ing was rather difficult, especially of solids. The eyesight was not as good as before his illness, but he somewhat exaggerated his weakness in this respect. Ophthalmoscopic examination revealed no lesion in the eyes. His general health was otherwise pretty good; but he was both excitable and depressed, from consciousness of the annoyance caused to other people by his noisy breathing. Sensory and motor powers in the limbs were perfect.

The only previous history that seemed to bear upon the causation of these symptoms was that, nearly a year before his present illness began, he had had a severe blow on the cervical region of the spine from a boy at school. My belief was that the boy was suffering from paresis of the phrenic nerves and irritation of the recurrent laryngeal, the results of an irritative condition of the cervical cord induced by the blow. In the absence of *post mortem* investigation of the cord, the lesion must remain unknown; but it may be presumed that it was entirely connected with the circulation in the spinal cord.

Under gelseminum, and then strychnia, with faradisation used with one pole over the cervical spine and the other along the upper and most prominent part of the epigastrium, the diaphragm in about two months time began to act slightly, and after three months abdominal respiration was restored. His power of swallowing and his eyesight improved, and the dose of henbane was gradually reduced. His mother and he were turned out of several lodgings in consequence of his noisy respiration; but in six months' time this also improved, mainly under the use of strychnia, with the good air of country lodgings, and with farmhouse occupations and food; and it ceased twelve months ago. Whilst he was getting better in this respect, the peacock's cry could always be induced by any loud sudden noise, or, indeed, by anything that caused a jar. He has now been perfectly well for a year, and is able to resume his education.

SUGGESTIONS ON THE HOSPITAL OUT-PATIENT AND OTHER DIFFICULTIES.

By FURNEAUX JORDAN, F.R.C.S.,

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THE great evils which follow the attendance of armies of out-patients at our hospitals are now so widely recognised and earnestly discussed, that something will be done for their relief. I am not about to dwell on those evils or their causes. I cannot but think, however, that there is some exaggeration on a few points connected with the wide-spread inquiry into hospital affairs. What, for instance, is the amount of improvidence excused by a certainly too indulgent system of hospital relief, compared with the pauperising tendency of the garish gin-palace, the squalid home, and the long absence of any teaching that it is well to have some thought for to-morrow? Are we not, as a profession, unduly alive to the microscopic pauperisation of hospitals, and unduly indifferent to the alpine pauperisation of "drink"? There prevails also a too rose-coloured view of the general benevolence of the medical profession. We are as good as persons in other callings; we are no better. It is frequently said that no other profession is so generous in the gift of time and effort. Comparison, however, is attempted where no comparison is possible. Let us see. A working man marries; the couple have their accidents and ailments; the wife has half a dozen or a dozen confinements; each child teething, is vaccinated, has measles, mumps, scarlet fever, whooping-cough, diarrhoea, and so on—a long and weary list. If these fifty events necessitated a legal proceeding, we may be sure that large legal charities would exist, and that lawyers would prove to be as self-sacrificing a class as any other.

But now to the objects which this short paper has in view. The number of out-patients is unmanageable, and leads to many evils. The especially urgent cases are robbed of adequate care by a multitude of trivial cases. How came this? The fault lies mainly with hospital physicians and hospital surgeons. They have encouraged mere numbers: an easy task, seeing that the advice was good, the drugs plentiful, and the cost nothing. They have failed to condemn the growing mischief which they should have been the first to see. Lay hospital authorities could scarcely interfere when physicians and surgeons pointed with pride to numbers, and said, "See what good we are doing". The apparent good has proved a real evil, and it is not unfair to ask those who helped to do the mischief to help now to undo it. I propose to show how this may be done. *The numbers of out-patients can best be reduced by hospital physicians and surgeons.* There is a clear principle to guide them in doing this. Hospitals should be

simply consulting institutions to the poor; they should supply "second opinions" to those who otherwise must go without them. Cases requiring "consultations" are the proper cases for hospital relief. Consulting or second-opinion cases are exceptional cases—cases of urgency, or obscurity, or obstinacy. Let the hospital medical officer, then, ask this question on every case which comes before him: Is this a case of such urgency, or obscurity, or obstinacy, that, if it were in another social position, a second opinion would be suggested or asked for? Yes; then the case is precisely the one needing hospital assistance. But, if the reply be No, as in nine out of ten cases it will be, then let the case, with a few kind words of direction, be referred to family medical advisers, or general, provident, self-supporting, or friendly, or parochial dispensaries. A certain number might with benefit be told to go nowhither and do nothing. There will follow but little saving of the time and labour of hospital physicians and surgeons. The urgent, obscure, and obstinate cases need all the attention now given to cases which are not urgent, are clearly understood, are easily treated, or are obviously incurable.

