for the free criticism I am now seeking. At any rate, I have endeavoured to look at the subject from every point of view. I had sought, in the first instance, for an explanation in some type of position of limbs in animals generally, towards which in rest they might revert. I had noticed that the position of all the limbs in a state of rest is a falling back towards the typical position in other mammalian animals; but one could only dismiss this as a curious circumstance, having no practical value. The question has, however, its practical side. Let us deal with it as affecting particular joints in disease.

First, as to the hip: One of the first symptoms of disease is a flattening of the nates, in other words, a wasting of the glutei, of which I would offer the following explanation: That the muscles are "told" of something wrong in the joint, and the glutei, so far from being excited to act, are led to remain quiet, wasting in consequence. The reason of this seems clear; for, if it be true that the commencement of hip-disease is almost invariably in the ligamentum teres, anything which causes this ligament to be stretched must be injurious. Now, the muscles which would do this, by drawing the limb outwards, *relax*; those which flex and draw it inwards, *contract*; and tension of the ligament is removed; "*harmony* between the co-operating structures". It will be noticed, too, that another great ligament of the hip-joint is by this means made comparatively tense: this, the ilio-femoral, is relaxed when the thigh is flexed and everted, which is exactly what occurs when effusion into the joint stretches it.

The usual treatment of hip-disease is at once to put the limb straight, and so make the ligamentum teres comparatively tense; but the indication which I should deduce from the considerations set forth would be, *to give the joint all the benefit of extension, both as regards steadiness, and relief of interarticular pressure, without changing it from the position of rest*; and this may readily be done by extension from the knee, obliquely upwards and diagonally across the bed, a treatment which is actually recommended as a temporary measure when the limb cannot at once be put straight.

Mr. Hilton argues (pages 149-150), that the flexed position is not the easiest, because, in hip-disease, "when the femur is put straight and the flexed position is destroyed, the patient from that time is free from pain". Not "from that time", I should say, though it soon becomes less painful, provided means are adapted to fix the limb quite still, and further to relieve interarticular pressure; but surely it is not fair to contrast this with the limb left all to itself in its previous position. Further, it may be said that stretching of ligament, provided it be continuous, soon ceases to cause pain in any position: Nature has her remedy in absorption of the unyielding element, on a principle applied every day in the treatment of deformities by mechanical means.

The desire, on the part of surgeons, to treat fracture of the thigh in an oblique position, is a very old one; and if it be accepted, that what I describe as such is really *the position of rest*, the desire would be strengthened, as a means of preventing the tendency of the upper fragment to project and as less irksome to the patient.

Again, as regards the knee, though it is less easy to fulfil the conditions of extension while retaining the position of rest, it follows, if my views are right, that it ought to be done. And here let me revert to the old question of flexors and extensors. It seems to me that, given a flexion of the limb as a means of attaining the *position of rest*, it is not necessary to conclude that the flexors are the stronger because of the dislocation which follows. The flexors, in *this position*, draw in the same plane as the opposing surfaces of the bones; while the extensors, with whatever force they draw, so long as the flexors do not relax, can only pull the head of the tibia against the posterior surface of the condyles.

Lastly, as regards the ankle, if for any purpose we wish to maintain a state of complete rest of it, or of the parts around it, for the healing of an ulcer or other purpose, it follows that, looking to the "physiological harmony" of all the parts, the joint itself should be free from tension—should be in a position of rest; but the effect of fixing the foot at right angles to the leg, as is usually done, is to force the wide part of the astragalus between the malleoli and stretch the ligaments which hold them together. A more extended position of the foot with the knee bent is clearly indicated.

It will be observed that I draw my illustrations from the lower limb alone; the fact is, that the joints of the upper one are habitually treated in the position they naturally assume. And when we consider how numerous are the cases in which disease of the hip or knee goes on to destruction of the joint, and that these are the joints which are forcibly fixed in positions most widely differing from the *position of rest*, it would seem to be possible that in our persistent determination to fix limbs in what would be the best position, should ankylosis occur, we may be doing something towards making ankylosis the best result to be hoped for.

