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THE RELATION OF GYNECOLOGY TO OBSTETRICS.

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Modern gynecology is the legitimate child of ancient obstetrics. Marion Sims was the accoucheur and Emmet, Thomas, Peaslee, and Bozeman may fairly be said to have been the godfathers, while the child is kept alive—for alive it certainly is—in spite of more or fewer sins of omission, as well as of commission, of the modern accoucheur. It has been the custom of late years to say that gynecology has passed its usefulness and has become merged into general surgery, and that there no longer exists a necessity for attempting to prolong the life of this hopelessly doomed department of medicine. With this proposition we take issue, and shall endeavor to maintain that until modern obstetrics approaches more nearly the ideal standard there will be a large field for the gynecologist proper.

Marion Sims found a condition among negro women which practically disabled them for all the duties of life, thus materially reducing their commercial and industrial value. In vain had the profession striven for years to heal the vesicovaginal fistula; not even had a relief been found for the pitiable, hopeless, and helpless victim of this

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abnormal performance of a function so necessary to comfort both of body and of mind. Endowed with a heart keenly alive to the claims of suffering humanity and with a zeal for scientific investigation almost unparalleled in the history of the noblest of professions, with the most patient perseverance he contended against innumerable failures, hoping almost against hope, until he was rewarded at last by a result that conferred a priceless boon upon thousands of women and won for himself imperishable renown throughout the civilized world, so that he became *facile princeps* among the benefactors of his time.

We may then fairly claim that scientific gynecology had its birth in America and was founded by Marion Sims. No gynecologic surgery prior to his day had made any impression on surgical practice that has endured until the present time. His speculum, silver-wire suture, and methods of plastic work gave to the profession means for exploring the genital tract and perfected a surgical technic hitherto unequalled. Not alone as a strict gynecologist did he contribute to his fame throughout the world, but his suggestions and predictions in relation to abdominal surgery, especially regarding gunshot wounds and removal of gallstones, placed him among the most advanced general surgeons of his day. But what was strictly gynecologic and what entitles him to the appellation of Father of Gynecology was his success in the treatment of vesicovaginal fistula. That a large percentage of these lesions was due to ancient obstetrics no one doubts, certainly no teacher of the art questions it. "Meddlesome midwifery" was the keynote sounded by all the instructors during the latter part of the eighteenth and the early part of the nineteenth centuries. Not only were the students taught that frequent examinations were bad, but that manual interference should be cautiously used. Forceps were only a *dernier ressort* for experts. Parturition was a natural physiologic process, not to be hurried, not to be

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shortened by any artificial means, and its pangs and agonies not to be soothed or ameliorated by any seductive drugs. Even when the blessing of anesthesia was invoked the anathemas of the Church were hurled against the accoucheur, and members of his own profession cried out against him for attempting to assuage the anguish of the suffering woman. It was at variance with the Divine authority that "in sorrow thou shalt bring forth children."

Such teaching and such public sentiment led to most disastrous consequences to the parturient woman. The long labor, delayed during the second stage, especially from disproportion between pelvis and head, produced necrosis of tissue and its calamitous results. This was clearly the fault of the obstetrician of that day and generation, and was corrected only after the careful investigations consequent upon Sims' painstaking gynecologic work. Reform in the management of labor began from that time, and just in proportion as the reform was successful the number of cases of vesicovaginal fistula decreased, until at the present time it is almost unknown even in our largest hospitals. The leading instructors in obstetrics taught the intelligent use of forceps in lingering labors, and, *pari passu* with this intelligence, the lesion was largely eliminated from the list of injuries in childbirth.

Prior to that time all that was known of gynecology was included under the head of obstetrics, and for many years all the teaching in relation to women that was received by the medical student came from the professor of obstetrics and diseases of women, the latter subject playing but a minor part in the curriculum. In many schools this professor was continued years after gynecology was a well-recognized department of medicine, and no practical instruction whatever was given. Many of these professors of "obstetrics and diseases of women" never did a gynecologic operation of any kind, therefore their teaching, like their practice, was purely theoretic; students grad-

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uated from such schools necessarily knew nothing of practical work, having seen none, and as a consequence the ambitious young surgeon either attempted plastic operations on the uterus and vagina with knowledge gained only from text-books or qualified himself as well as he might by a few weeks at some metropolitan post-graduate school.

