Original Articles.

THE ABUSE OF MEDICAL CHARITY: THE PASSING OF THE "CHARITY" HOSPITAL AND DISPENSARY.¹

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A STUDY of medical charity impresses upon one two considerations that seem to be fundamental:

(1) That medical charity is only one division of the great subject of charitable relief, and that its problems must be solved along the lines evolved by workers in the main subject. The same laws are followed: as soon as general charitable relief was instituted it began to be abused; similarly, as soon as medical charity was instituted it also began to be abused. The abuse of general charitable relief always tends to outgrow and to destroy the resources of charitable relief unless constantly kept in check. The abuse of medical charity has the same tendency, and it now threatens to destroy all the sources of relief, which are, *first*, the medical profession, and, *second*, the hospitals and dispensaries. I place the medical profession first because a circle of medical charity radiates from every individual doctor, and it is only when the individual doctor has been overburdened that the community has required hospitals and dispensaries.

(2) The second prominent consideration forced on one's attention is that practically all students of the right administration of charitable relief — those who have had the most extensive practical training in the work — are unanimous in their condemnation of the existing system of medical charity. Not only do they condemn the system as being wrongful and evil in itself (as is all indiscriminate charity), but as being by its peculiar nature singularly fitted to begin a process of personal degradation.

I could quote from every writer on the subject, but will limit myself to a few, the remainder being but repetitions, but spoken with equal earnestness, as the outcome of the experience and conviction of the writer. I call special attention to the fact that these are all non-medical people. I begin with Lord Brougham,² who, in 1818, when serving on a parliamentary committee on The Abuse of Charities, expressed himself in words which cannot be improved upon to-day, and whose views must be accepted as a starting-point by every one who would attain a rational solution of the vexed question of charitable relief in all its forms. He said:

I take it to be a principle which will admit of no contradiction, that the existence of any permanent fund for the support of the poor — the appropriation of any revenue, however raised, which must peremptorily be expended in maintaining such as have no other means of subsistence — has upon the whole a direct tendency to increase their numbers. It produces this effect . . . by discouraging industry, foresight, economy, and by encouraging improvident marriages. . . . But charitable funds will prove harmless (and may be beneficial) exactly in proportion as their

application is limited to combinations of circumstances out of the ordinary course of calculation, and not likely to be taken into account by the laboring classes in the estimate which they form of their future means of gaining a livelihood.

Henry Fawcett³ says:

Thousands in whom it is most important to promote prudent habits are discouraged from making any self-sacrifice, when they observe that the parish does nothing for the industrious, whereas it creates a refuge and an asylum for those who have spent their resources improvidently or those who have wasted their substance in drink.

Mr. George E. McGonegal,⁴ of New York, says:

There is nothing except intemperance in the use of alcoholic liquors which is more demoralizing to the head of a family or more ruinous to children than to become imbued with the idea that the public is bound to provide for them. . . . If people could only realize when they recommend, bring or send a family composed in part of bright, intelligent children who have never yet received public aid . . . and insist upon aid being furnished, that such an act was almost sure to ruin these bright children, and educate them for pauperism or crime when they become men and women, it seems to me that such people would exhaust every other resource to provide a way for such families to overcome their immediate difficulties before incurring the fearful responsibility of being instrumental in making them paupers. People very soon after coming to receive public aid lose their energy and self-respect, finding it easier to rely upon the industry of others than to exert themselves; their children are almost certain to follow in the footsteps of their parents.

Mr. George S. Hale,⁵ of Boston:

It has grown to be an axiom of this [the charitable] branch of social science that no system of charitable relief should be encouraged which weakens the spirit of independence or tempts the recipient to rely upon others. In this respect, the influence of the prevailing system of medical relief is more dangerous and insidious than any other. Men who would not beg — who might not accept alms — may be led to accept this form of relief, and thus gradually be prepared for a condition from which at first they would have shrunk. The care and relief of the sick do not seem to require the same caution as the administration of other forms of charity; we give more readily, we investigate less carefully. . . . Gradually, a portion of the community tend, more or less consciously, to the feeling that they are entitled to expect such relief from it, and come to feel that it may be demanded as a right rather than solicited as a boon. Habits of thrift and caution, nay, even that care which keeps away disease and its expenses, are discouraged.

