patients? Whatever may be our lot in the future, let us all recollect

Our ancient lesson will be ever new ;
That priceless lesson will be ever true ;
Time did not teach it, time will change it not.
This, this shall last though all our lore's forgot.
To give what none can measure, none can weigh,
Simply to go where duty points the way ;
To face unquestioning the fever's breath,
The hundred shadows of the vale of death ;
To bear Christ's message through the battle's rage,
The yellow plague, the leper's island cage,
And with our noblest "well to understand
The poor man's call as only God's command."
Ay, under every century's changing sky
Shall the Greek Master's triple signal fly—
Faith, honour, duty—duty calmly done,
That shouts no self-praise o'er a victory won ;
One bugle note our only battle call,
One single watchword, Duty ! that is all !

There is no monotony in our work ; and, while trying to prevent disease, as well as to prolong life and to relieve suffering, we have frequent opportunities afforded us of training and developing our intellectual faculties, the result of which is apparent, above and beyond mere professional knowledge, in general culture, an inestimable possession, which is found in that community of men and women of all nations and of all classes who, as Sidney Whitman writes, are "united by sympathy of thought and ideas in a harmonious all-round conception of life, its dignity, its loftiest aims." We can also constantly observe, in its protean aspects, the most interesting of all studies—human nature.

Let us practise our calling as much as possible free from every trace of narrowness, bigotry, or superstition ; let us be tolerant of the opinions of all races and sects, ever keeping before us the glorious example of Him who went about doing good, in the hope that to each of us it may come

As on thy task-field closed the day
In golden-skied decline,
His angel met thee on the way,
And lent his arm to thine.

Introductory Address

ON

KING'S COLLEGE HOSPITAL: A RETROSPECT.

DELIVERED AT THE OPENING OF THE MEDICAL SESSION,
OCTOBER 2ND, 1906.

By T. PRIDGIN TEALE, M.A. OXON., F.R.S.,

CONSULTING SURGEON TO THE GENERAL INFIRMARY AT LEEDS.

FIFTY-FOUR years ago I sat in this hall of King's College listening to the opening address of my first medical session ; a time preceding the Crimean war and the Indian mutiny, when ideas as to the improvement of hospital construction and sanitation, if they existed at all, were in their infancy.

It is just over twenty-two years since I became, along with my friend and colleague, Mr. Wheelhouse, Consulting Surgeon to the Leeds General Infirmary, and had the privilege, whilst ceasing to be full surgeon, or to take any serious responsibility in clinical teaching, of being able to use six beds for patients ordered in by myself.

I need hardly say that this right I used fully with advantage to myself in keeping in touch with advancing surgery, and I venture to hope with no countervailing detriment to the work of the hospital or medical school.

Now, however, I have gradually withdrawn from the active practice of my profession and have become a looker-on. As such, may I not claim the privilege of making the subject of this address a looking backwards, rather than a critical review of the present, or a forecast of the future?

Indeed, I feel justified in so doing, inasmuch as I am one of a very small number now living who have seen through and taken part in the greatest revolution in surgical and medical practice and in medical education that probably the world has ever known, and one of a still

smaller band of men whose student life began in the original King's College Hospital, who, having witnessed the replacement of the old by a new one, your present hospital, are still living to wish God-speed to the magnificent new building of which the plans have been worked out by your architect, Mr. Pite.

The very name, King's College Hospital, is an epitome of its history. When the medical school of King's College was first established it had no hospital of its own, its students being dependent upon the hospitality of an alien hospital, not conveniently situated for students working at the College in the Strand.

Feeling the need of a hospital of their own, at a more convenient distance from the school, and under the control of the staff, the authorities purchased the old Clement Danes Workhouse, flanked by a disused burial ground as an "open space."

Such was the hospital to which I came as a student in 1852, graced by the perfect surgical manipulation of Fergusson, by the consummate clinical teaching of Todd, and the exquisite and delicate surgery and fine diagnostic instinct of Bowman. As my contemporaries, most of them my seniors, I recall Hulke, George Lawson, Christopher Heath, Samuel Dougan Bird, Conway Evans, William Preston Goodall, now passed away ; and Buzzard, Edward Liveing, and Duffin still amongst us. Partridge, anatomist and artist, was Fergusson's colleague as a surgeon ; Budd was Todd's colleague as physician ; Henry Lee was assistant surgeon along with Bowman ; George Johnson and Guy were Assistant Physicians, and John Wood in the dissecting room at the College was the prince of anatomical demonstrators.

