

THE TREATMENT OF PLACENTA PREVIA.<sup>1</sup>

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THERE are few more interesting topics of discussion for the obstetrician than the treatment of placenta previa, and although many papers have been written on the subject in recent years, yet there still exists a wide difference of opinion and of practice with respect to the methods to be pursued in the treatment of the condition.

Recently several papers have appeared advocating Cesarean section as the best method of treatment for placenta previa, but the arguments in its favor are far from convincing that the operation is a suitable one, or that its results will be attended by a lower rate of mortality than is obtained under other methods. A very few cases of placenta previa have been reported in which Cesarean section has been performed, but the results of these are not at all promising.

Certainly any procedure which can be shown to hold out promise of a material diminution in the maternal or even in the fetal mortality is worthy of serious consideration and trial, but under the present methods of conducting labor cases among the vast majority of people, the early diagnosis and treatment of placenta previa, by which I mean the recognition of the condition before labor or hemorrhage begins, is only rarely possible. For this reason most cases of placenta previa are first seen in more or less unfavorable conditions for good results by any method of treatment, without adding the additional shock of an abdominal operation.

In this connection the mortality results of placenta previa at present, under the methods of treatment which have been in general use are particularly valuable, owing to the fact that earlier statistics were gathered at a time when puerperal sepsis played an important part in the convalescence of all obstetric cases, and especially so in placenta previa and other operative conditions. At present, however, the question of death from septic infection may practically be eliminated from consideration in determining the mortality from placenta previa, as that now usually constitutes the least of the obstetrician's worries, and a small proportion of the aseptic precautions necessary for abdominal section renders the vaginal delivery free from all danger of infection.

By this I would not wish to be understood as making light of aseptic practice in obstetric work, but that as the advocates of abdominal section put forward the liability of puerperal sepsis in vaginal delivery in placenta previa as one of the leading arguments in support of the practice, I would say that the same precautions which we adopt in abdominal surgery, if used in obstetrics, would undoubtedly absolutely stamp out puerperal sepsis, and yet peritoneal infection not very infrequently

occurs in abdominal work in the most careful hands in spite of every precaution.

I have recently collected the cases of placenta previa at the Boston Lying-in Hospital and found altogether 75, of which 56 were treated in the hospital wards and 19 in the Out-Patient Department at patients' homes.

Among the 56 house cases there occurred 6 deaths—a mortality of 10.7%; all the fatal cases were complete placenta previa except one. Of the 19 out patients there were 2 deaths, 1 of the complete and 1 of the incomplete variety—a mortality of 10.5%. Taking the whole 75 cases together, there were 8 deaths—a mortality of 10.6%.

This mortality is somewhat higher than should occur under normal conditions with careful treatment in private practice, since a large proportion of these cases are sent into the hospital by outside physicians in Boston and vicinity, for delivery after severe hemorrhage has occurred. As under these circumstances the hospital receives and cares for many very unfavorable cases, some of which are in a desperate state before any treatment can be undertaken, it would be natural to expect that the mortality of the hospital cases would be above normal, and that any supposed advantage to be gained by hospital treatment and skilful operating, is more than counterbalanced by what amounts to early neglect. Upon prompt attention and treatment and the prevention of antepartum hemorrhage, a low maternal and fetal mortality largely depends.

For this reason the mortality of the Out-Patient Department, in which the women are seen and cared for usually after the onset of hemorrhage or labor and are treated without being subjected to the delay and danger incident to removal to the hospital, would seem to offer a fair basis for comparison with the house cases, inasmuch as the out patients are usually of the poorest class and often suffer from lack of the necessities of life. It is rather curious, however, to observe the slight difference of mortality which exists between the house and out-patient cases—only two-tenths of 1%.

There are some interesting points in connection with the 8 fatal cases which can only be brought out by reviewing them briefly:

CASE I. Eight months pregnant. At entrance weak, anemic and much exhausted, having had copious hemorrhages for 1 week; version. Very slight post-partum hemorrhage, easily controlled, but mother and child died within 2 hours.

