strenuously but futilely tried by the Royal College of Surgeons. So long as the chair is filled by an eminent man, perhaps no harm is done; but such exclusive privileges might be productive of the greatest harm under other circumstances.

In 1782 Richter began at Göttengen the first of those admirable cliniques which have made many of the German schools famous; and now at nearly all the medical centres there exists a most elaborate system of bedside teaching.

In 1792 Sir Astley Cooper began to employ his hospital cases to illustrate his surgical lectures. The effect of this, he tells us, was most gratifying. While in 1791 his class only numbered seventy-three, the year he made this change it increased to one hundred, and the steady augmentation to four hundred and six in 1824 he ascribes to this clinical method of instruction. In 1792 some arrangements for teaching clinical medicine appear to have existed at the London Hospital. In 1813 Sir Benj. Brodie began to give regular bedside lessons.

In Dublin, wards were set aside for clinical purposes as early as 1785, and by degrees a practical school of great eminence arose; for while Crampton, Smyly, and Porter taught clinical surgery, Marsh, Corrigan, Graves, and Stokes brought practical medicine to great distinction.

In our own city clinical teaching appears to have existed as early as 1787, as a ticket for a course of "Lectures on the Cases of Patients in the Town's Hospital, Clyde-street, by Robert Cleghorn, M.D.," is in the possession of my colleague, Professor Cowan. The Royal Infirmary was established in 1793, and shortly afterwards bedside teaching was to some extent pursued, but it was not till 1829 that such instruction obtained a permanent or important place in the instruction of students. No proper or efficient system of teaching could be pursued by the general practitioners of that day, who were elected to serve in the hospital for two years at a time, and who were only in actual charge of patients for three months in each year. In later times, in the hands of Macfarlane, Lawrie, Andrew Buchanan, Moses Buchanan, Lyon, and Fleming, clinical surgery in Glasgow was more carefully cultivated. The teaching has always been quite open, and at no time has this been the case more than at present, when every surgeon in charge of wards in either hospital is placed, as regards the recognition of his teaching, on precisely the same footing, and students are at perfect liberty to choose any of them as their instructor. In order to fulfil the necessary course, each student attaches himself to two teachers, and he is compelled to divide his time between them, attending the "lecture" of both every week, but confining his visits to the wards of one for three months at a time. He has thus the opportunity, during the six months' session, of watching the practice of two men, and yet following to a termination the cases treated.

Before the clinical teaching was transferred from the Royal Infirmary, Professor Gairdner and myself were the only representatives of the University engaged in clinical teaching. When this institution was opened last year, two of our former associates as clinical teachers in the Royal Infirmary joined us here, and to them the University gave the well-earned status of professors. In this way Drs. McCall Anderson and George Buchanan were associated with Dr. Gairdner and myself in this very important and laborious work; but their appointment and official position as Professors of Clinical Medicine and Surgery has in no sense changed the relation in which Dr. Gairdner and myself stand to the teaching, nor has their appointment in any way narrowed or restricted the choice which you are allowed to make of your teachers. These appointments have brought augmented force to our school, but they have conferred no exclusive position on their holders such as was pointed out existed elsewhere.

The conditions favourable to the healthy development of clinical teaching have greatly improved of late years in our school. The division which now so markedly exists between medical and surgical practice, and the restriction to consultation work which several of the teachers have imposed on themselves, have allowed more time to be devoted to hospital duties, and has enabled them to concentrate their attention on special departments; and to this circumstance more than any other do I ascribe that increased vigour which has marked the teaching of later years, and the rapid increase of our school which has followed. The prolonged hospital appointments permit such improvements to be made in practical teaching as were before impossible, and to no event of my professional life do I look back with more satisfaction than the part I took in that reform. The almost complete severance which existed between the University and the hospital up to a few years ago was a total bar to the development of the clinical teaching.

Gentlemen, in closing these remarks I would only add that the duty demanded of us teachers is most anxious and responsible, whether viewed with reference to you or the patients. It is a very grave affair to be charged with the instruction of others in any matter; how infinitely more serious is it when the issues are so momentous and far-reaching as those embraced in medical education! We are entrusted with the practical education of men who go to all quarters of the earth wherever the British name has penetrated. Your knowledge and skill may affect the health and happiness of innumerable families, and any error you imbibe here may be multiplied in endless ways. Yet, on the other hand, all good and true lessons will have a wide circuit for their action, so that the clinical teacher is, as it were, the centre from which far-reaching waves of good and evil may spread. It is also a most anxious duty we have to perform, as we have, as it were, to think aloud before an intelligent audience, and to recognise disease, foreshadow results, and direct treatment almost on the spur of the moment. If this is most trying to a teacher's reputation, there is at least a compensating gain both to himself and his patients, as it must needs render him careful in his words and actions, and in this augmented attention and caution the patients secure a further guarantee for their prudent treatment. All of us, whatever our experience may be, are too likely to err and fail, but if each strenuously endeavours to do his best, he has a right to rely on the loyal support of every true student.

