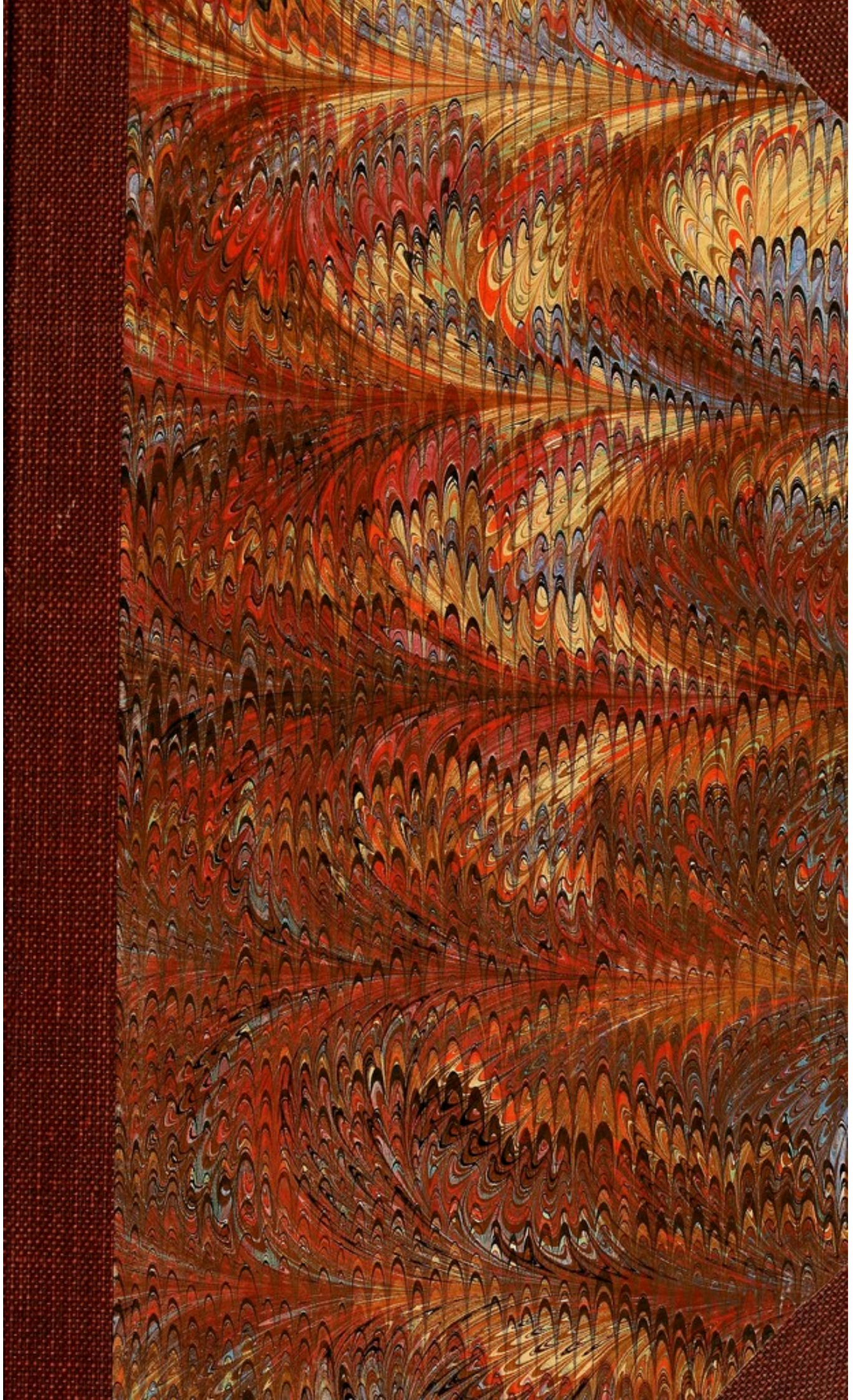
The alleged malpractice suit : Thompson vs. Smith. Statement of experts and surgeons / Evidence reported by R.J. Hammond, reported for the Circuit court Nov. term, 1874, for Madison county, Iowa.



THE ALLEGED MALPRACTICE SUIT.

THOMPSON *vs.* SMITH.

TESTIMONY

Of the Surgical Experts, Corroborated by the statements of Fifty of the leading Surgeons of the U. S.

EVIDENCE

Reported by J. R. Hammond, Reporter for the Circuit Court for Madison County Iowa.,

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SWORN STATEMENTS OF SEVEN OF THE JURORS.

Magna est veritus et prevalebit."
"Fiat justitia."

WINTERSET
NEWS PRINT.
1875

THE

ALLEGED MALPRACTICE SUIT.

THOMPSON *vs.* SMITH.

STATEMENT OF EXPERTS AND SURGEONS.

EVIDENCE

Reported by R. J. Hammond, reported for the Circuit Court Nov. Term, 1874, *for Madison county, Iowa.*

"The Union of '*Shyster*' and '*Quack*,' is frequently met with in suits for Malpractice."—
McCLELLAND.

"*Magna est veritas et prevalebit.*"
"*Fiat justitia.*"

WINTERSET:
NEWS PRINT.
1875.

Letter from Dr Davis, of Indianola, Iowa.

"Dr. A. B. Smith:—Your letter giving the result in the case of Thompson *vs.* Smith, was received last evening. I am astonished at the verdict. There must have been some clandestine influence outside of the prosecuting testimony to warrant such a decision. I heard testimony of the plaintiff, as well as your own, which would convice any surgeon of experience and reading, that your diagnosis was correct. How humiliating and disgraceful to the medical profession are these malpractice cases. A few more such decisions as in your case, will work great detriment to the community at large. Individuals who are unfortunate enough to sustain an injury will be compelled to forego surgical aid.

"A surgeon adjusts a fracture correctly and with skill, is prosecuted by the malicious patient for malpractice to obtain damage. A physician who urges on such a suit is unworthy, and should be expelled outside the pales of professional brotherhood.

"You made, I consider, a perfect and complete defence. Your *diagnosis* and treatment was sustained by all the experts as well as by the best authorities. I am confident that every unbiased person who heard the trial, will say that you sustained the correctness of your diagnosis, with skill and ability, proving your qualification as a careful and experienced surgeon. I think it would be well to have the case published as a vindication of youself and for the profession at large. I think there should be no difficulty in obtaining a new trial, as the vernict is most certainly unwarrante by the facts, the testimony and tho law.

Very Respectfully,

"*Indianola, Iowa, Nov.* 22, 1874. C. W. Davis, M. D.

PREFACE.

The subject of malpractice, at the present time, seems to be one of great importance, not only to the physicians and surgeons but also to the public.

No surgeon who is responsible in the way of property would dare to undertake a case in surgery in this county, unless he knew well the character of the patient he treats. Some of our best surgeons during the last few mouths have refused to attend to such cases, unless they were secured against such unwarranted prosecutions. Others have put their property out of their own name, in order to practice their profession without fear of such prosecution. Ours is indeed a hazardous calling, judging from the history of the past year, as two suits for malpractice have been instituted within that time in this county; both of which, we believe, have been instituted and urged on by envious and malicious persons, for selfish purposes, and to injure, if possible the professional standing of the surgeon. The patient, encouraged to believe that he can make some money out of it, consents to bring suit.

If we examine the history of the malpractice suits that have been brought within the last ten years, we will find that nine tenths of them have been against surgeons of the highest professional standing, when no malpractice existed but the suits were instituted and encouraged by physicions on whom the plaintiff relied for witnesses, agreeing to testify so that the patient might recover damage. We might here refer to individual case, such as Walsh *vs.* Sayer, N. Y., Steel *vs.* Newton, Cinn., also Salyer *vs.* Hutchinson, Winterset, and numerous other might be mentioned. Thus the surgeon who has discharged his professional duties correctly and with skill, is put to the expence of a long and tedious trial before a jury who are incompetant to judge of what are the duties of the surgeon; or, of the correctness of the testimony brought before them. "Does it not behove us, as professional men, responsible for our professional acts, to defend ourselves against such uncalled for attacks as have been made upon the professional character of the most worthy and responsible members of our profession." "Do not the public owe it to the medical profession that they be protected against such *unrighteous* prosecutions?" In order to ac-

complish this, there ought to be, we think. at least one well qualified medical expert allowed on every jury to try a case of this kind. Jurors are expected to know only what they hear in the testimony, and if a surgeon testifies that the "*Femur articulates with the Scapula*," "*That the Glenoid Legament is attached to the great Tuberosity*," "*That the Trapezius muscle has nothing to do with the shoulder*," "*That there are no nerves involved in dislocation of the shoulder, consequently wonld produce no pain*" And this, as ridicuious as it may be, is to be received by the jury as correct. But a physician who understands the anatomy of the human system is better qualified to judge of the correctness of the testimony than one who has no knowledge of such cases. The case here presented to the profession and the public has been prosecuted with the most *malicious vindictiveness* that has, perhaps, ever characterized a case of this kind. I will also say that there was never a case of malpractice in which there was as complete defence. And in no case was a physician or surgeon so well and fully sustained in his treatment of a case in every respect, not only by all the experts, but by the unanimous profession. Is this no surely a day of corruption when courts and juries can be controled by rings and cliques, or by an influence entirely foreign to the evidence. All who have examined the facts and the evidence, say without hesitancy, that this was a put up case; be this as it may, it is very certain that those who labored so hard for the prosecution utterly failed in the object of their prosecution. I think no one that knows the facts doubts but what the jury was tampered with by interested parties. The evidence and facts as given by disinterested parties is herewith submitted to the public. The experts. to whom I am indebted for a *perfect, complete and triumphant vindication* of the right, have not been selected as personal friends, but have been selected as surgeons of reputation, who stand at the head of their profession in their respective localities, and we may say in this State, some of whom I had no personal acquaintance with, and knew only by reputation. Hoping the case will receive an impartial investigation and be a benefit to the medical profession *In perpetuam ret memoriam*,

I submit, Respectfully,

A. B. Smith, M. D.

THE

ALLEGED MALPRACTICE SUIT.

THOMPSON *vs.* SMITH.

This is a case in which Thompson was thrown from his horse striking upon his right shoulder, producing a fracture of the acromiom process. Dr. Smith was called and treated it properly for that injury. Another physician, one month afterward, claimed that there was a Subcoracoid Dislocation of the shoulder, and proceeded to reduce it. Thompson was induced to believe he could make some money out of it by bringing suit against Dr. Smith for not reducing the supposed dislocation. We who were experts in this case and heard the testimony, hereby request the publication of the evidence and other facts of the case, not from curiosity of self, or from any desire to misrepresent, or to be misrepresented; but for the following reasons:

1st. That our characters as medical experts, and the honor of our profession may be vindicated.

2d. That the public may judge whether or not there was a cause for alleged malpractice, and also of the motives that prompted the suit.

3d. Because the evidence proves to the public, and the profession, that the most absurd and ridiculous medical testimony was allowed to be received by the jury as sound and correct medical evidence, while the evidence or the experts who testified to facts scientifically was not allowed to be considered by the jury. (See sworn statement of the jury, and the decision of Judge Mitchell, who tried this case).

4th. Because the evidence proves the ability and qualification of the experts and defendant, and the incompetancy of the *prosecuting Surgeon*

5th. Because it proves that it is the qualified and competent Surgeon that is attacked and prosecuted, while the less qualified and envious physician encourages such prosecutions.

6th. Because it proves the fact that no surgeon, however competent and skillful he may be, or however faithfully and perfectly he may have performed his surgical duties, he is not safe from suits that are instigated through envy, or malice and are intended not only to ruin our fortunes, but our reputations. More especially is this the case when the surgeon is the owner of property and his patient is not, as is generally the case. (See affidavit of the jurors in this case, in which they state that they regard the "plaintiff as a poor man, and that it would break him up if the verdict went against him, and that the defendant was well off and it would not hurt him.) This was argued in the jury room and proves that the *prejudices* of the jury were with the plaintiff. They find a verdict against the defendant for not discovering a dislocation under circumstances in which nine medical experts swear that it would be a physical impossibility for a dislocation to exist. The symptoms as described by Thompson and the prosecution were, "arm hung powerless by the side; took "the forearm of injured limb in the other hand and carried it "across the breast. The shoulder drooped when not supported, "and the deformity corrected when supported, or by pressing up "on the elbow of the injured arm; the shoulders looked alike "and no deformity." All of which symptoms indicate fracture of the acromion process.

The above symptoms were testified to over and over again in the evidence of Thompson, and, also, by Mr. and Mrs. Graham, all testifying that there was a deformity, a drooping of the shoulder, and that their attention was called to it by the Dr. and, also, that the deformity was corrected, and the rotundity of the shoulder restored when the Dr. would press up on the elbow, and when held in that way shoulders looked alike. After the bandages were all on the elbow was to the side and the forearm across the breast with no difference in the shoulders, and no deformity. This was also corroborated by the testimony of the defendant. Dr. Leonard, (the surgeon for the prosecution, who claimed that there was a dislocation), testified that he "rotated the arm and brought the two arms, extended, straight out in front of the patient with the palms of the hands meeting"; and, also, that "that rotation of the arm and extention was made readily and without any inconvenience to the patient, and that he did not

complain of pain." We claim that these symptoms, together with the manner in which the diagnosis was made was sufficient to warrant the decision given in our testimony. No physician, or surgeon, of ability, would even claim that there could possibly exist a subcoracoid dislocation with the conditions described.

The testimony has been read by over thirty physicians, besides the experts, and not a single one of them has ever pretended to claim that it was even possible for a dislocation of the head of the humeras of any kind to exist under the conditions and circumstances as detailed by the plaintiff himself and his witnesses.

