SOME OBSERVATIONS ON OUR OUT-PATIENT DEPARTMENTS.

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Now that the Medical Schools of London aspire to form a constituent part of a university, it becomes necessary that each governing body should put its house in order. The fact that the London hospitals have hitherto been regarded mainly as charities, destined for a certain class of sick only, must yield to the more important fact that their chief function, by force of circumstances, has become the training and education of the medical student. The greater attention paid during the last fifty years to the development of workhouse infirmaries, the admirable manner in which these are conducted, the spread of excellent nursing of the poor, both in and out of the infirmaries, renders the exclusively eleemosynary character of our hospitals a minor consideration. Their teaching value, and the teaching power of their medical officers, now, more than ever before, assume a position of national importance.

It is especially with reference to our out-patient departments that I venture to submit a few remarks which appear to me to bear closely upon the present tendencies, though for the last forty years I have borne similar testimony when the opportunity offered.¹ Hitherto the ardent love of their profession has induced our out-patient physicians and surgeons to submit to unreasonable demands of the governors of hospitals which ought no longer to be borne; a regulated system should be uniformly introduced which would enable the students to study disease and its treatment in a manner which the unavoidable urgency of time and the numbers of the patients at present render generally impossible. As I have said elsewhere, the out-patient departments ought to bridge over the interval between clinical instruction in the wards and independent practice. The numbers that at present attend as out-patients render adequate teaching perfunctory, and it is quite impossible for the physicians and surgeons, however they may be conscious of the flagrant abuses to which the out-patient department is subjected, to distinguish between deserving and undeserving applicants. Both on economic as well as on scientific grounds (the latter of which I am alone concerned with at present), a thorough weeding out of unsatisfactory cases is the first consideration.

If the view is adopted and acted upon that the out-patient departments of our hospital schools of medicine are to be made more prominent features in medical education than has been hitherto the case, there are three factors that require special notice and demand great attention. They are: 1, the patients; 2, the students; and 3, the teachers.

1. *The Patients.*—If the teaching is to be effective it seems to follow that a definite mode of selection of suitable cases must be adopted. A variety could not fail, and probably every school would prefer its own procedure to having one dictated to it. If the principle is adopted, a definite number of new cases should be agreed upon, and any surplus should either be handed over to other institutions or left to their own discretion. A long experience in hospital work teaches us that patients to whom special clinical attention is paid would be rather flattered than not by their particular cases receiving the extra care and discussion which would be unavoidable. Perhaps the physician or surgeon in attendance would most speedily discriminate at a cursory glance the particular form of disease specially suitable for teaching; which patients should be left to the house-physicians or house-surgeons, or which admitted to his consulting room. These, as well as other matters connected with the question, require

careful elaboration, and would, assuming the main principle to be acceptable, probably be best solved by a discussion of the points of practical importance by a friendly meeting of the physicians and surgeons of out-patients of the London schools of medicine.

2. *The Students.*—The haphazard way in which medical students have attended the out-patient departments has generally been of a most irregular and perfunctory kind, and ought under any circumstances to be put an end to. It seems very doubtful whether they ought to be permitted to receive instruction such as can be conveyed in the out-patient department until after they have not only attended to systematic lectures on medicine and surgery, but also received bedside instruction in the wards of the hospital. They ought to have laid a foundation to their practical knowledge of disease and the social as well as therapeutic treatment of patients, from their clinical, before they present themselves to their polyclinical,² teachers. Each student should, after the case has been duly examined and the outline of treatment determined by the physician or surgeon, be required to take notes of the case and its progress, and, if requested by his teacher, to follow it up at home and report upon it. The limitation of the number of patients would prevent any abuse of such a system and avoid converting the polyclinic into an ordinary dispensary, or appearing to compete with the neighbouring general practitioners. If this method is conscientiously and rigidly carried out, it would in a great measure form a substitute for advantages often attributed to the ancient apprenticeship; while, as said before, it would serve to bridge over the chasm that now exists between hospital teaching and independent practice.

