

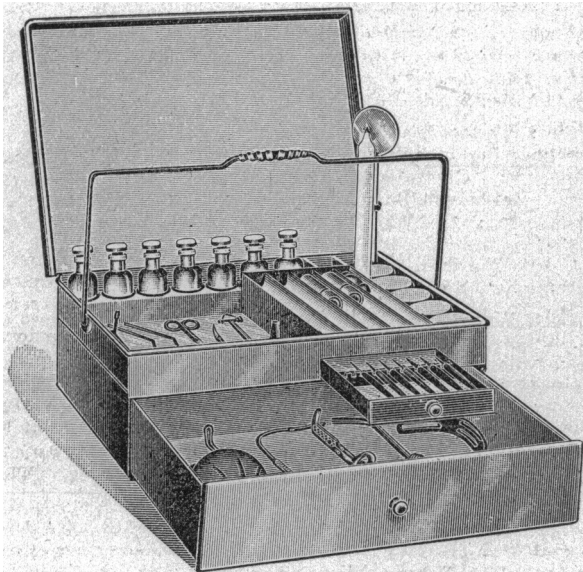
were held when the school to which they belong was born, but simply because there is money in it. The majority, we believe, cling to the name because under the present conditions they see no way of escape, and if they should openly renounce the creed which they have long ceased to believe, they would find themselves adrift with no port in sight. . . . We believe that it will be generally admitted that many of those who practice medicine under some sectarian name are men of good education and are perfectly competent to take care of their patients, and indeed that they treat their patients exactly as other physicians do, and are perfectly familiar with the modern principles of pathology, diagnosis and treatment. These men, or at least a large proportion of them, would be glad to drop their exclusive name and join the ranks of scientific practitioners of medicine if an opportunity to do so were offered them. A great deal of opposition would have to be overcome, especially among the older men, many of whom would find it impossible to give up the prejudices of a lifetime, but the complete organization of the whole profession which would ultimately result from the disappearance of all the false systems, which even although they exist in name only, are still a very real barrier to the progress of scientific medicine, would accomplish such a vast amount of good that we hope to live to see it brought to pass.—*St. Paul Medical Journal*.

## New Instruments.

### SOME NEW INSTRUMENTS.

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An annoying feature of eye and ear work in a general hospital is the lack of concentration of instruments, drugs, appliances, etc., necessitating many delays incident to nurses or internes going from ward to ward in search of needed articles. I have endeavored to obviate this difficulty by designing an eye and ear case for hospital work which will contain practically all that is essential for ordinary service. The case is constructed of nickel-plated copper.



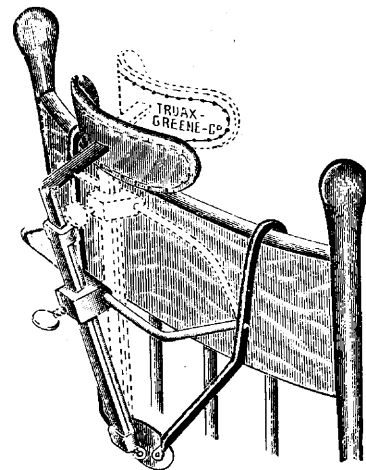
It has a strong handle, making it easy of transportation from ward to ward. It has a cover for protecting it from dirt. The top compartment is divided into large spaces for holding bulky objects, such as head mirrors, insufflators, tuning forks, etc., and small places for holding solutions, ointments, cotton, etc. It has a large drawer also for holding bulky objects, and a small drawer for holding knives, scissors, forceps, etc. In my own hospital service I find it a great time-saver, and most convenient, and I trust it may prove so to others.

An instrument which I have found useful is a simple gauze-

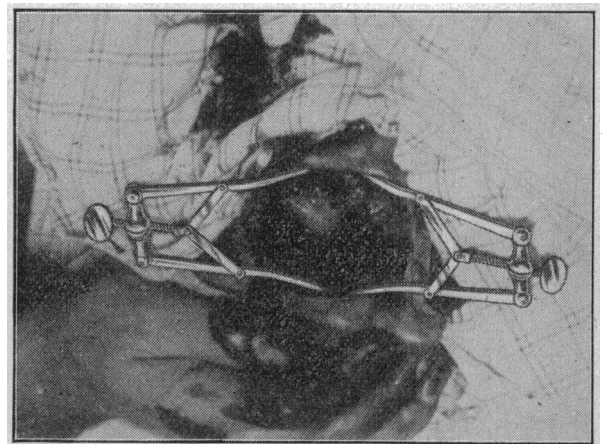
packer, originally intended for mastoid work, but which may find a use elsewhere. The end of the packer is conical in shape with a flat base, thus presenting no tendency for with-



drawing of the gauze as the instrument is withdrawn, nor perforation of the gauze by the point of the instrument, as the wound is packed.



