

alleged malpractice. The former had sustained a fracture of his left arm between the wrist and elbow. Both of the bones of the arm were broken. He employed the doctor sued to reduce the fracture and treat the injury. The latter at first bound up the arm in splints, and afterward incased it in a plaster cast. After giving attention to the injury for a little less than two months by examining the condition of the fracture the cast was removed, and the surgical attention ceased. The ground of the complaint was that the doctor treated the injury so unskillfully that when the treatment ceased the injury was not cured, but a false joint was created between the elbow and wrist at the place of fracture. There was a trial by jury, and a verdict and judgment for the party suing, which is affirmed by the Supreme Court on appeal.

One paragraph of the trial court's charge to the jury was as follows: "If a physician or surgeon be sent for to attend a patient, the effect of his responding to the call, in the absence of a special agreement, will be an engagement to attend the case as long as it needs attention, unless he gives notice of his intention to discontinue his services, or is dismissed by the patient; and he is bound to exercise reasonable and ordinary care and skill in determining when he should discontinue his treatment and services. If you find from the evidence that the condition of the plaintiff's arm is due to his having been dismissed when he ought not to have been dismissed, the defendant would be liable, unless the evidence further satisfies you that the defendant, in dismissing him, if he did dismiss him, used ordinary and reasonable care and skill in determining when to dismiss him; and, if he dismissed him under a mistaken judgment, he would be liable, and you should hold him liable unless you find from the evidence that, in making up his mind when to dismiss him, he exercised reasonable and ordinary care and skill and had regard for, and took into account, the well-settled rules and principles of medical and surgical science."

It was argued that the last part of this instruction required a greater degree of diligence and skill than the law imposed upon a physician and surgeon in the practice of his profession. He was required by the instruction, in determining whether his patient had so far recovered as to require no further medical or surgical attention, to exercise reasonable and ordinary care and skill, and to have regard to and take into account the "well-settled rules and principles of medical and surgical science." This the court holds was not erroneous, especially as the jury were told in another part of the charge that the law required a surgeon to have and exercise the average or ordinary skill possessed by members of his profession in his locality.

It may also be noted that in this case it is further held that it was not improper to permit the plaintiff, as a witness, to state in general terms that he complied with the instructions given by the doctor, as it would not be practicable for him to state what he was told to do, and then relate the particulars of what he did.

CORRESPONDENCE.

Ligation of Uterine and Ovarian Arteries.

To the Editor:—In your issue of Feb. 10, 1894, a report of a case is made by J. B. Greene, M.D. of Mishawaka, Ind. The report consists of a description of *ligating the uterine arteries and both ovarian arteries*. The writer said: "Accordingly I made the ligation of the uterine arteries and a part of the broad ligament, after the method described by Martin, but found it impossible to reach the ovarian arteries per vaginam. I then cut through the abdomen and with considerable difficulty was enabled to pass a ligature around both ovarian arteries, passing my needle under the Fallopian tubes and then back and around the vessel, tying close to the uterus. The uterus showed such a great engorgement of blood that I felt certain there would be no danger of gangrene of the uterus, as there was sufficient collateral circulation from branches of the ovarian arteries to maintain life in the organ."

As this report appears in one of the best journals of this country I deem it proper and just to criticise it.

Just think of ligating both ovarian and uterine arteries in a living woman. They are the only source of life to the uterus. I state this from some sixty careful dissections of the human uterus by my own hand. For in no single case could the uterus be kept alive by the tiny little branch which springs from the deep epigastric that runs toward the uterus on the round ligament. Besides, the writer says, the tumor would likely weigh ten pounds, and yet he cut off the nourishing arteries of ten pounds of tissue. But no gangrene followed, for months afterward the same operator examined and found that she was menstruating regular. The writer said he tied both ovarian arteries and both uterine arteries and then "felt" there was sufficient collateral circulation to maintain life in the uterus. Where is such collateral circulation found? It can not be in the artery of the round ligament, and anatomy so far has not demonstrated any other.

The fact is, that such reports are dangerous, and they show how new operations may be abused by those unacquainted with natural facts. Any one familiar with anatomic facts of uterine circulation would expect nothing but gangrene if he ligated both ovarian and uterine arteries, especially when the uterus is large. If the ovarian and uterine arteries are ligated the uterus can be cut out of its place with anatomic certainty without fear of hemorrhage being fatal. There is no doubt that the operator in this case did not secure either ovarian artery, as in cases of tumor it frequently is situated a considerable distance below the tube. The reporter, in this case, combined Dr. Martin's operation of vaginal ligation of the uterine arteries with the operation that I presented some time ago, which is, to ligate the ovarian arteries and the uterine as it courses along the side of the uterus. But these two operations must not be done at the same time on the same patient. Such a procedure will bring gynecology into disrepute. Large active viscera will nearly always gangrene by suddenly cutting off the arterial supply. The change is so sudden that they have not time to atrophy. Sloughing of uterine tumors is not a rare matter,

even without the interference of surgery. No doubt the intended view in this operation missed its mark and saved the life of the woman. But in any case it was such a radical, ill-advised and hasty application of the operation that, no doubt, had the surgeon time to reflect he would not even attempt it with an understanding of anatomic facts.

I do not think that any expert could go into court and support any physician who would ligate both ovarian and uterine arteries and not extirpate the uterus. Even if no disaster followed (which is anatomically and physiologically contrary to known laws), I would consider it an unjust experiment to ligate both uterine and ovarian arteries. Again, the physician who will ligate both uterine arteries and one ovarian artery at one operation is, so far as we know at present, putting the life of a patient in jeopardy.