Mr. W. Chance,⁶ of England:

While outdoor medical relief is open to the same objections as outdoor relief generally, the main objection to it is that in so many cases it is the beginning of a career of pauperism. . . . "Why should I pay when the people next door get their medical relief for nothing?" The facility with which medical relief is obtained encourages among the poor the belief that medical aid differs in kind and eligibility from other relief. Guardians [of the poor] are too apt to regard it in the same light, and are apt to be lax in granting medical relief because it costs [them] nothing.

³ Henry Fawcett, M.P., and Millicent Garrett Fawcett: *Essays and Lectures on Social and Political Subjects: Pauperism, Charity and the Poor Law*, p. 80.

⁴ George E. McGonegal, Superintendent of Poor of State of New York, 1882, in *Public Relief and Private Charity*, by Josephine Shaw Lowell, p. 55.

⁵ George S. Hale: *Medical Charities*, p. 3.

⁶ W. Chance, M.A.: *The Better Administration of the Poor Law*, p. 115.

¹ Read before the New England Hospital Medical Society, February 16, 1899.

² The Pamphleteer, 1818: A letter to Sir Samuel Romilly, M.P., from Henry Brougham, Esq., M.P., F.R.S., upon The Abuse of Charities.

I quote from the "Introduction to the English Exhibits in the Bureau of Charities and Correction" at the Columbian Exposition, 1893, p. 19:

The newer Poor Law Infirmaries are large, well-equipped hospitals. Admission is obtained with comparative ease, and the indoor pauperism in London and in some other towns is in part to be accounted for by the numerous and constant admissions to them.

Bradfield Board of Guardians, 1893⁷:

... a long experience has only strengthened their conviction that free medical relief, unless carefully guarded, is an open door to pauperism, and is, in the long run, not a boon but an injury to the poor. They are of the opinion, moreover, that it is *prima facie* the duty of heads of families to do their best to provide medicine as well as other necessities both for themselves and their children, and that anything which may encourage the expectation that such responsibility may be shifted on to the shoulders of the rate-payers, will weaken the sense of this duty, and is calculated to hinder the growth of habits of thrift and forethought.

Sir Charles Trevelyan⁸:

Of the various modes in which our people are educated to dependence and mendicancy, there is none more pernicious than the arrangement by which they are relieved from all necessity for forethought and thrift in providing for the care of their health.

Report on Metropolitan Medical Relief in London⁹:

In hundreds of thousands this system of medical relief is the entrance gate to those habits of dependence ... so that our London hospitals and dispensaries have been converted into schools of pauperism. Our people are educated by them to improvident and mendicant habits by being entirely relieved as regards this requirement of civilized life from all necessity for forethought and thrift. ... All the arts of deception flourish in connection with misapplied charity. In 1870 a society organized for the improvement of the permanent condition of the poor soon came to the conclusion that one of the most powerful causes by which their condition had been depressed was this system of gratuitous, indiscriminate medical relief, and that every other arrangement for their benefit must fail in producing its full effect while this evil remained unremedied.

Medical Committee Charity Organization Society, London, 1871:

Your committee believes there is no one class of charity which is doing so much to pauperize the population, to undermine their independence and self-respect and to discourage habits of providence, as the medical charities.¹⁰

The study of this tendency to take advantage of any and every opportunity to shift one's burdens to another is a curious one. Traces of it are seen in every class and phase of society. It is not the reaching out of the self-respecting man to help and be helped in turn; on the contrary, it is a species of *parasitism* leading to degeneration or reversion to a lower type. It is not surprising that this tendency to reversion should be so widely diffused in man, waiting merely a favorable environment for its development, when it is remembered that "of the animal kingdom as a whole more than half the species are parasites,"¹¹ and when it is also remembered that the tendency to reversion to a lower type is always imminent.

⁷ W. Chance, M.A.: *The Better Administration of the Poor Law*, p. 122.

