John Campbell (1862–1929)

President of the Ulster Medical Society 1902–03 and 1903–04

Presidential Opening Address
Ulster Medical Society
11th December 1902

THE RELATIONS OF
THE MEMBERS OF THE MEDICAL PROFESSION
TO EACH OTHER AND TO THE PUBLIC.

Sir William Whitla, Ladies, and Gentlemen, My first duty is to convey to you my sincere thanks for the honour you have done me in electing me to the presidential chair of the Ulster Medical Society. To be at any time chosen to fill such a position is a distinction of no little importance, not only on account of the antiquity of the society, and the traditions with which its name is associated, but also on account of the eminence of my predecessors in office. Since the foundation of the society the most prominent medical men in the city have, in their time, been in the position which I now occupy. Representatives of the purely scientific departments of our profession, men eminent as practitioners, and men engaged in special fields of work, have given the presidential chair a dignity and an importance which has increased year by year, and has culminated in the efforts of yourself, Sir William, to whom we owe this noble hall of assembly and an unprecedented increase in the membership and activity of the society.

It is an especial pleasure to me to occupy the chair at the present time. To be the first to preside over our meetings in the new Institute is a source of present gratification; and to have been the first will hereafter provide a delightful retrospect. This feeling of pleasure is enhanced by the fact that I succeed the founder of the Institute, and that I now preside over a larger than it has ever had.

The very importance of the position to which you have elected me has, however, been a source of some embarrassment to me in the selection of a topic on which to address you. The historical and biographical themes have been so ably dealt with in the recent past that I could not turn to them. Some special subject in which I was myself interested had charms for me, but I felt that I could not, on the present occasion, allow myself to be drawn aside into the bye-ways of surgery, however gratifying such an excursion might have proved to myself. I have, therefore, chosen to

address you on a wider subject: a subject which will, I think, interest every member of my audience, and arouse feelings of agreement or dissent in the breast of many of the listeners. The title I have given the address which I am about to deliver is “The Relations of the Members of the Medical Profession to Each Other and to the Public.”

In Belfast we are singularly fortunate in having a medical family, the members of which are, on the whole, very well united. It is inevitable that differences should occur. Disputes and quarrels are, however, rare. The late Lawson Tait is reputed to have said that a more friendly feeling existed between the medical men of Belfast than between those of any other similar community with which he was acquainted. The man who uttered this statement was not given to the making of complimentary speeches, and I think we may fairly congratulate ourselves on the truth of it. But, good as our relations with one another are, they might be still better. Everyone is familiar with the axiom, that the observance of medical etiquette consists in “doing to others as we

would be done by," but few of us have, I am afraid, taken the trouble to study the rules which are laid down for the application of this general principle to special circumstances. Perhaps I would not be wrong in saying that a good many of us are unaware that a printed code of etiquette has been drawn up by this society, and is in existence. Possibly I might even, without fear of correction, affirm that many practising members of the profession are ignorant that a book containing rules for our guidance, under almost all circumstances, has been published by a deceased English physician, and has received a sort of semi-official recognition from the profession as a whole. The perusal of the code of medical ethics should invariably precede the start in practice. The knowledge gained therefrom would prevent many an unintentional mistake in conduct, and would smooth the thorny path of the struggling young doctor. An occasional glance at its pages might be beneficial to even the more mature practitioners. It might serve in some cases to soothe their ruffled feelings; and in others to awaken consciences which were drowsy, if not asleep. How many a young man has been driven on a wrong track by a snub from a senior, to whom he has in his anxiety to do right reported the defection of an important patient, when a, courteous reception by his older colleague, and the recognition of the fact that people will change their doctor, and that the blame, if any, for so doing is theirs, would have maintained good feeling. How many an old man has been cut to the heart by a younger man supplanting him without a word, and has nursed a life-long wound in consequence. Such occurrences could easily be avoided by the endeavour of each man to see the case from the other's standpoint. Unfortunately, while all admit the general principle on which the code of ethics is founded, many allow personal feeling to warp their judgment in applying it in particular cases, and many quiet a restless conscience by telling it that there are extenuating circumstances. In fact, each man is inclined to follow the impulse of the moment, and when he has done so is fain to persuade himself and others that his action was in accordance with "medical etiquette." The calling up of etiquette to cover what has been done rather than to guide us in the doing has brought the term into public contempt, which can only be removed by our strict adherence to the letter and to the spirit of the code of ethics. This adherence we cannot give till we have read and pondered over the book.

The relations of a family doctor to his patients are of such a character as exists in no other line of life but the medical. The ties between doctor and patient are often strong personal ones, and the feeling of friendship often dominates the doctor's business instincts. That this should be so is creditable to our profession, though it is liable to be used to our disadvantage, and it probably explains the feeling of soreness which we have when a patient deserts us for another adviser. The fact that we feel aggrieved under such circumstances is not to be wondered at. Naturally a man would expect to feel some bitterness against a patient who had taken his best services, and then thrown him over; but curiously the animosity is not usually displayed towards the patient, but towards the doctor to whom he has gone. This is rational enough when the patient has been induced in some unfair or underhand way to change his allegiance. As a rule however, no influence has been brought to bear on the patient by the rival practitioner, and the latter should not be blamed for a defection for which he is in no wise responsible.

