and failure to warn against the harm of continued using, and to insist upon—giving to this earnest personal attention — entire narcotic quitting when the need for its taking is ended. For details, see papers by the writer, "The Responsibility of the Profession in the Production of Opium Inebriety," and "The Genesis of Opium Addiction."

Chloral and cocaine inebriety—happily decreased and decreasing—owe their rise and progress to the same incautious prescribing and continuing. Added thereto, in the case of cocaine, I have little doubt, has been the mistaken, pernicious opinion of Hammond and Bosworth, as to its non-toxic, non inebrial power. *Vide* my papers: "Chloral Inebriety," "Chloralism," and "Cocainism."

While insisting on the part played by the physician in the genesis of narcotic inebriety, I do not overlook the peculiar neurotic status, both ancestral and acquired, of these cases. Nor the facility with which this specially nervous temperament favors the use of one or other drug, as a stimulant in depressed conditions, or a calmant in the reverse. Nor do I forget that some have their rise in vicious design, morbid curiosity or other outcome of damaged *morale*. All these, however, hold second place in causation.

If these premises be correct, the weightiest deduction is this, Narcotic inebriety is a preventible disease. That I believe a fact—of large and far-reaching importance—and the pivotal point of all precept and practice along this line. The forms of narcotic inebriety are on the wane, due to wider recognition and appreciation of their cause and the danger of continuance, and to the advent of less harmful hypnotics. Erlemmyar thinks morphinism will grow worse from year to year. I am less pessimistic than he. I am hopeful and sanguine of its steady decline. But this hope will be realized only when two results are reached. First, a lessened medical use of morphine. This must be secured by teaching and example. Those whose province it is to instruct in medical lore, both in and out the schools, must rise to the need of the situation, and urge the wisdom of prevention and care. This is of paramount importance, if my belief be true, that the younger men are making most morphinists. With a wish for speedy effect and larger repute they are too apt, when called to a case of pain or insomnia, to use that modern mischief-maker, the hypodermic syringe, without proper thought as to risk incurred. Their fathers have gained wisdom by experience—sometimes most unhappy—and, as a result, we believe the use of morphia—especially sub-dermic use—is steadily decreasing among the senior members of the profession.

With non-opiate resources of modern medicine to bring ease and sleep—never so ample as now—we feel bound to say that in most cases these first should be availed of, and the more riskful remedy held as a *dernier ressort*. And in the should-be fever cases where an opiate is deemed necessary, we have, in codeine, that which gives, largely, the good of morphine with much less risk of entailing harm. See the writer's papers: "The Prevention of Morphinism: Codeine and Narceine *vice* Morphine," and "Codeine in the Treatment of the Morphine Disease."

We have no wish to banish opium; we are not inveighling against the use of morphine. But the over-use, the needless, careless use, especially hypodermically, we decry. The risk of inebriety from this method is larger than any other. Unless urgently required, it should not be preferred. And to counsel its self-using—save under conditions peculiar or beyond control—is more than culpable, it is a crime.

Second. A lessened general use of morphine. Restrictive legislation that will restrict; making it a felony for retail druggists to sell morphine, chloral or cocaine, or to refill a prescription containing either drug, save on order of a physician. To neglect these potent measures for protection is damaging to the public and a discredit to the profession. The prevention of disease ranks higher than its cure, and in the whole realm of prophylactic medicine there are few finer fields for good work than this.

Selected Articles.

THE TREATMENT OF ANAL FISSURE, OR IRRITABLE ULCER OF THE RECTUM

There are some general rules that must always form a part of the treatment of anal fissure, to wit: to lessen as much as possible any inordinate action or detension of the bowel, and to prevent the ulcerated surface being irritated and abraded by the passage of hardened feces.