The Revival of Didactic Instruction.

MEMPHIS, TENN., July 25, 1904.

To the Editor:—The didactic lecture hall, the recitation room, the clinical amphitheater, the hospital wards and the laboratories should all be utilized to the fullest extent in teaching modern medicine. I regret to note the sentiment prevailing in some of our great schools against didactic work. No student can read unless he first learns his alphabet. Nor can he solve a problem in mathematics unless he knows his figures. He can not parse a sentence in English or solve a problem until he has been thoroughly grounded in the rules governing each case.

The didactic lecture is the alphabet, the unit one, the rules in teaching medicine. Let the didactic professor preach typhoid fever in the most forcible manner, then let the clinical professor teach typhoid fever in the hospital wards. I am a hearty champion of didactic work along with clinical. Medical schools to-day need more men like Pepper, DaCosta, Flint and Gross. We need men of culture; men of personality; men with powers of expression; men with clinical instinct; men who have acute observation as teachers. Politics is reigning supreme in many of our very best universities. In my opinion one of the oldest and greatest universities in this country is absolutely honey-combed with politics. Schools which are liberally endowed, and which should set the standard of medical education should in every sense eliminate politics forever. Let our schools, whether they are endowed or not, select their teachers with reference to their capacities and not according to their financial or family pull. No doubt there is too much technical work. Our pathologists and bacteriologists should adopt a better nomenclature. The terms now in vogue are harder to memorize and to remember than the muscles of the forearm in Gray's Anatomy. There is too much ornamentation of nonsensical terms, and not enough dress of good, plain English.

The recitation method is a good one and should be encouraged. It stimulates the student body to action and brings him in a more intimate touch with his teacher. A more cordial relationship should exist between student and professor.

FRANK JONES.

The Clinical Teaching Pendulum Has Swung Too Far.

PHILADELPHIA, July 29, 1904.

To the Editor:—My experience with students has convinced me that we have swung a little too far in the direction of clinical teaching; that at the present time we are giving them too few systematic ideas in regard to disease. The picture of disease as presented to them in a single clinical case may show but a few of the characteristic evidences of the malady, and may differ widely from the usual and ordinary. The student needs in the first place to acquire a thorough outline of the average case; after that he can apply with greater advantage his knowledge to the individual. The clinical lecturer as a rule lays especial emphasis on the symptoms of the case before him, which may be very misleading, or at least, imperfect.

DE FOREST WILLARD.

Queries and Minor Notes.

UNINTENTIONAL TRESPASS.

TEXAS, Aug. 2, 1904.

To the Editor:—Dr. A was attending Mr. X, who had parenchymatous nephritis. The case was serious, and Dr. A called Dr. B in consultation, after which they advised Mr. X to spend the summer at some watering place, referring him to physicians there. While at the watering place he was treated by the physicians to whom he was referred. After a few weeks he returned home and continued the treatment recommended by the latter. He was suddenly taken with severe dyspnea, and sent for Dr. B at 2 o'clock in the morning. Dr. B went and was asked to continue in treatment of the case, as they could not now return to the watering place. Nothing was said about Dr. A. Dr. B was under the impression that Dr. A had relinquished the case when Mr. X went to the watering place, or he would never have taken it. Dr. A is now offended, and Dr. B wishes to know if he had committed an error in

taking the case. He is very desirous to have the matter adjusted, as the mistake was not made from malice, but only from a wrong impression of the situation.

ENQUIRER.

ANSWER.—The conduct of physicians in such cases, according to the Code of Ethics, is to be based on the golden rule. This will lead to careful inquiry as to the rights of other physicians to avoid unintentional trespass, even though a patient may consider that for him to summon a new attendant is *ipso facto* a discharge of the old. The physician can not always consider it so. When one makes an error or offends a confrère in the way described, one should frankly explain and apologize, and even give up the case if the patient agrees, because the loss of a patient from one's clientele is a small matter compared with the loss of professional fellowship and good feeling toward a confrère. For the same reason the physician represented in this case by Dr. A should exercise charity and heartily accept an apology when offered. If he knows his friend to be an honorable physician, let him think that he lost the case through his own inferiority rather than through any dishonorable action on the part of his friend.