In the early days of gynecology, however, these schools did not exist, but hundreds of physicians availed themselves of the clinical advantages afforded by the Woman's Hospital in New York, and sat at the feet of that Gamaliel of the profession, Thomas Addis Emmet, learning wisdom from his words and skilful technic. While we retract nothing that has been said for Sims as the Father of Gynecology, to Emmet belongs much credit for the concise, plain, practical manner in which he placed before the profession his careful, painstaking work in plastic surgery of the generative organs. That which the keen, brilliant genius of a Sims made possible, the intelligent, patient, practical common-sense of an Emmet made probable to every afflicted one of womankind. The field was wide, and from all parts of the country came the sufferers from childbed injuries, many of which were due to the faulty obstetric work of that day.

Among the causes were: first, long-delayed use of forceps; second, careless and needless use of forceps; third, a disregard of the accidents that occurred, and lastly, a total lack of aseptic precautions during the progress of labor.

From the first came the lesion already alluded to, vesicovaginal fistula, while from the second came the lacerations of uterus and perineum, many of which could have been remedied had the accoucheur regarded them at all and treated them according to the best known surgical principles. The great fault lay in entirely ignoring such accidents. It was no uncommon thing for old practitioners to assert in the most positive manner that in their whole

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lifelong experience they had never seen a laceration of the perineum. If the statement were true it is evident that no observation was made, for the careful examination by the gynecologist detected the grossest lesions, not only partial but complete ruptures, occurring in the practice of these proud boasters.

These are trite and hackneyed themes to the Fellows of this Society, but they are the evidences of the influence of gynecology upon the practice of obstetrics, for when once they were made known to the profession generally a new light dawned upon the obstetrician and a new incentive was given at least to more careful habits of observation. Gynecology thus in turn became the parent of a new obstetrics, and under the eloquence of that "silver-tongued" orator of the profession, T. Gaillard Thomas, to whom thousands of students and practitioners listened with a fascination rarely equalled in didactic teaching, the new department of medicine commanded the earnest attention of the profession throughout the civilized world.

For a long time the text-books of Emmet and Thomas were standards for all that was best in the new science, and they remain and will continue to be the classics in gynecology.

As a teacher Thomas had no superior, and this teaching faculty he carried especially into his text-book. While detailing his methods of operating in the simplest manner he omitted nothing that was necessary for a clear understanding on the part of the diligent student. He gave due credit to Sims and Emmet for all they had done before him, claiming nothing as original with himself unless fully justified in so doing. He was always the gentleman and scholar in his profession. While asserting his opinions in a graceful and earnest manner, he was not dogmatic to a degree that prevented him from retracting any views entertained when he became satisfied that they were not well founded.

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Among the early operators for ovarian tumors, he did much to advance abdominal surgery, which has now become a part of the field of the general surgeon. No man criticised more severely the obstetrician of his day than did Thomas. He says: "When it shall become the duty of the obstetrician, as it surely soon will under the influence of advancing knowledge, before relinquishing the care of a recently delivered woman, to inform himself as to the existence of laceration of the cervix or perineum; when the false and vicious doctrine of undervaluing or ignoring these grave accidents is silenced forever, and when a neglect of their early repair by surgical resort shall be regarded as a flagrant dereliction, then the number of women afflicted by pelvic disorders will become suddenly and wonderfully diminished. The time for this is now at hand, and the profession everywhere should raise its voice in a matter of preventive medicine as important as that of infectious diseases."

He thought twenty years ago that "creating harmony by blandness of manner and well-turned compliments do not constitute a competent obstetrician. These are the practitioners who, day by day, year after year, send forth women with lacerated cervices and ununited perineums, to furnish the gynecologist of the future cases of uterine engorgement, leucorrhea, prolapsus, and other displacements, cystitis, and a long list of pathologic states which will cling to them for life, sapping their usefulness and destroying their households."

Perhaps few men in the profession have given more study and careful practical attention to both obstetrics and gynecology than Thomas, for he was fairly entitled to be numbered among the experts in each department. Twenty years ago he wrote on these two subjects as follows: "So intimately are gynecology and obstetrics connected, in reference to this subject, that a few words upon its relations to the latter will not be inappropriate. It is no

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exaggeration to say that a very large proportion of female diseases take their origin in the mismanagement of the lying-in chamber. If this be so, and no gynecologist will deny it, to the obstetrician the importance of the perineum in this connection cannot be exaggerated. Its rupture furnishes one of the most fruitful sources for absorption of septic elements, and I do not hesitate to say that thousands of women suffer throughout their lives from uterine displacements, engorgement, and vesical and rectal prolapse in consequence of injuries inflicted upon it during the parturient act."

