On the relations between medicine, surgery, and obstetrics in London / by Robert Barnes.

Sir William Macormac

with the writer's best regards

ON THE RELATIONS

BETWEEN

3.

MEDICINE, SURGERY, AND OBSTETRICS

IN LONDON.

BY

ROBERT BARNES.

Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XVII., No.* 8.

NEW YORK:
WILLIAM WOOD & COMPANY, 56 & 58 LAFAYETTE PLACE.
1884.

ON THE RELATIONS

3.

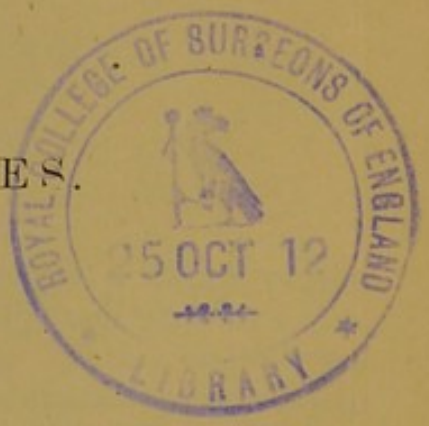
BETWEEN

MEDICINE, SURGERY, AND OBSTETRICS

IN LONDON.

BY

ROBERT BARNES.



Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XVII*, *No.* 8.

NEW YORK:
WILLIAM WOOD & COMPANY, 56 & 58 LAFAYETTE PLACE.
1884.

ON THE RELATIONS

BETWEEN

MEDICINE, SURGERY, AND OBSTETRICS

IN LONDON.

BY

ROBERT BARNES.

Dear Dr. Mundé:—I promised to send you a sketch of the actuál relations between medicine, surgery, and obstetrics, including gynecology, in London especially. These relations are somewhat peculiar, even anomalous, and, it appears to me, adverse to the sound progress of all three departments of the healing art, separately and in their solidarity.

If we start upon the general principle that medicine is a whole, each part of which stands in vital relation to the rest, we cannot escape from the conclusion that the tendency, so marked in this town towards disintegration into specialties, is pernicious in its influence upon science and upon those who pursue it, and therefore unjust to those who are the subjects of that science when applied. I do not enter upon the task of exposing this evil with much present hope of removing it, but rather with the purpose of explaining how it is that in this, the greatest centre of population in the world, abounding in clinical materials, with two Royal Colleges of Physicians and Surgeons and a University, with numerous flourishing medical societies, and a body of teachers

and practitioners that may fairly challenge comparison with those of any other community, the condition of gynecology is not one to which we can point with pride.

The unsatisfactory position of obstetrics and gynecology inthis country, and more especially in London, may be traced to several causes, some traditional, some of our own creation or tolerance.

In the first place, there is the old tradition that obstetrics, having been almost exclusively practised by women, was an inferior branch of medicine, one hardly deserving to be ranked with medicine and surgery proper. Although this old prejudice has been shaken in modern times; although obstetric science and practice have been illustrated by such men as Harvey, William Hunter, Smellie, and a long succession of men not inferior to those who have adorned the other branches of medicine, it still lingers amongst us, and exercises an unjust and depressing effect upon the present representatives of obstetrics. Thus, for example, even now, eminent physicians and surgeons esteem it a point of honor, if not of self-congratulation, that they are ignorant of midwifery, as if a little knowledge of midwifery could hurt or disgrace their special medical or surgical skill.

This notion once received a merited and characteristic rebuke from Robert Lee. At a full meeting of the Medical and Chirurgical Society, the late Mr. Skey, bursting with an exultant sense of his surgical dignity, exclaimed: "Thank God, I know nothing of midwifery!" The rejoinder was prompt and crushing. "If," said the veteran obstetrist, "the gentleman who has just spoken is thankful for his ignorance, he has much to be thankful for!" Yet to emphasize this boast of obstetric ignorance, and to illustrate our text, I afterwards saw Mr. Skey perform a Cesarean section at St. Bartholomew's Hospital. Although a good surgeon, he himself perhaps would not at that moment have contended that he was the better able to deliver a woman by Cesarean section because he knew nothing of midwifery. I am of opinion at any rate that the then obstetric physician to Bartholomew's, Dr. Greenhalgh, would have done the operation better because he knew something of midwifery. But the traditions and rules of this great hospital forbade their obstetric physician to carry out to its consummation a strictly obstetric case.

The same force that works against obstetric surgery is found in the constitution and traditions of our colleges. The relation of obstetrics to the colleges is remarkable. It would naturally be supposed that obstetrics, being more surgical than medical, the teachers and consultant practitioners of obstetrics would find their home in the College of Surgeons rather than in the College

of Physicians. But the reverse is the case. I believe there is no example of an obstetrist having had a seat on the Council of the College of Surgeons unless he came as a provincial representative of surgery. This exclusion is not justified by the charter of the college. The qualification laid down in the charter is simply that the councilman shall be a Fellow of fourteen years' standing in the bonâ fide practice of his profession as a surgeon, and shall not be practising as an apothecary. Thus to an expressed disqualification there is added, by a tacit conspiracy, an unauthorized disqualification, inflicting a stigma upon obstetric practice.

