involuntary muscular fibre; but when distension is excessive, or the tissue degenerate, however, abolition of function may, and certainly does, take place. The experiment may be tried on any thin muscular man—viz., place the tip of your finger on the exact apex-beat, and bid him hold his breath; the right ventricle dilates until the apex-beat is lost behind the distended ventricle, which acts like a water-cushion between the left apex-beat and your finger. Still keeping your finger in its place, tell the man to breathe again; the distended condition passes away, and soon no trace of it remains. Now, all the time the heart has been beating away, and there has been no abolition of junction. Claude Bernard has gone so far as to suggest that a normal distension of the heart takes place through the action of the depressor nerve of the heart of Cyon and Ludwig, and that the heart can undergo a certain amount of accommodation to the blood-vessels, and by dilatation become, for the time being, a regulating reservoir. Without endorsing the theory of Claude Bernard, it must certainly be admitted that the condition is unquestionably common enough, and is not detected because, probably, it is not sought for: it is intimately related to the short, weak, fast pulse, which in a remarkable manner is rendered slow by digitalis, with great improvement in the systemic symptoms. Now, what has gone on? The condition is one of distension; the ventricle, just at the point of distension always, from inefficient contraction, soon becomes so over-distended as to be excited to contraction in spite of the vagus; the pulse-wave is feeble, for only a small quantity of blood is thrown into the aorta, and the elastic walls are not sufficiently distended to bring out a good pulse; the needs of the circulation are not properly supplied, and the body generally partakes of the feebleness of the circulatory centre. Then administer digitalis, and soon the pulse falls, say from 130 to 72; the radial pulse is much improved, being fuller and more sustained, and relief of the system is attained. Sometimes, but rarely, we read of a curious irregularity of rhythm accompanying the alteration, viz., sometimes a series of beats at the rate of 130 per minute, and then another series at the rate of 72; it seems as if it were some time before the old habit was broken. Never having met with such a case, I cannot explain the condition. The slow pulse is due to the ventricle making a more complete contraction, taking up, of course, more time over it, and requiring longer time for distension again. In fact, to again use our old simile of the bladder, the condition of distension is like the bladder behind the enlarged prostate, only contracting to the extent of over-distension—soon full, because never empty; while the altered condition bears more resemblance to the normal bladder capable of complete contraction, and consequently requiring longer time for distension. The heart in distension is incessantly at the point of over-distension, and is acting unnaturally quickly; the administration of digitalis, by producing more perfect contraction, relieves this condition of irritable, or, rather, irritated distended ventricle, while, at the same time, more complete contraction produces more thorough aortic distension, and thus brings out more thorough arterial recoil or systole; that, again, gives relief generally to the systemic symptoms, and also permanent benefit as an ulterior result. It must be borne in mind here that the contraction of the ventricle fills the vessels and distends them; the recoil of the elastic arteries completes the propulsion of the blood. The series of altered actions consequent upon increased contraction, run in the following order or sequences; and it may be desirable for the sake of lucidity to arrange them in a series of propositions, each depending on the one before, like a logical syllogism. The effects of increased contraction are, then:—

1. Increased arterial distension and tension, which give relief to the systemic symptoms, and further causes
2. Increased arterial recoil. This is the propelling power for the coronary arteries; and thus arterial recoil means
3. Increased or improved coronary circulation; and that, in its turn, produces
4. Increased nutrition of the heart, which results in
5. Compensatory hypertrophy. In connection with these, we have also to consider
6. Atheroma and fatty degeneration of the heart-fibres.

[To be continued.]

PLUGGING THE NOSTRILS AS A PRECAUTIONARY MEASURE.—M. Verneuil, in a paper published in the *Bulletin Général de Thérapeutique* for May 30, recommends plugging of the posterior nares as a precautionary measure in all cases of operation on the face where there is danger of the passage of blood into the pharynx. Besides preventing this as long as the soft palate is uninjured, the plugging also, M. Verneuil says, enables chloroform to be given during the whole operation. It ought to be done before the induction of anæsthesia is commenced.