As a transition, I doubt not, the makeshift hospital worked well ; certainly there was great clinical enthusiasm amongst us, and the most was made of opportunities by the students of that day. Yet this did not blind the authorities to the inadequacy of the building and of the accommodation for patients, an inadequacy which you will appreciate with a sort of horror when I tell you that the theatre served the double purpose of providing for operations and for *post-mortem* examinations, the dead-house being placed beneath a trapdoor in the floor of the operating theatre.

It was during my studentship that your present hospital was commenced, and the first portion was completed and brought into use in my final year, the initial year of the Crimean war.

Fine as your building is, and planned as it was in accordance with the views of hospital construction then prevalent, it had the disadvantage of being designed on the plans of the block buildings, when economy of space was deemed imperative, and when windows on one side of a ward were all that were called for.

It was just a few years too early. Nursing, as a calling which needed careful training, was just coming into being, and I remember that in the new wards recently opened ladies came for a short training in nursing before going out to join Miss Nightingale in the hospitals of the Crimean war.

I have just had the privilege of looking over the hospital, guided by Mr. Peyton Beale, whose father, the last survivor of my teachers at King's, has but recently passed away. I was struck with the very great difficulties with which the committee have had to contend in order to meet even approximately the increasing and exacting demands of modern practice, teaching, and nursing, and the remarkable way in which in such a contracted area these demands have been met.

If your present hospital has lost, by having to be built too soon to benefit by modern ideas of construction, the new one will now benefit by the experience gained during the active period of hospital construction of recent years, and so may become the most perfect building of the kind in the kingdom.

The motive, that is the moving force, which has brought about the decision of your council to take the bold step, and to face the pecuniary responsibility and effort of building an entirely new hospital on a distant site south of the Thames was the change that has come over this neighbourhood and the shifting of population, so that the present building has become, so to speak, stranded, and out of the way of the poor who need such an institution in their midst. But it seems to me that, had this not been the case, and had the demands of the neighbourhood

continued at the high level of former days, the question of a new hospital on a larger site must have become still more urgent, so great are the demands of the modern developments of medicine and surgery, and the requirements of teaching in the prolonged medical course.

By the courtesy of Mr. Pite, I have looked over the plans for your new building, and I cannot but admire the courage of your Committee in aiming at an equipment so complete, and the skill with which, provisionally at any rate, the varying and exacting demands of every department have been met.

Your old workhouse hospital served its purpose in its day, was the scene of the advanced surgery of its time, and was the sphere of work of one of England's greatest clinical teachers, Todd, and one of our greatest surgeons, Fergusson. Its cost was probably under £100,000, and it had probably 100 beds. Your new hospital will be planned in the first instance for 408 beds, with a possible increase to 600, and the preliminary estimate of cost is £366,712.

What a contrast! And what a lesson can be learned from its consideration! Let me endeavour to read the lesson by the light of the hospital I am myself familiar with, and of which I possess the annual reports of the last forty-five years. I select the Leeds Infirmary because I can speak of what I know, and I take it to be a type illustrating changes and advances which are common, more or less, to hospitals, not only in England, but all over the world, so free is the intercommunication between nations and so cordial the intercourse between medical men who are using their best faculties for furthering the science of their profession.

There are three aspects under which this lesson can be studied:

A. The history of the Leeds Infirmary during the last forty-five years.

B. A comparison of the operations recorded in the annual reports of the Infirmary, taking for this purpose five periods of five years each.