Such teaching as this undoubtedly had its influence upon the profession all over the country, and resulted in diminished mortality, while at the same time more care was taken of the various injuries and accidents that were inevitable, even under the best management by accomplished and competent accoucheurs. And yet the ideal in obstetrics has not been reached. Theory and practice are still very far apart. What we may know and what we may do, both in morals and in science, are sometimes two altogether distinct propositions. We may not, like the country clergyman made famous by Goldsmith, always "point the way to heaven" and "lead the way."

There are many faults yet to be overcome in the practice of obstetrics before the millennium shall dawn for the gynecologist. While our public institutions are doing good work, for the most part, in eliminating germ disease and bringing the mortality almost to the vanishing point, much missionary work needs to be done among the professional men in private practice. The criticisms I would offer are:

First. The too early use of forceps. When the pendulum began to swing from their too rare employment it went to the opposite extreme of their too frequent use.

A very large majority of cases should and will, if left alone, terminate naturally. It is a matter of small importance how long the first stage of labor continues, if all is

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normal with presentation and position. It is the second stage in which the harm is done. Twenty-four hours is not a long time for a primipara, especially when the second stage is not more than three or four hours. This time at least should be given in uncomplicated cases before forceps should be used. If pains are not especially frequent or strong, even a longer period in the second stage may be normal. A normal labor should not be interfered with, and the accoucheur who does interfere should be held responsible for accidents to mother or child.

While our predecessors were guilty of sins of omission, our contemporaries are equally guilty of sins of commission. The perineum must be dilated slowly and by degrees, and allowed intervals of rest, whereas, if forceps be applied, a laceration is sure to occur. This is no unusual case, but altogether too common. Too many practitioners give as an excuse that they have not the time to wait, and console themselves with the fact that they can safely repair any accident that may occur. This may be done partially in case of the mother, but too frequently the child suffers as well. No man has a right to practice obstetrics who is not willing to sacrifice his time to the best interests of his patient.

Second. Accidents occurring in labor are not properly repaired at the time. Young men especially have a fear of letting friends know that such accident has occurred, so either nothing is done or a careless repair is made. Every case is a surgical one, and must be treated upon the most approved surgical principles both at the time and until repair is fully established.

The fashion of late seems to be to prohibit antiseptic douches after labor. While these may not be necessary in normal labors with no accidents, lacerations should be kept surgically clean, and this can be done only by frequent irrigation with germicides. Surgical cleanliness on the part of accoucheur and patient, from the beginning of labor

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until convalescence, alone insures safety to the one and duty well performed on the part of the other.

As an additional safeguard against laceration of the perineum, I believe the timely employment of anesthetics to be invaluable. It prevents the use on the part of the patient of the voluntary muscles, which do much to cause this accident. If she be entirely unconscious, this element is eliminated. Aside from this, the suffering should be considered and relieved, even as a prophylaxis against future complications. I indorse fully what was said on this point by one of the distinguished Presidents of this Society, Dr. Reynolds, in his annual address: "I find it hard to excuse our growing supineness in regard to anesthesia in ordinary labor. There are few prejudices more utterly unfounded than our timidity about this resource. Not only does the timely and judicious use of ether in confinement not augment the liability to hemorrhages; it unquestionably lessens this risk by saving that nervous power which the unrelieved endurance of pain exhausts."

My preference in anesthetics is the A. C. E. mixture, given only during the pain. It acts promptly and does not excite the patient. It should be given cautiously by someone instructed by the accoucheur. Postpartum hemorrhage is not due to the use of an anesthetic, but to the carelessness of the attendant. A steady, careful, *persistent* manipulation of the uterine tumor during the expulsion of the child and placenta, continued until a firm contraction is produced, insures safety in almost every case.

My own experience during professional life fully justifies me in making the assertion that a strict adherence to this rule will nearly always prevent postpartum hemorrhage. It is to be feared that the rule either is not understood or is "honored more in the breach than the observance." While this may not be considered strictly within the line of discussion marked out in the beginning of this paper, and may seem to have no bearing on gynecology, yet any

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accident connected with the parturient process must of necessity bear more or less relation to that subject, and is, if not in the line of surgical, certainly in the line of medical gynecology.