We surely require to be more businesslike in our feelings towards patients. They have a perfect right to change their advisers as often as they like, but they should be made to settle up accounts with former attendants before they are allowed to incur liabilities with new ones. A frank and friendly attitude of the practitioners of a neighbourhood towards one another would do more to strengthen the profession than anything else. Co-operation between the senior and junior members is especially wanted. A young man starting in practice is glad to have people coming to consult him without too keenly inquiring into their motives for doing so. It is only when he has had a few years' experience of human nature that he realizes how many of his patients have left unpaid bills behind them with several of his neighbours, and have flattered him in his youth and innocence with the gratuitous care of their health. Many such people go through life without ever paying for medical attendance by the simple expedient of changing the doctor when he begins to ask for payment. Due observance of the rule not to take up the case of another man's patient without communicating with him would obviate all this unrewarded waste of time and energy. A section of the public regard us as a necessary evil. They use us because they cannot help it; they flatter us while they want our good offices; they revile us when they no longer require our services; they pay us when they cannot avoid doing so. Yet it is often on account of these people that we medical men quarrel among ourselves. Some of the bitterest animosities have arisen over cases which were absolutely worthless to the profession. We have unfortunate instances of the "etiquette of the

profession" being paraded to cover mere senseless jealousy between men contending for the possession of a patient they would have been better without. We should strive to render such occurrences as few as possible; they tend to render us ridiculous in the eyes of business men ; they tend to destroy our reputation for common sense; they undoubtedly lessen our influence in the community. We, as members of a great profession, should, above all things, stand up for our order. We should be loyal to one another. In all cases where one of us is represented in a bad light to another we should reserve judgment till we have assured ourselves that our confrere is as black as he is painted. We should ever bear in mind the proneness of the public to draw a red herring across the trail. They are clever enough to cover their own delinquencies by setting us on one another, and we are often so eager to find faults in a brother that we fail to see the ruse. This is not as it should be. Family disputes are bound to arise amongst us, but these need not cause us to betray our brethren to the world at large. Each man of us should do his duty to the public, but he should also do his duty to his professional brethren. The friendly intercourse which this Institute will enable us to have with one another should do much to break down misunderstandings and to disseminate a feeling of confidence in each other. By so doing the Institute will fulfil a most important part of its work – fostering lofty sentiment, cementing professional relations, and broadening out the views of the members.

While the relationships of general practitioners towards each other are often delicate and complicated, those of the consultant to the family doctor are even more so. The ideal consultant would be one who would see only those patients who were introduced to him by another medical man. Such an one does not exist, and the nearest approach to him which we have is the man who receives all comers at his own consulting rooms, and refuses to attend patients at their own homes, except in conjunction with the family attendant. Even this type is not widely represented, for the simple reason that the majority of men who attain a consultant's position have worked their way up through family practice, and have perforce to consider the feelings of their older and more faithful clients. The difficulties in the way of the ideal consultant are two-fold – those put before him by the public, and those raised by the profession. A certain proportion of men and women regard the medical fraternity as a band of guessers. They go from one to another in search of a diagnosis or of a remedy, in the hope that they may some day meet with a man who will guess right. Such people are very desirous of "independent opinions," and are so suspicious of collusion on the part of their advisers that they strenuously oppose any communication between them. Each opinion is to them a different one, though to the initiated the distinction is rather in the wording than in the meaning; and each prescription is a new line of treatment, though they all contain drugs of similar action. Persons of this habit of mind seriously hinder a man who strives after the position of the ideal consultant. Not less obstructive to him is the attitude of some of his colleagues. When a patient surreptitiously visits a consultant, and the latter communicates the fact to the family attendant, the result is not always pleasant. At one time the family doctor will feel aggrieved at the patient, and will vigorously express his feelings; at another he will regard the consultant's letter as uncalled for and presumptuous, and will bear him an unmerited grudge. Thus it comes about that the consultant follows the line of least resistance, and keeps his own counsel, while the patient goes on using his prescription without proper supervision, and the family attendant is deprived of legitimate employment. Such a state of things should surely be changed for the better. Co-operation, between the consultant and the usual attendant would be beneficial to the patient, as well as to the profession. At the present time, when the profession has been levelled up until no great inequality exists between its members in respect of their knowledge, a consultant's task, when called in by a friend, is a comparatively easy one. He has but to confirm the diagnosis and express his approval of the treatment. It is but seldom that any material difference of opinion as to the nature and treatment of a case can exist. Minor points may call for discussion, and should have due attention, but the consultant should remember that while his first duty is to do his best for his patient, his second duty is to avoid anything which would unfairly exalt him over his colleague. Hence it is important that he should convey the joint opinion in the same terms as it has already been expressed in, and that he should state that the line of treatment has his entire approval. The temptation to prescribe some new remedy, often no better than the old, is great, but it should be withstood, because it is founded on a desire to please rather than to benefit the patient. The cases in which a complete change of diagnosis or of treatment is necessary are happily few. They might be still further reduced in number if we all bore in mind that cases of disease are divisible into three classes – namely, (1) Those in which the facts absolutely

warrant one conclusion, and no other, and in which a *diagnosis* can be given; (2) Those in which more than one conclusion can be justified by the facts observed, and in which an *opinion* rather than a diagnosis is possible; and (3) those in which there is so much obscurity that at the very best a *guess* is the only length we can go, and often not even so far as that. Were the position of affairs put before the patients and their relatives on some such principle as this, there would seldom be any room for divergence of medical opinion.

