

the political divisions of our country to adopt a stringent medical practice act, which was approved only last June, and as it is under the direct control of Congress the enactment is in its way a National one, though the territory in which it is enforced is small. In nine States and Territories, however, there are no medical boards, and the medical practice laws can hardly be said to have much effect.

On the whole the outlook is more promising each year as regards the regulation of medical practice in the interest of the public and the profession. The movement is fairly under way and it will not be many years, in all probability, before efficient medical practice acts will exist in all or nearly all the political divisions of our Union. The question will then arise as to the unification of the standards so as to do away with certain inconveniences that must follow from the existence of so many separate laws varying more or less from each other. This however is a matter that need not trouble us at the present time; the living question, and it is that in more than one sense to the individual practitioner, is that of raising the local or State standard of professional qualifications.

When we turn to the Commissioner's report to see what is being done in other ways to bring this about we find some further encouraging facts. In the Eastern medical centers the increase of medical students is not in proportion to the increase in the total number of students, and while it has increased in Chicago, it would probably be shown, were the figures published, that it is there caused by the multiplication of minor schools whose existence is due to the raising of the requirements of the larger and well established ones. This is clearly enough an evil, serious at the present time, but, it is to be hoped only a temporary one. As State examinations, as a requirement, become more universal the conditions that permit these mushroom growths to exist will be done away with and students will find it necessary to go where the means and appliances for a thorough medical education can be found. This statement applies still more to the many small medical colleges in minor towns, where clinical advantages can hardly be said to exist to any extent. The time may soon come when any medical school outside of the great cities will be a rare exception.

Another significant sign of the times, shown in the report, is the increasing cost of medical education. It appears that the richest and best endowed schools charge the highest fees, and the tendency seems to be to increase rather than to diminish the cost of medical education. This might not appear, at first sight, an unmixed benefit, but considering the crowded state of the profession it can hardly be seriously objected to if it is in any way efficient in preventing the excessive production of doctors. It is to be presumed, moreover, that the quality of the medical education given corresponds with the price it costs, and that being

true, no one ought to complain. There are, and probably always will be, some State-endowed colleges where the fees are moderate, and scholarships and other endowments for poor but meritorious students will also increase in time.

One of the most hopeful features of the report is the evidence it gives, that endowed medical professorships and colleges are beginning to make their appearance. As yet it is only a beginning and a small one, but it will increase, and the time when a medical professorship will necessarily mean something more than the possession of a certain amount of stock in a speculative enterprise or a device for "legitimate" medical advertising, may be said to be in sight. When it comes, and it is to be hoped it may come quickly, the status of a physician will be higher socially and financially, and one might perhaps even say morally, than it is, sometimes at least, at the present day.

CORRESPONDENCE.

Ether and Chloroform.

BOSTON, MASS., Jan. 6, 1897.

To the Editor:—Considerable has been written on the comparative use and danger of ether and chloroform. Only a few weeks ago I saw an article in which was the statement that a number of deaths by chloroform had occurred in women in confinement. Not many months ago I also saw it stated that no such case is on record. Now, which of these writers is correct? Has chloroform killed any woman under such circumstances? I, for one, have no remembrance of seeing such an instance reported. If both ether and chloroform cause death in such cases we must then select accordingly. There are several points, however, we may properly consider as between the two.

1. Help: An etherized patient, unless thoroughly under its influence, must be regarded as drunk or crazy, requiring considerable assistance to control and take care of her. It is not so with chloroform. The patient rather likes it and will call for it when not given to full anesthesia, and is able to think and talk and help the physician, quite different from ether. So that the assistance of the nurse and one other woman is all the help really required. I put the chloroform on the handkerchief and keep watch on the patient. The whole apparatus required is a lady's pocket-handkerchief, folded as it comes to me, and a small phial having a small neck for the chloroform. Then by placing the kerchief firmly over the mouth of the phial, the bottle is inverted so that only a few drops escape on to the kerchief. This bottle I keep within my reach and handle myself, using my left hand and removing and inserting the cork with my teeth. Thus any woman can hold the chloroform to the patient, returning the kerchief to me for renewal of the chloroform just preceding the next pain and keeping the more or less exhausted kerchief to the nose in the intervals of the pains. Thus more or less of the anesthetic can be used as the exigency requires to keep the pains bearable. If more chloroform has to be given during the last few pains that does not seriously affect the child. And even in instrumental cases, it is rare to need any extra skilled help; for by the time this is reached the woman giving the chloroform has become quite competent to follow the directions of the physician and take full charge of giving the anesthetic herself.

2. In heart cases chloroform has the advantage over ether.

3. Chloroform is not so dangerous to the child, since the

mother takes less of it to make her confinement comfortable, so that the child is rarely but slightly anesthetized as compared with ether, and speedily, in most cases, responds to changed circumstances and begins to breathe. Even in the heavier cases of anesthesia of instrumental cases, the time being short, there is usually little difficulty in bringing about respiration in the child, if the chloroform is laid aside and the cord is not cut. I remember but one child over which I worked many minutes before respiration was established. This mother was a particularly nervous woman and required considerable anesthesia and it was continued a much longer time than usual. When I hear of a stillbirth, the child being alive before, I always inquire if the mother did not take ether at the confinement, and this is generally answered in the affirmative.

4. Ether, by its greater stimulation of the circulation, I believe, is much more liable than chloroform to be followed by hemorrhage.

