able office. The matter is I think of great importance alike to the public and the profession, and of supreme moment to our medical students.

The subject I refer to is the teaching of operative surgery in our schools. Among a body of experts I need not dwell upon the importance of such teaching.

Each one of us knows that years after our book studies, and after having passed our examinations, we were diligent students in the art of our calling; to some operative dexterity never comes even after years of practice—to none does it come without reiterated experiences.

It must be apparent to all that for the credit of our profession, nay, in the sacred interests of humanity, this important branch of study should be so taught and examined in as to render our students competent if not expert operators.

Such competency is at the present more important than at any previous time. Twenty to fifty years ago operative work was in the hands of the few—country surgeons, or what are termed general practitioners, rarely attempted operative surgery. The cases drifted to the county or city hospitals, and the private cases fell under the care of hospital surgeons, but now the case is widely different. The complete education in the science of surgery accorded to our students has shown them that surgical operations are not the fetish they were formerly when a noted lithotomist in my hearing after an operation, fell on his knees, saying, "thank God, that is safely done," while the establishment throughout the country, in every large village of cottage hospitals has created a necessity for operative dexterity in a class of surgeons in whom it was formerly unnecessary.

I look upon it as a solemn duty to bring this matter forward on this occasion, and to urge its importance upon the regulators of medical education. At the present time England is behind other countries in this matter. Almost every school on the Continent, in France, Germany, Austria, Russia, Italy, and Switzerland, requires instruction and examination in operative surgery. In America the same holds. In Ireland for years past operative surgery has been the subject not only of instruction but of examination, while our English qualifying examinations required neither the one or other, and in the higher examination for the F.R.C.S. the matter appears to be considered of minor importance.

I am aware the subject presents difficulties, the cost of tuition must be considerable since instruction in operative surgery necessarily entails more than ordinary time and trouble. Moreover, the cost of subjects is a serious item, and their sometime scarcity a grave difficulty. Similarly the cost of examining must be alike costly and laborious, but the necessity is I think paramount and if it present itself to our surgical law-makers in the same serious light as it does to me, means will be found to carry into effect a system of instruction and examination in operative surgery which will be a credit to our schools, a help to our students, and a benefit to suffering humanity. Before closing I would express a hope that our Section may be alike interesting and useful. We are greatly indebted to gentlemen who have devoted time and trouble to initiate the discussion on arterial surgery and on intestinal obstruction. I have often thought how useful these meetings might be if in their respective sections one new fact each year was evolved, one vexed point finally settled. I believe we all wish to secure this on the present occasion in our Surgical Section, and I hope and believe that the annual meeting of 1890 will not only be interesting and pleasurable, but will leave its mark upon the science and art of surgery.

A NATIONAL DEAF AND DUMB ASSOCIATION.—A congress, attended by deaf and dumb delegates from all parts of the United Kingdom, was held at Leeds, on July 24th, for the purpose of forming a National Deaf and Dumb Association. The Rev. W. B. Sleight, of Northampton, presided. It was decided to form such an association, its chief objects being to protect the interests, to elevate the social status, and as far as possible to secure higher education for the deaf and dumb, to afford to the Educational Department, Members of Parliament, school authorities, and others information as to the condition, education, and opinion of those so afflicted, and to promote the establishment of suitable missions in neglected districts, and homes for the aged and infirm. The rules were adopted and the officers elected, the proceedings throughout being conducted by means of the deaf and dumb alphabet.

AN ADDRESS

DELIVERED AT THE OPENING OF

THE SECTION OF OBSTETRIC MEDICINE AND GYNÆCOLOGY.

At the Annual Meeting of the British Medical Association, held in Birmingham, July, 1890.

By THOMAS SAVAGE, M.D., M.R.C.P.LOND., F.R.C.S.ENG.,

President-elect of the Birmingham and Midland Counties Branch of the British Medical Association.

GYNÆCOLOGY IN ITS RELATIONS TO INSANITY.

GENTLEMEN,—I have, in the first place, two pleasant duties to discharge. One is to offer, as President of this Section, a most hearty welcome to all of you members of the British Medical Association and visitors, especially foreign visitors, who have honoured this annual meeting in our city of Birmingham with your presence. My other duty is to express my acknowledgments for the honour conferred upon myself by the Council of the Association in allotting to me the occupancy of this chair during this meeting. I can only say that, while I might easily name many other more distinguished members who could preside over you with more grace and ability than myself, I would yield to none in my loyalty to the British Medical Association, and to the department of work which this Section embraces, and also in my desire to follow the best traditions of the best men in our common profession.

