to penetrate the peritoneum. By careful, dull dissection it will be recognized, and the ureter, if large, will be quite easily noticed. If smaller, it can still be detected attached to the separated peritoneum. When the kidney has been removed some time, the search for the upper end of the duct is very often perplexing. Concerning his case Gerster says: "The most difficult portion of the task was to find the renal end, which was searched for in a large cicatricial mass closely connected with the peritoneum," and Abbe found the same difficulty. This may be avoided if in nephrectomy the practice of fastening the end of the ureter in the lower end of the incision is followed. This procedure furnishes a definite location for it, a secondary ureterectomy being much more easily accomplished. When the peritoneum has been raised from the rest of the abdominal wall all along the duct, care being necessary to avoid injury to the round ligament and arteries about the inguinal canal as well as the spermatic cord in prolonged incisions, the ureter may be completely separated, though much danger of opening the peritoneum exists. In the female, if complete exsection seems necessary, the vaginal roof is incised along the course of the ureter. The ureter is to be ligated before being severed, and as further precautions cauterization of the stump and suturing of the mucosa of it have both been recommended. In my case these were unnecessary, as the intravesical portion was solid. The uterine artery is in a dangerous location and may require ligation. Great care is necessary to avoid injuring the sigmoid flexure or the cecum, under which the ureters pass, the ovarian vessels which cross and recross them and the uterine arteries which also cross them. Kelly found it necessary to split up the bottom of the broad ligament in order to remove the portion of the ureter passing through it. As in many of these cases considerable pus is present and a large cavity left, owing to separation of the peritoneum, which permits oozing to occur and fluids to accumulate in the pelvis, it is best to carry a strip of gauze down to the lower end of the wound. Another may be needed in the upper end. The wound, except drainage spaces, may be closed by buried or through-and-through suture.

NOTE.—Since the above paper was written I have found four additional cases of complete ureterectomy:

Garceau, E.: Secondary operation on a woman for tubercular ureter, combined loin, experitoneal and vaginal, Nov. 24, 1897; recovery. Boston Med. and Surg. Journal, 1899.

Le Dentu: Primary operation on a man for papillomatous tumor at vesical orifice of ureter; recovery. Semaine Méd., 1899.

Noble, G. H.: Primary operation for tubercular kidney and ureter; recovery, December, 1899.

Montgomery, E. E.: Primary operation on a woman, January, 1900, for tubercular kidney and ureter; recovery.

The last two cases are unpublished.

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SUGGESTIONS ON RIGHTS AND LIABILITIES OF SURGEONS.*

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The lawyer is nothing if he is not generous. He is willing to help you out of your difficulties—for a retainer. If, so be it, he can not get a retainer, he will tell you how to keep out of difficulties, for glory; and if there is neither retainer nor glory in sight, he will do it out of pure force of habit.

It is doubtless true that the surgeon is more often compelled to face a situation in which he must consider his own rights and liabilities than is the general medical practitioner. He is often called on to make an election between taking desperate chances and doing nothing. He is called to treat a man who has met with a serious accident. The patient is unconscious. An operation of an important and serious character, involving elements of danger, seems to be necessary. The man is in a critical condition, and if the operation is to be performed at all, it must be without loss of time. The patient is not in a condition to give his consent to the operation. What shall the surgeon do in such a case? What are his rights, and what are his liabilities? Will he be charged with neglect if he refuses to act, or will he be held liable for malpractice if he takes off a limb or opens the abdomen without the patient's consent?

Surrounding circumstances will often assist in resolving these doubts. If the injured man is at his home or surrounded by members of his family, the law will constitute his family his agents to consent for him, that the operation may proceed, and such consent will protect the surgeon to the same extent as if it were given by the patient himself, in the full possession of his mental faculties. But the injured man may be a guest at a hotel or a passenger on a railroad train. He is not in a condition to speak for himself, and there is no one present with either express or implied authority to represent him. Neither is it practicable to communicate with his relatives with any hope of receiving a response in time to be available. In such a case the difficulties of the situation are quite serious. If an important operation is attempted and it should turn out badly; if a limb is removed and the patient, on recovering, can make it appear that the surgeon's judgment was erroneous, even though honestly exercised and with average skill and care, the surgeon is liable and may be compelled to respond in damages, as for malpractice.