If Dr. Smith's treatment in this case was malpractice then no surgeon could ever treat a case without being guilty of malpractice. This is a case in which all surgeons must, and do agree, and there can be no question as to the nature of the injury; and, also, the correctness of the treatment. The symptoms detailed by the plaintiff himself, and his witnesses, is too plain to admit of any controversy on the subject. Dr. Smith has, without doubt, been deeply wronged by some unlawful, or clandestine influence brought to bear, in the case, on the jury, and justice calls loudly for an investigation.

The following facts and figures may point in the direction of who was the cause of the suit. We take this from the records, and the evidence:

The fee for reducing the supposed dislocation.....	$125 00
Witness fees, claimed by the Surgeons for the prosecution, Sixty dollars and ten cents each.....	240 40
Total.....	$365 40

A very good business for an idle set of doctors to pass away the time. But the witness fees, as claimed above, have not yet been allowed by the court. If they should be allowed, these doctors cannot do better than to get up another malpractice suit, as they can make more money in one suit than they do at their legitimate business in three months.

In our testimony in this case we gave it as our opinion formed by the evidence of the prosecution, (Mr. Thompson, the plaintiff, and Mr. and Mrs. Graham), that Dr. Smith was correct in his diagnosis and treatment of the case in every respect. We also testified, as will be seen by the evidence, that it was impossible for a subcoracoid dislocation to have existed with the conditions as claimed by the plaintiff.

We also testified that the symptoms as given by them upon

the witness stand, were the symptoms of fracture of the acromion process, and that the treatment of Dr. Smith was the proper treatment for that injury.

As our evidence and opinion as medical experts, and our character and standing as such has been questioned, and an effort made to have it disregarded, we herewith present to an intelligent public the testimony of forty-six physicians and surgeons, among whom are the most eminent surgeons of the U. S., who have given their opinions formed by reading the testimony of Thompson himself, and that of Mr. and Mrs. Graham, or from a fair and impartial statement of the facts in the case, all of them sustaining us in the opinion expressed in our testimony: *There is no truth in science, or problem in mathematics more clearly demonstrated than the fact that no dislocation existed in the plaintiff's shoulder.* We regard the verdict of the jury in this case, not only an anomoly, but an outrage upon the justice of law unequalled in the history of the past. We also submit with the evidence, a sworn statement of seven of the jurors, leaving an intelligent, thinking public to judge whether or not there was some influence out side of the testimony brought to bear upon the jury that rendered the verdict.

We only have to refer to the testimony of the physicians who claimed there was a dislocation to prove that they were misled or mistaken in their opinions. In proof of what is here stated the reader is referred to the evidence given in the case, together with the opinions and statements of the following physicians and surgeons:

C. W. Davis, A. M., M. D.....Indianola, Iowa.
John Cooper, M. D.....Winterset, Iowa.
E. L. Hillis, M. D..... " "
David Hutchinson, M. D..... " "
G. M. Rutledge, M. D..... " "
I. A. Cooper, M. D..... " "
A. G. Fields, M. D.....Des Moines, Ia.
T. Roberts, M. D.....St. Charles, Ia.
L. J. Forney, M. D..... " " "

Experts.

STATEMENT OF SURGEONS

WHO HAVE

READ THE EVIDENCE.

We, the undersigned physicians and surgeons, hereby certify that we have carefully read the testimony of Hugh Thompson, and Mr. and Mrs. Graham, as given in the case of Hugh Thompson *vs.* Dr. A. B. Smith, at the November term of the Circuit Court, of Madison county, Iowa, 1874, as reported by Mr. Hammond, reporter for said Court, and we unhesitatingly state, as our opinion, based upon our knowledge and experience, that a subcoracoid dislocation could not possibly have existed under the circumstances as detailed by said witnesses.

The anatomical structure of the parts prevents the possibility of such an occurrence while the symptoms indicate fracture of the acromion process. The treatment of Dr. Smith as detailed by them, was the proper treatment for such an injury. Our opinion is also sustained by the latest and best authorities on this subject.

Witness our hand this 3rd day of April, 1875:

J. D. McCleary, M. D.,	Indianola, Iowa.
Thos. S. Parr, M. D.,	" "
L. Leonard, M. D.,	Patterson, Iowa.
J. A. Rawls, M. D.,	" "
John Seevers, M. D.,	Greenfield, "
W. S. Grimes, M. D.,	Des Moines, "
R. Geo. English, M. D.,	" "
Geo. P. Hanawalt, M. D.,	" "
E. H. Carter, M. D.,	" "
Thos. W. Baugh, M. D.,	Carlisle, "
G. H. Bonney, M. D.,	Indianola, "
Orison Plumly, M. D.,	Liberty, "
H. F. Salter, M. D.,	Indianola, "
J. W. Marmon, M. D.,	Mitchelville, "
A. J. Applegate, M. D.,	Laconia, "
Geo. Douglass, M. D.,	Sioux City, "
James J. Wakefield, M. D.,	Spring Hill, "
E. H. Munk, M. D.,	Newald, "

J. S. Turner, M. D., - - - New Virginia Ia
J. A. McElveen, M. D., - - - Chariton, "
John Pipher, M. D., - - - Norwalk, "

In addition to the above named physicians, who have read the evidence, will be found the statement from the following physicians and surgeons, all sustaining the experts and the diagnosis of the the defendant in the case:

J. A. Comingor, M. D., Indianapolis, Ind.
Prof. of Surg. Ind. Med. Col.

Theo. A. McGraw, M. D., Detroit, Mich.
Prof. of Surg. Detroit Med. Col.

C. H. Rawson, M. D., Des Moines, Iowa.
Gives statement from reading the Evidence.

Edwin Powell, M. D., Chicago, Ill.
Prof. Surg. Anat. Rush Med. Col.

M. A. McClelland, M. D., Knoxville, Ill.
Author on Melpractice.

A. Sager, A. M., M. D., Ann Arbor, Mich.
Prof. Med. department Mich. University.

W. S. Grimes, M. D., Des Moines, Iowa.
Statement from reading Evidence.

J. T. Woods, M. D., Toledo, Ohio,
Prof. Cleveland Med. Col.

E. H. Carter, M. D., Des Moines, Iowa,
Statement from reading Evidence.

D. A. Stanton, M. D., St. John, Mo.
W. H. Parcells, M. D., Toledo, Ohio.
Geo. P. Hanawalt, M. D., Des Moines, Iowa,
Statement from reading Evidence.

W. F. Peck, M. D., Davenport, Iowa,
Prof. of Surg. Med. department Iowa State University.

C. A. Kirkly, M. D., Toledo, Ohio,
Edmund Andrews, A. M., M. D.. Chicago, Ill.,
Prof. of Principles and Practice of Surg. and of Clinical Surg.
J. H. Kersey, M. D., Redfield, Iowa, [*Chicago Med. Col.*
W. W. Dawson, M. D., Cincinnati, Ohio,
Prof. of Principles of Surg. and Clinical Surg. Ohio Med. Col.
A. J. Howe, M. D., Cincinnati, Ohio,
Prof. of Surg. E. M. College Cin.
P. S. Conner, M. D., Cincinnati, Ohio,
Prof. of Surg. Anat. and Clinical Surg. Med. Col. of Ohio.

John McNulty, M. D.,

Fellow of the Academy of Medicine, and Member of the Pathological Society, N. Y., and permanent member of A. M. A., and formerly Medical Director of U. S. A.

The following questions were submitted to A. M. McClelland, Author on malpractice:

"Suppose a man falling from his horse and receives an injury to the shoulder; he gets up with his arm hanging powerless by his side. He takes his forearm with the other hand and carries it across his breast; there is drooping of the shoulder when not supported; the deformity is corrected when supported. Would it be possible for a subcoracoid dislocation to exist? Would you suspect a dislocation of any kind?"

Ans:—"To both interogatories I would emphatically answer, *No!* "The symptoms clearly indicate fracture of the *acromion process*, or seperation of epiphysis, which is essentially the same.

Having so answered, I will be permitted to give my reasons:

"The drooping of the shoulder, its rotundity being restored, and the deformity corrected by pressing upon the elbow from below. The mobility of the limb, as shown by the patient placing it across the breast with the other hand, all indicate fracture of the acromion process and precludes the *possibility of the existence of a subcoracoid dislocation*, for the reason that in a subcoracoid dislocation the head of the humerus lies under the coracoid process and *no* support or upward pressure of the elbow could correct the deformity, not even if the pressure was forcible enough to fracture the coracoid process, which, in such a dislocation, is a firm obstacle above the head of the humerus. The deformity is only removed by replacing the head of the humerus in the Glenoid cavity. Again, the question is asked: 'If there was a subcoracoid dislocation could the hands and arms of the patient be brought out straight in front with the palms of the hands meeting?' To this I answer, *No!* In all dislocations of the shoulder the axis of the humerus is changed, the elbow being carried away from the body, and in a subcoracoid dislocation the elbow stands outward and backward. The Deltoid muscle, wtih the Supra Spinatus and Infra Spinatus, together with the Teres minor muscles, are put greatly upon the stretch; all draw the arm backward and out from the body, and the forearm could not be brought across the breast without great violence and pain. And further, the placing of the arm in this position necessitates a greater or less amount of rotation of the head of the humerus, which would still further stretch the Supra Spinatus and Infra

Spinatus muscles, they being attached to the great tuberosity of the humerus. The Teres Major and Latissimus dorsi muscles, both arising posterior to the shoulder and attached to the bicipital ridge of the humerus, draw the humerus backward and would be serious impediments to bring the arm in front or placing it across the breast. And the bringing of the arms straight out in front of the body would produce all the rotary motion of the heard of the humerus that would be necessary in bringing the hand to the opposite shoulder. This being another proof that there was no dislocation.

From the history of the case of Thompson *vs.* Smith, from the symptoms as detailed above, there can be no doubt but Dr. Smith's diagnosis was correct and his treatment *eminently so.*

Respectfully, M. A. McClelland, M. D.

I hereby certify that I have read the foregoing questions submitted to Dr. M. A. McClelland, and most heartily concur in his answers and statement in the case in every respect; and in the case of Thompson *vs.* Smith, there can be nothing more positive and clear than the fact that no dislocation ever existed in plaintiff's shoulder. John M. Nultz, M. D.,

Med. Director U. S. A., Mem. Path. Soc'y, Per. Mem. A. M. A.

The same questions were submitted to D. A. Stanton, M. D., of Mo. The following are his answers:

"It would be impossible for a dislocation to exist with the symptoms detailed. In a subcoracoid dislocation the elbow cannot be brought to the side with the forearm across the breast. If there was a dislocation of the head of the humerus of any kind, the deformity could not be removed, or the rotundity of the shoulder restored by any support or pressure to the elbow. The deformity of a dislocation is only removed by reducing the dislocation. The symptoms given are the symptoms of fracture of the acromion process, as in this case there would be a drooping, and the deformity would be removed and the rotundity of the shoulder restored by support or upward pressure to the elbow. In the case of Thompson *vs.* Smith, the manner in which Thompson carried his arm, and the manner in which it was dressed, was sufficient evidence that there was *no dislocation.* A demonstration with the skeleton will certainly satisfy any intelligent jury of that fact. Trusting that science and right may assert herself, I am Fraternily,

D. A. Stanton, M. D.

The following statement is made by Prof. W. F. Peck, Davenport, Iowa:

"Suppose a man with his arm hanging powerless by his side, (having previously received an injury either directly or indirectly to his shoulder,) reaches across the body with the uninjured arm and grasps forearm of injured limb and carries it across the breast with the elbow to the surface of the body. And with upward pressure to the elbow of injured side deformity at the shoulder disappearing.

"Under such circumstances could a *subcoracoid dislocation exist?*

"To the foregoing interrogatory I can give but one answer—*No!*"

W. F. Peck,
Prof. Surg. Med. Department of Iowa State University.

The following questions were submitted to Prof. J. T. Woods, M. D., of Toledo, Ohio:

"Supposing a man receives an injury to the shoulder; his arm hangs powerless by his side; takes his forearm in his other hand and carries it across his breast; there is drooping of the shoulder when not supported, and the deformity is corrected when supported. Would it be possible of a *subcoracoid dislocatian to exist?*

"What would be your diagnosis?"

Ans:—"Referring to the preceding questions, my reply to the first, is *No!* It is entirely impossible for the symptoms to be produced by the dislocation named. But the symptoms *clearly indicate* the *existence of fracture.*

"The symptoms indicate *fracture of the acromion process*, and on this information such would be my *diagnosis.*"

J. T. Woods, M, D.,
Prof. Cleveland Med. Col.

Toledo, Ohio.

We, the undersigned, after a careful consideration of the foregoing questions, hereby certify to the correctness of the answers

given by Dr. Woods, and furthermore, that it is our opinion that in the case of Thompson *vs.* Smith, the diagnosis was correct, and from an examination of the facts in the case we conclude that the phy sician who claimed there was a subcoracoid dislocation is a most *reprehensible ignoramous.* And the prosecution of Dr. Smith, under the circumstances, should be regarded as nothing less than an *outrage.*

W. H. PARCELLS, M. D.
C. A. KIRKLY, M. D.

The same questions as above were submitted to Prof. Theo. A. McGraw, M. D., of Detroit, Mich:

"ANS:—A subcoracoid dislocation of the humerus could not exist with the symptoms as described. I would not suspect a dislocation of the shoulder of any kind in a patient who could carry his forearm across his breast in such a way as to cause the elbow to touch the chest. Such symptoms as are described might occur in fracture of the *acromion process*, or of the clavicle?