I wish the reporter of this case to understand that I have no ill feeling to present, as I am not acquainted with him personally. The report appears in public print, and it is the right of liberty to criticise in public print. It may be the means of restricting the attempt of the ligation of both uterine and ovarian arteries on the same patient at the same time.

F. BYRON ROBINSON, M.D.

CHICAGO, Feb. 13, 1894.

“Superfluous Spectacles.”

CHICAGO, Feb. 9, 1894.

To the Editor:—The editorial in the *JOURNAL* of February 3, under the above title, is on the whole excellent. I had read Dr. Pooley's article which was the text for the editorial carefully and with much pleasure, and in the main concur in his conclusions. There are some points in the editorial, however, which are not deducible from Dr. Pooley's article, and others which are entirely apart from it, which, it seems to me, are open to criticism. First, you seem to argue, though that is not very clear, that if a patient when out of health has glasses prescribed which he wears with relief and comfort until the general health improves and then voluntarily relinquishes them, that the glasses were of no service. As well might you argue that the tonic or restorative medicine taken when out of health was of no benefit because not needed when the health is restored. I believe it is a very common practice with oculists (it certainly is with me) to prescribe lenses with the distinct expectation that they can be taken off when the general health and the eye health improves. The rest given to the eyes by the glasses assists the eyes to so recuperate that they may be used comfortably without glasses; and the relief given thereby to the nervous and muscular systems, is, I am sure, a potent factor in the general restoration of health. It is not at all uncommon to find young persons suffering from almost constant headache from eye-strain, and in whom the headache is relieved at once and entirely by proper lenses, after a time gradually leaving off of those lenses, without a return of the headache. Does that prove that the glasses were of no use? Does it not rather prove that the eyes have been so strengthened and improved by the glasses that they are now able to do their proper work without the fatigue and pain formerly experienced? In such cases, where there is a moderate degree of ametropia only, I invariably instruct my patients that the glasses are a means, not an end, and that it is to be hoped that they may later be able to discard them wholly or in part. You ask: “Does every optic defect need correction?” Certainly not, nor do I think that any prominent ophthalmologist so teaches. It seems to me that the indications for lenses are and should be very distinctly kept in view. They are but two, the relief of discomfort in the use of the eyes and the improvement of vision. If there is no discomfort from the use of the eyes but vision is improved by lenses

the patient may, I think, elect whether he will wear glasses or not. If the bother of wearing glasses is greater than the pleasure of improved sight he may with propriety refuse them. (Except in progressive myopia which is foreign to this topic.) If on the other hand there is discomfort from the use of the eyes which can be relieved more easily by the use of lenses than by any other means, I care not whether the required lens be of high or low power, such lenses should be prescribed and worn so long as, and no longer than they are beneficial. And this leads to the consideration of what it seems to me is a most important misconception in your editorial when you comment on the use of low degree spherical and cylindrical lenses. You argue that the eye can not appreciate a less degree than 0.75 D. sphere and a less degree than an 0.50 D. cylinder. If this were so it would very much simplify our trial cases of test lenses. There is no logic in saying that the eye can not appreciate less than 0.75 D. S. below 0.75 D. and yet can appreciate a shorter interval above that; or that the eye can not appreciate less 0.50 D. C. below 0.50 D. and can appreciate less than that above. So that, if your statement is correct our trial cases instead of having, as usually now, twelve pairs each of spherical and cylindrical lenses up to 3.00 D. need have but four pairs of spheres viz: 0.75 D., 1.50 D., 2.25 D., and 3.00 D., and eight pairs of cylinders viz: 0.50 D., 1.00 D., 1.50 D., 2.00 D., 2.50 D., and 3.00 D. The fact is, however, that the ordinary eye can appreciate a difference of one-fourth of a diopter in either a sphere or cylinder between one and three diopters and one-eighth of a diopter below one diopter. But the ability of the eye to appreciate such small differences is no proof that such differences are of practical importance; that must be determined by clinical experience. In regard to that you say: “The majority of oculists have learned from their own experience, as well as from the failures of the champions of the 0.25 D. cylinder, that such weak glasses are merely of mythical value.” I think you are mistaken in that statement. So far as I have been able to learn and observe, the oculists who believe that such weak glasses are of merely mythical value have not used them. They do not believe that such lenses can have any value and so have never tried them. While those who now use them have many of them, like myself, started in skepticism to try weaker glasses than were formerly used and finding them helpful have tried again and again until now, speaking for myself, I should rather lose any other one lens from my trial case than the 0.25 D. cylinder. Again you say, “It is true that a cylinder of 0.25 D. is not only employed but even highly recommended by a few prominent oculists, but they have as yet furnished no proof that such lenses benefit their patients.” Now that statement surprises me very much, for I thought a great deal of proof of such benefit had been furnished. I will therefore make this proposition, for if such proof has not been presented it should, if available, be before the profession. If you will indicate what proof you consider conclusive, I will endeavor to furnish the proof to establish the fact, if it is a fact, as well as any fact in medicine is established, that an 0.25 D. cylinder is a most valuable therapeutic agent.

HORACE M. STARKEY, M.D.

An Undignified Letter.

To the Editor:—The complaint of Dr. Cohen, published in the *JOURNAL* several weeks ago, was no doubt prompted by a keen sense of professional propriety; but did he not forget his high aim in the unprofessional and undignified tone of the latter part of his communication? As a matter of fact, a portion of it should not have been printed.

CONSTANCY.