I cannot pass from this portion of my subject without some reference to the relationship of consultants to one another. Amongst those residing in the same city, and intimate with one another, unpleasant difficulties can rarely arise. Things are, however, far different when distant or metropolitan consultants are called to meet the local men. Under these circumstances there is a risk of what appears to be a temporary triumph for the stranger occurring. Usually it is of short duration, as the men who have had ample opportunities of watching the case are more likely to have a thorough grasp of its requirements than any casual consultant can, and changes which the patient's relatives hailed with delight turn out to be signal failures. To protect the patient's interests, and to avoid unfair criticism of themselves, it is necessary for the men in charge of a case to be very slow about accepting a radical change of diagnosis or treatment from a consultant; and unless they are convinced of the wisdom of the change to protest against it in no uncertain way. Happily the necessity for such protest does not often arise, but when it does the circumstances are usually such as to make decided action important. Lives have been lost or shortened through changes of programme originated by a consultant who got an imperfect appreciation of the case at his brief and hurried visit. Far off fields look green, but the grass they yield is not always wholesome.

The duties of the profession to the public are unique in character. We require to be ready to respond to urgent calls at all times and seasons: to go as willingly to the filthy hovel as to the rich man's mansion: to keep an even temper under the greatest provocation; and to undertake duties and responsibilities which are always trying and often unpleasant. We have to do our best for the patient regardless of our own feelings or of our own convenience: we have oftimes to keep his secrets from prying relations and mischievous friends, as well as from his inquisitive acquaintances: we have at times to preserve or promote harmony in disrupted households: we have to act as advisers, confessors, and friends: we have to bear misrepresentations from patients and calumnies from the public. All these things we do and more. I question if there is a profession more upright on the whole than that of medicine. Every fold has its black sheep. The baser traits of human nature will assert themselves in all callings and among all classes of men, but take them all round I think the doctors are hard to beat for sterling honesty of purpose.

While we are fully entitled to credit for our good qualities, it is essential that we should not rest content with a feeling of satisfaction. We must constantly be on the alert to prevent selfishness from interfering with the performance of the higher duties of our calling. We have to avoid narrowness and faddishness in our practice. We have, and this is perhaps our hardest duty, to fight against the feeling of contempt for men and women, and the cynicism which contact with the baser natures we so often meet is apt to engender.

While the ancient traditions and customs of our profession are a great help to us in maintaining a proper line of conduct towards our clients, there are, unfortunately, no such guides for the public in their behaviour to us. As regards his doctor, each man is a law unto himself. In studying human nature we are struck by certain curious facts. Most people in their secret hearts think they are born with a greater or less amount of knowledge of disease, and have strong and frequently ludicrous opinions as to their ailments. The majority of people expect to be made able to understand all about their complaints in a five minutes interview, and the doctor must express his opinion in such a way as to make them think they understand it. This often entails the presentation of some very crude or absurdly mechanical idea; even a name will suffice, if it be a familiar one, though it conveys not the faintest real knowledge to the listener. Should you fail to make your hearers feel they understand you, woe betide you. They will surely think that your mind is as befogged as their own, and set you down as an incompetent duffer. I have no doubt that a great deal of a practitioner's success depends on his knack of conveying a rough sort of notion of their condition to his patients.

Another extraordinary phase of human nature is the widespread belief in cures, from which results the tendency to blame the doctor for the unfavourable termination of a case. That death comes to us all is a commonplace; yet how seldom do we doctors see death coming at what the patient and his relatives regard as the right time. Whether he comes in youth or age, the black angel nearly always seems to come

too soon, and a feeling not infrequently arises that his visit might have been postponed had the doctors been more skilful or more strenuous in their efforts against him. Men have not yet learnt that every species of disease may, under certain combinations of circumstances, prove fatal. Finally, let me allude to one more failing of poor human nature. It is the fact that you find few people too proud to beg from their doctor. It is a lamentable fact which we can only deplore and endure. Language would fail to express our feelings on the matter.

For the larger proportion of the public, in whose service we spend our lives, we can have nothing but admiration. They trust us as honourable men; they are loyal to us; they are straightforward with us; and they remunerate us fairly for our services. There are, however, a minority of them who do not merit gratitude at our hands. Chief amongst these are the gossip-mongers, who glibly talk about the illnesses of their friends, and can tell you about the mistakes of the doctors, or about the differences of opinion of the doctors, or what should have been done under the circumstances. Rumour is proverbially a lying jade; but never does she sin so deeply as when she takes a medical subject on hand. How seldom do we hear a case of illness discussed or see it reported in the newspapers with even approximate accuracy! Often this public gossip is ludicrous; often it is distasteful to patients and their relatives and friends; but most often it is designedly annoying or even harmful to the doctors concerned. I question if we as a profession would not improve our position by occasionally calling to account our detractors. Certainly no men in any other line of life would condone the calumnies we sometimes pass over. As with nations so with men, magnanimity may be mistaken for weakness. The formation of Medical Defence Associations is a step towards teaching the public the duty of fairness towards us. They have already done much good, and are destined to do more in lessening this evil.

Closely allied to the gossips is a lower species of humanity, the members of which try to extort money on some pretext, most frequently that of malpractice. Such people can be best put down through a protection society, to one of which every practitioner should belong. We never know when a patient may prove a source of annoyance to us, and should, therefore, while hoping for the best, be prepared for the worst.

