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THE JOURNAL

OF

MENTAL SCIENCE

(Published by Authority of the Medico-Psychological Association).

EDITED BY

D. HACK TUKE, M.D.,

GEO. H. SAVAGE, M.D.

"Nos vero intellectum longius a rebus non abstrahimus quam ut rerum imagines et radii (ut in sensu fit) coire possint."

FRANCIS BACON, *Proleg. Instaurat. Mag.*

APRIL, 1886.

LONDON:

J. AND A. CHURCHILL,

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MDCCCLXXXVI.

H. WOLFF, LEWES.]

To be continued Quarterly.

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"In adopting our title of the *Journal of Mental Science, published by authority of the Medico-Psychological Association*, we profess that we cultivate in our pages mental science of a particular kind, namely, such mental science as appertains to medical men who are engaged in the treatment of the insane. But it has been objected that the term mental science is inapplicable, and that the terms, mental physiology, or mental pathology, or psychology, or psychiatry (a term much affected by our German brethren), would have been more correct and appropriate; and that, moreover, we do not deal in mental science, which is properly the sphere of the aspiring metaphysical intellect. If mental science is strictly synonymous with metaphysics, these objections are certainly valid, for although we do not eschew metaphysical discussion, the aim of this Journal is certainly bent upon more attainable objects than the pursuit of those recondite inquiries which have occupied the most ambitious intellects from the time of Plato to the present, with so much labour and so little result. But while we admit that metaphysics may be called one department of mental science, we maintain that mental physiology and mental pathology are also mental science under a different aspect. While metaphysics may be called speculative mental science, mental physiology and pathology, with their vast range of inquiry into insanity, education, crime, and all things which tend to preserve mental health, or to produce mental disease, are not less questions of mental science in its practical, that is, in its sociological point of view. If it were not unjust to high mathematics to compare it in any way with abstruse metaphysics, it would illustrate our meaning to say that our practical mental science would fairly bear the same relation to the mental science of the metaphysicians as applied mathematics bears to the pure science. In both instances the aim of the pure science is the attainment of abstract truth; its utility, however, frequently going no further than to serve as a gymnasium for the intellect. In both instances the mixed science aims at, and, to a certain extent, attains immediate practical results of the greatest utility to the welfare of mankind; we therefore maintain that our Journal is not inaptly called the *Journal of Mental Science*, although the science may only attempt to deal with sociological and medical inquiries, relating either to the preservation of the health of the mind or to the amelioration or cure of its diseases; and although not soaring to the height of abstruse metaphysics, we only aim at such metaphysical knowledge as may be available to our purposes, as the mechanician uses the formularies of mathematics. This is our view of the kind of mental science which physicians engaged in the grave responsibility of caring for the mental health of their fellow men, may, in all modesty, pretend to cultivate; and while we cannot doubt that all additions to our certain knowledge in the speculative department of the science will be great gain, the necessities of duty and of danger must ever compel us to pursue that knowledge which is to be obtained in the practical departments of science, with the earnestness of real workmen. The captain of a ship would be none the worse for being well acquainted with the higher branches of astronomical science, but it is the practical part of that science as it is applicable to navigation which he is compelled to study."—*J. C. Bucknill, M.D., F.R.S.*

No. 137. (New Series, No. 101.)

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THE JOURNAL OF MENTAL SCIENCE.

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No. 137. NEW SERIES, No. 101. APRIL, 1886. VOL. XXXII.

PART 1.—ORIGINAL ARTICLES.

On the Right of Reclamation of the Insane before the Civil Courts.* By Dr. ACHILLE FOVILLE, Inspecteur général des Établissements de Bienfaisance.

[The subject discussed in this article, and the facts stated in regard to the actual practice of the French Courts in reference to the claims of the insane under restraint, with a view to recover their liberty, are of such vital importance at the present time in our own country, that we have thought it well to reproduce Dr. Foville's paper, which was read before the Congress of Psychiatry and Neuro-pathology held at Antwerp, September 7, 1885. The deliberate opinion of so great an authority cannot fail to be of much practical value, in view of the changes in Lunacy Law which seem imminent.—EDS.]

Among the laws relative to the insane, those of France and Belgium are distinguished by a provision common to both of them, which gives them a liberal character such as it would be in vain to search for in other special legislations. I refer to the right accorded to every one placed in a lunatic asylum, to claim his discharge before the Civil Court, as often as he pleases, and at any time. Thanks to this right, every patient is at liberty to have his mental condition examined by the law of his country, without delay, without complicated formalities, and without being hindered by pecuniary considerations.

No doubt it is legally possible in other countries to have recourse to the Courts; but, as a matter of fact, it must be

* This is a French legal process, to which there is no equivalent in England, by which a lunatic detained in an asylum, any relative or friend, or any person interested, may claim his discharge before the Civil Court. Throughout this article the word "*réclamation*" is translated "*claim.*"

acknowledged that they are absolutely inaccessible to almost the whole of the inmates of asylums, and especially to all indigent patients.

For instance, in England it is necessary to take the roundabout road of the process called "*de lunatico inquirendo*," while in most of the States of North America recourse must be had to an action of "*habeas corpus*;" in both cases the course of the law is very complicated, very slow, very expensive, and involves publicity.

In France and Belgium, on the contrary, it is enough to address a simple claim to the ordinary Civil Court, which proceeds to take an exact account of the condition of the claimant, and decides whether he ought to be discharged or kept in the asylum; and this without any delay, without discussion in public, without any statement of reasons, and without any complicated or expensive process.*

This right of claim is evidently the strongest guarantee which the law can give to individual liberty. It is no less valuable, I am convinced, to asylum physicians. In my opinion, it is a very mistaken view which some of them take, who regard it as a mark of personal distrust, and wish it to be resorted to as seldom as possible. I, on the contrary, think that this process furnishes alienist physicians with the best means of minimising their responsibility, of clearing themselves from every imputation of abuse of authority, and of displaying, in all circumstances, the sincerity of their opinions and the rectitude of their conduct.

Without dwelling further on these considerations, and taking for granted the excellence of the principle of the right of claim before the Courts, I ought to point out that though, in the two countries, this principle is exactly the same, there are nevertheless certain variations in the method of its application.

At the present moment, when serious attention is being given in France to the revision of the laws relative to the insane, it appears to me very fitting to analyse the analogies and the differences existing between the practice of France and that of Belgium, so that we may be able with certainty to select from each of them its most valuable points.

This comparative study, which I am about to attempt here, will consist almost entirely of quotations from official and Par-

* The law of Holland includes analogous provisions (Art. 29 and 30), but the method of procedure is less simple and the initiative of the claimant less complete. In the Bill at present before the Italian Parliament nothing of the sort appears to be contemplated.

liamentary documents. It will in consequence be very dry, and I must therefore solicit the indulgence of my *confrères*.

The right of claim before the Civil Courts, accorded to persons placed in lunatic asylums, was an innovation entirely due to the French law of 1838. Before that time nothing of the kind had ever been attempted, and the credit for this innovation belongs entirely to the initiative of the Committee of the House of Deputies, of which M. Vivien was the eminent Chairman.

True, the first Bill presented by the Government to the House on January 6, 1837, had already made the acts of the administrative authority subject to the control of the judicial authority; but this control could only be exercised indirectly, by means of an action of interdiction.*

That resulted from the provisions of Article 4 of the Bill, of which paragraphs 3, 4, 5, and 6 are thus worded:—

"The *reasons for admission* shall legally be considered to have lapsed:

"(1) If, since the admission, a judgment given at the demand of a person placed in an asylum, or of his family, or at the instance of the Attorney for the Crown, have ruled that there was no ground either for an interdiction or for a provisional administration.

"(2) If the period for which the authorization or the order for admission were issued have elapsed without their having been renewed, or without there having been any judgment ordering either an interdiction or a provisional administration.

"No authorization, or order, shall have effect for more than six months, or be renewed more than three times."

The result of this, in brief, was that a patient could be kept in an asylum for two years, on the strength of mere administrative decisions; but that at the end of that term he had to be discharged unless the judicial authority had ordered an interdiction, or had provided him with a provisional administration.

This system was not approved by the Committee, and M.

* This action, which is often referred to in Dr. Foville's paper, is analogous to the English action "de lunatico inquirendo." Interdicted lunatics are deprived of the power to administer their personal affairs and property, and are under the direction of a guardian or trustee appointed by the Court. This guardian is charged with the management of the lunatic's interests, and also with seeing to his proper maintenance. If there is a slighter degree of intellectual weakness, the Court is satisfied with appointing a committee to protect the patient, who then remains master of his conduct and free to dispose of his income, but cannot undertake any transaction involving the capital of his fortune without the approval and sanction of his committee.

Vivien raised the following objections (amongst others), the weight of which one cannot fail to recognise :—

"The obligation to apply for the interdiction at a fixed time, is contrary to the feeling which dictated the section of the civil code on the subject of interdiction. The intention was that this application should be always optional; it involves heavy expense; the publicity attending it wounds scruples which the law ought to respect; it may, in the present state of our ideas—prejudices if you will—cruelly humiliate a family; those against whom it is directed suffer from it painful impressions during their illness, and sometimes implacable resentment when they have recovered. To such consequences as these the legislature ought not to expose families with impunity."

Having thus opposed the system of compulsory interdiction, the Chairman substituted for it a new guarantee, which he stated thus :—

"What is wanted is a more open and more direct process. What is the object of the claim addressed to the Court? Clearly, under whatever form it may be disguised, to put an end to the state of detention. Why not have this question put for solution—Is there any occasion for keeping the patient any longer in the asylum? Have the causes which led to his admission ceased to exist? In these terms, the Court will decide after being acquainted with the whole case, and it may happen that it will keep a patient in the asylum whom it would not have interdicted, and that it will order a person already interdicted to be given up to his family."

Thus was clearly set forth the problem, which from that time has never ceased to be ardently discussed whenever the placing of lunatics in special establishments is under consideration; the problem, namely, of deciding what, in any such case, should be the part taken by the administrative and the judicial authorities respectively. In other words, the point was to settle whether the intervention of the law should be compulsory and exercised of necessity in all cases, or whether it should be merely optional and reserved for those cases alone in which the persons interested claimed it.

Although the first alternative was supported with the utmost energy before the House of Deputies by such advocates as Isambert and Odilon Barrot, the second opinion was supported by the Committee and the Chairman, and was adopted.

In the House of Peers also the new Article gave rise to a long and interesting discussion. M. Pelet (de la Lozère) and the Duc de Broglie found fault with it for being out of harmony with the general spirit of French legislation, and for gratuitously provoking the conflict between the administrative and the judicial authorities. MM. de Barthélemy (chairman), de Montalivet (Minister of the Interior), Mérilhou, and others refuted this argument, and urged the necessity for maintaining, side by side with the acts of the prefects, the control of

the magistrates. In the end they prevailed. The right of persons placed in an asylum to demand their discharge before the Civil Court was established by an Article, the text of which, discussed at great length in the two Houses, runs thus:—

"Every person placed or detained in an insane institution, his guardian if he be a minor, his trustee, or any friend or relation, may, at any time whatsoever, appeal for his discharge before the Court in the locality where the institution is situated; and the Court shall, after the necessary verifications, if it think proper, order his immediate discharge.

"The persons who asked for the commitment, and the Attorney for the Crown, *ex-officio*, may present the same application to the Court.

"In case of interdiction this demand may be made only by the guardian of the interdicted person.

"The decision shall be given, on a simple request, and without delay, '*En Chambre de Conseil.*' * The reasons for the decision shall not be given."

From 1838 to the present time this Article has not ceased to be in force, and to be the subject of frequent applications.

When the Belgian Government, in its turn, desired to draw up a Lunacy Law, it was in many respects inspired by the French legislation, and especially adopted from it the right of direct recourse to the Courts. The Article of the Belgian law of June 18th, 1850, which establishes this principle, is No. 17. It agrees in most respects with Article 29 of the French law, but differs from it in several points of detail.

Though Belgium was a dozen years behind France in passing the first law relating to the insane, she anticipated her in the revision of this law. On November 13th, 1872, the Belgian Government moved the introduction of amendments, which, after being thoroughly discussed, were passed into law on December 28th, 1873, without the nomenclature of the Articles being changed. The new Article 17 maintains, in their general effect, the provisions contained in its predecessor, but the wording of almost all the paragraphs has undergone certain changes.

Naturally, then, when quite recently the Government of France and the French Senate inquired what modifications were advisable in the legislation of 1838, they had to compare the French laws with those of Belgium, so far as concerned the right of claim before the Civil Courts; and they both of them recognised the advantage of making certain selections from the latter. The result is that two new Bills have been drawn up, on which the French Parliament will soon have to express its opinion. This has been explained by Dr. Th. Roussel, the eminent Chairman of the Senate, with his usual force.

* *i.e.*, in a private sitting, where the public is not admitted.

Those interested in the study of this question have then to make their choice of five different Articles :—

(1) Article 29 of the French law of June 3rd, 1838.

(2) Article 17 of the Belgian law of June 18th, 1850.

(3) Article 17 of the Belgian law of December 28th, 1873.

(4) Article 41 of the Bill to amend the law, presented by the French Government, November 25th, 1882.

(5) Article 50 of the Bill to amend the law, adopted in 1884 by the Committee of the French Senate.

It is no part of my plan to reproduce here *verbatim* all these Articles in succession ; their comparison, reduced to a mere enumeration of words, would be monotonous and sterile ; and, moreover, it would but prove their identity in most respects.

On the other hand, it appears to me that it would be interesting to study in detail those points treated in these Articles which have given occasion to different solutions, and to inquire which of these various solutions should have the preference.

That will be to compare together the ideas to which the different Articles correspond, and to demonstrate the evolution of these ideas, which, I make it my duty to acknowledge, have always been inspired by a great spirit of equity and by uniformly liberal intentions.

I pass by, then, in silence all the points on which the different Articles are agreed, and concern myself solely with those on which they vary or disagree.

I.

Who are entitled to make this claim ?

According to Article 29 of the law of June 30th, 1838, anybody can demand from the Court the discharge of a person placed in a lunatic asylum, except that person himself when he is interdicted.

This exception was not introduced till a late period in the preparation of the law. The first mention of it is found in the last report presented to the House of Peers by the Marquis de Barthélemy, from which the following is quoted :—

"The object the law has in view is not to make demands in interdiction indispensable, but to leave unaltered all the consequences of an interdiction which has already been ordered. One of the rules which results therefrom is that the guardian of the interdicted person is in sole charge of the management of his person and his rights. So long as the interdiction is not superseded, it is no one's business, not even the public prosecutor's, to re-

quire the discharge of an interdicted person from the house in which his guardian has had him placed. And even when the admission has been due to an order from the authorities, only the guardian has the right to ask for his discharge. We propose the introduction of this principle into the law."

This was voted by the House of Peers without any debate. It was also adopted by the House of Deputies, on the proposition of M. Vivien, who said :—

"A new provision has been added to Article 29, the object of which is to confer on the guardian the sole right of claiming legally the discharge of an interdicted person. This is the consequence of Article 14, which also restricts to the guardian the exercise of an analogous right. The interdiction has placed the lunatic under the exclusive authority of his guardian; as long as this lasts it must be allowed to operate. The addition made by the House of Peers is, then, perfectly just and wise, and you will doubtless have no hesitation in adopting it."

In point of fact the Article was passed without even having been debated; and hence a fairly numerous class of insane was deprived of the right of claim which was liberally accorded to all the rest.

The same restrictions having been introduced into its first Bill by the Belgian Government, the cause of minors and interdicted persons found champions in the House of Representatives: M. Lelièvre said: "The right of demanding their discharge must be conceded not only to adults, but also to those under age. The question is one of personal interests and rights, of which the minor is just as well able to avail himself as the adult. The minor has an equal right to do all that is necessary to protect his liberty." M. de Broukère added: "Suppose the guardian have abused his position, who then shall make the claim? Suppose a husband have had his wife shut up, who shall make the claim? The President of the Court will advise, but no one must be forbidden to take action."

The Government declared that, as these observations were favourable to liberty, it agreed to accept them, and to this end it proposed the following amendment, which was adopted :— "Every person not interdicted who is detained in a lunatic asylum, or any other interested person, may," &c. The words "*any other interested person*" seemed, in the eyes of those who made the law, to open the door as wide as possible to legitimate claims.

It was however recognised, even in Belgium, that this interpretation was not the most natural one, for the preamble of the Bill of November 13th, 1872, runs thus :—

"Article 17 authorises, in case of detention, direct recourse to the President of the Court, but this recourse is only permitted by the law to persons who are not interdicted.

"In the present Bill these latter words are omitted.

"Whatever may be the incapacity of an interdicted person from a legal point of view, there is no reason at all why he himself should be deprived of the right of providing for the defence of his liberty."

Moreover, the new Belgian law, as it now stands, no longer shows any trace of restriction. It is worded thus :—

"Every one detained in a lunatic asylum, or any other person interested, may apply at any time," &c.

In France also it has long been admitted that the right of claim ought to belong, without exception, to all persons placed in asylums; and more than once magistrates have thought it their duty, notwithstanding the wording of the law, to examine claims made by interdicted persons.

Several French authors have expressed the same opinion, which has been shared by the Government, for the preamble of November 25th, 1882, is thus worded :—

"We do not think it is just to refuse this right of claim to an interdicted person when the law grants it indiscriminately to all persons placed in asylums. We therefore propose to grant it in these cases also. The same right should be given also to the Attorney for the Republic, the natural guardian of the interdicted person."

Consequently, the paragraph in question in the Government Bill was drawn up in the following manner :—

"In a case of interdiction, this demand shall be made only by the guardian, the Attorney for the Republic, or by the interdicted person himself."

—and the Academy of Medicine has styled this measure an "*excellent innovation.*"

The Committee of the Senate, while adopting the idea of the Government, thought that nowhere was it better expressed than in the Belgian law. The Chairman pointed out that "the long enumeration of guardian, trustee, relation, or friend, which figures in the French law is replaced by this shorter and more comprehensive formula, '*any other person interested.*' The Committee of the Senate," he added, "proposes to adopt this formula from the Belgian law."

To sum up. It is now universally agreed that the right of claim should be given to all persons placed in asylums, without any exception; and among the various propositions made to express this idea, Article 17 of the Belgian law of 1873 appears, by reason of its simplicity and comprehensiveness, to be worthy of preference.

II.

How the claim should be presented.

It was evidently the intention of the Legislature in 1838 to make recourse to the Court as easy as possible, and they thought they had attained that object by saying "the decision shall be given on the simple request."

Practically, however, there is no general agreement on the method of interpreting this phrase. It is true that most frequently magistrates have regarded the spirit of the law, and admitted that a person placed in an asylum may make his demand, either by a letter sent to the President, or by a verbal claim addressed to the Attorney of the Republic at one of his periodical visits; but certain courts require the request to be presented to them through a solicitor, which remarkably complicates matters, since it is necessary for the solicitor to consent to come to the asylum to take his client's instructions, while usually the latter has not at command the means necessary to furnish the solicitor with the sum which he does not fail to exact before commencing proceedings. In such cases what becomes of the permanent right of claim, nominally accorded to every one placed in an asylum?

The inconvenience of this has been recognised both in France and Belgium. In the latter country, just as in France, the law of 1850 had merely used the word "*request.*" But in the preamble of the Bill of 1872 this was recognised to be insufficient, as the following quotation will show:—

"The consideration whether the agency of a solicitor is requisite has given rise to debate. We think that the intervention of this official, apart from the expense involved, may possibly render illusory, in certain cases, the privilege conferred by Article 17. In order to put an end to all uncertainty, the Bill proposes to add that the request shall be signed by the party concerned or his proxy."

This clause, which was voted, and forms part of the law of 1873, still, however, leaves room for doubt. It points out clearly that a person placed in an asylum who demands his discharge from the Court may make this demand himself, or have it made by some one chosen by him, without the intervention of a solicitor. But is it the same with the demand made, not by the person placed in the asylum, but by "*any other person interested*"? As regards this case, the controverted point is not decided, and the uncertainty remains.

The French Government, in its Bill of 1883, set itself to attain the same end, and did so in a most complete manner. In the preamble we read :—

"Article 29 does not solve the question under what form a person placed in an insane institution shall be able, with a view to obtain his discharge, to appeal to the Court of the locality in which the institution is situated. We propose that solution which is most favourable to the patient, and ask you to decide that it shall be sufficient for the claimant to address a demand on unstamped paper to the Attorney for the Republic, whose duty it shall be, without delay, to lay it before the '*Chambre du Conseil.*' It will thenceforth be impossible for a person placed in an asylum to find himself practically deprived of the exercise of his right of claim, because of his inability to appoint a solicitor and to give security."

The Committee of the Senate approved, without modifications, the ministerial proposal, which has the advantage of exempting from the intervention of a solicitor the *claimant*, whether he be the person in detention or any other person interested.

But, liberal as it is, the text adopted is still somewhat open to criticism. Why should the claimant be obliged to address his claim to the Attorney for the Republic? Why might he not, as indeed is almost always done, write direct to the President of the Court? We think this omission was quite unintentional, and that it would be better to allow the claimant the right to address himself to whichever of these two officials he may choose.

III.

What should be the necessary verifications? Should rebutting evidence be heard?

When once the application has been made, the law of 1838 lays down that the decision shall be given "*en chambre du conseil,*" and without delay, after the Court has made the *necessary verifications.*

This last expression has the advantage of being elastic, and of leaving the Court full liberty in its choice of the methods of gaining information. In certain respects that is extremely judicious, and it would have been imprudent to prescribe, for use in all cases, an identical mode of investigation. In certain circumstances, for instance, the application will be made periodically by a person who is manifestly a dangerous lunatic, of the necessity for whose detention in an asylum there cannot be the least doubt; the necessary verifications will then be reduced to a minimum, and the Court will not

require to deliberate long in order to pronounce its decision. In other cases, on the contrary, the question for solution will be one of the most obscure and most debatable. The Court will have to require reports from the asylum physicians, to institute inquiries at the residence of the person placed, to interrogate the person himself, to have him examined by medical experts chosen by himself; in such a case the necessary verifications will be prolonged and complicated. Between these extreme cases there are numerous intermediate degrees. It would clearly, then, be useless and unreasonable to impose on the Court the adoption of the same methods of gaining information in all cases, and the Court has prudently been left to decide what verifications are necessary.

The Belgian laws, however, while adopting the same formula, have introduced into the method of procedure a very important addition. The law of 1850 directs that, before the decision is given, "the request shall be communicated previously to the Public Prosecutor, and by him to the official or the person who asked for the commitment." In the law of 1873 this phrase is kept, and another added: "The guardian of the interdicted person shall, in all cases, be heard by the President."

These measures were evidently intended to secure for both sides a fair hearing, by allowing the persons who asked for the commitment, whether they be the family or the representative of the public authority, to be informed of the application that has been made, and to bring before the Court any information and observations which may tend to throw light on the possible consequences of its decision. The Court is not less free, but the necessary precautions are taken in order that it may be better informed.

The passages of the Belgian laws with which we are now concerned were, both in 1850 and in 1873, proposed by the Belgian Government, and voted by the Parliament, without debate.

The French Bill of 1883 does not contemplate anything of a similar nature; but the special provisions of the Belgian law have attracted the attention of the Committee of the Senate, which has adopted them. M. Roussel's report contains, in this respect, the following passage, which is of very considerable practical importance:—

"It must be remarked that though the French law, with the liberality displayed in its Article 29, authorises any patient whatever to ask for an examination of his mental condition by the Court, and that as often as the patient can desire, yet, as a matter of fact, claims of this sort only occur

when the other modes of discharge have been opposed on the part of the physician, the family, or the prefect. It may be understood, then, how important it is for these different persons to be notified of the claim addressed to the Court, so that they may be in a position to present, at a proper time, their observations to this Court; the same facility should be given to the guardian of an interdicted person. The Committee is of opinion that these precautions of the Belgian law merit introduction into the French law."

This measure is very judicious, and its adoption is to be desired.

IV.

Cost of the judgment.

The right of claim before the Courts would in most cases have been illusory, if its exercise had remained subject to the payment of the expenses of the Court and of registration. The great majority of persons placed in asylums are indigent; most of the others have no money at their command.

In order that the claim of individual liberty might not be subordinate to pecuniary difficulties, the law of 1838 ordered that all the documents of the proceedings should be stamped and registered "*en debet;*" that is to say, that the Treasury had not to demand the immediate payment of any fees, and that it only reserved to itself the power to claim ultimately the sum total of these fees, from those who might be able to pay.

The Belgian law, adopting the same principle, had the merit of applying it in a more complete manner by the words "All judicial or extra-judicial documents required in the cases contemplated by the present Article shall be stamped and registered *gratis.*"

In its Bill of 1882 the French Government showed that it also desired to divest the right of claim of every pecuniary encumbrance, for it said, "The decision shall be given without any expense;" but at the same time, by a singular contradiction, it left standing the paragraph which enjoins the registration "*en debet.*"

The Committee of the Senate has examined this question with its usual care. The following quotation from M. Roussel's report shows, by the most conclusive arguments, in what respects the French law is still not thoroughly satisfactory, notwithstanding the good intentions of the Legislature :—

"The documents registered '*en debet*' are the subject of claims on the part of the Registration Office every time that the latter expects to be reimbursed. These claims are addressed either to the lunatic's family, or, if he is

placed in a public asylum, to the '*receveur*' of the asylum, as the possible holder of funds belonging to the lunatic.

"In the first case, the family may reasonably be dissatisfied to pay the cost of proceedings in which they have taken no part, which they have regarded as useless, and which may be repeated again and again, since the renewal of demands for discharge addressed to the Court is subject to no legal delay.

"In the second case, when the Treasury exacts from the '*receveur*' of the asylum payment of a sum of about £2 10s., to be levied on the patient's property, or on the eventual resources of a patient admitted as indigent, the application of the law becomes extremely harsh. It is all the more so because demands for discharge, and their repetitions, are often only one of the manifestations of disease, so that, in such a case, to claim a registration-fee is very like putting a tax on insanity itself.

"These inconveniences have given rise to complaints, which seem to have become more frequent since the Registration Office has shown itself more severe in its fiscal exactions."

The Committee of the Senate has not failed to prescribe a remedy for these grievances, so clearly expressed and so thoroughly practical. This remedy it has found ready to hand in the Belgian law, from which it has adopted *verbatim* the paragraph previously quoted, in accordance with which all documents relating to demands for discharge are registered *gratis*.

V.

Should the decision be subject to appeal?

Decisions given by the *Chambre du Conseil* of the District Court are rarely appealed from; it, however, does sometimes occur, that certain insane claimants, having seen the first judges reject their demand for discharge, seek to get the Court of Appeal to reverse this decision. This causes some embarrassment to the latter court, for, from a legal point of view, its competency is, it appears, very questionable.

This difficulty had not escaped the attention of the Legislature of 1838, at which time it gave rise, in both Houses, to debates which are too long and too technical to be reported here. The following extract from the last report presented to the House of Peers by M. de Barthélemy will be a sufficient summary of them :—

"On the proposition of an honourable Ex-President, the House had placed in Article 29 a clause relating to appeal; the delay had been reduced to a fortnight; in order to give it effect notice appeared to be necessary. To whom, and by whom, should this notice be given? It was almost impossible to decide, because decisions of this nature, given on request, are given without there being any opposing party in the case. These difficulties of procedure have led to the suppression of all reference to appeal. We have thought it best to pursue the same course."

In Belgium also there has been much discussion on the question of appeal, and it has been decided otherwise than in France; but there is much difference between the solutions adopted in 1850 and in 1873 respectively.

The law of 1850, after having pointed out the way in which the decision of the District Court should be given, adds: "In the same way, decision shall be given on the appeal which may be lodged by the person in detention." Here it is clear that it is only the person in detention who has the right to lodge an appeal, and that there is no modification of the ordinary delay.

In the law of 1873, on the contrary, the corresponding paragraph runs thus: "In the same way, decision shall be given on the appeal which may be lodged within five days, either by the person in detention, the person who requested the admission, or the guardian of an interdicted person."

According to this last reading, the time during which an appeal may be lodged is reduced to five days, and no mention is made of notice being required; and the right of appeal, instead of being reserved to the person placed in an asylum, is extended to the person who put him there, and to the guardian of an interdicted person. But should not this extension be considered as illusory? As a matter of fact, if the Court orders the discharge of a patient, such discharge ought to be immediate. Then, it may be asked, in the case of a third party making use of his right of appeal to the Court of Appeal against this decision, of what value would be a decree of this Court reversing the decision of the inferior Court? How would it be possible, when once the patient was discharged, to bring him back by force into the institution?

On this question of appeal, then, the Belgian method of procedure is far from displaying the same simplicity and the same advantages as in many other questions which have just been examined. Nor has the French Government, in its bill of 1882, proposed any change in the existing condition of things.

The Committee of the Senate, struck with the inconsistent interpretations to which this question had given rise, desired, it said:—

"To put an end to this uncertainty, by determining the point of legality in one way or the other. Some of its members were inclined to admit the right of appeal, granting it, of course, to both parties, not to one only. After mature examination, it was recognised that this power of appeal would be a source of complications, in a matter in which it is of special importance to avoid them; moreover, it would be of little advantage, since the party most interested can renew his claim as often as he likes. The Committee has, like the Government, decided to leave things as they are."

There is, then, no more mention made of appeal in Article 50 of the Bill of the Senate than in Article 29 of the law of 1838. But the difficulty is nevertheless met, indirectly, in another part of the law; for the Committee of the Senate, which contemplated the intervention of the *Chambre du Conseil* of the Civil Courts in many other circumstances relating to the insane, and which has, in a general way recognised the advantage of avoiding recourse to appeal, has added to Article 66 of its Bill a second paragraph, which is entirely new, running thus:—

"Decisions of the 'Chambre du Conseil,' given in virtue of the present law, are not subject to appeal."

This measure naturally applies to decisions given in cases where discharge was demanded, as well as to all others, and thus are solved the uncertainties and controversies to which we have made allusion.

This solution is decidedly the most simple, and there does not seem to be any likelihood of its being practically inconvenient; it ought, then, to be preferred.

Conclusions.

The right given to every person placed in a lunatic asylum to apply to the Civil Court, at any time whatsoever, in order to claim his discharge—which right was established by Article 29 of the French law of June 30, 1838, and by Article 17 of the Belgian laws of 1850 and 1873—is a very valuable safeguard, both for the patients and the physicians of lunatic asylums.

The excellence of the principle which is common to these two Articles is admitted, but there are several differences of detail in the application of this principle in the two countries; it is, therefore, important to select from amongst the different solutions that have been adopted those which ought to have the preference.

From the considerations which have just been dealt with in this paper, on each of the practical points on which differences exist, I think the following conclusions may be drawn:

(1) The right of claim ought to be accorded indiscriminately to all persons placed in asylums; consequently, there ought to be no exception made in the case of minors and of interdicted persons.

(2) Persons placed in asylums ought to be allowed to make their claim in as simple and inexpensive a manner as possible, namely, by an ordinary letter addressed direct to the President

of the Court or to the *Chef du parquet,* without the intervention of a solicitor being necessary.

(3) The persons who procured the admission, whether this were voluntary or ordered by the public authority, ought to receive notice of the demand for discharge made by the person in detention, so that, should there be occasion, they may be able to make before the Court any statements they may desire.

(4) The right of claim before the Court ought not to be subject to any pecuniary obligation; consequently, the documents relating thereto ought to be registered, not "*en debet,*" but quite gratuitously.

(5) Decisions given *en Chambre du Conseil* by the Civil Courts, on claims demanding the discharge of persons placed in a lunatic asylum, ought not to be subject to appeal.

On Irish Asylum Dietary. By E. Maziere Courtenay, M.D., Medical Superintendent of the District Asylum, Limerick.

In bringing before you the subject of the dietary in use in public asylums in this country, I have, in the first instance, to apologise for my inability to treat so great a subject in a manner in any way commensurate with its importance. I omit altogether touching on those fields for research as to the nature, quality, and quantity of food best suited in the treatment of acute insanity for the support of bodily strength, allaying excitement and producing sleep, as to the arguments for and against artificial alimentation, and as to the use and abuse of stimulants.

My present object is to compare the various published tables of diet in the Irish public asylums with each other, and with those in similar institutions in England. Unfortunately I have been unable to obtain any information of the Scotch asylums, as they do not publish their diet-tables in their reports; and, though most valuable tables appear in the Blue Book of the Scotch Commissioners of the cost of each article of food used, still no quantities are given. The American customs and tastes differ so entirely from ours that no comparison could be made with advantage.

I trust that from these comparisons of different diet sheets some discussion may arise on the articles of food best suited to the habits and tastes of the pauper insane in this country, and that some definite opinion may be arrived at as to the form of

dietary which would meet the requirements of our various institutions.

In Vol. xiii. of the "Med. Chirurgical Review," an article will be found by Dr. Beneke "On the Amount of Nitrogenous and Non-Nitrogenous Elements in Various English Dietaries." In this he compares the quantity and quality of food in various educational and invalid establishments, prisons, hospitals, and asylums, giving the amount of each article of food for each person weekly, in ounces. The return for Hanwell is as follows:—

Meat, 21; bread, 96; potatoes, 60; greens, 10; sugar, 3½; flour, 16; fat, 3; milk, 20; cocoa, 3½; beer, 140; cheese, 14; rice, 3. Dr. Beneke goes on to compare the proportion of nitrogenous and non-nitrogenous elements, and finds the mean proportion to have been 1 to 5 in the various institutions. In like manner I have drawn up two tables (see pp. 18 and 19), giving similar articles of food in ounces per week, one for the twenty-two public asylums in Ireland, and another for fourteen English asylums taken at random.

I would also refer you to an able article on "Asylum Dietary," published in the "Medical Times and Gazette," in which like details are given of 14 English asylums. In these the average amounts were found to be—meat, 25 oz.; bread, 108½ oz.; vegetables, 65 oz.

Perhaps I may be excused in stating that a certain amount of vagueness exists in the dietary lists of some of the Irish asylums. For instance, in some no information is given of the quantity of meat issued for each patient, in some ox heads are used, of which there is no comparative value of the amount of bone and flesh. In almost all both oatmeal and either tea or coffee are given for breakfast on the same day. I do not say that these objections exist in practice; they may only be the result of condensing the tables for publication.

The meat in all cases in the tables given by me has been reduced in weight for bones and cooking, allowing one-fourth of the weight for bones and one-tenth for cooking, or, roughly, by deducting one-third from the original weight allowed.

One principal object to aim at in framing scales of diet for public institutions in any country is to take into consideration the habits of the people. No food, however nutritious and costly, no matter how well served, will give satisfaction or cause contentment to those who have not only lost their freedom, but their power to select their own food, unless it is of a similar kind to that which they have been accustomed to in early life.

IRISH ASYLUMS.

Estimated Amount of Food Consumed by Each Person Weekly, in Ounces.

Name of Asylum,	Meat.	Bread.	Potatoes.	Vegetables.	Sugar.	Milk.	Tea.	Coffee.	Cocoa.	Indian & Oatmeal.	Rice.	Remarks.
Armagh	20	168	24	8	Average: Six ounces each.	36	2	—	—	56	—	Ox heads used.
Ballinasloe	20	134	168	8		36	1	—	2	56	—	Ox heads used.
Belfast	18	116	168	12		140	—	—	—	56	—	Ox heads used.
Carlow	20	130	64	10		76	—	—	3	56	—	
Castlebar	20	128	90	8		96	—	—	3	56	—	
Clonmel	18	140	96	12		36	1	—	2	56	—	
Cork	24	120	144	10		36	2	—	—	56	—	
Downpatrick	26	112	96	6		36	1	—	2	56	2	Ox heads used.
Ennis...	16	168	80	10		68	1	—	2	56	—	
Enniscorthy	18	134	160	8		70	—	—	—	49	7	
Kilkenny	18	154	—	8		140	2	—	—	49	7	
Killarney	20	120	64	64		36	1	1	1	56	4	
Letterkenny	20	80	196	12		90	1	—	—	56	—	
Limerick	30	140	96	32		48	1	1	2	70	—	
Londonderry	24	72	196	—		80	—	—	—	112	—	Ox heads used.
Maryborough	28	78	168	6		90	—	—	1½	56	—	Ox heads used.
Monaghan	24	112	192	12		48	1	1	2	56	—	
Mullingar	24	168	128	12		48	1	—	2	56	—	Ox heads used.
Omagh	24	168	128	12		48	1	—	2	56	—	
Richmond	30	168	48	32		36	1	—	2	56	—	
Sligo	24	136	64	12		90	1	—	—	112	4	
Waterford	20	126	96	12		90	—	—	2	56	—	
Total	486	2870	2466	308	132	1474	18	3	28½	1344	24	
Averages for 22 asylums	22	130	112	14	6	67	·82 16 asyl'ms 1½	·13 3 asylums 1	1·3 14 asyl'ms 2	61	1·08 5 asylums 4·80	

NOTE.—Oatmeal and Indian Meal are issued to non-working patients in most asylums.

ENGLISH ASYLUMS.

Estimated Amount of Food Consumed by Each Person Weekly, in Ounces.

Place.	Meat.	Bread.	Potatoes.	Vegetables	Sugar	Milk.	Tea.	Cocoa & Coffee.	Rice.	Flour	Butter.	Beer.	Skim Milk.	Cheese.	Remarks.
Worcester	25	112	40	12	7	35	1	1	12	3	7	60	—	—	
Warwick	25	110	50	10	7	35	1	1	—	4	5½	70	—	—	
Northampton	30	112	70	10	7	35	1	1	—	6	7	80	—	—	
Leicestershire	25	105	48	10	7	42	1	1	—	3	5	60	—	2	
Staffordshire	27	135	40	10	7	20	1	1	20	6	7	80	—	—	Working patients, in addition to the ordinary dietary, are allowed—Bread, 3 oz.; cheese, 1 oz.; beer, ½ pint (in most asylums), daily.
Derbyshire	25	115	48	10	7	35	2	—	—	3	7	—	—	—	
Hereford	25	119	70	13	7	52	½	2	—	3	5½	—	80	—	
Birmingham { Winson Green	26	107	54	16	7	30	1	1	—	10	7	—	—	1	
Birmingham { Rubery Hill ...	22	112	48	10	7	30	1	1	—	10	5	—	—	—	
Glamorgan	18	136	64	16	7	20	1	1	—	3	7	—	—	—	
Beverley	24	102	60	10	7	50	1	1	4	6	7	—	—	—	
Devonshire	26	94	56	16	7	28	1	2	—	16	6	—	—	—	
Cane Hill, Surrey	21	99	70	5	7	22	1	1	1	15	7	—	—	—	
Nottingham Borough... ...	20	110	60	10	7	35	1	1	2	6	7	70	—	—	*Extras.*—Fruit pies during the season.
Total—14 scales	339	1568	778	158	98	469	14½	15	39	94	90	370	80	3	
Average	24·2	112	55·5	11·3	7	33·5	1·05	1·07	5/7·8	6·7	6·4	6/61·6	1/80	2/1½	

It must further be remembered that the habits of the people in all parts of the country have greatly changed. That nearly all live more luxuriously than they did fifty years ago. Whereas the agricultural classes were then accustomed to potatoes and milk as an almost unvaried article of diet, now they are not satisfied unless they have tea, bread, butter, bacon, and flesh meat. Further, I may add that all the inmates of our asylum, though reduced to poverty through disease, were, in very many cases, originally able to maintain themselves in moderate comfort. They, therefore, deserve to be treated with every consideration for their changed position.

On examining the table giving the amount of food per patient in Irish public asylums, we find that meat is, on an average, 22 ounces per week, and varies from 16 ounces to 30 ounces. Ox heads are given in addition at Armagh, Ballinasloe, Belfast, Maryborough, and Mullingar. In all bread is given in large quantities; milk is also largely used, especially at Belfast and Kilkenny, where each patient gets 140 ounces in the week, exclusive of skim or mixed milk. Potatoes, as might have been expected in Ireland, form one of the principal articles of diet, except at Armagh and Kilkenny; other vegetables seem to be given according to the supply. Cocoa is used in all except five, and tea in all except six.

If we now take into consideration the tables giving the quantities of food used in the two countries, we find, in accordance with the different habits of the people, that animal food is in excess in the English asylums, whilst bread, milk, and potatoes form the larger part of the dietary in this country. Some difficulty exists in determining the quantity of milk used in English asylums, as it was seldom given unmixed. Now, I believe it is used in some asylums in place of beer. In Ireland, on the other hand, it has always been looked on as the staple article of diet. Why bread should have been given in such large quantities in Ireland I am at a loss to understand.

I cannot but think that the food given in Irish asylums is to be commended on one point, and that is for its bulk. My belief is that in institutions of the kind bulk of simple food, such as porridge, bread, milk and potatoes (of course within proper limits) gives much more general satisfaction than a highly concentrated diet. We must, of course, allow that it results in a certain degree of waste. But dealing as we do with an agricultural people, always accustomed to live on the produce of their own land to a very large extent, I believe they are much more contented on a farinaceous regimen than on animal food.

Of course we have not, nor would it be wise to introduce, as it would be utterly unsuited to the tastes and former habits of our patients, the constant use of fruit and meat pies, suet dumplings and cheese. The use of fish in England is much to be commended. Here, however, the supply is so precarious that, unless in those institutions situated near the sea, it would be impossible to obtain a regular supply of fresh fish. I have always understood that the use of salt fish has been found unsatisfactory, but should be glad to hear of any experiences in this article of diet.

One article of food has increased in favour with the Irish more than perhaps with any other people, namely, tea. Used in their homes twice, and oftentimes thrice a day, there is no loss they feel more on admission to a public institution. Its use as a means of nutriment is of course most doubtful, but the ready way in which a cup of tea will be taken by those who would perhaps refuse to touch any other form of food renders it most useful as an encouragement to other more strengthening food.

On the other hand cocoa, though forming a part of the dietary of 14 out of the 22 Irish asylums, is utterly unknown in the Irish cottage, and though undoubtedly more nutritious than tea, is disliked from the first, and never can be rendered palatable, no matter with what persistency it may be retained on the diet-sheet.

We do not find butter given in any of the published diet-sheets of Irish asylums, though, as far as I am aware, it is largely given as an extra. Undoubtedly it is looked on as a costly item, increasing largely the trouble of serving the meals in our institutions. Its importance, however, in adding to the comfort and homeliness of the meals, in rendering the food more palatable, and increasing the nutritive value of the quantities of bread by the addition of fat, renders it worthy of a place amongst the most simple diet.

Another most important consideration in a dietary is variety. In an admirable article on asylum dietary, Dr. Lauder Lindsay, formerly Superintendent of the Perth Asylum, thus speaks of the importance of some variety in the food :—"The experience of athletes, boxers, wrestlers, and pedestrians, of the trainers of race-horses and fighting cocks, shows that the most vigorous health cannot long be maintained on a uniform diet, however nutritious and substantial this may in itself be, and how necessary therefore is the selection of food for the insane." Such is the importance of variety as an element of diet that food in-

ferior in nutritive value is frequently superior in usefulness or suitableness, simply because a greater and more judicious variety is supplied. Fortunately it frequently happens also that greater variety is not necessarily synonymous with greater expensiveness. On the contrary, the more varied diet may be the more economical as well as the more palatable and digestible. Hence it is desirable, within due limits, to vary the diet in a public institution from day to day, so that no special food or article of diet may be suffered to pall upon the appetite on account of its uniformity.

In Ireland, owing to the simplicity of the fare, it is difficult to vary the meals to any very great extent. However, something might be done by substituting different kinds of meat for the unvaried supply of soup made from beef. One dinner of mutton in the week would not increase the expense to any very great extent. But what appears strange is that bacon is not more used. In Ireland it is perhaps the most universal, and in many cases perhaps the only form of animal food, amongst the poorer classes, and amongst all it is more prized than any other article of diet, whereas the amount consumed in public asylums is small.

In these few remarks I have not made any attempt to discuss the subject of feeding the pauper insane from the standpoint of expense—perhaps under this view of the question we may find it come most prominently before us. Living as we do in a very poor country, we generally find that all suggestions for improvement are considered under the head of "cost," in the first instance. However, it is a part of the subject which does not concern us so much to-day as the consideration of the articles of food most suitable to the health and habits of our insane poor, whose wants are well described in the article on the diet of the insane in the "Medical Times and Gazette" already referred to. "The insane are really the subjects of disease, whose most general character is depression of vital energy, weakness, or imperfect nutrition. Hence it is that inmates of an asylum must be supplied with food not only nutritious in quality, but abundant in quantity."

Drunkenness in Relation to Criminal Responsibility. By Geo. H. Savage, F.R.C.P.

Read at the Quarterly Meeting of the Medico-Psychological Association, held at Bethlem Hospital, Feb. 24, 1886.

Till recently we believed that, however much the members of the legal and medical professions might differ in regard to the definition of insanity, and to its relations to responsibility, they agreed in the main as to the question of drunkenness and its responsibilities.

It seemed a pretty good, and, at least, comprehensible and straightforward decision that acute drunkenness was no excuse for a criminal act, and, further, that if a man were unduly, that is morbidly, susceptible to drink, this morbid state was not to be accepted as an excuse for any crime.

On the other hand, though a man may not be responsible for acts performed during drunkenness, yet it was considered just that he should be excused if his act were performed while he was distinctly out of his mind in an attack of delirium tremens, or still more certainly if he committed the crime while suffering from some recognised form of insanity which might have been caused by drink.

There must be difficult cases in which it will be the duty of the judge to point out extenuating circumstances. Thus a man who has recently received an injury to his head may be ignorant of the fact that drink may affect him more powerfully than it did previously; or again, a man who may have recently recovered from the effects of illness or privation, or who may be in the earlier stages of some brain-disease, may be morbidly susceptible to the influence of drink, and may be excused if, under such circumstances, he committed a crime while drunk.

On the other hand, it seems hardly reasonable to condone drunkenness in a man who has already had several attacks of delirium tremens. Such a patient knows from past experience what danger he runs, and though his will-power may be weakened, yet it seems to me that in some cases, persons who have committed crimes while suffering from delirium tremens might fairly be punished.

It has, however, been ruled that a person suffering from delirium tremens may legally be placed under certificate, and if this were accepted as generally justifiable, the right to punish such persons must be denied.

I should say that though some persons suffering from delirium tremens may be certified as insane, yet the most ought not to be so treated, and that similarly there may be shades of responsibility in such cases.

If delirium tremens be made to be an excuse for crimes of all kinds committed under all circumstances, it appears to me to be difficult to punish persons who are very drunk at the time the act is performed.

I have seen persons suffering from mental disorder varying in every degree from simple silliness to undoubted insanity as a result of acute drunkenness. There are cases in which, from congenital and other physical defect, a person may pass direct from acute drunkenness into moral perversion, without having any distinct delirium, and there are other cases in which delirium tremens has been followed in a few days by true insanity, which has lasted for weeks or months. The points above noticed are noteworthy at the present time, for not only are crimes of violence perpetrated during drunkenness very common, but the ruling of judges varies most widely, as will be seen by the cases given below.

The writer of this article had to be present for part of two days in January, 1886, at the Old Bailey, where Mr. Justice Denman presided, and during that time four cases were considered in which the plea of insanity was raised, and in three of these, two of which we shall consider, drink was the chief or immediate cause of the crime committed.

Mr. Justice Denman in each case most emphatically laid down the law as follows: that a crime committed during drunkenness was as much a crime as if it were committed during sobriety, and that the jury had nothing to do with the fact that the man was drunk. The prisoner was supposed to know the effect of drink, and if he took away his senses by means of drink it was no excuse at all. There was no hesitation about Mr. Justice Denman, and the general feeling was that his decision was just, but might in some cases be unduly severe. We shall refer to some of these cases in more detail later. Sir J. Stephen, in his "History of Criminal Law in England" (vol. ii., p. 165), says: "A man wildly excited by drink can hardly be said to know at the moment of that excitement that any particular act which he may do is either right or wrong. That which prevents him from knowing it is not mistake, but excitement. The reason why ordinary drunkenness is no excuse for crime is that the offender did wrong in getting drunk, but a person brought into this state by some

kinds of fraud is said by Hale to be in the same position as a man suffering under any other frenzy. If so it would seem to follow that if madness produces an excitement like that of a drunken man, the person so excited may, during such excitement, be said to be prevented by disease affecting his mind from knowing that his act is wrong."

After such decisions it is very strange if the recent ruling at Lancaster by Mr. Justice Day can be accepted. In the case of Joseph Baines, charged with wilful murder of his wife, Ellen Baines, Mr. Justice Day is reported as saying, in reference to the ruling of Mr. Justice Manisty, in Reg. v. M'Gowan, "that a state of disease brought about by a person's own act—*e.g.*, delirium tremens, caused by excessive drinking—was no excuse for committing a crime unless the disease so produced was permanent," that he could not agree to this; that the question was whether there was insanity or not; that it was immaterial whether it was caused by the person himself or by the vices of his ancestors; that he could not follow the decision of Mr. Justice Manisty in Reg. v. M'Gowan; and that it was immaterial whether the insanity was permanent or temporary. His lordship added: "I have ruled that if a man were in such a state of intoxication that he did not know the nature of his act, or that his act was wrongful, his act would be excusable."

There seems to be no way out of this ruling, but yet we are inclined to think most judges will not follow the ruling of Mr. Justice Day.

The short report of the case will be found below, and the jury found the man guilty.

At Lancaster, on Friday, before Mr. Justice Day, Joseph Baines, fish-hawker, aged 41, was charged with the wilful murder of his wife, Ellen Baines, at Barrow, on December 25 last.—Mr. Cottingham and Mr. Cross conducted the prosecution on behalf of the Treasury, and Mr. Henry defended the prisoner.—Mr. Cottingham, in opening, stated that for some time previous to the committal of the crime the prisoner and his wife had lived unhappily together, owing to his drunken habits. About a year ago prisoner had been judicially separated from her; but at the time of the murder they were living together. Prisoner had been an abstainer for some time, but on Christmas Eve had been drinking heavily, and a violent quarrel ensuing, which continued all night, the prisoner never went to bed, but continued walking up and down stairs in a restless state. About eleven o'clock on Christmas morning

deceased went to the house of John Evans, next door, to ascertain the time, when the prisoner came in. He made for his wife, who fell back into a chair, calling out "He has a knife." The prisoner stabbed her four times, the wounds being from four to five inches deep. Evans knocked the prisoner into the fireplace, and the knife fell from his hand. The deceased crawled out of the house on her hands and knees, and was carried to a sofa in her house, where she died in fifteen minutes. Evans said, "Is she dead?" and the prisoner remarked, "If she is not dead she ought to be." Before the prisoner was taken away he wished to kiss his wife, and said to her, "Whether you live or die, you know what has been the cause of this." On being charged at the lock-up prisoner said, "It is all over last night's affair; I saw it with my own eyes. I did it deliberately over that." The prisoner was under the delusion that his wife had been unfaithful to him.—The defence was that the prisoner was insane and not responsible for his actions when the murder was committed.—The evidence proved that the prisoner was in a wild, excited state at the time the crime was committed, that he beat himself with a stick, and ran his head against the wall. He had on several occasions been under treatment for delirium tremens; he had one attack a week previously, and another two days after committing the crime.—The jury retired to consider their verdict, and, after an absence of seven minutes, returned into Court with a verdict of guilty.—His Lordship sentenced the prisoner to death in the usual form, expressing his concurrence with the verdict.—The prisoner was apparently unmoved.—"Times," Monday, January 27, 1886.

I must say that the decision of Mr. Justice Day appears to me to be so logically correct that I accept it as a very good example of the wide difference which must exist between the legal mind and the medical mind. To the former everything must be regular, consistent, and definite, while to the scientific observer of natural and diseased processes everything is seen to be shifting and undefined.

It appears to the judge that if a man has no control over his actions he cannot be blamed for not exercising what he has not, and it is absurd to let one man off because by self-indulgence for years he has reduced himself to weak-mindedness, and punish another who has only taken a few steps on the downward road.

Again, the admission of the doctors that the sins of the fathers are visited on the children must free the sons from

responsibility, and there can be no question of punishing an insane child, whose insanity has been produced by a vicious parent.

That drunkenness and insanity should be treated as if they were one and the same thing appears to me to cause the mistake.

And, having thus referred to several points of interest, I shall pass on to the cases which originally suggested this article.

The first was that of James Williams, tried at the Old Bailey, before Mr. Justice Denman and a jury, on January 13th, 1886.

James Williams, 18, labourer, was indicted for the wilful murder of Ellen Williams, his sister.—Mr. Poland and Mr. Montagu Williams conducted the prosecution for the Treasury; Mr. Geoghegan and Mr. Vincent were counsel for the defence. —The prisoner was living with his father, a net-maker, and the deceased, his sister, a girl 16 years of age, in St. George's-in-the-East. All three were stated to have occupied one room. The prisoner returned home at midnight on the 2nd of December the worse for drink. He told his father to go to bed, and he asked the deceased how she spelt the name of a woman to whom he owed some money. The prisoner, who was a volunteer, instead of going to bed, went out into the yard and returned shortly afterwards. Thereupon he took up his rifle, which was in the room, and, as alleged by his father, without putting it to his shoulder or taking aim, he discharged it at random. The bullet struck his sister, who was lying in bed, and caused her death. The prisoner's father struggled with him and took the rifle from him. The prisoner made various statements to the effect that he had intended to kill his father first, his sister next, and himself last. He said he had shot his sister, and that he had cause to do so, as she had received a letter he did not like. He had, he said, made up his mind to do it on the Monday, and had brought three rounds of ammunition from the butts, and he added that he hoped she was dead and he would swing for her. It seemed that a soldier named Maloney had become attached to the girl, that he had gone to Ireland with his regiment, and had written a love-letter to her. It was said that this was the letter the prisoner said he did not like. It was stated that the prisoner had always been an affectionate brother to the girl, and that lately some one he was much attached to had died, which had caused a noticeable change in his demeanour.—Witnesses for the defence were called to show that the prisoner had at one time attempted to commit suicide.

—Dr. Bastian and Mr. Morgan, the medical officer of the House of Detention, were called on the part of the prosecution to show that the prisoner was of perfectly sound mind.—For the defence Dr. Savage, the medical superintendent of Bethlem Hospital, was examined for the purpose of supporting the defence of insanity which was raised. He said that although the prisoner might not be actually insane, yet that he was of low mental power, and would be easily affected by drink.—Mr. Geoghegan addressed the jury for the prisoner, and raised the two-fold defence that the accused was of such unsoundness of mind at the time of the act that he did not know the nature of the act, and consequently was not responsible for his actions, and that, in the absence of any evidence of premeditation, and considering that the prisoner was very much under the influence of drink, no weight could be attached to the statements made by him. If, however, the jury were not satisfied as to the allegation of insanity, they ought only to find a verdict of manslaughter.—Mr. Justice Denman having directed the jury on the law as regards insanity, the jury retired to consider their verdict, and after an absence of about an hour and a half, they returned into Court at twenty-five minutes past seven, finding the prisoner guilty of manslaughter only.—Sentence: Fifteen years' hard labour.

It may be well to state a few particulars as to this man Williams. He is 18 years old, and one of three surviving children out of a family of over twenty, most dying in infancy. His father was said to be intemperate; the prisoner had drunk steadily since he was 15; he took spirits as well as beer.

He was engaged to be married, but the girl died of small-pox eighteen months before the murder.

Since the death of this girl he had been more and more intemperate, and had attempted suicide on several occasions, but it was stated that all these attempts were made when he was drunk.

On examination I found the prisoner an under-grown youth, with a very small head. He was very quick and bright in his answers to questions, having the quickness of a city Arab. He seemed quite indifferent to the position he was in. He said he had no recollection of the criminal act, but there was reason to believe that he had some vague recollection of it, but denied this for a purpose.

There was, in my opinion, no active insanity, and no delusion as a cause for the act, but one had to deal with a young man of

very unstable inheritance, small capacity, and of very prematurely vicious life, who, while unconscious from drink, perpetrated an act without cause or premeditation.

The drunkenness was a vice, but the physique and the general mental and moral weakness were beyond the prisoner's control. I could not say he was actively insane, but I believed him to be weak-minded, and that this weak-mindedness preceded his intemperance.

The punishment was, however, in my opinion, a just one on the whole, and might, under some conditions, be the best training for so defective a being. Fifteen years of education and training might do good.

In the next case the plea of insanity was raised and accepted by both judge and jury, the only point of special interest being that the prisoner was a young married woman, who had had delirium tremens, and whose mental disorder resembled, in many particulars, insanity due to alcohol.

I have no doubt the murder of the child was perpetrated while the mother was insane, and was the outcome of her hallucinations, but at the same time the mental disorder was almost certainly the result of intemperance.

The following is the report of the trial in the papers:—

Esther Base, 31, married, indicted for the wilful murder of Henry Base, aged nine months.

The prisoner was living with her husband, and had this one child, of which she was exceedingly fond. She had been noticed to be strange and suspicious for some time before the murder on December 6. She was under the impression some one wanted to take the child from her. A doctor, on December 4th, told the husband that his wife ought to be certified and taken care of. On December 6, about 8 p.m., when the prisoner, her husband, and his brother were in a room together, the woman got up excitedly and walked towards the window, which was shut, but the glass of which was out, and before any one could interfere to stop her, she threw the child out of the window. She then screamed out "I have done it."

She said several times that *they* wanted to take the child from her.

The child had fracture of the skull, and was past surgical aid. When taken into custody the mother said she was *driven* to do it, and she was glad she had done so, because the child had gone to the angels in Heaven. The prisoner had always been affectionate and had treated the child well, and the question was

whether at the time she did the act she knew the nature and quality of it and that it was wrong. Medical evidence was given that the prisoner was of unsound mind, and did not understand the quality of the act. It was stated also that she had suffered from delirium tremens.

Mr. Justice Denman took no notice of the drink question, and only said that after the opinion of the medical men that the prisoner was of unsound mind, he did not think further evidence necessary, and ruled that the jury must be satisfied that the prisoner at the time the act was committed, from a defect of reason, did not know the nature and quality of the act, or that it was wrong. The jury found that she was insane, and the Court directed that she should be treated as a criminal lunatic.—"Times," Jan. 15, 1886.

And thus these three interesting cases end, and, to my thinking, there is a general inconsistency in the result. The first man was hanged, though he committed his crime as the result of delusions which probably were due to drink, and though the judge is reported to have said that acute drunkenness is in itself an excuse. The second man was sentenced to a term of imprisonment when he either ought to have been hanged or sent to an asylum. And the third case was sent to an asylum, no question being asked, presumably because before the crime was committed a medical man recognised insanity, and did not refer to drink as the cause.

The Psychological Bearings of the recent Matriculation Examination of the London University. By TRIBOLETES.

The questions set at the recent Matriculation Examination of the London University afford food for the student of mental science. The whole system of competitive examinations, as understood by our universities, is so much at variance with the true principles of mental development that it is somewhat difficult to judge the papers by the standard of the metaphysician. When the present system is tending to make of education an *art* rather than a *science*, when the test of a man's capabilities is rather to see how many pages of carefully prepared "Guides to University Students" he can assimilate rather than how much he has had called into play his powers of

personal observation, and how much experience he has really mastered; when, in short, an undue importance is given to book *knowledge* to the detriment of mental *wisdom*, it is not to be wondered that we find the questions of the Matriculation Examination of the London University falling below the standard that we should like to see our universities set before them. If there is to be any reform in our educational systems (and it is sorely needed) one would naturally look to our universities for its genesis; but for the most part we look in vain. Perhaps the temptation to extol mere book learning, and to lose sight of the aims of education, beyond those merely of acquiring knowledge, is more likely to be experienced by the examiners of the London University than by any others. For in a university where residence for a certain academic course is not a *sine qua non* of becoming a graduate, and where elaborate crams and "examination papers worked out in full" are ready a few days after the conclusion of the examination, it may be a difficult matter for an examiner to avoid falling into the errors to which we have referred. On the other hand, no body of people in the whole country have more opportunities for good or more facilities for raising the intellectual status of our teachers, and so of our educational systems, than have those gentlemen who draw up the questions of the London University Examinations. And let us say, at the outset, that we are fairly well pleased, on the whole, with the result of their efforts in the January matriculation questions. We shall have to point out errors and failings, but many of the questions strike us as a decided improvement on the general run of such questions, and may assist in opposing the vicious system of cramming that is decimating the ranks of the teaching profession of its best—because most independent and original—men.

With these general remarks, let us proceed to examine the questions in some detail. Taking up the paper on Latin, we think that, as long as the examination is based on the principle of having a set book to prepare, the examiners have succeeded very well in evolving a paper well suited to distinguish the really competent student from the mere retainer of knowledge. The three extracts from Ovid's *Metamorphoses* and *Tristitia* are well chosen, and their translation affords numerous opportunities of testing the amount of real mastery of Latin that the student has attained—that is, provided they are examined in a proper way. Of course we have the inevitable and useless question on the family of the Cæsars, and, of course, the students were required to "explain clearly"

the position of certain spots, on whose whereabouts the examiners themselves would be the first to differ. It is to the third part of the paper we turn with most interest. By a wise extension of the use of "Extracts from Books not Prescribed," rather than by a correct rendering of stated works, is the true state of the student's mind to be ascertained. No amount of cramming can help a man here, and the effect is not one of memory only, but has as well a real and powerful influence on his mental education. It calls into play at every point his own faculties and thought. Our friends in Switzerland are in advance of us in this matter, and in their examinations the books from which the extracts are selected are not previously announced. This involves much greater care on the part of the examiners and a large amount of personal attention to each paper, but the results are immeasurably superior from an educational point of view.

In speaking of the Greek paper, we are sorry to have to drop our notes of praise. The aim of the examiners here has apparently been to air their own erudition rather than to ascertain the attainments of the examined. Not that the questions themselves are out of the course as a test of thorough acquaintance with the Greek language; but when it is borne in mind that the object of a matriculation examination is to decide whether a student is fitted to *begin* a university course, they do strike us as unfair and absurd. We believe we are correct in saying that the regulations of the matriculation speak of Greek accidence only as required. What then could be more unjust than to put close questions on the "exact force" of the middle voice, or the "precise force" of a preposition in a string of isolated verbs? The hair-splitting differences in meaning of Greek prepositions may be a very useful and pleasant study for Greek *savants*, but it is shameful that a youth should be debarred from entering at once upon his university studies because he fails to point out the exact signification of a most fickle particle. Learned dissertations on the shades of meaning of κατα, μετα, and προς ought not to be expected from lads of sixteen. Altogether we must strongly condemn the paper in Greek. It is one that only needs a little "cramming" to enable the candidate to shine in parts, and just that portion which *is* designed to train the mind to justly appreciate Greek from a philological point of view is aimed above the heads of the examined, and is therefore unfair.

For the French paper we have nothing but unqualified praise. A more searching and thorough, and yet judicious and fair,

set of questions we could not wish. The framer of these questions is evidently a teacher of the first order, and one who has studied closely the development of the ideas of language in the mind. One error, however, must be noted. We should not have cared to have had to get through the merely mechanical work the paper involves in the time allowed.

Nor would we cavil at the questions in English. Those on the grammar are, perhaps, a little too suggestive of the book which seems to have appropriated to itself the position of being, *par excellence*, the matriculation grammar. We find no fault with Mr. Morris' excellent little work on "Historical Grammar," but it is not well to cramp the minds of our students by thus practically insisting on any one method, however excellent in itself. We have never seen a better collection of history and geography questions—subjects, by-the-bye, which are among the hardest to examine.

Among the mathematical papers we were disappointed in the questions on Arithmetic and Algebra. Not that they involved any principle that was in any way too advanced, but it does seem a mistake to give to matriculation students questions which are only designed to test mechanical accuracy. To divide the cube of 1·236068 by 2·36068 to five places of decimals, and to extract the square root of $\sqrt{\frac{1}{5}}$ to seven places, may be excellent questions where a junior class is beginning the work, but are hardly suited to the class of students who go in for the matriculation examination. The propositions of the geometry paper are well chosen. There is no doubt that by far too much importance is put on geometrical exposition as a means of mental discipline. The solution of problems is as much a method—a knack—acquired by practice, as a real sign of the power of the mind to view objectively the affairs of life. Yet this is, we presume, the ostensible reason of the study of pure geometry to the majority. It is in a well-balanced scientific course of philosophy that this breadth of view is obtained, not in the mere facility of solving geometrical problems. But as long as geometry holds the position it does, we could hardly expect a better set of questions, though the manner in which they are enunciated is capable of emendation as regards perspicuity—due to the carelessness of the examiner, which on such an occasion is extremely culpable.

We can hardly criticise the Natural Philosophy paper. The treatment of natural philosophy by the London University has up till now been so absurd and so radically opposed to the true principles of mental education, that we can only say the paper

before us is no worse than many, and vastly superior to some that have preceded it. We are glad to note that the University is at last waking up to the fact of the inutility of its present system—whereby a month or two's cram may suffice to pass in this section with flying colours, the knowledge to be retained for about the same period of time. Let us hope that this is one of the last of the papers of its kind, and with this hope let us be lenient to its failings.

A more complete sham of an examination than is exhibited by the meagre and badly designed Chemistry questions could hardly be found. Six short questions are considered to cover the range of the non-metallic elements! with the result that it were quite possible to pass this paper creditably with but little knowledge of the science, and, on the other hand, for a real student of the subject to fail to obtain the requisite marks for a pass. We believe that the largest number of failures is usually in chemistry, and no wonder, with such questions as these before us. However, perhaps the University is alive to this also, and then a new era may dawn at last on these examinations in common with those in natural philosophy.

In these remarks we have for the most part refrained from commenting on the subjects themselves as educational agents, and have confined our attention to criticising the examiners' use of the materials before them. From the standpoint of the metaphysician we are conscious of very much that is still to be done in curtailing or eliminating certain subjects, and in extending or introducing others, but we will here continue to confine our observations to the delineation of those lines on which, even with the present curriculum, much may be done to raise the standard of the examination.

We would have our examiners bear in mind that *divergence* and difference of thought, not *uniformity*, is the goal at which they should aim—to bring out the full powers of the *individual* mind, not to try and reduce all to the dead level (however high in itself) of a book, a mind, or a system. In this light we hail with pleasure the suggestion now made from an influential quarter to "increase the number of questions, leaving a greater choice to the student." Let the examiner first frame his questions in such a way as to court the utmost freedom from the student, not tying him down to any writer or text book, and then make the student feel that divergence from any "received notion" or "dominant idea" is not likely to bias the examiner in determining his position. Thus a check would be put on the cramming system, and the matriculation examina-

tion would be, as it should be, a real test of the *intellect*, or power of *choosing between* the various theories, rather than the cultivation of the *reason* or mere *calculating* faculties of the mind.

We have striven in the foregoing observations to speak temperately of the course which some examiners think proper to pursue; but, in truth, it is difficult to express in measured language our sense of the evil which they inflict upon the minds of students, and of the heavy responsibility which attaches to them. We fear that in the endeavour to be fair we have failed to convey an adequate idea of the light in which we regard them. It seems impossible to induce them to put aside the flippancy with which they treat remonstrance and to be willing to regard the subject as a very serious one. They either cannot, or will not, realise the cruel injustice which they do to those who suffer from their inconsiderate action, and the very serious injury they cause in blighting the prospects of a competent youth's career. Little care they for the blow frequently struck at the physical or mental health of the lad at sixteen, or a young man capable of answering reasonable questions, but not fit sport for the play of examiners anxious, above all things, to show their knowledge at whatever cost to their victims. It seems to be in vain that some of our ablest men have stated that they could not answer the questions set by examiners at the London University, even in the department in which they themselves are authorities; in vain that medical men reiterate their opinion as to the mischief done to the brain by the incitement to over-work and cram to which too many examiners deliberately addict themselves; in vain that psychologists write on "Intemperance in Study," and detail the cases in which they have observed the irrevocable harm inflicted on the minds of pupils, advanced students, pupil teachers, and the like; and in vain that the melancholy catastrophe of self-destruction emphasises the teachings of those who endeavour to disseminate correct ideas on the subject of this intemperance, and to stay the uplifted hand of the examiner labouring under *question-mania* ere it fall on the innocent and unfortunate head of the industrious and well-taught student, who only fails in consequence of the unreasonable requirements of the examiner. We can only hope against hope that public opinion will eventually shame the folly of examiners who sin against light and knowledge, and that some check may before long be put on the present abominable system.

CLINICAL NOTES AND CASES.

Two Cases of Larvated Insanity. By CONOLLY NORMAN, F.R.C.S.I., Med. Supt., Monaghan Asylum.

(Read at the Quarterly Meeting of the Medico-Psychological Association, held at Dublin, January 21st, 1886.)

The two following cases, the first altogether, the second in great part, noted several years ago, present a common point of interest. In both, insanity existed for a great number of years in a highly-developed state, and in forms commonly dangerous. Both patients held positions that might be supposed to subject them to peculiar scrutiny, and to test their mental integrity pretty severely, yet both succeeded in concealing their aberration for lengthened periods.

CASE I.—S. K. came under treatment on the 20th December, 1879. He was at that time about 45 years of age. He was married, and the father of several children; a member of the Roman Catholic Church; by occupation a sub-constable in the Irish police.

Nothing was certainly known of his hereditary history. One of his children had died in early infancy seemingly of convulsions; another at about two years of age, of what was called "water on the brain;" in the latter case death had been preceded for some months by convulsive seizures.

No information was obtainable as to the patient's early life. His history commences when he became a policeman in his twentieth year. He then at once made himself remarkable among his comrades by his extraordinary boastfulness. He lost no opportunity of asserting his high opinion of his own powers, physical and mental. His associates used to entertain themselves by recounting in his presence remarkable examples of superiority in either kind, knowing that he would always cap their statements by some extravagant assertion about himself. There seems to be no doubt that he was a man of considerable muscular strength. He was also possessed of decidedly more than the average of mental activity common to his class. He had a very capacious memory, and was fond of reading as well as of displaying what he had read, so that in spite of a very defective primary education, he acquired sufficient general information to pass for a man of learning among his comrades, and even to be esteemed a smart fellow by people more capable of judging. He was given to the study of Euclid and algebra. He does not, however, appear to have penetrated very far into the mysteries of those sciences. He was a skilful chess-player. He was a great sportsman in a small way, and had claims to the mastery of

the art of "trying a fly." In conversation with his equals, he made the most of all his powers and accomplishments, and treated less gifted individuals with good-humoured contempt. He would seem to have been ready and intelligent in the performance of his duties, and thus to have earned the goodwill of his superiors, although they were not unacquainted with his weakness.

The first distinct sign of aberration which he showed is dated by its nature. At the beginning of the Crimean War, that is in the year 1854, he maintained that he had invented a machine whereby a whole army could be destroyed. Nobody could understand the detailed description he gave of this invention. When his friends laughed at the fancy, he showed vexation, and said that the interposition of certain wheels, whose exact locality he had not yet decided, was all that was necessary to perfect the discovery, and that he would soon be able to make a working model and demonstrate the feasibility of his notions.

Some years later (the exact date is not ascertainable), he began to give expression to the delusion that he was heir to, or rightful possessor of, an estate near his native place in county Kildare. He spoke of the matter so collectedly that he quite deceived those who were not familiar with him. In the year 1865 he told the story of his claims to landed property to a woman to whom he was paying his addresses, and she believed in it, not only at the time, but for many years after they were married. For some years he drank freely. In 1875 he lost promotion on a charge of drunkenness. Since that he has been an abstainer from alcohol. When under the influence of drink he allowed himself to be drawn into long descriptions of his property, and would draw maps of it on the floor with a piece of chalk. On the other hand, when sober, he was reticent on the subject, and declined to talk about it to any one who showed signs of scepticism.

This delusion with regard to property, like the earlier one relative to the infernal machine, was so thoroughly of a piece with his whole character, and his talk on both topics fitted in so well with the generally boastful nature of his conversation on all subjects, that no one seems to have looked upon him as insane. No doubt it also contributed to this result that he does not appear to have allowed his high notions of himself to in any way interfere with the ordinary performance of his duties.

On the 16th December, 1879, he was observed to be very silent. During the following night he was sleepless, and towards morning became violent, attacking his wife and everybody who came near him, declaring he was beating off the fiends from him, and raving incoherently on religious subjects. He was with difficulty overpowered. He remained very violent, and obstinately refused food. On the 20th December he was admitted to the asylum for the district. Very minute notes were made of his mental and physical condition, and of the progress of the case, all of which it will be only necessary here to summarize. He was a strong, muscular man, in good condition,

Tongue deviated markedly to the right, but was steady. Right pupil rather larger than left; both responsive. No peculiarity of gait or speech. On admission he spoke quite collectedly. He was inclined to be reticent about the events preceding his admission, but said that he had had a revelation from God on the night of the 16th to the effect that the world was coming to an end. His reason for refusing food was because he "imagined there was poison put in it." He complained much of constipation, and said if that symptom were relieved he would be all right. Next day he said the revelation, like the belief as to poisoning, was all a delusion. He spoke on general subjects quite rationally, and with considerable intelligence. He told his history freely, but one learned nothing of importance in addition to what is mentioned above, save that when about ten years old the patient had suffered from a fever, accompanied by protracted delirium, for which he had been blistered in the temporal region and on the nape. Being questioned as to the property on which he had a claim, he said that his grandfather had owned a large property in the county Kildare, and had been ousted therefrom by the operation of one of the old penal laws against the Catholics. The patient was familiar with the terms of the statute in question, though I believe wrong as to the date of its repeal. He could give no account of who the person was who had succeeded his grandfather in the property. He admitted that the extensive tract is now divided among a number of wealthy proprietors, none of whom are connected with him. He stated that his father lives as a tenant farmer under one of these proprietors, holding about seventeen acres of land which his grandfather had also farmed "in his latter days." How his family sunk in one generation he could not explain, nor in fact could he, properly speaking, give any reasons for his statements, further than he knows the facts to have been so. He remained under treatment till the 10th January, 1880, when he was discharged to the care of his relations, and at their earnest request. They strongly asserted that he had returned to the *status quo ante*, and such seemed to have been the case. He showed, indeed, extravagant boastfulness and self-esteem, and the delusion as to his property was quite unchanged, but he spoke collectedly, he seemed to understand business affairs very intelligently, and his behaviour was always rational. Little more than six weeks later he was again admitted. This time he was full of delusions to the effect that he was inspired, that he had revelations that the world was coming to an end, and so on. He was now fourteen months under treatment. For a long while he believed that he possessed a special key to the prophetic books of the Old Testament. Gradually, and with many remissions, he improved, till he finally returned to a condition quite the same as that preceding his first discharge. The deviation of tongue and the slight inequality of pupils noted in the beginning lasted throughout, but he never showed any further signs pointing towards general paresis. He has been lost sight of since the latter part of 1881.

Case II.—K. K., male, single, aged 51; Protestant. Came under treatment in June, 1880. No hereditary neurotic taint known. Patient was a strong, healthy boy, and early developed a considerable talent for numbers. After some years spent at a public school he entered a university and distinguished himself in mathematics. He obtained science honours several times. During these earlier years he was never suspected of insanity, nor was he even called eccentric. He was, however, habitually taciturn. He cared little or not at all for sports or games. He seldom associated with youths of his own age, and while at the university wished to separate himself from his only brother, a divinity student, because he said the habits of the latter were different from his, being more sociable. He rarely used this plea of disinclination for pleasure or company as an excuse for his solitary ways, but almost always gave some perverse reason for his dislike to particular people or particular amusements. The reasons, except for the fact that they were so frequently forthcoming, were not singular nor incomprehensible; he spoke clearly of them and adhered to them obstinately. Accordingly he formed no friends. To his own relatives he was cold and indifferent, and very often misunderstood them, fancying they wanted to make little of him, and attributing untrue and invidious motives to their behaviour towards him. His brother states that when they were at the university together he was so much struck by the patient's want of affection that he determined to put the matter to the test, and having, as he says, tried him thoroughly, came to the conclusion that the patient was entirely without any natural feeling towards him, and did not care whether he was dead or alive. His brother states that the patient never over-worked himself. He kept the first place in his class in science, but he was not extremely studious. He was quite temperate and regular in his mode of life. At this time it was his intention to become an engineer. He went up for a science scholarship and obtained third place. He was much disappointed, expecting to have been first. It was found that there had been an error in the marking and that he was entitled to first place. This the authorities publicly announced in a few days, but K. was so much chagrined at what had occurred that he would not return to college; but, having collected some money from his friends, went to England under the pretext of entering Cambridge University. His friends heard nothing of him for more than two months, at the expiration of which time they received from him a brief intimation that he had enlisted in an East India Company's regiment which was being recruited in London. He had never gone to Cambridge. His relations, who were influential people, at once procured an order for his discharge, but he refused to accept it and went to India. Possessing many advantages over the men among whom he served, he soon attracted attention in his regiment. He acted as sergeant to the recruits before leaving England, and was appointed pay-sergeant soon after reaching India. This post he held till 1859, when the East

India Company's service was broken up, between seven and eight years after the period of his enlistment. He returned home, declining the offer of a commission in Her Majesty's service, then made to him, on the ground that its acceptance would have involved further residence in India and that he was "tired of the Indian climate." While he served he appears to have borne a high character in his regiment, and to have been treated with much confidence and consideration by his officers. During his stay in India he wrote very seldom to his friends at home, and his letters were short and cold. When he came home he resided with his brother (above mentioned) for a time. At this period (after his return from India in the year 1859) the patient explained to his brother his reason for going to London and enlisting. He said that when he left Ireland he had believed there was a conspiracy against him and that people were endeavouring to poison him. He went to London hoping to escape from his persecutors. While in London, however, he still believed himself to be the victim of their machinations. Consequently he took little food, so as to avoid poison. He went about the streets often very hungry, and when he passed some small out-of-the-way eating-house he would go in and buy a few morsels of food, thinking "They cannot know anything about me in this house yet; my enemies can hardly have given these people notice." He took care never to get food twice from the same eating-house, and never got it at the places where he slept. Finally he enlisted, thinking to escape from his enemies by going to India. Retaining this delusion he refused to accept the discharge his friends procured for him, both before he left England and after his arrival in India. When he told all this to his brother he was apparently perfectly sane; he quite recognised that his belief had been false, and he laughed at them. He also mentioned that when a boy he had at one time thought he had the devil in his pocket, and consequently had leaped across the broadest stream he could find because he had heard that demons could not cross a running stream. His brother notes that he was, when a boy, remarked and often laughed at by his schoolfellows for his unaccountable trick of leaping across every stream or puddle he passed by. The patient also gave his brother to understand, though not distinctly, that he had at one period of his boyhood believed himself to be "commissioned from the Most High."

He now adopted the study of medicine, and attended lectures, &c., for about three years at one of the Dublin medical schools. His delusions soon (exactly how soon is not ascertainable) returned in full force and were pretty openly expressed. He said everything he ate was poisoned, and as a proof, "The other day I gave a piece of the steak I had dined off to a dog. He has never been seen or heard of since." His brother endeavoured to reason with him, and reminded him that he had formerly had delusions of this nature, the absurdity of which he had later on fully acknowledged. His reply was, "If an angel came down from Heaven to try and persuade me that my food is not

poisoned I would not believe him." Though he completed his other medical lectures he utterly refused to attend those on midwifery or to go to a midwifery hospital. After a time he said he was "converted" and would become a clergyman, but hating the religious denomination of which his brother was a member (in which he himself had been brought up) he announced his intention of joining another. He never adopted any steps to carry out this resolution. His temper, formerly exacting and sullen, had become irritable and violent. He quarrelled with, and threatened, those who opposed him. He wrote insulting and violent letters to such of his relatives as interested themselves in him, but his letters were not incoherent, nor did they express delusion in any form. Finally he disappeared from Dublin without leaving any clue as to his whereabouts.

After an interval of more than two years he wrote to his brother from New York demanding money. He said he had been ever since in America, where the Secession War had been going on, and had served as commissariat clerk in the army of General Sherman till it was disbanded at the close of hostilities. This statement his relatives found to have been a true one. He came back to Ireland and exhibited in his intercourse with his relations all his former delusions as to being poisoned, &c. He had so much self-control and appearance of sanity when only coming into contact with strangers that his friends endeavoured to find him employment, thinking that if he worked he would be all right. He declined to do anything, however, and threatened to kill himself if he were forced to work. An uncle procured him an offer of a mathematical mastership in a school, and the patient wrote him a furious letter accusing him of wishing to insult him, &c. He behaved in a similar way to all his friends. He does not appear to have believed at any time that his own relatives were endeavouring to poison him, but vaguely referred his persecutions to his "enemies;" yet he misinterpreted every attempt his friends made to be kind to him, accused them perpetually, without the slightest cause, of wishing to insult him, of misunderstanding him, &c. He accused his brother, on whom he was dependent for support, and who was himself a very poor man, of supplying him so ungenerously that he was in danger of dying of hunger, and wrote such cruel and insulting letters that his brother, though still keeping him up, declined to have any personal communications with him.

Several years ago he came to live in a cottage in the country. He dwelt altogether alone, and, as far as possible, avoided seeing every one. He appears to have become entirely absorbed in his delusions, and latterly was angry and threatening with anybody who tried to reason him out of his fancies and rouse him from his singular mode of life. He frequently threatened to commit suicide, usually when it was suggested to him that he should rejoin society and try and do something for his living. In the early part of 1880 there seemed to be some danger of his suffering from want of food, as he thought every-

thing was drugged except eggs. Nevertheless, after a period of abstinence he would eat ravenously. He occasionally gave expression to other delusions, for example, that he had seen hell open and people being dropped into it and coming out again under the forms of animals and old women.

In June, 1880, he was admitted to the asylum of the district, where he still remains. A very brief abstract of the notes made on his case will suffice for our present purpose. No physical peculiarity was noticed except in the condition of the external genitalia, which were puerile, resembling in appearance the same organs in a boy of fourteen. He spoke quite collectedly. His manner was calm, and only singular because strongly suggestive of constraint. When questioned closely he used to flush suddenly, but gave no other sign of annoyance, maintaining his deliberate manner and calm, monotonous tone of voice. His memory was apparently good. He gave expression to no delusions of any kind, but attributed rational motives to all his actions. Thus he pleaded poverty as a reason for his not having taken flesh-meat; said that he was afraid to drink the water in the well near his cottage because he feared it was sullied with sewage and the like.

There is little noteworthy in the progress of the case. For months after his admission he denied his delusions and parried with wonderful skill all questions intended to evoke them. Even now, though the medical officers occasionally hear them, few others do. In ordinary conversation he never alludes to them nor allows them to be elicited. Yet no one knowing his history and watching the man can doubt that they remain in full force. One delusion is worth recording. I asked the patient on one occasion whether he had ever been married. He replied, "No; my breasts are quite small," and went on to say that he had observed the other men who slept in the dormitory with him, and he knew they were all unmarried for the same reason.

Remarks.—I do not describe the foregoing cases of what I have ventured to call larvated or masked insanity (using this phrase merely as a term of convenience) because I think they are unique. On the contrary, I suppose cases not differing greatly from these may have occurred in the experience of several of our associates, and I await with interest the observations of the other members who are present to-day.

These cases are interesting from a social and medico-legal rather than from a scientific point of view. In the first we find a man exhibiting delusions of exaltation for five-and-twenty years, during the whole of which time he occupied a position of considerable trust. He was, no doubt, often engaged in duty requiring much self-command. He had habitually the charge and carriage of arms, and he must have

often appeared in the witness-box, sometimes, without doubt, in cases of a grave nature.

The march of symptoms is worth a moment's notice here. How far a severe illness in childhood operated as the starting point of mental degeneration it is impossible with such scanty evidence to say. It will be observed that the delusions appear in a curious gradation. First, the fundamental tone of the man's character is exaggerated self-esteem. Then appears a delusion of inventive capacity, *i.e.*, intellectual superiority; then a delusion as to fortune and family, and finally, delusions as to his relations with the Deity. Not till the appearance of these last does he violate the laws of society.

In the second case we have a young man who, upon a basis of intense predisposition, either inborn or acquired at the period of puberty, developes through the agency of a comparatively slight exciting cause well organised delusions of persecution. To avoid his persecutors he flies from home and enters the army. Here he succeeds and rises to a post of special responsibility; having been for a time entrusted with arms he also attains to, what some would count a more delicate charge, the distribution of money. At this time, perhaps, a partial recovery has taken place. But again, driven by delusion, he vanishes from among his friends; again he becomes a soldier, and again he is entrusted with the handling of large sums. There are two or three points about this man's symptoms that are of interest. A trace of sexual delusion, together with a certain degree of arrest of development of the genitalia, seem to indicate a probability that sexual aberration may have been among the phenomena of the case, whether causal or concomitant. The delusion that the devil was in his pocket and that he got rid of him by leaping across a stream points in the same direction. The perpetual leaping across streams would have much the appearance of an imperative act but for the explanation offered by the patient, which after all refers to one instance only. The connection of imperative acts with moral insanity has been pointed out by a recent author. Much of this patient's conduct when in his more lucid condition, his callous selfishness and ingratitude, his determination to live on his relatives, and his readiness all the while to abuse and annoy them, recall the traits of some of the recorded cases of moral insanity.

Had either of these patients during a long course of years been charged with a grave offence—each of them suffered from delusions very apt to lead to crime; each of them was in a

position which gave facilities for crimes of violence—and had an attempt been made to claim exemption from punishment on the ground of insanity, one can imagine what an immense mass of evidence would be at hand to invalidate the plea. In the case of the second man mentioned, however, there can be little doubt that such a defence would not have been thought of. He lived largely at a distance from his friends, and his command over himself is even still so great that, except under peculiar circumstances, it is next to impossible for a stranger to induce him to betray what would be legally recognised as a sign of insanity.

The conduct of the second patient is in one respect very interesting, as throwing some light on the occurrence of mysterious disappearances. I daresay some of my hearers will remember the case of a gentleman moving in good circles in London whose disappearance excited a profound sensation some years ago. A new silk hat which was identified as his property was found in a public place, but no further trace of him was discovered till some three months afterwards, when he was recognised under the disguise of a cattle drover in one of the western counties. He returned at once to the society of his equals, and attained a good position in one of the learned professions. No satisfactory explanation of his disappearance was ever given, at least to the public, but several years later the circumstance was significantly recalled when the poor gentleman put an end to his own life immediately after having sustained a severe domestic bereavement. There can be little doubt that his disappearance was prompted by a delusion, probably not dissimilar to that of patient K. K.

Case of Persistent Self-Mutilation. By Eric Sinclair, M.B., Medical Superintendent, Hospital for the Insane, Gladesville, New South Wales.

P. McT., æt 25, a native of Ireland, where he is said to have left a wife, was admitted into the Hospital for the Insane, Gladesville, N.S.W., on the 18th November, 1881, suffering from mania, said to be caused by intemperance. For 12 months after admission he had frequently recurring attacks of acute insanity, with intervals of comparative quiet. He never, however, was free from delusions, and occasionally through acting on their promptings was an aggressive and dangerous patient, who required much watching. His disposition gradually changed, and though he became, if possible, more insane,

he was not so violent or aggressive, but grew more demented, and developed a tendency to mutilate himself in various ways.

The first serious self-inflicted injury occurred two and a half years after admission, when he excised the left testicle. The instrument used was a fragment of a wire nail, about half an inch long, which he had somehow obtained and sharpened. With this, whilst in bed at night, in a single room, he cut through the scrotum, and dissected out the testicle, partly cutting and partly tearing through the spermatic cord and vessels as high as the external abdominal ring. The explanation he gave of his conduct was, that the testicle did not belong to him, but to another patient, a black man, in the same ward. And when asked if it hurt him, he replied, "No, but it did the other b—r." As the black man seemed obnoxious to P. McT. he was removed to another institution.

Five months after this P. McT. during the night removed the remaining testicle, this time using the tongue of a trouser-buckle. This operation was much better performed; a clean incision two inches long leading into the tunica vaginalis, which remained to line the cavity, the cord being separated close to the testicle. In the former case a large quantity of blood was lost, but at this time there was little or no bleeding. He said he had swallowed the testicle to prevent any one else getting it; and this was probably true, as there was blood about his mouth, and the organ could nowhere be found. He would give no reason for this mutilation, but expressed the opinion that there was now no reason for his detention in Hospital.

No mental improvement followed the castration, and indeed no great change could be detected in the mental symptoms, though care was taken to watch for this. He became, however, decidedly stouter and sleeker in appearance. His dementia slightly increased, and he continued his habits of self-mutilation. He would scratch himself with pieces of wood, with fragments of stone or glass, if he could pick up any such in the grounds, with buttons removed from his clothing, or with his nails. The only serious injury inflicted, however, was a small punctured wound on the left temple, which had somehow pierced the artery, causing considerable hæmorrhage.

The next injury was the most serious, and eventually caused his death. On September 27th, 1885, he complained of feeling ill, but careful examination failed to discover any cause for it, though he was pale, looked ill, and refused his food. A small scar on his right temple attracted attention; this he said he had made with a nail about two months before, and that part of the nail was there still. When questioned as to how the entrance of the nail was effected, he said that he had placed the point against his forehead, had then struck it with his hand until it became fixed, then bumping his head against the wall had driven it quite in. It was then remembered that a small wound, probably that made by the entrance of the nail, was noticed and examined about two months before he became ill, but owing to the swell-

ing caused by the bumping it was impossible to detect the presence of the nail—which was not suspected. At the time he said that the wound was made by a buckle, and there were no symptoms to lead any one to suspect that the injury was other than a superficial scratch with bruising around it.

A small hard lump about the size of a split pea could be felt under the skin, which had quite healed over it. On cutting down on this it was found to be the head of a wire nail, two inches long, which had been driven through the skull up to its head. Its removal was effected with some difficulty, and a small quantity of pus followed it. There were no head symptoms present, no paralysis of any of the muscles of the body, eyes, speech, &c., no vomiting, and no special pain complained of. He was quite conscious, and apparently in the same mental state as he had been for some time, and decidedly not more demented or stupid. After the removal of the nail no improvement resulted, and he gradually sank and died next day.

A post-mortem examination was made seven hours after death. The incision, half an inch long, which had been made to remove the nail, was seen on the right temple immediately to the outer side of the frontal prominence. Round the opening in the skull, on the outside, the bone was deeply eroded; on the inside the internal table had been pushed aside, making a raised and burred edge. On the surface of the convolutions there was a small quantity of pus, about ʒiß, but the suppuration had not extended deeply enough to destroy any of the grey matter. In this position the dura mater was absent, and round the edges of the "abscess" it was firmly adherent to the brain. In the substance of the frontal lobe there was a cavity one inch in diameter each way, filled with altered blood and broken-down brain substance. Its walls were soft, shreddy and pulpy, and the brain-substance all round was stained a deep yellow. The track of the nail was easily followed; entering the centre of the "abscess," in the middle frontal convolution, it passed backwards and inwards in the horizontal plane, ending just in front of the anterior extremity of the corpus striatum.

In other respects the brain was normal, as were the other organs of the body.

Self-Mutilation in a Lioness. In connection with the foregoing case it may be of interest to add the following example among the lower animals, communicated to the Pathological Section of the Irish Academy of Medicine by P. S. Abraham, F.R.C.S., and published in the 3rd Vol. of the Transactions of the Academy, Dublin, 1885.—Eds.

On the 18th of May, last year, a fine lioness in the Zoological Gardens, in Phœnix Park, was discovered to have devoured, during the night, some six inches of her tail—the hair, skin, bones, and

everything. She did not then touch it for some days, but appeared to be very restless, and on the 27th of the month she recommenced her extraordinary conduct, and demolished, during the night, a great part of the remainder of the organ. She then rested awhile, but again went at it, and at the end of a month there was nothing left of her caudal appendage but the "butt," some four inches or so, which I here exhibit. The organ was now so short and un-come-at-able that she could not reach it with her mouth, and it was hoped that in consequence she would resume her usual tastes and be satisfied with the flesh of other animals; but on the 1st of July she began to lick and gnaw off the skin of the dorsum of the right hind paw. The integument and subjacent tissues are seen to be removed from nearly the whole of the extensor surface of the foot, and it is evident that the tendons would be exposed were it not for the granulation tissue which has formed, as a superficial layer, over them. It was quite certain that while all this was going on the animal suffered extreme pain; the stump of the tail was seen to be in a constant state of quiver, and when a part of the foot was gone, the leg was drawn up, and the creature limped about the cage on the other three legs.

There was nothing apparently to account for this strange behaviour on the part of the lioness. She was in splendid condition, as regards her fur, flesh, and appetite, and her excretions were normal. It is needless to say, various methods were tried to induce her to leave herself alone—complete change of food, sulphur and other aperients, syringing the parts with bitter liquids, &c., but all with no effect. At last, indeed, it was deemed advisable to destroy her, for her suffering seemed so great, and the extent of the wound on her foot was so large, that, even if she left off the bad habit, it appeared impossible that the raw surface could ever properly heal and skin over.

At an examination of the body, made shortly after death, I found the thoracic and abdominal organs all perfectly normal; the right ovary was larger than the left, and its surface presented several large protrudent Graafian follicles. At first I was inclined to think that this ovary presented some abnormality, but after consultation with Dr. Neville, and on its microscopic examination, I have arrived at the conclusion that, beyond some degeneration, it is the seat of no very great pathological change. The brain and spinal cord were not examined.

The lioness, which was about twelve years old, had been in the gardens for five years, and had always been in good health. She had produced cubs three times, but her offspring were, with few exceptions, unhealthy, mostly becoming rickety and dying young. For one year previously to May, 1884, she had not been in season, although formerly she had been tolerably regular in "coming round."

It is well known that foxes and many other animals when trapped by one foot will sometimes gnaw themselves free and leave a portion

of their bodies behind; and a gradual gnawing and picking away of the tail has also been observed as a not uncommon habit in monkeys in confinement, as well as occasionally in rats, dogs, and several other creatures. The present case, however, does not come under precisely the same category as these; for there appeared to be absolutely no external cause for the procedure, and instead of a gradual gnawing and disappearance of the organ, large pieces were scrunched off at intervals and swallowed.

I have made a great many inquiries as to similar occurrences in other zoological gardens and menageries, and I here take the opportunity of thanking several superintendents and others, some of whose names are mentioned below, for the information which they have been kind enough to give me. The distinction pointed out above does not seem to have occurred to my correspondents, many of whom have mixed up the cases of gradual gnawing with those more nearly like that of our lioness.

As far as I can find out, the only instances of self-mutilation which had previously occurred in our own gardens, were in (1) a female hyæna, who devoured her tail some years ago; (2) a female wolf, who fed upon one of her legs, and had to be destroyed; and (3) a female jaguar, who ate a good half of her tail, which had been injured by the claw of her neighbour, a tiger, over whose cage she was kept. One day, unfortunately, she let down her tail between the bars, and the tiger made a stroke at it; she ate the fragment, which was hanging by a little skin and tendon, but did not further interfere with the stump. This last case, indeed, is not exactly comparable with the others.

A keeper at the Zoological Gardens in London has informed me that some three or four years ago a young female cheetah, scarcely full grown, commenced suddenly to eat her tail. She would bite off two or three inches, then stop for a few days, then become excited and set to work again. This went on for some weeks, her excitement during the time being very great, and she frequently gave loud screams. Finding no improvement, she was destroyed. An old female hyæna, who had never bred, also some years ago at the London Gardens demolished her tail. She would wait till the stump was nearly healed, and then make another meal off it, until ultimately the whole organ disappeared.

Mr. Jackson informs me that the only case which has occurred at the Clifton Gardens was that of a lioness, a piece of whose tail had been bitten off by a neighbouring tiger. She kept the wound open and sore for two or three months, after which it healed over, and she subsequently became a good mother. This also is not quite in point.

M. Hüet, of the Jardin des Plantes, writes that such occurrences have sometimes happened in the case of leopards, lions, and smaller carnivora, and that they are especially common among the monkeys of that collection. He considers the habit due to a disease of the skin, which can be sometimes cured by treatment.

The late Dr. Bodinus, Director of the Berlin Zoological Gardens, had often observed animals of prey gnawing their tails and nibbling themselves; and he held that the bad habit has its origin in a faulty state of the blood. He recommended, therefore, a change of diet, such as from horse-flesh to young veal, and castor-oil in milk, also local applications, carbolic solution, tincture of aloes, &c. He stated, however, that it is very difficult to prevent wild animals from gnawing themselves when suffering from pain. He had nevertheless been quite successful lately with a young female jaguar who was eating her tail.

M. Herman, Director of the Amsterdam Collection, has only met with one instance of anything of the kind, in an experience extending over forty-six years. This was in the case of a rhesus monkey, "which, becoming mad, began to eat its forehands."

At the Antwerp Gardens no carnivore has ever attacked its tail, unless that organ had been wounded. More than once an animal has shown a tendency to constantly lick the tail, but a good dose of sulphur has removed the irritation. The monkeys, however, have frequently eaten their tails, and nothing but amputation of the organ has stopped them.

Mr. Jamrach has several times met with such cases among leopards and lions, and, of course, often with the monkeys. He ascribes the cause to be either a healing wound or an irritation of the skin, the intolerable itching developing into a mania. He states also that parrots frequently eat their feathers and flesh.

Mr. Salva, of Cross's menagerie, has frequently observed carnivorous animals mutilating themselves, especially among those which are suffering from scrofulous sores. He considers the only successful treatment to be by amputation of the injured limb.

Through the kindness of Mr. Snow, of the Phœnix Park Gardens, I have recently seen a letter from Mr. Carpenter, animal dealer, of Liverpool, who writes of a young Bengal tigress—"I had a letter last November (from the present owner) saying the tigress was very fine, but had a habit of dropping its tongue out and rolling it about a good deal; and a few days later I received a letter saying that it had eaten the whole of its tail off." This animal had never bred.

Lastly, Mr. F. Collins informs me that many years ago he knew of a lioness in Wombwell's menagerie who devoured her tail.

It will be observed that several of my informants ascribe the morbid appetite to some irritation of the skin; and, no doubt, this may account for the gradual disappearance of the tail in the case of monkeys. A sore may be originally formed at the tip, and, when the itching of healing begins, the scab is picked, licked or gnawed off; the newly rawed surface agains heals over, again to be denuded; and this may go on till the organ at last is all gone. Of course a continuous licking with the prickly feline tongue will soon produce a sore, but it seems unlikely that this or the other suggested causes

will account for an animal suddenly munching off large pieces of its person. On the whole, I am inclined to consider that this departure from the creature's usual habits is due rather to something akin to a mental derangement; and I think that M. Herman is probably right in saying that his rhesus had "gone mad." My inquiries tend to show that the carnivora which have "taken on" in this way have been nearly always females, which have been either very young, just before they began to breed, or old, at the menopause, when their breeding period had come to an end: and I venture to suggest that we may look upon this perversion of taste, in our lioness at all events, as one of the manifestations in the lower animals of that Protean affection which we call "hysteria."

A Case in which an Old Amputation of the Left Upper Arm was associated with an Atrophied Right Ascending Parietal Convolution. By JOSEPH WIGLESWORTH, M.D. Lond., Assistant Medical Officer, Rainhill Asylum. (With illustration.)

The subject of this communication was a female epileptic, æt. 56, who died in Rainhill Asylum on September 18th, 1884, of catarrhal ulceration of the large intestine.

The interest of the case centres in the fact that when patient was only four years of age she met with an accident which necessitated amputation of the left upper extremity. The section had been made about the middle third of the left upper arm, so that a small stump was left, which was partially movable. For a period, therefore, of 52 years this patient was deficient in the movements and impressions connected with the left arm and hand, and it was consequently to be expected that the cerebral centre in correspondence with this region would exhibit some amount of defective development.

The convolutions of the motor area of the cerebrum were therefore submitted to close scrutiny, with the following result:—The right and left ascending frontal convolutions were equally developed throughout, but the right ascending parietal convolution presented a notable diminution in size as compared with the left. For the first three-quarters of an inch (measuring from the median fissure of the cerebrum) the two convolutions were nearly equal in size, the right being, indeed, a trifle the broader, but for the next two inches the right gyrus was about half the breadth of the left, this proportion being observed until just before the termination of the con-

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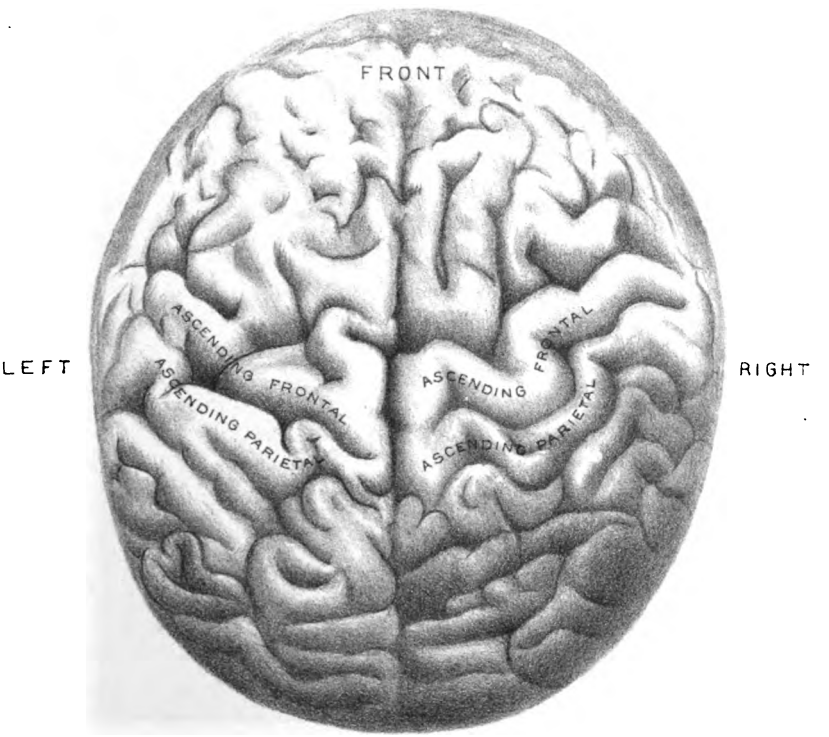

TO ILLUSTRATE DR WIGLESWORTH'S CASE

Brain_ from case of old amputation of left upper arm,_viewed from above: (from a photograph). The right ascending parietal convolution, (except at its upper and lower ends) is seen to be much smaller than the left.

Mintern Bros. lith

volutions, when they again became nearly equal. The exact measurements in sixteenths of an inch were as follows:—

DISTANCE FROM UPPER END.

	Upper end (tip).	¾in. from tip.	1½in. from tip.	2in. from tip.	2½in. from tip.	3in. from tip.
Right...	$\frac{6}{16}$	$\frac{8}{16}$	$\frac{5}{16}$	$\frac{6}{16}$	$\frac{6}{16}$	$\frac{10}{16}$
Left ...	$\frac{4}{16}$	$\frac{15}{16}$	$\frac{12}{16}$	$\frac{9}{16}$	$\frac{10}{16}$	$\frac{11}{16}$

These measurements were taken from the brain immediately after its removal from the cranium.

We may therefore say, broadly, as the result of the examination, that the right ascending parietal convolution in its lower three-fourths was half the size of the corresponding convolution on the opposite side.

No other convolution presented any abnormality.

It is right to observe here that the patient was not a dement, but between her fits, which were not very frequent, she was quite rational.

Her brain* as a whole weighed 1,240 grammes, and the convolutions were well formed.

The condition noted in this case is strikingly in harmony both with previously recorded cases of a similar nature and with the results of experimental investigation.

In the first volume of "Brain"† is a case reported by Dr. Gowers in which congenital absence of the left hand was associated with a marked diminution in size of the right ascending parietal convolution as compared with the left.

"At their origin at the longitudinal fissure for the first inch of their extent they were nearly equal in size, and continued nearly equal for the upper inch and a half. In the next (middle) two inches there was a very marked difference, the right being a narrow single convolution and the left broad and depressed by a slight secondary sulcus. . . . The lowest extremities of the two convolutions were equal in size."

Another very similar case is recorded in the third volume of "Brain"‡ by Dr. Bastian and Mr. Horsley. In this case there was a congenital defect of the left upper limb, which was shorter and much slighter than that of the right side, and the left hand was small and abortive. The right ascending parietal

* This brain was exhibited at a meeting of the Liverpool Medical Institution.

† "The Brain in Congenital Absence of One Hand," p. 388.

‡ "Arrest of Development in the Left Upper Limb, in association with an extremely small Right Ascending Parietal Convolution."

convolution in its middle three-fifths was much smaller than the corresponding region on the left side.

It will be noted that in both these cases the atrophy was limited to the middle area of the convolution, the upper and lower ends being equal in size, which conditions also existed in the case before us, although here the diminution in size occupied a somewhat larger area of the convolution, in correspondence, doubtless, with the greater extent of the defect in the limb.

It is sufficiently interesting and striking that it is just this middle area of the ascending parietal convolution in which Ferrier has localised, by experimental investigation, "the centres of movement of the hand and wrist."*

It would be an interesting inquiry whether minute measurements in perfectly normal individuals might not give a slight preponderance in size of the left ascending parietal convolution over the right, in accordance with the greater complexity of movement of the right hand, in the great majority of individuals.

Case of Accumulation of Hair, &c., in the Stomach, with remarks. By C. S. W. Cobbold, M.D., Medical Superintendent of the Earlswood Asylum.

A somewhat inaccurate account of the inquest held in the following case went the round of the newspapers. The true facts are these :—

W. A. H., aged 18 years, was admitted into Earlswood Asylum on May 31st, 1883. His parents stated that at 18 months of age he had an "accident," which was followed by epileptic fits during the three following years; he had also been idiotic from that time, and had had hydrocephalus. On admission it was noted that the patient was tall, ill-nourished, and cachectic; feeble and stooping in gait and carriage. The head was large and elongated, with marked bulging in the frontal region; the incisor teeth were notched and the palate narrow. The mental powers were very feeble; there was no power of speech nor of understanding the simplest question; saliva continually dribbled from the mouth, the calls of nature were disregarded, and the patient could neither dress, undress, nor wash himself. He had the habits of putting his fingers in his ears, picking clothing to pieces, and occasionally pulling out one or two hairs at a time from his head. During the first

* "Functions of the Brain," 1st Ed., p. 307.

few days of his residence in the asylum it was difficult to get him to take food, but his appetite afterwards was usually ravenous, though it occasionally failed for a few days at a time. He always fed himself with his hands, making a great mess with his food, but refusing to be fed by others, or to use even a spoon himself. Altogether his mental condition more resembled dementia than idiocy. In accordance with our system of industrial training and the patient's habit of picking clothing, &c., he was sent for several hours daily to join the cocoa-nut fibre "picking-class," but he was never able to follow the occupation usefully. Owing to this, and to his feeble health, his attendance at the workshops was entirely discontinued for a year before his death. He was frequently under treatment in the infirmary for general debility; no definite cause for this could be ascertained, and it was ascribed to defective nerve-function. During the year 1883 he had three epileptic fits, in one of which he broke his left humerus; the fracture united without trouble. No fits were registered during 1884, but in 1885 they became more frequent, reaching in March and April to 20 in the month. In April it was noted "he is given to whining both by day and by night;" but he never by any gesture referred his pain or uneasiness (if indeed he were suffering such) to any particular region.

On December 10th, 1885, he was sent to the infirmary ward with œdema of the legs and general debility; the heart-sounds were natural; urine could not be examined, as it was always passed in the bed. On the 15th the anasarca had subsided, and the patient being again as well as usual, returned to his ward. On the 20th vomiting came on, it was accompanied by great weakness, and the patient was again transferred to the infirmary. It was difficult to get the stomach to retain nourishment, but under appropriate treatment some liquid food was retained, and the patient was somewhat better during the two following days, though he vomited from time to time. At about 10 a.m., on the 23rd, obstinate vomiting again set in, and could not be controlled. The abdomen was greatly distended by flatus. Both the vomit and the light-coloured liquid motions emitted quite an exceptionally offensive odour. Throughout the day the patient's strength became gradually exhausted, and towards 7 p.m. he was evidently sinking; he died at about 9.30 the same evening.

Necropsy.—The body was ill-nourished, but not markedly emaciated. Skull thick and dense. There was considerable excess of intracranial fluid both in the ventricles and between the membranes; the latter were thickened and clouded; the white cerebral substance presented a well-marked example of the doughy consistence and stickiness often seen in chronic epilepsy. Thus the brain was also that of dementia rather than that of idiocy. Heart and lungs normal, but the former small and flabby. The peritoneum showed no signs of inflammation; the intestines were throughout greatly distended by flatus. The stomach was enormously dilated and inflated; upon grasping it a

solid mass was felt within. The œsophagus and pylorus having been tied, the stomach was removed entire; after allowing a large quantity of fœtid gas to escape from its cavity, it was laid freely open; the solid mass within it was then seen to consist of an elongated roll of human hair, cocoa-nut fibre, and horsehair. The hair, etc., was closely matted together, for the most part concentrically arranged, and, as it were, cemented together throughout by decomposing semi-digested food; a few dead leaves were also incorporated with it. The whole mass in its wet state weighed 2¼lbs. It did not occupy more than a fourth part of the enlarged stomachic cavity. There were no signs of irritation, inflammation, or ulceration of the mucous membrane. Some liquid food remained in the stomach. The intestines contained only gas and a small quantity of liquid fæces.

Remarks.—The patient died of persistent vomiting supervening in a system debilitated by chronic indigestion; both being due to the presence of the accumulation of hair and fibre in the stomach. The failure to diagnose the presence of the foreign substance is chiefly attributable to the absence of any history of the patient's habit of eating hair. The mental inability of the patient to indicate in any way his subjective symptoms, and the absence of any visible abdominal swelling until extreme tympanites made precise palpation impossible, were also elements of difficulty in the case. It is probable that the tumour might have been felt if it had been suspected and definitely searched for, but the patient would have had to be placed under an anæsthetic, as he always resisted every kind of examination.

It was known that the patient had a habit of chewing neckties, pieces of cloth, &c.; the attendants frequently removed these from his mouth, but they never seem to have suspected him of swallowing them. Since his death I learn that he was occasionally seen to put his hairs in his mouth after pulling them out; they were removed, but it was believed that he merely liked to chew them. He was never seen to place cocoa-nut fibre or horsehair in his mouth at the upholsterer's shop. His parents inform me that he had the habits just described before coming to Earlswood, and they agree with me in believing that a roll of hair was in his stomach when they brought him to Earlswood. I have no doubt that the accumulation increased rather rapidly while the patient was attending the picking-class, and only grew slowly during the last year of his life, when he had ceased going to the workshops. The difficulty of swallowing small quantities of hair or fibre by themselves is evident, and I do not believe that my patient was able to perform any such feat. I believe that the hair, fibre,

or other foreign matter which he retained in his mouth for chewing purposes (or merely from force of habit) passed down into the stomach with his food at meal times. The small quantities he thus kept in his mouth would not attract the notice of the attendants, but their accumulation during several years would easily produce the mass which was afterwards found in the stomach. It is highly probable that W. A. H. also swallowed portions of cloth and linen, but these, as a rule, pass through the bowels without harm to the patient. It is only when these substances are swallowed in great quantity, or when there is already a tendency to fæcal accumulation, that they lead to obstruction, usually of the large bowel. Hair and fibre, on the contrary, seldom pass the pyloric orifice with the chyme; they remain and accumulate in the stomach. Hair-balls are common in the stomachs of long-haired cats, and of calves (even fat ones). Butchers state that no injury usually results in the case of the latter, but I have been informed of one case at least in which death was attributed to this cause.

