

Albert Clarence Shaw, M.D. Medical College of Ohio, Cincinnati, 1900; Rush Medical College, 1908; died at his home in Eaton, O., January 12, from tuberculosis, which followed a fall and injury of the knee in 1907; aged 45.

Frederick William Kuhn, M.D. Long Island College Hospital, Brooklyn, N. Y., 1896; for several years surgeon of the Richmond Hill (L. I.) Fire Department; died at his home in Morris Park, L. I., January 8, aged 41.

Samuel S. Leith, M.D. Northwestern University Medical School, Chicago, 1899; a member of the State Medical Society of Wisconsin; died at his home in Junction, January 10, from cerebral hemorrhage, aged 44.

Thomas Samuel Murdock, M.D. University of Michigan, Ann Arbor, 1865; for many years a practitioner of Northville, Mich.; died in Ypsilanti, Mich., January 13, from cerebral hemorrhage, aged 74.

James M. Gray, M.D. College of Physicians and Surgeons, Keokuk, Ia., 1883; Kansas City (Mo.) Medical College, 1893; died at his home in Hutchinson, Kan., about January 7, aged 50.

Jasper Newton Sims (license, Indiana, 1897); a member of the Indiana State Medical Association; died at his home in Doverhill, Ind., January 3, from cerebral hemorrhage, aged 60.

Robert C. Alexander, M.D. College Physicians and Surgeons, Keokuk, Ia., 1883; of Nevada, O.; was found dead near Wyandotte, O., January 10, from cerebral hemorrhage, aged 63.

John Calvin Young, M.D. Beaumont Hospital Medical College, St. Louis, 1899; formerly of Roanoke, Ill.; died in Phoenix, Ariz., Nov. 10, 1912, from tuberculosis, aged 42.

George S. Liggett, M.D. Washington University, St. Louis, 1876; a member of the American Medical Association; died at his home in Oswego, Kan., January 11, aged 59.

James L. Quinn, M.D. Miami Medical College, Cincinnati, 1869; coroner of Preble County, O.; died at his home in Eaton, January 7, from bronchial asthma, aged 71.

William H. Jones, M.D. College of Physicians and Surgeons, Keokuk, Ia., 1874; died at his home in Forest City, Ia., January 12, from cerebral hemorrhage, aged 68.

J. F. J. Patten, M.D. Victoria University, Coburg, Ont., 1868; since 1880 a practitioner of St. George, Man.; died at his home, Nov. 15, 1912, from heart disease, aged 67.

Thomas Hawkins Stull, M.D. College of Physicians and Surgeons, Keokuk, Ia., 1877; died at his home in Algona, Ia., January 4, from cerebral hemorrhage, aged 60.

P. Edward Thibodaux, M.D. Tulane University, New Orleans, 1892; of Montegut, La.; died suddenly in Houma, La., January 6, from valvular heart disease, aged 52.

Henry Woodward Jones, M.D. Detroit Medical College, 1874; of New York City; died at his home in White Plains, N. Y., January 14, from diabetes, aged 65.

Jonathan Wingate Winkley, M.D. College of Physicians and Surgeons, Boston, 1894; died at his home in Boston, Nov. 20, 1912, from acute gastritis, aged 81.

Nicholas Louis Talbot, M.D. Miami Medical College, Cincinnati, 1876; died at his home in Austin, Neb., Dec. 25, 1912, from progressive paralysis, aged 62.

Francis G. Arter, M.D. Rush Medical College, 1868; for twenty-four years a practitioner of Chicago; died at his home in that city, January 22, aged 74.

Artemesia Brumback Winter, M.D. Physio-Medical Institute, Cincinnati, 1883; (license, Ohio, 1896); died at her home in Newark, O., January 10, aged 67.

Mortimer Hall Clarke, M.D. Boston University School of Medicine, 1888; died at his home in Auburndale, Mass., about January 14, aged 52.

Edward Perry Bowles, M.D. College of Physicians and Surgeons, New York City, 1874; died at his home in Wolfville, N. S., Nov. 20, 1912.

May McClaren Judy, M.D. Kansas City (Mo.) Hahnemann Medical College, 1909; died at her home in Kansas City, January 4, aged 37.

William Jacob Wagner, M.D. University of Toronto, 1870; died at his home in Toronto, January 10, from nephritis, aged 63.

Significance of Uncomplicated Spastic Paraplegia.—An uncomplicated spastic paraplegia should suggest in the child cortical disease, in the adult disseminated sclerosis.—Judson S. Bury in *Clin. Jour.*

Correspondence

The Diagnostic Doubts of Dr. Cabot

To the Editor:—Allow me to express my approval of Dr. Croftan's letter (*THE JOURNAL*, Jan. 11, 1913, p. 145) concerning Dr. Cabot's paper ("Diagnostic Pitfalls," *THE JOURNAL*, Dec. 28, 1912, p. 2295).