⁸ Sir Charles Trevelyan: *On the Extension of Provident Dispensaries throughout London and Its Environs*, p. 3.

⁹ Quoted in full in *Medical Relief to the Poor*; compiled by William R. Lawrence, M.D., p. 6.

¹⁰ *Loc. cit.*

¹¹ Herbert Spencer: *Principles of Biology*, I., p. 342.

The most alarming evidences of degeneration resulting from this *parasitism* are seen first in the youngest, and hence most perishable, faculties of the human race — in the higher spheres of mentality — though, if the degeneration proceeds unchecked, the lower centres, and, later, what are called the more purely physical, and even the vegetative, spheres are affected. A fully-developed human parasite undoubtedly shows aberrations in all his functions. The chain is intact; beginning with a moral obliquity, hypocrisy and deceit follow, then a conscious or unconscious tendency to malingering and to shift to the doctor responsibility for health that should be assumed by the patient (and met by avoidance of sources of disease and of indulgence in temptations which undermine health or strength, by regular work and exercise, by cleanliness of person and home surroundings, etc.), next a shifting of responsibility to the hospital for sustenance during temporary depression of health. From this it is scarcely a step to shift to the community at large the responsibility for his sustenance when well. What he can demand for himself he demands for his wife and his children. They follow in his footsteps and recommence the vicious circle.

But the striking fact elicited by the study of this question is that the parasite fastens himself most readily upon the community through the medium of medical charity. To express it differently: *Parasitism* appears to be latent in us all; indiscriminate charity of any kind develops a rapid and luxuriant growth; the most favorable culture medium is medical charity — exposed to the stimulating effects of this, few of us would fail to respond and send out little clinging, grasping shoots. I tremble to think of the effects if landlords would compete with each other in offering free rent and skilled attendance to doctors.

Let me quote some figures showing with what luxuriance parasitism grows when fed freely with medical charity. I quote largely from Mr. Henry C. Burdett, of England,¹² who has devoted an immense amount of time and labor to the question of hospital administration, and whose writings are admitted to be standard:

In Birmingham, in 1876, there had been an increase in ten years of 56 per cent. in the number of applicants for medical charity, though the population of the town had increased only 13.8 per cent., and the prosperity of the town had not appreciably decreased. At the Queen's Hospital, investigation showed that 30 per cent. of the applicants to the out-patient department were unfit objects for charity. Again, 10 per cent. were able to pay the full, ordinary fee of a private doctor, as proved by the test question: "Are you able to pay a lump sum for a doctor's bill, say \$20 or \$25?" At the Birmingham and Midland Hospital for Sick Children ... "the out-patient department is growing beyond the power of the staff to prescribe for, beyond the capacity of the waiting-hall to hold with safety, beyond the strength of the dispenser to deal with or of the porter to keep in order, finally, beyond the revenue of the charity." Finally, in 1876, about one-third of the entire population of the city was receiving free medical treatment.

In London, during a period of years, while the population had a little more than doubled, the number of out-patients at eight hospitals had increased more than fivefold. At the Royal Free Hospital, investigation

¹² Henry C. Burdett: *Pay Hospitals and Paying Wards Throughout the World*.

showed 74 per cent. of the applicants to be unfit objects for charity. Finally, in 1879, one-fourth of the whole population of London was receiving free medical treatment. In 1877 one-half of the population of Liverpool was equally favored.

In America, parasitism is growing with equal or greater vigor. In 1886 about one-fourth of the population of Boston, in 1893 one-fifth of that of Philadelphia, and in 1897 about one-half of that of New York were estimated as receiving free medical treatment.

Side by side with this growth of parasitism, and proportional to it, has been the suffering of the medical profession and the hospitals, until now both are merely staggering along under the weight of this ever-enlarging Old Man of the Sea.

THE EFFECT OF PARASITISM ON THE MEDICAL PROFESSION.

