may be; that "Decidual cells are present"; or that "There is no evidence of malignancy." This may all be very interesting, and in certain cases, of course, all that is required. It is not sufficient, however, when the cause of an obscure case of uterine haemorrhage is at stake.

If we employ the services of a specially trained pathologist, however, and expect a report that will be useful, we also must follow a strict routine. In the first place, the type of bleeding should be submitted with the specimen to the pathological laboratory, whether it is menorrhagic, menostatic, epimenorrhoeal, or metrorrhagic. The pathologist should also be informed as to the date in the menstrual cycle when curettage was performed. Finally, the tissue submitted should be selected at the time of operation by the surgeon and transmitted to the pathologist as free as possible from blood clot in an appropriate fixing solution. More than one specimen should, of course, be examined. If these precautions are taken curettage becomes a valuable diagnostic asset. My own practice is to examine or have examined without exception all material removed by the curette. Even when the cause of haemorrhage is apparently obvious, surprises are sometimes in store. An apparently simple adenomatous polypus has shown under the microscope malignant characters, or what appeared to be a placental polypus has turned out to be chorion-epithelioma. Hypertrophy, atrophy, or hyperactivity of the endometrium can, of course, only be diagnosed by curettage, although previously suspected from the history.

As a therapeutic measure curettage for uterine haemorrhage must, of course, depend upon the cause of the bleeding. If this is due entirely to the uterus then it may be curative, such as when a simple localized hyperplasia of the endometrium or the products of a gestation are removed. If, on the other hand, it is the result of incoordination of various hormones, it will be but palliative, or fail completely, as in the case of diffuse hypertrophy or atrophy of the endometrium respectively. Under these circumstances, curettage must be combined with other therapeutic measures designed to combat the primary cause. Treatment, to be effective, must depend upon accurate diagnosis. Much of the disappointment and failure that has attended and still attaches to the treatment of uterine bleeding arises because we are content to rely upon empirical methods which sometimes, but not always, prove effective.

Haemorrhage from the uterus is a symptom of such diverse conditions involving the whole realm of medicine that no one panacea such as curettage can ever be expected to prove effective in all cases. It is only by approaching the problem in a logical and routine manner that we can hope to be successful. If, on the other hand, we fail, we at least have the satisfaction of knowing that we have made an honest attempt.

REFERENCES.

¹ Hunterian Lecture, *Lancet*, 1914. ² *Practitioner's Encyclopaedia of Gynaecology*, edited by J. S. Fairbairn; 1921; Oxford Medical Publications.

DISCUSSION.

Dr. W. R. GROVE (St. Ives) said that in the course of investigations as to calcium deficiency in ulcers a reference had been made by Dr. Vines and himself (in a paper read before the Therapeutic Section on "The etiology and treatment of varicose ulcer") to one case of catarrhal trouble of the uterus in which calcium deficiency was present. He pointed out that calcium salts administered by the mouth were not absorbed into the blood, the whole dose being recoverable from the faeces. They were a good intestinal stimulant, and in large doses an excellent treatment for intestinal parasites. He stated that calcium deficiency was remedied by parathyroid extract—tab. gr. 1/10 daily (Parke, Davis)—administered by the mouth, and that any good result obtained by thyroid extract was probably due to contamination by parathyroid. He also referred to intramuscular injection of calcium chloride with a view to increasing the clotting power of the blood as a palliative treatment in all haemorrhages (*BRITISH MEDICAL JOURNAL*, July 9th, 1921).

Mr. GORDON LEY (London) congratulated Dr. Beckwith Whitehouse on his excellent paper. He could not agree that menstruation was entirely dependent on ovarian secretion; he had seen many cases in which menstruation

had continued after the removal of both ovaries; these cases were too numerous to be explained by imperfect removal owing to the presence of accessory ovarian tissue.

Professor RANKEN LYLE (Newcastle) said that he was in agreement with other speakers that, owing to the highly scientific nature of Dr. Beckwith Whitehouse's paper, it would be very difficult to discuss it without first having the opportunity of studying the whole paper in detail; and he therefore looked forward with the greatest interest to the reading of the paper when it was published.