An eminent authority in hospital administration—Mr. Timothy Holmes—suggests that selected cases should be sent to hospitals by family advisers and dispensaries. This is a suggestion of much value as a collateral and later agency in hospital reform, but it would take a long educational period to bring it into operation. When a family adviser chooses to forward a comparatively poor person for an "opinion", every element of hospital fitness is present; and much experience enables me to say that such cases are most important and instructive. To make this a rule would be an unjustifiable tax on the practitioner's time. At present, however, and probably for some time longer, crowds will come to the hospital; and the crowds will not first ask the family or dispensary doctor if they may, or if they are fit. Hospital physicians usually, and hospital surgeons occasionally, are in private practice "consultants" also. Clearly, then, they are best able to say "Come" to the proper cases and "Go" to the improper. They have, or ought to have, the needful knowledge; they are on the spot.

By the method now proposed, any physician or surgeon, may to-day, or to-morrow, or next week, begin an important and much needed reform—a reform which will also tend to greater knowledge, experience, and judgment in the men who carry it out. I venture, further, to say that the time is quickly coming when any hospital physician or surgeon who has a large number of out-patients will be open to one of two charges: either he is seeking notoriety and private ends by unfair means, or he is incapable of judging of what is urgent, or obscure, or obstinate.

The reduction of numbers by a method at once simple, just, and easily put into practice, brings about indirectly another reform. If the numbers of out-patients are reduced nine-tenths, the financial, social, and provident aspect of the out-patient difficulty is also reduced nine-tenths. I shall not dwell on this. It is not the duty of physicians or surgeons to pass the out-patients through a financial sieve. But, however the "financial fitness" inquiry be made, or whoever makes it, the task is greatly simplified by reducing the out-patients to one-tenth of their present number.

Another difficulty would be lessened by the transformation of a crowd of trifles into a group of problems. To put continuous investigation in the place of wearisome routine would bring about the highest educational benefits. The out-patient rooms might thus be made as useful for medical instruction and experience as the hospital wards.

One administrative condition is needed to make the changes which are now suggested. The physicians and surgeons must be entirely free to admit suitable and reject unsuitable cases. Without this freedom, no kind of reform is possible. By the privilege or ticket system, the subscribers practically select; and selection by subscribers involves neglect of the most pressing cases. To modify an expression of De Maistre's, it may be said that "contempt for tickets is the beginning of hospital wisdom". To me it is a real gain to be connected with a hospital where I am able to do that which I believe I ought to do, and that which I now ask others to do.

The unmanageable numbers of out-patients are mostly on the medical side of the hospital. In other words, the out-patient difficulty is largely a physician's difficulty. Seeing that the medical labour is double or treble the surgical, it is surprising that hospital authorities have not seen the need for more physicians than surgeons. As regards out-patients at least, a hospital having four surgeons should have eight physicians. To this the reply will probably be, that physicians cannot be got. I rejoin, that "pure" physicians are more numerous than "pure" surgeons. If a family medical adviser, whose private experience is mostly medical, be converted into a hospital surgeon (as our social exigencies require), why should he not be more frequently con-

verted into a hospital physician, whereby his private and public experience would unite in securing the best results? The position of a family adviser in a hospital surgeoncy has significant bearings. His private experience is medical, and gives him no assistance in the heavy responsibility of hospital duty; his hospital experience is surgical, and gives him no assistance in the heavy responsibility of family medical care. I do not wish to give undue importance to this "hospital difficulty"; but I cite it as another trouble that would be greatly lessened by the change which it is the chief purpose of this paper to urge. To diminish the out-patients to one-tenth, and, it may be, the in-patients to some extent, would facilitate the better organisation of hospital staffs—would render easier the adaptation of men to work.

Before closing, one word on the division of hospital beds. With in-patients as with out-patients, it is the duty of a hospital to do the most good to the greatest number of the gravest cases. These "gravest cases" are those which are most difficult to treat at home: accidents, operation cases, and cases needing exceptional surgical appliances. The gravest medical cases are less grave than these, if they can possibly be treated at home. If this proposition be true, the proportion of surgical beds, in the hospitals of large provincial towns at least, should be much larger than it is. The proportion ought not to be the same in all localities and under all circumstances: sometimes there should be two surgical beds to one medical; sometimes three, or four, or five to one. That pale faces with serious injuries should be seen on temporarily made up beds, while medical cases with comfortable beds, perhaps empty during the day, are enjoying their tobacco on the green, or adjusting their hair to the latest fashion, is an anomaly which fair-minded physicians themselves will help to remove. I am here presuming that the surgeons are so alive to just views on hospital relief and hospital economy that they do not permit their beds to be filled by cases which are not of that "gravest" character already described. If I err in this presumption, there is no ground for asking for a change in the distribution of beds.

