The practice of medicine at St. George's Hospital forty years ago / [W. Howship Dickinson].

whereas with the larger [illegible] dilatation as well as parietal thickening. It looks as if the smaller vessels had some special cause of hypertrophy beyond that which affects the larger. There may be a special inhibitory mandate addressed to their muscular tissue, but against this we have to place the fact that the fibrous tissue, to which no such mandate could be held to apply, is at least equally thickened. Whatever be the cause of the hypertrophy, it must relate equally to both coats.

In searching for the primary seat of obstruction, however our attention may be arrested by the arterioles, we must not disregard the capillaries. These have been proved to be contractile, though they are not muscular.[1] These vessels are in more intimate relation to the blood than any others, and may be supposed to be the first to be influenced by its abnormal conditions; and as evidence that they are so influenced we have the appearance of dropsy—or, in other words, of abnormal capillary transudation—at the outset of renal disease. This process is capillary and not arterial, and at least points to a morbid condition of which the capillaries, not the arterioles, are the seat. Arterial obstruction, indeed, must be prohibitive of dropsy by cutting off the blood from the vessels which are its source. These considerations appear to indicate that, whatever be part of the terminal arteries, the capillary system is the point of departure of the series of changes which have been described. Whether these terminal arteries have any special sympathy with the capillaries with which they are so immediately connected is a question which suggests itself. Whatever be the explanation of the vascular changes upon which I have dwelt, it must include the fibrous thickening as well as the muscular.

Without attempting to pursue these questions to the end I will content myself for the present with having demonstrated the fact that under renal disease, putting aside the

[1] Paper by Dr. Roy and Dr. Graham Brown on 'The Blood pressure and its Variations in the Arterioles, Capillaries, and smaller veins.' (*Journal of Physiology*, 1879-80, Part 2, p. 323.)

pulmonary department to which the same rule probably applies, there occurs a hypertrophy of the cardio-arterial system which is universal from its origin to its termination, and comprises not only the ventricle and the arterioles, but affects also the intermediate arteries of every size.

In conclusion, I have to thank Dr. Rolleston, Dr. Lee Dickinson, and Dr. Cyril Ogle for procuring the specimens of which I have made use. My especial thanks are due to Dr. Rolleston—and to a larger extent to Mr. Fenton—for cutting and mounting the sections.

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* *THE PRACTICE OF MEDICINE AT ST. GEORGE'S HOSPITAL FORTY YEARS AGO.*[1]

It was my good fortune, between the years 1852 and 1854, to serve as clinical clerk under Drs. Wilson, Page, Bence Jones and Pitman respectively, added to which, Dr. Wilson and Dr. Page, on their retirement from the Hospital, presented to me, unasked, their entire collections of clinical books. The notes were then kept in books, not on detached sheets as at present. With these at my command, together with the post-mortem books, I will try to present the practice of the time, avoiding, as a rule, any personal reference to the practitioner. As regards one series only, which belongs to an earlier period than that of which I shall chiefly speak, shall I identify the physician.

Among the books which I received from Dr. Wilson is one which records the practice of 'the great Thomas Young,' who was physician to the Hospital from 1811 to 1829. The volume, which relates to the years 1828 and 1829, was passed on to Dr. Wilson, together with Dr. Young's hospital patients, on Dr. Wilson's appointment. This book appears to me to have especial interest, as exhibiting the state of medical practice in the early part of the century, and as exercised by the most comprehensive genius and greatest man of science who ever held the office

[1] *St. George's Hospital Gazette.* May and June. 1893.