Mr. Knowsley Thornton's recently published case of successful gastrotomy for the removal of a mass of hair from the stomach, naturally raises the question whether my patient might not have been similarly relieved by operation if a correct diagnosis had been arrived at. I do not myself believe that so unsatisfactory a subject would have recovered after the operation, but it would probably have been right to perform it if the diagnosis had been made.

Dr. Bucknill kindly allows me to mention an unpublished case which occurred under his care at the Devon County Asylum; it differs from mine chiefly in the manner of the patient's death:—

An imbecile, aged 19, who had been epileptic for six years, being sometimes maniacal and sometimes demented, having a voracious appetite, and enjoying good general health, was suddenly attacked by abdominal pain and collapse; death rapidly ensued. On autopsy a large and firm mass of cocoa-nut fibre (the fibres being rolled quite regularly), was found in the stomach, the cavity of which it so fully occupied as to excite wonder as to how food could get between the mass and the mucous membrane in order to its digestion. It is certain, however, that digestion had been well performed, for the patient died in fully good case as to nourishment. The fibre-tumour had caused a small chronic ulcer, which eventually perforated the coats of the stomach, and caused death. The mass held together firmly after removal; no hair or other substance was visible in it, but cocoa-fibre only. This patient had been employed in picking cocoa-nut fibre.

The moral I draw from my case is, that it is not sufficient for the attendants to remove only from the patients' mouths foreign bodies which they may have seen introduced into them, or which are of such size as to cause a noticeable alteration in the patients' facial appearance. This practice is, of course, both necessary and usual, but it is now proved to be insufficient. My case shows that it is necessary before every meal to thoroughly search the mouth of every patient who is in the habit of placing improper substances in his mouth. This must be done with considerable care and with a view to the removal of even the smallest quantities of deleterious matters. Among the latter, hair and fibre probably hold a more prominent position than other insoluble substances when swallowed in similar quantity.

A Case of Saturnine Insanity. By W. Hale White, M.D., Assistant Physician to Guy's Hospital.

Thomas H., æt. 40, was admitted into Guy's Hospital under my care on February 6th, 1886, for unconsciousness following fits. No family history of insanity or fits; father has gout, otherwise the family history is very good. The patient is a plumber. Ten years ago he had colic, and also eight years ago. Seven years ago he had "rheumatic gout," to which he has been subject ever since. He has been a moderate drinker. On February 2nd he was troubled with a severer attack than usual of pain in the wrist. On February 4th in the evening he had a fit, commencing by his making a loud, shrill noise, rapidly followed by trembling in the body and limbs. He foamed at the mouth; the teeth were clenched; the eyes were staring. The fit lasted thirty minutes, when he seemed to recover himself, but on being spoken to did not answer, seeming stupid. He got up, dressed himself, and went downstairs. He appeared fairly well till five o'clock the next evening, during which time his power of speech partly returned. He expressed a wish to go to bed, which he did, and fell off into a quiet sleep, remaining undisturbed till 12 o'clock, when he had another fit resembling the first. This second one lasted for fifteen minutes, and about three minutes after it had ceased another took place. He then had a succession of them for about three hours, each being rather more maniacal than the previous. His voice entirely left him, and he again would or could not speak. A medical man administered a draught, after which the patient fell into a quiet sleep. He remained free from the fits till the following night, when he had another series rather severer than on the previous night. During this night the patient was very restless, getting out of bed and throwing his arms about. He became so violent that he had to be held down by four

men. After a time he became quieter, and was brought to Guy's Hospital.

Condition on admission.—Patient is well nourished, with dark hair and eyebrows. Complexion dark and face rather blue, and also of a sallow hue, being just the kind of countenance that would give one the impression that the patient had worked in lead. Eyes brown, with discoloured conjunctivæ. Pupils unequal, the left being rather more dilated than the right, but both are rather contracted. They respond readily to light and accommodation. The lids are pigmented. He has a somewhat staring, silly look, but is quite sensible of what is going on around him, the slightest noise attracting his attention. When spoken to he takes no notice whatever of what is said, but sometimes after a long interval he will drawl out "Yes," or "No," but without any reference to the question, so that often his answer is quite stupid. Usually he, however, places his hand on his forehead as though trying to collect his thoughts, and slowly hesitates but does not respond. Protrudes his tongue when told, and can hold up his arms. No wrist drop; no paralysis of either arms or legs; no facial paralysis; reflexes normal; characteristic blue line on gums; breath very foul and offensive; tongue furred; appetite poor; bowels regular; no sickness. When asked if he feels any pain anywhere, says "No." Abdomen dark coloured; liver and spleen normal. Cardiac and respiratory systems normal. Urine contains a deposit of uric and cystals; minute trace of albumen; no sugar or blood; two per cent. of urea. Sp. gr., 1022. Temperature normal.

February 7th.—Seems rather more sane to-day. Speaks when spoken to, but hesitatingly. Was able to say his name and his occupation.

February 8th.—He seems much improved, but still answers badly, for when I asked him how long he had been in his present employment he slowly said, with a hesitating manner reminding one very much of a general paralytic, "Fourteen years." During the answer he stared at one in a vacant manner. The next question he was asked was how old was he, and again, in just the same way, he said "Fourteen years;" and again gave the same answer to some third question we put to him. No treatment was adopted. The improvement in intellect was very marked from day to day, and also the improvement in speech, so that at the end of a week he went out quite well. At no time had he any delusions. Dr. Savage, who kindly saw the man with me, quite agreed in the diagnosis.

We have now had several cases in Guy's Hospital. Four of them will be found recorded in the "Guy's Hospital Reports" for 1882, by Dr. Goodhart. This case agrees with the third of them in that epileptiform convulsions were present, and also with cases that are described, as in the matter of speech, resembling general paralysis of the insane. The peculiarity

of the present case is that patient recovered so quickly. Most of the cases have lasted for months, and many of them have lapsed into confirmed lunatics.

There was a case which came to my out-patients room some months ago in which the patient suffered from the most striking epileptiform seizures as a result of his lead poisoning. He was 45 years old: had had painter's colic for 20 years. For 15 years he has been under treatment at the National Hospital for the Paralysed and Epileptic, for severe epileptiform seizures. His account of them shows that they are indistinguishable from epilepsy. Three times he has been locked up as drunk and incapable, but on each occasion he has only been suffering from his saturnine eclampsia. In order to prevent his being locked up again, he has his name and address stitched inside his coat, together with a statement to certify that he suffers from fits as a result of his lead poisoning. He wears paper collars in order that they may be the more readily loosened and torn when his fits come on. There is a slight amount of albumen, some cardiac hypertrophy, a high-pressure pulse, a slight blue line; and many scars, due to his having hurt himself whilst in his fits, may be seen.*

Some Abnormal Forms of Breathing. By W. Julius Mickle, M.D., M.R.C.P., Grove Hall Asylum, London.

Read at the Quarterly Meeting of the Medico-Psychological Association, February 24, 1886.

The first form is pure typical fully-developed Cheyne-Stokes's respiration, examples of which, in the insane, I fully described some years ago.† On the present occasion, therefore, I shall merely mention it as introductory to the consideration of the other forms.

The second form is a subdivision of the first, and consists of cases which are essentially examples of modified Cheyne-Stokes's respiration, that form of respiration existing in them on a dwarfed scale, and shorn of many of the features of the fully-developed typical form.

Examples of the third form were briefly referred to in my paper already cited. Clinically this has the general mould of Cheyne-Stokes's respiration *minus* the period of apnœa.

* For a series of cases of Saturnine Insanity, and their resemblance to the symptoms of General Paralysis, see Journal, July, 1880.

† "British Medical Journal," Aug. 31, 1878, p. 308.

It consists, therefore, of the successive dyspnœal periods, which are essentially the same as those found in Cheyne-Stokes's respiration, and the several phases of each such dyspnœal period jointly constitute a cycle, and the succession of cycles constitutes the phenomenon which I have termed "up and down respiratory rhythm." It is, indeed, the phenomenon for which I claim that to it alone the name of "respiration of ascending and descending rhythm" is accurately applicable; but as this name has been used as synonymous with Cheyne-Stokes's respiration, I hesitate to employ it here, lest confusion should arise. This phenomenon also, I believe, gives to Cheyne-Stokes's respiration its clinical mould, a view which I gathered from watching for hours a typical case described in my paper already referred to. On several occasions I observed it precede or follow typical Cheyne-Stokes's respiration.

The clinical phenomenon is this: respiration, at first light and infrequent, becomes, by an ascending scale, fuller, more forcible, and frequent and exaggerated, until dyspnœa is attained, and then gradually subsides by a descending scale to the condition as at starting; after which a fresh dyspnœal period begins. In some examples the subsidence is considerably or much more rapid than the rise.

Although I found distinct microscopical change in the elements of the medulla oblongata in one of the cases reported by me,* I felt scarcely justified in absolutely connecting this change with the production of Cheyne-Stokes's respiration. But recently, in one case of that mode of breathing, Tizzoni found chronic inflammatory changes ascending the vagi, with blood extravasation into the lymphatic spaces of the perineurium and endoneurium. The whole length of the right nerve, the periphery only of the left, was affected. In the medulla oblongata itself were small foci, chiefly on the right side, and beneath the ependyma at the longitudinal furrow of the calamus. Similar lesions affected the upper half of the medulla oblongata in another case (uræmic), but the vagi were normal.

Series 1.—*Examples of Modified Cheyne-Stokes's Respiration.*

Case I.—S.; soldier, died, aged 41, of general paralysis of about two and a half years' duration. At first, the delusions were of a depressed character, subsequently exalted. There was a vague history as to an

* "British Medical Journal," Aug. 31, 1878, pp. 309 and 312.

early right hemiplegic attack. Left othæmatoma supervened. Once he became pale and broke out into a profuse perspiration, which was followed by apparent transitory sleep, after which, with slow and soft pulse, there was muscular flaccidity and motionlessness, apparently with powerlessness of left limbs, and silence was maintained by him under the delusion that he was dead.

Later on, transitory left hemiparesis, at least in the lower limb. Still later, seizure of paresis of right leg, the tongue also being protruded slightly to the right. Left hemiplegia came on eight months before death, and the left arm was somewhat contracted and flexed. After this there was marked muscular twitching.

Seven weeks before death, he had for months been confined to bed with palsied and contracted left limbs, fatuous, noisy, "dirty," and teeth-grinding, and on the morning the note I am quoting from was made he had, since the previous evening, been in an apoplectiform attack, and was lying with the head and eyes turned to the left, the left forearm flexed, rigid and hyper-pronated, the left leg rigid, somewhat flexed, the right resistant to passive motion; knee reflex well-marked, especially in right leg, which showed some ankle-clonus also; ears heated; teeth-grinding; pupils equal, smallish, sluggish, and irregular. There was a recurrent apnœal pause. Thus, after noisy respirations with guttural sounds, came one or two light respirations, and then respiratory cessation, after which the recommencing respirations were light, but immediately became slightly noisy and guttural. For example, there were seven respirations rising and falling as just described, and occupying the space of 15 seconds, then a pause of five seconds, then five or six respirations lasting 15 seconds, a pause of five seconds; then successive respiratory periods, each consisting of nine respirations, and lasting 20 and 23 seconds, with intervening pauses.

Dysphagia; slight spasmodic jerking of limbs; pulse 84; temperature right axilla, 100·2°; phthisical changes in lung, tracheal and bronchitic râles; urine thick, sedimentous, urate-loaded, ex-albuminous.

Three days later head and eyes to left, spasmodic twitches of mouth and face to left.

This was essentially a case of Cheyne-Stokes's respiration, but not highly pronounced; a modified form.

Case II.—M.; soldier, died aged 39, a protracted and unusual case of general paralysis. The question of syphilitic causation arose.

About five months before death, apoplectiform symptoms and right hemiparesis supervened, with some deviation of head and eyes to left. At first the pulse was 78, and the heart irregularly intermittent, as for example, at the 4th, 8th, 20th, 24th, 30th, and 40th pulsations. Afterwards the pulse was 96, and there was an aortic systolic murmur. Temperature, right axilla, 100·3°; left, 99·6°. The respiration was irregular and of a modified Cheyne-Stokes's character. Thus two or three full respirations occurred in close succession, and then there was

either *(a)* a pause of some seconds' duration followed by a few short jerky respirations, or, again, by respirations made as if effected in several spasmodic attempts; or *(b)* a pause followed by a prolonged expiration, succeeded by occasional short jerky inspirations. Then, for a time, came respiratory cycles varying each from 12 to 18 seconds in duration, consisting of four respirations, increasing in depth, fulness, and loudness, and followed by a complete pause of from five to eight seconds' duration. In nearly every second cycle the respiration terminated with a very prolonged expiration. Next, each of two successive cycles was noticed to occupy 15 seconds; half of this time being occupied in the respiratory period, and half in the apnœal pause.

Briefly to summarise the course of this case, there were, successively, active mania, great improvement, mental depression, acute nephritis, taciturnity, feeble circulation, erysipelas capitis, aortic bruit, cardiac hypertrophy, bronchitis and pneumonia, mitral bruit, occasional maniacal attacks with exaltation, increased arterial tension and albuminuria, apoplectiform attacks (one of which is described above with the modified Cheyne-Stokes's respiration), left hemiplegia, "cerebral" bedsore on left natis near cleft, rigidity and contraction of palsied left limbs, occasional convulsion, failure of sensibility and reflex action in left limbs, choreiform movements on right side, convulsions, pulmonary gangrene, death.

Short abstract of necropsy.—Slight rusty hæmorrhagic trace on right side of inner surface of cerebral dura mater; meningeal opacity and œdema, mainly in frontal and parietal regions. Adhesion and decortication slight, rather more on right than left side, and affecting the temporo-sphenoidal and orbital surfaces and right marginal convolution. Cortex somewhat wasted anteriorly. Large and granulated lateral ventricles. Right hemisphere one ounce less weight than left. Arteries of circle of Willis and branches atheromatous. Some spinal myelitis (diffuse). Thickening of mitral and aortic valves, slight hypertrophy of left heart, atheroma of coronary arteries and aorta, in the latter semi-transparent nodules, also. Pale, whitish, renal cortices. Old adhesions, and recent gangrene of right lung.

Case III.—O.; dementia, following chronic mania; died, aged 41 years, having suffered from chronic phthisis with intercurrent bronchitic attacks, and occasional asthma-like symptoms.

Four days before death the pulse became slow. On the day before death the patient was dull, drowsy, and apathetic, and, with dysphagia and some hiccough, there was Cheyne-Stokes's respiration. At times there was merely an ascending and descending respiratory rhythm, at others a distinct apnœal pause separated the respiratory periods. During the respiratory period of the cycle the pulse was sometimes slower, sometimes not. Temperature, 98°; pulse, varying from 78 to 96; respiration, 26. Feet and left hand œdematous; urine exalbuminous.

Necropsy.—It need only be said that there were slight general

wasting of the brain, tuberculosis and slight incipient inflammation of the convexity of the cerebral hemispheres, especially of the right. Although there was no tuberculosis or marked inflammatory effusion visible to the naked eye about the brain-base, yet the fornix, corpus callosum and other tissues surrounding the lateral ventricles were extremely softened.

Phthisis pulmonalis, especially of right lung; tuberculosis of bronchial and mesenteric glands, of intestines, and of kidneys; old perisplenic and peri-renal adhesions; small liver and heart; only a trace of aortic atheroma.

Case IV.—This, having been published in my former paper, will be noticed very briefly. General paralysis; ten weeks before death there was slight pneumonic mischief; several days afterwards, an apoplectiform seizure occurred, and, a few hours later, three severe epileptiform convulsions, beginning in the right upper limb, and followed by right hemiplegia. Next day, the right hemiplegia was much less; the right conjunctiva almost insensitive; the face and ears were flushed. Respiration 25, possessing modified Cheyne-Stokes's characters. The period of apnœa occupied one-third of the cycle; then two-thirds of it were occupied by respirations, which increased in depth, loudness, and frequency, and then diminished; but each period of respiration included, on the average, six respirations only. After a severe paroxysm of coughing there was "up and down respiratory rhythm." Muco-purulent expectoration, scattered pneumonic consolidation, numerous *râles*, especially over right lung. Temperature, 101·2°; pulse, 114, full, soft. Supported by nutritive enemata for five days. The right hemiplegia cleared up, but previous left hemiplegia returned, and persisted until death.

Series 2.—*Examples of Up and Down Respiratory Rhythm: True Respiration of Ascending and Descending Rhythm.*

Case V.—C. E.; soldier; general paralysis, depressed form; death at age of 34. Syphilitic history: markedly ataxic gait; right hemiparetic seizure, especially affecting lower limb; tænia solium; moderate apoplectiform attacks.

Nine days before death convulsions for hours, mainly of right eyelid, right side of face, and right upper limb. On later days, recurring convulsions, conjugated deviation of head and eyes towards left side. Temperature, right axilla, 99·4°; left, 99°; subsequently, left axilla ·5° higher than right. Convulsions, mainly of right face and upper limb. Right hemiplegia. Finally, left ptosis, rapid pulse, and respiration. Two days before death, patient partially unconscious; pulse 135, feeble, thready; respiration 50, at times noisy, but variable, and of a peculiar rising and falling rhythm, in fact, true "respiration of ascending and descending rhythm." Respiration mainly thoracic, crepitation over lower posterior surfaces of lungs; cheeks

flushed ; right eye was occasionally opened very widely, and staring; abdomen had gradually been becoming excurvated.

Abstract of necropsy.—Much thickening and opacity of the cerebral pia-arachnoid. Some induration of the cerebral grey cortex, and the left cerebral hemisphere the more diseased of the two.

Adhesion and decortication in left hemisphere, particularly over the posterior third of inferior surface, posterior half of internal (median) surface, external surface of temporo-sphenoidal lobe, and tip of frontal lobe. In right hemisphere, a very similar distribution, but much less extensive and severe. Yellow-white nodule in meninges on cortex of second left frontal gyrus. Fornix soft ; spinal cord softened, much chronic spinal meningitis on posterior aspect, with two embedded, flattened, firm, yellowish-white masses in the arachnoid and pia mater.

Pneumonia at bases of lungs, tuberculosis at apex of left lung. Heart 10½ ozs., its muscular substance slightly soft, valves healthy ; slight aortic atheroma; kidneys congested.

Many details of this and of the next case are given in my work on general paralysis.

Case VI.—C. C. ; soldier; general paralysis of over four years' duration ; death at stated age of 30 ; early and marked dementia. Towards the last there were pulmonary phthisis, right pleuritic effusion, cough, profuse sweating, teeth-grinding. Later on, left pleurisy with effusion and lobular pneumonia ; recurring vomiting, fever, semi-coma, subsultus, marked tremulousness of movements. During the night succeeding this he took fluid food, but at seven next morning was comatose and unable to swallow. At 9.30 a.m. pulse 90, full, quick, compressible ; respiration varying from 44 to 54 per minute, irregular in rhythm, depth, and frequency. Thus, perhaps, at first there would be a few audible respirations with guttural sounds ; then came a few quiet, easy, noiseless, and less frequent respirations, during which the heart could be heard distinctly, and its action was then of moderate strength, but its sounds were still feeble and short. Surface of body moist, clammy, flabby, relaxed. Temp., right axilla, 95·2° ; left, below 95°. Conjunctivæ suffused, watery, insensitive to touch. Pupils equal, dilated, immobile ; slight ocular oscillation. Limbs very flaccid. No distortion of face. Saliva ran from either side of the mouth that was the lower. Slight facial flush. Profound coma. Later in day, mucous bubbling in throat; pulse 96, weaker; respiration 36, and, as before, of irregular rhythm ; temp. below 95° ; left pupil rather the larger ; head and eyes somewhat to left. All the limbs remained equally flaccid, relaxed, motionless, until death. Inability to swallow. Skin cool, moist.

Abstract of necropsy.—Meningeal opacity, thickening and œdema. Cerebral atrophy, softening and anæmia. Adhesion and decortication widely spread, affecting both the superior, external, internal, and inferior surfaces ; particularly on the posterior part of the frontal, and

on the parietal convexity. These changes fairly symmetrical in the two cerebral hemispheres. Fornix much softened; basal ganglia atrophied, softened, pallid. Pons Varolii and medulla oblongata softened and pale; the meninges over the medulla oblongata thickened and somewhat adherent to it.

Tubercular spinal meningitis, and softening and pallor of cord.

Heart small, slightly too friable. Only a few points of aortic atheroma.

Left lung, adhesions, cicatrices, a vomica, caseation, recent pleurisy.

Right lung, adhesions, caseous masses, tubercular granulations.

Possibly some of the symptoms noted above were due to extension of tuberculosis, and inflammatory action to the meninges of the pons Varolii and medulla oblongata, or even to the brain-base or ventricles, and not yet perceptible to the naked eye.

Case VII.—F. S.; chronic delusions of persecution with hallucinations; died, at age of 40, of pneumonia of eight days' duration, supervening on phthisis pulmonalis.

During the final illness the dyspnœa was at times paroxysmally increased, and the respiration of an ascending and descending rhythm, but without a period of apnœal pause. On the first day, pulse 106, respiration 44; temperature, left axilla, 102·3°; second day, pulse 86, respiration varying from 32 to 42, temperature 98·4°; third day, pulse 84, respiration varying from 26 to 48; fourth day, pulse 92-100, respiration 31; both pulse and respiration rising on last days of life.

Eyelids and face œdematous, slight ascites; diarrhœa, greenish-yellow stools containing partially unmixed blood; pneumonic sputa.

At the *necropsy* there were, briefly: slight wasting of brain, slight increase of pericardial fluid, segments of aortic semi-lunar valves much thickened and deformed, and two of them coherent, slight atheroma of coronary arteries. Heart-muscle too friable, 8¼ozs. Phthisis, pneumonia, and bronchitis, especially on the right side, where also the bronchial glands were enormously enlarged. Spleen soft, 7¾ozs. Kidneys slightly granular. Inflamed vascular ulcers in small intestine, some of them obviously tubercular.

Case VIII.—J. S.; before admission latent pulmonary tuberculosis, and older changes. These were followed by meningeal tuberculosis, and incipient inflammation. He became very stupid, somewhat deaf, gave no reply, or answered incoherently, took food badly, scarcely spoke. Respiration became difficult, noisy, and irregular; slow pulse; dysphagia; attempts to swallow gave rise to coughing. Patient restless and fidgety. Congestion of lungs and pneumonia advanced rapidly; the cheeks flapped in respiration, the tongue could not be protruded; the jaws closed tightly when attempts were made to open them; the restlessness; writhing, fingering, pulling movements, and resistance to any form of passive movement or of handling; the

tremulous movements and muttering, and incoherent ejaculations were followed by gradually deepening stupor and coma. The respiration was of the form above-termed "respiration of up and down rhythm," and varied on last two days from 56 to 62; pulse from 90 to 108, and feeble; temp., 100·4°; dry tongue and lips. There appeared to be more or less palsy of seventh and ninth cranial nerves, with retained power of motor branch of fifth.

At the *necropsy*, amongst other morbid parts, there was tuberculosis (with incipient inflammation) of the cerebral pia; especially over the anterior two-thirds of the upper aspect of the cerebral convexity. Some tubercles also existed at the base of the brain, about the interpeduncular space, and on the back part of the orbital surface. The gyri at the upper aspect were somewhat closely packed; the pia contained a little serum; the meninges were congested; the fluid at base was increased. Flabby heart. Slight ordinary cystic change of kidneys.

OCCASIONAL NOTES OF THE QUARTER.

*Lord Bramwell on Crime and Insanity.**

Lord Bramwell deserves our thanks for enunciating his views upon crime and insanity in a way which even the dull medical intellect cannot fail to understand. These views may conveniently be thrown into the form of a creed, thus:—

I believe that medical doctors make furious attacks on the lawyers of a very unbecoming character.

I believe that as it takes two to make a quarrel, and as, happily, the lawyers are not inclined to join in it, a terrible quarrel between the two professions is prevented.

I believe that the law ought to punish all that it threatens—when convicted.

I believe that the law ought to threaten all who would be influenced by threats.

I believe that this is the same thing as saying that all such must understand the law's threats.

I believe that this is the law of the land, and is right to demonstration.

I believe my argument goes to the length of punishing insane people more severely than the sane, cruel as it may seem.

I believe that medical men, especially those who have ex-

* "Nineteenth Century," December, 1885.

perience in dealing with insane persons, have no special right to give opinions when a question of insanity is raised; and I wholly deny that they are experts, or that this is a question for experts.

I believe that one man is just as competent as another, so long as he knows the facts, to judge whether an individual is insane or not.

Lord Bramwell does not inform his readers why, by now coming forward in the lists, he has made a terrible quarrel no longer impossible. He says that the lawyers only smile at the attacks made upon them. This is hardly correct in view of Sir James Stephen's admirable chapter on this very question in his work on Criminal Law, and in which he takes great pains to parry these attacks. Moreover, Lord Bramwell himself has not hesitated to do something more than smile when in the character of judge he has spoken of the opinions held by medical men.

Thus at the trial of a case in which three medical men, versed in mental disorders, gave evidence, Baron Bramwell contemptuously exclaimed in reference to them :—

"Experts in madness! Mad doctors! Gentlemen, I will read you the evidence of these medical witnesses—these 'experts in madness,' and if you can make sane evidence out of what they say, do so; but I confess it's more than I do!"

The complaint is made that the doctors are mistaken in supposing that the lawyers are in any way responsible for the goodness or badness of the law relating to crime and insanity. Doctors are not so ignorant as to suppose that the lawyers directly and alone make Acts of Parliament, but in this instance they are justified in considering the lawyers largely responsible for the present law regarding criminal responsibility. We find Sir James Stephen implying this when he says, "It is perfectly true that the law relating to insanity, like the definitions of murder and theft, is '*judge-made*' law, that is to say, it consists of judicial decisions." Further, "although some of the terms in which the law is expressed are well settled, their meaning and the manner in which they ought to be applied to certain combinations of facts are not settled at all." The lawyers are the persons to perform the latter all-important function, and are fairly subject to medical criticism for the manner in which they settle what the law has left unsettled. But still more to the point is the fact that every judgment delivered since 1843 has been founded upon the authority of the answers given by the judges to questions put

to them by the House of Lords in consequence of McNaghten's case (Sir James Stephen). Whether this authority ought to have been taken as binding may be a matter of doubt, but as, "until some more binding authority is provided, no judge can be expected to do otherwise than follow it," the doctors can hardly be blamed or smiled at with reason if they regard the lawyers, and especially the judges, as largely responsible for the goodness or badness of the present law of criminal responsibility. Doctors do not blame Baron Bramwell or any of his brethren for following this authority of the judges, but they endeavour to convince them that they err in thinking it correct and just. If, however, they should criticise any of the judges for their directions to the jury in a case of murder by an alleged lunatic, they would be only doing what Baron Bramwell himself does when he blames "the unwise mercy of some judges" for their directions. It is equally open to medical men to speak of unmerciful judges, and we do not see that Lord Bramwell can consistently complain of it.

We pass on to the next article of Lord Bramwell's creed—that the law ought to punish all who would be influenced by threats. If this means *effectually* influenced or controlled, we offer no objection to it, and had he been content to stop here, his position would have been mainly open to the criticism that it is not synonymous with the legal test so warmly approved of by his lordship, and expressed in another form when he maintains that if the accused *understands* the threat of the law he is responsible. In his charges to juries, Baron Bramwell has always laid down the law in the boldest, simplest manner in the latter and not the former sense. Thus in the trial of Dove, to which he refers in his article, he restricted himself to the following statement of the law in his summing up :—

"It was for the jury to say was the prisoner conscious that the act was one which he ought not to have committed, that it was contrary to the law of the land; and was he possessed of sufficient reason to know that the act he did was wrong."

This is a very different thing from saying that if a man would be prevented doing a certain crime by the threat of the legal consequences, he is responsible. It is surely one thing to understand the law's threats, and another to be influenced by them. In this lies the gist of the dispute between the lawyers and the doctors. We agree with Lord Bramwell that "it is hard to say why the lawyers, generally supposed sharp enough, should go so wrong on this particular subject." Or if we must say why, we might venture to suppose it is due to the fact

that the lawyers, however sharp, are not necessarily acquainted with the character of the insane. Lord Bramwell simply confounds, as most lawyers persist in doing, the power of controlling certain actions with the knowledge that such actions are regarded as criminal. Granting that, among those admitted to be insane and in confinement, threats have, as maintained by Lord Bramwell, some, although a qualified deterrent influence, the fact proves too much for his purpose, for these insane persons ought to be punished as criminals, although in asylums. We mean that it proves too much for the humanity and common sense of Englishmen in general, for it does not prove too much for the Baron, seeing that he holds that "the insane man having less mental control than the sane, there is the more necessity for the law stepping in to help him and deter him from doing mischief." An illustration follows which, as it is no illustration at all, painfully disappoints anyone who desires to believe in the logical character of a judge's mental constitution. A man has two children, A. and B. A. is a good boy; B. is vicious. What, asks the Baron, would be thought if the father said to A.: "You are a good boy; if you do wrong while I am away, I will punish you. B., you are a bad boy. It is of no or little use to threaten you, so I shall not, and of course I shall not punish you." This, we are told, would be parallel to allowing a man to go unpunished whose insanity made him less able to resist committing a crime. The doctors may be very poor lawyers, they may excite the contemptuous smile of a learned judge, but at their worst they would hardly be guilty of such a transparent *non sequitur* as this. Vice and a mental affection are assumed to be synonymous. To prove how absurd it would be not to punish a lunatic, the case of a bad son, whom everyone would think ought to be corrected, is brought forward. Perhaps the doctors, who would be too polite to smile, may be allowed to indulge in wonder. Those familiar with asylums for the insane may also be allowed to do the same when they learn from Lord Bramwell that "mad people are managed in asylums by the hope of some good or fear of some harm, according to their conduct" —a description which possesses just enough superficial truth to make it tell, but enough profound error to make it a caricature of the real system of treatment pursued in every good asylum for the insane.

It is, as we have seen, an article of Lord Bramwell's creed that a lawyer, or, indeed, any person, is competent to diagnose a case of insanity. We are sorry that he has so poor an

opinion of those who are familiar with the insane. Most people will still, we think, attach more weight to such an opinion in regard to symptoms which may resemble those of the insane, but be really the effect of a drug, or be simulated, than to that of an ordinary person, or even a judge. We strongly suspect that Lord Bramwell would practically ignore his own creed were he desirous of obtaining a trustworthy opinion in regard to suspicious symptoms of mental disorder arising in a personal friend or relative. Lord Bramwell would leave his readers to suppose that differences of opinion as to the tests of criminal responsibility only exist between the two professions of law and medicine. This, however, is not the case, and we cannot better exhibit the wide difference of sentiment between Lord Bramwell and, for instance, Sir James Stephen, than by stating that the latter believes that medical men are sometimes treated in courts of justice, even by judges, in a manner which they are entitled to resent; that although the principle which the legal authorities have laid down will be found, when properly understood and applied, to cover every case which ought to be covered by it, the terms in which it is expressed are too narrow when taken in their most obvious and literal sense; in short that the law of England on legal responsibility is insufficiently expressed; that, for example, Hadfield,* when he fired at George III., knew clearly the nature of the act; that he also knew its quality (high treason); moreover, that he knew it was wrong (*i.e.*, against the law), and that, therefore, he ought to have been convicted if the answers of the judges to the House of Lords are sufficiently comprehensive, which would be a monstrous consequence. And lastly, that this law, if interpreted in a wide sense, may be made to mean that the mental elements of responsibility are not only the knowledge that an act is wrong, but the power to abstain from doing it. With this the reader may contrast the direction to the jury by Baron Bramwell in the trial of Dove. As Sir James Stephen attempted to introduce into the Draft Code of 1879 terms which would render his construction of the legal test of responsibility free from doubt, and as the Commission on the Code considered that this was not a "practical or safe" proceeding, we have high authority for concluding that the usual and narrow construction of the test is, or will be, deemed the correct one. Yet it is this test so understood which would,

* Lord Bramwell, as we have seen, holds that if a criminal understands the law's threat he ought to be punished. This Hadfield certainly did, and no doubt Lord Bramwell holds that he ought to have been sentenced to death.

according to Sir James, lead to "a monstrous consequence." Such being the case, medical doctors may be thought to have some justification for even the "furious attacks" directed, as Lord Bramwell complains, against admittedly judge-made law.

What the late Lord Chief Justice (Cockburn) thought of the existing law of criminal responsibility is well known. So far from thinking it "right to demonstration," as Lord Bramwell maintains, he held that it was insufficient because "it is only when mental disease produces incapacity to distinguish between right and wrong that immunity from the penal consequences of crime is admitted," and he strongly approved of Russell Gurney's Bill of 1874, in which "a new element, the absence of the power of self-control, was introduced." Lord Cockburn said he had been always strongly of opinion that a person might be quite aware he was about to do wrong, yet the power of self-control be destroyed or suspended by mental disease. As this is the position uniformly taken by mental physicians, it is not very likely that they will be converted to Lord Bramwell's belief in the perfection of the present tests of criminal responsibility.

In conclusion we cannot but express our regret that after Sir James Stephen has so recently held out the olive branch of peace to the medical profession, a counter-blast should come from his late brother on the bench calculated to destroy the good effect produced. We hailed with sincere pleasure the spirit which pervaded the "Criminal Law of England." Sir James threw a bridge across the gulf separating the two professions on the question under discussion. Lord Bramwell has ruthlessly destroyed it, or, at least, has done his best to do so.

A Court of Lunacy.

Lord Bramwell's article in the "Nineteenth Century" on criminal responsibility has been succeeded in the issue for February by another, entitled "A Court of Lunacy." This essay, written by the Right Hon. Lord de Mauley, consists mainly of a number of propositions, dogmatic assertions, and crudities, which at once excite astonishment and invite criticism. Had the article been anonymous, or appeared in a journal of less distinction, it might have been passed over in silence. We are quite at a loss to know what claim the noble author has to be heard on a subject requiring, as he himself allows, special knowledge and ability. "The signature of a

magistrate, the countersign of a physician, and the man disappears"—such is the curt description of the security of the liberty of the person, in order to show how flimsy it is and how dangerous is the laxity of our lunacy laws. No reference is made to the double certificates required for private cases—those only in which there is any serious fear of improper "incarceration"—nor is there any adequate recognition of the checks upon the interested detention of patients in asylums when they have been too hastily admitted.

"Lunacy Commissioners may act," it is allowed, "as a check upon the abuse of imprisonment; but the fact remains that a man may be immured within the precincts of an asylum surrounded by horrors which may nourish the disease which it is the object to avert." Such a statement, followed by a protest against private asylums, is in curious contradiction to the admission that the "inspection of Visitors forbids the suspicion of the existence of cruelty or neglect." Yet they are the "abodes of misery," and the author can discover "nothing in them to relieve the monotony of existence, nothing to enliven the dull routine of daily life." He finds "a mass of human misery jumbled together without order, regularity, or system." There are the raving maniac, the harmless imbecile, and the cretin! Lord de Mauley is difficult to please, for "private asylums are too large for minute inspection, too small for the general welfare of their inmates."

We do not understand what the writer means when he says that "private asylums should be looked upon as refuges for temporary derangement of the intellect, not as sanatoriums for the cure of the disease." Surely temporary derangement, if treated in a private asylum at all, is so treated with a view to its cure. The writer turns with relief from the "dead-alive" aspect of the private "madhouse" to Caterham Asylum or Hanwell, where he finds in pleasing contrast an air of vitality. "No compulsion is required, but a moral restraint is exercised in withdrawing the mind from the contemplation of its woes and fixing it upon industrial pursuits."

Then follow a series of statements, mostly platitudes, of which it may be emphatically said that those which are true are not new, and those which are new are not true.

Of heredity in regard to mental affections the author says: "We disbelieve in it." The following is his etiology:—"Were the evil traced to its source, it would be discovered to spring from a defective education or moral and physical ill-treatment." Comment is really unnecessary.

Here again is a high-sounding sentence, but one which betrays a singular want of acquaintance with the subject on which the noble lord writes:—"A national disease demands a national remedy; *as the malady originates in over-pressure of the brain to supply our national wants*, it is a public duty to restore to society those members who have fallen out of its ranks through the cares and anxieties of life. . . . The remedy will not be discovered in the seclusion of private asylums."

Whoever thought that it would? Where, then, is the remedy? The author with justice allows that the mysteries of insanity must be elucidated by science, and he allows that it requires the highest order of talent to discover the agency which controls the intellect. He relies with some degree of confidence upon the genius which has modified the ailments of our frame; but then we are assured that while many persons have risen to eminence by the successful treatment of mental disease, their efforts have been spasmodic and the results uncertain. Unhappy beings have been made the subject of haphazard experiments, and been handed over to the care of dependents who have treated them as outcasts of society. It is singular to find Lord de Mauley, after expressing his admiration of the large asylums of Caterham and Hanwell, representing as among the "first and foremost" causes which militate against success "the lunatic asylums, those huge excrescences on the soil, offensive to the eye, revolting to the senses; their long corridors, their bolts and bars, the high walls which enclose them, convey the impression of the discomfort of a workhouse, the confinement of a prison. They cannot fail to create an irritation of the feelings destructive to the repose which it is the object to secure." (!)

And yet it is these huge excrescences, so revolting to the senses, which, inasmuch as they supply material for study, are, Lord de Mauley allows, to be the means by which our special department of medicine is eventually "to elucidate the character of an occult insidious disease."

We regret to have to speak so critically of this essay; the more so because one intention of the writer appears to be the praiseworthy one of controverting the mischievous paradox of Lord Bramwell in regard to the equal value of lay and medical opinions in lunacy. Thus Lord de Mauley says—and we are glad to agree with him on at least one point—"It is out of the question for any person who has not made mental pathology an object of study to pronounce a trustworthy opinion upon so

complex a subject as insanity." The feeble manner, however, in which the reply—if reply it can be called—is made, will not serve the cause we have at heart, mixed, as it is, with so much that is pointless, unfounded, and contradictory. The article is altogether disappointing. The greater part of it has little or nothing to do with its title. In half a page the writer advocates the establishment of a "Court of Lunacy," over which a judge shall preside who has special knowledge of insanity. Here the trial of an alleged lunatic is to take place. The remarks which follow in the essay have reference to cases in which the management of property is involved, and it is not clear whether this proposal extends to criminals. We are assured that if this scheme were carried out, a large number of patients would no longer be "imprisoned" in asylums, but would be allowed personal liberty while their property was placed in Chancery. Lord de Mauley is scarcely aware, we suspect, of the large amount of liberty already enjoyed by many Chancery lunatics. He proposes that patients should be located in cottages in the vicinity of an asylum. Here again, he is hardly aware, we apprehend, of the extent to which this system is carried out. With regard to the "Court of Lunacy," we do not believe that we shall ever see a judge appointed, specially educated in medical psychology—in fact, in order to be so he must become a physician, and we suppose that a Medical Court is not what the author intends to propose for a remedy. While it is highly desirable that all judges should be better informed than they are as to the character of the insane, that which determines the verdict must mainly be the judgment formed by skilled physicians after patient examination and with special opportunities afforded for testing a prisoner's insanity. Were this done in a systematic manner by competent men, we have no doubt that juries would gladly be guided by the medical evidence given. However good, therefore, may be the intentions of the noble writer of "A Court of Lunacy," we are afraid that they will lead to no practical result, and suspect that Lord Bramwell and ourselves will in this particular be of the same mind.

The Lunacy Bill.

As was anticipated, the Lunacy Bill introduced by the Lord Chancellor into the House of Lords is very similar to that which his predecessor, Lord Selborne, had prepared last year. Baron Herschell spoke with the ability and lucidity which have always characterised Sir Farrar Herschell at the bar. It has proved a great advantage to the new Lord Chancellor, and to those concerned in proposing amendments to the Bill, that he sat upon the Select Lunacy Committee of the House of Commons in 1877, and took an active interest in its proceedings. On the occasion of the second reading of the Bill the Lord Chancellor began his speech by stating that none would deny the necessity of legislation on lunacy, inasmuch as the public mind was more and more convinced that it was far too easy to "incarcerate" any person as a lunatic, and that the safeguards were quite too few. He allowed that it was highly creditable to the medical profession that there had been so little abuse of the powers granted them, and he gave credit to the Lunacy Commissioners for these abuses not being greater. The interposition of a County Court Judge, a Stipendiary Magistrate, or a Justice of the Peace, chosen by Quarter Sessions, is the chief means by which a proper safeguard may be obtained. The petition for confinement in an asylum must be presented, if possible, by a relative of the alleged lunatic. A report of each lunatic under detention must be forwarded at the end of the three years for which the order will last, and if not satisfactory the patient will be discharged. Superintendents of asylums are to forward unopened all letters written by the patients to public officials. No person not actually a pauper is to be confined in a pauper asylum. The Lord Chancellor laid it down as an axiom that "so long as there are institutions the keepers of which have a pecuniary interest in the detention of patients in them, there can be no absolute security against improper proceedings." Private asylums are not to be abolished, but no new licenses are to be granted, and no increase will be allowed in the number of lunatics who can be kept under any existing licenses. "This," observed the Lord Chancellor, "will produce a gradual cessation of the number of licensed houses, and thus prepare the way for public asylums." These were the main points referred to by Baron Herschell as characterizing the objects the framers of the new Lunacy Bill have in view.

Having in a former number of this Journal stated our opinions in regard to the previous Lunacy Bill, it is unnecessary to comment upon the provisions of the new one, so far as they are identical. The Parliamentary Committee of the Association took the earliest opportunity of considering the proper course to pursue in order to miminise the very objectionable clauses in the Bill, and to introduce other clauses in the interests of the superintendents of asylums, whether public or private, and they communicated their views as quickly as possible to the Lord Chancellor.

It may be observed that in the debate on the second reading, the Earl of Milltown expressed his disappointment that the Bill was not of a more drastic character as regards private asylums, and also urged an increase in the number of the Commissioners. Lord Coleridge was in favour of the entire suppression of licensed houses, and asserted that he had seen, both as counsel and as a judge, many cases in which it had been manifest that persons perfectly unfit to be detained in a lunatic asylum had been kept there because it was to the interest of the keepers to do so. It was surely unnecessary to remark that it had come to his knowledge that the proprietors of private asylums are not regarded in an altogether favourable light by other members of the medical profession. A certain suspicion, he hinted, attached to these unfortunate men. The general tone of Lord Ashbourne's speech was one which likewise indicated singular misgivings as to the mode in which patients are treated by those under whose charge they are placed. With scarcely any exception, indeed, the current of sentiment was anti-medical, although the Lord Chancellor paid a high compliment to the profession in general, and even Lord Coleridge expressed the opinion that no examination of a supposed lunatic before a magistrate should take place without the assistance of a medical man. It might have almost been supposed that we were living at the time when little had been done to increase the comfort and prevent the improper detention of those confined in asylums, and we regret to observe the continual use by the peers during this debate of the terms "incarceration" and the "keepers" of private asylums in an obnoxious sense.

We have said that the present resembles the former Bill. There are, however, several extremely important additions, and to some of these the Lord Chancellor did not refer in his speech. Clause 26 enacts that "After the

passing of this Act, except in the case of lunatics so found by inquisition, no order shall be made for the reception of a lunatic as a single patient." Granting that this is the logical conclusion of the clause which aims at the gradual extinction of private asylums, it is none the less a very objectionable proposal, and we trust that it will never become law. As we write (March 8th), the Parliamentary Committee of the Association has asked permission to form a deputation to the Lord Chancellor, in order to urge their objections against this as well as other clauses, the passing of which would seriously affect the interests of patients and their friends, not to mention those of a large number of medical men. There are, we contend, special advantages connected with the placing of many cases of unsound mind in the houses of medical men as single patients. One of these obviously is the avoidance of the stigma which still unfortunately clings to a residence in either a public or private asylum. Another advantage is the family treatment of a first attack, and one perhaps of short duration, in which asylum associations may be actually injurious, and give unnecessary pain to the feelings of the patient. A third reason for permitting single patients is the fact that in many instances the relatives are willing to remove the lunatic from home, but will not listen to the advice given by the medical attendant or the mental physician to send the patient to a lunatic asylum. Should this objectionable clause be passed, the consequence will be that those suffering from attacks of insanity will be kept at home far too long, or they will be removed to asylums out of England.

Another important clause which appears for the first time in this Act, confers upon the Lord Chancellor the power to amalgamate the Lunacy Departments, namely, the office of the Masters in Lunacy, of the Chancery Visitors, and of the Commissioners in Lunacy. He may also give such directions as he thinks fit for the reconstruction of a Lunacy Board. This certainly is a power which, if exercised, will involve a great change in the Central Lunacy Department.

The new clauses, then, which propose these changes in the Lunacy Board, single patients, and private asylums, are, it must be allowed, of a serious character, although so few in number. Proprietors of the latter justly complain.

PART II.—REVIEWS.

Thirty-fourth Report of the Inspectors of Irish Lunatic Asylums.

This Report tends to the conclusion that the condition of the insane has differed from that of the sane inhabitants of that unhappy island, in that they have enjoyed a year of comparative repose. On December the 31st, 1884, the total number of registered lunatics under treatment amounted to 14,279, thus located :—

In district asylums	9,687
In Criminal Asylum, Dundrum...	178
In private asylums and hospitals	639
In workhouses	3,775

The difference in numbers between the two sexes is said to be very small. In the criminal and district asylums the males exceed the females by about 900, while the females are more numerous in private asylums and workhouses. A marked difference in this respect exists between England and Ireland, as in the former country females are in excess by 15 per cent.

Attention has been frequently called to the large number of individuals of unsound mind, or whose sanity is doubtful, wandering about in Ireland who are not under public supervision. To this class the Inspectors evidently refer in the following sentence :—

"Independent, however, of the registered insane as just adverted to, there are vagrants on the borderland between reason and insanity, under the denomination of imbeciles, and for the most part in rural districts ; while in populous communities, adjoining towns and cities, no small number of persons, particularly females, are to be found so utterly depraved and incapable of moral feeling, as to be deemed unaccountable for their conduct, and who, if relegated to asylums, evincing after some time no symptoms of mental disease, would necessarily be discharged."

Whether these individuals are included in the statistics of insane persons in Ireland is left doubtful.

Setting down the population of Ireland at five millions, and dealing with recognised statistical facts, it *may be assumed* that about one individual in every 350 is more or less mentally affected, and that actual lunatics, or those who at one period of life possessed clear reasoning powers, may be approximately set

down at one in every 450, the difference for the most part being constituted of epileptics, idiots, and congenital imbeciles.

On turning to the statistics, no table is to be found bearing out these figures, such as given in the English and Scotch reports, showing the proportion per 10,000 of lunatics to the population.

In a country such as Ireland, with all the appliances of the Local Government Board and Constabulary for taking statistics, no difficulty should exist in obtaining accurate returns of the insane wandering at large. Of this neglected condition there can be no doubt, and of the benefit which would have resulted by the introduction of Mr. Lytton's Bill, so far, at least, as to extend to Ireland the clauses of Act 16 & 17 Vict., c. 97, referring to the protection of lunatics not under care.

At the close of 1884 the number of insane under treatment in Irish district asylums amounted, as we have seen, to 9,687. It would appear, however, that no adequate accommodation existed for that number, as though in some asylums a few vacancies existed, others were very much overcrowded. The struggle to obtain sufficient accommodation for the insane in Ireland seems to be a never-ending one. Year after year the Inspectors suggest the necessity of the extension of the original buildings of district asylums to meet the inevitable increasing influx of the insane, and have uniformly endeavoured to obviate deficiencies with a view of adding to the comfort, occupation, and well-being of the inmates, by the addition of simple structural additions carried out without any attempt at architectural display, or giving any excuse for the charge of lavish outlay at the expense of the ratepayers. But their difficulties appear insurmountable from the variety of opinion exhibited on all sides on the subject.

On January the 1st, 1884, the twenty-two district asylums contained 5,196 males and 4,346 females; total, 9,542.

During the year the admissions amounted to 1,519 males and 1,217 females, or 2,736 patients, raising the total during the year to 12,278. Of these 1,151, namely, 633 males and 515 females, were discharged cured, 462 improved, and 111 not improved—the deaths amounted to 474 men and 391 women; total 865. Of these six were from suicide, in which cases coroner's inquests were held, but no detailed history is given of these inquiries. Incredible as it may seem, no mention is made of any post-mortem having been held in any asylum in Ireland, or of any pathological investigation on any subject. Two patients made good their escape. There thus remained under

treatment in district asylums at the end of the year 1884, 9,687 patients, being 145 more than at the commencement; the increase for the year 1883 amounted to 271, and for 1882 to 293, so that no evidence exists from the statistics of these institutions of any increase of insanity amongst the population, the annual accumulation of the old and chronic becoming smaller year by year.

The recoveries in district asylums amounted to 41 per cent., if calculated on admissions, the practice generally adopted in public reports at home and abroad. The Inspectors invariably point out the more legitimate basis is on the daily average during the year—this would amount to 9½ per cent.—so that so far as recovery is concerned, about a tenth of those under treatment in district asylums during the year were benefited. The year's total expenditure in district asylums amounted to £221,695 17s. 9d.

The annual cost per head for the year amounted to £23 0s. 11d., being a reduction of 8s. 1d. as compared with the previous year. This amount would include the cost of repairs and alterations of buildings, and many other items, which would not in England be included in the maintenance account. We cannot help repeating the suggestion so often made in this Journal of the importance of assimilating in some degree the statistics on expenditure as well as on other subjects to the tables published in other parts of the kingdom, and would draw attention to the useful tables introduced in the Scotch Commissioners' Report of this year (page 43), which, if brought into general use, would do much to simplify the comparison of the expenditure on our insane poor in different parts of the kingdom. But we are like one crying in the wilderness; our good advice is persistently ignored.

At the beginning of the present year the inhabitants of England and Wales amounted to 27,500,000, and the number of the insane to 79,700 patients. Similarly in Ireland, with a population of 5,000,000, there were 14,288 registered insane. So far, showing that while there was one mentally affected in every 345 resident in England, the ratio of Ireland stood at about one to 348.

As to the condition of the 9,687 patients in the district asylums with reference to curability, as many as 2,288 are returned as curable. This is considered to be a most favourable return in comparison with the proportion of curable to incurable in England, which is little over 6 per cent.

The term, however, "possibly curable," is undoubtedly

vague and expansive; opinions might differ on the progress of any given number of cases. If the words are to mean improvement, as the Inspectors would suggest, few cases are so hopeless as not to allow some change for the better so long as life exists. The object, however, of the Inspectors in making the comparison is to meet

"The prevalent impression that the establishment and current maintenance of lunatic asylums are, generally speaking, attended with uncalled-for expenditure, the end, and principally so far as cures are concerned, not as it were justifying the means, while the outlay of them steadily increases. No doubt the cost of these institutions, both in their erection and annual support, is very large, but it should be remembered that it is for a specific and unavoidable purpose, not only as regards the inmates whom they harbour, but society at large. Insanity, however inexplicable the causes, bears in these islands a notable proportion, as above observed, to their respective inhabitants. That a larger provision should gradually become requisite for accommodating the insane is mainly attributable to the fact that, with a more judicious treatment and a generous regard to domestic comforts, in return for deprived liberty, their longevity has, even within the present generation, been much increased; hence, and in the great proportion of cases, with the absolute incurability of mental disease in itself, and its frequent recurrence after a temporary recovery, an explanation is afforded why asylums should be congested with chronic cases, even to 95 per cent. in one of the wealthiest, most populous, and enlightened counties of England, where, out of 5,890 patients, 263 only are accounted curable."

The explanation of this, given by the English Commissioners, should have been added, which was that the four Lancashire Asylums were flooded with chronic and incurable patients from certain Union Workhouses in that county.

At the end of the year 1884, 178 patients were confined in the Dundrum Criminal Asylum, the number being 18 males above and 15 females below the accommodation. This has called for an expression of opinion on the part of the Inspectors to the Executive on the necessity of structural enlargement for 30 beds, increased day-room and dining-room accommodation, with suitable workshops.

Some of these improvements are being carried out.

During the past year 26 males and three females, charged with various offences, were admitted, the total under treatment amounting to 201. Of these, 15 were discharged, three men escaped, and four men and one female died, leaving, at the end of the year 1884, 146 males and 32 females; total, 178—being six more that at its commencement. The number of escapes

appears, according to the Inspectors, to have been unprecedented, amounting to three effectual and three temporary departures without leave, causing them much uneasiness, as responsible to a great degree for the management of the institution. They therefore express regret that the character which the Dundrum Asylum had evenly maintained for 36 years should be, even passingly, affected, and that recommendations conveyed in official reports from time to time had not been adopted.

These recommendations appear to have referred to the paucity of male attendants and the unsafe condition of the boundary wall.

To this subject the Resident Physician refers in his report, and states that the facilities which have led to these escapes are as follows :—

1st. Lowness of the boundary walls.

2nd. Insufficiency of staff.

3rd. Insufficiency of punishment of the attendants when escapes have been traceable to negligence on their part.

The insufficiency of staff would appear to be so valid a reason for any number of escapes that the insufficiency of punishment would not follow as a natural sequence. Does the Resident Physician propose to make up for the deficiency of numbers of his attendants by goading them on to a state of restless activity ?

The proportion of attendants to patients at Broadmoor is stated to be about one to six ; at the insane prison at Perth, in Scotland, one to five and a quarter. In Dundrum, on the other hand, the proportion is one to twelve patients. The attention of the Government having been directed to these facts, decisive steps have been taken to remedy them. Until then the temporary employment of twelve members of the police, resident on the premises, has been authorised for protective objects.

The expenditure amounted to £6,644, and the average cost for each patient to £36 7s. 1d., exclusive of fuel, light, and washing.

According to the official returns of the Local Government Board, 3,775 persons labouring under some form of mental disease were to be found in Union Workhouses in Ireland on the 1st January, 1885. Of these, 1,518 were males and 2,257 females, the greater number of whom were epileptics and imbeciles. These individuals are described as "indigenous" to poorhouses, having been located in them in early

life, when abandoned and in a state of destitution, comparatively few having been transferred from district asylums; in fact, according to the Inspectors, Boards of Guardians are for the most part strongly opposed to the detention of insane patients in workhouses, although aware that if *suitable provision* were made for their treatment in them the benefits derivable from district asylums would be largely increased and their overcrowding by hopeless cases obviated, and the admission of acute and curable ones facilitated at the proper time, genuine advantages accrue, and a true economy secured by "an early recognition of the advisable." With reference to this we can only say that we are very much inclined to agree with the Guardians. The question might be asked, What is the "*suitable provision*" necessary for the treatment of lunatics considered suitable for care in the Workhouse? Has it been provided in the Irish Workhouses? Only to those adjacent to large towns is there even a paid attendant to take charge of these helpless imbeciles. Generally they are in charge of aged paupers, with no opportunity for exercise in the open air or means of employment, without the appliances for washing or cleanliness, constantly sitting or lying on stone floors, oftentimes without shoes and stockings. It is only to be hoped that public opinion will in time insist that either the insane shall be removed to separate institutions for their care or that proper provision shall be supplied for their safe keeping under paid officials. That a number of aged inmates still exist in what is denominated the idiot cell of workhouses affords no proof that they are treated with proper care; it merely shows the tenacity of human life under disadvantageous circumstances.

The number of private asylums in Ireland amounts now to 22, having been increased by one, of which four are in part supported by private donations, and would correspond with the *Registered Hospitals* of England, viz., Swift's, Bloomfield (Society of Friends), the Stewart Institute, and the Hospice of St. Vincent de Paul, conducted by a community of ladies attached to a religious order of the same name.

The number of patients in these institutions has changed little for the last six years. At the beginning of last year there were 227 males and 389 females, making a total of 636 under treatment.

During the year 162 were admitted, making the number up to 798. Of these, 73 were discharged recovered, 18 improved, and 21 incurable, leaving 639 on December 31, 1884. The proportion of recoveries is stated to be equal to those in

public asylums for the same time. The mortality amounted to 46, with one death from suicide and another from accident.

With the management of licensed houses the Inspectors are satisfied. As no magisterial visitors for private asylums exist in Ireland, the responsibility of their management falls more on them, and entails more frequent inspection, so as to guard against

> "Undue detention and contingent irregularities. In a social point of view many of the institutions in question are maintained in a highly satisfactory manner, and in a mode becoming the antecedents of the afflicted themselves; others are by no means so well circumstanced, particularly where stipends are not only small, but, as we are informed, irregularly paid."

The meaning of "the social point of view" of a private asylum is not quite plain. Does it mean that the patients dress for dinner and are visited by the best society of the neighbourhood, or that the dinner is properly served and is of substantial quality?

The depressed state of the country has told on the owners of licensed houses as well as on the rest of the world, as shown by the number of transfers from private to pauper asylums.

The Inspectors conclude their report with the highly satisfactory statement that no charge of cruelty or neglect has been made, and that within the last 20 years one action only was brought into Court for illegal detention, and that in this case a verdict was given in favour of the defendant. This is certainly comforting to the owners of Irish licensed houses, and will doubtless be sufficient compensation for their finding some difficulty in getting paid what is due to them.

The only alteration in the statistics appears to be the addition of two tables showing the social condition of those discharged and died. No practical attempt has been made to assimilate any of the old tables to those published in the English and Scotch Reports, or to render them of greater value to the student in psychology and medicine. No tables appear showing the forms of mental disease, of the causes of insanity, of the percentage of the insane to the population, of the percentage of recoveries and deaths, or of the number of patients with suicidal tendencies. Our present estimation of the worthy Inspectors of Irish asylums would, if possible, be still greater than it is if they would satisfy the legitimate aspirations of their English readers.

Hospital Construction and Management. By FREDERICK T. MOUAT, F.R.C.S., Local Government Inspector, &c., and H. SAXON SNELL, Fellow of the Royal Institute of British Artists. London: J. and A. Churchill.

(*Second Notice.*)

The object of our former notice having been to deal generally with the medical recommendations and to summarise the chief points requiring attention in planning, it is now proposed to deal with the particular examples of various buildings as given by Mr. Snell.

For the sake of obtaining some clear conception of the comparative qualities of these it will be desirable to try to classify them, and this may best be done as follows:—

a. Types of buildings at home generally commended.
b. Buildings erected from the designs of Mr. Snell.
c. Types from abroad generally commended.
d. Types of buildings at home and abroad, the chief features of which are specially condemned.

Belonging to the category *a* are the Herbert Military Hospital, Woolwich, and St. Thomas's Hospital, London, which may be considered as affording types of the fairly well-planned hospital, though of course open to much improvement in some details.

By permission we are able to give illustrations of these buildings.

The first-named was erected between the years 1860-64 for invalid soldiers of the Woolwich garrison, and accommodates 650 beds. The designs for the building prepared by Captain Douglas Galton were submitted to Miss Nightingale, whose practical experience was thought to be of much assistance.

The general scheme is that of pavilions set in pairs with staircase and nurse's rooms to each pair.

The chief fault found with this building is as to the arrangement of the water-closets, baths, &c., and it is pointed out that no direct cross-ventilation exists between the ward and the water-closets. Special insistance is used as to the necessity of this direct cross-ventilation being made an axiom of hospital planning, and this is of course equally applicable to asylum and similar work of all kinds.

It is referred to again and again, and the reader's attention may suitably be drawn to some remarkable instances

presently to be given of the almost total disregard of any such precaution in hospitals on the continent of Europe.

The author points out that the soil and drain-pipes are carried down inside the walls, and adds that he considers it would have been better had they been kept entirely outside

It may be remarked that the main sick wards are full large for an efficient supervision, and that the tendency is now to somewhat reduce the number of patients into more manageable limits.

The cost (exclusive of land) was £330 per bed.

Almost the only other English example not severely criticised by our author is St. Thomas's Hospital, London, containing 573 beds. He says —

> The propriety of erecting palatial structures for charitable purposes has recently been seriously questioned by some of the most eminent authorities on the subject of hospital construction, and this building, which has been designed upon a grander scale than perhaps any other hospital in the world, has frequently been pointed to as an exemplification of this error.
>
> It ought not, however, to be forgotten that a very large proportion of its total cost was due to the treacherous nature of the ground upon which it stands, rendering unusually expensive foundations necessary, and that this was probably a contingency impossible to have been foreseen at the time the erection of the building was determined on. Perhaps, too, its apparent grandeur is due more to the effective grouping of its various parts, and to the architect's skilful treatment of the external details, than to an undue employment of costly material.

Here the author seems to be unduly lenient. We need but direct attention to the amount of external ironwork of a purely decorative (?) character and the cost of keeping it properly painted and repaired.

Taken, however, on its merits as a carefully-planned building, the result may be pronounced fairly successful.

The sanitary arrangements are not unfavourably criticised, but we would remark that they appear to have been somewhat sacrificed to external effect.

The arrangement of ventilating shafts is rightly objected to as affording a possibility of the foul air from one ward affecting others.

The total cost of the building, exclusive of site and furniture, reaches the prodigious sum of £445,525, or about £777 per bed.

The two foregoing examples practically exhaust category

a, for although portions of other establishments receive qualified approval, the major part is freely condemned.

Passing on, then, to category *b*, we have two examples of buildings erected from Mr. Snell's designs, the St. Marylebone Infirmary and the St. George's Union Infirmary. The most interesting of these would appear to be the first-named, and we may accordingly attempt some examination and illustration of its leading features.

Of its general character the architect modestly says, "It must not, however, be supposed that I consider it to represent the model of a perfect hospital building; the limited extent of the site would alone render this impossible; nevertheless it is allowed to be 'the most perfect building of its kind yet erected.'"

The form of structure may be described as that of a set of three-storied double pavilions connected on the ground floor by a corridor 10 feet wide.

"The axes of the pavilions run nearly directly N. and S., so that the windows of the wards face E. and W."

The planning of the central offices is somewhat marred by the excrescent structure containing the nurses' w.c. and slop sink, which has the effect of an after-thought.

The sanitary offices at the end of each ward appear perfect in their arrangement.

The pavilions are separated from each other by nearly twice their own height, a very fair proportion to maintain.

Following the divisions of the author's detailed description of the building, we are specially directed to the matter of the fitting up of the windows. He states that his recommendation in this case was over-ruled (by the committee apparently), otherwise the sashes would have been arranged as in some other buildings for which Mr. Snell has acted as architect—the lower part of the window in them being fitted with casement sashes opening inwards, the upper part with sliding sashes.

In the matter of warming our author describes at considerable length, and fully illustrates, a stove introduced and used by himself in this and other buildings. He considers it to be an unqualified success, but the cost of the structural work consequent on the use of this apparatus must be very heavy.

He shows them as applied in the centre of the wards, and also illustrates the manner in which they may be used fitted to an outer wall.

Probably for a grate with an ordinary bottom grid they are as efficient as any form yet devised, but we should have desired to see the slow combustion principle adapted to this combination, especially in view of the length of smoke flue to be kept clean, and the consequent importance of having it fouled as little as possible.

Our author does not, so far as we can find, in any case attempt the method of warming the structure of the ward, but is content with endeavouring to accomplish the warming of the air and introduction of fresh warmed air, both being desirable and necessary.

Under the heading of ventilation we may quote the exact words, specially having in mind the alternative method of large exhaust shafts leading from each ward to a central shaft as elsewhere described.

Here "the ventilation of the wards is effected by purely natural means, and is dependent therefore upon the very simple and well-known fact that the heated air will always rise to a point higher than that of the colder air surrounding it, and that in its passage it will carry away with it noxious and other deleterious gases which would otherwise, by reason of their greater density, remain stationary or descend to the floor level. Behind the head of each bed, and next the floor and wall, there is a large hollow skirting box, the front of which is formed of perforated zinc; this box is made so as to be easily lifted out of position for the purpose of cleaning, but when in its place it covers an aperture in the floor, from which a ventilating inlet pipe descends in a slanting direction to the outside wall, and through this pipe the external fresh air is admitted, first into the skirting box, and then out of it through the perforated zinc panels (situated under the heads of the beds) into the room. It was intended that hot-water pipes should also pass through these boxes. In the ceiling immediately over and between each pair of beds there are perforated panels running the whole width of the ward; these panels cover large channels, the full depth (12in.) of the floor, and these channels communicate at each end with flues 14in. by 9in. which run upwards in the thickness of the wall like ordinary chimney flues. Now, returning to the skirting box, it will be obvious that a great part of the air passing into the room through the perforated front immediately under the head of the bed would be drawn upwards, and passing through the perforated ceiling channel be conveyed through the upright flue, and find an exit at

its termination; and it will be observed that the air, in thus passing upwards from the skirting box to the ceiling, must encircle as it were the space surrounding the head of the sick patient, and carry away with it his or her foul emanations. Thus, therefore, each pair of beds is provided with its own separate system of ventilation, whilst the general ventilation of the wards is supplemented by the central stoves previously described, and also by up-cast shafts in the side walls. The total area of outlet and inlet flues in each of these wards is 15 feet, and no means are provided by which they can be closed excepting in the case of four of the outlet shafts in the end walls, which have doors that may be opened and shut as occasion may require."

We give the above description at length because it largely exemplifies our earlier remarks as to the desirability of subdivision of ventilating apparatus. We doubt the direct action of the flues described, under all conditions, but they are at least carefully arranged to use as far as possible the natural movement of the air.

A satisfactory feature of this building is the day-room arranged to serve two wards. In concluding this notice of the St. Marylebone Infirmary we may call special attention to the fact that neither in this building nor in the St. George's Union Infirmary (a building very similar in character to St. Thomas's Hospital) does there appear to be any provision for balcony, covered or otherwise, for giving convalescent patients access to the open air to any extent. This is one of the pleasant features of some of the Continental buildings, particulars of the best examples of which will form our next and concluding notice.

Fagge's Principles and Practice of Medicine. 2 Vols. J. and A. Churchill, 1886.

We are ever ready to boast of the progress which has taken place in medicine, and if measured by the number of books on the principles and practice of medicine, the advance during the past twenty years has been great indeed. Sir T. Watson, with his pleasant and attractive lectures, clothed the dry bones, and made principles clear and memorable; but these lectures were soon obsolete, as far as treatment was concerned, and the bleeding, blistering, purging, and vomiting were only learnt to be administered to certain old-fashioned examiners who were supposed still to believe in old practices. Tanner

filled a very important gap, and provided in a handy form the chief clinical facts which a student should look for in disease; but as means for teaching increased, and standards of examination were raised, other and more elaborate handbooks were needed. Roberts, of University College, formed a definite place for himself, and Bristowe, of St. Thomas's, soon provided one of the best, if not still the very best, book ever provided for the medical students of medicine. Bristowe is not only a general physician of long experience, but he has taken special pains to be well in advance with reference to the specialities or departments of medicine, and in reviewing any later book it will be necessary to compare it with what has already been produced. From Guy's no system of medicine had appeared since Dr. Barlow wrote his once popular book, and the way was understood to be stopped by the *magnum opus* of Fagge, which has been so long and anxiously waited for.

It lies before us, but the author has not the pleasure and satisfaction of seeing the literary result of his years of labour and observation.

A critic feels it specially difficult to do justice to his subject and to the author when under such sad circumstances a posthumous book has to be reviewed. All who knew Fagge were certain that the book would be both original and authoritative, for no man was ever gifted with greater power of work, both in observing and comparing. Few men have worked so industriously from student days to their death, and few men were gifted with clearer insight into natural and diseased conditions. He had much of the clearness of insight and of expression of John Hilton, his uncle.

But now for the book itself. It would be unfair to condemn it for what it is not, and to judge it from the specialist's standard; but, at the same time, we must say that though it has fifty pages on insanity and allied neuroses, these pages evidence a complete ignorance of the subject from a practical point of view, and we can only regret either that Fagge had not left the subject untouched, or, better still, had, with his masterly way, like Bristowe, waited and studied the subject pratically for a later edition. In this last case we should have been without these chapters, which to the alienist must appear meagre and superficial. Nearly all the knowledge is taken second-hand, and not always from the best authors or the latest of their works. To this part we shall refer in detail later.

The book consists of two large volumes, and there is one small complaint we should make as to the quality of the paper; it is thin, and easily torn, and the type is only fairly good.

After an introductory chapter, which is a bright, clear, and philosophical introduction to the whole subject, the first grand division of the book is devoted to general morbid processes, including contagion, which is at present asserting itself as the giant in morbid causation; next fever, inflammation, tubercle, tumours, and syphilis are discussed. This division contains all that was known on the above subjects, and much that was conjectured, and it will be seen that many of the conjectures of Fagge have now become established facts.

Specific diseases are next considered, enteric fever (typhoid) occupying much space and attention. Hydrophobia is treated not as a specific, but as a nervous disease, but we suppose it is impossible to be perfectly consistent.

Diseases of the nervous system are considered next, and following this division we have that one treating of neuroses, including spasmodic neuroses, such as writer's cramp and "professional" spasms, paralysis agitans, chorea, and paroxysmal neuroses, such as migraine, epilepsy, paroxysmal vertigo, and paroxysmal insanity. This division of paroxysmal insanity is novel, and includes cases of masked epilepsy, and though Fagge describes certain cases, and also refers to Falret, Trousseau, and Dr. H. Jackson, he does not in our opinion fully understand their true relation, and places with them epileptics, somnambulists, and children of nervous families.

Hysteria is fully considered, and treated as a real and distinct disease. We can hardly accept the statement that the suddenness of recovery from delusions can be used as a test of the reality or not of the insanity. We are used to motor perversions in the hysterical which pass off suddenly, but we do not think we are justified in saying that everything motor or mental which passes off suddenly is hysterical. Hystero-epilepsy is referred to, but Charcot's observations have been too recent to be fully discussed.

Weir Mitchell's treatment of hysterical wasting is altogether omitted. The consideration of hypochondriasis follows, and Fagge appreciates fully Hysteria and Hypochondriasis when he points out the tendency in both to simulate organic diseases, though he also sees the wide differences which also exist. The chapter, though very brief, and we might say meagre, is, perhaps, sufficient for the ordinary student.

Psychoses are next considered. These are regarded as

mostly functional disorders, the chapter on "General Paralysis of the Insane" being separated from the rest of the subject of insanity, and this appears to be rather a mistake, for if chronic dementia is to be considered among functional disorders general paralysis should not be far off. Under the head of Psychoses, we have the consideration of acute delirious mania, acute mania, chronic mania, acute dementia, melancholia, and chronic dementia. Then the general ætiology of insanity is discussed, idiocy and cretinism concluding this division.

Fagge recognises in insanity not one disease but many, each consisting of groups of symptoms, and as a pathologist he only allows general paralysis and idiocy to have physical bases of disorder in the brain. We fear that even here he has gone too far, for certainly we have no general pathology for idiocy, and an unformed one for general paralysis. As we have said, most of the descriptions of the forms of insanity are taken from other writers, and there is really nothing original in the descriptions or in the way of considering them.

Fagge accepted acute dementia without any doubt, but whatever may have been his opinion, we think he might have mentioned its close resemblance to "mélancolie avec stupeur."

The part on the ætiology of insanity is not full enough. Heredity and syphilis alone are specially noticed, and the question of whether those with insane inheritance should marry is raised.

When writing on sporadic cretinism Fagge is more at home, and with myxœdema he is also on ground which should be classical to Guy's men and students under Sir W. Gull.

After the study of the psychoses, the affections of the nervous system due to poisons and heat are discussed, and this closes the part specially devoted to the brain and nervous tissues. Volume one is closed by a study and description of diseases of the respiratory system.

In volume two the heart and vessels, the digestive organs, liver, spleen, and kidneys, as well as the bones, joints, blood, and skin, are discussed. It would be an endless task to go through in a review the contents of a book like the one before us. As a system of medicine, it is excellent, not only because it is the careful production of a careful observer, but also because it is the production of a young energetic man, who had a widely philosophic view of the scope of medicine, and if we cannot praise the part devoted to psychoses, we must remember that the subject, even to experts, is a very difficult one to handle, and that a general physician used to teach dogmatically about

groups of symptoms and varieties of disease is greatly puzzled when he seeks for definitions of the psychoses and finds no one ready to give him what he wants. Fagge was a precise thinker, and having no intimate personal experience of insanity he made a *précis* of what had been written and what was comprehensible to him, so that instead of being dissatisfied we should take it for granted that in this book is represented what an outsider thinks of us and of our speciality, and if this is not flattering we must look to ourselves.

Klinische Psychiatrie. Specielle Pathologie und Therapie der Geisteskrankheiten, von Dr. Heinrich Schüle. Von Ziemssen's Handbuch der Speciellen Pathologie und Therapie. XVI. Band, 3 Auflage. Leipzig, 1886.

Schüle's Handbook of Clinical Psychiatry.

This is the third edition of the work on Clinical Psychiatry, or Pathology and Therapeutics of the Insane, in the series edited by Prof. v. Ziemssen. We have in a former number of the Journal reviewed at some length Dr. Schüle's "Manual of Mental Diseases," and if we were disposed to criticise its style as too flowery for a treatise of this kind, we did not fail to recognise its substantial merit. The present work is really a new book, although a revised and adapted edition of the "Manual of Mental Diseases" above mentioned. We consider that the treatment of the subject, upon which the author has evidently bestowed much labour, is worthy of the reputation which he deservedly enjoys, not only on the Continent, but in this country.

As the classification of mental diseases is occupying fresh attention at the present moment from the action taken by the late Antwerp Congress of Mental Medicine, with a view to obtain an international *consensus* on the subject, we shall reproduce that adopted by Schüle.

I. Psychoses of complete organo-psychical development.

1. Psychoses of the healthy brain (Psycho-neuroses in a restricted sense).

(*a*). Melancholia
(*b*). Mania (partial) } with secondary forms.

2. Psychoses of the feeble brain (Cerebro-psychoses).

(*a*). The severe forms of Mania: Furor, Mania gravis.
(*b*). Insanity in its acute, chronic, and attonic forms.

(*c*). Acute primary dementia. Variety, stupor with hallucinations.

(*d*). Hysterical, epileptic, and hypochondriacal insanity. Varieties: (*a*) Periodical circular and alternating Psychoses; (*b*) mental disorders following non-cerebral bodily affections (febrile, puerperal, &c.), together with those from intoxication.

3. Pernicious conditions of brain-exhaustion.

(*a*). Acute brain-exhaustion of a dangerous character. Acute Delirium.

(*b*). Chronic brain-exhaustion of a destructive character (Degeneration)—the classical General Paralysis.

4. Psychical cerebral disorders. Psychoses following sub-acute and chronic organic affections of the brain (diffuse and local)—modified General Paralysis.

II. Psychoses of defective organo-psychical constitution.

(*a*). Hereditary neuroses. Variety, transitory psychoses.

(*b*). Simple hereditary insanity—the insanity of imperative conceptions (Maladie du doute et du toucher). Variety, litigation insanity (*Querulantenwahnsinn*).

(*c*). Delusional Insanity (original *Verrücktheit*).

(*d*). Degenerative hereditary insanity—moral insanity.

(*e*). Idiocy.

Melancholia comes first in order of description, and the analysis of the symptoms, the disorder of the feelings and will, the main types, the sensory hallucinations, the vaso-motor, trophic, digestive, and repiratory derangements, &c., are enumerated. The treatment follows. Paraldehyde is favourably regarded, having the merit of safety, even with long use. The author begins with 45 grains, and increases the dose, if needful, to 90 and 120 grains, the larger dose being often divided into two portions, 60 grains at bedtime and 30 grains in the night. Our own experience confirms this proceeding. The disappointment some experience in its use arises chiefly from using a stale article; it is necessary to make it up frequently. Schüle prefers paraldehyde to 15 to 30 grains of chloral, for although the latter may be more powerful, its prolonged use paralyses the vessels. In old feeble melancholiacs with weak heart, camphor is found to be a valuable hypnotic. As in very acute cases sleep at night is not enough, and brain-rest in the day must be ensured at any price, opium or morphia as the great,

cerebral sedative, and bromide as the spinal sedative, are administered. Opium is declared to be the "König der Heilmittel," commencing with 12 to 15 minims of the tincture,* given very early in the morning. A second dose is administered at bedtime, and if indicated a third or even a fourth is given in the twenty-four hours according to the painful intensity of the daily exacerbations. Stress is laid upon the necessity of giving sedatives before the accession of a paroxysm, in order to ensure safe and effectual treatment. Experience shows that a small dose administered at the *right* time is much more effective than a large one at the *wrong* time, *i.e.*, at the height of the paroxysm. It is a mistake to rest contented with having produced quiet once, for this must be followed up with continuous effect. If the foregoing doses are not sufficient, they must be increased by 5 or 10 minims as required, rising to 50, 60, 80, or even 100 minims of the tincture, without any inconvenience beyond constipation, which is easily relieved. "The object of treatment is ever the greatest possible cerebral rest; temporary diminution or removal of the depressed feelings; toning down the thoughts, so that the supremacy of the one idea becomes relaxed, and the normal state of the perceptions is restored. But this must be continuously carried out, if the wounded nerves are to be healed. The skilful opium-rest is the plaster-of-Paris band of the disordered nerves. According to our experience, in the *methodical* application of the opium treatment lies at once its secret and utility" (p. 42). Continuous injections of morphia are favoured by our author, especially in recent cases of melancholia agitata, the indications being the necessity for prompt action, neuralgia, and the opposition of the patient to taking medicine. Cases of paroxysmal anguish are especially benefited by morphia-injection. Special indications are here particularly needful, and the application must be made as early on, in the case as possible. He begins with $\frac{1}{6}$ of a grain of morphia, increases the dose to gr. i, or even higher, and has seen very satisfactory results therefrom. Bromide ("the spinal opiate") is valuable in cases in which neurasthenia is the basis of melancholia, or sexual excitement is suspected, as well as in hypochondriacal and hysterical melancholia.

In regard to forced alimentation, Schüle's motto is excellent—"better too early than too late."

* The strength of the German tincture is one grain in ten drops.

Dr. Schüle proceeds to briefly describe the varieties, viz., Passive and Hypochondriacal Melancholia, Raptus Melancholicus, Melancholia Agitata, Chronic and Senile Melancholia, and Melancholia Attonita. To this we shall return under another head. Mania is fully described. In its treatment the author prescribes baths, prolonged and for a short time, with ice to the head, wine being given during and after the bath as well as rubbing and rest in bed. "*Man vermeide Kopfdouchen!*" Bleeding is forbidden, but a couple of leeches behind the ear are sometimes found useful. The wet pack has in many cases been found very useful with ice on the head, and cold ablution afterwards with friction. This course is repeated daily. Digitalis and ergotin are favourites in cases of violent excitement, while for hypnotics, paraldehyde, chloral, beer, bath at bedtime—a cold one being found of the greatest service in inducing rest and sleep—the bromides, and opium. Hyoscyamin is approved of in grave forms of mania. Dr. Schüle begins with a dose (for women) of not more than $\frac{1}{12}$ of a grain, increasing it to gr. $\frac{1}{8}$ or gr. $\frac{1}{6}$. With men he begins with $\frac{1}{6}$ of a grain and goes up to gr. $\frac{1}{4}$ and gr. $\frac{1}{3}$, with due caution, one dose in the day being sufficient; he finds the drug more potent if administered by the mouth than subcutaneously.

There are given as clinical varieties of mania: mania mitis, gravis, and chronic.

Conditions of mental weakness follow, these being either congenital or acquired. Anergic, erethismic, or torpid and excited forms are given. The torpid variety is subdivided into the intellectual, the emotional, and the psycho-motor, in which acts are performed with an entire absence of forethought or consideration of the consequences. Mental weakness with excitement is similarly divided, and although the opposite of the preceding, is in reality analogous in its result.

True dementia receives separate notice in its apathetic and "versatile" phases, but we pass over these and some other forms to mark the minute divisions of acute hallucinations, of which there are no less than seven types: (*a*) the acute and peracute form of exaltation (catamenial); (*b*) sub-acute maniacal megalomania; (*c*) acute and sub-acute persecution-mania; (*d*) the double form of depression and excitement; (*e*) acute uniformly depressed-expansive state; (*f*) acute hypochondriacal insanity; (*g*) sub-acute cerebro-spinal insanity.

Then follows attonic insanity—katatonia. This, a form of insanity which can hardly be said to be recognised in England under that name, is defined by Schüle as a special form of mania with acute hallucinations, the essential element of which is motor tension, sometimes continuous, at others somewhat intermittent, the perception of external objects being more or less shut out by overpowering hallucinations. The motor rigidity may retain the physiognomic character which represents a delusion, *e.g.*, the attitude of crucifixion; or it may be purely organic without taking any intelligent form, having a cataleptoid or tetanoid character. The mental condition may accordingly remain either continuously in the dream stage of acute delusional insanity or else sink down to the level of actual temporary mindlessness or stupor without hallucinations. From both phases complete recovery may take place. In the latter the patient passes through a peculiar stage of weakmindedness with occasional katatonic recurrences. The course is cyclic, accompanied by vaso-motor changes, and is marked by exaltation, depression, and rigidity. The several types of katatonia may be diagnosed according to the underlying mental state, according as they are expansive, depressive, or hysterical.

From these divisions we are afresh reminded that German psychologists carry the analyses of mental symptoms to a much greater pitch of refinement than the English school does. It must not be forgotten that many of these distinctions, while representing genuine clinical states, are, to a large extent, but phases of the same essential disorder.

(*To be Continued*).

De l'Alcoolisme et de ses diverses Manifestations, considérées au point de vue physiologique, pathologique, clinique, et médico-légal. Par Dr. F. Lentz, Médecin Directeur de l'asile d'aliénés de l'État à Tournai. Bruxelles, 1884.

This is the work of a careful observer, a clear thinker, and an able writer. It extends to nearly 600 pages, and treats of Alcoholism in all its ramifications. The author deals in general considerations on the physiological action of alcoholic drinks upon digestion, circulation, the heat of the body, respiration, the blood, the kidneys, and the nervous system. He acknowledges that this last is the most difficult to deter-

mine. New researches are indispensable to establish the true nature of the action which alcohol exercises upon the whole nervous system. He endeavours to prove, however, that alcoholic stimulation which is usually believed to infuse fresh energy and vigour into the brain and nerves is only factitious, that it very indirectly reaches the nervous system itself and exercises an indirect influence upon the motor, sensory, and intellectual functions. In fact the stimulation of the nervous system is regarded as the consequence of cerebral excitement, the complex nature of which may be difficult to establish, but is analogous to the effect of good news upon the mind.

Passing over those sections which refer only to ordinary intoxication, we note the description of maniacal excitement due to alcohol, which contains a good sketch of the prodroma, course, and termination of the attack. Lethargic sleep lasting from 12 to 24 hours may completely put an end to the outbreak of fury. The most characteristic circumstance here is the complete re-establishment of the previous mental activity without the persistence of any morbid manifestations. Homicide or suicide may have been attempted during this attack of acute alcoholism, and striking cases are given in illustration. Closely allied is convulsive intoxication, the stress of the attack falling on the motor system. The attack is sudden, being preceded by little more than irritability, precordial pain, and headache. A graphic description follows of the contortions, dangerous violence, and loss of consciousness, the manifestations of mental activity being mainly hoarse cries and inarticulate sounds. When aroused from the profound sleep which terminates the crisis the patient retains no memory of the storm through which he has passed.

Dr Lentz treats of the abnormal states of intoxication which occur among the insane, imbeciles, and epileptics. It is laid down as a general principle that all who fall under the great class of mental maladies present a greater susceptibility to alcohol, and display in their symptoms of intoxication special characters which carry it beyond its ordinary type. The general paralytic is usually very susceptible to alcohol, in fact he can rarely absorb a sufficient quantity to permit the successive symptoms of intoxication to follow their normal course. A true maniacal excitement is the principal symptom, and often in the first stage occasions *vagabondage*, quarrels, thefts, assaults, and even murders. As the author observes, it is strange to see this same general

paralytic, who bears alcohol so badly in the fully-developed stage of the disease, able to bear great excesses and yield with difficulty to intoxication when dipsomania results from, and constitutes the first symptom of, general paralysis (page 121). Dr. Lentz insists with reason that the intoxication of the weak-minded is the most abnormal and generally the most dangerous. With regard to the dipsomaniac, he scarcely knows, paradoxical as it seems to say so, what true intoxication is during the active stage of his disorder; it consists rather of a continual semi-maniacal agitation with rambling and incoherence. Certain authors, as we know, hold that intoxication is always due to a pre-existing chronic alcoholism. Granted that it is rare with those who only occasionally take alcohol, still, glaring exceptions do not permit us to regard it as an absolute rule. In the exceptional cases there is a neurotic predisposition which explains the origin of the abnormal intoxication. This altogether special susceptibility to intoxicating beverages which may so easily lead to a maniacal attack, nearly always depends upon a constitution marked in the neurotic by a tendency to delirium and hallucinations in the course of various disorders, especially fevers; great mobility, excessive susceptibility to atmospheric influences and to diet, and exaggeration of vaso-motor excitability under the action of the slightest mental impression. Hence breathlessness, palpitations, blushing, precordial anxiety, vague uneasiness, rapid and facile appearance of the same phenomena under the influence of drink, excessive irritability of the nerves and senses, too continuous a state of irritation and emotion, increase of reflex irritability, and tendency to convulsions. In the psychopathic constitution there is great excitability, instability of the moral sentiments, frequent change of humour without cause, inconstant sympathies and antipathies, too vivid an imagination, and rapid and exaggerated but very momentary voluntary determinations. Dr. Lentz is one of the few medical writers who point out that the neurotic or psychopathic constitution, although usually hereditary, is not necessarily so, but may be acquired by causes which profoundly affect the cerebral and nervous functions, as traumatism, typhus fever, and other zymotic affections, meningitis, moral shocks, &c. From these causes, as well as from heredity, may unquestionably arise a tendency or susceptibility to alcohol which gives rise to many forms of pathological intoxication.

In diagnosing maniacal from ordinary drunkenness it is necessary to bear in mind that the former is marked by sudden outbreak, while the latter pursues a regular course in its commencement, progress, a certain period of continuance, and then decline. In the former, movements are well directed, and remain under the control of the will. In the latter, motor action is not long maintained, and soon becomes feeble, the drunkard having little power of resistance. Hence the childish conduct of ordinary intoxication and the violent and well-combined acts of the pathological form; in one there is restlessness and progressive relaxation, in the other the display of extraordinary force. The mental condition is fundamentally different. The maniac, although unable to give an exact account of the situation, will recognise his *entourage*, will understand the questions asked of him, and may even reply sensibly, there being, therefore, a certain conscious intelligence which renders the patient all the more dangerous. There is, however, in that variety of pathological intoxication which assumes a convulsive form an almost complete mental stupor, and in this respect it is more allied to the grave forms of ordinary inebriety. Pathological intoxication is marked by profound sleep, and as the quantity of alcohol has been insufficient to cause general disorder in other organs, its disappearance is complete. Ordinary drunkenness, although usually followed by profound sleep, is not marked by the elimination of alcohol, the effects of which on the system continue for a considerable time. Its victim awakes fatigued, vertiginous, or dyspeptic, whilst the maniacal inebriate shows no signs of indisposition. Lastly, the patient, on recovering from maniacal or convulsive intoxication, remembers nothing. This rarely happens after a drunken bout. Attacks of acute alcoholic mania, arising in the course of chronic alcoholism, are often confounded with pathological intoxication, but the former is characterised more especially by terrific hallucinations, emotional paroxysms, furor, and stupidity (page 131). Unfortunately, clearly defined as these distinctions seem on paper, the several forms are considerably mixed in practice.

Dr Lentz has to confess that the different forms of abnormal intoxication are not connected as yet with a definite pathology. Pathological intoxication is only a transitory insanity having a special origin, and yet alcohol is often so little taken into the constitution that in most cases it does

not offer the general characters of alcoholic delirium. Of hallucination there is not a trace; the change in moral sensibility so characteristic of really alcoholic disorder is wanting. It is indeed as far removed on the one hand from the group of true alcoholic mental disorders as it is on the other from ordinary intoxication. The term pathological intoxication is therefore employed to mark its relations with alcohol, and at the same time the differences which separate it therefrom.

In discussing the relations of intoxication and insanity the author points out, in a philosophical manner, the resemblance and the difference between the two.

The analogies between general paralysis and the effects of alcohol are minutely described, and the author adopts the opinion of Bayle that drunkenness, if permanent instead of transitory, would be nothing else than general paralysis. The pathological analogy lies not only in the organ affected, but in the region, namely, in the pia-mater and the cortex; as also in the nerve-cells and the morbid evolution which mark the two affections. It does not, however, follow that intoxication is a state identical with general paralysis.

We reserve for another occasion a further analysis of this work, of which the present brief notice, consisting mainly of the author's opinions, will serve to show that this difficult and important subject, which in its criminal relations was discussed at the last quarterly meeting of the Association, has in Dr. Lentz a thoughtful expositor and an experienced observer.

Hobbes. By GEORGE CROOM ROBERTSON, Grote Professor of Philosophy of Mind and Logic in University College, London. W. Blackwood and Son, Edinburgh and London, 1886.

This is the tenth volume of the "Philosophical Classics for English Readers," edited by William Knight, LL.D., the Professor of Moral Philosophy in the University of St. Andrew's. It contains an interesting notice of the life and a clear expositions of the opinions of the philosopher and psychologist, who, with Bacon and Locke, stood out in such remarkable relief in the seventeenth century. Like many other celebrated men Hobbes was a twin. He was born in 1588 at Malmesbury, Wiltshire. His father, who was Vicar at Westport, having assaulted another parson, was obliged to escape, and died

in obscurity near London. The children were cared for by a glover in Malmesbury, who brought up the twin brother to the glove trade. One of the latter's sons, who resembled his uncle the philosopher, was a drunkard and a bad husband. In powerful contrast to his surroundings, Thomas Hobbes so thought and wrote as to influence psychology largely, both in Britain and abroad. He studied at Magdalen Hall, Oxford, from the age of 15 to 20. Many years afterwards he spoke of Oxford as a place where the young "were debauched to drunkenness, wantonness, and other vices," so that Professor Robertson remarks that Hobbes "could almost forgive the Commission of 1648 its Puritan and Parliamentary origin for the good work it did in purging the spot." Between the time he left Oxford, on taking his bachelor's degree, and his entering upon the work of philosophy, twenty years passed by. It was during this period that he became a tutor in the Cavendish family, with three generations of which he was connected. He travelled on the Continent for many years, and no doubt was a keen observer of men and opinions; but Professor Robertson tells us a little too much as to whom he *may* have met and by whom he *may* have been influenced. Probably Hobbes himself would be the first to smile could he read what our author supposes him to have seen and learnt during his journeys through France, Germany, and Italy. It was in 1637 that Descartes published his "Discourse on Method." The New or Mechanical Philosophy had already sprung up. With Bacon Hobbes was acquainted, but, although he may have been affected by this association, he was not his disciple. Mainly through Galileo arose the new doctrine respecting the world and man. Professor Robertson thus writes:—

So far as the physical world itself was concerned, Galileo's idea, which had already, in the first years of the seventeenth century, been taken up by many scientific workers, was fully accepted by Descartes. Through Galileo, or independently, Descartes was convinced that all physical facts and processes were to be interpreted as purely mechanical —as local arrangements and re-arrangements of moving matter. Descartes, however, as the world was at last learning, did not conceive of any physical doctrine but as part of a far wider and more deeply grounded system of general philosophy. And thus was it also with Hobbes, who, in a fashion of his own, could be content with nothing less than a universal system of human conceiving. But while Descartes, starting from the subjective point of view, made it his first care to understand the relation of nature to mind, Hobbes, immersed in

objective considerations, is to be called a philosopher chiefly because of the comprehensiveness of his scientific survey and its practical direction to the guidance of human conduct.

The author adds :—

The thought that sensation and all mental states thereon depending are explicable as peculiar motions in the human body, determined by motions in other bodies, took Hobbes at once beyond the field of investigation to which the so-called mechanical philosophers, in the first instance at least, confined themselves (p. 43).

It would carry us far beyond the space at our command to follow Professor Robertson's sketch of Hobbes' doctrines. The reader will find them ably, impartially, and learnedly described by the author. Especially interesting are the remarks on the relation of Hobbes and his system to modern thought. Robertson holds that his influence on philosophy has been indirectly wrought through psychological science, that is to say, by promoting the positive investigation of mental functions. Philosophical radicals of the school of Bentham first gave effective currency to the ethico-political ideas of Hobbes (p. 232). His followers, beginning with James Mill, saw in Hobbes "what he actually was, a man who had the same regard that they had for the common weal as the true aim of human action, and the same faith in intelligence as the one means of realising it. Through James Mill, Grote and Austin in particular were fired with admiration for the most clear-headed and logical of political thinkers ; and from Grote, as Mouldsworth has left on record, came the first suggestion of doing homage to his power and increasing its effect by the publication of a complete and accessible edition of his works" (p. 233).

Hobbes died at the age of 91, in 1679, at Hardwick, Derbyshire, a black marble slab, with a Latin inscription, being placed over his remains in the Church of Hault-Hucknall.

This volume, like its predecessors, contains a portrait, and can be recommended to all who wish to have in a small compass a clear and philosophical description of this remarkable man and the psychological atmosphere in which he lived.

A Palace-Prison; or, the Past and Present. New York, Fords, Howard and Hulbert. 1884.

This anonymous book cannot be said to be pleasant reading. The author asserts that, although a fiction, the facts themselves are true, and within his or her personal knowledge. The heroine is Marion Page, a charming maiden in every way. She was fond of study, and over-worked her brain; she lost her sleep, she was injudiciously treated at home, and, although her brother was a doctor, all out-of-door relaxation was denied her. Dr. Page had a friend, Dr. Lamarette, the Superintendent of a large State asylum for the insane. To this institution Marion was sent, that her over-wrought nerves might be restored. If we are to believe the description given in this book, Dr. Lamarette was a plausible, unprincipled man, deceiving the friends of patients, and making everything subserve his own pecuniary interests. Still worse was the assistant medical officer, Dr. Lovering, and the attendants were brutal in their conduct. These evils, however, are not represented as due to anything exceptionally wrong in the superintendent or his officers, but as the natural products of the system.

> Our insane asylums are huge prisons, governed by prison rules, hedged in by iron bars, and in both ward and cell there is absolute irresponsible sovereignty on one side and abject submission on the other . . . . Nature never adapted the human race to a life of captivity. People moan under prison privations. The few who recover in asylums are cured by time and in spite of their surroundings, for imprisonment never cures insanity.

Marion has violent fits of excitement, occasioned for the most part by the treatment to which she was subjected (according to the author), and she goes from bad to worse. Dr. Lamarette always makes some excuse for detaining her in the asylum, and convinces Dr. Page that all is right. Years pass over the head of Marion Page, and she grows old and grey.

> What shall be done, says the author, to prevent our young people and our middle-aged from falling into the prison that has slowly destroyed the lovely mind and beautiful body of Marion Page? . . . The tenacity of the asylum system is wonderful. Exposures of its cruelties have appeared in pamphlets, books, and newspapers—criticisms have been passed upon it—legislation has

attempted to reform it—prosecutions and investigations have been instituted ; but, like a serpent which writhes and raises its sparkling eyes again, the system revives, enlarges its coils, and grasps all our civilised States in its hideous embrace. Still Marion exists within her secret cell. The air of freedom encircles the building in which she is entombed, but never does she know the joys of one free breath. People come and go; physicians study, meet and consult; legislatures convene and dissolve; young people marry, the old pass to other shores; but Marion Page exists only in prison air, lives only in a tomb above the ground, while dully waiting for a tomb below."

Such a romance, asserted to be founded on fact, might have been written in England as well as in America. It may well be supposed that it is composed by some one formerly in an asylum, who desires to expose what he or she believes to have been abuses, but which may have only been the distortions of a disordered fancy. But that which renders such a book unpleasant reading, not only at the time, but in the impression left upon the mind, is, that in any country, whether in Europe, the United States or Canada, such a state of things as is here described may conceivably exist. The best planned supervision may fail; all the devices to secure good treatment and kindness are human, and being human may miss their object. Boards may be deceived into placing implicit confidence in the statements of a superintendent unworthy of their trust; Commissioners in Lunacy may be altogether misled, assistant medical officers may be as immoral as Dr. Lovering, and the attendants may be, and often are, brutal. Marion Page, as here described, can hardly be said to be an absolute impossibility. But all this comes from the fact that there are insane persons who must be deprived of their liberty and placed under the care of strangers, and another fact, namely, that all human arrangements have imperfection stamped upon them. All we can do is to relax no effort to obtain the best possible officers and attendants in asylums, and the most ample inspection. "It must needs be that offences come; but woe unto him by whom they come."

A Manual of Cheirosophy, being a Complete Practical Handbook of the Twin Sciences of Cheirognomy and Cheiromancy, by means whereof the Past, the Present, and the Future may be read in the Formations of the Hands, preceded by an Introductory Argument upon the Science of Cheirosophy and its claims to rank as a Physical Science. By Ed. Heron-Allen. Ward, Lock and Co., London, 1885.

The Handbook of Physiognomy. By Rosa Baughan. London, George Redway, 1885.

The author of the first work states that the studies and personal observations of some years have been embodied in this book. It has the advantage of being illustrated by Miss Rosamund Brunel Horsley, who has depicted the features of Johann Hartlieb, the author of "Die Kunst Ciromantia" (1448), who is represented as examining the configuration of his own hand. We have figures of the elementary hand, the spatulate or active hand, the conic or artistic. Then we have the hand which is square or useful, knotty or philosophic, and the pointed or psychic hand. For these common experience shows there is a certain amount of evidence, and, indeed, it would be strange if there were not a certain parallelism between the hand and all the members of the body and mental characteristics and aptitudes.

But when the author passes to map out the hand much in the fashion of the old phrenological busts, apportioning specific names and the planetary signs to each part, we enter upon the path of pure fancy and astrological fictions and part company with Mr. Heron-Allen. We do not say that there are no lines on the hands which are associated with certain forms of hand, and may therefore serve to indicate the character; but the author's standpoint is altogether unscientific and fanciful, and does not deserve consideration by the psychologist. However, no one will be the worse for reading Mr. Heron-Allen's work, so long as he does not believe it when the author romances; and for any one who wishes to hear all that can be said in favour of Cheirosophy in an agreeable style, and in a book beautifully got up, we can honestly recommend this manual.

The other work at the head of this review is written by a lady who has already produced "The Handbook of Palmistry," "Cheirognomancy," &c. The author goes in for astrology, and we are informed that the sanguine temperament is shown by a skin with a good deal of colour in it, either of a soft

pinky white, with a rosy peach-like colour on the cheeks, in which case it is Jupiter which dominates in the temperament, or of a deep red colour all over the face, when the sanguine temperament is dominated by Mars, the hair being red or brown, crispy or curling; the lymphatic temperament is the result of the Moon and Venus, but more especially of the Moon; the bilious of Apollo and Mercury, the planets which give artistic feeling and intelligence; and the melancholic temperament springs from the dominance of the sad planet Saturn; and so on, and so on. This will suffice to show the character of this handbook, and although the description of the features associated with mental characteristics are true to nature, the production cannot be commended, and its chief use is to serve as a contrast to the publications of Dr. Warner and Professor Mantegazza, reviewed in our last.

Handbook of the Diseases of the Nervous System. By JAMES Ross, M.D., LL.D., Fellow of the Royal College of Physicians of London, and Senior Assistant Physician to the Manchester Royal Infirmary. London: J. and A. Churchill, 1885.

"Rise, honest Muse! and sing the man of Ross."

We are not surprised that the well-merited success of the previous work on the nervous system by Dr. Ross should have encouraged him to produce a handbook containing all that is essential in the two portly volumes referred to. The present work runs to 708 pages, has 184 illustrations, is printed on excellent paper, and last, but not least, the leaves are cut, altogether reflecting great credit on the publishers as well as the author. Nothing could serve better to mark the extraordinary stride made during the course of the last few years than the publication before us. We strongly recommend it to our readers, and none the less so because the author does not include general paralysis of the insane or, indeed, any form of cerebro-mental disorder, in his definition of diseases of the nervous system. Alienists have at hand a sufficient number of treatises in their own department of medicine, and are much more likely to want a treatise like the present on nervous affections outside their own specialty.

Old Age, and Changes Incidental to it. The Annual Oration delivered before the Medical Society of London, May, 1885, by G. M. Humphry, M.D., F.R.S.

Dr. Humphry's Oration contains much that is suggestive, and the writing is befitting the subject. Old age receives due reverence at his hands. The word development is, perhaps, used in an unusual sense, since it is applied equally to those changes which mark the ascending scale of life and those which accompany its decline. We are accustomed to witness during childhood, youth, and into adult life the triumph of the organism over its surroundings, but from adult life onwards into old age the reverse, the triumph of the surroundings over the organism—a triumph completed at the moment of death. To apply the word development to a retrograde movement of the organism is to use the term in an unusual manner. It is an aspect of the subject, however, which is new and worthy of consideration.

The changes in the skeleton which accompany old age are of much interest, in particular the manifestation of an exactly opposite process at one and the same time in different parts. We refer to the diminishing density of the bones of the lower limbs and the increasing density of those of the skull. These, however, appear to be *exceptional* cases, and to be in some degree accountable by the peculiar conditions present in such cases, viz., a closed cavity, the cranium, and an organ within diminishing in volume, and withal a nature outside abhorring a vacuum. Dr. Humphry's view of the calcification of cartilages as a process distinctly morbid, and not as a necessary or usual accompaniment of senility, runs counter to prevailing notions. Again, the statements as to rapid healing in old age are certainly not common property, and are very difficult of comprehension. These points are certainly worthy of further investigation, and, as Dr. Humphry points out, will need such on a very much larger scale if they are to be established. Meanwhile, we think it probable that the explanation of some of the rather unlooked-for results of quick healing in old people will be more reasonably explained in the words of Dr. Humphry—as being due "to the general soundness of the system and the good working balance of the several organs which has brought them to old age." In other words, we must look upon the examples of old age as in many cases selected specimens, who by virtue of their soundness have survived, and must not pit against these the average reparative powers shown by younger but unselected individuals.

Fools and Buffoons. Fous et Bouffons; étude Physiologique, Psychologique, et Historique. Par le Dr. PAUL MOREAU (de Tours). Paris, 1885.

This book belongs rather to the curious than the instructive. The object that of relegating to distinct pathological types the strange class of beings without whom in former days no court was complete, and no grand seigneur as great as by antithesis he might be—this seemed both worthy and philosophical. But the carrying out of this object does not appear to us to have been very successful. The physiology or pathology is both meagre and weak. Rachitis is credited with much, and accordingly the question of an exaggerated psychical development in rickets is assumed at the outset—is made even to form part of the definition of rickets. With equal fearlessness the question of the existence of late rickets as a disease identical with that of childhood is assumed (see p. 22). But we would commend the reader to p. 26 for a specimen of loose physiology, if, indeed, we may dignify by that name such, we had almost said, trash. The section on scrofula is remarkably feeble, but, perhaps, is for that very reason a fitting introduction to the chapter on "*Faibles d'esprit.*" The historical portion of the book contains many anecdotes which may amuse those who have nothing better to do than to read them.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

By T. W. McDOWALL, M.D., Morpeth.

Annales Médico-Psychologiques. November, 1881.

Physiological Theory of Hallucination. By Dr. Prosper Despine.

What the author sets himself to demonstrate is, that although hallucination is psycho-sensorial, the functional anomaly which gives rise to it belongs to the sensorial system alone. He believes that this theory expresses the method nature employs in the production of this phenomenon.

We will allow Dr. Despine to expound his theory by the following abbreviated extracts from his paper:—

In order that what follows may be understood, it is necessary to start with this principle, that a complete organ of sense includes not only (1st) the external organ which receives the impression from external objects, but also (2nd) the nerve conducting this impression to

a sensory ganglion; (3rd) this ganglion, in which the impression produced upon the external sensory organ and transmitted by the sensory nerve, is specialised in its nerve cells, and is changed into sensation representing the external object, into a sight, a sound, a taste, a smell, a touch, according to the external organ affected; (4th) lastly, the sensory fibres which, starting from the sensory ganglion, proceed to the grey cortical layer of the brain, there to produce sensation. Such is the complete system of a sense. This sensation, arrived at that part of the brain which, according to the data of physiology, manifests mind, the ego, is there converted into a psychical act, in the perceiving this sensation, that is to say, in consciousness by the ego of the sensation. This consciousness, whatever philosophers may say, requires no effort of intelligence; it requires only organs capable of performing their functions, since certain animals, particularly the herbivora, in whom the sensory organs and the brain possess an organisation and a development almost complete at birth, perceive at once and accurately surrounding objects, their size, shape, colour, distance, &c., which allows these animals immediately to use this knowledge for their requirements. Once perception is effected, there is also produced a natural phenomenon which terminates perception. The ego which has perceived the sensation refers it to the sensory organ which received the external impression. Thus it appears that it is the eye which sees, the ear which hears, &c., although the perceptions occur in the grey cortex of the brain. This attributing of perception to the external sensory organ is also a natural effect of the nervous activity of the sensory system, and not a result of habit, as has always been supposed, since everything points to the belief, judging from the actions of the young animals to which we have referred, that these also from birth refer their perceptions to their external organs of sensation.

In hallucination, the course of events is exactly the same. The object seen is not real, external; it is produced by a psychic act, by memory or the imagination. This object is generally in relation to the habitual occupations of the individual; there is nothing contrary to reason in the hallucination of a healthy person, but in the insane it is extravagant, terrific. An excitation originating in the cells which retain the impression of objects previously known, or else an excitation arising in some part of the sensory system and transmitted to the grey matter of the brain, produces there the ideas which form the subject of the hallucination. If the phenomenon stopped there, it would be normal, it would produce a simple reminiscence, or an imaginary creation as so often occurs. But here begins the functional anomaly which produces hallucination. The vibratory movement of the cerebral cells which has led to the formation of the idea is propagated to the sensory ganglion of one or more of the senses, by a thoroughly abnormal centrifugal activity, by means of white fibres which connect the psychic centre with this ganglion. When this movement

has arrived at the ganglion, the disturbance which it excites there transforms the idea into sensation, just as would occur with a disturbance produced in this ganglion by an impression derived from a real object and transmitted to it by an external sensory organ. This idea, thus become sensory ("sensibilisée,") being next sent back to the grey matter of the brain by means of the centripetal activity which, as in the normal state, succeeds every external stimulus of the sensory ganglion—this idea, then, will be perceived exactly as if the ganglionic sensation had an external origin. Such is the physiological mechanism of hallucination in its greatest simplicity. In a certain number of cases the phenomenon always occurs thus; it does not extend beyond the sensory ganglion—witness the hallucinations which occur in persons whose external sensory organs have been destroyed, in the blind, deaf, in whom hallucinations are completely accounted for by means of this theory. But generally the phenomenon extends beyond the sensory ganglion. The disturbance which in this ganglion converts the idea into sensation is propagated to the external sensory organ, and affects it. There exists, indeed, a proof which demonstrates the fact that the external sensory organ is affected by the ganglionic sensation of imaginary origin exactly as it is, in its normal activity, by the external world. Brewster noticed that in destroying the parallelism of the two eyes during a hallucination of sight, by pressure exercised on the external side of one of them, the patient, upon whom he experimented, saw the object of his hallucination double, exactly as we see a real object when we squint. This experiment, as far as I know, had never been repeated, when a chance of verifying it occurred to me. This was in a young man under my care, who, as the result of fright, was attacked with acute hysteria with convulsive attacks, sometimes without loss of consciousness, sometimes with it, attacks of somnambulism, of mystic ecstacy, &c. When ecstatic he saw, by a hallucination of sight, the Virgin surrounded by angels, as often represented in pictures. Whilst he experienced this derangement of sight, I pressed upon the external angle of one eye, and he said that he saw the Virgin double: then and there, he pointed with his finger into space. The double image became single whenever I ceased to destroy the parallelism of the eyes. This experiment, frequently repeated with the same result, convinced me that in this case, as in Brewster's, the eye was affected by the sensation of subjective origin, and that this impression returning to the brain by its ordinary centripetal path was perceived by the ego as it would perceive a sensory impression produced in an external sensory organ by real objects. In this and other cases it is incontestable: 1st, that the cerebral activity which produced the idea was propagated to the sensory ganglion where the idea was sensationalized ("sensibilisée"); 2nd, that the disturbance of this ganglion which produced the sensation was transmitted to an external sensory organ, which was affected by this dis-

turbance; 3rd, that it is this sensorial impression which, returning to the brain in pursuing its natural centripetal path, was perceived in the hallucination, since the action which modifies the impression occurring in the eye modifies the perception which occurs in the brain.

But it may be objected, how can we conceive that a vibration originating in the brain can transmit an idea to a sensory centre there to be converted into a sensation? It is impossible to conceive it; it is a mystery of nature like all function.

According to the knowledge we possess concerning the physiology of the nervous system, hallucination can be produced only by the process just described. This psycho-sensorial theory indicates exactly which of the phenomena belong to the mind, to the grey cortical layer of the brain, and to the sensory system. What belongs to the domain of the mind is, first of all, at the beginning, the idea, that is, the subject of the hallucination, and then, at the end, the perception of this idea, after it has been converted into a sensation by the sensory nervous system. What belongs to this latter system is: the centrifugal nervous activity which conducts the cerebral stimulus creative of the idea to the sensory ganglion where this idea is converted into sensation, and which conducts it also to the external sensory organ, which it affects as an external object would do. That is the only functional anomaly we meet in hallucination. This theory, by showing that what is abnormal in hallucination is sensorial and not mental, explains why this phenomenon may co-exist with perfect soundness of mind and with normal organs. As an illustration of hallucinations occurring in a state of health, I may mention one which happened to myself. One morning my wife got up whilst I was asleep. Suddenly I heard her voice calling me so loudly that I awoke with a start, and asked, "What do you want?" I looked round, surprised at receiving no answer, and found myself alone in my room with the door shut. I was able to convince myself that no one had called me, but that I had been the victim of an auditory hallucination. Its origin must have been a stimulation of the cerebral cells which preserved the impression of the call, but it would be difficult to specify further the internal cause.