CASE OF NYSTAGMUS OCCURRING IN A COAL-MINER, ASSOCIATED WITH PALPITATION AND PROFUSE SWEATING.

By BYROM BRAMWELL, M.B.,
PHYSICIAN AND PATHOLOGIST TO THE NEWCASTLE-ON-TYNE INFIRMARY.

THOMAS L——, aged thirty-eight, a pitman, married, was admitted to the Newcastle-upon-Tyne Infirmary on the 10th of June, 1875, complaining of dimness of sight, palpitation, and debility.

Previous history. — He has worked as a coal-miner for twenty years, and has been particularly healthy. Has never had syphilis nor rheumatism. For the last four years he has suffered occasionally from palpitation. Eighteen months ago he first felt his sight dim, and noticed when he looked at an object intently that it seemed to move quickly backwards and forwards. The palpitation and dimness of sight have been worse since March, and since this date he has felt short of breath on exertion. He thinks the dimness of sight was brought on by the glare of the lamp which miners use. The pitmen, he says, often complain that the light hurts their eyes; he never, however, knew anyone affected in the same manner as himself.

The family history is unimportant.

Present condition. — He is a pale man, tolerably well nourished, but not muscular. The pupils are equal, contracted, and sensible to light. When he fixes the eyes on an object, the eyeballs oscillate quickly backwards and forwards with a slight rotatory movement. The oscillation is greatest when he looks upwards or to the right. It is also increased by looking at distant objects. It is not increased by a dim light, and is not worse when he assumes a stooping position. He states that the nystagmus is worse since he left off work. When at work he used to look chiefly downwards and to the left. On ophthalmoscopic examination the fundus is seen to be normal.

The thorax is well formed. On palpation a very marked systolic thrill is felt in the first and second left interspaces, just outside the sternum. The percussion note is impaired over the same area, the dulness being best marked between the second and third left costal cartilages. On ausculta-

tion a loud systolic murmur is audible over the area of thrill. Its point of maximum intensity is at the middle of the sternum, on a level with the third costal cartilage; from this point it is propagated upwards over the area of thrill to the left sterno-clavicular articulation. The murmur is unaccompanied by a second sound. At the second right costal cartilage and over the course of the aorta, the murmur is heard, but much less loudly. There is no venous hum in the neck. Pulsation and thrill can be faintly felt when the finger is placed deeply in the suprasternal notch. The murmur is just audible in the left suprascapular region. The radial pulse numbers 72; it is equal in the two wrists, full and regular. There are no pressure signs. Every three or four days, sometimes more frequently, the patient is attacked with violent palpitation; the attacks last from a few minutes to half an hour; they occur at all times of the day, and without any apparent cause. The slightest exertion causes profuse sweating. The sweating sometimes comes on when he is at rest, and always follows the attacks of palpitation. The appetite is fair; tongue clean. The temperature in the axilla is 97° F. The other systems and organs are normal. There is no enlargement of the thyroid.

Five minims of tincture of digitalis and ten minims of the tincture of the muriate of iron were ordered three times a day.

June 21st.—Since patient's admission it has been noted that the pupils are frequently unequal, the right being sometimes smaller, sometimes larger than the left. The sweating is sometimes confined to the left side of the face. The temperature on both sides is the same. His general condition is unchanged.

July 3rd.—An attack of palpitation came on to-day in my presence. It commenced at 12.30. The eyes became slightly prominent; the pupils considerably dilated; the cardiac pulsations numbered 144 in the minute. The face was slightly livid; the extremities cold. The patient stated that the attack was a very slight one. At 12.35 he said he would try and "put it away." He took two deep breaths and said, "It is away." At the same moment the pulse fell from 150 to 60 in the minute. Slight pain over the front of the chest was complained of while the palpitation lasted. The patient says when it goes away he feels the heart give a sudden jump, and the pulsation immediately ceases. He can always "put it away" by taking one or more deep inspirations. Sometimes the attack continues for half an hour before it is stopped. The digitalis and iron to be discontinued. To take two minims of liquor arsenicalis thrice a day.

15th.—Was made an out-patient to-day as he had to go home to attend upon his wife who is ill. The liquor arsenicalis has produced no effect, although the dose has been increased. To discontinue it, and to take half a drachm of the liquor ergoti instead.