of physician to St. George's, or, indeed, to any other hospital. Dr. Young's notes comprise those of 145 cases. They are ample and minute in treatment, but without any clinical particulars excepting an occasional word of diagnosis, and here and there a brief note of the post-mortem appearances. In the list of diagnoses we miss some which in the present day we are but too familiar with. There is no mention of albuminuria or of any renal disease excepting 'nephritis calculosa'; only one of disease of the heart, in the terms 'pleurisy or carditis.' Strange to say, there is no reference to anasarca or any kind of dropsy excepting ascites; there are frequent notes of fever with ulceration of the bowels (the typhoid of to-day); some of pneumonia, pleurisy, hydrothorax, phthisis, rheumatism, scarlatina, erysipelas, chlorosis, and ague—the last with some frequency. There appears to be no reason to think that the diseases in this Hospital then were very different either in kind or character from what we have now; though, as there were fewer means then of tracing disorders to their organic origins, they were named more superficially. I find that of the 145 patients, 18 were bled and 11 cupped, besides which many were leeched. Thus, every eighth person suffered phlebotomy, every eleventh cupping, but the amounts were not enormous. The average of venesection was ten ounces, of cupping eight ounces. The most striking feature in Dr. Young's practice was his constant use of blisters. Of the 145 patients of which I have records, 89 were blistered. The total number of blisters employed was 158, so that Dr. Young used more blisters than he had patients. The largest number applied to any one patient was eight. This man, apparently suffering from rheumatism, had one to the sternum, one to the nape, one to the temple, two to the head, one to the hip, and two to the heel. I dare say some may have done good, especially if locally applied, for local rheumatism—a practice which has since been largely resorted to. But Dr. Young appears to have used blisters somewhat indiscriminately, applying one over any part which was thought to be diseased, and often one

to the nape of the neck—I suppose on some general theory of derivation. Sometimes the blisters were kept constantly open, and Dr. Young frequently employed a plaster under the name of Emplastrum Carui. This, I presume, is what was called Emplastrum Cumini, which contained cumin, caraway, and resin, and probably had irritating properties. Dr. Young evidently had great faith in counter-irritation. In this respect he may have caused some unnecessary discomfort, but probably did little other harm. He gave small quantities of wine not infrequently and cinchona frequently. Of the 145 cases, 51, or more than a third, had this bark at some time or other, besides a few who took quinine.

It may be of interest to look at Dr. Young's practice in regard to one or two individual diseases, selecting some which can be clearly identified. One of these is 'Fever'—certainly in most cases typhoid, though not so named.

Nine cases of this kind are recorded. Seven were 'cured,' two died, in both of which the small bowel was found to be ulcerated. The treatment comprised general and local blood-letting, blistering, calomel and antimony, cinchona and wine. One was bled to 10 ounces; one was cupped on the nape to 12 ounces; one had 12 leeches to the head; another, 32 leeches in three instalments, of which 20 were to the head. Three patients were blistered, two upon the nape. Six had calomel and antimony, one calomel without antimony, and one antimony without calomel. The calomel was usually given every four hours in doses which varied from half-a-grain to two grains; the antimony, as James' powder, as often, in doses of from two to five grains. Cinchona was given in five cases; wine in two.

A fatal case of pleurisy was treated with leeches and blistering, and the administration every four hours of James' powder, Dover's powder and calomel, the last only in half-grain doses. One, not fatal, had only antimony and ipecacuanha. A case described as pneumonia was first blistered, then treated with haustus salinus, squills, ammonia and wine.

In the whole of Dr. Young's practice of which I have record there is no instance of the internal use of iodide of potassium. In two cases tincture of iodine was given in doses respectively of eight and six minims ; in one case iodine ointment was used, and in another an ointment of iodide of potassium.

Iodine was discovered as far back as 1812. Iodide of potassium had become known as a sorbifacient, and had even been credited with the power of absorbing the mammæ and testicles, but whether from neglect or distrust, this remedy found no place in Dr. Young's pharmacopœia. We can scarcely realise the exercise of medicine in this sinful world without it.

We discern in Dr. Young's practice much moderate blood-letting, much counter-irritation, a general but not excessive use of mercury and antimony in most febrile and inflammatory affections, a liberal administration of bark, and occasional recourse to wine. Dr. Young's methods were more lenient, less exhausting and more supporting than much which came after; and I can scarcely doubt that they gave better results. I have been told that he was regarded by some of his contemporaries as a feeble practitioner, and described by the students as 'a great philosopher, but a bad physician.' But the Apothecary of the Hospital, who in those days had a subordinate charge of all the medical cases, appears to have thought differently ; for it is recorded as his experience that a greater proportion of Dr. Young's patients were discharged 'cured' than of those who were subjected to the more energetic treatment of his colleagues. And Dr. Wilson speaks of his predecessor in terms which suffice to show that both these learned physicians were in advance of their age. Dr. Wilson writes thus in 1845 :—'For many years past, by a system of mock-energy in the treatment of disease, reckless in its means because opposed to reflection, and pretending to facts from the absence of principles, the study of physic has been discouraged in this country, and its practice degraded' ; and subsequently, looking back upon the