It took a long time and considerable pressure to induce the Council to acknowledge by action that a little knowledge of obstetrics was a useful qualification for its membership. When it instituted a midwifery board in 1852, and enlisted as examiners Arthur Farre, Oldham, and the late James Reid, and later, in succession, Charles West, Robert Lee, Robert Barnes, and Priestley, the diploma authenticated by these examiners was not held to be an essential qualification for the membership. Candidates for the membership were not compelled to pass the midwifery examination. A man might be registered as licensed to practise all branches of medicine, surgery, and obstetrics on the diploma of M. R. C. S. without having given to the public any guarantee that he knew anything of obstetrics. The men who came up for the midwifery license came of their own free will to supplement a deficiency in their qualification which they had been made to feel under the pressure of public opinion. Down to 1876 this state of things continued. None were admitted as candidates but men who already possessed a registrable qualification. Thus the college midwifery license fulfilled a useful purpose. It afforded an opportunity to many men who suffered in their own estimation and in that of the public to repair in some degree the consequences of the laches of the College. At the same time, however, this Board was a standing impeachment against the conduct of the College. In the first place, they ought never to have neglected the plain duty of basing the title to practise on a true and complete examination. They ought not, by this negligence, to have gone on inflicting upon their own members, whom they had sent out into the world as fully competent to practise, the indignity of having to come back to the College to seek a special testamur of obstetric competency. Yet this indignity was cast upon many men of mature age, some of whom were indeed older than the examiners themselves.

Notwithstanding the self-condemnation conveyed by this flagrant inconsistency, the Council of the College was still so op-

pressed by the ancient prejudice that, instead of making obstetrics an integral part of the examination for the membership, it took the very opposite course, of detaching obstetrics altogether, by endeavoring to create a special license in midwifery distinct from any surgical or medical qualification. And since it was a part of the scheme to admit women to the examination for this bare midwifery license, the College, so far from honoring obstetrics or advancing medicine in the public estimation, was really degrading it back to the position it occupied in the dark ages. But in this scheme the Council happily failed. The Midwifery Board refused to be agents in this ignominious work. I resigned a seat no longer one of honor. Dr. Farre and Dr. Priestley took the same course. The Board was broken up. No teacher in London would accept the vacant posts. And so the College went on without a Midwifery Board for some years, until in 1881, the principle I had all along contended for, of making obstetrics, like surgery and medicine, an integral part of the examination for the diplomas of Fellow and Member, was conceded. Then special examiners in obstetrics were appointed.

The wisdom of the course adopted by me in refusing to aid in the unnatural scheme of divorcing obstetrics from medicine and surgery has quite recently received emphatic recognition at the hands of the Council, Fellows, and Members of the College of Surgeons. On the 24th March of this year, for the first time in the history of the College, the Fellows and Members met the Council to deliberate on certain proposed "alterations in the charters of the College adopted by the Council on the 10th of January, 1884, to be reported to the meeting of the Fellows and members of the College, convened for the day named." The sixth alteration submitted was as follows: "That Section 17 of the Charter of the 15th Victoria be abrogated, it being inexpedient to contine the examinations for the license in midwifery of the College." The chief argument urged in favor of this abrogation was that, the section standing, any *person* might compel the College under *mandamus* to examine for this anomalous license, and the Council might find itself in a very awkward and undignified position. It need not be said that the proposal to abandon this unpleasant duty was unanimously assented to by the Fellows and Members.

So ends one scheme for degrading obstetric science and for injuring the profession and the public, by adding one more to the nineteen already existing titles to register as qualified to practise.

Since the Council of the College of Surgeons is composed almost exclusively, and by a kind of prescriptive right, of surgeons

to the general hospitals, it is but natural that the policy of the council of the college should be reflected in the government of the hospitals. The governing bodies of the London hospitals are variously constituted. Three principal forms may be noted. First and worst is the autocratic form in which an absolute ruler is nominated by the corporation of London or in some other irresponsible arbitrary way, under the name of treasurer. It is not considered necessary that the person chosen should be conspicuous for ability, or for knowledge of hospital work, or the needs of medical education, although he is suddenly invested with considerable power over both. What the qualifications are can only be known by those who elect. Absolute power should be coupled with absolute wisdom, and certainly such union has rarely been seen at the three great hospitals. Power the treasurers have had, the correlative faculty has generally been conspicuously absent. A second form of government is a representative one of the body of governors or subscribers to the hospital. A committee practically self-elective is appointed by the governors. This holds at the London hospital, an institution conducted with admirable efficiency. A somewhat similar constitution exists at University College and King's College hospitals. At these three institutions the medical staff is fairly if not completely represented. They hold an equally independent position; but of course are in hopeless minority. The third form of government is that in which a board of management open to all the governors rules. Since it is open to all the members of the staff to qualify as governors, they meet the lay governors with equal voice. Thus the representation of the medical staff is complete. This form obtains at St. George's and the Middlesex. It is the most free, liberal, and satisfactory, and offers the best security against back-stair influence and jobbery.