The modern methods of Cesarean section have given such good results in diminished mortality that the barbarism of craniotomy has practically ceased, and the morbidity which furnished such abundant gynecologic material has correspondingly decreased.

This great progress is practically due to anesthesia, asepsis, and improved technic; and for this we must give credit to the gynecologists who have perfected the operative details of abdominal section, made possible by the discovery of anesthetics and by cleanly surgery. The credit is by no means all due to gynecologists, for obstetricians proper have felt the need of improvement and have given much to the sum total of the good work. Berry Hart, in a review of the obstetrics of the nineteenth century, says in closing:

"In summing up the general impression this perfect appreciation of obstetrics gives we may say that we have pride in the present status of our subject and unbounded hope for the future. The progress in the latter half of the nineteenth century has been most striking. A loyal and determined effort on the part of all obstetric teachers to utilize with unbiased minds their opportunities and influence in the furtherance of scientific research, aided by the enlightened clinical work of the practitioner, might make the new century one of the greatest in the history of obstetrics."

On the other hand, have we as gynecologists kept up to the ideal? Have we kept the faith transmitted to us by the fathers? Nay, more, have we improved upon the methods first made known by the fathers? Or have we departed so far from the practice given us as to merit their disapprobation? It may also be pertinent to the subject

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under consideration to inquire, Have we as gynecologists made any progress since the early days of the fathers? It would be passing strange if we had not.

Among the many good things taught by Dr. Emmet was the caution against operating upon the vagina and uterus before they were entirely free from inflammation, or, to use his own term, "pelvic cellulitis." We all know how long and persistently he used the glycerin tampon and hot-water douches to get rid of this *bête noire*—many think too long and too persistently; and yet Emmet did not believe in "chronic inflammation," for he distinctly says so. That a certain amount of exudate is left after each acute attack of pelvic peritonitis or cellulitis is well known to all of us; that pain, tenderness, soreness, and congestion belong to this condition we also know, but we should understand that this is only a product of inflammation, not inflammation itself. And though Emmet said we should not operate upon these cases while inflammation lasted, it seems that he carried the preparatory treatment too far or, at least, continued it longer than was necessary. This condition was "chronic passive congestion," a result of the inflammatory process, and not "chronic inflammation," as was taught by most teachers.

Peaslee, who was the most eminent pathologist of his time in America, and indeed had few equals anywhere, taught fifty years ago, and continued to teach as long as he lived, that inflammation was a process and not a condition or state of a part; that it was a short process (only a few days) and always a destructive process, leaving certain products called exudates; such products were either absorbed quickly (by resolution), were infected (resulting in pus), or, lastly, were partially organized, causing enlargement (swelling), heat, pain, and redness (where visible). This last impeded circulation in the part affected and gave rise to "chronic passive congestion." This was the "chronic cellulitis" of Emmet, which he spent many

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months in removing by glycerin tampons and hot douches. He feared to do a trachelorrhaphy or a perineorrhaphy until all of this "thickening and pain" were gone; in short, until the parts were well and thoroughly prepared for operation. The men who recognized this condition as one of "chronic passive congestion" and not "chronic inflammation" proceeded at once to do trachelorrhaphy and perineorrhaphy, and, when the cervix was free from cysts, the operation was a most pronounced success, for the bleeding at once relieved the condition, and the process of absorption began from that time. The hyperplasia of the uterus and vagina soon disappeared, while much time was saved that formerly was occupied by "preparatory treatment." In properly selected cases, with extreme care in the asepsis and curettage of the uterus when needed, the patient did well. If cysts or any purulent infection existed, treatment for these conditions preceded any operation. Laceration of the cervix, especially of long standing, was not always an indication for trachelorrhaphy, destruction or extreme atrophy of tissue of the cervix being a decided contraindication to the operation. Thousands of women suffered much more after the trachelorrhaphy than before. The cervical canal was closed too much, thus drainage was prevented, and often infection developed in uterus and tubes, and the last condition was much worse than the first.