"I have no doubt, from what I can learn, that the verdict rendered in the case of Thompson *vs.* Smith was *exceedingly unjust!*"

THEO. A. MCGRAW, M. D.,
Prof. Surg. Detroit Med. Col.

The following statement was made by Prof. Comingor, Indianapolis, Ind:

"If you were called to a patient who had been thrown from a horse, and fell on the shoulder; found him with his arm hanging powerless by his side, and you could take his arm by the elbow and hand, and rotate the arm backward and forward, carrying it to his side, and arm across the breast and bandaged in that position. Would you suspect either a subcoracoid or any other kind of luxation of the humerus.

ANS:—"*Most emphatically No!*"

"After receiving an injury to the shoulder, you found the patient with one shoulder lower than the other, and arm by the side, and could rotate the humerus, what would you suspect was the nature of the injury.

Ans:—"I should at once look for and expect to find fracture of the acromion process. Less than two years ago I manag-d a case of fracture of this process which presented the same symptoms you have described, and injured in like manner, (falling from horse) and treated by flexion and support at the elbow.

Truly Yours, J. A. Comingor, M. D.,
Prof. of Surg. Ind. Med. Col.

The following questions were submitted to Prof. Edwin Powell, M. D., Chicago.

"Suppose you were called to see a man that had fallen from a horse and received an injury to the shoulder, with the following symptoms: Arm hung powerless by the side, patient takes the forearm of injured limb in his other hand and carries it across the breast; the shoulder droops when not supported and the deformity is corrected by pressing up on the elbow. Would you suspect a subcoracoid dislocation.

Ans:—"The symptoms as here enumerated entirely precludes the existence of a subcoracoid dislocation of the head of the humerus."

"What would be your diagnosis?

Ans:—"Fracture of the *acromion process.*"

"Would you suspect a dislocation of any kind?

Ans:—"Certainly not."

If there was a subcoracoid dislocation of the humerus, could the hands and arms be extended straight in front of the patient to measure their comparative length.

Ans:—"Very little if any information would be obtained by the procedure, even if it were possible to do it, but it is not."

Edwin Powell,
Prof. of Surg. Ant. Rush. Med. Col.

The same questions were submitted to Prof. E. Andrews, A. M., M. D., Chicago.

Ans:—" Drooping of the shoulder is not proof of dislocation. The deformity of dislocation is not corrected by pressing up the elbow."

" With the elbow to your side and forearm across the breast, would you expect to find a subcoracoid dislocation of the humerus.

Ans:—" *No!*"

" In a subcoracoid dislocation, would it be proper to bring the arms extended straight out in front of the patient to ascertain their comparative length.

Ans:—" *No!*"

" Could it be done if there was a subcoracoid dislocation.

Ans:—" Probably not in a subcoracoid dislocation."

Edmund Andrews, M. D.,
Prof. of Surg. Chicago Med. Col.

I hereby certify that I have carefully read the evidence of Hugh Thompson and Mr. and Mrs. Graham in the case of Hugh Thompson *vs.* Smith as reported by J. R. Hammond, and hereby certify: That the symptoms as detailed by them clearly indicate fracture of the acromion process and the treatment of Dr. Smith as described by them, was the proper treatment for such an injury. And with such symptoms a subcoracoid dislocation could not *exist.* W. S. Grimes, M. D.,

Des Moines, Iowa.

I hereby certify that I have read the evidence of Hugh Thompson and Mr. aud Mrs. Graham, in the case of Thompson *vs.* Smith, reported by Mr. Hammond, and would say that the symptoms as given by them in their testimony clearly indicate fracture of the acromion process; and the treatment of Dr. Smith, as described by them, was the proper treatment.

In my opinion a dislocation could not possibly exist with the symptoms as detailed by them. No support will remove the deformity and restore the rotundity of the shoulders if there was a dislocation of any kind. E. H. Carter, M. D.

Des Moines, Iowa.

DES MOINES, IOWA.

Dr. C. H. Ramson, certifies that he has carefully read the evidence in the case of Thompson *vs.* Smith. And that from the statement of Thompson, himself, how the injury was caused, and how he carried his arm, I do not see how there could have been a subclavicular or a subcoracoid dislocation.

Having examined the evidence in the case of Hugh Thompson *vs.* Dr. A. B. Smith, I do not hesitate to denounce in plain terms the finding of the jury. The evidence of the plaintiff simply verifies the correctness of Dr. Smith's diagnosis and treatment.

To this add the testimony of all the experts called in the case, and the verdict rendered seems to have been actuated by something far from a sense of the facts in the case, or a desire to do justice.

The statement of the seven jurymen, who state that it was not their verdict should not only place Dr. Smith unspotted before the profession and community, but should put to shame such unjust proceedings. GEO. P. HANAWALT, M. D.

Des Moines, Iowa, May 12th, 1875.

Letter from Dr. Davis, Indianola, Iowa:

"I was present during the trial of the all ged malpractice suit of Thompson *vs.* Smith, and most unhesitatingly say that the testimony of the plaintiff and the physicians for the prosecution was amply sufficient to prove to any unbiased mind that Dr. Smith was correct in his diagnosis and treatment in every particular. There could not have been a dislocation of any kind according to the testimony of the prosecuting witnesses; they failed to make out the least shadow of a case against Dr. Smith.

The well known reputation of Dr. Smith as a successful physician and surgeon, and his popularity among his patients was envied by some members of his profession, hence in the opinion of many the man Thompson was urged to sue. The Doctor by success in his profession has accumulated some property, and no doubt Thomoson was made to believe he could make

something out of it by bringing suit. This is an age of corruption and crime, and I consider that the physician who would recommend a poor weak minded creature to sue his attending physician or surgeon, especially in a case where the surgeon had done everything correctly as in this case to be too mean and contemptable to live in a civilized and intelligent community. I have heard more than twenty of the leading physicians and surgeons say, after reading the eveidence in the case, that Dr. Smith had sustained himself perfectly, and that the testimony was a most triumphant vindication of the correctness of his diagnosis and treatment. How the plaintiff got a verdict no human reason can show.

Why it was that a new trial was refused after the eloquent showing of the attorney for the defence, and the disaffection of a majority of the jury, is most certainly an anomily in a court of justice. Surgeons of property will hesitate to treat such cases, when suits of this kind are brought up.

C. W. Davis, A. M., M. D.

Extract of a letter to Dr. Cooper from Prof. A. J. Howe, Cincinnati, Ohio:

"In answer to your letter of Nov. 30th, 1874, I would state that when there is a subcoracoid dislocation, the arm is rigid, the elbow stands off from the body and *cannot* be brought to the side. The strain on the biceps muscles prevents the extension of the arm. If there was a *fracture* of the *acromion process*, the arm cannot be brought out at right angle with the body, the deltoid muscle having lost its function for that purpose. The point of the shoulder is drooped or lowered and pain is produced by manipulating it. From the history of the case and the symptoms of theinjury there is no doubt but Dr. Smith's diagnosis was corrrect, and treatment proper for such an injury.

A. J. Howe, M. D.,

December 3rd, 1874. *Prof. of Surgery.*

Extract from a letter to Dr. Hutchinson:

"The idea that in a case of subcoracoid dislocation the elbow can be brought in contact with the side, argues very strongly of

defective proficiency in the science of anatomy. The shape of the thoracic walls alone would prevent such an occurrence. The elbow must be thrown outward and backward. In answer to your questions:

1st. "Can a subcoracoid dislocation exist for one month in a man, with his arm secured to his side, forea rm across the breast?

Ans:—"No, most emphatically no. A sub coracoid dislocation could not possibly exist with the arm in that position. The skeleton will demonstrate that assertion.

2d, "If you found a man with his arm by his side, he being unable to elevate the arm, would you ever suspect a su bcoracoid dislocation?

Ans:—"I should as soon think of the *stiffness* of the shoulder being occassioned by *croup*, as by any state of affairs that could not possibly exist. A subcoracoid dislocation would be impossible under the circumstances. I should naturally suspect a *fracture of the acromion process* if the shoulder was flattened or drooping. J. H. Kersey, M. D.

Adel, Iowa, December 3rd, 1874.

Extract of a letter from Dr. Field, Des Moines:

"There was, as it appears to me, sufficient in the testimony of the *prosecution* itself, to strengthen Dr. Smith's position and to exonorate him, to say nothing of the extent to which his diagnosis is sustained by the nature of the case and the published experiences of the best authors. A. G. Field, M. D.

"Suppose a man falling from a horse, and striking upon the back part of the shoulder producing an abrasion of the skin along the spine of the scapula; the man's arm hangs powerless by his side, and he then takes the forearm in his other hand and carries it across the breast, and there was drooping of the shoulder when not supported, and *when* supported the deformity was corrected. What would be your diagnosis? Would it be possible for a subcoracoid dislocation to exist with the arm in this position and no rigidity of the muscles? Would you suspect a dis-

dislocation of any kind?

In reply to the above I would say that with the above symptoms presenting I would not suspect a dislocation of the head of the humerus in any direction.

The symptoms of a subcoracoid dislocation are so marked that it is almost impossible to mistake them.

When the head of the bone has left the glenoid cavity you determine positively by the depression under the acromion process.

The elbow is thrown away from the side and cannot be brought in contact with the side without force and pain.

The axis of the limb is changed so as to direct from behind forward towards the middle of the clavicle.

When the head is out of its cavity you cannot place the hand on the opposite shoulder.

Mere support will not restore the rotundity of the shoulder in subcoracoid orany other dislocation of the head of the humerus.

W. W. Dawson, M. D.,
Prof. Surg. Med. Col. of Ohio.

Question:—"Suppose a man falling from a house, striking upon the back part of the shoulder producing an abrasion of the skin along the spine of the scapula, the man,s arm hanging powerless by his side, and he then takes the forearm in his other hand and carries it across the breast and there was drooping of the shoulder when not supported and when supported the rotundity was restored what would be your diagnosis?"

Answer:—The symptoms detailed are not sufficient to enable me to say positively what was the nature of the injury. It is quite probable that the acromion process was broken or separated at the epiphysial line.

Question 2:—"Would it be possible for a subcoracoid dislocation to exist with the arm in this position and no rigidity of the muscles?"

Answer:—In subcoracoid dislocation the elbow cannot be made to touch the front of the chest, or the hand carried to the opposite shoulder, the forearm may be carried across the breast, but the elbow will not at the same time be brought to the side; there will be flattening of the shoulder, but this flattening is not removed and rotundity restored by simply sup-

porting the elbow and forearm. There would be muscular rigidity to a greater or less extent if dislocation existed.

QUESTION 3:—"Would you ever suspect dislocation of any kind?"

ANSWER—"With the symptoms detailed, No!"

P. S. CONNER, M. D.,
Prof. Surg. Anat. Med. Col. Cincinnati, Ohio.

Questions submitted to Dr. J. A. McKlveene, Chariton, Iowa:

"Suppose a man receives an injury to the shoulder by falling from a horse; there is drooping of the shoulder when not supported, but on pressing the head of the humerus upwards by pressing upon the elbow the rotundity of the shoulder is restored. He takes the forearm in the other hand and carries it across the breast with the elbow to the side, and no rigidity of the muscles. With these symptoms what would be your diagnosis?"

ANS:—"I should certainly look for and expect to find *fracture of the acromion process.*

"Would you expect to find a subcoracoid dislocation?

ANS:—"With the symptoms detailed there could *not* be a subcoracoid dislocation.

"In a subcoracoid dislocation would it be proper or scientific to attempt to extend the arms in front of the patient with palms of hands meeting to ascertain their comparative length?

ANS:—"*No.* You could tell nothing by such an attempt about the comparative length of the arms. It could not be done in its unreduced state. J. A. MCKLVEENE, M. D.

SYNOPSIS OF THE

ARGUMENT PRESENTED

ON MOTION FOR A NEW TRIAL,

BY

T. C. GILPIN, ESQ., ATT'Y FOR DEFENDANT.

Our first objection is, the verdict is not sustained by the evidence.

There is not a particle of evidence that the plaintiff's shoulder was dislocated at the time defendant treated it on *Sept. 5th*, 1874. The plaintiff himself, nor any one of his witnesses, any where, pretended to swear that such was the case. And the only reason why the jury could possibly have inferred that there was a dislocation on that day is because it was claimed that there was a dislocation thirty-two days afterwards, on Oct. 6th, 1874. And that was not testified to any one positively, except by Dr. Leonard. The other witnesses for plaintiff do not testify positively that there was a dislocation, while Dr. Sloan testified that he was present when the shoulder was examined, that he examined it, with the others, and that he did not know that there was a dislocation. Dr. Anderson testifies that he formed his opinion that there was a dislocation from what the others said and not from an examination of the shoulder. These slender statements are the only evidence that there was a dislocation, even on Oct. 6th, from which to infer that there was one on Sept. 5th. For defence to this inference, we have the simple story of plaintiff, in which there is no pretence of dislocation on that day, corroborated by his sister and brother-in-law, also the defendant, Mr. Seevers, Dr. Hutchinson, and Dr. Cooper as to the facts surrounding the case at the time the injury was received, viz.: "Injury on the top of shoulder;" "Arm hung powerless by the side;" "Took the forearm in the other hand and carried it across the breast;" "Drooping of the injured shoulder and the deformity removed by pressing up on the elbow;" "The arm

was then bandaged up with the elbow to the side, with the fore arm across the breast, where it remained for four weeks," the plaintiff most or the time going about, doing his chores, driving his wagon to town, &c. All this was testified to, over and over again. Then we have the positive and unequivical testimony of nine surgical experts, that, under the circumstances, as detailed by the plaintiff himself, there could not possibly be a dislocation of the plaintiff's shoulder. These positive statements made under oath, were supported by reasons for making them, by a demonstration of the anatominal structure of the parts showing the impossibility of the existence of a subcoracoid dislocation with the symptoms given by the plaintiff. We believe we have presented the point fairly, giving the plaintiff the benefit of all he can claim from the evidence, and respectfully submit the question to to this court, Is the verdict sustained by the evidence? We think not.