Still, under all these various forms of government, it may be truly said that obstetric medicine is tolerated rather than represented. The obstetric physicians occupy a position scarcely better than that of supernumeraries. They have a few beds assigned to them for diseases of women, far less in number than those assigned to the physicians and surgeons, and ridiculously inadequate to the needs of the poor women suffering from diseases peculiar to the sex. And the cases admitted to these beds are rigorously defined and controlled by the surgeons. The obstetric physician is at liberty to treat surgically a uterine polypus, for example; but he has no monopoly even in this. The surgeons admit into their wards any cases they please, including

gynecological diseases. But cases touching ever so slightly upon to border-line between the uterus and the adjoining regions are jealously denied to the obstetric physician.

This is most strikingly exemplified in the regulations existing at St. Bartholomew's. At this hospital, which, from its magnitude and antiquity, is naturally looked to by those in search of precedents to support the policy they are inclined to, the relative position of the obstetric physician illustrates in a remarkable manner the tyranny of the surgeons. By a law or equivalent authority passed in 1855, it was ruled that "all surgical operations as may be requisite in Martha's (the gynecological) ward shall be done by the surgeons in rotation." This very comprehensive law, it seems, was infringed by Dr. West who, in 1859, was summoned to attend a committee of the treasurer and almoners to explain how it was that he had taken upon himself to perform an operation of a surgical nature upon a patient admitted into Martha's ward. Dr. West explained and apologized. He stated his intention, not only to abstain from performing such operations, but "would at once send to a surgical ward such cases as might require surgical operations." The committee accepted Dr. West's explanation, but declined to sanction any such proceedings as he contemplated, and "required him to admit to Martha's Ward the same class of cases hitherto sent there, and then to send to the surgeon to operate." This order was confirmed in 1861, when Martha ward was declared to be a ward set apart for the obstetric physician who is to call in a surgeon to operate. In 1870, it was ordered that, in lieu of the surgeons operating in turns every three months, the performance of surgical duties in the ward be intrusted to the fourth surgeon and the first assistant surgeon. It will be readily imagined how hard it must have been for a man of high spirit, as Dr. West is well known to be, to brook such insolent tyranny as this. The rules under which he was called upon to perform his duties actually compelled him to admit cases into his ward which he was not allowed to treat. At a certain point, or whenever anything which the surgeons might declare to be surgical treatment was indicated, his hands were tied, and he was obliged to call in a surgeon to take up the case. He was not even permitted to decline to receive patients whom he was declared incompetent to treat. And yet he was expected to teach.

It could not be expected that things would go on smoothly under such a régime. Dr. West retired. But the rules under which he writhed are still in force upon his successors. The interpretation of what falls under the expression "surgical treatment"

does not rest with the obstetric physician. The words, if rigorously interpreted, might forbid him to remove a polypus or to apply cautery, actual or potential. If he goes so far as this, it is by tolerance, not by right. Latterly some relaxation has been granted. The obstetric physician is now allowed to deliver a woman by Cesarean section. But he must be very sure that the woman is pregnant, for he is forbidden to remove ovarian or uterine tumors, and *à fortiori* other abdominal tumors, by abdominal section. He is not allowed even to make an exploratory incision. Like Minerva, he is expected to come forth fully equipped, without going through the ordinary processes for acquiring knowledge. And even this concession of Cesarean section is liable to be revoked or limited. For example, it remains to be seen how far the surgeons would recognize the propriety of performing the Porro-Cesarean operation. As this involves the removal of the uterus and ovaries, it would be prohibited under the strict interpretation of the rule which forbids the obstetric physicians to practise ovariotomy. And even if liberality were stretched to the point of permitting such an operation in a hospital, it must still be obvious that practice under a system of surveillance and control by men necessarily unable to appreciate fully the history of these cases, must be destructive of that spirit of independence and enterprise which is the very life of medical progress.

The surgeon at St. Bartholomew's also performs the operation for vesico-vaginal fistula. A curious arrangement was made with regard to perineal operations. If required for relief of prolapsus uteri, the obstetric physicians might do them; if for incontinence of feces and flatus, then the surgeons claim the operation. What a nice distinction! how ingeniously the line is drawn just between wind and water! Is it never transgressed by the surgeon on the one hand or by the obstetric physician on the other?