The requirements for the medical profession have been steadily increasing; a more advanced preparatory education, a longer college year, a greater number of years, a greater variety of books and scientific apparatus, a longer or shorter course of clinical or technical study after graduation, are now demanded of even the average physician. This means a large increase in the expense of medical education and a restriction of candidates to the ranks of those who possess a certain financial surplus. When a graduate at last is ready to begin his lifework he finds practice difficult or impossible, according to the stage of development of medical parasitism in his neighborhood. There is plenty of work if he wishes to do it, but no financial return. Why should people pay him for that which they can get for nothing around the corner? The result is, he sits in his office alone, or, filled with a blind desire to work and develop his powers, regardless of the consequences to others, he gives of his strength to feed the parasites. Meantime his resources are disappearing. Long ago "Poor Richard" warned him that "Always taking out and never putting in soon comes to the bottom." When he comes to the bottom he drops out—often one knows not where. Sometimes, trying desperately to cling to some faint trace of his chosen profession, he acts as agent for a medical publishing house, a medical journal, a more or less reputable drug house; sometimes the less reputable beguile him with a mess of pottage into lending them the endorsement of his legitimate title of M.D.; sometimes he falls into quackery, selling the prescriptions of his old professors as secret remedies; sometimes he accepts the golden offering of the abortion seeker; sometimes, and more often of late, he chooses the radical remedy of suicide.

So it is coming to pass more and more that the survival of the fittest among physicians means the survival of the financially strong, and that more and more the ranks of the medical profession must be recruited from among those men and women who possess a living income outside of any expected professional returns, rather than essentially from among those who respond to its call as a vocation. This is not a necessity, nor is it best for either the profession or the community. Personal fitness should be the determining factor, especially in the choice of a medical career, and an honest worker should be able to make an honest living. There is plenty of work and there would

be no difficulty if every one paid for his medical attendance in proportion as he pays for his rent, his food, his clothes and other necessities of life.

THE EFFECT OF PARASITISM ON THE HOSPITALS.

The suffering of the hospitals and dispensaries—that is, of those who support them—is great, though less vital than that of the medical profession. What Sir Charles Trevelyan says of the English hospitals is equally true of those in this country:

With two or three exceptions, the hospitals are all out at elbows. The whole system is breaking down by its own weight. They are spending more than they get and are constantly making appeals to be rescued from bankruptcy. How can it be otherwise? The burden to be borne is nothing short of the medical treatment of the entire community, with the exception of a narrow, upper margin.

What is the remedy? It is like asking, What is the remedy for headache? The quack or the novice will have a hundred suggestions to make off-hand, but the scientific physician knows that since the head is connected with every organ in the body, so every organ in the body must be consulted and studied before the head can be cured. So it is with the abuse of medical charity: the necessitous sick, the people afflicted with inherited or acquired parasitism, the self-respecting people, the medical profession, the charitable people, who build and support hospitals and dispensaries, the community as a whole, which grants public aid to hospitals and dispensaries—all these are vitally interested in the problem.

Before enumerating some of the remedies which have been suggested by experienced workers, the writer would suggest that no remedy can be effectual which does not recognize the ethical soundness of the following propositions:

(1) Medical advice is a marketable commodity, representing the investment of capital and the expenditure of labor as truly as does the output of the mine, the gathered produce of the field or the finished product of the factory.

(2) It is the duty of every member of the community to make provision for sickness, which is as inevitable as hunger or the inclemencies of the seasons or death.

(3) It is as harmful to the individual and to the community to offer free medical advice and treatment as it is to offer free fuel, free food or other necessities of life.

Much reference has been made to English views on the subject of this paper, because in England the problem has been more acute for a longer time, has been longer under study and hence has a larger literature. The problem is essentially the same in both countries, though there are minor differences, owing to variations in institutional foundations and in class characteristics. All English authorities are agreed that some form of paying system, according to the means of the applicant, is the only method of relief for the evils about which there is no difference of opinion.