Finally, the important class who make our bad debts come to mind. To wholly avoid them is an impossibility, because they so often occur in unlikely connections; but to lessen their number a good deal may be done. They are particularly the enemies of the rising young doctor, who is anxious to please and has not yet attained to the wisdom of the serpent, for they not only afford him no financial assistance, but they add insult to injury, and proclaim his deficiencies to the world. This very peculiarity has its uses in enabling us at once to determine to what order of mankind they belong. As a rule the person who abuses his or her former doctor to you has not paid him, and will in due course desert you and abuse you to another. These people recognise no duty towards us, and our only remedy is to keep them at arm's length.

The malicious gossip, the blackmailer, and the abusive debtor are so unpleasant as to forcibly attract our attention, but we must not be too much impressed by them. After all they are in the minority, and most of our patients belong to the high-minded, healthy-natured agreeable type.

In addition to the above general matters in which the public owe us consideration, there are others of a more restricted and special nature. I refer to hospital abuse, clubs, Poor Law appointments, and the public services. The question of hospital abuse is a serious one both for the medical profession and for the charitable public. Its effects on the doctors are too painfully manifest to many of you ;but, in addition to injuring you, it diverts to the use of the well-to-do mean-spirited people money given for the benefit of the poor and needy. A remedy for the evil has not yet been found. The profession are not agreed as to what is best, chiefly, I fear, because each man thinks of individual cases rather than of broad general principles. The charitable are somewhat apathetic, and are content to distribute their money without taking much personal care as to whether the utmost good is done with it. My own conviction is that enquiries into an applicant's circumstances by a hospital official appointed for the purpose do little good and often conduce to deception. Enquiries by the doctor are equally useless and are unbecoming.

The direction in which we are most likely to get good results is in making our hospitals, as far as we can, places for the relief of people recommended by a medical man as suitable cases for charitable treatment. I am well aware that a scheme of this kind would meet with the disapprobation of a few medical men, and that a few others would be too indifferent to the general good of the community to aid the hospital staff in carrying it out. I am also quite conscious that many members of hospital committees would at first sight disapprove of it, chiefly on account of the fear that it would lessen the good work of their insti-

tutions. In spite of these objections, however, I am convinced that it is the only plan by which we are likely to protect our charitable institutions and ourselves from the sordid souls who are now so numerous. Such a scheme could only be made successful by the co-operation of the members of hospital staffs with one another and with the other practitioners in the community. In the larger hospitals the house-surgeon would have a good deal to do with its success or failure, and his assaults upon the diagnosis of his brethren would probably have to lose some of their ardour. The plan is a practical one, and is the best we can formulate at the present time with the view of checking hospital abuse.

Medical clubs are an essential part of modern life, and, within limits, are beneficial to the doctor as well as to the members. The tendency is for them to usurp their legitimate functions and to admit the wealthier members of the community to their ranks, and thus infringe the just rights of the doctor. In this respect as well as in regard to underpayment we can protect ourselves, We only need combination to make us able to defend ourselves against injustice and to ensure to ourselves fair treatment.

The Poor Law appointments have always been underpaid, and latterly the emoluments have in many cases been still further reduced. The certainty of the salary, and the hope that the position will indirectly benefit the holder, encourage many to take them, though the step is apparently often deeply regretted. For this again we have our remedy if we will but use it.

In the Medical Departments of the navy and army dissatisfaction has prevailed, and to some extent, still exists. 'The united and energetic action of the profession brought about great improvements in these services, and is capable of doing still more. In the case of all Government appointments our efforts should not be spasmodic in pressing for reform. At times the pressure needs to be severe, but at no time should our grasp be quite relaxed.

When all is said and done we cannot but admit that most of the disadvantages under which we labour are of our own making. The public in the main do their duty to us according to their lights. If those lights are not very brilliant it is as often as not our own fault. We are too often ready to put our heads under the hammer, and then to make a great outcry when we are struck. Like all other lines of life in these countries the profession is overcrowded. This, undoubtedly, accounts for a good deal. But, even with the overcrowding, do we as a body make the best of ourselves? I fear not. At one end of the stream we see the unfortunate beginner swimming for dear life, and grasping at the straws the public throw him; at the other end we find the prosperous old man basking on banks of asphodel, and forgetful of the trials of his neighbours. What we want for the young is education in the business of life as well as in the profession of medicine; and what we require from the old is sympathetic advice and assistance for the beginners. We want co-ordination. We want co-operation. We want *esprit-de-corps*. We want the doctors of every town and of every district to be bound together by closer ties, by pride in their position in the community, and by pride in the good work they are doing in the world. When, gentlemen, that state of things is realised amongst us, the medical profession will be the most powerful organisation in society as well as the most beneficent.

Towards the realization of this ideal we have recently taken the greatest step forward which we have ever done in Ulster. In founding the Medical Institute Sir William Whitla has displayed not only his generosity but his foresight as well. He has done more than any man has ever done to consolidate our profession here. Within the beautiful home with which he has provided us better understandings and closer bonds of fellowship must arise, until the members of the Ulster Medical Society are more firmly united than they have ever been.

John Campbell

Presidential Opening Address
Ulster Medical Society
5th November 1903

THE TREATMENT OF SOME MINOR GYNAECOLOGICAL CONDITIONS.