CASE OF LARGE PROSTATIC CALCULUS, WITH NATURAL PERFORATION FOR THE URINE: REMOVED BY RECTO-URETHRAL LITHOTOMY, AFTER EXTRACTION OF A PENILE URETHRAL CALCULUS.*

By RUSHTON PARKER, F.R.C.S.,
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THE patient was a man aged 54, a native of the Edinburgh district, who came under notice and submitted to operation in the first week of July 1877. Five years previously, he had suffered from difficulty of micturition and other urinary inconvenience, in consequence of which he had entered the Liverpool Royal Infirmary, where an operation was proposed and was on the point of being performed, but was frustrated on account of the fear and sudden departure of the patient. Since that time, he had had repetitions of the old trouble, but not to a severe extent until shortly before the date of the present observations, when he consulted his private medical attendant, Mr. T. W. Evans of Liverpool, who found a stone in his urethra, and sent him to me at the Stanley Hospital.

The penis was thickened, and very much hardened about its middle, and so tender that little examination could be endured. The urethra terminated anteriorly at the margin of the retracted prepuce, where it was wide enough to admit the point of a finger, being, in fact, now but a wide sinus. That part of the urethra which should traverse the glans penis had ceased to exist, owing to sloughing chancres which he had had many years ago in India. There was, moreover, a fistulous perforation of the urethral floor about an inch behind the preputial orifice, of the width of a crow-quill.

Under ether, on July 6th, the penis was explored with forceps, and eventually a triangular stone was removed, less than three-fourths of an inch long, more than half an inch wide, and a quarter of an inch thick. The surfaces were irregular; one concave and the other convex. This stone lay in a space lined with granulations; a wide sinus, bounded by a portion of the urethra and corpus spongiosum.

On passing a sound towards the bladder, it stopped in the prostatic region, and struck a stone or stones. By the finger in the rectum, it was felt that the foreign material was close above the mucous membrane of the roof of the bowel. The prostate felt hard, slightly enlarged, and of the usual shape. The patient was then turned on his side, and the stone cut down upon with a small knife in the middle line of the roof of the rectum; the hole was enlarged forwards and backwards with a blunt-pointed bistoury, after which a calculus with several projecting lobes could be distinctly explored with the finger, but not easily dislodged. However, at last, with the aid of a scoop, the stone was removed.

The patient had a severe rigor shortly after the operation; but, in other respects, he has been very well. The wound was left to take its course. In two or three days, he had a stool. He has complete control over his fæces, and urine when in small quantity; the latter escapes partly by the penis and in part *per anum*.

The treatment adopted was the administration of morphia subcutaneously for the first few days regularly, and afterwards when required. The diet was at first warm sago and water; afterwards bread and other farinaceous stuffs. Throughout, milk has been avoided.

The left testicle, which had years ago been swollen during his attack of syphilis, and which had dwindled down to small dimensions, became the seat of acute inflammation, which at its height was perceptibly relieved by the operation of a single leech. This complication was probably set up a fortnight after the original operation, on an exploration of the penis under ether, undertaken on account of persistent pain and tenderness in the organ, on the supposition that possibly some stone still lay unremoved. It was found, however, that the original operation had in this respect been complete. The case is still in progress, and the recto-prostatic aperture still remains; but I have thought that, in view of the extraordinary size, shape, and general circumstances of the stone concerned, its relation, at even this early period and in this imperfect form, would not be altogether inappropriate to the present occasion.

I have not been able to find any record of a prostatic stone, perforated in this manner and pervading the prostatic substances so completely as this has evidently done. The calculus has the shape of the prostate itself, with the addition of a promontory or spur at one end. Including the spur, the total length is $1\frac{1}{2}$ inches; without it, $1\frac{1}{4}$ inches. The greatest

* Read in the Section of Surgery at the Annual Meeting of the British Medical Association in Manchester, August 1877.

width is a little over $1\frac{1}{2}$ inches—strictly speaking, $1\frac{1}{8}$ inches. The remaining diameter is $1\frac{1}{4}$ inches. The canal runs parallel to the side which I take for the upper, at a distance below it of three-eighths of an inch, having a length of about half an inch, and opening forwards into a shallow groove on the surface in question, and extending along the promontory before referred to. Its horizontal diameter is an eighth of an inch, but the vertical less, so that a no larger catheter than a No. 2 of the English scale will pass.

