An Address

ON

PROFESSIONAL REGRETS.*

BY

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I was asked some months ago to take part in a discussion on "Professional regrets," and agreed to do so. A fortnight ago I was rather staggered by a request from your secretary that I should open the discussion—a very different matter. I take it that my duty is to say a few words on each of a series of subjects that may be discussed by those who follow me, and to point out traps for the unwary. I hope that none of my remarks may give any offence. If they do I shall have added yet another to my professional regrets.

Pre-cancerous conditions or very early carcinoma of the uterus.

A case which caused me very great regret was the following:

A woman, aged 57, three years after the menopause, had had for about a year a good deal of vaginal discharge, with sometimes slight bleeding on douching. The vaginal mucous membrane was normal, the external os small, virginal. There was a small, raw-looking patch on the vaginal portion of the cervix. The body of the uterus was distinctly enlarged. I could not cause even the slightest oozing of blood. I wanted to explore the interior of the uterus, but she was a very busy woman, and begged to put it off. She promised to let her doctor know, and to submit to dilatation of the cervix and exploration of the interior of the uterus, if there was any return of bleeding. I heard nothing more of her for thirteen months, when she came back to me. She had quarrelled with her doctor soon after I saw her, and had seen no other doctor, in spite of having had practically continuous slight bleeding ever since I saw her. I found that she had extensive carcinoma of the body of the uterus. I regretted that I had not insisted on her having the interior of the uterus explored, even if it meant telling her that I feared malignant disease.

This was rather an exceptional case. I have generally found that, if a patient gives a definite promise that she will come back if symptoms recur, one can rely on her to do so, but there is always a danger of a patient changing her doctor and telling the new one nothing. I very much regretted that I had not been firmer with this patient.

Not examining under an anaesthetic.

If one does not feel reasonably certain about a patient's condition one ought to insist on an examination under an anaesthetic. This is almost axiomatic. In hospital practice examination under an anaesthetic is an everyday occurrence, and one has often had two or three examinations under anaesthetics at the end of a long operation list, but it is not always easy to insist on in private practice. It is specially important in any painful or acute abdominal trouble occurring during pregnancy when one is handicapped, not only by the tenderness, but by the presence of a large tumour. One ought to insist on an anaesthetic, and to say that one is so much handicapped that a definite opinion cannot be given without it. In one case in which I thought that the patient was suffering from red degeneration of a fibroid during pregnancy I foolishly agreed to a policy of "wait and see," as she was tremendously keen on having a living child and afraid that any interference, however slight, might bring the pregnancy to an end prematurely. I waited too long, and found eventually that the "tumour" which I had noticed was due to volvulus. Examination under an anaesthetic two days earlier would have shown that the tumour had no intimate connexion with the uterus, and would have led to immediate and probably successful abdominal section.

Another case in which I ought to have examined under an anaesthetic is worth quoting at some length.

In 1906 a patient, aged 31, came to me for advice about an abdominal tumour which had been diagnosed by her own doctor and by a well known gynaecologist as uterine fibroids. There were

two large, hard, round swellings, one behind the uterus and the other on top of the lower one, reaching up to 1½ inches below the umbilicus. She had no symptoms of any sort. I agreed that the tumours were uterine fibroids, and told her that operation would probably be necessary later, but was not specially indicated at that time. In 1914, eight years after I had first seen her, she was seized with abdominal pain. I opened the abdomen, and found that each tumour was an extraordinarily large pyosalpinx, filled with a putty-like matter, infected with *B. coli communis*. The right one had just begun to leak. I left both ovaries and the uterus behind. She made a perfectly smooth recovery, and is in excellent health now, but I felt that I had let her run an absolutely unnecessary risk. A history of an illness at the age of 6 suggested that she had had tuberculous peritonitis, and that the tubal trouble was tuberculous in origin.

Not having the rectum and bladder emptied in a difficult case.