Ladies and Gentlemen, As a rule the surgeon is restricted to one patient at a time when he is operating, but at the opening meeting of the session it is the privilege of the President of this Society to exercise his art upon numerous victims without fear of remonstrance or criticism. To-night I shall endeavour to keep you in pain as short a time as possible, and I shall at the same time endeavour to mitigate your pangs as far as I can by giving to all who are willing to take them the fumes of the modern universal soother, tobacco. I, therefore, request the Honorary Secretary to administer the anaesthetic with his usual skill, and I abstain from beginning to operate till you are sufficiently under.

It is customary at the present time to boast a good deal of the advances of surgery, and to point to the marvels which these advances have brought to pass, especially in the region with which I am personally most concerned – namely the abdomen. I have no fault to find with such vaunting. It is legitimate enough that we should glory in what has been done within the past quarter of a century; but it is also right that we should remember how much more there is yet to do, and that we should at times contemplate the deficiencies of our art as well as its triumphs. These successes have been for the most part obtained in the domain of the gross and fatal diseases, and have been won by the planning and execution of great operations. Their value is not to be denied, but in contemplating them with satisfaction we must not forget that there are a host of so-called minor ailments, which make life miserable for thousands of people, and for which the resources of surgery, as yet, furnish no satisfactory remedy. To the consideration of some of these affections I shall now direct your attention, discussing as I proceed some of the most useful methods of treatment with which I am acquainted. In so doing I shall not weary you with a recapitulation of things that you may try, but shall indicate briefly those methods which I have found to give reliable results. Often these results are far from satisfactory, but I lay them before you as the best that we can at present attain.

At the outset I should like to remind you that pelvic and abdominal diseases are seldom simple entities. They are nearly all more or less complicated. We classify and name them by seizing upon the most prominent feature of the case. Hence we are prone to forget the concomitant conditions, and to think of the problem of treatment as a more simple one than it really is. Moreover, the terms, we use are liable to convey an erroneous impression, for they often are applicable equally to severe and chronic conditions and to trivial and ephemeral ones.

Pruritus Vulvae may be due to a variety of causes, and is a fairly common and very distressing complaint. It occurs in both young and old. Apparently it is much more frequent in advanced life; but I think this prevalence in the old is largely due to the reticence of younger women about it. A host of remedies have been used for it, but success in its treatment will follow minute personal care from the doctor when prescriptions have utterly failed. When it is due to pediculi the cause is sometimes overlooked on account of the patient's social position. Here you will work a miracle by simply douching well with i in 2,000 perchloride solution, and applying on three or four occasions in your consulting room a large compress taken dripping wet from a 1 in 500 perchloride solution. In diabetic cases the treatment is very obvious, but it is difficult to get the patient to carry out systematic douching and bathing with antiseptics, so that it is desirable to combine douches of perchloride solution with occasional dusting with a dusting powder containing a little calomel. For the numerous cases in which an exact cause cannot be found douching with a mixture of Salicylic acid and Boric acid, and the use of a dusting powder, answers admirably, but with this local treatment you must combine dieting. In a very intractable case of this kind I got a complete cure through getting the patient to keep a daily record of her diet for 56 days, and an account of her pruritus for the same period. We found that certain articles of diet were followed by attacks. By eliminating them she became quite free from any trouble. In such cases dieting is more important than anything else, though local treatment should not be neglected. Each patient will require a special dietary.

Inflammations of the female genital organs arise from many causes, but all pale before the gonococcus. It is the veritable curse of womankind, and plays havoc with their anatomy from the vulva to the brim of the pelvis. Nor does it stop at local lesions. So-called rheumatic joints, pseudo-paralyses, and a vast array of symptoms claim paternal relations with it. The gonococcus lurks in the urethra, and more especially in the little Skene's glands which lie along