It is to be hoped that the discussion on hospitals now going on, in which the public take a real interest, will not tend to lessen their income. There cannot be much fear of this. The closer the inquiry into hospitals, the more clearly seen are the benefits they confer on the sick poor. Let any large town be deprived of its medical charities, say for one month, and their need would be so keenly felt that they would start into existence again with double the number of subscribers and treble their income.

ON THE ETIOLOGY OF AURAL EXOSTOSES.

By JAMES PATTERSON CASSELLS, M.D., M.R.C.S.Lond.,
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THE following conclusions in regard to the origin of aural exostoses are the result of several years' observation of such cases. They are now very briefly laid before the profession, in order that further, and mayhap wider, observation on the part of others may prove or disprove their correctness. Those of my *confrères* in the practice of aural surgery who are familiar with such cases, and who also know the mystery that has hitherto surrounded the subject of aural exostoses, both in regard to origin and treatment, will find the subject more fully treated by me (illustrated by the kindness of my friend Dr. Foulis, Pathologist to the Glasgow Royal Infirmary) in the next issue of the *Archiv für Ohrenheilkunde*, to which I beg to refer them. Meantime, so far as my knowledge of the subject goes, I may claim to be the first observer who has given a rational explanation of the origin of an aural exostosis supported by clinical and pathological facts. These conclusions are as follows.

Premising that aural exostoses and hyperostoses are totally distinct affections in regard to origin, situation, form, and treatment, an aural exostosis is benign in origin, only to be found on the outer half of the external meatus, has its point of attachment *always* at the posterior wall, is pedunculated, and has its origin in the periosteum of the mastoid, close to the meatus.

The origin and development of an aural exostosis are as follows. At the outset, a subperiosteal abscess forms over the mastoid, and makes its way out into the meatus by way of the line of junction between the cartilaginous and osseous portions of that canal—sometimes even through the cartilage itself—discharging itself, and continuing to do so for some time. By-and-bye, highly vascular granular-like growths sprout from the opening of the abscess and go on increasing in size, while at the same time they are being gradually changed into bony tissue in their interior by the gradual conversion of

their cells into bone-cells. The final size of the osseous tumour, as well as its form, is determined by the original size and form of the granular-like growths. After complete ossification, no further increase takes place in the size of the tumour.

The treatment that suggests itself in such cases, and which I have found effectual, is as follows: in the early stages, removal of the soft growths, and freely laying open the abscess; in the latter, removal of the bony tumour by the *écraseur* (Wilde's) armed with a fine steel wire. In cases in which the tumour so fills the external meatus as to hinder the use of this instrument, I would recommend electrolysis of the tumour, as devised and successfully executed by Dr. Clark of Bristol, and reported by him in this JOURNAL in December 1873.

CASE OF ATHETOSIS.

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THE following case is a fair specimen of the condition described by Dr. Hammond under the name of *athetosis*. It resembles the third of the series published by Dr. Gowers in the last volume of the *Medico-Chirurgical Transactions*. The illustration is copied from a photograph; and, in order to take this, it was needful to steady the left hand.

Sarah B., aged 44 (in 1877), single, is one of a family of eight children, said to be healthy. She had some illness when between two and three years of age, and has ever since suffered from epileptic fits

and paralytic enfeeblement of the left side. She was admitted into the Cambridgeshire Asylum on March 8th, 1872, and was then described as imbecile from birth. Her condition since admission has not varied much, and may be described as follows.

She is rather tall and well nourished. Her hair is greyish, and she looks older than her years as recorded. Her head is well formed, and has a circumference of twenty-one inches and one-fifth. She has rather prominent eyeballs, has a lacrymal fistula of the right eye, and an external squint of the left. The face is drawn slightly towards the left; and the tongue, when protruded, also inclines to the same side. The left limbs are paralysed, and much contracted. The left arm is shrunken, and held spasmodically to the side. The left ulna measures half an inch less in length than the right, *i.e.*, from olecranon to styloid process; and the circumference of the left wrist is rather less than that of the right, and that of the left forearm at its largest diameter is rather less than that of the right. The left leg measures less than the right in length and circumference; the left foot is incurved, and the heel does not rest on the ground, but is permanently drawn upwards, as in talipes equinus. When placed upright, the patient stands with the left heel drawn up and the toes pointed in-