We are also as confident that the evidence as certainly shows that there was no dislocation on Oct. 6th, as that there was none Sept. 5th. Let us look at the evidence. On Oct. 6th, (thirty days after the injury) we find the plaintiff, according to his own evidence, with his arm in bandages, elbow down close to his side and forearm across his breast, able to use his forearm, and hand a little. He then submitted to an examination by Dr. Leonard and Cherry as testified to by Dr. Leonard. They "removed the bandages; feel around his shoulder; move his arm and rotate it in every direction; take hold of his hands as they were hanging down by his side, and brought them straight out in front with the palms of the hands meeting, while the other "holds the shoulders as near square as possible." They do not yet discover the trouble They then "manipulated it and rotated it," and Dr. Leonard says, "examined to see if there was any downward dislocation and found the difficulty was not there." Then they rotated both arms while Leonard held his fingers on the coracoid process and says he "could feel a difference in the rotation under the coracoid process;" they then told the plaintiff there was a dislocation. Leonard says, "now the next thing is to reduce it." They then "pulled on the arm and manipulated and rotated the arm:" then another prolonged effort at pulling and then what? *Did* they know when the dislocation was *reduced?* *No!* But when they were through they "all agreed it was reduced." *Reductio ad absurdum* "fee $125 00."

The best works on surgery and anatomy; the majority of the most scientific, experienced and practical physicians and surgeons of this and other counties; men whose character for truth and veracity is unquestioned; gentlemen who value their professional reputation more than gold, all unite in stating, in terms most positive to the jury, that there is nothing, absolutly nothing in any part of the symptoms, facts or circumstances surrounding this case as detailed by these physicians, that indicate a subcoracoid dislocation. While every fact detailed by them goes to prove there was *not.* They also testify that the manner of diagnosing the case, as described by Dr. Leonard, is sufficient and conclusive proof that there was *no dislocation.* And I am glad, for the credit of the profession in this part of the country, to know that only one of this conclave testified positively that there was a dislocation. The mobility of the joint, as shown by plaintiff placing his arm across his breast, was enough to prove *no dislocation.* The very fact that the arm hung powerless by the side, could be manipulated and rotated, was another stuborn fact against dislocation, and an infalible diagnostic symptom that there could *not possibly* be a subcoracoid dislocation. Again, all testify that "there was a deformity, a drooping of the shoulder," and that "this deformity was removed and the rotundity of the shoulders restored by pressing upon the elbow." This was positive proof that the head of the humerus could not have been under the coracoid process, and all these signboards, pointing to anything else than a dislocation, with the cautionary language of Gross, and others, telling inexperienced surgeons (as these gentlemen swear they are, and that it was the first case of the kind they had ever seen or treated,) that they are liable to mistake fracture of the acromion process and contusion of the deltoid muscles for dislocation and resort to heroic treatment, when the most simple treatment is required.

But suppose we lay aside the books on surgery, and the testimony of all the experts, and come down, or up, if you please, to common sense. Such as the jury had a right to use when the demonstrations were made before them. Now, dislocation means a displaced joint. Subcoracoid dislocation means that the head of the humerus is removed from its socket and placed under the coracoid process. The head of the humerus, with its cartilaginous surroundings in plaintiff's shoulder, could not be less than one and one half inches in diameter; in its proper place in the glenoid cavity it completes the rounded form of the shoul-

der. Now take that humerus and move it to the front sufficient to clear it of the glenoid cavity, place it under the coracoid process and what did common sense and demonstration inform this jury? There will be a cavity under the acromion process, the process would be very prominent, the rotundity of the shoulder would be destroyed and a prominence in the new place occupied by the head of the humerus. Why was it if a dislocation existed, that such a deformity, as must necessarily result, was not the first thing noticed by Dr. Leonard when he diagnosed a subcoracoid dislocation, and why was this deformity not noticed and immediately pointed out by the conclave at Dr. Leonard's office. Plaintiff's sister, Mrs. Graham, testified that she "noticed a drooping of the shoulder as soon as she saw her brother after he was hurt, even before he got to the house," and "saw this deformity removed when Dr. Smith raised plaintiff's arm by placing his hand under the elbow." But all these wise men could not and *did not*, under far more favorable circumstances, discover a much greater deformity, that must absolutely have been visible, if there was a dislocation. Yes, three greater deformities. But these deformities were *not present* and we must conclude that the humerus was in its socket. Again it was clearly demonstrated to the jury that the glenoid cavity with its peculiar construction is the proper place for the head of the humerus to move in, and the ligaments, muscles and tendons are so nicely adjusted as to hold it there and assist the arm in performing its various motions and functions; that any other place would not answer as well. But Dr. Leonard testified that he "manipulated his arm and rotated it." "We pulled it backward and forward, upward and downward, outward and inward, but could not yet discover any dislocation." He also says, "his arms were hanging down by his side; I took hold of his shoulders and held them as near square as I could, while Dr. Cherry took hold of his hands, as they hung by his side raised them up, brought his hand straight out in front, with the palms of the hands meeting, to measure which arm was the longer." Now if these are true statements, the head of the humerus must have been in its proper place, and the muscles and ligaments performing their proper functions. The anatomical structure of the shoulder as shown to the jury and demonstrated by the experts, would of itself be sufficient evidence that no dislocation could possibly have existed in the plaintiff's shoulder. Even without any other authority on this subject. But the ex

perts *all* not only testify most emphatically and positively that it would be a physical impossibility for a dislocation to have existed, but they explain the anatomy of the parts and show to the jury plainly the reason why this motion of the arm could not be made if there was any kind of a dislocation. The law required the defendant to use such reasonable skill and dilligence as are ordinarily exercised in the profession by the members thereof as a body having regard to the improvements and advanced state of the profession at the time. Before the jury could find a verdict for the plaintiff it must be shown that the defendant failed to use and apply such skill and dilligence. We submit that in the very nature of the case, as well as upon the review of the evidence, no such failure was proven. They do not pretend to say that Dr. Smith failed to use such skill and dilligence on Sept. 5th, or at any subsequent time. *But nine physicians and surgeons from the body of the profession in this part of our State, gentleman of learning, experience, ability and character,* after listening carefully to the statements of both plaintiff and defendant, swear that with the symptoms as detailed they would never suspect dislocation of any kind, and had they been called to the case they would have treated it, most of them, exactly, all of them, substantially the same as did the defendant. They all further swear that defendant's diagnosis was correct and his treatment proper. Is the defendant required to use more skill and greater dilligence than the law imposes; the verdict of the jury, in the light of the evidence, requires it, and therefore it is contrary to law. If the jury decide that there was a dislocation existing on Sept. 5th, then their verdict requires of defendant more skill and greater dilligence than the law requires. If only a fracture of the acromion process existed then the defendant's diagnosis was correct and his treatment proper. The same evidence which proves a fracture also positively proves due skill and dilligence and proper treatment There can be no question as to this. The plaintiff demands judgement because he thought the defendant had negligently failed to diagnose and properly treat a dislocation.

What says the evidence: "I fell from my horse and struck "on the top of my shoulder; my arm hung prowerless by my "side." Nine surgical experts and also Dr. Leonard and Cherry tell the jury such a fall could not produce such a dislocation without breaking down the structure of the shoulder. The nine experts also testify that the arm would not hang by the side if

there was a dislocation, but would stand outward and backward, while Gross and other authors on surgery state that in a subcoracoid dislocation "the elbow stands out from the side more prominently in this than in any other dislocation; that the elbow cannot be brought to the side." "I caught hold of my fore-"arm with my other hand and brought it up across my breast "and held it there and walked to the house." (Indicating to the jury with elbow to the side with forearm up across his breast.) Nine experienced surgeons sustained by all the works on surgery say to the jury, "Plaintiff could not place his arm in that position and at the same time have the dislocation he claims; besides the anatomy of the joint demonstrated the impossibility of two such facts existing at the same time in the same person.

"The defendant moved my arm backward and forward as it "hung down by my side; took my shirt off left sleeve first and "let it drop down off my right; placed his hand under my el-"bow, raised my arm, and called attention to the fact that the "shoulders were now alike in appearance and no deformity; that "when he took away his hand from the elbow the shoulder "would again droop, and seem lower than the other shoulder "He then again pressed upon the elbow and the rotundity of "the shoulder was restored. The elbow was to the side; placed "the forearm across the breast, bandaged it in that position and "when the bandages were all on there was no difference in the "appearance of the shoulders, and no deformity; it remained "thus for three weeks, and caused me but little pain, except the "first 24 hours."

The best authors on surgery and the anatomy, and all nine of the experts deny the possibility of each of these statements being true and a *subcoracoid dislocation exist* at the same time. They all testify that if there was a dislocation as claimed the plaintiff could not have had his "arm hanging down by his side" nor near it. That his "shirt sleeve would not drop off naturally." That the deformity produced by a subcoracoid dislocation could *never* be removed and the "rotundity of the shoulder restored" even *apparently* in the way indicated, and the anatomy of the parts proves it as well as common sense. Certainly any one who examines the anatomy of the parts cannot fail to see that if the head of the humerus was placed under the coracoid process, that no support or upward pressure to the elbow, would correct that deformity. The pain produced by thus bandaging up a subcoracoid dislocation would be unbearable for one day, to

say nothing of three weeks. The plaintiff introduces a Mr. Wallace as a specimen to illustrate the similarity of cases. He testifies: "I could not bring my arm or elbow near my side" "could not bring my arm in front of me;" "I had to have a large bed pillow under my arm for a support, and had to carry it there for six months, and the least jar, without this support, would almost kill me." "I never could bring my elbow down to my side." Thus corroborating the testimony of authors and experts. We might refer to the speedy recovery of the plaintiff after the supposed reduction, which, if there was a dislocation, would be a positive contradiction to the testimony of authors and experts on that point. But we think sufficient has been shown above, that, taking the evidence introduced by the *plaintiff alone*, this verdict is contrary to that evidence.

We maintain that the evidence *conclusively, undoubtedly and positively* shows that there was no dislocation and if there was not, defendant is not liable, and the verdict is wrong,—contrary to the evidence. Being thus contrary to the evidence it is also contrary to the law as given by the court. If there was fracture of the acromion process, defendant is not liable, for he diagnosed that. If there was no fracture, as the plaintiff claimed and attempted to prove, the defendant could not be held; if there was a fracture, notwithstanding the disclaimer of the plaintiff, the same evidence by which fracture is proven, also establishes proper treatment. Plaintiff may claim that there was a discrepency in the testimony in regard to a certain bandage under the elbow, as to how far this bandage reached; but what says the evidence? The plaintiff in his examination in chief, says: "The Dr. put a bandage around here (indicating forearm and elbow) and over my opposite shoulder." He also testified that he "used his hand and forearm while the bandages were on back here. (Indicating elbow.)

It was only on his rebuting evidence he states the bandage was not under the elbow; while the defendant states the bandage was under the elbow, across the back and over the opposite should. Mr. C. Seevers testifies that this bandage was on three weeks after the injury; that it was under the elbow, and across the back and over the opposite shoulder; that he helped to take off this bandage, and helped Dr. Smith put it on again in the defendant's office. Again, this is corroborated by the evidence of Dr. Hutchinson and Dr. Cooper, to whom the plaintiff stated how his arm was dressed, and also the position it was placed in

Dr.Cooper testifies that plaintiff was in his office, that he had his elbow bound to the *antero lateral aspect* of the chest with the forearm across the breast pointing toward the opposite shoulder, and that plaintiff stated that this was the position Dr. Smith had placed it. This also corroborated the statement of defendant; there can be no question on this point.

All of those who are supposed to know, whom the court tells the jury are the proper ones to know, swear positively that from the statements of plaintiff himself, defendant's treatment was proper and in accordance with the best authorities on surgery; plaintiff's testimony nowhere controverts this fact.

We fail to see how the verdict can be sustained by the evidence, or can, in any view, harmonize with the instructions given by the court.

Our next objection is based upon the decision of our Supreme Court, in 5th Iowa, page 400, and we respectfully refer to the affidavits of seven of the jurors herewith presented. We suggest in addition thereto, the facts well known to this court, that the jury in this case retired to deliberate on Wednesday and delivered their verdict on the next Friday morning, and that when poled by defendant's counsel, several of the jurors answered, "under the circumstances." The affidavits refered to explain what those "circumstances" were.

It is only upon this ground and in the light of these "circumstances" that we can account for the verdict in this case, and explain why, in the view of the evidence, the verdict was for plaintiff. Manifest injustice would result to defendant if this verdict rendered for such reasons should be allowed to remain and judgement be by this court rendered thereon.

Our last objection is upon the ground that plaintiff tampered with the jury. That he was seen in conversation with one of the jurors, and that conversation was had about this case, during the progress of the trial, we have the affidavit of a fellow juryman, as to the criminality of the juror who permitted plaintiff to talk with him, and about this case, and his unblushing confession of it to a fellow juror and the still more reprehensible use of it in the jury room as a reason why judgement should go against defendant. We can only say he was not a fit juror to decide upon any case, much less a case involving reputation, since he values his own so lightly.