the urethral floor, and open at the meatus. Here it often passes unnoticed, and can only be detected by the practised hand and eye. By stroking the anterior vaginal wall downwards with the forefinger a little pus will frequently be expressed from the urethra, or two little spots of matter will be made to appear at the mouths of the Skene's glands. The meatus should be previously wiped to get rid of any superficial lencorrhoeal discharge. This simple proceeding will often clear up a case which is obscure, but, while it gives us the cause of the trouble, it does not, unfortunately, provide a remedy. Swabbing the anterior half of the urethra with 15 grains to the oz. sulphate of copper solution will heal ulcerated spots, and alleviate the urethral condition, but will not appreciably benefit the Skene's glands. They are so fine that applications to them are impossible, and the slitting of them up so as to lay open their canals is a very difficult matter. In contrast to our powerlessness in dealing with gonorrhoeal affections of the female urethra is the ease with which we can eradicate the mischief, when it is well marked in Bartholin's glands. I say "when it is well marked," because slight affections of these glands, giving rise to no perceptible thickening or enlargement of them, are capable of causing a great deal of pain and tenderness which is hard to locate and difficult to alleviate. When, however, the glands are enlarged they can be readily excised. Excision is much to be preferred to incision, because it lessens as far as possible the risk of future trouble in this locality. When possible excision should be resorted to before the pus has got beyond the gland capsule. Once it has escaped into the tissues of the vulva incision is the only practicable treatment, though it is open to the objection that the gland may remain as a focus of infection or a source of irritation. While the recognition of pus in the urethra or urethral crypts is of little use, so far as treatment of the urethra is concerned, it is of great importance as a guide to treatment of the uterus. The ordinary methods of treatment for chronic metritis do not appear to me to give good results in the gonorrhoeal form. With or without treatment the gonorrhoeal infection of the uterus has an obstinate way of ascending, and ultimately involving, one or both tubes to a greater or less degree according to the severity of the infection. Why some cases run a rapid and severe course we do not know. Probably it is due to some difference in the virulence of the infecting material; possibly it may be the result of some weakness in the tissues of the subject attacked. Be that as it may, I have reason to think that cases which are curetted, drained, and treated in the thorough manner recently advocated are more prone to rapid advance and widespread extension than those which have not been so actively handled. A large proportion of cases which have been curetted develop marked tubal conditions, or have already existing tubal lesions aggravated by the operation. Granting that this statement may be too strong for some of you, I submit that the very least that can be said against it is that it does no good in gonorrhoeal cases. What method of treatment have we to take its place? Crystals of carbolic acid. The crystals are melted by standing the bottle containing them, in hot water or before the fire. Probes thinly dressed with cotton wool are then dipped in the liquid and laid aside for a few minutes till the carbolic has had time to cool and recrystallize upon them. These probes can be readily and without violence or pain introduced into the uterus. The crystals can be carried right to the fundus, whereas liquid preparations are lost in their passage through the narrow cervix. In the uterine cavity the crystals dissolve upon the moist mucous membrane, and form a strong disinfectant and moderately caustic solution. This method I hold to give the greatest benefit with the least chance of injury, and I believe it to be by far the best plan of treating uterine inflammation of gonorrhoeal origin. The curette fails to remove the cocci entirely; it leaves behind it weakened or disintegrated tissues, in which they can multiply and thrive; it possibly carries them into tissues which have as yet escaped invasion. The carbolic crystals kill wherever they touch, and probably inhibit growth within their sphere of influence. Used immediately after the curette a caustic is so much diluted by the blood as to be practically inert. To put the whole mater in a sentence – Wherever there is pus in the urethra, Skene's glands, or Bartholin's glands, and endometritis co-existing, treat the latter by carbolic and crystals, and bend your probes to suit the curve of the uterus.

Coming now to the treatment of the other forms of uterine inflammation, whether they occur, as they do to a greater extent than one would think possible, in virgins, or in women who have borne children, we find that the degree of metritis or endometritis will indicate the plan of treatment best suited to each case. Broadly speaking, they arrange themselves in three classes – those which require the curette, those which require a caustic, and those which require a stimulant. Wherever there is a large amount of leucorrhoeal discharge, or an unusual loss of blood, the curette should be freely used. In a good many such cases its use will require to be supplemented by from five to a dozen or more intrauterine applications

of iodized phenol, the number of treatments being gauged by the severity of the symptoms before curetting. Where loss of blood has been a prominent feature the phenol should be injected once a week by an intrauterine syringe. In a few cases even this will fail, and injections of 50 per cent. chloride of zinc solution will have to be resorted to; but this is a severe measure, and applicable only to bad cases. When it fails the condition is not one of ordinary metritis or endometritis, but is the result of the presence of a minute fibroid or other affection requiring a radical operation. The second class of cases, which embraces all those which are amenable to simple caustic treatment, includes the numerous examples in which neither leucorrhoea nor loss of blood is a very pronounced feature. One or two applications of carbolic, followed by eight or ten of iodized phenol at intervals of four or five days, will produce excellent results. To cases where the menstrual discharge is normal, and yet other phenomena of endomatritis are present, or where the monthly flow is diminished from the atrophy which naturally succeeds the flare up of inflammation, caustics are banned. Here we get most good from stimulating and disinfecting the uterine cavity by tincture of iodine applied on a probe. By no means must this be injected through a syringe, as it is then capable of setting up the most intense uterine colic. In all cases rest, hot douches, and the familiar glycerine tampon are valuable adjuncts to whichever of the above lines of treatment you pursue. The hot douche, however, to be of any use, requires to be well given. It should be prolonged to 15 or 20 minutes, and the patient should lie on her back, with her shoulders low, during its administration. The foregoing statements hold good as to the vast majority of cases, but in gonorrhoeal cases with haemorrhage the curette will be required, and in cases of endometritis, with marked erosion of the cervix and distension of the Nabothian follicles, a thorough laceration of the cervical tissues in numerous places will evacuate mucous secretion from the follicles, and materially hasten the improvement. It must be borne in mind that the treatment of an erosion alone is not sufficient. The erosion, or ulceration, as it is so often called, is merely the outward and visible portion of a condition involving the whole endomerium, so that treatment of the whole intrauterine surface is required. Uterine inflammations have a way of seizing hold of particular portions of the uterus to a great degree, while at the same time implicating the remainder of the organ to a less extent. Hence we get fundal and corporeal metritis and endometritis when the upper reaches of the uterus are involved, and cervicitis or endocervicitis when the lower segment is affected. In the former treatment must be directed to the whole organ, but more especially to that portion which is high up; in the latter vigorous measures are to be applied to the cervix, and gentler attentions to the regions beyond.