The utility of these rules may be tested from three points of view. *First*, the patient's. Can it be contended that it is good for a patient to change her doctor at the critical moment of treatment? Is it reasonable to suppose that the knowledge of the case in its origin, development, and progress, which had been gradually acquired by the first doctor, can suddenly be transferred to the second doctor who steps in to take possession of the case for the purpose of surgical treatment? Is it not clear that each of the two, studying half of the case only, will be imperfectly fitted to do justice to the patient? Is this divided care consistent with the responsibility which properly attaches to the

doctor? Does it not tend to weaken the interest he might feel in the patient's welfare, if she were in his sole charge? Does it not encourage both doctors to shift the blame of error in diagnosis and failure in treatment upon each other? The obstetric physician may say, "I diagnosed the disease, and there my responsibility ended." The surgeon may say, "I operated on the judgment of the obstetric physician, and upon him must rest the responsibility."

Secondly. Does this division of work, involving partial knowledge of the case, conduce to the scientific and clinical improvement of either? Take first the position of the obstetric physician who begins. He studies the case up to a certain point, and there must stop, and stop just at the point when the luminous experiment of treatment is made, when the seat of the disease, the relations of the diseased structures are exposed to closer and more precise observation than was possible before. It may be said that the obstetric physician may look on and see the surgeon do all this. But surely no one of experience will contend that the information so acquired can be compared with that which comes to the man who operates for himself. The operation is the culminating point which brings all the theories hitherto formed as to the nature and complications of the disease to the test. How often do we find, whilst carrying out an operation, things not suspected before, cropping up under our fingers and eyes, throwing new light not alone upon the case in hand, but suggesting new thoughts to be developed into fuller knowledge of cognate pathological problems. An instance in point, full of interest, lately came home to myself. During an ovariotomy at St. George's Hospital, after having removed the tumor, I had some trouble in finding the other ovary for inspection. I found it at last low in the pelvis, nipped under the fundus of the retroflected uterus. Having uncurled the uterus, I was able to draw up the left ovary into view. The lesson to be deduced from this direct physical observation is this: The ovary so imprisoned would, under the engorgement of the menstrual nisus and the attendant swelling of the uterus itself be so compressed that pain would be caused; that is, there would be ovarian dysmenorrhea. It may be said that all this might be made out under ordinary circumstances by vaginal and rectal examination. Perhaps, but not so clearly or in such a convincing manner. To me it has been a source of profitable physiological, pathological, and therapeutical speculation.

Take ovarian tumors for further illustration:

How can a mere man-midwife arrive at a full or accurate knowledge of the manifold varieties in these tumors, in their

origin, development, history, complications, and the many accidents they are liable to, unless he enjoys frequent opportunities of seeing and handling these tumors as exposed in operations? How otherwise can he possibly cultivate the diagnostic skill which is necessary for the differentiation of ovarian tumors from the numerous other tumors of pelvic and abdominal origin? As well might he pretend to understand the anatomy of the pelvic and abdominal organs without dissection.

Wanting the knowledge of what can be accomplished by operation, he will hardly appreciate the conditions that indicate the expediency of an operation. He will be apt to postpone advising an operation until the most favorable opportunity has been lost. I do not hesitate to express my conviction that the opinion of a man who does not operate, upon a case of abdominal tumors, is entitled to scant respect.

If that is the position of the fettered obstetric physician, what is the position of the surgeon? It is no better. In the first place, by his neglect and practical ignorance of gestation and of pelvic diseases, his diagnostic faculty fails in a vital point. This objection, of course, applies with varying degrees of force to different surgeons. Exceptionally trained men, like Sir Spencer Wells, may, by special experience, be armed at all points. And Sir Spencer Wells' experience was not attained in a general hospital. Our concern is chiefly with the ordinary hospital surgeon, who denies to the obstetric physician the right to operate. To the majority of these the objection applies in full force. Acting under their own imperfect light, they incur the most imminent danger of opening the abdomen to reveal a gravid uterus, of tapping a solid fibroid, and of overlooking some serious pelvic complication. So paralyzing has been the influence of this system upon the knowledge and practice of abdominal surgery that, although an occasional ovariotomy was performed in the general hospitals, the fact remains that no advance of importance in this direction was made in these institutions until they felt the impulse of enterprise from without.

The system, then, is injurious and degrading to both. The obstetric physician is degraded by his subjection to the surgeon. What sense of independence can remain in the man who can tamely accept the duty of feeding the surgeon with operations, of playing the part of jackal to another man's lion? What honor can he reflect upon his department when he declares to the public his incompetency to carry out the most important part of the treatment of the cases naturally falling to his care?

Thirdly. How does this system lend itself to the great work of

teaching? It must be assumed that one main duty of the obstetric physician to a hospital is to teach. But how can he teach who is not permitted to practise and learn?