THE LIMITATIONS OF GRATUITOUS SERVICES TO PHYSICIANS' DEPENDANTS.

Aug. 5, 1904.

To the Editor:—Will you kindly reply to the following query through THE JOURNAL? A student, the son of a homeopathic physician of a distant town, and a complete stranger to me, contracted chancreoids while attending school some distance from here. He consulted me and was treated for several weeks. The severity of the case and the development of chancroidal bubo necessitated several time-consuming visits and surgical treatment. An anxious impersonal letter to the attending physician was replied to by me, stating the boy's exact condition, and that he would be carefully looked after. No reply to this was received. The young man was emphatic in his statements that all would be paid for, and, indeed, a small part was paid. The bill was sent to him several times, and several months ago to the father, without response. Now, what is the proper and respectful course for me to pursue? Surely no self-respecting physician would expect another to do that kind of business for his erring son for nothing.

Y.

ANSWER.—The Principles of Ethics advise all physicians to render gratuitous service to any other "practicing physician and his immediate family dependants." In addition, it is suggested that an obligation lies on a physician in comfortable circumstances to recompense a colleague for professional service requiring sacrifice of considerable time. In the case submitted, it is perfectly clear that the homeopathic physician is under real obligation to our correspondent and should be ready to recompense him in suitable amount—something less than ordinary charge in similar cases in that locality. As to the proper course for our correspondent now to pursue, we can hardly advise; that is so largely a matter of personal taste and inclination, and of opportunity. Certainly it would not quite be wise to risk loss of prestige by publicly pressing such a claim, however aggravated the circumstances might be.

SLOW PULSE IN TYPHOID.

EDMOND, OKLA., July 27, 1904.

To the Editor:—Will you please explain the cause of slow pulse frequently found in typhoid fever? I have seen three or four cases during the last year with pulse ranging from 40 to 70 or 80, with a temperature of 101 to 103. Text-books speak of the slow pulse, but do not give its cause. Do you suppose the typhoid toxin influences the pneumogastric nerve to the production of this condition?

T. H. FLESHER, M.D.

ANSWER.—Your observation of the slow pulse in typhoid fever is, as you say, a confirmation of the statement made in many text-books. But it is well to emphasize the value of the slow pulse in spite of high fever, because in many books no mention of the fact is made, and too often the practitioner overlooks what is really a valuable help in the matter of diagnosis and prognosis. As is well known, too, the pulse of the *convalescent* typhoid is apt to be slow. While this slow pulse is probably commoner after typhoid than after other febrile diseases, it is seen after other infections, and is an example of the post-febrile bradycardia, or bradycardia of convalescence of Huchard and others. The explanation of this phenomenon is largely a matter of speculation. It may be, as suggested, due to an involvement of the vagus nerve or its center, but it is more likely, we think, due to the action of the toxin on the heart muscle itself. Many of the so-called neurotic affections of the heart are in reality myocardial in origin, and, while the influence of the pneumogastric and of the intrinsic cardiac nerve fibers and ganglia can not be excluded, one would feel inclined to look on the bradycardia as in large measure due to the effect of the typhoid infection on the heart itself. That the heart muscle is affected in typhoid, sharing in the acute parenchymatous degeneration of the viscera, is well known; and cardiac weakness and instability of its muscular power is often shown during convalescence when a patient whose pulse while in bed was perhaps only 50 or 60, has on first getting up a pulse of 100 or 120. In all this question there is an unknown element that is not explained, and that is, why the poison of typhoid generally causes a slow pulse, while that of some other disease, e. g., scarlet fever, causes a rapid pulse. We may speak of a selective action of these toxins as we do of drugs, and of their specific effect, yet there is still left much that is not quite clear.