In behalf of justice and fair dealing, as well as in behalf of the defendant in this case, I have the honor to request of this

court a review of the evidence, as we have it here by the reporter for this court, fully convinced, that upon that review justice will point to a fair and impartial rehearing; that a future verdict may be in accordance with either law or the evidence; not contrary to both.

State of Iowa, } We, Alex Patterson, E. Kinkade, W.
County of Madison. } G. Lucas, P. McLaughlin, J. F. Armstrong, and Wm. Miller, being duly sworn on our oaths, state that were jurors in the case of Hugh Thompson *vs.* Dr. A. B. Smith, at the Nov. term, 1874, of the circuit court of Iowa, in and for Madison county. That we consented to a verdict against defendant upon the representation made by John I. Brown, foreman of said jury. That he, with two or three others of the jury while in consultation upon the verdict in our jury room, repeatedly stated and insisted that the testimony of the experts introduced by defendant had nothing to do with the case; that it was matters of opinion about which they testified and should not be taken into consideration. That in consequence of said repeated statements, these affiants, with several others of said jurors wrote a note to the Hon. Judge, of said court, asking in substance, if said position and statements was correct. That we placed in the hands of our bailiff, requesting him to hand the same to the said Judge, and return the answer to same. That said bailiff, W. O. Ludlow, Sheriff remained away from us about one hour or more, and returned stating that he had not given our note to the Judge that it would not amount to any thing if he did, and that the Judge would attend to us himself if we did not agree pretty soon. That we had been confined so long in the jury room that we were anxious to agree upon some terms, and it was represented to us that if we would consent to a small verdict, the defendant could get a new trial and we would be released.

We further state, that for the reasons above stated we are satisfied that great injustice was done the defendant by our verdict; and it was not the result of our free, unbiased judgement upon the evidence submitted to us, but was forced upon us by long continued confinement in the jury room, and the reasons above stated.

ALEX PATTERSON.
E. KINKADE.
WM. G. LUCAS.
J. F. ARMSTRONG.
PERRY MCLAUGHLIN.
WM. MILLER.

Sworn to, and subscribed before me, by each of the above named persons. Witness my hand and Notarial Seal, this 27th day of February, 1875.

{ SEAL }

T. C. GILPIN,
Notary Public.

I, James M. Rhodes, being duly sworn, do say that I was one of the jurors in the case of Thompson *vs.* Smith, at the Nov. term, 1874, circuit court, Madison county, Iowa, and that while in the jury room consulting on said case, it was claimed by John I. Brown, foreman of the jury, that the evidence given by the experts in said case should not be consided by them, as their evidence was only matter of opinion. That I wrote a note to the Judge, by the advice and counsel of others of the jury, asking for advice on this subject; gave said note to the Sheriff to deliver to the Judge; but we received no answer. We also then wrote a note, and sent it the Judge by the Sheriff, asking to be discharged as we could not agree, and from this we received no answer, but after a long time the Sheriff, W. O. Ludlow, returned and when asked about said note, stated that he had not given it to the Judge, but that we had better agree on a verdict, or the judge would attend to us himself. And after being kept out an unreasonable length of time, as we thought, and one of our number being sick, we felt that we were compelled to consent to some kind of a verdict in order to get released from the jury room. And I hereby testify that the verdict, as signed by us, was not, and is not, the verdict of our unbiased opinions. But from the law and evidence in said case, it was, and is our opinion that the defendant should have a verdict in this case.

J. M. RHODES.

Subscrided, and sworn to, before me, this 1st day of March A. D., 1875. J. W. BOGARDIS, J. P.

We also have the affidavits of several of the jurors, that if the verdict was against the plaintiff it would break him up; that they regarded him as an object of pity, and that the defendant was well off and it would not hurt him; that this was used in the jury room as a reason for giving the plaintiff a verdict.

Can any person of ordinary intelligence conceive of any construction that can be put upon the evidence that could give the plaintiff a verdict. The case is so plain that a wayfairing man, though a fool could not *err* therein.

EVIDENCE

IN THE CASE OF

THOMPSON *VS* SMITH,

NOVEMBER TERM, 1874,

Reported by R. J. Hammond.

Hugh Thompson sworn:—Testified on the part of the plaintiff as follows:

Q. Are you the plaintiff in this case?

A. I am.

Q. Where do you live.

A. In Jackson township, Madison county.

Q. How long have you lived there?

A. Some six years.

Q. What is your age?

A. I am twenty-seven years old

Q. You may state whether or not you received any injury about the fifth of last September, and if you did state where it was.

A. On the morning of the fifth of September last I went out on a horse to drive up a heifer.

Q. State to the jury how and where you were hurt.

A. I was hurt on my right shoulder.

Q. Well, state to the jury whether you sent for Dr. Smith, or any body else, and whether Dr. Smith came.

A. I sent to town for Dr. Leonard and Dr. Smith came.

Q. Now, I will ask you to state to the jury as near as you can what you said to Dr. Smith when he first came.

A. I had never seen him before. and asked him if he was the doctor, and he said he was.

Q. Well, go on and state what else you said and what was done.

A. He asked me what was the matter with me, and I told him I was riding after, a heifer and in making a short turn my horse fell and threw me off, and I struck on my shoulder; my horse was going about as fast as he could go when he fell. My shoulder was all sore, and I could not raise my arm up at all.

Q. Well, what was done ?

A. In the first place I was lying on the lounge, he had it moved out in the floor so he could get at my right side. They lifted me up and I sat upon the lounge with my arm down by my side in this position. (Indicating arm down at his side.) He then unbottened my shirt-wristband and then opened my shirt and cut it down a little in front in order to get it off easy; he took it off my left arm and dropped it down off of the other arm very gently. Then he moved my arm backward and forward. Then he commenced feeling along my shoulder, all the way out from here (the neck) to the point of the shoulder. When he got about here, (the point of the shoulder) he said, the cap of your shoulder is broken. Then I asked him if the shoulder had a cap like the knee. He said no, it was a bone that came up over the shoulder joint, which served as a covering for the joint and as a seat for the muscles of the shoulder. He then pressed upon my elbow and stepped around in front and asked Mr. Graham if he didn't think that shoulder looked like the other. He then called for bandages.

Q. Well, go on and tell what he did.

A. In the first place, he put a pad under my arm close up and a bandage under it to hold it up. He then put another bandage around my shoulders in the shape of a figure eight. I believe he called it a figure eight bandage, another around my shoulder and under here. (indicating elbow) he then put one around my arm and body and a sling to put my hand in.

Q. Is there anything else that the doctor said at the time, that you remember of ?

A. He told me to come up to his office, and I asked him where his office was, and he told me it was on the South side of the square, in Winterset. I asked him how long it would be before I could use my arm, and he said about one month.

Q. Is that about all the doctor said to you ?

A. I don't recollect anything farther.

Q. You say the doctor moved your arm.

A. Yes, sir.

Q. Please explain to the jury how he did it.

A. This way, (moving his arm backward and forward).

Q. Did he raise your arm out from your body in this way ?

A. No sir.

Q. I will ask you to state whether or not you fell down or was struck in any way to injure your shoulder from the time Doctor Smith treated you up to the time it was examined by Doctor Leonard.

A. I did not hurt it to any great extent. If I made any mis-step and jared my shoulder, it would cause pain, but I never fell down or done anything that would cause any serious injury to it.

Q. Can you perform any of your ordinary business as well as you could before ?

A. I can drive my team as well as I did before.

Q. I will ask you to state who were present at the time Doctor Smith fixed up your shoulder.

A. Samuel Graham and his wife and my wife.

Q. Tell the jury what expense you have been to in procuring the reduction of that dislocation.

A. Well, I have not paid them yet but they said it would be about one hundred dollars.

Q. I will ask you to state in regard to the pain at the time Doctor Smith fixed up your shoulder, and afterwards.

A. When he came there I was suffering, and it continued about twenty-four hours after it was hurt, and then it got easier. I did not sleep much the first night, but the next night I rested better.

Q. State when it was reduced ?

A. On the 7th day of October.

Q. Where was that done?

A. In Doctor Leonard's office.

Q. How long had you to carry your arm in a sling after this dislocation was reduced.

A. It was about two weeks.

Q. Have you had any medical treatment for your shoulder since, and if so who gave it to you?

A. Doctor Leonard has been treating it ever since.

CROSS EXAMINATION.

Q. You received your injury about the 5th of September?

A. Yes sir.

Q. You received it by falling from your horse while riding after a heifer ?

A. Yes sir, my horse fell and pitched me off.

Q. Explain to the jury how your horse fell?

A. He fell on his side.

Q. Was there any obstruction in the way, did he stumble?

A No sir, he slipped and fell.

Q. How did you strike the ground?

A. Very hard.

Q. Did you hit on your face or head?

A. I thought my head and shoulder both struck, from the fact that my head was dizzy but I could not say how I hit.

Q. Where did you feel hurt the most when you got up?

A. My shoulder hurt me the most.

Q. Where did your shoulder hurt most ?

A. It pained me all over; do not know where it hurt me most.

Q. Did you take off your coat to examine your shoulder at that time.

A. No sir.

Q. What was the next thing you did ?

A. My father came out and led my horse home and I walked home.

Q. How far was that from home ?

A. I went to my father's house; it was about forty rods.

Q. Walked along home?

A. Yes sir.

Q. Did you notice any difference in your shoulders?

A. Yes sir.

Q. Well, how did it feel?

A. My arm was helpless and I could not raise it up.

Q. Was there any pain anywhere except in your shoulder ?

A. No sir, I think not.

Q. Did you try to raise your arm up from your side before you got home ?

A. No sir, I just took my other hand and caught my arm about this way (indicating left hand about middle of forearm and brought it up across his breast) and held it tightly until I got home.

Q. You brought your forearm forward across your breast and held it there tightly with your other hand while you walked.

A. Yes sir, I did.

Q. Did you feel any numbness in your arm, in your hand or fingers?

A. No sir, I could use my fingers.

Q. How long was it after you got up that you took hold of your arm in the way you have described. Did you take hold of it right away?

A. No sir, I let it hang for a little while, until my head felt better, and until I had strengthened up a little.

Q. Then, after you had strengthened up a little you took hold of your arm in the way you have described, and walked home?

A. Yes sir.

Q. Did any one examine your arm before the doctor came?

A. Yes sir, the folks opened my shirt and looked at it.

Q. Were you lying down at the time?

A. No sir, I was sitting on a chair.

Q. When they were examining your shoulder, was your arm hanging down by your side?

A. Yes sir, unless it was on my lap.

Q. Did they discover any marks or bruises about the shoulder?

A. Yes sir, they thought there was something wrong with my shoulder.

Q. How do you think your shoulder struck the ground when you fell?

A. I think I struck about here, (point of the shoulder.)

Q. How were you sitting when the doctor came?

A. I was not sitting, I was lying on the lounge.

Q. You asked him when he came, if he was the doctor?

A. Yes sir.

Q. He said he was, and commenced to examine your shoulder?

A. Yes sir. In the first place he pulled the lounge out in the middle of the floor, and then he examined it.

Q. Do you know where he took hold of your arm?

A. Yes sir, I think he took hold of it about here, (between the wrist and elbow.)

Q. Were you still lying down on the lounge?

A. No sir, they had lifted me up.

Q. Explain to the jury how he took of your shirt, which sleeve he unbuttoned first.

A. This one (the left).

Q. After he let go of your injured arm, did it hang down by your side?

A. I don't recollect, but think it was.

Q. Which sleeve did he take off first?

A. The left one.

Q. Did they tear the shirt to get it off?

A. Yes sir, they tore it down in front, and then took off the left sleeve first.

Q. And lif ted the shirt up?

A. No sir, they took my left arm out and dropped the shirt and the other sleeve dropped off. (right sleeve)

Q. They took the left arm out and that let the shirt drop down?

A. Yes sir.

Q. Well, then what did he do?

A. He then moved my arm this way. (backward and forward).

Q. Then he commenced examining your shoulder?

A. Yes sir.

Q. How did he do that.

A. He felt along my shoulder until he came out about here, (point of shoulder) and then he told me that the cap of my shoulder was broken or knocked down, I am not sure which he said.

Q. Your arm was hanging down naturally by your side, and the doctor just moved it backward and forward.

A. Yes sir.

Q. And then commenced to exame your shoulder.

A. Yes sir.

Q. Then he called for bandages?

A. Yes sir, and after he had put on part of the bandages, he took my arm this way, (with hand upon the elbow) and lifted it up and pressed it up in this way, (indicating) and then, while he held it in this position, he asked Mr. Graham if he didn't think that shoulder looked like the other.

Q. You do rccollect of him raising your arm in that way, and then asking Mr. Graham if he could see any difference between the shoulders?

A. Yes sir.

Q. Show the jury the position of your arm after the bandages were all put on and your arm in the sling.

A (Witness explains) by placing forearm across the breast.

Q. Did you remove or change any of the bandages?

A. I think they were taken off to bathe the shoulder, but put right on again. I could not say whether they took them off, or just pulled them up off my shoulder so as to bathe it with linament.

Q. How long was it after this treatment before you saw the doctor?

A. About three weeks.

Q. Now state whether you were not, during this time, going about your ordinary work and doing chores?

A. O, I tried to do little things, such as carrying in wood, I could work my hand and fingers in this way (indicating by moving forearm and hand).

Q. Did you drive your team to town during that time?

A. I was in town twice with wheat, in that time, but think some one was with me.

Q. You say you never hurt your shoulder during those four weeks, except by some mis-step, that would cause pain?

A. That was all.

Q. I will ask you if you are acquainted with I. S. Ford.

A. Yes sir.

Q. Do you recollect of meeting him on the road west of town, before the time you had your shoulder treated by Dr. Leonard?