THE POSITION OF THE MEDICAL PRACTITIONER CALLED IN TO ATTEND A CASE OF PROCURED ABORTION.*

BY

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THE medical profession desires to prevent crime in the interests of the individual and of the community. The question as to how this can best be done is an important and interesting one, because the medical practitioner has a dual identity. He is both a citizen and a trusted adviser of the patient. As a citizen it is incumbent upon him to prevent crime and to aid in the detection of criminal offences. As a doctor he is bound to preserve the secrets of his patients, in accordance with the rule which has been observed by the medical fraternity from time immemorial. Without the fullest confidence in the integrity of the medical man the patient will not tell him the truth and the whole truth. Unless she does so he will be at a great disadvantage in arriving at a correct diagnosis and in formulating a proper scheme of treatment. Reticence on the part of the patient may be a serious disadvantage to her. Hence in most cases of criminal abortion the doctor will find himself on the horns of a dilemma. His duties as a citizen and his obligations to the patient will clash with one another. He must be prepared to make up his mind as to whether he will, in his capacity of citizen, disclose the fact that a crime has been committed, or whether he will maintain professional secrecy and confine his activities to the proper treatment of the case.

In practice the medical profession as a whole rightly puts the patient's interests first and justifies the confidence reposed in it, although this course gives the doctor a feeling of mortification that he is precluded from exposing a crime. Thus by observing the obligation of professional secrecy the medical man will be disregarding his duty as a citizen. He will shield the criminal who committed the offence, the woman who was a willing victim, and those who instigated her to have the operation performed or helped her to procure the services of the abortionist. The doctor's position in these cases is an unpleasant one, but a medical man as such is concerned solely with the proper treatment of the patient, and the fact that she has been a party to a criminal transaction can have no place in regulating his conduct. His duty is to endeavour to save life regardless of the moral character of the patient.

There are three sets of circumstances under which medical men become cognizant of crime of this kind:

1. Before the crime has been committed the doctor may become aware of the intention to have an illegal operation performed.
2. After the crime has been committed but a fatal result to the woman has not occurred.
3. When the crime has been committed and a fatal result has followed.

1. When a doctor becomes aware that a criminal operation is contemplated he can do nothing. Not only is he bound to keep the secret of the patient, but his evidence would be uncorroborated. In a small country town a prominent and influential man seduced a girl of the working class and asked the local doctor to perform an illegal operation. When the doctor refused, the man was very indignant and taunted him with the fact that he knew where he could have the operation done. He subsequently

* A paper read in the Section of Obstetrics and Gynaecology at the Annual Meeting of the British Medical Association held in Newcastle-on-Tyne, July, 1921.

took the girl to a neighbouring city and had the operation successfully carried out. The doctor was naturally much annoyed that he was unable to expose the crime, but he had been consulted by the man in confidence, and, even if he had decided to abuse that confidence, he had nothing but his own uncorroborated testimony to offer. The crime remained undetected and unpunished, but the doctor had pursued the only course open to him.

2. A medical man most frequently comes to know that a criminal abortion has been accomplished when he is called in to treat the woman for haemorrhage or sepsis. The patient, in her anxiety to give the doctor full particulars, usually discloses the whole circumstances under which the operation was performed, giving the names of those who directed her to the abortionist, of the abortionist, and often also of her paramour. Here the doctor is bound to maintain professional secrecy and allow the criminal and those who aided and abetted the crime to escape. There is no other course open to him.

3. When a doctor is called in to attend a woman who is about to die as a result of having had an illegal operation performed, he is bound to maintain professional secrecy so long as the patient is alive. Her death, however, breaks the contract as to secrecy, and he can then notify the coroner of the circumstances under which the woman died and can assist the authorities in bringing the criminal to justice. It might be argued that the obligation of professional secrecy exists even after the death of the woman. This position can hardly be seriously maintained. The great reason for professional secrecy in these cases is the fact that publicity would injure the future position and prospects of the patient. Her death does away with this reason and allows the punishment of the person whose action caused her death to become the important consideration.

It would seem to be clear that when a doctor in his capacity of a trusted adviser becomes aware of the intention to have a criminal operation performed, he must keep silent. It is equally clear that when he becomes aware that the crime has been committed, he must be silent so long as the patient is alive. It is only after her death that the obligation to remain silent is removed. Consequently the medical profession can only assist in the detection of crime in a small minority of cases of criminal abortion.