C. A consideration of the factors which have contributed to this development and these results.

A. THE EVOLUTION OF THE LEEDS INFIRMARY.

In March, 1864, I was elected surgeon in succession to my father, and within a few days the foundation stone of the new Infirmary was laid by Mr. Kitson, Mayor of Leeds; five years later we commenced work in the new building. After much discussion, some of it animated and heated, the decision had been made not to patch up and enlarge the old building on an inadequate site of three acres of inconvenient shape, but to build a new hospital on a fresh site of five acres, and planned on the best-known principles of the day. The leading principle which was then coming to the front was the pavilion system, which secured light and air on each side and at the end of every ward. The first hospital built on this plan, I believe, was the Lariboisière Hospital in Paris. The next I believe, and certainly the first in England, was in course of construction from the designs of Captain Douglas Galton, one of the pioneers of sanitary science in this country. The Committee selected Gilbert Scott as architect, and he, with the late Dr. Chadwick, Senior Physician to the Infirmary, visited hospitals in England and on the Continent in order to collect data on which our new building should be planned. Sir Douglas Galton placed his plans of the Herbert Hospital at Woolwich and his trained knowledge most generously at the service of the architect and Committee. The result was a building which in general arrangement of parts, had it to be planned anew on the present site, could hardly be surpassed now. Faults there were in detail, and as new needs arose these have been corrected. Drains were laid in all directions under buildings, and sanitary conveniences, except as regards the wards, were placed where they ought not to be. Indeed, sanitary science of house drains was not violated—it was simply non-existent. Eight years after the opening of the new building I read in the report of the Infirmary for 1877 the following sentence:

During the year the Board have given great attention to the sanitary arrangements of the hospital. The system of drainage has been altered so that the waste pipes from the lavatories, sinks, and baths have been disconnected from the soil drains and carried outside the building. The soil pipes have been

ventilated and a great number of other alterations have been made, all contributing to better light and ventilation and to the prevention of the possibility of any escape of sewer gas into the wards.

This period of the late Seventies was the time when the medical profession was waking up to the fact that a great proportion of the illness with which it had to deal was the direct result of faulty sanitary arrangements in the dwellings of their patients. Further reconstructions of drainage have taken place from time to time, and now I feel sure that the sanitary condition of the hospital is not far short of, even if it does not reach, the best standard of the present time.

Let me illustrate the evolution of the Leeds Infirmary by the consideration of three departments—out-patient, nursing, and operation theatre.

1. The Out-patient Department.

In the old Infirmary out-patients had to wait in the entrance hall at the bottom of the main staircase leading up to the wards. Cold and comfortless for those waiting, such an arrangement could not but impair the air of staircases, corridors, and wards. The patients were "seen" in a room of moderate size, the three physicians on one day and the three surgeons on another day sitting together in a crowded room, with one very small retiring room. In the new hospital this imperfect arrangement was replaced by a large well-lighted waiting room, with three rooms for the surgeon and three rooms for the physician, and a separate entrance and exit for the out-patients, who were thus cut off from the hospital proper. For many years this served its purpose admirably. But in medicine and surgery science and the requirements of practice advance, staff and patients increase in number, and these provisions of 1869 became inadequate. In 1892 an extension of the Infirmary was made at a cost of £48,000. This included as a main feature one of the most complete out-patient departments then in existence.

This department consists of a large central hall surrounded by separate suites of rooms for medical, surgical, gynaecological, and ophthalmic patients. Each compartment as well as the dispensary opens direct into this hall, and an out-patient operating theatre is provided for the surgeons, and a second for the ophthalmic surgeons with rooms for the recovery of patients after anaesthetics. Thus the arrangements for the treatment of out-patients were raised in the course of less than twenty-five years from being amongst the worst in the kingdom to a position second to none.

2. Nursing.

The old system of nursing was in full play during the early years of my surgeoncy, and came to an end with the removal to the new building in 1869. It is appalling to look back on the night nursing. Two elderly women had charge, one of each floor, with its six wards large and small, and their chief function probably was to summon the resident medical officer in case of a death—not to keep alive a poor creature hovering between life and death.

One of the day nurses coming on duty at four or five in the morning would rouse the male patients by "Now my lads arise and shine." Training of course was unheard of, and the nurses were under the charge of and were engaged by the resident medical officer, a young recently qualified man, and the housekeeper matron.

In 1869 came the "superintendent of nurses." The Board would not have a "lady superintendent" or a "sister" at any price, and the domestic arrangements were placed in charge of a housekeeper. This was the beginning of better things, but it was three years before we had a "lady superintendent" thoroughly trained and experienced in nursing.

3. The Operating Theatre.

Need I say much as to the "Operating Theatre," the development of which, as elsewhere, was gradual? In the old Infirmary—one theatre—and no room annexed for any purpose. In the new building of 1869 only one theatre with a small lobby for the staff was provided.

There was no anaesthetic room. Anaesthetics were administered in the theatre itself, not only entailing loss of time, but exposing the patient to the pain of facing an audience gathered to witness the operation he was about to undergo. There was no recovery room nor room for

the staff. For illumination at night ordinary gas-burners; no electric current either for illumination or other purposes. Cases occurring at night, smashes of limbs, strangulated hernia and such like, were operated on in the wards by the aid of large tallow candles. From this initial stage improvements and additions went on until in 1897 the old theatres were replaced by our new ones, embodying all the best known arrangements and appliances, and built at a cost of over £6,000.