CASE II. At 7 months. Poor condition at entrance. Two severe hemorrhages outside hospital. No post-partum hemorrhage; version. Baby stillborn. Mother collapsed and died within 2 hours.

CASE III. At 8 months. Moderate hemorrhage for 2 weeks, considerable 1 day, considerable during labor, no post-partum. Collapsed and died 12 hours after labor.

CASE IV. At 7½ months. Considerable hemorrhage for 4 days. Condition poor; marked pallor. Pulse 120. Primipara. Manual dilatation requiring only 9 minutes, version and extraction only 3 minutes, whole labor 9 minutes. No hemorrhage after delivery and placenta allowed to remain 1 hour. Died in 10

<sup>1</sup> Read before the Obstetrical Society of Boston, May 21, 1901.

hours of profound anemia. This was 1 of the 2 fatal cases in which the previa was incomplete.

CASE V. At 8 months. Severe hemorrhage for 7½ hours before entrance, beginning with labor. Was given whiskey, digitalis, and nitroglycerine, and vagina packed by physician outside. Condition at entrance poor; blanched, and patient fainted. Pulse 156. No post-partum hemorrhage. Uterus packed. Fibroid in anterior wall of uterus interfered with delivery and packing. Died 2½ hours after delivery.

CASE VI. At 9 months. Hemorrhage considerable for 1 day before delivery, and post-partum, requiring packing which controlled it. Patient did well for 3 days, then developed abdominal symptoms, vomiting, distention and a rapid pulse. Died suddenly on the 5th day. Autopsy showed a diphtheritic colitis with secondary infiltration of perinephritic tissue. This death was not traceable to the placenta previa or to the delivery, and might perhaps be excluded without inviting criticism, but I have included it as 1 of the 8 fatal cases.

CASE VII. At 5½ months. Considerable hemorrhage for 1 day. Out-patient case. Did not send for assistance till late. Condition poor. Pulse 120. Severe post-partum hemorrhage, packed, but did not control hemorrhage very well. Died several hours after delivery. Second case of incomplete previa.

CASE VIII. At 9 months. Hemorrhage began 5 days before labor, moderate but increasing in amount and was severe for 1 day. Pulse 148. Fainted before delivery. Packed, but there was no post-partum hemorrhage. Very weak, and died in 12 hours.

These fatal cases suffice to show the desperate condition in which many patients are received at the hospital. There were a number of others seemingly quite as bad but which survived under similar treatment. The state of indifference or neglect which many of these women allow themselves to fall into with respect to hemorrhage seems incredible. I suppose it is due to the fact that they become accustomed to seeing considerable loss of blood about a quarter of the time during most of their life, and an increase in the amount does not impress them as of serious importance until they begin to notice the weakening effect.

In only one of the fatal cases, the seventh, was there a severe post-partum hemorrhage which was difficult of control, the others having little or none. This illustrates a fact which I wish to emphasize strongly, namely, that while post-partum hemorrhage may be an active danger and one always to have in mind to be guarded against, it is not nearly as dangerous an element in placenta previa as continued antepartum hemorrhages, which so weaken the patient as to render any form of delivery dangerous.

Only one primipara died out of 16, and her death seems to have been directly due to the exhaustion from the antepartum hemorrhages. The dilatation and delivery were easy and rapid, as they were in all of the 7 primiparous cases in which version was performed. Eight primiparæ delivered themselves without difficulty, and the labors were comparatively short for primiparæ, averaging not over 10 hours, undoubtedly due to the softness of the os and the easy dilation characteristic of placenta previa.

Version, then, usually contra-indicated in a primipara because of natural difficulties, is easily performed in placenta previa.

In any of these 8 fatal cases which I have reported it does not seem as if the most enthusiastic advocate of Cæsarian section would care to do the operation under the conditions in which the patients were received. Moreover, 6 of the labors were premature, only 2 being at term, prematurity generally, I believe, being a contra-indication to abdominal delivery except when possibly in rare instances it might be done in behalf of the mother.