3. *The Teachers.*—If the proposed system is carried out, it is not calculated to increase the drudgery of the present out-patient work, but to enhance the intellectual interest and the prestige, now not very exalted, attaching to the office of out-patient physician and surgeon. The terms, which are most misleading, of "assistant-physician" and "assistant-surgeon" should be reserved for cases in which the physicians or surgeons are really assisted by their subordinates, and not applied to gentlemen whose qualifications and social status are in every way equal to those of the gentlemen attending the in-patients. It is a question whether it would not be wise to let each class of officers be interchangeable annually, so that the clinical and polyclinical professors had throughout the same interest in the students and their careers. The question of fees requires reconsideration, the more so as, under such a system as proposed, there would be a similarity of duties and responsibilities. It certainly seems hard that, according to present arrangements, the arduous work of the out-patient officers is neither acknowledged by prestige nor by remuneration. Labouring as they do, they have never found a politician to make pets of them, and it is only common justice that their claims to recognition and to reward for their devotion to the public good should be listened to, though they themselves are probably the last to advance them. There seems no reason why the fees now received for hospital practice should not be equally divided by all who are engaged in teaching, whether in the wards or in the out-patient department.

The object of the foregoing remarks is solely the advancement of the scientific study of medicine and an enlargement of the value of our large hospitals. It is not to be denied that there are difficulties; especially is it to be apprehended that some of the present supporters of hospitals may be alienated when they find that they do not obtain an exact *quid pro quo* for their subscriptions. But it is to be hoped that, when they understand the importance of doing everything that is possible for the advancement of the most beneficial of all professions, and know the sacrifices made by those who cultivate it, their objections may yield.

If my readers adopt the general views suggested in the preceding remarks, there ought to be no doubt that their

² The term "polyclinical" has not found favour in England, but it seems very convenient as a substitute for our more cumbersome term. When it was first suggested to a distinguished Oxonian friend of the writer many years ago, now deceased, he misinterpreted it as being derived from *πολύς* and not from *πόλις*.

¹ The gist of the present remarks are to be found in the Report of the General Medical Council's Report on Professional Education for 1869, p. 157.

influence would sooner or later ensure a realisation of the principles involved, and thus place the medical schools of London and the country on even a higher plane than they have already occupied.

AN INTRODUCTORY ADDRESS ON THE RELATIONS OF DERMATOLOGY TO GENERAL MEDICINE.

Delivered at the First Meeting of the Dermatological Society of Great Britain and Ireland.

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THERE is, perhaps, no branch of medicine, not even ophthalmic surgery, which is so instructive in the broad principles of pathology and therapeutics, as that of diseases of the skin. Like the eye, the affected parts are obvious and easily investigated; so that we can see the various stages of disease which are invisible in the case of the mucous membranes, the solid viscera, or the bones and joints.

Unfortunately it was long before the morbid changes of the skin were studied as a matter of direct observation. The two foibles of medicine—the desire to explain instead of to investigate which has always impeded pathology, and the desire to cure instead of to understand which has always obstructed therapeutics—have been, perhaps, more mischievous in this than in any other department.

At the new birth of science which followed that of literature and art in the sixteenth century, medicine was found dominated by the ancient Greek hypothesis of the four humours with the temperaments which resulted from their union. The whole of a physician's knowledge then consisted of an acquaintance with Latin writers and Latin translations of Greek and Arabian writers, a knowledge of books and phrases and theories, with contented ignorance of objects and of facts. The first step in advance was made by Vesalius and the great Italian anatomists of the sixteenth century. The second was the work of Harvey in demonstrating that the heart was a muscle, and that the blood was driven round the body by its contractions. Succeeding inquiry proved that phlegm is not secreted by the pituitary gland, and that there is no such thing as black bile. Nevertheless, by a common infirmity of human nature, physicians clung to the conclusion when the premisses were proved fallacious, and still ascribed cutaneous disorders to humours and their ill mixtures. Even now there are insurance offices which gravely ask whether an applicant is of sanguine or lymphatic temperament.

Another hypothesis which long took the place of observation was that affections of the skin, beside being due to diseased humours and impurities of the blood in general, were in particular caused by a widespread condition known as scorbutus or scurvy, a real disease, as we now know, of dietetic origin, preventable, and by the efforts of scientific medicine now happily prevented, except in rare cases, when officers of Her Majesty's forces refuse to follow the physician's advice. Even now our patients will sometimes speak of eczema or scabies or syphilis, as "a breaking out of the scurvy."

