

What is the ideal doctor? He should be a gentleman above all. He should respect the rights and condone the prejudices of his patient. He should realize that it is idle to treat the body and neglect the mind. He should reflect that a sick body means a sick mind, and discount all that the sick say.

It is difficult for the healthy physician to appreciate the state of the patient's mind. Some are querulous, many are timid, many diffident and distrustful; all are tormented by phantoms of doubt and uncertainty. It is the doctor's part to reassure, to cheer, even to prevaricate, if necessary. We do not understand mental operations; we never shall. We coarsely study the mechanism and we fail to reach the motor. We can try, however; we should try; nothing does more good if we touch the right spring. The writer took one despairing, hysterical young woman out of bed, and cured her by his will power. He utterly failed in the next case. Here is where tact is as valuable to the doctor as professional knowledge.

The ideal doctor is sympathetic but not weak; he concedes, but he requires. The doctor is the confidant, adviser and friend of his patients. He knows all their secrets. He does not willingly betray them.

Pathology and not dollars should be the ideal doctor's first inquiry; caretaking, relief, his first duty. But to save himself from starvation he should have business tact.

Some people succeed, others do not; why is this? Business tact enables him to see chances; to trim to circumstances; not to oppose the inevitable; to accept defeat goodnaturedly; to please people; to oblige them. Unless the doctor cultivates egoism to a degree, he fails of success. He *must* think of himself.

He may use legitimate means of advertising; he must not hide his light. He may let it be known that he has had certain successes, or made use of original means of treatment. He must advertise to his brother doctors only, never to the public. Let others advertise him by favorable comment.

It should be a cardinal maxim of the ideal doctor to do his best always; never to shuffle, procrastinate, or half do a thing. Every case must be thoroughly treated, well digested, the best done possible. This may be difficult, but he must come as near to it as he can.

The ideal doctor is sparing of visits in a sub-acute or chronic case. In acute sickness, as peritonitis, pneumonia, meningitis, or in young children, he cannot go too often and he cannot go too early. Hours are days here. But in ordinary cases he can easily over-visit. There is the taint of commercialism, the abuse of the patient's means, in too frequent visits. Besides, they are destructive of diagnosis and prognosis. They weaken observation; seen too often, judgment is confused.

It is a question whether dispensary and hospital practice does not unfit the doctor for his private business. This sounds strangely, but there are two applications:

One who sees fifty Colles's fractures in a winter is better equipped for diagnosis and perhaps treatment than he who sees two cases. But, on the other hand, he who runs through a hundred cases of snap-diagnosis in a morning, gets an oversight and not an insight. It is the difference between the rustic and the cit. The former sees few objects and studies them down to the bottom; the latter tries to shut out and not see myriads of passers and a babel of sounds.

Another cardinal point for the doctor is to believe that no effort is wasted; all solid work tells in the end.

Now the ideal doctor, being kind to the poor, self-denying, overworked, has to push his egoism to the front, or he will be worn out. Self-preservation is an instinct not to be neglected. The altruistic doctor may feel that he ought to respond to every call, but can he? or ought he?

The doctor has legally a right to refuse any call; he is not obliged to go. If he is the only doctor to be had, humanity bids him go; otherwise he has a perfect right to decline.

The doctor is annoyed by bad debts, unpaid accounts. Most of them are lost; unless the patient pays willingly, he rarely pays at all. The discontented patient assumes poor treatment or an unfortunate result as a means of evading payment. Worse than this, he is easily led by bad counsel from others to bring claims and suits against the doctor. The latter must stand up against them or he loses his self-respect, and, moreover, the respect of others. On the other hand are many cases of gratitude or real effort to pay in later years which remunerate the doctor for his grievances.

Looking back on long years of practice, the doctor may fairly say that his professional life has been full of disagreeable incidents and anxieties; but, on the other hand, he has had many exquisite pleasures, the latter due to the recovery of patients from desperate sickness.

The ideal doctor looks after the interests of his brother physicians; he says no evil. Perhaps we are describing an impossible character, but we are striving for an ideal.

He who has a healthy body, he whose mouth is shut, whose heart is kind, whose intentions are sincere, who does his best, who treats his patient as himself, who looks after justice as well as mercy in his dealings, is altruistic and egoistic both, is the ideal doctor.

Does he exist?

THE TECHNIQUE OF RESECTION OF THE CECUM.

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Mr. L., thirty-nine years old, a young adult, was suddenly seized with acute abdominal pain forty-eight hours ago. He complained of some nausea, but he did not vomit. All the first day he felt chilly. The pain, which was at first general, settled finally in the right side of the abdomen, and to-day, the second day of the illness, became very severe. The bowel moved

the first day of the illness normally. The second day of the illness the bowel did not move. He had had no attack like this before. He had never been troubled by indigestion, nor had he ever been jaundiced. He had a slight rise of temperature and pulse.

Examination found the heart and lungs normal, the abdomen slightly tympanitic and showing moderate rigidity of the right rectus abdominis. There was tenderness over McBurney's point, where there was a small mass to be felt. Rectal examination discovered nothing abnormal.