I think that regrets connected with full bladder and imperfectly emptied upper part of the rectum and sigmoid colon are probably associated with early days in practice, because most men learn then the dangers of the bladder-and-faecal-masses-trap and avoid them carefully afterwards. In the women's medical wards at the London Hospital there was for some years a rule that if a request note was sent to me to see a patient she must be given an enema at once, before I came, as otherwise I should probably say that I refused to give an opinion until this had been done. I was once just saved from opening the abdomen for what seemed to be the most perfect case of cornual pregnancy that I have ever seen. The rectum was empty when I saw her, but she was given an enema later because she was to have an operation. The doctor was so much struck by the aged appearance of a scybalous mass removed by the enema that he asked me to examine her again before she went to a nursing home. I did so and found a normal pregnancy. I was brought up to empty the bladder and to examine per rectum in every doubtful case, and this early training has saved me from many regretful occurrences, though once, to my shame, I opened the abdomen for a bladder which had been distended for at least a fortnight in a medical ward. I can only plead that I was very young at the time, but I was old enough to have known better, in spite of regular micturition. The value of routine rectal examination was well shown by one case in which I was asked to give an opinion. I examined the patient and said that she had two large hard faecal concretions in the rectum. I was then asked, "What about the uterine fibroids?" I said, "She has not got any." The retort was, "She is going to have abdominal hysterectomy for fibroids to-morrow." The upshot was that I removed the faecal concretions with a lithotomy scoop and she was allowed to keep her uterus.

Induction of premature labour.

Here again I may get myself disliked, but I cannot help it. I have been asked to talk about professional regrets, and I must be truthful, nothing extenuating nor setting down aught in malice. The essential after induction of premature labour is that nature should be interfered with as little as possible, any unnecessary intervention being likely to be dangerous to the life of the infant. Artificial rupture of the membranes, because the progress is slow, is a most dangerous procedure. The head is not meant to act as a dilator of the cervix—the bag of membranes is there for that purpose—and the head ought to be spared any unnecessary pressure. Delivery with the forceps three or four weeks before term, unless only by gentle coaxing, is a dangerous procedure, as an amount of compression that would do no harm to the fully ossified skull may cause fatal damage to the imperfectly protected brain, while moulding due to the natural forces, spread over a few hours, is unlikely to be harmful. If one does not know from experience that the patient's doctor in the country is a man with sufficient knowledge of midwifery to look on, to treat the labour with masterly inactivity—in other words, a man who realizes that patience is the most important quality in the make-up of an accoucheur—it is one's duty to insist on the management of the case oneself. Do not think that I often insist on this; on the other hand, I have never done so, but I have twice regretted it deeply, as the

* The opening paper in a discussion at the Chelsea Clinical Society.

baby was killed by unnecessary use of the forceps before the natural forces had been given a chance. What I regretted was that I had not rubbed in the virtues of patience—a difficult thing to do when dealing with a man who had probably attended more confinements than I had. I have sometimes regretted that I had not induced labour prematurely, but I have never regretted inducing it. I think that it is a method of immense value in the treatment of minor degrees of contraction of the pelvis.

Not giving sufficiently definite instructions as to treatment after operation in strange nursing homes.

Surgeons are sometimes accused of being fussy and disobliging because they are unwilling to perform severe operations in any nursing home which they do not know well. They ought not to be blamed for this, as it is usually done entirely in the interest of their patients. I have several times regretted that I had gone to a strange nursing home at the request of the patient or her doctor. In one case I performed Wertheim's hysterectomy for extensive carcinoma of the cervix in a very fat woman. We left her in a warm bed in a warm room at 10.30 a.m. with a good pulse, and the doctor, the anaesthetist, my assistant, and myself were all very well satisfied with our work and considered that the patient had at least a 20 to 1 chance. I was telephoned to soon after 2 p.m. and told that the patient had died suddenly. I went straight to the home and was told that the patient came round well from the anaesthetic, with a good colour and a good pulse, and that as she was rather restless and uncomfortable they propped her up in bed with four pillows. Directly after they had propped her up she died suddenly. Was this to be wondered at when she had just had a severe operation, and had been in the Trendelenburg position for about an hour and a quarter?