The rule as to consent may be briefly stated thus: Where the operation is consented to either by the patient or by those authorized to speak for him, the surgeon is not bound to an unerring judgment; he is protected, if, in his diagnosis, in obtaining consent, and in the operation itself, he exercises average professional knowledge, skill and care. But where he has no consent to operate, he will be bound to the exercise of an absolutely correct and unerring judgment, and he takes on himself the risk that it may afterward be established, even by the aid of

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facts not known to or discoverable by the surgeon at the time, that the patient would have been better off had the operation been omitted, and that damages may be recovered where no want of skill or care is shown. Cases may no doubt arise in which the desire to save human life—an impulse of humanity—coupled with such certainty that the operation is necessary, will justify proceeding without the patient's consent. But in every such case, the surgeon, by proceeding without consent, takes the risk of any evidence that may be afterward discovered tending to show that the patient was, in fact, damaged by the operation.

On the other hand, where the consent is obtainable, either from the patient himself, or from those who have a right to speak for him, a surgeon would be liable for malpractice for failing to operate where the exercise of average professional knowledge and skill would disclose the necessity for an operation; but where consent is not obtainable—where all the risks of an operation are thrown on the surgeon—he will never be held guilty of malpractice for failing to operate.

Consent may be implied as well as expressed. If a conscious patient puts himself in the charge of a surgeon, and afterward becomes unconscious, he has by that act given implied consent that the surgeon shall take such course as his best judgment suggests, and he has, in like manner, imposed on the surgeon the obligation of operating if average professional knowledge and skill would indicate that an operation ought to be performed; or if a person, conscious of having received an injury, sends for a surgeon and becomes unconscious before the surgeon arrives, he has thereby given his consent to whatever course of treatment may be reasonably necessary or proper, and has imposed on the surgeon the obligation of so proceeding.

In considering rights and liabilities of surgeons, we are now dealing with legal and not ethical questions. I have no doubt that the surgeon's own code of ethics is sufficient guide in determining the propriety, from a professional standpoint, of making any disclosure respecting information intrusted to him by his patient. But because of the necessary uncertainty of all ethical codes, they are not safe standards in determining legal responsibilities. The law deals with two classes of disclosures; those given on the witness-stand, and those given out of court. As to the former, the surgeon will not experience much difficulty, because the court will in each instance determine whether the information should be disclosed or not. Still, the rules applied by the courts in deciding what matters the surgeon may disclose on the witness-stand afford the only safe way in which to determine what disclosures may be made out of court. These rules may be thus briefly summarized:

1. The relation of physician and patient must be established or there is no restriction in the making of disclosures.

2. The information must come to the physician or surgeon in his professional capacity.

3. The information, to be privileged, must be such as is imparted to enable the physician or surgeon to perform his duties in the usual course of practice.

4. It will include all information imparted, whether orally by the patient, the statements of nurses and attendants, and the facts learned by a physical diagnosis.

5. Even facts not bearing on the ailment for which the treatment is given, but learned incidentally in the course of treatment or diagnosis, are privileged, and may not be disclosed.