One remedy has been tried in both countries—the charging of a registration fee, varying usually from ten to twenty-five cents (to insure uniformity, I shall translate the English money into our currency). Mr. Sampson Gamgee voices the condemnation which all who follow it to its final workings must visit upon this remedy. He says:

By such a regulation, the hospital is made a vast competitor against provident sick clubs [and against the individual doctor], and the self-respect of the working population is undermined by inducements to untruthfulness, with practical immunity from detection. Under such circumstances, the hospital becomes not only a training-school for pauperism [parasitism] but for duplicity.¹³

Another remedy tried in some parts of England is what is called *medical relief on loan* or *by case fee*, where guardians of the poor grant medical relief when it is truly needed, collecting the amount later, when the patient is able to pay. Thus, in the St. Neot's Union, the doctors are paid \$1.50 for each case which they are ordered by the relieving officer to attend, and fifty cents a quarter for each permanent pauper.¹⁴ After several years the system is reported working satisfactorily, and it has not been found open to any abuse. Its great advantage is that it shows that medical relief costs *something* and has the effect of curbing the foolish generosity of those who think it costs nothing.

The remedy most generally recommended at the present time is the transformation of all free dispensaries into what are called Provident Dispensaries. The scheme of a Provident Dispensary is a form of health insurance, similar to the plan of life or fire insurance. The members join when in health (or if ill, by paying extra), and by paying certain fees, based on their earning capacity, are entitled to call in any member of the dispensary staff when ill. No one is admitted who is able to pay a doctor's ordinary fee. Surgical operations and confinement cases are attended for a definite extra fee. After paying the whole or part of the running expenses of the dispensary, the fees received are divided among the doctors who have done the work. So-called "doctor's clubs" or "medical aid" societies are organized on similar lines in communities where no dispensary exists. For instance, there is a club in Kent, made up of working people whose earnings from every source do not exceed, if married, \$7.50 a week, or, if single, \$5.25 a week; domestic servants whose wages do not exceed \$60 a year are included. Members join for one year and pay in semi-annual instalments the following fees: Members over fourteen years of age, \$1.00 a year; a man and wife who have children, 75 cents each for themselves; a widow with children, 62½ cents for herself; members under fourteen years of age, 50 cents, except widow's children, who pay 25 cents each. Confinement fees are \$3.75; minor surgery and tooth extraction, 25 cents; members find their own bottles, bandages and trusses and send for their medicines, which are supplied by the doctor. All office calls and calls for visits must be made or sent in before 10.30 A. M., except in case of sudden illness. Surgical operations are done for a definite extra fee. Habitual drunkards and persons affected with venereal diseases are not admitted to the club. The membership of this club, which includes a whole Union, is 3,000, hence the smallness of the fees. The pauperism of the Union is small, owing in large measure to the club. The effect of such clubs and Provident Dispensaries is said to be remarkable in a growing disinclination of the poor to apply for free medical aid. The advantage to the doctors is that although the fees are small they are certain of them, and they are relieved of the trouble of collecting them. The club

just described had no expenses, so all the fees went to the doctors.¹⁵

This might be contrasted with the Provident Dispensary at the Royal Albert Hospital at Devonport,¹⁶ a city of 50,000 inhabitants. In 1878 3,522 patients joined the dispensary; the fees amounted to \$3,190; the expenses were \$2,185; these were paid, and \$1,005 was left to be divided among the three doctors who did the work. It must be remembered that the number of members does not mean the number of patients; the members pay whether they are ill or well, else the element of insurance would be absent. To give some idea of the practical workings from the doctor's point of view I quote one doctor's report of his work:

Number of attendances, including visits, last year 1,245 and receipts \$301.25, about twenty-five cents each; number of patients 256; longest attendance on one patient twenty-four calls; five were seen twenty or more times; five deaths, that is, two infants from malnutrition, one child from diphtheria, two old people; with these exceptions, there was only one case of really serious illness. Midwifery not included in above.¹⁷

All authorities are united in praising the Provident Dispensary system, *provided* — and this cannot be emphasized too strongly — *provided the wage limit is strictly maintained*. Where this fundamental precaution is omitted abuses creep in, parasitism develops, and the evils of the present system are reproduced and aggravated. Thus, we read of doctors receiving three cents a visit; of one doctor making 5,600 visits and receiving \$75 for them, not quite two cents apiece.¹⁸ Another necessary factor to the success of the Provident Dispensary is that it shall not have to compete with the free dispensary. The parasitic tendency is so strong in all classes that, as one writer says, "people will not put by even a penny a week to buy that which they can obtain for the asking." Still, even with this drawback, it is interesting to see that in the summary of hospital and dispensary accommodation in London, laid before the Committee on Hospitals, of the House of Lords, 1890-92, twenty-six free dispensaries were reported, with a deficit of \$10,015; thirteen part-pay dispensaries, with a deficit of \$3,570; thirty-five Provident Dispensaries, with a balance of \$55.¹⁹