The cerebral stimulus, which is the point of origin of hallucination in the great majority of cases, arises in the brain itself. Persons most subject to hallucinations are lunatics amongst the diseased, and the preoccupied amongst the healthy.

Although the exciting cause of the centrifugal activity producing hallucination resides generally in the brain itself, and this cause may be an organic lesion, there are certain cases where this cause may be found elsewhere. It may be met in the excitement of each of the parts of the sensory organ affected: either in the white fibres which connect the mental centre with the sensory ganglion; in this ganglion or in the nerve which conveys to it the impressions which the external sensory organ receives from the external organ; or in this organ

itself. All painful nervous impressions, especially those which occur in the organs supplied by the great sympathetic, are an abundant source of hallucinations.

Unilateral hallucinations are naturally explained by the theory advanced. In the normal state, the twin sensory organs act simultaneously, and so the external sensory impression, though double in its origin, is perceived as single by the mind. But it may happen that the sensory anomaly which produced the hallucination affects only one of the sensory organs. In other words, though the idea may be produced through the action of two hemispheres, it may happen that the centrifugal activity producing the hallucination rises in a single hemisphere, and consequently may be transmitted to the sensory ganglion on that side only. In such cases the hallucination will be markedly unilateral.

That an hallucination may be produced, it is necessary that the abnormal sensory impression (subjective) be more distinct than the normal sensory impressions (objective) which occur at the same time, and that it eclipse them by its distinctness; it is necessary that the imaginary object seen in the hallucination be superimposed on the real object seen at the same time, and that the distinctness of the impression produced by this imaginary object prevent the perception of the real objects which occupy the same place in space, or make the perception more obscure. The distinctness of the abormal sensory impression is thus one of the conditions for the production of hallucination. This is so true that if the normal sensory impression becomes more distinct than the abnormal sensory impression the hallucination disappears. Thus, light often dissipates nocturnal hallucinations. The attention which considerably intensifies sensory impressions has consequently a great influence on the production of hallucinations.

A Contribution to the Study of Pyromania. By Dr. Rousseau.

This paper consists essentially in the record of two cases. The first is that of a young girl who became insane during the development of puberty. She heard voices urging her to set fire to the house. Her first attempt at fire-raising was associated with her first menstruation; the second attempt with the third menstrual flow. There were marked symptoms of hysteria; anæsthesia of the skin and mucous surfaces was complete. After her removal to an asylum from prison her mental derangement became more marked, but she completely recovered in about six months.

The second case occurred in a young woman suffering from congestive dysmenorrhœa. She made three attempts at fire-raising, and added to her crimes by trying to throw the guilt on an innocent person. She was also hysterical, and suffered from night-mare. In prison she became extremely and suddenly violent. She was re-

moved to an asylum, developed marked symptoms of hysterical mania, and recovered in about ten months.

It is worthy of note that in both cases it was with difficulty, and only after careful and prolonged examination, that the true mental condition was discovered. In England it is quite certain that they would both have been sentenced to imprisonment, and once in prison as convicts would have undergone a great deal of punishment for insubordination, &c., before their mental condition was made out.

Clinical Cases.

1. By M. Lélut. A violent epileptic tried to escape, was pursued, and the attendants, to restrain his violence, applied unskilfully and for too long a time an apron to his face and neck. An attack of epilepsy occurred, and death in a few minutes. M. Lélut feels certain in attributing death as partly due to the occlusion of the mouth and constriction of the larynx.

2. By M. Foville. In this case, a man, aged 42, some difficulty was experienced in excluding general paralysis from the diagnosis. He laboured under mania, with delusions of persecution and grandeur. His speech was indistinct, but this was found to be due to imperfection of the teeth, and to the inability of the man to speak French well, as he was from the mountains of Savoy.

3. By M. Parant. There are no special features of interest in this case. The man was insane for many years. He had marked delusions of persecution, and was unusually dangerous, carrying a revolver and dagger. He had also very exalted delusions. As might be expected, after so many years of mental derangement (about 20), he is gradually progressing towards dementia. He has always been free from any disorder of movement.

Broadmoor. By Dr. Motet.

As this account of Dr. Motet's visit to Broadmoor has already been noticed in the Journal, we need only say that it would be difficult to imagine a clearer and abler account of this great asylum than Dr. Motet manages to convey in his thirty-five pages.

Medico-Legal Case. By Dr. A. Motet.

A man, aged 62, door-keeper at the Passage des Panoramas for many years, and a steady drinker for perhaps as long, suddenly underwent a great deal of annoyance and anxiety in connection with the arrest of a lady for stealing. His mind became quite upset, and, amongst others, he developed well-marked delusions of suspicion against his colleague, whom he attempted to shoot. His insanity was evident, and the only feature of interest in the case was the unusually rapid development of the delusions of suspicion.

Remarkable Attempt at Suicide.

As a contribution to the curiosities of suicide, the following is worth reproduction from the "Siècle Medical":—

A man quarrelled with his wife about money for the rent, which he could not give her. Overwhelmed by her reproaches, he desired to destroy his life. Taking a dagger, ten centimetres long, he placed it vertically on the top of his head, and with a hammer he drove it in up to the guard. This done, he was no nearer his object. Not only had he not got the money, he had not destroyed his life, and he felt nothing. He retained his intelligence completely, as also his movements and senses. Quite at a loss by having placed his dagger so unskilfully, he was obliged to call the doctor, who tried to withdraw the knife from the cranial wall, but all his efforts were useless. Dr. Dubrisay was then called, but their united efforts were not more successful. They fatigued the patient by drawing on the handle of the dagger, but it remained fast. They then removed him to a neighbouring workshop to obtain sufficiently powerful means of traction. Placed between two supports having a strong and steady pincer between them, the blade of the dagger was seized and withdrawn without jerking, lifting the patient a little, who then fell on the floor. He immediately got up, began to walk, chat, and conducted M. Dubrisay to his carriage, thanking him.

The blade was a little bent towards the point. One could see that it had been against a hard body, the occipital fossa. Fearing symptoms of meningitis, the patient was taken to Saint-Louis, and placed under the care of M. Pean; but he was discharged at the end of eight days without any inflammatory or paralytic symptoms having developed.

As a method of suicide, the above is curious, and may be published without fear of producing an epidemic of imitation.

Note on an Alteration of the Brain, characterised by Separation of the Grey and White Matter of the Convolutions. By Dr. J. Baillarger.

Some thirty years ago Dr. Baillarger published three cases in which this unusual condition was found. In describing the lesion in the first case he wrote: "At the anterior and superior part the membranes raise in a single piece quite a group of convolutions which separated clean from the white matter. On examining this portion on its inner surface, I had genuine convolutions, whose summits were formed by the bottoms of the sulci. These inverted convolutions were smooth, and of a bluish-white colour at their summits.

In the second case the lesion, limited to the posterior lobe, presented the same features. On raising the membranes, one brought away with them the entire cortical layer, leaving the white substance quite bare, firm, smooth, of a bluish-white colour, and exposing the fibrous prolongations and the sulci. In this manner the whole posterior lobe was decorticated. The cortex, which remained adherent to the membrane, was extremely thin; yet it preserved the shape of the convolutions, and appeared, like them, inverted. One could re-apply them to the white substance.

In the third, the lesion is described as limited to one of the posterior lobes: the entire cortical layer came away in a single piece, leaving the white substance naked and very firm.

In a fourth, the change was yet in the first stage. Between the grey and white matter there was a very distinct line, much more marked than in the normal condition. Removing the membranes did not produce decortication. The commencing lesion was only observed in this case by direct examination, and after section of the convolutions. To make the separation between the two substances very marked, it is only necessary to put a portion in water.

It should be added that in the other cases the change was not everywhere by any means so well marked. When the separation is complete, and the cortical layer is much atrophied, there is a distinct cavity between it and the white matter; and if a portion is placed in water, the cortex is raised. On the other hand, the convolution may appear quite healthy, with simply a very well-marked line of separation between the two substances.

This lesion, when it is in the first stage, may easily be overloooked; still, it appears to be rare. It has, however, been described somewhat vaguely by Calmeil.

It must not be confounded with the adhesions so frequently seen in general paralysis:

1st. Instead of raising only a layer of the grey matter, more or less thick, the membranes lift this layer in its entire thickness.

2nd. Instead of a kind of ulcerated surface, unequal and mammilated at the bottom, after raising the membranes one sees the white substance firm and smooth.

3rd. Lastly, and this is the most important point, complete decortication occurs at the bottom of the sulci, where there are no adhesions, as at the tips of the convolutions.

This can only be explained by the complete separation of the two substances which are merely lying together. So the adhesion on the tip of the convolution is sufficient to drag away the entire convolution. Besides, even before raising the membranes, one can feel that the cerebral cortex is detached from the subjacent substance; it really slides upon it, proving its complete separation. Calmeil has pointed this out very distinctly: the cortical substance of the posterior lobes presented this peculiarity, that it was no longer adherent to the framework of the white substance which served to support it.

In the majority of the cases the grey matter was soft or very soft; the white matter firm, very firm, or even much hardened. Both were atrophied. The minute pathological changes are not understood.

All the patients in whom this lesion was found were general paralytics; in three, paralysis was most marked on the side opposite the lesion; in the fourth this was not so, as the posterior lobes were the seat of the disease.

T. W. McD.

May Feigned Insanity develop a Genuine Attack?

The important bearing of feigned insanity upon medico-legal inquiries attracted fresh attention some time ago in France, and the question has been recently discussed whether the simulation of insanity by a sane man may not have the effect of inducing an attack of the disorder itself. In the prison at Toulouse was a man named Laurent, charged with robberies of an aggravated character. He became very much excited, and his violence was such that his hands and feet were secured by heavy fetters. The *Juge d'instruction* of the Civil Court of Toulouse appointed three physicians to examine the prisoner's mental condition and report. One of these—M. Parant, medical superintendent of a well-known *Maison de Santé* in the town—has published the report and made a number of valuable notes upon the general question of feigned insanity, more especially in reference to its alleged influence on the mind. We pass over the description of the mental symptoms which the experts found present in this case. Suffice it to say that they decided that the symptoms did not correspond with any known form of insanity, that the prisoner was feigning, and that he was entirely responsible. Unforeseen circumstances delayed the trial for three months, and in consequence the prisoner's counsel, maintaining that the condition of his client might have changed in that time, and urging the opinion of some writers that the simulation of insanity might terminate in inducing it, demanded another expert examination, to which the Court assented. The fresh report confirmed the previous one. The jury adopted the medical opinion, and the prisoner was condemned to twenty years' hard labour. This verdict was not, however, allowed to pass unchallenged, in consequence of a technical point, and his trial took place before another jury, which, satisfied that Laurent was a simulator, brought in the same verdict. During the interval the prisoner persisted in his simulation, and after the trial he had several apparent attacks of epilepsy, during which frothy sanguineous saliva collected in his mouth. He was transported to New Caledonia, where he abandoned his simulation, his conduct became exemplary, and he confessed that he had all along feigned insanity.

M. Parant, among other comments, justly observes that in such a case the intervention of physicians is shown to be absolutely necessary. Baron Bramwell would no doubt think differently, and would consider three lawyers as competent to diagnose between real and feigned mania or genuine and pseudo-epilepsy as skilled physicians.

It will have been observed that counsel for the prisoner employed in his defence the opinion that the imitation of insane conduct might eventuate in a real attack of insanity. There certainly seems a great deal to be said *à priori* in favour of the possibility, nay, the probability, of such a consequence. Have we, however, any actual proof of this result? M. Parant has brought this question before the Paris

Medico-Psychological Society, and has collected together the opinions of several authors of authority on the question. Tardieu says: "It is a point of great delicacy upon which it is right even to insist that simulation itself, if sufficiently prolonged, exerts an incontestable influence upon the moral and physical state of the individual. Why should not remaining for years in the silence and immobility of melancholia with stupor eventually cause a real and complete stupidity? There is not one among those who, after having feigned insanity, have been unmasked or have confessed their simulation, who have not declared that they felt they were going mad, and that they would not undergo such suffering again were it even to save their life" ("Etude médico-légale sur la folie," 1872, page 239).

Another author (Dr. A. Laurent*) had in 1866 expressed an equally strong opinion. "We know," he says, "that genuine insanity results from its simulation. Among other instances, two French sailors, prisoners on board English hulks, persevered in simulating mental disorder during six successive months. But at the end of that time they only recovered their liberty at the cost of having really lost their reason." In his "Traité de médecine légale" M. Legrand du Saulle adopts the same opinion, and relates the same cases, but no more.

M. Parant recalls the fact that in 1848 Dr. Brierre de Boismont, speaking on a paper read before the Paris Psychological Society by M. Bois de Loury upon the same subject, asserted that *many* simulated forms of insanity passed into actual mental disease, and in support of his statement cited the historic sailors, but no more. It must be added that M. Parant has in vain ransacked the "Annales Médico-Psychologiques," the journal of "Médecine mentale," the "Annales de Médecine légale," and other recent journals, as well as treatises on insanity, but has altogether failed to find any positive proof of the transformation of simulated into real insanity. He is therefore fully justified in maintaining that it is a very bold course to base a definite opinion upon the isolated history of these two unhappy mariners whose only good fortune seems to be the immortality they have acquired in French medical literature. Even granting that they became insane after simulation and were not insane all the time, it is quite as probable, the writer maintains, that privation and suffering on the English hulks induced mental disorder as the attempt to simulate.

As regards the assertions of simulators themselves, a word must be said. The case of Derozier may be cited in addition to the cases already referred to. He kept up the imposture for seven or eight months, and when exposed declared to the late Dr. Morel, to whose observation he was subjected: "You cannot believe what I have suffered. I believed that I should really become insane, and I had more dread of this than of going to prison." While not altogether ignoring such statements, the fact remains that these persons

* "Etude médico-légale sur la simulation de la folie," p. 374.

did not become lunatics, only feared that they would. On the other hand, the fact is equally certain that numbers of prisoners have passed through the process of feigning insanity without the alleged result ensuing. Among these a case is reported of a prisoner who simulated deaf mutism and imbecility for no less than three years, another case which continued for 10 months, and a third which lasted 14.

We are therefore in full accord with M. Parant in his conclusion that the direct transformation of simulated insanity into the true disorder ought not to be admitted among the proved medico-legal facts of mental medicine. T.

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2. *American and Colonial Retrospect.*

By D. Hack Tuke, F.R.C.P.

The Longue Pointe Asylum, Montreal.

The Canadian press has been again greatly exercised in regard to the condition of this notorious institution. One paper contains the following :—

"In addition to the horrors which have been pictured on account of small-pox having broken out in this asylum, where are about 1,000 lunatics, harsh treatment has just come to light. A young man whose appetite for liquor was uncontrollable was placed there as a private patient. Being allowed considerable freedom, he crossed the road through the asylum gate without any intention of running away, when he was placed in the idiotic ward, and all attempts to get taken away from these incurables has been unavailing. Even the Government Inspector, Dr. Howard, is powerless in the matter. In an interview today Dr. Howard said, 'There is no supervision of private patients. The law enforces it, but it is not carried out. Any sane person might be placed in the asylum and kept there for an indefinite time. I have no control over private patients, and know nothing about them.'"

Another paper says :—

"To a reporter who called upon Dr. Henry Howard, Government Medical Superintendent of Longue Point Asylum, he said (in reply to inquiries respecting the prevalence of small-pox), 'Whatever information I can give you I will cheerfully do. I must preface what I have to say by a few general remarks. . . . On the 12th Sept., 1879, under the Jolly Government, an Act was passed by the Provincial Legislature by which the sisters were empowered to have their own physician for the treatment of the insane in the establishment. By this same Act I became Government Visiting Physician of the asylum, my power being very limited, and having nothing whatever to do with the treatment of the insane. Patients could not be admitted without my authority, and the power to discharge was supposed to be vested in me, but it seemed, upon investigation, that it must be recommended by the

resident physician. This again caused public scandal, as it was generally believed that many were detained who should have been discharged. It was not unreasonable that the public should think so, seeing that the greater the number of patients in the asylum, the greater would be the profit of the contractors; and their physician being their paid servant, would be obliged to do whatever they required. Under these circumstances, the Government had another Act passed, 47 Vic., chap. 20, which came into force August 10th, 1884, by which the contractors were obliged to report upon all private patients in their asylum to myself. This Bill was resisted by the contractors, and the law became inoperative. Another Act was then passed by the Quebec Legislature, 48 Vic., chap. 34, by which the Government gained the control of all lunatic asylums in the province, not only to have them supervised by a Medical Board, but to have the insane patients treated by the said Board, which was to be appointed by the Government. This Act, which was most liberal, was approved of by the entire medical fraternity, and I was appointed medical superintendent, with Drs. Perrault and Duquet as house physicians. This Act took all power out of the hands of the contractors and placed it in the hands of the Medical Board. This law has been set at defiance by the contractors, who have refused up to the present to submit to its provisions. When the small-pox became epidemic, in September last, I wrote to Drs. Perrault and Duquet, by the advice of certain members of the Central Board of Health, instructing them to proceed at once to vaccinate all patients and employés in the asylum. They proceeded to the performance of their duties, but were met at the door by the Mother Superior, who absolutely refused to allow them to proceed. No further action was taken until the 2nd of December, when it was reported to me that small-pox had actually broken out in the asylum, when I again wrote to the doctors, sending them a letter which I had received from the Central Board of Health, and instructing them to go again and demand as a right, by virtue of the Government authority, admission to vaccinate all patients and employés in the asylum. They were again refused admission by the Mother Superior. On Monday last I went, by the advice of the Central Board of Health, to the asylum, accompanied by Drs. Perrault and Duquet, and again demanded to be allowed to vaccinate the patients, when we met with a positive refusal. She stated that she was having the work of vaccination carried on by her own medical men. We examined 274 patients out of the 975 in the asylum, and found that 128 had been successfully vaccinated, and I believe that this constitutes the whole number vaccinated. We then went to examine the hospital in which the sick small-pox patients were kept, which is over the laundry. The Mother Superior said that if I entered that hospital the doors of the institution would be afterwards closed against me. I did not go inside. All of the facts were made known to the Central Board at their meeting to-day, and a report was sent to the Provincial Secretary at

Quebec. The rule is for the contractors to furnish me every fifteen days with a list of all patients admitted into and discharged from the asylum, as well as of those who have died. Yesterday's report for the period above named showed the names of two patients who had died from small-pox, and a letter accompanying states that there were others who had died from the disease whose names would be furnished in a report to be sent in within the next two days.' "

The newspaper adds, " It was learned, on what is considered good authority, last evening, that there have been 20 deaths from small-pox in the asylum within four weeks."

There appears to be an extraordinary want of power in the Executive Government to enforce the provisions of the Acts of the Provincial Legislature. It passes comprehension how the law is allowed to be contravened by the female head of this asylum. Dr. Howard is obliged to confess that while the new law gives him and his associates full power to superintend and administer to the wants of the insane patients, he is not permitted to do as the law contemplated he should do, and that he is sick and tired of the farce which is daily enacted in regard to their treatment. · How long is this state of things to be allowed to last?

Dr. Benjamin Rush.

In an interesting address delivered by Dr. Thomas G. Morton before the Association of Resident Physicians, Pennsylvania Hospital, held in Philadelphia, Dec. 17th, 1885, there is a reference to the celebrated Dr. Rush which ought to be made generally known. It appears that Dr. Morton has recently discovered some papers in the old hospital which add to the claims which Dr. Rush already has on the respect and admiration of all who are interested in the history of the reforms effected, whether in America or elsewhere, in the condition of the insane. Among these papers is a letter written by Rush to the managers of the hospital, in Nov., 1789, in which he says:—

" Under a conviction that the patients affected by madness should be the first objects of the care of a physician of the Pennsylvania Hospital, I have attempted to relieve them, but I am sorry to add that my attempt, which at first promised some success, was soon afterwards rendered abortive by the cells of the hospital.

" These apartments are damp in summer and too warm (?) in winter. They are, moreover, so constructed as not to admit readily of a change of air; hence the smell of them is both offensive and unwholesome.

" Few patients have ever been confined in these cells who have not been affected by a cold in two or three weeks after their confinement, and several have died of consumption in consequence of this cold.

" These facts being clearly established, I can see the appropriating of the cells any longer for the reception of mad people, will be dishonourable both to the science and humanity of the city of Philadelphia.

" Should more wholesome apartments be provided for them, it is

more than probable that many of them might be relieved by the use of remedies which have lately been discovered to be effective in their disorder."

In the same address, Dr. Morton, passing from Dr. Rush's letter, gives some curious proofs of the treatment of the insane in former days by restraint. A bill, dated 1752, contains a charge to "ye hospital for a pair of handcuffs and 2 legg locks and 2 large rings and 2 large staples, 5 links and 2 large rings, and 2 swiffells for leg chains." In a letter from a patient to the manager, 1788, the writer says, "I am confined here in chains at the instance of a relation of my wife's. I hope you will desire the steward to unchain me, but as his duty he could not do less." And again he writes a few days afterwards, "The present serves to inform you that pursuant to your orders I am unchained." Dr. Morton justly remarks that "Although the Pennsylvania hospital, early in its history, naturally followed the prevailing custom which harshly coerced the more violent cases, we should likewise remember that in this house nearly 70 years ago (1817), far in advance of the times, were introduced those enlightened and humane views which later became more generally accepted."

The whole address by Dr. Morton (the son-in-law of the late Dr. Kirkbride, and an active member of the Committee on Lunacy of the Board of Public Charities in Philadelphia) will well repay perusal, and will be found in the "Philadelphia Medical Times," Dec. 26th, 1885, under the title of "Reminiscences of Early Hospital Days."

Dr. Earle's Retirement.

In a former number we referred to the retirement of this well-known physician from the superintendency of the Northampton Hospital for the Insane, Massachusetts. The last report of the Board of Managers is now before us, and we append the Resolutions passed by them on accepting his resignation. The Board is fortunate in having Dr. Nims for a successor. We hope that the leisure thus afforded Dr. Earle will favour contributions to medical psychology from his able pen. A retrospective glance at his experience in cases of insanity would be of much value, and perhaps the writer of it might not object to send it for publication to this Journal.

Resolved, That in accepting the resignation of Dr. Pliny Earle, superintendent of this hospital, the Trustees have reluctantly yielded to the conviction that his advancing years and impaired health demand rest and relief from the responsibilities and labours of his position.

Dr. Earle has been at the head of this institution twenty-one years, and, during nearly all that period, has also been its treasurer. In its management he has combined the highest professional skill and acquirements with rare executive ability. By his thorough knowledge, his long experience, his patient attention to details, by his wisdom and firmness, his absolute fidelity to duty, and devotion to the interests of the hospital, he has rendered invaluable services to the institution and to the community which it serves.

The Trustees are deeply sensible of the assistance which he has given them in the discharge of their duties, and follow him, in his retirement, with the assurance of their highest respect and esteem.

***Resolved*, That the Trustees indulge the hope that Dr. Earle will continue to make his home in this institution, that they may continue to profit by his counsels; and they will provide that his rooms shall always be open and ready for his use.**

Lectures to Attendants and Nurses.

We have received an unassuming little book of 70 pages by Dr. Williamson, Assistant Medical Officer of the Hospital for the Insane at Paramatta, entitled "Lectures on the Care and Treatment of the Insane, for the Instruction of Attendants and Nurses." While it is certain that no mere book-reading will make a good attendant out of a bad one, and that it may result in the acquirement of superficial and theoretical knowledge in place of that which comes of practice and experience, we nevertheless believe that a few well-chosen practical directions will help to make a good attendant still better. Probably the best way to secure the end in view would be for one of the asylum medical officers to give a course of lectures and demonstrations to the attendants, which might then be supplemented by the perusal of such a book as that before us.

Dr. Williamson's book consists of ten lectures, of which the first five treat of the qualifications necessary for attendants and nurses and the characteristic symptoms of the chief classes of mental disease, special sections being devoted to the consideration of epilepsy, suicide, restraint and seclusion, and artificial feeding. The next four lectures deal with bandaging, the treatment of wounds and sores, bruises and burns, &c., together with the care of the sick and the bathing of patients. The concluding lecture treats of the value of occupation for patients and of amusements and religious services.

Though this book does not cover the whole ground, its directions are generally well-considered and practical, especially those concerning epileptic and suicidal patients. The advice given in the opening lecture on obedience and discipline, personal neatness, courtesy to patients, and the avoidance of ridiculing their delusions is very good, and the comfort of all in asylums would doubtless be promoted were such advice universally followed. We agree with Dr. Williamson that "black eyes, cut faces, bruises, and scalp wounds received by epileptics or by other patients in conflict with them are in a large number of instances evidences of a lack of proper supervision and precautions on the part of nurses and attendants."

Dr. Williamson has done well to omit all description of the anatomy and physiology of the brain in a book intended for the use of attendants and nurses.

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3. *German Retrospect.*

By William W. Ireland, M.D.

Die Krankhaften Erscheinungen des Geschlectssinnes. Eine Forensisch-psychiatrische Studie. Von Dr. Med. B. Tarnowsky, Professor an der Kaiserlichen M. Med. Akademie in St. Petersburg. Hirschwald, Berlin, 1886.

While men exalt certain aspects of the amative faculty, celebrate them in poetry, and glorify them in painting, there are others which they habitually conceal and strive not to think of. The only person suffered by conventional usage to lift the veil is the priest of the healing art, who must know the whole man. He cannot escape from regarding the variations and perversions of the sexual propensity. They are the cause of disease in ordinary practice, and force themselves on his attention in medico-legal inquiries. But it is in caring for the insane that we see with the least disguise the great and pervading strength of the erotic feelings and the strange modifications and exaggerations which they may undergo. There is a tendency now-a-days to put all traditional knowledge into books, and we can at least certify that Dr. Tarnowsky's exposition of the subject is very complete. His knowledge and experience in such cases are unusually great, and his list of books and papers, filling four pages, shows how far-reaching his inquiries have been. The book was originally published in Russian, and now appears in German in an octavo form of 152 pages. It is written in a grave and scientific style, and is fitted for the physician or the anthropologist who wishes to take a complete survey of all the aspects of human nature. It is neither designed for nor is it at all fit to be perused by other readers. Dr. Tarnowsky has found that sexual perversity is often hereditary. This makes him divide it into two groups, hereditary and acquired; but a third section is needed for the complicated forms.

Thermal Brain Centres.

Dr. R. W. Raudnitz ("Prager Medicinische Wochenschrift," 1885, No. 18) does not consider the existence of a centre for the regulation of animal heat in the cortex cerebri, as indicated by Eulenburg and Landois, to be sufficiently proved. In experiments upon dogs these physiologists observed a rise of temperature in one paw after extirpation of the grey matter of the brain, and when this supposed cerebral centre was stimulated there was a sinking of the temperature in the same paw. This change of temperature, however, Dr. Raudnitz observes, was not invariable, and might be simply owing to the diminished muscular tonicity and its influence upon the vessels. When the animal is under the influence of curare the alteration of the temperature of the paw cannot be induced. As stimulation of the same region of the cortex induces muscular motions in the limbs, this may

be the cause of the alteration of temperature. Eulenburg and Landois have stated that they succeeded in producing changes of temperature in the limbs in animals while under the influence of curare. On repeating these experiments, Dr. Raudnitz has not been able to confirm their results. He is therefore disposed to believe that these physiologists have not sufficiently attended to the many different sources of fallacy.

The Cause of the Knee Phenomenon.

Dr. Theodor Rosenheim ("Archiv.," xv. Band, 1 Heft) gives a description of his experiments to determine the nature of the clonus or tendon phenomenon. Since the discovery of this symptom by Erb and Westphal it has been a debated question whether the involuntary motion is owing to reflex action in the cord or direct stimulus acting on the muscles. Eulenburg declared that the latent time between the shock and the reaction was in the patellar clonus too short for the stimulus to be conducted along the excito-sensory nerves to the cord and then back along the excito-motor nerves. He therefore inferred that it could not be reflex, and thought it dependent upon the muscular tonicity of the quadriceps extensor and the quickness of the peripheral sensibility and conduction of impressions. Rosenheim has arrived at the conclusion that the time of the latent stimulus of the knee phenomenon is never so short as to make it impossible for it to be reflex. He never found this period to be less than 0·025, but Eulenburg gave the shortest period observed by him as 0·01613. Gowers gave the latent period of the knee-clonus as from 0·09 to 0·15, that of the ankle-clonus as 0·025—0·04. While he held the patellar reaction to be reflex, he thought the ankle-clonus to be the result of the direct muscular stimulus. Westphal has observed that a tap on the border of a tendon or muscle was the only stimulus which could call forth the knee phenomenon. By some carefully-devised experiments Dr. Rosenheim succeeded in producing an analogous motion by shocks transmitted from a magneto-electric rotation apparatus through a needle inserted in the tendon. The general results of Dr. Rosensheim's experiments seem to confirm the view that the patellar clonus is reflex.

Relation of the Tendon Phenomenon to the Reaction of Degeneration.

Dr. Ernst Remak ("Archiv.," xvi. Band, 1 Heft) examines the connection of the symptoms of the tendon phenomenon with diminished irritability to the continued and induced currents following on degeneration of the affected muscles. He observes that a slight stretching of the crural nerve in animals causes failure of the tendon reflex of the knee. He notes the failure of the knee phenomenon in cases of partial and peripheral paralysis dependent upon neuritis, and also its failure in complete motor paralysis of the mixed nerves. In case of recovery the altered reaction to the faradic and galvanic cur-

rents returns more quickly to the normal state than the patellar reaction. Dr. Remak comes to the following conclusions :—

1. The increase of the tendon phenomenon, especially in the foot, accompanied by partial degenerative reaction of the corresponding muscles, can occur only in spinal disease, and only in amyotrophic lateral sclerosis.

2. The maintenance of the tendon phenomenon, in spite of partial degenerative reaction, occurs, in all probability, only in atrophic spinal paralysis (*polio-myelitis anterior*).

a. The loss of the tendon phenomenon generally follows upon all severe paralysis with relaxation of the muscles and degeneration of the muscular tissue and diminished irritability of the nerve, whether of spinal (polio-myelitic) or of peripheral origin (neuritic), and it lasts longer in cases of recovery than the galvano-muscular reaction of degeneration.

b. The tendon phenomenon fails in peripheral neuritis of mixed nerves.

c. The tendon phenomenon also fails in complete peripheral paralysis, even where there is no consecutive reaction of degeneration.

A New Group of Symptoms.

Dr. Westphal has in a reprint from the "Archiv." (Band xvi., Heft 2) called attention to a group of symptoms in connection with a pathological lesion such as has not previously been described. The patient was 47 years of age on admission to the hospital at Berlin, where he remained two years and three months. He was free from taint of neurotic inheritance, of syphilis, or from alcoholic excess. The disease began with paresis of the left rectus internus of the eye; later came ptosis and giddiness. The legs began to fail, till at last they became almost completely paralysed. Then followed loss of strength in the arms. The paralysis was followed by rigidity in groups of the muscles of the legs, increase of the knee phenomenon, and later on by paradoxical contraction. The last symptom was observed first in dorsal contraction of the foot, then in plantar flexion and in the movements of the knee and hip joints by stiffness. Paradoxical contractions in the arms followed later. Similar disorders of innervation in the muscles of the jaw and tongue, loss of sensibility, spread almost over the whole body, at last implicating the region of the fifth pair. Besides the feeling of giddiness and distress and broken sleep there were no cerebral symptoms till towards the end of the illness, when some blunting of the intelligence seemed to result; but this was no greater than what is observed to follow other severe diseases. The patient was at the same time affected with tuberculosis. The diagnosis of the nervous disease seemed uncertain, but the symptoms were supposed to indicate multiple cerebro-spinal sclerosis. The result of the post-mortem examination was quite unexpected.

There was found disease of the posterior pillars of the cord, affecting especially the inner part of the columns of Goll up to the margin

of the pillars of Burdach. The peripheral nerves of the affected limbs were much atrophied and the muscular tissue degenerated. Dr. Westphal explains the persistence of the patellar reflex by the entirety of the root-zone in the dorsal region and the want of ataxia by the incompleteness of the degeneration of the posterior columns.

He regards it as a case of chronic parenchymatous neuritis. He is unable to decide whether the disease had a peripheral or spinal origin.

Dr. Westphal's paper, which fills 38 pages, is illustrated by two pages of lithographs.

The Ano-vesical Centre.

Dr. Kirchoff publishes ("Archiv.," xv. Band, 3 Heft) the symptoms in a patient who was thrown from his horse and severely injured in the loins. The accident was followed by paraplegia, but in six months he was again able to walk about. There remained incontinence of the urine and fæces, with recurring attacks of cystitis, which in the end extended to the kidneys, causing death exactly twenty months after the accident. On examination the cord was found to be compressed by the displacement of the first lumbar vertebra. Dr. Kirchoff considers that this case supports the view that the ano-vesical centre is situated near the point of origin of the third and fourth sacral nerves, as indicated by Stilling.

Hitzig on the Motor Centres.

Professor Hitzig, who had been kept for six years by other duties from treating of the vexed question of the motor area of the brain, at a meeting of neurologists and alienists held at Baden on the 17th of June, 1883 (see "Archiv.," Band xv., Heft 1), commented on the manner in which his researches had been interpreted and extended. He had been induced to renew his experiments by the statement of Munk, who had found that the application of the interrupted current to the convolutions of the frontal lobe produced convulsions, and that their extirpation was followed by paralysis. Munk found that the removal of one frontal lobe rendered the animal unable to bend the back sidewards, and that removal of both lobes made it incapable of arching the back upwards. He therefore concluded that the function of the frontal lobes was the innervation of the muscles of the back. That the great development of the frontal lobe in man should have no further function than presiding over the movements of the back seemed to Hitzig very improbable.

Hitzig found that the symptoms described by Munk were only occasionally observed. In many of his experiments he found that large portions of the frontal lobe could be removed without these deficiencies in the movements of the back being present. Whilst he found that there was much less disturbance of outward functions after injury to the frontal lobes, Dr. Hitzig was able to make out that there was a loss of sight in the opposite eye, a disturbance in the motions of the limbs, and a loss of intelligence.

In order correctly to estimate the injury to the intelligence of the animal, one requires to know something of its habits and intelligence before it is made the subject of experiment. Dr. Hitzig confirms the statement of Goltz that removal of any part of the brain causes disturbance of vision which passes away in a few days, otherwise, he observes, he will not range himself in the camp of Goltz. Instead, however, of combating this formidable opponent he here turns aside to criticise the theory of Schiff, that the movements produced by the application of electricity to the brain are nothing else than reflex motions caused by irritation applied to the termination in the brain of the sensory nerves.

Hitzig concludes by observing that from the centres in the cortex proceed motor, sensory, and, perhaps, other fibres, and that it is the motor fibres which are affected by the electric stimulus. "I still hold," says he, "as I did in the year 1870, that the centres discovered by me are nothing else than gathering places; and I apply this theory to the other centres since discovered. I share the often repeated view that deep or extensive lesions to the central machinery of the brain necessarily disrupt a number of connections between the parts, and must thus produce such symptoms. In this category would I place the temporary disturbance of vision after injuries to different parts of the brain." Hitzig opposes the theory of Munk that no especial organ is needed for the higher intellectual capacities. "It is true," he observes, "that the intelligence exists in all parts of the cortex, or rather in all parts of the brain, but I hold that abstract thought needs a separate organ, and seek for it in the frontal lobe."

Gudden on Cerebral Localisation.

At a meeting of the German Medico-Psychological Society at Baden, in Sept., 1885 (reported in the "Neurologisches Centralblatt," No. 19, 1885), Gudden referred to the great difference of opinion about the results of experiments on the grey matter of the brain. He had little faith in the charts in which different centres were put down as in a map. On the whole, he stood on the standpoint of Goltz. His own observations had led him to doubt Munk's results about the visual centres. He had extirpated the whole occipital lobe in young rabbits, and found that they could still see very well. He thought our methods of investigation too rude to give trustworthy results. The method of investigation to which he trusted most was destroying the conducting tracts, and observing what portions of the cortex became atrophied. If one extirpated the frontal lobe, there was degeneration of the tract which passed down through the pyramids, but if the rest of the brain were extirpated, leaving the frontal lobes entire, there was no degeneration of the pyramids. If the hemispheres were removed, the fillet became degenerated. If one extirpated the parietal and occipital lobes, the corpus geniculatum internum became atrophied as well as the corpus mammillare. Gudden removed the so-called motor sphere in cats, and after a few hours they

showed no motor disturbance. He considered the arrangement of the different layers to be the same all over the cortex. The only centre which Gudden seems disposed to admit is that for Language.

Exner and Vareth on Motor Areas in the Cortex.

At the Congress of Scientific Men and Physicians, held at Strasburg in September, 1885 ("Neurologisches Centralblatt," No. 20, 1885), Dr. Exner and Dr. Vareth gave an account of a number of experiments made by them in the Physiological Institute of Vienna. Their object was to determine more nearly the areas of the cortex which preside over different muscular motions. They experimented on dogs under the influence of morphia, using the constant current. The muscular contractions were registered upon Marey's drum. In order to determine the so-called motor centres, they severed the side connections so as to leave the portion of grey matter isolated, save by its downward connection with the centrum ovale. If a part, after this lateral division, still retained its influence on particular muscles until its continuity below was severed, it was assumed that this was a presumable determination of a motor centre.

On mapping the results thus obtained upon a diagram, these observers arrived at the conclusion that the so-called motor centres are not separable from one another, and are not reducible to given points. The posterior and outer part of the sigmoid gyrus is the common area of the muscles of the extremities, the flexor, and the extensor digitorum, and the abductor pollicis of the fore-paw and of the flexor and extensor digitorum of the hind-paw.

The cortical areas of these single muscles for the most part seem to overlap one another, or to be crowded against one another; the outer part of the sigmoid gyrus constitutes the area of the orbicularis palpebrarum; the area of the facial is sharply divided from that of the extremities. In the discussion which followed, Goltz repeated his well-known views. He observed that we cannot dismiss the possibility that the electrical excitation of the muscles through the cortex may be dependent upon irritation of the white substance.

Goltz on Cerebral Localisation.

At a further meeting of the Congress at Strasburg ("Neurologisches Centralblatt," No. 21, 1885), Goltz presented four brains taken from dogs which had been shown alive in the morning. He laid most stress upon one brain in which the occipital lobe had been completely removed, so that no remaining motor centre could be pointed out, and in which the so-called excitable zone of the cortex was, in a great measure, destroyed. The visual area on the left side was reduced to a very small margin. Yet this dog, as they had seen, had retained sensations of pain or pressure of the right fore and hind paws, as well as what Hitzig calls motor consciousness. The dog

presented no trace of paralysis. On the left side the centres of the limbs had been removed as well as the so-called centres of sensation. In the brain of the second dog the so-called visual centres were destroyed. According to Munk this animal should be stone blind, which was not the case. In the third brain only, the frontal lobes had escaped; the so-called motor zone was completely destroyed, and only a small portion of the occipital lobe on the right side had escaped. This animal had to be fed; in fact, the dogs thus mutilated became demented but did not suffer from paralysis or apparent loss of sensation. There seemed some difference of opinion as to the character of the lesion in the brain of the fourth dog, but Goltz regarded as already proved the point which the vivisection was intended to show, viz., that the complete severance of the internal capsule does not cause a paralysis of the limbs of the opposite side. Nothnagel, while admitting the apparent absence of symptoms after the destruction of almost an entire hemisphere in the dog exhibited by Goltz, was still of opinion that a similar lesion in man would cause complete hemiplegia. The majority thought Goltz established his point.

Dr. W. Bechterew, of St. Petersburg, has been making fresh experiments by means of vivisections and electrical excitation of the cortex. He has arrived at the conclusion ("Neurologisches Centralblatt," No. 19, 1885) that the loss of motor power in certain parts, after destruction of the corresponding motor centres, is not accompanied by loss of sensibility. The loss of motor power following the extirpation of these centres consists in an incapacity to perform voluntary and designed movements rather than of simple associated actions, such as walking or swimming.

Disease of the Back of the Pons.

In an original communication in the "Neurologisches Centralblatt" (Nos. 16 and 17, 1885) Drs. Mierzejewsky and Rosenbach analyse some of the symptoms of disease of the pons Varolii. In a patient, a man of thirty-four years of age, the symptoms were paralysis of the right facial, the face on that side being immovable and the right eye not being closed. The paralysed muscles were more affected than those of the opposite side by the galvanic and faradic current. There was no paralysis of the extremities, though the patient's gait was weak and tottering, and he yielded a little to the left side. The knee clonus was wanting on both sides. There was paralysis of the external rectus of the right eye, and the left eyeball could not be turned inwards beyond the middle line. This paralysis of the external rectus, and paresis or imperfect action of the internal rectus, were observed not only in associated movements of both eyes, but also when the patient looked at an object with one eye alone. There was double vision. The pupils of both eyes were dilated, and the visual power diminished, and on being examined with the ophthalmoscope neuro-retinitis was observed. The intelli-

gence and memory were unaffected, but he was troubled with giddiness and pain, especially at the back of the head, with nausea, progressive weakness, and fever. These last symptoms were probably due to phthisis pulmonalis of an inflammatory type. The patient died thirty-five days after admission to the hospital at St. Petersburg. There was found a tumour about the size of a horse-pistol bullet, occupying the back of the pons and the floor of the fourth ventricle. It lay on the right side, and had pushed to the opposite side the raphe and left half of the pons. The tumour was a glioma, rich in vessels, and sharply separated from the nervous tissue. It had caused chronic inflammation and destruction of the nuclei of the sixth and seventh pairs on the right side, and in a lesser degree of some adjoining parts.

Drs. Mierzejewsky and Rosenbach cite a number of cases in which paralysis of the sixth pair was associated with that of the facial nerve of the same side. They explain this combination by quoting the researches of Duval, who showed that a part of the fibres of the facial come from the same nucleus as the sixth pair. They regard facial paralysis, with loss of power to turn out the eye, as indicating lesion of the posterior part of the pons and the floor of the fourth ventricle. They regard increased excitability to galvanic and faradic currents, with slow contraction of the muscles, as a proof that the facial paralysis is not peripheral. In facial paralysis following disease of the pons, the atrophy of the muscles supplied by the seventh pair is generally confined to the lower muscles of the face. Dr. Mierzejewsky maintains that the combined symptoms observed in his patients, paralysis of the external rectus with imperfect action of the internal rectus muscle, have been repeatedly observed with disease of the nucleus of the sixth nerve and integrity of the deep origin of the ganglion of the third pair (oculomotor). While admitting that there must be some physiological connection between the sixth pair and the innervation of the internal rectus muscle, Drs. Mierzejewsky and Rosenbach consider that this connection has not yet been satisfactorily explained. Most authors who describe similar cases confine themselves to the statement that lesions of the nucleus of the sixth pair paralyse the movements of both eyes towards the side of the injury, which they explain by the assumption that the said nucleus presides over the outward motion of the eyeball on the injured side, and also over the associated sideward movements of both eyes. This explanation fully suits those cases in which the paresis of the rectus internus in the opposite eye is remarked only with associated movements of the eyes sidewards; but they observe that such cases are exceptions, and that in most cases the motor power of the internal rectus is directly injured independently of the other eye. It is also worthy of remark that in most observations of the kind, while there is complete paralysis of the external rectus, there is only an incomplete paralysis of the internal muscle of the other eye. W. W. I.

Dr. Brosius. Heilanstaltern für Nervenkranke, Bendorf a. Rh., Villa Sayn, und Waldesruhe.

We have received this description of the private asylums of Bendorf, Villa Sayn, and Waldesruhe, which have been under the charge of the veteran Brosius for more than a quarter of a century. It may not be generally known to our readers that so long ago as 1860 this physician translated Dr. Conolly's work on the Treatment of the Insane without Mechanical Restraints, and he has himself endeavoured to dispense as much as possible with their use. Indeed, his asylum was the first in Germany in which they were disused. Now other physicians in much larger institutions have introduced the non-restraint system, more or less completely.

Dr. Brosius's institutions are pleasantly situated on the Rhine, not far from Coblenz, and have recently been enlarged by the addition of a small villa, fitted out with every comfort and convenience. During a recent visit we paid to Bendorf, the doctor took one of the gentlemen patients out hunting with him in the neighbourhood. The patients of both sexes take their meals with the family, unless their mental condition renders it absolutely unsuitable. We are sure that English alienists visiting the Rhine will be warmly welcomed and hospitably entertained by Dr. Brosius should they be disposed to spend a few hours in visiting the asylum. T.

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4. *English Retrospect.*

Asylum Reports for 1884.

Through the abundance of more important matter, the notice of the reports has fallen somewhat behind. It is, therefore, our intention to be exceedingly brief on the present occasion, and to compress this abstract into such small dimensions that it can be published conveniently in one number of the Journal. It will thus be possible to notice the reports for 1885 in the course of the present year.

We would again beg the medical officers of asylums to favour us with a copy of their annual report. From England we receive an almost complete set, but from Scotland and Ireland the number forwarded is small.

Aberdeen.—Various structural alterations have been made in the older buildings, thereby increasing comfort and bringing the accommodation up to the requirements of the day.

The report of Dr. Arthur Mitchell is a most thorough production, and should greatly assist the managers in deciding various questions as to their relations with the guardians of the poor. The asylum is already overcrowded, and from its position incapable of enlargement, yet the managers seem to have been on the point of agreeing to receive 400 pauper lunatics instead of 350 as heretofore. Dr. Mitchell's report has saved them from committing such an error.

In order to ascertain the extent of the overcrowding referred to, three of the more crowded day-rooms were measured, and it was found that they gave respectively 19·2, 18·8, and 16·8 square feet of floor space to each occupant. These figures represent a serious overcrowding, especially if it be borne in mind that the occupants, in consequence of there being no general dining-hall, take their food as well as live in these rooms. They are occupied by 188 patients in all. At 25 feet of floor space for each patient, which is the lowest space allowed, the number would require to be reduced to 137; and at 30 feet, which is now usually recommended, the number would require to fall to 115. That is, 51 or 73 patients would require to be withdrawn according as 25 or 30 feet were given.

There are other paragraphs in Dr. Mitchell's admirable report which, did space permit, we would gladly reproduce. All engaged in lunacy administration may profitably consult it.

Abergavenny.—The new accommodation, provided at a cost of £50,000, is now in use, and there are 790 patients in residence. It is proposed to make a small addition to the estate. The weekly charge is now reduced to 7s. 3½d. How is it done?

The Commissioners point out that —

In none of the wards is the staff too strong, and in wards 5 and 6 on the female side, where the more turbulent women are placed, two nurses for 28 and 26 patients respectively seem to us barely sufficient, and we think these wards ought never to be left with less than two nurses in them. In No. 6 on the male side there are collected 30 patients, several of whom are disposed to be violent and aggressive, and in charge of them are three attendants, a number only sufficient, in our opinion, when all are on duty in the ward.

These criticisms appear judicious. Dr. Glendinning reports that no fewer than 11 male attendants were dismissed during the year. Two male and two female attendants were dismissed summarily, and their wages forfeited, for ill-treatment of patients.

Barnwood House.—Signs of progress continue undiminished. A mansion in the Forest of Dean, 900 feet above sea level, combining the advantages of a perfect sanatorium with the most beautiful surrounding scenery, and providing for all the patients to whom it might be beneficial, a constant change of air and scene, has been rented for eight years. It can accommodate from 15 to 20 patients. All special restraints of every kind are removed, and the patients live as if at home in a country residence.

The applications for admission continue to exceed the vacancies. The flourishing financial condition of the establishment enables the committee to extend its benefits to many persons whose pecuniary means do not correspond to their social position.

We are glad to find that Dr. Needham succeeds in inducing a few gentlemen to work in the garden.

Bedford, Hertford, and Huntingdon.—In December a serious outbreak of small-pox occurred. In many cases the disease was most malignant. In all 56 persons were attacked; of these 14 died. Mr. Swain has prepared a special report on the subject. The emergency seems to have been met with great promptitude, and he and the staff are worthy of all praise. Should a similar epidemic occur in another

asylum, the superintendent could not do better than consult him as to the construction of a temporary hospital. The one at Arsley was put up in a week, at a total cost of £140, provided accommodation for 27 patients, and appears to have been thoroughly efficient in every respect.

Berkshire, &c.—The sanitary condition of this asylum is receiving attention. During the year there were five fatal cases of diarrhœa and one of typhoid fever.

A large number of patients hitherto confined to the airing courts now exercise in the general grounds. The next step is to encourage walking beyond the estate.

The report of the Commissioners is not given.

Bethlem Hospital.—Much of Dr. Savage's report is taken up with the questions of discharging on parole and the kind of cases suitable for more or less liberty whilst under asylum treatment. As he very correctly remarks —

> Risk has to be run, and it is only after long and often painful experience that a physician learns whom to trust, and how much, and even with the best experience one may be mistaken.
>
> During the past year hundreds of patients have been on short or long leave, and a fair number have been allowed to go out alone on parole. One only broke his word, and instead of returning enlisted. He remained a short time in the army, and was then bought out by his friends. The present unsatisfactory state of the lunacy laws, or rather the unsatisfactory result of foolish, misguided opinion on the lunacy law, was well shown by two cases during the last year. In one case the friends removed the patient, who was temporarily sane, against my direct advice; they seemed to think that he was being kept unduly in the hospital. He became worse, and after a redevelopment of his old dangerous homicidal symptoms, endeavours were made to obtain fresh certificates, but the dread of prosecutions and lunacy vexations prevented the certificates being signed, and the patient killed himself. In a second case the wife insisted, in spite of warning, in taking out her husband during a sane interval, and the result in this case was that she was murdered by him during the succeeding outbreak of violence.

In some cases where progress to recovery is slow, or at a standstill, Dr. Savage would recommend removal to another asylum. This, no doubt, does very well sometimes, but not unfrequently the change of residence is followed by relapse.

The suicidal patients are now under constant supervision at night.

Birmingham. Rubery Hill.—A portion of the estate has been set apart for use as a cemetery, and a mortuary chapel has been built therein.

Many of the cases being of a feeble type, a warming apparatus has been introduced into several additional single rooms.

There was a slight outbreak of typhoid fever.

Winson Green.—Mr. Whitcombe has introduced the educational form of treatment in a modified form. As the result of a visit to the Richmond Asylum, he has begun drill and calisthenic exercises, and singing classes, and he reports that they have met with general approval. Will not more follow his example?

The comments of the Commissioners on these asylums are not included in the annual report. It is of no use for the Visitors to say that they may be seen at the Asylums' Office in the Council House.

Bristol.—Lands adjoining the asylum estate have been purchased, and plans have been prepared for the enlargement of the buildings.

The Commissioners notice that —

In no ward on either side is the staff too strong, and in some decidedly weak, *e.g.*, "new 4" male side and "12 new" female side. In the former are warded 67 patients, 30 being epileptics, with three attendants; and in the latter ward 54 patients, 21 epileptics, with three nurses.

The general condition of the patients, wards, dormitories, &c., was, however, as satisfactory as could be expected.

The report by the Commissioners contains some remarks as to the means of raising an alarm in case of fire. Dr. Thompson evidently considers these (the remarks) very far from reasonable, and gives his official visitors a sound wigging. It should be remembered that in official as in private life, silence is golden.

Cambridgeshire.—In consequence of the large annual increase in the number of patients, 76 in three years, the Visitors obtained a return of all those in the asylum whose maintenance was partially or wholly repaid by friends, and of the weekly amounts paid in each case. In 25 cases it was wholly repaid, and in 37 partially. It was found, however, that only six had friends who could afford to make additional payments, and in respect of these six 14s. per head per week is now charged.

The Commissioners point out that —

The minor casualties appear to be numerous, after the perusal of the medical records, and the fact that so many bruises have happened from "causes unknown" points to rough treatment or neglect by the attendants, if they be sufficiently numerous.

The Visitors take notice of this, and report that, two female attendants having left in the meantime, they have been unable to discover, against those remaining, any grounds for the complaints of ill-treatment. We would, however, remark that if bruises are frequently discovered and cannot be accounted for, there is urgent need of increased supervision, and probably of a more numerous staff.

Carmarthen.—A chapel is in course of erection, and will be paid for out of the surplus profits from out-county patients.

The prevailing feature of insanity in this, as in the other asylums of Wales, seems to be morbid depression of spirits, connected with religious views.

Dr. Hearder is evidently much interested in the beer and wine question. About beer we have nothing more to say, but we may reproduce his remarks about wines and spirits.

In the same year (1879) it was reported to you that "the use of wine and spirits in the management of disease has now been practically discontinued in your asylum for a period of three years;" and the further experience since acquired of the non-alcoholic treatment has confirmed me in the belief of its efficiency. There can be no doubt that this belief is steadily and irresistibly

gaining ground with the medical profession. Evidence in support of this statement may be difficult to obtain as regards the body of general practitioners, and reliable statistics could scarcely be procured; but as regards asylum practice it admits of easy and full proof. In the report of the Commissioners in Lunacy, published in 1876, we find that the average weekly cost per head for "wines, spirits, and porter," in county asylums was 1½d. and in borough asylums 1⅛d.; and in their report for 1883, the last published, the average weekly cost for "wines, spirits, and porter" in county asylums was ¾d., and in borough asylums ½d. Thus in eight years the consumption of "wines, spirits, and porter" as medical extras has decreased in county asylums by 50 per cent., and in borough asylums by 73 per cent. In your asylum these medical extras have been almost entirely replaced by eggs and milk, at an average cost of 1¾d. per head per week. The change has not effected any money saving, but it has replaced alcohol by the easiest digested of foods, our types of nutrition.

Cheshire. Parkside.—On the retirement of Dr. Deas the Visitors unanimously passed a complimentary resolution.

Cornwall.—The statistical tables are not those recommended by our Association.

Crichton Royal Institution.—An intermediate department has been established, into which patients from all parts are admitted, at rates of board of £40 and £52 per annum. This most excellent arrangement has already been largely taken advantage of.

A large country house has been leased. To it patients are sent for change of scene and amusement. There is shooting over 3,000 acres, and fishing in both loch and stream.

Thirty-six acres have recently been added to the asylum estate.

The reports of the Commissioners in Lunacy are not published.

Cumberland.—The Commissioners remark that they consider the staff in some of the wards hardly equal to the duties placed on them. For instance, on the female side in the infirmary there were 21 patients, 19 in bed, and only two nurses; and in No. 8, on the same division, 20 patients, five in bed, and only one nurse. In the male infirmary, 40 patients, 14 of whom were in bed, were in charge of two attendants. They recommend an extra attendant in each of these wards.

Apropos of diet, Dr. Campbell says:—

That the diet is ample, I think that the following will go far to show. Seventy patients were discharged during the year as recovered. With one exception they were weighed on admission and before discharge; 61 gained an average of 14lbs. each, the greatest gain in one individual was 46lbs. Seven lost weight, an average of 5lbs., and one patient's weight remained stationary. Though the diet scale here is ample and excellent, it might, I think, be altered in some respects with advantage. I think asylum dietaries generally should have a greater difference in the heat-producing foods given during the summer and winter months, and there is also room for improvement in changes which would relieve monotony without diminishing real nutritive value.

During the gale of 26th January extensive damage was done to the building. Fortunately no person was injured.

Denbigh.—The death-rate has been remarkably low for about 10 years. This is more noteworthy as the wards and dormitories are seriously overcrowded.

The Commissioners remark :—

Wards No. 1 (the private patients' ward), 2, and 6 have sufficient floor area per patient. No. 4 ward affords only 25½ superficial feet per patient, and No. 5 only 31 feet; the minimum required by our Board in all new buildings being 40 feet. Secondly, as to dormitories, the cubic space per patient which we require in associated dormitories is 600 feet. Here in No. 5 dormitory there are only 430; in the special observation dormitories, 453; in No. 4 dormitory (the bedroom), 381; in the hospital ward, 507; in the so-called church dormitories, 444; and in No. 4 dormitories, 532 cubic feet. From the above figures it will be obvious that the female division of this asylum is much overcrowded; and as there is evidently a strong tendency to increase in the number of females to be provided for, the question of extension cannot be postponed.

Derby.—The Committee of Visitors have taken the precaution to cover their legal liability under the Employers' Liability Act of 1880. They have effected a policy of insurance for £700, being the annual amount of salary and wages paid to the engineer and workmen. The premium is at the rate of 3s. 3d. per cent. per annum. So far as we know this is the first asylum in which this has been done, and it appears to be a very wise precaution.

Dorset.—In consequence of a notice served on them by the Local Sanitary Board, the Visitors had under their consideration the disposal of the asylum sewage. They adopted the process of upward-filtration. It is said to be satisfactory.

The Commissioners point out that in some of the wards the number of attendants is not sufficient.

Dundee.—It is to be regretted that this asylum is still in financial difficulties. The staff has been increased by the appointment of a female head attendant. The accommodation is so deficient that from December to April no female patients could be admitted. Seventy patients have been transferred to the wards of workhouses, and boarding out is adopted wherever possible.

We note the omission to publish the reports by the Visiting Commissioners.

Earlswood.—The financial state of the institution appears to improve. Large legacies were received and the debt extinguished.

Eastern Counties' Asylum for Idiots.—In reading such a report as the Governors present, it is impossible to avoid surprise and thankfulness for the abounding charity of the public. The institution has been enlarged, so that it can now accommodate 200 patients. There is now a resident medical officer. After a service of 24 years, Mr. Symmons retires from his post of visiting physician; and after the long period of service of 37 years, the superintendent, Mr. Millard, retires from bad health. It is pleasing to find that the great services rendered in past years by these gentlemen are cordially acknowledged by the Governors.

Edinburgh Royal Asylum.—The following is the only extract we have room for from Dr. Clouston's admirable essay; we wonder how he finds time, in the midst of his abundant work, to devote to the preparation of such a report. We congratulate him most sincerely

on the great work he has done at Morningside. If he has done nothing else, he has earned the undying gratitude of the Scottish public.

The completion of wards 1, 2, and 3 marks the end of the reconstruction of the whole establishment that has been going on for the past eleven years. Our 25 wards of both houses have been so modernised, that one who knew them before would scarcely know he was in the same place. We have managed to get light, ventilation, colour, and cheerfulness everywhere. Our two cottages, our mansion-house at Craig House, our seaside house, our workshops and laundry, have also been improved. Two new wings at the East House, and four large dining-rooms at the East and West Houses have been put up. And now we are at last out of the mortar-tub. It has all cost up to this time about £57,000, not including the land at Craig House, and there will be some money yet to be paid for the work in process of completion. About £29.000 of that has been spent for the comfort and cure of pauper patients, and £9,000 for the poor private patients at the West House. It is a large sum, but I maintain it has been well-spent money, and that the results are worth the cost, and more. It has undeniably been a noble effort thus to do all that could be done for that portion of afflicted humanity that has been committed to the care of the managers and officers of the institution, without having the direct security of any public rates or any private endowments for the repayment of the money expended. No one can say that we have done better by the rich than the poor. And that we have done what has been done up to the requirements and knowledge of the time, is attested by the Reports of the Visiting Commissioners in Lunacy, as well as in a less formal way by many skilled observers who have come to see the institution, and published their observations both on the Continent and America.

Glamorgan.—Amongst the admissions, the proportion of melancholic and suicidal patients continues to be very large.

Glasgow Royal Asylum.—A spirit of active benevolence characterises the administration.

In his report Dr. Yellowlees mentions two interesting cases. Among the admissions were two sisters, maiden ladies in advanced life, who deemed themselves the victims of plots and persecutions, and whose eccentric and reserved habits had gained for them the name of the Hermits. They were brought to the asylum together, and their cases were very interesting, as it seemed evident that the insanity of the one sister had gradually—through close association and constant anxiety—induced that of the other.

One death was due to a very singular cause. The patient had been an inmate for some years, and at some unknown period of her excitement had swallowed the needle and thread with which she had been sewing. The needle had stuck in the lower part of the gullet, but did not obstruct the food nor cause pain, so that its presence was quite unsuspected—until it was found, after death, to have perforated the largest blood-vessel of the body, and thus occasioned fatal vomiting of blood.

Gloucester.—A second asylum has been built, and is now partly occupied. In equipping this building some novelties have been introduced. The most important seems to be the extensive use of gas. The whole of the cooking, the motor power of the gas-engines used

for the pumping of the water into the water-tower, and moving the laundry machinery, heating water for washing and bathing, heating the drying closets and baking ovens, have been effected by the employment of Dowson's gas, and by this means great economy is exercised in the consumption of coal. The application of this power to so extensive an establishment has been somewhat of an experiment, and the various apparatus used will probably require slight modification, but the Committee believe the inconveniences which have arisen will be overcome, and that this new power will prove a great success.

Many important improvements have been carried out, and the management appears to be energetic and enlightened.

Hereford.—An outbreak of severe diarrhœa occurred, but it disappeared when various defects in the drainage were rectified. Two cases ended fatally.

Dr. Chapman is of opinion that in a rural district, such as Herefordshire, where workhouses are small and have few paid officers, and are therefore very doubtful places for the reception even of mild cases of imbecility, the true solution of the difficulty is to be found in placing suitable cases in private dwellings (their own homes where possible), with adequate safeguards for their proper care and treatment there.

Hull.—The patients have been removed from their old and dingy quarters, and lodged in the new asylum at Cottingham. As always happens when an asylum is first occupied, a great many matters require attention and alteration, but it is evident that efforts are being made to get the place into good working order as soon as possible.

An assistant medical officer has been appointed.

Isle of Man.—So far as we know, this and Broadmoor are the only British asylums where an inquest is held in the case of every death.

Strenuous efforts are made by Dr. Richardson to promote rational and profitable occupation among the patients. Two spinning-wheels are in use, and all the yarn required in the asylum is home-made.

Kent. Barming Heath.—Attention continues to be devoted to sanitary matters. During the summer there was a serious outbreak of enteritis, causing eight deaths, and necessitating the closure of a ward.

An attendant was convicted and fined for assaulting a patient.

There is now an electric fire-alarm. In this and other departments Dr. Davies believes the electric arrangements leave little to be desired.

Kent. Chartham Downs.—The Commissioners point out that more than half the insane population of the asylum are confined to the airing courts for exercise.

Post-mortem examinations were made in little more than half the deaths. In the other asylum in the same county they were made in every case.

Killarney.—It is quite evident that several matters call for amendment connected with Irish asylums. Concerning admissions Dr. Woods reports—

I have referred to this subject so often in my annual reports that I do not wish to dwell on it this year. It is sad to see the poor uneducated friends of

patients wandering about the country—sometimes for days—endeavouring to have a lunatic committed, and often giving it up in disgust. All this might be remedied by the adoption of the English form.

As to chronic, harmless cases, he says—

At your last meeting you asked me to select some harmless patients to be sent to the workhouses, but in this I have considerable difficulty; none but feeble-minded patients can be so transferred, as the more sensible would demand their discharge from the workhouse, and soon become a burden on society, and an enemy to themselves. Those who would remain in the workhouses would, I fear, fare badly there; there being no provision made for their comfort or care, most of them, when handed over to the tender mercies of pauper inmates, would in all probability become troublesome, possibly dangerous. The history of my former transfers does not encourage another trial.

During the summer there was a slight outbreak of typhoid.

The control exercised by "The Castle" seems to be very arbitrary and troublesome. What would the superintendent of an English or Scotch asylum think of such a system as is disclosed in the following paragraph?

It is a great pity that most of the increases so strongly recommended by you during the year to deserving officials were refused by the higher authorities. If those in authority could only realise the dreary life of those living amongst the insane, the responsibilities of the duties, and the absolute necessity of procuring trustworthy asylum officials, they would at all events put them on a par, in the way of salary, with other public servants of the same class After long correspondence the salary of the head laundress was increased by £5, it being found impossible to procure a competent person at the salary allowed. The loss in clothing for the past few years, from the want of a competent person to take charge of the laundry department, has been considerable.

Lancashire. Lancaster.—The unsatisfactory sanitary condition of this asylum is in process of remedy; but not before time. During the year there were 10 fatal cases of typhoid, and five of diarrhœa.

The Commissioners remark that in no ward is the staff of attendants too strong; in one ward 31 patients are in charge of one nurse. This is obviously inadequate.

The associated gatherings are numerous. On Sundays there is a sacred concert; on Mondays a social gathering, with songs, &c.; on Tuesdays a small dance, &c.; on Wednesdays the weekly ball in the recreation hall in winter, and on the green in summer; on Thursday there is music in the Annexe; and on Friday and Saturday the patients themselves give entertainments, either unaided or with assistance from attendants and nurses.

The airing courts are not used, but all patients are exercised in the grounds of the asylum.

Lancashire. Prestwich.—The duties devolving on the staff, in connection with the opening of the Annexe must have been very onerous. Six hundred and sixty-two men and 756 women were admitted. The total accommodation is occupied, and the influx of patients continues uninterrupted. No less than 70 per cent. of the admissions were from the various workhouses—to the great indignation of the Commissioners.

We so constantly use and hear used the phrase "harmless lunatic"

that it is advisable to utter a word of warning by reproducing the following paragraph from Mr. Ley's admirable report :—

I am happy to say there have been but few accidents during the year. The most serious was a sudden and unprovoked attack by a supposed harmless patient upon a female attendant. The attack was most unexpected, and might have been attended with fatal consequences had it not been for the interference of another patient. The constant dread of such occurrences as these, and others of a kindred nature, makes the care of the insane a very harassing responsibility. These warnings also bring home to all who have to do with lunatics the fact, often overlooked or forgotten, that all insane persons are dangerous to themselves and others, and that the phrase "a harmless lunatic" is simply a contradiction in terms. In a very large number of cases an insane person is one who has little or no control over his impulses, and whom the law relieves from the ordinary consequences of yielding to those impulses when they are of a criminal kind. Such a one can hardly be otherwise than dangerous, because his conduct can rarely be foreseen.

This asylum appears to maintain its high standard of excellence in all its departments.

Lancashire. Rainhill.—No fewer than six persons admitted were found to be not insane.

One of these was suffering from peritonitis, from an injury received in a drunken brawl, which was probably attended with some delirium, which, however, had passed off when admitted. Another had been drinking heavily, but any maniacal symptoms had subsided before admission; and a third had received an injury on the railway, which was said to have been followed by epilepsy and maniacal excitement, of which, however, he showed no symptoms whilst in the asylum. Two others were suffering from epilepsy, but displayed no mental infirmity whilst under observation; and the last appeared to be a wayward girl.

Leicester (Borough).—A considerable number of minor structural improvements were effected during the year.

Leicester and Rutland.—

For the purpose of economising fuel, "discs" (two feet in diameter) made of fire-baked clay have lately been placed in the flues of the two boilers. There are three or four of these "discs" standing vertically in each flue, and they are intended to spread the flames and heated gases circumferentially, and thereby to increase the generation of steam, and also to cause a more complete combustion of the smoke which impinges upon their hot surfaces. The boilers will now readily burn slack, and grey smoke may be seen issuing from the mouth of the chimney instead of the former usual dense black clouds. These "discs," called "economisers," have been introduced by Messrs. R. Gosling and Co., of Ipswich.

Limerick.—The sewerage is far from satisfactory. It has been somewhat improved, and continues to engage attention.

Lincoln.—The question as to how this asylum is to be enlarged is still unsettled. Dr. Palmer very justly points out that provision should be made for patients belonging to the poorer middle classes.

London.—The percentage of deaths was remarkably small—only 3·8 on the average number resident. A post-mortem examination was made in every case. Plans have been prepared to provide accommodation for 31 male patients. As an inducement to the nurses

to remain longer in the asylum service, the scale of wages has been increased.

Middlesex. Banstead.—Dr. Shaw's salary has been increased to £1,000. The asylum continues to receive acute cases, although not originally intended for such.

The Commissioners report that letter-boxes have been placed in the wards, but the patients as a rule prefer giving their letters to the medical officers on their rounds to posting them in the boxes. This is what might have been expected. We have always considered the proposal to have letter-boxes in the wards the veriest folly, bad in every respect.

Middlesex. Hanwell.—A male patient when proceeding with a party of patients from his ward to the airing court in the afternoon, appeared to have placed some cinders in the pocket of his trousers, which it is supposed he took from one of the fireplaces in passing, although he was not seen to do so. He then went into the airing court, where he was under the close observation of an attendant. In about forty minutes he was seen to be in flames, and immediate steps were taken to put them out, but before this could be effectually done he was so severely burnt that he died from the effects two days afterwards. Careful experiments since have proved that the cinders must have set fire to his clothing, which smouldered like tinder until exposed to the outer air. There is no reason to think that this patient intended suicide, but rather that he secreted the cinders thinking they would keep him warm.

Montrose.—Forty-seven per cent. of the deaths were due to phthisis. Ten of the cases had the disease on admission, but even making allowance for this fact, Dr. Howden rightly concludes that the rate is too high, and he attributes it to over-crowding.

Murray's Royal Asylum, Perth.—This institution continues to pursue its useful course under the able management of Dr. Urquhart. During the year there was but one entry of restraint and seclusion. It was found necessary to resort to the use of gloves in the case of an extremely suicidal woman. She bit the bowl off an egg-spoon at breakfast and swallowed it there and then, the buttons of her dress disappearing in a similar way.

Newcastle.—This asylum is over-crowded, and plans have been prepared for its enlargement. Thirty-five acres have been added to the estate.

Mr. Wickham reports an increase of general paralysis among women. Relative to drunkenness he says —

My attention has occasionally been called to a case of the following nature: —A man has practised this degrading vice for a number of years, and has been known to his acquaintances as an habitual drunkard. Then some one with more influence than others over him successfully awakens him to a sense of his shame, and points out to him how he is pauperising his family and lowering them to the depths of misery and privation by his sensuality. He then becomes a total abstainer, and in the course of time he goes insane; and such

cases of this kind as have come under my notice are generally incurable. Mentioning this matter to a friend, who has done much good in advocating total abstinence among the weaker brethren, he suggested that if such a man had not given up drinking he would probably have died; but this is assuming that the advantages of continuing to exist are indisputable.

Northampton.—To remedy over-crowding and other defects, various structural alterations and additions have been effected during the year.

The deaths numbered 47, but in only 20 of these was a post-mortem examination made.

Northumberland.—The enlargement of this asylum is in progress. In his report Dr. McDowall says:—

The agitation for revision of the Lunacy Laws continues as active as ever, but as no Bill has as yet been introduced by the Government, I need not refer to other proposals which have been made. On only one point would I like to make a remark, and it is this:—Should the admission of lunatics into asylums be retarded and not facilitated by the new arrangements, great harm will be done both to the patients and the public at large. The number of lives lost every year through suicide is surprisingly great, and it might be at once reduced by the adoption of such care and treatment as an asylum affords. The truth is that instead of too many patients, pauper and private, being sent to asylums, there are too few. Violent cases, the noisy, destructive, and troublesome, are sent quickly enough, for the friends or officials in charge are only too glad to get rid of the anxiety and responsibility of such patients; but the quiet, as melancholiacs, though quite as curable and as urgently requiring treatment, are detained at home or in the workhouse. Much valuable time is lost, and the chances of recovery thereby greatly diminished; and it too often happens that when at length such cases can no longer be kept out of the asylum, they arrive absolutely incurable, and a burden on the rates for life. I would further remark that in my long official experience I never knew of an instance of *mala fides* in sending a patient to an asylum. On very rare occasions a mistake has been made, chiefly with drunkards. These men had drunk themselves into a state of wild frenzy, and were for the time certainly insane; but between the time of their apprehension and their transference to the asylum all their symptoms had disappeared. After undergoing observation for a week or two, they were accordingly discharged as "not insane." Such has been my experience of public asylums, and mine is not exceptional but universal. Whether threatened legislation will make any change in the administration has to me very little interest. County Boards, increased inspection by Commissioners and their Deputies, and all the other new-fangled proposals have no terrors for me. I would, indeed, regret if they brought to an end the official relations which have gone on so smoothly for so many years; but should they prove to be of any practical value they will be welcome. When the lunacy question is before Parliament, I hope that the Visitors of public asylums will come forward and place their knowledge and experience at the service of the Government. It is a matter of great regret that the important question of Lunacy Law Reform has hitherto been so much neglected by the well-informed and judicious, and has afforded such excellent opportunities for professional agitators and crotchet-mongers.

Norwich.—The statistical tables are not always those recommended by our Association.

Nottingham (*Borough*).—This asylum is already full, and fully 60 patients are boarded in other asylums.

An assistant medical officer has been appointed. Very few patients

are confined to the airing courts. The majority exercise in and beyond the estate.

Nottingham (*County*).—Year by year it becomes more and more surrounded by buildings, and thus more unsuitable for its purpose. The Commissioners consider that its removal to a country site is inevitable, and hope that the question will soon be taken into serious consideration.

Nottingham Lunatic Hospital.—The management by Dr. Tate continues to receive high praise from the Commissioners. The charity carries on a good work by affording assistance to a large number of patients.

Perth.—A detached hospital for infectious cases is in course of construction. When not required for its special purpose, it will afford accommodation for about 12 quiet cases.

An addition to the estate is much needed.

Portsmouth.—Plans are in preparation for the erection of a detached hospital for infectious cases.

Efforts are being made to increase the number of patients usefully employed. With this view a ward specially fitted has been appropriated for the workers, and an attendant and some patients are about to be instructed in mat-making.

Richmond Asylum.—Dr. Lalor reports that he has at last effected the separation of the epileptic from the general insane, and the formation of a comparatively small class consisting of them and the very aged and infirm. These patients have now a building to themselves and free access at all times to the adjoining recreation grounds.

The asylum schools continue to prosper. Long may they do so!

Royal Albert Asylum.—Did space permit, we would reproduce the remarks by the Committee on legislation for pauper idiots, and on the necessity of altering the existing laws relating to non-pauper imbeciles. With the views expressed we cordially agree.

Roxburgh, &c.—Efforts continue to be made to keep down the number resident by boarding suitable chronic cases in private dwellings. Mr. Grierson seems to be rather doubtful of this method of dealing with such patients, and we cannot help thinking that he aims a shot at the Scotch Commissioners, when he says—

> Thus it may well be feared we have a long and painful journey to travel, as well as a bitter experience to undergo, ere we arrive at that higher and happier civilization some of our neighbours are boastingly said to have attained to, which regards the introduction of an alien and a lunatic into the family as an advantage and a boon.

Salop and Montgomery.—Some of the structural changes are complete, and many patients boarded in other asylums have been recalled.

A patient was murdered by one of his neighbours, but the circumstances do not call for special notice.

The Comissioners notice that a very large proportion of the inmates

are confined to the airing courts for exercise. They also refer to an unfortunate circumstance—the seduction of a female patient employed in the kitchen, and a good deal trusted, by an employé.

A head female attendant has been appointed. In an asylum of such size, such an officer should have been on the staff years ago.

St. Luke's Hospital.—Extensive repairs have been carried out, and the waste pipes from the lavatories altered. The hospital received a legacy of £5,303 from Lord Henry Seymour.

A patient, who had been at home on trial for three months, committed suicide by hanging. A similar case occurred last year.

Somerset and Bath.—This asylum is now full. The reports by the Visitors and Dr. Wade are therefore largely taken up with the question of how to provide for the insane poor of the county. Dr. Wade believes that the true remedy for the existing state of things is to be found in the erection of smaller mixed asylums for smaller areas, not in the enlargement of present asylums, nor in the erection of separate institutions for chronic patients. He suggests that a small grant should be made by Government for lunatics in workhouses, or in small cottage buildings. He is very strongly of opinion that county asylums should afford accommodation for the poorer middle classes at rates from 15s. to 30s. per week.

The report by the Commissioners is not given. This is a serious omission.

Staffordshire. Stafford.—The recent additions to the buildings have been handed over by the contractors, and the male block contains 146 patients.

For the religious requirements of 70 patients, the Committee have appointed a Catholic priest at an annual salary of £20.

The Commissioners notice that in 106 cases of death only 39 were the subject of post-mortem examination.

Staffordshire. Burntwood.—As much attention is at present paid to all matters relating to the extinction of fire in asylums, it may be well to note that here there is a very complete electric apparatus for giving the alarm. The Commissioners point out that from the top floor on the male side to the lower floor an escape ladder has been ingeniously contrived; it might wisely be taken as a model for a fire escape stair in many buildings.

Suffolk.—Although much has been done to improve the structural condition of this asylum, it seems to be still very far behind the average county asylum. Plans for its enlargement have been prepared; we hope that the new work will be quite up to date.

Mr. Eager's report is of unusual length. A considerable portion of it is devoted to objecting to the class of cases sent to his asylum. His remarks about workhouse masters are far from complimentary, and not very discreet.

The average weekly cost was 9s. 9¼d., whilst the charge made to the Unions was 11s. 3¾d. It is explained that the charge is thus

high because of the patients boarded in other asylums at 14s. to 16s. per week. The Visitors are not justified in making such a charge. They are bound to provide accommodation for their patients, and when they fail to do so the county is obliged (within certain limits) to defray the extra cost. Certainly the Unions should not be asked to pay it.

Surrey. Cane Hill.—This great asylum is now in working order. Much of course requires to be done in the way of detail, but if we may judge from what has already been effected, the whole establishment will be speedily completed in a most liberal and enlightened manner, and then carried on in the same excellent spirit.

Dr. Moody's report is chiefly an account of the structure, position, arrangements, &c., of the building.

Although liberal wages are given, and great attention paid to their comfort, the changes amongst the attendants and nurses are frequent. To prevent this evil as much as possible, Dr. Moody suggests that there should be an understanding between medical superintendents not to engage any attendant or nurse who had previously served in any asylum for less than two years. Some superintendents go further by never engaging any attendant or nurse who had previously been in asylum service. In so doing we think they generally act wisely.

Surrey. Wandsworth.—The sanitary condition of this asylum is receiving attention. Several cases of typhoid, diarrhœa, erysipelas, and enteritis occurred during the year.

A patient complained to the Commissioners that he was a pensioner from the Royal Navy, in receipt of £27 7s. per annum, but that his pension was entirely applied to his maintenance. Such cases are very hard, and we think unfair. When a pensioner has a wife and family, we consider it nothing short of robbery (legalised) to seize his income and leave his wife and children to do the best they can for themselves.

Surrey. Brookwood.—Here, as in the other Surrey asylums, the movement of population has been very great during the year, consequent upon the opening of Cane Hill. The work thrown upon the staff thereby must have been excessive.

Sussex.—As there is no urgent pressure on the accommodation at Haywards Heath, the question of building a second county asylum is postponed for the present.

The whole drainage system has been renewed at great cost, and on the most approved principles.

Warneford Asylum.—During the year 60 patients received assistance from the charitable funds. Some pay as little as 5s. per week, although the actual cost is 26s.

Warwick.—We gladly embrace this opportunity of again expressing our feelings of sincere regret at Dr. Parsey's sudden death, by which our Association lost an honoured and valued member, and the asylum a most efficient officer. During his 32 years of official life he did much good work.

Wilts.—As a result of the improvements effected in the sanitary arrangements of the asylum the health of the inmates has been greatly improved.

A second assistant medical officer has been appointed.

From the report of Mr. Bowes it is quite evident that much is being done to bring this asylum up to modern requirements.

Wonford House.—It must be very satisfactory to Dr. Rees Philipps to learn that the improvements effected by him during his tenure of office were striking.

The charitable assistance afforded to needy patients continues large.

Dr. Deas appears to have the usual troubles endured by a newly-appointed medical superintendent. The resignation of several superior officers is a great difficulty for a time; but in the end it is often an advantage.

Worcester.—The new buildings are completed, and are expected to be ready for occupation in a few months.

Two patients suffered from typhoid fever, but the origin of the disease could not be discovered.

Dr. Cooke again gives, in the form of an appendix, some details of interesting cases treated during the year. We would again suggest that these records, given perhaps somewhat more in detail, would form valued contributions to the Journal, as "Clinical Cases."

York.—Dr. Hitchcock reports—

> During the winter months I have been giving a course of lectures on elementary anatomy, physiology, and the immediate treatment of injuries and accidents, &c., to the nurses and attendants of the asylum. I was much gratified by their regular attendance and the interest manifested in the subject; the more so that several, not specially enaged in attendance on the patients, were amongst my class; even some of the patients asked if they could attend, but I drew the line there. I shall not mind if the knowledge they gained is not tested by practice; but at all events the subject was right and necessary for them to be instructed in, and if all's well I shall give a similar course next year.

Yorkshire. East Riding.—During the months of March, April, July, and August, typhoid fever prevailed in this asylum, no fewer than 48 cases occurring, with six deaths. The cause of the outbreak is disputed. Dr. Macleod attributes it to the escape of sewer gas into the buildings. Dr. Page is of opinion that it was due to the water containing sewage matter.

Means have been taken to prevent the disease recurring through either of these causes.

York Retreat.—Various alterations have been made in this institution during the year, including that of the central partition in one of the ladies' galleries, by which it can be folded back against the walls or used as a partition as occasion arises, a small but not unimportant point of detail suggested to Dr. Baker by the practice of some of the American Asylums. Another change consists in setting aside a special room for dining purposes in almost all the galleries. It is evident that the general comfort of the house has been increased, and

the Superintendent refers more than once to the "larger liberty" enjoyed. Dr. Baker was much struck with the disuse of alcohol in the American Hospitals for the Insane, and highly approves of this course. He also approves of the non-appointment of a stated chaplain, preferring the custom of ministers of various denominations taking the service in turn. English critics pity the patients who listen to the utterances of pastors holding such different religious views as Episcopalians, Congregationalists, Unitarians, and Universalists. "As far as I could learn, this exemplary and practical carrying out of a spirit of large-hearted Christianity answered perfectly."

The usual statistical tables of the Association are appended. It may be as well to point out that in Table III. the percentages of Recoveries on Admissions, which are given for females and for the total as 21·42 and 23·33 respectively, should be 28·6 and 26·7. The error has evidently arisen from the addition of a female discharged recovered after the percentages had been worked out. The mortality is stated in the body of the report to be at the rate of 8 per cent. on the average number resident, whereas in the tables it is given as 6·37. It will be observed that both in regard to recoveries and deaths the Superintendent's report fails to do full justice to himself. We are always ready to excuse those who under-value themselves, although in the realm of statistics we think it better not to allow even a praiseworthy modesty to take the place of accuracy.

Yorkshire. North Riding.—The Visitors have purchased the estate of a Stud Farm Company about a mile from the asylum, and consisting of a large dwelling-house, four cottages, 120 loose boxes, cow-sheds, and other buildings, and about eight acres of land. To these premises they propose to remove the whole farm stock, and to use the present farm buildings for the accommodation of patients.

Yorkshire. South.—Six cases of typhoid occurred in December, two of which were fatal. In consequence, a thorough examination of the entire drainage by Mr. Rogers Field has been ordered.

A special pathologist has been appointed. There are now four assistant medical officers—not too many for an asylum where the movement of patients is so great. Five hundred and fifty admissions and 159 deaths represent a great deal of work for the medical staff.

Yorkshire. West Riding.—

The general health of the patients during the first half of the year was far from satisfactory, and the Committee have to report an outbreak of typhoid fever, in which fifteen male patients and two attendants were attacked, resulting in three deaths. A special investigation into the causes of the outbreak revealed a condition of the drainage which, while satisfactorily explaining the insanitary state of the inmates, called for immediate interference.

By the advice of Mr. Rogers Field the whole system of drainage is to be altered at a cost of £8,000.

Whilst we heartily congratulate Mr. Bevan Lewis on the position he now so worthily holds, we cannot but regret that bad health removed Dr. Major from the direction of the Wakefield Asylum.

It will be seen from the extracts given that the sanitary condition of asylums is receiving much attention, and it is satisfactory to observe that there is a decided effort in most to keep up with modern requirements in every respect. It must be admitted that in one or two instances the Visitors seem disinclined to effect improvements on account of the cost, but fortunately such weakness is exceptional.

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

The quarterly meeting of this Association was held at Bethlem Hospital on Wednesday, 24th February, 1886, Dr. H. Rayner in the chair. There were also present Drs. G. Amsden, H. A. Benham, D. Bower, P. E. Campbell, R. W. Dalzell, Wilson Eager, F. C. Gayton, J. S. Grubb, Robert Jones, Moody, W. J. Mickle, H. C. MacBryan, J. D. Mortimer, J. Neil, H. Hayes Newington, F. Needham, S. Rees Philipps, J. H. Paul, W. H. Platt, G. Revington, H. Stilwell, C. D. Sherrard, Percy Smith, J. B. Spence, H. Sutherland, D. Hack Tuke, C. M. Tuke, T. O Wood, H. F. Winslow.

A letter was read from the President, Dr. Eames, regretting his inability to be present at the meeting.

The following gentlemen were elected Members of the Association, viz. :—

W. R. Dalzell, M.B.Edin., Colney Hatch Asylum, Middlesex.

Jno. Maye, M.R.C.S. and L.S.A., Burntwood Asylum, Lichfield.

Allan MacLean, L.R.C.S.Ed. and L.S.A., Harpenden Hall, Herts.

J. Strangman Grubb, L.R.C.P.Ed., &c., Silsoc Villa, Uxbridge Road, Ealing.

S. Hollingsworth Agar, jun , B.A.Camb., M.R.C.S., Hurst House, Henley-in-Arden.

F. W. Pilkington, L.R.C.P.Lond., M.R.C.S., County Asylum, Littlemore, Oxford.

Dr. MICKLE read a paper on "Some Abnormal Forms of Breathing." (*See* Original Articles).

Dr. RAYNER, in expressing the thanks of the meeting to Dr. Mickle for his very interesting paper, said that probably all present had often noticed peculiar variations in the rhythm of the breathing of the insane, even in some cases where there had been recovery ; but, for his own part, he had never taken the trouble to note them with the careful accuracy with which Dr. Mickle had done it, nor had he observed them sufficiently to have any theory as to the conditions under which they arose. He had no doubt that Dr. Mickle, having observed them so carefully, and having noted many cases, had probably formed some theory, and therefore, without wishing Dr. Mickle to commit himself to any definite theory, the meeting would be glad to know his views in the matter.

Dr. MICKLE said that, in his anxiety not to trench too much upon the time of the meeting, he had omitted more of his paper than he had supposed. The typical Cheyne-Stokes's respiration itself was a matter with regard to which there had been a very great deal of discussion, and as many distinct theories as one had fingers on both hands. It was a very difficult subject, and he would not, under the circumstances, like to advocate a cut-and-dried theory in regard to the cases now in question ; but one of the passages in his paper which he had omitted to read was as follows:—"Although I found distinct microscopical change in the elements of the medulla oblongata in one case, I felt scarcely justified in absolutely connecting this change with the production of Cheyne-

Stokes's respiration. But recently Lizzoni found in one case chronic inflammatory changes ascending the vagi, with blood-extravasation into the lymphatic spaces of the perineurium and endoneurium. The whole length of the right nerve, the periphery only of the left, was affected. In the medulla oblongata itself were small foci, chiefly on the right side, and beneath the ependyma at the longitudinal furrow of the calamus. A similar lesion affected the upper half of the medulla oblongata in another case (uræmic), but the vagi were normal." Referring to cases of that kind, the most likely theory as regards the nervous condition appeared to be that the respiratory centre of the medulla oblongata was in a condition of defective sentient perception. There was also another theory, viz., that there was anæsthesia of the mucosa of the lungs. In one of the cases mentioned, the blood-vessels of the medulla oblongata had the same changes in their walls as those of the cerebral cortex had; but that was a case in which there was a generalised vascular lesion. It was a case in which there was a general arterial disease of which the kidney disease at first was merely one part, and the morbid state of the arteries of the kidneys aggravated the conditions which gave rise to the arterial atheroma, the arterial disease in this case leading to atrophy. The renal arteries participated in the general change, and their alteration affected an organ which, in consequence of that, had its excreting power lessened. These were the cases following arterial disease; and although differences existed, they might come to closely resemble primary renal disease; but if they were compared at different stages with renal cases which really gave rise to cardiac and arterial changes, the differences were great. Those differences did exist, and, in the case mentioned, the only other point was that there was some granular change in the nuclear nerve centres in the medulla oblongata. There one had the damaged nerve centre. As to the state of the nerve centres involved, local vascular dilatation might occur, and, occurring paroxysmally, would cause cessation of respiration by keeping the medulla oblongata over-supplied with blood. If there was blood of a good quality, and the blood-vessels of the medulla oblongata were in a dilated condition, there was, temporarily, no call on the respiratory centre, for that centre was not stimulated to call forth renewed movements. These were cases which were not due to changes in the pneumo-gastric nerves themselves. Those that were, were usually associated with some lessening of the sentient function of the mucosa of the lungs.

Dr. RAYNER suggested whether some of those cases might be due to feeble power of the heart and restricted circulation of the lung acting from the periphery on the centre.

Dr. MICKLE said that was a different matter altogether. The question put to him had merely referred to the nervous mechanism. There were, of course, a number of mere mechanical peripheral conditions connected with the same central result.

Dr. HACK TUKE said that all would agree that Dr. Mickle's paper was an important contribution to the subject on which it treated. It would be easier, however, to study it in print than to follow it out on the present occasion, and he therefore hoped that Dr. Mickle would allow his paper to appear in the Journal.

Dr. Savage, who was unavoidably absent, contributed a paper on "Drunkenness in relation to Criminal Responsibility." (*See* Original Articles.)

Dr. RAYNER said that Dr. Savage's paper was a very interesting one, and offered several points for discussion.

Dr. HACK TUKE said it seemed to him that if Mr. Justice Denman's ruling was to be taken literally and strictly, there was very little to be said in these cases. The whole thing was much simpler than in countries such as France, where intemperance was allowed to be an excuse; but though this ruling seemed to be just, still it was open to great exception, and each case should be treated in accordance with its own particular character. They had seen many cases where there had been very frequent drinking, but where there had also been a prior mental affection, which might, in fact, have been the cause of the drinking

rather than the drinking the cause of the mental affection. Then again, in regard to epilepsy, which was so often associated with drink. Where the crime was committed by the epileptic while under the influence of drink, Mr. Justice Denman's ruling would in many cases seem too hard. Indeed, they knew that in cases of epilepsy, where the prisoner had been found guilty, the law had hesitated to carry out the sentence, and there had been several cases in which there had been a reprieve afterwards, not exactly on the ground of irresponsibility, but simply from the feeling that when a person was epileptic he ought not to incur the extreme penalty of the law. Several other questions arose if we allowed that drunkenness might be some excuse for crime in conceivable cases. For instance, as to the degree of consciousness of the prisoner at the time that the alleged act was committed, as affecting his knowledge of the nature of the act, and then again as to his memory after he had committed the act. If the fact had passed away from his recollection, were they to consider amnesia as a proof that he committed the act in a state of unconsciousness? It was, of course, possible that a man might commit a murder under the influence of alcohol, and might the day afterwards forget all about it; therefore was it to be taken as a proof that he did not know what he was doing at the time? In France, a man in a restaurant fell out with another while playing at cards. He was drinking at the time, had some weapon with him, and killed his companion, making some remark immediately after implying that he very well knew what he had done. The next day he knew nothing at all about it. At all events, in that particular case it was admitted that there was complete amnesia, and the man was not punished, because it was considered that at the time he was committing the act he was not sufficiently conscious to make him responsible. He (Dr. Tuke) thought that the general ruling in regard to intemperance being no excuse for a crime was fair on the grounds that in some cases men took alcohol to nerve themselves to commit the crime, and that, of course, if it were thought that intemperance would be an excuse, men would get sufficiently drunk to exonerate themselves. Therefore it seemed very dangerous to allow intemperance to be an excuse. But what they wanted to know was the real law in England in regard to it, seeing that they had on the one hand Mr. Justice Day saying that in a case of delirium tremens a man was irresponsible, and Mr. Justice Denman saying he was responsible. It would seem that the old proverb as to doctors differing might have originated in regard to doctors of law rather than doctors of physic. There was a very able doctor in Belgium, Dr. Lentz, who had written an exhaustive book on alcohol, and he held that drink was, to a certain extent, an excuse for the crime committed under its influence, but he said that a man ought to be punished for getting drunk and not for the crime committed when he was drunk; that he ought to be punished for putting himself in a position in which he lost his self-control. That, however, hardly seemed to be a practical way of dealing with the question, because, on that view of the case, a man who got drunk ought to be severely punished whether he committed a crime or not. He thought Dr. Savage's paper would have the effect of eliciting some authoritative statement as to what the law of England was in regard to the responsibility of drunkards when they committed serious acts of crime.

Dr. RAYNER said he was rather inclined to the opinion that drunkenness should not be held as any excuse for crime except under certain conditions, as in the case of a man being unaware of the conditions under which he was affected by alcohol. He remembered being with some men, who, after a very long walk in cold weather, had a glass of whisky all round, and for a very short period one of them was hardly responsible for his actions, and, in fact, committed an act of which he had no remembrance afterwards, although the total period of his drunkenness did not exceed half an hour, and the moment he got food he was sober. This illustrated how transiently drunkenness might affect an individual, and how completely it might affect him even to amnesia.

Dr. MICKLE said it appeared to him that the law of England was that drunkenness was no excuse at all, and did not in any way lessen the responsi-

bility of the individual for any crime committed in the state of intoxication. The ruling of Mr. Justice Day, as he understood it from the paper they had just heard read, was, if correctly reported, a simply astounding one, and one which, if admitted in the courts, would lead to an enormous amount of crime. For then many persons about to commit a crime and wishing to be free from punishment would previously, as had been said, get drunk. He thought that no difficulty would be likely to arise in the class of cases mentioned by one of the speakers, in which insane persons became drunk and did a criminal act. If the person was insane, so far as his responsibility for the crime was affected by his insanity, he would be relieved from responsibility, and in that case it would seem that both law and equity would demand that drunkenness should make no difference. As in the sane so in the insane; the sane person remaining responsible for the crime committed whilst drunk; the person insane to the degree producing irresponsibility, remaining irresponsible for the crime committed during drunkenness, he being then both insane and drunk. He thought it had been lost sight of in the discussion that, after all, punishments imposed were not punishments for the crime committed. It had been over and over again laid down that they were for the prevention of the commission of crimes by others, so that he thought the discussion as regards that point was a little wide of the mark.

Dr. HACK TUKE said that the case was different where the patient was susceptible to very small quantities of alcohol, and with constitutional tendencies leading him to commit crime.

Dr. MICKLE said he thought such a man should avoid the small quantity of alcohol. Dr. Rayner's suggestion that the person should not be held responsible unless he took what he knew was enough to make him drunk would, in effect, relieve of responsibility a person who committed a crime while he was drunk for the first time, because until he had been drunk once how was he to know how much would affect him?

Mr. C. M. TUKE thought that the present law was sufficient in most cases. A great deal of ordinary crime was, more or less, to be traced to the influence of drink, certainly such crimes as assaults. He had recently been reading a book called "New World Answers to Old World Questions," in which the author gave some very interesting statistics upon the influence of drink in regard to crime, and had taken great pains to see what crimes had been committed and under what circumstances, in one of the smaller States of America, and he found that ninety per cent. were directly or indirectly caused by the influence of drink. In that State the percentage of insanity was very small, but the drink was very large, and it was very evident that drink was mainly responsible for nearly the whole of the crime committed in that State. He thought that with the present law of England the cases now under consideration might fairly be left to the discretion of the judges, but where there was direct evidence of insanity it was a matter of great importance that medical evidence should be called, but in most of the ordinary cases the judges were able to deal with them.

Dr. BOWER said it appeared to him that judges and others having to do with this subject ought to be acquainted with the amount of drink which was connected with insanity. He had always had grave doubts as to the proportion of insanity which was stated in Blue Books to be caused by drink; something like fourteen per cent. He could not himself get more than five or six per cent. He had sifted the causes of insanity and found that drunkenness was more often caused by the predisposition to insanity in the family.

IRISH MEETING.

A quarterly meeting of the Medico-Psychological Association was held at the Hall of the King's and Queen's College of Physicians, Dublin, on Thursday, January 21st, 1886. Present: Drs. Duncan (in the chair), Patton, Draper, Moloney, Conolly Norman, Courtenay.

CONOLLY NORMAN, F.R.C.S.I., read a paper on "Larvated Insanity," giving the history of two men who had, through life, shown at times well-marked delusions, but whose insanity had not been brought to light during their period of service in the army and police, though both were constantly in the possession of arms.

Dr. DUNCAN asked was there any history of masturbation in these cases?

Dr. DRAPER asked were these to be looked on as distinct types of insanity? That the fashion now-a-days seemed to be to divide insanity into different species, whereas he agreed with Dr. Sankey that insanity was only one disease, and that many persons walking about might be said to be types of larvated insanity. He instanced the case of a gentleman who, on the death of his first wife, almost became insane from grief, but in six months married again, at the same time insisting on decorating his first wife's grave with wreaths.

Dr. NORMAN replied that he used the word "larvated" only to describe the course of the disease. In one of his cases distinct delusions had been shown for twenty-five years, during which time the man had continued in the public service with arms in his hands. In the second case the man had taken to the profession of arms under distinct delusions, which had never been discovered, though there were no lucid intervals. His delusions, which were always of an exalted type, had continued from his youth.

Dr. MOLONEY read a short paper on two cases of insanity from masturbation.

GUILD OF FRIENDS OF THE INFIRM OF MIND.

We have been requested to bring this Society, instituted in 1871, under the notice of our readers. The President is the Bishop of London, and the Secretary the Rev. H. Hawkins, the chaplain of the Colney Hatch Asylum, who will be glad to furnish particulars to any one desiring them. No further payment is required than a contribution of 1s., payable on membership, which will only be granted to those strictly in communion with the Church of England, and who are willing to promote the objects of the Association by prayer and help. The day of commemoration is the festival of S. Luke.

The objects of this Association, which takes for its text, "He shall be for a sanctuary," are stated to be as follows:—

1. Intercessory prayer.
2. Visits to friendless patients in asylums, in conformity with the regulations of the establishment.
3. Correspondence by post.
4. Seeking situations for convalescents.
5. Promoting Convalescent Homes for temporary rest after mental illness.
6. Maintaining friendly intercourse with discharged patients.
7. Recommending efficient attendants.
8. Furthering, in any other way, the interests of the infirm in mind.

The number of past and present associates is about 200.

1. *Intercessions* of many have been offered on behalf of the objects of the Association.

N.B.—A special "Union for Prayer for the Infirm in Mind" has been formed. This might suit the case of those who could not otherwise assist. "You that can be no other way useful, yet you shall be no small helpers, if you be much in prayer."—LEIGHTON.

2. *Personal visits* have been paid to many patients: nearly forty associates

—some long-tried friends—have shown kindness in this manner. Kind gifts have been brought, invitations to tea given, &c., and many tokens of sympathy evinced.

3. *Postal communications* have been very numerous and varied. Letters, books, magazines, pictures, Christmas, Easter, and other cards, almanacks, flowers, postage stamps, &c., have been forwarded, and given much pleasure.

POSTSCRIPT ON THE LUNACY BILL.

Since the observations on the Bill in the "Notes of the Quarter" were written, the representations made by the Parliamentary Committee of the Association and other bodies to the Lord Chancellor on the very unfair and injurious clauses it contains have had a favourable effect, and his Lordship, on the Bill going into Committee on March 18th, introduced certain valuable amendments and promised others, which materially modify the clauses referred to. A communication was made to Lord Esher, in which stress was laid upon the necessity of still further protecting medical men by the introduction of a clause requiring the sanction of a judicial functionary before a civil action can be brought against medical men, and the granting of power to the defendant in a threatened lunacy action to require the plaintiff to give security for costs.

It may be observed that there was a marked improvement in the general tone of the debate in the House of Lords on going into Committee in the references made to the branch of the medical profession practising in lunacy.

Putting aside minor points upon which the Association has made suggestions, the main proposals and protests have reference to:—

1. More complete protection of medical men signing certificates, and of private persons and institutions receiving patients.
2. Prevention of frivolous actions brought by discharged lunatics by requiring security for costs.
3. Prevention of the confiscation of the vested interests of the proprietors of private asylums.
4. Single patients.
5. Examination of alleged lunatic by medical men, and not the magistrate, in cases in which the latter defers the granting of an order for admission into an asylum for the purpose of a further examination.

The Chairman of the Committee, Dr. Rayner, writes:—

The following suggestions (many of which have been adopted) were forwarded to the Lord Chancellor prior to the second reading of the Act, and in a second communication to his Lordship the Committee expressed the opinion that Clause 43 "was a veiled confiscation of the vested interests of the private asylum proprietors," and that Clause 26, s.s. 1, by compelling every person suffering from mental disorder requiring treatment away from home to be "incarcerated" in a public asylum and branded by legal process as a lunatic would inflict grievous harm and much social suffering in many cases of acute and transient insanity. This was exemplified by cases of puerperal mental disorder. To each communication his Lordship returned a courteous reply, promising attention to the suggestions and criticisms forwarded.

SUGGESTED AMENDMENTS AND REMARKS ON THE "LUNACY ACTS AMENDMENT BILL" (H. L.), 19TH FEB., 1886. BY THE PARLIAMENTARY COMMITTEE OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

Clause.	Sub-section.	Page and Line.	Suggested Omissions.	Suggested Amendments.	Remarks and Inquiries.
3	7	p. 3, l. 27		It is suggested that the name and address of the usual medical attendant (if any) be inserted in Form 2.	What constitutes a person? The "usual medical attendant?"
3	15	p. 4, l. 43			In cases of postponed petitions, in which the petition is refused, what protection from actions for libel is given to the signatory of a medical certificate? The patient may have recovered during the period between the signing of the certificate and the refusal of the adjourned petition.
3	12	p. 4, l. 26	Omit "of or."	After "to do," line 27, insert, "appoint two medical persons to."	Objection is made to the Judge visiting a supposed lunatic to determine a medical question. It is suggested that he should appoint two medical persons to visit for him.
3	13	p. 4, l. 34			"Summon." Under what conditions are the persons summoned to attend? How are their expenses or remuneration to be paid?—*e.g.*, in the case of physicians summoned from a distance, what penalty is incurred by neglect of summons?
3, 4	16, also in 8	p. 5, l. 9. p. 6, l. 41.			"Taking" by whom? By the petitioner or his agents, by the asylum authorities, or by public authorities?
3	17	p. 5, l. 17		After "him," l. 17, insert, "or his agent."	The petitioner, by age, infirmity, &c., might not be able to attend personally.

3	20	p. 5, l. 35		After "made," l. 35, insert, "or dismissed."	
5	2	p. 7, l. 29			After "Justice" should not "Stipendiary Magistrate" or "County Court Judge" be inserted?
8	4	p. 10, l. 16			"Affidavits" are privileged. "Certificates" are not. Is it the intention of this sub-section to put certificates on the same footing of privilege?
8	4	p. 10, l. 16			As the clause stands no protection is given to a medical man who does an act for the purpose of signing a certificate but does not so sign it, and generally no protection is given to any one, as the door will be opened to litigation in all cases by the term "good faith."
31	1	p. 21, l. 30			By this section the present power given to Visitors to grant leave to boarders is withdrawn, which will in many cases lead to delay.
33	1	p. 23, l. 15		After "person" insert "other than a husband or wife or relative within the first degree."	Without this provision the mere fact of insanity in a family would render them liable to an inspection of all the family circumstances and "property," and render the position of the family extremely dubious. Does this prohibit the introduction of fresh licenses in existing houses?
43 44	1 9	p. 30 p. 31. l. 11			It is proposed to omit this section, for generally, the authorities have sufficient power to increase their accommodation, and specially, such institutions are useful in case of temporary want of room in county asylums, by reason of destruction by fire, by rapid increase of demands for admission, by alterations in county buildings, as in cases of epidemic disease.
Forms 2 and 10		p. 45, l. 52	Omit the question as to the occurrence of insanity in a near relative.		The objection is that it will increase enormously the present objection on the part of the relatives to sign any papers.

THE STEWART SCHOLARSHIP IN MENTAL DISEASE, TRINITY COLLEGE, DUBLIN.

Very little appears to be known in England of this valuable prize in Psychological Medicine. We are informed that the late Dr. Stewart, of Lucan, whose name is associated with the Institution for Idiots at Palmerston, left a considerable sum of money, for the encouragement of the study of insanity, to Trinity College, Dublin, and to the Royal University. The two Universities have combined, and have founded a scholarship, of £40 a year, tenable for three years, to be shortly competed for.

The following are some of the articles of the Scheme, issued pursuant to the Decree of the Master of the Rolls, bearing date July 11th, 1882, and the Rulings of the 21st day of March and 23rd of April, 1883, for the distribution of the Residuary Estate of the late Dr. Henry Hutchinson Stewart, of Dublin, long a member of our Association.

One medical scholarship, at least, shall be awarded for proficiency, to be ascertained by competitive examination in the subject of the treatment of mental diseases, according to a course to be prescribed by the Provost and Senior Fellows of Trinity College.

Each medical scholar elected for proficiency in the subject of the treatment of mental diseases shall, as the condition of retaining such scholarship, be bound, within six months of his election to such scholarship, to proceed to some recognised institution for the treatment of mental diseases, to be approved of by the Board of Trinity College, and there continue as either a resident or outdoor pupil for such period, not less than six months, and under such conditions as the Provost and Senior Fellows shall by a general regulation prescribe, and on failure to observe such condition the said scholarship shall, in the discretion of the said Provost and Senior Fellows, be liable to be declared vacant.

No person shall compete for a scholarship to be awarded for proficiency in the treatment of mental diseases but within two years after he shall have graduated for a Bachelor of Medicine.

The above regulations refer to Trinity College. Those relating to the Royal University are identical, substituting the "Senate" of this University for the "Board of Trinity College."

No student shall compete for the scholarship a second time.

Every candidate must hold the M.B. of the Royal University and Trinity College, Dublin.

An M.B. of Trinity College cannot compete for a scholarship in the Royal University, nor *vice versâ*.

The next examination for the Stewart Scholarship in Mental Diseases of the value of £40 a year, tenable for three years, will take place in Dublin on October 20 and following days.

For particulars apply to the Secretary of the Royal University of Ireland, Earlsfort Terrace, Dublin.

WAS BAINES MAD, DRUNK, OR DELIRIOUS?

[We are indebted to Dr. Cassidy, Medical Superintendent of the Lancaster Asylum, for the following note on the case of Baines, referred to by Dr. Savage in his article (p. 23); and regret that it came to hand too late to appear among the original articles.—EDS.]

Baines murdered his wife on Christmas Day. When I first saw him, at the instance of the Treasury officials, on January 8th, he was calm, and *apparently* rational. He spoke of his wife, however, in a rather childish way; said that

she used to beat him; that, owing to his lameness, he could not get after her, or out of her way, as the case might be; that she deceived him, and went with other men; that on Christmas Eve she brought a man into the house; that he went to bed and left them together; that shortly after he heard them engaged in obscene conversation, too filthy to repeat, outside his door, which was partly open; and that, on looking to see, he found them committing, or attempting, an act of adultery on the stairs, two of his young children being within view at the foot of the stairs; that they left the house together, or soon after one another, after some words; and that he then went to bed and slept till morning, seeing no more of his wife that night. This story he adhered to, and positively asserted, when I twice subsequently examined him.

As a matter of fact, however, as shown by the evidence, no such thing ever took place. Baines had been for many years—from 20 to 25 years—a hard drinker; and had been drinking steadily from last June to December, never in all that time quite sober. He had had several acute attacks of delirium tremens within the last three or four years, and was often troubled with hallucinations, restlessness, and tremors, without becoming acutely delirious. When sober, he was described to me as a quiet, sensible sort of man; but under the influence of drink became wild and furious. At such times, and not at others, he had the belief that his wife was unfaithful to him; or, at all events, this belief became prominent then, and took an active shape. Thus he complained of her conduct, taunted her about other men, watched and dogged her sometimes for weeks, with a view to catching her in an act of infidelity. During one such access of "acute suspicion" he bought a pistol with which to shoot himself; on another he swallowed sixpennyworth of laudanum and some horse-powder; on another he secreted a razor in the chimney, and several times he attacked her with weapons. Baines did not tell me these facts himself; I ascertained them by going to Barrow and making inquiries. When questioned about them at my third interview, he said, "I felt so miserable about the way she was going on, I wanted to make an end of it and kill myself."

At this period he still asserted that his story of what took place on Christmas Eve was "Gospel truth." He admitted that, instead of sleeping all night, he might have got up and come downstairs once or twice to see if his wife had come in. I formed the impression that his mind was really confused as to the events of that period, and that he could not recollect clearly what took place. He said if his son swore it, it was most likely true. He admitted, when pressed, that this was the only occasion when he had ocular proof of his wife's infidelity. In reality, the night was spent in sleeplessness, quarrelling, and excitement. Young Baines said his father was up and downstairs all night, that he beat himself with a stick, and ran with his head against the wall.

In the morning all the observations concur in this, that Baines was full of what he supposed had occurred during the night. He was "roving wild" when telling the witness Gardner all about it half-an-hour before the crime. He told his wife when she was dying, and the officers when they they were apprehending him. Was this the hallucination of a drunken man, or was it that constant wandering of the mind which constitutes delirium? Does it not rather suggest the perversion of a mind which, weakened by drink, has become deluded from constant dwelling on this one theme? The murder clearly was done either from a sudden impulse of fury or deliberately (as he himself stated), and, in that case, from a fixed and definite motive. If from motive, was the motive a sane or an insane one? Are the circumstances of the crime most consistent with intoxication, delirium, or delusion? He obtains and ostentatiously sharpens two knives, which his chums take from him, half unknowingly, perceiving that he is not to be trusted with such weapons. A third time he secures and sharpens his knife, and the servant girl from whom he got it, after detailing her conversation with him, says "he seemed quite sensible at that time;" but ten minutes or less afterwards, John Evans, in whose house the murder was committed, says (in a letter to me dated January 11th), "I saw

Baines going out up the street about half-an-hour before the murder. He seemed right enough then, but when he came in our house to his wife he seemed nervous and excited and trembling; his whole frame seemed as if he was suffering from delirium tremens." In these two episodes I see the cunning and secretiveness, the suppressed excitement and ferocity of the homicidal lunatic, rather than the uncalculating passion of a drunkard. Such conduct I consider as quite consistent with his former irrational concealing of a razor, spying upon his wife, &c. His own statement to me as to the act is worth repeating: "I never intended to kill her. I thought I would give her a good fright, but when I got near her something came over me, and I could not help doing it. I don't rightly know how it happened. I was not master of myself." Thirty hours after he began to grow delirious, and for some days was acutely excited. The minute description given me by the officer in charge of the prison of his symptoms during the stage of acute excitement seemed to point to a curious mixture of the terrors and hallucinations of delirium tremens and delusions of a more purely mental character. He proclaimed, as a piece of news, that he had killed his wife, and had been let off on payment of a fine, &c.; that his inside had been taken out, and that half of his member had been cut off, &c. He was also very noisy. Was this delirium tremens pure and simple, and did it originate *de novo* a day and a half after his apprehension? My own answer to both of these questions would be in the negative. I fully satisfied myself by personally examining the witnesses that he had been more or less subacutely delirious for a fortnight before Christmas, and that for three or four nights before, he had not had his clothes off, and had hardly slept at all.