practice of Dr. Young, and his want of popularity as a physician, his successor thus explains the position of the elder philosopher :—'He lived in an age when what is called *vigorous practice* was very generally prevalent ; when the use of calomel and the lancet was in the ascendent ; when symptoms were rudely interfered with and combated without any proper study of the causes in which they originated.' Dr. Young had the caution of a philosopher, Dr. Wilson the temper of a sceptic. The public asked neither for philosophy nor scepticism, but like Christian and Hopeful, preferred to follow Mr. Vain Confidence, too often, like them, to find themselves in the clutches of Giant Despair.

I will now put together some particulars of treatment belonging to the four years from 1851 to 1854—roughly speaking, forty years ago. My aim will be to present not so much the practice of individual physicians as the fashion of the time in the treatment of particular diseases.

To take first, 'Fever.' This was mostly typhoid at the time of which I speak, and was then beginning to be described by that name. Typhus was less frequent, but nevertheless was well known in the wards. To take typhus first, two fatal cases were treated with haustus ammoniæ acetatis every six hours, and mercury—in one, two grains of grey powder, in the other, three grains of calomel—three times a day. In one case a little wine was given towards the end, in the other none.

Of the treatment of typhoid I could adduce numerous examples. The same 'antiphlogistic' principles were carried out mainly by means of salines, mercury and antimony. Haustus potassæ tartratis with perhaps twenty minims of antimonial wine, every six hours, was common, sometimes varied by the omission of the antimony and substitution of citrate or acetate of ammonia for the potash-salt. It was usual to give also mercury, sometimes two or three grains of grey powder three times a day, sometimes either Dover's powder or calomel and opium at

night only. Wine was for the most part withheld or given but sparingly, or only at last.

Dr. Wilson's practice was somewhat exceptional in his usual avoidance of mercurials in typhoid. An ammoniated saline with a little chloric ether was his ordinary prescription, with perhaps two ounces of wine and 'Fever diet.' Whey and Wenham Lake ice comprised the rest of his dietary. 'Fever diet' was emphatically a low diet, consisting only of a pint of tea morning and night, with a quarter of a pint of milk, twelve ounces of bread daily, and barley water *ad libitum*. The diet employed by the other physicians was not very different. In the treatment of fever at this time we see the same belief in mercury and salines which ruled practice in all febrile and inflammatory diseases. With our present notions we can but regard the mercury, at least, as wholly injurious in fevers, which, like typhoid, kill by depression, and believe that the results would have been better had no medicine been given. A contrary system was introduced at this time, experimentally used, and soon abandoned. Large doses of quinine were given in some cases of typhoid—in one case 20 grains every six hours; in another, 10 grains every two hours. Both were fatal, and this method of treatment was discontinued.

Especial interest attaches to the treatment of pneumonia, in consequence of the violent oscillations of medical opinion in this matter. At the time of which I speak there was little difference of opinion, at least at St. George's Hospital. Bleeding, calomel, antimony, blisters, and starvation were the means employed with more or less severity by all. To give a few instances:—Pneumonia of the lower lobe of the right lung was recognised in a previously healthy man of 27. He was at once bled to 12 ounces, next day to 8 ounces, and on the third day 16 leeches were applied to the chest. In the meanwhile, he had every six hours two grains of calomel, a quarter of a grain of antimony, and a quarter of a grain of opium, which combination was continued to salivation. Erysipelatous inflammation then presented itself in both arms, starting from the punctures, and he died, says the medical registrar, 'debilitated by his illness and loss of blood.' Post-mortem there was found partial consolidation of the lower lobe of the right lung. Had he been left alone he might have been alive now. A girl of 18 was admitted with pneumonia. She was in a condition of great depression, faint, and 'evidently unable to bear active treatment'; the pulse was weak and rapid. Wine was ordered by the apothecary. On the advent of the physician there was 'much hesitation as to the propriety of bleeding,' but the breathing was greatly oppressed, and 'a small bleeding was practised with great care'; a large blister was placed upon the chest, and calomel and opium were given every three hours. She died next day with hepatisation of the right lung. Perhaps she would have died in any case; but if her tendency to death was, as it seemed, by exhaustion, the treatment could not have done much to obviate it. The treatment was conducted by a physician of great ability, and evidently with the most anxious consideration. This case displays in a remarkable manner the faith of the time in blood-letting and mercury. The physician fully recognised the constitutional indications against them, but he dared not in any circumstances withhold remedies which he held to be so essential. *Now* we should have had regard only to the general condition.