The work provided for our consideration in this Section is this year, as it has been in previous years, so large and varied that it seems to me the time is now not far distant when it will have to be seriously considered and decided upon whether it will not be for the general good to have a separate Section or Subsection for Gynæcology, apart from the original one of Obstetrics. Within the memory of most of us gynæcology was merely a part of the work of the obstetrician; now, having made such great and rapid advances, it has become almost independent of obstetrics. It is true that the two sisters touch, or may even encroach upon, each other's domain at certain points, but that the projected divorce is to some extent a natural one is seen in the large number of men who practise exclusively diseases of women and who yet do not attend obstetric cases, and, on the other hand, the comparatively few obstetricians who operate to any great extent upon the abdomen.

I am aware that sometimes a difficulty may arise in attempting to draw a hard and fast line of separation, and I think the difficulty would generally come from the obstetrician, who, having failed, for example, to extract the foetus, per *vias naturales*, might hesitate to send for his friend, expert in abdominal operations, to perform a Cesarean section.

Then, again, who is the most fit and proper person to be called in as a consultant in cases of so-called puerperal fever? The general physician, the obstetrician, or the gynæcologist? If the first-named sees the case is it not likely that, whilst recognising the general constitutional condition of the patient, he might, from want of special experience in women's ailments, easily overlook some local pelvic condition, the proper treatment of which might just turn the scale between recovery and a fatal issue? Even if he fully realises the potentialities of abdominal surgery in such cases, I mean in reference to the washing out of a purulent peritonitis or the removal of distended pus-containing Fallopian tubes, etc., he would have to call in the aid of a gynæcologist to complete the treatment. Then if the obstetrician attends the case throughout what is to become of his other patients in the meantime? And ought he, when the time for an operation arrives, to send for the gynæcologist?

Although I wish to credit every practitioner with an earnest and honest desire to do his very best for his patient, yet I am sure that a feeling somewhat akin to jealousy would sometimes be likely to arise in the mind of an obstetrician when called upon to send for a fellow-practitioner to complete work which he himself in his own and nearly-allied department had failed to do.

There is one more point I should like to refer to, and that is the necessity, or otherwise, that exists for most, and certainly all large lunatic asylums, to have a gynæcologist as a member of their medical staff.

Among the causes of insanity in women, heredity, intemperance, and the vicissitudes of female life are said to be the most frequent; and it has long occurred to me, as I know it has to others, that in regard to the latter element as a cause, much good might result if every case in which there was the least doubt were thoroughly overhauled and investigated by an experienced gynaecologist.

Every one knows that occasionally, although rarely, a case of insanity has been cured by the application of a properly adjusted pessary to a displaced uterus. Then, in regard to the influence upon the mental state which is produced by the presence or the absence of the ovaries, little is known. Observation on this point has not been sufficiently extended or pursued.

We do know that sometimes the operation for the removal of both ovaries is followed by mental derangement; but we cannot, at present, say why it is so. In my own practice I find that, excluding cases of supravaginal hysterectomy, I have performed the operation, for various abnormal conditions, of removal of the appendages on both sides in 500 cases; and that the operation has been followed by insanity in four instances. Of these, three recovered, and one committed suicide. I have never seen insanity follow the removal of one ovary alone, or any other pelvic operation.

The insanity of the climacteric period, and of the puerperal period, may or may not be dependent on some occult influence seated in the ovaries, the exact nature of which, if, or when, it exists, has yet to be investigated.

Then, the mental and hysterical state of many unmarried women, of 30 years of age and upwards, is one which may well engage the careful attention of gynaecologists, especially of those who have access to fields where such cases may be seen and studied in numbers and variety.

I am aware that the above remarks are of the crudest character, and have been jotted down in the form rather of asking questions than of dogmatic statements, and also that, in my position as President, I cannot be at once replied to or argued with; but I trust that they may be regarded as thrown out for future discussion and fruition.

AN ADDRESS

DELIVERED AT THE OPENING OF

THE SECTION OF PUBLIC MEDICINE.

*At the Annual Meeting of the British Medical Association,
held in Birmingham, July, 1890.*

By ALFRED HILL, M.D., F.I.C.,
Medical Officer of Health, Birmingham.

THE PROGRESS OF SANITARY REFORM.

In view of the large number of important sanitary subjects set down for consideration and discussion in this Section, I shall purposely avoid trespassing upon your time to any great extent, but at the same time shall avail myself of the opportunity, in conformity with time-honoured custom, to address to you a few general remarks introductory to the more special business of the Public Medicine Section.

