CONCENTRATION OF EFFORT IN MEDICAL SOCIETIES.

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In spite of the utmost conservatism in joining organizations, I find that, beside belonging to the county, district, state and national organizations in affiliation with or rather component parts of, the American Medical Association, I belong also to four other distinctly medical societies. This does not include honorary membership, or *de facto* alumni membership in five or six others, and membership in one or two scientific organizations bearing somewhat closely on medicine. There are also, at least five other, distinctly medical organizations, in which I ought really to have membership, if I followed the advice of my friends and my own first inclination.

From this personal experience it is obvious that any fairly active physician might easily and without pushing himself in the least, hold membership in twenty-five or thirty medical organizations, while it is altogether probable that one with the instincts of a "joiner" could increase the list well toward a hundred.

It seems pertinent to question whether such diffusion of energy is economic. It needs no argument to establish the fact that specialization of interest is necessary in medical as in other organizations. On the other hand, such specialization is, to a large degree, compatible with unity, subject to the establishment of sections, more or less completely separated from the main body.

In my home city, which is doubtless typical of most cities of the first and second magnitude, the most active medical work is done by a local academy of medicine, open to all physicians in good standing who have had two years' practice. Practically, even this restriction amounts to little as, from the beginning of practice, physicians are not only welcome but are urged to attend meetings and, in the face of some individual opposition, even undergraduates are frequently present and have, on a few occasions, presented papers. While known as the Buffalo Academy of Medicine, membership is enjoyed by many out-of-town members.

Since the fusion of the state society and the association, the membership of the academy is practically identical with that of the county society. Curiously enough, there formerly was a controlling element in the latter organization which was not especially interested in the scientific and literary aspects of medicine, and this early precedent has been perpetuated to some degree, in that business rather than medical science marks the meetings of the county society. There are in the city also five or six, perhaps more, semi-social clubs of physicians, nearly or quite all of which do excellent medical work.

Now, independently of the belief that every good-sized city ought to be a county, in the political sense, I would raise the question, not in any local way, but as a general principle, why the dues, organization and scientific and social momentum of all these essentially local units should not be combined? It would then be possible to have one great society, with authority to throw its influence in any desired direction. This could be exerted in securing legislation or municipal and county sanitary reforms, combining social and scientific features—the former having for some years been a recognized function of the academy—and enjoying, at a less average total per capita tax, a much larger income than have any of the separate societies. It would thus better be able to supply the urgent demand for permanent quarters, an adequate medical library, and other advantages for which cooperation is necessary.

Unquestionably convenience and common sense would dictate that such a united society should not exercise all of its functions at any one meeting. For that matter the by-laws of both the county society and the academy provide that certain business shall be transacted at specified meetings and the academy resolves itself, on four successive meetings in each month, into sections for considering various subdivisions of medical art and science.

In this state, as doubtless in others, there are several societies covering areas analogous to those of the district branches of the state society. At the risk of seeming inconsistent, I would advocate the retention of the former, rather than the latter. This view is based on three grounds: 1. As a matter of practical experience, the independent organizations seem to be more enjoyable, interesting and valuable. 2. There is no urgent need of a formal, official organization intermediate between the local and the state societies. 3. While no serious, nor indeed in my opinion any, indications of officialism menace the profession from the present workings of the huge

machine of the American Medical Association, it is not a bad plan to have an independent check on any possible tendency in this direction.

A considerable number of special organizations commonly meet in connection with the American Medical Association and for the most part to their mutual advantage. Some of these organizations, as of editors, examiners, etc., and the American Academy of Medicine, obviously can not be affiliated officially with the American Medical Association. There remain, however, a considerable number of national societies, having no exclusive requirements for admission, some meeting at the same time and place as the national organization, others independently, which might well be reorganized as special sections of the American Medical Association. In the same way a local medical society, beside the commonly recognized divisions of medical art and science, might have smaller sections to carry on certain lines of study in which the majority of the members would not be interested.

This leads me, with some hesitation, to raise the question whether it is advantageous to have medical societies whose principal reason for existence is the establishment of a medical aristocracy. In using this expression, I want to be understood in the literal sense and not as a demagogue, making an "impassioned appeal to the people" in a Fourth of July oration. Note, therefore, that I do not imply an answer to the question. It must candidly be admitted that up to a few years ago—almost exactly to the year 1900—there was need of medical organizations to discuss more serious issues and in a more authoritative way than could be done at the meetings of the American Medical Association. This need probably always will exist for expert laboratory investigators along certain lines but, so far as the various branches of clinical medicine are concerned, it ought to be seriously and frankly considered, whether (1) better results can be obtained by exclusive standards of membership or by mingling men of quite diverse degrees of attainment in the same society; (2) whether it is feasible and advisable to allow the establishment of special sections of the American Medical Association requiring special attainments or greater or less limitation of practice; (3) whether in general medicine and surgery it is advisable and economic for approximately the same nucleus of leaders to maintain two distinct organizations, of different grades of exclusiveness, and if so (4) whether these gradations should be recognized tacitly as calling for different grades of scientific work.

As stated, I do not pretend to decide these questions for others nor even for myself in an offhand way. To avoid the suspicion of having raised a rhetorical question that requires a certain answer, I would confess that the declaration that all men are born free and equal appeals to me as the expression of an aspiration rather than as a fact. Moreover, there are times when one may humbly and sincerely thank God that he is not as other men are. But it does seem to me worth while to consider carefully whether there is sound practical wisdom in carrying on all of the multitudinous independent medical organizations that we have at present. I feel that consolidation and unity along truly democratic lines should be favored unless there are cogent reasons to the contrary. It is only in a society with liberal requirements as to membership that great minds can exert their best influence and receive the greatest credit, by virtue of the educative value of such societies to minds of less power.