Without trying to exhaust the subject, I think these four points are greatly on the side of chloroform. And then if it is true that it is safer for the mother it becomes almost imperative that the accoucheur should give it, and give it instead of ether in confinement cases; for, if judiciously administered it is a most glorious blessing to this feature of suffering humanity. To be sure, etherization is a home invention, and the writer entered Harvard only a few years after its first application, and has witnessed the continuous prejudice in its favor ever since. Yet, from my own judgment and experience, I am strongly in favor of chloroform instead of ether in confinement cases, and from its easy application I believe no woman should be left to suffer much without it, and certainly we can not hesitate to use it when we would be slow to begin with ether.

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NEW INSTRUMENTS.

NEW AND COMPACT CASE FOR A COMPLETE SET OF OPHTHALMIC INSTRUMENTS WITH STERILIZING TRAY.

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Much annoyance is frequently experienced in transporting either a broad and unwieldy instrument case which will not fit into any convenient sized bag, or by the necessity of carrying about numerous smaller boxes containing instruments. I have avoided this for a long time by a number of smaller boxes containing a complete set of instruments for any of the more usual operations.

One of these contained a cataract set, another the instruments required for iridectomy, while a third contained a complete set for tenotomy, advancement, etc. Miscellaneous instruments were mingled in a fourth.

This plan requires an unnecessary multiplication of many instruments, *e.g.*, specula, lid elevators, forceps, scissors, etc., needed in almost all operations upon the eye. Then too it is not always possible to anticipate every requirement, so that in operating away from the office, it became necessary to carry a large bag, containing numerous instruments, boxes, a sterilizing tray, dressings, etc. To avoid these several inconveniences and annoyances, I have had constructed by Wall & Ochs, a small sterilizing apparatus, and a series of small trays, into which all the necessary instruments for any ophthalmic operation are carefully fitted with ample room for a considerable additional supply of knives, keratomes, etc. Each of the trays is readily withdrawn and replaced like the drawers of a desk, or bureau. The instruments are held firmly in place in each tray, by a readily adjusted binder. The entire case is so compact, that it will fit in a small sized hand bag, and still leave

room for necessary dressings. With it the surgeon goes to his patient, confident that he has at hand every possible instrumental requirement.

The accompanying cut illustrates the general appearance of the case when open. The drawers or trays are represented as partially open. When pressed home and the front closed, and clasped under the flat leather handle at the top, the outside dimensions of the case are, $4\frac{1}{2}$ inches wide, $6\frac{1}{2}$ inches long and 6 inches high. The case may be purchased of the manufacturers, with or without these instruments, or orders for any portion of them will be received.

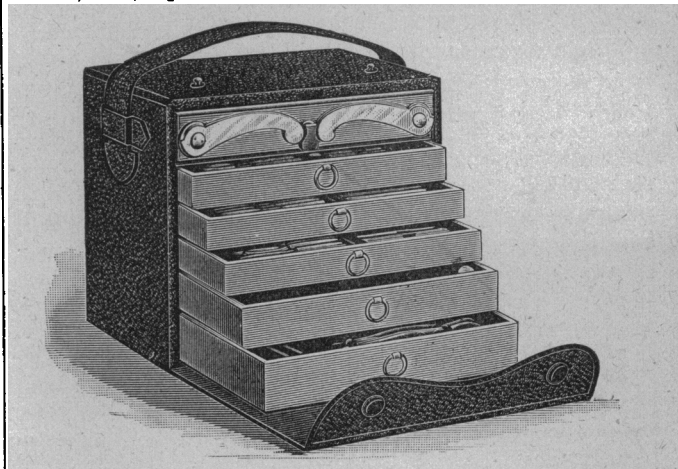
The following is a list of the instruments which have been carefully selected for filling the trays:

Speculum: Knapp's aseptic; lid elevator.

Forceps: Fixation, broad serrated grip; Stevens' fixation; tenotomy, fine rat tooth; iris; Knapp's capsule; Prince's advancement; cilia; Snyder's needle forceps; Knapp's roller forceps for trachoma.

Scissors: Spring, McClure's very small for operations in the anterior chamber, iridectomy, etc.; Knapp's iris; Stevens' tenotomy; angular; enucleation, curved on the flat; straight, one probe point.

Knives: 3 cataract, hollow ground; 1 Weber's canaliculus, probe point; 1 Beer's; 1 bistoury; 1 scalpel, small; 3 angular keratomes; 2 capsule knives, Risley's, secondary cataract, dissection, etc.; 1 paracentesis; 1 cystotome and spoon.



Miscellaneous: aluminum spatula; needles, assorted in case; Desmarre's clamps; set of Bowman's probe silver Nos. 1 to 8; Risley's special lachrymal syringe, 2 canulas; Risley's canaliculus dilator; 2 fine silver lachrymal probes; 2 strabismus hooks; Stevens' strabismus hooks; Stevens' divulsor; Stevens' advancement hook; iris hooks, sharp and blunt; Knapp's silver spatula and probe; tortoise-shell spatula; tortoise-shell spoon; fine grooved director; foreign body spud; double hook; wire cataract loop.

These instruments have all been selected with special care, and are so constructed as to meet the writer's views of desirability in form and size.

Attention is called especially to the cataract knives, which are hollow-ground, the radius of curvature being 32 mm. Particular attention has been given to securing a suitably shaped point. A serious practical defect in many of the Graefe knives, as found in the market is the finely drawn long point. While this favors the easy puncturing of the cornea at the commencement of the incision, it often embarrasses the surgeon in making the counter puncture. Since the fine, almost needle point can not be readily followed in its course across the anterior chamber and at the corneal limbus, the counter puncture is almost certainly made further back than is intended. The large Annel's syringe I have found extremely cumbersome and unnecessarily large. The one included in the case is smaller,