As regards the first part of the question, my view was, and is, that inherited neurosis made all the difference between his attack and ordinary delirium tremens. Baines's maternal grandfather, and several other relatives on the same side, and in the same generation, were imbecile or melancholic, though none were confined in an asylum. The important witness who was to have given evidence of this at the trial was there on the day, but too hopelessly drunk to be presentable; and this leads me to remark that there is strong evidence of inherited drink propensity on the other side of Baines's family.

Dr. Bastian's opinion was that all the symptoms and all the effects mentioned were due to intoxication and to jealousy; and Dr. Rogers and Dr. Wallis, who saw him after the trial, appear to have agreed with that opinion.

Had I, however, thought that Baines suffered from delirium tremens only, I would have expressed my conviction that that, in a medical sense, constituted unsoundness of mind; but when I look through my case-books and notes of cases of drink-caused insanity, I see Baines's case staring me in the face from nearly every page. Of all the men of this class admitted last year into this asylum there is hardly one to be found where homicidal or suicidal propensity, or both, associated frequently with insane jealousy, and delusions as to wives or mistresses, does not appear in the medical certificates as one of its principal bases. My view of all these cases, including Baines's, is that they are always (in habitual drunkards at all events) borderland cases. When drunk they are mad drunk, and continued drinking leads them to fixed mental aberrations, and leaves them in an asylum or on the scaffold. Baines was hanged on Feb. 9th.

Postscript.—I have before me a collection of Baines's letters written whilst in prison. The following is taken from one dated January 13th, the day after the second examination before the magistrates, and appears to have been prompted by the evidence then given by his eldest son, to whom he refers as Jack. It is addressed to the supposed paramour. "There is nothing so sure that I saw it and heard the words used. Ask Jack was Alfred and Thomas (his two young children) up when he came home, and write and tell me, for I heard them and saw them as plain as I saw you and her. Now, Bob, I adjure you to tell me the truth with you or against you. I shall pray for you till I

get an answer that you may be guided to tell the truth, as I have been guided to ask you if it is a delusion (note, he had heard me call it a delusion before the magistrates). If I have taken the poor woman's life innocent may the Lord have mercy on my soul, and the poor innocent soul that has gone up. Till yesterday, or rather to-day, it would have been dangerous for you and me to have met. As I am, to-day my sufferings are only beginning. Her guilt was holding me up. When I thought about it I could immediately answer myself, feeling justified doing it." . . . "Answer all truthfully, as God will be your judge some day." To my mind this indicates that about this time three weeks of abstinence, rest, and regular exercise were beginning to have their natural effect, and his mental balance was being restored. D. M. C.

Obituary.

DR. JOHN W. SAWYER.

Dr. Sawyer recently visited this country, and to those who became acquainted with him in connection with his inspection of asylums it will be a cause of great regret to learn that so soon after his return to America his life was cut short, and his useful career as Medical Superintendent of the Butler Hospital for the Insane, Providence, Rhode Island. He succeeded the celebrated Dr. Ray in 1867. During the nearly twenty years which have elapsed since his appointment he had discharged the duties of his office to the entire satisfaction of all concerned; and those who have visited this institution can bear witness to the proofs of his administrative capacity and the kindness of his heart. The trustees of the hospital speak the simple truth when they say that "his manners were gentle and winning; his character was marked by singular modesty, united with gentle firmness of purpose, by rare good judgment, by manly independence, by self-denying benevolence, by unfailing devotion to the duties he was called upon to perform. He has died at a moment the most unexpected, of which those who loved him had received no premonition, and when his plans were broadest and his hopes were highest, in the full meridian of his usefulness and his renown. The trustees mourn his loss, not alone as a loss of an accomplished and faithful superintendent, eminent in his profession and honoured in the community, but also as the loss of a personal friend, endeared to them by the graces which adorn his character, and by the noble and generous services which filled his daily life."

Dr. Sawyer was born at Danvers, Mass., Nov. 5, 1834, and received his medical education at Hartford University, where he graduated as Doctor of Medicine in 1859. He filled the office of assistant-physician at the Butler Hospital for the first two years, under Dr. Ray. After practice in Boston for a short time, he became assistant-superintendent of the State Hospital for the Insane at Madison, Wisconsin, where he remained during the six years preceding his appointment at Providence. About ten days before his death Dr. Sawyer attended a maniacal case with a view of a removal to the Butler Hospital. The patient, a strong, athletic young man, clutched the doctor by the throat, and it required the policemen in attendance to drag him off. Although Dr. Sawyer never mentioned the accident to his physician, there appears to be no doubt that it was the immediate cause of his death. The cellular tissue of the neck was infiltrated, involving the submaxillary glands, which had previously been somewhat enlarged. It became necessary to perform tracheotomy, but death followed a few minutes after the operation, Dec. 14, 1885, at the age of 51. His loss will be

severely felt in the institution which he superintended, and by the American alienists.

He has been succeeded in his office by Dr. Goldsmith, the late superintendent of the Hospital for the Insane at Danvers, who has many friends in Britain who will wish him success in the performance of the duties which have thus unexpectedly fallen to his share. Butler Hospital is once more fortunate in the possession of a wise and zealous medical superintendent.

DR. JOSHUA HUSBAND WORTHINGTON.

Another American physician has gone to his rest, not prematurely, as in the case of Dr. Sawyer, but at the age of 69. In 1842 Dr. Worthington became resident physician of the Frankford Asylum near Philadelphia, conducted by the Society of Friends, and became its superintendent in 1850, an office which he filled until 1877, so that he was connected with the institution for 35 years. He was born in 1817, in Hartford county, Maryland, and received his medical education at the Jefferson Medical College, graduating there as Doctor of Medicine in 1838, after which he practised his profession in his native place. Dr. Worthington "was a member of the Association of Medical Superintendents of American Institutions for the Insane, and a prominent member of the American Medical Association, and was identified with all the important local and State Associations, serving as Vice-President of the State Medical Society in 1859. He became distinguished in his treatment and studies of insanity and his contributions to the literature of the institution were liberal and valuable. In connection with Dr. Charles Evans, from 1843 to 1850 he published eight reports of the Frankford Asylum, and after that for some years became their sole publishers." To this statement of the "American Journal of Insanity" (Jan., 1886) it may be added that after his retirement he lived quietly at Baltimore, and at German Town, Philadelphia, where he died Dec. 27, 1885.

Dr. Worthington was one of the kindest of men, and was beloved by the patients under his charge. In his general views of asylum construction, and the provision for the various classes of the insane, he could hardly bring himself to approve of much that has been proposed or adopted during recent years. He was eminently conservative, and in a letter written to the writer shortly before his death he expressed his apprehension lest the movement largely carried forward by laymen for the protection of the insane in the States would not prove disadvantageous, as well as advantageous, in the true interest of the insane by prejudicing the public mind against institutions for the insane. Possibly he did not fully recognise the fact that all entrusted with the guardianship of the insane do not possess the same kindness and consideration for their welfare as has characterised himself; and was, therefore, hardly aware of the danger of abuses in asylums unless constantly looked after by outsiders, although in many instances forming an incorrect judgment, and in some doing an injury to the class they desire to benefit. Be this, however, as it may, Dr. Worthington performed his own duties faithfully; and his memory will long be cherished, alike by his old patients and by his friends both in England and America.

Correspondence.

"SOME POINTS IN IRISH LUNACY LAW."

District Asylum, Sligo,
12th January, 1886.

GENTLEMEN,—I quote from the above paper, which appears in your last issue:—

"The magistrates issue a warrant ordering the patient's admission to the asylum, where he is then conveyed by two policemen. To those who are not familiar with these functionaries, it may be mentioned that policemen in Ireland usually go about fully armed, and are more like riflemen than English constables."

On the 24th April, 1877, the Inspector-General of Constabulary in Ireland issued a circular, in which the order is given: "In future, all escorts with lunatics are to carry truncheons only."

I draw attention to this because Dr. Norman read his paper to an English audience.

Faithfully yours,
JOSEPH PETIT,
Res. Med. Supt.

The Editors "Journal of Mental Science."

712, Lexington Ave.,
New York, January 13th, 1886.

TO THE EDITORS OF *The Journal of Mental Science.*

GENTLEMEN,—Your reviewer of Dr. Westcott's book on Suicide says ("Journal of Mental Science," January, 1886, p. 566) that "in the United States suicide is not and never has been regarded in the light of a crime against statute laws." This is not strictly correct—to-day, at least. The new, and in many features brutal, code of Criminal Laws of the State of New York, sometimes spoken of as the "Field Code," makes of suicide a "felony," punishable by imprisonment, fine, or both. This is the law to day in the largest State of the Union.

With regard to its practical working, the following may interest the readers of the "Journal of Mental Science":—There has been in the City and County of New York but one conviction under the new law (now in operation over three years). This was in the case of a person who was not a suicide in any sense, having jumped out of a row-boat in the frenzy of acute alcoholic intoxication, and innumerable would-be suicides have been arrested since then, but in no other instance could a judge or prosecuting officer be found to push the case to its bitter end. The person convicted had had the misfortune of jumping into the water too soon after the adoption of the New Code to escape. A week later the provision relating to suicide became, and has to this day remained, a dead letter.

Respectfully yours,
E. C. SPITZKA.

TO THE EDITORS OF *The Journal of Mental Science.*

The Asylum, Hanwell, W.,
14th March, 1886.

GENTLEMEN,—In reference to the answer of Mr. Morley to Mr. Corbett in the House of Commons "that English Asylum Officials in regard to pensions were on the same footing as Her Majesty's Judges, &c.," I wish to state that I have forwarded copies of the Pension Resolutions passed by the Association in 1878 to each of those gentlemen, drawing attention to the vast difference that exists between our pension status and that of the first-class civil servants quoted.

Believe me, yours very truly,
H. RAYNER, M.D.,
Hon. Gen. Sec.

Appointments.

DONALDSON, ROBERT, L.S., A.B., M.B., B.Ch. Univ. Dub., appointed Assistant Resident Medical Superintendent to the Monaghan Lunatic Asylum, *vice* J. A. Johnston, L.K.Q.C.P., resigned.

EARLE, P. M., L.R.C.P., L.R.C.S. Ed., appointed Junior Assistant Medical Officer to the Salop and Montgomery Counties Lunatic Asylum, *vice* H. McAndrew, M.B. and C.M. Ed., resigned.

GEMMEL, JAMES FRANCIS, M.B., C.M. Glas., appointed Assistant Medical Officer to the County Asylum, Lancaster, *vice* Dr. Dalzell, resigned.

HORTON, WILFRED W., M.D. Edin., appointed Assistant Medical Officer to the Wonford House Lunatic Hospital, Exeter, *vice* J. J. G. Pritchard, M.R.C.S., L.R.C.P. Lond., resigned.

MCANDREW, HERBERT, M.B., C.M. Edin., appointed Assistant Medical Officer to the Seacliffe Aslyum, Dunedin, New Zealand.

NEIL, JAMES, M.D., C.M., appointed Assistant Medical Officer to the Warneford Asylum, Oxford.

PRITCHARD, J. J. G., M.R.C.S., L.R.C.P. Lond., late Assistant Medical Officer, Wonford House, Exeter, appointed Assistant Medical Officer of the County Asylum, Lancaster.

RUTHERFORD, ROBERT LEONARD, M.D., Qu. Univ., Irel., M.K.Q.C.P., Irel., late Senior Assistant Medical Officer Devon County Asylum, appointed Medical Superintendent of the City of Exeter Lunatic Asylum.

ARTHUR RANNIE, M.B., C.M. Aber., late Pathologist and Second Assistant Medical Officer West Riding Asylum, appointed on the Colonial Medical Service, British Guiana.

WILLIAM DUDLEY, M.B. Lond., Pathologist at West Riding Asylum, Wakefield, to be Second Assistant Medical Officer, *vice* Dr. Arthur Rannie.

CONTENTS OF No. 135.—OCTOBER, 1885.

PART I.—ORIGINAL ARTICLES.

PART II.—REVIEWS.

PART III.—PSYCHOLOGICAL RETROSPECT.

PART IV.—NOTES AND NEWS.

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APRIL, 1886.

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EDITED BY

D. HACK TUKE, M.D.,

GEO. H. SAVAGE, M.D.

"Nos vero intellectum longius a rebus non abstrahimus quam ut rerum imagines et radii (ut in sensu fit) coire possint."

FRANCIS BACON, *Proleg. Instaurat. Mag.*

JULY, 1886.

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H. WOLFF, LEWES.]

To be continued Quarterly.

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The Journal of Mental Science.

Original Papers, Correspondence, &c., to be sent direct to Dr. HACK TUKE, Lyndon Lodge, Hanwell, W. (Town address, 63, Welbeck Street, W.)

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The copies of *The Journal of Mental Science* are regularly sent *by Book-post (prepaid)* to the Ordinary and Honorary Members of the Association, and the Editors will be glad to be informed of any irregularity in their receipt or overcharge in the Postage.

The following are the *EXCHANGE JOURNALS*:—

Zeitschrift für Psychiatrie; Archiv für Psychiatrie und Nervenkrankheiten; Centralblatt für Nervenheilkunde, Psychiatrie, und gerichtliche Psychopathologie; Der Irrenfreund; Neurologisches Centralblatt; Revue des Sciences Médicales en France et à l'Etranger; Annales Médico-Psychologiques; Archives de Neurologie; Le Progrès Médical; Revue Philosophique de la France et de l'Etranger, dirigée par Th. Ribot; Revue Scientifique de la France et de l'Etranger; L'Encéphale; Annales et Bulletin de la Société de Médecine de Gand; Bulletin de la Société de Médecine Mentale de Belgique; Russian Archives of Psychiatry and Neurology; Archivio Italiano per le Malattie Nervose e per le Alienazioni Mentali; Archivio di psichiatria, scienze penali ed antropologia criminale: Direttori, Lombroso et Garofalo; Rivista Clinica di Bologna, diretta dal Professore Luigi Concato e redatta dal Dottore Ercole Galvani; Rivista Sperimentale di Freniatria e di Medicina Legale, diretta dal Dr. A. Tamburini; Archives Ital. de Biologie; The American Journal of Insanity; The Journal of Nervous and Mental Disease; The Quarterly Journal of Inebriety, Hartford, Conn.; The Alienist and Neurologist, St. Louis, Misso.; Medico-Legal Journal; The American Journal of the Medical Sciences; The Dublin Quarterly Journal; The Edinburgh Medical Journal; The Lancet; The Practitioner; The Journal of Physiology; The Journal of the Anthropological Society; The British Medical Journal; The London Medical Record; The Asclepiad; Reports of the Psychical Research Society; Brain; Mind; The Canada Medical and Surgical Journal; Polybilion; The Index Medicus; Revista Argentina; Il Manicomio.

THE JOURNAL OF MENTAL SCIENCE.

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No. 138. NEW SERIES, No. 102. JULY, 1886. VOL. XXXII.

PART 1.—ORIGINAL ARTICLES.

Insanity and Crime. Paper read before the York Law Students' Society. By S. W. NORTH, M.R.C.S.Eng., Visiting Medical Officer to the York Retreat, and Medical Visitor to Private Asylums in the North Riding.

The questions I propose to consider are:—

1. The relation of insanity to crime.
2. The question of responsibility.
3. How far the legal dictum on the responsibility of alleged lunatics is true in fact.

In every civilised community, however imperfectly the wish may be fulfilled, the desire is to do equal justice to all; to uphold the law as a terror to evil-doers, and the protector of the innocent.

Whether punishment is to be regarded as an act of vengeance against the wrong-doer, or simply as an agent for deterring others, is a question about which it is possible there may be divers opinions. For myself I prefer to regard punishment as an act of lawful vengeance, whereby society, with all the safeguards of law, marks its sense of wrong and its determination to prevent it—this state of the public mind being itself the great deterrent.

Accepting this view, and that the vengeance of the law should be sharp and implacable, never wavering and never hesitating when once satisfied that the wrong has been done and the wrong-doer secured, it behoves those who have the administration of the law, and society whose highest behest it obeys, to weigh with all diligence, and with all the aids which knowledge can bring to bear on the matter, the question of personal responsibility, so that no man may say that the sword has descended on one whose actions were not of his own free will.

Liberty of action is the very essence of responsibility, and in this lies the great difficulty, not only as regards the question of

mental competency for the commission of crime, but in the affairs of daily life. The wise man often forgives because he recognises the difficulty of deciding the question of personal freedom, and courts of law are not unmindful, when sentence is pronounced, of mitigating circumstances.

It is the very quality of charity, human and divine, to forgive them, "for they know not what they do."

The limitations on personal responsibility arising from social conditions and the acts of others are not within the scope of this paper. I refer to them simply to remind you that such limitations exist, and are recognised as such.

The same act in the eye of the law is not invariably a crime, and when it is an offence, its legal magnitude may be diminished by evidence showing limited freedom of action.

The law does recognise limitations on responsibility, though knowledge be abundant and the offender thoroughly understand the nature and quality of his act, and that it is in itself unlawful. Your experience and knowledge will supply abundant illustrations of the fact.

The object of my paper is to show that limitations on freedom of action arising from disease, equally cogent, nay, often far more so, do exist; that these disordered conditions of personal health give rise to such disturbances of the mental powers as may and often do operate as agents in impelling the sufferer to acts of criminality, overmastering or, it may be, destroying his moral sense and power of restraint, even at a time when he may retain a full knowledge of the nature and quality of his act and that it is contrary to law; that these mental disturbances exercise a coercive influence over his actions, far more powerful than any influence which can be brought to bear by others; that persons so diseased, being deprived of their freedom of action, are of necessity, and in fact, and in justice ought to be held, irresponsible to the law for their acts; that the question of what they know or what they do not know is of no importance, and in the light of knowledge of no value in determining their power to control their conduct; such persons are slaves despite their knowledge, unable to resist that which to them is more than a master.

Remembering with admiration the extreme care bestowed in our courts of law to protect the accused, the diligence with which all irrelevant evidence is excluded, and the minute attention which is paid to every fact which may show a want of legal responsibility, it does seem strange that so little con-

sideration has been given to those excuses for criminal acts which are afforded by disorders of the intellect, and that so little respect has been paid to the teachings of experience, and the observations of men whose lives have been devoted to the study of these disorders.

Though during the past century there has been an enormous advance in our knowledge of disorders of the mind, and in hundreds of hospitals and asylums opportunity has been given for investigation—and though the whole literature of the subject is directly opposed to the legal dogma—it remains unchanged, and the same definition of responsibility may still be heard from the bench whenever the question is raised. Except in the domain of theology, I know no region of human thought in which a dogmatic adhesion to a phrase having no basis in fact is so rigidly adhered to as in this corner of our jurisprudence. If, happily, in spite of judges and judge-made law, few insane persons are hanged now, it was not so thirty years ago. The question is rapidly becoming one of historical rather than practical interest, and the day is probably not far distant when this judge-made law will become a question of the past, and some happy judgment in a Court of Appeal will extinguish it for ever.

Before I proceed to discuss the main questions at issue it may be well, and will probably serve to clear the ground for argument, if I endeavour to define and limit the question before the Society. In all controversy more than half the difficulty and nearly all the obscurity in which complex questions are involved is due to the want of a clear definition of terms and a full appreciation of the limits of knowledge.

There is no precise definition of the word responsibility. So far as I know, no such limitation of the term is possible as would enable us to use it as the basis of a scientific argument. Hence the diversity of opinion which men form of the conduct of others. In the mind of the multitude the estimate of duty, justice, and honour, what men ought and ought not to do under given circumstances, is as shifting as the wind, and as diverse as the thoughts, habits, education, and social position of the individuals who compose the multitude.

In morals, the question of responsibility has never been clearly defined; no theologian has ever, except in the matter of belief, itself vague and illusory, dogmatically stated what he means by man's responsibility to God or to his fellow-men.

Read by the light of history, responsibility is a shifting and probably advancing quantity, increasing with the progress

of knowledge, and with the complexity of our social state. In some vague and indefinite way, when we speak of responsibility we imply knowledge and freedom of action, terms in themselves almost as ill-defined. When we are obliged to consider the application of them to some given case the difficulty confronts us. The individual forgives the wrong or foregoes his right. The Church devises means of escape from the consequences of error. The law weighs all the facts with care, giving the full benefit of doubt to the accused, and society at large breathes more freely when it can forgive—so thoroughly do all men recognise the difficulty of defining responsibility.

In like manner there is no definition of insanity. No one has ever yet framed a definition of mental unsoundness capable of embracing all cases of derangement of the intellectual faculties, and at the same time of excluding sanity. The difficulty of defining what we mean by sanity or insanity is as great as that of defining responsibility, and for the same reasons. Probably the more we advance in civilization and social complexity the wider and more evident becomes the area of man's incapacity. Whilst, in the lowest stages of social development, mental powers of an elementary order might suffice, it is obvious that these would become inadequate in an advanced social state to enable the individual to discharge all the duties of citizenship, or to be held responsible for the due performance of them. From him that has little we have no right to demand much.

If these opinions are sound, and it seems to me difficult, if not impossible, to say they are not, then it is clear that we have no data which enable us to say beyond doubt what constitutes responsibility and what does not, or what constitutes insanity or its converse sanity. Both conditions are undefinable, and no definition which can guide others to our meaning is possible.

Notwithstanding all this, we have a legal definition of responsibility, expressed in words clear and distinct, enforced on the attention of juries with all the solemnity of assured truth, by which the range of freedom of will is defined, not in the sane, but in the victims of disease.

The human mind is parcelled out into divisions, and it is boldly declared that some portions may be unsound, yet that which guides the whole, the will, is sound, and able to control the vagaries of the rest, provided the subject of disease has an intellectual knowledge of what he is doing and of its legal rela-

tions. This dogma, held and enforced for at least a century and a half, became crystallized into a formula by the opinions of the judges expressed in answer to questions submitted to them by the House of Lords in 1843.

Men of great ability, of wide learning and experience, deemed it right, and their successors follow them, to affirm the dangerous and unsound doctrine that knowledge is power.

They tell us in their books, and often with scant courtesy from the bench, that medical men are not lawyers, that they do not understand the law. The members of our profession never, so far as I am aware, claimed either the one position or the other.

We do not understand the law—it is not our province to do so—but we do claim to have the ordinary understanding of jurymen, and to comprehend the law as it is laid down for their guidance in cases where insanity is pleaded in defence. Jurymen, as a rule, are not lawyers; they do not understand the law, but they are expected to understand the exposition of it by judges. The medical profession claims no more. With this exposition of the law to guide me, I say unhesitatingly, and of knowledge, that the law as laid down by all the judges, living and dead, for the guidance of juries, with possibly one or two exceptions, is unsound in reasoning and untrue in fact. I do not say it is bad law—of this I am no judge—but I do say the law is bad, in that it is not true, and that scores of helpless lunatics have perished on the scaffold in consequence.

Every form of incapacity for crime is protected by law and the opinions of judges, except that which springs from disease. It is a wise and generous provision that no act done by a person over seven and under fourteen years of age is a crime, unless it be shown affirmatively that such person had sufficient capacity to know that the act was wrong.

On what conceivable basis can this presumption of law have been founded, except that persons of tender age, by lack of experience and habits of independent action, are supposed to be deficient in self-control?

It cannot be based on lack of knowledge. It can never be said that a boy who may be in the front rank in a grammar school does not know the nature and quality of his acts, and that they may be illegal. Yet men without number have been hanged, under the solemn direction of judges, whose capacity was far behind that of the schoolboy, on the assumption that this knowledge made them responsible and liable to punishment.

Let us for a moment briefly consider in broad outline the faculties which may through disease of the organism be disturbed.

Without raising the question of what mind in the abstract may be—whether it is simply a function of matter, a quality of the organism, or something having an independent existence, and only for a season abiding with the body as the spirit within the temple—it may be asserted, without fear of contradiction, that we know nothing of mind apart from a material organism. We know that through infancy and childhood to manhood it grows with the growth and maturity of the brain; that in advanced life it fails as the fabric fails; that its manifestations are destroyed or disturbed by injury or disease. A blow on the head may extinguish it for weeks or months, and enfeeble it during the life of the individual; an effusion of blood, as in apoplexy, will produce the same result. Various forms of food and drink disturb its operations. Drugs may steep the brain in oblivion or develop wild excitement. The abuse of alcohol and opium too sadly testifies to the truth of this.

States of health affect it, as every one can bear witness. Who has not felt the joy of health and the misery of disease? Disorders of digestion and disease of the liver notoriously produce depression and melancholy, the very word melancholy being an ancient term expressing this fact.

The joys and pleasures of daily life, ease, and plenty, produce their marked effect on the human faculties; so pain and sorrow, poverty and despair, make their impress. What the poet says of the body may with equal, if not greater, truth be said of the mind:—

> Danger, long travel, want and woe,
> Soon change the form that best we know;
> For deadly fear can time outgo,
> And blanch at once the hair.
> Hard toil can roughen form and face,
> And want can quench the eyes' bright grace,
> Nor does old age a wrinkle trace
> More deeply than despair.

We may recognise three great divisions in what as a whole we call the human mind: faculties which bring us into relation with the outer world; faculties which enable us to reason on the facts perceived; and, lastly, faculties or a faculty of the mind which enables us so to conduct ourselves as to render the social state possible—broadly, our sensations and appetites by which we perceive and live, and by which our own existence is continued and the race

perpetuated; a power of reason by which we are able to combine facts and events and avail ourselves of the knowledge and experience of others; a moral sense by which we understand our relation to each other, and our duty to society at large, culminating in the religious sense. I do not pause to ask whether these are separate portions of the human mind or simply faculties of the whole. They are, we know, one or other, more or less prominent in different individuals.

The whole of the human faculties may be grouped under one or other of these three divisions, and so may the disturbance of their operations which we designate insanity.

So surely as disease of structure or arrest of function may disturb the motion of a limb, as certainly will disease of structure or arrest of function disturb any one of these departments of the mind.

As certainly as no organ of the body can be diseased or lost without disturbing the well-being of the whole, and limiting its powers, so surely no portion of our mental organism can be disturbed without disturbing the whole, and thereby limiting the power of the whole.

To regard the body as a series of independent parts is absurd, as every physician and every sufferer knows. A tooth is, perhaps, as independent of the rest of the body as any part. Will any one who has ever suffered from toothache assert that it does not disturb the whole body? The nutriment of the body is supplied from one common source, the blood, elaborated and prepared in certain organs of the body, extracted from the food we eat and the air we breathe. Is it conceivable that disturbance of these organs or the defective performance of their functions will not affect the whole body? It is only necessary to state the proposition in its baldest form to see its absurdity.

If it be unphilosophical, and, as I believe, contrary to sound knowledge, to assert the independence of one part of the body of another, to say that disease of one organ may exist without more or less affecting the healthy performance of function in all the others—that the hand may say to the foot, "I have no sympathy with thee," that the brain may say to the stomach, "We have nothing in common"— how much more unphilosophical and contrary to sound knowledge must it be to say that our mental faculties can be parcelled out into divisions so distinct that disturbance of one does not disturb the other, that one portion of our intellectual organism may be in ruin whilst the rest is in sound working order?

That a man may be deprived of his moral sense whilst his reasoning powers retain their integrity, or that his appetites and passions may be disordered without disturbing his moral sense, that his powers of ratiocination may be defective in some points and not as a whole, seems to me a proposition so absurd, and so utterly at variance with all experience, that I marvel how in any form it could be possible to accept it. Yet this startling assertion is, if not in precise words, yet in practical effect, the deliberate opinion of the law as expounded by judges for the guidance of juries in cases where insanity is pleaded in limitation of responsibility.

Let me now very briefly call your attention to the relation between insanity and crime. Whole groups of acts, in themselves criminal, may be, and often are, the direct outcome of insanity—acts of destruction, murder, arson, every form of violence, and the acts of lust and appetite—that which calls the passions into play being disease and not vice.

The same motives may influence an insane as a sane man. Investigation alone will prove their character, and in which category the act should be placed.

It is said by those who have had much intercourse with habitual criminals that they are all more or less mentally unsound—persons in whom the moral sense is in abeyance; men without forethought, pity, or remorse; criminals because they recognise no control except their own appetites and passions; men who rob and excuse themselves on the ground that all property is theft, that it belongs to those who require it; men who covet and desire other men's goods, and take them when they have the chance, on the ground that property, if it is not, ought to be a common possession; assertors of the rights of men, forgetful only that others have claims besides themselves. It would not be difficult in some popular assemblies to find men elected by the free choice of the people who still retain traces of this opinion. Yet these are not insane. Such men not only fully know the nature and quality of their acts, but dread and shrink from punishment, and take every means to avoid it if possible. Theirs is the insanity of bad habit, and not of disease. This is neither the time nor place to discuss how far defective social conditions may be responsible for the creation of these people. They are a criminal class in every sense of the word, and no one would desire to shield them from the due reward of their works. They differ in a very essential degree from those we recognise as insane, both in their life history, the circumstances surrounding their acts of

criminality, and their feelings and opinions on the subject. They have no delusions, no divine command impels them, nor are they hurried to destruction by devils. They are haunted by no visions, hear no voices of men, of angels, or of demons telling them what to do. They have no belief that some command is laid on them different to other people, obedience to which must override all law and all regulations. They are impelled by no fancied wrongs, and know no grievances unless it be the grip of the law.

No man of experience could by any possibility confound the habitual criminal with the lunatic, or would suggest that he should escape the punishment due to his crime. It is only when metaphysical subtleties come in, when lawyers and judges seek to confound a medical witness, that voluntary crime is confounded with the criminal acts of the lunatic.

The distinction in words between the two is difficult, and it is easy to confound a witness by this dilemma. Crime itself is no proof of sanity or insanity, though the method of the criminal act may be.

There are three well-marked aspects of mental unsoundness, about one or other of which the dispute between law and medicine ranges itself. These are :—

1. Deficiency of mental power from whatever cause, including every form of imbecility and dementia, forms of mental unsoundness, either congenital or the direct result of positive disease.

2. Delusions—embracing every form of illusion or hallucination—auditory, optical, &c.

3. Impulse—destructive fury without necessary delusion, or any marked weakness of intellect.

Let me briefly describe each form with an illustrative case. They each contain many sub-divisions, and were I writing for a medical audience I might consider them under a variety of aspects. For the purpose of legal discussion and administration I have always thought this minute sub-division unnecessary, serving only to create obscurity and confusion. Minute sub-divisions are in courts of law the hope of lawyers, the horror of judges, and the destruction of the witness. Medical witnesses are too apt to forget that capacity or incapacity is the sole question before the court, and how incapacity is to be proved the sole business of the defence. For this purpose and for the ends of justice learned sub-divisions and minute distinctions are worse than useless.

Cases illustrative of the first group, viz., simple defect of

intellect without evidence of other unsoundness, are common in every class of life.

They may be divided into two great classes, viz., those who, born with feeble intelligence, continue so through life, and those who, for the most part, somewhat late in life pass into a state of mental feebleness, as the result of paralysis, brain softening, and other diseases. These latter seldom if ever figure in our criminal courts. They are the great subjects of dispute in civil courts, when business or testamentary capacity is called in question.

The first group, as every one knows, may be seen in every phase, from the man whose intellect is not quite up to the average of his class to the simple idiot. It is with this class of cases that the question of responsibility becomes difficult to answer. Such people behave themselves like other men, only on a lower platform. Their friends and neighbours pity them for their weakness, or blame them for their vices, as temper or circumstances may chance to direct. Every variety of opinion as to their responsibility and criminality may be honestly obtained, when they are charged with any offence, from those who have known them intimately. Large numbers of such people are amiable, harmless individuals when surrounded by kindness and comfort, capable of much useful occupation and of much happiness and enjoyment; amongst the poor, of much useful work under proper guidance. They have no initiative power, and little or no capacity for adapting themselves to circumstances. In the rough world of every-day life they are thrust aside; they interest no one; they are but fragments of humanity cast on the shore by the torrent of that busy life which can take no thought for the feeble and the helpless. On the other hand, with feeble mental power, large numbers of these people have strong animal passions. Enraged by the slightest provocation, they are guilty of inordinate violence towards those who cross them. Driven by lust, they are prone to acts of violence in its gratification. They have full intellectual knowledge of the nature and quality of their acts. They know that society is prone to punish such deeds, but, as in the brute, passion and appetite overmaster their fear of punishment, the deed is done; remorse is slight if it exists at all. Such men are often found amongst the lowest dregs of the criminal class, where friendly care has not kept them apart, or where early crime has not placed them in safety. Except in the case of murder, where the sanctity of life is in question, their mental condition is seldom the subject of inquiry. Now

and then society is startled by some crime of great brutality, homicide or rape, committed by a person who, from social position or parental kindness and care, has not been allowed to sink into the lowest depths, and the question of competency is raised. Offences of a less atrocious kind than murder committed by such people seldom attract attention. They are accompanied by no mystery. The facts are generally easy to prove, and no interest is felt in the accused. Hence it is that the whole interest in the question is more or less associated with homicide, and the cases reported are for the most part cases of murder.

Yet the same principles are applicable to many other forms of crime.

I will briefly state three cases in illustration of my previous observations.

1. *Deficiency of Mental Power.*

A case tried in this city (York) in 1859, in which I was largely concerned, will serve as an illustration of this class.

James Atkinson, aged 24, was indicted for the murder of Mary Jane Scaif, at Darley. The man and woman, who had been reputed lovers for some years, left chapel together on the evening of August 1st; took the usual direction to the girl's home. She was found the next morning in a ditch by the road-side with her throat cut, there being eight distinct wounds. There were reasons to believe that the man had some cause for jealousy; further, the girl's mother strongly objected to their marriage. There was no doubt but that immoral relations had existed between them for a long time. After the murder the man hid the knife in a wall, washed his hands in an adjoining pond, and went home. He seems not to have slept. At an early hour in the morning he awoke his brother, who slept in an adjoining room, and said he had murdered his sweetheart. He said he must have done it, and seemed confused. Before the magistrates he made a full confession, describing the particulars of the crime and the attendant circumstances. He was imperfectly educated, but could read and write, and had done some arithmetic. He acted as mechanical overlooker in a mill, and his father had named him an executor under his will. A medical man who had known him for several years said he considered him a man of weak mind—weak, frivolous, and vain, easily excited when crossed, and subject to violent outbursts of temper on the slightest provocation. His manner of speaking was slow and hesitating. He manifested no emotion when speaking of the murder, and talked of it as of other things. The common testimony at the trial was that he was more or less of weak intellect, but capable of doing some regular work and

apparently of such capacity that his friends did not object to his marrying.

The defence was that, being of weak mind, he was not able to control his actions. After a trial lasting three days, and a deliberation by the jury of nearly four hours, he was acquitted on the ground of insanity. Newspapers, from the "Times" downwards, spoke disparagingly of the verdict, and disrespectfully of the medical opinions. Many clergy said that such opinions confounded all moral distinction between right and wrong.

The verdict was beyond all doubt at variance with the ruling of the judges on the question of responsibility. The man knew right from wrong, and knew full well that to kill another was wrong, a wrong for which he might be punished.

Viewed by the light of our present experience, it seems strange that there should have been a moment's hesitation as to the verdict. Viewed by the light of thirty years ago, his acquittal was a surprise to those who honestly believed him irresponsible, and who, at the risk of a good deal of odium, so testified in court.

This is one of the clearest and best cases I have met with of the acquittal of a man guilty of homicide on the evidence of simple defect. No witness in so many words said that he did not know the nature or quality of the act he was doing, or that he did not know that it was wrong.

The medical testimony asserted that, being of weak intellect, he had not reasonable control over his actions, and could not be held responsible as other men. This case did something in practice, if not in ruling, to break through the legal dictum.

2. *Cases characterised by Delusion.*

Persons suffering from delusions, using the word in a very general sense, either see visions—this is rare—or hear voices—which is common—or are the subject of some extraordinary and unreasonable belief, as, for example, that they are royal personages, or some other and different person from what they are; that they are the victims of conspiracy or the subject of machinations of one kind or another. Their delusions are as various as the events of daily life.

I quote a historical example of this form of mental unsoundness in the words of the judge who tried the case, as given by Mr. Justice Stephen in his history of the criminal law.

McNaughten, being under an insane delusion that Sir Robert

Peel had injured him, mistaking Mr. Drummond for Sir Robert Peel, shot Mr. Drummond dead with a pistol. His acquittal on the ground of insanity made a great sensation. Certain well-known questions were by the House of Lords propounded to the judges, their answers forming the rule on which juries are to this day directed.

The medical evidence was that a person of otherwise sound mind might be affected with morbid delusions; that the prisoner was in that condition; that a person labouring under a morbid delusion might have a moral perception of right and wrong; but that in the case of the prisoner it was a delusion which carried him away beyond the power of his own control, and left him no such perception, and that he was not capable of exercising any control over acts which had a connection with his delusion, and that it was the nature of his disease to go on gradually until it reached a climax, when it burst forth with unmistakable intensity; that a man might go on for years quietly, though at the same time under its influence, but would at once break out into the most extravagant and violent paroxysms.

I have never been able to see the full medical testimony in this case. I am not sure that the learned judge gave a correct interpretation of it in every particular.

It is a very common thing for persons of unsound mind to hear voices, to receive commands from heaven or suggestions from the devil as to what they shall or shall not do. They are forbidden to eat or to drink, or to walk in a certain direction; or they are directed to destroy themselves: with a firm belief that others are conspiring to injure them, they revenge themselves by acts of violence on persons who have done them no wrong, or where the wrong is of the most trivial or imaginary character, their acts far exceeding what the real or imaginary wrong might justify. They neither reflect, reason, nor investigate. To them, as to the jealous,—

> Trifles light as air
> Are . . . confirmations strong
> As proofs of Holy Writ.

Yet all such people know well enough what is right and wrong. They will tell you plainly enough what you ought to do or ought not to do under the same conditions. But then they say they are different; you may have hope, they have none; no voice commands you, but it does them; you are the victim of no conspiracy, but they are; the law will protect you, but not them: and in this way, separating themselves from others, they

become a law unto themselves. Their acts are not subject to the same controlling influence as the acts of sane people. Their moral purpose is perverted because their reason is disturbed. They have the knowledge. Should we hold them responsible for their acts? I am sure we ought not, even though the act may very much exceed what would be justifiable were the delusion a fact.

3. *Impulse. Transitory Frenzy in Persons otherwise Sane.*

These cases are beset with considerable difficulty.

Destructive fury, without necessary delusion or marked defect of intellect.—I distinguish these from the violent outbursts of imbecile persons. They (the imbecile) are violent when provoked, and act like other people when angered, but, by reason of their imbecility, cannot control their actions, and should not be held responsible because of this want of reasonable power. The cases I refer to are fortunately rare, though well known and understood. They differ from the imbecile in the fact that their ordinary intelligence may be good, and that for long periods they may show no symptoms of disease, but in all things act as other men. The violence they commit is not of necessity the outcome of provocation, but in the majority of cases seems without a cause.

A case affording a good example of this form of mental unsoundness was tried and acquitted on the ground of insanity some year-and-a-half ago at the York assizes.

Martin Kioll was indicted for the murder of his child by killing it with a hatchet in his own house.

This man's wife had for two or three years complained of repeated acts of violence, apparently unprovoked, or, at all events, on very trivial provocation; that he would strip himself and go out into the yard naked; that he did not work. There was no evidence of intemperance. He was under my observation for some time, about two years before the murder. Beyond the fact that he was dull, somewhat stupid, and subject to fits of violent temper, he showed no signs of insanity. He was taken by his friends to a holy well in Ireland, but without effect. He left his family and went to America alone, returning to England in about eighteen months, apparently having earned his own living whilst there. He came home in good condition and joined his family.

Early on the morning of the third day after his arrival he was heard by a lodger speaking kindly to the child. He carried it downstairs, speaking kindly to it as he went. Within a very short time of this the child was found downstairs dead, horribly

mutilated—a hatchet covered with blood, and a block of wood, on which sticks were cut for firewood, in the same condition.

There was not the slightest reason to believe that he had seen any one between the time he brought the child downstairs and its murder. The child was too old to raise any suspicion of his wife's fidelity during his absence.

I saw him several times after he was taken to prison. He was dull and sullen. To all questions put to him he replied, "I do not know." He seemed to have no thought as to the murder—manifested no emotion when spoken to about it. I have not the least doubt but that a large proportion of his ignorance and stupidity was assumed.

He was acquitted on the ground of insanity, and was of sufficiently sound mind to express some satisfaction at the result. I have since heard that he has had several attacks of fury.

I have no doubt whatever that this man on all occasions knew what he was doing, and knew whether it was right or wrong. I am equally certain that he was not responsible for what he did. The summing up of the judge, though in favour of his acquittal, was marked by a singular evidence of the decay of the old ruling as to responsibility. No witness was pressed with the impossible question of what the man knew or did not know at the time of the murder.

This case was a good example of the form of insanity—marked by simple outbreaks of sudden fury of an epileptic character—well known to those who have charge of the insane. Such men are not, in the intervals of their attacks, quite like other men. There is, or would be if it could be ascertained, always a history of some change in habits and character, of some loss of mental power, often obscure, but still a clear and distinct history of the fact.

The mere mention in a court of law in times gone by of the existence of such cases, and that an accused person was an example of them, was received by judges with scorn and derision. If the unhappy outbreak of fury was spoken of as an irresistible impulse (not a happy phrase), it was quickly met by the statement from the bench that the law had an irresistible impulse to punish such people, *i.e.*, hang them, and hanged they were.

These three cases will serve as illustrations of the three conditions of unsound mind under which the question of criminal responsibility is likely to be raised.

The *first*, one of defective intellect, in which the moral and intellectual powers were of a low and limited order.

The *second,* one in which crime was the direct outcome of a delusion.

The *third,* an example of what is known as insane impulse.

In all, I say the plea of insanity was justly raised—their acquittal right—because they were not in any sense able to control their actions as other men. Yet every one of them was acquitted in direct violation of the ruling of judges on the question of responsibility. Every one of them knew full well the nature and quality of his act, and that it was contrary to law. In the single case of delusion, the delusion, had it been a fact and not a delusion, would not have in any sense excused the crime.

The whole of my paper thus far may be regarded as an answer to the last question—How far the legal dictum on the responsibility of alleged lunatics is true in fact?

It may not be out of place, however, to say something further on this question.

I have no doubt but that the opinion expressed by the judges on this question is good law—that is, that it has ancient prescription and abundant precedent for its justification. What I say is that the law is wrong, being contrary to knowledge; that, under its sanction and by the direction of its administrators, irresponsible lunatics have been hanged and may be again; that for this reason the law on this question is not respected as it ought to be, and the most righteous punishment of death for wilful murder is jeopardised by doubts as to the possible sanity of the accused. A man guilty of wilful and deliberate murder should be hanged without doubt and without hesitation. But manslaying is an act often committed by lunatics, whose execution would shock the moral sense of the community did it know and believe they were lunatics.

That the vengeance of the law may be sure and unmistakable, I urge that this question of responsibility needs to be settled on a clear and unmistakable basis and in accordance with knowledge.

The law of responsibility as defined by the judges is this:—

That to establish a defence on the ground of insanity it must be clearly proved that *at the time* of committing the act the accused was labouring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong (illegal). If the accused was conscious that the act was one which he ought not to do, and

that the act was at the same time contrary to the law of the land, he is punishable.

Mr. Justice Stephen, in his history of the Criminal Law, puts it thus—adding some important modifications of his own—modifications which would go far to secure the end I have in view, if adopted, as the authoritative interpretation of the law as regards responsibility in criminal cases. Mr. Justice Stephen is not, however, quite satisfied that his exposition is sound law. His illustrative cases clearly show that under the existing ruling palpably insane persons might and ought to be punished. He says:—

First, then, what is the law of England as to the effect of madness upon criminality?

No act is a crime if the person who does it is at the time when it is done prevented (either by defective mental power or by any disease affecting his mind)—

(*a*) From knowing the nature and quality of his act, or

(*b*) From knowing that the act is wrong, or

(*c*) From controlling his own conduct, unless the absence of the power of control has been produced by his own default.

But an act may be a crime, although the mind of the person who does it is affected by disease, if such disease does not in fact produce upon his mind one or other of the effects above mentioned in reference to that act.

The interpretation of the law on the question of responsibility by this learned author, if generally adopted by the judges, would give a wider liberty in directing juries, and enable a judge to include in his category of limitations of responsibility many forms of mental defect hitherto excluded, and at the same time to admit as evidence many facts now excluded. For I take it that a judge is bound to keep from the jury all evidence which is not in accordance with the law, and to prevent its being given. With this principle, if I understand it aright, I entirely concur. Were it not so, witnesses in matters of opinion would become advocates assigning reasons for acquittal outside and beyond the law. What I assert is that this limitation of evidence, and of that which is laid before a jury in accordance with the ordinary and accepted ruling of the judges on the question of responsibility for crime, is unwise and unjust, because it deprives the accused of the benefit of existing knowledge—knowledge which is none the less a fact relevant to the case in question because it has to be given in evidence as a matter of opinion. If it be true that

there are hundreds of persons whose insanity and inability to control their own actions is beyond all doubt, who nevertheless do, with equal certainty, understand the nature and quality of their acts and that they are illegal, *i.e.*, wrong in the sight of the law, then surely where insanity is pleaded as an excuse for crime a witness should be at liberty to say so, and this knowledge, gained by experience and observation, should not be withheld from the jury. As the law is now administered, a witness, after giving evidence of facts which have come within his own observation and examination of the accused, is asked if the accused at the time of doing the act knew what he was doing, and knew that it was wrong. A conscientious witness, unlearned in legal subtleties, anxious to keep strictly to the letter of his oath, answers "Yes" to both questions. He would like to say more, but he is stopped. He has brought the accused within the law of responsibility; all else is irrelevant. A more adroit witness, or one who has studied the matter from a legal point of view, takes his own view of what is meant by knowledge and answers "No," and unless his evidence be discredited the accused is acquitted, the conviction or acquittal of the accused being more dependent on the skill of the witness than the justice of the case. This cannot be right. I am certain it is true. What is the practical outcome of the exclusion of well-ascertained facts and opinions? It is this: Two or more men of experience examine an alleged lunatic before his trial. They are satisfied of his insanity, but equally so that he knows right from wrong and the nature and quality of his acts. The conviction of his insanity arrived at, one says: "Well, he is a lunatic. Are we to save the man or hang him, because it rests with us? If we think he is insane and ought not to be hanged we must take care to say so; that is to say, that he does not come within the legal definition of the knowledge of the nature and quality of his acts, or that they are wrong, which constitutes legal responsibility."

To save the life of a criminal now it is only necessary to raise some modest doubt of his sanity—to furnish a few facts, more or less doubtful. Conviction may follow, but not execution. An official expert visits the prisoner, and he is not hanged. The execution of the law on persons charged with murder is removed from the proper authorities and the direction of the court to some irresponsible person, no doubt a man of knowledge and experience, but one who seldom, if ever, dare take upon himself the functions of executioner. Mercy is more acceptable than severity, and Home Secretaries must err on the side of mercy.

The contention of this paper is, that the law of responsibility in criminal cases is wrong in fact and contrary to knowledge and experience—that the result is to introduce great uncertainty into the administration of justice, especially where persons are charged with murder—that the punishment justly due to the greatest of crimes is rendered halting and uncertain.

I contend that the ruling of judges should be altered in accordance with knowledge and experience, so that the whole truth may be submitted to the jury, that this modification would restore the certainty of punishment in a department of our criminal law which of late years has become uncertain.

The error in the ruling of the bench on the question of criminal responsibility has chiefly arisen from the fact that they have studied the sound mind only, and not the unsound. Applied to the sane man, the opinions seem to me sound and just; applied to the insane man, unsound and dangerous, fraught with peril to the accused and to that sense of right which all men desire to see characterise the administration of justice. That the views of the judges on the responsibility of persons alleged to be lunatics is derived from a study of the sane mind is confirmed by the following quotation from the work of Mr. Justice Stephen, to which I have previously referred. Speaking of the law generally, under the head "Knowledge of Fact," he says:—"The degree of general knowledge usually presumed in criminal cases may be inferred from the law as to madness. It appears to contain two elements; first, a capacity of knowing the nature and consequences of the act done, and next, a capacity of knowing the common notions of morality current in England on the subject of crime." Herein lies the error. The acts of the lunatic cannot be compared with those of the sane man. His motives and his actions are ruled and modified by different causes. Whilst it is reasonably possible to predict what a sane man would do under any given circumstances, it is impossible to say what an insane man would be likely to do.

With these observations I bring this paper to a close. I have entered on the discussion of the subject in no spirit of cavil, but from a simple desire to lay before you the leading features of the question as seen from a medical point of view.

On the Admission of Idiotic and Imbecile Children into Lunatic Asylums. By WILLIAM W. IRELAND, M.D., Preston Lodge, Prestonpans.

(Read to the Branch Meeting of the Medico-Psychological Association at Carlisle, 8th April, 1886.)

The separate grouping of divers diseases in hospitals for their better treatment is a constant accompaniment of progress in medicine. Medical complaints have been separated from surgical ones; contagious diseases have been isolated from non-contagious diseases, and from one another; acute cases have been separated from chronic ones; those under medical treatment from those simply convalescent. But of late years, in the domain of mental science, so far from the separation of different groups becoming more and more definite, it might be held with some plausibility that for years back the tendency has been the other way. The asylum is becoming more and more an infirmary, a place for stowing away all the wreckage of our social system, all the flotsam and jetsam of disease and misfortune—a place where is thrown together everything in human nature troublesome and unsightly. Eccentric and dotard old people, deserted children whose feeble mental faculties made unusual demands upon the care of the poor-house matron, helpless paralytics, and many of the miscellaneous cases where bodily disease has brought with it mental feebleness, are all shoved into the District Asylum, to be kept till death walks them off.

Perhaps the greatest improvement since the days when non-restraint became diffused has been effected in the treatment of what was long thought to be the most hopeless class which found its way into these universal receptacles of mental derangement. This was principally owing to the exertions of Edward Seguin. Combining great skill in medicine with consummate knowledge and resource in the art of teaching, Dr. Seguin was enabled to lay down a course of treatment and training for idiots which has been everywhere adopted with little change or improvement. Unfortunately, this system of education required special studies to comprehend its methods, and long and patient attention to details to appreciate its results. Hence it was not readily accepted or understood by medical men, though it caught

the fancy of people of an enthusiastic turn of mind, who took it up with somewhat extravagant expectations. The Training Schools for Idiots which slowly came into existence in the most civilized countries of Europe were at first principally maintained by charitable contributions. In a country so wealthy and philanthropic as England it was impossible that they should not gain some support; but the amount was quite insufficient to meet the large number of cases soliciting their assistance. Under such difficulties, those who had the direction of the new institutions for idiots, in an unhappy hour, allowed them to take the form of voting charities, *i.e.*, the beneficiaries were elected by the votes of their subscribers valued by the proportion of their subscriptions. It is clearly impossible that the subscribers could know or judge of the relative merits and claims of the different candidates. They gave their votes to one or other as pity, solicitation, or fancy might dictate.

Some of these cases on the roll are idiots whose brains are degenerating under epileptic attacks or other nervous diseases; but these are considerations which the electors can scarcely take up. At Larbert, one-third of the cases were elected by the Directors. When there, though my time was much occupied with clerk work and miscellaneous fag, I tried to visit every candidate for admission whom I could reach in a day's journey, and some of the Directors were disposed to lay stress upon my reports. But taking it all in all, after witnessing the working of the voting system in that institution for ten years, I am thankful to know that all the other charities in Scotland get on without having to import from England its fussy and expensive machinery. Men who set a value on their time, and upon whose advice others set a value, though they might occasionally suffer their names to be quoted as Directors, did not care about taking part in the management of a system which exposed them to numerous solicitations from canvassers, and the endless talking of committees. For my part, I found that directing the education of imbecile children was nothing to the task of educating Directors. The children, at any rate, never thought that they were expected to pretend to understand what they had never studied, nor tried to throw the blame of their own failures upon those who had given them timely warning.

To the parents of imbecile children the system of voting had some unpleasing features. Instead of a timely relief,

the hope of gaining a sufficient number of votes was dangled before the eyes of the competitors, whose private circumstances were published in a printed roll sent to each voter. In general, the candidates whose parents were poorest and most helpless had the least chance of being elected. Their only chance often was that a well-meaning lady with redundant leisure, or a male philanthropist at a loss for something to do, should take the case in hand, and run a candidate against the rest. Combining the excitement of the polling booth with that of the betting ring, this system had a charm for those to whom, from the holiness of their lives, the pleasures and excitements of the turf were forbidden. There was enough of worldly craft about the voting system to make it on some occasions a ready means of raising money. When there was a number of claimants and their backers eager for admission, it tended to swell the subscription list; but when the candidate was admitted, the excitement died away and the subscriptions fell. Thus the more the roll was cleared by admissions, the fewer became the subscriptions gained in this way. Hence, though the voting system had a specious amount of self-acting power, it was also liable to be clogged by its own machinery when its working force was most needed.

The result of my experience was that about one-half of those who applied for admission to the Larbert Institution failed to get in. Some who gave little hope of being educable were rejected at the outset; the names of others were withdrawn by their friends, wearied with unsuccessful efforts to get them elected; others became paupers, and were thus struck off; others reached fourteen years of age, which was thought too late for admission.

From the last election roll (77th) of the Earlswood Asylum for Idiots we learn that out of 12 applicants for whom part payment was offered, five were successful; and out of 141 ordinary applicants 35 were successful. Of the ordinary cases, 28 had applied three times, 25 had applied four times, and 16 had applied five times. According to the Report of the Eastern Counties Asylum for Idiots at Colchester, Essex, Suffolk, Norfolk, and Cambridgeshire were found by the census of 1881 to contain 2,270 idiots and imbeciles, or one in every 785 persons. It is known that these returns are very defective from the unwillingness of parents to enter their children under such a heading, and by an amended estimate the number is stated as 2,918 idiots and imbeciles,

or one in every 610 persons. In the election of 1882 for the Eastern Counties Asylum there were as many as 85 candidates for admission, of whom only eight got in. At the next election, nine candidates got in out of 86; at the next, ten got in out of 84; and at the fiftieth election, 1884, there were 81 applications, and out of these only nine were elected, that is, admitted for a term of five years, which in most cases is quite insufficient for the training of the pupils.

The Eastern Counties Asylum will only be able to hold when full about 200 cases. Mr. Millard, the late Superintendent, in a letter dated 3rd October, 1885, wrote as follows:—"A Guardian of the West Ham Union, who is wealthy, asked me to help him to get up a Pauper Idiot Asylum for Essex. He pities so much the 70 idiots in their Union-house, and he feels now that a similar need for such an asylum exists throughout the county. But it would be extremely difficult to carry this out by voluntary benevolence, and he has accepted my advice to await legislation next session. Meanwhile, some of their idiots will be sent to the Western Counties Asylum."

These statistics are, of course, not presented to show any particular failure, but to indicate the general truth that these benevolent institutions, though superintended by men both zealous and able, and doing good work, educational, therapeutic, and scientific, have not in England been able to gain enough money, through charitable contributions or paying boarders, to relieve more than a fraction of those applying for their aid; and that the relief given generally comes after years of waiting, and then only for a period which is often insufficient for the proper training of the pupil.

The different institutions or training schools for idiots which struggled into existence at intervals of years through the help of charitable contributions had in all accommodation for about 1,600 or 1,700 cases. They had generally some spare room. They were ostensibly designed to take paying boarders, and help the parents of those who could not pay, either by taking the children in part payment or by election. As many of those elected came from families on the verge of pauperism, this might be held as practically relieving the rates; but, for declared paupers, the parochial Boards, if they sent them to training schools, had to pay at the cost charged by the committees. The Directors being anxious to make money out of the paying boarders, to get in more of the

elected cases, were disposed to exact more board than was needed to defray the actual cost for the paupers, nor were they anxious to get pauper boarders even at a remunerative cost,* as they saw that their contact kept away the children of the better classes. Besides, it is clear that the cost of simply keeping an idiot child must be less than the cost both of keeping and educating him. Hence the parochial Boards, finding that the cost of keeping such idiots as fell upon their hands was much lower in workhouses, generally preferred to keep them there, or if, as they got bigger, they turned troublesome, they sent them to lunatic asylums where the board was less than in the training schools.

In the report of the Special Committees of the Charity Organisation Society, which met in 1876 to inquire into the education and care of idiots, imbeciles, and harmless lunatics,† it is stated at that time "upwards of ten thousand idiots and imbeciles were scattered amongst the six hundred union houses of England and Wales, where nearly all the conditions required for their proper management are wanting."

How many idiot children there were or are in lunatic asylums has never been ascertained in England. In the thirty-eighth report of the Commissioners in Lunacy, Table XVIII, it is stated that there were in 1883 in the different asylums, registered hospitals, and licensed houses, 835 cases of congenital insanity (including idiocy and other mental defects from birth or infancy); 219 of these were private patients and 616 paupers, in the proportion of 9·8 per cent. for the private patients and 5 per cent. for the paupers to the total number admitted.

The Commissioners in Lunacy remark in their report for 1865: "It has long been our opinion, as the result of extended experience and observation, that the association of idiot children with lunatics is very objectionable and injurious to them, and upon our visits to county asylums we have frequently suggested arrangements for their separate treatment and instruction. It is always to us a painful thing to see idiot children, whose mental faculties and physical powers and habits are capable of much development and improvement, wandering about the wards of a lunatic asylum. The benefits

* In a pamphlet on "The Present Public and Charitable Provision for Imbeciles" it is stated that the Northern Counties and the Starcross Asylum alone admit pauper cases (p. 2).

† See the first report presented to Council, December, 1876, p. 8. The Special Committee published two instructive reports. Longmans, London, 1876 and 1877.

to be derived, even in idiot cases, apparently hopeless, from a distinctive system, and from persevering endeavours to develop the dormant powers, physical and intellectual, are now so fully established that any argument upon the subject would be superfluous."

Though obliged by the law to receive them, superintendents of county asylums have always viewed the arrival of idiotic or imbecile children with deep dislike, and have frequently endeavoured in one way or another to get them sent to more suitable places. Some superintendents have pointed out this abuse of the lunacy laws in their annual reports.

Dr. Lindsay in the thirty-second report of the Derbyshire County Lunatic Asylum (1883) observes:

"The youngest patients admitted were an epileptic boy, four years of age, who was discharged to the union not insane; an idiot and epileptic girl, seven years of age; and an idiot and epileptic boy of the same age. It can hardly be contended that a lunatic asylum is the best or the proper place for children of such tender years, and it shows a grave defect in any system of lunacy administration which not only permits, but, to a certain extent (by the operation of the 4s. Treasury Capitation Grant, and otherwise), encourages their removal to lunatic asylums. If workhouses are not capable of taking care of such children, they should be made capable by suitable arrangements, or proper idiot asylums should be provided. I have previously pointed out there is no idiot asylum available where young pauper idiots and imbeciles belonging to Derbyshire can be received, or derive the benefit of special training and education when the cases are likely to be improved thereby."

In a letter to me Dr. Lindsay writes: "Among the admissions here in 1885 we had a female idiot, æt. 20, and two male imbeciles and two epileptics æt. 16 and 19. We have now in the asylum: 1. An idiot girl who was 12 on admission. She has been here since April, 1882. 2. An idiot and epileptic girl, æt. 7 on admission. She has been here since April, 1883. 3. An idiot and epileptic boy æt. 7 on admission. He has been here since Oct., 1883. 4. A male congenital imbecile æt. 15 on admission. He has been here since Jan., 1882. 5. A male imbecile epileptic æt. 16, admitted in 1885. 6. A male imbecile and epileptic æt. 19, admitted in 1885. Several of these are educable to a certain extent; they might be trained, and at all events improved in a special institution."

Dr. Campbell, in the report of the Cumberland and Westmoreland Asylum for 1883, thus writes :—

"An imbecile child of eight years, but small and young-looking for his age, was sent here and appeared to me so unsuitable for treatment in this institution, that I brought the matter specially before you. He was afterwards removed by his parent. Lunatic asylums are not proper places for the treatment of imbeciles of tender years, and it seems hard, at least, if spare accommodation exists at the imbecile asylum, that those imbeciles who have the further misfortune to take epileptic fits, should be debarred from profiting by skilled attention and appliances. That only the most easily improvable, the least troublesome, and the most manageable, should be eligible for admission, seems rather an anomaly in this humane age."

In these cases admitted by election, as all could not get in, it seems best that the most educable should be selected. I myself was never in favour of the exclusion of epileptics, for whom medicine, regimen, and training can often do a good deal.

Some examples of imbecile children in lunatic asylums dwell unpleasantly in my memory. I once had occasion to see a girl on the way to a district asylum with her aunt. The girl appeared about fourteen or fifteen. She was somewhat paralysed on one side, soft and weak-minded, but not difficult to manage. I asked the woman why she wanted to put her niece into an asylum? "To tell you the truth," said the aunt, who was a little provoked by her niece walking so slowly, "I am tired of her. She needs more care than I can give her. I went to the Inspector of Poor, who said she should be sent to the asylum." I confided this out-spoken statement to the medical superintendent, who showed the girl to the Visiting Commissioner a few days after, when she was dismissed.

I saw a boy about twelve years old in another district asylum. He was an epileptic, wayward and uncertain in temper. He used to terrify people by running to dash his head against walls; but finding that he did it with a certain tenderness, the superintendent told them to let him alone, when he soon stopped. A respectable-looking man in the male ward denounced, with great indignation, some indecent practices with the grown-up lunatics, on which one need not enlarge.

I had several times occasion to see a little boy about eight years of age, in the infirmary ward of a district asylum. He

had some obscure cerebral disease. As far as I could see, the poor child could have been well enough treated in an ordinary hospital. He told me that he was dreadfully afraid of the men, one of whom used the most horrible oaths and threats. The boy said, "When he begins to swear I am so much afraid that I run along the passage up to the door." The child died in a few weeks, when an abscess was found in his brain.

I have frequently seen old pupils discharged from the Larbert Institution in asylums. Having become a burden to the Inspectors of Poor, or their guardians or parents, they had been thus disposed of. I have often been shocked by the degeneration of their manners. There is great need in Scotland for an asylum for adult idiots and imbeciles.

Imbeciles are generally weak, timid, and imitative. In a single night passed in an asylum for adults, they learn practices which they never forget. They are often terrified by the wild words and antics of maniacal patients, catch up the oaths and curses which float about, learn their lowest habits and imitate their wild movements. Naturally soft and credulous, they sometimes adopt the delusions which their insane companions take the trouble to teach them. Mr. Millard, in a letter to me, mentions two idiots in a large public asylum, "who had been told by a lunatic that they were two persons of the Trinity. They believed it, and spoke of themselves as such."

Surely this confinement of idiotic children in asylums is an outrage both to the idiotic and the insane. It must be very unpleasing to those who have suffered the deep misfortune of losing their mental balance to find themselves shut up with such companions. I know of idiots of a low type who are kept in asylums with lunatics in all the stages of their attacks and recoveries. In the present rage for decoration it is a marvel that it has not been discovered, not that it is cruel, but that it is not in good taste to have idiots wandering up and down your æsthetic corridors. Would it not be pleasant to be able to announce in your reports that in place of unsightly idiots you had got some new statues or relievos to commemorate the day when these unhappy guests had left your asylums for more appropriate quarters?

> "Und Marmorbilder stehn and sehn mich an:
> Was hat man dir, du armes Kind, gethan?"
>
> "And statues of marble look on me so mild,
> As if saying, Why thus did they use thee, poor child?"

For many years back most men who considered the question have come to the conclusion that if the work of caring for and training the idiots and imbeciles belonging to the poorer classes is to be properly done, it must be done with the aid of the State. This has been accomplished many years ago in the United States, which have long taken the lead of the mother country in education. There are also several training schools and idiot asylums for idiots in France, which are maintained at the expense of the State. It is more humiliating to be behind a poor country like Norway. It gave me great pleasure to see men so intelligent and skilful in teaching as J. A. Lippestad in 1880, and Jakob Sœthre in 1884, who were commissioned by the Norwegian Government to inquire into the methods for training idiots and imbeciles in this country and on the Continent. Mr. Sœthre assured me that there were in 1884 three training schools in Norway, one for imbecile boys at Lindern, another for girls at Thorshang, near Christiana, while there is a third for imbecile children, both boys and girls, at Bergen.* State aid for the education of imbeciles is also given in the Province of Ontario in Canada, in the kingdom of Saxony, and in several of the German principalities. Things, however, are not everywhere bad in our own island, for while this chaos exists in the counties, in the London districts everything has been arranged. Under the Metropolitan Poor Act of 1867 the London Union districts have the right of making suitable provision for the care and training of idiots. The result has been the erection of the fine asylum at Darenth, in Kent, where, in a well-planned suite of buildings on an eminence looking down on the Thames, 600 idiot children from the wretched homes of the London poor receive good food, kindly care, and wise training. There is also within the same ground an asylum for adult idiots holding about 800 cases. What, then, is needed is simply to extend the system which is working in the Metropolitan districts to the rest of England and of Scotland. This subject has been thoroughly

* The reports of these institutions were reviewed by me in the "Edinburgh Clinical and Pathological Journal" for March 29 and May 24, 1884. To quote the last paragraph:—"These institutions receive a grant from the Storthing, and of the remaining expenses three-fourths are defrayed by a grant from the amt or county rates, and one-fourth from the poor rates. There are few private boarders. By an Act which passed the Storthing in June, 1881, the education of the deaf, blind, and imbecile has been made compulsory in Norway. This law is already in force in the case of the deaf, and will be also carried out with the blind and imbecile, as soon as suitable provision has been made for their reception and education."

dealt with by the Special Committee of the Charity Organisation Society, whose disinterested efforts will, it is to be hoped, yet bear good fruits.

You all know that an Act framed by the Lord Chancellor for giving facilities for the care, education, and training of idiots and imbeciles is at present passing through the House of Lords. The proposed Act seems to me a wise, useful, and well-drawn measure, and it ought to be extended to Scotland. A most cheering point is that Lord Herschell has, by separating the Lunacy from the Idiots Bill, cut himself away from the entanglements which resulted from mixing up the medical treatment and detention of lunatics with the care and training of idiots. It is to be hoped that in future they will remain separate and distinct questions. The object of the Bill which is passing through the House of Lords is simply to remove the absurd and oppressive regulations which exacted that idiot children, ere being sent to a training school, should go through the formidable process of being certified as lunatics under the Lunacy Acts. Apparently, should this new Bill become law, idiots could still be certified as insane with a view to their being sent into lunatic asylums. We should, therefore, propose adding a clause to the Act that no idiotic or imbecile child should be allowed to be sent to a lunatic asylum for the care of adults. The question of imbecile children in workhouses, as also that of insane children, may be afterwards considered. The question how to treat adult imbecile women has been the subject of a previous paper.*

The operation of the proposed clause in the Bill would demand the erection of training schools for pauper idiots in different districts over England. It may be asked, What will this cost? As far as I can guess, the extension of the Metropolitan Poor Acts to the whole of England would throw upon the poor law administration about 10,000 idiots under 20, and double the number above that age. It must, however, be remembered that a very large proportion of these creatures are already living upon public relief in asylums and poorhouses, where they cost money which would be better spent elsewhere in properly attending them. It is impossible to disguise the question of finance, and for my part I have always held that money acquired, whether through charitable contributions or by compulsory taxation,

* Remarks and notes upon the branch asylum at Newark for adult imbecile women, "Journal of Mental Science," July, 1880.

should be most carefully spent. I do not think that the working and producing classes should be taxed for mere superfluities, or that considerable sums should be spent in order to decorate institutions for idiots with tawdry grandeur to catch the eye of the outside visitor. If those administering those institutions had the will to resist the tendency of the age to an expensive *mise en scène*, the pupils in the schools would be able to have everything really good for them and really needed to teach them and make them happy at a cost no higher than the board charged at county lunatic asylums. To the best of my belief and knowledge, a board of £23 a year, exclusive of rent, in an institution containing above 150 patients, would be enough to give each child good training and medical care, a sufficient and wholesome diet, comfortable bedding and clothing, with proper amusements, and that with these they would be quite happy, and really need nothing more.

In the course of the debate on this paper it was agreed that an attempt should be made to ascertain the number of idiots and imbeciles in the different asylums in England, Dr. Clouston offering to get the circulars printed. A letter was composed, stating the objects of the inquiry, signed by Drs. J. A. Campbell, T. S. Clouston, W. W. Ireland, and James Rutherford, with the following queries appended:—

1. How many Idiots and Congenital Imbeciles under Fifteen years are in your Asylum?
2. How many above Fifteen?
3. Can you give any information about the number of Idiots and Congenital Imbeciles in neighbouring Workhouses?

Copies were sent to all the County and Borough Asylums, Registered Hospitals, and large Licensed Houses in England and Wales. We are grateful for the courtesy of those superintendents who have furnished returns. Some have kindly added such information as they could obtain about the number of idiots in neighbouring workhouses. We hope yet to publish, along with a *resumé* of all the information afforded, some letters regarding the views of medical superintendents upon the disadvantages attending the detention of idiots and imbeciles in lunatic asylums. It is to be hoped that those superintendents who have not yet answered the circulars will not think it too late to send returns. We hope that all have received our letters. If any one was missed out it was assuredly not by design. As far as the answers go there are in 31 County Asylums in England and Wales 176 idiots and imbeciles under 15 years, and 1,731 above that age. In four Borough Asylums there are 14 under 15, and 112 above 15 years of age; in Broadmoor, under 15 years, 1; above, 7. Few returns

have come from Private Asylums, and none of them have many imbecile boarders. Some physicians of Private Asylums have written that they habitually refuse such boarders.

In the Special Asylums and Training Schools for Idiots there are in:—

	Under 15.	Above 15.
Earlswood	114	459
Royal Albert, Lancaster	225	317
Midland Counties Asylum, Knowle ...	21	29
Western Counties Asylum, Exeter	56	53
Metropolitan Asylum for Idiots at Darenth ...	376	224

I learn from Mr. Millard that there are in the Eastern Counties Asylum, at Colchester, about 128 idiots and imbeciles, of whom perhaps one half are under fifteen, but no return has as yet been received from the present superintendent.

On the Appetite in Insanity. By J. A. CAMPBELL, M.D., F.R.S.Edin., Medical Superintendent, Counties Asylum, Carlisle.

(Read at the Carlisle meeting of the Medico-Psychological Association, April 8th, 1886.)

In submitting the following short paper, I do so clearly realizing that deductions from limited observations present many sources of fallacy; also that even extended observations made in a limited area are very liable to error, and need correction by extended observation; that peculiarities of race, and circumstances connected with locality may even in such a matter as this exercise a marked influence. I trust, however, to hear the experience of others on the subject.

In speaking of normal appetite I take what appears to me the common-sense view of the term, *i.e.*, a normal appetite is the appetite at varying ages of a healthy person located in health-retaining surroundings, and enjoying with regularity a sufficient and proper amount of outdoor exercise in a temperate climate.

Appetite in health is, as we all know, easily affected, even by slight causes. Previous excesses produce in many what is in common *parlance* called a bilious attack, and even stopping short of this, a want of appetite for a day or two. The effects of certain mental feelings and states in those who are sane also affect the appetite; excitement, joy, grief, expectation, even surprise, have been known by experience in many individuals to do away with appetite for a time.

Ordinary physical diseases exercise a great influence on the appetite, and during the initiatory stages of most diseases a marked want of appetite is present. Yet there are certain diseases in which an excess of waste takes place in which the contrary is observed, as in diabetes, and there are certain states recognised as natural in which perversities of appetite are common, as in pregnancy, while in the borderland cases of hysteria the vagaries of appetite have been much written about, and in very many physical diseases the appetite is uncertain, irregular, and capricious, as in phthisis. In certain persons a craving is at times felt for certain kinds of food or vegetables, and, even among the sane, dislike of what was at one time much relished is often observable.

The varying tastes of varying ages as to food-supply is well known. Even in children there is a vast difference in the appetite for different forms of diet, some having a keen desire and appetite for flesh food, while in others this is almost entirely wanting.

The extraordinary appetites of certain nations for what would be revolting to others is no doubt in many instances as much the result of climatic and natural calls from the system as anything else. The taste of the Esquimaux for half-putrid blubber, oil and fats generally, and no doubt the high seasonings which are so much in use in hot climates, from the curry of the Indies, to the assafœtida in use as a condiment in Persia, could be rationally accounted for not merely as an acquired taste, but a supplying of some required want, if the matter was closely investigated. Natural longings for articles of diet meet now with considerable attention. At one time in the history of medicine, when sickness occurred, the sufferer usually got none of the things he felt a desire for, hardly even cold water; nowadays the tendency seems to be that what you feel an appetite for is what will be good for you, a much more pleasant doctrine, and probably as safe as the other.

Seeing what variations take place in the appetite in the sane, even in health, and much more so in disease which does not to a great extent affect the mind, it is not extraordinary that very marked alterations in this function should be met with in insanity.

In glancing at the indices of six recognised text-books on insanity I find that appetite does not find a place in three; in three it does: in Griesinger it is shortly treated of, in Maudsley perverted appetites are dealt with, and in Buck-

nill and Tuke an analysis of the state of the appetite in 50 maniacal cases by Dr. Jacobi is quoted, showing that in 23 of the 50 only it was normal.

Of course, in dealing with the different varieties, the subject is dealt with. There are certain recognised and well-marked abnormalities of appetite recorded by all observers in given forms of insanity, viz. :—

1. The voracity of *General Paralysis.*
2. The same to a slighter extent in *Epilepsy.*
3. The same in certain cases of *Chronic Mania.*
4. Want of appetite in *Melancholia.*
5. Cases of *Mania* in which certain delusions are of such potency that they overcome the natural feelings of hunger.
6. Extraordinary voracity, with persistent thinness, in cases of *Masturbation.*
7. Certain cases of intense excitement, in which the patient talks so rapidly that he has not even time to swallow.
8. Certain cases in which the excitement is so intense that it seems to prevent the absorbents of the stomach and intestines from acting.
9. *Perverted Appetites* in several forms of insanity, when all sorts of things abominable and indigestible are swallowed.

Before entering into details, or treating of these special headings which I have given, I may roughly express the views which a long experience and a careful general observation have forced on my mind. The population from which the asylum inhabitants in Cumberland and Westmoreland are received live, as a rule, fairly well, and are fond, not only of good food, but of a sufficient supply of it. They are well-grown men and women, and have been accustomed to a nourishing and filling diet, yet my experience is that the recent insane take their food very badly, in many cases refuse it, and this, as far as I can learn, to a greater extent than in many other districts. A great number of the patients admitted here in the early part of their attack seem to want appetite, to loathe food, and in very many cases this is a source of very considerable trouble in their early treatment.

During early convalescence appetite returns with vigour, and frequently for a short time the patient eats voraciously. Ultimately the appetite decreases to its normal standard. I have exchanged opinions on this matter with numerous asylum physicians. Dr. Rorie, Dundee, some years ago told me that he had little or no trouble about making his patients take their food, and that up to that date he had not required

to use mechanical aid for forced alimentation. Several Irish superintendents have told me that their patients, who, as a rule, did not fare too sumptuously when at home, nearly always took food well in the asylum, and that complete refusal of food or necessity for forced alimentation was almost entirely unknown. I have, however, ceased to be surprised at incongruities in Irish affairs! The frequency of crimes and injuries in Ireland outside asylums, their paucity in asylums, must strike anyone who studies the subject. I know asylums in Great Britain in which more concatenations (this, I think, is the term used by the Scotch Commissioners for evils we care not to name) have frequently occurred in one year than in all the Irish asylums put together. In the Report for 1883 the Irish Inspectors are able to state that no death occurred from accident, violence, or suicide during the past year in the Irish asylums.

As I believe I shall show you, when I discuss the matter in detail, my experience is totally at variance with that of the Scotch Deputy-Commissioners. Their reports would lead one to think that the *summum bonum* of earthly bliss consists in being a boarded-out dement and being cheaply kept. Dr. Lawson gives a diet scale, in which the whole weekly expenditure of a patient amounted to 3s. 0¾d. a week for food, lodgings, &c., or rather total maintenance. My experience—and it now extends over 20 years—is that dements as a class have appetites greater than curable insane or than sane, and that in England the difference in diet scale is a principal cause of deterioration in mental state, physique, and habits when such cases are sent to workhouses. The food supply is under the demand.

This view is strongly expressed in the report for 1885 of Dr. Grierson, the sagacious and kindly superintendent of the Roxburgh Asylum, as regards the patients boarded out from his asylum.

I have gone over the patients in this asylum, which is worked greatly on the block system. I find in one portion containing 67 male dements, of whom only three have been less than eight years in the same building, that in all, the appetite is constantly good and regular, and, although the diet is ample, hardly anything is ever left from any meal.

The same occurs in another block with 82 patients, where the patients are of the best class of chronics, with a few convalescents; and in two similar blocks on the female side, containing 50 and 65 patients, the results are very similar.

I, however, find a very different state of matters to exist in the recent cases. I have examined into the last 50 admissions of public patients from these two counties, male and female, with the following results: Of the males 25 took food ill, and required pressure, five almost completely refused food at first, two had voracious appetites, one had perverted appetite, and in only 17 was the appetite normal.

Of the females 32 had bad appetites, and were got to take food with some trouble; 18 had normal appetite.

Of course it is only by exchanging opinions that we can arrive at general conclusions on such subjects. I think, however, that physical illness is very frequently concomitant with disordered mental action, in the public patients received into Carlisle Asylum more so, I think, than is the case in many asylums, and to this is partly perhaps due the high recovery rate which we have had for many years.

During the four years ending 1882, I admitted 495 patients; of these 38 per cent. required and received tonic treatment.

During 1885 sixty-two males were admitted from these two counties, 25 required immediate tonic treatment; fifty-one females, of whom 25 required tonic treatment—44 per cent. of the admissions.

I shall now conclude with some remarks on the special headings I have mentioned.

1. In *General Paralysis* the voracity is well known; patients bolt their food without regard to the size or heat of the viands, yet in my experience, as a rule, they confine themselves to articles of real food, and though they secrete and hide stones, &c., under the delusion that they are jewels and other valuables, this class of patient rarely eats clothing or dirt. In my experience I find it advisable at a very early stage to put these patients on special diet. We use here mince meat with potatoes two days in the week, broth and milk diet on the remainder, and restrict the food to a given allowance. I think it better that general paralytics should not be allowed to get very fat, as if they do they have a tendency to bedsores in the latter stages. The power of assimilating a vast quantity of food and of rapidly increasing in general bulk is most extraordinary in this disease.

2. In *Epilepsy*. In only one case of this disease have I seen persistent refusal of food; in nearly all the appetite tends to voracity. I hold the opinion that a reasonable restriction in diet is also necessary in this disease. A great

increase in fatness renders life more uncertain in epileptics, and I believe a surfeit may induce a succession of fits, and thus cause death. I recollect on two Christmas Days several years ago, a patient, after partaking too well of plum-pudding, succumbed to a succession of fits; post-mortem examination showed the stomach overloaded with plum-pudding; since then I have even put a restriction on the Christmas dinner of this class.

3. In a limited number of cases of *Chronic Mania* the appetite is truly extraordinary. I have at present a private patient who eats two rations to each meal without either gain in bulk or making himself ill.

4. In the large number of *Melancholiacs* that come under care, want of appetitite is one of the most marked features in many cases; both it and the melancholia probably result from visceral causes. A good purge, a course of blue pill and saline treatment frequently proves efficacious. A pretty sensible melancholiac once told me if I just let him fast for a couple of days his tongue would become clean, and he would take his food; but though this in his case turned out quite true, the opposite is usually the rule.

5. *Cases of Mania* exist, and every now and then come under treatment, where certain delusions are so strongly held that they constrain the patient to overcome the feelings of natural hunger; such as when he thinks he is commanded by the Almighty not to eat for a given time—usually it is 40 days—or that he has no stomach, &c.

Recorded cases of sane sufferers from starvation state that the feeling of thirst is more severe than hunger, and that the pangs of hunger pass off after a limited time. I have in a former paper detailed the experience in this asylum as to forcible feeding, and the class I allude to here I always feed on the third day of abstention. I have had to feed less frequently during the past 18 months than ever previously in my asylum life, the "tube" only having been used in five cases. Of course feeding comes in runs, but I also think that, as one gains in experience, feeding is not so frequently required. Nurses press food better on patients; the obnoxious and deterrent effect of an enema of food is tried previous to feeding, and practically one does not feed so many cases; at least I, with a larger asylum, do not, and yet I do not let patients completely want for more than three days.

6. In *cases* of youths who *Masturbate* we often find

voracity and extreme emaciation coexist. A satisfying, yet non-stimulating, diet is now quite recognised to be the correct thing for such cases—a farinaceous and milk diet, and little or no flesh food.

7. In my experience I have met with cases in which the excitement has been so intense, and the patient has been so restless, and talked so incessantly and rapidly that he seemed really not to have time to swallow. I have seen at least one case of this nature in which, owing to the patient being almost choked by the efforts made to spoon food into him, I have had to use the "tube." I should say that most probably the excitement entirely did away with the feelings of hunger in such a case.

8. I believe certain cases occur in which the absorbents fail to act, the nerve-supply which should reach them being misdirected, and acting to a fearful excess in other directions. I should think that this must really be the case in certain cases of acute and persistent excitement, as well as in certain cases of acute melancholia. Feed such cases how you will, little benefit seems to result. I believe this really is the explanation of the tolerance that certain cases exhibit to heavy doses of narcotics and to noxious substances picked up and eaten during attacks of excitement, such as the eating of laburnum and other injurious seeds without discomfort. I have had melancholiacs under my care who, though properly fed, have yet become weaker, and died without apparent lesion; and a marked case of the type I allude to occurred four years ago under my charge. A young lady, of a highly nervous organisation, became acutely excited. I fed her from an early period of her attack with most nourishing food and stimulants, and yet she died without apparent cause other than the excitement. In this case I rather regretted not having tried the effects of mechanical restraint. At the post-mortem I found undigested fluid food in her stomach, and in the course of the whole intestine. Both large and small intestines were uncommonly dilated. I believe the nerve-energy expended in her excitement had prevented the normal action of the intestines, and that her death really resulted from this.

I think it highly probable that want of action of the absorbents really accounts for the absence of ill effects in those patients that Dr. Clouston * describes as daily taking

* "Edinburgh Asylum Report for 1881."

16 eggs and eight pints of milk; few healthy people could do it.

9. I do not enter on this subject at any length; it is disagreeable and loathsome. That creatures originally made in God's image should so far descend in the scale, owing to disease, as to eat with relish the most filthy, disgusting, and unnatural things is a matter of deepest regret. I have patients under my charge at present who I have seen eat their own fæces, drink their urine from the pot, and, even more abominable still, I have one patient who has to be watched to prevent him from emptying the spittoons. Such cases are truly horrible, and fill one with intense sadness that human nature can descend to such an abyss. Though I have frequently read of masses of hair, cloth, &c., being found in the stomachs of patients dying in asylums, only one such case has come under my observation, though post-mortem examinations are the rule in the Carlisle Asylum. A report of this case will appear in the July number of the "Journal of Mental Science." In this case I considered death to have resulted from slow starvation, caused by the presence of an accumulation of hair, string, and portions of blankets in the stomach.

If my paper elicits from those I see here an expression of opinion on the points touched on, it will have done its work well, even if my views on many of the topics are not at all borne out by others.

St. John Ambulance Classes for Asylum Attendants. By G. E. Shuttleworth, B.A., M.D., Medical Superintendent, Royal Albert Asylum, Lancaster.

Much attention having recently been given (in the pages of this Journal and elsewhere) to the subject of the systematic training of asylum attendants, it occurred to me last autumn that some advantage might be gained in this direction by the instruction of the staff of this institution in "first aid to the injured," as prescribed in the scheme of the St. John Ambulance Association. I accordingly announced my willingness to give the necessary course of five lectures and demonstrations, and having obtained the moral and pecuniary support of my Committee, who granted £5 in

aid of the project, two classes were speedily formed, the one consisting of 28 men and the other of 39 women (the rules of the Association forbidding mixed classes). The fees were fixed at 2s. for the men and 1s. 6d for the women (including an anatomical diagram), and each pupil was advised also to purchase Shepherd's Manual of "First Aid," price 1s., and an illustrated triangular bandage, price 6d. The staff of attendants and nurses were so eager to enter the classes that the only difficulty I had was to exclude a sufficient number for the necessary service of the patients on lecture evenings, which were Thursdays, at 8 p.m. Each lecture occupied about an hour, and another half hour or so was subsequently devoted to practical work, in which I had the aid of the assistant medical officer, Dr. Taylor. The subjects embraced in the course included a general outline of the structure and functions of the body, with special reference to the formation of the skeleton, the course of the circulation, and the functions of respiration and the nervous system. The practical instruction was in the application of bandages, chiefly triangular, the various extemporary means of arresting hæmorrhages, and of protecting and securing fractured bones, and what to do in certain emergencies, such as suffocation, drowning, burns, scalds, &c.; also in the removal of the injured on ambulance stretchers and otherwise, and (for women) a cursory account of the principles of nursing. The classes were from time to time questioned on the subjects of the lectures, the matron undertaking the supervision of the practical work of the women. By these various means I think I may say that the pupils were well taught, and at the examination by Surgeon-Major Hutton, one of the Association examiners, out of 15 men and 19 women presenting themselves, 15 men and 18 women passed with credit. The examination was of a fair and specially practical character, the women having, in addition to *vivâ-voce* questioning, a paper of six questions to answer in writing, and the men being subjected to an extended examination in ambulance drill.

Some objections having been suggested to the course of instruction I have described (such as that "a little learning is a dangerous thing," and that subordinates might be apt to apply their "little learning" independently of the medical officer, &c.), I can only say that the course of events has not justified any such prognostication. It

happens, on the contrary, that during the three months which have now elapsed since the course was given, the ambulance men have on two occasions been signally useful, as within a week of their examination they were called on to pick up and carry to the infirmary an attendant who had fallen 20 feet from a ladder in the course of fire brigade drill, and had sustained a Colles's fracture and other injuries; and quite recently they have rendered most useful aid to a medical man who was thrown from his gig whilst driving past the asylum. But it is not so much in regard to these greater emergencies which, however, are bound to occur pretty frequently in connection with large establishments, as in the daily routine of duty falling to the lot of an asylum attendant, that the elementary physiological knowledge, and instruction how to handle patients with care and discretion, seem likely to be advantageous. So far from subordinates being tempted to exceed their duty, I think the effect of lectures judiciously addressed to them will prove of value in enabling them intelligently to apply for, and to carry out, the instructions of the medical officers. Of course such lectures as those given in connection with the St. John Ambulance will not supersede the necessity of the specific instruction of attendants in their special duties, but there is the advantage that the certificates granted by the Association are fairly well understood by the community at large, and, the system of examination throughout the country being uniform, have a certain definite value. I venture, moreover, to think that in our large asylums, at any rate, the preparation and delivery of suitable lectures will be found of interest to some member or members of the medical staff; and, if experience elsewhere accord with ours, the pains devoted to this object will be fully appreciated by the officers, attendants, and nurses forming the audience.

CLINICAL NOTES AND CASES.

A Case in which a Lesion of one Hemisphere of the Cerebellum was associated with Degeneration of the Olivary Body of the opposite side. (*With Plate.*) By WILLIAM DUDLEY, M.B. Lond., Assist. Med. Officer West Riding Asylum.

W. H., 62, married, was admitted into the West Riding Asylum May 8th, 1884; died March 31st, 1885.

History.—From his youth patient has been subject to attacks of excitement and violence. Seven years before admission his wife left him because of his bad conduct. After that he wandered about, getting work here and there as a common labourer, though a weaver by trade. During the last four years he has been in the workhouse; he entered it because he could not get work. While there he has been morose, stubborn and destructive at times. He was formerly intemperate.

His sister was imbecile.

Mental state on admission.—He is extremely imbecile; unacquainted with the simplest facts of his history, and incapable of maintaining any rational conversation. He is ignorant and inappreciative of his position and surroundings, and frequently fails to understand the meaning of simple questions.

Physical condition.—The patient is partially paralysed. The left arm is weaker than the right. In walking there is a distinct drag of the left leg. The tongue is steady, protruded straight, well under control. His articulation is extremely difficult, imperfect, and indistinct, but he is not aphasic.

After admission, the patient gradually became more feeble and demented. His left leg was kept stiff in walking; he staggered and was apt to fall. His habits were generally clean, but he frequently suffered from incontinence of urine, especially at night.

On Jan. 25th, 1885, for the first time, he had a convulsive seizure, described as an ordinary epileptic attack. After the fit he was able to walk into his room.

Jan. 26th.—Another very severe fit. Examined the next day, he was observed to be more feeble on his legs, and could stand and walk with much difficulty.

No more fits occurred. The paralysis increased, so that he became quite unable to walk without assistance. There were no contractures.

Post-mortem appearances.—At the P.M., 24 hours after death, the more important appearances observed were the following:—

The skull-cap was very dense and heavy. The dura mater was very firmly adherent to the cranial vault. On the inner surface of

the dura mater in the right middle, and in both posterior fossæ, were thin, soft films of false membrane, of dark colour, almost like blood-clot. There was a large amount of clear serum beneath the arachnoid, which was opalescent. The arteries exhibited most extreme atheromatous degeneration, and could be torn across with very slight force. The inner membranes were much thickened, and were stripped with great ease. The convolutions were markedly atrophied, especially in the frontal and parietal lobes. The lateral ventricles were much dilated. The cortical grey matter was of diminished depth, and its striation indistinct. The white matter was of a dirty hue.

In the cerebrum were many areæ of softening, none of them very extensive. In the right hemisphere there were two in the optic thalamus, and one in the white matter beneath the middle of the ascending parietal gyrus; in the left hemisphere one just behind the orbital fissure, one involving the outer part of the lenticular nucleus and the claustrum, and several in the optic thalamus. In both hemispheres were several spots the size of a hemp-seed in various parts of the white matter.

In the left hemisphere of the cerebellum, near its central part, and involving the corpus dentatum, was an area of softening, about $\frac{3}{4}$-inch in diameter, of irregular shape, and of a deep brown colour. The wall of this area was firm and fairly-well defined. The tissue in the neighbourhood was slightly stained and softened. The right olivary body presented a gelatinous appearance. There was no indication to the naked eye of its convoluted grey matter. It was rather firm, and apparently not diminished in size. The left olivary body appeared quite normal.

The brain generally was much reduced in consistence. Between six and seven ounces of serous fluid were collected from the skull cavity.

In sections through the hardened medulla, stained with aniline blue black, the olivary bodies are seen to be of nearly equal size, the right being slightly narrower than the left. In the left the convoluted grey matter is sharply defined. In the right it is blurred and indistinct, and appears from diffuse staining broader than that of the left. Under a low power a great difference is seen in the appearance of the two sides. The left olivary body is normal. The grey matter shows a blue band with sharply-defined margins; the cells are normal in number, size, and appearance. The rest of the olivary body is much more faintly stained. Nerve fibres are seen converging from the grey matter towards the centre, and are collected into very distinct bundles as they pass out through the hilus.

The grey matter of the right shows a much broader and fainter blue band, the margins of which gradually fade into the surrounding tissue. Comparatively few cells, and in parts none, having anything like a normal appearance are here seen, but there is

much coarsely granular matter, probably the remains of atrophied cells. Some of the few cells which remain are larger than those on the healthy side. The nerve-fibres in the interior are not so distinct as on the other side. The parolivary body and the nucleus of the pyramid are unaffected. The hypoglossal nuclei and nerve roots are alike on both sides. The cells of the nuclei have an excess of pigment. I have been unable to detect any tract of degeneration either in the medulla or in the spinal cord.

The case is of interest as a pathological illustration of the crossed connection between the hemispheres of the cerebellum and the olivary bodies. The recorded examples of this condition, so far as I have been able to ascertain, are by no means numerous. Meynert describes the fibres which form the connection, and states that atrophy of one-half of the cerebellum always coincides with atrophy of the opposite olivary body; he makes no further reference to the cases which prove this.

The marked difficulty in articulation, without aphasia, and with complete control over the tongue so far as coarse movements were concerned, is also important. The part of the olivary bodies in controlling the movements of articulation has long been known. It was hinted at even by Willis, but it appears to have attracted little notice till revived by Retzius in 1836. (*Vide* Shroeder Van der Kolk on the Medulla.)

For the illustrative drawings I am indebted to Mr. T. B. Hyslop, pathologist to the asylum.

Three Cases of Choking. Reported by David Welsh, M.B., Assistant Medical Officer Kent County Asylum, Maidstone.

Case I.—J. W., aged 38, a shoemaker, was admitted Oct. 7th, 1876, in a state of acute mania. He was noisy, restless, full of delusions, dirty in his habits, and very destructive. Physically, he was in poor health, and had harsh breathing at the apices of the lungs. The mania, after about 18 months, passed into secondary dementia.

Nov. 2nd, 1876.—Taken ill to-day with sub-acute bronchitis.

Oct. 27th, 1877.—Has again a sub-acute bronchitic attack.

Nov. 22nd, 1878.—Suffers from slight attacks of bronchitis.

July 29th, 1880.—Has again an attack of sub-acute bronchitis.

Dec. 10th, 1884.—Lately has been suffering from slight dyspnœa, apparently due to chronic bronchitis.

Feb. 22nd, 1885.—Remained in his usual state until to-day. After dining in the Hall, he carried off a piece of tough meat, and whilst devouring it he choked. I was at once sent for, and reached

him about two minutes after. The larynx was blocked, and as a last resource I at once performed tracheotomy, thereafter keeping up artificial respiration for 15 minutes, but without avail. When I reached the patient he was apparently lifeless; his face was livid, hands were firmly clenched, respiration had ceased, and pulse was imperceptible at the wrist.

Post-mortem, Feb. 23rd, 1885.—Temperature 45° F. Air moist. Position since death, supine. Cadaveric rigidity, well marked.

External Marks.—Body well nourished. Tracheotomy incision in neck.

Scalp.—Normal.

Calvarium.—Dense; diplöe absorbed.

Dura mater.—Sinuses full.

Arachnoid and Pia mater.—Thickened and opalescent; non-adherent to convolutions; a large amount of subarachnoid fluid.

Cerebrum (34 ozs.).

Grey Matter very much atrophied and very anæmic.

White Matter.—Softened; puncta few.

Ventricles.—Floor smooth; choroids cystic.

Basic Ganglia.—Very soft; anæmic.

Cerebellum (4½ ozs.).—Anæmic; œdematous.

Pons and Medulla (¾ oz.).—Firm; anæmic.

Vessels of Brain.—Healthy.

Organs of Respiration.—Pleuræ : Adhesions of long standing on right side.

Larynx, Trachea, and Bronchial Tubes.—The larynx contained fragments of food, almost completely filling its interior. Within the trachea, just above its bifurcation, and extending for a distance of 1½ inches upwards, was a firm deposit of organised lymph, evidently of long standing, forming a cast of the lower part of the trachea. This structure was slightly adherent to the walls, almost completely blocked the lumen of the tube, and left only a narrow chink, about ⅛ inch in diameter, for air to enter the lungs. The bronchi exuded muco-pus on pressure.

Right Lung (15 ozs.).—Collapsed; congested.

Left Lung (13 ozs.).—Deeply congested.

Organs of Circulation.—Pericardium : Normal.

Heart (9½ ozs.).—Muscular structure, healthy.

Cavities.—Right side filled with recent clots.

Valves.—Healthy.

Aorta.—Slightly atheromatous.

Organs of Digestion.—Peritoneum : Normal.

Stomach and Intestines.—Healthy.

Liver (40 ozs.).—Deeply congested.

Spleen (3 ozs.).—Soft; congested.

Kidneys.—Right (4 ozs.), congested.

Left (4 ozs.), deeply congested.

Bladder.—Half-full of urine.

Remarks.—The chief point of interest in this case is the deposit of lymph found at the bifurcation of the trachea. In considering the post-mortem notes and the clinical history, I think there can be no doubt that this was the result of the repeated attacks of bronchitis; but that life was maintained, and that the patient showed so few signs of distress, with one lung in a state of collapse and the entrance to the other almost closed, is somewhat remarkable. In a case like this tracheotomy was so heavily handicapped that, even had it been performed the very instant the food passed into the larynx, a favourable result could scarcely have happened.

Case II.—G. S., aged 46, a carpenter, was admitted June 19th, 1882, in a quiet, but very demented condition. His bodily health was good, but he had all the physical symptoms of general paralysis; this disease ran a very slow course, and nothing worthy of note occurred until June 2nd, 1885. On that day, whilst taking his dinner, he choked. I was present at the time, and at once went to his assistance, and removed about 3 ozs. of half-chewed food from his mouth. Feeling there was still some obstruction, I endeavoured to remove it by forceps, but failed. Tracheotomy was then performed, and followed by artificial respiration for about eight minutes, natural breathing being then quite restored. Owing to patient's weak state of health, and the shock of the operation, he could not be moved from the room adjoining the dining hall until the evening, when he was taken to the infirmary ward. By this time he was breathing quietly and easily through the tube, but if the finger were placed over the orifice, breathing at once ceased, showing that the larynx was still blocked. Patient was very restless, continually throwing off his bed-clothes, and endeavouring to get up.

11.30 p.m.—Spat out of his mouth a piece of meat which weighed $1\frac{1}{4}$ ozs. On placing the finger over the orifice of the tube, breathing was carried on easily by the mouth and nose.

June 3rd, 9 a.m.—Was able to take some fluid nourishment; still very restless; constantly throwing off his bed-clothes.

5 p.m.—Tracheotomy tube removed and wound dressed. Breathes easily by mouth and nose.

June 4th, 9 a.m.—Not nearly so well; pulse is 125 per minute; respiration rapid and shallow; vesicular murmur harsh and accompanied by fine crepitations; temperature 102° F. Evidently caught cold yesterday, and is now in the early stage of acute pneumonia.

5 p.m.—Very restless; no dulness on percussion over lungs. Pulse 130. Temperature 103° F.

11 p.m.—Sudden œdema of lungs has set in. Despite every effort this gradually increased, and he died at 12.30 a.m.

Post-mortem, June 6th, 1885.—Temperature of air 74° F.; dry. Position since death, supine.

Cadaveric Rigidity.—Well marked.

External Marks—Body well nourished; tracheotomy incision in neck.

Scalp.—Healthy.

Dura mater.—Sinuses full.

Arachnoid.—Thickened.

Pia mater.—Adherent to convolutions, especially in frontal region; vessels engorged.

Cerebrum (38 ozs.).—*Grey matter.*—Deeply congested, much atrophied, especially in the frontal lobes.

White matter.—Softened, congested, puncta numerous and well marked.

Ventricles.—Walls and floor granular; choroids cystic.

Basic Ganglia.—Congested.

Cerebellum (5 ozs.).—Congested.

Pons and Medulla ($\frac{1}{2}$ oz.).—Congested.

Vessels of Brain.—Atheromatous.

Organs of Respiration.—Pleuræ: Old adhesions on left side.

Larynx, Trachea, and Bronchial Tubes.—Contain a large amount of frothy fluid; mucous membrane deeply congested.

Right Lung (26 ozs.).—Middle and lower lobes very deeply congested. Whole organ very œdematous.

Left Lung (25 ozs.).—Slightly more œdematous and congested than right lung.

Organs of Circulation.—Pericardium: Adherent to surface of heart.

Heart (10 ozs.).—Muscular structure, pale, fatty, and friable. Right side filled with recent clots. Aortic valves incompetent, cusps thickened and contracted.

Aorta.—Very atheromatous.

Organs of Digestion.—Peritoneum: Normal.

Stomach and Intestines.—Normal.

Liver (42 ozs.).—Fatty, anæmic.

Spleen (4 ozs.).—Soft and pulpy.

Right Kidney (4 ozs.).—Normal.

Left Kidney.—($3\frac{1}{2}$ ozs.).—Normal.

Bladder.—Contracted.

Remarks.—This case shows the value of immediate tracheotomy if the obstruction cannot be removed by the fingers or forceps. The operation undoubtedly prolonged the patient's life, and had he not been so restless would have saved it, but by his constantly throwing off the bedclothes he caught a chill which set up acute pneumonia, and this occurring in an advanced general paralytic at once precluded any hope of recovery.

Case III.—H. T. D., aged 38, a painter, was admitted December 4th, 1884, in a very noisy, restless, and excited condition, full of very exalted delusions. Physically, he was in good health, but had all the symptoms of general paralysis.

February 16th, 1885.—Is very restless and destructive; requires constant supervision to keep him from devouring filth, rubbish, &c. Nothing further worthy of note occurred until May 20th, 1885, when he was put to bed in a single room at 7.45 p.m. About five minutes later he was heard making a peculiar gasping noise, and the attendant at once went to see what was wrong. He found him gasping for breath, his face livid, a piece of cloth hanging from the corner of his mouth, and with a circumscribed swelling about the size of a hen's egg on the left side of his neck. The attendant removed the piece of cloth, which proved to be the collar of his shirt, and then sent for assistance. When I reached the patient two minutes afterwards respiration had ceased, and he was apparently lifeless; the swelling mentioned above was now diffuse, and the only sign of its presence was a slight fulness on the left side of the neck. Artificial respiration was kept up for fifteen minutes, but without avail.

Post-mortem, May 21st, 1885.—Temperature 56° F. Moist. Position since death, supine.

Cadaveric Rigidity.—Well marked.

External Marks.—Slight fulness on left side of neck. Body well nourished.

Scalp.—Normal.

Calvarium.—Dense, diplöe absorbed.

Dura mater.—Sinuses engorged.

Arachnoid.—Thickened and opalescent.

Pia mater.—Adherent to convolutions in frontal region; vessels engorged.

Cerebrum (45 ozs.).—*Grey Matter:* Deeply congested, atrophied in frontal lobes.

White Matter.—Congested, puncta, numerous and well marked.

Ventricles.—Floor granular.

Basic Ganglia.—Recent clot, $1\frac{1}{2}$ inches long by 1 inch broad, in anterior part of the right corpus striatum, tearing up the brain tissue and extending laterally into the frontal lobe.

Cerebellum ($4\frac{1}{2}$ ozs.).—Congested.

Pons and Medulla ($\frac{3}{4}$ oz.).—Congested.

Vessels of Brain.—Fairly healthy.

Organs of Respiration.—Pleuræ non-adherent.

Larynx, Trachea, and Bronchial Tubes.—On making the incision to remove the larynx a large quantity of recently extravasated blood was found occupying the area of the left anterior triangle, extending upwards to the base of the skull, downwards to below the clavicle, backwards to the middle of the posterior triangle, and forwards to the median line of the neck. In the midst of the

clot were the carotid artery and the vagus nerve; their sheath had been ruptured and lay deeper in the clot. The upper and lower parts of the internal jugular vein were found, but unfortunately, owing to the large amount of blood effused, the precise point of rupture could not be ascertained. The carotid artery was intact and showed no sign of disease.

The larynx was clear, and there was no obstruction in it or in the bronchi.

Lungs.—Right (18 ozs.), slightly œdematous at base.

Left (16 ozs.).—Similar.

Organs of Circulation.—Pericardium: Normal.

Heart (13½ ozs.)—Muscular structure firm and fibrous; hypertrophied in left ventricle. Cavities empty. Valves: Aortic valve incompetent; cusps contracted and thickened.

Aorta.—Healthy.

Organs of Digestion.—Peritoneum: Healthy.

Stomach.—Several small ulcers in pyloric region.

Intestines.—Healthy.

Liver.—(50½ ozs.).—Pale and fatty.

Spleen (6 ozs.).—Large and soft.

Kidney, Right (4 ozs.)—Capsule strips with difficulty, leaving a granular surface, cortex diminished, and structure crowded.

Left (4 ozs.).—Similar, but diseased condition further advanced.

Bladder.—Half full of urine.

Remarks.—The choking in this case was only the first step in the chain of events which led to death. In all probability the patient tore off his shirt-collar and stuffed it into his mouth; it became impacted at or near the glottis, and in the subsequent struggles, which resulted in its expulsion, the vessel in the corpus striatum gave way and also the internal jugular vein. The blood from the latter was at first confined within the tough sheath of the great vessels of the neck, giving rise to the circumscribed swelling; soon, however, the sheath, unable to resist the pressure, ruptured, and the blood became diffused amongst the muscles.

This case shows the value of post-mortem examinations in determining the precise cause of death; the clinical history points to suffocation, the result of impaction of a foreign substance in the air passages; needless to say, the post-mortem notes show that the immediate cause of death was of quite a different nature.

Notes of four Abdominal Cases of interest. By J. A. Campbell, M.D., F.R.S.E., Medical Superintendent, Cumberland and Westmoreland Counties Asylum, Carlisle.

(Read at the Dumfries Meeting of the Border Branch of the Brit. Med. Association, April 9, 1886.)

In private practice abdominal diseases are among the most obscure and difficult of accurate diagnosis that come under observation. In asylum practice they certainly are about the most difficult that we have to deal with, owing to the want of any reliable information from patients as to symptoms, feelings, origin, or progress of the case, and frequently obscure abdominal diseases are concomitant with, or very probably give origin to, marked delusions which further tend to complicate the case.

That the difficulties I allude to are felt in other asylums are clearly indicated by occasional cases which are reported or brought before meetings of our Society. At page 220 of our Journal for 1882, a case of extraordinary fæcal accumulation discovered at death is reported by Dr. Johnstone as occurring in the Edinburgh Asylum. In this case the ascending colon measured 2 feet 2½ inches in circumference, and the rectum, closely packed with hard fæces, completely filled the pelvis; while, at the November meeting of the Northern Section of the Society, Dr. Clouston * "showed an enormously distended stomach which was interesting from the circumstance that the patient had for some time before death been fed by the stomach tube; the fluid was retained in the stomach by the occlusion of the pyloric orifice by a cancerous mass. This condition was not discovered during life; the case resembled one of ascites, the more so as the liver was known to be affected." In the "Lancet," December 16th, 1882, I recorded three abdominal cases of considerable interest that occurred in my practice: one a cancerous ring causing stricture in the intestine an inch above the sigmoid flexure, another a case of cancer of the caput cæcum, and the third, a twist involving eight feet of the small intestine in which the patient died from shock within four hours of exhibiting symptoms of illness.

In drawing up the following notes from the records of the cases and autopsies, I have condensed the account as much as possible, and have purposely omitted entering into details which had not direct bearing on the history of the case, or the

* "Journal of Mental Science," Jan., 1886, p. 611.

pathological lesions discovered, with the view not only of sparing possible readers needless mental exertion, but also with the view of leaving for other clinical records of interest space in this number of the Journal that may be more worthily filled.

CASE I.*—M. A. T., female, *ætat.* 23, was admitted into this asylum in May, 1863, suffering from dementia. She had been a mill girl, had been confined of an illegitimate child in a workhouse, became feeble-minded, and subsequently noisy, excited, and dirty in habits, would sit all day mumbling to herself, shaking her head and body.

During her first year of residence, she became thinner, and it is recorded that, though she looked phthisical, examination showed her lungs to be in a normal state, and that there was an absence of cough or spit. Frequent entries were made in her case for a period of sixteen years and two months, when, owing to the crowded state of this asylum, she was removed to another Asylum. She at this time weighed 102lbs. She was brought back here in November, 1883, when she only weighed 76lbs., a loss of 26lbs. since leaving this.

Her mental condition had altered little, but that for the worse. Physically she was emaciated, her muscles wasted. She was one of the most difficult patients to examine I ever met with.

She was able to move herself in spite of all efforts to keep her still, and she twisted, wriggled, bit, and scratched to such an extent as to render anything like an accurate examination impossible. The entry as to the state of her lungs on admission was: "Percussion generally more dull than normal over both lungs, R.M. abnormal, where it could be heard tubular, with wheezing râles."

No abnormality was detected as regards abdominal organs. I frequently attempted unsuccessfully to satisfy myself as to the state of her lungs, for at times she had a slight cough, and I thought it most probable, as other cause was not apparent, that her emaciation and general state of weakness was due to phthisis.

When let alone she lay quietly. She took her food fairly, and her bowels were regularly moved; her stools were formed, and natural in colour. During January she became more weak and emaciated, while yet she took food well. During February she became worse, and at the end of the month frequently vomited a portion after a meal. She took little food, and vomited frequently for the three days previous to her death, which took place on March 4th, 1884.

Autopsy.—For my purpose I may briefly state that the cranial, thoracic, and abdominal cavities were opened, their contents

* This case was written prior to my reading Dr. Cobbold's cases in the April Journal.

examined. There were traces of meningitic alterations, thickenings, and adhesion, probably the result of former inflammatory processes; there were also old pleuritic adhesions, but there was no tubercular deposit in the lungs. In the stomach there was found a mass containing matted hair, portions of blankets, and a hank of brown fine twine, unwound. A portion of this twine extended through the pyloric orifice down two feet of the small intestine.

Case II.—I. T., female, *ætat.* 40, admitted on March 1, 1881. She had been dull and melancholic for four months, refusing food at times, becoming noisy in a mournful way. A complete examination of her mental and physical state was made on her admission, and recorded. The summary is stated. She was intensely melancholic; nothing except her anæmic state and subnormal temperature calls for comment. She was treated by tonics, stimulants, malt extract, and out-door exercise. She varied in mental state from the depths of depression, when she would neither notice anything nor take food, to an excited state, when she was both dull and noisy, a short interval existing when she spoke coherently and took food well, though she continued thin.

With the exception of having the neck of her femur broken by another patient, from which she recovered, she continued much in the state she was in when admitted till March, 1883. She was then heavier than when admitted.

During 1883, she was, if anything, worse in mind; if sent out she continuously wailed out in a piteous voice, "I want to go in;" if in she cried out, "I want to go out." At times she seemed as if she had abdominal pain, and was frequently sent to bed and examined, with the only result that her temperature was found subnormal, and that a rather tympanitic state of abdomen was found, and this in different positions at different times. Her bowels were regular, and nothing unusual was found as regards her fæces.

During the first six months of 1884 little change is recorded, but during the latter half of the year she became weaker, had several attacks of sickness; her temperature, however, continued subnormal.

She became rapidly weaker, was confined to bed, her feet and legs became œdematous; her urine was frequently examined without any trace of albumen being found in it.

