

and if I am correct in this conclusion, I am also correct in the conclusion that he is only proving, just what I have hinted at, that a more conservative study and treatment of these cases would save many lives which are not saved by the knife. One of these cases I reported, in which I was called to operate, proved that if he had been operated upon at any period of his recurrent attack, it would have been useless, as the changes produced in the tissues, revealed by postmortem, showed that no operation could have saved him.

Again, I refer Dr. Carstens to a controversy between Dr. Terry of Utica, N. Y. (in the *Medical Times*), and Dr. R. P. Morris of New York, also a warm advocate of the knife and quoted as an authority upon appendicitis.

The case is not settled by Dr. Carstens, nor by any one observer, in favor of the knife, no matter how strongly he states it, yet we believe it will come to be settled, as many other surgical questions are being settled, by a more careful diagnosis and a more careful, conservative treatment, which does not necessarily exclude the operative method, when safely or judiciously applied. My conviction is still, that when a larger number of cases with careful diagnosis and treatment, promptly begun, with a rigid rule of quiet in bed, the statistics will still be largely on the side of recovery by conservative treatment, and I would use this treatment, even with knife in hand, and would operate if I became satisfied I ought. And a man should have the courage of his convictions on either side in harmony with all facts known to exist bearing on the case. I do not here enter into any discussion of the pathology but adhere to my first position, that we are coming to the time when a more enlightened and conservative treatment will yet relegate the surgeon's knife in this and other abdominal troubles to the shelf. I have indubitable proof, in my own experience as compared with other surgeons, that the knife, which was supposed to be the only resort to save life, has failed and patients have recovered without it, and continue to live and enjoy good health.

Comments: *Obiter dicta* in practice are opinions expressed by those who think they know, on points which do not necessarily arise or exist in cases under consideration.

*Dicta* are to be regarded as of but little authority, on account of the manner or form in which they are presented, and are often given without much or sufficient reflection and without sufficient data. If, says Huston, "general *dicta* in cases turning on special circumstances are to be considered as establishing rule or law, nothing is yet settled, or can long be settled." It has also been said to be a great misfortune that *dicta* are cited (opinions) and then, when gone into print, are taken as absolute propositions. This may be the position our reviewer is in, and yet his *dictum* does not go. It was not supposed that a few cases would settle a rule of statistics, but only as going to make up a large number which guide to the truth.

The facts in the cases reported clearly show that the five cases which recovered were those who received a careful, discriminating treatment, not all by the writer, and those who were lost neither had judicious nor safe treatment, but refused the aid of surgery when offered them, and this puts an entirely different view than the one supplied by Dr. Carstens.

I am not alone among medical men who have grown old in experience who are taking the same view, that the *obiter dicta* of the present generation of younger surgeons does not yet settle questions, but that the statistics which will prove a rule of action to the surgeon are not yet complete and will not be till more cases and more time has been taken to determine them. I only expressed a personal judgment drawn from a large private and hospital experience which a large body of men in the profession now entertain, that the knife has been too handy an instrument, and we want a more careful and methodic study of cases before we rush in "where angels might fear to tread."

Thalamon, one of the younger men in medicine and surgery, has given us a masterly résumé of the subject and in it says, "and moreover, if we take all the forms of appendicitis as they come, without making any distinction, we know with certainty that in 90 per cent. the disease gets well without the aid of the surgeon, which shows that as far as the life of the patient is concerned the immediate progress is not so grave and that one may safely wait." Again, he says: "No precise time can be fixed for an early operation; the limit may vary from the third to the fifteenth day." Carstens says the first day, and there is but one case reported as being operated on in the first twenty-four hours, or first day. This case recovered, and yet how does anybody know that in the progress of the case recovery might not have occurred. I would be glad to know in how many cases which recover the operation was indispensable to save the life of the patient. Can any man answer? "The chances," says Thalamon, "for life offered by laparotomy are not very great and it is probable that the chances are *nil* after the fifth day." Here we must draw a clear distinction between the circumscribed and general peritonitis or hyperacute forms and those not so. The rule of Treves was "not to operate before the fifth day." The question recurs, when is the opportune time and who shall decide but the surgeon who has the case? Evidently Dr. Carstens is one of those who believes in immediate operation or early operation, and thus sets up a standard of his own. One thing now to be noticed is the statement that the operative measure is attended by 2 to 5 per cent. mortality, which is much larger than this. When facts are studied on both sides of the question, viz., statistics of operations and those of non-operative cases, they will show from 10 to 15 per cent. of recoveries after operation, while the results of carefully conducted treatment show a better result, which leads Thalamon to say, "that naturally there has been a reaction against this zeal for use of the knife." And to the apparently triumphant statistics of the American surgeons, physicians have replied by statistics more emphatic and decisive (49 to 51). Yet we are still to remember that statistics will not finally settle this question, but judgment, skill in diagnosis, effective control of patient and control of pain in each case, judicious use of remedies in control of inflammation, so-called peritoneal.