Aug. 26th.—Was readmitted, as he has been much worse of late. The palpitation and sweating have been most intense; the oscillation of the eyeballs is less; he can now look steadily forwards, downwards, and to the left; when he looks upwards, or to the right, it always commences; when the eyes are at rest, vision is good; his physical condition is otherwise the same. To take one-eightieth of a grain of sulphate of atropia three times a day, and twenty grains of bromide of potassium every six hours.

Sept. 10th.—A violent attack of palpitation came on at 11.10 to-day; the cardiac pulsations numbered 174; the murmur was inaudible, its place being taken by a short rapid pulsation; the radial pulse was small and thready; the extremities cold; the eyes were prominent and staring, the pupils dilated; the respirations numbered 28. He made several attempts to "put it away," but did not succeed till 11.20. He then said "It is away." The pulse at the same moment became full and steady (72 in the minute); the murmur at the same time became loudly audible; no irregularity nor intermittency was observed before the fall. To take half a drachm of the bromide three times a day.

25th.—Says he feels a good deal better; the attacks of palpitation are less frequent and less severe; he has gained four pounds in weight since his readmission; he feels weak and shaky about the legs, but otherwise well; the sweatings are much less profuse. To inhale nitrite of amyl during the paroxysms.

Oct. 1st.—The patient went out to-day greatly improved. The nitrite of amyl completely controls the paroxysms. He said on his discharge, "I wish I had had that medicine sooner."

Remarks.—In THE LANCET of June 12th, Dr. C. Bell Taylor, of Nottingham, reported several cases of nystagmus occurring in coal-miners, and stated his belief that the oscillation of the eyeballs was in these cases a sort of chorea, brought on by strained efforts of vision in an imperfect light. This case agrees with those reported by Dr. Taylor, in so far as the patient is a miner and that he suffers from nystagmus. It differs, however, in the following essential points:—1st. The nystagmus is associated with other symptoms—viz., palpitation, loud systolic murmur, and profuse sweatings. 2nd. The oscillation of the eyeballs is not increased by an imperfect light, nor when the patient stoops. 3rd. It is worse when he looks at distant objects, and when he looks upwards or to the right. 4th. It is not easily curable; for it still continues, although he has been off work for seven months.

We know so little as to the cause of nystagmus that it is impossible to say whether the oscillation of the eyeballs, the palpitation, and the other symptoms of this case were associated as a mere coincidence or not. I am inclined to think their relation was not merely accidental.

In some particulars the case resembles exophthalmic goitre—a disease in which there is good reason for believing the cervical sympathetic to be at fault. Certain facts in this case point in the same direction, and show that the palpitation was due to stimulation of the accelerators of the heart, and not to suspension of the inhibitory functions of the vagus. These facts are—1st. The variable state of the pupils, the right being sometimes larger sometimes smaller than the left. 2nd. The profuse sweatings, sometimes unilateral. 3rd. The condition of the patient during the attacks of palpitation—notably the prominence of the eyeballs, dilatation of the pupil, and coldness of the extremities. 4th. The marked benefit which resulted from the use of nitrite of amyl—a drug which acts by dilating the vascular system.

It is a remarkable fact that the patient was able to "put away the beating" by taking a few deep breaths. This was no doubt due to reflex stimulation of the vagus. Here again is another fact in support of the theory that the palpitation was due to stimulation of the accelerators, for it is unlikely that the vagus would be so readily aroused if its inhibitory functions were suspended.

The instantaneous manner in which the attacks of palpitation ceased is worthy of note. The pulse, from being 174, thready, and almost imperceptible, became *all at once* full, regular, and of normal frequency. There was no stoppage for several beats, no irregularity before the fall took place—facts which were observed by Dr. Farquharson in his lately published "Case of unusually Rapid Action of the Heart."

The characters of the murmur were peculiar. At first I was of opinion that it was hæmic, and in the pulmonary artery. Against this view were the dulness on percussion, the very marked character of the thrill, and the absence of venous hum. I am now inclined to think that the murmur was due either to organic disease of the pulmonary artery or more probably to some congenital malformation.

CLINICAL ESSAYS.

BY T. PRIDGIN TEALE, M.A., F.R.C.S.,
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No. VI.—ON THE TREATMENT OF VESICAL IRRITABILITY AND INCONTINENCE OF URINE IN THE FEMALE BY DILATATION OF THE NECK OF THE BLADDER.*

THE discussion at the late meeting of the British Medical Association at Edinburgh on Dr. Duncan's paper "On the Examination of the Female Bladder by Dilatation," and his testimony to the benefit resulting from the proceeding, and the extract from the *New York Medical Record*, Aug. 14th, 1875, "On the Cure of Cystitis by Dilatation of the Neck of the Bladder,"—warn me that it is time that I brought before the profession the observations I have made on the

* Read before the West Riding Medico-Chirurgical Society at Leeds, February, 1873.