The stone weighs $1\frac{3}{8}$ ounces, is of a pale yellow colour outside, and paler within. One or two chipped surfaces show a laminated texture.

The only specimen I have seen which bears it any resemblance is one nearly as large, like it in structure, but unlike it in shape, in the possession of Mr. Bickersteth of Liverpool.

PREVENTIVE MEDICINE IN ORDINARY MEDICAL PRACTICE :

BEING A SEQUEL TO DR. RANSOME'S ADDRESS ON
STATE MEDICINE.*

By WILLIAM OGLE, M.A., M.D., F.R.C.P.,

Physician to the General Infirmary, Derby.

DR. RANSOME'S able address (BRITISH MEDICAL JOURNAL, August 18th, 1877) on State Medicine closes with some valuable suggestions to the legislature, and he indulges the hope that these suggestions may be adopted before many more years have elapsed. There is also a final paragraph asking for supplementary aid from "voluntary sanitary associations", similar to the one in Manchester.

It is principally to this concluding paragraph that I desire to direct your attention, and, indeed, to propose an amendment. I understand the word voluntary to mean "gratuitous". Against this I entertain a twofold objection. First, the profession is already overweighed with this kind of "voluntary" work; and, secondly, an agency is required much more comprehensive and thorough than any yet devised, even in Manchester, and one that is capable of doing work which it were both visionary and wrong to desire done by unpaid agents. I shall show presently how sanitary associations of this comprehensive, and, if you please, commercial, character might be organised, not only in large towns, but, as Dr. Ransome says, "in every locality". But, before doing so, and, indeed, by way of introduction, I must offer some remarks upon the hope expressed that the legislature will adopt a more enlightened sanitary policy, and in particular that it will give greater consideration to, or at least will not wholly ignore, the suggestions of medical men in framing new laws that relate to the prevention of disease. These two aspects of the question—the legislative and the voluntary, *i.e.*, the individual, are in fact inseparable.

At first sight, it may seem incredible that an enlightened Government should have framed laws for the preservation of the health of the people without a reference at every step to the medical profession. But the reason is not far to seek. Legislation cannot safely be very far in advance of public opinion. A little in advance it may and ought to be; but to be far ahead is not possible, nor, if possible, would it be workable, for the simple reason that obedience to law must be willing and intelligent if it is to be effective. Men cannot, even if they would, thoroughly carry out laws which they do not comprehend. This is my first remark. My second is that public opinion on medical questions is very much, if not better, yet not worse, than what the medical profession (in a past generation) has made it; and consequently that the faults in medical legislation, which Dr. Ransome has so fully and so justly exposed, must in some way or other, if not directly, then indirectly, which practically amounts to the same thing, be chargeable on the profession itself. If you will dispassionately look into this, you will perceive that the very same fault might be found with us for our defective mode of dealing with our patients that Dr. Ransome finds with the legislature for its mode of dealing with the profession. We ignore preventive medicine in ordinary medical practice; therefore, the public ignores us when it frames its preventive laws.