HOW TO REFORM OUR PROFESSIONAL GRIEVANCES.*

By W. OGLE, M.A., M.D.Cantab., F.R.C.P.Lond., Physician to the Infirmary, Derby.

GENTLEMEN,—By accident rather than by my deserts I find myself in the honourable position of President of the Midland Branch of the British Medical Association. It is impossible that any one can forget—least of all that I should not be painfully conscious—that one who has gone to his rest was elected by you to preside on this occasion. Mr. S. W. Fearn occupied a first position in the profession in this locality; and no less for his ability as a surgeon than for his sterling worth and high professional character, we all should have rejoiced to see him in the Presidential Chair. An all-wise Providence has decreed otherwise, and upon me, by your favour, has devolved the difficult and almost impossible task of worthily succeeding him.

I crave your indulgent hearing of the remarks that follow. They are the result of much earnest thought, and, so far as they shall be worthy of your acceptance, are the outcome of conversations that I have had with many of my seniors. Throughout my professional life it has been my happy privilege to be thrown much among my elders, and with them I have frequently discussed questions which, for lack of a better term, I may call our "professional grievances". I venture to think that our time will not be misspent if I take up some of these grievances and invite you to look at them in their different lights, and ask you to consider whether the day has not arrived for us to get rid of some of them. If, with your assistance, I succeed only so far as to break the ground for future more skilful cultivation, we shall not have met in vain. Who is there among us that has no grievances? Is the parish-doctor free? or the club-doctor? or the general practitioner? or the physician? There are not wanting those who feel it something of a grievance that there should be this classification. Why should the title of "Physician" be restricted to a few? or, if restricted, be a more honourable one than any of the rest? I for one, as one of the privileged class, am quite prepared to see the distinction removed, if only the levelling be a general upraising, not a general depressing, of the profession. In the work of attending upon the poor as a servant of the state, still less of attending on the poor under an arrangement made by themselves, as the fruit of their own forethought and self-dependence, and in the arduous and responsible duties of "family doctor", there is no necessary inferiority. The physician who says that there is, does not know the true dignity of his own position. But we are dealing with things as they are, and are, therefore, accepting these distinctions merely for convenience of illustration.

Accordingly, I begin with the parish doctor, subject to the control of men who, to a proverb, "have no idea beyond that of keeping down the rates". There are, no doubt, honourable exceptions in Derby, perhaps, and elsewhere, which will occur to every one; but none know better than parish doctors that a board of guardians is an acknowledged type of parsimony, and exceptions here or elsewhere only serve to make the rule more palpable. From these his masters he receives in many cases scarce enough to cover the cost of drugs; he has, moreover, an acreage of duty so extensive as to make his work impracticable. Yet he is obliged to hold on for fear of leaving an opening for a rival; and after all he gets from the public often not even thanks. There are those among the poor who call him "blessed"; but when the time comes that he wishes to retire from his onerous duties, the public makes little or no sign of gratitude or of sympathy.

Take next the case of the club-doctor, striking a bargain with the committee at the "Fox and Goose". He receives a small capitation fee on each member, with the chance of attending the member's wife and children. This is the bait held out to the young, and too dearly purchased to be given up by the old, though they have long since found out the truth of the proverb, "All is not gold that glitters". The capitation fee is to include everything—no extra fees, no charges for physic, no protection against the admission of well-to-do tradesmen, small farmers, with the publican himself, at whose house, and for the good of whose house, the club meets—of many, in short, who join the club for nothing else than to be able to claim medical attendance and physic at a nominal cost when they are sick. And, worst of all, to an honourable, high-minded man, there is the degradation of being in the eyes of the public, of the profession, and of even the members themselves, "only a club-doctor".

But leaving these the so-called lower ranks of the profession, how fares it with the general practitioner—the man who perhaps eschews parish work and will not condescend to club-practice?

* President's Address, delivered at the annual meeting of the Midland Branch, 1871.