An appendectomy was done. At the time of the appendectomy there was discovered on the anterior wall of the cecum a firm mass the size of a hen's egg. This mass was entirely distinct and separate from the appendix. It was thought that the mass was either the beginning of malignant disease, a thickening due to an old ulcer of the cecum, or a chronic inflammatory process of unknown origin. Three days after the appendectomy, the patient's permission having been obtained for the major operation, a resection of the cecum, including this mass, was done, and an end-to-side anastomosis of the ileum and transverse colon made. The patient has done uninterruptedly well since the operation. One small wick of gauze was left down to the retroperitoneal tissue at the situation of the resected colon. The microscopical examination showed the mass to be due to a chronic inflammatory process. The appendix showed no pathological changes.

Certain occasions arise when it is necessary for the surgeon unexpectedly to resect the cecum without previous preparation. Every surgeon doing abdominal work should be familiar with the technique of this operation. The abdomen should be opened by that incision which will render most easily accessible the parts to be operated upon. An incision in the right linear semilunaris is satisfactory in most instances. This incision may be enlarged by an incision at right angles to it, extending into the loin. The oblique incision parallel to and above the crest of the ilium is also a convenient one. This latter is practically the continuation forward of the incision for nephrectomy.

The parts being well exposed, an incision is made through the posterior parietal peritoneum at the outer side of the cecum and ascending colon. The colon is freed from its bed until the hand passes beyond its inner border behind the peritoneum. The vessels behind the posterior parietal peritoneum—the branches of the ileocolic artery—are divided and ligated with fine silk by the use of a Cleveland needle. All mesenteric vessels to the cecum and to the ileum, so far as it is decided necessary to remove the ileum are likewise ligated. This leaves the part of the bowel to be removed entirely free. A rubber-covered clamp is placed upon the distal portion of the ascending colon. A clamp without rubber cover is placed near it upon the ascending colon. The bowel is divided between the clamps as is indicated in the drawing. Sufficient space is left upon the proximal end of the ascending colon, that is, between the clamp and the cut end, to enable a purse-string suture to be placed as indicated in the drawing. The distal divided end of the colon is closed by an over-and-over continuous Pagenstecher linen suture. This suture closes

the colon and checks all bleeding from the mucous membrane. The rubber-covered clamp is then removed. The closed end of the colon is pushed within the purse-string suture, which is drawn taut and tied. Three or four interrupted mattress sutures are now placed over the dimple formed by the puckering purse-string suture. There are thus three sutures between the mucous membrane of the divided gut and the general peritoneal cavity. These are sufficient to secure absolute closure of the bowel.

The clamped cecum is now held with gauze by an assistant while two clamps are placed upon the ileum, the rubber-covered clamp being placed upon the proximal portion, the clamp without the rubber cover being placed tightly upon the portion to be removed. The ileum is divided, as shown in the drawing, obliquely, so as to preserve by a good circulation the integrity of the bowel opposite to the mesenteric attachment. A point is selected upon the ascending colon or transverse colon at which the divided ileum is anastomosed to the colon. In the instance at hand I was unable to utilize the small remaining portion of the ascending colon, as it was tightly fixed and immovable. I therefore performed an end-to-side anastomosis between the ileum and the transverse colon. After transverse division of the bowel it may be longitudinally divided opposite the mesenteric attachment, the corners thus formed rounded off. Thus is secured a larger opening and one less likely to be subsequently constricted. The portion of the transverse colon where the anastomosis was made was isolated by means of a rubber-covered clamp, thus checking hemorrhage and occluding the bowel. The suture used was the Pagenstecher linen thread, with a straight No. 6 milliner's needle. A posterior peritoneal muscular suture was first used, the colon was then opened to the width of the diameter of the ileum, then a suture placed, including all coats of the bowel, around the entire circumference of the ileum, and finally the peritoneal muscular suture was completed. A bit of omentum was fastened as a plastic over the line of suture.

The general abdominal cavity through the whole of this procedure was entirely protected by gauze. The operation was done practically extra-peritoneally. Upon the removal of the superficial layer of soiled gauze the deeper layer of unsoiled gauze still protected the abdominal cavity. The parts were washed carefully with salt solution. The clean gauze was removed from the abdomen. The abdomen was closed with the exception of one small wick to the retroperitoneal attachment of the ascending colon.

A lateral anastomosis of the side of the ileum to the side of the colon is often a convenient method of completing this operation. If there is need for speed in finishing the operation, the Murphy button may be used to advantage.

I believe that an end-to-side anastomosis may be done as securely and safely as a lateral anastomosis.