Emmet never taught such gynecology as this. He did not even teach that all cases of laceration of the cervix should have an operation. On the contrary, he believed that many of them did not require any interference, simply because they were not producing any morbid symptoms. The tendency has been too much in the direction contrary to his teaching, with the result that gynecology has been brought into disrepute. Many of the symptoms that were attributed to laceration of the cervix have been found to be due not to the laceration but to disease of the other

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pelvic organs. In a majority of women during the child-bearing age dilatation to give free drainage is needed rather than trachelorrhaphy. In long-standing cases, in which ragged lacerations exist with atrophy of tissue, amputation of the cervix is much better surgery. The men who gave the most thought to this matter are the men who are still doing strictly gynecologic work. The sins of commission need atonement, and the general surgeon, I fear, is far too prone to do routine trachelorrhaphy if lacerations exist. The well-trained gynecologist is still needed in this most important condition—a condition so common and, when badly treated, fraught with so much danger. Aside from closing the canal so that stenosis follows, the scar tissue becomes a troublesome factor in future pregnancies, pre-disposing to a more serious laceration at labor.

Closely related to this subject is the matter of dilatation and curettage. While valuable in properly selected cases, such as fungoid degeneration, hemorrhages and leucorrhea due to "passive congestion" of the endometrium, its frequent use for dysmenorrhea, etc., cannot be too strongly condemned. Few cases of dysmenorrhea are even relieved by this operation, while very many are made much worse. The cause lies either in some nervous lesion or in the uterine appendages. It is an operation that requires as much care and skill in its proper performance, and good judgment as to its necessity, as any gynecologic operation that is done, and yet any tyro in the profession, with no experience whatever, attempts it and believes it a simple matter. There are places where "angels fear to tread." The gynecologist is very much needed in this very simple operation.

The plastic operation of perineorrhaphy, so often done by the general practitioner, to say nothing of the general surgeon, is far too often apologetic when compared with the work of Emmet, Thomas, Marcy, and others throughout the country. Denuding the mucous membrane and

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uniting the cut edges without gathering up and uniting the torn and separated muscles and fascia do not constitute a perineorrhaphy, yet it is within the observation of many of us that such work passes as the proper thing. It is to be feared that the "faith once delivered to the fathers" has not been kept in this particular. That intra-uterine medication is still practised to a considerable extent is apparent to every gynecologist of large experience, who is seeing constantly its evil results in infected uteri and appendages. In this instance we have made a wide departure from the pioneers in gynecology, with much advantage to women in general; but as error is rarely overtaken by truth, much remains to be done by the true gynecologist.

The field for bladder work is large and has been cultivated only to a limited extent. Emmet and Skene in particular labored faithfully and intelligently in certain directions, while Pawlick and Kelly enlarged the field of vision and laid the foundation for more accurate and more scientific treatment. Laborers still are needed in this department of gynecology.

Displacements and deformities of the uterus are yet matters of the utmost importance, while the question of treatment is far from being settled; at least, the profession believe that the various "best methods" are at present on trial. No body of medical men is more competent to investigate this than the American Gynecological Society. We believe the proper solution of the problem will be found among the Fellows of this or similar organizations—certainly not among general surgeons. Alexander, Kelly, Dudley, Mann, Goffe, and many others have contributed to the large list of operators who have done good work in this special direction.

From plastic work about the vagina and bladder, which was the primary step in gynecology, the advance to the pelvis and abdomen was rapid. Here we may claim properly that the progress and even the inception of all

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that was and is best came by and through the men that may be classed strictly as gynecologists.

It is not necessary in this paper and before the Fellows of this Society to review the work done by all men who have labored in this field. Suffice it to say that no one man is entitled to more credit than each of several others. Those most familiar with vaginal manipulations soon discovered that the uterine appendages above the vaginal vault were the cause of much suffering and subject to nearly every form of disease. At first the large cystoma seemed the only proper disease to attack by abdominal section, and Spencer Wells, Atlee and Peaslee were among the early operators, giving the world confidence in the necessity for such operations and establishing the fact that they were feasible and safe to a great degree; at least, that the mortality by operation was much less than from the disease, which showed an average duration of life of not more than three years.