And if we would see absurdity in the superlative degree, we have only to reflect that the obstetric physician is called upon to teach gynecology to students who, by simply declining to take the style of physicians, resting content, as the majority of London students are compelled to be, with the style of surgeon, thereby become qualified to do what their teacher cannot do! And they are truly more fortunate than their teacher. They are free to learn, free to practise, and in this freedom they find the opportunity of advancing science, of applying it to the benefit of mankind, and of earning an honorable reputation.

But this freedom they will seek elsewhere than in a London school-hospital.

Another evil consequence of the neglect of the pure physicians and surgeons to study the physiology and pathology of the female generative system by the objective method, is that they are necessarily incapacitated from judging with precision of the nature of most cases of disease of intrapelvic origin; and for the same reason they are unable to judge fairly of the merits of the men who more especially study gynecology. They yield to the natural bias of believing in those whose dicta reflect most closely their own imperfect knowledge. In this way the most grievous wrong is often done to the more enterprising and able obstetrists. These are branded as specialists by men, many of whom are themselves specialists in the closest meaning of the term. They who refuse to apply the recognized methods of objective observation to the pelvic organs, for whom there is no pathology below the hypogastrium, have surely no right to denounce as specialists those who, not neglecting other regions and the body as a whole, embrace the pelvic organs within their field of research.

I have submitted a definition of the term "specialist" which I venture to repeat: "A specialist is one who specially neglects important factors in the causation and process of disease." Tried by this definition, which is the specialist; he who so neglects essential factors in the problem, or he who, studying with particular care those factors which the other neglects, does not neglect all recognizable factors in their individual and collective characters? For my own part, I emphatically repudiate the title.

Not less erroneous than the current idea of a specialist is that of the correlative so-called "all-round man." In its large and true sense, "the all-round man" would be the highest type of

physician. Where are they? There are indeed a few who well deserve the distinction. A man is not necessarily a good "all-round-man" because he is not credited with especial skill in one class of diseases. By far the greater number of so-called "all-round men" would more correctly fall under the description of "specialists." Their knowledge is not represented by a circle, but by a segment only. The arc that is wanting in their estimate of disease in woman, is often precisely the most important part of the circle, without which there can be no completeness in diagnosis, no rational indication for treatment.

This argument might not without profit be extended beyond the discussion of the more strictly female diseases. In the study of gestation, the true pathologist might get nearer to the origin, and therefore to the nature, of many diseases which now baffle his research. He might trace back some diseases to mere excess of physiological action. He might trace others to the influence of gestation in evoking latent and unsuspected morbid conditions. This theme, so rich in suggestiveness, I cannot here pursue. It is discussed and illustrated in the "System of Obstetric Medicine and Surgery" I have recently published in conjunction with Dr. Fancourt Barnes.

In the whole range of medicine there is no experiment more fertile in physiological and pathological knowledge than gestation. It is an experiment that is being continuously repeated, with the certainty of a natural law. It is beyond the control of the shrieking crew of unwomanly women and unmanly men who, impelled by the cruel bigotry begotten of ignorant dilettanteism and vanity, appeal to the lower reflex and emotional qualities of the unthinking, to help them to propagate loathsome diseases, and to trammel science in her efforts to prevent them.

I have cited the special hospitals for women as practical protests against the exclusive pretensions of the general hospitals. And this is true. But even in some of these the prejudices of the surgeons are reflected.

Quite recently this came into prominence at the Vincent Square Hospital for Women. Dr. Culver James brought a complaint against his colleagues, Messrs. Skene Keith and Smythe, before the Metropolitan Counties Branch of the British Medical Association. It appears that Dr. Culver James, being physician to the hospital, acting temporarily for Mr. Smythe, one of the surgeons, had the audacity to perform an ovariotomy. Mr. Keith, holding this to be an unjustifiable invasion of surgical functions, accused Dr. James of "performing an operation contrary to the laws of the hospital; and of knowingly and wittingly inducing him, Mr.

Skene Keith, innocently to take part in a forbidden operation, thereby rendering Mr. Keith guilty of a breach of the rules of the hospital." The most touching feature in this charge is the making the surgeon an unwitting accomplice in the crime of "*lèse-majesté chirurgicale.*" How very shocking thus to entrap unsuspecting innocence!

The decision of the committee who sat in judgment is tainted with the surgical prejudice. They declare that the dispute "has arisen from an unfortunate union *in one and the same person* (Dr. Culver James) of two distinct and separate functions, viz., those of physician and of surgeon at *one and the same hospital.*" They regard this union as unnatural. Their judicial faculty is on a par with their grammatical perception. How can Dr. Culver James be other than "one and the same person"? It might have been expected that a tribunal, that could lay down this remarkable proposition, might also have grasped the oneness and sameness of medical science. If Dr. Culver James could be other than "one and the same person," then the medical and the surgical qualities might be disjoined. But I must give up the task of subjecting this decision to further analysis. The decision may do for the Vincent Square Hospital, whose governing body compelled Dr. James to resign.