B. WORK DONE AND RESULTS.

So far I have spoken of structure and management. Let me now deal with the second aspect under which our lesson can be viewed, the "work done and results," taking the facts from the annual record of the operations by the surgeons, and excluding for the sake of simplicity those done in the gynaecological and ophthalmic departments.

For this purpose I have taken five periods of five years each—five half-decades—commencing with 1861 and ending with last year.

Nothing, I think, could afford a more perfect picture of the progress of surgery or justify more completely the outlay on the improvements of hospital structure and management than these remarkable records, from which, at the risk of being tedious and of departing from the custom of introductory addresses, I will venture to bring before you certain telling facts. And here I must apologize to an audience largely composed of lay persons interested in the welfare of the King's College Medical School for dealing for a time with matters essentially professional.

As I stated before, I have taken and compared five half-decades, 1861 to 1865, 1871 to 1875, 1881 to 1885, 1891 to 1895, and 1901 to 1905.

These statistics I propose to deal with from four points of view:

1. The increase in the actual number of operations recorded.
2. The increase in the nomenclature of operations—that is, the introduction of operations new to surgery.
3. The gradual oncoming and progressive increase in the number of cases operated upon under certain selected headings.
4. The progressive diminution of death-rate in nearly all the great classes of operation.

1. Increase in the Number of Operations.

I will, in the first instance, compare the first year and the last year of the series, not the half-decades.

In 1861, 211 operations are recorded with 16 deaths (1 in 13); in 1905, 2,544 operations with 142 deaths (1 in 18). And this number does not include the operations in the gynaecological or ophthalmic or casualty departments; the deaths of 1905 include 83 deaths out of 829 cases of accidents (1 in 10), and 57 deaths out of 1,715 (1 in 30).

2. Increase in Nomenclature of Operations.

In 1905 there are 90 names of operations which do not appear in 1861, and 1,158 operations, nearly half, were performed which were not thought of, many of which could not have been undertaken at that earlier period.

3. The Introduction and Gradual Increase of certain Classes of Operation.

The term "abdominal section" appears for the first time in the second half-decade, 1871 to 1875. Under this heading neither rupture nor hysterectomy, nor operations on the kidney or appendix are included. The numbers are—none in the first period, 2 in the second, 67 in the third, 279 in the fourth, 1,258 in the last.

Let us take another class, "Operations on lymphatic glands." These appear first in the third period, 1881 to 1885, as 28, in the fourth period as 462, in the fifth as 429. "Operations for appendicitis" appear first in the fourth period, 1891 to 1895, as 25 in number, in the fifth period as 540.

"Operations for the radical cure of rupture," when not strangulated, and therefore not in an acute condition. These first appear in the second period, 1871 to 1875, as 3 in number, in the third period they are 13, in the fourth 225, and in the fifth 790.

So much for the increase in numbers.

4. The fourth point which I bring before you, and the most telling, is the *progressive diminution of fatality*.

Let us take first "ovariotomy" and its kindred operations. In the first two periods, out of 86 cases 1 in 3 proved fatal; in the last period, out of 195 cases 1 in 21 proved fatal.

To return to "abdominal section," which includes operations in dangerous conditions, such as obstructed bowel and perforations of stomach and intestine, we find that in the third period, 1881 to 1885, out of 67 cases more than half were fatal; in the fourth period, out of 267 cases 1 in 3½ was fatal; in the fifth period, out of 1,258 cases 1 in 4 was fatal.

"Operations on the kidney": Of 38 cases in the fourth period, 1 in 4½ was fatal; of 132 cases in the last period 1 in 12 was fatal.

"Radical cure of hernia": Of 225 cases in the fourth period fatality was 1 in 11; in the fifth period, out of 790 cases the fatality was 1 in 197.

"Strangulated hernia": In the first two periods the fatality was nearly 1 in 2; in the third, 1 in 3; in the last two, 1 in 5.

The last illustration shall be taken from "amputations." If amputations for accidents and for disease are grouped together the results work out as 1 death in 3½ in the 1860, 1 in 5½ in the 1870, 1 in 6½ in the 1880 and 1890, and 1 in 10 in the 1900 periods. If amputation for disease alone is taken a somewhat similar progressive diminution occurs.