Battey did conscientious work in removing ovaries, which he deemed the cause of much of the suffering of women, and accomplished an amount of good which long-continued treatment in other directions had failed to accomplish. If oöphorectomy were done too much, it was the consensus of opinion of gynecologists that checked its advance and adopted what is now deemed "conservative surgery of the uterine appendages." Polk and Dudley, of this Society, are among the most prominent in advocacy of this new departure. We are only in the beginning of the work, and certainly we must look for its completion to the gynecologist, not to the general surgeon. Many of these operations have been done through the vagina rather than by abdominal section. Between these two methods each man must choose for himself. The French gynecologists made the vaginal route the popular one; but if, as is said, this was done in defence against general surgeons, who claimed that gynecologists were

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encroaching upon the domain of the general surgeon, some better reason must be found if the practice is to be continued. Not only is so-called conservative surgery of the appendages done per vaginam, but panhysterectomy and all the major operations upon the pelvic organs are performed in the same manner.

So long as the question of choice of methods remains *sub judice* so long will the strict gynecologist be in evidence. Perhaps no man did more for the advancement of abdominal section and all that relates to its technic than the aggressive and belligerent Tait. He simplified the methods and taught practically by the force of his example and by his earnestness modern asepsis in place of the cumbersome, dangerous paraphernalia of germicidal solutions. While none of us would desire or be willing to detract one iota from the world-renowned Lister's fame, we must admit that the men who, like Tait, opposed the introduction of toxic material into open wounds are to be numbered among the promoters of surgical progress. He demanded only cleanliness, which he maintained could be secured without the use of poisonous chemicals. He popularized and improved the forceps, for the discovery of which Koeberle and Péan are justly entitled to the credit, and gave these hemostatic instruments a prominence in operative procedures hitherto unknown. His treatment of septic peritonitis by salines instead of by opiates was adopted by general surgeons. His method of preparing patients for operation, by purgation, baths, and general stimulation of all the eliminative functions as a preliminary step in all surgical operations, has been adopted as well into other departments of surgical practice.

We owe much to such gynecologists as Tait, Keith, and August Martin. They were chiefs among the scores of workers, both in this country and in Europe, who almost entirely invented and perfected the methods and technic of abdominal surgery, from the diaphragm to the pelvic

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floor, that have been adopted by general surgeons. That anastomosis of the intestines and gastric surgery have been perfected by general surgeons we do not wish to deny, but the familiarity with abdominal section that had been acquired by gynecologists gave an incentive to these later operations that otherwise would not have obtained.

Lest the general surgeon may say that abdominal surgery did not originate with gynecologists, and that, therefore, they are not entitled to the credit, our reply is that the few cases operated upon in the first half of the nineteenth century had so high a degree of mortality that the operation was practically abandoned until it was taken up and made successful by the men who were not general surgeons but specialists. In this country, Atlee, Peaslee, Thomas, Kimball, Dunlap, and many others were prominent operators.

The best work for malignant disease of the pelvic organs has been done by gynecologists, and to them must we look for further progress. Probably no man can show better results in the way of relief and even cure of cancer of the uterus than Dr. John Byrne, a former President of this Society. Whether hysterectomy in any stage of the disease is to be the ideal method is by no means well settled. The past does not give very satisfactory results from this operation, even when the most radical dissection has been done. I believe that a more careful examination and more close observation of women by general physicians will detect malignant disease in its earlier stages, at a period when hysterectomy will be the ideal operation. To gynecologists, men most familiar with these organs, we must commit the detection and treatment of a disease so widespread and fatal. The large percentage of cures in cases of cancer of the lip, which is early apparent and generally removed early, should lead us to hope that in uterine cancer a similar result may be had whenever diagnosis can be made in the incipient stage of the disease. The

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gravity of the situation demands all that science and skill of the highest order can possibly give to eradicate this the most dreaded affliction to which woman is subject.

Much yet remains to be done in plastic operations about the vagina, not only in relation to prolapsus uteri, but for vesicocele and diseases of the urethra, especially caruncle. Incisions into the posterior cul-de-sac for acute inflammatory attacks, whether attended by pus or not, may well deserve the attention of the gynecologist. While this was one of the early gynecological operations for pelvic abscess without reference to ulterior results, it is now well known that thousands of women can be saved from long and painful illness and subsequent hysterectomy by timely, common-sense application of the surgical principle of removing the products of inflammation as soon as formed.

These may seem trivial matters, which scarcely deserve presentation in a paper of this character, but they are of immense importance to the patient, for whose good we are earnestly laboring. In her behalf I make this appeal, fearing lest, attracted by the fame that follows the capital operations, participated in by both gynecologist and general surgeon, we may depart from the "faith once delivered to the saints" and learn to despise the day of small things.

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