I was rung up a few hours after a hysterectomy during pregnancy, and told that the patient was very much collapsed and that they were very anxious about her. I was too far away to get there in time to do anything, so I asked about her position, and was told that she had two pillows. I said that they must be removed and the foot of the bed must be raised. A few hours later I was told that her condition was excellent. In any of the homes in which I am accustomed to operate the first patient would probably have lived and the second would have caused no anxiety, as common-sense after-treatment would have been looked on as a part of the nurse's duty, and I should have known that all the nurses were competent; but in these two cases I regretted that I had not given definite instructions, even at the risk of causing offence to an experienced nurse. In strange nursing homes I have sometimes regretted that I had not inspected the patient's room before the operation. If I had done so the patient would not have been taken from a warm theatre, on a cold day, to a room with a miserable fire and both door and windows open. One may find the patient before operation, clad in a Gamgee jacket and a dressing-gown, with thick stockings on and a blanket wrapped round her thighs and legs, enjoying the fresh cool air, but during the operation the bed and the room ought to be warmed thoroughly.

On another occasion my anaesthetist helped to take a patient back to bed, removed several hot-water bottles, and said that they were not to be replaced until she asked for them. I followed him up and repeated his instructions. When I inquired from her doctor a few days later about her progress he said, "She has done very well, but she has a horrible burn over almost the whole outer surface of her right upper arm and forearm." I said, "How on earth could she get burnt when both my anaesthetist and myself made certain that no hot-water bottle was in the bed?" He answered, "Oh, soon after we had all gone they put a hot-water bed under her!" Some people consider that a nurse is a nurse, and do not agree that there are nurses and nurses, and even in a fairly good home one may find on inquiring that a special nurse, an absolute stranger, has been engaged to look after the patient, arriving about an hour before the operation and allowed to act on her own responsibility. If this is found

out in time very definite instructions indeed are given, feeling one's way so as not to give offence if the nurse is competent; but if it is not found out in time there may be many regrets. There is the very uncomfortable feeling that the patient has put herself in one's hands, and that one has let her down if all the arrangements are not perfect.

Not taking one's own anaesthetist and assistant to a difficult case.

I realize that I am treading here on rather dangerous ground, but feel that I ought to have the pluck to say something on this point. I wish to say first of all that among my general practitioner friends are some of the best anaesthetists and assistants with whom I have the privilege of working; but there are others! An anaesthetist is born, not made. I have had perfect anaesthetics given to my patients by newly qualified men of very small experience, and have laboured, toiled, and been filled with anxiety and dread as to the immediate and after results of anaesthetics given by men who have studied the matter deeply and done their utmost to improve their skill in the art of inducing anaesthesia. To insist on having one's own anaesthetist may require some moral courage, and may give offence, but it is one's duty to stand out for it if it be considered, from past experience, that the patient's safety is jeopardized. The difficulty of the operation, especially if it entails deep pelvic work, is enormously increased if the patient strains and coughs throughout, and the wear and tear to the operator is doubled or trebled if he has intestine shooting into the pelvis whenever he has a sharp instrument inside that cavity. Apart from the increased danger of the operation, the patient will suffer far more from vomiting, distension, and abdominal discomfort during the first few days, and will run risk of bronchitis. When I have been weak enough to accept a second-rate anaesthetist or assistant I have regretted it bitterly, because of the exhausting fatigue and anxiety caused to myself, even although my anxiety about the patient has been of short duration as I heard that she was doing very well. Team work produces the best results, and the operator ought not to have to worry about the anaesthetic, or about the asepsis of his assistant. To look up in the middle of a difficult job and see his assistant arranging, with his gloved hands, his spectacles and the mask through which he has been breathing for half an hour, adds greatly to the worries and anxieties. Unlike the art of inducing anaesthesia, an aseptic technique is never inborn, but has to be learned by experience and instruction. I think that some men who do not operate themselves are rather inclined to consider an operator to be fussy and neurotic if he expects an anaesthetic to be perfectly given, and that he ought not to take it as more than a "rub of the green" if gag, tongue forceps, and throat swabs are used throughout, with artificial respiration only at infrequent intervals. This sort of anaesthetic would not matter much if a toe was being amputated; it is not only disconcerting but really desperately dangerous in abdominal and pelvic surgery. I have not really had much to complain of recently, as most men are very sensible on these points, but I have had some regrets in the past.