R. E. HAUGHTON, M.D.

### Proportion of Physicians to Population.

SYKESVILLE, MD., Jan. 24, 1898.

To the Editor:—The statistics quoted in the *JOURNAL* of January 22 (p. 231) from "Hirschwald's Medical Directory" furnish a good refutation of the reckless statements so often made by careless writers in American medical journals concerning the great disproportion in the number of physicians to population in this and other countries. I have thought it might be of interest to give a comparative statement of the number of physicians to the population in a few of the large cities in the United States and in the German Empire. The figures for the former are taken from "Flint's Medical and Surgical Directory" for 1897 and the "New York World Almanac" for 1897 and 1898, and those for Germany from the work mentioned above. The statistics are as follows: United States: New York, 1 physician to 650 of population; Philadelphia, 1 physician to 661 of population; Chicago, 1 physician to 840 of population; Baltimore, 1 physician to 676 of population. German Empire: Berlin, 1 physician to 780 of population; Breslau, 1 physician to 864 of population; Munich, 1 physician to 798 of population; Frankfurt, 1 physician to 795 of population. For the entire German Empire, 1 physician to 2143 of population. For the Kingdom of Prussia, 1 physician to 2184 of population. The population of New York is as estimated on Jan. 1, 1897; that of the other American cities as estimated

Jan. 1, 1898. The German statistics of population are said to be from the latest official census.

It is well known that in American registers of physicians there are many entries of persons who may have the degree of M.D., but who do not practice medicine. Others have the degree of Ph.D., and still others are called Doctor or "Doc" by courtesy. I have gone over the list purporting to give the names of physicians in Baltimore, and find that 4 per cent. have no right there. They are either Ph.D.'s or M.D.'s who have devoted themselves to other pursuits than the practice of medicine. By excluding this 4 per cent. of non-practicing doctors, I find that in Baltimore the proportion of physicians to population is 1 to 704, not very much in excess of the proportion in Berlin. The 4 per cent. eliminated does not include homeopaths, herb doctors, and all other quacks, nor those who have died within the year. I imagine the German statistics only give those who are legally entitled to practice.

There is another point to which I want to call attention. The belief is general in this country that in Germany, and especially in Prussia, no one is allowed to practice medicine without having passed the so-called "Staats-examen." Now, I have good reasons for doubting this, but it may be true. If true, there ought to be some way of finding out beyond question that it is so. Have all the 14,582 physicians practicing in Prussia, or the 2148 practicing in Berlin, passed the Staats-examen? Or, are there persons practicing medicine in Prussia or in Berlin, who have not passed this Staats-examen, which is constantly held up to us for our admiration and imitation? and if the answer to the last question is affirmative, as I believe it will be, where does the great superiority of the Prussian system come in?

Very truly yours,

GEORGE H. ROHE, M.D.

#### A Genuine Department of Health versus Psychic Sanitary Measures; Which?

CHICAGO, Feb. 7, 1898.

*To the Editor:*—I was curious to learn the purport and meaning of the "Caffery Bill," pertaining to legislation for the hygienic welfare of the people of this county and, after reading the same as published in the JOURNAL (February 5, pages 330-331), I can say that I am utterly opposed to this substitute bill.