Arising out of the consideration of the question of criminal abortion is the relation of the law as at present administered towards those who have been accessories to the crime. Punishment is awarded to the chief culprit whose hand caused the death. Those who put the woman into communication with the criminal operator go free. The person who supplied the money to ensure the performance of the operation also remains unscathed. In a recent case the woman's lover, who was responsible for her trouble, himself employed and paid the operator. Nevertheless, while the operator received a severe sentence, the paramour was allowed to escape with a few admonitory remarks from the judge. In this case the lover was really the most guilty party. He suggested the operation to the girl, although there was no reason why he should not have married her. He tempted a drunken criminal operator with a fee. He paid the fee and sent the operator to the girl's house. Her lover was the primary cause of her death, yet he escaped punishment.

In other cases women friends of the patient have instigated her to have the operation done. They have brought her into touch with the abortionist, and have sometimes afforded facilities for having the operation performed. Of these people the law takes no cognizance, and they remain unpunished. Such a state of things surely requires to be remedied. Until those who administer the law see that just punishment falls upon those who aid and abet the commission of the crime, as well as upon the chief criminal by whose hand the deed is done, criminal abortion will remain one of the great blots on our civilization.

DISCUSSION.

Dr. W. ROBINSON (Sunderland) said he had rarely, to his knowledge, attended a case of procured abortion. He pointed out that a woman, married or single, who took drugs to procure abortion, whether successful or not, legally committed a crime just as much as those who used instruments. He knew of no drug which was efficacious in

terminating pregnancy. He knew of one married woman who successfully gave herself an intrauterine injection of glycerin, and another who had used a crochet needle; both recovered. In such cases the great personal danger and the immorality of the act must be pointed out. In the case of a single woman brought into hospital, for whom an abortionist had procured an abortion by operation, he persuaded her to make a statement on oath to a justice of the peace; the latter sent it to the Home Office, but no legal action was ever taken. The patient recovered. Another single woman, upon whom he performed an autopsy, had dosed herself with matches and had died of phosphorus poisoning without aborting. There was an epidemic of similar cases at that time. A practitioner should inform the nearest relative and call in a brother practitioner or consultant in all cases of procured abortion. If a consultation be refused he should give up the case. Should a woman die of a procured abortion no certificate of death must be given and the coroner must be informed. Every practitioner who was called to attend an abortion and "knew" that it had been induced, was *legally* bound to inform the police; if he did not, he would be guilty of concealment (misprision) of a felony, and be liable to legal proceedings (though apparently these were now never taken) or to censure by the judge, if the case came into court. In court, if ordered by the judge, a medical practitioner must state what he knew of the case. There was no law to save him from doing so, neither was there in the case of a solicitor or a priest; only custom in these two protected them.

Dr. J. D. DAVIES (Llanelli) did not agree with Dr. Campbell upon some points. Surely, he said, a man who went to a doctor and asked him to procure an abortion did not come under the protection of professional secrecy. He believed that in all cases where professional abortionists (non-medical) were concerned the medical man called in should do his best to assist in cutting short the career of these individuals, even going to the extent of refusing to attend unless information was given to the police. In these cases the patient was never prosecuted. Where the abortion was self-procured the duty of the doctor was to be silent.

Professor RANKEN LYLE (Newcastle) said that although the views expressed by Dr. Campbell were held by a number of practitioners, he was not in agreement with him. The question of professional secrecy was all very well when no criminal question was involved, but in cases of procured abortion, where a medical man was called in, the reputation of that medical man was at stake, and if any legal question arose, then the medical man would probably be made a party to the crime in a case in which he had concealed the facts. It must be remembered that a doctor's reputation was his most valuable asset, and it was essential that that reputation should be above suspicion, and that he should do nothing that would endanger it in any way. He was of opinion that no medical man should attend such a case without first obtaining the consent of the patient or the patient's friends to inform the police, and if this was refused, he had a perfect right to refuse his attendance on the case. Let them for a moment consider what would happen if the practitioner adopted the other course, that of secrecy. The abortionist would very soon become aware of this, and he would recommend his victims one after another to call in that practitioner, knowing that he would not tell, and he would then be able to carry on his criminal work by the aid and assistance of that practitioner. He might say that he had adopted this rule for many years in Newcastle, and so had many other men, with the result that all the abortionists in that neighbourhood had been run to earth, and any person now desiring an illegal operation had to travel many miles in order to have it performed. He was convinced that if the whole profession adopted this attitude the operation of criminal abortion would almost immediately cease to exist in this country.

A PAMPHLET received from Dr. de Almeida gives the clinical history of a case of syphilitic infection of the chin acquired at a barber's shop from a dirty razor. Such infections are not extremely uncommon, and the author gives a general account of their occurrence and treatment.