Not reopening the abdomen soon enough when symptoms of intestinal obstruction come on a few days after an abdominal operation.

Intestinal obstruction is not as common after gynaecological operations as it was formerly, because an attempt is always made to cover up with peritoneum any raw surface or stump and to prevent any oozing after operation, but in some cases, particularly old pyosalpinx cases, it is difficult to find any peritoneum loose enough to be sutured over a raw surface. I can remember five cases of intestinal obstruction after operation. The first was after myomectomy from the posterior surface of the uterus. Practically the only symptom of which the patient complained was pain. As she was having a monthly period, and always had severe dysmenorrhoea, I was deceived, and delayed opening the abdomen for too long, and she died

soon after the second operation, in which a coil of small intestine was freed from an adhesion to the suture on the uterus. Delay is most dangerous, if not fatal, in such a case. The surgeon has a natural objection to reopening the abdomen, and is tempted to delay and hope for the best, but the proper treatment is to harden one's heart and explore as soon as suspicions are aroused. The other four cases—in three of which I had performed the first operation myself, while in the fourth the first operation had been performed by one of my colleagues—were ovariectomy, pyosalpinx with terrible adhesions, pyosalpinx, and severe bleeding from an ovary. Profiting by my experience in the first case I lost no time in operating on these four, and they all recovered. I have never ceased to regret that I had not sufficient common sense to explore the abdomen of the first patient as soon as she looked ill and complained of pain, as, if I had done so, she would almost certainly have lived, as the adhesion was easily dealt with.

Not strapping the abdomen when a patient has a cough during the first fortnight or so after an operation.

I have regretted bitterly that I had not reinforced the stitches, or the recently united tissues after removal of stitches, by carefully applied strapping, when a patient has developed a cough after an operation. If the cough is violent the abdomen is strapped almost as a matter of routine, but it is important to remember that a patient who has a mild, fairly harmless cough may cough violently once or twice when she wakes up after several hours' sleep and finds some tenacious mucus in her throat, difficult to dislodge. I can only remember two cases in private practice in which patients have burst the wound open by coughing. I ought to have strapped the wound in both, and have regretted ever since that I did not do so. One patient died a fortnight later, the other recovered.

There are some cases in which I have had *no regrets*. In some of these I have told a patient that in my opinion no operation was necessary, and have later heard that she went on to someone else, who sent her into a nursing home immediately and operated the next morning. I find that I spend a good deal of my time in advising patients to avoid operations. Some of them are exceedingly grateful, but some go straight to another man. One case in which I was given most fulsome thanks may be worth a detailed account as showing how difficult it is to prophesy what a patient will do.

