of the patient before examining the lesion. In an examination, I think it better *first* to use the visual memory and sense of touch, and *last* one's powers of interrogation. By this method time is not wasted in asking useless questions.

In practice, to determine the nature of a case of disease or injury—that is, to make a correct diagnosis—the exact history and present symptoms must be ascertained from the patient or his friends; the patient is examined to observe the facts of the case, and then these facts must be interpreted. This method is valuable where there is time, for while the patient is telling his story in his own words we can observe his mental and physical condition. In an examination, however, it is prudent to make a complete local and general examination by observation and palpation, and then supplement this by eliciting points in the history which have a bearing on the case.

**Value of
Obtaining
Correct
History.**

To treat the patient as well as the disease requires judgment, discretion and prudence. Judgment is the faculty of making a correct and skilful interpretation of the facts of a case; the employment of discernment, discrimination and good sense. Depending as it does on clearness of thought and accuracy of observation, judgment must not be biased by the notions of others or weakened by too hasty conclusions. Judgment also determines the choice of what is good for the patient and therefore requires knowledge and experience. Discretion guards against error and chooses what is nearest the truth, requiring reflection and consideration. Prudence looks to the good or evil which may result and is therefore but a mode or accompaniment of discretion.

We must have prudence when we exercise discretion, but we may have prudence when there is no occasion for discretion.

Those who have the conduct or direction of others require discretion; those who have the direction of their own affairs require prudence.

A CASE OF ERB'S PARALYSIS AND RUPTURED BICEPS TENDON SECONDARY TO OSTEO-ARTHRITIS OF SHOULDER.

BY R. J. MCNEILL LOVE, M.S.

H. C., aged 63. Three years ago while carrying a heavy roll, the load slipped and fell on his left shoulder, after which he was unable to raise the arm from his side. A few months later while lifting a chair with the right arm "something snapped in the shoulder." For some years the joint had been painful.

History.

Left arm: Obvious wasting of the deltoid and flexors of the elbow, with inability to abduct the arm. Weakness of the flexors of the elbow. Right

**Physical
Signs.**

side: "Bunching" of the biceps muscle on flexion of the elbow.

Left arm: Erb's paralysis, which has partially recovered. Right arm: Ruptured long tendon of the biceps, secondary to osteo-arthritis of the shoulder-joint.

Diagnosis.

Left arm: Omitting to test the action of the supinator longus muscle. The forearm should be placed in mid-supination and actively flexed against resistance, when the contracted muscle can be seen and felt. Right arm:

Errors.

Ignorance of the fact that a complication of osteo-arthritis of the shoulder is snapping of the frayed biceps tendon.