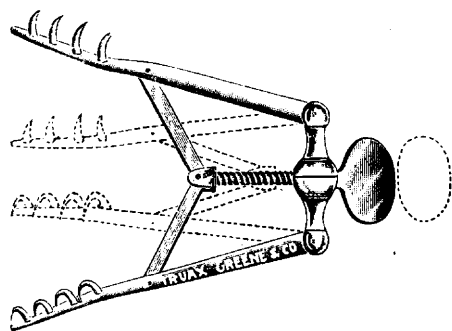
I desire to call attention to a head-rest which I have used in my office for nearly twenty years. It is especially useful for the external examination and treatment of eyes. It may also be used in small operations where the patient may maintain a sitting posture, and I have frequently used it in hospitals and homes, for cataract and iridectomy operations, etc. It can be used upon the back of any plain wooden chair, and when thus placed makes an exceedingly good operating chair. The head can be raised or lowered by a simple thumb-screw on the back of the frame.



I have referred so many times in the past to my mastoid retractors that I am almost ashamed to speak again at the present time, my excuse being their frequent imperfect manufacture, and misuse. I claim complete priority in the suggestion of self-retaining mastoid retractors, notwithstanding which fact several surgeons have devised modifications of my retractors without the courtesy of a recognition of my original instrument. I have yet to see a retractor the equal of my first instrument in simplicity, practicability and efficiency. I am, therefore, anxious that it should be manufactured and used correctly.

When small openings and drills were used in opening the mastoid bone, one retractor was sufficient, but now that large openings and chisels are deemed the best surgery, I use two instruments, one in each end of the wound, as shown in the picture.

When thus used the retractors open the wound to its fullest capacity, and give the operator an ample field for his work, without an extra pair of hands around the head, which is, of course, necessary in using hand retractors. The teeth on the arms of the retractor should be placed well under the periosteum, and the arms then dilated as widely as possible, using considerable force to thus separate the sides of the wound. Such force necessitates a strong and substantial instrument, and this point is one frequently overlooked by manufacturers who aim to produce a pretty and delicate instrument, rather than one substantial and forceful. The forcible dilatation of the wound not only gives a fine unobstructed and permanent view of the field of operation, but also entirely does away with any material hemorrhage from the soft, flap tissue. I never use artery forceps in a mastoid operation, and it is certainly most desirable to dispense with them if possible. But in order to do this, the retractors must be widely and forcibly separated. Some manufacturers defeat this end by constructing the instrument in such a way that the screw pin is so short as to render a wide dilatation of the blades impossible, thus rendering the instrument practically useless. Other manufacturers accomplish the same undesirable result by making the screw handle round or square, whereas it should be flat, to enable the operator to secure a firm hold, and use all desirable force in turning the screw-head and thereby separating the blades. The distance between the extreme ends of the blades when expanded should be at least two and one-half inches.



It is hoped that manufacturers desiring to make the retractors will heed the above directions, and make them accordingly. It would seem as if a surgeon designing instruments should at least have the courtesy accorded him of having his instruments made according to his specific instructions. I recently went into two Chicago instrument houses, and in the first one found three mastoid retractors of different designs, being sold under my name. They did not bear the slightest resemblance to my retractors, except that they had teeth and spreading arms; one of them was absolutely grotesque in its appearance. At another store they showed me some retractors bearing my name, in which the arms would not spread much over one inch, which of course made the instrument absolutely useless. Such circumstances naturally make surgeons reflect whether it should be considered unprofessional to hold a patent on an instrument. As it is now, the moment he publishes an instrument all manufacturers have a right to make it, and before long the instrument on the market bearing the inventor's name may be so far removed from his original idea as to make him ashamed that he ever gave it to the profession. There certainly should be some way of allowing the surgeon to control the manufacture of his own instrument. It may not be well for him to benefit pecuniarily by its sale (although I believe this to be a subject capable of double-sided argument), but he should at least be able to dictate who should participate in the manufacture of his own devices, and to insist that he be given the opportunity of inspecting all of his own instruments should he care to claim this privilege.

