

## EDITORIAL.

### MISTAKES OF PHYSICIANS.

It may be deemed ungracious to write of the mistakes of other physicians, and more particularly when errors of judgment entail fatal consequences, and it may seem suicidal to confess one's own blunders, but the welfare of the race is paramount to the interests of individuals.

There are fundamental principles which should underlie the conduct of physicians and govern their actions and their relations, both with each other and with their patrons. Referring first to some faults of the specialists, and second to those of the general practitioners, we are driven to the conclusion, with regard to the former, that many of them are guilty of committing a serious mistake when they undertake to confine themselves exclusively to a special branch of practice from the time when they obtain their medical degree. The inevitable tendency of such a course is a regrettable narrowness, which a few years of general practice would forestall. Five years of such an experience (the writer had fifteen) would lay a foundation, upon which one could establish a more masterful grasp of the subjects of the specialties and render his services generally more to his own satisfaction and of greater value to his patients. It broadens the horizon and enables a man to measure up to the liberal standard of a well-equipped, all-around physician, and to recognize the various diseased conditions which may require the attendance of specialists in other lines, or of general practitioners.

The following cases will serve to illustrate this contention: An eye specialist was called in consultation by a general physician in a case of suppuration of the middle ear with mastoiditis. The nature of the disease was not recognized in time to avert an intracranial involvement and death, although an ear surgeon would have detected the conditions readily. Had it been an eye disease, a better consultant could not have been called.

A physician from a distant city referred a patient to me for a mastoid operation, but, before seeing me, the young lady was piloted (I do not say pirated) to a specialist in operative surgery, who operated upon her, with the result of producing a facial paralysis. The distortion of her features so shocked the fine sensibilities of the pa-

tient that she declared she had rather be dead than so hideously deformed." The operating surgeon, who has long since gone to his reward, was highly accomplished in the field of general surgery, but made the mistake of invading the domain of the specialist in aural surgery.

Here is another illustration of the same deplorable usurpation of an unfamiliar department of surgery: A general surgeon, with an enviable reputation as such, performed a mastoid operation on a patient for suppuration of the middle ear and mastoid process. Seven months after the operation the suppuration of the ear continued, a keloid growth occupied the site of the mastoid scar, and a polypoid mass filled the space which was originally the external auditory canal. There was no hearing in the affected ear except by bone conduction, and facial paralysis was added to the pitiable results. The new growth was removed from the canal, following which the hearing was good for ordinary conversation at a distance of more than 30 feet, but it required nine months of treatment to overcome the facial paralysis sufficiently to make firm closure of the eye and angle of the mouth possible. The fibres of the occipito-frontalis muscle remained paretic. The duplicate of these results has never occurred in the writer's practice, nor, indeed, a single example of complete, permanent facial paralysis from an operation. Such unhappy illustrations could be multiplied where it desirable to emphasize this phase of the subject.

The duties of the specialist and of the general practitioner often approach and overlap each other, dovetailing as it were, necessitating a comprehensive knowledge of the principles involved in the coördinate branches of medical practice, so as to conserve, first, ones own success and the patients' interests without duplicating the cost to them; and, second, to serve the patients intelligently and in good faith by intrusting their care to another, when necessary, in a line of practice in which the other is more skilled. One should not attempt to do what another can do better, speaking in a general way. Each man should confine himself to that which he can do best. This combination of specialized skill and conscientious coöperation among medical workers constitutes the ideal of modern medical practice.

The young physician may be depressed, at first, by the fear that he will not retain the patronage of all patients who consult him, but he should reflect that, if all physicians will adhere to the same high principles, he will be compensated by the mutual benefits resulting

from this reciprocity. And even if all his confreres do not evince this spirit of fraternal courtesy, he will eventually earn a reputation for efficient and fair treatment, which will bring its returns. But, if one is inclined to question this proposition, he should regard the feeling of having fulfilled the Hippocratic conception of the ideal physician as worth possessing. A consciousness of true worth and self-approval should be highly prized assets in one's stock of manliness. No doubt such old-fashioned ideas will provoke a wink and a smile from the rare medical grafter, but life is too short and eternity too long to be disturbed by them. The rank and file of the medical profession are sincere, and worthy of the confidence reposed in them.

In order to elucidate the argument I will resurrect some illustrations that have come within my own knowledge, but they are so ancient as to work no injury to those who were involved :

A boy, 14 years old, was brought to the writer's clinic, suffering with pain in the ear. There were, also, pain, redness, swelling and tenderness in the region of the corresponding mastoid process. His mother was informed regarding the nature and danger of the disease, and it was endeavored to impress upon her mind the imperative necessity of daily treatment and constant attention to the case. This advice was totally ignored for several days, when the writer was sent for in urgent haste and found the boy unconscious, delirious, with inequality of the pupils and convulsive facial movements. A suppurative inflammation of the middle ear and mastoid process was plainly responsible for the symptoms. An incision disclosed a mastoid fistula; pus was liberated, the cavities were irrigated, the pressure relieved and the danger appeared to be over. The parents were informed that, notwithstanding the improved condition, it would be necessary to operate upon the bone in order to insure ultimate recovery; but they demurred. A few days passed, in which the boy seemed to be getting well. He was a bright little fellow and amused himself by beating a drum for the edification of the neighbors. Suddenly a relapse occurred; the parents were advised that further temporizing would be futile, and that, unless I were permitted to follow the dictates of my judgment, and to operate, I would not be responsible for the consequences. They decided to act upon the advice of their neighbors instead, who said: "Don't let Dr. Bishop butcher your boy," and I withdrew from the case.