A. I have met Mr. Ford several times?

Q. Did you meet him a short time before you had your shoulder reduced as you say, and didn't you tell him that your shoulder was getting along as well as could be expected. That you had commenced using it too soon, and had hurt it. Did you not state that to him in substance?

A. I dont recollect,

Q. You state that as a fact do you, that you never hurt your arm except by taking a mis-step.

A. Well, I recollect now, one time I stumbled and came pretty near falling and I naturally threw my arm out from me to catch me, and it hurt me considerable.

Q. You say you used your arm some in gathering corn?

A. Yes, a little, you see the sling was around my arm here, (indicating forearm and elbow,) and I could work my hand and fingers.

Q. I will ask you to tell the jury how long it was after your

arm was reduced, as you call it, before you went without any support or sling?

A. Probably two weeks.

Q. Did you ever complain to Dr. Smith, of his treatment?

A. No sir.

Q. Did you not tell Dr. Smith that your arm was doing as well as could be expected?

A. I think he told me that.

Q. Who was in the office with Dr. Smith when he examined your shoulder?

A. A young man that was studying medicine, I did not know his name.

Q. Did he assist Dr. Smith in puting on your bandages?

A. I believe he did part of them.

Q. Did you say that your arm was getting along as well as you could expect?

A. I think I did. [*excused*

Plaintiff introduces Mr. Wallace, who had received a dislocation of the shoulder:

Q. When did you receive that hurt?

A. About four years ago.

Q. Tell the jury all the movements you could make with you arm.

A. I could not move it in any shape, My arm stood out from me, and I had to carry a large bed pillow under my arm and a bandage around it over my other shoulder to hold the pillow up. I carried it in that way for six months, with that large bed pillow under it. The least jar would almost kill me, I could never let my elbow come down to my side, I had to keep a big support under it all the time.

CROSS EXAMINATION.

Q. You received this injury about four years ago.

A. Yes sir.

Q. You say you could not use your arm?

A. I could not use it any at all, only as I would move it with my other hand.

Q. You say you could not put your hand down by your side?

A. No sir, I cannot get my arm down to my side to this

day, but can get it down better than I could, but it gives me great pain when I try to force it down. [*excused.*

W. A. Graham, sworn:—Testified in behalf of the plaintiff as follows :

Q. Were you present when Dr. Smith was called to attend Mr. Thompson?

A. Yes sir.

Q. State as near as you can all that was said and done?

A. When Dr. Smith came in he pulled the lounge that Mr. Thompson was on out in the floor from the wall, so that he could get behind him, then he took his shirt off. Then he took hold of his shoulder and arm, and worked his shoulder and said, as I understood it that the cap of his shoulder was broken, then he got some muslin and bandaged it up. My wife was helping the Doctor, I did not watch how they fixed it. I saw the Doctor moving the arm backward and forward and then he took hold of the arm at the elbow and pressed the shoulder up in this way. (pressing up on elbow.) The Doctor called my attention to the difference in the shoulders. He would then press the arm up and hold it there while he would step around and compare them. He asked me if there was any difference. I told him I could see no difference when he would press the arm up. When the bandages were on I could see no difference in the shoulders, they looked alike. The shoulders were both bare. Mr. Thompson ate dinner with us; his arm was hanging down by his side or lying in his lap. When he got through his dinner, I helped him to the lounge; he had hold of his right arm with his left hand about here, (indicating forearm) and carried it across his breast, or in front of him. Dont remember how he had his arm after that. [*excused.*

Mrs. A. Graham sworn :—Testified on the part of the plaintiff as follows :

I am a sister of the plaintiff. I was in the room when Dr. Smith examined my brother's arm. I heard the Doctor say the cap of his shoulder was broken. He asked me for something to make bandages; he then put the bandages on and said he would be well in about four weeks.

On cross examination she said :

When I first saw my brother after he was hurt, he was walking towards the house, and I went out to meet him; he

was holding his arm with his left hand. When I was going to meet him I could see that one of his shoulders was drooping, it seemed lower than the other one. After dinner my husband helped him on to the lounge, he had hold of his arm in the same way when he went to lie down. And I think he held his arm that way most of the time. I think he kept his arm lying on his lap when he ate his dinner. I heard the doctor ask my husband if the shoulders looked alike. I looked at it when he was pressing it up in that way, and it seemed to be all right, it looked even with the other shoulder. Both shoulders were bare, When the doctor was putting on the bandages, he would press up on his arm, and then he would step back and examine the shoulders. I noticed him looking both from the front and behind, and then he asked Mr. Graham if they looked alike.

[*excused.*

Dr. T. Sworn:—Testified on the part of plaintiff as follows:

Q. You are a practicing physician of this place?

A. Yes sir.

Q. You have seen the plaintiff, Mr. Thompson?

A. Yes sir.

Q. I will ask you if you saw him the 7th of October last?

A. I dont recollect just what time it was, but I saw him in Dr. Leonard's office.

Q. State if you made an examination of Mr. Thompson and what you found.

A. Yes sir, when I went in he was sitting with the upper part of his shoulders bare, and he had as near as I could make out a partial dislocation of the shoulder.

Q. You may state whether the dislocation was reduced at that time.

A. We thought we reduced it. I assisted in manipulating the limb in reducing the dislocation.

Q. Please explain to the jury how you reduced the dislocation?

A. (Here the witness takes what is termed the humerus and the scapula and explains by placing the head of the humerus on the edge of the glenoid cavity, and says): This is about the position of the humerus in a partial or a subcaracoid dislocation.*

*Incorrect.

Q. Doctor, how many kinds of dislocations are there?

A. There are four dislocations of the humerus: Backward, downward inward and forward. Some authors call this a partial dislocation, the head of the humerus is thrown out of the socket and rests on the edge of the Glenoid cavity.*

Q. At the time you examined the plaintiff's shoulder did you make any examination of the acromiom process.

A. Not especially.

Q. Did you discover any indications of a recent fracture?

A. No sir, we did not.

CROSS EXAMINATION.

Q. Did you ever have any dislocations of this kind in your practice?

A. Not until this one.

Q. Have you had any experience in dislocations of this kind?

A. *This is the first case of the kind I ever saw.*

Q. Where did you see the plaintiff on the day you say this dislocation was reduced?

A. In Dr. Leonard's office.

Q. Did you notice anything in the appearance of his arm or shoulder?

A. I thought it *drooped* a little.

Q. You thought you could see that his shoulder drooped a little?

A. Yes sir.

Q. Did you make an examination of his shoulder yourself?

A. Yes sir, I manipulated the joint in the usual way.

Q. Please take this scapula and humerus and show to the jury the position of the head of the humerus with relation to the caracoid process in a subcaracoid dislocation?

A. (Witness takes the humerus and scapula and explains by placing the head of humerus on the front edge of the glenoid cavity) and says: This is about the position of the head of the humerus in a subcaracoid dislocation.*

Q. That would be your idea of the true position of the humerous in a subcaracoid dislocation?

A. Yes sir, with the head of the humerus overhanging the glenoid cavity.*

*Incorrect.

Q. I will ask you if in a subcaracoid dislocation the elbow can be brought down to the side?

A. I think it can in some subjects, in the plaintiff's, his arm was considerably forward, his forearm was resting in the sling or on his lap.

Q. Where are the spinatus muscles attached?

A. To the spine of the scapula here.*

Q. Now when the head of the humerus is thrown out of its socket on the edge of the cavity here would not these muscles draw it back again into its socket.

A. It would be held by the subscapularis muscles.*

Q. Where is the subscapularis muscle attached?

A. To the *great tuberosity* of the humerus*.

Q. What is the origin of the subscapularis muscle.

A. The spinnous process here (indicating).*

Q. The origin of the subscapularis muscle then is the spinous process of the scapula?

A. Yes sir.*

Q. Where is its insertion.

A. Into the *great tuberosity* of the humerus.

Q. What is the origin of the supra spinatus muscle?

A. *Spinous process* of the *scapula.**

Q. Where is its insertion?

A. In the *great tuberosity.*

Q. What is the origin of the Infr. Spinatus muscle?

A. Spine of the scapula.*

Q. Where is it inserted.

A. Into the *great tuberosity* of the humerus, and blends with the glenoid ligaments.*

Q. You are sure that it blends with the glenoid ligament?

A. Yes sir.

Q. All these four muscles you have mentioned unite or blend with the glenoid ligaments.

A. Yes sir.*

Q. Now, what is the origin of the teres minor?

A. I don't recollect.

Q. Do you know its insertion?

A. It is inserted into the lesser tuberosity of the humerus.*

Q. All of these muscles you have mentioned have their

*Incorrect.

origin in the scapula and are attached to the *great tuberosity* of the humerus?

A. Yes sir.*

Q. Are there any more muscles that have their origin in the scapula and are attached to the *great tuberosity* of the humerus?

A. Not that I know of in particular.

Q. Are there any other, whether particular or not?

A. Well, I dont know as there are.

Q. Now, will you please give me the origin and insertion of the teres minor muscle?

A. It rises from the clavical and ribs, and is inserted into the tuberosity of the humerus.*

Q. What are the attachments of the trapezins muscle?

A. I dont know, but it has nothing to do with the shoulder.*

Q. What is the origin of the latissimus dorsi muscles?

A. It arises from the anterior of the chest and is inserted into the *great tuberosity* of the humerus.*

Q. Explain if you please the attachments of the glenoid ligament of which you say these muscles form a part?

A. It is attached to the glenoid cavity *

Q. Where is its origin?

A. In the *glenoid cavity.**

Q. Its origin and attachments both in the *glenoid cavity?*

A. Yes sir.*

Q. The glenoid ligament then, if I understand you arises in the *glenoid cavity?*

A. Yes sir.

Q. And is attached where?

A. To the anatomical neck of the humerus.*

Q. Would the glenoid ligament be ruptured in a subcoracoid luxation?

A. Yes sir, it is the only one that would be torn away.*

Q. Now you say these muscles unite with the glenoid ligament. Would they be ruptured when the ligament itself is ruptured in a subcoracoid luxation?

A. They would be very apt to be.*

Q. Is there any other ligament that is ruptured in this kind of a dislocation?

*Incorrect.

A. Not necessarily any other. There is the caracoid and pectoralis that might be, but of course that would depend upon the amount of force.*

Q. How many classes of articulations are there in the human body?

A. I do not recollect now. It has been a good while since I read anatomy minutely.

Q. Do you know to what class of articulations the shoulder belongs?

A. I dont know that I recollect.

Q. Please state how many of those muscles you have named are attached to the great tuberosity of the humerus?

A. I dont intend to give a lecture here on anatomy for your benefit.

The plaintiff's council objected to the further cross examination of witness.

(The court intimated that the examination had been pressed sufficiently.)

The defence are compelled to rely upon scientific demonstrations to prove our position, and we expect to prove to this court that these physicians who claimed that a dislocation existed, are incompetent to diagnose a dislocation. And sir, we expect to prove to this court that from the statements of the plaintiff himself, as testified to by him, that it would be *impossible* for a dislocation of the shoulder to *exist*. The defence claim the right to test the knowledge of the witness in the presence of these experts, who are here for the purpose of forming opinions from the facts stated. And the defence propose to show by a scientific demonstration of the anatomical structure of the shoulder, that *no dislocation did exist*. And also that the physician or surgeon who would tesify that a subcoracoid luxation *could exist* with the elbow to the side, forearm across the breast and the syptoms as testified to by the plaintiff, knows nothing of the anatomy of the shoulder, or the diagnastic symptoms of that luxation. We therefore claim that the defendant has a right to examine into the extent of the witnesses knowledge of the anatomy of the shoulder and thereby test his competency to diagnose a dislocation.

Court. Be as brief as possible.

*Incorrect.

Q. What do you mean by a partial dislocation?

A. What anybody else would mean by saying the same thing when the head of the humerus was partially out of the glenoid cavity.

Q. Then you say this was a partial dislocation, is that what you call it?

A. You can call it what you please. Some call it partial. No man living could tell whether this bone was clear past the glenoid cavity or not, without dissecting the shoulder.*

Q. Your idea is that the head of the humerus was only partially out of the glenoid cavity in this case.

A. I would think that a portion of the head of the humerus overhung the glenoid cavity.

Q. Doctor, what nerves are involved in this dislocation?

A. There are no nerves involved.*

[*excused.*

Dr. Leonard:—sworn:

Q. You are a practicing physician and surgeon?

A. Yes sir.

Q. How long have you known the plaintiff?

A. About four years, have been his family physician.

Q. I will ask you to state if your attention was called to his trouble with his shoulder at any time?

A. Yes sir. I met him and he asked me to look at his shoulder. I told him I would not do it alone, but would do it in the presence of another physician. The next day Dr. Cherry and I were in his neighborhood at Mr. Ford's, we found him there, and proceeded to make the examination. After taking off his shirt and the figure eight bandage, and making both shoulders bare, Dr. Cherry and I proceeded to examine his arm. The first thing I did, as I remember it now, I stood behind him and took him firmly by the shoulder, in this way, (indicating by taking hold of both shoulders) and Dr. Cherry took hold of his hands as they were *hanging down by his side* and raised them up in about this position, (arms extended and hands pointing in front of the body with palms of hands meeting) and brought his hands together, while I held his shoulders as near square as possible. *And upon comparing the*

*Incorrect.

length of the two hands. I found the right one about one inch further out than the other. I then took hold of his arm and rotated it and *manipulated* to see if there was any *downward dislocation*, and also the *acromion process* and was satisfied the trouble was not there. Then Dr. Cherry took hold of the arm and rotated it while I held my hand upon the coracoid process and I made the remark that I believed there was a forward dislocation.