At the Soho Hospital for Women, the first I believe of the kind, the physicians also act as surgeons. At the Samaritan Hospital, there are physicians and surgeons, as in the old hospitals. I believe the surgeons alone operate. At the Chelsea Hospital for Women, the titular name applied to all the ordinary staff is that of "physician." The term is used comprehensively. All are physicians; and the impossible task of splitting up "one and the same" case into medical and surgical is not attempted. The consequence is that no intestine or unseemly disputes arise; there is no fighting over the beds of the patients; and scientific investigation is prosecuted in the best and happiest spirit.

The first effective blow struck at the monopoly of the surgeons over abdominal and pelvic surgery in our London hospitals was dealt by Tyler Smith, on the foundation of St. Mary's Hospital. He, being appointed obstetric physician, asserted the duty and right of the obstetric physician to carry through, even to surgical treatment, the cases that by common consent fall under the domain of obstetrics and gynecology. He initiated in this hospital, which, being a new foundation, was unfettered by precedent, the practice of ovariotomy by the obstetric physician. This practice is continued by his successors, Dr. Meadows and Dr. Wiltshire, and it is to be hoped will be perpetuated. It is a distinction of

which the youngest hospital-school in London may well be proud. We believe the example thus set has been turned to account at University College Hospital and Kings College Hospitals, where Dr. Graily Hewitt and Dr. Playfair respectively perform ovariotomy and other cognate operations. By special favor of my surgical colleagues, I enjoy and practise the like privilege at St. George's Hospital. This right, although affirmed by the governing body of the hospital, rests on a personal concession made to me by the surgical staff, which has declared that it shall not be extended to my successor.

At Guy's Hospital, I have seen both Dr. Hicks and Dr. Galabin perform the Cesarean section; and I believe that the obstetric physicians are still permitted to practise obstetrics. to the extent of delivering a woman by this operation. They have also practised abdominal section for delivery of the extrauterine fetus. Until recently they even performed ovariotomy. But against this the surgeons revolted, and bringing their influence to bear upon the Treasurer, who occupies the position of dictator, they succeeded in depriving the obstetric physicians of this privilege. It was not because it was shown or contended that it was better for the patients, or that the obstetric physicians were not competent operators. That would have been too absurd. The surgical staff of Guy's includes, it is true, very able surgeons; but, we are well assured, not one who is more able to treat an ovarian or other abdominal tumor from beginning to end, than Braxton Hicks. The question of oöphorectomy or of Tait's operation has not been raised; but probably the surgeons would object to these operations being done by the obstetric physicians, which is tantamount to stopping all advances in this direction.

It is a remarkable and very significant fact that, although the obstetric physicians attached to some school-hospitals are thus prevented from the practice of abdominal and pelvic surgery in some of these hospitals, they all, with at most two or three exceptions, who thus practically confess their want of surgical aptitude or of independence, perform ovariotomy and cognate operations outside their hospitals. In this way, they give unmistakable evidence of their convictions upon the subject. And since they cannot acquire the necessary experience and skill to excel in these operations by practice in their hospitals, several of them have knocked at the doors of the special hospitals for women. Thus Dr. Galabin has taken office at the Bolingbroke pay hospital. Dr. Edis, obstetric physician to the Middlesex, where the old superstition reigns supreme, and Dr. Horrocks, assistant obstetric physician to Guy's, have attached themselves to the Chelsea Hos-

pital for Women, avowedly for the sake of the opportunities for operating which are denied them in their school-hospitals. This mode of emancipating themselves from the thraldom of the surgeons is not altogether satisfactory.

The school-hospitals which fetter their obstetric physicians, the general medical and surgical staff, and the patients lose the great benefits which could not fail to accrue from the mutual impulse of generous emulation and reciprocal instruction. The surgeons especially are losers. They might usefully reflect that under their jealous monopoly, hardly a step in the enormous progress made of late years in the knowledge of abdominal and pelvic surgery is due to them. The initiative work has sprung up as almost all initiative work does, under the conditions of freedom from arbitrary restrictions. This freedom is found outside the general hospitals. The longing for freedom of research is not to be repressed. Hence what are called "special hospitals" have been established; and in these, the departments of medicine and surgery, which were comparatively neglected or tabooed in the general hospitals, have been successfully cultivated. Amongst the first instances of this movement was the establishment of the Moorfields Ophthalmic Hospital, founded, I believe, by the father of Arthur Farre. Now there are numerous ophthalmic hospitals. Institutions for the cultivation of orthopedic surgery, nervous diseases, diseases of children, diseases of women, have sprung up. Under the natural pressure of need for hospital relief, some extension of accommodation beyond that afforded by the general hospitals was no doubt inevitable. But it is not the less certain that the greater number of special hospitals have been founded to supply a field for the exercise of surgical energies excluded from the general hospitals. And they have abundantly justified their existence. Ophthalmic surgery, neglected or discouraged in the general hospitals, has flourished at Moorfields, making great reputations and conferring endless benefits upon the community. Special hospitals having thus achieved an independent position, it began to be felt that the general hospitals would be strengthened, made less special, if they too cultivated ophthalmic surgery a little more carefully. At first, one or two of the junior surgeons were charged with the care of eye-patients in addition to their ordinary duties. Gradually this half-measure was found to be unsatisfactory. Students called for more accurate instruction. And now, I believe, every general hospital in London has attached to its staff a distinct ophthalmic surgeon, and in some cases an assistant also Upon these devolved, not alone the care of out-patients afflicted with eye-diseases, but also of an ophthal-