In January, 1885, she became markedly worse, circulation feeble; a slight general dropsical state followed, and she died on January 23rd, 1885.

At the *Autopsy*, the contents of the various cavities were examined; those of the cranium do not call for comment. The right lung was adherent to chest walls by old adhesion, the left merely at apex; the left pleura contained 20 ozs. of pale straw-coloured fluid.

There were several ounces of clear serous fluid in the abdominal cavity; the intestines generally were matted together; and to the parietal layer of the peritoneum thin firm light-coloured narrow

bands crossed and recrossed portions of the small intestine. The small intestine contained much flatus and pressed by these bands, was in portions much distended, and looked like a series of small bladders blown up and tied at the ends.

Case III.—J. B., female, *ætat.* 45, reported as suffering from mania, and being in weak health, was admitted in October, 1862. Little of her history was known or noted at her admission. She had delusions about her inside being wrong, and having the smell of blood in her nostrils and the taste of it in her mouth at night. She is reported as thin but healthy, and with a good appetite; excited and noisy at times. Entries fully describing her state occur with regularity, but call for no remark here until January, 1877, when she is stated to have a pale, cachectic look, but to be taking food well. In April of 1882, her delusions, which had previously been of a varying character, are reported to have assumed a fixed and definite form. She said that she had rats in her stomach, that she felt the pains of their gnawing, and this delusion she retained persistently till death. Owing to her cachectic look, and to the fact that she was steadily losing weight, I examined her on several occasions most carefully during the early part of 1884, but could detect nothing abnormal as regards her abdomen.

In November, 1884, she had several attacks of sickness; she became thinner, more pale, and weak. Though repeatedly examined, it was only on January 5th, 1885, that a distinctly localised, irregularly edged, small tumour could be detected; it occupied a position two inches to the right of the middle line of the abdomen. its upper surface being one inch above the level of the umbilicus, The tumour was slightly movable, and measured three inches sideways by two from above downwards. The patient became rapidly worse, suffered from frequent severe sickness and coffee-ground vomit, and died on January 12th, 1885, aged 67.

Autopsy.—A full examination of organs was made and recorded. I extract the following: "The stomach was much dilated, projecting downwards almost to the pelvis. On the anterior aspect of the larger curvature there was the cicatrix of an ulcer the size of a shilling, and there were also two or three points of ulceration in its neighbourhood. The edges of the large ulcer were not hardened, but the smaller ulcers had a hard feeling implicating the pylorus. There was a tumour surrounding the orifice in the whole of its circumference three-quarters of an inch in thickness. The tumour was of a scirrhous character, hard for the most part, but in some parts softening and breaking down. The pyloric orifice was much contracted."

Case IV.—E. W., female, *ætat.* 56, was admitted in November, 1884, suffering from melancholia. She was stated to have been previously insane; for the last six weeks to have been very dull indeed, and to have attempted suicide. Her mental disease was considered on this occasion to have resulted from ill-health, and

she became worse in mind and more actively suicidal after an attack of sickness, when she vomited coffee-ground-like fluid.

On admission she was found to be in a most melancholic state, could scarcely be got to reply to questions; but on persistent questioning she told that voices urged her to commit suicide, that she scarcely slept at night, and that when she did she had frightful dreams.

A thorough investigation was made of her bodily condition. She was extremely thin and emaciated, and she had a sallow complexion and cachectic look. Nothing in the state of her thoracic viscera calls for note, and no evidence of disease of any of her organs could be detected by ordinary modes of examination, but from her age, history, and general appearance and condition, cancerous disease of the stomach was diagnosed to be present.

From her feeble state she was kept in bed, and was carefully and frequently fed with digestible food, principally fluids, and she was treated with numerous remedies, external as well as internal, with the view of relieving pain and sickness, which she complained at times of suffering from.

During November and December she had several attacks of sickness, with coffee-ground vomit; and during January, February, and March of 1885, her condition altered little. At times she was constipated and required an enema. Examination showed extreme tenderness over the region of the stomach.

During April and May she seemed rather better in mind, and said that her sickness was always preceded by intense pain in the stomach, that this pain was relieved by vomiting, and that owing to this she frequently made herself sick by putting her fingers down her throat. She took sufficient food. Though many modes of treatment were used in attempts to improve her state and mitigate her severe attacks of sickness, they and the coffee-ground vomiting became more frequent. She became more weak and blanched, and died on July 9th, 1885.

Autopsy.—For my purpose it is unnecessary to deal with the contents of other cavities than the abdominal. As the stomach lay *in situ* it was seen to be constricted, and divided into two unequal portions; the cardiac end constituting two-thirds, the pyloric end the remaining third. The front and lower edge of the stricture was puckered and drawn, the constriction being situated four inches from the pylorus. Examined from the outside it was thinned in one localised portion; inside in one of the puckered folds there was an ulcer the size of a threepenny-bit much thinned, with a punched-out look, and invested with deposit of hæmatine. The state of the other abdominal organs was not abnormal.

Remarks.—My reason for grouping these cases is not from their having many points in common, but from the fact that, with a small population amounting to some 250 females, it

seems strange that one should have in one year three such cases. One only occurred in 1884.

Case I.—Is the first of its class that I have met with, though I have made a post-mortem on each case that died under my care in an asylum for 20 years. I, at intervals, notice such cases reported as occurring in kindred institutions; and, wonderful to say, the public papers seem to deal with them, probably from information gleaned at inquests.

I have read, though I cannot quote my authority, that concretions formed by matting of hair were common causes, not only of disease, but also death, in the inhabitants of out-of-the-way highland districts in remote times, when the population subsisted greatly on oatmeal, which was carried in skin bags from which the hair had not been completely removed.

I have also been told by stock-keepers that calves at times acquire the evil habit of sucking each other's ears, and that cases have occurred in which they have become emaciated without known cause, and the emaciation proceeded to exhaustion and death, and that hard balls of hair have been found in the stomach in such cases.

Gastrotomy, with removal of such masses, has been proposed and carried out successfully.*

In this case I report, my idea of phthisis being the cause of failing health was excusable, I think, as I never really could get the patient examined. I think it would, in this case, have been extremely difficult to diagnose the presence of the mass of twine and hair in the stomach.

I believe the patient died of exhaustion from slow starvation, as the twine descending into the small intestine kept the pylorus constantly open, and the mass in the stomach prevented the muscular action of the stomach. The twine was not of the character of that in use here, and probably had been swallowed in the asylum the patient had been in while away from this.

Case II.—Though I have, since the death of the patient, endeavoured to ascertain the fact of a former attack of peritonitis, I have failed. I believe, however, that in some portion of her life she must have had a severe attack of peritonitis to have left such matting and such bands of adhesion; and I am sure, from observation, that she had not this attack while here. I am quite of the opinion that abdominal diseases not only produce in some, mental phenomena, but also give a character to the mental symptoms, and that cases where mechanical altera-

* See paper by Mr. Knowsley Thornton, "Lancet," Jan. 9th, 1886, page 57.

tions cause constipation, colic, and general abdominal discomfort, show a melancholia of the deepest and most persistent character, and usually have a most piteous, anxious expression of countenance, and rarely are for any length of time free from this, or from the melancholic symptoms.

Case III.—In this case I long suspected cancer of the stomach. We know that in old women scirrhous may kill very slowly, and I myself have known a scirrhous tumour of the breast to exist for more than 16 years. I believe it most likely that the cancer began about the time the patient's delusion about rats gnawing her stomach first appeared in 1882, three years previous to death. Of course it is well known that physical disease may really be the starting point of what appears to a casual observer a ridiculous delusion. Numerous cases which have come under my observation, many of them cancerous tumours of abdominal organs, have been, I am well aware, the real cause and origin of delusions.

Case IV.—The appearance, symptoms, and age of the patient, and the course of the disease, were so similar to what is found in cancer of stomach, that a much more experienced physician than I am might readily have assumed, as I did, that cancer of the stomach existed.

The post-mortem cleared the matter up. The altered blood vomit was from the recent ulcer, and no doubt the stricture was the cause of the pain and increasing emaciation.

In my reading I have not come across a report of such a case as this, though I know that such cases have been recorded. I think it more than probable that the whole train of mental symptoms originated and was continued by the bodily disease and want of nutriment.

Lead-Poisoning, with Mental and Nervous Disorders. By Alex. Robertson, M.D., Physician to the Royal Infirmary and City Parochial Asylum, Glasgow.

In the Journal for July, 1880, several groups of cases were recorded by Dr. Savage and others, including myself, on insanity and other disorders of the nervous system, resulting from the poisonous action of lead. The following note may be regarded as supplementary to my contribution to that series of articles.

Quite recently three cases of lead-poisoning were under my care in the Royal Infirmary of this city, all being inmates of

the same ward at the same time. However, only two of them need be referred to here, as in the third patient there were no nervous symptoms, the disturbance being entirely confined to the abdominal organs. Both of the others were packers in the warehouses of dyeworks, where yarn is dyed different colours. Arsenic as well as lead enters into the composition of the dye stuffs. It seems that much fine dust is thrown off from the yarn in the process of packing, and this is inhaled to some extent by the workers; their hands are also constantly soiled by it. If the statement of one of the girls is to be credited, there had been gross carelessness on the part at least of one of the masters in not taking ordinary precautions to prevent the injurious action of these dangerous ingredients of the dyes on the employées.

The most serious case was that of Margaret I., aged 14. She was admitted on 14th December, 1885. Her mother stated that patient had been employed in a dyework since June last, but that on two or three occasions during that time she had to stop work for some days on account of sickness and vomiting. A more than usually severe attack of this kind set in about three weeks before being brought to the Infirmary, and did not subside till two days after admission. Headache had also been very troublesome during the present illness, and mind began to wander two days ago. Menstruation had occurred at 13, and had been regular till she went to her present work, since which it had not appeared. Family medical history was good.

State on admission.—She talked quite incoherently, and was very noisy, crying out at the top of her voice. She did not recognise her mother, and was evidently unconscious of her position. She was carried into the ward, being unable to stand; still there was no palsy, as she moved her arms and legs freely. There was a distinct blue line on the margin of the gums. Pulse was 72, weak; temperature 98° F.; bowels constipated. In summarising the entries in the journal respecting her progress, it will suffice to say that noisy incoherence—in fact delirium—continued for about five weeks, and she disturbed her fellow-patients greatly, even though in a side-room apart from others. She required to be fed, and her evacuations were passed in bed. During the first six weeks of her residence the temperature was generally subnormal, ranging from 97° to 97·4 in the morning, and 97·5 to 98° in the evening. It soon became evident that both sight and hearing were materially affected. Slowly she became calmer, and reason returned about two months after her illness set in. Hearing is also greatly improved, and now (4th March) she hears when addressed in a moderately loud tone of voice. Sight, it is feared, is irretrievably lost. About a month after admission

my friend Dr. F. Fergus, an ophthalmic specialist, succeeded, under much difficulty, in making an ophthalmoscopic examination of the eyes, when he reported that both optic discs were in a state of white atrophy, and since she became rational I have satisfied myself that this condition is very marked. The line of treatment has been of an ordinary kind. For the first few days great care was required to prevent the patient from sinking through exhaustion; fluid nutriment, with alcoholic stimulants, were administered at brief intervals, and external heat was applied. At the same time it was sought to eliminate the lead from her system by the administration of saline laxatives and iodide of potassium. Bromide of potassium as a calmative, and paraldehyde as a hypnotic, have also been given, and counter-irritation applied to the scalp by cantharides.

Case II.—Jane I., aged 20; admitted 20th December, 1885. Since the beginning of last summer patient has been employed in a dyework, in the same department as Margaret I., though in a different work. She has been in indifferent health while so occupied, complaining often of gastric disturbance and constipation. Four days before admission, while suffering from such symptoms, she was seized with convulsions, and within two hours had six fits. Three other fits occurred during the first week of her residence, but no more before her dismissal, about a month afterwards. The convulsive movements were stated to be more severe on the left than the right side; unconsciousness was complete while they lasted. Intelligence was good in the intervals, and there was no emotional weakness. She complained at first of headache, as well as of severe pain in the stomach and bowels; the blue line on the gums was well marked. Dr. Fergus found "both nerves oval and pale, but not markedly atrophic; thinning of the choroid round the margin of both discs. On the left side there is a distinct band of thinned choroid extending up and out along the vessels. In the eye the pigment is disturbed in its distribution, and the entire fundus is mottled with distinct white spots at several places, particularly towards the periphery." The vision of this eye was weak and limited in an upward direction. On re-examining the eyes before dismissal Dr. Fergus did not find any improvement in the condition of the left one.

Remarks.—It will be observed that the mental derangement in Margaret I. was more of the character of delirium than of ordinary insanity. It was not, however, a febrile delirium, as the temperature was in general subnormal during her illness. The question suggests itself: What was the condition of the brain during the existence of the delirium? The state of the temperature precludes the supposition that there was an inflammatory condition, at least of an acute kind present.

A direct irritation of the cerebral substance by the particles of lead carried to it by the circulating blood, with a consequent disturbance of its functions, seems the most probable explanation. The further question arises: How far may we regard the state of the optic nerves as indicative of the condition of the brain, and particularly of the convolutions? In neither patient did the morbid changes in the eyes give much support to the idea that there was or had been neuro-retinitis; the appearance of the optic discs in Margaret I.'s case rather pointed to a primary atrophy of the nerves. Still, as fully three weeks elapsed after the commencement of the cerebral symptoms before it was practicable to make an ophthalmoscopic examination, possibly an inflammation may have existed and subsided, and the inflammatory products may have also been absorbed, leaving only a progressive wasting of the nerve. However, assuming that the wasting is primary, is it to be regarded as a descending morbid action extending from the centres in the brain with which the nerve is connected, either those in the upper basal ganglia or in the convolutions? If this be so, as is not improbable, the condition would be somewhat similar to what exists in progressive muscular atrophy, where, along with disease of the multipolar cells in the anterior cornu of the spinal cord, there is atrophy of the associated motor nerve fibres, as well as wasting of the muscles to which they are distributed. The mental recovery favours the idea that the hemispherical ganglia have not suffered, and the probable central lesion is therefore in the thalamus opticus, and other parts of the lower order of ganglia with which the optic nerve is connected. It is interesting to note that the restoration of the sense of hearing and of soundness of mind advanced nearly *pari passu*.

Cure of Insanity by Removal of a Beard in a Woman. By Geo. H. Savage, F.R.C.P.

Mental disorder of a very simple kind may be often traced to the frequent repetition of some slight cause of irritation, the repetition having the most injurious effect. The effect of a constant or constantly recurring cause of disturbance may be seen to produce not only the simpler forms of mental disorder, but may also be recognised as a true cause of the gravest form of nervous disease. The mind may be upset, just as the temper may be ruined, by slight domestic worries; and this disturbance of mind may be followed by disease of the brain. In my ex-

perience, the brain is destroyed in general paralytics more frequently by constant causes of excitement or anxiety and worry, than by any sudden injury or shock.

We know that frequent recurrences of slight epileptic fits are more dangerous to the mind than are a few very severe ones; and this all points in the same direction to the danger of the more constant cause.

The stone is worn by the constant dropping, and not so much by the flood-tide.

The causes of worry are as varying almost as the individual, but we all recognise some as more efficient for one sex or one age than another.

The shy, self-conscious youth has worries which the man of the world does not feel; and the old man fears poverty, while the woman dreads loss of affection or dishonour.

To my thinking, the worry produced in a woman by any disfigurement is hardly sufficiently recognised. I have seen women with hairy moles whose lives were burdens to them; and in Bethlem we had one "pig-faced" woman whose insanity was associated with her appearance. In another case, a very broad-rooted nose, which gave the woman a very bull-faced aspect, was, to my mind, the chief cause of mental disorder. Facial peculiarities affect both young men and women in a similar way. They make them more and more self-conscious and we all know the terrible feeling produced by a persistent consciousness of something being peculiar in our dress or appearance.

The peculiarities may be slight or great. I saw one youth who wished to die simply because he could not control his blushes; and but for the fact that he was convinced that suicide was a weakness, he would have destroyed himself to hide his blushes.

Of the peculiarities, none are so potent as those which, in a woman, make her believe that she is no longer lovable. A woman who thinks that because of her aspect she is repulsive to husband and to children, is already far down the road to melancholia. These cases of peculiarity of appearance and self-consciousness with melancholia may be often met with in young people. Thus I have seen a girl who, as the result of torticollis, had unequal development of the sides of her face. She was unconscious of her peculiarities as long as she was guarded and educated at home, but when a change of fortune drove her to seek work, she found out her defect, and passed into a state of melancholia.

Again, these feelings may develop after some severe illness, like small-pox, which has altered the appearance, or they may follow the loss of one of the senses, such as sight or hearing; but in these cases other forces are concerned in the upset.

A more common group of cases is that occurring about 40 and later. Single women have come to the conclusion that they are not attractive, and magnify some defect; and married women, fearing the loss of their husband's love with the change in their own feelings, may become morbidly self-conscious or jealous. If at this period any bodily peculiarity appear, the morbid mental growth may rapidly develop. Skin eruptions, or the growth of hair on the face, are the most common sources of trouble.

I would here say that these hair-growths are common, as we all know, among insane women, and in many cases do not in any way affect the mental state; but there are other cases in which the mind, already unstable, is completely upset by the constant worry about the unnatural and disfiguring growth. Such a case I have to describe, and one in which surgical treatment was associated with complete recovery.

Mrs. E. E. G., admitted December, 1884, married. Paternal aunt insane and one brother phthisical. Patient always nervous and easily depressed, but of a cheerful temperament. Aged 38. Four living children, two miscarriages during past six years. In 1883 had a premature labour, and suffered from some uterine trouble later. She was sober, industrious, well-educated, and in comfortable circumstances. The cause assigned for her insanity was a recent growth of hair on the chin. The earliest symptoms noticed three weeks before admission were sleeplessness, depression, restlessness, and a wish to die. She said she was no longer any good to her family, that she had committed all sorts of crimes, and was accused of sins. She had no longer any affection for her children; she attempted to kill herself by strangulation and by precipitation; she thought she was damned.

On admission she was described as being a thin and spare woman, who had the aspect of profound melancholia; she had to be fed with a spoon.

Within a week there was some slight gain, as she slept better and voluntarily took her food.

In February, 1885, it is noted that she was doing needlework, but was still dull. Her chest was examined, and there was no sign of disease of the lungs.

Early in March the report is still more favourable, but toward the end of the month she suddenly broke down, and it appeared that all her quiet and calm were assumed, as she cried vehemently, and

accused herself of producing all the illness and madness in the Hospital.

By June there appeared to be real gain, and she was allowed to go out with her husband for a day at a time, and after these visits she appeared better, though she still said we were all too good to her.

In June she was sent to the Convalescent Hospital at Witley, and on July 4 she escaped, and was lost for two days, having cleverly managed to wander away from roads and to conceal her excitement and unreason. She was discovered on July 6 near Dorking. She said she had slept one night in the woods, and one in Godalming churchyard, and she had taken only one glass of milk during her absence.

She says her escape was the result of a sudden impulse, but the appended letter, which was found among her clothes, renders this doubtful.

[*Copy.*]

"July, 1885.

"They will not kill me here. I quite thought they would, so I must kill myself, I cannot go on living (or rather existing for I cannot live), killing people every minute, putting thoughts into their heads even that never came into my own. How I do it is, and must remain a mystery; it is something too awful to harm people and not be able to help it. I ask you would anyone do it if they could help it? It is misery after misery. Why does God permit it? Why not let me fall dead or take the power away? I cannot explain it yet I am certain it is true and certain it is no one's fault but my own. By my death I hope to save all the rest. The Devil has been cruel to me because I had all to make me happy, such a good kind husband and dear children, a pretty home and every comfort, kindest of relations always good to me. None can forgive, but if they would or could forget I ever lived. And Fred, I pray and beg, live for the Boys' sake and your Mother's, and NEVER let the boys know I took my own life. They thought I came away because I was ill, let them in mercy to them, think I have died a natural death. I have had the baptism service, confirmation, marriage and churching of women read over me; there remains but the burial and that must never be read. It is too awful to think of but I know it's true. And *all* this caused by the vile hairs on my chin—they have cursed my whole life, made a happy life miserable, taken away the power to enjoy it, until I see too late the folly of it. They and they alone made me think of such a dreadful thing as killing myself. Oh if only I had never thought about them at all! It seems such a trifle to cause the ruin of body and soul, and others too—more awful still."

During July and August she remained very miserable, but when talked to admitted that she might have been insane, and even went so far as to acknowledge that she might not have done

so much harm as she had imagined, but all these confessions were wrung from her, and I believe she was in no way better. She was, as she had been before, occupied and industrious. She was now seen by Dr. Radcliffe Crocker, of University College Hospital, who decided on the possibility of removing the hairs from the chin and destroying the bulbs by galvano-puncture. The patient appeared pleased at the idea, and she was sent twice weekly for several months to Dr. Radcliffe Crocker, who with the utmost care and perseverance removed the hairs, one by one, introducing a needle cautery into each follicle, once or more frequently. At each sitting from 10 to 40 hairs were removed, the patient submitting most stoically.

With the treatment little change appeared at first, but as the offending hairs became reduced in number, and did not reappear, she steadily improved, and after 900 hairs had been removed and destroyed and the chin left with only a slight, smooth scar-like aspect, she was sent home on trial, on December 23, for one week; and from time to time further trials were made, till in February she went for a month, and in March she was discharged recovered, now thinking life was worth living, and that home was happy and desirable. She had lost all morbid self-consciousness and all self-accusing thoughts.

There remains little more to be said about the case, and it will stand or fall by itself. We all know that cures occur as coincidences of treatment, and that there are very few perfectly trustworthy experiments possible in so unstable surroundings as are provided by the human body.

In this case some may say time was the chief element in the cure, others that the attempted escape acted as a stimulant, others, more reasonably, to my thinking, that hope of relief from the chronic cause of worry was established, and that the hope, not the depilation, was the efficient cause.

Anyway, the patient recovered, and the case is sufficiently interesting to suggest similar trials in future.

Case of Ovariotomy in an Insane Patient. By R. Percy Smith, M.D., Assistant Medical Officer to Bethlem Royal Hospital.

Annie S. R., aged 33, single, engaged in domestic duties at home, was admitted into Bethlem Hospital on September 8th last.

There was no family history of insanity, but one brother had died of phthisis.

The patient had always had somewhat delicate health, and had scarlet fever some years ago. Beyond this there was no history of any definite illness, and she had never before been insane. Recently

she had been noticed by her friends to be getting stout about the abdomen. Menstruation had always been somewhat irregular and scanty. For about two years she had been getting increasingly deaf.

The attack of insanity dated from about six months before admission, and began by her making remarks about passers-by, and imagining that when they scratched their faces, lifted their hats, or blew their noses, that those actions were directed to her. These ideas gradually grew, so that she began to think she was a person of importance, and that everybody was taking notice of her. Eventually she thought herself a princess, and said that she was not the child of her supposed mother. She then became troublesome, struck her mother, and threatened to drown herself. She also thought that some person had injured her ears by placing a telephone in them.

On admission she was in good general health, but was found to have an ovarian tumour reaching up to the umbilicus. She was restless and untidy, constantly looking out of window as if expecting some one to visit her. She answered questions in a guarded manner, and with some condescension. She stated that she was the daughter of the King of the Netherlands, and thought she was being brought to Buckingham Palace. She realised, however, where she had been brought, and seemed annoyed at it. She thought that the Marquis of Hartington took a great interest in her, and wanted to marry her. She was troublesome at bed time, and had to be undressed, and also had to be dressed the next morning. The same ideas and conduct persisted after her admission, and she further would not believe that any of the medical officers were such, but mistook them for dukes and princes. In addition she constantly complained of the smell of dead bodies in her room at night, and said that people were buried underneath a stone in the floor. She also complained of telephones in her ears, and was somewhat deaf from chronic thickening of the membrana tympani in each ear. In December the tumour had increased to a considerable extent, reaching above the umbilicus, and causing her a good deal of discomfort, and she began to look pale and haggard.

It was decided to perform ovariotomy for two reasons, first, because the presence of the tumour began to be a source of serious discomfort, and seemed to be interfering with her general health; and secondly because it was thought that the ovarian disease might be possibly a cause of her insanity, and that its removal might be curative of the latter condition. The operation was performed in this hospital by Mr. Pitts, assistant-surgeon to St. Thomas's Hospital, under strict antiseptic precautions; and with regard to the details of the operation, one need only remark that there was no hitch of any sort; the adhesions were few and unimportant. The tumour consisted mainly of one large cyst, with a considerable amount of solid material in the pelvis, and sprang

from the left ovary. The right ovary was normal in size and appearance, but somewhat hard. The question of its removal was discussed, but it was decided not to increase the risks of the operation in any way, and so it was left *in situ*.

Six hours after the operation she was restless and talkative. She felt that her abdomen was flatter than it had been, but did not believe any tumour had been removed. She further said that none of us were surgeons, and that we ought not to have done any operation. She seemed to be wonderfully little affected by the operation, and subsequently had no vomiting and very little pain. Beyond a rise to 101° in the afternoon of the next day, the temperature remained normal throughout. The principal thing that had to be combated was her great restlessness and attempting to get out of bed if left for a moment, but she was kept quiet by morphia. She soon became hungry; and was very early able to take food. She still talked about telephones and the Marquis of Hartington. She, however, never complained of bad smells. Fifteen days after the operation she recognised her medical attendants and nurses by their names, said what she had said before was all fancy, and wrote sensibly to her mother. Ten days later she seemed quite rational and happy, and had no hallucinations of smell. The only thing noticeable was that she changed rapidly from one subject to another. It was hoped that the operation had had the desired effect, and that she was on the way to cure.

On January 22nd, however, nearly six weeks after the operation, she became fidgety again, and said that the Marquis had said she was not to wear the belt that had been ordered for her. Subsequently her mental condition became worse, and though now in good general health, she is very deluded; imagines she is the real Princess of Wales, thinks she has seen her mother in the airing court, mistakes one of the clinical assistants for one of the Royal Family of Denmark, and has unpleasant visceral sensations, at one time complaining of wires being put in her throat, and at another of a rat running about in her body. She has also seen snakes crawling about the garden. She, however, makes no complaint of bad smells, and denies any when questioned about the matter. She is restless, and in conversation flies from one point to another incoherently; still, she is much more tractable than on admission, and writes fairly sensible letters to her mother. She has menstruated since the operation.

There appear to be several points of interest about this case:—

1. The duration of the patient's insanity corresponded roughly with the growth of the ovarian tumour. Although there are many cases recorded of the association of irritable

conditions of the ovaries and insanity, I have not been able to find it definitely stated that an ovarian tumour has been related to insanity as a cause. On the contrary, Spitzka states his opinion that even the grossest lesions of the female generative organs are not competent by themselves to produce insanity. The presence of the tumour with insanity in this case may therefore be merely a coincidence.

2. The operation of ovariotomy in a lunatic must always be a matter of interest, because of the difficulty there may be, as in this case, of making the patient understand the nature and severity of the operation, and the need of absolute rest and quiet afterwards. It is worthy of note that she hardly suffered from a constitutional disturbance afterwards, and in three days seemed as if nothing had happened.

3. Shortly after the operation, the patient's mental condition improved to such an extent that it seemed as if she would be restored to mental health. This, I suppose, must be considered in some way parallel to what is frequently seen, viz., the temporary or sometimes complete removal of mental disturbance, concurrently with the establishment of some local inflammation.

4. Although the patient is now apparently hopelessly insane, yet it is worthy of remark that the hallucinations of smell have entirely disappeared. Dr. Savage has frequently pointed out to me the presence of hallucinations of smell in persons whose delusions are mainly sexual, and the fact of their disappearance in this patient after removal of a diseased ovary, though, perhaps, a coincidence, should lead one to watch more closely the association between such hallucinations and sexual disturbance.

I have been unable to find any account of the results of the removal of ovarian tumours in insane patients, and have brought the case before the Association with a view to elicit the experience of other members as to the effect of ovariotomy on the mental condition of patients suffering from these tumours.

OCCASIONAL NOTES OF THE QUARTER.

The Lunacy Bill.

"An Act to amend the Acts relating to lunatics," passed the House of Lords on April 16. Although its death and burial appear imminent,* it is only right to acknowledge the amendments introduced since the Bill was originally brought in by the Lord Chancellor. In the comments which we made in the last number of the Journal, on the form in which it then appeared, we pointed out some of the very objectionable clauses which it contained. It is satisfactory to know that should the Bill ever pass in its present form, the mischief done will be greatly lessened, in consequence of the pressure which has been brought to bear upon the framer of the Bill. Vested interests in proprietary asylums have been respected; the complete abolition of the system of single patients has been withdrawn, and County Justices are left to their discretion in regard to their provision of public asylums for private patients. Medical men are also still further protected from vexatious actions in lunacy. On many minor points the Lord Chancellor was induced to make modifications in the direction desired by the medical bodies, which have taken the Bill into their consideration and represented their opinions to his lordship.

On the other hand, further amendment is required in order to reduce what remains objectionable to a minimum, and to this end the Parliamentary Committee of our Association, and that of the College of Physicians, have drawn up reports upon the Bill, which contain important suggestions, and will retain their value, although the Bill is not likely to pass into law during the present Session of Parliament. In the endeavour to escape from the injustice which the Bill in its original form perpetrated upon the proprietors of licensed houses, the Lord Chancellor has introduced a limitation which some regard as a monopoly, and which it is generally felt would be objectionable in its working, as it is obviously open to criticism in theory. With regard to single patients, it is much to be regretted that with certain exceptions an order must be obtained from a Judge in Lunacy before they can be admitted. At the same time, as the Lord Chancellor has met the remonstrances of the profession by so considerable a

* June 8, 1886.

modification of the original clause putting an end to the system altogether, it is not likely that further concessions will be made. Again, the clauses in the Bill which give power to the judicial authority who grants the order for admission to hold an inquiry and summon any person to give evidence when such authority is not satisfied with the medical certificates, are obviously open to very great objection, and they have in consequence been strongly opposed by the Parliamentary Committees to which we have referred. To other points on which the Bill as amended falls short of what we deem advisable, the document which follows makes reference. We will only enter our protest here against the system of appointing legal Commissioners in Lunacy. Patients themselves are alive to the absurdity of such appointments, and we well remember the rebuff given by one of them to a barrister, to whom he had begun to relate his case. He suddenly inquired whether he was speaking to a physician. On finding that such was not the case, he left him with the very sane remark, "Then I have no more to say to you."*

The following "Observations on the Lunacy Acts Amendment Bill" have been issued by the Parliamentary Committee of the Medico-Psychological Association, signed by the Honorary Secretary, Dr. Rayner:—

The Association has ever asserted the principle that the insane are sick persons suffering from disease, and that, in legislation relating to them, great care is demanded to prevent the legal disabilities entailed by insanity from militating against their receiving the careful, considerate, and judicious treatment required by their disease.

The introduction in this Bill of magisterial intervention in the procedure necessarily antecedent to the placing of an insane person under proper care, requires great consideration, that it may not by publicity or formality act as a deterrent to the adoption of appropriate treatment, nor, by its machinery, cause delay.

The Committee while holding the opinion that the magisterial intervention is unnecessary, and calculated to be antagonistic to the welfare of these diseased persons, recognises that with the safe-guarding provisions made in this Bill, the result of such introduction will have been

* Since the above was in type, a forcible letter, written by Dr. Batty Tuke, has appeared in the "Lancet" (May 30), enforcing the same opinion.

reduced (except in one respect to be hereafter alluded to) to a minimum of evil, while, indirectly, by the protection given to medical persons in signing certificates, the insane are advantaged.

This protection will remove the existing and daily increasing difficulty of placing insane persons under control, due to the reluctance of medical persons to expose themselves by so doing to vexatious prosecution by legal procedure.

While withdrawing opposition to the principle of magisterial intervention, and admitting that it may be in some respects expedient, the Committee affirm that it is contrary to the philanthropic principle of regarding insanity as a disease, and that its adoption is not based on any adduced or proven facts.

The power given to the magistrate (Clause 3, s-s 12) to "visit the alleged lunatic," appears to be in direct antagonism to the principle enunciated above.

In the case of a delicately-nurtured lady suffering from puerperal insanity, the feelings of her relatives (and her own on recovery) would be outraged, by the exposure of her possible obscenity and filthy conduct to a stranger, or, even worse, to a neighbour.

If the object of the magisterial "visit" is to determine the question of insanity, this would certainly be rather the function of a medical person, deputed by the magistrate, than of the magistrate himself, however experienced.

It is suggested that after "to do" (line 41, page 4), the words "appoint one or two medical practitioners" should be inserted.

A difficulty in the magisterial visit might arise, in the case of the insane person being removed on an urgency certificate to an asylum at a distance, say from Yorkshire into Kent. The power to depute a medical visitation would obviate this difficulty.

The power of demanding reports of mental state, property, &c., given to the Commissioners in Lunacy (in Clause 34, s-s 1 and 2) appears to be inquisitorial, and in many cases might bring the Commissioners into popular odium, even if exercised with the greatest circumspection.

The suggestion is made that insane persons under the charge of near relatives should be excepted by the insertion after "person" (Clause 34, s-s 1, page 25, line 14) of the words, "other than a husband or wife or relative within the first degree."

The posting of notices, as directed in Clause 38, s-s 2, is felt

to be contrary to the spirit of treatment, which has hitherto prevailed in asylums, of withdrawing the mind of the patient as much as possible from the fact of his detention and condition.

This regulation would continually remind him of, and direct his attention to, these circumstances, and such notices would be entirely out of harmony with the environments of the majority of private patients.

The Committee wish strongly to express the feeling that the penal clauses in the Bill are excessive in number and severity, and could only be justified on the assumption that in the past, professional men engaged in the treatment of insanity had been guilty of conduct calling for stern repression; an assumption which would be indignantly repudiated, and which the facts of the Parliamentary Inquiry (in 1877) would prove to be without foundation.

The Committee are grateful for the protection accorded against unfounded prosecutions by clauses in the proposed Bill; but are of opinion that, since vexatious proceedings are often commenced by recovered or imperfectly recovered lunatics, further protection should be given, so as to prevent asylum medical officials being mulcted in the initial costs. Such protection might be given by adding to Clause 5 a subsection to the effect that "no proceedings should be undertaken under this clause except by the direction of the Attorney-General, and after deposition of a sum equal to the probable costs of the defendants."

The remuneration of physicians "summoned" (Clause 3, s-s 13) to attend the inquiry on an adjourned petition is felt to be doubtful. A leading physician might be summoned a distance of several hundred miles. Would the remuneration in such a case be the fee of an ordinary witness, or proportioned to his professional standing? If the latter, would not the petitioner in this way be heavily fined by such adjournment, if such expenses are paid by him. The liability to such additional costs would deter petitioners from employing men of eminence, and the non-payment of just fees would deter the latter from signing certificates.

The Committee fully recognise the justice of the provision that no private asylum shall be refused its license except on the ground of unfitness, and wishes to reiterate the opinion that these establishments have done good service in the past in the treatment of the insane, that they have been progressive, as certified by Lord Shaftesbury in 1877, that their competition

with public asylums is beneficial, and that they supply to certain classes, by their privacy and individuality of attention, a want which the public asylums will never entirely fulfil.

The Committee, while acknowledging the important changes which have been made in the Bill in regard to the vested interests of the proprietors of licensed houses, are opposed to establishing a limitation in these institutions, and would, in the interest of private patients, prefer free competition. In addition to the essential objections attaching to such limitation, there is much reason to fear that the object in view, that of eliminating the worst asylums, will not be secured. On these and other grounds, the Committee are of opinion that it would be better not to interfere in any way with private asylums by repressive legislation, but trust to the voluntary discrimination of the public in deciding whether to place their friends, when afflicted by mental disease, in public or private institutions.

The Hospitals for the Insane, which are benevolent institutions, would seem to be undesirably affected by the clauses of the Bill referring to them.

To confer power on a State department summarily and without appeal to close these important institutions, managed by an unpaid body of Governors, is without parallel or precedent.

The Medical Superintendents of these institutions, who are paid officers of the governing bodies, are made responsible, under certain circumstances by a severe penalty, for the admission or retention of patients, whose admission or retention they (the Superintendents) are absolutely unable to limit or control.

In reference to "Boarders" in Hospitals and Licensed Houses, interference with the present regulations is considered unnecessary and even harmful, with the exception of the proposed removal of the limit imposed by the necessity of a previous residence in an asylum, which the Committee regard as an advance on the existing regulations.

Boarders, when relapsing into insanity, often demand their discharge from the control under which they had voluntarily placed themselves when still retaining their self-command: to enable them to summarily demand their discharge, Clause 32, s-s 5, would expose them to the danger of suicide, &c., and would not give time to their medical guardians to communicate with their friends and thereby prevent anything untoward resulting from the returning insanity.

As the clause stands, medical men would have to face the alternative of breaking the law and incurring penalties by detaining an insane person, or of turning out on the world a possibly dangerous lunatic.

The governors of a hospital would appear to be as freefrom taint of interest as the magistrates governing other asylums, and the opinion is held that both petitions and certificates might without disadvantage be signed by them.

The Association numbers upwards of four hundred medical men engaged in the treatment of insanity, and their varied experience, as well as the interest naturally felt by them, seems to impose the duty of bringing the above observations to notice.

Classification of Insanity.

It will be remembered by readers of the Journal that the subject of the classification of mental disorders was discussed at the Congress of Psychiatry, held at Antwerp in September last, and that certain members of the Congress representing different nationalities were appointed to obtain the best-recognised classifications of medico-psychologists in their respective countries, in the hope of obtaining an international system on which all might agree for practical purposes. The nomination of this Commission arose out of a paper read by M. Lefebvre, Professor in the University of Louvain, in which he himself laid down as types of mental disease, idiocy, cretinism, general paralysis, dementia, toxic forms of insanity, mania, melancholia, and circular insanity. The author did not confine himself to classification, but included in his statistical investigations, the number of insane persons in a given area, the causes of insanity in general, the duration of the disease, and its termination and mortality. However, the question of classification took precedence of all others.

The subject was brought under the notice of the Council of the Association by Dr. Hack Tuke, and, after mature consideration, the following report was drawn up by the Council, and forwarded to the Society of Mental Medicine in Belgium, which undertook to receive and digest the various communications made by the physicians nominated by the Congress for this purpose:—

"The Council of the Medico-Psychological Association of Great Britain and Ireland, having been requested by one of their

members to unite with him in responding to the request made by the Congress of Psychiatry which recently met at Antwerp to propose a Classification of Mental Diseases for international adoption, have carefully considered the subject, and are of opinion that they cannot advance further than to recommend that Classification which after much consideration has been adopted by this Association itself in their official statistical tables, namely :—

I. Congenital or Infantile Mental Deficiency (idiocy, imbecility, and cretinism)—

a. With Epilepsy.
b. Without Epilepsy.

II. Epilepsy acquired.

III. General Paralysis of the Insane.

IV. Mania—

Acute.
Chronic.
Recurrent.
A Potu.
Puerperal.
Senile.

V Melancholia—

Acute.
Chronic.
Recurrent.
Puerperal.
Senile.

VI. Dementia—

Primary.
Secondary.
Senile.
Organic (*i.e.*, from tumours, hæmorrhage, &c.).

VII. Delusional Insanity (monomania).

VIII. Moral Insanity.*

The Council feel that a classification intended for international adoption must be extremely simple, while freedom is left to individual alienists to add supplementary sub-divisions to the classification ultimately adopted by the Commission.

Should the International Commission entertain the consideration of the *causes* of insanity, the Council would beg to refer to the Statistical Tables of the Association—Table X.—for a statement of the causes adopted by them as the best for practical use, being that employed by the Lunacy Commissioners."

The above was signed on behalf of the Council by the Chairman, Dr. Rayner.

* Moral Insanity, Delusional Insanity, and the sub-classes (acute, &c.) are stated to be optional in the English Statistical Tables.

The Late Samuel Gaskell, Esq.

Although Mr. Gaskell had retired so many years from his official duties as a Commissioner in Lunacy, his worth and ability remain fresh in the memories of many. Those who knew him in his prime will never forget his zealous endeavour to advance the interest of the insane, his sound judgment, and his practical knowledge of details acquired in the Lancaster Asylum.

Mr. Gaskell, F.R.C.S., was born in the year 1807, at Warrington. As his father died young, leaving a widow with a large family and slender means, he owed much to his mother, for it was to her self-denial and good sense that he received the best education which the locality and the times afforded. In early life he evinced a decided preference for the medical profession, but to his great disappointment the weakness of his eyes, caused by an attack of measles, induced the family doctor to discourage the adoption of medicine as his profession. The youth was, therefore, obliged to relinquish his design, and he was apprenticed for seven years to a publisher and bookseller in Liverpool. Here he had access to the best literature of the day, including that of his favourite subject, of which he was not slow of availing himself, and every spare moment was spent in study. It not only marks the confidence reposed in him by his employers, but it is a curious illustration of the difference between the present and the past, that when any important news arrived from America he was employed to convey the intelligence to London by post-chaise. These long journeys gave him further opportunities for studious reading. His master, recognising such a decided bias towards medicine, consented to remit several years of his apprenticeship, and he became free in consequence to follow his original bent. He went through the necessary curriculum at Manchester and Edinburgh, and having obtained his degree he was shortly afterwards appointed Resident Medical Officer in the Cholera Hospital at Stockport. In 1834 he was elected to the office of house apothecary at the Manchester Royal Infirmary and Lunatic Asylum. Dr. Bardsley, physician to this institution, thus wrote after Mr. Gaskell had filled the office for six years: "I have had the most ample opportunities of judging of his talents, diligence, unwearied application to his duties, practical knowledge and moral conduct. I can most conscientiously state that it is impossible for any public medical officer to have excelled him in the exercise of these qualities."

In 1840 Mr. Gaskell entered on his duties as resident surgeon to the County Lunatic Asylum at Lancaster, where his treatment of the patients, and the consequent amelioration of their condition, did him the greatest credit. He banished the instruments of restraint which may even now be seen collected together in a room in the institution. Lord Shaftesbury, at the annual meeting of the Medico-Psychological Association in 1881, stated how much he had been struck with Mr. Gaskell's management, especially with the sight of a number of female patients, each having a young child under her care, and how he determined to induce the Lord Chancellor of that day to appoint him a Commissioner on the occasion of the next vacancy. Mr Gaskell took office in 1849, and held it until 1866. As a Commissioner he was highly esteemed, both by his colleagues in office and by the superintendents of the institutions of the insane, although the latter were at times disposed to resent his very thorough and minute examination of the institutions he inspected from floor to ceiling. His influence, however, was excellent, and we can well remember the sound advice he gave to assistant medical officers to associate familiarly with patients, and accompany them in their walks in a way which, as he observed, the superintendents could not properly do. Perhaps in no particular did he effect so great a change in asylums as in the matter of dirty bed-linen, which he maintained from his own experience could be reduced to a very small item if the superintendents insisted upon proper precautions being taken with dirty patients before they retired to rest, and their being systematically roused in the night to attend to the calls of nature. It must be admitted that even now his system is not carried out in every asylum, while where it is resolutely observed, the effects are in the highest degree satisfactory.

In 1865 Mr. Gaskell's useful career was practically closed by a lamentable accident. While crossing a street he was knocked down by a vehicle, and from that time experienced so much discomfort in the head that it was not only impossible for him to pursue his work, but painful to enter into social life. Consequently he became, to a great extent, a recluse, although he maintained his mental faculties to the close of his life.

Mr. Gaskell died, at the age of 79, at his residence, Walton, Surrey, on the 17th day of March, 1886.

The Retirement of Dr. Orange, C.B.

But one feeling, that of regret, has been felt at the retirement of Dr. Orange from the post he has so admirably filled in the State asylum for criminal lunatics at Broadmoor. The event is saddened by the reflection that his health has been seriously impaired by the injury received from one of the patients (Rev. H. S. Dodwell) four years ago, commented upon at the time in this Journal. The efficiency with which the specially difficult administration of this institution has been marked is acknowledged by all who have made themselves acquainted with its condition. One fact among others has struck us forcibly as evidence of this, that during many years, but few casualties have occurred. We can from our own knowledge testify not only to the favourable impression produced upon ourselves when visiting Broadmoor, but to that also produced upon the minds of the French Commission on the occasion of their visit in the autumn of 1883. In their report to the Senate this feeling finds expression when they speak with satisfaction of the small number of escapes and other casualties, as also of "the unexpected spectacle of good order, tranquillity, and perfect discipline which strikes strangers who visit it;" and M. Motet, who visited Broadmoor during the International Medical Congress in 1881, thus wrote: "We have returned from Broadmoor satisfied with having found the realization of an idea that has always appeared to us to be right."

When, in 1862, Dr. Meyer was elected Superintendent of Broadmoor, Dr. Orange, who had previously been Assistant Medical Officer at the Surrey County Asylum, Wandsworth, was appointed Deputy-Superintendent, and went into residence in February, 1863, when the asylum was opened. On the death of the former in 1870, he was promoted to the vacant Superintendentship, and has therefore held the office for sixteen years. The dangers of the post are painfully emphasized by the three assaults made upon the Medical Officers, the first upon Dr. Meyer, the second upon Dr. Orange, and the third upon Dr. Nicolson. After hard and anxious work, Dr. Orange succeeded in reducing the complicated details of the asylum-administration and of questions which thereafter arose as to the best methods of dealing with the criminal lunatics of the country, to a complete system, such as has earned the unqualified praise of visitors from all parts of the world.

As President of the Reading branch of the British Medical Association in 1877, Dr. Orange delivered a most instructive address on the "Present Relation of Insanity to the Criminal Law of England," in which he vigorously attacked the legal tests of responsibility maintained by English law.

Then, again, as President of our Association in 1883, he justified to the fullest extent the confidence reposed in him, and his Address at the Annual Meeting, held at the College of Physicians, will long be remembered as at once able and full of practical suggestions on the subject upon which his mature experience enabled him to speak with so much authority. It was, we have reason to know, an outcome of this Address that a different course was pursued by the Government in relation to the examination, before their trial, of persons accused of crime, by means of which a vast amount of conflicting medical evidence has been prevented and the scandal connected therewith avoided.

The appreciation in which Dr. Orange was held at Broadmoor was evinced by the presentation of a handsome silver salver by the officers and staff of the Institution on the 31st May, the value of which, we doubt not, was much enhanced by the expression that it was "a token of their personal esteem, and in affectionate remembrance of many acts of kindness." The proceedings on the occasion were of an enthusiastic character, during which Dr. Orange feelingly referred to the cordial assistance he had received from all during the quarter of a century he had been with them as superintendent or deputy.

It is some alleviation to the painful side of Dr. Orange's retirement that he has not only been thus warmly appreciated in the circle of his own Institution, but that the Prime Minister recommended to Her Majesty to bestow upon Dr. Orange the Civil Companionship of the Order of the Bath, to mark the sense entertained of his services by the Government, the public, and the profession. We are sure that but one feeling is present to the minds of the members of the Medico-Psychological Association, that, namely, of cordial congratulation of the recipient of so well-merited an honour, one wholly unsolicited and due solely to sterling merit, apart from any political influence whatever.

We trust that many years are in store for Dr. Orange, and that his health may be eventually restored by rest and change of scene. Should this be the case, we may hope that he will embody the results of his vast experience with

regard to criminal lunatics in a permanent form. As is well known, it was not only as Superintendent of Broadmoor, but as the adviser of the Home Office in doubtful and difficult cases, that Dr. Orange matured his experience, so that in both relations his opportunities of observation of the delicate shades between criminal and insane conditions have been exceptionally great, and would afford materials for Commentaries of the greatest utility to experts in Psychological Medicine.

The successor to Dr. Orange is Dr. Nicolson, well qualified for the post by his practical acquaintance with Broadmoor, and widely known by his contributions to the literature of insanity and crime. The best wish we can express for him is that he may walk in the footsteps of his former chief.

PART II.—REVIEWS.

Hospital Construction and Management. By FREDERICK T. MOUAT, F.R.C.S., Local Government Inspector, &c., and H. SAXON SNELL, Fellow of the Royal Institute of British Artists. London: J. and A. Churchill.

(*Third Notice.*)

Taking up that part of the book covered by category *c.*, —examples from abroad,—we are in the presence of a number of schemes, from which, for our purpose, a choice must be made.

Foremost would appear to be the "Johns Hopkins" Hospital of Baltimore, United States, America.

A most interesting account is given of the circumstances leading to the founding of this institution, together with a subsidiary asylum for orphan coloured children.

The hospital is a fair specimen of the pavilion system, treated in a somewhat different fashion to any other examples given in the book before us. The adjoining illustration shows the disposition of the general plan and some details.

Mr. Snell says of it: "There can be but one opinion, that the design now being carried out will produce a building worthy in every respect the object of the founder, and highly

creditable to the genius and ability of Dr. Billings and the architects engaged with him in carrying out the work."*

As will be seen, nearly the whole of the building is arranged to consist of one story only above a basement. A very special feature is the arrangement for warming each pavilion, and on this point Dr. Billings, in a preliminary essay, said :—

With regard to heating, it is necessary to keep in view the peculiarities of the climate of Baltimore. It will be seen that we have to provide for a temperature varying from zero to about 100° F.

For at least three months in the year special provision against cold will be needed, and this, if ventilation is allowed, can only be effectually secured by warming the air before it is admitted into the wards, which can best be effected by the use of hot water or steam in what is known as the method of indirect radiation.

He goes on to deprecate the use of open fire-places for the warming of hospital wards, and here Mr. Snell appends the following note :—" The opinion here expressed as to the utility and value of open fire-places in large sick wards is not shared by those in this country who have made the subject their especial study."

The extraction of foul air from this building is arranged for by connecting (through several openings) a shaft crossing the ceiling of each ward and leading into an " aspiration " shaft, through which a constant up-current is sought to be produced by a powerful hot-water coil above the roof level, the whole discharging at some height above this.

Here we would observe, as specially applicable, that the weakness of all arrangements such as those above described is, that, in case of one part being defective, the whole may become inoperative and possibly dangerous.

The risk of this where fire-places of varied form are used is, of course, lessened in proportion by the number of units established as co-operative forces.

The water closets, &c., are not well situated for adopting the plan of cross ventilation, and this appears to us a serious defect in the detail of the building.

Taken as a whole, and bearing in mind the difficulty and consequent expense of meeting the requirements of such variations in outside temperature, we cannot but think that the

* An inspection of this remarkable building while in course of construction, in 1884, entirely bears out Mr. Snell's praise. The greatest credit is due to Mr. Francis King, Dr. Thomas, and others for the pains they have taken to secure the very best plans for the hospital without parsimony and without favour.

scheme has proved an unduly expensive one, the result showing an approximate cost of £866 per bed.

We may next notice the group of French hospitals designed on what is known as the Tollet system. The chief of these are St. Eloi, Montpelier, St. Denis, Bichât, and Bourges.

The first of these is the latest in execution, and at the time of the publication of Mr. Snell's description was not complete. It is estimated that the cost, exclusive of fittings and furniture, will be about £114 per bed.

Similar in form of ward, and with a more detailed illustration ready to hand, is that of St. Denis. Mr. Snell says :—

The St. Denis hospital is remarkable as being one of the best of the executed types of M. Tollet's system of constructing sick wards.

The principle consists of forming both the sides and the roofs of the wards with curved wrought-iron I-shaped ribs, placed about five feet from centre to centre, and filled in between at the lower part with brickwork, and the upper or roof portion with tiling and brickwork or concrete.

In the building erected by M. Tollet the outer surfaces of the roof are finished with a coating of cement or tiles, and the inner surfaces with plaster, upon which are laid three coats of oil paint. M. Tollet's claim for originality rests not only upon the novelty of this mode of construction, but upon the formation of the finished interior faces of the walls and roofs in the shape of a painted arch "de forme ogivale," and it is claimed that buildings constructed in this manner are not only incombustible, but that the absorption of disease germs and other organic matter is prevented; also that free passage of air is not checked by sharp angles; and, lastly, it is pointed out that it is at all times possible, should it be requisite after an epidemic, to flush the whole of these inside surfaces either with flames of gas or streams of water.

As to sanitary arrangements —

M. Tollet has at all times strongly advocated our English plan of separating the w.c.'s from the wards by cross-ventilated lobbies, and it is really quite refreshing, after visiting other French and German hospitals, to find in the building now being described that this principle is carried out in its entirety.

One feature of this building is the form of a special provision for ventilation by an extract shaft containing the flue for the stove, the whole carried up considerably above the ridge of the roof.

The Heidelberg University Hospital is an interesting building, the special feature of its design being thus described :—

The most important feature in this establishment, as also in that

at Friedrichshain, is the introduction of pavilions one storey only in height above the basement. The authorities, to whom the task of erecting the buildings was delegated, seem to have been in some doubt as to the advisability of introducing what was at that time (1868) a comparative novelty. It was known that huts and tents had been extensively used during the time of war and epidemics, and on all sides it had been admitted that fewer cases of hospital diseases occurred in them, than in the many-storeyed buildings of more permanent establishments, and moreover cures had been effected more rapidly. But on the other hand it was feared that the expenses of management, heating, and ventilation would be increased inordinately, and so it came about that six only of these one-storeyed pavilions were erected here, two being for the reception of a certain proportion of the medical patients, and four for a proportion of the surgical patients. At Friedrichshain similar one-storeyed huts were erected for the whole of the patients of the surgical division, but those of the medical department were provided for in pavilions two storeys in height.

The various portions of the building are connected by covered ways open on both sides.

The axes of the wards are placed nearly east and west, the result of many deliberations, but at Friedrichshain the opposite course has been taken, as the result also of much deliberation.

The chief feature of the provision for ventilation is the large lantern-light running the length of each of the wards, this being constructed on such a scale that a gallery is used with special staircase for access to the lights for opening, &c.

The sanitary departments are not well situated, and though better than in many Continental hospitals, would not be tolerated in England.

A noticeable feature is what is called a verandah, a room with a glazed side, which, as Mr. Snell says, should properly be used for giving patients the benefit of external air while remaining under cover. These do not now appear to be in use at all. Something, similar, however, is found very advantageous at the Friedrichshain Hospital.

The basement, used chiefly for stove and furnace room, is, except during very severe frost, kept in free communication with the open air by means of large window openings.

The weak point in the building, taken as a whole, seems to be the size of the wards, which are arranged to accommodate 16 patients only.

This would appear either to render an extra number of nurses necessary, or to separate in an embarrassing manner the duties of one.

We may now shortly notice the leading features of the Antwerp Civil Hospital, a building of this special interest that it was the first hospital having circular sick wards.

The design was originally prepared by M. Bæckelmans, but on being referred to a Commission appointed by the "Conseil Supérieur d'Hygiène Publique," met with such adverse criticism and recommendations incompatible with the retention of the original idea of the scheme, that he declined to act as architect, and two of his pupils undertook the work. In the result the main features of M. Bæckelmans' scheme have been largely maintained.

The diameter of each ward is 61ft. 6in., and the height 17ft., a small enclosure for the use of a nurse being reserved in the centre of each.

The water-closets and bath-room are cut off from the ward very distinctly by a bridge-like construction, and the wards are in like manner detached from the administrative departments.

It may be instructive to quote some of the arguments used by the Commission above mentioned as bearing unfavourably on the circular system. They said:—

"In the first place it is evident that in a round room the beds next the walls are a less distance apart than they would be in a rectangular ward having the same superficies, and that the beds at the feet being very close together, the nurses and doctors will be inconvenienced. Then again, although it has by some been thought otherwise, we have no doubt that this radiating position will be found distressing to the sick, since any patient can the more easily see a large number of his companions in misfortune.

"Now comes the question, 'Would superintendence be more easy?' We do not think so.

"The nurses, placed in the centre of the circle in a sort of cabin, would certainly not be able to so easily keep their eyes upon the patients confided to their care, as if they were at the extremity of an oblong ward; and when so placed in the middle of the emanations of sick patients, will they not be under much more unfavourable conditions, especially during an epidemic, than if they were out of the ward and in a separate room overlooking it, and provided with special ventilation?

"Finally, with respect to the principal argument advanced in favour of the circular system of wards, that a maximum capacity with a minimum surface is to be obtained, thus securing the acquisition without extra cost of an enormous cube of air, one of the most sure guarantees of salubrity.

"We at once admit that the volume of air will indeed be considerable, for according to the calculations of the author of the

plan each sick person would have 2,120 cubic feet. But is this great cube of air the best solution of the problem of ventilation?

"With good ventilation much less would suffice, and it is but rational to admit that a smaller quantity of air would be more easily renewed in a given time. In the matter of ventilation, the important fact must not be forgotten that it is not only necessary to supply pure air incessantly, but we must arrange for the evacuation in the smallest possible time of *all* the vitiated or altered air, and this without causing troublesome draughts. The present methods of ventilation have not yet arrived at such a degree of perfection as to give us full and entire confidence in them, and our mistrust would therefore warn us not to run the risk of constructing wards of too large a size, and so exposing ourselves too near the other of the inconveniences referred to.

"In our opinion, then, gentlemen, there is nothing which authorizes an *à priori* declaration that circular wards, as proposed by the designer, are better than oblong pavilions with rounded corners."

This ends our examples. We may, in conclusion, refer to the chief faults found with establishments particularized by Mr. Snell, though we need not follow him into the full detail of these:—

1. Insufficient area space round sick wards.
2. Administrative offices badly placed for communication with all parts of the building.
3. Sanitary departments badly placed and badly arranged.
4. Window openings and ventilation defective in principle.
5. Method of warming inefficient in maintaining equable temperature.

Manuel de Technique des Autopsies. Par Bourneville et P. Briçon. A. Delahayes et E. Lecrosner. Paris. 1885.

Part I. of this small volume treats of the practice of post-mortems in France and abroad, and of the State regulations appertaining to the same. It then proceeds to consider the organization of pathological departments in hospitals and universities, and the methods of instruction. These matters, though very important in themselves, have yet a significance quite distinct from that which, so to speak, is the kernel of the book, and to which the above are but preliminaries and accidentals—we mean the art of searching the body. This is entered upon in Part II. In this we first find a sufficiently complete list of the requisite instruments; and to this list, though we have no objections to make on the score of its being

excessive, yet we may append, as a commentary, the story of a pathologist who, in the absence of all instruments except a pen-knife, yet performed the post-mortem—Necessity!

Some social precautions are then considered—and these no doubt are necessary—but we rather wish the humorous aspect of the question had been omitted. Plain speaking and honest speaking will, in most cases, succeed in obtaining from the relations the desired permission, and it really is not necessary to have recourse to anything outside this. Chapter II. commences the examination which is to give the answer to the question: *Quare (qua re) mortuus est?* Literally post-mortem examination is the taking of a present state, and seriatim the organism must be questioned. First, we take note of: the height and weight of the corpse; then of the build or architecture of the body (noting deformity if present); then of the tissues which clothe the frame-work, whether they be well or ill-nourished; then of the surface-appearances (wounds, scars, bruisings, local deformities, etc.; also the signs of commencing decomposition); then of the presence or absence of stiffness (rigor-mortis). In detailed description an order is best adopted, *e.g.*, head and neck, trunk, limbs, upper and lower. Having learnt all we can from a careful surface-examination, we must then open the body. In this the order and methods of procedure inculcated are those of Virchow,* with few and unimportant modifications. According to this order the abdomen is first opened and inspected, but not dissected, it being sufficient at this stage to note the surface relations of the abdominal viscera and the surface appearances of the same. Then the thorax is opened, and likewise inspected. Upon this the thorax is dissected, and then return is made to the abdomen, and this also is dissected. Then the head is opened, and upon this, if need be, the spinal canal also. The reasons for adopting this order are fully set forth in Virchow's book, and are here reproduced, as are also the reasons for departing from this set order in special cases, *e.g.*, the opening of the cranial cavity first in those cases in which the pathological interest centres there, or the dissection of the abdomen immediately after opening it in those cases which are of essential abdominal interest, *e.g.*, poisoning cases. In relation to this latter method of procedure, the governing laws are quite like those of *case-taking* in the wards, *i.e.*, we always begin with that system which symptoms indicate to be most obviously at fault. In the present manual

* "Post-mortem Examinations." Trans. from Second Germ. Edit. by Dr. J. P. Smith.

one has to object that slight deviations from the natural order are sometimes met with, *e.g.*, on p. 88 we find stated that after the removal of the sternum the hand is passed into each pleural cavity, and the presence of adhesions, etc., noted. Then, in the next paragraph, it is said "the attention is then directed to the greater or less extent of retraction of the lungs, their adhesion to the pericardium, the presence or absence of the thymus." Surely this last should precede and immediately follow removal of the sternum. The same objection may be made in regard to the examination of the heart. We are told on p. 93 to first take note of the amount of subserous fat after opening the pericardium; then to observe the position of the heart. its state, systolic or diastolic, anomalies of conformation, its size, etc. Surely here, also, the natural order should be: first, position; then, form and size or size and form; then, the state in diastole or systole; and then, the conditions as to amount of fat, etc. These may seem trifling matters to object to, but on points of order contention is perhaps always justifiable, and these small deviations, from a simple ground plan, according to which the body as a whole and in each part may be equally fitly described, spoil the simplicity.

The method of opening the heart is that taught by Virchow, one essential in which is the incising of the separate cavities *in situ*. By this we are enabled to determine the relative amounts of blood in each cavity with accuracy. The description given by Virchow is more full, and possesses the further advantage of illustrative figures. On page 102 we are rather sorry to see still retained the terms *eccentric* and *concentric* hypertrophy.

We might proceed to pass in review the lungs and the several organs of the abdomen, but these do not call for special note, and we may therefore pass to the consideration of the cranium and its contents. The removal of the skull-cap, dura mater, and of the brain itself is effected in the usual way, and we then come to the examination of the brain itself. This is a subject not easily described in words, and we think a few figures in the text would very much have facilitated the understanding thereof, and would have very beneficially replaced the figures from Charcot which the authors think wise to introduce. These latter figures no doubt are useful, but for the purpose in view far less so than some skeleton diagrams giving the several stages of the dissection. The method adopted is "Virchow modifié," but the modification does not appear serious, and the essentials are retained.

The value everywhere of Virchow's method is that it is reasonable; scarcely a cut is made in the body for which there is not a reason why it should be made, and made as directed. Virchow directs that after the examination of the membranes has been completed, the ventricles shall at once be opened on either side by longitudinal vertical incisions through the corpus callosum, close to, and on either side of the raphe. From these incisions it is easy to open up on either side the anterior and posterior horns of the lateral ventricles, and lay bare the whole extent of each of these. The knife being now passed through the foramen of Monro, the corpus callosum with the fornix is reflected backwards, and the upper surface of the velum interpositum uncovered. This is then reflected with the handle of the scalpel and the third ventricle exposed, together with the corpora quadrigemina and pineal gland. A vertical incision is then carried in the mid-line through these structures into the iter, and through the thickness of the middle lobe of the cerebellum. On separating the parts we obtain thus a complete view of the fourth ventricle. In this way the entire system of the cerebral ventricles is examined, and with it the important structures adjacent to them so far as they are visible from within. There remain for examination the cerebral hemispheres, basal ganglia, crura, pons, and medulla. This is effected, according to Virchow's method, by a series of transverse incisions through the hemispheres—the direction of the incisions being across the long axis of each hemisphere, and the depth sufficient to expose practically the whole of the cortical and white matter at the level of the section, just sufficient being left undivided below as may serve as attachment or "*binding*," as Virchow puts it, to the several segments, and hence enable the localization of any lesion discovered by re-approximating the cut segments A similar series of sections is carried through the basal ganglia, *i.e.*, they are made vertically, but they are made to radiate from the crus. Bourneville and Briçon alter slightly the direction of their incisions, and further make horizontal sections through the corona radiata, but it is difficult to see the precise advantage of this method. Indeed, if we but keep the end in view, which is a sufficiently thorough investigation of the substance of the cerebral hemispheres with, at the same time, for purposes of localization, the power of putting the sections together again and reconstructing the hemisphere, we shall admit as adequate any method permitting of this, and shall not quarrel with the precise direction of the cuts, for except as means to an end these have no significance. To

complete this part, the authors give M. Pitre's method of division of the hemispheres by transverse sections made at fixed points. The fixing of these points and the definite relations of the sections to determinable landmarks constitute the value of this method. And localization is certainly more easily obtained thus. Figures of the sections according to this plan are given.

No mention is made of Meynert's method of dissecting the brain, which method is adopted by a large number of alienists, and one special advantage of which appears to be the isolation of the cerebral hemispheres, cerebellum, and basal system (ganglia, crura, pons, and medulla), and so the power of taking separate weighings of these parts.

The concluding portions of the book contain a list of methods of preservation of the tissues or organs for the purpose of museum preparations; also a table of weights and measurements of the organs.

On the whole the work is done well, and the book will serve a useful purpose. Whether the same purpose would not have been fulfilled by a simple translation of Virchow's book is another matter. In so far as simple post-mortem examination is concerned it probably would, but this forms but one, though the most important section, of the present small volume. To do justice to Bourneville and Briçon's production, we must admit that even in this section there is comprehended more than in Virchow's treatise, inasmuch as, after the manner of Orth, there is given a compendium of the morbid conditions met with in the body; but this part is rather condensed, and serves more the purpose of illustration than of complete synopsis.

Klinische Psychiatrie. Speciells Pathologie und Therapie der Geisteskrankheiten, von Dr. Heinrich Schüle. Von Ziemssen's Handbuch der Speciellen Pathologie und Therapie. XVI. Band. 3 *Auflage.* Leipzig, 1886.

Schüle's Manual of Clinical Psychiatry.

(Continued from p. 96.)

Resuming our notice of this able work at the point where we referred to the author's description of "Attonische Wahnsinn," or Katatonia, we note, before leaving this form of mental disease, that he admits three varieties, namely, (*a*) the religious

expansive form, (*b*) the depressed form (Dæmonomania), and (*c*) Katatonia based upon a hysterical constitution. In Katatonia relapses are frequent, ending at last in a demented condition with verbigeration. It is impossible to do justice within our limits to Schüle's description of this affection. The reader must go to the original work for details.

Acute primary dementia follows, and of it two great divisions are given. In one there is a sleep-like and imperfect action of the perceptions and dreamy condition of consciousness, tending to dementia (stuprose form); in the other there is a condition without stupor, with gradual loss of mental power. The former constitutes a transition to acute states of insanity; the latter passes into dementia, secondary to the primary form. Again, the stuprose form may be further divided into an attonic form, with accompanying tension of the muscles, and a state of stupor with hallucinations. In the first sub-variety post-maniacal stupor is included, and in the second a condition which the author terms pseudo-stupor. As to primary dementia without stupor, it forms a group by itself. It often succeeds a severe attack of typhus or variola and puerperal states.

The form of mental disorder next described is hysterical insanity, under which, after a clear description of the well-known temperament, Schüle sketches hysterical melancholia, mania, delusional insanity, and dementia. The treatment is somewhat fully given, including the Playfair-Mitchell system, in cases complicated with nervous dyspepsia.

Epileptic insanity is described under the two conditions of post-epileptic stupor and post-epileptic excitement with hallucinations, the *grand mal intellectuel* of Falret, both forms ending in the majority of cases in dementia. Minute differences in the symptoms find their place under stupor, whether with profound unconsciousness of short duration and amnesia as to the attack, or with dreamy consciousness and partial memory. Next to stupor follows acute excitement, with hallucinations of a frightful character, and attacks of violent fury, lasting from several hours to from three to fourteen days. Protracted conditions of dreamy consciousness lasting for weeks and months follow; this stupid condition also arising especially from the administration of bromide of potassium. Maniacal excitement, continuing for weeks, months, or even years, and often passing into dementia, is another variety, and a gay form of excitement, associated with mental weakness, is a fifth variety. A sixth is a state of suddenly developed apprehensiveness of a

very marked character, with confusion, irritability, suicidal impulses, and acts of violence, the duration being very short or possibly some days. The seventh variety is the momentary loss of consciousness with automatic acts and complete amnesia. The eighth and last variety is the usual habitual form of melancholia, mania, and delusions, which are frequently presented in their typical form without any modification from epilepsy. In other cases there are associated mental disturbances which recall those of epileptic insanity. The author's love of minute differentiation is here evinced.

Schüle quotes from Fischer the interesting case of severe and deeply rooted epilepsy, converted by an attack of typhus into genuine hysteria, from which the patient eventually recovered.

Hypochondriacal insanity comprises an acute and chronic stage, the latter accompanied with marasmus. Neurasthenia falls under hypochondriasis, the treatment of which calls for a more than usually careful mental and bodily regimen, best secured, the author thinks, in a well-conducted curative establishment. Brain-congestion must be avoided by means of bodily occupation, not completely giving up mental activity, so long as it is not carried to excess. Let the patient, says Schüle, learn the great art of moderation, and of confining himself within proper limitations, and he adds: "The command, 'Thou shalt keep holy the Sabbath day,' has a deep significance in the practical philosophy of life."

We come now to the periodical, circular, and alternating psychoses, the consideration of which extends over some forty pages. No less than five types of periodical mania are given, the last being marked by choreic movements and meaningless gesticulations. Periodical melancholia escapes this minute differentiation. Circular forms of mental disorder comprise successive stages of mania, melancholia, and a lucid interval. Circular stupor has several sub-varieties. Several tables given, noting the actual periods of periodical symptoms through successive years, exhibit valuable records of clinical observation. Under the designation of alternating psychoses are ranged the disorders whose essential character presents a course of regular oscillation between good and bad days. It may be said that the course varies in a typical manner between exacerbation of the fundamental disorder and a lucid interval, both having an extremely short duration, generally one day or part of a day, occasionally from two to three. Cases occur in which there are paroxysms of three days' duration, one being marked by maniacal restlessness, one by melancholy depression, while

the third forms the interval. A sub-variety comprises the catamenial psychoses.

Acute delirium, the next group, is divided into the irritative form, or that of cerebral excitement, and one of inanition or anergic acute delirium. Under the former we have acute maniacal delirium, the acute delirium which, not unfrequently, is associated with general paralysis, and consists of active excitement, ending in incoherence and muscular tremor and strong fibrillar twitching of the facial muscles. Hence rapid collapse. Thirdly, acute melancholy or stuprose delirium or delusional stupor, which is carefully described to its end in chronic mental weakness tinged with melancholy, or in death. Under the form of inanition or mental paralysis the pathological anatomy is carefully given.

Schüle insists upon rest in bed as absolutely indispensable in all forms; it must be carried out by force if necessary. All excitement from without is to be most carefully excluded; isolation in a darkened room with all possible quiet of surroundings is insisted upon, as also ice on the head and frequently held in the mouth. Along with cold applications, tepid baths, under careful observation, are to be employed. A little local blood-letting may be safely practised at the commencement. In the adynamic state, champagne and musk are recommended.

To the foregoing forms of mental disorder follow typical, general, or progressive paralysis, which is described under the heads of psychical, motor, sensory, vaso-motor, and trophic disturbances. Varieties are hypochondriacal paralysis and paralysis with primary dementia. Under the former Schüle recognises a circular form and delusions of persecution with hallucination. In hypochondriasis there is the singular condition known as micromania in curious contrast with the usual symptoms of megalomania.

"Patients with disorders of digestion feel the stomach sewn up and obstructed, their mouth and rectum closed, the body filled with pus; they are reduced in size, refuse to sit at table, because no chair is high enough for them; they feel themselves changed into all sorts of forms, a triangle for example; they have no head, no feet, can eat and digest nothing because the bowels cease to act, because the spoon is too large, and the soup set before them seems to them, in comparison with their diminutiveness, a limitless ocean in which they are afraid of being drowned; while from the umbilicus proceed boxes of Nuremberg toys. These delusions of size may have a melancholy colouring; patients

regarding themselves as the products of hell and of most horrible forms, &c. The sudden change from the expansive to the depressed phase is pointed out by the author as a strong proof of the unreflective character of these morbid conditions. Quite suddenly the patient plunges with his ætherial joys of Heaven into the bottomless deep; first of all he is "Obergott," now he is one of the lost. Both phases may alternate in a single hour, or in the course of the same day; expansive in the morning, depressed in the evening, the latter often bringing with it a desperate suicidal impulse."

These descriptions of the exceptional symptoms occurring in general paralysis are among the many indications of the careful clinical observations of the author.

Of the tendon-reflexes Schüle observes that their reaction is variable, being frequently increased in the early stage, and certainly so in lateral sclerosis. If there is an accompanying affection of the posterior columns, the tendon reflexes are absent, as in some other cases; however, the deficiency appears to occur in the first instance in the majority of cases. Although, certainly, absence of patella-reflex warrants the diagnosis of spinal disease, its persistence does not accord with the kind and intensity of the anatomical brain changes in general paralysis. Schüle also holds that the occurrence of electrical reaction of the nerves and muscles in this disease is too uncertain and inconstant to be worth much, hitherto, as a help to diagnosis. Not unfrequently electrical reaction of the nerves is weakened in proportion to the preceding increase thereof. More frequently a difference in the quantitative electrical excitement of both sides of the body is observed, especially in the peronei muscles. Qualitative changes of excitability in general paralysis occur only when there is associated with it lesion of the anterior cornua or anterior roots of the cord.

As to the pupils the author's experience is to the effect that in at least half the cases of general paralysis their reaction is sluggish, and that they are unequal. Often the outline varies, sometimes for a long period, and sometimes for only a few hours. Marked mydriasis may occur suddenly, the pupil returning to its natural state after the subsidence of the excitement. Reaction to light may fail, while that to accommodation remains, but the reverse may hold good, reaction to accommodation failing while that to light remains, as in lesion of the oculo-motor fibres in the median peduncle. In many cases myosis is observed with failing reaction to light. In one of the author's cases this remained the one symptom after entire disappearance of the others.

Want of space will not allow of more reference to the chapter on general paralysis, which contains a pathological section very fully given. We may, however, add that according to Schüle's observation the duration of the disease is from two to three years in the majority of cases, exceptional instances, lasting from five to six years, being mentioned. Probably he has met with cases of much longer duration.

Next follow what are termed psychical cerebropathies or modified paralyses, under which meningo-periencephalitis, pachymeningitis, primary atrophy of the brain, encephalitis, with disseminated sclerosis, cerebral tumours, spinal complications (tabes, spastic paralysis, myelitis, &c.), and syphilitic disease of the brain are included. Under primary cerebral atrophy are grouped (1) atrophy without symptoms of excitement, of which there are four types, the first marked by melancholy or hypochondriacal characters, the second by hallucinations based on obscured mental perception and profound depression termed by the author "nihilistic." Primary chronic depression followed by deep mental stupor constitutes the third type of brain atrophy, whilst the fourth usually presents the form of primary dementia. Pathologically it is indicated by chronic ependymitis of the ventricles, which are distended with fluid. Then follows (2) primary brain atrophy with marked symptoms of excitement, but not ideas of grandeur as in the classical form of general paralysis. As a pendant to these two forms of primary cerebral atrophy are cases with local softenings or capillary apoplexies with miliary deposits or with multiple sclerosis. There may be primary dementia with progressive paralysis with intercurrent hemiplegia and apoplexy; apoplexy with secondary dementia; dementia with general progressive paralysis complicated with local paresis; or, lastly, monomania of persecution with hallucinations, connected with magnetism and imaginary rheumatic pains.

Following primary brain-atrophy is encephalitis with disseminated sclerosis which forms a natural transition to syphilitic insanity, tumours of the brain, and gross lesions of the cord.

Once more, comment is inevitable on the wonderful power possessed by the Germans of dividing and subdividing mental disorders. However interesting and useful these may be for the advanced investigator, we are not prepared to recommend their adoption by the student or general practitioner.

For those, however, entering upon the special study and practice of psychological medicine, and for those who are

actually engaged in the care and treatment of the insane, such an analysis of mental disorders must be invaluable; and in those instances in which the division between minute shades of insanity does not appear to be necessary, the suggestion excites observation and interest, and sharpens the faculty of diagnosis in subtle phases or varieties of mental disorder. Definitions and classifications, which nature may seem at times to abhor as much as a vacuum, are at least pegs on which to hang knowledge as it is freshly acquired, although in many instances only provisional until a further and fuller collection of clinical facts authorizes a better, because a more simple and natural classification.

This work does credit to, and is very characteristic of, the German School of Psychiatry. It is clear that the Germans have more convolutions or cerebral cells than we have. No better man could have been chosen than the author for the preparation of a scientific work suited for the medical series edited by Prof. v. Ziemssen.*

Compendium der Psychiatrie. Zum Gebrauche für Studirende und Aerzte. Von Dr. EMIL KRAEPELIN, Docent an der Universität, Leipzig. Leipzig, 1883.

This compendium, although designed for the German student in psychiatry, cannot fail to prove useful to the English medical psychologist. It treats of the general pathology of insanity, including ætiology, symptomatology, the course of the disorder, the diagnosis, and the classification of the psychoses. The last subject is one which at the present time attracts much attention, and is widely discussed both in Europe and America. An English psychologist finds it necessary to know the conclusions arrived at by a nation—or, at least, its psychologists—having such a singular aptitude for delicate psychological distinctions, and in this work and in the much more extensive treatise of Dr. Schüle, which we have noticed, he will find what he desires to learn. Under the "German Retrospect," the reader will be be able to follow Dr. Kraepelin's classification in some detail.

* In a future number we shall, in the "German Retrospect," complete the enumeration of the various forms of mental disorder given by Schüle.

Ebstein on the Regimen to be adopted in Gout. Translated by JOHN SCOTT, M.A., M.B. J. and A. Churchill, 1885.

Gout and its relations to Diseases of the Liver and Kidneys. By ROBSON ROOSE, M.D., F.R.C.P. Ed. London: H. K. Lewis, 1885.

The first pages of Dr. Ebstein's short treatise deal with the pathology of gout. The author's theory is certainly his own. It recognises in the gouty patient "a congenital and generally hereditary predisposition" towards the production of uric acid in the muscles and the medulla of the bones; further, it recognises a "limited retention in definite parts of the body of the fluids overladen with uric acid combinations." The reasons brought forward in favour of these views are very few, and those few certainly not conclusive; and on the simplicity of the doctrine we cannot compliment the author.

The author passes to the consideration of the treatment of gout by dieting, and he runs counter to some prevailing views on this subject. Thus he maintains that fats are beneficial in the dietary of the gouty, and that, rather than cause dyspepsia, fats may beneficially act on those forms of dyspepsia which result from a diet over-rich in starchy foods. On p. 28 the author states that fats "are only really contra-indicated in those cases (of dyspepsia) which are developed in consequence of mechanical insufficiency of the stomach, *i.e.*, where the muscular elements of the stomach are insufficient to empty its contents into the bowel in the normal fashion." Does this mean that fats constitute an increased impediment in the above cases, or what does it mean?

On the matter of alcohol, the author is not very clear, as may be seen on comparing pages 32 and 51. The abundant potation of water is not advised.

The work strikes us as a very meagre production; it may, however, serve this purpose, namely, to make us long for more knowledge of dietetics. At present in this field each man can ride his own hobby to his heart's content, however sorry the jade.

If we now take up the little treatise by Dr. Roose and test it by the question, Are we any further advanced in our knowledge of gout? we think the answer must be in the negative. Chapters I. and II. embody the facts of gout and the theories as to the nature of gout. Chapter III. pursues

the questioning as to the nature of gout, and at the end of this chapter the author sums up in eight propositions his own views on the subject. These propositions, however, are not in substance new, and as they stand in position they are in part self-destructive. Thus, Proposition I. recognizes in uric acid the "materies morbi" of gout; this, we learn from a previous page, is equivalent to saying it is "the cause" of gout. Proposition III., on the other hand, refers the production of uric acid in excess to the "imperfect transformation of albuminous substances," and this, Proposition IV. declares to result chiefly from "functional disorder of the liver." It is, however, clear that, if this be so, uric acid can hardly take rank as the materies morbi—it can, at least, only stand as the proximate cause of the disease.

In the chapters on "Errors in Diet as a Cause of Gout, etc.," on "The Irregular Manifestations of Gout," and on "The Treatment of Gout," the reader is taken over familiar ground.

We are rather surprised at the rapid exhaustion of the first edition of this brochure.

The alienist who so frequently has to treat patients whose mental symptoms are associated with gout, turns to such works as those under review for help, but finds such a want of definite direction, or advice which is so very dubious, that he rises from their perusal with anything but a sense of gratitude to the authors.

The Discoverie of Witchcraft. By Reginald Scot, Esq., being a Reprint of the First Edition, published in 1584. Edited, with explanatory notes, glossary, and introduction, by Brinsley Nicholson, M.D., Deputy-Inspector-General. London: Elliot Stock, 62, Paternoster Row, E.C., 1886.

Dr. Nicholson has done good service in bringing out this reprint of a work which must always be remarkable in the history of Witchcraft. The original title ran thus:

The Discouerie of Witchcraft, wherein the lewde dealing of witches and witchmongers is notablie detected, the knauerie of coniurors, the impietie of inchantors, the follie of soothsaiers, the impudent falshood of cousenors, the infidelitie of atheists, the pestilent practises of Pythonists, the curiositie of figurecasters, the

vanitie of dreamers, the beggerlie art of Alcumystrie, the abhomination of idolatrie, the horrible art of poisoning, the vertue and power of naturall magike, and all the conueiances of Legierdemaine and iuggling are deciphered; and many other things opened, which have long lien hidden, howbeit verie necessarie to be knowne. Heerevnto is added a treatise vpon the nature and substance of spirits and diuels, &c., all latelie written by Reginald Scot Esquire 1584.

The second edition appeared in 1651.

Dr. Nicholson states that the present reprint would not have been undertaken had not Professor Gairdner, of Glasgow, regarded the work as worthy of reproduction. The editor is careful to state that he is "no student of the Pseudo-Science of Witchcraft, but a student only of what is useful, true and good," being a little alarmed apparently at the association of his name on the title page with Witchcraft! It is an honour, however (and doubtless he feels it so), to be associated in literature with Reginald Scot; and the careful preparation of the work before us is in its turn an honourable tribute to the memory of this enlightened man, as well as a labour of love on the editor's part.

Reginald Scot, born near Smeeth, Kent, in 1538, was the son of Richard, and grandson of Sir John Scot, of Scot's Hall. When seventeen he was sent to Oxford, whence he retired, after his studies, to Smeeth, without having obtained a degree, and gave himself to reading obscure authors, and also to gardening.

We now come to the occasion of Scot's celebrated work being written. It must be observed that before Henry the Eighth's time, so-called sorcerers were punished as heretics by Church law. In his reign, however, it was enacted that sorcerers, &c., should be put to death and forfeit their goods as felons, and lose the privileges of clergy and sanctuary. By an Act passed in Edward the Sixth's reign, the deeds of sorcerers were no longer to be regarded as felonies. Again, an Act of Elizabeth declared that sorcerers causing death should suffer as had been enacted in King Henry's time. When, however, a person was not put to death by sorcery, but only injured, the offenders were to be imprisoned one year for the first offence, and exposed in the pillory once a quarter; while for the second offence they were to suffer death as felons. Thus Elizabeth's Act was an improvement upon Henry's, but was less humane than that of Edward vi, for whom, or his councillors, mercy had always a remarkable attraction. Unfortunately Bishop Jewel,

in a sermon preached before Queen Elizabeth in 1572, entreated that a law touching witches and conjurors should be put into due execution, "for the shole of them is great, their doings horrible, their malice intollerable, the examples most miserable. And," he added, "I pray God, they never practise further than upon the subject." The result of this appeal to her Majesty was a fresh inquisition for sorcerers, and many were brought before the justices (one of whom was Sir Thomas Scot) charged with witchcraft. Reginald Scot, as stated by Dr. Nicholson, had seen poor old creatures accused of selling their souls for the sake of a position in the world, and of other crimes such as any one of common sense must laugh at. Doubtless some were insane, and may have fancied themselves in league with the devil. Scot had also seen several instances of alleged sorceries completely exposed, and "he had taken part in the trial of one Margaret Simons, and knew the history of Ade Davie, and of her restoration to sanity without exorcism, hanging, or burning." Hence it is inferred that his suspicions were aroused, and that he was led to take up the subject of witchcraft. In 1582, thirteen poor old women were hanged as witches, and it is suggested that he himself witnessed their condemnation. Anyhow, Scot's indignation appears to have been aroused, and nothing was more natural than a compassionate appeal to the people of England on behalf of the men and women who, in his day, were so barbarously murdered for having the misfortune to be either ugly old women or lunatics. It must not be forgotten that Johann Wyerus had written a book in 1567, calling in question popular views on witchcraft; and before him Henry Cornelius Agrippa, his master, although a believer in witchcraft, made a noble protest* against the attempted condemnation of a poor woman charged with witchcraft. Scot, however, although he doubtless had the advantage of reading their works and making considerable use of the book of Wyerus, was an independent observer and writer. It appears doubtful whether Queen Elizabeth took any notice of the "Discovery of Witchcraft;" but James I., in 1597, published his notorious and characteristically bigoted work entitled "Dæmonology," which he tells us he wrote "chiefly against the damnable opinions of Wyerus and Scot." By his orders Scot's work suffered the fate of the best books in

* Given in "Chapters in the History of the British Isles," by Dr. D. Hack Tuke, 1882, p. 37. Kegan, Paul, Trench and Co., London.

former ages of ignorance and intolerance, that, namely, of being burned by the comman hangman. By an Act passed in the first year of his reign the Act of Elizabeth already referred to was repealed, and any conjuration, &c., of an evil spirit became a capital offence. The plea often urged in favour of this King that his superstition and severity were merely in accord with the age in which he lived, falls entirely to the ground, for instead of advancing in humanity and enlightenment he retrograded, and is therefore justly the subject of condemnation and contempt by the medical historian of his reign.

We heartily agree with the encomiums passed on Scot's work by the Rev. Joseph Hunter and Isaac D'Israeli, the former of whom wrote: "It is one of the few instances in which a bold spirit opposes himself to the popular belief, and seeks to throw protection over a class of the defenceless. In my opinion he ought to stand very prominent in any catalogue of persons who have been public benefactors." The latter asserted that "this singular work may justly claim the honour in this country of opening that glorious career which is dear to humanity and fatal to imposture." Professor Gairdner observes that Scot's production "stands brightly out amid the darkness of its own and the succeeding age, as a perfectly unique example of sagacity amounting to genius."

We have said enough, we hope, to induce those who have never read or even glanced at the work of a man who must ever be regarded with feelings of admiration and gratitude, and who was in advance both in knowledge and boldness of even the physicians of his day, to repair their neglect of so remarkable an author, and read him with the additional advantage of the excellent introduction and notes of Dr. Nicholson.

Great credit is due to the publisher, Mr. Elliot Stock, for the manner in which the work is issued. It is published by subscription, and only a few copies remain unsold.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

(Continued from p. 118).

Annales Médico-Psychologiques.

By T. W. McDowall, M.D., Morpeth.

Note upon Megalomania or Partial Lypemania with predominance of Grandiose Delirium. By Dr. Ach. Foville.

This paper goes over the same topics that are quite familiar to those at all acquainted with the interminable discussions connected with the nomenclature and classification of mental disease. There are brief notes of some fresh cases. The concluding paragraphs are as follows:

"The details which I have just given as to the pathogenesis and symptoms of megalomania, although very short, permit, it seems to me, a clearer knowledge of its nature, and enable us to determine its exact place in the list of mental diseases.

"Thirty or forty years ago it was, without hesitation, considered a distinct form of monomania; it was called the monomania of pride or ambition. Now-a-days this view no longer holds good; it is not a monomania, for the delirium is very complex, very extended; it is not a distinct vesania, a pathological entity by itself, for it forms part of another disease of which it is only a phase, an advanced stage of evolution.

"Megalomania belongs entirely to the history of partial lypemania, with predominance of hallucinations and ideas of persecution; it is the highest degree of insane systematising which the delusions of persecution attain.

"This nosological theory, already partly indicated by Morel, and distinctly formulated by myself twelve years ago, has been received favourably by the majority of French authors who, since that time, have had occasion to work at this subject."

Non-restraint. By Dr. Bécoulet.

It is a matter of surprise that this subject should still be so earnestly debated by our French colleagues. Those who have not already been converted to the system as seen in our asylums, will not be changed by any number of papers, no matter how fair, how temperate, how reasonable they are; nay, though one rose from the dead they would remain unmoved. Non-restraint, like every other system in this world, is not perfect, never will be perfect, and, so far as we know, no one was ever foolish enough to say that

it was perfect, and that through its use all accidents, dangers, troubles were to be banished from asylum management. As a practical method of treatment no true knowledge of it can be got from papers, discussions, and arguments. So be it understood it must be seen in use, and were we unfortunate enough to be present at a meeting where it was to be discussed, no power on earth would restrain us from flying to the door. It must be practised.

With Dr. Bécoulet's paper we have really no fault to find, except that it goes over well-trodden ground, and will probably fail to influence those who might derive some benefit from its very temperate conclusions. We, however, take exception to his statement that there are scarcely any epileptics in English public asylums, which is altogether erroneous; and we should feel highly flattered as a nation when we are told that our character is calmer and more easily amenable to discipline than that of the French.

Clinical Cases.

1. *Tumour of the Brain with Mental Derangement.*

The patient, æt. 23, a chair-maker, was admitted to the Saint Anne Asylum, under the care of Dr. Dagonet, in April, 1873. His history, as furnished by his father, was as follows:—No hereditary tendencies, no previous serious illness, habits steady. When aged 17 he fell on the head, was stunned for the moment, but there were no other immediate symptoms. During the war of 1870 he served as a mobile and suffered much from cold. It was after this campaign that he began to complain of violent pains in the head; then attacks of vertigo occurred, then, one after the other, paralysis of the right arm and leg, loss of sight, deafness. From the beginning of these symptoms, a little more than a year, a circumscribed swelling had been observed, limited to the posterior part of the scalp. At the same time the patient's character changed; he became irritable, mischievous, at last his mental symptoms necessitated his being placed in an asylum.

On examination there were found incomplete right hemiplegia, with marked diminution of sensibility; double amaurosis, deafness. In the median line and slightly posteriorly, there was a small, badly-defined prominence of the scalp, depressible and elastic in the centre, where pressure caused pain. Both discs atrophied; pupils unequal and both globes markedly protruded.

The mental symptoms call for no special attention; there were alternate quiet and excitement with delusions of persecution.

Towards the end of February, 1874, a very limpid serous fluid escaped by the nose, drop by drop. The pains in the head were very severe, and the patient became more feeble. On 29th March the nasal discharge became sanious; the patient was confined to bed. He died on 16th April, after being comatose for several days.

An incision carried through the cranial swelling disclosed a mass of semi-fluid matter, yellowish, mixed with pus; it was partly removed with the integument. On the under surface, towards the posterior third of the parietal suture, the bone was injected and spongy; in raising the skull-cap a fragment became detached; this fragment was really a small osseous tumour, in the substance of the dura-mater. On cutting this membrane, a large tumour came into view; it was adherent at, and around the point corresponding to the osseous fragment. The tumour rested on the parieto-occipital region of both hemispheres, though more upon the left, where it had hollowed out a pretty deep cavity. It was not adherent to the cerebral substance, which was a little softened superficially in the area of compression.

The tumour was the size of two fists, weighed 350 grammes, rounded and smooth on the surface; it was easily cut with a knife, the cut surface of a yellowish-white colour; no fluid escaped from it. Unfortunately no microscopical examination of its structure was made.

2. *Case of Double Consciousness.* By Dr. L. Camuset.

This patient was a young man affected with hystero-epilepsy, who completely lost all recollection of a year of his life. This long period of amnesia began with an attack of hystero-epilepsy in May, 1879, and ended in a similar, though very severe and prolonged attack in April, 1880.

The account of this case is long and minute, and gives an excellent description of this remarkable condition. As many such are now on record, we will content ourselves with reproducing the account of the hystero-epileptic attack.

First of all, the epileptic attack: the patient uttered a cry and fell; then tonic movements for some seconds; then clonic convulsions continuing the whole day and part of the night, with intervals of various length, during which the patient was comatose. The convulsions were extraordinarily severe; the legs, previously paralysed, were, like the arms, forcibly struck out in every direction. The trunk was raised in an arch and then so suddenly unbent, that the body rebounded by the shock, like the stroke of a fish's tail. He fell by chance either on the back or on the head. The face was distorted by horrible grimaces. Had he not been protected by placing mattresses on the floor and against the wall, the patient would certainly have killed himself.

Attempts were made to arrest the attack by compressing certain organs, the flanks, the testicles, but without result. It having been noticed that during the intervals moderate compression of the epigastrium caused a recurrence of the convulsions, attempts were made, by strongly compressing this region during the attack, to arrest it, but without result.

It was undoubted, however, that an aura existed, arising in the

region of the stomach. The patient had stated after previous attacks that when his illness seized him it ascended from the stomach. Besides, in the intervals between the actual attacks, it was only necessary to press slightly upon the stomach to cause the clonic convulsions to begin afresh. The eyes first filled with tears, then turned upwards, next the fingers closed slowly, and then the general attack recommenced. This phase of the disease continued till the middle of the night. The intervals of rest became closer in proportion as they became longer.

Next day the third stage appeared—the ecstatic. It continued almost twenty-four hours. The patient lay on his back; his face expressed intense contentment; his eyes were brilliant and looked up. From time to time the face brightened up; the patient smiled. When spoken to he did not answer; if one insisted by shaking him slightly, he smiled more, he laughed outright. Towards night, the laughter was spontaneous and more and more noisy. It was accompanied by hiccoughing, and occasionally by positive barking.

Medico-legal Cases.

Incendiarism. By Dr. G. Giraud.

In this review a number of instances of this perversion are given in more or less detail. Attention is very properly drawn to the fact that attempts at this crime are very frequently associated with the development of puberty.

Case 1.—A lad, aged 16. He is a typical example of mental weakness, with dangerous tendencies in one direction. The experts authorised to examine into his mental condition reported:—

1°. That G— had presented unmistakable signs of mental weakness from childhood.

2°. That the physical and mental disorders which he had presented before, during, and after the commission of the criminal acts of which he was accused, without being characteristic of a well-defined pathological condition, still indicate that in yielding to a morbid impulse he did not enjoy mental liberty, and that consequently he should not be considered responsible.

3°. That on account of the permanent danger there would be in allowing a person affected with this form of insanity to be at liberty, he should be confined in a lunatic asylum.

In little more than a fortnight he set places on fire sixteen times, often several times in the same day. Suspicion was attracted to him by the fact that he almost always gave the alarm and was present at all the fires. At first he denied, but ended by acknowledging that he set fire to the sheds, crops, &c. When asked as to his motives, he always answered that he did not know. He was 16 years of age, tall for his age, but rather feeble, being thin, pale, and anæmic. He complained of frontal headache. He answered

simple questions readily, but though he had been at school for five years, he could scarcely read or sign his name. His intelligence was decidedly limited, but he had some religious ideas, and he knew that it was wrong to kill, steal, &c. His appetite was irregular, he slept little, and his sleep was disturbed.

Case 2.—L. was accused of having caused four fires in his commune. He was 19 years of age, badly educated, and had been a farm labourer from boyhood. He acknowledged his guilt. He also admitted that he had caused eleven fires in a neighbouring commune, but he subsequently withdrew this statement and maintained his innocence.

The lad was evidently stupid, but nothing else could be said against him. At the age of 13-14 he appears to have had some transient mental derangement, for a former master stated that, "after a few days the lad exhibited signs of extravagance, which were considered fun, but they were renewed so often that it was concluded that he could not be in the enjoyment of his senses. He became remarkably excited when scolded for his conduct. He extended his arms, raised his eyes to heaven, sang some incoherent words, spoke of God, repeating some words from sermons which he had heard. During these attacks of excitement his eyes were wild. No wickedness. He did his work as cowherd well, but he had neither inclination nor aptitude for anything else. One day he took it into his head to take a plough to pieces which had been left in the field." Such attacks never returned. His intelligence developed somewhat, for he learned to drive the horses, to labour, to sow, to thresh, to make cider, &c.

The experts were unable to certify that he laboured under any form of mental or nervous disease, though they thought that the absence of all motive might raise a doubt as to the absolute integrity of his power of free will.

He was condemned to five years' penal servitude.

Case 3.—A girl, 17 years of age, made two small attempts at fire-raising. There was no positive evidence, but appearances were very much against her. In the end the prosecution was abandoned. At all kinds of manual household work she did well, but she had never been able to learn to read and write, although a schoolmaster's daughter. She alone of the whole family was in this condition. She could not be considered an idiot or an imbecile properly so-called, but her mental development and degree of responsibility did not agree with her age, but rather with a child of eight or ten.

Case 4.—An old man of 69 burnt his house down because of his destitution. He threatened to do so, and said that he would destroy himself or be arrested. There could be no doubt that he laboured under senile dementia; he was removed to an asylum, where he soon died.

Case 5.—A man, aged 34, was accused of setting fire to an

arbour and destroying trees in a pleasure garden, about a kilomètre from his own commune. He was found on the place when the fire occurred. He desired to revenge himself upon the proprietors, because he believed that they had improper relations with his wife and that they met in the summer-house. He did not regret what he had done, declaring that God would not call him to account for the act, and that he had only done his duty.

He lived badly with his wife, who had not the best of characters. In consequence he took to drink, and in the end his neighbours did not consider him right in his mind. Whilst under detention and observation his conversation and conduct were markedly insane. He remained in an asylum for a few months, when he improved so much that he was discharged.

A few other cases are given, but they need not be reproduced.

On Febrile Delirium in Lunatics.

At a meeting of the Société Médico-Psychologique Dr. Christian read the history of a case—a man who had been insane for many years, labouring under what may be called monomania of persecution. He fell ill of erysipelas and died. During his illness he became delirious, and it was noted that this delirium appeared to have no connection with his ordinary state of mental derangement.

The reading of this paper led to several of those present expressing their experience in the treatment of similar cases, and on the effect of intercurrent diseases generally on mental derangement. The remarks are, as a rule, interesting, but they need not be further noticed, as the total result was to admit that we do not yet understand the relations in such cases. In any given case of insanity we cannot foretell whether an intercurrent disease will intensify or diminish the mental symptoms, or whether it will assist or retard recovery.

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2. *American Retrospect.*

By D. Hack Tuke, F.R.C.P.

Proceedings at the Twelfth Annual Session of the National Conference of Charities and Correction held at Washington, D.C., June 4-10, 1885. Boston, 1885.

Among the papers read at this Conference eight are by experts in the Psychological Department of Medicine, and occupy more than 60 pages. Dr. Chapin, the Superintendent of the Penn. Hospital, Philadelphia, presents a report of the Committee on the Provision for the insane, in which it is stated that of the 92,000 insane persons in the United States 43,000 are not in asylums. Of Boards of State Charities it is held that their powers in respect to asylums should be limited to the examination and report of their condition and the investigation of abuses. The policy of committing

the responsibility of administration to such Boards is not wise. It is observed that whatever may be the objections to Local Boards entrusted with State Institutions, there are other largely compensating advantages in their favour. It is added that "Boards of State Charities" may exercise a wholesome oversight and supervision, observe the best methods, and urge their general adoption. Great satisfaction is expressed at the wide departures that have been made from former plans of asylum construction, as at Willard; Middletown; the open wards of the Government Asylum, Washington; the asylum at Kankakee; the Bancroft wards at the Concord Asylum; the "Cottage by the Sea," under the direction of the Friends' Asylum, Philadelphia; and the Mountain House connected with the Vermont Asylum. Such asylums as Kankakee have succeeded in showing that the cost of construction and the maintenance of patients may be considerably reduced, thus removing a great obstacle to the extension of State provision for the insane; while there has been an increase of personal liberty and a greater opportunity for the various occupations in which a community engages. Dr. Chapin makes this honourable acknowledgment:—"Candour compels us to acknowledge some of the results have been aided by fair and wholesome criticism, which has furnished moral support to bring about changes as well as incentment to devise ways for improvement. It is an unfortunate error to cultivate an opinion that any human work is perfect or cannot be improved." He advocates for the accommodation of bed-ridden patients, feeble dements, and epileptics, large associated dormitories (like our Caterham and Leavesden), with an efficient staff of night attendants, or a total separate building one storey in height, comprising a day-room or ward, and a dormitory with a few adjoining single rooms. Of the patients at Willard, 10 per cent. were of the class suited for this arrangement.

Dr. Godding contributes a paper on "Asylum Construction," the whole of which is well worth reading. In constructing an asylum for 1,000 lunatics, he estimates that 7 per cent. of the male patients will need infirmary care, 3 per cent. will be halt and blind, 5 per cent. convalescent, 5 per cent. epileptic, 5 per cent. very noisy, 5 per cent. considerably disturbed, 5 per cent. depressed and suicidal, 5 per cent. especially dangerous, and 10 per cent. careless and untidy. The remaining 50 per cent. will be comparatively quiet. Seven-eighths of the whole will be chronic cases. Altogether he reckons eight classes which require special conditions in construction.

We have been interested in the contribution from Dr. Vivian, of Mineral Point, Wisconsin, a member of the Board of Charities for that State. It is a temperate but forcible defence of the system pursued in Wisconsin: "So satisfactory has been the result of this experiment (so-called) that no more large institutions will be built

in Wisconsin; and if one of our present hospitals should be burned down, it is not probable that it would be rebuilt. The citizens of that State are satisfied that one of their hospitals has capacity for all the insane that are amenable to medical treatment, and that the chronic insane can be better and more cheaply cared for in the County Asylums." The cost of the buildings, including the administration building, varies from £26 to £75 per patient, exclusive of furniture. The cost of the State buildings is five times as much. The cost of maintenance, including salaries, and exclusive of the product of the farm, averages about 7s. 3d. a week, the cost in the State Asylums being about 16s. However, Dr. Vivian is alive to the dangers attending the County Asylum system and the absolute necessity of unceasing supervision.

Professor Hitchcock has an interesting paper, entitled "What the College may do to prevent Insanity," which contains some excellent observations, fully in accordance with the article on the recent Matriculation at the London University in the last number of this Journal. "Is it the highest type of mental solidity and growth to cram and unload as fast as the vocal organs can be made to articulate? Thoughts are not punched out as are the coins in a mint; but if worthy of anything more than a meteor shows, they are worked out by a slow process of crude production and careful manipulation, slowly turning them from side to side, laying them away on the shelf of reflection, and then over and again taking them down and recasting them, until they are garnished and polished." The writer concludes that "the College may possibly do something to check insanity by so arranging its courses of study that the reflective processes, the calm and slow reasoning methods, shall have a larger place in the development of young men." Unfortunately, however, as Professor Hitchcock sorrowfully admits, the "College of to-day excites, to say the least, a tendency to mental unsoundness." The same lamentable result is produced, as was shown in the article which appeared in our last number, by the system of examination pursued by the London University.

Dr. Gundry, the superintendent of the Maryland Hospital for the insane, has a very interesting paper on "Non-Restraint," which he warmly advocates. He observes that it "substitutes tact for force. It leads to forbearance in the adjustment of the patient and his environment, instead of exacting an unthinking compliance with arbitrary regulations. It does not wound the self-respect of the patient, nor blunt the sympathy of those around him. It modifies the feelings of all concerned, and promotes a mutual feeling of trust and better qualities of our common nature." Again, he says, "After more than eight years' careful trial of non-restraint in the treatment of the insane, I am convinced of its practicability, its expediency, and its beneficial results. Every day increases my appreciation of its merits."

"The Care of the Insane at Home and Abroad" is a valuable paper by Dr. Goldsmith, now superintendent of the Butler Hospital, Providence, Rhode Island. It scarcely admits of quotation, and we would therefore refer our readers to the paper itself, which has been reprinted in a separate form.

Dr. Stephen Smith, State Commissioner of Lunacy, New York, contributes a practical paper on the "Care of the Filthy Classes of the Insane," in which he suggests that State asylums should have separate buildings constructed with special reference to their care, with facilities for bathing and cleansing the patients. He further advocates the organization by county asylums of a night service for filthy patients, maintained with well-qualified attendants. Dr. Smith contrasts the present condition of asylums in which a night service for this class has been instituted with the former condition of the same asylums, when none such was adopted. The system carried out is simply that so strongly insisted upon by the late Mr. Gaskell. We are very glad that Dr. Smith has brought forward this important subject before the Conference.

The last paper of this series is entitled "Insanity and Lunacy Laws," by Dr. Fletcher, superintendent of the Indiana Insane Asylum. Among good suggestive remarks is the following:—"I know of no one thing which this Conference could do that would so largely aid in the treatment of the insane as the encouragement of the establishment of a National School for the training of attendants who have taken as a life vocation the care of the insane."

The succeeding section in these proceedings is occupied with two papers on the provision for idiots, by Dr. Kerlin and Mr. Richards, but our space will not allow of quotations from these instructive communications.

International Record of Charities and Correction. Edited by Frederick Howard Wines. G. P. Putnam's Sons, New York and London. One dollar per annum.

We are glad to welcome this new journal, of which the first number appeared in March, and is to be continued monthly. The name of the editor is a guarantee that it will be conducted with energy and ability, and, moreover, with impartiality. Mr. Wines has been for sixteen years the secretary of the Illinois Board of State Commissioners of Public Charities, and was the special agent of the Tenth Census of the United States. It is devoted to the interests of the officers and managers of public and private charitable and reformatory institutions and associations, but not only so; it will be found to have a claim on all interested in the elevation of mankind. The numbers which have been forwarded to us contain much interesting matter, and cannot fail to be useful. We heartily wish it success.

At the April meeting of the Society of Medical Jurisprudence and State Medicine, held at the Academy of Medicine in New York City, Dr. Spitzka opened a discussion on the "Legal Definition of Insanity," as follows:—

* * * * * *

I have always entertained the view that the law has not alone the right, but the duty, to set up standards by which the rules of human action are to be judged, even though these standards appear arbitrary to physicians and metaphysicians. But for the law to set up an arbitrary definition *within* the domain of Medical Science, is clearly an encroachment. The law should limit itself to defining criminal responsibility, morbid influence, civil capacity, and such other conditions which the physician has no more right to attempt moulding to exclusively medical theories than the lawyer is entitled to force a scientific term into the Procrustean bed of the requirements of Civil and Criminal Practice. In some lines on this matter addressed to physicians, I have ventured to caution them against ever attempting to define insanity as a legal conception. A physician is never called upon to certify to a railroad injury in a legal as distinguished from a medical sense; there is no contagious disease which has a different name in law than in medicine, and indeed I feel inclined to challenge proof that any fact in science can be declared a fiction in law in one and the same breath. I know of one, and but one medical writer of eminence, who holds opposite ground, and, as usual with him, he demonstrates his position by an exceedingly vigorous illustration. Dr. Hammond holds that the law has a perfect right to construe a legal definition of insanity, just as he maintains it to have a perfect right to assert that a whale is a fish, notwithstanding that science classifies the leviathan of the deep as a warm-blooded animal. I am willing to admit that if the right be conceded the law to define the whale as a fish, because when they framed the common law according to which the Queen had a right to his bone, and the lord of the manor where the animal was cast ashore, to his tail, they knew very little about zoology; if it be permitted to adhere to such a definition in opposition to the concurrent testimony of scientists and whalers, if it be encouraged to perpetuate an absurdity on the statute book which a school-boy would blush to utter, that then I am wrong, and that the law has a perfect right to set up definitions of insanity which seemed antiquated even to mediæval physicians.

Let lawyers entrust the strictly medical task of determining what acts, declarations, and physical signs occur among the insane, as manifestations of insanity, to physicians; let them accept the definitions, limitations, and the classifications of insanity at the hands of those to whom the unanimous voice of civilized mankind has entrusted the custody and treatment of the insane. Then let the wise heads of their profession apply the results of medical observation to the practical needs of society, just as it applies the

results of arts and sciences generally to the intercourse of mankind in its great and complete task of prohibiting what is hurtful, and enjoining what is beneficial to the common welfare. It is the aim of civilized society to be humane; if insanity be considered a misfortune, and it be shown that the escape of the exceptional criminal who can truthfully plead insanity does not exercise a pernicious influence in the way of encouraging crime, then the law may elect to regard insanity and irresponsibility as practically convertible terms. But if it were apprehended that the medical definition of insanity covered so wide a ground that to admit it as a bar to punishment would hamper the administration of justice, and reduce that certainty of retributive penalty which is the chief protection of society, I do not see how any utilitarian philosopher can object to such limitations being made as will ensure the safety and happiness of the sound and productive part of the community at the expense of some part of the defective and burdensome classes.

I suppose that others, particularly on the legal side of the house, will enlighten you as to the various definitions which have from time to time been framed in the codes, or delivered from the bench. The few opinions which I shall cite are submitted more for the purpose of showing that the lack of unanimity among alienists referred to in the question before us is fully paralleled among the interpreters of the law. Medical men are frequently reminded that "doctors disagree," but I remember a distinguished judge who, in speaking of the uncertainties of the law, dwelt at some length on the case of a gentleman who had been on the losing side so often that he had come to look on courts and juries in a hopeless way. But on one occasion he assured his friends that he had finally gotten into a position in which he was sure to be sustained by the law, as it could not help, from the nature of the case, but be right in taking one horn of a dilemma. The fact was, that his wife sued for divorce on the ground that he was and had been impotent for years, while the servant girl sued him for bastardy. However he was wrong, for he lost both cases.

In his testimony before the Select Committee on the Homicide Bill, Lord Justice Bramwell declared *verbatim et literatim* as follows:—"I think that although the present law lays down such a definition of madness that nobody is hardly ever really mad enough to be within it, yet it is a logical and good definition." I believe there are few lawyers in this room who would agree with this opinion, and none who would express it in exactly such terms. In welcome contrast is the declaration of the Lord Chief Justice of England, who, in a criticism on one of the plans for codifying the law of insanity which grew out of the McNaughten case, said:—"As the law, as expounded by the judges in the House of Lords, now stands, it is only when mental disease produces incapacity to distinguish between right and wrong, that immunity from the penal consequences of crime is admitted. The present Bill intro-

duces a new element, the absence of the power of self-control. I concur most heartily in the proposed alterations of the law, having been always strongly of opinion that, as the pathology of insanity abundantly establishes, there are forms of mental disease in which, though the patient is quite aware he is about to do wrong, the will becomes overpowered by the force of irresistible impulse; the power of self-control, when destroyed or suspended by mental disease, becomes, I think, an essential element of responsibility."

And in his testimony before the same committee before which Lord Justice Bramwell made the singular declaration alluded to, Lord Justice Blackburn said:—"On the question of what amounts to insanity that would prevent a person being punishable or not, I have read every definition which I could meet with, and never was satisfied with one of them, and have endeavoured in vain to make one myself. I verily believe it is not in human power to do it. You must take it that in every individual case you must look at the circumstances, and do the best you can to say whether it was the disease of the mind which was the cause of the crime, or the party's criminal will."