How much we in America can benefit by the English experiences summarized above and what modifications might be required in adapting the Provident system to our own institutions are questions not to be settled by one person or group of persons. What is required is consultation and co-operation among the several bodies of people concerned: (1) those members of the community who are in sympathy with the efforts of organized charity to improve permanently the condition of the poor and to suppress mendicancy, especially those interested in the medical division of this subject; (2) the wage-earners themselves; (3) the hospital and dispensary authorities; and (4) the medical profession. No unity of effort, however, is possible till the sources of friction between the two latter bodies are removed. The writer would suggest that much of this friction is due to the fact that the rela-

¹³ Henry C. Burdett: Pay Hospitals and Paying Wards Throughout the World, p. 13.

¹⁴ W. Chance, M.A.: The Better Administration of the Poor Law, p. 122.

¹⁵ W. Chance, M.A.: The Better Administration of the Poor Law, p. 124.

¹⁶ Henry C. Burdett: Pay Hospitals and Paying Wards throughout the World, p. 19.

¹⁷ Charity Organization Review, London, n. s. 1, 1897, p. 73.

¹⁸ Loc. cit., n. s. 2, 1897, p. 219.

¹⁹ Hospitals, Dispensaries and Nursing. International Congress of Charities, Correction and Philanthropy, Chicago, 1893, p. 30.

tion of hospitals and dispensaries to the whole community has undergone a complete change within recent years, that many details have not been adjusted in harmony with this change and that the friction existing is only a question of readjustment. The hospital is no longer a mere hospice or refuge for the sick traveller; it is not even merely a place of rescue and solace for the helpless sick poor, who would otherwise die by the wayside or suffer alone in a hovel. Theoretically, the hospitals are operated on these traditional lines, but practically their position has changed, almost insensibly but none the less completely. Modern medicine and surgery have been almost transformed and now require appliances that in their preparation, storage and use may be likened to the products of a laboratory. The doctors, who have made these changes and originated these appliances, have made the hospitals the centres for the practical application of modern scientific advances. Through such centralization of effort on the part of the medical profession, the hospitals have become, as it were, large laboratories where not only is scientific research put to the practical test but where modern medical and surgical appliances may be prepared, stored and used under the most favorable circumstances. The community has been educated by the doctors to appreciate these appliances, but, as a rule, can obtain them only by a complete or partial parasitism; complete as regards the doctor who must give his services for nothing; partial or complete as regards the hospital, for, infected with parasitism, the patient pays as little as he is permitted, and has no hesitancy about throwing the burden on the hospital.

One point has been fully set forth in this paper, that is, the unjust competition of hospitals and dispensaries with physicians by encouraging parasitism in out-patients. As just stated, the same evil exists among in-patients. Among these latter the evil is still further aggravated by directly antagonizing individual physicians. For example, a physician is in charge of a patient outside. He knows the patient would be less liable to a severe type of the disease and would recover sooner if he could have the nursing care of a hospital. If he advises this it means that he loses the patient, which means (1) the experience which he would obtain from the case, (2) the professional reputation, and (3) the financial return. In addition, the patient is infected with parasitism, for he learns that entering a hospital is an easy way to avoid paying a doctor. The only exception to this is that, in a very few instances, members of a hospital staff are permitted to transfer their patients from private life to hospital care, but in most of such cases the prices charged by the hospital for board and nursing are so high as to be prohibitive to all but the very well-to-do. At the same time that the hospital thus competes unfairly with the individual physician it advertises itself to the community as the physician is not permitted to do, and makes every effort to entice patients from their regularly attending physicians; and having caught the patient, it then insists that its staff shall treat him for nothing! The hospital does this that it may hold its own with its commercial rivals in a mad race for the highest number of patients treated, so that it may justify itself in demanding a larger alms from public and private donors. The members of the staffs, in many cases, join the merry crowd, and the patients are only embarrassed by having to choose among such ardent suitors. The reduc-

tion to the absurdity was shown when a new superintendent of charities for the District of Columbia called at an out-patient department where he was unknown, and offers were twice made to prescribe for him before he could escape.²⁰ Alluding to this "pernicious habit of advertising the number of their applicants as a means of exciting the sympathies of the public," one writer forcibly says:

It cannot be too strongly urged upon the attention of the public that the mere statement of the number of applicants to a hospital forms no proper index to the amount of good which it does; nay, rather it may tell in the opposite direction, for the highest good is to discriminate the cases, to weed out those that are unsuitable, and to give relief only to that comparatively small number who are really fit applicants, and to whom the advice and medicine thus given will be an unmixed boon. It is the ability of its staff, the skill of its nursing, the excellence of its general arrangements and the wisdom of its benevolence which ought to recommend a hospital to the support of the public, and not merely the numbers who have passed through its consulting-rooms in a week or a year.²¹

There does not seem to be any good reason why some form of the provident system should not be applicable to the in-patients of the hospital as well as the out-patients; and a proportionate amount of the fees should go to the physicians and surgeons who do the work. Further, no physician in good standing should be expected to give up his patient when the latter enters a hospital; if he is competent to care for the patient outside, he is equally competent at the hospital. Again, remembering the changed relation of the hospital to the community, some plan might be evolved by which it would not be necessary for the patient to leave home to receive the benefit of the modern appliances to which allusion has been made—operative preparations, sterile dressings, special portable apparatus, occasional attendance of trained nurses for day or night; these might all, in selected cases, be supplied from these central laboratories or hospitals to patients at their homes, at expense adapted to the pecuniary resources of the patient. The benefit would be to the patient and to the hospital; to the patient, in that in many cases homes would not need to be broken up and the family scattered, as so often occurs when, for instance, the wife and mother goes to the hospital; to the hospital, in that there would be much saving of space on cases that could be equally well cared for at home, leaving the beds free for the more serious cases which now are often crowded out for lack of room; also, a saving of expense on these less serious cases, since Mr. Burdett has calculated that, on an average, one in-patient represents an expenditure about equal to that of thirty out-patients.

It can be at once seen how a recognition of the justness and fairness of these points would not only remove friction and hinder parasitism but would immensely favor co-operation among the whole community, patients, hospitals and doctors. Mr. Burdett, the hospital authority already quoted, is of the opinion that American hospitals are grievously mistaken in not paying their attending staffs; indeed, he says, "I am one of those who have come to this conclusion, that, for the well-being of all the hospitals, I would pay every medical man who gave any services what-

²⁰ Report of Sixth Section of the International Congress of Charities, Correction and Philanthropy, Chicago, 1893, p. 129.

²¹ Quoted in full in *Medical Relief to the Poor*; compiled by William B. Lawrence, M.D., p. 35.

ever to any hospital."²² The only argument I have ever heard made in favor of doctors giving their services free to hospitals is that the doctors were increasing their knowledge and reputation by being permitted (!) to do this. But this is no argument at all, and it is most unjust to use what is the glory of the medical profession as a means for destroying their livelihood. Every conscientious man in every profession, trade or business is learning his work better and is perfecting himself daily by the accomplishment of each piece of work; yet that is never put forth as a plea for paying him less, rather is such a man worth more. It is the same with the doctor; instead of paying him less because he is learning more, he should be paid more.