A multiplicity of organizations is expensive, directly in money and in time, neither of which is superabundant with physicians. The mere matter of dues is a minor factor and yet, by itself, it would double the efficiency of the profession as a whole, so far as available funds for functional activity are concerned. I am perfectly willing to confess that the financial loss in traveling expenses, hotel bills and loss of practice, in making two or three separate trips to attend medical meetings that might be united, would be a determining argument in leading me to vote for the amalgamation of such societies whenever practicable. A purely statistical study of medical polity leads to the belief that at least 90 per cent. of the medical profession must be seriously influenced by such considerations. I do not claim to have a practice of extraordinary magnitude, and yet there have been numerous occasions when I have been obliged to miss meetings of importance because either sound business reasons or professional responsibility or even a sentiment of humanity, or all three, kept me at work at home. The indifference to these considerations implied by the readiness with which medical meetings are multiplied, is something that amazes the doctor in active private practice. It seems proper to mention this personal opinion since, if it is the experience of a specialist with comparatively little emer-

gency practice, it must apply *a fortiori* to a surgical specialist and to the general practitioner.

But such reasons for medical concentration are of very insignificant importance as compared with the possible results of unity of effort, condensation of literature, consequent facility for keeping track of medical progress and the economy of executive effort. There is no question but that unity of the profession in the State of New York was delayed for years after it was desired by the great majority of both organizations, simply by the fact that two societies appealed to the personal vanity of would-be medical politicians. Now there must be men to conduct the affairs of all organizations and, even in medical societies, there is inevitably a class of men who crave offices for selfish and petty reasons. But, the larger and the greater the society, the less will be the influence of the medical politician, the less opportunity will there be for him to exist, the more useful will he be, whatever the fault in his motives, and the greater will be the tendency to recognize genuine executive ability and to breed true statesmanship, as well as to honor with offices, men of influence, in strictly medical and scientific ways.

Clinical Notes

A SIMPLE METHOD OF EXCISION OF THE FAUCIAL TONSIL.*

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The tonsil lies lengthwise between the two palatal arches; superiorly it is buried in the "supra-tonsillar" fossa and it extends downward as far as the base of the tongue, where as lymphoid tissue it may reach much lower and be lost in the lateral pharyngeal wall. It

Fig. 1.—The Seiler knife—about $\frac{1}{2}$ size.

may be closely adherent to one or both pillars, and either lie clearly in view or be embedded between the arches, and be well covered or obscured by the adherent fold from the anterior pillar, known as the plica-triangularis. That the diseased tonsil should be removed from its matrix or bed as completely as possible does not now admit of argument, and in bringing this subject before the Section this evening nothing new is claimed except the method of excision. The improvement in the operation which I shall describe consists in its simplicity, chiefly through the use of the Seiler knife (Fig. 1), double-edged, curved on the flat and devised for septal work. This, with four other instruments, the tongue depressor, the tonsillar syringe, the Myles tonsillar punch forceps and the Pynchon tonsillar forceps, enables us to make a rapid and clean excision. The operation to be described is applicable to any form of tonsil. As you well know, there are great differences in form and the difficulties of removal likewise vary greatly. To illustrate the operation I shall describe the tonsil that is the most difficult of all to remove. This variety of tonsil is buried deeply in the supra-tonsillar fossa, and is in close contact with the uvula, extending well below the base of the tongue, adherent to the posterior pillar in its entire length, and almost completely enveloped by the triangular membrane, which is so thick as to obliterate the anterior palatal arch, even on close inspection. In beginning this operation on, I will say, the left tonsil, the surgeon will use the tongue depressor with his right

hand, with the left the adrenalin-cocain solution should be injected well around the gland, particularly in the supra-tonsillar fossa, and in the lower third, where the lymphoid tissue about the base of the tongue is sensitive and bleeds easily. Should the anterior pillar or membranous fold be drawn too closely over the tonsil, the injections should be made through the pillar. If this procedure is carried out properly, the operation is painless and practically bloodless.

The patient then holds the tongue depressor, the operator, with the Pynchon forceps in the left hand, seizes and draws downward and forward the extreme upper part of the tonsil, at the same time severing, with the Seiler knife held in the right hand, the attachments to the fossa (Fig. 2). The tonsil is then seized at a lower point, but pulled on very lightly, while the knife is drawn firmly down its length just within the anterior pillar, completely dividing the triangular fold and disclosing the glandular tissue within (Fig. 3).

Should the posterior pillar be adherent as in the case under description, the knife is taken in the left hand, and with the forceps in the right the tonsil is pulled for-

Fig. 2.—Severing the attachments to the fossa.

ward and outward, at the same time severing its adhesions with the pillar (Fig. 4). The knife is again changed to the right hand and with the forceps in the left, drawing strongly on the tonsil, with a few strokes the excision is completed. The forceps are then used to discover any remnants large enough for removal with the knife. Or the Myles tonsillar punch forceps may be used, and are particularly useful in completing the work in the fossa and in removing any superabundant lymphoid tissue left as a continuation of the tonsil down the pharyngeal wall. The time occupied in the local anesthesia for both tonsils depends on the patient and the syringe and will average about ten minutes. The time necessary for the actual operation on both tonsils should be from two to six minutes. There is usually, during the peritonsillar injection, a period of high arterial tension, due to the adrenalin preparation, quickly followed by faintness, which almost as quickly passes off.

I have found a dental obtunding syringe, sterilizable, and with a long, specially-made needle, the most useful. The syringe should be held with the barrel between the

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