The operations at the Boston Lying-in Hospital were performed by as many as eight different members of the staff, so that the credit either of the good results or of the deaths cannot be attributed to the work of any one man. The only suggestion that I would offer in regard to the treatment of the hospital cases is that possibly some of the patients might have been gotten into better shape by delaying operation for a while, by packing the vagina tightly to control hemorrhage and to allow dilatation, while the patient is being stimulated and strengthened and brought into better condition.

With regard to the general maternal mortality from placenta previa, it was without doubt formerly high, probably between 20 and 30%, but these early percentages were obtained from cases collected at a time when puerperal sepsis was frequent, and was an important factor in the maternal mortality from childbirth, especially so after placenta previa and other obstetric conditions requiring operative interference. But nowadays, with the practical elimination of puerperal infection under aseptic precautions, and with marked improvement in operative technique, the maternal mortality has been greatly reduced, and under favorable conditions and good treatment it is probably below 5% in placenta previa.

That the mortality ever reached the 50% attributed to it by Tait I cannot substantiate by any record of cases I have been able to find. Simpson's figures which Tait mentions placed it at 29%. The earlier editions of Lusk, published nearly twenty years ago, place the maternal mortality at 25%, and the conservative writers of the present day give the earlier mortality at about these figures, while under modern methods authorities agree that it is very low.

Hirst, in his textbook, says that under modern methods the mortality almost disappears, and reports 104 cases which he has collected, 16 of which are his own, with only 1 death. Nearly 10 years ago Barnes, in 67 cases, lost only 8.8% of the mothers. Murphy, in 1893, had 61 cases with only two deaths, and one of the two was moribund when first seen. Noble says the mortality to the mother is probably 5%. Recently Hirst says he has met with 24 cases without having lost any, and he thinks the mortality is about 1%. Recently the mortality statistics at the Rotunda Hospital have been published. It is 4% in 74 cases in the last 10 years.

In considering the question of superseding the present methods of operating in placenta previa by Cæsarean section, it is desirable to see upon

what grounds its advocates base their arguments in its favor, as well as to consider the results likely to be attained.

Lawson Tait, although not the first, seems to have been the most prominent advocate, and his communications chiefly have been quoted by recent writers. Early in 1899 Tait, in a short communication published both in the *Lancet* and the *Medical Record*, "On the Treatment of Unavoidable Hemorrhage by Removal of the Uterus," advocates the Porro operation for enucleation of the uterus, and reports a successful case. His patient was in her fourth confinement, with a history of one post-partum hemorrhage and several miscarriages. The operation was performed because, in his words, "It would save the child, it would probably save the mother, and it would relieve her of the condition of perpetual misery and risk in which she had been living for years, and would therefore assist her in properly rearing the children she had, rather than tend to procreate others to whom she certainly showed no likelihood of ever being able to give proper care."

The foregoing are his reasons for removing the uterus in place of the classical Cæsarean section; but I desire also to call your attention to his arguments in favor of abdominal delivery in general. These are: "In looking up the authorities on placenta previa for some assured statement concerning its mortality, there is nothing more definite than is to be found in Simpson: 'All obstetric authorities seem to agree on this point, that there is no one complication in midwifery attended with more anxiety to the practitioner, and few, if any, with more real danger to the patient, than cases of unavoidable hemorrhage from presentation of the placenta.' He proceeds to give figures which go to show that the fatality is close on 40%, but I gather from the smothered confessions of other writers and the open admission of my friends who have had large obstetric experience, that it really is much higher; and in spite of the sound principles laid down for its treatment and the improvement therein made by Simpson himself, it is probable that more than half the cases die."

The above was published by Tait in 1899, while the quotation which he uses from Simpson's writings was first published in March, 1845, or fifty-four years before. As a matter of fact, in this very paper from which Tait quotes, Simpson reports 654 cases which he collected, with 180 fatalities. Simpson's words are: "One in every 3.6 of the mothers perished in connection with this complication." This is a mortality of 29%, and Tait magnifies it to 40%, and says he believes it should be 50%. This not only amounts to a distortion of the facts, but goes back over half a century to quote opinions and figures, which at the present time are of absolutely no value except for purposes of comparison. It would be as fair that we should cite the maternal mortality of Cæsarean section of a half-century ago, which was practically 100%, to refute such arguments.