Even the busy, thriving man, the envy of many, who has perhaps bought a good practice, and is able to keep it together; or has, by steady probity, perseverance, ability, and tact, worked his way up to be one of the five or six leading men in a populous thriving town—even such an one has something to recount as a serious set-off against his seemingly enviable position. Even assuming that his receipts are considerable, he has in the first place the nuisance of dispensing, which he cannot afford to give up; there are also not a few bad debts, as well as heavy expenses; his charges, also, with “particulars if required”, are scrutinised more than is pleasant to a sensitive, honourable-minded man; and for one patient that treats him as a friend and a gentleman, from two to ten will look upon him as a kind of upper servant who must be kept in his place, or as a sort of “ogre” who is to be avoided as long as possible and dispensed with as speedily as possible. However eagerly and peremptorily he may be summoned when his presence seems to be a necessity, he is liable at any moment to be dismissed, to find himself supplanted, to have his best endeavours forgotten, or even misunderstood and turned to his own disadvantage. And at best he is exposed at every hour of the night as well as the day, without any extra protection against needless calls, so that he is a stranger for weeks and months together to the comforts of family life. A social dinner like the one which we have in prospect, or a quiet evening with his wife and children, and the hallowed rest of a Sabbath day, are to him unknown luxuries. Surely the gains of such labour must be great! some great inducements in the shape of honour or emolument must be in store! But no; experience can quote few who can afford to retire upon their earnings. A visit to the office of the Royal Medical Benevolent College would undeceive many who talk about doctors’ profits; and as to honour, medicine obtains no such recognition as either dignity or law. Who, then, can be surprised to hear even the well-to-do practitioner declare that no son of his shall enter the profession—that he would sooner (as I have heard it said more than once) “see him break stones upon the road”?

But, again, suppose the means are not wanting, and that *per saltum* a man can begin at the top of the tree—can be independent of general practice, or at least can pick and choose, undertaking none but of an easy kind; he has no dispensing; it would be *infra dig.*; he is seldom called up at nights; his Sundays are his own if he pleases; his fee is understood to be nothing less than a guinea; he holds as many hospital appointments as he pleases—can obtain them in the country for the asking, and even in London without much difficulty—has such an one any grievance? His grievances are of a different kind, but none the less real. There is very little encouragement to such an one to support the dignity, *i.e.*, to discharge the special duties, of his position; the pressure is quite the other way. It will “pay better” to make himself notorious in a puffing, pretentious way—as by giving advice gratis, not merely at the hospital, but on particular days and at particular times, which must be proclaimed aloud; or by writing a book, or by adopting some other way of advertising himself, than by doing his own business quietly—a little it may be, but that little well. It is almost impossible to do so. He finds himself in an undefined region of practice—neither in general practice nor in consultation practice, but between the two; accordingly, the acknowledgment that he receives is of a nondescript character; his fee is not a guinea, nor even “a guinea or nothing”, but a fraction of a guinea or nothing. For the guinea (if not vexatiously shorn of its shilling), two or three visits are expected; whilst the guinea a mile extra is reduced to two guineas for three miles even in the metropolis, and in the country to half a guinea a mile, to a third of a guinea a mile, to smaller fractions if he will accept them, till it becomes a question whether the mileage will cover comfortably the cost of cab-hire. The tendency of all this is to discourage first-class endeavour, to encourage a slipshod mode of doing his work—and this to a man who loves his profession is a grievance. Even his duty in connection with public hospitals partakes of the same character; a large portion of it is mere routine, and, as a natural consequence, the appliances at command are often of a very second-rate description. It naturally follows that the appointment of physician to a hospital does not confer the honourable distinction that it used to do, nor is it the same introduction either to first-class practice or to first-class society. By first-class practice I mean, of course, consultation practice. And here let me not be misunderstood; I count it no grievance, but the contrary, that consultations should pass into the hands of those who are engaged in general practice; but that consultations should seldom be held, and, when held, should be attended with so much difficulty, so much chance of injuring a professional brother, and so little chance, in comparison with what might be, of benefit to the patient, is a great grievance. Under these and other such disabilities the class of which I am now speaking is fast becoming extinct. I say this with no bitterness. I have already intimated the condition under which I should hail with satisfac-

tion this consummation. Let general practitioners become physicians; but the converse—*absit omen!*

Besides these “class” grievances, there are others which all alike feel more or less. There is counter-practice—a custom largely prevalent, whereby druggists who have no legal qualification prescribe, as well as dispense prescriptions.