The active revival of sanitary work may be regarded as taking place about 1873, and a glance at the death-rates of either the country generally, or of the aggregate of the twenty largest English towns, or of the few principal towns individually, proves that in the seventeen years (to 1889) there has been a great improvement in every instance in the public health as marked by the decline in the death-rate. In the whole of England and Wales the diminution is from 21.2 to 17.9 per 1,000 of the population, in the twenty largest towns the fall is from 24.4 to 19.0 per 1,000, while, taking certain individual communities, we find that in London the death-rate has fallen from 22.5 to 17.4, in Liverpool from 25.9 to 21.6, in Birmingham from 24.8 to 18.4, in Manchester from 30.1 to 26.7, in Salford from 29.3 to 20.5, in Leeds from 27.6 to 22.1, in Bristol from 23.1 to 17.6, in Norwich from 21.5 to 18.4, and in Maidstone in the same time it has declined from 22.8 to 13.7. The ratios of these amounts of diminution in the death-rate are very various as indeed might be anticipated from a knowledge of the original sanitary and other conditions existing, even supposing that similar sanitary efforts have been made by each town. Cal-

culated to percentages, the diminution of general mortality for England and Wales is 15.6 per cent., for the twenty large towns it is 22.1 per cent., for London 22.6 per cent., for Liverpool 16.6 per cent., for Birmingham 25.8 per cent., for Manchester 11.3 per cent., Leeds 20 per cent., Sheffield 19 per cent., Salford 30 per cent., Newcastle-upon-Tyne 16.3 per cent., Norwich 14.4 per cent., Bristol 23.8 per cent. For Maidstone the diminution in the death-rate has attained the extraordinary figure of 40 per cent. It would be interesting to know why the three towns, Manchester, Salford and Newcastle, having in 1873 death-rates very nearly the same, should differ so much in the results of their sanitary operations, that while Salford has effected a reduction of 20 per cent., Newcastle should have benefited to the extent of only 16.3 per cent., and Manchester of only 11.3 per cent., particularly as it is notorious that the last-named town has displayed most marked sanitary activity during the whole period in question. I am inclined to think that the differences must be due to the circumstance that the sanitary defects of the one community are of a nature to admit more easily of correction than those of the others, and that in course of time the improvements in all of them will become more equal. It is interesting to observe that Bristol and Birmingham, with similar death-rates in 1873, have reduced them by amounts much more on a par with each other, namely, 23.8 per cent., and 25.8 per cent. respectively.

These results are most encouraging to sanitarians, inasmuch as they clearly demonstrate an enormous saving of life and health and money already, while they point to still greater achievements in the future, clearly refute the unfavourable opinions and predictions of those who opposed active sanitary measures as unnecessary because they considered the then existing inspectors of nuisances all-sufficient in the interests of public health, and more than justify the professional advice and Governmental action which have resulted in the sanitary organisation of the present time. It must be clear to everyone now how wise and far-seeing were the early sanitarians such as Chadwick, Southwood Smith, and others, who did so much to effect a renaissance of sanitary action about fifty years ago.

It will be observed that the improved sanitary condition of the twenty large towns results in a diminution in the death-rate 6.5 per cent. greater than that in the whole of England and Wales, a result probably due to two circumstances—first, the existence of a greater number of sanitary defects in the large towns than in the country generally, and secondly, the greater sanitary activity in the towns. But whatever may have been the difference in the proportion or rate of improvement in different areas in the country or in different sections of the population, it is quite certain that it has been very pronounced generally, and considering the short time in which the change has been brought about, it is highly satisfactory with regard to the past, and equally encouraging as to the future.

But, notwithstanding the great fall in death-rates generally, most of the large towns have death-rates which ought not to satisfy health authorities or health officers. While the death-rates of individual towns compared with similar death-rates years back show great progress, a comparison of one town with another is by no means so satisfactory. To take an example, the corrected death-rates of Leicester and Preston in 1889 are respectively 17.73 and 32.61, the former having only a little more than half the mortality of the latter. As it is hardly to be supposed that such serious difference is due to geographical, geodesic, or social conditions, one is forced to the conclusion that it is due to the difference of the sanitary state of the two towns. In Derby and Norwich we find a death-rate less than that of England and Wales, while in Brighton it is 2.2 per 1,000 below it. It would be unreasonable to expect manufacturing towns to vie with Brighton, but I cannot think it unreasonable to aim in any such town at a condition of health equal to that obtaining at present in Derby and Leicester.

Two hundred years ago, if anyone had predicted that the then death-rate of 80 per 1,000 in London would be reduced to 20, his statement would have only excited ridicule. If so late as 1873 the prognostication had been made that the sanitary activity then commencing would result, in the comparatively short period of seventeen years, in a reduction of the death-rate in the twenty large English towns to the extent of 22 per cent., and of that of Salford to the extent of 30 per cent., or of Maidstone by 40 per cent., such a forecast would have been regarded as visionary; yet these magnificent results are now accomplished facts. But it cannot be supposed that the limit of improvement is reached, that