To present the treatment fairly I must give that of successful as well as of unsuccessful cases. A man who recovered of pneumonia under Dr. Wilson was bled in two consecutive days to a total of 22 ounces, was blistered, and took every four hours a draught of tartrate of potash with a drachm of antimonial wine. Dr. Page's practice was not very different. A man was admitted with pneumonia, having had shivering one week before, which probably marked its beginning. He was cupped to 12 ounces, had 'fever diet' without wine, and a pill containing three grains of calomel, a third of a grain of antimony, and a quarter of a grain of opium, three times a day. He was

made out-patient on the seventh day after his admission. Another, who did well, was cupped to 10 ounces, and dosed every six hours with three grains of calomel and one of opium. He was discharged convalescent fourteen days after admission. In the light of many such cases similarly treated with a successful result, I have sometimes asked myself whether the modern practice in pneumonia is wholly right and the old treatment wholly wrong.

No doubt our progenitors often, perhaps generally, pushed their 'antiphlogistic' method too far, and had too little regard to the general condition. But was there no truth in their theory, however extravagant their practice? Under the influence chiefly of Todd, pneumonic patients have since been drenched with alcohol, as if this were a specific for the disease instead of sometimes its cause. But may not the dispassionate mediciner look on both sides of the question, and say here I perceive a divided duty?

The vascular system of the lung is in a condition certainly of leakage into the air-cells, and presumably of over-pressure in the vessels; the general powers of the system are apt to fail under the process, so that there is a tendency to death by asthenia. We must have an eye to both these opposed but associated conditions. The morbid products in the air-cells have come out of the blood-vessels, and have to go back into them. They are got rid of more by absorption than expectoration. If we lessen the pressure within the pulmonary vessels we presumably lessen the exudation from them, and facilitate its return into them. Thus depleting drugs or depleting measures may, and even *must*, benefit the local state of the lung. But the pulmonary disorder is attended with general asthenia and failure of vital power, which is the chief immediate danger and the usual mode of death. If we deplete or depress too much, we promote this fatal tendency; and no doubt our predecessors often did so. If we deplete too little or charge the vessels too much, as perhaps is sometimes done now, we prolong the morbid process or retard that of recovery; allow matters to remain in the lung which might otherwise

be got rid of; and, by protracting the disease, invite the occurrence of secondary changes.

Of late I have reverted with caution and abatement to parts of the old practice in pneumonia—and I think with advantage. I have always been accustomed to begin the treatment of this disease with a mercurial purge; I now carry on the mercurial afterwards, with a grain of calomel or blue pill two or three times a day. I give no opium, for which I see no indication. Without it the small mercurials keep the bowels loose, which cannot but be an advantage when there is so much morbid material to be got rid of, and it may be fairly presumed that they lessen exudation and promote absorption. As to diet and stimulants, I endeavour to keep a rational course, free from the falsehood of extremes, taking for my daily guide the constitutional state of the patient. Many do well without alcohol; some require a good deal. My only experience of the 'fever diet' is what I have gathered from witnessing the practice of my predecessors; my own rule of food has always been somewhat less parsimonious.

To look next at Acute Rheumatism, and first at fatal cases; a man of 45 had it in a severe form as regards the joints, the heart escaping. He was afterwards found to have granular kidneys. On the day of admission, April the 7th, he was bled to 14 ounces; on the 8th, again to the same amount; to 12 ounces on the 10th. On the 13th he became subject to epistaxis, which recurred frequently and with severity until his death. On the 21st he had some confusion of intellect, and was cupped on the back of the neck. His medicines were at first five grains of calomel with one of opium three times a day, which were afterwards commuted for frequent five-grain doses of calomel followed by haustus sennæ. He died on May the 4th, which he surely would not have done if he could have been saved by depletion.

A man, aged 45, was admitted with acute rheumatism and pericarditis. He had a draught of tartrate of potash

with a quarter of a grain of antimony every four hours, and calomel and opium three times a day to salivation. Fluid was then discerned in the abdomen, which was accordingly rubbed with blue ointment, and a pill was given containing mercury, squills, and digitalis. He sank, with diarrhœa.