As I said before, these distorted facts as given by Tait have unfortunately been frequently quoted by later writers, and of course without adding to the value of their arguments.

Dr. Dudley, in the *New York Medical Journal* (Nov. 3, 1900), quotes Tait and argues in favor of the elective Cæsarean operation on every case of placenta previa, qualified neither by the degree of previa nor by the development of the fetus, so far as I am able to make out. He believes that the diagnosis should always be made antepartum and before hemorrhage, that the patient should then be removed to a hospital and the operation made elective. Under these conditions he believes success would invariably attend. His ideas with respect to antepartum diagnosis and removal to a hospital for skilful treatment would be ideal if they could be carried out, and would reduce the maternal mortality from placenta previa to almost nothing by almost any method of treatment, but unfortunately these conditions are far from possible at the present time. Dudley, moreover, does not take into account the fact that in 62% of the cases of placenta previa labor occurs and the child is born premature, and also the extremely high mortality of premature babies. He does not report having done the operation himself for placenta previa.

Dr. Donoghue also quotes the mortality figures of Tait and from them argues for abdominal section in placenta previa under certain conditions as opposed to version. He has had one successful case which he reported. Since the report of his first case he has had another operation which terminated fatally, but which I am at liberty to mention. He has not as yet published this second case, but I presume his experience with it and the fact that it was not successful have caused him to materially modify his views with respect to the extreme safety of the operation which he recommends.

Dr. Hare also has had 1 fatal case of Cæsarean section.<sup>2</sup> The mother died in 11 hours after delivery and the premature child of 7½ months lived 13 days. Here, then, are 3 cases operated upon in this immediate vicinity within the past few months with a maternal mortality of 66.6% as a direct result of recent advocacy of this treatment. Doubtless there are many other cases with equally appalling results but which will never be published, owing to the well-known and unpleasant odium attached to fatalities by any new and radical procedure. Hare says that so far as he knows his was the fifth case to be treated by Cæsarean section. Dr. Sligh of Montana performed the first one in 1891 for a rigid os, which he claimed was an absolute indication for the operation. The child was stillborn and the mother lived 12 hours only. Another one said to have been performed by Drs. Hypes and Halbert of St. Louis, but not published in detail, also proved fatal. Dr. Bernays of St. Louis, in 1894 (*Journal of the American Medical Association*), publishes a case which he says was the first successful case of Cæsarean

<sup>2</sup> Boston Medical and Surgical Journal, Feb. 14, 1901.

section for placenta previa. His success lay in the recovery of the mother, for the child, premature at 8 months, died in a few hours. He also remarks that his case was an ideal one so far as the condition of the patient was concerned.

Bermays says the reasoning which led him to perform Cæsarean section in this case was based on the brilliant results of this operation in the hands of expert operators in recent years, and that the statistics of the mortality of placenta previa, when treated by the Braxton Hicks method in the hands of experts, are not as favorable as those of the Cæsarean section under the same conditions.

This statement on its face appears plausible and might possibly prove true in exceptional cases, although as yet no large series of Cæsarean operations have been performed by any one man, the 20 of Reynolds so far being the greatest. Dr. Reynolds' cases, however, were all carefully selected and performed under the most favorable circumstances without previous shock, hemorrhage or exhaustion from long continued labor. These are conditions of selection which it is impossible to attain in placenta previa. The Cæsarean operation for contracted pelvis is an operation of election, and the results can no more be compared with the mortality results of placenta previa, than can the result of appendix operation in the interval be compared with operation in the attack, or the results of operation for extra-uterine pregnancy before rupture be compared with those after rupture.

That the elective operation of Cæsarean section is a relatively safe and easy one in skilful hands in suitable cases is fortunately true, and that it may be performed many times without high mortality is also conceded, but that it is often indicated or justified in placenta previa, or that it will reduce the percentage of mortality in this disease, is far from likely.