Another imaginary cause of cutaneous eruptions was scrofula or struma; terms applied at first to swellings of the neck whether of the thyroid or lymph-glands, and afterwards to any condition of ill-health which the physician or surgeon chose to "explain" instead of investigating.

To some extent the diagnosis of syphilis was abused in the same manner as an arbitrary explanation of whatever could not be understood, and I have known a surgeon pronounce an eruption to be syphilitic "because he did not know what else it could be." Since, however, Mr. Hutchinson has taught us to recognise the later stage of congenital syphilis

by definite marks, we no longer hear of it as a possible remote cause of non-syphilitic diseases, including what was once described as the "ugly type of scrofula."

In countries where malaria is common there have not been wanting attempts to ascribe one, or many, or all of common affections of the skin to this source, but they have not been accepted by any but their authors. A similar fallacy is, I think, the ascription of eczema and psoriasis and countless other diseases to what in England is called a gouty diathesis, and in France *arthritisme*. Now "diathesis" in Greek is "disposition" in Latin, and how, I would ask, are we to define a gouty disposition? If carried out the patient is no longer "gouty" but has gout, and if the disposition is not carried out it remains an unproved assertion.

So far as these various hypotheses were guesses at the real nature and cause of disease their aim was right, but they were all absurdly premature, almost as much so as the conclusion of a patient of my own who once said, with frank inconsequence, "Of course, I know nothing about medicine, but I am quite certain all diseases arise from the stomach." The fact is that our patients are adepts at etiology. They are sure that consumption is not (in their family) hereditary; that dyspepsia is never due to overeating, nor cirrhosis of the liver to intemperance in drink; that rheumatic fever is caused by sleeping in a damp bed, and Bright's disease by overwork, and psoriasis by "worry", and scabies by mental strain, and tinea versicolor by too frequent use of soap and water.

True etiology is the last outcome of long-continued observation and experiment. We can now assert that every child with the rash of measles has been in contact with a case of the same disease; that every case of anthrax depends upon the presence of a particular species of plant in the lymph, blood and tissues; that every case of rupia has been preceded by specific infection; that ringworm is caused by a fungus, and scabies by a mite; and thus far we are as certain as when a blue line on the gums tells us the cause of paralysis of the arms, when we ascribe a case of pericarditis to rheumatism, or one of multiple synovitis to gonorrhoea. At present, however, what most hinders progress in this department is that our questions are prematurely answered by the allegation of causes, some of them non-existent, some of them unproved and unprovable, and most, even if true in part, so limited in their action and so dependent upon concomitant conditions that their influence may be practically neglected.

We now know that the Galenical theory of the four humours was false, and if by chance it included an accidental admixture of fact here and there, this must be proved on independent grounds. Diseases which once were confidently attributed to disorders of the blood—as scabies to a "psoric dyscrasia"—are now known to be the result of definite local irritants. We know the very limited and constant effect of scurvy on the skin. We have abandoned such misleading terms as "scrofulous" or "strumous" because, so far as they have any meaning, they are insincere synonyms of tubercle. We recognise an eruption as due to syphilis or not due to it, and warn our students against talking of a syphilitic psoriasis as they would of a measly scarlatina or inflammatory sarcoma. Let us hope that our German colleagues will no longer call iritis "rheumatic" only because it is not syphilitic, and that we in England shall leave the use of "gout"—when we do not mean deposit of urate of soda in the tissues—to our patients and the term "nervous debility" to advertising quacks.

In dermatology we are taught by the clearest examples that we must begin by accurate observation of anatomical facts. Willan and Bateman were the first writers to be imitated; Alibert was the example to be shunned.

When the various anatomical lesions have been recognised and defined; when their microscopic as well as their external characters have been thoroughly investigated, then only may we proceed to a pathological classification. This was the attempt of Hebra, following Rokitansky, as Willan and Bateman followed Linnæus.

Thirdly comes the "historical" classification, we may call it, of diseases of the skin by their origin, development, and natural history.

An important step in this direction was made by Bielt when he grouped together all diseases of syphilitic origin.