To my mind this substitute bill is not what the medical profession nor the great majority of the people of this country desire. It has very little semblance looking toward the establishment of a genuine department of health as a separate branch of our government, and I will venture the prophecy that the views of 90 per cent. of the members of the medical profession throughout the United States are not in accord with this proposed substitute bill which has been suggested to take the place of the bill that has been carefully prepared by the special committee of the AMERICAN MEDICAL ASSOCIATION and which was introduced into the Senate by Senator Spooner of Wisconsin on January 27 last, and is known as Senate Bill 3433.

There may be mugwump bacilli or psychic bacilli that science and sanitarians will have to contend with in the far distant future, but for the present generation at least, we are entitled to, and should be afforded the most ideal and thorough scientific department of health that it is possible to contemplate, exactly on the theory that when any person or any of our national legislators of either house of Congress, or within their domestic fireside are stricken with disease, they desire the best medical skill obtainable.

We are admonished that, presumably within a week or two, this substitute bill known as the Caffery bill will be introduced into the House, and our influence and work must necessarily, for some time at least, now be exerted with representatives in Congress. Shall this be done?

Before closing, I might with propriety propound this query also (which is not intended so much for the aggrandizement of our profession as some might be led to believe).

Would it not be well for the President's cabinet to be dignified by the acquisition of a scholarly and thoroughly scientific medical secretary exactly on the same principle as the presidential family is composed of gentlemen versed in diplomacy in matters of state, finance, the judiciary, the science and art of war, etc.

Let us have a department of health, therefore, as has frequently been outlined in the JOURNAL, on the same theory that if we want a spade, a spade will be provided for us and not a spatula, or if we ask for a stick of wood that a wooden toothpick will not be substituted.

Very sincerely yours,  
LISTON H. MONTGOMERY, M.D.

#### Method of Examination of Urine.

OMAHA, NEB., Feb. 3, 1898.

*To the Editor:*—Apropos of the ingenious method for the detection of casts described by Drs. Haines and Skinner in the JOURNAL of January 29, it may be of interest to describe the method which has been in use in my laboratory for the past few months. I depend entirely on the centrifugal method and use only tubes containing at least 15 c.c. Both tubes are filled to the 15 c.c. mark with the freshest possible specimen of urine and centrifugalized at from 1800 to 2500 revolutions per minute for three minutes; then at least 10 c.c. are withdrawn from the tubes with a pipette, being careful not to shake; the tubes are again carefully filled with the pipette and again centrifugalized; this process is repeated ten or twelve times, so that in about half an hour we have the sediment in each tube from at least 115 c.c. urine, 230 c.c. in all. Then the bottom 3-5 c.c. of both tubes are placed in one tube and again centrifugalized. This method has been especially useful in the examination of urine for tubercle bacilli, where by spending a little more time we often use the sediment from 500 c.c. This method is rapid, thorough and avoids a tedious delay, as well as the necessity for any preserving agent. As a proof of this efficiency I may add that in over 200 examinations of which records are kept, a few casts have been noted in every instance, even in apparently healthy individuals.

Respectfully,

AUGUSTUS DETWILER, M.D.

#### X-Ray Dermatitis; Suit for Damages.

PADUCAH, KY., Feb. 2, 1898.

*To the Editor:*—In October, 1897, the undersigned was sued for malpractice in the sum of \$10,000 for subjecting a patient to the X-rays which produced a severe dermatitis, the plaintiff setting up the claim that the apparatus was carelessly used, and further that the means used was not yet sufficiently well understood as to warrant its use for the purpose of locating foreign bodies, etc. The suit was ably contested and fortunately was decided in my favor, the court holding that in this as in other cases the physician was bound to use ordinary skill and judgment, and placed the case upon the same footing as chloroform anesthesia.

Knowing that there were several suits of this character in the courts I thought perhaps it would be of some interest to report it, since I have as yet been unable to find that the subject has been previously passed upon by the courts.

Respectfully,

FRANK BOYD, M.D.

#### PUBLIC HEALTH.

**Louisiana State Board of Health.**—The *New Orleans Medical and Surgical Journal*, January, alludes to the fact that that Board of Health is temporarily dismantled, all the members who were in office during the recent outbreak of fever having