Then there is the hydra-headed grievance of quackery—quackery sanctioned by the legislature and quackery which defies the law—quackery without, and, alas! quackery within, the profession itself. Add to this, that the public never lose an opportunity of giving a doctor a rub. Individuals may think and speak highly of individuals in the profession; every one thinks his own doctor a “none-such”, at least for the time being; but the good-will and praise, even of one’s own patients, is so commonly goodwill at the expense of all the rest of the profession, that no one whose heart is in the right place can feel it otherwise than as a professional grievance to be thus exalted. If further proof were needed of the disability under which the profession generally suffers, look at the doctor put upon his trial for malpractice. The cardinal principle of English justice is almost reversed; instead of considering him innocent till proved guilty, a doctor is held to be guilty until he can prove his innocence. This is the more oppressive, in that an unqualified quack will escape scot free under the very same circumstances from which the legally qualified practitioner suffers heavy loss.

This is a dark picture; and though it be ever so true, and true it is that most of these clouds have a silver lining (at least to every one who is devoted to his profession, for to such there are charms—scientific, philanthropic, social, and religious, using the term in its widest sense—which are rather intensified than lessened by the trials which accompany them), nevertheless it must be confessed the picture is sombre, and fully justifies my challenge at the outset, “Who is there among us that has not his own particular grievance?”

But let us not forget that there is another side of the question. *Audi alteram partem*, say the patients. If parish doctors are overworked, not paid, and little thought of; if club-doctors are imposed upon and a bye-word; if general practitioners are servants and leave no inheritance behind them; if physicians have little less than the shadow of their former dignity; if the whole profession is depreciated and does not occupy a position to which, in virtue of its important and responsible duties, it feels itself justly entitled; what of the patients—club-patients, pauper patients, private family patients, and physicians’ patients, hospital and other? Though the pauper often receives an amount of attention and consideration regardless of cost, fatigue, and even of life itself, which makes many a despised parish doctor a veritable hero, has the pauper patient no grievances? There is an old proverb, “Dead men tell no tales”, and this is true of dead paupers. The provision made for them is generally so utterly inefficient that suffering is inevitable, however great the energy, the self-denial, yea, the self-sacrifice, of the parish doctor.

Again, club-patients find to their cost that *my club-doctor* is a very different person from *my own doctor*. Perhaps it so happens that the one selected by the club is the very one against whom the member voted; or he may live so far off as to be practically beyond reach; or, if there be nothing more against him than the knowledge that the terms under which a medical man undertakes a club are not satisfactory, all the service rendered is suspected, and it (physic included) is assumed to be worth no more than the little or nothing that has been paid for it. There is, in short, wanting in the transaction that first element of success—the element of confidence. Add to this, if the wife or child be ill, he does not feel free to employ any one but the club-doctor, and this curtailment of his liberty tends to make him dissatisfied; so the club-patient finds, when it is too late, that the system on which he depends breaks down.

Passing on to private practice, we often hear of ruinous long doctors’ bills—of attendance for days, and weeks, and months, and the patient little better. We hear ourselves accused of prejudice against this and that clever person—of unwillingness to try this and that new mode of treatment. We are blamed for coming too late, we are blamed for arriving too soon; and at best, as already intimated, if there be one doctor in the world who is perfect, his reign is short, and there is only one. These are some of the ordinary grievances urged by patients—grievances which make many an one either do without a doctor or take refuge in quackery. And as to physicians’ patients—using the term in its conventional sense—when a consultation is desired, there is so much difficulty in the way, so much fear of giving offence, so much questioning about who shall be called in, so much mystery when the second doctor does arrive, so little apparent result from the transaction—in a word, so large a fee and so little for it, that we must admit that these are grievances, or something very like them.