My retractors are usually well made by Tieman & Myrowitz, of New York; Truax, Greene & Co., and Chambers, Inskeep & Co., of Chicago.

92 State street.

## Societies.

### COMING MEETINGS.

Tri-State Medical Association of Mississippi, Arkansas and Tennessee. Memphis, Tenn., Nov. 19-21, 1901.

Indian Territory Medical Association, Muskogee, Dec. 3-4, 1901.  
Western Surgical and Gynecological Association, Chicago, Dec. 18-19, 1901.

**St. Louis Academy of Medicine.**—At its annual meeting, November 5, the Academy elected the following officers: Dr. Augustus C. Bernays, president; Dr. J. William Williamson, vice-president; Dr. Alfred Roulet, secretary, and Dr. G. Howard Thompson, treasurer.

**Little Rock (Ark.) Medical Society.**—At the annual meeting of this Society held November 4, Dr. William A. Snodgrass was elected president; Dr. Strodder U. King, vice-president; Dr. Charles C. Stephenson, secretary, and Dr. Rezin W. Lindsey, treasurer. The annual banquet will be given by the president November 18.

**Detroit Physicians' Association.**—At the meeting of this Association at the Cadillac, October 25, the finance committee reported that in the past 10 months about \$15,500 has been collected and although a deficit of \$450 still existed, due to the small amount of business during the first months, it was decided to continue the system six months longer.

**Dodge County (Neb.) Medical Association.**—A number of physicians of Dodge County met at Fremont, Neb., October 31, and organized this Association, with Dr. Leander B. Smith, Fremont, as president; Drs. Robert C. McDonald, Fremont, and J. M. Doan, North Bend, vice-presidents; Dr. A. P. Overgard, Fremont, secretary, and Dr. William J. Davies, Fremont, treasurer.

**Somerset County (Pa.) Medical Association.**—At its recent annual session held at Rockwood, the following officers were elected: Dr. Harmar D. Moore, New Lexington, president; Dr. W. H. Gardner, Rockwood, vice-president; Dr. H. Clay McKinley, Meyersdale, secretary; Dr. Asa F. Speicher, Elklick, corresponding secretary, and Dr. Walter S. Mountain, Confluence, treasurer.

**Aesculapian Society of the Wabash Valley.**—The fifty-fifth annual meeting of this Society was held at Paris, Ill., October 31, with 75 members in attendance. Dr. Charles B. Fry, Mattoon, Ill., was elected president; Dr. Edgar L. Larkins, Terre Haute, Ind., vice-president, and Dr. Harry McKennan, Paris, Ill., secretary and treasurer. The Society adjourned to meet in Mattoon, Ill., in May, 1902.

**West Texas Medical Association.**—The twenty-fifth annual meeting of this Association was held at San Antonio, October 31. Resolutions of regret and sympathy on the death of Dr. McPherson Barnitz were passed and the following officers elected: Dr. William E. Luter, San Antonio, president; Drs. Alfred G. Heaney, Corpus Christi, and Edward B. Jackson, San Antonio, vice-presidents, and Dr. W. B. Russ, San Antonio, secretary and treasurer.

**Rock Island County (Ill.) Medical Society.**—More than 20 physicians of Rock Island, Moline, and Rock Island County, met at the Harper House, Rock Island, October 31, and formed a county organization in accordance with the plan formulated by the American Medical Association. Dr. Carl Bernhardt, Rock Island, was elected president; Dr. Lewis D. Dunn, Moline, vice-president; Dr. John G. Swensson, Moline, secretary, and Dr. Warner L. Eddy, Milan, treasurer.

**Central New York Alumni Association of the Albany Medical College.**—At the annual meeting of this Association, held at Fulton, N. Y., October 31, the following officers were elected: Dr. Wilmer C. Kellogg, Syracuse, president; Drs. Richard F. Stevens, Lysander, Charles J. Bacon, Fulton, G. Griffin Lewis, Syracuse, William C. Fawcley, Lorraine, Charles B. Tefft, Utica, and Charles Bernstein, Rome, vice-presidents; Dr. Frederic H. Brewer, Utica, secretary, and Dr. Merritt B. Fairchild, Syracuse, treasurer. The next meeting will be held at Syracuse in September, 1902.

**Ingham County (Mich.) Medical Association.**—The physicians of Ingham County met at Lansing, October 29, and perfected the organization of a society, whose work will be to ascertain the legal status of doctors in the county. Dr. Frank E. Thomas, Mason, was elected chairman, and Dr. D.