Dr. Wilson employed blood-letting and mercury in the treatment of rheumatic fever, often with the addition of alkalies and colchicum. I may adduce the following among many instances. A case at first without heart mischief, after a purge of calomel, opium, and senna, was ordered haustus potassæ citratis with a scruple of bicarbonate of potash, and 15 minims of colchicum wine every six hours. Three days afterwards, on the occurrence of pericardial grating, there were ordered in addition three grains of calomel and two-thirds of a grain of opium every six hours, and these continued to salivation. The epigastrium was twice leeched. The patient recovered. A man with rheumatic fever, pain in the left side and difficulty of breathing, was at once bled to 12 ounces, and the operation repeated in the evening to the same amount. Two and a half grains of calomel and two-thirds of a grain of opium were given every six hours, together with haustus potassæ citratis and 40 minims of antimonial wine. Next day the patient displayed pericarditis, and ultimately recovered. I need not multiply examples to show the general belief which at this time prevailed in the uses of blood-letting, mercury, and opium in the treatment of rheumatic fever. The general impression which I have derived in looking through a large number of cases is of the frequency of pericarditis among them. For particulars with regard to the frequency of heart affections under the treatment which was employed for acute rheumatism at the time of which I speak and later, I may refer to p. 236.

To show the belief in counter-irritation which still prevailed, I will relate a single instance:—A woman with chronic albuminuria and many complications, was blistered for each of them. For broncho-pneumonia, two blisters

were applied to the sternum; for pericarditis, one to the precordium—and the sore afterwards dressed with savine ointment; a blister was applied to the epigastrium, to relieve vomiting; and one to the abdomen, in consequence of pain and tenderness, which were traced ultimately to enteritis, now recognised as among the albuminuric sequelæ.

The trust in mercury in almost every affection of the liver was frequently displayed. A man had jaundice associated with a large round hepatic tumour, which proved to be a hydatid cyst. He had five grains of blue pill three times a day, to salivation, together with a draught containing nitre, nitric ether, nitric acid, and taraxacum. I suppose now the aspirator would have been used.

To give our predecessors their due, I may mention a disorder in which their practice was more consistent with the latest views, and probably more beneficial than that which a short time ago was generally employed. They, with one consent, treated hæmoptysis with small repeated doses of sulphate of magnesia in infusion of roses. The infusion of roses was a survival of the mediæval doctrine of signatures. The sulphate of magnesia is in conformity with the latest considerations with regard to arterial tension and the usage based upon them. Judging by recorded experience, the early practice was far more successful than the ergot, by which it was superseded.

The tendency which prevailed in the middle of this century to cast blame upon the liver, and the belief that mercury would put it right, if anything could, were emphatically declared in the treatment of cholera. I refer to the epidemic of 1854. The process of purging to death, which is the way of the disease, very soon empties the liver and bowels of bile, so that the evacuations become bileless and colourless. This appears to have suggested the liver as primarily concerned in the disorder, and as a necessary consequence, calomel as the remedy. At the beginning of the epidemic, until experience had demonstrated its futility, this drug was generally employed,

and with an energy which was commensurate with the severity and rapidity of the disease. The patient, commonly blue and cold, was first comforted with a mustard emetic; he then took calomel, usually in scruple doses and at short intervals; he drank eagerly and vomited abundantly, bringing up drink and medicine together with the characteristic rice-water vomit. Thus it is to be hoped that much of the calomel was got rid of without injury. That some was is certain. I cannot forbear relating an experiment which was not perhaps in the best taste, but which was conclusive as to the calomel. Much of this was vomited scarcely changed, and, in one instance, was collected and subsequently converted into black-wash, and used as such—rather an unclean application of the *reductio ad absurdum*.