And what of hospital and dispensary patients? Surely here, where so

many thousands are expended, and where the patient has to pay nothing, the patient can have no grievance. My experience of dispensary work and of hospitals is probably as large as, or larger than, that of anyone here present; and it is my very decided conviction that hospital and dispensary patients in the long run, and in one way or another, as much as any class in the community, have grievances neither small nor few. Put yourselves in their places. Suppose yourselves now for the first time in your lives obliged to go to a hospital or to a free dispensary for medical aid. This is probably the very first time you have been obliged to beg: but, passing by this and all such social considerations, important though they be, and judging of the circumstances simply on the ground of efficiency, think of the increase to a man's suffering from the delays in obtaining the assistance needed. First, there is a letter to be procured; then he has to wait for the day of admission; the proper day arrives, but it is not the day on which the doctor of his choice attends at the hospital, so he has to wait another week, or perhaps a fortnight; and then, though the day be wet, windy, or cold, and he likely to get as much harm on the way as good from the visit, there is no alternative but to go, or to wait another fortnight or three weeks. At last, however, he is admitted; but even then the doctor may have been called away—may be gone for a holiday, or may be ill himself. But supposing yourself to meet with none of these minor drawbacks, and that the goal is attained—you have arrived at the proper time, on the proper day, and the doctor of your choice is there too; still there is the ordeal of the waiting-room, surrounded with others like yourself—some not so ill; others, it may be, worse. Imagine yourself one of twenty, forty, or more, waiting for your turn; and then four minutes and a quarter is the average (and this is a large one) of the time that you will have devoted to your case. Then you wait again for the physio, subject once more to the inconvenience and dangers of a crowd; and then you have your journey home, and in another week—not sooner, whatever may have happened meanwhile—you run the gauntlet again, with this difference, that a minute and a quarter is now your allowance; and so on. And the more ill you are, the worse it is. If you are so ill as to wish to be an in-patient you must wait the longer, for in-door letters of recommendation are less easily obtained than "out", there being fewer of them; also the same rules as to admission must be observed, and there is the additional chance of being sent home again after all, because there is no room. Then after admission there are, in nine hospitals out of ten, regulations which, if you were the patient, you would think very hard. Governors, boards of management, even the doctors themselves, have often very little idea of these grievances, simply because they do not put themselves even in imagination in the place of the patient. By this simple process, however, which is but carrying out the golden rule, "Do unto others as you would be done by", it will be found pretty generally true, that, for most of doctors' grievances, corresponding ones might be urged by the doctors' patients.

[To be continued.]

A STATISTICAL ACCOUNT OF TWO THOUSAND CONSECUTIVE CASES IN MIDWIFERY.

By GEORGE JONES, M.R.C.S., L.M., Birmingham.

Fellow of the Obstetrical Society.

At the present time, when hospitals may be considered in some measure to be put upon their trial, on account of the attack made on them by an eminent member of our profession—now no longer amongst us—it behoves all who wish to see truth prevail, and the question whether hospitals are an evil or a blessing honestly and correctly solved, to bring forward all the facts and statistics which can legitimately bear upon this subject, and throw them into the common stock, so that a sufficient number of statistics of home-practice may exist to make a comparison with the large numbers treated in hospitals anything like fair.

It is not in a spirit of partisanship for either side of the controversy that I am induced to contribute my mite towards amassing a sufficient number of figures to bear the comparison, but solely with a view to assist in elucidating the truth; and I trust that many obstetricians may be induced to do the same, so that the records of home-practice may collectively be as large as those of the great lying-in hospitals.

Dr. Matthews Duncan, in his recent work *On the Mortality of Child-bed and Maternity Hospitals*, says: "In order that any confidence in the data of home-practice may be expected, the following conditions are necessary.

"1. They must not be derived from memory.

"2. The items should be noted down at the time of their occurrence.