It is really singular that, after this deliberate and philosophical opinion in conservative England, there should, in the bosom of a Society where lawyers and physicians were once in the habit of meeting, and in this progressive city and decade, pass unchallenged the statement of a legal writer, R. S. Guernsey, who says: "As to the rule above stated and illustrated, should the question of *sanity* and *insanity* of a person be passed on exclusively by physicians? This question may best be answered by inquiring into the *standard* by which the subject is to be measured. *That standard must be the average man, and hence what we may call common sense—that is a due regard to the usual institutions and habits of mankind.*" A little further on we are enlightened as to the drift of this declaration by these words: "There is no question that arises in the administration of the law where expert testimony may be less necessary, and where it should be less controlling on the jury, and where the common observation and experience of man should prevail over all theory, than in cases of alleged insanity."

That kind of common sense to which this writer refers, and which he appears to regard as an ideal, evidently attempted to be attained by himself, has a dangerous resemblance to the "common sense" displayed by Sir Matthew Hale when, in summing up against two witches, he said that he had not the least doubt that there were witches, "first, because the Scriptures affirmed it; secondly, because the wisdom of all nations, particularly our own, had provided laws against witchcraft, which implied their belief in such a crime." Such opinions I can understand the development of in an atmosphere of a dusty closet filled with antiquated folios. Actual contact with the subject about which the writer argues

with such refreshing positiveness would prove the only corrective. Unfortunately that corrective is not always as efficiently administered as in the case of a judge of the Brooklyn City Court, who had a man charged with being insane brought before him about a year ago. On hearing a voluble and connected narrative from the accused, he decided that he was not insane. Then, referring to the logical manner in which the prisoner explained that he had stolen a ride in a milk waggon to get from Hoboken to Brooklyn, he waxed quite eloquent over the absurdity of the expressed opinion that the man was insane, and ordered the clerk to make out the discharge papers. The prisoner then raised his voice in praise of the enlightened judge; from declamation he passed to yelling, and soon there was the spectacle of a violent maniac flying around the court-room. The judge became alarmed, and hurried up his commitment to the nearest asylum. "Common sense" of ten minutes before *versus* "common sense" of then; just as common sense declared the man a lunatic adventurer who suggested that the earth was round centuries ago, and to-day would declare something very near the lunatic the man who, with Kosmos Indicopleustes, would venture to declare the earth flat.

It is due, I think, to an unconsciously fostered tradition that lawyers and judges, who would consider themselves presumptous if they ventured to decide what broken legs, kidney troubles, and eye or ear diseases are, do not hesitate to assume the position of critics and even of experts in the most subtle and difficult branch of medical science. That tradition was practically overthrown in the memorable contest between the immortal Kant and his fellow-townsman Dr. Metzger; the former maintained that the determining of mental states in courts of law is the province of mental philosophy; the latter claimed it for his own profession, and gained the day over him who was perhaps the greatest thinker of his nation. It was under the inspiration engendered by this great contest that Hoffbauer's Treatise on the Medical Jurisprudence of Insanity was written. Much harm has been done, too, by the Anglo-Saxon vice of following precedents. It so happened that when Erskine defended Hatfield, who shot at the King in Drury Lane Theatre, delusion was proven to exist on the part of the accused. In his great plea Erskine concentrated his reasoning on *this* particular point, and so eloquently argued out the *dictum* of John Locke that "delusion is the test of insanity" as to tincture the minds of whole generations of lawyers and even of physicians with this notion, so that more than one now in this room has been stared at with surprise if not indirectly held up to ridicule for declaring that delusion is not necessary to constitute insanity. Those who fall back on Erskine's interpretation seem to forget that he was making his plea for Hatfield, and not for the insane at large. He made the most of his case. It was his object to save his client, not to vindicate scientific definitions. All who have even

a limited familiarity with the insane have gathered the experience of Pinel expressed in these words: "One may have the greatest admiration for Locke, and yet confess that the ideas he gives of insanity are very incomplete when he regards it as inseparable from delusion. I thought myself like this author when I resumed my researches at the Bicêtre, and I was not a little surprised to find numerous insane who never at any time showed a lesion of the understanding, and who were dominated by a sort of furor, as if the affective faculties were alone involved."

As I understand the question, it is so framed that we are excluded from discussing such subjects as the definition of responsibility and punishability of the insane, or the determination of their testamentary and other contract capacity. Nor do I believe it would be proper to drag in the medical definitions of insanity except in so far as they have been deliberately coined for use in courts of law. I have sometimes ventured to think that a very fair way of interpreting the relations between the medical definition of insanity and the legal interpretation of civil and criminal responsibility would be the asking of this question: "Is the subject of this inquiry suffering from a mental disorder which would justify physicians in committing him to, and restraining him in an asylum?" I believe that some such test of insane irresponsibility is the one lawyers, with a justifiable desire for tangible formulas, are in search of. Certainly the sense of society at large seems to regard the person insane enough to be restrained of his liberty as insane enough not to be held criminally accountable, and insane enough to have the burden of proof that he is competent to perform civil acts thrown on those who defend it. But it is not in the power of medical science to clothe such a conception in exact and concise English. The law has the advantage of medicine in every way here. It must be and can be more exact, dealing as it does with human and artificial institutions. Many of the legal definitions of responsibility are expressed in clear and unmistakable terms. If we are to judge of the desirability or need of a project by its success, the palm must be awarded to those legal authors who have limited themselves to defining legal conceptions, and no progress has been made in any State where lawyers have wandered away from the legal domain, and instead of developing and elaborating legal tests have blundered (for I can call it nothing else) into metaphysical disquisitions. All such, unless associated with actual contact and experience with the insane, are as barren of result as the writings of those old controversialists whose tomes lie mouldering on the remote and higher shelves of our theological libraries.

It is nothing less than the non-expert badgering to which physicians have been compelled to submit, after they had been entrapped into defining insanity for legal purposes, that could, I will

not say excuse, but palliate Doctor Sheppard when, in his work on lunacy, he advises physicians to define insanity as a "disease of the neurine batteries of the brain," with the express intent to "puzzle the lawyers!" I know of an instance where this definition was used by the leading alienist of St. Louis, with precisely this object, and the cross-examiner "failed to come up to time" in consequence. But it is much more dignified, I think, and runs more in the direction of enlightenment, for the medical witness to admit that he cannot pretend to give an exact definition, and then to offer an approximate one. The brief and easily remembered one which I employ is that "it is a term applied to certain results of brain-disease and brain-defect which invalidate mental integrity." I once had the ambition to frame an exhaustive definition, but you will appreciate my not inflicting it on you when I add that, in order to shut off every source of ambiguity, I had to insert as many clauses as there are links in a tapeworm, that it contains one hundred and twenty-four words, and that it is only in particularly favourable moods that I can remember even half of them myself. I heartily subscribe the *dictum*, which I think originated among the legal fraternity, *omne definitivum periculosum est.*

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3. *German Retrospect.*

By William W. Ireland, M.D.

Aphasia with loss of an ear for Music.

Dr. A. Kast ("Aerztl. Intelligenzblatt," No. 44, 1885, quoted in the "Centralblatt für Nervenheilkunde," No. 2, 1886) has given a curious case of loss of the power of speech, and injury to the musical faculty.

A country lad, 15 years of age, was thrown from a waggon, and in falling struck his head against the wheel. He lost consciousness, and awakened several hours afterwards paralysed on the right side, and unable to speak a word, but he could understand what was said to him. The power of the right leg returned partially after two weeks, and after three weeks he was able to speak some words. On being taken into the hospital at Freiburg, two months after, there were still some remains of the hemiplegia, and motor aphasia, though he could already repeat some words said to him. He could only partially understand writing. Before the accident the patient had been a prominent member of a choral society; but now he found that though the melody was always rightly given, the tone was incorrect, and there were false intervals. Dr. Kast found that he could not even correctly follow another person in singing. After two years' interval Dr. Kast found that the lad could pronounce very few more words, and the

musical deficiency had become greater, for though he could keep up the tone of songs pretty correctly when they had previously been sung to him, when left alone he sang false. The musical ear was pretty good, as he could distinguish the smallest deviation from a true chord. Dr. Kast wishes to distinguish between the motor and sensory faculty in music as in speech, and their connection with particular parts of the brain. One of these capacities may be lost without the other. He recommends that a careful inquiry should be made into the musical capacity of aphasics in order to clear up many questions in the psychology of music and the relation of this faculty to the brain. In neither of the reports of his paper are we told whether there was any injury to the mental capacity of the patient.

Sensory Aphasia.

We take from the "Neurologisches Centralblatt" (No. 12, 1885) a report extracted from the "Berlin Klin. Wochenschrift" (Nos. 17 and 18) of two cases observed in the Klinik of Professor Kussmaul. A woman of 63, admitted with furunculus in the right auditory meatus, and erysipelas of the face, died of bleeding into the intestines. On examination there was found wanting about one half of the left temporal lobe. This deficiency included the top and under portion of the anterior part of the first temporal gyrus, and almost the whole of the anterior part of the second, and the whole of the third temporal, and the end of the second occipital convolution. On microscopic examination Dr. Stilling found that the posterior half of the first temporal gyrus was intact. In front some of the cortex remained, but the nerve fibres below showed undoubted marks of degeneration. The second temporal gyrus, which remained, showed no microscopic change. The patient could hear quite well, especially through the left ear, for the right one had been completely shut by the furunculus. She read letters and newspapers, and spoke German and French fluently. Nothing was remarked of her mental condition, save that for the last two years her character had changed. She was selfish and quarrelsome. It was thought that the deficiency must have been of old date, perhaps going back to a severe illness which she had in her 20th year. Thus the greater part of the left temporo-sphenoidal lobe, including the half of the Wernicke's sensory speech-centre, was lost in a right-handed person, without either the comprehension or the utterance of words or the power of hearing in either ear, being injured.

Kussmaul gives another case, a man of sixty years of age, who died of empyema after being for a fortnight in the hospital at Strasburg. The patient appeared of feeble intellect, but could understand what was said to him within the bounds of his capacity. On examination there was found an old standing deficiency

implicating almost the whole of the lower surfaces of the right occipital and temporal lobes, the whole third and a small piece in the middle of the second temporal convolution, the whole of the gyrus occipito-temporalis lateralis, and the posterior part of the gyrus uncinatus. The grey matter of the gyrus occipito-temporalis medius was thrown out of function by the atrophy of the underlying white fibres. On the left side of the outer part of the ganglion lenticularis and of the posterior cornu of the ventricle there was a softened spot. It appeared that in 1854 he had meningitis, and ten years after violent headaches, when the limbs were partially paralysed, especially on the left. The left hand was quite useless, and he could not write with the right hand. He recovered in some months, but was always stiff in the left leg, and never regained the power of writing well. From 1872 to 1878 he filled a situation in an insurance office. The only permanent deficiency seems the power of blowing the flute, which he lost after 1862. Thus after a destructive lesion to a wide area of the brain, which is put down as purely sensory, the only permanent functional injury was of a motor character, with a loss of intelligence!

Motor Disturbances in Insanity.

Dr. Roller confines his attention to those movements which, if not under the control of the will, are at least accompanied by consciousness. This separates them from the involuntary motions of hysteria, epilepsy, and chorea. The character of the motions in insanity has, he observes, seldom been carefully examined. Dr. Roller's own paper occupies 60 pages of the "Zeitschrift" (xxxii. Band, erstes Heft), and after mentioning the disturbances of the voice in insanity, purposeless talking, and repetition of words, he considers these paroxysms of restlessness which form such a striking symptom in mania. Some of these motions may be owing to an irritated condition of the motor centres. Meynert regards the inclination to movement in mania as often owing to hallucinations of the muscular sense.

Dr. Roller quotes a remark of Baillarger: "The more I see of these things, the more I am convinced that one must seek the point of departure of all mental derangement in an involuntary exercise of the faculties. Often the insane have the consciousness of this domination which subdues their will. They are caught by a series of ideas which one by one possess the mind for a moment." Roller gives the following as an example. A woman suffering under maniacal excitement and hallucinations of hearing possesses in a high degree the susceptibility to sensory impressions and the desire to seize upon what attracts her notice. She grasps the things which she sees, especially clutching at shining objects. Some one pulls out his watch in her presence;

she immediately snatches at it, crying out: "That is my husband's watch." Dr. Roller asks: "What is the origin of this sudden delusion and abrupt action? Which idea came first? Was the notion that the watch belonged to her husband the cause of her clutching at it? or was she attracted by the simple childlike desire to seize the watch, and the idea that it was her husband's watch came after her action to possess herself of it?"

In accordance with Darwin's axiom that the repression of the emotions tends to diminish their power, Dr. Roller holds that in acute cases motor action in no way quiets the excitement. On the contrary, he remarks that with many excited patients yielding to their motor impulses only heightens the excitement. Violent muscular activity may cause exhaustion, but not a healthy weariness. In physiological life exhaustion does not tranquillize, but rather conduces to nervous irritability. This may be owing in some measure to the products of exhaustion in the blood.

It seems to me that the actions to which the excited patient gives way do often augment the irritation, but not always, and where weariness does good it acts by causing somnolence. It is the sleep which quiets. Dr. Roller observes that isolation often brings rest. He tries to keep his excited patients in bed, inducing them again and again to lie down after they have started up.

Traumatic Insanity.

Dr. Hartmann has collected ("Archiv," xv. Band, 1 Heft)—from his own observations and the description of others—138 cases of insanity following injuries to the head. Such a result is not so common as one might have expected. Schlager found that among 500 patients scarcely 10 per cent. were affected with traumatic insanity; and Krafft-Ebing, amongst 462 cases, found little more than 1 per cent. Then, again, there are generally concurrent causes. In fact, injuries to the head rarely cause insanity, save when there is a predisposition, or the condition of the patient is unfavourable for quick recovery. The injuries to the head, which were stated to be the causes of insanity, were generally of a severe character, inducing in half the cases analysed complete loss of consciousness. Between the insanity and the injury there was, in most cases, a period of greater or lesser duration, in which the patient suffered from irritability of the brain. Where the insanity followed it generally came on within three years. One of the most constant symptoms following the injury to the brain is a disposition to be easily affected by spirituous liquors. There was also increased sensibility to painful emotions. Among other affections were hyperæsthesia of the retina, amblyopia, amaurosis, scotoma, sounds in the ears, difficulty of hearing, strabismus, double vision, inequality of vision, headaches, weakness of

the extremities, sometimes loss of speech, and giddiness. The character is often changed: the patient is irritable, unsteady, and fond of wandering about. There is no characteristic type of traumatic insanity, but mania is more common than melancholia. Sometimes it appears in the form of primary dementia; sometimes in the different forms of melancholia; sometimes the injury entails a condition of mental weakness or fatuity. Delusions and hallucinations are not uncommon. Schüle and Bergmann noticed that injuries to the head were not unfrequently assigned as causes of general paralysis. The following case is from the author's own experience. A gunner got a kick from a horse in the left occiput. There was a severe concussion with exposure of the skull and wound of the brain. The man was carried away insensible, but soon raised himself, and began to rage and shriek and to strike himself, so that he could scarcely be overpowered by four men. Vomiting took place several times, and epileptic convulsions twice, with gyration of the head to the left. The attack lasted for several hours, during which he gradually got weaker. Next day there was still some disturbance, later on there was complete forgetfulness of what had happened to him. He recovered after extraction of a splinter of bone.

Dr. Hartmann gives a *résumé* of his inquiries, which embraces 14 conclusions, out of which we give three. The primary traumatic psychosis follows immediately upon the commotion caused by the injury. It forms either the weakened continuation of the disturbance to the functions of the brain or the reaction against the injury. It appears in the form of primary mania, either periodic or continuous, and is often accompanied by convulsions. At the same time there are frequently motor and sensory disturbances especially affecting the organs of sense.

W. W. I.

We have briefly referred in our "Reviews" to a book written by Dr. Kraepelin, entitled a "Compendium der Psychiatrie," but reserved for this section a fuller abstract of its contents. Our object is to put the reader in possession of German classifications, employing, as we proceed, the most important definitions of the writer in his own words, or nearly so. It is a fact that English students of medical psychology frequently find it difficult to obtain readily the information which they seek in this matter.

The author gives seven great groups of mental disorder, namely —(1) Depression; (2) Semi-Consciousness or Stupor; (3) Excitement; (4) Periodical Psychoses; (5) Primary Verrücktheit; (6) Paralytic Dementia, or progressive paralysis of the insane; (7) Weak-Mindedness. Under the first heading we have simple melancholia, and melancholia with delusions; the second division, rather an unusual grouping, comprises morbid states of sleep, as hypnotism, somnambulism, and what the Germans call *Schlaf-*

trunkenheit, or that condition in which on awaking from deep sleep a person remains for a longer or shorter time in an intermediate stage of mental confusion and imperfect perception of the outer world. Intoxication often favours this occurrence, and in some instances the individual is epileptic. The next sub-class is that of genuinely epileptic and hysterical states of semi-consciousness, the most accentuated form being that of epileptic stupor. Then comes the sub-class of stupor and ecstasy, with the synonym, melancholia attonita or *cum stupore*. Under this head falls catalepsy (Starrsucht). The last, or fourth sub-division, is acute dementia, and involves the most complete depression of psychical function. Its pathological basis is exhaustion of the brain, and may be caused by loss of blood, the puerperal condition, severe bodily illness, especially typhus fever, insufficient nutrition, intellectual or emotional strain. Unstable inheritance and youth are powerful predisposing causes. This condition, while resembling stupor, differs from it in exhibiting a minimum amount of mental activity. The author points out that the distinguishing characteristic of this, as contrasted with melancholia *cum stupore*, lies in this: that in the former the whole psychical activity has sunk to a minimum, while in the latter it is only its expression which is inhibited. The perception of the outer world is almost suspended, the course of thought arrested; there is complete apathy, and no motive for action remains. As with the patient in melancholia with stupor, the patient does not react to external influences, never speaks, while his expression is dull and vacant, and he has no backbone; he offers no opposition to any manipulation; there are no spontaneous movements; he requires to be dressed like a child; he has to be led to the closet, washed, and put to bed; he is dirty if not attended to, and allows the saliva to trickle down from his mouth. The temperature is subnormal; the pupils are dilated, and react slowly; while sensibility and reflex action are strikingly diminished. Such a patient may display excitement of a confused character, in which he speaks some coherent words, not understood by himself, or dances about the room; but all is done without any deep feeling, which, the author points out, distinguishes the excitement of acute dementia from the impulsive violence of patients labouring under *melancholia cum stupore*. The differential diagnosis of acute dementia from secondary states of profound apathetic dementia depends entirely upon the previous history and the course of the affection; it is rendered certain by the occurrence of remissions. From stupor it is principally distinguished by the complete absence of indications of mental tension, such as the facial expression, passive resistance, and explosive violence (p. 232).

Nothing could more clearly show the difficulty of distinguishing so-called acute dementia and melancholy with stupor than part of the description of the ecstatic form of the latter. Here

the perception of the outer world is quite veiled by the intense and overpowering fancies which oppress the whole consciousness, but their character is not painful or depressing, but very agreeable; the patient sees the Almighty and the angels, and feels himself in heaven. During this condition the patient is regardless of his surroundings; with wide-open eyes and fanatical expression, looking heavenwards, he remains motionless on his knees without making any response to questions. The muscles are not strongly contracted. The patient allows himself sometimes to be led quite automatically; in other cases he answers every interruption by an angry attempt to withdraw himself from the external interference. Such conditions are generally only of short duration, rarely longer than a few days, but frequently return, especially in the night. They are analogous to those mental states which arise from poison, especially opium, prolonged fasting, as well as after excessive bleeding. No peculiar treatment is required on account of its rapid disappearance. More or less marked symptoms of stupor and ecstasy are met with in many forms of delirium from severe bodily illness. Especially are those forms of delirium very unfavourable in their prognosis which arise from great exhaustion of the brain. Still deeper is the condition in the so-called coma vigil, a condition of profound stupefaction from which the patient can only be aroused by powerful external stimuli. The course of thought is at a standstill, the consciousness is filled only with obscure indefinite mental images, under which imperfect common feelings may play the most prominent part. It cannot be said with absolute certainty whether there is a condition of life preserved in the patient in whom a transformation of brain function into mental processes no longer takes place—in other words, whether the consciousness is really fully lost. We have anyhow to do, in the symptoms of progressive paralysis and coma, &c., with those morbid conditions in which the signs of psychical activity are wanting, and therefore most probably consciousness no more exists.

Under the third head—conditions of mental excitement—we have, first, active melancholia. Doubtless, this may occur in the course of other mental affections, as, for instance, in primary Verrücktheit; but there, as a rule, the anguish or fear does not form the basis of the disorder, but is the consequence of delusions or hallucinations. Secondly, mania, the foundation of which is the abnormal vividness of the thoughts or imagination, and the transition of the central excitement into acts. The mildest form of mania has been designated by Mendel "hypomania," in his Monograph published in 1881, in which there is always the loss of an internal cohesion of ideas and the inability to pursue a logical train of thought. The next sub-class is that of acute delirious mania, in which there is marked disorder of the perceptions, which bears no relation to the strength of the morbid affections.

There is a certain dreamlike confusion and loss of connection of ideas, along with illusions and hallucinations, and a defect in the power of judgment which brings this form of disorder into near relationship with the semi-conscious states of a former group, only the presence of intense motor excitement is generally a marked feature. The first stage of febrile delirium is marked by a certain restlessness, mental excitement, susceptibility to powerful sensory impressions, and disturbance of sleep in consequence of vivid and often painful dreams; in the second stage the mind is more disordered, perception is perverted by illusions, and more rarely by hallucinations, and ideas assume great intensity. Expansive ideas increase until the height of the third degree of the disorder is reached, and the confused chain of ideas (ideenjagd), and often furious movements occur. Exhaustion, involving symptoms of palsy, passing into stupor and uncertainty of movements, constitutes the fourth stage of febrile insanity. The temperature is high, and the condition of the brain is considered by the author to be hyperæmic. Alcoholic delirium, or delirium tremens, is next described, but need not be noticed further. We pass on to the fourth grand group—Periodical Psychoses—which embrace periodical mania, periodical melancholia, and circular insanity. Under "periodical mania" Dr. Kraepelin includes dipsomania, defined as the uncontrollable propensity to indulge in alcoholic drinks. In periodical melancholia, which is by far less frequent than the maniacal form, there are most frequently delusions, hallucinations, and suicidal propensity, along with intense mental anguish followed by slighter degrees of melancholy in the periodical return.

Circular insanity is characterised by periodical oscillations between mania and melancholia, which follow one another, but are separated from one another by a comparatively lucid interval. Generally a low and high state form together an attack alternating with remissions. More rarely is the reverse sequence the course of symptoms, as also the interpellation of an interval between each phase of the paroxysm. As a rule a melancholy stage precedes the attack—usually simple mental depression.

The fifth division is that of primary "Verrücktheit" which may be regarded as the pet division of German nosologists, and therefore deserves to be clearly defined, more especially as it is constantly misinterpreted. The author defines it as a chronic deeply-seated loss of mental personality which makes itself known primarily in a morbid apprehension of the operation of external and internal influences. Chronicity marks this disorder as a rule, because it has its root not in transient disorder, nor in a process which will pass over, but in an abnormal condition of the entire psycho-physical organism. The clearness of the consciousness is undisturbed. The power of thinking is fully preserved, but the material of thought is falsified through the manifold subjective elements, and is manufactured into a morbid,

distorted, deranged (verrückt) mode of viewing things in the patient's environment and in his personality. It is therefore usual to regard as the characteristic symptom of "Verrücktheit," a fixed delusion firmly and persistently held by the patient, or still better a whole system of such delusions. The distortion of the perception and consciousness as such is a specially frequent symptom; as the "Verrücktheit" becomes marked, so is the circumstance that this distortion is not corrected, although the consciousness is clear and intellectual work is not disturbed through the affection itself, overpowering as the morbid feeling is. The disorder has consequently here seized upon the highest mental functions, for the *fixed delusion* is no isolated pathological symptom like a sensory hallucination—a motiveless disturbance—but is the infallible sign of a persistent fundamental incapacity (Unzulänglichkeit) of the whole intellectual being.

This foundation of the weakness, upon which alone this form of alienation can attain to perfection in its production, is either *primary* and congenital (originäre Verrücktheit), or it is gradually acquired in the course of individual development; or it is a stage from another psychical disorder (*secondary* Verrücktheit). The old German psychiatry knew only this last form, and sought to place all fixed delusions (Wahnsysteme) as survivals of a previous mania or melancholia. Now we have learnt to recognise *primary* Verrücktheit as particularly frequent and complex (formenreiche), which makes its appearance before the secondary form through a succession of clinical peculiarities.

In *primary* "Verrücktheit" the form of the disorder is governed by the insane current of ideas which morbidly distort the understanding of the relation between the individual and his surroundings. The healthy perception is in the highest degree perverted through hallucinations of all kinds as well as through the subjective interpretation of normal impressions; the disposition and conduct are guided into abnormal paths through the influence of delusions. The origin of the delusions may be effected principally in two distinct ways, through the operation of hallucinations or in the form of so-called primordial mental derangement. There are doubtful cases in which hallucinations, mainly of hearing, represent the proximate and exclusive cause of the delusion; especially do delusions of persecution originate in this way. The patient hears occasional remarks, threats, insulting words, calls for help from his relations, believes himself despised in consequence, hated, everywhere observed, his beloved in danger, and now begins to interpret under the persistent influence of his hallucination other perceptions also in the sense of these morbid imaginations. An unprejudiced consideration of the clinical course allows us to recognise in it, with clearness, that certain peculiarities in the majority of cases precede a commencement of the phantasies, that is to say peculiarities in the apprehension of the surroundings which indicate a more deeply-seated disorder. As a rule the external world appears to the patient in quite a different light before the formation of his halluci-

nations; so that without the perceptions being exactly false, he sees things and persons with other than healthy eyes. Unessential secondary circumstances strike him and acquire a different meaning, whilst often what is nearest and most obvious remains unobserved. The character of the hallucinations stands, therefore, as a rule, in a certain relation to the patient's former thought, while it strengthens his fears, encourages his hopes, and especially varies the *thema* of the delusion, in a variety of ways, without the patient himself being conscious of this connection, which no doubt is frequently only quite general and indefinite. The hallucinations are, in other words, not always the cause of the mental derangement in the patients, but may be only a symptom of his general morbid condition. The psychosis would not be put aside in any degree through the removal of the hallucinations; it would remain essentially unaltered.

Certain cases may be observed in which the disappearance of the false perceptions, or their possible correction after some years' duration, indicates a certain recovery of the patient. Here the phantasies possess mostly a great uniformity; the construction of the delusion always remains upon a lower plane of development, and does not involve a complete derangement of the whole mental personality, so that it is doubtful whether one can regard this morbid condition as, properly speaking, "Verrücktheit." In the case of those who labour under the true disorder, a correction of the delusion would be impossible by means of the most patent argument, because his capacity for objective criticism is wanting; he appears to be impelled in the highest degree to hypotheses of the most absurd character. But where a false isolated idea depends upon hallucinations which, not on account of the intellectual incapacity of the patient, but on account of the objective difficulties of control, are not recognised as such, we have to do obviously with a totally different kind of disorder.

If we may not recognise hallucinations as special causes of delusions to any great extent, still it is unquestionable that they possess great importance in the characteristic form and the further development of the delusion. When the once-awakened general distrust of the patient is led through a false perception into definite paths, and is immovably fixed there, the slumbering, exalted idea, which has an obscure form in the consciousness, suddenly assumes a clear ineffaceable form. The powerful irresistible power which the hallucination exercises over the patient does not depend so much upon its vividness to the senses as upon its profound, although to the patient unconscious, connection with the peculiar circle of ideas, and of the internal correspondence with his secret fears and wishes. No sane man would consider the words of a passer-by, "This is the Emperor," as referring to himself, or suppose that he was on that account truly the Emperor, while such an hallucinatory perception produces upon the person labouring under "Verrücktheit" the most profound and overpowering influence, and has the direct effect of making him believe not only

that the words were truly spoken, but that they also contain the real truth.

The origin of the delusion of those labouring under "Verrücktheit" is generally much deeper than the hallucinations to which the patients are accustomed frequently enough to return, when they have not become conscious of the complete derangement of their whole mental being, which first must be accomplished before the delusions can altogether develop their influence. As a fact, we meet with many persons labouring under "Verrücktheit" with whom particular hallucinations have never been present. One cannot be easily misled in the determination of this question through the apperception of hallucinations and illusions, which not unfrequently are described by patients with similar expressions. By means of a fresh examination one may almost always distinguish them from actual sensory disorders. To these belong the inner voices, the thought-speaking, the telegraphing, and many visions, &c., which frequently are expressed by the patients with newly-invented fantastic names. They always stand in the most direct relation to the course of thought—sometimes even under the influence of the patient's will—and are by him referred, under the complete separation from normal perception, to mystical distant influences, secret magnetic relations, divine inspiration, and so forth. Clearly such apperception indicates already a widely extended loss of critical power and confusion of the patient in his deranged (Verrückt) perception of the world.

These apperceptive delusions, to which one can scarcely give any other name, form, to a certain extent, a transition from hallucinations to primordial derangement. We find in them, as a general rule, the conception related to external, if of no longer simple sensory, origin, whilst the primordial derangement has throughout the character of the conceptions, which suddenly rise to consciousness and acquire an overwhelming power therein. Hence it happens to the patient labouring under "Verrucktheit" that in perceiving a few chestnuts the idea strikes him at once that they are the symbols of lordship over the five divisions of the world; to another, a female patient, who contemplates the likeness of the Russian Emperor, it suddenly becomes manifest that he is her father. Indeed, these conceptions have, in the patient's circle of ideas, acquired even at the moment of their origin the character of such unquestionable truth that they stick to him in this form for probably his whole future life, and mould all further experience in accordance therewith, instead of being itself corrected at every step thereby.

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(To be continued).

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4. *English Retrospect.*

Asylum Reports, 1885.

In running through these publications we shall chiefly extract such portions as may be of practical value. However experienced a medical superintendent may be, he can generally pick up some hint by learning what has been going on elsewhere, though this desire may be carried too far, and degenerate into the merest curiosity and love of gossip. Perhaps the most valuable portion of the Reports are the criticisms by the Commissioners in Lunacy. Any defect pointed out, any suggestion made, should suggest to every medical superintendent the propriety of inquiry as to the condition of his own asylum in that particular. If a man does that honestly he will do much good work.

Argyll and Bute.—The deaths from phthisis, which had considerably risen while the house was overcrowded, fell in a marked manner when overcrowding disappeared by transference of patients to the new block, and the removal of others to care in private dwellings.

A very considerable reduction in the number of patients was effected during 1882 by weeding out those who had ceased to require asylum treatment; and though, from relapse into active insanity and other causes, several of the patients who were then discharged have been sent back to the asylum, 40 of them have been found permanently suitable for care in private dwellings.

The changes among the attendants appear excessive.

Barnwood House.—The Committee report that in the administration of the Hospital its charitable objects have, as heretofore, been prominently kept in view, and desire again to express their conviction that the most effective means of carrying out these objects is by affording to those persons who have been accustomed to the comforts and elegancies of life a similar existence, at a very small cost. It has been repeatedly stated, but cannot be too often reiterated, that the condition of the patient, and not the money payment, is the chief criterion by which the treatment is regulated. Under such conditions 63 patients have been maintained during the year at a greatly reduced rate, 6 altogether gratuitously, at a cost of upwards of £1,900.

There are now two assistant medical officers, the senior, we are glad to state, being married.

Dr. Needham's report is, as usual, marked by great common sense —the first qualification for success as an asylum officer. *Apropos* of the "open-door" system he says:—

"There has been no change during the past year in the general principles upon which this Institution is conducted. While personal freedom has been widely extended to the patients, I have still been unable to persuade myself of the practical value or expediency of the general application of an arrangement which has been called 'the open-door system,' and which I have, therefore, not attempted to

adopt generally. In every institution for the insane this, which has been claimed as a modern system, has been in partial operation for many years past, and in this Hospital it prevails to as wide an extent as I consider to be compatible with the safety of the patients and the proper discipline of the establishment. At the detached houses it operates without restriction, because of the different character of the cases which are received into them. There can now be no doubt, from our experience, of the value, in the treatment of patients of the better class, at least, of a limited number of detached houses, which can serve as outlets from the parent establishment, and afford temporary change to those who require or wish it, and a freer atmosphere for the convalescing. They, of course, add considerably to the difficulties of management, and they are probably not economical, but their obvious advantages would seem to more than counterbalance these drawbacks."

Dr. Needham also reports that, in order to secure for the gentlemen the benefit of more sane association, which has operated so successfully in the ladies' division, an educated companion to the gentlemen has been engaged, and his services have met with much appreciation. We shall watch such an experiment with much interest. What combination of adverse circumstances can compel or tempt an educated gentleman of good character to accept such a position it is difficult to conceive, but we rejoice that such are to be found.

Bedford, &c.—It is gratifying to find that the Visitors are making efforts to secure and retain good attendants. Superannuation allowances are held out as inducements to good and continued service, and every opportunity is adopted of making the life of the attendants as little monotonous as possible. Billiard-tables have been added on the male side, and a comfortable sitting-room has been provided for the nurses. All this is in the right direction.

The Commissioners report favourably as to the occupation of the patients, and also as to the amount of exercise beyond the airing-courts enjoyed by the men, but they point out that of 527 females, 364 do not walk in or beyond the grounds.

Berks, &c.—The asylum farm has been enlarged by renting 24 additional acres. The original estate was only 54 acres in extent, but in 1879 other 84 acres were taken on hire. The amount of land now appears ample for all purposes.

Extensive sanitary improvements have been effected, but one case of typhoid and several of erysipelas occurred.

The report of the Commissioners is not published.

Bethlem.—Dr. Savage's report touches upon such a variety of subjects that it is impossible to notice them all; but all through there are abundant evidences of honest, earnest work.

He feels yearly the immense importance of having, as medical officers to asylums, men who have had broad medical culture, and whose medical experience has not been limited to asylums, where,

with the best intentions, general medical culture is neglected. To the latter part of the sentence we would object, if Dr. Savage means that in all asylums general medical culture is neglected. Life is too short for a man to cultivate the whole field of medicine, and asylums, by the character of the patients contained in them, necessarily limit the field of observation, but that some men make determined and successful efforts to deserve the character of "accomplished physicians" we affirm from personal knowledge.

Dr. Savage believes that next year he will be able, with the help of the recently-appointed assistant medical officer, Dr. Percy Smith, to lay before the Governors a more ample report of the work done during the year, in the hope that it may be of sufficient value to justify its separate appearance as a Medical Report.

It is stated that a new departure has been made during the year in performing surgical operations on some insane patients. A difficulty in these cases arises from the fact of the insanity of the patient, which prevents him giving consent himself, and where the operation is of a very serious nature, it is difficult to satisfy one's self, as to who should give the authority. Dr. Savage obtained the consent of the nearest relations, including the one who signed the "Order" for reception, and after communicating with and getting the sanction of the Commissioners, he decided to act on the surgical opinion "that life was at stake, that without the operation the patient must die."

Evident efforts are made to allow as much liberty to the patients as is compatible with safety. The necessary results are increased responsibility of the medical officers and abuse of privileges by those intended to be benefited. Men and women do not become saints because they are convalescent from insanity and are placed on parole.

Birmingham.—Winson Green.—When the Commissioners visited this asylum, they saw in the hall at dinner 311 men and 221 women, who were seated, not as is general in asylums, on different sides of the hall, but only on different sides of the table. This arrangement seemed to be attended with very happy results, and the patients behaved with the greatest propriety. If we remember correctly, an even more intimate mixture of the sexes occurs at meals in one or more Scotch asylums, with excellent results.

In a total of 68 deaths, no fewer than 11 are attributed to "meningitis." This is remarkable, as all the patients returned as dying from this disease were above 20 years of age, most of them above 50.

Birmingham.—Rubery Hill.—This asylum seems to be reserved for the care of chronic cases only, and a few private patients. Of 41 deaths no fewer than 21 were due to epilepsy.

Bristol.—The Committee of Visitors reported that £65,676 would be required to carry out the necessary enlargement of the asylum. Although the plans have been prepared and sanctioned, it would appear that the Town Council is in no hurry to vote the money.

The Commissioners note that only 22 males are confined to the airing courts, but as many as 147 women. They state that they attach much importance to this subject, believing a change from monotonous sauntering in airing courts to a brisk walk in the grounds to be very valuable as treatment.

The following paragraph from Dr. Thompson's Report is of practical value. An adequate supply of hot water is not available in every asylum:—

"The Cornish boilers referred to in the last report were duly completed early in the year. Our experience of them is all that could be desired; and I might say that a ready means of keeping the asylum 'always in hot water' has been devised and carried out. The difficult point seems to be solved thus: the reserve of hot water should be as great as possible, so that, no matter how great the demand may be at any given time, the reserve water should be chilled as little as possible. So great, in fact, is our reserve that little or no impression is made on the temperature of the bulk of water remaining in the boilers. The stoker banks his fire at 4 p.m., leaving the thermometer, fixed to each boiler, registering 180° Fahr.; the bathing is often very heavy in the evening, and when he comes at six the following morning he finds the thermometer still at 180° Fahr. The height of the chimney is such that little or no draught is seen in the boiler flue, the draught being such as merely carries away the smoke. The fire, therefore, is a very slow one. The material used as fuel is of some consequence also. In the winter months the cinders which come from the ward fires are all that is required. At first the engineer had the cinders sifted; but a little experience showed him that that was an unnecessary waste of labour; and at any time the boilers may be seen with the fire-box doors open and a slow-burning fire upon the bars. I mention this improvement in detail, because what would at first sight appear to be an extravagant scheme is found in working to be a genuinely economical one."

We congratulate Dr. Thompson on his recovery, and are pleased to find that his Visitors have shown him so much consideration during his illness.

Broadmoor.—It is with regret that we read of the serious assault committed by a dangerous lunatic on Dr. Nicolson, but it is satisfactory to learn that a complete rest from work has been followed by recovery and ability to resume official duties.

Dr. Orange is naturally gratified by the very flattering opinion expressed by the Commission of the French Senate relative to the condition and management of Broadmoor. (See "Notes of the Quarter.")

Cambridge.—Although the demands for asylum accommodation continue to increase, the Visitors appear to be in no hurry to provide it. Various structural alterations and additions have been made, but the Commissioners begin their report with a long string of require-

ments. They point out also that there is only one service on Sundays, which is held at 9 a.m. This is a distinctly bad arrangement, and we agree that a second service would help to break the monotony of a long, dull day, which Sunday must needs be in an asylum when the religious observance is over early in the forenoon.

Carmarthen.—When the Commissioners visited this asylum they must have been very much out of temper; a more peevish, fault-finding report we never read. The Visitors were compelled to go through the complaints one by one, and they successfully disposed of most of them. Asylum medical officers are quite aware that if one is determined to find fault, the best asylum in England will afford ample opportunities for the employment of this delightful faculty, We cannot help feeling and expressing sympathy for Dr. Hearder. Such chastisement as he has received cannot be for the present joyous, but grievous, although if his asylum is in time benefited thereby he will be the first to rejoice.

Cheshire. Macclesfield.—The Commissioners bear witness to several improvements effected by Dr. Sheldon during his term of office. They also report that "the medical officers arrange their visits to the wards thus—the chief and his assistant each visit one division from 10 till 11.30 a.m. every morning, they then meet for conference at the surgery, after that conference the chief visits special cases in the division not already visited by him, and at five the assistant visits both divisions; this visit takes him about one hour and a half. We are disposed to think that the visits should be prolonged, in order that more opportunity for complaint be given to individuals." Although Dr. Sheldon notes that the above is not all the time spent by the medical officers with the patients, we agree with the Commissioners that it might be increased with advantage, though but for the record below, we should have thought the reason they give highly ridiculous. Time spent in the wards by the medical officers does great good in a variety of ways; to the officers themselves, not the least, by encouraging minute medical care in the treatment of the cases.

The following paragraph from the Chaplain's report is of a most unusual character; fortunately it does not often occur that the clergyman has to charge the nurses with ill-treating the patients. He says: "This year has been remarkable for the numerous changes in the staff of attendants on the female side, changes by no means to be regretted; for since September, while the work has been done quite as efficiently as before, there has been a marked diminution in the number of complaints on the part of the patients. This fact speaks for itself."

Crichton Royal Institution.—"The first and most essential element towards a successful issue is, in nearly every case, removal from home, and placing the patient under the skilled and special treatment which is best found in a good asylum." When Dr. Rutherford wrote

that sentence, Sir James Coxe must have turned in his grave and the present Scotch Board of Lunacy fallen back in their chairs. We cordially agree with him nevertheless.

Important structural alterations are in progress. Amongst other things it is intended to make a complete hospital for the treatment of patients of the lower and lower middle classes, viz., those paying from £25 to £52 per annum. The country residence at Kirkmichael is largely taken advantage of, and with the best results.

We would again point out that the entries made by the Commissioners at their visits are not given.

Cumberland and Westmorland.—The Commissioners, in expressing their entire satisfaction with the general condition of the asylum, state that the recent additions are most valuable improvements, and make the asylum as convenient and workable as any with which they are acquainted.

Additional land has been purchased, and the estate is now nearly 150 acres in extent. The whole of the sewage is used in irrigation with excellent results.

Dr. Campbell is confirmed in his opinion, formerly expressed, that in his district extreme prosperity and high wages among the lower orders are a more powerful factor in causing insanity than the opposite extreme. His experience also leads him to the conclusion that private patients "do not at all have the same chance of recovery as their poorer fellow-sufferers. A mistaken kindness on the part of their relatives allows them to exhaust all the questionable benefits of home treatment, often without recourse to special knowledge of the disease, and only when home treatment is found worse than unavailing is the patient sent to an asylum. In many cases the possibility of recovery does not seem even to have had its due weight in the consideration of the case, and suicidal or dangerous propensities are often really the cause of the patient's consignment to what should be an hospital for treatment. It is a sad fact that mistaken kindness, or the fear that having been in an asylum, if known, might blight a possible future career, should entirely outweigh other considerations and eventually condemn many to a joyless, passive existence, depriving them of the power of participation in all that makes life worth living for."

The following suggestion by Dr. Campbell, though not new, is well worth more attention than it has received :—"A certain proportion of recurrent cases from alcoholic excess come under treatment in this asylum, quickly recover, are discharged, and frequently relapse. Such cases are really a hardship to all industrious ratepayers. They would stand a much better chance of exemption from this self-brought-on insanity if after recovery in the asylum they were by law detained for an increasing period after each attack in some industrial institution, whose profits assisted to reduce the rates. Some project of this sort is well worth the consideration of legislators; it would do more to diminish preventable insanity than appears at first glance."

Suppose there were such a law, would it be possible to obtain a

true history of an alcoholic case? Not likely. What woman in her senses would state the cause of her husband's insanity to be drunkenness, if she knew that on recovery he would be sent for three or six months to a penitentiary? Excellent advice, nevertheless.

Denbigh.—The Commissioners appear to have great difficulty in getting the Visitors to carry out their suggestions. The asylum is overcrowded, but the Visitors cannot think of building a new wing for female patients, because a County Government Bill may be passed at no distant date. A detached hospital for infectious cases is much required, but it cannot be built, because it may be necessary to provide increased accommodation connected with the main building. Some day rooms, however, have been enlarged, and the work appears to have been well done.

Mr. Cox appears to have some difficulty in procuring suitable employment for his male patients. He concludes that the inadequate number of his indoor male attendants is the main cause of his inability to give regular employment to a certain class of patients incapable of engaging in agricultural work. If that be his only difficulty he is to be congratulated, as it surely admits of a very easy remedy.

Devon.—The mortality was the lowest since the opening of the asylum; only 4·32 per cent. on the average number resident.

We would venture to point out that the Commissioners' report is not given.

Dorset.—Two cottages have been built for married attendants. The staff of nurses has been increased by two, but it must still be considered weak numerically.

In their report the Commissioners say:—"We ought not to omit to say that outside some of the single rooms was a chain placed, which we saw in use yesterday, and though this is not considered seclusion it keeps the patient effectually within the room, and seems to us to come under the denomination of enforced isolation, *i.e.*, seclusion." We think there can be no doubt about it.

Fife and Kinross.—As was to be expected the addition of a plumber, painter, and upholsterer to the artizan-attendants has proved satisfactory.

Dr. Turnbull reports that a second night attendant is now regularly on duty at night in the female division in charge of a dormitory in which the suicidal cases are placed. A male attendant for corresponding duties is only employed when occasion requires.

Unfortunately one of the deaths was by suicide. It is thus reported by the Commissioners:—"The patient was known to be suicidal, and was under careful observation, but she nevertheless succeeded in destroying herself. No blame is attached to any one in charge of her." Had a similar accident occurred on the other side of the Border, the official references would have been in a very different tone, and the nurse would have considered herself fortunate in escaping a trial for manslaughter at the Assizes.

Strange that such difference should be
Twixt Tweedledum and Tweedledee.

It is satisfactory to find that this asylum continues to obtain the highest official commendation.

Glasgow (District).—A special feature about this asylum is the remarkable movement in the population. There is accommodation for 180 patients. During the year there were 127 admissions and 124 discharges and deaths. In the course of four years 713 cases have been admitted; so that the beds have been filled four times and emptied thrice. As Dr. Clark remarks, this is a rare if not unique experience. Every effort is made to board out chronic cases, and with evident success.

Bonuses were voted at Christmas to the members of the staff, graduated in proportion to position and length of service. The effect of this stimulus to long and faithful service is reported to be too palpable to be gainsaid.

Dr. Clarke urges the claims of attendants with much force and truth. He says: "The need of a superior and permanent staff as an element in the treatment of acute cases of lunacy, is one of the most patent necessities in asylums, and anything like an ideal staff will not be obtained under the present conditions of asylum management. The truth of this has been gradually dawning in this country, America, and elsewhere of late years, and the future treatment of attendants is certain to undergo an improvement as remarkable as the changes which have occurred in the treatment of the insane themselves."

Gloucester.—The second asylum is now occupied and the overcrowding in the old building is not so severe. In the latter several important structural alterations have been effected.

The scale of wages of the nurses and servants has been somewhat improved.

The Commissioners consider that the accommodation in the new asylum is very good. Unfortunately the water supply is not sufficient or satisfactory. Two deaths from typhoid fever occurred, but the origin of the disease was not discovered.

Mr. Craddock has been impressed by the frequency of syphilis as a cause of mental disease during the past year.

Hants.—An unusually severe form of typhoid appeared during the year, affecting 14 persons and causing 8 deaths. We regret to find that Dr. Worthington's sister was one of those who died. The cause of the outbreak has not yet been discovered, but Mr. Rogers Field has the matter in hand. The water is said to be wholesome, potable, and of good quality.

Twelve cottages, in two blocks, have been built for married attendants.

According to the returns made to the Commissioners, 127 men and 73 women go beyond the airing courts; 122 men and 256 women go

beyond the grounds; 139 women are confined to the airing courts; 32 women cannot or will not go out; and 179 men are entered as being unable or unwilling. As several female patients are described as very turbulent, it is probable that their habits would be improved by extended exercise in or beyond the grounds.

Hereford.—The occurrence of several cases of erysipelas seems to point to overcrowding, if not to any other insanitary condition.

Dr. Chapman devotes a considerable portion of his report to the consideration of the cases received from workhouses. His experience strongly confirms what has long been felt, that these are the most troublesome, expensive, and unsatisfactory of the admissions.

Hull.—The amount of organic brain disease in this asylum is quite exceptional. Dr. Merson reports that of 81 cases admitted, 18 suffered from general paralysis, and fully 9 per cent. more were afflicted with softening or other forms of brain disease. Forty deaths occurred during the year; 12 of these were due to general paralysis and 15 more to softening, atrophy, and epilepsy.

This new asylum appears to be rapidly getting into full working order. We are glad to observe that an assistant medical officer has been appointed.

Ipswich.—The Commissioners remark that at the date of their visit few patients were engaged in any trade; one man was with the tailor, another with the shoemaker, but neither the carpenter, painter, bricklayer, nor upholsterer was assisted by any patient. They were told that these artizans objected to having patients to work with them. They considered the solution of the difficulty was exceedingly easy when it was remembered that the asylum was intended for curative treatment of patients (amongst whom work proves, in many instances, a powerful agent) and not to give employment to artizans.

To the above we would add that in an asylum where the occupation of the patients is considered of high importance, much can be done in teaching trades. The more intelligent imbeciles and dements can be readily taught the more simple operations connected with shoemaking, tailoring, and upholstering.

Killarney.—This asylum is overcrowded, and its enlargement is under consideration. The admissions were the most numerous since the opening, and included one case of general paralysis, the first for 10 years.

Many important improvements were effected during the year, not the least so being the introduction of an abundant supply of wholesome water.

Dr. Woods has again to regret that the increases of salaries recommended by his Visitors were refused by the higher authorities.

Lancashire. Lancaster.—During the year much has been done to improve the sanitary condition of this asylum. All the external drains have been relaid, and the internal fittings are in progress. Already the health of the patients has been improved, but typhoid fever has not

entirely disappeared. Two deaths from this disease occurred in the old building and two in the annex.

The Commissioners notice with approval that the employment and occupation of the patients receive due attention. It is especially satisfactory to find that all patients, except those actually incapable, have exercise beyond the airing courts daily, weather permitting.

In his report Dr. Cassidy mentions that five American patients are under his care. They ought to be taken charge of by the United States Government, and returned to their own country. "Two patients lately admitted here tell me they were in American asylums, when they were taken, one by the clerk of the asylum, the other by two strangers, and placed on board steamers bound for Liverpool. One of these men was found wandering in the streets of Liverpool by the police; the other, who had been violent and placed in restraint during the voyage from New York, was handed over still in restraint to the custody of the parish officers on the arrival of the vessel in port."

Before we begin to demand the American Government to take charge of such cases, we had better see that we are not even greater sinners in getting rid of our lunatics by sending them over the whole world. It is notorious that many persons recently recovered from attacks of insanity leave our country and go to the United States, Canada, Australia, and elsewhere. The Governments of these countries have made considerable efforts to prevent the arrival of such undesirable colonists, and very rightly too.

Lancashire. Prestwich.—The Visitors have entered into an arrangement for the enlargement of the parish churchyard, and thus provide for the increased number of burials from the asylum. This, where it can be done, is so much more desirable than a cemetery on the estate, in most cases a most woeful, dismal, neglected spot.

There are several paragraphs in Mr Ley's report to which we would willingly direct attention, but we must content ourselves by reproducing his remarks about attendants. Than he there is probably no one in England more competent to utter words of wisdom on this subject.

"The great problem in asylum management is how to obtain good attendants, and when obtained how to retain their services. In every asylum this difficulty, in greater or less degree, has been felt, and in an institution of this magnitude, where obviously a greater proportion of experienced attendants is required, the difficulty in procuring and maintaining a staff of trustworthy subordinates has become a source of never-ending trouble and anxiety. No one conversant with the working of an asylum can doubt that much of the success of management, economical and otherwise, is dependent upon the character and reliability of the attendants, who are necessarily entrusted with the immediate care of the patients. The comfort, the safety, even the lives of those under their charge depend upon the good conduct, fidelity, and watchfulness of these officials, who are, in point of fact,

the instruments by which all the details of moral treatment are brought into practice. The service is an arduous one, and those who take to it are generally persons devoid of all training; consequently of the many who apply only a few are found gifted with the necessary qualities of temper and judgment, without which no good attendant can be made. Under the most favourable circumstances it takes months to train an attendant, and so great is the competition among kindred institutions, and so many are the careers open to skilled attendants, that there is always the fear that when they have been taught their duties they will transfer their newly-acquired experience to some other institution, where equal or greater advantages may be obtained at less personal sacrifice. There are few positions in life where experience is of greater value and more productive of good results, and to lose the services of well-trained attendants is unfavourable to the best interests of the patients, a loss to the asylum, and discouraging to all concerned. I think there can be no doubt that, apart from the question of salaries, much of the restlessness that affects the asylum attendant at the present day is due to the fact that their position is considered an inferior one, because the accommodation provided and the arrangements made for their comfort and relaxation are not equal to what persons in the same calling are able to obtain in other branches of the public service. In all the principal general hospitals and infirmaries it has been found necessary, in order to attract applicants of the requisite character and intelligence, to deal liberally with their nursing staff. Separate accommodation has been provided, and the comfort and convenience of the daily lives of these officials have been considered in every reasonable way. The result has been that the service is an attractive one, and hospitals and infirmaries have become serious competitors with asylums in the female labour market. I think it reasonable to expect that equal consideration for the comfort and accommodation of the attendants would be equally successful in rendering asylum service popular with candidates of character and ability, to whom the retention of their situation would be an object of some consequence. The plan has been tried successfully in the large asylums of Middlesex, and I believe it would be for the benefit of this institution and its inmates, and would also prove the most economical policy in the long run if some beneficial changes were introduced here."

(To be Continued.)

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Quarterly Meeting of the Medico-Psychological Association was held at Bethlem Hospital on Wednesday, 19th May. In the absence of the President, Dr. Eames, the chair was taken by Dr. Rayner. There were also present Drs. D. Bower, Fletcher Beach, P. E. Campbell, W. R. Dalzell, Stracey Forrest, J. S. Grubb, J. Tregelles Hingston, Robert Jones, Henry Lewis, A. MacLean, Hayes Newington, H. T. Pringle, J. H. Paul, H. T. Sells, Alonzo H. Stocker, Henry Sutherland, D. Hack Tuke, Samuel Wilks, E. S. Willett, T. Outterson Wood, &c.

The following gentlemen were elected members of the Association, viz., Geo. Revington, M.B., Ass. Med. Off., Prestwich Asylum, Manchester; Richd. B. D. Batt, M.R.C.S. and L.S.A., Ass. Med. Off., Barnwood House, Gloucester; Edward East, M.R.C.S. and L.S.A., 18, Clifton Gardens, W.; R. Gillies Smith, M.R.C.S., B.Sc.Lond., County Asylum, Sedgefield, Ferry Hill, Durham.

The CHAIRMAN announced that the Annual Meeting had been fixed for Monday, the 9th August, that date being chosen in deference to the wishes expressed by several of the North British members, who would also be attending the annual meeting of the British Medical Association at Brighton.

Dr. SAVAGE read a paper on "A Case of Insanity Cured by Removal of the Beard in a Woman." (See "Cases.")

The CHAIRMAN said that Dr. Savage's paper opened up a very wide subject, viz., the question of the value of the cause which the patient's own mind assigned as the cause of its insanity. He must confess that in such cases as this and that of the blushing young man referred to by Dr. Savage, and in hypochondriacal cases also, he was inclined to think that the mental condition was pre-existing, and that the developing disease of the mind merely seized on what was afterwards assigned to be the cause of the mental disease, and which, being thus seized on, remained fixed, and might then continue to act prejudicially, although not the original cause. This lady appeared to have seized on the growth of hair on her chin as a very horrible thing, and developed it until it remained on her mind as a continuing, although not the exciting, cause of the mental disease. Probably there was a tendency to get well in any case, but it was certainly doubtful whether she would have recovered had it not been for the depilation.

Dr. WILKS said that he had seen the patient at Lewisham, and she was exactly in the condition described by Dr. Savage. She talked of nothing but the hair on her chin, and said that if she could get rid of that she would be all right. He then knew nothing about the galvanic treatment, but he looked up the question, and wrote about the new method of depilation, which he had since heard had been satisfactory in many cases. It seemed to him that although in the case in question recovery must be attributed to the removal of the beard, it raised a very intricate question in regard to the relation of cases of insanity associated with bodily disease with others where the conditions were purely mental. Supposing that this patient had not really got those hairs on her chin, but only imagined it, how would the result have been affected? Undoubtedly, some forms of bodily disease were more closely connected with insanity than others. They knew the extreme depression associated with diseases of the abdominal organs, while, on the other hand, he knew people with headaches who never felt dispirited. It was frequently difficult, where there was a bodily aspect and a mental condition, to know which was the cause and which the effect. He remembered a gentleman who had a trouble about his bladder, and was always scratching himself. He

obtained the best advice, and he said that if he did not get rid of this irritation it would drive him mad. He actually became insane—furiously maniacal and dirty in his habits. He (Dr. Wilks) went to see him, and said, "Well, how about your trouble with the bladder?" He replied, "Oh, it is all right, I never have any at all now." He could also quote the case of a lady with bladder troubles. She became insane, and the whole of those local troubles went. Did those local troubles cause the mental state or the opposite?

Dr. HACK TUKE said he thought there must have been a predisposition to insanity in this case, because it was clear that every lady would not under similar circumstances become insane. They must assume that there was a mental condition closely approaching insanity before this immediately exciting cause occurred. The case was interesting, because there were all the mental symptoms which one supposes to be associated with a diseased condition of the brain, although, as the event proved, such disorder must have been of a very slight character—probably what they termed "functional," for want of a better term. The more they saw of cases of mental disorder the more they were made aware of the existence of a class of cases which were rather examples of derangement than actual disease. The functional pathology of insanity had not yet been fully studied. There were cases, also, due to sympathetic irritation, as in the bladder-cases referred to, in which the brain being more easily upset in some patients than in others, insanity supervened, but with no discoverable changes in the grey matter of the brain. These cases, as bearing upon treatment by moral influence, were of very great importance. One might often be liable to give an unfavourable opinion, when, with the knowledge of such cases as that reported by Dr. Savage, the prospect of recovery might be much more favourable, provided the mind trouble were traced and then removed.

Dr. OUTTERSON WOOD mentioned the case of a young woman, twenty-seven years of age, in which the removal of hair had been attended with most satisfactory results. The hair had been a constant source of annoyance to her, and had made her irritable and unmanageable. When admitted she was violent, but as she became accustomed to the asylum she got less impulsive, and her excitement passed off to a considerable extent, although she always seemed ashamed of being seen. At last the propriety of having the hairs removed was suggested to her. After some difficulty she consented, and, certainly, after the removal of the hair from her face, which was effected by shaving, her manners improved with her appearance, and she had a most rapid recovery.

Dr. SUTHERLAND said that he had had two similar cases. One of them thought she had got her beard from another lady. Although it might not be of any psychological importance, he could not help exhibiting a photograph of a sane woman at Brighton who had a beard four inches in length, and who, notwithstanding this, was one of the most cheerful women he had ever met, showing the necessity of predisposition to cause insanity from this cause.

Dr. HACK TUKE added that he had seen in one of the American asylums a lady with a remarkable beard and moustache, who had been taken the round of the States by Barnum as "The Circassian Lady," and who, whether from mortification or not, he could not say, had become insane.

Dr. SAVAGE said, in answer to an inquiry, that there was no erotic condition. In reply generally, he said that they were not discussing the whole subject of beards in relation to insanity, although that merited a paper apart. All connected with chronic lunatics must have seen very fine beards. He had got at least a dozen photographs of them. Undoubtedly there was a greater tendency with chronically insane women to develop beards than with others. Beards, it was true, might occur without upsetting the nervous balance. In the case he had mentioned there was a history of insanity: physical instability and nervous instability by inheritance; and he agreed with Dr. Rayner up to this point: that she was predisposed to insanity, but he believed that the hair was the one exciting cause in her case, neither more nor less. He believed that more could

be learnt from a patient who has thoroughly recovered than from any theory or generalization, and his conversation with this patient after her recovery had convinced him that the first cause of her hysteria was the fear that her strange aspect would alienate the affections of her husband and family. Of course there was ever a difficulty in saying what was a cause of insanity and what a condition. Then, as to the relationship between the bodily disease and the mental symptoms, he felt more and more that insanity should be looked upon in certainly at least three distinct ways. First, as due to brain disease. Then it might be regarded as a symptom of bodily disease—a mental aspect of bodily disease; and in reference to what Dr. Wilks had said as to the depression associated with abdominal trouble or gastro-intestinal trouble, he might mention the case of a man who, after a fit of diarrhœa, declared that he had lost himself. Then, of course, came the mental disorder of function, which they knew nothing about. Many persons having bodily disease became insane and lost the symptoms. Some time ago he saw an old clergyman who had been in a private asylum for some years with few or no symptoms of bladder trouble, but it was detected that something was wrong in that way, and a stone was removed. The whole of his insanity disappeared. Unfortunately, years and years afterwards he developed similar symptoms without any stone in the bladder. With respect to Dr. Tuke's remarks, he fully admitted that the fact had to be recognised that there was the neurotic state prior to the attack of insanity in such a case, and that there is a great difference between disorder or mere derangement and actual disease.

Dr. PERCY SMITH read a paper on "Notes on a Case of Ovariotomy in an Insane Patient." (See "Cases.")

The CHAIRMAN said that ovariotomy being a comparatively recent operation, there had not been many cases similar to Dr. Smith's, which, perhaps, was the first publicly recorded in England, although not the first which had really happened. There had been a case at Hanwell, the gross result of which was that the patient recovered very rapidly from the operation, but her mental state afterwards was rather worse than better. It would be very interesting indeed if they found that the sense of smell was proved to be so definitely associated with the sexual functions, but they had to recollect that hallucinations of smell were amongst the least persistent of sensory hallucinations. The quotation from Spitzka seemed so very much opposed to the now generally accepted belief on the subject that they would like to hear further opinions on that point.

Dr. NEWINGTON said he thought that the dictum laid down by Spitzka was too strong, very small lesions in females often causing a very serious state of mind. He had held for some years past that there was a distinct class of mental alienation produced by irritation of the os uteri, especially among elderly females, and appropriate treatment had produced such good effect that it had been quite clear to his mind that the irritation had caused even the insanity itself. In the climacteric period, elderly females would become melancholy and go through the ordinary course of moroseness and bad temper, and then they would begin to use indecent words. They did not become erotic, but used filthy expressions without any apparent purpose. After a time it would be reported that So-and-So had taken to masturbation, and it might then be found that after all it was not true masturbation, but simply the resort to a kind of counter-irritation to relieve the uterine trouble. If that could be alleviated the patient frequently got better. He had known cases like this, and should at all events stand out strongly against Spitzka's alleged dogma that uterine lesions would not cause insanity.

Dr. HACK TUKE said that he was not aware that Spitzka had spoken nearly so broadly as to include all uterine affections in his dictum. He thought it probable that, when taken with the context, his remarks would be found not to warrant the inference drawn from them. They must, he thought, admit that a morbid condition of mind often occurred in women which was associated with changes in the ovaries at the menopause; and, if so, the probability was that when there were ovarian cysts and mental disorder, then the two things were

connected. With regard to Dr. Savage's opinion, which Dr. Smith had quoted as to the relation between olfactory hallucinations and disordered sexual functions, anyone wishing to study that subject further would do well to consult Dr. Laycock's work on "The Diseases of Women," published more than forty years ago. Dr. Laycock there definitely pointed out the relation, in normal states, between olfactory sensations and sexual feeling, and it was interesting to find that when the mind was deranged, olfactory hallucinations appeared to be specially related to ovarian disease.

Dr. BOWER mentioned the case of a woman whose mind was very much upset, and who fancied she was a Knight Templar, but who would become absolutely sane as soon as she had an attack of asthma.

Dr. SAVAGE said that cases of asthma alternating with insanity always struck him with interest. He felt a kind of parental interest in them, as he believed he was the first to note them some years ago. Since then, Dr. Conolly Norman had read a paper on the subject. Some time or other he hoped that members of the Association would pile up the cases in which these alternations between mental and bodily disease occurred. Recently he had seen many cases in which diabetes of the most confirmed kind had been treated by doctors out of the asylum, and in which, after admission, there were no traces of glycosuria or polyuria. As to the relation between ovarian disease and insanity, he had been struck with the comparatively few cases they got in which there was post mortem evidence. It was very rare for them to find ovarian disease or fibroid disease in any way associated with symptoms of insanity. As to other cases of the class in question, perhaps they did not look for them, and they were perhaps encouraged in not going further by Dr. Wigglesworth's investigations, which showed that there was very little connection between mental disorder and uterine displacement or ulceration. In Bethlem very few cases had been relieved by the treatment of any uterine disorder. In one case of uterine prolapsus the patient was kept in bed for some days, and, with the return of the uterus and the keeping in bed, the patient—a melancholiac—became well. It was strange that so few real utero-hypochondriacs entered the asylums. He supposed the gynæcologists drew them. They had the gastro-hypochondriacal, the brain-hypochondriacal, and the spermatically hypochondriacal, but of women with utero-hypochondriasis they had very few. Yet they heard so much about it in the outer world. There every woman of forty-five seemed to have her womb upside down.

Dr. NEWINGTON said it was very hard that the uterus should be excepted when almost all other organs were allowed to have their share in producing insanity. In his view of the question the whole of the insanity specially associated with the female sex was more or less connected with the sexual relations. They hardly ever heard of any cases of insanity before these were established. At the latter end of life they, no doubt, did get a large number of cases, but that was due chiefly to brain-wasting. He had himself had two cases in which the patients had had no uterus at all, and they were no less examples of the position he contended for.

Dr. PERCY SMITH said that the words which he had quoted from Spitzka's book were that "even the grossest lesions of the female genitary apparatus are not sufficient of themselves to produce insanity." He thanked the meeting for the way in which they had received his paper, and only regretted that only one case of ovariotomy during mental disease had been cited.

Dr. BOWER read a short paper on "Suicide and the Lunacy Laws Agitation," in which he said the time has come for candid speech respecting the grave question involved in the increasing number of cases of preventible deaths, of which the inquest upon a late nobleman is a painful example. Technically suicide, I venture to suggest that such deaths might be more correctly described by the term manslaughter, as being due to the culpable negligence of a morbidly sensitive public opinion which rejects the warnings and advice of the philanthropic Earl who constantly advocated the early treat-

ment of mental disease, both as most conducive to its cure, and as ensuring the safety of the individual and the public. The lamentable occurrence of last month, and the violent death a few years back of a very eminent peer who was under "private care," and the increasing number of suicides of less notable, but not necessarily less valuable, lives, should make the public pause and think seriously whether they are not going on the wrong track. They are so far putting insuperable obstacles in the way of early treatment and cure, by the findings of common juries in lunacy cases, and by the groundless attacks made on doctors who certify mental disease by speakers and scribes, who, as a matter of fact, have admitted making egregious blunders in matters easy of verification. What the public at large need just now is to know from authoritative sources how important and how successful is the *early treatment* of nervous diseases. Facts there are, we know, innumerable and absolute to convince the most prejudiced person of the dangers involving sanity and life that are constantly accruing from neglect of early symptoms. If the patient is entrusted to the care of a specially skilled practitioner in a suitable institution, we should let the public know that there is nothing of prison privacy whatever about it. I wish to call special attention to the fact that often those for whom private treatment would be most beneficial, are now hurried off to public and private asylums, and those for whom institutional treatment is really necessary, are, as we see, left practically uncared for in what professes to be "private care." The results in both cases are or may be disastrous. It needs no arguing, if the public will but think it out for themselves. Almost every case of melancholia is potentially suicidal, yet it is one of the most easily curable forms of insanity if efficiently dealt with in its early stages. The essence of successful treatment, as we all know, is, simply apart from purely medical treatment, entire change of surroundings, and especially removal from the companionship of relatives and friends, whose presence only excites and intensifies the mental depression and suspicion. But then the patient should be placed in association with his equals in intelligence and social position where there are organised occupations and amusements, which is a very different matter to being relegated to the unsuitable surveillance of an uneducated "attendant," who soon makes the poor sufferer feel he is in the clutches of a "keeper." Were it not for the obstacles set up by the law, and certain recent interpretations of it, the proper cases for prompt institutional treatment and care would be *not* those of acute mania, mania after child-birth, fevers, &c. (too hurriedly sent away to asylums), and whose duration is short, nor the quiet cases of chronic harmless imbecility with which all our public and private institutions teem, and by which our pauper rates have been considerably increased, but cases such as the recent one referred to—of melancholia—cases of insanity from drink, hysteria, paralysis, opium, epilepsy, hallucination, and of homicidal tendency. To these I would add those cases of recurrent and of moral insanity where there may be no delusions, but where the presence of the patient in domestic life is intolerable both to the sufferer and to his friends. The pith of the matter is simply this:—While unskilled juries intimidate conscientious doctors by such verdicts as we have seen of late, the medical profession shrink from giving certificates which, being promptly acted upon, would bring about the early cure of mental sufferers; and the responsibility for preventible deaths indisputably lies on the culpable ignorance or negligence of an artificial and spurious public opinion.

Dr. SAVAGE said that the question of who was to be treated in single care was one more easily suggested than answered. Almost every individual case ought to be decided on its own merits. The patients' friends were also an important consideration, as they were frequently the hardest to deal with. Many a person was a lunatic principally because of his friends. In some cases it was absolutely necessary that the patient should be moved from home, but he did not think it so much mattered where he was taken. He quite agreed with Dr. Bower that it was a very trying thing for a man of intelligence and education to be placed under very ill-selected servants, but it was not to be taken for

granted that all attendants were of one class. He had known one or two men engaged in private work who were most favourably situated in that respect. He had known private care, with a conscientious doctor, a well-selected attendant, and all proper facilities for health and exercise, which could scarcely be improved. On the other hand there was a fallacy to be guarded against. Taking the large number of hypochondriacs and other cases who were sent travelling about in the winter to the Nile and other places, he believed the time would come when it would be recognised that a certain number of those people were definitely passing through a nervous process in the same way as a typhoid patient was passing through a nervous process, and, just as it would do harm to a typhoid patient to trot him about, so he believed many of these hypochondriacal people might be trotted about to their detriment. If some of them were quietly allowed to rest away from worry and away from their friends for a time, following out Dr. Clouston's gospel of "fatness," they might afterwards, be trotted about with advantage. Of course in the very early stage these benefits might be derived from travel, but there were cases of hypochondriasis which were best for rest first.

Dr. HACK TUKE said that he felt strongly that the prejudice against institutions, and in fact the placing the insane under any care at all, was a very serious one and did, in some cases, lead to suicide, which might have been avoided. As a general rule suicidal cases ought to be placed in an asylum. As Dr. Savage had remarked, there were a great many cases not suicidal (hypochondriacal and others) where private treatment would suit best, but in suicidal cases the best thing to prevent a catastrophe was to place the patient without delay in an asylum. One had hoped that, as more knowledge was gained of insanity, the stigma connected with placing a patient under care would have been lessened; but at present this feeling did not appear to be on the decline. People would not consider insanity as the manifestation of one form of physical disease. From the close bearing which the question of insanity had upon crime and testamentary matters there would doubtless always be elements attending mental disease which were not present in such diseases as rheumatism, phthisis, and other maladies; at the same time the medical profession ought to do all in their power to lessen the popular prejudice against institutions and to dispel the absurd ideas prevalent on the subject of treatment.

Dr. NEWINGTON said that one heard a great deal of the prejudice of the British public against asylums, but it was quite a question whether that prejudice was mainly on the part of those people mostly concerned, viz., the patients. There was, of course, much prejudice on the part of the patients' friends, but, taking patients themselves, the acute maniac did not care where he was, the melancholiac would be miserable anywhere, and it was principally the "moral insanity" cases which made the noise from the patients' point of view, and they were just the people in asylums whose opinions should be considered the least on this point.

Dr. BOWER said that he did not wish it to be assumed from his paper that he was averse to private care, which might be a good thing in many cases. As to attendants, there were no doubt many good ones, but he had found that attendants who were very good in an asylum speedily developed very bad practices when they took charge of patients themselves. In Dr. Newington's remarks he concurred. He might add that he had one patient at all events especially in mind who would be much happier and more comfortable if he were in an asylum instead of dwelling with an attendant. This patient had plenty to eat and drink and other material comforts, but he had not those elevating influences which he would have in an asylum.

A Quarterly Meeting of the Medico-Psychological Association was held at the Central Hotel, Carlisle, on 8th April. Present: Drs. J. A. Campbell (Chair), Campbell-Clark, Clouston, Greenlees, Ireland, Keay, Macleod, Rutherford (Hon. Sec.), Urquhart, Wallis, Wickham, Yellowlees, &c., &c.

John Keay, M.B., Assistant Physician, Crichton Royal Institution, and John McPherson, M.B., Assistant Physician Royal Edinburgh Asylum, having been duly nominated, were elected members of the Association.

Dr. CAMPBELL-CLARK read "Notes of a Case of Caries of the Cervical Vertebræ, with Autopsy."

Dr. URQUHART described a somewhat similar case, in which the caries was not discovered till after death. The patient complained of slight rheumatic pains at the back of the neck. He consulted a friend, who was assistant to Dr. Fraser, of Aberdeen. In examining the patient he told him to retire and make water; while doing so he dropped down dead. The patient was not insane.

Dr. CLOUSTON stated that, in all his experience, he had not met with a case of disease of the vertebræ in an insane patient.

The CHAIRMAN stated that he remembered two cases; in one of them the chief symptom was a deep abscess in the thigh. This was opened; the patient afterwards became paralysed, and after death it was ascertained that the vertebræ were extensively diseased.

Dr. JOHN KEAY showed a specimen of, and read notes on a case of, cancer of the stomach.

The CHAIRMAN expressed the pleasure with which he had listened to Dr. Keay's account of this interesting case. He had observed in cases of this kind that the patient generally had delusions as to having certain things in his stomach, and was melancholic. He had also noticed that secondary cancer was rarely developed. He had recently heard Dr. Tait's address at the Edinburgh Medico-Chirurgical Society, and he strongly deprecated surgical interference with cancerous disease of the abdomen.

Dr. MACLEOD said that he had never seen a specimen in which the disease was so extensive. The case was interesting in showing how nutrition could be carried on with the stomach a mass of cancer.

Dr. CLOUSTON said that it did not accord with his experience that patients suffering from cancer of the stomach had suspicion of poisoning; there were a certain number of such cases, but the majority did not exhibit symptoms to correspond with the disease. During the past twelve months he had had three deaths from cancer of the stomach. One had suspicions of poison in the food; but he was an old drunkard, and this, apart from the cancer, might be the cause of the delusion. This patient died in the early stage of the disease. The other two cases had no such delusions.

Dr. IRELAND read a paper on "The Admission of Imbecile Children into Lunatic Asylums." ("Original Articles.")

The CHAIRMAN stated that he had long been of opinion that imbecile children should not be sent to lunatic asylums. It was injurious to the children and bad for the lunatics. He hoped the time would soon come when imbeciles would be properly cared for by the rates. He thought the present charitable system was doing as much harm as good. The institutions for imbeciles endeavoured to supply a want which, owing to them, did not appear so clamant as it really was. At the Royal Albert Asylum imbeciles who had the further misfortune of being epileptic were not admitted. The system of treatment also was directed too much to the brain, which was the weakest organ. He thought greater attention should be paid to physical development.

Dr. WICKHAM agreed with everything that Dr. Ireland and Dr. Campbell had said. He had been recently much impressed by what he had seen when visiting a memorial home lately erected in Newcastle to the memory of the late Roman Catholic Bishop. The inmates were young, uneducated children of the lowest

type, just one degree removed from the criminal or the imbecile. He was much struck with the facility with which these children were taught associated movements. They stood in rows, forming letters and spelling words mechanically. He thought a great deal might be done in this direction with imbecile children.

Dr. IRELAND said that it was often insisted on that these children should be taught to work, to do simple things, and to be clean, and that the brain, which, as Dr. Campbell said, was the weakest organ, should not be stimulated. But it should be remembered that there was an unusual degree of indolence in imbeciles, which kept them from working. The condition of the brain caused the difficulty in teaching them to work. Some of them could not execute an ordinary movement. He had known an adult imbecile who could not move his thumb. There were two channels through which imbeciles could be taught, either through the mind or through the faculties. As to cleanliness, he knew authorities who made a special point of this; but he thought the children did not learn to be clean, but rather learned to depend upon others to clean them, making no effort themselves. He had heard of an institution in which every child that was dirty had an enema before going to bed.

Dr. CLOUSTON and Dr. YELLOWLEES remarked that fewer imbecile children were sent to the Scotch than to the English asylums. In Scotland, inspectors of poor generally provided for them otherwise.

Dr. J. A. CAMPBELL read a paper on "The Appetite in Insanity." ("Original Articles.")

Dr. IRELAND said that he had always thought that, both in cases of lunacy and in ordinary disease, prolonged fasts sometimes served a good end; therefore he did not think that it was always good practice to press patients to eat when they had a repugnance for food.

Dr. MACLEOD said that he did not think that patients should be allowed to continue for any length of time without food. His experience was that if allowed to fast they went from bad to worse, and if they went a certain length in this, it was a matter of extreme difficulty to get them brought round. He knew from personal experience that the effect of any strong emotion was total suppression of appetite and loathing of food. He found that in order to remedy this he had to force himself to eat. He had been surprised at the differences with regard to the necessity for forcible feeding in different localities. At Garlands it was frequently difficult to get patients to take food for some days after admission, while in Yorkshire all took their food well.

Dr. YELLOWLEES agreed with all that Dr. Macleod had said. They were all familiar with the coated tongue, which indicated not a loaded stomach, but an empty one. In these cases forcible feeding was necessary. In cases of abstinence from delusions many patients would die if not fed. He had had some remarkable illustrations of this. One patient would not eat anything because he had a command from heaven. Another sometimes refused food because he saw portions of the human frame, generally of a female, chopped up on his plate; and he had recently a remarkable instance in a woman who refused to take food for eight and a half years under the delusion of poisoning. During that time she had been fed by the stomach tube three times a day; now she sat at table and took her food like the others. He did not know of another case where a patient after eight and a half years of refusal of food came to take food voluntarily. He had seen patients die in spite of all the food that could be administered to them, although given amply and continuously.

Dr. CLOUSTON said that the subject which had been started was a very wide one, which would require to be considered in a much larger aspect than the Chairman had treated it in his paper. He had no doubt that in a great number of cases the want of appetite in insanity was a purely nervous effect analogous to the case of a hungry man who lost his appetite on receiving bad news, and that the enormous appetite which Dr. Campbell had so vividly described as

existing in general paralysis and epilepsy was perhaps due to the degeneration of the higher nervous system. When they came down the scale in the animal world they found that those animals with the biggest, most voracious, and least capricious appetites were those with a poorly developed nervous system. And in proportion to the lack of mind in the general paralytic, they had a development of the ordinary appetite for food. In cases of melancholia, where want of appetite was part of the disease, his experience had been entirely in the direction of feeding, or rather over-feeding. He thought that for one case where starvation was good, there were ten where it was bad, aggravating the disease, and tending to the death of the patient. He upheld in his practice and in his teaching that over-feeding in these cases was a remarkably good thing.

Dr. URQUHART said that he could not see how they could treat all cases upon the same principle of over-feeding from any scientific basis. His experience was that, as a general rule, asylum patients required feeding up, because their insanity was usually associated with a low physical condition. A good deal, however, depended upon the diathetic condition of the patient, for example, whether they were treating gouty insanity or phthisical insanity. Each case, he thought, ought to be taken and treated on its own merits, and no absolute rules of feeding laid down.

Dr. CAMPBELL, in thanking the various speakers for their expressions of opinion, said there was one point which he had omitted, and on which no one had touched, that was the importance of giving a small quantity of alcohol with each feed. The beneficial action of the food was materially aided by this.

Dr. J. A. WALLIS read a paper on "Bleeding in Epilepsy."*

Dr. MACLEOD said that after hearing Dr. Wallis' remarks he was very favourably impressed with the system of treatment laid down, and he should not fail to adopt it on the first favourable opportunity. The proportion of epileptics under his care was large, and recently he had had several deaths from failure of the heart's action, as described by Dr. Wallis; but to treat them by bleeding had not occurred to him.

Dr. YELLOWLEES said he placed great value on Dr. Wallis' observations, which were enhanced by the great field he had to work upon. He confessed that, in his own experience, epileptics did not die from epilepsy, and he did not see a death from epileptic fits once in several years. He supposed there was less epilepsy in the Scotch than in the English asylums. He had not one death in four years from epilepsy, but the next case he had likely to die he might try Dr. Wallis' practice.

Dr. RUTHERFORD said that there certainly was not in Scotland the type of epilepsy that existed in England. In the Birmingham Asylum 20 years ago, when he had under his care about 600 patients, more than 100 of whom were epileptics, he was certain there must have been eight or ten deaths occurring every year from a rapid succession of fits, as described by Dr. Wallis, and, from what he remembered of these cases, he was sure that bleeding might often have averted death. When he left England and came to take charge of the Argyll Asylum, with only one epileptic inmate, he was very much struck by the change. Even the epilepsy that exists in Scotland is of a much milder type than is seen in such asylums as those of Birmingham and Staffordshire.

Dr. T. D. GREENLEES read a paper on "Observations with the Sphygmograph on Asylum Patients."*

The CHAIRMAN moved that, owing to the lateness of the hour, Dr. Greenlees be thanked for his paper, and that the discussion be deferred, which was agreed to. He had a resolution to bring before the meeting, of which he gave notice to the secretary, but not in time to appear on the agenda. He begged to move—"That for the safety of insane patients, as well as those brought into contact

* These papers will appear in the next number.—EDS.

with them, it is desirable that, previous to removal to an asylum, it should be the duty of the relieving officer effecting the removal to ascertain satisfactorily that such patients are not in possession of anything likely to cause injury to themselves or others."

Dr. MACLEOD, in seconding the motion, remarked that he thought it was a most necessary resolution. He had rarely seen suicidal patients arrive at the asylum without having a pocket knife in their possession.

Dr. CLOUSTON questioned the competency of the meeting to deal with such a matter.

The SECRETARY said he knew nothing in the rules against their doing so.

The resolution having been carried,

Dr. CAMPBELL proposed that a copy be sent to their Parliamentary Committee, to the President of the Local Government Board, and to the Commissioners in Lunacy, which was agreed to.

Dr. URQUHART said that before separating he wished to address himself especially to the physician-superintendents of the Scottish Royal Asylums, and to put in a plea for the "chronic bad patient." Most asylums for the upper and middle classes are now provided with means of giving change of air and scene to the less turbulent and dangerous; but there remains a residuum who are unable to enjoy these advantages. The lot of these patients who are condemned to live from year to year in the same wards and to perambulate the same ground, is so monotonous and unvaried that he felt constrained to make some remarks on the subject in his report of 1884. In the following year he was gratified by obtaining Dr. Clouston's sympathy and co-operation in so far that an arrangement was made whereby such patients in the Perth Royal Asylum might have a temporary change to the Edinburgh Royal Asylum and *vice-versâ*, with as few formalities as the law permits. In this way patients have been transferred for a month or a quarter, as might seem desirable, with benefit to mind and body. He would therefore urge a more extended application of this mutual agreement, so that it might be in the power of such patients or their physicians to choose a temporary residence in any of the Royal Asylums. It is evident that such transfers can only be made under sanction of the Lunacy Board and the friends concerned; but the expense involved only amounts to the sum of the railway fares, the medical certificate being granted free of charge. It is also important that the guardians should not be asked to enter into any fresh obligation for payment of board. The arrangement should be made between the treasurers of the various asylums, so that, *e.g.*, Perth treasurers would be liable for the board during such time as Perth patients were in, for instance, the Edinburgh Asylum.*

Dr. CAMPBELL-CLARK proposed a vote of thanks to Dr. Campbell for his conduct in the chair, and for the great interest which he had taken in this meeting at Carlisle. He hoped they would have many more meetings in the North of England, and that they would always be as successful.

* We cordially commend this plan, and have no doubt it will have the support of the members of the Association generally.—EDS.

CORK ASYLUM CHURCH.

Early in March the new Church for the Protestant inmates of the Cork District (Eglinton) Asylum was opened by the Bishop. It is an exceedingly fine Gothic building, consisting of chancel, nave, vestry-room, porch, tower, and spire, with an excellent bell. The windows are filled with tinted glass and ruby borders, and the inside walls are lined with red brick and coloured bands, giving a warm and pleasing appearance to the interior of the building. The grounds around the Church are tastefully laid with trees, plants, and grass plots, all the work of the patients. Dr. Eames is to be congratulated on the success of this undertaking. The Bishop, in his sermon, said that while they could not tell all the causes that led to mental aberration, he felt satisfied that the medical gentlemen present, and especially Dr. Eames, would agree with him that in drink they would, at any rate, find one cause and trace one germ leading to insanity.

"A very splendid luncheon"—from which we doubt not the above-mentioned germ was carefully excluded—"was subsequently given by some of the governors to the Bishop and Clergy, and many other guests, in the great Hall of the Asylum, one of the largest in Ireland." The kindly Bishop, in responding to the toast of his health, said "he appreciated the good feeling of those persons who, although not able to attend the service in the Church, yet joined with them at the luncheon." As we cannot suppose the speaker to have been ironical, the observation bespeaks a truly liberal mind.

Obituary.

PROFESSOR BERNHARD VON GUDDEN.

The melancholy catastrophe by which the life of this distinguished alienist came to a sudden and violent end, on the evening of Sunday, June 13, at the Starnberg Lake, Bavaria, is known throughout the civilized world. But commiseration for the fate of the mad monarch who occasioned it almost throws into the shade, in the public mind, that of the unfortunate physician, who, if he may seem to have displayed undue disregard of precautions, acted chivalrously in the belief that he should, by the course he pursued, cause the least irritation and pain to his royal patient, and concluded, not without some reason, that he would be sufficiently strong physically, and by his moral influence, to prevent any accident happening. Now that all is over, and Dr. von Gudden has fallen a victim to his well-intentioned proceeding, it is easy to criticise his action, and to accuse him of culpable rashness. But uppermost in the minds of mental physicians everywhere ought to be, and no doubt is, the loss sustained by Psychiatry, and pity for him and his family in the sad fate which has overtaken him. His name must be added to the not inconsiderable list of physicians who have been either injured in person and health, or killed outright by patients of whom they have had charge. The life of the mental physician is in truth constantly in danger. He carries it in his hand, and may at any moment have to resign a career of intelligent usefulness and devotion at the hands of some one deprived by disease of both intelligence and useful purpose.

Dr. von Gudden was, in the first instance, assistant physician at the Irrenan-

stalt, at Illenau, made celebrated by Roller, and we were struck with his mental qualities more than thirty years ago when we formed his acquaintance during a visit of several days to that asylum. He was, at that time, devoting himself to pathological study, and laying the foundation of that extensive knowledge which subsequently made the Medical Director of the Kreisirrenanstalt at Munich so high an authority in Mental Medicine and so justly honoured a Professor of Psychiatry in the University there—the "hochverehrte Lehrer" of many a German student past and present.

Last autumn Dr. von Gudden presided over the annual meeting of the German Psychological Association at Baden, and was President of the Section of Psychiatry at the meeting of German Physicians and Naturalists held immediately afterwards, at Strasbourg. Little did those think who had the pleasure of seeing his striking form and intellectual face on these occasions, and hearing his hearty genial welcome, that before another of these annual gatherings his voice would be abruptly silenced by so cruel a fate, and his eminent services to science terminated by a royal hand.

The funeral of Dr. v. Gudden took place on June 16, at the suburban cemetery, Munich, and was attended by Baron von Lutz, President of the Council, Baron von Crailsheim, Minister for Foreign Affairs, and Baron von Feilitzsch, Minister of the Interior. Several representatives of the civil authorities and many officers and military surgeons were also present, as well as delegates from the local medical societies, the students of Munich, and the whole of the Professors of the University. Wreaths were laid on the grave by Baron Wolfskehl on behalf of the Prince Regent, by the Dean as representing the University, and by Privy-Councillor Rothmund in the name of the medical faculty.

Of the suicide of King Ludwig of Bavaria and his extraordinary career we do not speak now, but intend to return to the subject in the next number of the Journal.

DR. BENJAMIN CONSTANT INGELS.

(Honorary Member of the British Medico-Psychological Association).

We regret to record the unexpected death of the well-known Secretary of the Society of Mental Medicine, Belgium, the Physician-Superintendent of the Guislain Asylum, Ghent, and the editor of the "Leçons Orales sur les Phrénopathies" of the renowned Belgian alienist, after whom this hospital was called, and to whom he succeeded. Those who in September last attended the Antwerp Congress of Psychiatry will not forget the urbanity and kindness of the Honorary Secretary to the Congress, combined with a modesty which made him always content to efface himself.

On April 26, Dr. Ingels made a post-mortem examination of one of the patients in the Hospice Guislain, who died of empyema. He grazed his hand with a rib in removing the lungs. The wound was at once cauterised, but in twenty-four hours fever set in, the axillary glands became swollen and painful, and in the course of a fortnight a very large abscess formed. It was opened, but the pyrexia continued in spite of 90 grains of quinine, and he died a martyr to medical science, May 22, 1886, in his 56th year. The funeral was attended by a large concourse of people. "Our Ingels," writes M. Jules Morel, "was known as the most sympathetic of men, and I may say I know no one who bore any antipathy to him." Before the *cortège* left the asylum six dis-

courses were delivered on behalf of the Belgian Government, the Royal Academy of Medicine, of which he was a corresponding member, the Medical Society of Ghent, and the Société Médicale de Prévoyance, of which he was the President. A profusion of wreaths covered the coffin, placed there by the family, the staff, the patients of the asylum, and former patients who came from different parts of Belgium. In the old city of Ghent business was suspended. The morning of the 26th of May, when the solemn service for the dead was performed at the Parish Church of St. Joseph, followed by the interment in the family vault at Mont-St.-Amand, was a day of "deuil," to mark the sympathy of all with the mourners.

We heartily join in the homage of respect and affection justly paid to the memory of the excellent Dr. Ingels.

DR. GILCHRIST.

Dr. James Gilchrist, the pupil and successor of the late Dr. W. A. F. Browne, the first superintendent of the Crichton Royal Institution, died at Dumfries, on 7th December last, after a brief illness. Dr. Gilchrist was born about seventy years ago. He prosecuted his studies first at the University of Glasgow, and afterwards at the University of Edinburgh. He distinguished himself greatly as a student, particularly in the department of Natural Science. Dr. Gilchrist's connection with the Crichton Institution began in 1851, when he was appointed Dr. Browne's assistant. This post he filled with singular ability, and inaugurated classes of instruction in botany and geology, which proved of much value in affording intellectual recreation to his patients. In 1853 he was promoted to the superintendentship of the Montrose Royal Asylum, on the resignation of Dr. T. Morrison. This was the oldest asylum in Scotland, dating from 1781, and with characteristic zeal Dr. Gilchrist recognizing its defects, urged the erection of a new building. This was commenced at Sunnyside, in 1857. The work was little more than begun when, on Dr. Browne's appointment as a Commissioner in Lunacy, Dr. Gilchrist was chosen superintendent of the Crichton Royal Institution. How faithfully and ably he performed his duties is well known. A reference to the Reports of the institution of his time shows the number of patients who sought his treatment —so many that numerous applications for admission had every year to be refused. In 1874 a large addition—the present ladies' department—was erected, and at various times during his superintendentship, large and important additions and improvements were made. He continued in office till the end of 1879, when his health, never very robust, began to fail under the strain of his arduous and anxious duties. Acting on the advice of his medical friends, he resigned the superintendentship of the asylum and retired into private life, spending his time usefully and quietly in those scientific studies and pursuits, particularly in geology and botany, for which he was distinguished as a student, and in which, all through life, he took such a deep and practical interest. He was an earnest and faithful physician, and leaves to his many patients and friends the recollections of a life well spent in devotion to good works.

A. MARVIN SHEW, M.D.

To any one who has visited the Hospital for the Insane at Middletown, Connecticut, during the period 1868-86, it must have been melancholy news to hear that so able, upright, and humane a superintendent had passed away. Regrettable under any circumstances, the regret is heightened from the circumstance that the end came in consequence of an accident. Dr. Shew fell on the stairs of the hospital, the result being injury to the spine, and, in the course of some weeks of suffering, apoplexy. Dr. Shew was born in 1841 at Le Ray, Jefferson County, New York. We recall a family incident which he told us when visiting the asylum in 1884, namely, that his father, a German, made a voyage to the United States, intending merely to visit the country, but during a violent storm, in which the vessel was in great danger, he solemnly vowed that if he ever reached land he would never return to Germany. Shew received his academic education at the Jefferson County Institute, and, having chosen the medical profession, and studied under Dr. Bates of Waterton, he became a medical officer in the Asylum for Insane Convicts at Auburn, where he resided a year before his graduation in 1864 at the Jefferson College. During the war he was in the army for fourteen months in a medical capacity. Subsequently he was one of the resident physicians at the Blockley Hospital at Philadelphia. In the spring of 1866 he was elected assistant medical officer in the New Jersey State Lunatic Asylum, Trenton, of which Dr. Buttolph was the superintendent.

When the Legislature of Connecticut chartered a hospital for the insane, Miss Dix named him to the trustees as well fitted to organise and take charge of the institution, and on the 15th of October, 1866, he was appointed medical superintendent. "It was a responsible and difficult work," says the "Memorial," from which we have obtained the particulars of Dr. Shew's life, "enough to tax the wisdom and strength of a much older man. But his wide experience in hospital and army life, his quickness of perception and maturity of judgment, his remarkable faculty of presenting his own views so as to win the assent and co-operation of others, and his singleness of purpose fitted him for the emergency. He had the hospital in readiness to receive patients in the spring of 1868. His devotion to his work after a few years seriously impaired his health, but it won for him the affectionate regard of his assistants and of those who were daily associated with him, and the confidence of the good people of Connecticut; also the profound respect of the foremost men of the State, with whom his duties brought him in contact; of the members of the legal profession who had occasion to consult him as an expert in cases of insanity, and not less of a wide circle of the members of the medical profession who enjoyed his acquaintance. He was ready with his pen to contribute to the medical journals, to the Association of Superintendents of Hospitals for the Insane, and not less to the literary and scientific associations to which he belonged in Middletown. His annual reports of the hospital were uniformly interesting and valuable. He was not satisfied with what had been done, but ever said that improvements might be made. He was not content with veneer or mediocrity in building or administration."

The particular service rendered by Dr. Shew in hospital management consisted in his providing separate buildings and cottages in the establishment, adapted for the different classes of cases which must always exist in asylums for the insane. Besides the enlargement of the main building, two additional ones, each capable of accommodating from 250 to 300 patients, were erected, the last being completed a little before his death. He had 1,100 patients under his care, with room for 150 more.

Dr. Pliny Earle (Northampton, Mass.), in a letter to us, thus writes:—"The characterization of Dr. Shew in the 'Memorial' is no exaggeration, but is truthful and just. He was a worthy, meritorious man, a genial friend, to whom I was sincerely attached, and whose loss I as sincerely mourn."

Correspondence.

To the Editors of the *Journal of Mental Science.*

Gentlemen,—In the following remarks, I wish to be animated with a humble spirit; and, if I state anything strongly, I am conscious that I aim at moderation in my sentiments. I would be lacking in the bare and comparatively beggarly elements and first principles of Christian feeling, if I entertained for a moment the idea of unfriendliness on the part of asylum officials, or doubted that the least amiable of them had any desire but the welfare of such as are committed to their charge. It cannot be expected that the laws which govern society as a whole are altogether applicable in asylums. The ruling and guiding principle, the mind, being more or less morbidly affected in the insane—to anticipate that laws will have the same force with them as with those possessed of mental health, is like expecting fine music from a broken instrument or from one that is entirely out of tune. Regard will be paid to this in all well-regulated asylums. It will ever be uppermost in the thoughts of the officials that those amongst whom they mingle are not like themselves able to control their actions; since they are not, as in the case of sane persons, actuated by ordinary motives, or similarly influenced by outward circumstances. If a man's will is so over-borne, and his power of self-control so over-mastered, that he acts in a manner that lays him open to censure—is he to be blamed and punished? If a man suffers from temporary aberration of intellect during a paroxysm, he is not responsible. He feels, on recalling any particular action he may have done during illness, that he could not have done otherwise; for his reason—such as it was, defective and weakened as it must then have been—approved: though admittedly it was this power of the mind, pressed and harassed by the force of emotion and passion, that pronounced the verdict. The nature and consequences of his action were not for a moment thought of. If quite well, he would certainly have acted otherwise in the same circumstances: but the question arises—would the same convention of circumstances ever occur in a state of mental health, or during a period of convalescence? Were the element of punishment eliminated from the asylum treatment, it might be asked—how are order and discipline to be maintained? We know how much the non-restraint system was at first opposed. We know how very gradually, as a rule, ameliorating influences are allowed to have their due weight upon society of all kinds. In the minds of Tuke, Hill, and Conolly, the removal of restraints implied that in the treatment of the insane nothing should be present which has a tendency to thwart or irritate. There is a lingering aversion among some alienist physicians to cast from them the idea that wickedness is an element in the conduct of the insane which necessarily presupposes responsibility. If this stumbling-block were removed, the object I aim at would be more easily attained. It is certain that in many cases insanity is owing to accident or misfortune, and not to sin; and in judging of other cases, it is

advisable for all—limited and imperfect as human knowledge is at the best—to attribute this calamity to the same cause. Is it not conceivable, is it not the fact, that with some, self-imposed restraint may have caused mental derangement, from which they might have been saved if they had been less ascetic? Were statistics available, might it not appear that immorality has as much to do—to say the least of it—with cancer, consumption, heart-disease, and other ailments, as with insanity? Why, then, should insanity alone have a stigma attached to it, and the insane be invariably designated as under a cloud? Specialists themselves are much to blame for this. Is it not the case that some of them with no reluctance, but seemingly with pleasure, attest in lectures on insanity or in asylum-reports that insanity is sometimes attributable to or accompanied with immorality, and sometimes even hold up the finger of scorn at what they in some cases consider its debasing causes? It is a pity that such should be the case. The world is hard enough upon the insane, without any seeming ground being afforded it for cherishing bitter and uncharitable thoughts; and it is impolitic in the highest degree to inculcate upon the rising members of the medical profession principles most prejudicial in their tendency. How can I expect a medical man to take an interest in my case, to show marks of sympathy and kindness in his treatment, if all the while there is running through his mind an undercurrent of aversion, a feeling that I am only worthy to be despised! The idea that I have broached in this letter, of eliminating everything of the nature of punishment from asylum treatment, need not be considered Utopian, when we remember the revolution that has taken place within the last forty years in the management of asylums and the treatment of the insane. And if so much has been done in the past, why may we not expect more in the future? Why may not the good work go forward, till every discordant element shall have been purged—till the very last shred of intolerance has been torn away—till the word "asylum" shall be a synonym for humanity, care, consideration, and generous sympathy. This will only be when everything of the nature of punishment shall have been ejected. The difficulties in the way will disappear in the face of determination of purpose, and a strong desire to reach the *ne plus ultra* in asylum treatment. Trust begets faithfulness. Love generates kindness, forbearance, and respect. Perish the thought that anyone suffering from an attack of insanity is responsible—as if he could be partly one thing and partly another. The very fact of his committing an imprudence, of his doing something against which his better nature rebels, of his making a mistake however slight, shows that he is impelled by a force which is stronger than his will—a power which for the time being usurps the place of reason and conscience. The same person, if well, would commit no indiscretion, would be liable to no censure. Why, then—if disease exercises its sway over the highest part of his nature, causing him to commit some indiscretion, such as breaking his parole—should he be made to pass through a second fire, as if the work of the physician involved also that of a governor of a house of correction?

I am, &c., &c.,

A PATIENT.

March 6, 1886.

[Our correspondent is referred to the comments made on this subject in the Journal of April, 1883, with which, we think, he will find himself in accord.—EDS.].

Appointments.

CLAPP, ROBERT, L.R.C.P. Lond., M.R.C.S. Eng., appointed Senior Assistant Medical Officer to the Devon County Asylum.

HABGOOD, WILLIAM, L.R.C.P. Lond., M.R.C.S., L.S.A., appointed Resident Clinical Assistant to St. Luke's Hospital, London.

PERCIVAL, FRANK, M.R.C.S. Eng., appointed Assistant Medical Officer to the Lunatic Hospital, The Coppice, Nottingham.

REVINGTON, GEORGE, A.B., M.B., B. Ch. Univ. Dublin, appointed Junior Assistant Medical Officer, Prestwich Asylum.

MURRAY, J., M.B., appointed Assistant Medical Officer to the James Murray Royal Asylum, Perth, *vice* David Greig, M.B., resigned.

REYNOLDS, E. S., M.D., appointed Pathologist and Assistant Medical Officer to the West Riding Lunatic Asylum, Wakefield, *vice* W. Dudley, M.B., resigned.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

ANNUAL MEETING, 1886.

The Annual Meeting will be held in London, on Monday, August 9th, under the presidency of Geo. H. Savage, F.R.C.P.

Council meet at 10.30 a.m.
General Meeting at 11.
Afternoon Meeting at 2.

The Agenda will shortly be forwarded to members by the Hon. Secretary, Dr. Rayner.

EXAMINATION FOR CERTIFICATE OF EFFICIENCY IN PSYCHOLOGICAL MEDICINE.

For ENGLAND	Nov. 29, 30, 1886.	
„ SCOTLAND	July 29,	„
„ IRELAND	July 1,	„

(For particulars see Circular accompanying Journal.)

CONTENTS OF No. 136.—JANUARY, 1886.

PART I.—ORIGINAL ARTICLES.

PART II.—REVIEWS.

PART III.—PSYCHOLOGICAL RETROSPECT.

PART IV.—NOTES AND NEWS.

CONTENTS OF No. 137.—APRIL, 1886.

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JOURNAL OF MENTAL SCIENCE.

JULY, 1886.

CONTENTS.

The Editors do not hold themselves responsible for the views of Contributors whose names or initials, &c., are given.

No. CXXXIX. (New Series, No. 103) will be published on the 1st of October, 1886.

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THE JOURNAL

OF

MENTAL SCIENCE

(*Published by Authority of the Medico-Psychological Association*).

EDITED BY

D. HACK TUKE, M.D.,

GEO. H. SAVAGE, M.D.

"Nos vero intellectum longius a rebus non abstrahimus quam ut rerum imagines et radii (ut in sensu fit) coire possint."

FRANCIS BACON, *Proleg. Instaurat. Mag.*

OCTOBER, 1886.

LONDON:

J. AND A. CHURCHILL,

NEW BURLINGTON STREET.

MDCCCLXXXVI.

H. WOLFF, LEWES.]

To be continued Quarterly.

CONTENTS OF No. 135.—OCTOBER, 1885.

PART I.—ORIGINAL ARTICLES.

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THE JOURNAL OF MENTAL SCIENCE, OCTOBER, 1886.

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CONTENTS.

The Journal of Mental Science.

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English books for review, pamphlets, exchange journals, &c., to be sent by book-post to the care of the publishers of the Journal, Messrs. J. and A. Churchill, New Burlington Street. French, German, and American publications should be forwarded to Messrs. Churchill, by foreign book-post, or by booksellers' parcel to Messrs. Williams and Norgate, Henrietta Street, Covent Garden, to the care of their German, French, and American agents:—Mr. Hartmann, Leipzig; M. Borrari, 9, Rue des St. Pères, Paris; Messrs. Westermann and Co., Broadway, New York.

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PART 1.—ORIGINAL ARTICLES.

Presidential Address, delivered at the Annual Meeting of the Medico-Psychological Association, held at the London Medical Society's Rooms, Chandos Street, W., August 9th, 1886. By GEO. H. SAVAGE, F.R.C.P., Resident Physician, Bethlem Royal Hospital.

Before proceeding with my Address I have a painful duty to perform. Instead of receiving the presidency from my predecessor, I have to join with you in lamenting his death. In full, vigorous manhood, energetic, sympathetic and kind, yet firm and full of purpose, he has passed from the active stage.

Those of you who last year met him in Cork, and enjoyed his gracious hospitality, will feel the more deeply the loss which has been sustained.

No man had the good of his patients more at heart, and no one was more ready to help others in trouble.

His premature death has left a wife and family not provided for, and I trust the Association will not fail to assist liberally those depending, until so recently, on your official head.

GENTLEMEN,—I appear before you in my official position to-day for the first time, and I trust the year of office will pass leaving me with the same feeling of contentment with which I begin to-day. I trust with your help to do my duty, and if we can advance the position of this Association by work and mutual help, I feel sure we shall.

But now to the more important object which is before me. I have necessarily for some time past thought over what I should speak about to-day, and after much consideration I have, like an hospitable host, determined to give you of my best, though that best may be, after all, inferior.

I might have spoken of the legislation in lunacy, but it seems that year after year we are to perform the work of Sisyphus and roll up the stone which ever returns.

For my own part I feel sure that the postponement is not altogether a loss, for the legislation of two or three years ago would have been the result of panic, and as such would have been both weak and tyrannous. But this subject must be put aside by me, and I shall devote the hour allotted to me to consider in as large a way as I can the pathology of insanity, or rather I should say some important questions in this pathology.

I have neither anything very new nor anything very startling to lay before you, but each of us has had opportunities for observing the growth and development of insanity, and has formed some ideas of his own, and I take this opportunity of telling you the way that at present I prefer to look at the pathology of insanity.

I have not referred much to authorities; therefore, if I have to bring forward facts or theories which may be claimed by others, I am only too glad that, independently, more than one has hit on the same idea or fact. I am not in the least jealous of originality; I want truth, and care very little for the steps by which it is reached. My work is more like that of the spider; I have assimilated material from without, but I have spun my own web, and I have neglected the ways of the bee, not having collected the results of others' work "mid sweetness and light."

To begin then at once upon my subject, there is pathology and pathology. I have no idea of discussing the appearances of the brain, cord, and other parts of the nervous system as seen in various groups of cases, though I believe I have some right to speak on this part of pathology, for more or less persistently have I cut sections for fourteen years, and I may say I have studied sections by the thousand. Without wishing to discourage younger men from following up this line of work, I would say that, without learning very much from the sections, I think I have learnt a good deal while cutting them, and thinking over them, and the cases from which they were derived.

Mind, I do not think the fault rests either with the sections or with the pathologists; but as yet the time is not ripe; we are groping in the dark for what we do not yet know. There is at present a very deep ditch of ignorance between us and the true pathology, and for that matter,

physiology of mind, and this ditch has to be filled by those who sacrifice their time and their energies in steady unremunerative labour. Their sacrifice will be the stepping stones for future achievement. So let us go on cutting sections in all meekness, not expecting too much, but only regardful of truth in observation and recording.

Thus there will be the service of sacrifice which brings with it a satisfaction worthy of the labour.

I am sure that the time will come, and from the steady and rising light I think the dawn is not far off, when along with Harvey there will be linked the name, I trust, of an Englishman who has discovered the circulation of nervous force, or whatever the power which moves the limbs and rules the faculties is called. Before Harvey's time the structure of heart and arteries was known, but the little fact of the circulation of the vital fluid was not known; we, too, know our centres and our nerves, but we have not yet got the nerves to tell their secret. Probably science, with all its boastful self-satisfaction, has not yet advanced nearly far enough to help the physiologist in his search. The time will come when these things will be made clear, and to my mind the asylum physician has a responsibility which he either does not appreciate or which he is strangely careless of. I am happy to say the metaphysicians are beginning to visit us, and to find that we can show something instructive among our mental aliens. Mind you, I may be rather heterodox, but I feel that the great physiological workers like Ferrier, Horsley, and others, are only the engineers who are studying the machinery, while we in asylums have the much more difficult problem of studying the motive power. There is all the difference between the living and the dead. Does the surgeon learn all he knows from the dissecting room? We have to remember that much more has to be learnt from the living than from the dead; the dead cannot be modified, while the modifications of the living are almost infinite. One other point nearly allied to this deserves my attention. We have all heard of the tyranny of our bodies, but I would at once protest against the too full acceptance of this deadening belief in the all-powerfulness of the organ. Feelings as well as coarser environing conditions modify the body, and in the body which has evolved so far, and so wonderfully, there are yet powers for further development in relation to the wants and the desires of the body and mind. In the simplest way we see

that there are such things as compensations in the body, one part taking on the function of another, and as a result modifying structures. And as to function modifying structure, as Dr. Sutton has well said, the blacksmith does not make the iron, but he fits it for service when he makes the horse-shoe.

And I wish here emphatically to say that I have a great belief in the existence of functional disorders especially of the most highly developed functions. As might be expected, that which is most complicated is most likely to be disturbed, that which has most parts has the greatest number of possible points of weakness, and also the greatest number of possible re-arrangements of parts, and thus alteration of power. I shall have much to say about these functional disorders in a later part of this address. To my mind, in selecting the subject which I have, I have selected one which reaches very far, for with the fuller appreciation of the pathology of insanity, not only shall we have to modify our nomenclature, but our treatment must also be simplified. First, as to its relation to classification. I know I shall tread on some corns and offend those who love the definite by my want of respect for the absolute, but I can only say that the definite is all but unknown in nature, no two blades of grass are alike, and no two flowers are definitely the same. In fact, as has been said, you no sooner define a thing in nature than it changes. The use of definition is for convenience, but though you do not hinder nature in her work of varying and adapting by your naming and defining, you unfortunately, by naming and defining ideas or diseases, do hinder the full development of the student. By naming a disease you erect an idol with special qualities which you set yourself at once to destroy. I wonder if many of us here still look upon mania as a definite disease; I trust that epilepsy and locomotor ataxy are on their last legs. There is great evil in this definite aspect of disease; thus, a student asks if "religious mania" is specially dangerous, and another asks if epilepsy is ever recovered from. I should at once decline to give definite answers to such questions, letting the student understand that for the convenience of discussing groups of symptoms we have to label them; but I would not allow him to think that there is a definite something which is mania, or you at once get to the dangerous position of having a definite something which must have as definite an antidote. As a result of defining, the student asks how do you treat mania or epilepsy?

"We define to go further," as Sutton says.

As I grow older, I am more and more content to watch and record groupings of symptoms, to note groupings of vital relations, without at once wishing to name them. The naming leads to a period of worship, followed by a period of neglect; the idol of to-day is the object of contempt of to-morrow.

The definition is after all but the summing up of the knowledge of to-day; it is not an absolute reflex of nature. Every step in advance leads one to have more symptoms. The definition of general paralysis was all very well for a time, but how is one now to give it without referring to the changes in the optic disc and the reflexes? and in another generation there will be many other things to add, till we are forced for convenience to divide further and so proceed.

By pathology of insanity, I mean the morbid conditions which give rise to unsoundness of mind.

And first I wish to make as divisions, the pathology of insanity as related to disease of the organ of mind; secondly, the pathology of the insanity resulting from diseases of other parts of the body, that is the mental expression of bodily diseases; then, thirdly, I have to consider the disorders of mental functions. This last division contains most of the cases which are commonly looked upon as true cases of insanity.