mic ward, and the duty of giving instruction clinically and by lectures. Notwithstanding this recognition of the claims of ophthalmic surgery, it is a fact not without significance, that almost all the ophthalmic surgeons attached to the general hospitals find the position and the opportunities granted them in these hospitals insufficient to satisfy their ambition, or to give them full scope for clinical activity. Almost all hold appointments in special ophthalmic hospitals as well.

This relation of ophthalmic surgery to the great hospitals, then, presents a parallel to that of obstetric medicine and surgery. It has been felt that the curriculum of education dictated by the progress of science, the demands of the examining boards, and those of an instructed public, made it imperative to institute separate courses of lectures on ophthalmic surgery and on obstetrics and gynecology within the walls of the hospitals; and so special chairs have been instituted. So far the parallel holds. But points of difference must be noted. The ophthalmic surgeon is allowed to treat the eye according to the therapeutical indications presented; that is, he may treat it throughout medically and surgically, not harassed and thwarted by the case being taken out of his hands at the moment of greatest interest; whereas the obstetric professor is crippled in his treatment of the ovaries and uterus; he must not operate beyond the point which the surgeons may declare to be proper.

Why is this? The answer, if answer it be, lies in the fact that one is called "surgeon," the other "physician." And these titles, the one given by a college of surgeons, the other by a college of physicians, are held to distinguish and to limit the range within which each shall be considered competent to practise. Until recently the examinations of the colleges respectively were based upon this distinction of functions. The College of Physicians did not examine in surgery, and the College of Surgeons did not examine in medicine. This division, entirely arbitrary, artificial, and injurious, received to a certain extent the assent of of the profession. But it has always been more strictly observed by the physicians than by the surgeons.

The physicians rarely operate. The surgeons on the other hand have been less punctilious. They find it very wrong that a physician should handle a knife; but they find it quite right that surgeons should prescribe for medical cases. They accept Sir William Lawrence's definition of medical and surgical cases: "Surgical cases are those that pay fees, the rest are medical."

So long as the physician failed to study surgery, and the College of Physicians did not require evidence of surgical skill, it was

right that the "pure" physician should abstain from practising surgery. But the disability is now simply arbitrary and traditional. The physicians who operate are competent surgeons who have gone through a surgical education and surgical examinations. The University of London degrees embrace a complete curriculum in medicine, surgery, and obstetrics. The Scotch Universities, although less exacting in degree, require the same qualifications in kind. Besides possessing this title to practise surgery, many of the obstetric physicians are also members or fellows of the College of Surgeons. It is, therefore, on the intrinsic merits of the case, simply absurd to declare that because being surgeons they add the qualification of physician, they become thereby incompetent to practise surgery. The case of the obstetric physician, as contrasted with that of the pure surgeon in presence of an obstetric patient, is briefly this. "The obstetric physician is a surgeon and something more. The pure surgeon is a surgeon and nothing more." As the whole includes the parts, so the obstetric physician is the better qualified *ad hoc*.

I have not learned that the College of Physicians as a body has ever expressed a formal objection against its fellows, members, or licentiates practising surgery. Certainly the college has not inflicted the penalty of disability for high office upon those of its fellows who practise obstetrics, including the correlated surgical operations. Arthur Farre, Charles West, and myself have filled the office of Censor. And members who practise obstetric surgery have been raised to the fellowship. The college charter covers the right of surgical practice. Still the liberality of the college of physicians in extending hospitality to obstetric practitioners, receiving them within its fold, and giving them a status in the governing body has not been without disadvantage to those whom it has so honored. Adopting them, it made them nominally physicians, ostensibly detaching them from the orthodox surgical faculty. And thus the traditional law, strong by custom, and jealously enforced by the small ruling body of the College of Surgeons, declaring that a physician is not a surgeon, leaves the obstetric surgeon to fight for his right to carry out the surgical treatment of the obstetric cases that fall within his care.

It would be difficult at the present day to trace the steps that led the obstetric practitioners to the portals of the College of Physicians rather than to those of the College of Surgeons. Certainly, the element of surgery predominates over that of medicine in the amalgam of obstetrics.

The obstetric practitioner is necessarily a surgeon. He might almost dispense with the pharmacopeia; but his hands and in-

struments he must use. To use them skilfully, he must exercise them frequently and in the greatest variety of operations that fall within the range of his department. Not only is this exercise necessary to the acquisition of mechanical skill, but it is not less necessary to the acquisition of full and accurate knowledge of the art he practises.