There is one remarkable fact in reference to amputations which demands notice. Whereas in every other instance of operations of which for the purpose of this address I have taken out the figures there is a progressive and often very remarkable increase in the number performed, there is in the number of amputations a progressive and very marked diminution. The figures for the last four half-decades are, in the case of accidents, 166, 113, 91, 84; in the case of accident and disease combined the numbers are 316, 291, 261, 208.

What can be the explanation? Two things probably concur in producing this result. One that severe accidents calling for amputation are probably more rare owing to the falling off in new railway construction in the neighbourhood and also to the more stringent laws in reference to protection of machinery and the Employers' Liability Acts. The second, and probably the leading factor may be that, by the aid of improved conditions pervading hospitals and improved methods, many limbs can now be preserved which in former days would have been condemned to amputation as the only safe course.

Have we not here a striking picture of the progress of surgery and of its results? It now remains to complete the lesson by a consideration of—

C. THE FACTORS WHICH HAVE RENDERED POSSIBLE SUCH RESULTS, AND THIS ENORMOUS INCREASE IN THE NUMBER OF OPERATIONS JUSTIFIABLE.

First of all came the recognition that the source of nearly every blood poisoning disease, such as erysipelas, pyaemia, and the like, the curses of surgery, was something introduced from outside, a germ which could be introduced into the body and multiply and produce destructive changes tending to impede repair or to destroy life. The new doctrine, thanks to the labours of Pasteur and Lister, rapidly spread, in spite of non-acceptance and even opposition on the part of some surgeons. The word went forth to fight the germs, which were assumed to be all pervading—in the atmosphere as well as in wounds. Hence followed—and a valuable step in progress it proved—the "antiseptic" period, when the carbolic spray was used to form a protective atmosphere about the patient, and chemicals were used to preserve the dressings and wounds from septic influence.

Then came the science of Bacteriology which has unmasked for us the natural history and source of the baneful germs, and in the case of many of them has taught us where they are to be found, and how they are to be excluded; in fact, it has laid the foundation of "aseptic" surgery, which aims at the exclusion of germs rather than at their destruction after they may have gained a foothold.

This, then, is the meaning of the elaboration of design in a modern hospital.

Sanitary science has taught us how to keep the air of our wards pure and to secure the most perfect cleanliness. Hence the polished floors and walls, the corners rounded, the abolition of cornice ledges and of every place where dust, possibly germ-laden, may lodge. This is the meaning of the careful arrangements of the operating theatre, clean washing coats for surgeons and staff, cleanliness of person of patients and attendants, sterilization of water, dressings, swabs, and instruments.

These are the means which, aided by the accumulating knowledge and skill of surgery, have led to the astonishing results I have already laid before you.

May we not now take stock of our position?

Let us consider where we, as medical men, stand compared with those early days I have spoken of.

In 1852, fifty-four years ago, sanitary science was a sealed book to nearly every medical man in the kingdom; and to nearly every architect and builder, and the sanitary engineer had not arrived. At that time chloroform was the only anaesthetic, and was used sparingly and timidly, and, under the influence of Dr. Snow, Anaesthetist to King's College, was winning its way into favour. Now anaesthetics are used freely, and, thanks to the introduction of ether, can be used for examinations and operations which, without anaesthetics, would have been out of the question, or hardly justifiable.

In 1854 came the ophthalmoscope, introduced into the Royal Ophthalmic Hospital, Moorfields, from Germany by the late Dr. Bader. This opened out a world of discovery in ophthalmic science, and, thanks to the work of Professor Clifford Allbutt, it has proved a valuable addition to the clinical resources of the physician. As surgery gave the ophthalmoscope to the physician, so in turn the physician gave the clinical thermometer to the surgeon. And here the profession is again under obligation to Clifford Allbutt, who, perceiving the possibilities of clinical thermometry, saw at the same time that the long thermometers in a wooden case carried under the arm would never come into general use, and at one stroke rendered everyday use of it practicable by reducing the size to a "pocket edition," and inventing, or procuring the invention of, the recording index.

Next came the laryngoscope—at first a sort of toy and looked upon as a fad, but now claiming a special physician and a full share in the suite of six rooms assigned to the "ear and throat section."