It is impossible to fully elaborate or illustrate these rules here, but a few explanations may be given. The payment, or even promise, of compensation is not necessary to establish the confidential relation. A charity patient is entitled to the same protection as the best paying one. Neither does it matter whether the employment is by the patient or by some stranger, as by a carrier of passengers, as in case of wrecks and other accidents, or by the public, as in the case of paupers. In all such cases, whether the physician or surgeon assumes to treat the patient, or to examine him with a view to deciding whether he shall be treated at all, the relation is established and the obligation of secrecy is imposed. It is not every communication that is privileged. A patient may voluntarily make many disclosures, to his physician, that have no relation to the professional duties of the latter. He may talk about his family or business affairs; but communications of this character are not imparted to the surgeon in his professional capacity and are therefore not privileged. Neither is it true that every communication imparted for the purpose of obtaining treatment is privileged. It must be such as is imparted to enable the surgeon to perform his duties in the usual course of practice. The usual course of practice does not include conspiracies to defraud. Thus, one man may subject himself to treatment for the honest purpose of remedy, and the information imparted by him will be privileged, while another man may inform his physician that he has a certain ailment for which he desires such treatment as will mask the ailment and thereby enable him to perpetuate a fraud on a life insurance company. Such a communication is not privileged, because it is not made for treatment in the usual course of practice.

There is some conflict as to whether confidential communications include anything more than the mere statements of the patient, but the greater weight of authority, as well as the better reasoning, is in harmony with the rule just stated. A more serious difficulty arises in regard to facts incidentally learned. A very strong case in point is that of a woman who brought suit on account of an injury claimed to have caused an umbilical hernia. The defendant sought to prove, by a physician who had attended the patient in childbirth, previous to the accident, that at that time he observed the hernia and it could not, therefore, have been caused by the accident; but the court held that even though the physician had not treated the woman for the hernia, and learned of its existence only incidentally, still it was information which came to him in his professional capacity, and in enabling him to perform his duty in the usual course of practice, and he was therefore not permitted to disclose it.

These suggestions on confidential communications should be qualified by the remark that the privilege did not exist at common law, that where it does now exist it is by virtue of statute, and as statutes as well as their interpretations differ in different jurisdictions, the rules here given can not be regarded as of universal application. They do, however, fairly present the law as most generally enforced in this country. It may be added, also, that no matter how good the motive of the physician or surgeon may be in disclosing confidential communications of his patient, the motive will not protect him. This was well illustrated in the comparatively recent case of a London physician, who, desiring to prevent his wife and daughter associating with a certain woman, disclosed to his wife confidential communications received from his patient. As disclosing the secret to his wife was equivalent to disclosing it to her friends, the physician afterward had the satisfaction of paying a judgment of £12,000, and the costs of the suit.

An enterprising Omaha newspaper recently published a symposium of letters from a number of physicians in answer to the inquiry "whether the doctor is ever justified in refusing to prolong the life of a patient mortally ill." Most of the physicians took the postition that in no case should the physician permit the patient to die while it is possible to prolong life. But a few did not fully agree with that doctrine, and one, who discreetly concealed his name, said that in cases of mortal illness, the means of committing suicide might be placed in the patient's reach, and if he is intelligent he will use them promptly. I shall not discuss this subject from a scientific, ethical, or theological standpoint. The rule of law is very simple, and in exact harmony with the commandment: "Thou shall not kill." The statutes defining murder and manslaughter make no distinction between killing a sick man and a well man. Neither do they recognize as legal, in this country, a practice said to prevail among certain tribes of Patagonians who have not sufficient intelligence to stand on the shady side of a tree, by virtue of which those who have grown so old as to be unable to help themselves or others, and who are certain to die soon in any event, are boiled into soup for the nourishment of the rising generation. Permit me to say, in closing, that I am not an advocate of "Jacks of all trades," and that when the surgeon is really in need of a legal opinion, the best advice I can give him is to hire a lawyer.