Lacerations of the *Perineum* and *Cervix* are well worth attention. The effect which a laceration of the perineum has upon the patient's welfare depends to a large extent on the toughness of her tissues. We see one woman lacerated to a moderate extent last year and already complaining of discomfort from bulging of the rectal and vesical walls. We see another who is only commencing to complain of symptoms from a similar tear after the lapse of fifteen or twenty years. The only explanation I can offer for this apparent anomaly is that the fibrous and muscular tissues are so much better developed and of so much better quality in the latter that she can resist for years what the other woman succumbs to in so many months. We cannot foresee which patient will be adversely affected by a laceration, hence the safe thing is to repair all tears at the time of their occurrence, or as soon afterwards as possible. About two months after labour is a suitable time to operate in cases which have not been repaired, or have failed to unite during the lying-in period. When a perineum is partially lacerated either through skin and all, or subcutaneously only, a series of phenomena set in which can only be appreciated by considering for a moment the contrast between the natural and the lacerated condition, as shown in the diagrams, and observing how the rectum bends near the anus. When the perineum is good the Levator Ani muscles of opposite sides meet in front of the anus in the perineal body. During the act of defaecation these fibres, together with the others further back, steady the anus in such a way as to antagonize the tendency of the abdominal and intestinal muscles to thrust it downwards until the sphincter ani has yielded. When the perineum is bad the lower end of the rectum is left without support anteriorly. The front is then the weakest part in its circumference. The faecal mass is driven downwards, and meets with the resistence of the sphincter, and before the latter will yield the weakened and unsupported anterior rectal wall is stretched. This slight amount of stretching is repeated at frequent intervals. The bowel fails to regain its normal calibre, and an appreciable protrusion towards the vagina forms, so that we have a rectocele. The larger this becomes the more rapidly does it tend to become larger, and to hang between

the patient's legs. The rectocele pulls upon the posterior vaginal wall. It in its turn drags down the cervix into the vaginal axis. This favours the occurrence of retroversion, which is followed by descent and finally by prolapse of the uterus and vagina. An early repair of the perineum would probably prevent this vicious sequence of events, but we will return to the matter again when dealing with displacements.

Corresponding to the rectocele posteriorly we have the cystocele anteriorly. Protrusion of the bladder results from stretching or subcutaneous laceration of its attachments. Like the rectocele, it has small beginnings, and like it, the larger it grows the quicker it increases. How far the dragging down of the anterior vaginal wall, which occurs so often in early forceps operations, is a cause of it I am not prepared to say. It most often occurs in conjunction with a relaxed or torn perineum, but is sometimes found when the perineum is not appreciably injured. In the treatment of these conditions the great point to remember is that rectocele is always benefited, and often cured, by operation, while cystocele is seldom much improved and never cured by operative measures. A perineal repair will apparently give the cystocele some support, but from the patient's point of view the benefit is but trifling. In making this somewhat strong assertion I include in the condemnation all the plastic operations hitherto devised for cystocele except the almost total closure of the vagina, which is only applicable to a very small percentage of those who need relief. Other forms of plastic operation give at the most a few months' improvement. Hence you can recommend operation for rectocele with confidence of success, more or less, but for cystocele you must advise some other means of alleviation. A ring pessary is about the most effectual remedy we have. Where the perineum is bad, and the cystocele also marked, repair of the former and the application of a ring for the latter is the best compromise we can at present make.

In connection with perineal lacerations another consequence of them deserves mention. I refer to endometritis, which is kept up owing to a too free admission of air into the vagina. This occurs as a result of even comparatively small tears, more especially in women who are thin, and have the labia majora poorly developed. A tear may, therefore, require repair even though it is not causing rectocele or favouring cystocele.

Cervical lacerations, when at all marked, as a rule should be repaired. When they extend as far as the fornices on one or both sides they keep up a condition of chronic metritis or endometritis which cannot be permanently remedied until the laceration has been repaired. Different cases require different modifications of operation, but into these details it is not now my intention to enter.

Displacements of the uterus form a very important set of gynaecological affections. From the practical standpoint we need only consider the backward deviations and descent. In the treatment of retroversions and flexions we have to bear in mind that the patient's sufferings are usually due to accompanying lesions rather than to the mere altered position of the womb. Broadly speaking, we meet with two classes of cases. In the one the uterus is not adherent, and its appendages are free from disease or deformity. The uterus itself is enlarged, and probably this increase in size is caused or at least maintained by interference with venous return in the broad ligaments owing to the malposition. Such cases are frequent after confinement. The uterus is easily replaced and kept in place by a Hodge or Albert Smith pessary. After three months or so it will often remain in place without the pessary, and become reduced in size and innocuous to the patient. In a few instances minor treatment will quite fail, and a fixation operation be required. In the other set of cases the uterus is more or less fixed either by adhesions between itself and surrounding parts or between its appendages and the adjacent viscera. According to the number and length of the adhesions it may be irreplaceable, or it may be replaceable more or less completely, and soon return to its false position. Here replacement need not be attempted. It will do no good, and may do harm. Pessaries can only be used with great discrimination. In a few cases a ring pessary will give some comfort, but wherever the ovaries are prolapsed and adherent beside or on the back of the uterus a pessary is usually intolerable. The cold comfort of general medical supervision is about all we have to offer to those whose symptoms are moderate in degree. To those whose lives are absolutely miserable we can only recommend surgical measures. In point of fact the complications and not the mere displacement require attention. Unfortunately, in this category is included a very large number of patients. Many of them are unmarried, and have developed their ailment in childhood; others are married, and suffer as a result of gonorrhoeal or septic infection.