"3. The statistics should yield credible results.

"4. They should be collected with no particular object in view."

I can conscientiously say that my account fulfils all the conditions considered necessary, as I have regularly kept a record of every case (save the first two) that I have attended from my student days until the present time.

I have taken two thousand consecutive cases for two reasons: first, as supplying an even number for comparison; and secondly, because the first series of cases attended are not so complete in all particulars as the later ones. I have also eliminated from this account all those cases in which I had been called in to assist another practitioner, or for consultation. The number of pregnancies is as follows.

First pregnancy	403	Tenth pregnancy	39
Second pregnancy... ..	369	Eleventh pregnancy... ..	34
Third pregnancy	294	Twelfth pregnancy	27
Fourth pregnancy... ..	253	Thirteenth pregnancy	11
Fifth pregnancy	170	Fourteenth pregnancy	7
Sixth pregnancy	136	Fifteenth pregnancy	5
Seventh pregnancy	106	Seventeenth pregnancy	1
Eighth pregnancy	89	Twenty-second pregnancy	1
Ninth pregnancy	55		

Sex of Children.—The 2000 labours produced 2018 children—1014 males, 1003 females, and 1 of no sex. Of these 131, or 1 in 15.41, were still-born; viz., 79 males, 51 females, and 1 of no sex.

The *Presentations* were—

Of the face	5, or 1 in 400
Of the brow	5, or 1 in 400
Of the arm	8, or 1 in 250
Of the foot or feet	25, or 1 in 80
Of the knee	1, or 1 in 2000
Of the breech	30, or 1 in 66.66
Of the shoulder	2, or 1 in 1000

The remaining 1943 presentations were of the head; but what were the relative proportions of the different positions of the head I am unable to say, as in many of the cases, especially the earlier recorded ones, I did not always endeavour to ascertain; being satisfied if it was the head. Forty-four were born with the face to the pubes.

Of the ten face- and brow-presentations, three were with male children and seven with female. One male and one female were still-born; the other eight were living.

Of the eight arm-presentations, five were with female children and three with male; two males and one female were still-born.

Of the twenty-five footling cases, fifteen were males and ten females. Thirteen males and four females were still-born; five of the living children were of twin cases. Seventeen out of twenty-five seems at first sight a great mortality; but nine of these cases were premature, and the children had been dead from two to three weeks. One case was complicated with ascites, and the abdomen had to be punctured before delivery could be effected; one was complicated with serious hæmorrhage from partial separation of the placenta implanted near the os uteri; in one the mother had a distorted pelvis. These being fair cases for elimination, the mortality is reduced much below 1 in 2½, the proportion given by Churchill.

Of the breech-presentations, fourteen were males and sixteen females—nineteen living and eleven still-born. Of these, four were premature. Nine of the cases were first labours. The mortality in British practice, according to Churchill, is about 1 in 2.6; the mortality in these thirty cases is little less; and, excluding the premature cases, is only 1 in 4.25 nearly. The average duration of labour was 11½ hours.

The <i>Twin-cases</i> were 19 in number, or 1 in 105.26. Of these—	
4 occurred in the first pregnancy.	2 occurred in the sixth pregnancy.
5 " second "	1 " seventh "
1 " third "	1 " eighth "
2 " fourth "	1 " ninth "
2 " fifth "	

Of the thirty-eight children, thirty were born alive—fourteen males and sixteen females; of the eight still-born, seven were male and one female. In eight cases, the heads of both children presented; in one, the head and arm; in two, the head and breech; in six, the head and feet; in one, the feet in both. In one case the ovum came away entire, the membranes being unbroken, and containing the foetus and liquor amnii. This was a premature case.

Forceps Cases.—The cases delivered with the assistance of the forceps were fifty in number, or 1 in 40.

32 occurred in the first pregnancy.		1 occurred in the sixth pregnancy.	
6 " second "		1 " seventh "	
3 " third "		2 " eighth "	
1 " fourth "		2 " ninth "	
2 " fifth "			