There is a grand uniformity in all the proceedings of nature which, to my mind, makes the poet, who sees the many hidden likenesses, often the true interpreter of natural things, and I am always ready to learn from the pathology of some simpler organ what may be expected in the brain under morbid conditions. We must not be content to think, that as the brain is the most highly developed and most highly evolved organ, that it is to be erected on a special pedestal of its own, and is not comparable with other parts of the body; as I shall point out, there are many points of analogy between functions and the disorders of the kidneys and the brain. Thus we may have disease of kidney with disorder of function, as seen in Bright's disease; and, again, we may have similar disordered expression (albuminuria) associated with several different forms of disease of the kidney, and we may have several different forms of brain disease producing similar mental expression. The modes of complaint do not differ in each form of disease of the organ. On the other hand, we may have unhealthy excretion from the kidneys without any structural disease of the organs,

as seen in diabetes, and equally we may have perversion of mind without any brain disease as its cause; and, to complete the simile, we may have disorder of the function of the kidney resulting from disease of some other organ; we may have hæmaturia with heart disease or scurvy, and we may have insanity, perversion of mental functions, due to ordinary bodily diseases. We must be prepared to learn wherever we can how nature works, and thus we shall learn a larger pathology than that made up of post-mortem examinations and microscopic sections.

There are some forms of insanity in which the organ of mind is affected, and in which the brain affection is the cause of the symptoms. To discuss this subject fully, I suppose I ought, like the anatomist, to take each intracranial structure and study the possible symptoms which might arise from disease of each of these structures. But for this I have neither time nor taste to weave such a web. I shall proceed broadly to study the result of brain changes as producing insanity. In my experience, disease of the brain, when it produces insanity, leads to the worst prognosis. Here again we see the relationship between brain and kidneys. If albumen follow as a result of kidney disease the prospect is bad, and if the mental perversion follow brain disease the prospect is equally bad. To begin with, we all recognise general paralysis of the insane as the disease most commonly met with which is due without doubt to disease of brain structure.

Of gross brain disease we have little to say, but that insanity, as generally understood, does not accompany brain tumours or the like. These coarse diseases of brain may, and often do in the end, put a stop to the higher functions of brain, before they go on to stop all vital activity. Generally speaking, all brain disease which gives rise to insanity is allied to decay, is in fact some form of progressive degeneration; for this reason I am becoming less arbitrary in dividing cases of general paralysis according to age. What good is gained by calling one a case of simple general paralysis, and another a case of senile general paralysis, and a third a doubtful case of senile dementia with progressive paralytic symptoms? Age and wear-out are purely relative terms, and what is more, we have to remember that decay shows itself in varying ways in the brain as in the deserted village. If we visit a deserted village, we find the meaner structures falling into decay much sooner than the well-built, and the

more delicate parts of the structures failing before the coarser, and it is thus with the brain. We see some persons decay rapidly and altogether, so that nothing is left but their nervous foundation, while others seem to crumble but slowly, losing their higher and more delicate parts or powers, yet bearing long a semblance of their old form. The decay in general paralysis is as a rule a pretty steady process, but it varies to a considerable extent according to the person and the special cause. I am inclined to think that this progressive decay is varied if the patient come of insane stock, that in such an one there is more chance of remissions and that these remissions may be more clearly marked than in a person breaking down from sheer strain or work, not being already unstable by inheritance. In this case we may say that a more severe strain was required to cause the upset in the otherwise sound man, and that the prospect of an equally strong force being ready to set him right again would be but small. It is to be noted that we have not only the marked cases of brain disease due to decay, but we have a perfectly parallel set of cases as far as early symptoms are concerned in the cases of brain poisoning. We have, in fact, temporary removal of the powers in the one case, and permanent removal of the same in the other.

Dr. Wilks has been long in the habit of telling students to look at the symptoms of early alcoholic intoxication, and then remember that any one of these may be represented in the earlier stages of general paralysis. This is true, and is a useful way of looking at the subject. I would pursue this subject, and say that alcohol, lead and syphilis, and perhaps some other poisons, will not only produce the same set of mental symptoms as are present in general paralysis, but that in the end these so-called functional disturbances may pass into the real disease. As I said, function may make the tissue, and function perverted may destroy it. This is perhaps a truism which I need not have repeated.

While speaking of these poisons and their action, I would say that I believe the more stable the poison the more likely is it to produce the disease, and that while alcohol easily passes off, leaving little permanent change in the nervous tissues, lead on the other hand is much more likely to leave permanent changes. It is not so easy to place syphilis under this heading, for we know so little of its nature that it is more as a convenience that we call it a poison than from anything we know actually of its nature.

We meet with many cases of general paralysis with very similar histories, and perhaps by studying these we may come to a clearer view of the causes or the conditions producing this grave disease. In fact, I think if we can only put these facts together, that alcohol and lead produce functionally symptoms like general paralysis, and may in some cases give rise to the disease, and that wear-out will produce the same, and that syphilis under some conditions will be followed by the disease, we may yet get some light and perhaps a clue to their cause and help for their relief.

The history of one fairly distinct group of general paralysis is as follows :—A man gets syphilis and is treated for it. He has slight secondary symptoms, and thinks himself quite well. He marries and has several healthy children. Then some cause of exhaustion—bodily or mental—arises, and ptosis, external strabismus, and dilatation of one pupil follow. The patient is actively treated and loses all the paralytic symptoms, but in the course of a few months or a year he shows signs of mental change. Generally there is some feeling of impending evil, emotional disturbance, and the like. This may be rapidly followed by all the best known symptoms of general paralysis. I would say that in these cases there are just as commonly symptoms of degeneration in the lateral columns of the cord as of ataxic changes, and I have met with cases with both regions of the cord affected, and in one case there were symptoms of ataxy on one side and of spastic paralysis on the other.

From the one side, then, I look upon general paralysis as the result of progressive decay of the nervous system, but there still remains the question as to the cause of this physical break-down, and I shall be expected to give my ideas as to the causes most commonly setting it up, and not hide myself behind the mere statement that it is decay. In my opinion general paralysis results from prolonged strain. It seems to me that many things may produce this strain, and that some men suffer more from one form of strain than another. The extravagant expenditure of nervous force under conditions which prevent repair, or hinder the repair, are to my mind the causes of brain wear-out. A man who works as hard as possible, but eats well and sleeps well and is in harmony with his work, will not die of general paralysis. The man who is *anxious*—that is, the man who does not breathe freely, whose heart is irritable, and whose sleep is disturbed—is the man who breaks down. I may be said to be

making use of a term I cannot define when I say that *strain* is the cause of general paralysis. I can only say that the more I am able to study and investigate early cases, the more am I struck with the fact that there is sure in such cases to be found some cause or tendency to be rigid and fixed with a loss of the elasticity. This may show itself in various ways, and the strain may be anything from wearing a double social mask to excess of work, worry, or any other source of extravagant nervous expenditure. Other general pathologists have spoken of the part played by strain in the production of other diseases, such as kidney disease and locomotor ataxy, and I would at least claim the consideration of this as a common cause of general paralysis of the insane.

The very symptoms point to the same thing. The strain tells on the finest and highest adjustments, and general paralysis begins with loss of these very adjustments.

Before leaving the pathology of general paralysis I should like to refer to a group of cases, the pathology of which perhaps rather falls within the third class of functional disorders, but as it has recently struck me that there is some relation between their pathology and that of general paralysis, I give you my crude opinions for what they are worth. I constantly see, and now that I am looking for them I find them everywhere, cases of women from 45 to 55 who develop deafness, and with this progressive sensory loss, mental weakness. These cases are to my mind as hopeless as the general paralysis from the point of curability, but they are not cases which run to a rapidly fatal termination. It is possible that the chain of symptoms may be but the result of some not uncommon degeneration of the sense of hearing coming on at the decline of life—we are all used enough to see this happen—and that the insanity is but the result of the isolation thus produced acting on nervous subjects. But it is also possible that in general paralysis we have degeneration starting from the motor area of the brain and affecting the more vital parts of the nervous system, and that in these cases there may be a degeneration starting from a sensory centre, not implicating the real mechanism of life, and therefore ending in dementia only—not in paralysis and death. I throw this out merely as a suggestion, being equally ready to modify or retract on the production of proof.

But it is time I proceeded to the consideration of the second head of my subject—the diseases of the body in which there

are symptoms of insanity, or, to put it otherwise, cases in which bodily disease has an insane expression. There are several ways of looking at this. First, then, as Sir W. Gull once said to me, the brain is like a gentleman having many servants, and yet being badly served. The brain may, in fact, be badly nourished in consequence of some bodily disease. Thus in gout we may have the brain nutrition interfered with and its functions badly performed. I shall have again to refer to gout in other relations.

But to take another example, and one which has recently been much forced on my attention. With heart disease we often have some difficulty of breathing, and this may pass into a state of anxiety, which may, however, be quite reasonable. But in an asylum one meets with cases of heart disease in which this anxiety becomes something more. It appears to the patient that some dreadful thing is impending, and this in the insane mind becomes explained, so that the patient thinks that ruin or death, torture or vivisection, is in store. This may be very likely a compounded result. There may in the first place be unequal irregular nutrition of the brain, and the respiration being affected, this may act as a constant source of discomfort and unrest, which becomes explained as we have seen.

Again, to continue with the study of the circulatory system, we must all have recognised a special form of anæmia associated with insanity, as there is also a special form of insanity associated with anæmia. That the organ which is provided in the most careful way with a very perfect system for the supply of blood should suffer when the quantity or quality of the blood supplied is defective, is to be expected. I am constantly seeing cases of young women who are suffering, not from chlorosis, but from anæmia of a severe type, and these young women suffer, too, from mental depression, or from melancholia with stupor; or they may suffer from partial dementia; and, as we all know, the weak person is the timid one, so we may have in such cases a mixture of mental depression with suspicion, with all the delusions of persecution, and the like.

In this relation, too, it is noteworthy that there appears to be a special form of anæmia associated, if not caused, by insanity. In the third or later stage of general paralysis one meets very constantly with a peculiar aspect, and in some rapid cases this appears early, and, I believe, makes the

prognosis worse. Recently we had a case in Bethlem in which all the mental symptoms followed early on a fall on the head, which produced insensibility for the time and marked head-trouble for some weeks after, these developing into restless excitement, with weakness of mind; the chief point in the appearance of the case was very marked anæmia. The patient died of acute phthisis, and, therefore, the whole question was complicated, for it is well known that anæmia is a common early symptom of phthisis.

Phthisis itself is a very common associate with insanity, and has, I doubt not, its share, not only in producing the disease from the waste resulting, but from other causes, among these the anæmia to which we have just referred. But this relation of phthisis is specially interesting from the fact that there seems to be a nervous perversion which is hard to explain. We all know that with insane patients the cough and other symptoms may be absent, or may be replaced by delusions associated with gastric, not pneumal, troubles. But once more I am inclined to think that with insanity we have yet another point of importance to consider, for I have met many cases of melancholia in which, with signs of vital depression, there have been no signs of lung disease; but one has been prepared to say that very probably the patient would die of phthisis. The vital depression seems to prepare a fit site for the lower organisms to flourish in, and this leads to one other point which is worthy of consideration, as to whether the neurotic are more liable to suffer from diseases produced by these lower organisms than others. I know there are reasons against accepting this at once, for else why, some might say, are asylums so free from infectious diseases? Of course, one easy answer is that asylums are very carefully guarded from ordinary epidemic influences; but, on the other hand, I would say that I have been struck by the frequency with which members of highly nervous families do suffer from such diseases. I have many examples of families in which these fevers have not only occurred once, but repeatedly. Without making more of this point, I would suggest that the nervously unstable are very likely to be easily affected by these fine, but destructive influences. But to continue. As to the relation of bodily disease to mental disorder, I would say I have seen a fair number of patients suffering from insanity associated with renal disease. No one is surprised the body being a closely-united whole—that one part

being affected the rest should suffer with it. But my difficulty arises as to why in some the expression should be altogether physical, or at least should be referred to the peccant organ, whereas in another the explanation or the expression should be intellectual. That in one person more nervously unstable the circulation of morbid material through the brain produces insanity, and in another only distresses, is not altogether surprising; and, again, that a similarly unstable man be upset by the constant irritation produced by restlessness or sleeplessness is not unnatural. We see many connecting links in the chain of morbid expression. Thus one man who has some gastric uneasiness and is dyspeptic may become irritable, or take to moody, religious thought; another becomes a confirmed doctor-seeking hypochondriac; and a third becomes possessed by the idea that his bowels are closed, and that his soul is lost. In many ways the bodily state reacts on the mental expression, and all one can say is that some people, presumably those whom we call neurotic, explain their sufferings in a more graphic and imaginative way. The explanation here, as elsewhere, is the insanity.

This question of the insane explanation of feelings is ever cropping up, and deserves careful study. A woman with ovarian disease had hallucinations of smell, and said dead bodies were always in her room. The diseased ovary was removed, and no more hallucinations of smell occurred; so in this case we were able to trace cause and effect.

I think it is a pity that more study has not been made of the mental aspect of general diseases, and then we should, perhaps, less frequently be at a loss to explain some of the vague delusions of the insane; and we should see that, strange as these delusions are, they have quite an easy interpretation. Dr. Wilks, in the wards of Guy's, used in former years to call special attention to the aspect and attitude of patients, and pointed out how often the diagnosis was facilitated by noticing the facial aspect or the bodily posture of a patient. The aspect of a thoracic case differs from that of an abdominal one, and the appearance of a fever patient is quite distinct from that of one with cerebral disease.

All bodily disease, then, has its mental aspect, and this aspect may become more and more pronounced, so that it may assume what we call an insane aspect. The hysterical girl may complain of globus or clavus, and the insane

woman may say her throat is closed, or that her brain is wasted or swollen. It still remains to be proved that all these insane interpretations come from persons of insane type. They do not all come from persons with directly insane inheritance. There are sporadic lunatics, and I regret that time will not allow me to consider that most interesting question. As to what conditions are most favourable to the production of insanity in the first place, I can only say that my experience is that any source of degeneration in the stock may lead to evidences of nervous degeneration in the offspring. The consideration of the above leads naturally to a further study of the relationship between bodily and mental disorders; but as this subject of so-called alternation of neuroses is the subject of a paper I have to read at the British Medical Association Meeting at Brighton, I will only summarise here what I have to say on this subject.

First, we know that insane children not uncommonly come of parents suffering from some other form of disease, which, if not altogether nervous, has a strong effect upon or relation to the nervous system; and now we have to consider that such diseases may alternate in the nervous subject himself. Dr. Maudsley has pointed out that asthma in a parent may be followed by insanity in the child, and he has further shown that diabetes in a parent may be succeeded by neurosis in children, and I wish to point out that these same disorders may alternate in the individual as well as in the generations. Now I have seen four cases in which diabetes in a patient has been succeeded by insanity, and during the insanity the diabetes (both the glucosuria and the polyuria) have been absent. It is the same with several other diseases. Thus asthma has been referred to by Dr. C. Norman, and I hear from Dr. Maudsley that he and others have also seen cases in which there has been this alternation besides the true alternation. One has to recognise the fact that such a disease as rheumatic fever may alternate with neuroses, the fever being replaced by insanity on the one hand, or the insanity being replaced by the rheumatic fever on the other. There is also this to be noted, that in severe cases of rheumatic fever with hyperexia, with the high temperature delirium may set in, and the whole of the joint affection may disappear.

Among other alternations we have that between neuroses themselves, and I shall only here say that I have seen the

various forms of hysteria replace one another, and mind, not, as might be supposed, the lesser to be developed or followed by the greater, but at one time hysterical vomiting to be followed by insanity, and at another mania to be followed by paraplegia. I have at present one woman who, after seventeen years of hysterical paralysis, has regained the use of her legs, but now is suffering from depressed intellectual action, as seen in her slow melancholic movements, and her general depressed intellectual action.

To sum up this part of the subject, neuroses may alternate in generation, or they may alternate in the individual, or they may alternate with other diseases or bodily states which, in themselves, seem to have little to do with the nervous system, and here I may introduce the practical question as to whether by producing any alterative action we can do good. I believe that counter-irritation is at some periods of chronic mental disorder of very great service, and in some cases I have seen a seton remove hallucinations, and in another the unpardoned sin vanished when free suppuration was established on the scalp.

The third and last part of my paper refers to disorder of function. My favourite teaching simile is that with our minds as with a kaleidoscope there may be a perfectly similar set of parts, which, being rearranged, produce a new pattern. No amount of section-cutting will tell you what pattern will evolve from the shake, and no alteration will be discovered in the parts themselves. The brain is more or less to be considered in the same way. We have as yet failed to get as good an idea of what the parts of the mind are as we have of the parts of the kaleidoscope. We know the laws which govern the one, but we can only guess wildly as to the laws of mind. Yet, with all this ignorance, it does not seem to me a hopeless task to try to piece together the facts we have, and make, at least, some probable theories as to the way in which many delusions arise. In studying mind from this point of view, and in trying to study the pathology of mind, I have endeavoured to be as free as possible from the school terms, and from the cramping influence of forms. Doubtless, I have done much that is useless, but at least "it is my own."

We have to look at mind as consisting of a basis which is the foundation on which building is possible or impossible, as the case may be, and then we have to consider the structure which is built on this basis by means of the bricks

provided by our senses, and then cemented together by our memory, and by our memory, too, to a great extent arranged, and so that the parts become comparable—that is, may be seen in their special relations. In certain persons the defect is in the basis, in others the peculiarity is due to sense defect, or imperfect and inexact recording. One of the greatest of difficulties we have to explain is, how certain *qualities* are transmitted. We seem to find it easy to accept the transmission of some things we call material, but we cannot understand the transmission of what we call powers. I suppose it is nearly as difficult really to conceive of the power transmitted through an acorn to start into existence a tree which shall have within it the power of going on developing through varying seasons for centuries, as to understand the transmission of what we call moral or intellectual faculties; but both the powers of transmission to the oak and to the offspring are facts, and recently I met a very good example of the direct transmission of mental faculties in a lady who brought her daughter, aged 17, to see me. She said that her daughter had passed into an apathetic state, and she, the mother, was concerned for her future. The daughter, in a cool, matter-of-fact way, told me she did not see any interest in living; she felt everything so unreal, she did not know or care whether this world and all in it were ideas or things, she had no love, no feeling, and no interest. With these symptoms there was amenorrhœa, so I hoped for improvement, which has, in fact, followed judicious removal from home, with active occupation among strangers. But now comes the special interest of the case. The mother, some time after, came and said that she wished to tell me her story, which was, that at the same age she passed through a similar state, that she never cared for anything or anyone, and what was more sad, she had never developed any healthy human affection even for her children. She said she had never mentioned this to any one, and so there was no possibility of her daughter having learnt to say the same thing from her. To complete the case, the only other child, a boy, passed into a similar state of not caring, when about 14 years of age. Here, then, we have direct transmission of faculty or feeling, which you will. This being granted, where are we to draw the line of possibility for transmission of insane ideas, or insane modes of thought, or insane ways of feeling? Patients with true mental disorder due to the perversion of the senses are commonly the children of insane parents, their impres-

sions are not as our impressions, and as a result their intellectual building is not as that of the world at large. There are doubtless some patients who are misled by their senses in other ways, and I wish here to refer to some of the cases in which sense-perversions have been the basis of the mental disorder. These naturally divide themselves into those with defect in the organs of sense themselves and those in which the defect is rather intellectual. Here we have again the double grouping—those in which an unhealthy intellectual impression is received and those in which an impression, healthy or otherwise, is received but wrongly interpreted. It would be altogether beyond the limits of my time to discuss all these cases; you all know the cases of hallucinations of one kind and another—the cases of "following," watching, persecution, of injury to friends and children, the persecution by telephones or Jesuits, the tampering with body, or the perversion of soul. The explanations are as endless as the power of human development, but there is one practical point I cannot pass over, which is that in some of these cases there are reasonable methods of treatment, and that in several very unpromising cases I have hunted the hallucinations out of house and home. I have brought one person after another who has been suspected before the patient, or taken the patient to him, and by this means I have not directly cured the unreasonable by reason, but each of the convincing proofs has acted as a mental soothing draught, and in the end, rest more and more complete has been gained, and the patient has got well. Mind! these cases have to be taken as exceptional, but they are real, and are to be studied and acted on. In my experience it is no good trying reason with such cases till they have been under care for some time. In the earlier and acute stages reason in no way appeals to them. I give a few examples.

Patients suffering from insanity which has developed in relation to perversion of senses are, in some cases, to be treated, not by drugs but by reason, and I should like here to give two or three cases in which the treatment of the unreasonable by reasonable measures has at least ended in cure. In one case a young man, who, having against his father's wish gone in for electrical engineering, instead of following arms, as his friends wished, gradually got more and more estranged from all near to him, and in the end took a foreign appointment where much of his time was

spent alone, and in an unhealthy, subjective state. This led in one way or another to the development of hallucinations of nearly all his senses, so that he was sure that his father had detectives following and watching him, and ready to report anything to his disadvantage. This state of uneasy suspicion gradually became to him intolerable, and, like so many similarly placed, he took to the sea, hoping thus, anyway, to escape; but even here he found he was tormented, and as soon as he got to England he placed his affairs in the hands of two advertising attorneys, who professed to believe his tale. Anyway, his father found him, and had him sent with certificates to Bethlem, where for some weeks he was a very brilliant but very troublesome patient, so that he caused constant annoyance to patients and attendants by his domineering ways. He caused the servants about the place all the trouble he could; would throw his bed clothes into disorder on purpose to give work; would make as much mess in washing as he could, and call the attendants "menials," and the like. At the same time, he would amuse himself by playing several games at chess at the same time without seeing the boards. He was, in fact, a very expert player.

Nothing appealed to him for a time, and he was as rude to me as an "official" as he dare be. I tried to get some clue to his past, and after some time found that he had the idea that his father had bought over his former schoolmaster to go to South America to watch and spy on him. No amount of reasoning could convince him that it was absurd to suppose that his father had means enough, even were it possible to buy up such a man. He said one day, "Well, let him deny it himself." On this hint I wrote to the headmaster, and got a letter which I gave to the patient. In this letter the clergyman gave a short account of the things that had happened to him during the previous years. This seemed to stagger the patient at first, but he said "Oh, yes; but this may be all made up. I cannot accept his statement alone. I must see him." I again appealed to the master, asking him, if in town, to come and see his old pupil. In course of time he did this, and a long afternoon was spent by them together.

On the next morning the formerly troublesome patient made his own bed, and asked if he could do anything for others. His whole nature seemed changed. On my visiting the wards he apologised for his conduct, asked pardon, and

by his words and his conduct showed that a mental change had taken place, so that in the course of a few weeks he was discharged, and though once since threatened, he has never, as far as I have been able to learn, had a relapse.

In another case a young man, also the son of an officer, was haunted by hallucinations. He was said to have lost a valuable appointment in India in consequence of homicidal violence resulting from these sense perversions. He was sent to England, and, happening to suffer from varicocele, he was sent to St. Thomas' Hospital, where he was operated on. Unfortunately his case took a bad turn; he had blood-poisoning, some joint troubles, and the result was a stiff knee and a stiff ankle. He was sent from the hospital to us, on account of his dangerous and threatening behaviour to some of the junior staff, and there is little doubt but that, if he had had the chance, he would have killed one or other of them. He fancied they called him obnoxious names, and that they also maligned his parents.

While in Bethlem he was for weeks the most dangerous man I had. A word and a blow were the general sequence, and at times the blow came first. I tried all I could by granting him special favours if he controlled himself, but with little good effect. But one day, when he said he had heard my voice on the roof, I was able to give him conclusive proof that I was spending the night at Oxford. This seemed to stagger him, and he said, "Well, if you send me to the convalescent, and I still hear voices in the cricket field, I will believe I have been deluded." I sent him down to Witley, but the experiment was not a success at first, for he disagreed with the others and had to be brought back. Still, though we had several outbreaks, I was able to do more with him, and I got the several men he accused to come and interview him, and he gave way on point after point till but one man seemed to be his enemy, and to him I sent the patient in a cab. The result was only partly satisfactory, but some way was gained.

I must own that though he was more reasonable he was as violent at times as ever, and I began to give up hope of doing him good. He seemed to be morally perverse; but, remembering the other case, I still said we may be misjudging him. He was sent to the county asylum, but never after leaving Bethlem did he show any signs of insanity, and was, in the end, sent at his own request abroad.

I could recall many other cases, such as one of a barrister

who had been for several years in a private asylum, where his delusions of suspicion got more and more marked. Yet, by bringing the causes of his worries before him and proving his mistakes, a cure was effected, and I now meet this barrister not only in the courts of law, but in society, holding at least his own, and fully persuaded that our plan, or reasoning, did him good.

Reason or emotion may cure a hysterical woman; prayer may restore a paralysed limb. The influence of a bishop, and once of an archbishop, have been invoked with success in the removal of sense perversions in patients in Bethlem, or of delusions growing from such perversions; but I do not believe such measures will cure an organic disease, whether it be of brain or kidney. This, then, is my point, that there is a large group of cases of insanity in which the thing to look to is the function, not the organ. Try to modify the surroundings if you like, but "throw physic to the dogs."

Now, gentlemen, my task is done, and though I fear it has been less practical in its bearings than many former addresses, yet it is important as far as its object is concerned.

Other presidents have taken stock of our knowledge and experience of legislation and treatment. Statistics have been generally largely called upon, but I have placed as clearly as I was able before you my ideas on the relationship of insanity to bodily disease, and to simple disorder of function. I feel yearly more and more convinced that unity is the one characteristic of natural working, in this planet at least, and that a law once discovered, whether it be discovered among the planets or the plants, has far-reaching powers which at first may not be seen.

My effort is to trace the great unity not only in the development, but in the dissolution of the body, and I trust that, at least, I shall have destroyed some "idols of the den" even though I have not discovered a law of mind.

The Insanity of King Louis II. of Bavaria. By WILLIAM W. IRELAND, M.D., Preston Lodge, Prestonpans.

The striking events surrounding the end of King Louis of Bavaria attracted the attention of the whole civilized world. Much has already been published on the subject in the newspapers; but as the "Journal of Mental Science" will go down to the future as a record of what took place in the department of insanity, it has been thought proper that this great historical tragedy should be reviewed in our pages. It is likely that State considerations will prevent any of the physicians who took part in the proceedings from publishing what came to their knowledge. Our principal sources of information have been three German pamphlets,* the extra edition of the "Berliner-Börsen Zeitung," of 15th June, 1886, and a collection of cuttings from English and American newspapers. A study worthy of the attention of psychologists is afforded, apart from the interest derived from the rank of the unfortunate prince and the pathetic character of the event which brought his life to a close. We see the evolution of an hereditary disposition to insanity helped instead of hindered by external circumstances. The family of Wittelsbach was one of the oldest amongst the ruling princes of Europe. The Duke of Bavaria, a prominent figure in the Thirty-Years' War, became an electoral prince of the German Empire in 1623. When Gustavus of Sweden entered Munich in 1632, he much approved of the taste displayed in the apartments of the palace of the fugitive Elector, and asked "Who was the architect?" "He is no other," answered the attendant, "than the Elector himself." "I should like to have him," said the King, "to send him to Stockholm." Thus a taste for decorative architecture seemed to have appeared at this early date in this princely family. Maximilian Joseph I. was made king by Napoleon after the battle of Austerlitz, at the same time receiving the Tyrol as the reward of his alliance. In this prince the family taste for art showed itself in many ways. He acquired the Aeginetan

* "Die Letzten Tage König Ludwig's II. von Bayern," von R. Graser. Stuttgart, 1886.

"Zur Königs-Katastrophe in Baiern" (Separatabdruck aus Dr. Wittelhöfer's, "Wiener Mediz. Wochenschrift," Nr. 25 und Nr. 26, 1886), Vienna, 1886. The author of this pamphlet is Baron Mundy.

"König Ludwig II. von Bayern. Sein Leben, Wirken und Tod geschildert von George Morin." Munich, 1886.

marbles, the Dürer and the Düsseldorf gallery. His son, Louis I., spent millions of money in adorning Munich with splendid buildings in the Greek and Italian styles, and was the patron of Cornelius and the elder Kaulbach. The weaknesses of a *virtuoso*, and the scandals and imprudences into which he was led by his mistress, Lola Montes, brought about his deposition in the stormy year 1848. He was succeeded by his son, Maximilian II., whose rule was unpopular, owing to his reactionary tendencies. Maximilian's brother became King of Greece, till his subjects got rid of him without much ceremony or difficulty in 1862, when he returned to Bavaria.

Maximilian married Mary of Hohenzollern, daughter of Prince Frederick William, the youngest son of Frederick William II. of Prussia. This lady is said to have introduced insanity into the family. It was, however, stated in the "Frankfurter Zeitung" that the King's paternal aunt, the Princess Alexandra, had been treated, about 1850, in the asylum at Illenau. She was possessed with the idea that she had swallowed a glass sofa. The Queen had only two children, Louis, born on the 25th of August, 1845, and Prince Otho, born on the 27th of April, 1848. When Louis succeeded to the throne on the death of his father in 1864, no one dreamed of the fate that hung over these two brothers, who bore a great likeness and were much attached to one another. Louis II. was then nineteen years of age. Tall, beautiful in person, endowed with great strength, carefully educated, and possessed of many pleasing mental gifts, it was not suspected that the hereditary tastes for music and art, and the desire to surround himself with beautiful objects, would grow into a consuming passion going beyond the bounds of reason.

Bavaria took the side of Austria against Prussia in the war of 1866, a step which could hardly be thought imprudent at the time, since it was generally believed that Prussia would be overpowered. More fortunate than her allies in Northern Germany, Bavaria escaped from the struggle with a small cession of territory and less diminution of independence than might have been feared. King Louis became a fervent admirer of Bismarck. The Bavarian people were much pleased when, in 1866, the young King became betrothed to the Duchess Sophia, daughter of Duke Max, and sister to the present Empress of Austria. The old King, Louis I., was much attached to his grandson. Being struck with his resemblance to Adonis in a fresco at Pompeii, especially in the passionate expression of the eyes (in dem schwärmerischen

Ausdruck der Augen), he composed a sonnet on the occasion, which was published in the "Allgemeine Augsburg Zeitung," dated 27th February, 1867. He promises a happy future for the young King and his betrothed. About the same time Dr. Morel, who was at Munich on the Chorinsky case, and saw the King of Bavaria, was also struck with the expression in his eye. "It is an eye," he said, "from which future madness speaks." Of the King's attachment to the Duchess Sophia romantic stories are told; but in his life everything was romantic. "She had the untamed air of a wood nymph, was passionately fond of sylvan sports, of dogs, horses, and the excitement of hunting. As she lived on the edge of a romantic sheet of water, on which she often shot out in a light skiff, he called her 'The Lady of the Lake.' It pleased him to come and woo her in secret, and if he had a fault to find with her, it was that she was too coy. When preparations were being carried on for the wedding, Ludwig, who was fond of coming unawares on those he loved, to afford them agreeable surprises, came with a band of wandering musicians, and disguised as a minstrel, to serenade his betrothed. He approached through a wild wood her father's castle, a little in advance of his musical comrades. What did he see in a glade? His betrothed toying with the locks of the groom who had been attending her on an equestrian excursion. He was sitting on a rock, and she was standing beside him, with her waist encircled by one of his arms. The King rushed to kill them both, and, as he was tall and muscular, he might have done so had not the other minstrels come to save them. He denounced her to her father, a bluff German. She denied the evidence of his eyes, and said that, being subject to hallucinations, he fancied he saw what never happened." The "Débats" says that it was her domestic chaplain, and not a stableman, of whom she was enamoured. The lady got married soon after to a French nobleman.

Whatever may be the truth in these stories, Louis about this time began to shun the society of women. He refused all proposals of marriages, and repelled other advances with indignation. It was reported in the "Boston Post" that he commanded a famous actress, a very beautiful woman, to read to him, which she did almost daily or nightly. At these times he always went to bed, and ordered her to sit beside him. One evening while reading to him from some tragedy, she rose, the better to render it, and whether by chance or purposely she sat down upon the edge of the foot of the bed. He instantly

ordered her to leave the kingdom for insulting his dignity by touching the royal bed, and she had to go, though the most popular actress in Munich.

We are told that, on one occasion, the King said abruptly to his secretary, who was living with his family near one of the royal country seats, "I have seen the countenance of your wife." The secretary remained silent, not knowing what to reply, on which Louis said again in a severe tone—"I have seen the countenance of your wife." The secretary, recovering his presence of mind, then said that he should take care that this would never again happen.

The French Emperor, in provoking a war with Prussia in 1870, thought he might count upon the neutrality, if not the assistance of Southern Germany, but the Bavarian army took from the outset an active part in the struggle, and did some of the hardest of the fighting. Louis, who had no military tastes, did not accompany his army, but his brother, Prince Otho, gained the iron cross for his bravery. During the war Louis addressed a circular to the German Princes and the Free Towns, inviting them to ask the King of Prussia to revive the German Empire, and was the spokesman on the occasion when William was made Emperor in the Palace at Versailles, while the siege of Paris was going on. It may seem doubtful whether Louis thought more of the political consequences of this event than that he was taking part in a grand and gorgeous pageant such as the world could not equal. After the war he gained some prominence in supporting Dr. Döllinger and the German Catholic party against the Ultramontanes, but he gradually withdrew his attention from politics, and used his wealth and power to gratify his artistic dreamings.

King Louis became an enthusiastic friend of Richard Wagner, whose lofty ideas and tumultuous music were highly fitted to strike his imagination. He contributed largely to build the huge theatre at Bayreuth, and got the operas of the great composer performed on the grandest scale. Louis delighted to personate the Wagnerian heroes. He used to put on the pilgrim robes of Tannhäuser, or the armour of the chivalrous Tristan; but his favourite character was Lohengrin, the son of King Parzival, described in an old Bavarian poem. This legend was revived in the well-known opera of Wagner, and King Louis in a boat on the Starnberg Lake used to rehearse the part of the Knight of the Holy Grail. We are* told that,

* "Grasser," p. 24.

finding the ordinary lake too realistic for this exalted personation, the Bavarian monarch got a large reservoir constructed on the roof of the Schloss at Munich, upon which, dressed in glittering armour, he sailed in a boat with a stuffed swan floating in front. As he wished to have blue water, it was coloured with sulphate of copper. This solution acted upon the metal of the roof and streamed through the royal palace, spoiling the splendid furnishings, after which an optician was employed to give a blue tint to the water by coloured light. He then complained that the water was too calm, so that workmen were employed to turn paddles, which made waves so effectually that the King was thrown into the water, on which he gave up further nautical rehearsals on the roof of the palace. On another occasion the King represented the Genius of the Mountain, and got six men to carry him in a litter or jaunpaun over the Bavarian Alps.

His intimacy with Wagner, more advantageous to the musician than the King, was dissolved in the end of 1865, whether through popular clamour, Court intrigue, or through Louis tiring of the imposing personality of the composer. He, however, still kept up a correspondence with Wagner, occasionally visited him across the frontier, and when he died in 1883 is said to have shown much grief. The King conceived some other warm friendships for artists and actors, to whom he would write long letters. These friendships soon passed away, sometimes coming to a very abrupt end, when he would remark that "*this* comes of associating with such common people." From boyhood he was extremely haughty, and considered it a liberty that a physician should feel his pulse when he was ill.

It ought to be borne in mind that we have as yet no continuous narrative of the King's neurosis, little more, in fact, than a series of anecdotes and observations, many of which have no dates. We may, however, take it for certain that the King's malady commenced in his youth, that it was of slow growth, but continuous and progressive, a rising self-will which, guided solely by his tastes and dislikes, brooked neither delay nor denial in the gratification of his fancies, a gradual diminution of mental balance and self-restraint complicated in the end with hallucinations, stormy fits of passion and violent assaults on his attendants, and orders for the assassination of those who had offended him beyond his palace walls.

In the report of medical evidence read to the Bavarian Landtag, symptoms of insanity were distinctly recognised since 1880.

Baron Mundy tells us that the King had been insane for at least ten years before his death.

The Germans, as a people, have a singular respect for the mere claims of birth and superior rank, and are disposed to acquiesce in an ostentatious display of power on the part of those who rule over them to an extent Englishmen can hardly understand. The King's vagaries were humoured with marvellous patience.* The lofty and æsthetic nature of his tastes with his patronage of art inspired awe and admiration. For a long time he was temperate both in food and drink, and free from the grosser vices.

Vanity seems to be the besetting weakness of men of artistic tastes; but the King seemed to regard as nothing the sympathy and admiration of other men, whom he only used as the means of helping him to gratify his dreams of beauty and art. He hated to be seen, and only enjoyed plays and operas when performed in a half-darkened theatre, he himself sitting alone. Once, at the Court Theatre, the entire audience, that is, the King, fell asleep during the play which followed after the public performance. Nobody dared to awake him, and he slept for hours. When his Majesty opened his eyes the play went on from where he had lost it, and was finished some time the next day.

At Court-dinners it was arranged that the guests were hidden behind vases of flowers and piled-up dishes, so that he might not be plagued by seeing them. A musical band drowned the sound of conversation. During the last years, as the love of solitude grew upon him, his dining-table was hoisted up by means of machinery through the floor, with everything ready, so that he could take his meals without seeing a human being. When he wanted a thing he must have it at once. When an idea occurred to him it must be immediately put into execution. If he read of a piece of architecture he would order a special train to go to see it. He would order his equerries to be wakened in the middle of the night to play at billiards with him, and dismissed one of them from his service because he came with his neckcloth awry. He often slept all day and remained awake all night, sometimes reading, sometimes wandering about in the moonlight amongst the grand scenery surrounding his castles, and during the winter he used to be driven about in a sleigh amongst the hill roads. The peasants would now and then see the splendid vision glide by, the out-

* Contrast with this the prompt treatment of George III., and his recovery under the Rev. Dr. Willis.

riders, the four plumed horses at full gallop, the carriage, a marvel of beautiful design, illumined by electric light, and the King sitting within alone. Numbers of labourers were employed in keeping the roads in good repair, for fear of an overturn.

His most expensive taste was building new palaces. He built the colossal castle Neuschwanstein on a precipitous rock, opposite the old Schloss of Hohenschwangau, also a model of the summer palace of the Emperor of China, and several new castles in solitary places amongst the mountains. These were decorated with rare taste, and at a cost that knew no stint. Of the millions that he squandered, a great deal of money no doubt fell into the hands of those who undertook to execute his artistic schemes. Dr. Schleiss, the King's surgeon, who seems to have at first doubted his insanity, though for many years he had seen little of him, is reported to have said:—"The King has his peculiarities; he is extravagant and good-hearted to excess; his passion is a love of architecture and the fine arts. For his eccentricities those are to blame who have been around him for so many years. These mercenary, selfish, lying, servile souls have done nothing but strengthen him in his wishes and heightened the fervid activity of his passions. They pillaged him, and pushed him into enormous expenses." Dr. Schleiss afterwards explained that the theory assigned to him that the King was only eccentric had not been stated by him in the form presented by the newspapers; but the words here translated have about them the ring of truth. The calculations of self-interest, the enthusiastic praises of the architects and painters and sculptors who had interviews with the King, the fear of bringing on a great scandal, and the dislike of disturbing existing relations near and far, combined with the veil which the King's retiring mode of life threw over his actions, long prevented the real condition of his mind being known save to a few.

Louis was esteemed to be a prominent supporter of the new German empire, the hegemony of Prussia, and was opposed to the pretensions of the Vatican in the Kultur-Kampf; his successor, it was feared, might be a partisan of the old state of things, an Ultramontane, a friend to Austria and the dispossessed princes of Germany. Most of the reports about the strange doings and fancies of the Bavarian monarch that appeared from time to time came from journals in Vienna and Pesth of reactionary tendencies. They caused some irritation in Germany, and were now and then contradicted. The Berlin

correspondent of the "Standard" of 20th January last, who had been making particular inquiries at Munich regarding the recent revival of reports hostile to King Louis, was now in a position to state, on the highest authority, that they are without foundation, and that the Bavarian ministers, so far from urging the King to abdicate, have discussed the propriety of prosecuting for libel those German and Austrian journals which have been publishing the reports in question. The highest authority is sometimes readier to conceal the truth than to tell it. The madness of the mysterious King and his degraded habits, the insanity of the Cæsars (Cesaren Wahnsinn), had about two years before been announced with Suetonian plainness in a feuilleton of the "Social Demokrat" of Zürich (21st February, 1884). Copies of this paper, passed from hand to hand, were eagerly read at Munich. The derangement of the poor King was ever becoming worse. It was no secret that his brother Otho had been insane for years, under restraint, watched by keepers.

The King's dislike to being looked at went on increasing. At last the only woman whom he could tolerate was the Princess Gisela, daughter of the Emperor of Austria, married to Prince Louis, the second son of his uncle Luitpold, who had caught his fancy. He used to send presents to her by his equerry at any hour of the day or night. The messenger was ordered to deliver the gift to the Princess herself, and she had sometimes to get up during the night to receive a nosegay or other mark of the royal esteem. Louis had long been in the habit of drinking a good many glasses of champagne before he could fortify himself to grant public audiences to ambassadors. His ministers found more and more difficulty in getting interviews with him. Sometimes he would interrupt their conversation by repeating pieces of poetry. For several years during councils he sat behind a screen. The last secretary of the Cabinet, Schneider, had never seen the King face to face. But the ministers said that his questions and remarks showed knowledge and shrewdness. Latterly his intercourse was almost entirely with servants of a lower grade. He took sudden likings for troopers of his guard, got them to attend upon him, and then chased them away in a few days. For years his chamberlain, Meyer, had to appear before him in a black mask, as his royal master did not like his face. A servant whom the King thought stupid had to come with a black seal on his forehead, to indi-

cate that there was some fault in his brain.* The King generally rose at three o'clock in the afternoon, when he rang for his valet, who entered bending low. With a tablet on his knees he received the royal orders. Louis would ask him sometimes as many as twenty questions. When these were written down the King would give the order, "Now answer." When the business was over the servant had to go out walking backwards and bending low. A story is told that Louis, not thinking his lacquey had bowed low enough, cried out angrily, "Bend lower!" The man bowed and bent till his face nearly touched the ground, on which the Bavarian monarch gave him a kick on the chin. It appeared from the report laid before the Bavarian Landtag that thirty-two of his attendants testified to being beaten, kicked, knocked against the wall, or otherwise maltreated. Some of them had received large sums as a compensation. Many orders were given to his servants through the closed doors; by tapping they intimated that he was understood. His habits became more and more degraded. He ate immoderately, and drank a great deal, principally Rhenish white wine, mixed with champagne and flavoured with violets. They had to remove weapons from his reach. He several times ordered offending servants to be put in chains and confined on bread and water, others to be put to death, and their bodies thrown into the lake. Luckily he did not insist on seeing these orders carried out. He, however, ordered a Secretary of State, von Ziegler, to be confined, and fictitious reports were sent him daily about this man's condition. He sent a trooper to an officer of high rank at Munich with a letter as follows: "The bearer dined with me yesterday at noon, and is to be instantly shot." When the Finance Minister announced that there was a deficit, and that they could give him no more money for his building of palaces, he sent a message to the States Commission to flog the dog and put his eyes out. Three orders for the execution of offending ministers were shown signed by the royal hand. Louis had a great hatred of the Crown Prince of Germany, who came every year to inspect the Bavarian army. He repeatedly told his chamberlain, Hesselschwerdt, for several years, to get a band of men and seize upon the Prince, and throw him into a dungeon, where he was to suffer from hunger and thirst. Similar orders were issued against some of the Bavarian princes and ministers.

* One might suppose the King had been reading "The Blot on the Brain." —Eds.

His servants testified that for years he had suffered from pains at the back of the head, to which he had ice applied. He was troubled with sleeplessness, for which he took chloral. He had frequent fits of motor excitement, when he would leap, dance, or hop about; sometimes he would tear his hair and beard. At other times he would stand still in one place.

He had many delusions and hallucinations of the senses. He often heard steps and voices. During frost and snow he thought that he was beside the sea. He used to bow to particular trees and bushes, took off his hat to busts, and made his attendants kneel to a statue believed to be that of Marie Antoinette. He would tell a lacquey to lift up things from the ground which were not there, and when the man looked at a loss would threaten to choke him. He fancied that he saw knives before his eyes.

One must remember that such symptoms and actions, concentrated as it were in a few sentences, did not represent the whole life of the unfortunate Prince. They were spread over years, and diluted with more sensible actions. What relation of frequency they bore to the rest of his doings, thinkings, and sayings, we have not the means of deciding. That Louis was suffered so long to drain the cup of power which has ere this intoxicated stronger heads, seems amongst the strange and most unaccountable things of history. We are in no way surprised to learn that the King's "privy purse and civil lists were very carelessly administered," and that after the final catastrophe the leader of the Opposition made a violent attack upon the Bavarian ministers, to which Dr. von Lutz replied in an excited manner. A king who is incapable of governing is likely to light upon someone willing to perform this task for him, and had it not been for the importunity of his creditors, for his extravagant demands upon the treasury, and his threats to hang the Finance Minister if money were not forthcoming, the name of Louis II. might still be in the "Almanach de Gotha" as King of Bavaria, Count Palatine of the Rhine, Colonel of Infantry, Lancers, and Hussars, in the armies of Austria, Prussia, and Russia, &c. The King had been seized with a consuming admiration for that grand parade monarch, Louis XIV., and read everything he could collect about him and his Court, including the disasters which his own ancestor, the Elector of Bavaria, suffered for his alliance with France. It is said that he used to wander about at night, dressed like the Grand Monarque, whose portrait was used to

represent the sun in one of his most splendid rooms. His admiration went down to Louis XVI. and Marie Antoinette. Hearing of an opera performed at Vienna which dealt with Madame Pompadour, he immediately sent to one of his envoys to procure a copy, which neither the composer nor manager would give. It was only obtained by engaging some short-hand writers to take a copy during the performance of the play. He built on an island the palace of Herren Chiemsee, in which Versailles was reproduced, room by room. He had gone incognito many times back and forward to Versailles to compare the work, and his plans for decorating the interior struck the ministry with despair. The King sent agents to foreign princes to borrow money, to Brazil, Stockholm, Constantinople, and Teheran. The story of his promising the neutrality of Bavaria in the event of a war between France and Germany, as an inducement towards a loan from the Count of Paris, seems to have been true. He instructed his servant to organize a band to rob the banks of Vienna, Berlin, and Stuttgart.

Baron Mundy assures us that in the month of March of this year Dr. von Gudden, the Superintendent of the Asylum at Munich for Upper Bavaria, was consulted, who declared that it was mental disease, not eccentricity, that was the matter with the King. In spite of this, Louis still continued in the possession of his legal rights as King for more than three months, during which time he gave his formal assent to the Bills which had passed through the Bavarian Parliament. It was not till the beginning of June, strange to say, that the Bavarian Ministers were ready to take advantage of the article in the Constitution which provided for proclaiming a Regent in the case of the serious illness of the King. On the 9th of June, Prince Luitpold, the King's uncle, the third son of Louis I., was declared Regent, on the day before the King's insanity had been certified on oath by four physicians. Here is a translation of their certificate:—

"1. His Majesty is in a far-advanced state of insanity, suffering from that form of mental disease which is well known to alienist physicians of experience as paranoia.

"2. From the gradual and continuous advance of this disease, which has now lasted many years, His Majesty is incurable, and only a farther diminution of mental power is to be looked for.

"3. Through this disease the free exercise of the will is completely excluded, so that the King is hindered in the

exercise of the Government. This will last not only longer than a year, but during his whole life.

"Signed, "GUDDEN,
"HAGEN,
"GRASHEY,
"HUBRICH."

On the 9th a Commission reached Hohenschwangau to communicate the new arrangements to the King. Louis, who was in the adjoining Castle of Neuschwanstein, was first told by his coachman of what was preparing for him. He received the news with calmness, and at once prepared means of resistance. He collected all the gendarmerie about, issued a proclamation calling on his army to defend him, and sent for a regiment of Jägers at Kempten, but their commanding officer, knowing the Regent's proclamation, did not come. When the three members of the deputation reached Neuschwanstein early next morning, entrance was denied to all save to the Count Holnstein, who was soon turned out after a short and defiant interview with Louis. The Commission returned to the old castle, and in a short time a sergeant of gendarmerie appeared with a written order from the King to arrest them all. As the Commission had no armed escort, and as the sergeant was accompanied by a sufficient force, they judged it best to yield, and were marched off to Neuschwanstein. About an hour and a half after three other members of the deputation, including Dr. Gudden and Dr. Müller, were also arrested and lodged in the Castle. The King's orders were to put out their eyes and tear the flesh off their bones. After two hours the Commissioners were released from their dangerous situation in the power of a lunatic ruler, as the gendarmes had heard of the proclamation of a Regency. They drove away instantly without looking after their baggage, making the distance to Munich in an incredibly short time. On the same day the palace was surrounded by gendarmes, under the Regent's orders, and all the servants save two were withdrawn from the vast building. At three o'clock on the morning of the 11th June the Commission again proceeded to the palace. The King was in the singing saloon when two keepers approached him. He immediately drew himself up, saying, "Oh, there they are already." He allowed himself to be conducted down the staircase, at the foot of which he met the Commission. In a composed manner he said that he was powerless to contend with the measures taken against him; that he did not know who had turned the German empire against him, which he had ever upheld, that

they should allow such things to be done. What pained him most was to be declared insane, and to be thought so by his people. He then gave his hand to Nickel, one of his attendants, thanked him for his true service, and mounted alone to the carriage, on the box of which one of the keepers had taken his place beside the coachman. The men who surrounded him sobbed aloud. A number of people awaited the carriage in the village. The King greeted them in a friendly way. All wept until the carriage disappeared from view. It took six hours to convey him to the Château of Berg.* He was accompanied by Dr. Gudden and a staff of attendants. There was a good deal of discontent, especially amongst the country people, about this summary deposition. The King had received offers of support, and if he had taken into his head to escape on the way to Berg some mischief might have followed. He expressed his approval of what had been done to arrange the Château according to his tastes, and talked in a friendly way to Dr. Gudden and Dr. Müller, his assistant. Sunday, the 13th, he took a walk about midday with Dr. Gudden, and his demeanour seemed quiet and friendly. About half-past six in the evening he asked to take another walk in the park, and the doctor and his patient went out. Dr. Müller sent two keepers after them, but at the King's request they were turned back. When the King had not returned at supper time, about eight o'clock, a search was commenced. The King's stick and Gudden's hat were found near the Starnberg lake, and on sending a boat along the shore about half-past ten two bodies were found floating with their faces downwards. The circumstantial evidence afforded by an examination of the spot showed that Louis must have led the doctor to the lake and then rushed in. Gudden had followed him into the water and laid hold of him, when Louis had thrown off his overcoat and coat. Dr. Gudden, who was a man of sixty-two, had either been stunned or held under the water till drowned by the King, who was twenty years younger and very strong. As Louis was a good swimmer, and as the water where their bodies were found was only about three feet deep and twenty paces from the shore, there is no doubt that the dethroned King had sought and found his death in the Starnberg lake. The body of the devoted physician,†

* On the Starnberg Lake, twenty miles south of Munich.

† It would appear that in gratifying the wish of his royal patient that the keepers should not follow them on their walk, the danger of suicide could not have been present to Dr. v. Gudden's mind, although it is said that the King had several times talked of making away with himself, had asked to be taken to the top of a tower, and had been even denied the use of a sharp knife since

who, true to his vocation, thought only of duty, was found nearest the shore, about half-a-yard from his royal patient. There were four scratches on the nose and a bruise on the forehead which Dr. Gudden had received in the struggle. The King's watch was found to have stopped at six minutes before seven, the water having got between the glass and the dial.

Even the terrible close of the King's life did not silence those who doubted whether he had been insane, and the examination of his body by experienced pathologists was regarded as affording valuable evidence to put the question at rest.

They found considerable alterations of a degenerative character in the skull, brain, and membranes. These were regarded as due partly to original abnormal development, partly to chronic inflammatory processes.

Amongst the details which have got into print we note that the length of the whole body was 191 centimètres (6ft. 3in.); the girth round the chest 103c. As compared with the size of the body the skull was somewhat small. It was asymmetrical. The diameter from the left frontal to the occipital plate was 17·2; from the right frontal to right occipital 17·9. The calvarium was unusually thin. On the inner plate of the skull there were degenerations of the bony tissue, especially at the frontal bone. There was an osseous growth springing from the clivus of two millimètres in length, and the bony tissue around was porous and brittle. There was a bulging of the left petrous bone of about one centimètre into the temporo-sphenoidal lobe. The pia mater was thickened, especially in the frontal region, where it was rougher and contained more blood. The arachnoid was thickened with milky discoloration. At the upper part of the anterior central gyrus a portion of the pia mater and arachnoid about the size of a shilling had become thickened and hardened, and had impinged upon the table of the skull, causing absorption.

The brain, which weighed 1,349 grammes, was full of blood and somewhat soft.

The stomach showed indications of chronic catarrh. While

coming to Berg. It does seem strange that the experienced physician of an asylum should not have dreaded a violent assault from a lunatic whom he had been so recently instrumental in depriving of so much liberty, and who had actually ordered his eyes to be put out three days before. Moreover, even granting that there was a sufficient cordon of guards round the grounds of the Château to prevent the King getting into the open country, an attempt at escape without any violence would have been at best an awkward and distressing affair.—W. W. I.

the want of symmetry and the defective development of the base of the skull were proofs of abnormal structural growth, the alterations in the soft parts might be said to indicate recent morbid action; otherwise the results of the examination, so far as published, contained nothing specific.

In the course of this sketch we have been more anxious to detail facts than to make reflections; but it is difficult to resist wondering at so strange a story. Bavaria for so many years to be ruled over by an insane King, and then to be treated as an hereditary possession in his family! For immediately after being freed from Louis II. we read that all the generals of the army and other functionaries had to swear allegiance to his brother Otho, who is, and has been for years, more insane than Louis ever was. Surely it is tampering too much both with divine right and the sanctity of an oath to make a man King known to be clearly incapable of reigning, and to compel people to swear obedience to one whom they knew they would never be called upon to obey.

It must be deeply abhorrent to the traditions of divine right that the relentless facts of pathology should intrude themselves into the palaces of Kings, but unless the princes of Germany shake off some of their prejudices, and show more wisdom and less exclusiveness in their marriages, they may find that a people so enlightened as the Germans will read their lesson for them, and in the words of Schiller will make it easier for their Princes to be men, and more difficult to be Kings.

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*How Can the Medical Spirit be best kept up in Asylums for the Insane?** By S. A. K. STRAHAN, M.D., Barrister-at-Law, Assistant Medical Officer, County Asylum, Northampton.

The supposition is that an asylum for the insane is a place where those who are mentally ill are received and treated according to the latest improved tenets of scientific medicine, and are so helped by all known means towards mental health—a place where disorders of the mind and diseases of the nervous system are specially studied and treated by men who have given up their whole time and energy to this one special branch of our profession, and where every opportunity is seized

* Read before the Section of Psychology at the meeting of the British Medical Association at Brighton, August, 1886.

upon to push forward our knowledge of insanity and prevent its lagging behind every other branch of medical science.

If this be what an asylum for the insane is, or ought to be, then it is certainly alarming to learn that the medical spirit is in danger of extinction in these places.

But when an error is once admitted it is in a fair way to be remedied, and now that Asylum Medical Officers have admitted the necessity for reform it is to be hoped that soon a better state of things will be arrived at, and as a result of such healthy change the medical spirit in asylums will revive.

Let us now briefly consider what in the present system most tends to extinguish the medical spirit in asylums for the insane, and how best that can be overcome. I would consider the matter under four heads, viz. :—

1. The necessity for a new system of classification of the patients which will separate the curable from the incurable insane.

2. The necessity for hospital treatment for the curable insane.

3. The necessity for training the attendants on the insane; and

4. The necessity for more medical officers to asylums, and some rearrangement of their duties.

1. *Classification of the Insane.* I think all will agree that the present system of classification of patients in asylums for the insane is far from satisfactory—if not absolutely bad. Make it a personal question: which of us having a friend suffering from mental disorder which we considered curable would think of placing him in the ward of an asylum with sixty or eighty other patients, most of them chronic maniacs and gibbering imbeciles? If we cannot have an hospital for the treatment of the curable insane, then, as the next best thing, let us have a ward where the recent and curable cases may be cut off from the contaminating influence of those chronically diseased—where signs and symptoms may be observed and noted with accuracy, and where the medical spirit shall not be smothered by a surrounding mass of incurable disease. Even if we can do nothing towards helping the disordered organ back to health, let us not impede Nature in her course healthward by unfavourable surroundings. I believe I have seen many cases which might have terminated otherwise than they did had the patient been placed under more favourable circumstances.

I should say that the feeling of utter helplessness and hope-

lessness which this want of a proper classification of patients inspires in the minds of the medical officers of asylums is the most effectual extinguisher of the medical spirit.

2. *Hospital Treatment for the Curable Insane.* The general clamour for hospital treatment for the curable insane which has of late become both loud and strong is, I think, a most reasonable demand. Why the brain should be the only organ in the human economy to which the expectant mode of treatment should always be applicable, is not at all clear. Our knowledge of the action and functions of the great nervous centres may be, nay, is, limited, yet with what knowledge we at present possess, very recent events have shown us what might be done for some who under the present mode of asylum treatment but exist to people our asylums. A few successful intra-cranial operations in asylums would do more for the medical spirit than almost anything else. There is, surely, a brilliant future for brain surgery. A still greater field for conquest lies before the physician, for the great mass of cases of mental disorder comes within his domain. If the medical spirit is to be kept up in asylums, we must recognise—we must make our attendants recognise—we must make the public recognise—that the man with a diseased or disordered brain is equally a sick man with the unhappy possessor of a diseased heart or a disordered stomach.

It is not enough that we take care of the insane who are curable. As we are able to treat the disorders and diseases of the other organs, so must we learn to treat those of the brain. If we can do little at first in our hospital ward; if we must begin, as not a few will say we must, *de novo,* then let us wake up the now slumbering medical spirit and begin at once; nothing can be gained by waiting. Let us call in to our help all the aids which modern science has placed in our hands, and let us work diligently at the bedside, in the operating-room, and, when opportunity offers, in the mortuary.

3. *Training of the Attendants on the Insane.* This subject, like those already noticed, is not by any means new. It is a matter which has been before superintendents for some time past, and it has received more attention than is generally given to proposed reforms in asylum management.

The Medico-Psychological Association has had drawn up and published a "Handbook of Instruction for Attendants on the Insane," and from recent reports it would appear that the matter is being taken up with greater spirit in America and some of the Colonies than at home.

There is no work or occupation known for which a man or woman is not the better fitted by training and special education, and it is difficult to imagine what objections can be advanced against this sensible proposal to give our attendants some instruction as to how they should perform their duties. Yet, on looking over the Annual Reports of the English Asylums, we find that in a very few instances only has anything been done in this line. While a very few superintendents have adopted and speak highly of the result of the system, it is a proof of the want of medical spirit in asylums, and of the amount of conservatism surrounding everything pertaining to asylum management, to find the great majority of superintendents passing the matter over without note or comment, or even endeavouring to find arguments against its adoption.

The medical spirit will not long flourish in a place where the physician's orders are left to be carried out, and his efforts to treat disease are to be seconded by persons ignorant of the most elementary rules of nursing.

4. *Necessity for more Medical Officers and some rearrangement of their duties.* With the medical staffs of asylums at their present strength it would be difficult to do much more than is at present being done for the insane, or to make the medical spirit burn more brightly than it does. As now conducted, an English County Asylum is the best place in existence for the care of the incurable insane. They are there fed, clothed, kept clean, and amused, as they could be in no other existing institution.

So long as asylums are looked upon as mere retreats where the insane are to be taken care of, and where care, kindness, and an occasional sedative or hypnotic are the only therapeutic agents to be employed, so long will the medical spirit burn low, and the present strength of the medical staffs suffice; but the moment we attempt to convert asylums into hospitals, where every case is to be studied and every patient treated as his or her case especially requires, we must augment the medical staffs, and so render possible what otherwise would be an impossibility.

At present asylums with five, six, or seven hundred patients have generally but two medical officers, a medical superintendent, and an assistant medical officer. Of course the superintendent must give up the greater part of his time, thought, and energy, to the fiscal part of his duties. But how can we expect it to be otherwise? The "rate per week" is of

vastly more importance to the superintendent than the "recovery rate," or any other rate.

A lowness in the "recovery rate"—should anyone ever think of inquiring—can always be rationally accounted for in a dozen ways, but an increase in the "weekly rate" is quite another matter. The superintendent has been appointed "to manage the asylum," and he is expected to do so.

Some of our superintendents have undoubtedly tried to serve two masters—business and science—but where one by force of intellect and the deputing of much of his fiscal work has to a certain extent succeeded, many have failed; and the greater number, believing in the soundness of the apostolic maxim, confine their attention to one only.

Of late years a custom has got abroad which is fast spreading. I refer to the abolition of the office of steward in asylums. This change, which makes the superintendent "universal provider," and still further adds to his fiscal duties and responsibilities, tends directly towards the stamping out of the medical spirit.

Of the assistant medical officer little need be said. He generally takes his cue from his superintendent, and as he in most cases has a very large amount of purely clerical work in the keeping up of "Case Books," "Medical Journals," &c., the treating of the bodily sick and infirm, with the dispensing, is generally enough to keep him fairly well occupied.

To conclude—What I have endeavoured to convey is the opinion: that while our curable cases of mental disorder continue to be mixed up with the incurable insane, and while our nursing staffs—if we may call them such—are without the most elementary training, and while the medical officers of asylums are engaged so largely in important and weighty business matters as to exclude the possibility of scientific research receiving anything but the slightest passing attention; that while this state of things lasts, the medical spirit in asylums must flicker and burn low.

*Remarks on the Use and Abuse of Seclusion.** By J. A. Campbell, M.D., F.R.S.E., Medical Superintendent of the Westmorland and Cumberland Counties Asylum.

As I take it, seclusion means the isolation of a patient from his fellows effected against his will and in spite of his remonstrances.

The reasons which should guide us in the use of seclusion are, to my mind —

1. The good of the patient from the curative point of view.
2. The safety of the patient, whether he is curable or not.
3. The safety of fellow patients and officials during intense paroxysms of excitement in a given patient.

At rare intervals it may be necessary to use seclusion as a disciplinary agent in patients who combine with their insanity much inherent wickedness, but such cases in my experience are few and far between. I shall shortly give the results of my practice and the numbers of patients under care for each of the last five years; before doing so I shall however, give my opinion as to the cases in which seclusion is a necessary and most proper form of treatment. If seclusion is used from the standpoints I have given at the commencement of my remarks no one can call it an abuse, but judgment and experience are necessary in the use of seclusion as in the use of any other remedial agent, and it should certainly be determined on in all except cases of the utmost violence by medical opinion.

In the following cases seclusion is the safest and kindest treatment:—

1. *Epileptic Excitement.*
2. *Delirious Excitement* in *General Paralysis.*
3. Certain stages in the early period of an attack of *Acute Mania,* when acts of sudden violence render it almost impossible to treat a patient for 12 hours consecutively in the open air or a ward with safety to himself and his attendants.

These are the cases when I consider seclusion very proper treatment, and I do not at all think it a matter to boast of in an asylum that seclusion is never used; if it is not used where it really should be, and the patient suffers, then the treatment is bad. In asylums, as in ordinary practice, the patient, not a system, should be considered. It is certainly better to live alone than die in company. Seclusion may at one time have been abused; I do not think it is now, but if used merely as a means of saving trouble, then it is abused. If I found a very

* Read at the Brighton Meeting of the Brit. Med. Association, July 13, 1886.

great amount of seclusion among chronic cases who were neither epileptic nor general paralytic, I should be apt to look into the matter; but my own experience in the past has clearly shown me that a variety of casual circumstances may cause one to have recourse to seclusion to an extent that afterwards seems to the same person with the same number of patients to have been great, yet at the time it seemed proper and necessary.

During a short period in which the asylum I have charge of was overcrowded it was a difficult matter, owing to a sudden rise in the labour market, to obtain and retain good attendants, and this same rise in the labour market sent me such a class of patients as never before or since, happily for me, have come under my care—uneducated, semi-savage Irishmen, who had been attracted by high wages to the pit districts, and who had succumbed to the excesses which had hitherto been, fortunately for them, inaccessible. The excess of Irish in my population in a state of excitement, with bellicose propensities prominent to a degree, caused seclusion in the interests of safety of life and limb of patients to be more used than it was ever before, or probably ever again will be in the Carlisle Asylum. A combination such as I mention is fortunately not of very frequent occurrence.

The following table shows the number of patients in the Carlisle Asylum for each of the years during which the return is made up for the number of epileptics, general paralytics, and the numbers secluded.

Table showing seclusion at Carlisle Asylum for five years ending 1885, separating epileptics and general paralytics from other cases, and giving numbers secluded and duration of seclusion:—

Years.	No. of Patients.	No. of Epileptics.	General Paralytics.	No. of Epileptics. General Paralytics Excluded.	Duration of Seclusion.	Seclusion of other Cases.	Duration of Seclusion.
					Hours.		
1881	440	38	17	8	191	7	283
1882	452	44	13	7	150	7	72
1883	494	53	12	4	80	6	140
1884	536	57	16	3	55	5	49
1885	546	48	18	4	165	2	81

The Relationship of Marriages of Consanguinity to Mental Unsoundness. By G. E. SHUTTLEWORTH, B.A., M.D., &c., Med. Supt. Royal Albert Asylum, Lancaster.

(Read at Brit. Med. Assoc. Annual Meeting, 1886.)

The subject announced as the title of my paper is one I proposed last year for general discussion in the Section of Psychology at the Cardiff meeting of the British Medical Association. Time not having permitted the discussion of this topic on that occasion, I venture now to bring under your notice a few facts and figures which I have collected in an endeavour to form an opinion upon this much-controverted question. I fear I have little that is new to place before you, the only original contribution I can offer being statistics drawn from my experience as the Medical Superintendent of an Asylum for Imbecile Children; but I trust that by attracting attention to the subject some useful discussion may be elicited as to the principles of investigation to be adopted in a more extended and exact inquiry.

Not unfrequently I am asked for my opinion as to the risk attending the marriage of cousins, more particularly in reference to the risk of idiocy in the offspring. There exists, no doubt, in the public mind, as one sees evidenced by remarks in Society and other journals, a misgiving as to the propriety of such marriages; and in medical literature also we find a disposition to attribute many evils, both physical and mental, to the intermarriage of relatives. Thus, Dr. Charles West, in his recent "Mother's Manual of Children's Diseases," states that "*First* among the causes of sickly infancy and premature death may be mentioned the intermarriage of near relatives."* Trousseau devotes a portion of a clinical lecture to a consideration "des funestes influences des unions consanguines sur la propagation de l'espèce," insisting specially on the prevalency of deaf-mutism in the progeny of such marriages. On the other hand, high authorities, medical and lay, maintain that consanguineous marriages do not furnish a larger proportion of imperfect offspring than do other marriages, and the late Dr. Jarvis, of Massachusetts, even believed "that when the parents, though related, have both perfect constitutions, the offspring have a double security against imperfections." In his view the sole objection to consanguineous marriages lies "not in the

* *Op. cit.*, p. 2.

fact of relationship of parents, but in the fear of their having similarly vitiated constitutions." In strong contrast to this is Devay's opinion, expressed in his "Hygiène de Famille,"* to the following effect:—"We charge upon unions between relatives of the same stock the production, *by the sole fact of the non-renewal of blood*, a specific cause of organic degeneration, fatal to the propagation of the species."

Thus much to show the perplexing difference of opinion held upon the question. A cursory glance at the teachings of history may, perhaps, throw some light upon the subject. It is evident that in the early ages of the world no evil results were feared from the marriage of near kin. Abraham married his half-sister, Sarah, Isaac his first cousin once removed, and Jacob his first cousins, Leah and Rachel, without any known injurious consequences to offspring. As Jeremy Taylor has it, "The elder the times were, the more liberty there was of marrying kindred"; and, among the ancient Egyptians and Persians, marriages which we should regard as incestuous were contracted by members of royal and aristocratic houses with public approbation. Indeed, marriages of sons with mothers, or of fathers with daughters, seem to have been regarded with no disfavour by certain primitive races, if we may believe the words put into the mouth of Hermione by Euripides:

> "*Τοιοῦτο πᾶν τὸ βάρβαρον γένος·*
> *πατήρ τε θυγατρὶ παῖς τε μητρὶ μίγνυται.*" †

Marriages such as these were, however, strictly prohibited to the Jews by the Mosaic law; but amongst civilized peoples we nowhere hear of the prohibition of marriages between first cousins until the time of the Emperor Theodosius, in the fourth century. Under the influence, it would appear, of ecclesiastical advice, further restrictions were subsequently imposed upon marriages between relatives of more distant degree; and at length the existence of blood-relationship within the seventh degree came to be considered by the Church as a bar to matrimony. The removal by dispensation of such restrictions in particular cases became, in fact, a considerable source of revenue to ecclesiastics, so that it is perhaps not to be wondered at that the iniquity of consanguineous marriages was insisted on as a most important article of the faith. I cannot but think that even in "reformed"

* 2nd Ed., p. 246. † "Androm.," v. 173.

countries, like our own, the influence of ecclesiastical tradition has tended to mould public opinion on the matter quite as much as have physiological considerations.

It is, however, with the latter aspect of the question alone that we, as physicians, have to do. Approaching it from the standpoint of the naturalist, what do we learn from experience as regards the lower animals? In this case, as in that of man, some difference of opinion exists as to the effect of "in-and-in breeding"; but we shall hardly be wrong in saying that it is generally admitted that whilst this process intensifies *points*, it is in the long run inimical to vigour of constitution. Mr. Youatt, a great authority, writes that "it is the fact, however some may deny it, that strict confinement to one breed, however valuable or perfect, produces gradual deterioration." The selection of animals for in-breeding must, it is admitted on all hands, be made with great care, to the exclusion of animals with any known morbid tendency; and this sort of care is but too often sacrificed, in the assortment of human couples, to sympathy and sentiment, if not to sordid motives.

Herein, no doubt, lies the special danger of consanguineous marriages. As Dr. Clouston remarks ("Clinical Lectures," p. 623), there seems to be "a special tendency for members of *neurotic* families to intermarry, and an affective affinity amongst such that tends towards love and marriage;" and I think we may safely assume that cousin marriages are more frequently met with among neurotic than among perfectly healthy stock. In such cases, of course, heredity may be considered as an important factor in the event of any evil result. Then again, in mountainous and other secluded districts, where the population is, so to say, of stagnant habit, cousin marriages are likely to be comparatively frequent. Inasmuch as

"Home-keeping youth have ever homely wits,"

we must not be surprised if in the offspring the intellectual level occasionally falls to that of imbecility. Certain it is that the Census Report bears testimony to the "much greater comparative amount of idiocy and imbecility that exists among the natives of agricultural counties, and especially of such agricultural counties as are also mountainous, than among the natives of manufacturing and mining counties."* And as Dr. Mitchell tells us, "the influence of

* "Census of England and Wales," Vol. iv, p. 70, 1881.

cousin marriages is more felt in producing imbecility and idiocy than in insanity acquired late in life."

Beyond this we unfortunately get no help in our inquiries from the Census Returns. In 1871 it was proposed by Sir J. Lubbock that a question should be inserted in the schedules with reference to cousin marriages, but it is to be regretted that the "proposal was rejected, amidst the scornful laughter of the House, on the ground that the idle curiosity of speculative philosophers was not to be gratified," at any rate by State aid. And I am not aware of any country where such an inquiry has been *satisfactorily* carried out.

In France, indeed, attempts have been made to obtain information as to the subsistence of relationship between the contracting parties to a marriage through inquiries at the Mairie at the time of registration. It would appear, however, that such inquiries have not been very systematically carried out, and very diverse conclusions have been arrived at as to the relative frequency of such marriages. Thus, M. Boudin reckons that only 0·9 per cent. of all marriages in France are between relations, 0·88 being between first cousins, whilst another return (quoted by Huth*) gives 1·28 per cent., and M. Dally contends that in Paris first-cousin marriages form 1·4 per cent. of all marriages. It would seem that M. Legoyt, chief of the statistical staff, estimated that throughout France first-cousin marriages form from 2½ to 3 per cent. of all marriages.†

In England the frequency of such marriages is little more than a matter of conjecture. Many years ago Dr. Langdon Down stated the proportion of first-cousin marriages in London as not more than 0·5 per cent. of all marriages, calculating upon somewhat limited data; and Dr. A. Mitchell has estimated the proportion in Scotland at only 1·5 per cent. In 1875, Mr. George H. Darwin (son of the great naturalist) made a somewhat elaborate inquiry into the subject, based upon the number of "same-name" marriages, and by a series of careful mathematical processes he satisfied himself that in England the proportion of such marriages (*i.e.*, marriages between first cousins) averages from 1½ per cent. in London to 2¼ per cent. in the rural districts for all classes of society, rising somewhat higher in the higher social grades.‡

* Huth, "Marriage of Near Kin," p. 206-211.

† G. H. Darwin, "Journ. Statistical Society," Sept. 1875, p. 347.

‡ "Journal of Statistical Society," June, 1875. ("1½ p.c. in London, 2 in urban, and 2¼ in rural districts," is the full statement.)

From these calculations and the further inference that the fertility of first-cousin marriages is not appreciably inferior to that of non-consanguineous marriages, Mr. Darwin goes on to argue that if the special population of idiot and lunatic asylums does not furnish a larger proportion of children of first-cousins than does the ordinary population (estimated by the number of consanguineous marriages), then no evils can be justly attributed to first-cousin marriages, so far as mental unsoundness is concerned. From information obtained from various British idiot and lunatic asylums, he ascertained that about 3·4 per cent. of the inmates (5¼ per cent. in Scotland) were supposed to be the children of first cousins.

These conclusions were based upon inquiries in the case of 4,308 patients whose history on this point was known. Special value is attributed to the returns from Earlswood Asylum, furnished by the then superintendent, Dr. Grabham, which set forth that out of 1,388 inmates, 53 were known to be children of first cousins.

In a paper published in the "British Medical Journal" (Jan., 1875) by Dr. Grabham himself, he states that "consanguinity of the parents accounts (partially only) for about 6 per cent. of the cases admitted (into Earlswood) during the last 6½ years. In 11 cases out of 543 the parents were first cousins, and no other cause could be ascertained." It would appear, therefore, from this and the preceding statement, that at Earlswood (during the period referred to) 3·8 per cent. of the patients were children of first cousins, and that in about 2 per cent. no other cause could be traced. As probably two or more children were in some cases the offspring of the same parents, the proportion of first-cousin marriages would be lower than the figures above given.

Dr. Langdon Down, in an interesting lecture published in the "London Hospital Reports for 1866,"* gives as his experience that out of 852 cases of known parentage, 60 were children of consanguineous marriages, being at the rate of about 7 per cent.; and among these 46 (or 5·4 per cent.) were children of first cousins. He goes on to show from a detailed examination of 20 unselected cases, that in 16 either insanity or phthisis existed in the family, and that in three others the presence of some parental debility was noted, so that it would appear that in only one was parental consanguinity the sole discoverable factor. He adds that

* p. 224, &c.

the average number of children to a family, in this series of cases, was 6·9, or that 53 per cent. of the progeny were in fair mental and bodily health.

At the Royal Albert Asylum, Lancaster, we have notes of 1,076 cases. It is our custom invariably to ask, whenever there is opportunity, as to relationship or otherwise of parents, but in no less than 164 cases satisfactory information on this point has not been obtained. A few readmissions are included in the 1,076 cases, so that we may put down the number of patients of known parentage at the round figure of 900. Of these 52 are known to be children of consanguineous marriages; but as in six instances there are two children of the same parents, the number of consanguineous marriages is 46. Of these 26 are the marriages of first cousins, 3 of first cousins once removed, 10 in which the grand-parents were cousins, and 7 in which other degrees of consanguinity existed. We may conclude, then, that these Case Books furnish, in the parental history of 100 imbeciles, 5·1 per cent. of consanguineous marriages and (included in these) 2·9 per cent. of first-cousin marriages. In five families the existence of other imbecile children not in the Institution has been noted, and it would appear that the average number of children to a family—the offspring of consanguineous marriages—is not less than five. In the case of the 26 first-cousin marriages, some other possible factor of idiocy is known to exist in 16.

I have no doubt much valuable information exists which I have not been able to cite here with regard to the present inmates of English imbecile institutions; but taking such statistics as I have been able to refer to, let us consider in what direction they point. Though our data are comparatively limited, there seems to be a certain concurrence in the independent inquiries referred to which will justify us in estimating the frequency of first-cousin marriages in the parental history of the inmates of English idiot asylums at from 3 to 5 per cent. If, therefore, Professor Darwin's estimate of the frequency of such marriages amongst the ordinary population is to be relied on (*i.e.*, ranging from 1½ to 2½ per cent.), I think we may fairly conclude that *first-cousin* marriages (at any rate) are to some extent favourable to the production of idiot children. I am aware that this conclusion is not in accord with that of Mr. Darwin himself, who, whilst stating that from 3 to 4 per cent. of our asylum population are probably the offspring of first

cousins, does not recognize that this is much in excess of the percentage of first-cousin marriages throughout the population generally. His statement that "probably 3 per cent. is a superior limit for the whole population" seems to me to raise too high a standard for comparison of averages obtained from Institutions most of whose inmates belong to the lower social grades.

We must, however, temper our purely statistical conclusions by such consideration of the facts of each case as may bring to light concurrent factors. In nearly all Dr. Down's cases, and in nearly two-thirds of my own, causes for idiocy were discovered, in addition to the consanguinity of parents, which would have been accepted as operative causes had no consanguinity existed. It is doubtless the case that morbid heredity, and especially mental morbid heredity, is likely to be intensified in the offspring of cousins; and, as Sir J. Crichton Browne has remarked, it is possible that "even healthy temperaments, when common to both parents, often come out as decided cachexiæ in the children."* I regret that the time at disposal does not permit me to refer to the admirable researches of Dr. Arthur Mitchell, C.B., upon the subject of consanguineous marriages in Scotland;† but his observation that "under favourable conditions of life, the apparent ill effects of consanguineous marriages were frequently almost *nil*, whilst if the children were ill-fed, badly housed and clothed, the evil might become very marked," will, I think, explain some apparent anomalies in our experience of this matter. On the whole, in these latter ages of the world's history, when so few families can show a lineage physiologically faultless, a "caveat" may almost always be entered against the marriage of cousins; at the same time, if a close scrutiny does not reveal any heritable weakness, neurotic or otherwise, I do not know that the facts and figures I have cited will justify us in invariably "forbidding the banns."

* Quoted by Darwin, "Journ. Statistical Society," June, 1875, p. 168.
† "Edin. Med. Journ.," March, April, June, 1865.

*The Alleged Increase of Insanity.** By D. Hack Tuke, F.R.C.P.

The proposition will no doubt be accepted by all whom I address (although the public is so slow to recognise it) that the only sound test of the increase of insanity is to ascertain *the number of occurring cases of Mental Disorder in proportion to the population during the periods of time we desire to compare.*† Most of the mistakes made upon this subject have arisen from taking *existing* cases of insanity at different epochs, thus totally overlooking the effect of accumulation arising from the fact that although the annual admissions may be stationary, the discharges from recoveries and deaths will fall far short of them. This in any case. But when we compare successive periods, still assuming that the admissions remain the same, the ratio of discharges and deaths may vary so greatly at different epochs that the *degree* of accumulation will be largely affected, being more or less according to the proportion of recoveries and the rate of mortality.

A striking proof of this may be given as regards the percentage of deaths on the number resident in asylums in England and Wales at different periods. Few realize, I think, how great is the difference which a reduced mortality makes in the number of patients. I find that the mortality during the six years from 1874 to 1879 (inclusive) was 10·26 per cent. resident in the asylums of England and Wales, while during the six years 1880-85 (inclusive) the death-rate was only 9·3 per cent. The actual number of deaths in the latter period was 29,783. Had the mortality continued at the same rate as during the previous six years, the number of deaths would have been 3,054 more than actually occurred. Again, in 151 institutions for the insane in England and Wales during a period extending

* Read at the Brighton Meeting of the British Medical Association, August 12, 1886.

† The correct test of the prevalence of insanity was insisted upon by Samuel Tuke in his "Introduction" to the work of Jacobi "On the Construction of Asylums," 1841, and previously in a paper read at York before the "Yorkshire Philosophical Society." Dr. Thurnam, the Superintendent of the York Retreat, in his "Statistics of Insanity," 1844, emphasized the necessity of this teaching. Dr. Lockhart Robertson made a most valuable contribution to the question in 1869 and 1871 ("Journal of Mental Science"), in which he showed by figures that up to that period there was no statistical proof of the alleged increase of insanity. Yet, every day, writers on the subject fall into the fallacy thus clearly pointed out, and therefore those who suggested the subjects for debate in the "Psychology" section of the British Medical Association were justified in including "The Alleged Increase of Insanity."

from 1766 to 1844 * the death-rate was no less than 12·12 per cent. of the average number resident. Now if the same death-rate had been maintained from the year 1859 to 1885 (dates to which I shall have frequent occasion to refer), the number of deaths would have been 128,796 during these years, instead of 105,813 (the number who actually died), making a difference of 22,983 † during the 27 years, and causing, of course, a vast accumulation, which without this explanation looks like an increase of lunacy; or to put the matter in as practical a form as possible, more than 20,000 patients have required asylum accommodation who but for the diminished death-rate would have gone to where maniacs cease from troubling, and where the weary melancholiacs be at rest.

The erroneous conclusions arising from this source of fallacy are, it is obvious, very serious if we are comparing the existing number of lunatics at different periods, but are avoided when we confine ourselves to the occurring cases as stated at the commencement of the paper.

Then, again, with regard to discharges on recovery, there might be at different periods a higher or lower percentage of recoveries to the admissions. In England and Wales, however, during the period covered by any figures we are able to obtain as at all reliable, it does not appear that this would be a disturbing element. Had the recovery rate been raised, as everybody naturally expected it would be, by the progress of medical science, we should have had to take this into account in its bearing upon the numbers of the insane at different times. It is difficult to say what the real truth is, because it is only since 1870 that lunacy statistics allow of our calculating recoveries on the admissions exclusive of transfers. If the calculation is made upon the total number of admissions (*i.e.*, inclusive of transfers and readmissions), we find that during the last five years the recovery rate is only slightly in excess of that during the five years 1859-1863.‡

Our comparison, therefore, of existing insanity at different periods would not be seriously affected by what might have

* This period is a convenient one to take, as the materials for the calculation are found in Dr. Thurnam's "Statistics of Insanity" published in that year.

† It is not overlooked that this number must be corrected by the subtraction of the number of deaths on the increased number resident consequent on the lower mortality. When, however, this correction is made there would be in round numbers at least 20,000.

‡ On the other hand, if the calculation be made upon the average number resident, the recovery rate was higher during the five years 1859-63 than during 1881-85.

been an important disturbing factor in the inquiry. Of course this possible source of fallacy does not come into force when we restrict our statistics to the occurring cases of insanity.

Before dismissing the consideration of the bearing of the recovery rate and the mortality rate upon the present investigation, it should be observed that the comparative *duration of residence* of patients in asylums during the different periods to be compared, which would be a test of the effect of mere accumulation upon the apparent increase of insanity, cannot be calculated from the Lunacy Blue Books. It is obvious that if the death-rate is reduced and the discharges remain the same, the duration of residence in asylums must be increased. As a matter of fact, in 1873 this was 198 days, while in 1883 it was 213, an increase of 15 days, being at the rate of 7·6 per cent.

Were I addressing a public audience and desirous to convey a popular and indisputable illustration of the necessary effect of accumulation and the part played by a decline in the mortality of the insane in asylums, I should take an example from the income and expenditure of a private individual. None probably would fail to see that if a man with a stationary or even a somewhat lessening income has fewer taxes to pay during the last ten years than he had during the previous decennium, and does not spend more on other items, he will have more sovereigns on hand than he had at the beginning of the term, although he has not made a penny more than formerly. The tax collector, who may serve to represent "the pale messenger," has not claimed so many pounds as before, while in our asylums he has not claimed so many victims as in former years. The illustration is certainly very homely, but we may perhaps use it for the public benefit when our dry statistical tables fail to reach their understanding.

Here it is not necessary to do more than point out that the admissions into asylums in different years have frequently varied with the accommodation provided. An asylum has been erected in consequence of the pressure brought to bear upon the county justices, and paupers previously in workhouses and boarded out are placed in it. They figure as certified admissions; they are not, strictly speaking, "transfers." But a new asylum does not operate only in changing the location of patients; it leads to the recognition and care of a great many who are at large, and thus the total number of lunatics returned becomes augmented. An apparent increase in lunacy in 1883 is in this way accounted for, as pointed out in the annual report of the Commissioners, by the additional provision for

pauper lunatics in Lancashire, and not by any real increase of insanity.

Before attempting to apply what, as I have said, is the only satisfactory mode of arriving at the truth as to the alleged increase of insanity, I will give the statistical results of other and more usual methods, premising that official returns do not allow us to go back farther than the year 1859, and that very unfortunately for our object we cannot go further back than 1869 for the returns of admissions exclusive of transfers, and not further back than 1878 for figures required to apply the only test of any practical value.

1st.—Let us take the total number of lunatics and idiots in England and Wales on the 1st of January, 1859, and compare them with the corresponding figures of January 1st, 1885 (Table A.) In these numbers are included the insane inmates of workhouses. At the former date there were 36,762 patients, and at the latter 79,704, being an increase of 42,942. It seems an alarming statement, yet one which is strictly true, that for every 100 lunatics and idiots in 1859, there are now 218 when absolute numbers are taken. And even when we take into account the increase in the population, we find the rise to be from 18·674 per 10,000 to 28·984, or 54 per cent.; in other words, from 100 lunatics and idiots in 1859 to 154 in 1885. It is not surprising that the public mind is much exercised when the newspapers in their comments upon the last Report of the Commissioners assert that lunacy has increased, after due allowance for population, more than 50 per cent. Again, if we take a block of the early years, namely, 1861-65, and the last five years 1881-85 inclusive (in order to avoid the misleading effect of comparing merely a single year with another), and compare these two quinquennia, we find the rise to be from 20·809 to 28·605 per 10,000, showing an increase in the later over the earlier period of 37·5 per cent. For the purpose of a subsequent comparison, I must add that if we take the block of years covering 1871-75, and the last five years 1881-85, we find the rise to be 11·06 per cent.; that is to say, for every 100 lunatics or idiots in detention during 1871-75, there was an average of 111 under detention during 1881-85. Thus since 1859 the increase in patients has been steadily maintained, although at a declining rate. This is also true of the period between 1878 and 1885, a term of years to which I shall have occasion to make special reference shortly. That this may be due to nothing more serious than the natural effect of accumulation and a lower death-rate will appear from what I have

already said, and will be confirmed when we come to the statistics of occurring insanity, and thus get rid of the fallacy of regarding the rise in existing lunacy only.

2nd.—The next grouping of figures (Table B) shows the total number of *certified* lunatics and idiots (omitting, therefore, workhouses) on the 1st January, 1859, to have been 23,001, while on January 1st, 1885, there were 56,525, being an increase of 33,524, or 141 per cent. When allowance is made for the increase in population, the proportion to 10,000 living in 1859 was 11·684, while in 1885 it was 20·555, a rise of 76 per cent. Taking again blocks of years as before, namely, 1861-65 and 1881-85, we find the average proportion of insane per 10,000 of the population in the former period to be 13·287, and in the latter 19·921, an increase of 6·634. This shows the rise in certified insane to have been 50 per cent. within a fraction. If we take the quinquennium 1871-75, and the last five years 1881-85, the rise is only 19·30 per cent. The increase is steadily maintained throughout, as in the previous table. To this, of course, the same explanation applies as that I have referred to in the previous table. The higher percentages, as compared with the previous table, are due to the relative increase of certified over uncertified lunatics (*i.e.*, asylums over workhouses).

3rd.—Next we take the more important returns of admissions of patients during the same term of years (Table C). These are restricted to the admissions of patients into asylums, because unfortunately no statistics are available in regard to admissions of lunatics into workhouses. In 1859 these admissions of certified patients amounted to 9,310, while in 1885 they had risen to 14,774. Corrected for population, these figures show a proportion of admissions per 10,000 of 4·729 in 1859, and 5·373 in 1885—being an increased proportion of 14·4 per cent. If we take 1869 and 1885, the rise is 6·6 per cent. The rise is greater if we take the same blocks of years as before (1861-65 and 1881-85). We then have 4·578 admissions per 10,000 population in the early, and 5·884 per 10,000 in the later block, being a ratio of increase of 28·5 per cent. If, lastly, we take the quinquennium 1871-75, and that of 1881-85, the rise is not more than 5·86 per cent. The increase is a fairly steady one up to 1878, after which the rate was almost stationary; indeed, for the last quinquennium, 1881-85, it was lower than for the preceding one.

4th.—We next eliminate the transfers in order to approach more nearly to actually occurring cases of insanity (Table D).

This, however, we can do only since the year 1869, as prior to that year the "Lunacy Blue Book" failed to discriminate between transfer and non-transfer admissions. Now in 1869 there were 10,617 admissions of patients into asylums, excluding transfers, and in 1885 there were 13,557, the proportion per 10,000 of the estimated population being 4·777 in 1869, while in 1885 it was 4·930, an increase of only 3·2 per cent. The corresponding increase, before eliminating transfers, was, as we have seen in the last table (C), 6·6 per cent. Taking blocks of years, the proportion per 10,000 of the population during the five years 1871-75 was 4·941, and during the last quinquennium it rose to 5·249, or 6·23 per cent., rather higher than when transfers were included in the calculation.*

5th.—Having now eliminated the transfers from the admissions, there remain the readmissions. I think that it is interesting to retain these at first, for this reason. There may be, it must be remembered, causes of insanity present in a community during a given period which were absent during another, and these, it is obvious, will operate upon persons who have once been insane as well as those who have never been so. If the question, therefore, were: Are certain causes of mental disease in greater force at one period than another? I think we ought to retain the readmissions, for were we to exclude relapses thus occasioned, we should receive an imperfect impression of the force of the exciting causes of insanity in operation. But as, on the other hand, the relapsed cases do not add to the number of persons who become insane, and as this is our present object of inquiry, I confine myself to the first admissions. As a result of deducting the readmissions as well as the transfers, we find the ratio of admissions to 10,000 of the population was 4·134 in 1869, and 4·210 in 1885, a difference of 1·84 per cent. Or taking three blocks of five years each, since 1870, we find that during the first, namely, 1871-75 inclusive, the ratio of admissions, minus transfers and readmissions, to 10,000 of the population, was 4·294; during the second quinquennium, 4·613; and during the third, 4·525. So that the rise of first admissions between 1880-85 over those between 1870-75 (inclusive) was not as much as 1

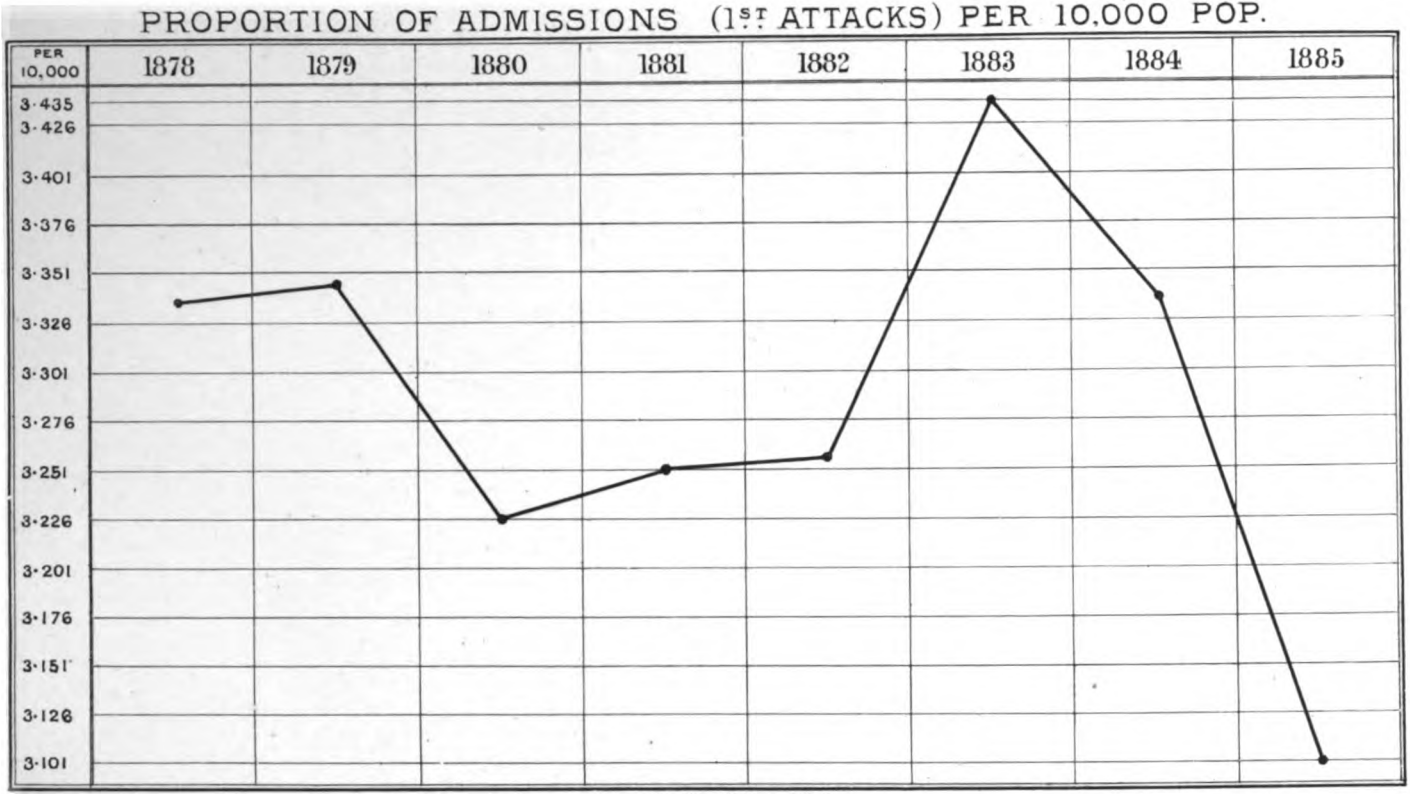
* The proportion of transfers to total numbers admitted was 11·1 per cent. in the quinquennium 1871-75; it rose to 11·9 per cent. in 1876-80; but in 1881-85 it fell to 10·8 per cent.; lower than in either of the two preceding quinquennia. The chief reason for deducting transfers is to get rid of a variable quantity, which is liable to affect the result, sometimes in one direction, sometimes in another, as actually occurs in the illustrations above given.

patient in the 10,000 (only one in 50,000), while, as compared with the second quinquennium, there was an actual decrease.

6th.—Having thus cleared the ground, I now arrive at the last and the only satisfactory test of the alleged increase of insanity, namely, the proportion of first attacks to the population during different periods. I need hardly say that first admissions, which we have already given, are not identical with first attacks, for obviously a patient may be admitted for the first time into an asylum and yet not be labouring under his first attack. Turning now to the Annual Reports of the Lunacy Commissioners, we notice that the earliest year for which returns of first attacks were obtained was 1876, but as there appears to have been something exceptional in that year, and as there is no similar return for 1877, I commence with 1878. These returns have been made regularly since then, so that we have the information we require for eight years. Congenital idiots are, it should be stated, excluded. It is, of course, deeply to be regretted that these returns do not go further back, so that we might include the same area as that over which we have travelled in the previous tables. But short as the time is, these returns are really the most important that can be procured in the attempt to solve the question upon which we are engaged, and as each year passes the value of such returns will increase. The table now given (F) is, I am glad to say, the most complete which has been published. Now the absolute number of first attacks in 1878 was 8,354 in England and Wales, while in 1885 it was 8,527. The rise was not quite uniform, and in 1880 it was actually less than in 1878, being during that year only 8,294, while in 1884 it was 9,054. When we allow for increase of population, we find that in 1878 the number of first attacks per 10,000 living was 3·337; in 1879 it was somewhat higher (3·345); in 1880 it was distinctly lower (3·225); in 1881 it slightly rose, namely, to 3·252, but did not reach the number for 1878; in 1882 it was almost identical (3·257); in 1883 there was a considerable rise (though still only a fraction), namely, to 3·435 (one-tenth of a patient in 10,000 living); while in 1884 the figure fell again to precisely what it was in 1878; and, lastly, during 1885 it fell below this, namely to 3·101. (See Chart of First Attacks.)*

Hence, *so far as statistics teach us anything*, they fail to

* It will be understood that the lowest line in the Chart is not at zero, but commences with what happens to be the lowest ratio per 10,000 in the term of years 1878-85. Had the Chart been graduated down to zero, the height of the top of the curve above the base-line would be nearly three feet.



Scale. 1 in = 100.

Mintern Bros. lith.

TO ILLUSTRATE DR TUKE'S PAPER

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show the slightest increase in occurring insanity in this country since January 1st, 1878, when we apply the only reliable test to the investigation of the problem under discussion.

I should add that the proportion of first attacks to not-first attacks has, during these eight years, been remarkably uniform, so that I think we may regard the returns now given as substantially correct.

These figures must be regarded as very satisfactory as contrasted with the prevalent opinion * that mental disorders have greatly increased during recent years. It would have been still more satisfactory had there been a marked decrease at a time when we boast of our added means of lessening the forces of evil, whether moral or physical; when education is expected to do so much for the race, and when we are told that to teach physiology to boys and girls will induce them to obey the laws of health. But, alas, too many of their teachers, and especially University examiners, do all in their power to tempt students to break these laws, and to impair the power of their brains.†

The question, therefore, presents itself, whether the present age may not be blowing hot and cold; whether it may not wage successful war against the causes of insanity in one direction, but at the same time favour their growth in another? May not one phase of excitement springing up take the place of another phase which has diminished? May not one form of insanity be less frequent, and another form be more rife? Take, for instance, general paralysis. I do not think it admits of reasonable doubt that it has increased of late years, after abundant allowance is made for its better recognition; but if the frequency of insanity as a whole has undergone little change, it would look as if some form of insanity other than general paralysis has declined. To help to determine this and some other questions arising out of the present inquiry, the Tables of the Medico-Psychological Association will be of great use, provided only that they are accurately prepared in our asylums (a serious proviso) and for a sufficiently long period of time.

There is another question I should wish to raise: Is it not

* The late President of the Medico-Psychological Association, guided by the number of existing, instead of the occurring cases of lunacy, maintained in his Presidential Address that there was an alarming increase of insanity. Such a fact would alone be a sufficient justification for reviewing the evidence in favour of this opinion.

† See article in this Journal for April, 1886.

possible that without any actual increase of the insanity which is actually certified, there may be considerably more "borderland" insanity and more of that instability of brain which scarcely reaches even this level? When one considers the number of cases unknown which exhibit more or less psychical trouble, although never included in official records, and therefore altogether outside the statistics I have brought forward, one feels how possible it is that this outer mass may fluctuate from one period to another according to various exciting and changing causes without being recognised in our returns. But how is it possible to estimate this floating unregistered element, and how can one do more than follow general impressions which are so proverbially misleading? Were I guided by my own impressions, I should be disposed to believe in a decided increase of the unstable cerebral commodity of which I have spoken, and I should incline to the belief that more, considerably more, young people of both sexes break down mentally than there did formerly, but I cannot prove it. I should be surprised if the tables of "Age on Admission" into our asylums do not show, when they extend over a sufficiently long period, that more patients are admitted under 20 now than formerly. Dr. Savage and myself have examined the Bethlem Tables with this point in view, but the reliable statistics are too restricted as to the number of years to warrant a decided inference. Dr. Savage's impression is, however, similar to my own.

It is not without significance that the number of suicides in England and Wales has increased in recent years. Comparing the period 1861-65 with 1881-84 (the return for 1885 is not accessible) there is a rise of about 12 per cent. Of those who commit suicide it may be said that, with few exceptions, they are persons with the mind more or less affected, but they are not recognised in the statistics of lunacy we have had before us.

It would, I am satisfied, be a great mistake to conclude from these figures that there is no occasion for disquiet in regard to the conditions of modern life in relation to insanity. It is, I repeat, quite consistent with these statistics to hold that there are influences at work prejudicial to mental health which at a previous period operated with less intensity than they do now. The prevention of insanity loses none of its importance, and all the cautions which the mental hygienist is wont to give to the community ought to be enforced as

zealously as ever. So long as there are preventable causes of the disorder allowed to remain in operation, so long ought we to instil into the public mind the peril run by allowing them to flourish unchecked, and so long ought we to teach that if men and women would not only learn but obey the laws of mental health more than they do, there would be for them and for their children a greater probability of escaping the dismal penalty of their infraction.

To sum up:—

1st (Table A). Taking the earliest year to which the returns in the Annual Reports of the Lunacy Commissioners extend, namely, 1859, and comparing them with 1885, we find that the total number of lunatics and idiots in England and Wales in 1885 was 118 per cent. in excess of the former, or allowing for increase of population, 54 per cent.

Taking the early block of years, the quinquennium 1861-65, and the last five years, 1881-85, we find an increase of 37·5 per cent.

If we take the quinquennium 1871-75 and compare it with 1881-85 we see a rise of 11·06 per cent. during the latter period.

This increase in the number of lunatics and idiots, which is steadily maintained, though at a declining rate, may be explained, mainly, if not altogether, by the effect of accumulation and a lower death-rate.

2nd (Table B). When we take certified patients only, and by that means exclude all workhouse lunatics, we find the rise in the number in detention in 1885 was 141 per cent. as compared with the number in 1859, but allowing for increase of population, it was 76 per cent. Again, taking the blocks of years 1861-65 and 1881-85, the rise was close upon 50 per cent. (49·9).

If we compare the quinquennium 1871-75 with that of 1881-85 the rise is shown to be 19·30.

The increase was thus steadily maintained throughout as in Table A.

3rd (Table C). The rise in *admissions* of certified patients (allowing for population) has been 28·5 per cent. for the five years 1881-85 over the five years 1861-65, and 5·86 per cent. over the block of years covering 1871-75. This percentage (5·86) is much lower than that obtained for the corresponding periods when the numbers *in detention* and not the admissions are taken.

The increase during the period 1859-85 is fairly steady up to 1878, after which the rate was almost stationary, indeed, the last quinquennium, 1881-85, was lower than that for the preceding one (1876-80).

4th (Table D). When transfers are deducted from the admissions, deductions which can only be made since 1869, we find on comparing the quinquennium 1871-75 with that of 1881-85 that the rise is rather higher than in the previous table for the corresponding period, namely, 6·23 (as against 5·86).

As in the previous table, there was a steady increase till the year 1878, after which the rate declined, and the rate in the last quinquennium was somewhat lower than in the preceding one.

5th (Table E). When not only transfers but readmissions are deducted from the admissions, we find the rise between the quinquennia 1871-75 and 1881-85 to be 5·38, which is 14 per cent. less than when only transfers were deducted.

6th (Table F). Taking, lastly, the admissions of patients labouring under first attacks (exclusive of transfers and cases of congenital idiocy) we find that during the last eight years (the only continuous term for which they are procurable) there has been very slight variation indeed, the tendency being on the whole in a downward direction. These figures are very satisfactory so far, as they exhibit no increase in the amount of *occurring* insanity since the year 1878.

7th. It is, however, necessary to enter a caution against supposing that there may not be an increase of insanity from some causes, although a diminution from other influences. Vigilance is still, therefore, required to check the unfavourable agencies which are at work, it may be, in greater force now than formerly.

There is also a large class of persons unstable of brain, and on the borderland of insanity, about which statistics are altogether silent, and this class may have increased without our being able to actually demonstrate it.*

* For valuable help in the preparation of this paper I am indebted to Dr. Banks, late assistant medical officer to the York Retreat. The calculations in the tables which I have prepared can be relied on as absolutely correct, having been made by Mr. J. H. Shoveller, General Register Office, Somerset House. Some of these carry on to the present time the statistics the writer gave in his "Insanity in Ancient and Modern Life, with Chapters on its Prevention," Macmillan and Co., 1878. I have also to acknowledge the courtesy of Mr. C. Deans, at the office of the Lunacy Board, Whitehall Place, in supplying me with advance sheets of the recent Report, &c., &c.

TABLE A.—Showing the Total Number of Lunatics and Idiots in England and Wales on Jan. 1st, 1859, and subsequent years, and the Ratio of Increase, allowing for Population.

Year.	Total Number of Lunatics on 1st Jan.	Proportion to 10,000 of the Estimated Population.	Proportion per 10,000 of the Population in various groups of years.	Rates of increase in the several periods (per cent.).	Percentage of *rise* or *decline* in the *rate of increase* in the several periods.
1859	36,762	18·674			
1860	38,058	19·122			
1861	39,647	19·706			
1862	41,129	20·190			
1863	43,118	20·905	20·809		
1864	44,795	21·450			
1865	45,950	21·731		11·918	
1866	47,648	22·255			
1867	49,086	22·644			—11·118
1868	51,000	23·236	23·289		
1869	53,177	23·928			
1870	54,713	24·315		10·593	
1871	56,755	24 911			
1872	58,640	25·421			—45·171
1873	60,296	25·815	25·756		
1874	62,027	26·229			
1875	63,793	26·642		5·808	
1876	64,916	26·776			
1877	66,636	26·979			— 14·084
1878	68,538	27·379	27·252		
1879	69,885	27·545			
1880	71,191	27·685		4·965	
1881	73,113	28·054			
1882	74,842	28·334			
1883	76,765	28 675	28·605		
1884	78,528	28·942			
1885	79,704	28·984			
1886	80,156	28·760			

TABLE B.—Showing the Number of Certified Lunatics and Idiots in Lunatic Asylums or Confined as Single Patients in England and Wales, during the 27 years 1859-85, and the Ratio of Increase, allowing for Population.

Year.	Total Number of Certified Lunatics on 1st January.	Proportion to 10,000 of the Estimated Population.	Proportion per 10,000 of the Population in various groups of years.	Rates of increase in the several periods (per cent.).	Percentage of *rise* or *decline* in the *rate of increase* in the several periods.
1859	23,001	11·684			
1860	23,859	11·988			
1861	24,989	12·420			
1862	26,369	12·944			
1863	27,505	13·335	13·287		
1864	28,544	13·668			
1865	29,637	14·016		15·195	
1866	31,095	14·524			
1867	32,141	14·827			
1868	33,487	15·257	15·306		—40·152
1869	35,005	15·751			
1870	36,269	16·119			
1871	37,266	16·357		9·094	
1872	37,592	16·296			
1873	38,883	16·220	16·698		+8·258
1874	40,170	16·986			
1875	41,558	17·355			
1876	42,880	17·687		9·845	
1877	44,286	17·930			
1878	46,059	18·399	18·342		
1879	47,650	18·781			—11·224
1880	48,747	18·957			
1881	50,173	19·252		8·609	
1882	51,753	19·593			
1883	53,180	19·865	19·921		
1884	55,072	20·297			
1885	56,525	20·555			

Table C.—Showing the Admissions of Certified Lunatics and Idiots into Asylums or Single Houses in England and Wales during the 27 years 1859-85, allowing for population.

Year.	Admissions of Certified Lunatics during each Year.	Proportion to 10,000 of the Estimated Population.	Proportion per 10,000 of the Population in various Groups of Years.	Rates of Increase or Decrease in the several Periods (per cent.).	Percentage of *rise* or *decline* in the *rate of increase* in the several Periods.
1859	9,310	4·729			
1860	9,512	4·779			
1861	9,329	4·637			
1862	9,078	4·456			
1863	8,914	4·322			
1864	9,473	4·536	4·578		
1865	10,424	4·930			
1866	10,051	4·695		+ 8·869	
1867	10,631	4·904			
1868	11,213	5·109	4·984		+ 12·986
1869	11,194	5·037			
1870	11,620	5·164			
1871	12,573	5·519		+ 11·517	
1872	12,176	5·278			
1873	12,773	5·469	5·558		— 25·328
1874	13,229	5·594			
1875	14,317	5·979			
1876	14,386	5·934		+ 8·600	
1877	15,963	6·463			
1878	15,102	6·033	6·036		—
1879	14,867	5·860			
1880	15,240	5·927			
1881	14,669	5·629		— 2·519	
1882	15,665	5·931			
1883	16,000	5·977	5·884		
1884	17,669	6·512			
1885	14,774	5·373			

TABLE D.—Showing the Admissions of Certified Lunatics and Idiots, less Transfers into Asylums and Single Houses, in England and Wales during the 17 years 1869-85, allowing for Population.

Year.	Admissions of Certified Lunatics, less Transfers.	Proportion per 10,000 of the Estimated Population.	Proportion per 10,000 of the Population in various Groups of Years.	Rates of Increase or Decrease in the several Periods (per cent.).	Percentage of *rise* or *decline* in the Rate of Increase in the several Periods.
1869	10,617	4·777			
1870	10,399	4·622			
1871	10,758	4·721			
1872	10,820	4·685			
1873	11,441	4·888	4·941		
1874	12,146	5·120			
1875	12,677	5·273			
1876	13,082	5·369		+ 7·610	
1877	13,163	5·329			
1878	13,570	5·421	5·317		—
1879	13,291	5·239			
1880	13,451	5·231			
1881	13,693	5·254		— 1·279	
1882	13,829	5·236			
1883	14,681	5·484	5·249		
1884	14,512	5·349			
1885	13,557	4·930			

TABLE E.—Showing the Admissions of Certified Lunatics and Idiots, less Transfers and Readmissions, into Asylums and Single Houses in England and Wales during the 17 years 1869-85, allowing for Population.

Year.	Admissions of Certified Lunatics, *less* Transfers and Readmissions.	Proportion per 10,000 of the Estimated Population.	Proportion per 10,000 of the Population in various Groups of Years.	Rates of Increase or Decrease in the several Periods (per cent.).	Percentage of *rise* or *decline* in the Rate of Increase in the several Periods.
1869	9,188	4·134			
1870	9,027	4·012			
1871	9,267	4·067			
1872	9,412	4·075			
1873	9,942	4·247	4·294		
1874	10,619	4·476			
1875	11,023	4·585		+7·429	
1876	11,404	4·680			
1877	11,428	4·627			
1878	11,844	4·731	4·613		—
1879	11,480	4·525			
1880	11,596	4·570		—1·908	
1881	11,821	4·536			
1882	11,871	4·494			
1883	12,767	4·769	4·525		
1884	12,539	4·621			
1885	11,578	4·210			

TABLE F.—Showing the Admissions of Patients labouring under First Attacks (exclusive of Transfers and Cases of Congenital Idiocy) into Asylums and Single Houses during the eight years 1878-85, allowing for Population.