Descent or *prolapse* of the uterus is in reality a form of hernia, in which the pelvic peritoneum forms the sac and the uterus and vagina supply the coverings. It occurs in women of all ages, from youth

to old age, and of all conditions from the virgin adolescent to the multipara of many winters. It is most frequent in those who have borne children, and have sustained laceration or stretching of the pelvic muscular and fascial floor; but it also occurs in nulliparae, and in them must be due to some deficiency in strength and development of the fascia and muscles of the pelvis. Among minor remedial measures the first thing to try is a rubber ring, which must usually be large. This will require frequent removal and cleansing by the patient or doctor. Unfortunately, a ring will only stay in in a limited number of cases. When it fails we resort to a Napier's pessary. Being made of rubber, and having a flexible stem, it is unlikely to do serious harm, or, indeed, any harm at all. Even this cannot be tolerated by some people, and we have to be content to let the uterus prolapse, and support it at the vulva by a pneumatic pad and bandage. This exhausts our resources for prolapse, so far as appliances are concerned, and leads us to the consideration of minor operations. Of these almost total closure of the vaginal orifice is the only one worth doing. It gives very fair results, and is devoid of the risk with which major operations are fraught. It is obviously applicable only to the unmarried and to the old wives. It is the best operation for those who are advanced in years. Others require to enter the domain of dangerous surgery to get relief. Prolapse appears to be mostly a sequel to a torn perineum, but, unfortunately, when it has become established mere repair of the perineum will not materially or permanently benefit it. Probably early repair of the perineum is a very important preventive measure, as it would prevent the occurrence of that train of events which we discussed when dealing with perineal lacerations.

Pains for which there is no tangible cause are, I regret to say, but too well-known to the gynaecologist. We are tempted to regard them as neurotic, that is the offspring of a morbidly sensitive nervous system, but I do not think they are. After all our methods of examination can only detect gross lesions, and many conditions capable of producing much discomfort cannot be felt. I have often found adhesions in cases in which I could detect nothing till the abdomen was opened. The familiar pain in the left side is usually regarded as a symptom of ovaritis. No doubt it is in many cases. Those of us who have had the misfortune to suffer from a poisoned finger well know what disagreeable aching, and occasional stounds of pain may follow an attack, persisting even for years after the acute inflammation has passed away. That pain about the ovarian region is often of a similar nature can hardly be doubted. It is the reminder of an ovaritis long past. In other cases it would seem to be a result of a varicose or congestive state of the broad ligament, and to be akin to that of which the victims of varicocele in the other sex complain. A three months' course of iron and aloes and fresh air and exercise will do these pains more good than anything else, but the presence of tangible disease should be excluded before such treatment is commenced, otherwise a dermoid cyst, an ovarian tumour, or an inflamed or tubercular tube may be overlooked. Wherever the history of the case points to a former slight inflammation having been the origin of the pain much benefit may be derived from a course of pelvic massage. This remedy has very properly not been used in Britain to such an extent as it has been abroad, but it is a very useful one in suitable cases, and should not be neglected where there is chronic pain of inflammatory origin, but without marked lesions. Backache is a symptom of chronic metritis, and is a prominent symptom when the cervix is much affected. It is usually very obstinate, but as a rule will yield to persistent uterine treatment. The chief difficulty is to retain the patient's confidence long enough.

Among the less common minor gynaecological affections *Urethral Caruncle* is worthy of notice. Removal by scissors and cautery is of very little use. It very frequently, nay almost invariably, returns. After many disappointments I have struck out a line of treatment of my own which has proved very satisfactory. I first of all freely excise the growth, and unite the wound edges by catgut sutures. Good union takes place in about fourteen days, and the patient is allowed to go about. She is instructed to return every two or three months for examination. If the slightest sign of recurrence is detected the spot is touched with fuming nitric acid by means of a stick whittled to a sharp point. This is repeated, if need be, at intervals. At the end of a year or eighteen months you can assure the patient that recurrence is unlikely.

Somewhat akin to caruncle are the small red patches which are so often present about the vestibule in cases of long standing chronic inflammation. They are small inflamed sebaceous glands. Here again the cautery is unsatisfactory. Why this is so I am not sure, but it may be that the moisture in the tissues cools the point, and that we get a far more superficial result than we think by its use. Nitric acid applied in the way above described will cure these cases. Needless to say it should be preceded by a free application of 10 per cent. cocaine solution. I should perhaps emphatically add that

neither a caruncle nor a red patch should be touched or treated unless it is painful or tender enough to make the patient complain of it. Unnecessary meddling will often result in local areas of sensitiveness. Furthermore, let me warn you not to apply nitric acid with a glass rod. The stick used should have a blunt or a tapered sharp point according to the area we desire to cauterize.

In this brief paper I have put before you methods of treatment which I have tried and found good. All of them are imperfect; many of them are very far from being ideal; but the perfect and the ideal does not exist in gynaecology. Suffice it to say that they are the best we have. Were this paper open to criticism I should expect it to be severely handled by some of my audience. I am sensible of having laid myself open to the charge of being an advocate of the caustic stick and pessary. To a limited extent I plead guilty to this impeachment. The caustic stick and pessary, in the heyday of their popularity, were indiscreetly used and often abused. The fault was in their users, not in themselves. When better methods come I shall be among the first to adopt them, but in so doing I shall lay aside the old as good and true servants, who have done their duty, and are pensioned off, rather than as deceivers who merit scorn and reproach.