Dr. Reynolds, one of the strongest advocates of the operation of Cæsarean section for contracted pelvis in selected cases, says that at present even the maternal mortality is probably not less than 25% in all reported cases, and that in the unfavorable cases it reaches the prohibitive figure of 33.3%; also that when the conditions are such that the child can be delivered with anything like reasonable ease by forceps or version, one of these operations is preferable to any cutting operation.

Hirst says that under favorable circumstances and in the hands of skilful operators the mortality of Cæsarean section may be very low, perhaps below 5%, but in general practice the mortality of the operation remains high and will probably continue so. In America the mortality, according to Harris' statistics, ranges from 30 to 40%. At the Boston Lying-in Hospital, within a period of about 5 years, there have been 32 Cæsarean operations, all carefully performed with scrupulous care and surgical cleanliness on selected cases at full term, and supposedly favorable from the standpoint of maternal and fetal condition and with the patients free from exhaustion, infection or hemorrhage.

Under these conditions, then, conceding the claims of those earnest in urging the safety of the operation, there should have been neither maternal nor fetal mortality in these cases. There were, however, 3 maternal and 3 fetal deaths, a mortality of 9.3%; in 1 case mother and child both died, in two cases the mothers died and the babies lived, and in 2 cases the infants died and the mothers recovered. As the mothers and babies did not die in the same cases, it can be said that the failures were not due to poor judgment in operating, but from the fact that such results will happen, as we all know, in abdominal work, seemingly after every precaution has been exercised. I believe the general mortality in Cæsarean section under favorable circumstances will run about 10%. With great care, exceptional skill in operating, and the most rigid scrutiny of the cases, it may in the hands of a few operators be almost nothing, just as series of 100 cases of general abdominal operations have been reported without mortality or with from 2 to 5% only; but such are not the prevailing conditions.

It has always been assumed that the prognosis for the child in Cæsarean section is entirely favorable, as one man has expressed it that "the Cæsarean baby is gently lifted up into the world." This in my experience is far from being true, and I have heard others comment on the fact that Cæsarean babies rarely cry out on birth or seem to have the vigor of those born by the natural passage. That there is some cause for this not yet explained, and that it is due to something more than the etherization, I feel confident. After high forceps operations or versions the babies cry out and breathe quicker, and the delivery usually requires more time than the Cæsarean delivery, and the patient is under ether longer before delivery. I believe I have seen 25 Cæsarean sections, and it is exceptional that the child does not cause more anxiety at the time of operation than the mother, or that it does not have to be resuscitated with great care and by prolonged immersion in hot water. One of the children's deaths at the hospital was in my own case, and the fetal heart was beating strongly for a considerable time after delivery. The child simply could not be resuscitated, and there was no apparent cause. Dr. Reynolds will also, I think, recall a case of his in which he and I together worked for about two hours on the infant before it was in a satisfactory condition. It is said that only 90 or 95% of Cæsarean children are saved. Robb gives the infant mortality as 13%.

Another aspect of the disease which we have not as yet considered, nor have I found that it is mentioned by other writers, but a side which appeals at once to the obstetrician and to one having much to do with young babies, is the large percentage of premature births in placenta previa. Müller says that only one-third ever reach maturity. In 74 cases at the Rotunda Hospital 62% were premature, and I have found precisely the same percentage in the 75 cases at the Boston Lying-in Hospital.

The mortality of premature infants is so high under the most favorable conditions, that it is unadvisable to subject the mother to the danger of an abdominal operation for anything less than a full term child can scarcely be questioned. Statistics in regard to premature infants are not frequently given, but at the Paris Maternity the mortality is over 70%; at the New York Nursery and Child's Hospital it is 60%.

The fetal mortality in placenta previa is conceded to be very high, probably from 50 to 60%, and very likely will always remain so, unless the percentage of premature births, now 62%, can first be diminished. The large proportion of premature births in itself is a sufficient cause of very high infant mortality, and when combined with prenatal hemorrhage and asphyxia, but little if any improvement can be expected. It is difficult to see how Caesarean section can solve this problem to any appreciable extent.