Let us now define the scope of obstetric medicine. In my address as President of the Obstetrical Society in 1865 (*Obst. Trans.*, 1866), I submitted the following as the proper definition: "The work of the obstetric physician embraces the treatment of the diseases of the female generative organs, including the disorders and lesions, general and local, which result from pregnancy and parturition." I do not see how limitation can be made narrower than this.

An exactly parallel definition accords to the ophthalmic surgeon co-extensive command, medical and surgical, over the eye. Why should not the like measure be dealt out to the obstetric physician? Why should the one be privileged to roam over the entire pathological field of his department, uncontrolled in his operations, and the other be crippled in his clinical work of research and treatment?

Again the only apparent plausible argument crops up: Is it because the one possesses the rank of surgeon, whilst the other is a physician? In every essential respect, the arguments in favor of the one apply with equal force to the other. It has been urged that the surgeon, by general exercise in operations, acquires more skill in operations than can be attained by a man whose operations are restricted to a particular region of the body. The proposition is not without plausibility, but it does not cover the case in contention. Why is it that the eye has, of late years, been almost exclusively intrusted to a special surgeon? Is it not possibly because he is supposed to acquire peculiar skill by exercising it upon a single organ? Does not this argument apply with at least equal force to the obstetric physician?

If the surgeon is permitted to say: "The obstetric physician must turn over to us all operations," by parity of reasoning the physician might say: "The obstetric physician must turn over to us all that requires medical treatment," for example, puerperal fever, which is not more a consequence of labor than is a slough of the vagina resulting in cicatricial atresia or in vesico-vaginal fistula. Now, this mode of reasoning, logical though it be, would lead to the annihilation of the obstetric physician—a manifest *reductio ad absurdum*. It leaves the obstetric physician without an apology for his existence.

Thus, looking at the question from whatever point of view, we are driven to this explanation, that a surgeon is free, by natural or prescriptive right, to do as he pleases, whilst the physician is only free to what the surgeon declares is right. Now, having gone thus far in the argument, I will not shrink from the logical consequence, audacious and revolutionary as it may appear, of questioning the right of the surgeon to dictate to the physician the limits within which he shall practise. Where is his commission?

The truth is, that the surgical dynasty rests entirely upon arbitrary conventional rules which have become obsolete by the progress of medicine, and the juster and broader system of medical education now prevailing. So long as physicians never made surgery a serious study, it was natural that surgery should fall to those who did. But now that surgery forms an integral part of medical education, by the same reason the physician who has so studied surgery possesses equally with the surgeon the right to practise what he has qualified himself to practise.

I do not venture to ask how long this injurious subjection is to endure. I will content myself, having no personal interest in the matter—for I, long ago, like Tyler Smith, emancipated myself—with pointing out that what some have done the rest may do, if they only have the courage to do it. They may reflect that almost all the men who have held or who hold office as examiners in obstetrics in the University of London and in the two Colleges are operators. This means that the University and the Colleges are obliged to accept operators. They have no choice. The same men are wanted in the hospital schools to teach. Is not the deduction clear? *Verbum sapientibus.*

I imagine that this sketch of the relations of medical, surgical, and obstetric practice in London will strike the professional mind in America and the Continent of Europe as somewhat remarkable. It is certainly exceptional. It offers a striking example of the evils resulting from the maintenance of two independent colleges, one medical, the other surgical. This splitting of the healing art into two divisions lends strength to the pernicious tendency now especially prevalent in this town to further subdivisions into so-called specialisms. This tendency is now so rooted in the popular mind that not only is the body regarded as a community of organs each of which is an independent constituent, and is therefore assigned to the care of a special doctor, but it has gone further still, so that now we have not only liver, kidney, and uterine doctors; but these are not secure in their nominal domains. One cannot have so much as an organ to one's

self. One kidney doctor, for example, is good for Bright's disease, and another for diabetes, and so with the rest. It seems not unlikely that there will be doctors for the right kidney, and doctors for the left.

The difficulties under which the obstetric physicians work in London are greater, I believe, than exist anywhere else. In the provinces, in Scotland, and in Ireland, their position is far more catholic and independent. It may be doubted whether the ardent spirit of Sir James Simpson, which led to such brilliant results, would not have been cramped, had his career been run in London. That career was essentially surgical. In no hospital in London could he have found scope for his genius, unless he had consented to divorce himself from obstetrics. And it is unnecessary to point out how intimately surgery and obstetrics were linked together in his work.

So, I believe, even the bold enterprise and the generous emulation of my American brethren, who have shed such lustre upon the medical history of your country, would have been crippled and chilled, had they been compelled to work under similar discouragement to that which afflicts us here.

Believe me yours truly, ROBERT BARNES.