And what shall we say about electricity in all its bearings? At one time the profession looked askance at its votaries, with suspicion as to their scientific aims, and with some doubts as to their perfect honesty. The truth that underlay the imperfect early attempts to utilize its power has gradually commanded the attention of the profession and enlisted earnest scientific workers in its service; and now we find in the instructions to the designer of your new hospital a requirement for a suite of not less than nine rooms to be devoted to radiography, treatment by x rays and Finzen light, electrical treatment, massage, and gymnastic treatment.

Truly, these are powers but recently incorporated in the resources of the profession, and new means by which, if used well, wisely, and intelligently, mitigation can be won for the ills of suffering humanity.

My theme has held me so long that time is not left for the consideration of the bearing of all these changes and expansions on medical education. I might have pointed out how much has been done to mitigate the increased demands of expanding knowledge by improved methods of teaching and by the development of opportunities of practical work, entailing increased cost in time and money on the part of medical schools and students. I might have deplored the increased number and increased stringency of examinations, so crippling to the best kind of study, and the helplessness hitherto of the authorities in facing and rectifying an excess which is an almost universally acknowledged evil.

May I be permitted to conclude this retrospect with the words of one of our greatest men, Sir James Paget, who, in his address to the International Medical Congress in London in 1881, said:

"We that can read in memory the history of half a century might look back with shame and deep regret at the imperfections of our early knowledge if we might not be sure that we held, and sometimes helped onward, the best things that were in their time possible, and that they

were necessary steps to the better present, even as the present is to a still better future.

"Yes, to a far better future; for there is no course of Nature more certain than is the upward progress of science. We may seem to move in circles, but they are the circles of a constantly ascending spiral; we may seem to sway from side to side, but it is only as on a steep ascent, which must be climbed by zigzag."

SEVENTY-FOURTH ANNUAL MEETING

OF THE

British Medical Association.

Held at Toronto, August 21st, 22nd, 23rd, 24th, and 25th, 1906.

PROCEEDINGS OF SECTIONS.

SECTION OF DERMATOLOGY.

NORMAN WALKER, M.D., F.R.C.P. Edin., President.

PRESIDENT'S INTRODUCTORY REMARKS.

THE PLACE OF DERMATOLOGY IN THE MEDICAL CURRICULUM.

In the first place I have to express my appreciation of the very great honour the profession in Canada has bestowed on me in asking me to preside over these meetings.

There are not many who are so intimately associated as I have been with the ins and outs of the arrangements of the Annual Meeting, and I can assure the dermatologists of Canada that while I admit that they could have got one more worthy they could not have got one more appreciative of the honour. It is a matter of great regret that the near approach of the International Congress in New York has prevented an adequate British, or rather Great British attendance at this meeting. But at any rate, I do feel that it is not inappropriate that you should have asked a native of that country to which Canada has owed so many of its leading men to preside over your meetings on this occasion.

In addition to the members of the Association, we welcome to our meetings the dermatologists of the other great branch of the Anglo-Saxon race. Lord Rosebery is the author of the happy phrase of "all the Britains"; at this meeting we welcome "all the Anglo-Saxons."

As a member of the Annual Meeting Committee since its inception, I am of course cognizant of the rule that the introductory remarks of the President of a Section are not to occupy more than fifteen minutes, and it would ill become one responsible for the administration of the rule to even come near breaking it. But I am equally aware that some introductory remarks are usually expected, and, though I fervently trust your expectations are not high, I fall in with the usual custom.

There are at present no very burning questions in dermatology, and its praises and its progress have been hymned so often that I do not propose to add another verse to the harmony. I might have sketched the history of our branch of medicine in Canada, but at a distance of 3,000 miles the necessary information would have been difficult to get. I did think that the connexion between Scotland and Canada was so close that an account of dermatology in Scotland might not be altogether inappropriate, but on second thoughts I abandoned the idea. The subject with which I propose to fill up the remainder of my fifteen minutes is the place and position of dermatology in the medical curriculum.

I have often noticed in those general addresses, which many of the leaders of our profession are so happy in delivering, that their counsels often amount to a glorified account of the practice and custom of the school with which they are or have been associated. This line I shall endeavour to avoid; it is not, I fear, humanly possible altogether to avoid reference to it.

I sometimes reflect that with all our progress in medical education the student of my time, now a quarter of a century ago, had some advantages. There was then in Edinburgh no skin department, and all the physicians