We all make mistakes, and we all have idiosyncrasies. Some men think it advisable to pose as pessimists concerning their own ability or accomplishments. They do not really desire people to rate them as they publicly rate themselves. We frequently see this pose in discussions, and sometimes among our patients, who are always running themselves down. They do not believe it themselves, and they really do not want any one else to believe it; often they are persons of ability.

Only a small number of patients under treatment by any one physician die, and only a small proportion of those that die come to autopsy. If Dr. Cabot's findings were statistically correct, the majority of our patients would recover in spite of mistaken diagnosis and treatment. Although there is no doubt that many of our patients recover in spite of diagnosis and treatment, those of us who are older and have more or less consulting or difficult office practice (receiving only "tough" cases) know that we would not succeed if we did not generally make correct diagnoses. Therefore I agree with Dr. Croftan that Cabot's article is ill-timed, ill-judged, and, being made public, unjust to his brethren in the profession. Such a talk as his should be given only to a small group of men in a confidential, personal discussion. [Dr. Cabot's paper was read and discussed before the Section on Practice of Medicine of the American Medical Association, and its publication approved.—Ed.]

Dr. Cabot entirely overlooks the fact that many diagnoses are made by exclusion, and that finally the case is rounded up to one, or one of two, or one of three causes. In such instances only an exploratory incision or a post-mortem examination could make the diagnosis positive. Such a decision is not a failure in diagnosis; it simply recognizes that difficulties are presented to us which science has not yet given sufficient diagnostic data to solve. But this is no failure on the part of the diagnostician, and the treatment of the patient is often the same, whichever diagnosis is chosen of the two or three possibilities reached by careful exclusion. In other words, the patient and not the name of the disease is to be treated. On the other hand, there are thousands of correct diagnoses made of patients who have no organic disease, and who, on account of the correct diagnosis, receive correct treatment and entirely recover. In other words, Dr. Cabot's paper is a sad proposition to present to laymen, but medicinally, and as far as the welfare of our patients is concerned, it means very little.

OLIVER T. OSBORNE, M.D., New Haven, Conn.

To the Editor:—I have read with much interest, but many doubts, the criticism by Dr. Alfred C. Croftan in *THE JOURNAL*, January 11, on the recent article by Dr. Richard C. Cabot, "Diagnostic Pitfalls." I am a great admirer of Dr. Cabot's unequivocal honesty and sterling integrity.

One must confess that professional honesty can be graded, the same as commercial products or even California fruit, and this superfine Cabot grade, which would proclaim the truth from the housetops because it is truth, no matter what the personal cost or sacrifice might be, is certainly a *rara avis*. Only twice have I met it before: once in a great medical teacher who no longer resides in this country, and again in a prominent surgeon with whom this teacher was long associated.

Dr. Croftan's statement that in Vienna he has "seen 152 consecutive cases correctly diagnosed in every clinical detail" will be hardly accepted by any surgeon who has had experience in operating after diagnoses made by internists. I have found the lily painted as frequently abroad and even in brighter colors than in my own country.

The Cabot grade can best be shown by contrast with one of Dr. Croftan's own statements. "The whole argument is illog-

ical," he says; "fifty men are not necessarily a centipede because one man is a biped." This is trite, it is apropos; its brilliancy smacks of good sound literature. But the Cabot grade would have enclosed this centipede biped wit in quotation marks, for the expression is not Dr. Croftan's. It belongs to the English essayist, Gilbert K. Chesterton ("What's Wrong with the World," p. 2).

RAYMOND RUSS, M.D., San Francisco.

Work of the Full-Time Instructor

To the Editor:—When a standard is established in food or drug analysis, a method of approximation to the standard is also established. Thus, if a sanitary authority fixes a limit of 25 parts per million for sulphur dioxide in gelatin, it also sets forth in detail the process by which the ingredient is to be determined.

I make this prologue because I wish to call attention to the fact that while severe standards are now being required for medical colleges, no definite methods of ascertaining compliance therewith are being furnished, nor, as it seems to me, are some of the standards clearly defined.

