their gratuitous services to all save those who are really unable to meet a fair charge from their own resources.

RUPTURE OF MALE URETHRA AND CORPUS SPONGIOSUM DURING COITUS.

BY F. S. WATSON, M.D.

CASES of rupture of the urethra during coitus are of such comparatively rare occurrence, that I have thought it worth while to report the following case, which came under my notice last summer, at the Genito-Urinary Clinic of the Boston Dispensary.

R. D. presented himself at the clinic with the following story.

Six days previous to visit, while drunk, had connection with his wife, coitus occurring *en postillon*, the man suddenly felt a severe pain in the penis, hæmorrhage from the urethra followed and persisted as a slight oozing for two days.

A swelling surrounding the urethra, and extending from about one inch behind the meatus, to the perineum appeared immediately after coition. Two days after the accident micturition became difficult, owing to a diminution in the size of the stream, and at the end of the next two days there was complete retention of urine. He then sought relief.

The bladder was distended, reaching two-thirds of the way to the umbilicus. A swelling as already de-

scribed occupied the tissues surrounding the urethra, and greatly increased the size of the penis; there was no discoloration; the swelling was hard and tense. A No. 12, English catheter was passed into the urethra, and met with an obstruction two inches behind the meatus; slight pressure easily overcame this obstacle, in passing which the impression to the fingers was as though the instrument had slipped over a ridge of ruptured mucous membrane. Immediately after the eye of the catheter had passed this point, the urine began to flow through the instrument. About forty ounces of clear urine were allowed to drain slowly away through the catheter, and the patient thus relieved was sent to the Carney Hospital. In the evening the patient being unable to urinate voluntarily, the house officer drew off thirty-one ounces more of urine.

The obstruction to the outflow of urine being complete, a soft rubber catheter was tied into the bladder and retained there; on the following day pus discharged itself freely from the meatus. The urethra was now irrigated several times daily with the following solution: Potass Permang. .04; Aquæ 200. The patient continued to wear the catheter, which was frequently changed, for twenty-six days, during which time the discharge of pus slowly diminished, and the swelling decreased in size. He then removed the catheter himself, and tried to urinate. Only a little urine came, the stream suddenly stopped, the swelling became at once very large and tense again; during the night he had several chills, and high fever.

On the following day, I freely incised the swelling from without, in the mediary line on the *raphé*. About an ounce of fetid pus was evacuated from an abscess cavity lying on either side the corpus spongiosum, and beneath the corpora cavernosa. A ragged transverse rent was seen to occupy the floor of the urethra, about two inches behind the meatus. The abscess cavity and the urethra were thoroughly washed out with a solution of corrosive sublimate, 1-10,000. Iodoform was blown into the wound, a drainage tube inserted, and the wound dressed. Directions were given to catheterize the patient at each call to micturate, and that the urethra be washed out after each catheterization with corros. sub. sol. 1-10,000. Two days later the drainage tube was removed, and the wound had entirely closed two weeks later, except a minute fistula, which persisted for a month.

The temperature fell to normal on the day of the operation, and did not rise again. At the seat of the rupture of the urethra, a traumatic stricture resulted, which was very dense, and showed a tendency to very rapid contraction.

The patient was last seen two months after being discharged, when he was advised to have internal urethrotomy performed, which he refused, and was lost sight of. This case besides being interesting from its rarity presents a few other points worthy of attention.

First. The accident caused rupture of the urethra and corpus spongiosum only. As shown by the hæmorrhage occurring from the urethra, and no discoloration of the penis taking place.

Second. The obstruction to the flow of urine and consequent retention, was probably caused by a valve-like action of the ruptured mucous membrane, and not by pressure from the surrounding infiltrated tissues. This was illustrated by the ease with which the catheter No. 12, Eng., passed the obstructing point.

Third. The pressure caused by the urine accumu-