To adduce a few illustrations:—A patient in the blue stage had three scruples of calomel in the course of an hour—exactly a grain a minute—then a scruple every hour for six hours. Another, whose hands and feet were blue to blackness, had a scruple of calomel every half-hour from two o'clock until ten, after which, strange to say, he appeared to be somewhat better, and was allowed a respite, after which the drug was resumed at the rate of 10 grains every two hours. Ten grains of calomel every hour was a not uncommon mode of administration. In one instance, the same drug was given every ten minutes, but I am unable to state the dose. With the calomel was often given a draught containing chlorate of potash and carbonate of soda. Perhaps the chlorate of potash was meant to impart oxygen and relieve the cyanosis. Sometimes the attendant draught contained sulphate of magnesia and antimony. Why the antimony, I cannot guess. The sulphate of magnesia may have been intended as an eliminant, though the cholera poison is an eliminant which would seem to require little assistance; it eliminates itself and the patient too. Many other drugs were tried, among which opium, acetate of lead and sulphuric acid may be mentioned. In one instance half-an-ounce of the dilute acid was injected into the bowel.

The foregoing experiences are all taken from the post-mortem book, and therefore necessarily relate to fatal cases; but others similarly treated might have been introduced where the result was different. Experience was rapidly gained in the epidemic, and with this practical result. The best treatment of cholera, and that which was finally adopted, was this:—First a mustard emetic, then iced water *ad libitum* (which was drunk with avidity and vomited copiously), and nothing in the shape of medicine.

As giving some information with regard to the results of treatment at different dates, I have selected one or two fairly definite diseases and ascertained their mortality, forty years ago, and recently, as displayed in our medical registers. For the earlier date I have consulted those kept by Dr. Barclay; for the later, I use numbers supplied by Dr. Lee Dickinson. It is necessary, in the first place, to bear in mind that the number of beds from 1851 to 1854 was less than that from 1888 to 1891, with the average of 331 to 353. First, with regard to fever, we meet with the difficulty that the old term 'continued fever' included typhoid, typhus, and other slighter and indeterminate febrile affections.

Number of Cases admitted into St. George's Hospital and Number of Deaths from several Diseases in separate Periods of Four Years.

	Cases	Deaths	Percentage of mortality
From 1851 *to* 1854.			
Continued fever . . .	574	68	12
Pneumonia	168	48	28
Acute rheumatism . .	307	11	2·9
From 1888 *to* 1891.			
Typhoid	136	26	19
Pneumonia	419	94	22
Acute rheumatism . .	181	5	2·7
Sub-acute rheumatism . .	355	1	0·28
Total of acute and sub-acute rheumatism	436	6	1·3

Thus the diagnosis is uncertain excepting as regards the fatal cases, where it rests generally on post-mortem evidence, with the warrant that death was due to either typhoid or typhus. Typhoid was the usual form; typhus exceptional. In the latter period, typhus did not occur at all. We cannot safely draw any conclusion as to the results of treatment, but must be content with the knowledge that not only was there typhus in the hospital forty years ago, whereas now there is none, but that of typhoid there was a larger number of cases and a larger number of deaths in the earlier than in the later period. What was the proportion of deaths to cases in the earlier period we have no means of ascertaining.

With regard to pneumonia and acute rheumatism, the first impression is that the difference between the past time and the present is not so great as might have been expected, though both were undoubtedly more fatal then than now. The difference is most marked with regard to acute rheumatism. To appreciate this it is necessary that the inquirer should be made aware that what is now classed as sub-acute rheumatism would formerly have been called acute. In old days the class *sub-acute* was limited to local and trifling cases which could not be called chronic and certainly were not acute. All cases of general or multiple rheumatism of recent date and with any degree of febrile action were then classed as acute. Of late, since the introduction of the clinical thermometer, this term has been limited to cases where the temperature has gone above 102. Thus, general rheumatism, such as would formerly have been called acute, is now classed as sub-acute, whence it is necessary, in order to obtain a series of cases comparable with the old 'acute' class, to fuse together the 'acute' and the 'sub-acute' of modern times. On this showing the death-rate now is not half what it was. The total deaths in the hospital from rheumatism, notwithstanding the increased number of beds and the increased transmission of patients which we owe to Wimbledon, is now little more than half what it was. But