I then took hold of each shoulder and held it firmly, my fingers resting on the coracoid process, while Dr. Cherry *rotated* the arms and I could notice a difference in the rotation of the bone between one shoulder and the other We told Mr. Thompson that there was a dislocation of the shoulder, and if he would come in the next day to my office we would administer chloraform and reduce it And the next day about eleven o'clock, Mr. Thompson came in. Within that time I had seen Dr. Davisson and told him to come to my office. I also saw Dr. Tidrick and Dr. Anderson and asked them to come over. When Mr. Thompson came they were all there. Dr. Sloan who offices with me was also there. And my impression I got then was that they all agreed that there was a dislocation. The next thing was to reduce it. Dr. Cherry administered ether, and we applied what is called *jarvis adjuster*. And when we got through we all agreed that it was reduced. My fee for reducing would be about *one hundred dollars.*

CROSS EXAMINED.

Q. When you examined the plaintiff's shoulder, could you feel the head of the humerus under the coracoid process?

A. Yes sir, part of it one side of the coracoid process and part on the other side of the coracoid process, but immediately underneath it.*

Q. Did the head of the humerus overhang any part of the glenoid cavity.

A. My impression now is that it did not, but when the bone strikes the coracoid process here, there would not be room for it to pass away from the edge of the cavity in this kind of a dislocation.*

Q. The head of the humerus then would strike against the

*Incorrect.

coracoid process and not pass entirely from the cavity?

A. Yes sir.*

Q. The head of the humerus would not be under the coracoid process then?

A. Not entirely so.*

Q. You say the arm may be brought to the side in this luxation?

A. Yes sir.*

Q. Doctor, are there any places in the glenoid ligament that are weaker than others.

A. It is possible there may be but I am not prepared to answer that question diffinitely.

Q. Where is the glenoid ligament attached?

A. To the neck of the humerus.*

Q. What is its origin?

A. I am not prepared to give the minute anatomy of it now?

Q. Would the glenoid ligament be ruptured in this dislocation.

A. I dont know whether it would be ruptured or not.

Q. Did you ever treat a case of this kind prior to this?

A. No sir.

Q. This is the first you ever saw?

A. I saw one before.

[*excused.*

Dr. Sloan Sworn:—testified as follows:

I made an examination of his shoulder and do not know whether there was a dislocation or not.

[*excused.*

Dr. Cherry sworn:—

Q. Did you make an examination of plaintiff's shoulder?

A. I did with Dr. Leonard, who was with me at the time.

Q. Were you present at the time it was reduced in Dr. Leonards office?

A. I was.

Q. Did you examine his shoulder then?

A. No sir, I dont think I did, I administered the chloraform, but did not assist in the reduction any farther than that.

[*excused.*

*Incorrect.

Mr. McCaughan sworn:—Testified as follows:

I met Dr. Smith on the road after he had been out to dress Mr. Thompson's shoulder. He said Mr. Thompson had broken the small bone or process on the point of the shoulder. He said it would be five or six weeks before he could use it.

[*excused.*

DEFENDANT'S EVIDENCE.

Dr. A. B. Smith—defendant—sworn:

Q. You are the defendant in this case?

A. I am.

Q. You may state about being called to attend the case of Mr. Thompson, and if so, when?

A. I was called there on the 5th of September.

Q. Now go on and tell the jury just how you found the patient.

A. I found Mr. Thompson lying on the lounge, was in his shirt sleeves. The injured arm was lying across his breast and was holding it with the left hand. And if Mr. Thompson will take this chair I will explain about the position his arm was in. Explains (with forearm across the breast) I took hold of his shoulder with one hand and took hold of his arm with the other hand and rotated it in this manner. (indicating) I then had him get up and sit on the edge of the lounge, and then took off his shirt. I took the left sleeve off first, and then let it drop down over this one (the right) as his arm was down by the side in this position. I then manipulated the arm satisfied myself that the head of the humerus was in the socket. I then stood around in front of him, letting his arms hang down, and I could discover that his right shoulder drooped a little; the shirt was off both shoulders. I then took hold of his elbow and pressed it up in this manner, and then stepped in front of him again, and could see no drooping of the shoulder, and while I pressed it up and held it in this position, there was no deformity, both shoulders looked alike. I called Mr. Graham's attention to it, and asked him if he could see any difference in the shoulders. The lady of the house, Mrs. Graham, also looked at it, and they said they could see no difference. Then when I took my hand away from the elbow the shoulder would again droop as before. After I took off his shirt and in examing the shoulder, I *found an abrasion of the skin along the spine of the scapula,*

and acromion process to the point of the shoulder here. I examined the shoulder carefully and rotated the humerus and found it in its socket, and finding the drooping of the shoulder and the shoulder resuming its proper appearance when I would take hold of the elbow and press it up, I was satisfied that the acromion process was fractured, and that produced the drooping by the action of the deltoid muscle. The acromion process being one of its points of attachment. And I will just say here that a dislocation of the humerus will not produce that drooping. But there will be a prominence of the acromion process and a depression under it at this point. (Indicating) Neither will the *deformity* of a *dislocation* be corrected by pressing up on the elbow, as it was in this case.

Q. It was on account of those symptoms that you proceeded to treat him in the way you did?

A. Yes sir, after a careful examination I was fully satisfied that there was no dislocation of any kind; but from the symptoms, the drooping of the shoulder, the position in which he held his arm, and the manner in which he received the injury, *all* indicated very clearly that there was a *fracture* of *the acromion process.*

Q. Go on and state your treatment.

A. Owing to the conformation of this man with his broad shoulders and spare muscles, consequently a large axillary space. I put a small axillary pad under his arm about the size of this one. (Exhibiting the pad and placing it under the arm with the elbow to the side and forearm across the breast) This is the position in which his arm was treated. I put a bandage around his shoulder to hold up the pad. I then put on a figure eight (8) bandage to brace up his shoulders. We have authority for that in *Gross on Surgery.* Then I put a bandage around under his elbow and across the opposite shoulder, and one around his arm and body, and pressing the arm up from the elbow so as to press together the two points of the acromion process. I also put a sling around his neck to carry his hand in.

Q. What was said as to any pain?

A. I asked him particularly about that and whether there was any numbness in his arm or hand, and he said his pain was all on the back of the shoulder and along on the point of the shoulder. There was no sign of any bruise or any injury only along on the spine of the scapula near the point of the shoulder.

Q. Did he complain of any injury about the elbow?

A. He did not.

Q. Did you give him any instructions about using his arm?

A. I told him he could not use his arm for some time, that he must keep it still, so that the fracture could unite. About three weeks after this he came in and said he had been using his arm more than he ought to. I asked him how it was doing, and he said it was getting along as well as could be expected. I then examined his shoulder and found it doing well. The shoulders seemed to be the same. He came in with a load of wheat at that time, and in a few days he came in again, and was in my office. Mr. Seevers, a young man that was studying medicine with me was there. We took off the bandages, and examined his shoul der, and found it doing well. We put on the bandages again the same as before. Mr. Seevers helped me to put on the bandages.

Q. State if at either of these times he complained of any pain?

A. He did not.

Q. What did you charge him?

A. Eight dollars.

Q. Tell the jury what the diagnastic symptoms of a subcoracoid luxation are?

A. When there is a subcoracoid dislocation of the humerus the elbow is always carried out from the body and backward in this position. (indicating) The elbow must be thrown out from the body far enough to allow the head of the humerus to pass under the coracoid process.

Q. Explain why that must be the position of the humerus in a subcoracoid luxation.

A. (Taking the scapula and humerus.) This is the scapula, and this cavity you see here is what we call the glenoid cavity. And this, the head of the humerus fits in the glenoid cavity in this position. (indicating.) This represents its natural or nor malposition. And this is the position in a subcoracoid luxation with the head of the humerus lying under the coracoid process, here (indicating.) We have in the first place the glenoid ligament which surrounds this cavity and merely deepens it and is not attached to the neck of the humerus as Dr. Leonard told you yesterdy in his testimony, neithor is it attached to the *great tuberosity* as Dr. Tidrick stated, but it is not attached to

either. It has no attachments but only surrounds the glenoid cavity, and deepens it. Then around that is the capsular ligament which entirely surrounds the cavity and is attached to this depression here, we call the anatomical neck of the humerus. Then we have the coraco humeral ligament that connects the coracoid process to the great tuberosity here at this point. These are the three principal ligaments of the shoulder joint. The muscles immediately surrounding the joint are important in the motions of the joint and in keeping it in its proper place, and are also involved in the dislocation of the humerus. We have here the subscapularis muscle, which arises from the underside of the scapula here, and is inserted into the lesser tuberosity of the humerus. Then we have three important muscles. The supra spinatus which arises in the supra spinous fossa here above the spine of the scapula. And the infra spinatus muscle arising from the infra spinous fossa below the spine of the scapula. And the teres minor muscle which arises from the inferior border of the scapula. And these three muscles are attached to these three facets or depressions you see here on the great tuberosity of the humerus.

Now these three muscles with their tendons are in immediate contact with the shoulder joint, and with the subscapularis muscle which I have just described, forms the ligamentous capsule and thus preserves the solidity of the articulation. They are the structures that are most generally ruptured in the dislocation of the head of the humerus. These three muscles in a subcoracoid dislocation would be put upon the stretch. You can all see how that would be, when the head of this bone is thrown under the coracoid process these muscles would be drawn tightly across the glenoid cavity. All having a tendency to draw the arm out from the body and backward. Then we have the deltoid muscle which is a large muscle on the top of the shoulder and arises from the spine of the scapula and acromion process and outer third of the clavicle and overarches the whole of the glenoid cavity, it is a large fleshy muscle of a triangular shape, with its base upwards and converges to near the middle of the humerus and is attached to this rough triangular elevation you see here, and is the muscle with which we raise our arm up in this position. (indicating) And in a subcaracoid dislocation the action of this muscle is to draw the arm out from the body, you cannot get the arm in any other position.

Q. What is it then that holds the humerus and the head of the humerus in a subcoracoid dislocation?

A. It is the action of these muscles that draws the arm out from the body and backward and the humerus is wedged under the coracoid process in this position. (indicating.)

Q. What then do you say are the diagnostic symptoms of a subcoracoid luxation?

A. The arm is thrown out from the body and backward in this position and it can not be got down to the side without causing great pain, the pressure of the head of the humerus upon the brachial plexus of nerves produces this extreme pain.

Q. Now I will ask you if you found any diagnostic symptoms of a subcoracoid dislocation or any other kind of a luxation in the plaintiff at the time you called to treat him?

A. No sir, there was no symptoms of a dislocation of any kind.

Q. Was there any disposition of the arm to remain out from the body?

A. None at all.

Q. Was the mobility of the joint complete or perfect at the time you were called to treat it?

A. Yes sir, it was.

Q. Was there any difficulty in bringing the arm to the side?

A. None at all, he had his arm close to his side when I first saw him.

Q. Did he complain of any numbness in his arm or hand?

A. No sir.

Q. State whether numbness in the arm or hand is not invariably present in a subcoracoid luxation?

A. Yes sir, it generally is.

Q. You are positive that subcoracoid luxation did not exist?

A. I know it did not. It could not possibly exist with the arm in the position in which I found it. It would be an impossibility if he is made like other men, and I think he is.

Q. If there was a dislocation it was after you examined the shoulder?

A. Yes sir, there was no symptoms of dislocation when I examined him last and *there was no dislocation.*

Q. State whether he had the symptoms of a fracture of the acromion?

A. Yes sir, he had drooping of the shoulder which is one of the diagnostic symptoms of a fracture of the acromion. He having received the blow in the position he did the mobility of the joint, the drooping of the shoulder corrected by support to the elbow together with the position of the arm was conclusive evidence of the nature of the injury.

Q. Have you treated any cases of forward dislocation?

A. Yes sir, I have one since I came to Winterset. Recorder Smith's boy and one at St. Charles. I have seen several.

Q. Now, I will ask you if the treatment you gave the plaintiff was the proper treatment as laid down by the books for the fracture of the acromion process?

A. Yes sir, it was.

CROSS EXAMINED.

Q. You think if these gentlemen knew anything they ought to have known that there was no dislocation?

A. Well, they might be deceived and think there was a dislocation when none existed. Dr. Gross in his surgery says that an inexperienced physician is liable to think there is a dislocation when there is none, and I suppose that these gentlemen are inexperienced for they all say it is the first case they ever saw, and I am sure if they ever had seen a case of subcoracoid luxation they would have known that this was not one.

Q. Did you ask Mr. Thompson anything about the pain in his shoulder?

A. Yes sir, I asked him particularly about that, and if he felt any numbness in his hand, and he told me the pain was all on the shoulder.

Q. Why did you ask him about numbness in his hand.

A. Because if there had been a dislocation the pressure of the head of the humerus upon the brachial plexus of nerves would produce a numbness.