It is fast becoming evident that Caesarean section, as advised and performed by some operators, is seldom indicated or justified, and it would appear fitting at present to utter a word of warning against its indiscriminate and almost reckless performance at times. It seems to have almost reached the point of being recommended as the panacea for every serious condition of pregnancy. It has been so widely advocated and performed in recent years, and appears so easy and simple, that it is now brought forward to replace obstetrical expedients of long-recognized value, by surgeons and others of small obstetrical experience. We see reported cases in which it has been done not only for placenta previa, but for eclampsia, for face presentations and for other conditions even when the child is supposed not to be alive or not viable. It would not be surprising then to learn that it was being done for other serious pathological conditions in the mother, such as grave cardiac or lung diseases, in which induced labor sometimes becomes necessary.

It is a fair assumption that any operation which is relatively safe, and which bids fair to improve existing conditions, is justifiable. We shall hear of sporadic cases of the successful performance of Caesarean section, even after severe hemorrhage has occurred, but the operation is to be deprecated under such circumstances, as it can terminate in the long run only in deplorable results. In any of these 8 fatal cases which I have reported it does not seem as if the most enthusiastic advocate of Caesarean section would care to do the operation under the conditions in which they were received into the hospital. I believe that the hospital mortality in these 75 cases is greater than should occur in private practice under careful management.

My own opinion is that the results of Caesarean section under favorable conditions, and of placenta previa in general under present methods are substantially the same, and that both will vary, according to circumstances, up to 10%, but that in Caesarean section for placenta previa, under the unfavorable conditions in which it would

generally have to be performed, it would be 2 to 3 times greater.

Many pages might be written on this subject, but one paper would not convince the unbelieving any more than the result of one favorable operation proves that the treatment is for the best interests of mother and child.

However, if this proceeding as a general resort in placenta previa gains a recognized standing in the profession at large, it will soon be done by general practitioners everywhere, and its consequences, unpleasant to contemplate, can readily be foreseen, and it will be true, as has already been very properly stated by Dr. Dewis, that "The time cannot be far distant when it will be considered necessary for the general practitioner who does obstetrical work to be competent to do this operation."

The rational treatment of placenta previa depends more or less upon the circumstances arising in each case.

Every patient, after the appearance of the first hemorrhage, and the diagnosis is established, should be put absolutely at rest and kept under most careful supervision, with every provision at hand ready for immediate interference. The first hemorrhage is practically never fatal, but a dangerous one may ensue at any time without warning. Before the fetus is viable or nearly so, unless the patient can be transferred to a hospital or surrounded by proper safeguards in her own house, induction of miscarriage is the only safe method of treatment and is practically without mortality to the mother if properly performed. After the viable period is reached, in the interest of the child it is advisable to defer delivery as long as possible with safety to the mother, but only when she can be at rest and carefully watched. Any other methods of procedure entail grave danger to both lives, and involve the physician with anxieties and risks which he himself should be unwilling to assume.

An important point to always keep in mind in deciding upon the methods of treatment is that if hemorrhage does begin early, it is rarely possible, even under the most favorable auspices, to prolong the pregnancy for any great length of time; a few weeks at best can only be secured. Miscarriage and hemorrhage may begin even while the patient is sleeping quietly.

The only safe way is to terminate pregnancy as soon as the diagnosis is established after the end of the seventh month, as after this time a hemorrhage may occur without warning, severe enough to cause ultimate death. After delivery is decided upon, if the patient's condition is in any way precarious from previous hemorrhage, and the bleeding continues, the membranes should be ruptured, and with the woman in Simms' position the vagina should be tightly packed with pieces of dry, baked gauze, which, if well applied, controls hemorrhage by pressure and by the styptic action of the dry gauze. The patient is then kept under careful observation, brought into better condition by stimulants and saline infusions.

The gauze will efficiently control hemorrhage for from 4 to 6 hours, and may safely be left in that length of time unless it soaks through before. The packing is of no value unless firmly applied. Under its use dilatation goes on with labor and practically without hemorrhage, the cervix being compressed between the packing and the presenting part. If the packing method was faithfully followed in every case as a routine measure, many cases which now bleed during dilatation till their condition becomes serious, would be kept in good condition for their subsequent operative delivery. Moreover, after removal of the gauze, the head, if presenting, not infrequently is found to be engaged, and normal labor or an easy forceps operation results.