Several days later I received a telephone message from Mercy Hospital stating that a boy whom I had previously attended had been brought to them in an unconscious condition, and that the physicians on duty were unable to make a diagnosis. It soon became evident that this was the patient just described, and I urged an immediate operation as the only means of saving him. However, as it was not convenient for them to operate at once, they preferred to wait until the following day, and asked if I would come at 9 o'clock in the morning. Before that hour arrived I was notified that the child had died during the night—a promising life sacrificed on the altar of prejudice and ignorance. Had I insisted at first upon operating, and had the parents permitted it when it was first advised, there is absolutely no doubt that the boy would have recovered.

Another lesson is that, with the symptoms of brain complications, a discharging ear and the evidence of the opening which I had made into a mastoid fistula, the nature of the malady was not recognized at the hospital and an operation, the only possible avenue of escape from a fatal issue, was not performed, although it may have been too late then to avail anything. In this connection one cannot lose sight of the fact that, had an operation been performed at the last moment and had it failed to prevent death, the parents and neighbors, wise and otherwise, would have attributed the death to the operation and not to the disease which killed, thereby justifying their ignorant warnings, and discounting the brilliant achievements of unhampered surgery. I have always blamed myself for not making the attendance upon this case conditional upon my right to exercise my own judgment from the first, or withdrawing from it as soon as my hands were tied, but, in extenuation, I may plead that this was my first sad experience of this kind.

Another occurrence which I have always regretted was the following: A young man, who was referred to me by a prominent eye specialist of Denver, was suffering from a chronic suppuration of both middle ears and bilateral mastoiditis. He was told at once that surgical interference would be necessary, but, as the symptoms were not then urgent, I did not insist upon an immediate operation. Before submitting to it, he fell into the hands of strangers, as I learned a year subsequently, became delirious, and was taken to the Cook County Hospital, where, it was said that he died of typhoid fever. All the evidence pointed toward an intracranial complication of the ear disease as the cause of death, but it was not recognized,

although the cardinal signs were conspicuously prominent—another valuable life consigned, metaphorically, to the human junk heap. I reproached myself afterward for not having demurred more strenuously to the delay, but one is sometimes at a loss to know how to address himself to such patients in order to protect their interests and yet not to appear brutally blunt and heartless.

A physician came from a distant State and requested me to permit him to witness a number of mastoid operations. He remarked casually (which suggests the word casualty) that he "supposed one had to kill four or five patients before he learned how to operate successfully!" He had operated upon four patients and they all had died! I expressed my astonishment at such a proposition, since I had been performing these operations for many years without having had a death as the result of an operation. I do not say this boastfully. It is a matter of clinical history, and no doubt other operators who have observed the same precautions and methods can cite like results.

Another anomaly is worthy of our serious consideration: It is to be deplored that American physicians do not more generally separate the specialty of eye diseases from that of disease of the nose, throat and ear as is done by the leading European practitioners. Either specialty is large enough to tempt any ambitious man to master. It is argued that there is not enough work in one of them alone to afford a lucrative income, and that Americans have been educated, from an early day, to the idea of resorting to eye surgeons for ear treatment; but if the profession generally would segregate these branches of practice in conformity to their natural remoteness of relationship, it would eventuate in an equitable distribution of work, and the results would be more creditable and satisfactory, both scientifically and economically. The present unnatural association of the two specialties is productive of a vast amount of service which is indifferent—or worse. Men who are enthusiastic and skilled eye surgeons drift along on the borderland of ear, nose and throat diseases, with which they dally as a mere side-show to their favorite eye practice. Their heart is in the one, but the financial returns from the other specialty are too great a temptation to resist.

Only one illustration needs to be cited to show how Americans are wedded to this artificial union of two specialties: It was desired by some Chicago ear, nose and throat surgeons to refer eye cases to an eye specialist who would limit his practice to eye work, and

reciprocate their courtesy. A proposition was made to one of our most prominent ophthalmologists that, if he would practice ophthalmology alone, the coterie of specialists would refer all eye cases coming under their sphere of influence to him, and he, in turn, should refer patients falling within the lines of their specialty to them. The offer was rejected. So, this anomalous and inequitable situation still exists: The ear, nose and throat surgeon refers his eye patients to an eye surgeon, who, the patients observe, treats all diseases of both specialists, keeps all the cases referred to him and does not reciprocate by conferring a like favor. This peculiar practice is so well known that young men who are preparing to practice as ear, nose and throat specialties equip themselves to treat eye diseases also, as a matter of self-preservation. The natural segregation of these two specialties, as we find them in Europe with the resulting highest attainment of perfection, scientifically and practically, seems to be a very remote possibility in this new world.

Let us make a passing note of another mistake, which is made by the occasional type of physician who pretends to be a "specialist" in the line of any disease which he happens to have a chance to treat; but this mongrel exception only serves to prove the rule that the average physician is a foe to fakes. With all its imperfections, I have unbounded faith in the simple honesty of the great mass of the medical profession. In pure and unaffected charity, disinterested faithfulness to its trust, self-sacrificing devotion to duty and immolation for the promotion of humane activities, in heroism unheralded and unpublished, but none the less worthy to be recorded on the pages of enduring history, the medical profession stands without a peer.

BISHOP.

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#### ERRATA.

Prof. Gustav Killian's article entitled "Cauterization of the Four Susceptible Areas of the Nasal Mucosa" was not presented before the American Laryngological Association as stated in footnote on page 341, May issue.

Read "a small neck" for a "small needle" in 7th line from bottom of page 380, May issue.