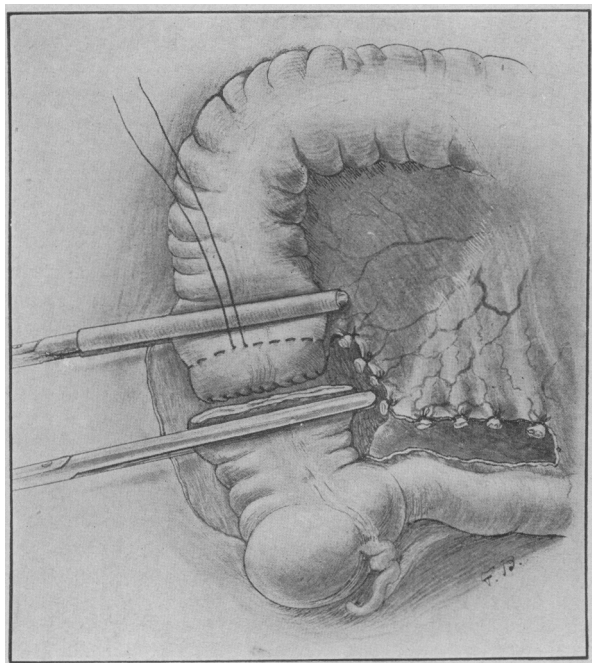


FIG. 1. — To illustrate the technique of the first part of the operation for removal of the cecum. Note peritoneal incision parallel and external to ascending colon, cecum and ascending colon freed from retroperitoneal attachment, clamps for cleanliness and hemostasis applied, continuous over and over suture to occlude distal colon, purse-string behind occluding suture, ligated vessels of colon in the freed edge of posterior parietal peritoneum, ligated vessels in the free mesentery of the ileum.

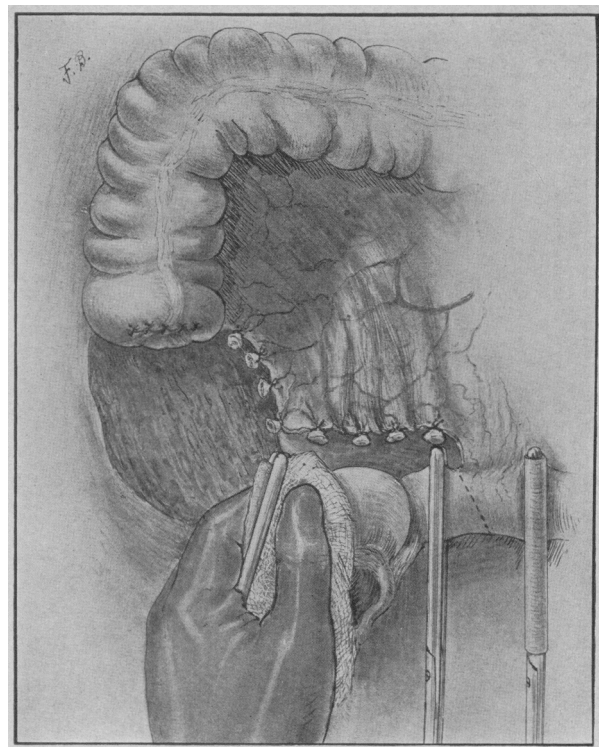


FIG. 2. — To illustrate the technique of the second part of the operation for removal of the cecum. Note the retroperitoneal bared area, the bed of the cecum and ascending colon, which have been lifted with gauze forward, clamps upon the ileum, the proper line of section shown as a dotted line. The occluded distal end of the colon has been placed within the purse-string suture and the latter has been tied, and this drawing shows a few interrupted Cushing sutures placed over the purse string to secure greater safety.

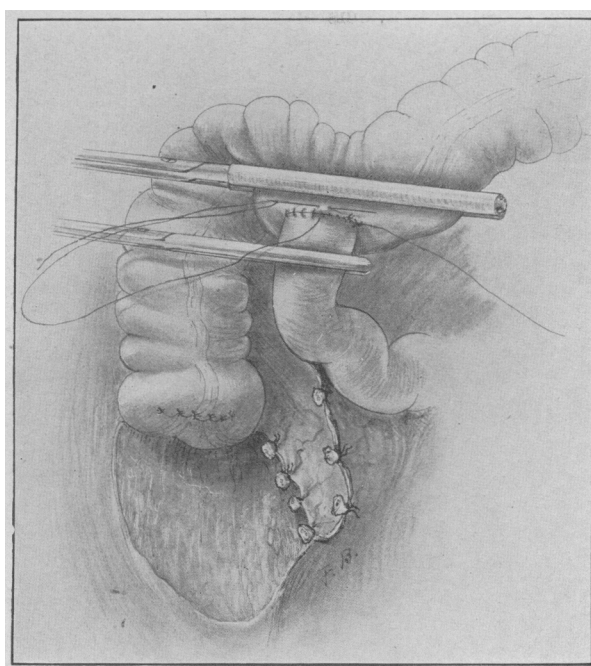


FIG. 3. — To illustrate the technique of the concluding part of the operation for removal of the cecum. Note the clamp upon the transverse colon and the one upon the ileum, the end to side anastomosis of the ileum into colon, the last half of the peritoneal Cushing suture is shown being placed. The omental graft placed about the line of suture is not shown.