To establish this position, and to enlarge, as I desire to do, the scope of my observations, I beg you to notice that there is the same sequence observable in regard to the cure of disease. The relations between patient and doctor are very from being in accordance with the requirements of modern medicine, and consequently public opinion on curative measures is generally at fault. We allow the form of acknowledgment for our services to remain very much the same as when medi-

cine meant "physic"—little more, and certainly nothing less; and, as a natural consequence, the public puts its faith in physic and in nothing else, even when, as in homœopathy, there is nothing of physic but the name. Whilst medical charges continue to be based upon the quantity of medicine supplied, it will be to little purpose that Dr. Johnson (the same Dr. Johnson, be it observed, who gives castor-oil in cholera, and therefore not to be charged with scepticism as to the value of physic when physic is wanted) is bold enough to teach that typhoid fever is best treated solely by adjuvantia, such as careful diet and skilled nursing, and that many similar instances might be quoted on equally high authority. Payment "per bottle", or even "per visit", takes no account of enlightened methods of cure, and so to the general public they are unknown. In like manner, so long as the prevention of disease is ignored in the ordinary acknowledgment demanded for professional service, so long will the public most naturally conclude that prevention is not commonly regarded by us as any part of our duty; and the example of such noble men as Anstie, though emphasised by his death, so far as influence upon public opinion is concerned, is in a great measure lost.

The first step, therefore, towards the realisation of Dr. Ransome's most reasonable hopes of more enlightened sanitary legislation, should be for each of us who are engaged in the practice of our profession to consider our own ways.

To bring the question to a practical issue, I submit to the members of the British Medical Association the following proposals; viz.: (A) a thorough readjustment of our professional relations with the public on a preventive basis; and, second, arising out of this, (B) sanitary associations such as Dr. Ransome desires.

A.—The family doctor to be recognised as the "health-officer" of the family at all times, as well as the medical attendant in times of sickness. To make this possible, the acknowledgment for his services to be—*a.* A certain sum *per annum* for all ordinary work, including, of course, "preventive" work; *b.* Supplementary fees for extraordinary visits. Physic, whenever possible, to be supplied by druggists, or at least to be charged for separately.

1. The amount of the sum *per annum*, and of the exceptional supplementary fees to vary according to circumstances, and to be determined beforehand by private agreement between the doctor and his client.

2. The term "ordinary work" to include all attendances for which the request has been made at an early hour of the day—say by the time of the first postal delivery; also all visits made by members of the family to the doctor at his own house when he is "at home" for consultation. "Extraordinary visits" to be: night visits, but only such as are specially requested by the patient; Sunday visits, specially requested; and visits in obedience to summonses to come immediately, as to a confinement, or to a consultation, or, in short, at some particular time fixed by the patient.

In this simple way, the interests of the patient and the doctor become identical. The arrangement has been tried and proved satisfactory.

Proceeding on the same preventive principles, and calling in the aid of the principle of co-operation, sanitary associations may be formed "in every locality", but specially in large towns, "much more comprehensive and thorough than any yet devised". Thus—

B.—I. All *per annum* sums of, say, under ten guineas to be paid to a common fund.

II. Of these sums, the respective "family" doctors to receive only a part, a principal part, but only a proportion (say two-thirds or three-fourths). The remainder, which might readily amount to a large sum, to be held in trust for the general purposes of the Association, available for—

a. Exceptional payments by way of aid to the associated members, *e.g.*, supply of physic under exceptional circumstances (by provident dispensaries);* organisation of hospitals and convalescent homes for the well-to-do, as suggested by Mr. Burdett, etc.

b. Expenses connected with the registration, as in Manchester, of disease; the purchase of expensive instruments, which, by reason of their cost, and that they are only occasionally wanted, are not within the reach of ninety-nine out of every one hundred medical men in the

* Read in the Section of Public Medicine at the Annual Meeting of the British Medical Association in Manchester, August 1877.

* Many years ago I studied carefully the working of all the then existing provident dispensaries in the kingdom. I came to the conclusion that the one at Coventry was the best; but even that I could not now recommend heartily without reservation. Provident dispensaries were a noble experiment forty years ago, but that is all that can be said in their favour. In the recent imitations of them—on the whole, inferior imitations—I see nothing to induce me to modify this opinion. I take, therefore, this opportunity of saying, that I believe provident dispensaries, unless they be as here suggested, part of a larger and more comprehensive scheme of efficient medical aid, will be found unworthy of confidence, and in regard to hospital abuses, will sooner or later be classed among the remedies that are worse than the disease.