even this leaves the story half told, for the mischief of acute rheumatism is not to be measured by its immediate mortality, but must be judged of by its course and complications. The abbreviation of the disease and the lessened proportion of heart disease when such measures as I have described as belonging to the old period were exchanged for alkalies, are among the greatest improvements of modern medicine. As touching pneumonia—much more common of late, owing to the influenza—it has shown a smaller percentage of mortality. In the old days, five cases recovered for two that died; in the recent period, seven recovered for two that died. In the severe old days one would have thought that fewer would have survived; in the later times of indulgence, that fewer would have died. But yet the difference is decided, and may be expressed in this way: in the old days, five died where four die now. If we assume that the disease and the subjects of it were the same then as now, and attribute the difference only to treatment, we may say that our predecessors killed every fifth man—a sort of double decimation. This assumes our death-rate as the normal standard, as if our deaths were all due to nature and none to art. If, as may hereafter be found, our methods are responsible for some of our mortality, it will follow that the mortality due to the methods of our predecessors must be correspondingly increased. After all, the nature of a disease determines its mortality more than the treatment, besides which, if there be reason in what I have already advanced, the old treatment may have had certain advantages. It may have been of use to the lung *per se*, though not sufficiently encouraging to the lung's owner.

In presenting these particulars of the practice of our predecessors, let it be at once acknowledged that whatever may be the superiority of the practice of to-day, no such superiority can be claimed by the practitioner. Without using the term 'degenerate,' I may at least confess that we are the less heroic products of a later age. Wilson and Bence Jones, in their separate ways, were of exceptional

ability and of exceptional knowledge of what was then known. Thomas Young was of supreme ability. It is to be observed that Dr. Young and Dr. Wilson, though both frequently employed moderate blood-letting, were less indiscriminate and less liberal with regard to mercury and antimony than their contemporaries, of whom it may be said without disrespect that their intellectual eminence was less. Neither Young nor Wilson had in any great measure the confidence of the public. A physician is judged by his methods, not by his results. His method must be obvious and applied with vigour. If the patient die, there is the satisfaction that all was done that was possible; if he survive, the credit is given to the doctor, who did so much not perhaps *for* him, but *to* him.

Looking back upon the practice I have recorded, there can be little doubt that it was for the most part injurious—not, perhaps, always wrong in principle, but generally overdone. Patients would probably have been better off had they had no medicine at all. The leading motive was the belief that mercury, antimony, and starvation were antagonistic to fever and inflammation, which, on the other hand, were increased by food and stimulant. The next article in the creed was that many diseases were due to the liver which are now not so attributed, and that mercury was a hepatic panacea. With regard to the treatment of specific fevers, such as typhoid, we now find no reason to suppose that grey powder was beneficial, excepting that it may have done something to prevent constipation, perhaps not now always sufficiently guarded against. On the other hand, the lowering measures must have tended not 'to obviate the tendency to death,' but to increase it, when, as must often have been the case then as now, the tendency was to death by exhaustion.

As touching inflammatory conditions—pneumonia, for example—it behoves us, as I have already shown, to speak with circumspection, and even with some degree of reverence, at least, for the intentions of our predecessors. If we should resume their practice in a modified way, the extravagance of their measures will ever be a warning against the like. I certainly do not see the use of the opium which they so constantly associated with the mercury. We no longer aim at salivation; while a slight purgative action would probably be beneficial where, as with pneumonia, there is so much to be got rid of.

The treatment of disease has advanced in the last forty years, not so much in the direction of what to do, as what not to do. We trust Nature more, and are less presumptuous in interfering with her. We employ more often than did our predecessors the policy of 'masterly inaction.' A few relics of superstition still remain—fewer, I will venture to say, at this hospital than elsewhere—but the three great scourges scourge no more. The lancet is in its sheath; mercury and antimony, employed with a parsimony which would call forth the scorn of our predecessors, do little harm and possibly some good; we have learned the use of iodide of potassium. The patient has no longer to struggle against the doctor as manfully as against the disease; and we may at least say this much for these latter days, that if he die, he dies of the disease, not of the physician.

ON THE PRESYSTOLIC MURMUR FALSELY SO CALLED.[1]

Some years ago I contributed two papers to the 'Lancet,'[2] which had for their purpose the correcting of what I then held, and still hold, to be an error—popular though it be—in regard to a murmur to which the term 'presystolic' has been applied. These essays gave rise to much discussion. They were directed against a favourite, I may even say a fashionable, hypothesis; and though they found some strenuous (it does not become me to say discerning) supporters, their opponents were, as might have been expected,

[1] The *Lancet*, October 1, 1887, p. 650.
[2] *Ibid.*, October 19, 1889, p. 779.