THYROID EXTRACT IN JUVENILE OBESITY: A CLINICAL NOTE.*

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Animal therapy is at this time an alluring subject, being unquestionably all in all the most revolutionary made in years toward the physiologic cure of disease. The medical profession should, figuratively speaking, bow its head in humble apology to the great physiologist and psychologist, Brown-Séquard, for when he contributed to his guild views which were the product of long years of delving and study, they were temporarily received with enthusiasm, but after only superficial consideration were laughed at as the product of a brain suffering from senile decay. We are now beginning to realize, as he did, that in the ductless glands lies the entire scheme of tissue building, repair, life. In this department of work the already established value of the thyroid gland in myxedema, obesity, idiocy, some forms of insanity and other conditions due to interrupted or misdirected metabolism is familiar to all, and favorable clinical evidence is accumulating constantly. More recently the reports on the use of the suprarenal glandular extract in Addison's disease opened up additional lines of experimentation. I should enjoy discussing the entire broad field of glandular therapeutics, but it is my purpose only to present brief clinical experience in the use of thyroid extract in the treatment of juvenile obesity.

At the Louisville meeting of the Mississsippi Valley Medical Association, in October, 1897, I reported, favorably, the treatment of four cases of this kind, children ranging from 6 to 10 years of age, weighing from 106 to 170 pounds. Since that time three more cases have come under my care, and have been under treatment for from twelve to sixteen months.

The most characteristic one of these, B. W., a boy aged 8 years, weighed on first presentation to me 131 pounds, was quite tall for his age, but excess of fat was the chief cause of extra weight. He was fairly bright, intelligent and cheerful, but becoming quite sensitive from being called "fatty" by his playmates. I found that his weight had made him quite "luggy," so to speak, and he had gradually become more and more disinclined toward physical exertion. He was quite constipated, not a "hearty" eater, and not specially inclined toward sweets.

I prescribed proper purgation and a course of medication and diet which would antagonize the constipation and favor a general activity of the secretions, regulating the diet by proscribing fats and sweets, and instructing him to eat freely of fruits and vegetables, such as tomatoes, cabbage, spinach, sauerkraut, etc. I also ordered him to pay especial attention to all hygienic rules, such as bathing and massage, and in particular to take plenty of exercise, walking, running, jumping, horseback riding, croquet, and all out-door athletic games.

I then ordered one-half of a 5-grain tablet of thyroid extract to be taken three times a day, and gradually increased the quantity until one tablet was taken four times a day. I observed that with the general increase of the thyroid a general improvement occurred. Within three months he had lost ten pounds in weight, and now, after about fourteen months of treatment, he weighs 106 pounds. The chief feature of his case, however, is that he has developed, very definitely and distinctly, muscle to a considerable degree. He is more active and alert in appearance, both physically and mentally. He lives in an adjoining state, and I see him once every month or two.

This case and the others similarly treated will necessarily be under observation for several years, possibly until complete maturity has been attained, or at least until they have "out-grown" the disposition toward obesity. General attention to exercise and hygiene on the part of the patient has been a factor in the management of the case, but there is no question in my mind that the thyroid has been of great service.

I found, commencing about three years ago, that a most excellent drug to be taken in connection with the thyroid, with a view to prevent depression and unpleasant effects, was strychnia, in doses ranging from 1/150 gr. to 1/50 gr. Not only is strychnia one of our best tonics, but it is almost specific in its helpful effects on the nervous system and on all processes of nutrition. During the past year, for convenience, I have had tablets of thyroid made in two sizes, 2½ and 5 grains respectively. I have combined the strychnia with the tablets, the 2½-grain tablet carrying 1/150 gr. of strychnia, and the 5-grain tablet 1/50 gr. By using either the one or the other of these tablets, in division or without breaking, the thyroid and strychnia have been regulated easily.

We can not too thoroughly appreciate the fact that the best results can be gotten in all of these errors of growth and development in children by commencing the treatment early. The profession and the public should be generally informed that there is a good chance of greatly improving these unfortunates. The results achieved in the treatment of the victims of cretinism and idiocy have been almost brilliant. The results which I have accomplished in my own cases have encouraged me in the hope that, as time passes, we may be able to cure the victims of juvenile obesity, and thus save them for valuable positions in life, rather than their being burdens to themselves and having open to them little in the way of a livelihood save service in the side-shows of circuses or dime museums, with the other freaks and blemished victims of Nature's apparent blunders.

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