patient. These clinics have been largely made up of abdominal cases, because the abdomen is the region wherein lies chiefly the borderland. Any inaccessible region, however, is a borderland one, because it is the inaccessibility of the disease that makes diagnosis difficult, and when diagnosis is difficult or impossible the necessity for operation is masked in the uncertainties of recognition.

There would be no borderland case, I am convinced, were the exact condition as demonstrable at the bedside as it is in the autopsy room. From this point of view there is no borderline case. Each lesion would be clearly mechanical, relievable or not. But, if mechanically relievable, there might well be a difference of opinion between surgeons and physicians as to the matter of surgical treatment.

From another point of view there is a distinct difference of opinion as to the comparative benefits of medicine and surgery. The stomach provides a borderland, and gastric ulcer a borderline in this class of cases.

A third point of view is that from which is considered the treatment, by palliative operations, of such diseases as cancer of the oesophagus, intestine, rectum, brain, and spinal cord.

And there is still a fourth point of view, that of certain diseases in which environment and hygiene play an important part. Such, for example, are tuberculosis of the kidney, of the peritoneum, and the like, in which operations present grave immediate risks, with at best somewhat doubtful prognosis, whereas medicine is safe though not radical.

With increasing experience I have realized more and more the importance of prognosis. Prognosis in most human occupations is the vitally important element guiding action. Upon prognosis depends decision. When prognosis is sure, decision is sure; when prognosis is uncertain, decision is uncertain. Hence in the majority of cases prognosis means decision.

But in the borderland case prognosis does not always mean decision, even if the prognosis is sure, for even when we know the outcome of disease, the best treatment, whether medical or surgical, palliative or radical, is debatable. This is one of the important considerations under my title.

For example, take cancer of the rectum or of the sigmoid flexure, in which the prognosis is even the most favorable cases is bad—the question of relieving obstruction by an artificial anus, or not, is debatable. Some patients would prefer to die at once rather than endure for a few months a living death; others would cling to every hour of life, no matter how agonizing. Some physicians look upon the attempted prolongation of life under such conditions as unwise; others regard life as so precious as to justify prolongation of its spark to the last second.