Q. You say there was drooping of his shoulder?

A. Yes sir.

Q. When did you notice that?

A. When I had him sit up on the lounge.

Q. When you saw his arm by his side you were satisfied there was no dislocation?

A. Yes sir.

Q. Then why did you examine to see if there was any dislocation.

A. Because I wanted to satisfy myself beyond any doubt. I rotated the arm to see if the head of the humerus was in its socket, and being satisfied that it was. Then taking hold of the elbow and pressing it up, the shoulder would appear natural the deformity disappearing, and taking my hand away the shoulder would again droop. These symptoms together with the manner in which he fell and struck his shoulder, and the pain where it was; all satisfied me that it was a *fracture of the acromion process.*

[*excused.*

D. A. G. Fields, of Des Moines—Sworn as an expert:—Testified as follows:

Am a practicing physician of over twenty years. I know the symptoms of a dislocation of the shoulder joint. The acromion process is more prominent. There is rigidity of the muscles, the head of the humerus is fixed in its new position. In the subcoracoid dislocation, the arm is thrown out from the body and backward in this position. (indicating) The hand is turned somewhat backward in this manner. The arm being thrown out iu this manner is a peculiar characteristic of a subcoracoid dislocation. The patient cannot bring his arm to his side in this form of dislocation. It might be brought to the side by the application of a considerable force, which would be at the risk of rupturing the tendons and muscles, and would cause the patient very great pain, more than they could stand. Drooping of the shoulder is one of the diagnostic symptoms of fracture of the acromion process. I heard the testimony in this case and would say that from the symptoms as testified to, that there was a fracture of the acromion process, and no dislocation. And the treatment of Dr. Smith was the proper treatment for the fracture of that process.

[*excused.*

Dr. Hillis sworn:

Am a practicing physician and surgeon. The symptoms of a subcoracoid luxation are inability to move the arm without great pain. We find the arm thrown outward and backward from the body in this position. There is also numbness iu the hand and fingers. The head of the humerus is thrown forward

of the glenoid cavity under the coracoid process. And the elbow is thrown out from the body. One of the principal diagnostic symptoms of a subcoracoid luxation is inability to bring the elbow down to the side of the body.

Q. Could the patient's arms be brought straight out in front with palms of the hands meeting so as to measure the comparative length of the arms, if there existed a subcoracoid dislocation.

A. No sir, they could not. The head of the humerus being thrown forward under the coracoid process, the elbow is thrown backward, and it would not be possible to bring the dislocated arm straight out in this position without first rupturing these muscles and tendons, and twisting it in this manner (explains with a skeliton why the arms could not be brought straight out in front.)

Q. What are the symptoms of fracture of the acromion process?

A. Drooping of the shoulder is the diagnostic symptom of fracture of the acromion and pain in the shoulder, along here. (Indicating point and back part of the shoulder.)

I heard the testimony of the plaintiff in this case, and would say that from the testimony of the plaintiff himself, no subcoracoid dislocation could have existed but the symptoms he gave were the symptoms of fracture of the acromion process. I also heard the testimony of Dr. Smith in this case, as to his treatment, and would say that it was the proper treatment as laid down by the books for a fracture of the acromion process and think he made the proper diagnosis of the plaintiff's case.

[*excused.*

D. Roberts sworn:—

Am a practicing physician and surgeon. Was prosector of anatomy in the Iowa Medical College. (He explains the bones of the shoulder, their muscles and attachments. The ligaments and their attachments. Explains why the arm cannot be brought to the side in a subcoracoid dislocation.) In such a dislocation the arm is always thrown out from the side, and cannot by any possibility be brought to the side except by force which would produce more pain than any person could stand and would be liable to rupture the muscles and tendons.

I heard the testimony of the plaintiff and defendant in this case and would say that a subcoracoid luxation could not have

existed with the syptoms as stated, but the syptoms as given by the plaintiff in his testimony were the syptoms of fracture of the acromion process, and the treatment of Dr. Smith was the proper treatment for the fracture of that process.

Q. Could the hands and arms of the patient in a case of subcoracoid dislocation be brought out straight in front of the patient, with the palms of the hands meeting?

A. No sir, they could not, for the reason already stated, that the dislocated arm would be thrown outward and elbow backward, and could not be brought out straight in this position, without first reducing the dislocation or rupturing the tendons and ligaments of the joint. (Here he explains with the skeleton, why this would be the case.)

[*excused.*

Dr. Forney sworn:—

Am a practicing physician and surgeon, I know the symptoms of a subcoracoid dislocation. The arm is raised from the body and the elbow, thrown outward and backward in this position, and the elbow cannot be brought down to the side with the forearm across the breast.

Q. Explain to the jury why this is the case in a subcoracoid dislocation?

A. (Witness presents an anatomy of the shoulder with the muscles and tendons attached to the scapula and humerus.) And explains the bones, muscles and ligaments of the shoulder joint.

It is the action of these muscles that causes the arm to be thrown outward and backward in a subcoracoid dislocation. Drooping of the shoulder is the most prominent symptom of fracture of acromion process.

Q. Would this drooping be produced by a subcoracoid dislocation?

A. No sir, there would be a prominence of the acromion process here on the point of the shoulder, and the natural rotundity of the shoulder would be destroyed, and the head of the humerus would produce a prominence in front of the glenoid cavity.

Q. Would a support to the arm or pressing upon the elbow correct this deformity if there was a subcoracoid dislocation?

No sir, it could not. No support would correct the deformity unless the dislocation is first reduced.

Q. In a subcoracoid dislocation could the arms of the patient be brought straight out in front of him with the palms of the hands meeting so as to measure the comparative length of the arms?

A. No sir. I would say that they could not, without rupturing the tendons of the muscles attached to the great tuberosity and also twisting the muscles and tendons which would produce more pain than any person could possibly stand. I heard the testimony of the plaintiff and defendant, and would say that from the symptoms as stated there could not possibly have existed a subcoracoid dislocation or dislocation of any kind, but the symptoms as stated were those of a fracture of the acromion process and Dr. Smith's treatment was the proper treatment as laid down by the books for the fracture of the acromion process.

[*excused.*

Columbus Seevers sworn—testified:

I am reading medicine with Dr. Smith. Was in the office when the plaintiff came there to have Dr. Smith examine his shoulder. It was about the first of October. Saw Dr. Smith take off the bandages and make the examination and then put them on again in the same way. He placed his arm by his side and his forearm across his breast in this manner, (indicating) and put a bandage around under his elbow, and pressed upon the elbow and passed the bandage across his opposite shoulder and drew it around tight pulling up on the elbow pressing up the shoulder. I heard the plaintiff make no statements as to pain.

[*excused.*

Dr. Hutchinson sworn:—

Am a practicing physician and surgeon, have been practicing for over 38 years. The diagnostic symptoms of a subcoracoid dislocaiion are these: The arm is thrown outwards and backwards. There is numbness in the hands and fingers, inability to move the arm without pain. The arm cannot be brought to the side without extreme pain, which is caused by the pressure of the head of the humerus upon the brachial plexus of nerves. There would also be rigidity of the muscles.

Q. If there was a subcoracoid dislocation, could the arms of the patient be brought straight out in front of him with the palms of the hands meeting in the manner as described by Dr. Leonard in his testimony.

A. No sir, they could not unless there was another socket formed for the head of the humerus, and in order to form a socket sufficient for that motion of the arm, you would have to cut away one rib. But as there is but one cavity for the head of the humerus, and if that motion could be made with the arm it would be good evidence that the head of the humerus was in the glenoid cavity, and that no dislocation existed of any kind. In fracture of the acromion process the most prominent symptom is a drooping of the shoulder. I saw the plaintiff in my office; he told me the manner in which he was hurt and the treatment he had received. He told me that his arm hung powerless by his side. He also said that Dr. Smith placed his arm in the position in which he then carried his arm, with the elbow to his side and forearm across the breast.

I heard the testimony of the plaintiff in this case, and would say that there was no dislocation of any kind, but the symptoms were the symptoms of fracture of the acromion process and the treatment of Dr. Smith was the proper treatment as laid down by the books for that fractvre.

[*excused.*

Dr. I. Cooper sworn:—

Am a practicing physician and surgeon. Am familiar with the bones, muscles and ligaments of the shoulder joint. This is the glenoid cavity and this the normal position of the humerus (witness explains the bones, muscles and ligaments) of the shoulder joint.

Q. Can the arm be brought to the side in a subcoracoid dislocation?

A. No sir, it cannot; if you attempt to bring the arm down by the side you press the head of the humerus against the brachail plexus of nerves, which would cause more pain than any person could stand. The arm is thrown outward and backward by the action of these muscles. (witness explains why the arm is carried out from the body.)

I heard the testimony of the plaintiff. Would say from the symptoms that no dislocation could have existed. But the symptoms as givan by him were the symptoms of a fracture of the acromion process. And the treatment by Dr. Smith was the proper treatment for the fracture of that process as laid down by the books. In a subcoracoid dislocation the muscles are rigid, the arm is thrown out from the body and back, the arms cannot be brought straight out in front of the patient

in the manner described by Dr. Leonard. There is also numbness in the hand and fingers.

[*excused.*

Dr. C. W. Davis sworn:—

Am a practicing physician and surgeon, have been practicing over twenty years. I was surgeon in the army and Medical Director. In a subcoracoid luxation the arm is thrown outward and backward. The elbow is carried out from the body and the hand turned in this manner. The elbow cannot be brought to the side with the forearm across the breast. The explanation of the muscles, bones and ligaments as given by the defendant was correct.

I heard the testimony of the plaintiff in this case, and from the symptoms as stated by him, I would not diagnose a dislocation of any kind. But would expect to find a fracture of the acromion process, and the treatment by Dr. Smith was the proper treatment for that fracture and think he made a correct diagnosis of the plaintiff's case.

Q. If there had been a dislocation, could the patient have his arms extended out straight in front of him with the palms of the hands meeting?

A. I would say they could not.

Q. Would two weeks be sufficiently long to keep on a bandage or support to the arm if there was a subcoracoid dislocation of four weeks standing reduced.

A. I think any use of the arm that would cause much movement in two weeks after reduction would be very likely to throw it out again.

[*excused.*

Mr. Smiley sworn:—

I had a dislocation of the shoulder. The arm was thrown out from the side and back in this way. My arm stood out in this shape and give me great pain. I had a numbness in my hand and fingers. I lost the use of it entirely; I could not move it in any direction.

Q. Could you bring your arm down by your side?

A. No sir, I could not move it toward my side at all.

[*excused.*

Dr. John Cooper sworn:—

Have been a practicing physician and surgeon for about nine years. The symptoms of a subcoracoid luxation are: The arm

is raised from the body in this manner and is held up by the action of the deltoid muscle. The head of the humerus is thrown under the coracoid process. There is numbness felt in the hand and fingers and inability to bring the arm to the side. From the symptoms as stated by the plaintiff I would diagnose fracture of the acromion process, the most prominent symptom is drooping of the shoulder. There could not be a subcoracoid dislocation with the symptoms as stated by the plaintiff. If his arm could be brought down by his side with his forearm across his breast, as the plaintiff stated and still a subcoracoid dislocation existed, I would say it was an anomalous case or that it was *congenital dislocation; that it had existed from birth.*

Owing to the peculiar anatomical structure of the shoulder, the arm cannot be brought to the side in a subcoracoid luxation without rupturing some of the muscles and tendons and causing more pain than any one could possibly stand, unless they were under the influence of anesthetics. I saw the plaintiff in my office; he told me the diagnosis that had been made and the treatment he had received, and also the treatment of Dr. Leonard and others. I told him it was my opinion that he never had subcoracoid luxation. I told him I was very certain that *no dislocation of any kind existed*; but that from his own statement it was a fracture of the acromion process, and Dr. Smith had treated him properly for that. I asked him the position his arm was in after he was hurt, and he said that his elbow was by his side, his forearm across his breast and he supported it with his other hand. He then had his elbow closely bound to the antero lateral aspect of the chest with the forearm across the breast pointing toward the opposite shoulder. He said this is the position in which Dr. Smith had placed it. I told him *then* and I say now, that it would be a *physical impossibility* to have his arm in that position and at the same time have subcoracoid dislocation of the humerus.

Q. In a subcoracoid luxation of the humerus could the patients arms be brought straight out in front of him with the palms of the hands meeting to measure the comparative length of the arms?

A. They could not.

Q. Would that be a proper method of measuring the arms?

A. It would be very unscientific under any circumstances.

CROSS EXAMINED.

Q. Did you tell Mr. Thompson that he ought not to put

any confidence in Dr. Leonard.

A. I did not tell him he ought not to put any confidence in Dr. Leonard but told him I had perfect confidence in Dr. Smith and that I would not have any confidence in any one who would say that he had a subcoracoid luxation with those symptoms. And if one-half of the physicians in Madison county were to testify that there was a dislocation, I would *still know that there was none.*

Defendant offers in evidence, Gross on Surgery.

The foregoing evidence has been published by the request of the experts and other members of the medical profession and by their request for the benefit of those not qualified to give an opinion on anatomical and surgical subjects, the incorrect and absurd statements and answers given in the testimony have been appended with a *

The report of this case is not only one of interest to the medical profession but one of importance to the public. The plaintiff not only failed to make a case, but their own testimony alone was sufficient to prove the correctness of the defendant's treatment.

Then add to this the positive and undeniable testimony of all the experts, not only to the correctness of the treatment but to the impossibility of the existence of a dislocation of any kind, with the symptoms as testified to by the plaintiff and verified by the testimony of others. Attention is called to the positive testimony of the plaintiff and Mr. and Mrs. Graham, that there was a drooping of the shoulder, and that this deformity was corrected by pressing up on the elbow. This is testified to over and over again, and corroborated by the testimony of the defendant. The experts all testify that this would be an impossibility if there was a dislocation, and their testimony is corroborated by the statements of fifty surgeons and sustained by the unanimous profession. They all sustain the correctness of the defendant's diagnosis and treatment of the case in every respect. These facts were all presented to the jury so plain that they could not be misunderstood, yet they say they were forced and compelled to consent to the verdict. The public can judge of the motives that prompted the action of the prosecution and the jury.

But the action of Judge Mitchell in this case shows the peculiar influence of the machinery that controlled his decision.

Ubi jus incertum ibi nullum.