The other expedient is bipolar version by the Braxton Hicks method, the os being dilated sufficient to admit two fingers, which are passed into the uterus, seizing a foot and extracting it until the knee appears outside the vulva. Moderate traction on this leg brings the breech against the placenta, controls hemorrhage and hastens dilatation, and extraction becomes safe usually after an hour or so.

In concluding, I would say that I believe it is clearly demonstrated, on study of the conditions, that under modern methods of treatment and reasonable aseptic precautions, which it should be scarcely necessary now to mention, the mortality from placenta previa is not over 10% in general, and under favorable circumstances, in skilful hands, it is below 5%; that abdominal section is rarely ever indicated; that it does not even in favorable cases hold out promise of better than 10% mortality; that its risks are much greater, and in unfavorable cases its mortality is prohibitive.

In my opinion the only cases of placenta previa in which Cæsarean section are ever justified, are those at full term, with complete previa, with a rigid os and seen before the occurrence of any severe or dangerous hemorrhage, and with the mother and fetus in good condition. Such cases would offer the best opportunities and conditions for the recovery of both mother and child, would allow sufficient time for thorough preparation, and would, perhaps, be justified, and in the hands of experienced operators the mortality would be low.

## PRIVILEGED MEDICAL COMMUNICATIONS.

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At the last meeting of the Councillors of the Massachusetts Medical Society an appeal was made<sup>1</sup> in favor of a statutory provision designed to eliminate from our civil courts a certain class of medical evidence. This appeal will impress the careful reader, first of all, as novel, in that this proposed legislative action is invoked in behalf of physicians; whereas, all similar legislation else-

where has been framed ostensibly upon grounds of public policy. Our society is thereby asked to act in disregard of the theory virtually adopted under our government, namely, that a statute obviously enacted to favor any class without due consideration of the rights of the public would be unconstitutional. While it is not to be apprehended that such class legislation will be solicited on a question which is purely ethical, it is equally important that we should avoid becoming involved in the promotion of ill-considered measures which have been tested and found unsatisfactory in other states.

The proposition laid down by Hippocrates, as to the sacredness of professional secrets, is based upon an abstract principle which commends itself to all. Nor is this salutary law applicable to physicians and the clergy only. The same ethical rule prevails, though doubtless to a less extent, in certain business relations. The banker, for instance, may not disclose the account or dealings of a depositor or client; the trustee is likewise bound to secrecy as to matters pertaining to his trust; and the bookkeeper should not betray the financial status or transactions of his employer.

Physicians are, however, especially prompted by instinct, sympathy, custom and even by self-interest to protect their patients. There exists, indeed, an implied understanding that revelations imparted by the *patient*, even when not for the sole purpose of facilitating proper treatment, are to be regarded as confidential and sacred, and whenever the gossiping physician unduly divulges medical secrets he disgraces himself and dishonors the profession. On the other hand, it is well understood, and is presumably appreciated by the patient beforehand, that circumstances may at times justify or even demand a departure from this unwritten rule; for in civil as well as in criminal actions, medical men, when best qualified to elucidate the truth, owe to the public also a duty which may become paramount to all other obligations. Thus under the common law of England, which until recently has prevailed throughout this country, it has been held their duty, in order to prevent serious damage to innocent parties, to expose by their testimony when summoned fraudulent attempts to exploit or conceal maladies or the effects of injuries.

A considerable experience in court trials has led me to the conclusion that the exceptional admission of such evidence has worked favorably to the best administration of justice, and to physicians themselves it has proved of value in providing, at times, the main defence in the vexatious suits for malpractice which, of late years, have so greatly multiplied. There is no contention, on the other hand, that our present rules of evidence have proved detrimental to the community or to the profession, that any serious public or private evil or grievance has been inflicted, or, indeed, that any exigency has arisen adequate to call for a radical change in our law. I am tempted, therefore, to reply to the arguments or reasons adduced in favor of this movement, considering them in

<sup>1</sup> See p. 444 of the Journal, Oct. 17, 1901.