A man, whom we will call Mr. H., rang me up on the telephone and said, "What would you charge to operate on my wife?" I naturally said, "What is the matter with her?" He answered, "It is the womb." I said, "I am afraid that I cannot give an opinion without seeing your wife." He replied that he thought that I would be able to suggest a fee without seeing her, so I said, "If you telephoned to a bootmaker and asked how much he would charge to mend your boots, would he not say, 'Let me see your boots?'" "Doctor, there is something in what you say; I will bring my wife to-morrow." I examined her, a multipara of 54, some years after the menopause, with a very loose abdominal wall, backache, and dragging sensation, with several small fibroids and retroversion of the uterus. She had seen many gynaecologists in Germany, some of whom had advised operation while others had advised against it. The patient said that she wished to avoid an operation. I suggested that an abdominal belt might give her a great deal of comfort, and she said that she had had one which had done her a lot of good, but it was worn out. The husband said, "Doctor, you are a British sport. Before the war I used to say, 'Go to the Continent for an opinion,' but since the war I say, 'No, stick to your own men!'" No one has asked the questions that you have asked, no one has taken so much trouble, no one has suggested a belt. Doctor, I thank you, you are a British sport; we will go and get a belt." Two days later I met a medical friend who said, "You remember Mrs. H.?" I said, "Yes, she's going to try an abdominal belt." He said "No; she went on from you to Y, and then to Z, who put her straight into a nursing home and operated on her yesterday morning!"

TREATMENT OF ENCEPHALITIS LETHARGICA BY THE REMOVAL OF POSSIBLE ETIOLOGICAL FACTORS.

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PART I, BY A. L. YATES.

SOME four years ago I began an investigation of the nasal ciliary mechanism, and found that the ciliated epithelium formed definite tracks which functioned in a backward direction so that mucus rolled over any particles introduced within the nose, and conveyed them backwards into the nasopharynx along certain definite paths.¹ This led to a further investigation of the ciliary and secretive mechanism, and the nasal mucous membrane in inflammatory states, and it was found that four groups of conditions could be observed—namely:

1. Those in which mucous secretion was excessive and the cilia active.
2. Those in which mucous secretion and the cilia remained active, and to the mucus was added serum and leucocytes, forming yellow muco-pus. In neither of these conditions was there any alteration in the staining power of the mucus, nor could the micro-organisms which were visible microscopically in the mucus be cultivated.
3. A condition in which the mucus became altered, apparently as a result of the action of the bacterial ferments, so that the mucus stained with aniline dyes, such as indigo-carmin. In this group cases were met with where the cilia were more than normally active, and where the mucus was conveyed backwards into the nasopharynx, causing in and around its path a chronic inflammation of the mucous membrane, and thus producing laryngitis, tracheitis, and oesophagitis. In another group of cases the cilia were less than normally active, and the altered mucus remained in the sinuses and in the nose. In Types 1, 2, and 3 an anterior nasal discharge appeared when mucus or muco-pus was greater in amount than the cilia could convey away into the nasopharynx.
4. In this group I found cases in which the cilia and mucous secretion were paralysed, so that the organisms which can often be obtained in pure culture from the interior of the sinus were present in a brownish watery solution containing the remains of leucocytes—that is to say, of water-soluble pus.

Certain cases in Group 4 showed the presence of toxic absorption and suffered from various complaints, such as periarticular rheumatism, neuritis, neurasthenia, skin complaints, and similar conditions. Other cases in this group showed no such signs of toxic absorption.

In order to determine the reason why some of the cases in this group had toxic absorption and others not, a solution of 0.4 per cent. indigo-carmin or 0.01 per cent. phenol-sulphonaphthalein was placed in the sinus. In the cases which showed signs of toxic absorption of nasal origin this dye appeared in the urine in from ten to fifteen minutes. In cases without toxic absorption, or in cases in which the sinuses were all relatively normal, or if swallowed, the dye did not appear in the urine.

Toxic absorption from the mucous membrane would therefore appear to be prevented in the early stages of inflammation by mucous secretion, and in the late stages by deposit of fibrous tissue.

The Nasal Condition in Encephalitis Lethargica.

Various writers on encephalitis lethargica have drawn attention to the presence of nasal and buccal discharge in practically all cases, and I found paralysis of the cilia and mucous secretion in fully developed cases in the posterior portion of the nose—that is to say, in the ethmoidal recess, the posterior ethmoidal sinuses, or the sphenoidal sinus—and that such inflammation tended to spread both forwards to the mucous membrane of the nose