A final plea for the parasitism of the hospital has been the teaching facilities which are nowadays an essential part of the scheme of every well-regulated hospital and dispensary. Probably nothing does more to promote the deplorable tendency to look upon sick people as "cases" and "material" than the belief that a poor patient is, because of his poverty, legitimately at the disposal of the teacher and his class of students, while the paying patient, in his private room, is exempt from this annoyance. Modesty and self-respect are as much or more to be cultivated in the poor as in the rich, and the use of his or her body or organs for the purposes of study or demonstration should be a free concession to the good of his fellow-beings on the part of every patient, rich or poor. The value, nay, the necessity, of such methods should be constantly taught every member of the community by every physician, and a public spirit promoted which should encourage every one to make this contribution to the common good. (The same effort should be made to educate people to the general performance of autopsies.) Much has already been done in this line, and it has been found that it is not necessary to offer free treatment as a bribe. In some of the English reports it is especially mentioned that the introduction of the Provident system has caused "no impairment of hospitals as places of medical education." The attendance was even increased at the Royal Albert Hospital, to which a medical school is attached. The experience of Professor Volkmann, at Halle, is in the same direction. One of his rules is that every operation shall be performed in the operating-theatre of the public hospital, so that the students may have the advantage of seeing it, the patient being brought in anesthetized and removed unconscious. He will not undertake the care of a patient who declines to submit to this rule. He has, the report says, six private hospitals, and there is no trouble.²³

As a final word, it must not be expected that any Provident scheme evolved shall, at any rate in the beginning, be self-supporting. Every community in this great and prosperous country has plenty of money, every community has plenty of people filled with the sincerest desire to help their weaker fellows. It should only be insisted upon that this money and this enterprise shall be directed towards making all independent and self-respecting and self-helping.

This résumé of the subject would not be complete without some reference to a new theory which is forcing its way into the management of medical, as

well as industrial, subjects. It may well be that in matters where mass action of the community is demanded, as in quarantine and the control of contagious diseases, socialistic or communistic measures may find favor. But it must not be forgotten that socialism or communism is, at its best, what one writer calls "compulsory co-operation,"²⁴ whereas the ideals of a free people, like those of this country, are all in the direction of the development in each individual of that sturdy self-reliance and mutual respect which lead legitimately to that voluntary co-operation which is the outgrowth of the Golden Rule.

CASES OF DISLOCATION OF THE OS MAGNUM.

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CASE I. I was called to a young married lady, and found her with her left forearm in a sling, the back of the wrist being considerably swollen and red and very painful. She told me the following story:

On the evening before, as her husband was sitting at the table in her drawing-room reading, she walked by him with her arms crossed upon her chest, and as she was passing he extended his right arm and drew her to him, his arm completely encircling her waist, outside of her flexed arm. In doing this he bent her left wrist so severely that she cried out with pain. The pain continued through the following night, and I was called to her in the morning. I found her still suffering, and as she held out her wrist for examination I saw there was considerable swelling with redness on the back of it, with a marked prominence towards the outer side. It looked so much like a ganglion that I said at once "That is a weeping sinew," although I had never seen one in that location before. It was quite tender on pressure and felt harder and was less rounded than ganglia usually are. On extending the hand on a plane a little above that of the forearm it subsided entirely, leaving no marked prominence above the level of the wrist. On flexing the wrist again the prominence reappeared, and I at once saw that the injury must be a dislocation of the os magnum. No other bone was displaced. As I had never seen such a dislocation before, I made my diagnosis with some hesitation, reserving my final decision.

The treatment of the condition was obviously simple enough. After extending the hand backwards until the prominence disappeared I applied a Bond splint with a roller bandage up to the elbow, leaving the fingers of the hand free. The arm was supported by a sling. I examined it carefully from time to time and was pleased to find that the bone remained securely in its place, so that my diagnosis became a positive conviction.

After watching the case for a few days I asked permission to show it to an eminent hospital surgeon, the late Dr. R. M. Hodges, as one of much interest. This gentleman examined it most thoroughly — bending the wrist repeatedly so as to raise the bone from its bed, and then replacing it again in its normal position. He said nothing to the patient about the nature of the injury, but most cordially approved of the treatment it was receiving. After leaving the house I waited a few moments for some expression of opinion

²² Hospitals, Dispensaries and Nursing. International Congress of Charities, Correction and Philanthropy, Chicago, 1893, p. 131.

²³ Henry C. Burdett: Pay Hospitals and Paying Wards throughout the World, p. 48.

²⁴ Herbert Spencer: Principles of Sociology, II, 2, p. 604.