Take, for example, the "full-time" instructors. What constitutes full time? Surely, it is not meant that the instructor is to spend all his, or her, waking hours in the teaching work. It is thought by many that research work should be performed by such teachers in the hours not actually occupied with students; but research work is not teaching, and students may not get direct benefit from the time that the instructor spends in the research laboratory. It is likely that many instructors will find research more attractive than the lecture-room, as to both immediate and prospective returns in fame and fortune, so that the student will be neglected. Will full-time registry prevent the teacher from preparing text-books or contributing within or without his specialty to journals and encyclopedias, or serving without compensation on commissions of inquiry under national, state or municipal authority, along lines of his teaching work? Some years ago I was a member of a milk commission. The service was without compensation. The report has been pronounced one of the most important yet rendered in the matter, and the information that I obtained in the course of service on the commission was of much value to my students in the department of hygiene. The service was carried on without loss of an hour from the prescribed schedule of my work at the college. Would such a service interfere with full-time registry? What about vacation work? Medical schools in this country are not usually in session between the middle of June and the middle of September. Suppose a teacher should take up some work for compensation during this period, would the "full-time" condition be broken?

From conversations with teachers in medical schools, I have learned that some consider that the full-time requirement means that no time shall be given to routine medical practice, but that teaching in two institutions or accepting expert duty does not conflict. I have not so understood the condition, but it may be worth while for those who are promoting the system to inquire how far the several institutions are complying with the requirements. The history of reform in American medical education shows too many instances of colleges deliberately keeping the word of promise to the ear and breaking it to the hope to permit us to suppose that in this serious matter they will all be true without supervision.

HENRY LEFFMANN, M.D., Philadelphia.

[COMMENT.—The term "full-time instructors" as applied to medical colleges means exactly the same as if applied to a scientific school or a college of liberal arts. No one thinks of arguing that a teacher in our standard colleges of liberal arts should be permitted to engage in private business in all except the strictly class-room hours. So for medical colleges the object sought by the requirement is to secure teachers who are paid sufficient salaries so that their life-work and their chief interests may be devoted to the training of medical

students. The teaching of modern medicine, particularly in the laboratory branches, can no longer be satisfactorily done by busy practitioners or by others who can devote only fragments of their time to teaching, and who are required to look to other unrelated lines of work for their livelihood. As to research in the medical school, the expert teacher must of necessity be engaged in research if he is to keep up with the rapid developments of his subject and if he is to bring into the medical college the spirit of investigation with which every medical student should become imbued. If the teacher by his own research is fully up to date in his subject and has something worth while to add to the world's knowledge of that subject it would by no means detract from his usefulness as a teacher for him to use his spare moments in reporting such facts, or in writing a book on that subject. Unless he is an authority in his subject he would scarcely be in position to write a text-book. Again, expert duty along the lines of the subject taught might really add to an instructor's teaching ability. Vacation time also is the instructor's, to be used as he may see fit. No outside work, however, should be allowed to interfere with his first work as a medical teacher. The "full-time" teacher is one whose work is in the college; his private library is there; his research work is there; his interests are there; he can be readily found by the students to whom his work is a constant inspiration. Instead of the empty, lifeless laboratory of former times headed by the busy practitioner, the full-time teacher's laboratory is an active, orderly place—a constant and present example to those who are fortunate enough to become his pupils.—EDITOR.]

The Special Package Evil

To the Editor:—There is much food for thought in the editorial from the New York Sun (THE JOURNAL A. M. A., Oct. 5, 1912, p. 1307) warning the public against physicians who prescribe proprietaries, blaming these physicians for the all-too-prevalent tendency of the public toward self-medication, and lauding the old-fashioned prescription because it at least cannot easily be duplicated.

It is but too true that the prescribing of proprietaries fosters self-drugging. When a patient learns that the medicine prescribed is "ready-made" he shrewdly concludes that it was not made for his ailment in particular, but that it must fit a series of similar conditions. Hence, if it is found of value, he will hereafter use it for all symptoms similar to those which caused his physician to prescribe the proprietary. He also will find little difficulty in finding symptoms in the ailments of his friends which will warrant a recommendation to patronize his remedy.

But there is another objection to the prescribing of ready-to-take proprietaries. Even if the preparation is the best possible medicine that could be selected for the particular case, the very fact that it was ready-made is bound to lessen the patient's confidence in his physician—about as much as one would lose faith in a tailor caught in palming off a ready-made suit.

While the patient has a right to know what medicines he is taking, it is desirable for the reasons just given that physicians take pains to give their prescriptions a character of individuality, and to avoid whatever possible giving the appearance of prescribing ready-made medicines.

Physicians who would follow this advice should bear in mind that almost every proprietary article is put up in a distinctive package, and also that the druggist is most likely to dispense it in this package. As a result it is more than likely that the patient will find it out if a proprietary is prescribed, no matter whether it is Fellows' Syrup with the name blown in the glass or the very ethical and probably valuable atöphan with its neat little "star-bespangled" box, even if the physician takes pains to write special directions and the druggist removes the printed label and affixes his own. And it must be understood that the druggist has good reasons for dispensing the proprietary in its original container. In the first place, many physicians have acted on the manufacturer's assertion that druggists are prone to substitute, and therefore tell their patients the kind of con-