Year.	Admissions, exclusive of Transfers and Cases of Congenital Idiocy.			
	First Attacks.	First Attacks per 10,000 living.	Admissions (including Readmissions).	
			Numbers.	Proportion per 10,000 living.
1878	8,354	3·337	12,582	5·026
1879	8,487	3·345	12,467	4·914
1880	8,294	3·225	12,478	4·853
1881	8,475	3·252	12,676	4·864
1882	8,602	3·257	12,901	4·884
1883	9,185	3·435	13,623	5·089
1884	9,054	3·337	13,548	4·993
1885	8,527	3·101	12,497	4·545

CLINICAL NOTES AND CASES

A Recent Medico-legal Case.—A Question of Insanity. By A. R. Turnbull, M.B.Edin., Med. Supt. of the Fife and Kinross District Asylum.

The following criminal case has some interest in a medico-legal point of view, and is indeed unique in some of its features. The charge was one of murder; and from the defence set up the main question in the case came to be the determination of prisoner's mental state at the time when the assault was committed. In giving a summary of the case I shall confine myself to the leading circumstances and to those points which are of service in helping us to estimate prisoner's mental state:—

Margaret Robertson, or Brown, from Inverkeithing, was tried on 15th March, 1886, in the High Court of Justiciary, Edinburgh, before Lord McLaren and a jury, on a charge of having murdered her two grandchildren, it being alleged that she placed them on the fire, whereby they were so severely burned that they died shortly afterwards. The assault itself was not denied; but a plea of not guilty was entered on the ground that at the time of committing the assault prisoner was in a state of insanity, or alternatively in a state of somnambulism. Before evidence was called, Lord McLaren stated to the jury that though the offence charged was murder, it was under that indictment competent for them to find a verdict of the less aggravated crime of culpable homicide. From his knowledge of the circumstances, and his reading of the medical reports in the case, his Lordship was able also to tell the jury that, in addition to the special defence put forward, they would have to consider the question whether or not prisoner committed the assault under the influence of intoxicating drink.

The evidence may be summarised as follows:—

a. *Circumstances of the assault.*—Early on the morning of 1st January, 1886, prisoner went to the house of her son, Richard Brown, to "first-foot"* him and his wife. Richard Brown had two children—Maggie, aged about four years, and Jeanie, between two and three years of age. The children slept in a crib, in the room in which prisoner sat, with their parents. After being in the house for some time, prisoner suggested that Richard and his wife should go to "first-foot" his married sister, Mrs. Ogg, whose house was a little distance away. She added that if they went they must not be long

* First-footing is the making the first visit to a house after the incoming of the New Year, and is the occasion for an interchange of alcoholic beverages.

in coming back. Richard and his wife went to Mrs. Ogg's about four o'clock, prisoner remaining behind to take care of the children. At this time prisoner was sitting near the fireplace, with Jeanie on her knee; and Maggie was in the crib. About five o'clock prisoner appeared at Mrs. Ogg's house and told her son and daughter-in-law that it was time for them to go home, for the bairns were burnt, and one of them was lost. The parents ran home at once, and found Jeanie in the crib, completely covered by the blankets, and Maggie on the floor beneath the crib. Both children were severely burned. Maggie's clothing was also much burned. Jeanie was burned on the left side of the body and on the left leg, but her dress was only slightly injured; and it seemed that the clothing must have been held away from the fire, or perhaps drawn over the child's head, while she was on the fire. The injuries could not have been accidental; and it must have taken some little time to produce them in the case of each child. The sleeping crib had been drawn out from its usual place in the room. Some hair was found on the floor, and was afterwards identified as Maggie's. Jeanie died on 7th January and Maggie on 14th January. During her illness Maggie stated several times that it was her grandmother who had put her and Jeanie on the fire.

b. *Prisoner's conduct before and after the assault.*—While in her son's house before the assault prisoner was very emotional, crying, and speaking much about her son David, who had committed suicide about 18 months previously. She said this was the second New Year he had been out of the house, and she missed him very much. When she appeared at Mrs. Ogg's house after the assault she had an excited, "raised" look. In speaking about the occurrence to a neighbour on the forenoon of 1st January prisoner seemed "much grieved and excited." Otherwise there was nothing in her appearance or behaviour, as observed by others, either before or after the assault, which attracted attention as being at all different from her usual state.

c. *Prisoner's general character, and previous relations with the children.*—The evidence showed distinctly that prisoner was intemperate in her habits. She had been twice in the hands of the police for breach of the peace. On at least one of these occasions she was under the influence of drink, and was violent in her behaviour while in the police-cell, making a great noise, using bad language, and breaking the furniture. Her previous conduct towards her grandchildren had always been kind and affectionate. She seemed fond of them and they of her; and the parents frequently left them under her charge when they were absent from home. She seemed particularly attached to Maggie, and often took the child about with her when she was going anywhere.

d. *The amount of intoxicating drink prisoner had taken.*—About six o'clock on the evening of 31st December prisoner had a glass of whisky from Mrs. Ogg. Between nine and ten o'clock she was one of a party of three who consumed a gill of rum, two bottles of table

beer, and a bottle of ale. About a quarter past ten o'clock she purchased a gill and a half of whisky, and about eleven o'clock a gill of rum. She was not known to share this last whisky and rum with any one, nor was any trace of the liquor again got, though prisoner was seen later in the evening going about with a bottle of raspberry vinegar. On going to her son's house she received another glass of whisky; and she became sick, vomited freely, and afterwards washed her face and combed her hair. A little later she had some more whisky with her son. A bottle about three-fourths full of whisky was in the open cupboard in the room; but there was no evidence that prisoner had taken anything out of it during the absence of her son and daughter-in-law. The various witnesses who saw prisoner during the course of the night concurred in saying that she was "not drunk," though some of them also stated that she looked as if she had "had a glass."

e. *Prisoner's statements regarding the occurrence.*—In conversation with a neighbour about six or seven hours after the assault prisoner said that she "did not know what had come over her. She thought a big woman had come into the house and was taking advantage of her, and that the children were the show people's children. She took Maggie by the hair and put her on the fire. Maggie cried out, and prisoner then took her off and put Jeanie on. Jeanie struggled to get off, and something came over prisoner, so that she could not take Jeanie off." To other neighbours she stated that a big woman or "show-wife"* had appeared in the room with some "towsey-headed children"; but she said nothing as to having put the children on the fire. She added that she thought she had fallen asleep, and when she awoke everything was dark about her, and she struggled hard to get out to tell her son. In her declaration before the Sheriff she said she had not done anything to the children that she was aware of; that "something not earthly," which she thought belonged to the show folks, appeared in the room and wanted to take advantage of her and the children; and that after a struggle she got past the unearthly person and went out of the house. Asked how she was able to inform her son that the children were burned and that one of them was missing, she said she did not know. In a second declaration she stated that she did not murder the children, and that she had accidentally dropped Jeanie in front of the fire. Her statements to the medical witnesses who examined her were substantially the same as made to the Sheriff.

The foregoing information was brought out in the evidence in court. The following further particulars bearing on prisoner's history were not included in the evidence, but were known to the medical witnesses in the case:—

* Meaning, apparently, someone connected with the travelling shows or booths which visit Inverkeithing at holiday times.

Prisoner's father, who died about the age of 73 years, suffered from epilepsy for three or four years before his death, and showed mental symptoms in connection with it. Prisoner's son, David, committed suicide by drowning in the summer of 1884. The circumstances leading to the act were not quite clear; but apparently he had been drinking heavily, and had been reproached by some of his relatives for his conduct. During the dinner-hour, when the other workmen were absent, he went along the pier, wrapped a heavy chain round himself, and threw himself into the water. Prisoner's grandchild, Maggie, had epileptiform seizures during the illness following on the burns. Prisoner herself was a coarse-minded, rough woman, who would "do anything to get drink"; and when under the influence of liquor she often talked in a maudlin way about her son David, and accused the other members of the family of having caused his death. In my examination of her, when I asked her to tell what happened while she was alone with the children, she said that she was in great dread because something like a show-wife came into the room and wanted to do harm to her. Asked to describe the appearance of the show-wife, she could not do so—she could not tell how she was dressed or what kind of woman she was; but she (prisoner) knew that such a person was in the room, and she had to struggle hard to get past her and make her escape from the house.

There were four medical witnesses in the case. Dr. Menzies, of Inverkeithing, was called first, and gave evidence regarding the injuries sustained by the children. He had examined prisoner on 2nd January, and found her perfectly sensible. Prisoner's counsel then asked his opinion of her mental state at the time of the assault; but Lord McLaren disallowed the question. His Lordship ruled that the medical witnesses could give evidence as to facts coming directly within their observation; but any statement by them as to prisoner's state at a time when she was not seen by them was an *opinion* only, and could not be received as evidence. It was for the jury to pronounce upon prisoner's mental state at the time of the assault. By his Lordship's direction, therefore, no further questions upon that point were put to the medical witnesses, though questions of a general character, as, for instance, on the nature and symptoms of homicidal mania, were still permitted. Dr. Drysdale, of Dunfermline, confirmed Dr. Menzies' evidence; and Dr. MacDonald, of Cupar, and I testified to prisoner's sanity while she was under observation in Cupar prison.

In addressing the jury, prisoner's counsel urged that the evidence of the relatives negatived the idea of drunkenness, and asked for a verdict of insanity.

In summing up, Lord McLaren advised the jury that, as there was no proof of malice or premeditation on prisoner's part, they should put aside the question of murder and confine their attention to the minor charge of culpable homicide. He explained that culpable homicide implies responsibility, but that the degree of responsibility

might vary very greatly in different circumstances, and that it was in the power of the judge to graduate the penalty according to the amount of responsibility that was present in each particular case. In the present case the sole question the jury had to try was the nature and degree of responsibility that attached to the prisoner. If they thought she committed the assault during a sudden and short-lived access of insanity, they would enter a verdict to that effect, and so would practically absolve her from the charge. If, on the other hand, they considered she was suffering from the effects of intoxication, and had placed the children on the fire either in a fit of drunken passion or under the influence of some drunken hallucination, formed, perhaps, when she was half-asleep, then the proper verdict was one of culpable homicide.

The jury unanimously gave a verdict of culpable homicide. Lord McLaren stated that he entirely concurred in that finding, and passed sentence of ten years' penal servitude.

Remarks.—The plea of somnambulism was put forward, apparently to cover the possibility of prisoner having committed the assault while she was asleep. But it was not pressed; and there was no evidence that prisoner had at any time been subject to somnambulism. The question for decision was therefore simply between insanity and drunkenness. The circumstances of the case were such as to make the question a very open one. By Lord McLaren's ruling, and in accordance with precedent, the medical opinions on this point were not submitted to the jury; but it may be mentioned that of the four medical witnesses two held that prisoner was insane and two that she was not insane.

Before we consider the arguments in support of each of these views, there are two points which call for some further remark:—

1st. What did the evidence prove in regard to prisoner being drunk or not? Prisoner's counsel very properly laid great stress upon the statement made by several witnesses that she was not drunk; and he also contended that it was altogether unlikely the parents would have left the children in prisoner's charge if they had thought she was drunk or unable to look after them. On the other hand, prisoner's known character, her being engaged in first-footing, the amount of drink she was known to have taken, and the admission of the witnesses that she looked as if she had "had a glass," all pointed strongly to intoxication. This is corroborated by prisoner's sickness, and by the character of her behaviour and conversation when in her son's house. The former was doubtless the sickness of alcoholism; and it has

already been mentioned that when prisoner was in her cups she often talked in a maudlin and silly way about her dead son. Lord McLaren evidently took the view that intoxication was proved. He pointed out that the witnesses might be quite conscientious in saying that prisoner was not drunk, for it is a matter of opinion when the term drunkenness should be applied, and the relatives would naturally speak of prisoner's state as leniently as possible; but that there might still be quite sufficient evidence to show that she was more or less distinctly under the influence of alcohol.

2nd. What weight should be given to prisoner's statements about her hallucinations? (appearance of show-wife, &c.). The circumstances of the case naturally make us suspicious of the extraordinary account given by the prisoner; and we at once ask if her statements about the hallucinations were made truthfully, or were they false, and put forward simply to excuse her crime. There were some important variations between the account she gave to a neighbour on the forenoon of 1st January and the statements she afterwards made to the Sheriff and the medical witnesses; but on the whole she was tolerably consistent so far as the hallucinations themselves were concerned. The impression made upon all the different persons who saw her was, I think, that she was speaking truthfully. Again, she spoke of the hallucinations within a very short time after the criminal act. Further, the character of the hallucinations was, to my thinking, consistent with what we surmised to be her mental state at the time; and it was unlikely that a person of prisoner's poor education could so quickly have hit on the appropriate delusions if she had not really experienced them. Her statements on these points were therefore accepted as truthful. I may here add also that she gave me the impression of having a better remembrance of other incidents of the assault than she chose to show to the medical examiners.

The arguments put forward in support of the view that prisoner was insane were as follows:—(1) Absence of proof of drunkenness; (2) the existence of hallucinations; (3) the extraordinary nature of the assault; (4) absence of motive for it; (5) prisoner's family history, showing a tendency to epilepsy or nervous disturbance; and (6) the emotionalism previous to the criminal act. Regarding these we may remark that the first is here perhaps the most important, for it is evidently necessary to eliminate the question of alcoholism. But we have already seen that in the opinion of the presiding judge the evidence did show that prisoner was more or less distinctly

under the influence of alcohol; and therefore this first argument scarcely holds good. The other arguments almost necessarily fall with it. Hallucinations may occur in drunkenness as well as in insanity. Extraordinary nature of the act, absence of motive, and family history may quite properly be quoted in support of other and *direct* evidence of insanity, but are not in themselves proofs of mental derangement; and they are as consistent with the theory of drunkenness as with that of insanity. The emotionalism was a symptom of alcoholism.

Previous to the trial prisoner was detained in Cupar gaol. As it was known that a plea of insanity would be set up, Dr. MacDonald, surgeon for the prison, and I were asked to see her and give Crown counsel a report upon her mental state at the time of our examination and her probable mental state at the time of the criminal act. We had no difficulty in saying that she was sane while under our observation. We had very considerable hesitation in speaking as to her mental state when she committed the assault; but the conclusion we ultimately arrived at was that the hallucinations were in the main the result of alcoholism. Keeping in mind prisoner's state immediately before and immediately after the crime, as brought out in the evidence, we considered it necessary to account in some way for the sudden appearance and very short persistence of the delusions. According to our view, prisoner fell asleep when left with the children; and either during this drunken sleep, or more probably at the time of awaking from it, the hallucinations were developed. We know that delusions are apt to show themselves, and to be most strongly marked, at the time of awaking from sleep. Had prisoner's sleep been long and sound, it would probably have tided her over her intoxication; but being short and unrefreshing, and perhaps suddenly interrupted, it left her in a state in which her brain was temporarily more susceptible than before to the action of the alcohol. If the hallucinations were developed in this way, and were thus in part the result of the sleep-condition, prisoner's state would be somewhat like one of nightmare; and we can easily understand that this state might be very transient, and that the morbid sensations would pass away as soon as the sleep-condition was thoroughly got rid of or the alcoholic poison eliminated.

Her condition, as we thus view it, has some analogy on the one hand to somnambulism, and on the other hand to insanity. From the former it is marked off by the essential difference that it was in the main produced by the alcoholic poisoning, though predisposed to in some degree by the sleep. In the

same way it is separated from insanity, for mental derangement which is the direct and immediate effect of a poison acting on the cerebral centres is not regarded as insanity.

The following were the considerations which led Dr. MacDonald and me to adopt this view :—1st. There was no indication of insanity in prisoner's conduct at any time, as observed by others. The excitement noticed after the crime was not more than was natural under the circumstances, and did not suggest the idea of mental derangement to the observers. Prisoner had not been insane at any previous time of her life. 2nd. There was distinct proof of alcoholism. 3rd. Prisoner herself said that she thought she had fallen asleep. 4th. The feelings described by her—the sense of dread, the struggle to escape from some impending evil, and the vague, undefined character of the supposed show-wife—point to a nightmare condition such as that indicated above. 5th. The very short duration of the hallucinations is what we might expect according to this view. 6th. Prisoner's partial remembrance, in a confused kind of way, of the occurrence is consistent with this view.

We considered that, while in the state above described, prisoner was not fully or properly aware of what she was doing. The law, however, as indicated by Lord McLaren, does not admit drunkenness as an excuse for crime, and therefore prisoner was still legally responsible for her deed.

The possibility of the assault having been committed under epileptic impulse was kept in mind, but was negatived. Prisoner had not been subject to epilepsy previously; and there was no indication of an epileptic seizure at the time in question. When an act is committed under epileptic impulse there is no remembrance of it afterwards—the memory is a complete blank; but in the present case prisoner had considerable remembrance of some of the incidents of the occurrence.

The plea of insanity in cases like Mrs. Brown's should always be examined with great care. We know that paroxysmal attacks of insanity may occur and be of very short duration. Still they are rare. And when the attack coincides with a time when the patient is away from any observation by others, covers the committal of a very serious crime, and passes off before the patient comes again under observation—all, too, within the space of one hour—one cannot but feel very suspicious of the alleged insanity. In Mrs. Brown's case it was not considered that she was insane at any time other than just during the hour when the criminal act was committed; and had the plea of insanity been upheld it would have been in consideration of

statements made by prisoner herself, and of the extraordinary nature of the crime, and not from any direct evidence of insanity in her conduct as observed by others.

A remark made by prisoner after our report had been sent in may be taken as confirming the verdict finally arrived at. She said, "It was the wee drap o' drink that did it a'."

Case of Chronic Lead Poisoning, with Epilepsy and Insanity. By William L. Ruxton, M.B., Pathologist and Assistant Medical Officer, South Yorkshire Asylum.

T. A., æt. 40, married, is a file cutter by trade. Family history is good, except that his paternal uncle died of general paralysis. He has never been a hard drinker. He commenced the trade of a file cutter as a young man, and up to ten years ago always enjoyed good health. About this time, *i.e.*, after some twelve years' exposure to the lead dust arising from the file bed, he was seized with lead colic and right wrist drop. The colic soon yielded to treatment, only, however, to recur after fresh exposure. The paralysis gradually improved so that work could be resumed, and it has never again recurred. Altogether five or six separate attacks of colic have occurred, and it was during one of these that the first epileptic fit took place four years ago. Epilepsy then, as is the rule, commenced subsequent to colic and wrist drop, and about eighteen years' work in a room where particles of lead dust are more or less abundant. The first fits occurred in a series of five, and were followed by stupor. Insanity dates from the commencement of the fits, and gradually becoming worse, he was admitted in March, 1885. Physical condition on admission was recorded as follows:—He is a thin, badly nourished man with an earthy complexion and pinched face. The teeth are coated with tartar, and there is a distinct blue line at their junction with the gums, which are retracted. Fine fibrillary tremor of the tongue is marked, but is absent in the muscles of the lips, and speech is normal. Pupils are equal, and all their reflexes are normal. Visual acuity is also normal. There is slight wrist drop of the right side with wasting of the posterior interossei, and especially of the small muscles of thumb. The long extensors of the fore-arm do not seem so well developed as their fellows of the opposite side. Triceps reflex is exaggerated on both sides, but tap over the radius produces a much more pronounced extension of the right than left wrist. Knee jerk is exaggerated on both sides, and ankle clonus is easily produced in both legs. Cremasteric and epigastric reflexes seem normal. Gait is steady. Cutaneous anæsthesia is present in the legs where, over the anterior tibial muscles, two points can be distinguished only when 1½ inch apart. Elsewhere sensation seems about normal. There is a trace of albumen in the urine.

Mental state :—He is unconscious of his surroundings, and is restless, knocking about carelessly, but not noisy. On one or two occasions he has attempted to make headlong rushes at the window. He has no hallucinations of sight or hearing. The subsequent progress of the case was characterised by short attacks of excitement or stupor of a post-epileptic character. After a week restlessness disappeared, to be followed by a post-epileptic excitement of a violent nature, from which he recovered in a few days, and in the absence of fits he became quiet, rational, and industrious, and was discharged after three months' residence. He returned to his trade, re-exposed himself to the influence of lead, had eighteen fits in a few weeks, and was again admitted in the following state :—He stands for some time in a fixed position staring vacantly in front, refuses to speak, resists everything done for him, is dirty in habits, and destructive. These symptoms soon passed off, and left a condition of slight dementia, characterised by slow ideation, slight loss of memory for recent and remote events, and very distinct loss of memory for proper names. Fits were strong, epileptic, not preceded by an aura, and followed, as a rule, by stupor of average duration. He continued to have fits at intervals, but remained free from stupor or excitement, and was again discharged. As on former occasions the epileptic seizures increased in number when work was resumed, excitement followed, and re-admission became necessary. The excitement soon subsided again, leaving only the dementia above referred to. After an absence of epileptic seizures for two months, and compared to what it was on first admission fifteen months previously, his condition, physical and mental, is recorded thus :—Dementia is stationary. The power of the right hand is almost as good as the left or unaffected, ankle clonus is difficult to elicit, the muscles of the legs are firmer, patellar reflexes are still exaggerated, but anæsthesia of the legs does not appear to be nearly so marked ; blue line is very distinct, and tremor of tongue remains as before.

The farther progress of the case is simply a repetition of post-epileptic stupor or excitement, and he is at present (August, 1886) passing through an attack of excitement.

The treatment adopted was the administration of iodide of potash and sulphate of magnesia at intervals.

Remarks.—The uncle's insanity is a predisposing cause in this case, but what is the exciting ? He had always been a temperate man. It is most probable that the prolonged action of lead, circulating as lead albuminate in the system, was instrumental by its direct action in the production of the cortical epilepsy which has now become chronic. The insanity was invariably characterised by post-epileptic phenomena. Colic and wrist drop were the more evident physical signs, but, as is sometimes the case, the legs also were affected, as

evidenced by ankle clonus and anæsthesia. The physical signs improved in the absence of fresh inhalations of lead dust, but the mental signs—epilepsy—have gradually become worse.

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*Cases of Suicidal Intent in Congenital Imbeciles.** By C. S. W. Cobbold, M.D., Medical Superintendent of the Earlswood Asylum.

At Earlswood Asylum during the past four years, at least six cases have come under my observation in which suicide has been definitely contemplated by congenital imbeciles. I am not aware that such cases have been previously described.

In most of my cases suicide was actually attempted, while in each of the others some very definite step was taken by the patient as a preliminary to the intended act of self-destruction.

I proceed at once briefly to record the cases, offering also a few remarks upon each:—

D. W. had had incipient phthisis for many years, and was always a bad sleeper. At the age of 37 he was a useful helper in the infirmary ward, able to amuse himself by reading the papers, and was fond of studying murders and tragedies generally. He had been imbecile from birth, his condition being ascribed to a fright sustained by his mother during pregnancy. One of his brothers died of epilepsy (there were at least five in the family), but nothing further of importance appears in the family history. Patient was of a brooding disposition, simple and childish in manner, always smiled happily when addressed, but replied always as briefly as possible. He was uniformly gentle with the children in the ward, and was fond (without my knowledge) of several cats which had come to be a nuisance in the hospital. I found it necessary to order that all the cats except one should be got rid of. Before all the removals had been effected, one Sunday morning in February, 1883, D. W. was reported to be missing, and had been seen leaving the building. I then first learned that he had been vexed about the cats, and had threatened to "make a hole in a pond." Diligent search was made, and the patient was brought in by two countrymen after nine hours' absence. He had run away with the intention of drowning himself, but had not the courage to carry it out. He had run and walked aimlessly along the roads until perfectly exhausted, and had then turned of his own accord to come back to the asylum before he was accosted by the men who afterwards helped him on his return journey. He was much exhausted, but cried passionately about the cats, and begged me to give him some

* Read at the Annual Meeting of the British Medical Association at Brighton, August, 1886.

poison and "finish him at once." I did my best to soothe him, and placed him under the care of a special attendant in the first-class patients' room. In a few days he was quite cheerful again, had recovered from his stiffness, and said he would never run away again even if six of his cats were killed. He returned to his work in the hospital wards.

Two years later, February, 1885, he was again mentally unsettled owing to a nurse leaving to whom he had been attached. Being carefully watched and kindly treated he soon settled down again to his usual work.

In January, 1886, he was distinctly melancholic for four days, and absolutely refused food for 48 hours; he threatened suicide, would not reply when addressed, and did not sleep except under the influence of drugs. This time there was no external cause for the depression; D. W. admitted this to me himself when he had again become quite cheerful. He was soon afterwards removed to a county asylum.

Remarks.—What strikes one most forcibly in this case is the slightness of the motive which induced a man of nearly 40 years of age to decide that his life was no longer worth living. The loss of a cat was absolutely the sole cause of this man's unbearable misery. This is a good example of that want of a due sense of the relative importance of things which is common to all humanity, but is most markedly exemplified in the insane. Then, again, one notes the feebleness of will and purpose which prevented the patient from either carrying out his original design or substituting anything definite in its place. He had sufficient money with him to reach his home, but he made no attempt to do so.

S. S., aged 29, imbecile. The mental condition is attributed *by his friends* to the shock of a scald at six years of age.

Says 11 + 7=17. Breaks down at repeating five figures, often at four; he can read and write fairly well, and is useful in doing light errands. He is rather quick-tempered when teased, and will then become abusive, but not violent unless interfered with. In July, 1886, another patient had been teasing him and "calling him names." S. S. went at once to the brook on the farm, divested himself of all his clothing except his shirt, walked into shallow water and dipped his head into the water. Having had his ardour partially cooled he walked out of the water again, but afterwards went in once more and repeated the operation as before. By this time he had been observed and was quickly brought back to the asylum. He afterwards stated that he had intended to commit suicide. When brought back he told me as his excuse that R. W. had called him "Mr. Dirty-Case;" he then dropped on his knees and prayed impulsively for forgiveness with one breath to the Almighty, to myself, and to the steward. In

an hour's time the patient was as cheerful and calm as if nothing had happened.

Remarks.—In this case again one cannot but be struck with the absurd inadequacy of the annoyance to serve as a motive for suicide; also with the weakness of purpose which fortunately prevented the patient from carrying out his intention. He has since told me that the water was too deep for him to commit suicide. He probably does not fully understand the meaning of suicide, and thought it was necessary to be very careful not to drown himself. I have purposely refrained from explaining the matter to him, so cannot say exactly how much he knows about it. Since this occurrence S. S. has been perfectly happy and cheerful as usual, and has promised freely *never to commit suicide again.*

J. L. M. was a congenital imbecile, with no idea of number, but able to read a little and make himself useful in small ways, and as a carpenter's labourer. In January, 1885, his age being then 39 years, it was noted, "Patient is more restless of late. He went to bed at midday yesterday without any reason for doing so. This morning he put a carving knife to his throat, but I cannot make out that he has any definite suicidal intent; he is perfectly cheerful, constantly laughing, but is exceedingly silly, many of his actions being apparently quite purposeless. It is difficult to understand what he says, but he answers questions in the affirmative as to whether he is happy and comfortable; he also appears to volunteer the statement that he 'doesn't want to kill anybody.'" The deputy-head attendant, an intelligent man, who was present when the patient put the knife to his throat, says he feels sure J. L. M. meant to cut his throat; a look in the patient's eyes appears to have been the chief element in producing this conviction.

During the 18 months since this occurrence the patient has been quite happy, and has not made any attempt upon himself. His mental tendency is in the direction of dementia; he talks incoherently, and has lately wet himself several times, which was never the case before.

Remarks.—The suicidal tendency in this case appears to have been of the nature of a momentary impulse, occurring without any apparent cause, and unaccompanied by depression or passion of any kind.

H. F. S., aged 19, son of a solicitor in New Zealand, stated by his father to be imbecile from birth, was always returned in census as "incapable of receiving instruction." Can read fairly. Writing and articulation defective from athetosis. Mother's uncle insane. He is an example of congenital moral imbecility combined with congenital

athetosis. Is sly, untruthful, cunning, deceitful, wanton, mischievous, and hypocritical by nature. Is always abjectly penitent after being *discovered* in evil-doing, but is utterly unable to restrain his propensities in the future. He provokes the attendants in every possible way, and occasionally becomes very violent himself. Can do simple mental arithmetic, but he breaks down when he is asked to repeat five or six figures consecutively after me from memory, though he sometimes repeats five correctly.

In July, 1885, he had been placed in a constant observation ward owing to his having been violent to other patients; just as dinner was being cleared away he cut the back of his right hand rather badly with a knife, trying to open a vein, and was just prevented by the attendant from cutting at his throat. He admits that he was so miserable (owing to his misdeeds and their consequences) that he wished to take his life. He has threatened this also at other times when in an excited and insubordinate state, *e.g.*, in February, 1886. He is subject to uncontrollable impulses of various kinds, *e.g.*, attacking an unsuspecting attendant from behind; running away through the town in the most demonstrative manner when not pursued, whereas if he had walked quietly he would have passed unnoticed.

Remarks.—The suicidal intent in this case is always essentially an impulse, and is not the result of reflection. The patient gets into a state of passionate excitement and feels he must do something desperate; but he lacks the steadfastness of purpose necessary to consummate the suicidal act, his excitement always passes quickly away, and he has no deliberate and fixed intent to take his life. These outbursts of uncontrolled passion only occur at intervals. Since the patient has been at Earlswood he has learned to do very useful work as a basket-maker.

A. E. O., aged 20, imbecile, has now been under observation for over eight months; he is a most amiable and apparently good-natured congenital imbecile who is markedly improving under training in our schools and carpenter's shop. Was in "a home" for two years at age 9 to 11. Breaks down at repeating five figures consecutively. Can calculate simple sums mentally. The certificate upon which he was admitted in 1885 stated, "When in desponding moods he has tried on four or five occasions within the last few years to commit suicide, she (his sister) and others having had to take knives away from him, and he has also threatened to drown himself." I have been unable to obtain definite details as to the patient's condition on the occasions referred to.

The threatening to drown occurred because his mother was very ill and likely to die. He remembers this and says he had many opportunities of drowning himself, but never tried to do so. He remembers

nothing of trying to cut his throat, but he has been told that it happened when he was in America.

Remarks.—This is another example of suicidal intent in an imbecile without adequate cause, and without the steadfastness of purpose necessary to the accomplishment of the act.

W. E. P., an imbecile. The mental condition is ascribed by the friends to a fright at three years of age, but this is doubtful; his father died of paralysis and softening; a half-brother is epileptic. Patient had been unable to learn any trade elsewhere, but became a good compositor at Earlswood. He was morally as well as intellectually imbecile. In November, 1884, being then 25 years of age, he became first hypochondriacal and then suffered from severe melancholia; he afterwards tried to starve himself, and hid himself away under some stairs, where he was not found for some time. He was soon afterwards removed from Earlswood Asylum.

Remarks.—This was a case of melancholia with suicidal intent occurring in an imbecile.

It will be seen that all the cases now recorded occurred in males; but I recollect two cases occurring in females at a county asylum. In one case, an adult female congenital imbecile, who was decidedly melancholic on admission, had just previously attempted to drown herself. The second case was that of an excitable imbecile girl, who was at times maniacal and very violent, at other times she was rational and well-behaved, while at others again she calmly but cheerfully avowed her intention of taking her own life as it was of no use to her. She attempted this in various ways at different times, and eventually succeeded in her object by strangulation. The suicidal intent in this case was not due to melancholic depression, nor to any sudden impulse, but was, for months together, a fixed and determined purpose in the patient's mind.

The facts now brought forward appear to show that suicidal tendencies may be exhibited by congenital imbeciles under at least three different aspects. First, as an accompaniment of a definite attack of melancholia; secondly, as a fixed purpose without emotional depression; and thirdly, as a transitory impulse arising either without any external cause or in consequence of some absurdly slight annoyance. The first two conditions are met with in other forms of insanity, but the last-named appears to be peculiar to imbeciles.

The transitory suicidal intent of the imbecile, to which I would now draw special attention, appears to have very definite

characteristics of its own. I would point out three of these as being illustrated by several of the above cases.

1. The absence or slightness of an exciting cause (the death of a cat and "being called names" are instances of the latter).

2. The want of the courage or steadfastness of purpose necessary to consummate the act of self-destruction.

3. The rapidity with which the suicidal purpose passes away and is forgotten.

OCCASIONAL NOTES OF THE QUARTER.

The Annual Meeting.

The Annual Meeting of the Association was a decided success. The only drawback was the small number who attended. This was due to the exceptionally late period of the year at which it was held, with the view of consulting the convenience of those members at a distance who desired to attend both the Annual Meeting of the Association and that of the British Medical at Brighton which immediately followed. The result of this attempt to serve two masters has so completely failed that it is not likely to be repeated another year, and it is well to place the fact on record as a guide to the Council of the Association in future. It will be seen from the report of the proceedings of the Annual Meeting that a proposal was made to hold this gathering in May, but a majority decided to leave the time unfixed, the determination resting as hitherto with the Council.

However valuable the Section of "Psychology" at the Annual Meeting of the British Medical may be, there is no desire, we are sure, to tag the Medico-Psychological Association on to it, to make the latter, in fact, a mere satellite of the former. Each has its place and function, and the proper course to pursue is not that of incorporating the two, but broadening and improving the character of the annual, and especially the quarterly meetings of our own Association. It is an extraordinary circumstance that while very many good papers are provided for the Medical Psychology Section of the British Medical Association, there is the utmost difficulty in inducing members of the Medico-Psychological to contribute to its own meetings. It is difficult to understand the preference shown for another Association. One reason may be that there is a systematic attempt made to secure papers and to propose

definite subjects for discussion in the sectional meetings of the British Medical. The secretaries of our own Association may perhaps be disposed to adopt a similar course. We cannot say *fas est ab hoste doceri*, because we do not for a moment regard the former medical body as inimical. Quite the reverse. But it is clear that if all or nearly all the good papers are to be contributed to it instead of to our own body, the effect will be that the Medico-Psychological Association will become little more than a society for the transaction of business, and not what we all surely wish it to be, a great scientific association for the study of insanity, and for improving the treatment of the insane. Nothing short of this is worthy of the original aim and purpose of the founders of the Association.

In carrying out the further development of the views here expressed, it would be advantageous, in fact necessary, to extend the sittings of the Annual Meeting to at least two days. We invite suggestions through the columns of the Journal on the general question now raised as to the best mode of advancing the work and promoting the design of the Association of which this Journal is the organ.

The Brighton Meeting.

The selection of Dr. Clouston as President of the Psychology Section by the Council of the British Medical Association was a happy one. His address, which appeared to take its colouring from the name of the Section, in the special rather than the medical meaning attached to it, avoided the subjects which a practical asylum physician might have been tempted to dilate upon. It was thoughtful and suggestive, and will no doubt have been perused and studied with interest by our readers in the Journal of the British Medical Association. How or why the rule, or perhaps rather the custom, has arisen in accordance with which these sectional addresses may not be discussed we do not know. We suppose the idea is that a President, in taking the official chair, stands, like a clergyman, six feet above contradiction. Be this as it may, the address, although not discussed, was cordially received. We shall not depart from the regulation in this place any more than in the meeting itself, but proceed to say that the observations of Dr. Clouston at a subsequent meeting of the Section, in introducing for discussion "How may the medical spirit be best maintained in our asylums?" were of a most practical character, and were lucidly

made. It was not to be expected that any particularly novel features of hospital management should be announced, but the salient points in their relation to the subject of debate were enforced with a directness and a "definition of outline," which not only answered the immediate purpose in view, that of promoting discussion, but were calculated to animate those engaged in this special and trying department of medical work, and we regret that Dr. Clouston's remarks, being mainly extempore, will not appear in print *in extenso*. We should like to have seen them widely circulated in the exact form in which they were delivered. On one point, the drafting of all recent cases into an admission ward, as advocated by Dr. Clouston, and practised at the Royal Edinburgh Asylum, some difference of opinion appeared in the discussion which ensued, it being maintained that some patients, a sensitive melancholiac for instance, would suffer much mental pain from mixing in their first experience of asylum life with excited and even dangerous lunatics. We failed to catch the President's reply to this forcible objection, but conclude that a certain amount of classification takes place in the admission ward itself, and that care would be taken where the case is, on the face of it, in danger of being unfavourably affected by association with other recent cases, to secure sufficient separation.

The papers read at the Section on other questions gave rise to interesting discussions, in which Prof. Ball, of Paris, we are glad to say, took part. Most, if not all, of these contributions will appear in this Journal. It is sufficient to enumerate them here:—"The Influence of Hereditary Predisposition in the Production of Imbecility," by Dr. Fletcher Beach; "Experimental Dietetics in Lunacy Practice," by Dr. A. Campbell Clark; "Suicidal Tendencies in Congenital Imbeciles," by Dr. C. S. W. Cobbold; "The Use and Abuse of Seclusion," by Dr. J. A. Campbell; "On Alternations of Neuroses," by Dr. G. H. Savage; "The Relation of Marriages of Consanguinity in Mental Unsoundness," by Dr. G. E. Shuttleworth; "How can the Medical Spirit be best kept up in Asylums for the Insane," by Dr. S. A. K. Strahan; "On the Separate Care and Medical Treatment of Recent Cases of Insanity, either in Existing Asylums or in Lunatic Hospitals to be Established for that Special Purpose," by Dr. D. G. Thomson; "On the Alleged Increase of Insanity," by Dr. D. Hack Tuke.

Dr. Palmer, the Medical Superintendent of the County Asylum at Lincoln, exhibited some beautifully prepared sections of the brain and cord in the insane, and we are glad

to be able to announce that the most typical of these will be copied for the Journal, and will appear along with explanatory comments by this excellent microscopist and most careful manipulator. Our only regret is that these preparations should not have been utilized before in this way, owing, in fact, to Dr. Palmer's modest appreciation of his own work.

Since the foregoing was in type we have received from a member present at the Section the following note on Dr. Clouston's observations on the maintenance of the medical spirit in asylums for the insane:—

"The subject proved of great interest to the large number of members who were present, elicited the frankest expressions of opinion, and most valuable and helpful suggestions from the earnest workers who took part in the debate.

"Dr. Clouston introduced the subject in an address of wide sympathy and practical importance. He approached it from the point of view of a physician who is engrossed in the treatment of his patients to recovery. Special attention was directed to the separate and individual treatment of recent curable cases. The general arrangements of the Royal Edinburgh Asylum in regard to this point were set forth by means of coloured plans. These were the adaptation of an old building to modern requirements, and were referred to as illustrating the means used to segregate the sick and feeble in a detached hospital; the acutely maniacal and troublesome in a ward fully supplied with experienced attendants, and furnished with adequate means of still further subdividing the cases according to mental states and indication of treatment. Dr. Clouston laid special emphasis on the training of attendants, they being first placed in the hospital wards and thence drafted to the main building. By so arranging their duties the attendants were impressed with the idea of medical treatment; they were trained to observe and report the varying states of the patients under their care, and they were led to recognize that the asylum is not merely a place for the detention of furious lunatics. The necessity of an increase in the number of assistant medical officers was also insisted on; and as a corollary an improvement of the position of the second in command. The increasing size of existing asylums and the multifarious duties of the superintending physician, together with the yearly decreasing rapidity of promotion, rendered such a suggestion necessary. The assistant medical officers

should be encouraged in their purely medical functions, and should have every opportunity and facility for observation and research extended to them. By raising their status, increasing their emoluments, and *enabling them to marry*, the service would be maintained at a high level of excellence.

"Dr. Clouston also insisted on the importance of the asylum physician continuing in contact with his brethren engaged in general practice. He would encourage them to visit asylums and to see the work done there. He would be hopeful that they would learn from the asylum medical staff, and that the gain to professional knowledge would be reciprocal. With this in view he would not impose any restraint on the medical officers of asylums seeing medical work outside the walls of the institution with which they were connected, so long as asylum duties were not neglected. Such restraints might be a hindrance in the way of the best possible work.

"The President was followed by Dr. Savage, Dr. Ball (Paris), Dr. J. A. Campbell, Dr. Hack Tuke, Dr. Urquhart, Dr. Outterson Wood, Dr. Needham, Dr. Campbell Clark, Dr. Lyle, Dr. Whitcombe, Dr. Aldridge, Dr. Deas, and a paper on the subject of the discussion by Dr. Strahan was read in his absence by the Secretary.

"It may be added that the many and interesting papers read and discussed at this successful meeting of the section of psychology afford proof that the medical spirit is at present maintained at a high level in our asylums, while the future, as forecast by Dr. Clouston, is full of promise."

The Poole Murder Case.

Another example is afforded by this striking case of the singular condition of English law in regard to the responsibility of supposed lunatics who commit the crime of murder. In May last a pilot, John Gerrard King, shot Alderman Hamilton, Commissioner of Pilotage at Poole, with a revolver. Nothing had happened previously to cause any animosity on the part of King to Hamilton, but the prisoner called upon him in order to obtain redress for what he considered a grievance in connection with his office as pilot. Shortly before Hamilton met his death he and King were seen talking together at noon nearly opposite the Poole police-station. What passed is not known, but the prisoner was seen to shoot the Commissioner,

and was arrested. In charging the grand jury before the trial, Mr. Justice Hawkins said that the facts were very clear, and that "he had no reason to believe that King was not responsible for his acts."

It appears from the account of the trial in the *Western Chronicle*, July 16, that during the whole of the evidence the prisoner sat sullen, and apparently half stupefied. Even while the terrible details of the murder were being related, not a shadow of repentance or remorse was reflected in his fixed features, and to all appearances he was a man thoroughly oblivious to the fearful position in which he was placed, and regardless of the fatal issue of the trial. Mr. Austin, for the prosecution, concluded his address "with deep impressiveness" (!) in the following terms:—"To say that at the time this man took Alderman Hamilton's life he either did not know what he was doing, or did not know that what he was doing was wrong, is impossible." The paper adds:—"This striking sentence in the learned gentleman's address produced a marked impression in the crowded court, and even the prisoner, sunk as he was in apathy and indifference, shifted uneasily on his seat." Counsel must have been impressive indeed. As to the medical evidence, it would probably satisfy all our readers of the mental condition of the prisoner to know that Dr. Symes, the experienced Medical Superintendent of the Dorset County Asylum, after repeated examination of King, by instructions from the Treasury, gave a decided opinion that he was a man of thoroughly unsound mind. Mr. Good, the medical officer of H.M. prison, as often happens with medical men holding this position, and with no special knowledge of mental affections, was quite unable to detect insanity.

Judge Hawkins laid down the law relating to insanity and crime in the usual fashion. It was not sufficient that a man should show he was eccentric, or that in some things he might indicate unsoundness of mind; neither was it sufficient to show that he was suffering under delusions which had nothing whatever to do with the act he committed. But it was necessary to show that he was so diseased in his mind as that his mental condition at the time was such that he did not know the nature of the act, or if he did know that, he did not know it was a wrong act—in short, that the prisoner did not know he was about to take the life of another, or if he did that he did not know it was a wrong act. It was important, in the interests of justice, that this case should not come to them on any false issue. It must be shown, not that there was any irregularity

of mind, mere eccentricity, or unsoundness, unless it amounted to what he had told them. If the law were otherwise, it would be a sad thing in the interests of society. His Lordship read the resolution of a majority of judges on the McNaghten case, which fully bore out the theory he had laid down. It was not a question to be raised whether or not there was any doubt about the prisoner's insanity; the issue and the burden of proof was upon the defence to satisfy the jury that his mind was such that he was criminally irresponsible. The question they must ask themselves was—Aye or nay; was the prisoner, when these shots were fired, labouring under such a defect of reason as not to know the nature and character of the act he was doing, or that he was doing a wrong act? He pointed out that although one member of the family was insane, there had been nothing whatever to show hereditary taint.

No one ought to blame the judges for doing what Sir Henry Hawkins did in this case, but the point is here—that while Mr. Justice Stephens maintains that the present law should be interpreted to mean very much what mental experts wish it to mean, he altogether fails to induce his fellow judges to do the same. They continue to understand the law in the literal sense in accordance with which not a few madmen have been executed, and if they had their way, some of the latter would suffer the extreme penalty of the law as responsible beings. Hence, Sir James Stephens having failed to convert his colleagues to the non-natural interpretation of judge-made as well as judge-interpreted law, it is as necessary as ever to expose the antiquated notions upon which it is based. It should be clearly understood that by English law the Poole murderer was condemned to death as not insane, that by an English judge this verdict was approved,* and that it was only by obtaining a further medical examination that the opinion of Dr. Symes was confirmed, and that of the gaol surgeon set aside. Dr. Bastian, Crown referee in cases of supposed insanity, and Dr. Sheppard, late Medical Superintendent of Colney Hatch,

* The Judge (having put on the black cap) addressed the prisoner as follows:—"John Gerrard King, it was quite impossible for the jury to have come to any other conclusion than they had done—that it was by your hand Mr. Hamilton met his death; and when I come to think upon the evidence before me, I must say they have come to the true conclusion with regard to the defence that was set up for you, that you were not responsible for your actions No man is irresponsible for his criminal actions unless it can be established to the satisfaction of the jury that he did not know the nature and character of the act he was doing, or that he was doing a wrong act. I cannot myself come to any other conclusion in my own mind than that which the jury have arrived at."

had no difficulty in determining the mental condition of the convict to be unsound. He was, in fact, a typical lunatic. He was on their report reprieved, and removed to Broadmoor.

The Certificate in Psychological Medicine.

It will be found on referring to the report of the Annual Meeting of the Association in this number of the Journal that the conditions and regulations respecting the examination for the certificate of efficiency in psychological medicine have been modified in several important particulars. At the time it was instituted it was intended to ensure, by means of a certificate and the requiring of a certain amount of practical experience antecedent to granting it, such efficiency as would commend to the public, persons holding the diploma as specially qualified to sign certificates in lunacy, and to determine on the delicate question of the best mode of carrying out the care and treatment of patients. It was also hoped that in any Lunacy Bill to be introduced by the Government, the force of such a certificate would be recognized as possessing special value. Hence, the minimum age was fixed at 25, and it was made a condition that candidates must produce certificates of having resided in an asylum (affording sufficient opportunity for the study of mental disorders), as clinical clerk or assistant medical officer, for at least three months, or of having attended a course of lectures on insanity and the practice of an asylum (where there is clinical teaching) for a like period.

During the year which has elapsed since this certificate was decided upon, there has not been the hoped-for response to the offer to grant this diploma of efficient knowledge and experience. It has, it is true, been made publicly known for only a shorter period, and the notice in the Journal probably failed to meet the eye of a large number for whom it was designed. We are not disposed, therefore, to make too much of the apparent failure referred to. Still, it appeared to the Council best to open the portals wider, and while the former conditions as regards previous attendance on lectures, &c., are retained, the alternative is added that candidates can be admitted to examination on presenting such evidence of antecedent study as shall satisfy the President. This qualifying clause removes the obstacles to examination which it is alleged would press heavily upon some desirous

of undergoing the examination. But while thus relaxing the conditions previously decided upon, and mainly relying upon the competence exhibited by candidates when examined, the Council attaches no less importance than before to actual experience in lunacy. The other important relaxation in the conditions has reference to the age of the candidate. This was originally fixed at 25; it is now left open to those who are 21. The fee is reduced from five to three guineas. The next examination for England will take place at Bethlem Hospital, Nov. 29 and 30, 1886. For further particulars application may be made to Dr. Rayner, Hapwell; Dr. Rutherford, Dumfries; Dr. Courtenay, Limerick.

PART II.—REVIEWS.

Psychiatry, a Clinical Treatise on Disease of the Fore-Brain, based upon a Study of its Structure, Functions, and Nutrition. By THEODORE MEYNERT, M.D. Translated by B. Sachs, M.D. Part I.—The Anatomy, Physiology, and Chemistry of the Brain.

It is a constant source of regret to us that though England is foremost in the management of the insane, it is far from being in the front in methodical study of psychiatry. Doubtless this is in a great part due to the fact that in England one man is expected to do more than half a dozen in Germany. The English superintendent is expected to be not only a physician, but an administrator of the highest order, so that he can treat his patients, employ, amuse, and elevate them, and at the same time reduce the rates as much as possible by good farming and judicious management.

Nowhere in England is there a professorship such as that held by Meynert in Vienna, and it seems as if it will be very long before it is understood that insanity will not be properly considered till men who are fitted to teach the principles of the treatment and to study the manifold mental perversions are freed from the worrying routine of official work. But this leads us to the book before us, which is the first instalment of what may be looked upon as the *magnum opus*, the life's work of Meynert. The translation before us has been most ably done by Dr. Sachs, of New York, and we must congratulate him on the production of at once a good translation and a readable

book, a thing not very common in books from the German touching on philosophical subjects.

Meynert writes with a very firm conviction of truth, and though one cannot agree with everything, one is pleased with the earnest dogmatism, no doubt one result of many years' teaching. To begin with, the book is on Diseases of the Fore-Brain, not Psychiatry or soul physic, and though our author has no objection to Diseases of the Mind, yet he prefers the title we have given. In passing, we would say "disorders" of mind appears preferable to "disease." We speak of uterine disease, but menstrual disorder, disease of body, and disorder of function.

We shall refer later to his study of memory, but in the introduction he gives us notice that he cannot allow the fore-brain to give rise to hallucinatory phenomena, or that "memories" are possessed by any sensory qualities. He prefers to look at the revivals as due to "memory symbols."

This part of the book makes us think of the dreadful amount of ignorance there is in our midst, and how few signs there are of its removal. We fear the number of superintendents who could pass a superficial examination on the convolutions of the brain and on the histology of the nervous system would be few, and we should be very glad if many would buy this book and devote three months steady work to it. As Meynert says, without a knowledge of these fundamental points, clinical facts will be misapprehended.

Meynert protests against the subjective method of study of states of mental disorder, and truly points out the small results of all the past labour. The time for objective work has come, and this needs prolonged care, record, and comparison.

By the way, Meynert's method of studying the brain is by a system of sections or cleavages from apex to base transversely, and he, as a follower of the older schools, thinks microscopy has crowded out macroscopy and has not replaced it. We have a record of some of Meynert's own discoveries, and also some of his opinions, in which, if not singular, he is, at least, at present in the great minority. As an addition to this book is the chapter on expression, and he, like Warner, is prepared to see the outward signs of disease and disorder expressed in regular ways, almost casually. Meynert runs a regular tilt at hereditary predisposition and moral insanity, but after all it does not seem to matter much whether we say a person has the power of transmitting organs to his children, which will not work in the ordinary conventional way, but in irregular and

unconventional ways, which cannot be calculated upon, or if we say a person transmits neurosis.

Of course no one believes that "neurosis" is a tangible substance which, like an estate, can be passed on, and we are ourselves at a loss to explain the relationship between inheritance and disease just as we are to explain the relationship between the organ and the function. For though we do not pretend to plead for "soul function," yet we do plead for time to discover the correlation of physical and "vital" energies which we call mind, and which are not to be explained by any at present known force. One very great advance is marked by the opinion of organic solidarity, which is expressed in the statement that the nutrition and the excitability of the brain must be regarded as depending upon the reciprocal relation existing between the weights of the brain and of the heart.

The contents of this part of the book are divided into: The structure and architecture of the brain; the minute anatomy of the brain; anatomical corollaries and physiology of cerebral architecture; the nutrition of the brain; appendix; mechanism of expression.

In studying the structure and architecture of the brain the surfaces are studies separately; thus the prosencephalon—fore brain—is studied on its convex surface first, next the median surface and the olfactory lobe. The ganglia of the prosencephalon, thalam-(di-)encephalon, mesencephalon, and metencephalon are considered together, and this division of the subject is closed by a general review of the architecture.

The whole of this part is excellently done, the subject being attacked from its developmental and comparative side, so that the development of the main sulci is traced from their fœtal state of mere depressions or folds, and are referred to where seen better marked in one or other of the lower animals; and here we must say that, though comparative anatomy has done something, comparative physiology has done but little in showing us the special faculties associated with prominence of certain divisions of brain.

Great care is devoted to the study of the Sylvian fissure and to the structure and relations of the island of Reil, and this is seen to be very necessary, as this is one of the very few parts of brain about whose functions physiology and disease have cleared up the chief points. The importance of tracing through development the same convolutions in different classes of animals is seen from the necessity of comparing artificially-

produced lesions in the one with lesions due to disease in the other—in fact, the necessity of comparing similars.

It appears a startling statement that wealth of convolutions is more characteristic of the human brain as compared with that of monkeys and of carnivora than with brains of herbivora and cetaceans.

Meynert points out that the sulcus rectus is not constructed to hold the olfactory lobe in man, and, as proof of this, he shows that monkeys with larger olfactories have no sulcus rectus.

Sulci and gyri are studied as to their anatomical relationships and their origin and positions, authorities being quoted where there are differences of opinion, but as this review is not intended to be a *résumé* we must pass over this part, which, though anything but light reading, is yet, with a few brains by your side for comparison, pretty readily followed.

The parts homologous in monkeys to those in man are given for the sake of experimentalists.

In the second sub-division of this chapter we have the consideration of the ganglia, including the brain-axis, the ganglia as ordinarily considered, and the island of Reil, and it is shown how easily the rest of the brain can be separated like a mantle enwrapping the ganglia.

After comparing the ganglia in man with those in the lower animals, Meynert says: "We infer from these facts that the cerebral structure is governed by a law which establishes an harmonic dependence between the formation of the brain axis and the development of the functionally highest organ—fore-brain."

The peculiarities of the brain might not inappropriately be said to be "mentalised" (durchgeistigt); but we have not yet got to like the word "mentalised" as English.

In studying the brain architecture, Meynert makes use of cleavage, that is the tearing away of parts of brain, thus leaving more or less distinct the course of the various fibres. He describes the various kinds of fibres, such as the fibræ propriæ, which run from one convolution to another, resting in the more superficial layers of the cortex, and also those fibres which are more directly connected with the grey masses at the base; these latter he calls projection-fibres. He gives the general and the special modifications of these two groups of fibres, and describes what he believes to be the relationships of the cingulum, fasciculus arcuatus, and fasciculus uncinatus. The whole part in the architecture requires careful study, and

great results have followed Meynert's cleavage method of dissection.

The minute anatomy of the brain is next described, and though the work is well done, there was little ground for originality, unless space quite out of proportion to the design of this work were occupied. There are only three forms of nerve corpuscles, the pyramidal, the granule, and the spindle-shaped, according to Meynert, in the entire cortex. This may be true, but we rather doubt the absolute truth of it. Throughout the central nervous system a morphological law operates, by reason of which the formative activity exercises an influence over the direction of the nerve cells, making the direction of their longitudinal axis parallel to that system of fibres which originates from them. Meynert looks upon all nerve cells of the cortex in the light of centres of plexuses, the axis cylinders and nerve processes being aggregations of fibrils; reasons are given for regarding the nerve-corpuscles of the cortex as independent elements within the network of ganglion processes.

But already we find that instead of briefly reviewing this book we are going in for a kind of digest, which must, after all, be imperfect, and, therefore, we must proceed more rapidly to consider the other portions of this very full book. The special anatomy and the minute structure and relationship of the various parts are taken in detail, passing from the fore-brain to the spinal cord. The work of Stilling on the structure of the cerebellum is referred to, and though the description of Purkinje's cells is correct, the hackneyed illustration of them which has served generations of physiologists again appears.

A very elaborate schema of the spinal cord and its component derived elements is given, and is very suggestive of the advance made since the days when we were content with anterior, posterior, and lateral columns.

The anatomical part of the book is followed by a chapter on the anatomical corollaries and the physiology of cerebral architecture.

It seems at first as if Meynert were going to give us some very simple mental food, easy of digestion and assimilation, but after receiving it one experiences the unpleasant feeling of a return of the idea in its crude form.

He says the only postulate he needs is Bell's law of conduction of nerve-force in a centripetal direction through the posterior, and in a centrifugal, through the anterior roots. All that is required is sensitiveness. This he owns to be quite inexplicable.

Everything depends on the end organs, *i.e.*, on the instruments in which the nerve fibres terminate. Muscles are made to move and eyes to see, hence nerve-force is effective in causing motion in one, and sight in the other case. No difference can be demonstrated in the brain cells of sight and hearing. For instance, "specific energies depend altogether upon the peculiarities of the end organs, and sensitiveness is the only specific property of brain-cells."

Within the fore-brain sensitiveness is converted into actual sensation. Meynert very prettily compares the concave fore-brain receiving the fibres from the sensitive surfaces of the body, with the retina entrapping light, or the amœba or molluscous animal, with its tentacles and projecting surfaces, catching, conveying, and absorbing from without.

He supports localisation of brain function from *à priori* anatomical reasoning. As is usual with German observers, Ferrier is not accepted as either a new or true light, and we regret that anything like jealousy of this kind should arise.

Meynert sticks to his old point that "volitional acts are nothing more than the perception or memory of the sensation of innervation, for such a sense of innervation accompanies each reflex act and is registered in the cortex." Psychical blindness and deafness, as contrasted with incurable cortical destruction of these senses, are discussed.

Meynert follows Munk in saying "Intelligence is localized everywhere in the cerebral cortex, and nowhere in particular." He proves, however, that there is a localisation of certain intellectual activities depending upon and coinciding with the localisation of definite sensory areas.

It has been proved that sensory perception may exist independently of the fore-brain, that is after destruction of the fore-brain, which is not quite the same thing.

Memory is to be looked upon as a cortical function.

The further consideration of this subject and the relationship of cortical and sub-cortical centres must be postponed with the review of the rest of the volume.

The Student's Guide to Medical Jurisprudence. By JOHN ABERCROMBIE, M.D. Cantab., M.R.C.P., Lecturer on Forensic Medicine at the Charing Cross Hospital Medical School, &c. London: J. and A. Churchill.

The author of this little book is careful to inform the reader that it is not so much an original work as a compilation from the standard works on the subject for the use of students. For this purpose the "Guide" is well fitted. Practitioners brought face to face with actual cases would doubtless consult the larger productions of Taylor, Wharton and Stillé, Casper, &c. The usual matters falling under the head of Medical Jurisprudence are succinctly treated in successive chapters. The chapter which is devoted to insanity occupies seventeen pages. In it the author adopts Dr. Bucknill's definition that it "is incapacitating weakness or derangement of mind caused by disease." The forms of mental disorder are those recently agreed upon by the College of Physicians, and have not escaped rather severe criticism. The observations on contracts and wills are sufficiently clear for the purpose in view. The regulations relative to certificates of lunacy are also given. Under the head of Commissions in Lunacy, the case of Gilbert Scott is detailed at some length, and the statement is made that it is the only instance of a Commission in Lunacy since 1862. We are surprised to see this statement made, as there have been at least twenty. There have been certainly a couple this year. It is a little too broadly stated that the necessary processes on an inquisition "cause an enormous expenditure of money." No doubt this is only too often the fact, but it is by no means essential that a large sum should be expended. It should have been added that for properties of small amounts, and in cases which are not contested, the process is by no means a difficult one, and may involve very small outlay. This part of the chapter might have been extended with advantage. Under "the plea of insanity" the case of Gouldstone, reported in this Journal, is adduced as the best instance that has been recorded of the unsatisfactory test of insanity laid down by the law and acted upon by the judges. The case of Cole, who, like Gouldstone, was found guilty of wilful murder, and like him was reprieved, is also referred to by Dr. Abercrombie. Whatever opinion may be entertained of the mental condition of Guiteau, the murderer of President Garfield, exception may be taken to the statement that "had the victim been less distinguished it is possible that in this case also the obvious imbecility of the convict would

have secured for him an acquittal on the ground of irresponsibility." When equally able men acquainted with mental disease arrive at different conclusions in regard to the insanity of a prisoner charged with crime, the case is hardly likely to be one of obvious imbecility.

The other sections of the book appear to be carefully prepared, and the student will find Dr. Abercrombie's work useful before proceeding to master the standard manuals of Medical Jurisprudence. In another edition the oversights in this can be easily corrected.

Scheme of the Functions of the Cranial Nerves. By Dr. Heiberg, Professor of Anatomy in Christiania. Wiesbaden, 1885.

The method of the plan is straightforward, and yet ingenious. The twelve cranial nerves, with the parts which they innervate, are printed in series. So far, we have a simple statement of fact as brief as the case admits of; this constitutes the straightforwardness of the plan. The ingenuity consists in the printing in three different colours—red, yellowish-brown, blue—(these three colours representing respectively motor, sensory, and special functions), and the combination, if necessary, of these colours in one and the same word. As an example, we may take the fifth nerve. This nerve is in the first place sensory, but it also contains motor fibres, and also some fibres of special sense—*i.e.*, it is a mixed nerve; and, accordingly, the word Trigeminus is spelt with yellowish-brown, red and blue letters. Thus, at a glance we gain the idea of the mixed character of the nerve, as, also, we recognise the nature of the fibres which enter into the composition of the nerve. The seventh nerve, the facial, is printed in two colours—red and blue—the red letters standing for the motor fibres, the blue letters for the special nerve fibres supplied to the sub-lingual and submaxillary glands. The second nerve is printed entirely in blue, its unmixed nature being thus indicated. The same plan is carried out for the sub-divisions of a nerve—*e.g.*, the many branchings of the fifth nerve.

For purposes of teaching and of learning, the method here adopted is certainly a good one; but whether it might not have been better is another question. We are inclined to think it might. The purposes of a plan are not those of a systematic treatise; the former aims at summarized knowledge, and we

think this aim has not here been pursued as far as it might have been. If at the end of the short table here given Dr. Heiberg had put together the knowledge contained in it, so that a general idea could be gained of the *areas* of skin or mucous membrane supplied by the principal nerves, the "Scheme" would have been yet more useful than it is.

The Private Treatment of the Insane as Single Patients. By Edward East, M.R.C.S., L.S.A. London: J. and A. Churchill, 1886.

Everyone conversant with the treatment of the insane will admit that some cases of insanity are better placed under single care than in an asylum. The attempt made in the defunct Lunacy Bill to abolish the system of private patients was extremely foolish, and, had it succeeded, would have been disastrous. Even with the modifications which the Lord Chancellor afterwards introduced when the threatened mischief was pointed out to him, the Bill would have seriously hampered the friends of patients and doctors consulted as to the best location for particular cases. We trust that any future Lunacy Bill will not lay down any inflexible law on this matter, but will leave to the Commissioners in Lunacy the decision whether particular cases may not be advantageously removed from single care to an asylum. That some patients suffer from being in lodgings, or in the house of a medical man, and would be more advantageously placed in a private or public asylum, we do not deny; but, we repeat, the remedy should be entrusted to the Lunacy Commissioners.

As a contribution to the subject, the *brochure* of Mr. East will be found useful, and will convey the information required by those wishing to decide upon the location of insane friends. We think it hardly falls within the scope of the book to give a chapter on "Treatment;" and as the subject cannot be done justice to in so short a treatise, the author would have been wiser to leave it out altogether. The statement made at p. 23, that "cures, especially in acute cases, are far more common" than formerly, cannot, we fear, be substantiated; and however much we may wish it to be true, it is as well not to hazard it without proof. Another statement can hardly be allowed to pass without correction, namely, that "the system of non-restraint was inaugurated by Pinel at Bicêtre," whereas neither Pinel nor Tuke contemplated or approved of what is

called non-restraint. They never said a word against the occasional employment of mild forms of restraint; in fact, they maintained that each case must be treated upon its own merits without laying down any hard and fast line. Whether rightly or wrongly Dr. Gardiner Hill and Dr. Conolly did lay down the formula which embodies the non-restraint system, and they must be credited with the doctrine. That Hill and Conolly regarded the humane system inaugurated at the Bicetre and the York Retreat as the root and forerunner of their own is no doubt true; but the two positions are obviously distinct, and the merits of each can only be determined by experience. As by the non-restraint system is meant Hillism or Conollyism, which "came in vogue about fifty years since," it cannot be said that it is "now universally employed in England." We are sure Mr. East himself is acquainted with some of the best asylums where the superintendent advisedly, and on principle, declines to adopt the system, and regards it as more scientific to treat each case as seems to him best at the moment, and not to bind himself in this matter any more than he would bind himself in regard to the administration of alcohol. We regret that so much clap-trap should pass current under the name of Conollyism. This observation does not apply to the book under review, as neither Hill nor Conolly are mentioned. With the reservations indicated, we think Mr East's book calculated to serve the purpose he has in view.

Mind-Cure on a Material Basis. By SARAH ELIZABETH TITCOMB, author of "Early New England People." Boston: Cupples, Upham, and Co. 1885.

When we state that the authoress of this work treats of the cure of disease by concentration of thought, the theology of the Christian scientists, the single-substance theory, mind in animals and the lower race of men, the origin of the doctrine of the immortal soul, and Bible proof of the single-substance theory, it will be seen that the work contains ample food for mental digestion. The really striking feature of the book is the full recognition of the influence of the mind upon the body in disease, and that the acceptance of this fact forms the material basis of mind-cure without having recourse to spiritual agencies. The writer acquired the method of curing disease practised by the "Christian Scientists" or "Metaphysicians," otherwise known as "Mind-

Curers," and arrived at the conclusion, after due consideration, that their success was entirely due to concentration of thought. Many illustrations of its efficacy, whether called by this name or imagination, expectant attention, or any other term, are cited from "Illustrations of the Influence of the Mind upon the Body in Health and Disease." What the Christian scientists teach may be easily gathered from this book. They teach that man has a mortal as well as an immortal mind, the former becoming extinct at death, while during life it commits crime. The latter, that is, the immortal mind, can no more be destroyed than the "infinite mind." As they are thorough-going disciples of Berkeley, they believe that the visible universe is the reflection of the thought of the infinite mind, and that, as consequently there is no substance appertaining to the nature of men, pain and disease are not realities, but simply beliefs of mortal mind. They even go so far as to hold that poisonous substances would not occasion death when taken, if only there were no belief among mankind that they possess these properties. Utterly absurd as such a belief is, it is really only the natural corollary of Berkeleyism in its bold and unqualified presentation, and it is certainly very curious to witness it made the foundation of a system of healing diseases which has obtained an enormous hold of a large number of persons among the educated as well as the uneducated classes of the United States. We have been informed that very large sums of money are made by this body, in Boston and elsewhere, in the practice of their art. It is said that one lady in Boston has an income of some twenty thousand dollars from her practice, and teaching the system to her class, the charge for each lesson being a hundred dollars. Most of her pupils, no doubt, give credence to the theory, not being sufficiently enlightened to see through it, and grasp, as Miss Sarah Elizabeth Titcomb has been able to do, the physiological explanation of the success which will always attend, more or less decidedly, the use of mental therapeutics in the treatment of disease. That material remedies are still required is shown even in the pages now under review, for in the appendix the writer observes that "as it will probably be some time before the Mind-Cure will be universally resorted to for the cure of disease, it will not be amiss to give in this connection the discovery of a remedy for nervous prostration and melancholia, which has thus far proved to be an unfailing cure for those diseases."

Having said so much, we are bound not to withhold the remedy from our readers. It consists of one to two tablespoonfuls three times a day of a mixture containing three drams of pulverized guaiacum, three drams of Colombo-root (Calumba), one pint of sherry wine, and two ounces of sugar. Credit is given to the guaiacum alone as the cause of the successful administration of this mixture.

It must be admitted that while the work before us is a singular mixture of philosophy and theology, it conveys considerable information in regard to a remarkable movement, that, namely, which is associated with the "Mind-Curers," of whom we hear so much, and, as a rule, know so little.

The Premonitory Symptoms of Insanity. By HENRY SUTHERLAND, M.D. (Reprint.) John Bale and Sons, London, 1886. Pp. 8.

The main point brought forward in Dr. Sutherland's essay is that in the large majority of cases there has been long prior to an outbreak of insanity some act committed which indicated an abnormal mental condition. The practical conclusion is, of course, that such isolated acts ought to be recognized, and, being estimated at their true value, they warrant the physician in recommending a mode of life calculated to ward off an actual attack. There is no doubt much truth in what the writer says and desires to be acted upon more generally. The caution emphasized by him applies not only to the particular walk of life which it is desirable for the patient to follow, but the propriety of entering into matrimonial relations, either contemplated or actually arranged. A more delicate question for the medical attendant or consultant to determine does not exist. The misfortune is that what may be really best for the patient may end in being a fearful injury to the other party involved in the marriage and to the children. Hence mental physicians, taking the least of two evils, are bound to discourage the marriages of persons showing signs of insanity, and to encourage the relinquishment of engagements already entered upon. If the child-bearing period has not passed, the physician is justified in advising more firmly than if there is the probability of a family.

Dr. Sutherland's description of the mental and bodily symptoms of the insane is clear and pertinent. The follow-

ing observation is well made: "A row of paupers at work on a road can thus be distinguished from a gang of lunatics. In the one case they will all 'catch your eye' as you drive past; in the other case they will not." Dr. Sutherland commits himself to the opinion that the skin of an insane patient emits, in some cases, a peculiar odour. We think he is right (and attendants on the insane strongly maintain it), although in many supposed instances the odour is due to want of cleanliness. It is not the insane only who have unpleasantly odoriferous skins; and seeing that a dog remembers people by their peculiar scent, it would seem that all have something distinctively odorous. In the few observations made by Dr. Sutherland on treatment, advice is given in regard to sending patients a journey or voyage in order to ward off a threatened attack of insanity, which deserves to be quoted. He says:—"If a patient have been known to have an attack regularly every year, which is not uncommon, send him for a trip with an expert and agreeable medical man a month before the time of the onset of the mental disorder is expected. This frequently not only staves off one attack, but sometimes even prevents an accession of future attacks." So much for prophylactic treatment. In an actual attack of violent mania, "antimony" is, with Dr. Sutherland, "the sheet anchor." This is, we think, a little too broadly stated, and the dose is not given. He might with advantage have added that the addition of morphia has a very beneficial effect in many cases in which neither drug alone can be properly administered. The recommendations as to the mode of giving drugs to the insane when medicine is refused are useful, such as giving chloral in beer or port wine, laudanum in coffee, antimony in any liquid, calomel between thin slices of bread and butter, syrup of senna in a cup of tea, in lieu of sugar, &c. The paper contains more information (for the general practitioner) than the title leads the reader to expect.

Paralyses: Cerebral, Bulbar, and Spinal. A Manual of Diagnosis for Students and Practitioners. By H. Charlton Bastian, M.A., M.D., F.R.S. London: H. K. Lewis. 1886.

We defer to a future number a review of this book. In the meantime we direct the attention of our readers to it, and can speak strongly of the evident labour bestowed upon its

preparation, and the great value of the cases observed and recorded by Dr. Bastian in their relation to diagnosis. To the specialist a book treating of cases immediately related to, although not identical with, those he is most familiar with, as occurring in asylums, &c., it is of the greatest value, when, as in the present instance, the result of hard work, long experience, and accurate observation.

The Medical Digest, or Busy Practitioner's Vade Mecum. By Richard Neale, M.D. Lond. (Second Edition.) London: Ledger, Smith, and Co. 1882 and 1886.

This Digest does not profess to be more than a contribution to medical literature culled from a small number of journals. To attempt more would, indeed, have ended in failure when the work is undertaken single-handed. Too much credit can hardly be given to Dr. Neale for the enormous labour he has bestowed upon his book. Unless this limitation in the range of journals be borne in mind, the alienist will be necessarily disappointed on referring to the Digest. For instance, the "Journal of Mental Science" is left out in the cold in the department devoted to insanity. Hence a number of second-rate papers which have appeared in the weekly journals have their titles chronicled, while the mass of original articles and valuable information contained in the Journal specially devoted to the subject is ignored. This, it would seem, cannot be helped, but none the less is the value of the work lessened for the purposes of the medical psychologist. We, however, thankfully recognise the excellent work which Dr. Neale has produced. He deserves every encouragement, and we trust he will receive it. No one can fully appreciate the conscientious labour which the author has performed who has not himself been engaged in similar undertakings. Not only ought every medical library to possess a copy, but all who are engaged in medical research, and the "busy practitioner" should have one also.

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*The Explanation of Thought-Reading, with description of a new method of recording involuntary movements.** By W. Preyer, Professor of Physiology at the University of Jena. Leipzig, 1886.

Prof. Preyer's essay is one of great interest. The subject under consideration, thought-reading, is dealt with very cautiously and quietly—in a word, very soberly, as would be expected by those who know the writer. The author touches at first on the history of attempts made to explain by the scientific method the facts presented to us by so-called mind-readers. Carpenter, in England, and Beard, in America, are particularly mentioned. By different routes they arrived at the same principle in explanation of the facts before them, and now by yet another route, and independently, the author reaches the same goal.

The explanation, which is now well known, is a simple one. The thought-reader in the act of thought-reading becomes a passive instrument, but one of great delicacy, in the hands of the subject whose thought is read. He, the thought-reader, is mentally in the condition of "expectant attention," his own will is withdrawn from the control of his body, and, for the time being, he is under the control of his subject; he awaits the guidance of the latter's will, and responds like a sensitive balance to the least impulse impressed upon him. The nature of the guiding impulse is muscular. How is this effected? To explain this we must pass to the subject whose mind is being read. The mental state here is one of absorption, and the will is at work only in so far as it causes the mind to concentrate itself upon the particular object selected. Perhaps one should say that the will is operative only at the commencement, in the act of bending the mind in a given direction. Once the mind is bent, and the subject is absorbed in thought, it is probable that the will ceases to act. Under these conditions what will be the bodily state, passive or active? The present theory says active; it says that the picture or idea which is engaging the thought, *the dominant idea* in fact, tends to express itself by a sound which anyone can comprehend, or by a gesture which many may interpret, or finally by a movement so slight, so imperceptible, that only the delicate mechanism of the mind-reader can respond to it. Thus, then, the thoughts which pass through our minds do not leave the

* "Die Erklärung des Gedankenlesens," etc.

body wholly inactive, but sign themselves more or less perceptibly, and the mind-reader is the one who is an adept at responding to and registering these signs. We see here the doctrines of Carpenter, &c. According to this view, "everybody," as Beard says, "is a muscle-reader" (by muscle-reader he, of course, means a reader of the mind, as it betrays itself by movements of the muscles), "but not everybody is capable of attaining the highest degree of perfection in the art." And he further enforces his position by the following illustration: "Every serviceable horse is a muscle-reader. It reads the thoughts of the driver by means of the pressure on the bit," &c. It must be added that the person whose thought is being read is not conscious that he is betraying the thought which is occupying his mind. The tell-tale movements are the result of "unconscious cerebration," as Carpenter would say. This we need not insist upon, for we are perfectly familiar with certain of the sons of men whose speech centres are so delicately balanced that they almost habitually think aloud, and with certain others in whom a regular pantomime of surface-play tells of the thoughts going on within, they being all the while unconscious of their actions.

Prof. Preyer has added much to complete the doctrines of Carpenter, and those who take the same view, in that he has devoted himself to the demonstration of the involuntary movements which the body performs and which we wot not of. His apparatus is simple in the extreme: a light strip of wood carries at one end a small prong, between the arms of which a cross-piece is inserted; this latter serves as the axis to a curved needle which swings from it. The strip of wood is then fixed firmly on to some part of the body, *e.g.*, the finger, and then the needle is made to press lightly against a blackened revolving cylinder. The movements of the finger are transmitted directly to the needle, and are graphically inscribed on the blackened paper. A number of tracings are given, and they demonstrate that, even when the will is engaged actively in endeavouring to control movement, to keep the finger at rest, even then movements occur. How much more, then, when the will is passive in this respect, and the subject in the state of "unconscious cerebration?" We are perfectly prepared for these results, and pathologically are quite familiar with them. Witness the tremulous movements of the drunkard, whose controlling centres are impaired. Fig. IX. shows this, the effect of

alcohol, exquisitely; unfortunately the subject was an Englishman!

A development of the above instrument allows of the multiplication of the movements; this is both described and figured. By means of this latter instrument movements of quite a different kind, viz., those of the pulse, may be accurately figured, so that Prof. Preyer has, in the course of his researches, further added a very delicate sphygmograph to our list of medical instruments.

Having demonstrated the involuntary movements of the body, the author next applies this knowledge to the guessing of numbers, letters, pictures, tunes, as these severally occupy the mind of the subject of thought-reading. Without doubt the application is ready where movement, however slight, is all that is required to tell the mind-reader which of a row of figures before him his subject has thought of; it may even serve to explain those cases in which the mind-reader will trace on a board the figure or the letter which has been thought of, but the application becomes strained, we think, when those cases are considered in which the thought-reader guesses correctly and plays a melody. Preyer insists that in all cases of thought-reading there must be bodily contact between the operator and his subject, and the movements of the latter *must be unrestrained*, and that contact without freedom of movement is quite useless. Real clairvoyance, *e.g.*, the reading of the contents of a letter by application of the same to the forehead of the clairvoyant, this and some other claimed forms of the same power Preyer declares to be simple imposture.

The concluding section of the treatise is devoted to the consideration of experiments which Prof. Charles Richet has brought forward, and which are supposed to indicate that thoughts may be transmitted from one individual to another without physical agency.

Prof. Richet's line of argument has been the simple one of first determining in a given case the chances of accidental guess work—this according to the theory of probabilities—then of comparing with these the results actually obtained. On these same data Prof. Richet gives a verdict in favour of thought influence at a distance, and Prof. Preyer the verdict of not proven. To us Prof. Preyer's criticism is sound. He considers that where the results indicate most strongly in favour of Prof. Richet's view, the experiments are too few in number to admit of the statistical method; that in other

cases, and these the majority, the results are really not other than, according to the theory of chances, they should be. The author illustrates his criticism by reference to the results of the State Lotteries of Germany, and these do actually show on a large scale the worthlessness of the statistical method for small numbers, and at the same time the considerable margin of fluctuation which must be allowed even for large numbers.

In conclusion we would quote the statement made on page 64: "Although, then, large and small are relative conceptions, yet in all experimental investigations, and in all dealings with statistical results, it must be at once apparent that the smaller the mathematical probability in a given case, the larger must be the number of instances taken in order to approximate to this probability." This is obvious, some may say it is a truism; it may be so, but it is one constantly forgotten by statisticians.

It will be well, finally, to remember the position taken up by Prof. Preyer; it is not a denial of the transmissibility of thought without physical agency, but a denial of the evidence for such up to the present time. More scientific researches are necessary.

Études Cliniques sur la Grande Hystérie ou Hystéro-Épilepsie. By Dr. Paul Richer. Paris, Delahaye, 1885.

(Continued from Jan., 1886.)

La Grande Hystérie chez l'Homme. By Dr. A. Berjon. Paris: J. B. Baillière et fils, 1886. With 10 plates (woodcut copies of photographs).

In the first part of this review we gave a very brief sketch of the clinical picture which Dr. Richer has drawn in such splendid detail of the condition now universally known as hystero-epilepsy. It may appear superfluous to insist again on the necessity of closely studying Dr. Richer's monograph, even if there are any who are not convinced of the frequency with which hysteroid affections occur in ordinary practice; but believing, as we do, that Dr. Richer's facts will ultimately throw light on alterations of function in obscure cases of organic disease, it is difficult to refrain from pointing out, first, that this work really puts the subject on a high scientific basis.

As it is quite impossible to devote space to a systematic examination of Dr. Richer's pages, we will close this notice of his work by drawing attention to his very solid contributions to the pathology of the malady. The term hysteria having most unfortunately acquired somewhat a meaning of reproach, it has always been a matter of difficulty with some, especially the more spiritually-minded, to regard the manifestations of the malady as in any way due to perturbation of the central nervous mechanism, or much less of any particular part of it.

Possibly, however, the very definite teaching of Professor Charcot and his school has succeeded in convincing the majority that constant repetition of such very obvious symptoms (*we* would not venture to call them phenomena), such as hemianæsthesia, hemianalgesia, narrowing of the field of vision, &c., is to be accounted for only by functional aberration affecting certain definite parts of the central nervous system, and notably of the cerebral hemisphere. In this connection it is well worth while to quote the extremely clear and concise observation of Dr. Bastian in his recent work, "Paralyses, Cerebral, Bulbar, and Spinal" (p. 90), viz.: "Since many of the phenomena associated with this condition are also met with in cases where actual structural lesions have existed in the posterior third of the hinder segment of the internal capsule, there is good reason for supposing that hystero-epilepsy is a condition having intimate relations with functional perturbations in this region of the brain." Although we shall adduce evidence presently which we believe suggests that search for the seat of active disturbance must be made in the cortex of the hemisphere, nevertheless the above quoted opinion appears to be the first definite attempt to elucidate the problem of the pathology of hystero-epilepsy in the most profitable manner, viz., by connecting anatomical investigation and clinical observation. It is obvious to the student of hysteria that the mischief must either be in the afferent channels leading to the highest centres or actually in those highest centres. We are inclined to the latter opinion, and believe that convincing evidence may be drawn from the extraordinarily powerful array of facts which Dr. Richer has so industriously collected. And yet while we are thus thinking of the disordered mechanism which actively demonstrates the

course of the malady, it is impossible to more than temporarily drive to the background the consideration of an extremely important question, viz., the relation of the disease to peripheral processes, *e.g.*, ovaritis, &c. In fact, we freely confess that it appears to us a sketch of the pathology of hystero-epilepsy would be incomplete without at the same time equally keeping in view the possibility of such an array of symptoms being evoked by disorders of the periphery of the nervous system, a possibility which is recognized by many to be a fact, although the evidence in its favour has yet to be carefully sifted, and a positive decision arrived at upon it before it can be fully admitted as scientifically established.

But to return to the examination of the evidence on which we ground our belief, that the nerve-discharge, however liberated, is in these cases an outflow from the highest centres in the cortex, motor or otherwise. We will, to be most brief, enumerate afresh Dr. Richer's grouping of the symptoms, and then consider each group in this connection. Take first the preliminary stage of prodromata. We cannot do better than quote Dr. Richer's own words (p. 3)—"Les troubles psychiques sont les premiers qui apparaissent," since we take it that most will grant us the contention that such "mental" disturbances as ill-defined restlessness, fits of excitement, or of its opposite, melancholy, are no other than functional aberration of the highest cortical centres. By way of illustration of this point and the fact that the above-mentioned excitement may be so very marked as to terminate in regular hallucination, we will quote an instance recorded by Richer (p. 9), as occurring among his clinical notes: "Marc. . . . Elle voit des rats et des chats courir les unes apres les autres. . . . Ils passent alors *à gauche** de la malade. Venant d'arrière en avant, ou bien faisant un circuit autour d'elle dans le même sens *de gauche à droite.*"* It can scarcely be doubted that in this instance, as in so many others, there was definite perturbation of *one* (the right?) visual perceptive centre, such centre being situated, as universally admitted, in the cortex cerebri. Many other examples of similar unilateral perversion of one auditory as well as visual perceptive centre are to be found in Dr. Richer's pages, all being instances of the state which has been termed "double consciousness," whether correctly is, we think, doubtful. To return, however, to our point, viz.,

* The italics are ours.

the seat of the disturbance (or lesion) in hystero-epilepsy, we must leave the preliminary stage, although intensely interesting, and pass on to the next stage, that of epilepsy. We must observe at the outset that it was this feature of the malady caused the great master of this subject, Professor Charcot, to lay especial stress * on certain very definite differences between hystero-epileptic attacks and epilepsy proper. At the same time Charcot, with his wonted scientific accuracy, was driven to point out that, in the main, hystero-epilepsy closely imitated "le grand mal," and, indeed, in certain rare cases so faithfully as to end fatally. We do not intend to do more than here urge that Dr. Richer's elaborate graphic records (tracings of the muscular contractions obtained by the usual arrangement of tambours) exhibit irrefragable evidence that the epileptoid state in hystero-epilepsy is nothing more nor less than a discharge from the motor cortex, and, therefore, ranks with many varieties of epilepsy proper. Now, the condition of preliminary tonic spasm, *i.e.*, prolonged tetanus, with very rapid muscle contractions, followed by clonic spasms becoming progressively slower, the rate being normally multiples of four per second, Mr. Horsley has shown to be obtained by irritation of the cortex cerebri alone in the higher animals, including man. It is very difficult, therefore, to resist the tempting inference from what we have just said, that the initial disturbance finds origin in the sensory perceptive centres (as described by Dr. Ferrier) and thence spreads to the so-called motor area, disturbance of which produces such violent symptoms that anything passing in the rest of the brain is entirely lost in the storm of motility. That such a course of events should be common in any form of epilepsy we can well imagine to be true, but it appears likely that in some cases the prodromatous stage as it culminates in the aura epileptica may be simply the effect of a disturbance in the so-called motor area itself. Especially will this be the case, we believe, in those instances where the aura is made up of "muscular sensations," we mean kinæsthetic sensations referred to the deep part of the body, *i.e.*, divisions of the so-called muscular sense. It is worth while to make special allusion to this form of the epileptoid aura in connection with the general question of the seat of the hysterical malady or perversion of function in the central nervous system. Since it is only within the last few years that,

* "Lectures on the Diseases of the Nervous System." New Sydenham Society's Translations, Lecture xiii, 1877, pp. 305-315.

through the energy of Prof. Charcot, a complete study has been made of the hysteroid states occurring in the male sex as a result of traumatism, good reason for believing that this condition in the male follows from disturbance of the cerebral cortex is but quite recently afforded by many of the facts in the ætiology of these cases, and since, in two cases under the writer's observation, injury of a known part of the "motor" cortex cerebri has evoked typical functional defect in the corresponding part of the body, we have evidence of an almost convincingly experimental nature. The interpretation of the final stages of the hystero-epileptic seizure is in complete harmony with that offered in explanation of the earlier periods. Thus, succeeding to the epileptic state we have the period of contortion and "clonisme," *i.e.*, violent movements of the whole body. The prominent fact that opisthotonus (producing the well-known "arc de cercle" figure of the body) is the characteristic form of this period, suggests very strongly the idea that the disturbance has at this stage spread down to the lower centres, notably the cerebellum. So far we have made no note of the state of consciousness in these different periods, but attention must now be drawn to the fact that whereas there is loss of consciousness up to the stage we are now discussing, from this point it begins to return. This is an additional point in favour of the hypothesis we have been developing in these pages, since it is obvious that the highest centres, no longer the seat of violent perturbation, would recover functional activity if the disturbance was alone affecting to any degree the lower centres. The investigations made so far, as to the mental state in this period of violent contortions, go to show that the patient is in a very ill-defined dream, the earliest stage of normally returning consciousness. Further, in the next and final periods of the attack, viz., the periods of emotional attitudes and delirium, including hallucinations, zoopsia, &c., we see the dream amplified more and more as the cortex recovers itself, and finally the patient wakes to full normal consciousness.

If space were possible, we should wish to recapitulate Dr. Richer's valuable generalizations on hypnotism, its relation to hystero-epilepsy, and more especially to the pathology of this very serious affection. But to do so would, we feel, be mutilating Dr. Richer's highly original communications, and, therefore, we must content ourselves with strongly recommending the study of the original work, only adding that the remarkable results of hypnotic experi-

ments throw very great light not only upon hystero-epilepsy, but upon those mental disorders which may properly be termed functional. The fact that delusions and hallucinations may be produced and removed at will by hypnotism has already led to the removal of corresponding insane states.

The work whose title we have placed next to that of Dr. Richer's is practically the record of very numerous and apparently carefully executed experiments on an hysterical patient, with especial reference to the production of mental and physical states by operating at a distance. The subject of most of the experiments was a male hystero-epileptic who is already known to the neurological world as having been described by MM. Bourru and Burot in their work on multiple personality. Notice is also taken of this state by Dr. Berjon, but we can only note the series of experiments referred to above.

The possibility of producing mental effects in one person by mental operations of another at a distance has recently been reasserted by the French neurologists to be of more frequent occurrence than is generally believed. Indeed, up to the present time such phenomena have always been regarded as the work of fraudulent persons. The experiments described by Dr. Berjon, to whose paper we must refer the reader for details, consist in enclosing different fluids, &c., in a glass flask wrapped in paper, the same being held a few inches from the patient's body, usually behind the bare neck. The effects, as described by Dr. Berjon, appear to be too well secured from error to be other than genuine. We had, through the kindness of Dr. Luys, the opportunity of witnessing similar experiments a few months ago, but such phenomena cannot, of course, be accepted or rejected without vastly more evidence than that at present in our possession. Dr. Berjon's work is a very valuable addition to the literature of the subject, and will doubtless stimulate further research in this direction.

The Influence of Sex in Disease. By W. Roger Williams, F.R.C.S. J. and A. Churchill. 1885. Pp. 39.

This brochure is an attempt to define the influence which sex is imagined to play in the ætiology of disease, to which are added a few of the author's views on various subjects, such as goitre, neoplasms, &c. Mr. Williams' labours,

although greatly assisted by the unacknowledged borrowing of other writers' ideas, will scarcely repay perusal. It would be very unsafe to accept his statements with regard to the influence of sex in mental disorders without further inquiry.

Undiné: the Spirit of the Waters. A poem, containing a version of the narrative by Baron de la Motte Fouqué. By WILLIAM HIPSLEY. London: Elliot Stock, Paternoster Row, 1886.

The psychology of Undiné has still to be written. Yet a more tempting study for the psychologist scarcely exists than the celebrated romance of Baron de la Motte Fouqué. The wayward child, always in mischief and slyly contravening the sober plans of her worthy foster-parents, represents a character familiar enough to the physician, but differing from cases of moral insanity in which there is positive vice. Here there is only the absence of control, the lack of inhibitory powers due to what the writer has been pleased to represent as the absence of soul from birth. The psychologist recognizes the imperfect or retarded evolution of the highest centres, and the consequent instability of character. Undiné is still a child when she ought to have put away childish things. Instability typified in the "Spirit of the Waters" takes the form of playfulness in the wrong place and time. Frolicsome when she ought to be serious; gay when she ought to be sober; yet lovely throughout, Undiné shocks the propriety of the old people who care for her, and perplexes the knight who is enamoured of her. Who does not know the parallel in actual life? Levity in season and out of season, irresistible charms, mischief without malice. At last, after maturity, a crisis comes. The flighty girl has become a woman, and love arrests the downward march of the character towards flippancy. New impulses are born; fresh motives are created; the tendencies to undue emotion are partly repressed, partly directed in a different channel, and at last the whole being is transfixed with the passionate attachment to an object worthy of affection; the barque hitherto tossed about by every breeze and ripple is now anchored in quiet waters. Marriage has solved the problem of girlhood; in another's love, in mingling with another's pure and noble nature, the merely natural has become spiritual; the mortal, immortal; the grub a butterfly, a true Psyche. Undiné has, in short, found her soul. Thus,

in the guise of a beautiful story, the mysterious influence of wedlock on such a mind is revealed, and the human is represented as emblematic of the divine love.

The psychologist is a dull creature if he cannot occasionally be transcendental, and take a higher flight than his brain studies can carry him. In these moments we recommend him to while away a few hours in the study of the imperishable romance of Undiné, the weird child of the imagination of the famous Franco-German author. Whether he read the original or not, let him possess himself of a copy of the clever poetical translation Mr. Hipsley has provided for him. It is a charming psychological idyl, written with true feeling and appreciation of the story; and although a rhyme here and there halts or lacks finish, the general effect is very pleasing, and carries the reader along with irresistible interest. We congratulate the author on his poetical power, and the success which has attended the attempt to make his beautiful heroine even more popular than she has hitherto been in this country.

The book is tastefully put out of hand by the well-known publisher, Mr. Elliot Stock, and is issued at a moderate price.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *English Retrospect.*

Asylum Reports.

(*Continued from page* 295).

Lancashire. Rainhill.—A murderous assault was made by a male patient on the head attendant, who fortunately escaped with a wound of the wrist. The patient had secreted a knife from the bakehouse, and intended to kill one of the assistant medical officers. He was committed for trial, and subsequently transferred to Broadmoor. The Commissioners recommended his being put on trial, "as a warning to other lunatics, many of whom think that they can commit crimes with absolute impunity."

Lancashire. Whittingham.—(1884) The Visitors report that a Post Office, at which Savings Bank and Telegraphic business can be transacted, has been opened on the premises, and has proved a great boon to all connected with the asylum. Plans for a detached hospital, capable of containing 16 beds, have been approved. The estimated cost is £3,500. A scheme for connecting the asylum, by a short

railway, with a line in the neighbourhood, has been submitted to the Committee. Its length will be 1½ miles. The estimated cost is £10,671. A Bill to carry out the same has been deposited in Parliament.

The above are sufficient evidences that there is no lack of enterprise in the management.

(1885). It must be a great relief to Dr. Wallis to be able to report:—"I hope that the present year will see the completion of all outstanding works, and the placing of the institution, as regards its equipment, in the most favourable position possible, so that all our efforts may be concentrated upon the development of our internal economy. The reign of bricks and mortar has been absolute ever since my entrance upon office, now more than seven years ago; and it is a trying time to all concerned in asylum-management, entailing, as it does, the presence of many strange work people, a fertile source of trouble and extra anxiety." He refers also to the new recreation rooms for the attendants as being completely and handsomely furnished. It is pleasant to find that this consideration for the comfort and well-being of attendants is gradually spreading.

It is extremely creditable to the medical staff that in 115 deaths post-mortem examinations were made in 109.

Leicester (Borough).—It cannot be said that the Visitors neglect their duties here. During the year they held 12 ordinary and four extraordinary meetings. Three Sub-Committees met monthly "to examine the condition of the buildings and grounds, to order the necessary supplies, to see the patients, and the condition of the various wards, dormitories, airing courts, &c., to inspect the medical and other journals, and the certificates on which patients have been admitted, and discharge patients recovered, or otherwise proper to be discharged."

New workshops are in course of erection, and will soon be ready for occupation.

A curious incident is reported by the Visitors. The office of storekeeper having been advertised, an application was received, accompanied by testimonials which the Visitors suspected to be forgeries. Inquiry resulted in a prosecution, and the defendant was fined £10 and costs. The conduct of the Visitors is greatly to be commended; the only regret is that the penalty inflicted was so absurdly inadequate to the offence.

A patient was found drowned in a pond on the estate. We regret to find that, as a result of this occurrence, the pond is being filled up. Accidents can never be prevented by such proceedings.

Leicester and Rutland.—The proposal to build a new asylum is in abeyance.

It is remarkable that the charity in connection with this asylum is so sparingly taken advantage of.

Lincolnshire.—The following paragraph from Dr. Palmer's report

is so interesting that we should consider it a valuable contribution to the Journal if he would write a paper giving his experience in detail. Very few superintendents have much experience of such cases, and would gladly learn from one so very capable of speaking from intimate knowledge.

"It is noteworthy, as showing a substantial diminution of opium-eating in the fen-districts of the county, that no case arising from this habit has been brought to the asylum during the last five years. It was formerly found to be a frequent cause of some of the worst forms of insanity, implicating both sexes, and ranging through all ages from youth upwards, while the quantity of the drug that had been daily consumed by many of the victims was almost incredible. It may also be stated that no trace of malarial agency has been detected in the admissions for years past."

City of London.—Accommodation for 35 male patients has been prepared, and is now occupied. A similar enlargement is required on the female side.

The mortality continues remarkably low—only 3·48 per cent. on the average number resident.

Middlesex. Hanwell.—The Visitors report that: "With a view to uniformity of practice in the granting of superannuation allowances, a basis of action consistent with the Statutory Provisions, and the Standing Order of the Court, has been agreed upon with the Committee of Visitors of the Colney Hatch Asylum, which it is considered will tend to more equitably secure the interests of meritorious officers and servants on their retirement, having regard to their respective grades, and the nature of their duties and responsibilities whilst in the asylum employ."

Middlesex. Banstead.—The Commissioners mention with approval a practice which, so far as we know, does not exist elsewhere. Patients desiring to have an interview with the Visitors have their names entered in a book, wherein the Justices commit to writing their remarks on the cases. In our opinion this is an excellent arrangement.

A male patient died of enteric fever; a female recovered, and in the autumn three women in the same ward developed masked attacks of it. Dr. Shaw uses the word "masked" because in none were the symptoms well and regularly developed. Two at least of these patients were of very depraved habits, which, in his opinion, accounted for their attacks; in fact, they suffered from what has been described as "fæcal fever." That may be so, but the Commissioners point out various sanitary defects which afford a more ready and more probable explanation of the occurrence of the disease.

Dr. Shaw reports that very few patients have been confined to the airing courts. With the exception of the feeble and most dangerous, all have enjoyed the use of large fields, and walks round the estate were taken daily as a matter of course.

Monmouth, Brecon, and Radnor.—No doubt it has occurred by mistake, but there is one thing in this report which is fortunately unexampled, and needs only to be pointed out to be discontinued. In the statement of accounts, the names of the private patients are given with the sums paid for board.

Montrose.—The dispute between the Committee and the District Board appears as far off arrangement as ever.

Of the deaths 45 per cent. were due to phthisis. Dr. Howden attributes this excessive rate to overcrowding of the wards, and to infection of persons predisposed to the disease.

Outdoor exercise and work receive due attention. No fewer than 49 patients are on parole beyond the grounds, in addition to 84 on parole in the grounds.

For valuable information on the "Functions of Chartered Asylums" we must refer to Dr. Howden's report.

Murray's Royal Asylum, Perth.—For many years we have heard a great deal about the wickedness of sending senile cases to asylums, but we must admit there is no rule without an exception. The following paragraph from Dr. Urquhart's report bears on this subject, and places it in a fair light :—

"Whilst it is impossible to look with satisfaction on the advent of a patient in the last stages of senility, labouring under symptoms rendering him dangerous to himself and an intolerable burden on his family, it is not easy to indicate how such persons, especially if belonging to the poorer middle class, can be better cared for than in such an institution as this. I may instance a case in point: J. H., who was admitted at the age of 78, suffering from senile mania, disease of the heart, and a fractured rib. She had no near relative except a daughter, who earned her living in a way that precluded her from giving her time to the care of her mother ; but she had saved a little money, and, in that sturdy spirit of independence that is not yet extinct in Scotland, she decided to send her mother here instead of handing her over to the parish authorities. The case was considered by the Directors to be worthy of help, and the charitable aid of the institution was extended to her. During the five weeks this patient survived, her presence in a house of moderate size would have rendered it uninhabitable for ordinary inmates. Even here she was treated in a remote room, and was waited upon night and day by nurses whose sole duty it was to do what was possible to mitigate the troubles of her disorder."

We are glad to find that useful occupations are provided for all able and willing to engage in them. Only one of the gentlemen and four of the ladies who are not incapacitated by their mental or bodily conditions refuse to employ themselves.

The asylum is quite full—a public testimony to its good management.

(1886).—The statistics of the institution since its opening in 1827

have been prepared by Dr. Murray, the assistant medical officer, and are now arranged as recommended by the Association. Dr. Urquhart says :—

"The chief event of the year was the addition of the mansion-house of Kincarrathie to the resources of the institution. As indicated in former reports, the ideal asylum for private patients should consist of a central hospital, perfectly adapted for the treatment of mental and bodily diseases, with adjunct villas for the reception of convalescents and those whose malady permits of their living under circumstances most nearly approaching home life. As a means of treatment, therefore, Kincarrathie is specially valuable ; but it has also proved useful in relieving the overcrowding of the wards here, and in giving facilities for change to those for whom it is desirable. The handsome and comfortable house, so beautifully situated in private, extensive, and finely timbered grounds; the instant communication by telephone; and the proximity, yet distinct separation, of this part of the institution are duly appreciated. Having regard to the experience of the three months during which Kincarrathie has been occupied, I feel justified in saying that it has proved entirely successful."

We are glad to find that in consequence of the suggestion of Dr. Urquhart, made two years ago, "an arrangement has been made with the Royal Edinburgh Asylum for the interchange of chronic patients who are only fit for the wards of an asylum, and whose turbulence or mindlessness prohibits their presence in convalescent houses or elsewhere." We think the interchange of somewhat chronic, but possibly curable cases, is still more desirable. Experience has shown that in not a few cases which make no progress in one asylum, and in which it may be the delusions have special reference to the superintendent, much good is done by transference to another asylum. The number of patients transferred from other asylums to the Murray was 19 from Jan. 1, 1880, to 1886, and to other asylums 31. Of the 19, 12 improved in mental condition ; while of the 31 removed there were also 12 improved.

The institution continues to obtain high official commendation. Dr. Sibbald says :—"The improvements that have been effected during recent years have completely altered the character of the establishment; and the benefit which has thus been conferred on the patients is evinced by the greater degree of contentment which they exhibit. Several pleasing instances of this were observed during the visit. There is little reason to doubt that this feeling of contentment is strengthened by the special attention given by Dr. Urquhart to the occupation of the patients in healthy work, so far as they are capable of it, or can be induced to engage willingly in it. . . . It seems proper to add that, in regard to this particular feature of the management of an asylum for private patients, this institution holds a prominent and very creditable position."

Newcastle.—Buildings for the accommodation of 170 patients are in process of erection, and additions are to be made to the kitchen, chapel, and laundry. The estimated cost is £22,527.

The purchase of 35 acres, at £300 per acre, has been completed.

The drainage is also receiving attention.

In his report Dr. Wickham says: "It will probably always be a vexed question whether the intemperate habits are the cause of the insanity, or the insanity is the cause of the intemperate habits. As the result of many years' careful study of the causes of insanity, I can only remark that in the great majority of those particular cases which have come under my own notice, the evidence is in favour of the conclusion that the insanity causes the intemperate habits. The reverse only happens when there is already some disease which is due to impaired nutrition. Perhaps it is for that reason that the descendants of a drunkard are more liable to insanity than the drunkard himself."

If Dr. Wickham's observations be correct we are and have been totally wrong in our treatment of such cases. Instead of drunkards being taken to a police-court they should be committed to an asylum as dangerous to themselves. As a necessary consequence our asylums must be multiplied at least tenfold.

Northumberland.—No fewer than 20 of the 39 deaths during the year were due to phthisis. This excessive proportion necessarily caused inquiries to be made as to the feeding, &c., of the patients. It was discovered that the ventilation had become to a great extent obstructed. The defects have been removed, it is believed with good effect. It is also suspected that there is slight overcrowding in the dormitories.

Norfolk.—Measles attacked a patient and two nurses.

The Commissioners point out that 100 men and 126 women are confined to the airing-courts for exercise, and they hope that it will be possible to reduce this number and to allow parties, even of the more excitable patients, in small numbers and with adequate supervision, to walk outside the walls.

Northampton.—Plans have been prepared for a hospital for infectious diseases. As originally drawn the Commissioners raised objection to them, considering the proposed buildings contained accommodation in excess of the requirements.

Two epidemics occurred during the year. During the summer months there were several cases of typhoid, and in November small-pox broke out. The source of the typhoid could not be discovered; the small-pox was introduced by an old man who developed the symptoms immediately after admission. Within a few weeks there were 18 cases, six of these being attendants. These epidemics appear to have been severe, as four cases of typhoid and six of small-pox died. The whole establishment was revaccinated—the fourth time since the opening of the asylum.

Nottingham (*Borough*).—It is quite evident that this asylum must be enlarged. As only harmless cases can be boarded in other asylums, the proportion of suicidal and epileptic patients is excessive.

Nottingham (*County*).—The supply of water from the asylum well has markedly decreased. The deficiency is supplied by the Corporation.

The Commissioners disapprove of artizans, however trustworthy, having keys which enable them to enter the female wards at any time. It can easily be understood that such an arrangement might lead to very serious and scandalous consequences.

St. Andrew's Hospital.—There is little calling for special notice in this report; but there are evidences of improvement in various directions.

Typhoid attacked two persons living in one of the cottages. They both recovered. The outbreak is supposed to have been caused by an old cesspit which was in close proximity to the well. On analysis the water was found to be quite pure and fit for use.

Norwich.—Fire broke out in the laundry. The resources of the asylum proved adequate to the danger.

Dr. Harris bears testimony to the advantages arising from a sufficient staff of night attendants. The amount of foul linen has been so much reduced that a contemplated addition to the laundry is no longer necessary. This striking fact speaks for itself.

No patient able and willing to walk is entirely confined to the airing-courts for exercise.

Nottingham Lunatic Hospital.—An assistant medical officer has been appointed. The management is much commended by the Commissioners, who remark that Dr. Tate is very successful in giving a home-like character to the Hospital. It is to be regretted that the efforts to induce the gentlemen to occupy themselves in garden work have not been very successful. They should be persevered in nevertheless.

Oxford.—Dr. Sankey reports "that Mr. Pilkington has, by a minute of the Visitors, been appointed a medical officer under the Lunacy Act, with a power to sign the statement of health required on the admission of a patient, and the statutory certificate of death, in addition to, and on all occasions, in the absence of the Medical Superintendent."

We are much inclined to doubt the wisdom of such a minute, and are strongly of opinion that the Medical Superintendent, when at home, should always sign all medical certificates. Such certificates are amongst the most important acts of his official life, and no good reason can be given why they should be signed by the assistant or anyone else.

Perth District (1886).—The death-rate was high, being 13·3 per cent. calculated on the average number resident. This excess in mortality was entirely among the female patients, among whom the

rate was 17·4 per cent. Eight of the deaths among the female patients were caused by phthisis, but in all save one this affection existed prior to admission.

A uniform has been supplied to the attendants and servants of both sexes.

Portsmouth.—Two nurses suffered from typhoid during the summer. In one case the disease was contracted before she came into residence. Both recovered.

Richmond District.—It is with pain we know that this is the last report which our old friend Dr. Lalor will issue. By his long service and good work he has certainly earned a rest which we hope will be long and happy. His labours in the asylum school will always be remembered to his credit. *

Salop, &c.—The new buildings have been completed, and are now occupied. The matron is now assisted by a head attendant.

The Commissioners notice that about 172 patients walk beyond the estate every week, but there is no daily walking exercise given to men or women beyond the airing-courts. They add that to many patients such exercise is of great value, and they would strongly press the propriety of its adoption.

Sligo District Lunatic Asylum.—Dr. Petit makes the following important remarks :—"It is a matter for serious consideration that though this asylum at the time it was built was intended to provide accommodation for the insane poor of the counties Sligo and Leitrim, nevertheless, when it had been in occupation only twenty years it was found necessary to enlarge it to nearly double its original size.

"Bearing in mind that this increased accommodation has had to be provided for the accumulation of chronic and incurable cases, I wish to point out to your Board that when additional accommodation is required it can be provided at a much less cost than heretofore if the method of treatment carried out in this asylum for the past three years be adopted.

"Not only is this method of treatment economical as regards expenditure, but it is also beneficial in its results to the inmates, and in carrying it out I was fortified by the fact that it had been already introduced and successfully carried out in the Richmond Asylum, Dublin.

"The changes to which I wish specially to direct your attention may be placed under two heads, viz., the abolition of single rooms, and the abolition of airing courts.

"*Single Rooms.*—On examining the plans of the old buildings of this asylum I found that the single rooms constituted one-fifth of the accommodation. Subsequently this was increased to one-fourth by converting some of the dormitories into single rooms. This latter proportion, viz., one-fourth, was carried out in the plans of the new buildings.

* In type before the news of his death reached us.—See Obituary.

"I restored those dormitories which had been divided into single rooms to their original state, thereby gaining increased accommodation to the extent of eighteen beds—nine on the male and nine on the female side. In connection with this change I may mention that four out of the nine female patients ceased to be of uncleanly habits from the time they were sent to sleep in the restored dormitories.

"*Open Doors.*—Tending in the same direction and following the example set me by my old master, Dr. Lalor, of the Richmond Asylum, I ventured upon the experiment of leaving the doors of both single rooms and dormitories open at night.

"There was some fear on the part of both officers and attendants that this change would result in injury to some of the patients from the violence of others, and the night attendants also dreaded they themselves might be attacked.

"However, by trying the experiment gradually I have now at the end of three years arrived at this state of things, viz., that out of a daily average total, in December last, of 412 patients, only seven females and five males had their doors locked at night.

"So far from being attended with risk, this change is now allowed by all connected with the asylum to have had a most tranquillizing effect upon the patients, besides being a decided improvement to the ventilation of the house at night.

"So satisfactorily, indeed, has it worked, that as the process of colouring and painting the divisions goes on, I am having the doors of most of the single rooms and all the dormitories taken off. I may here mention that in the female house of the Richmond Asylum there are only six single rooms to a population of five hundred patients.

"It is therefore evident that the proportion of single room accommodation usually provided in asylums is greatly in excess of that which is needed.

"It has been argued against the doing away with single rooms that it is an infringement of the privacy secured by separate apartments. This argument may hold good with regard to the inmates of private asylums. District asylums in Ireland were provided for the insane poor, and the patients who are accommodated in them have not been accustomed to separate sleeping rooms in their own houses.

"Previous to the building of district asylums, insane poor persons were sent to gaols when they became troublesome, and upon the gaol plan district asylums were, to a certain extent, built.

"The doors of the single rooms in the older asylums attest this, for not only were they provided with locks, and sometimes with strong iron bolts, but most of them *have spy-holes* through which the occupants could be watched, it being reasonable to infer that this watching was supposed to take place during the day, as it would be impossible to observe anything through them at night, there being no way of throwing light into the rooms while the doors were closed. The spy-

holes in the doors in this asylum, though by no means one of the oldest, having been opened in 1855, are one inch in diameter.

"It was not out of regard for the privacy of the inmates that single rooms were provided in gaols, but rather in a spirit of punishment, and so far as my experience goes, it is in that light single rooms in asylums are regarded by officers, attendants, and patients, upon all of whom they have consequently a demoralizing effect.

"*Airing Courts.*—My first practical experience of lunatic asylums dates from the year 1874, when I was appointed Assistant Superintendent of the Richmond Asylum.

"At the time of my appointment, and for years antecedent, airing courts were unknown in that asylum.

"When I was appointed Superintendent at the Donegal Asylum in 1875 I found airing courts in existence there. Acting upon the experience I had gained in the Richmond Asylum, I took steps to do away, to some extent, with those courts.

"Soon after taking up office here I had the walls of the airing courts on the male side taken down. Owing to the laundry green being partially bounded by the walls of the airing courts on the female side, it was only last summer I succeeded in abolishing these courts, the position of the laundry green having had to be changed, which proved a tedious piece of work. Practically, however, I may say they ceased to exist as airing courts almost from the time of my appointment, because in my first year here I sent the female patients out for exercise on the open grounds at the west end of the building.

"Airing courts were provided to guard against the possibility of escape while the patients took exercise in the open air. In district asylums these courts are usually so placed as to be bounded on two sides by the buildings, which are over forty feet in height. The atmosphere of these courts can hardly be called open air, and with regard to escapes, experience teaches, as might be expected, that the less the amount of restraint the fewer the escapes.

"Another very objectionable feature about airing courts is the bad effect they have upon attendants, who fall into the error of supposing that when the patients are put within the walls of an airing court they require no further looking after on the attendants' part.

"Judged from results, I think it will be admitted that money spent upon airing courts is not only uselessly but mischievously expended. This last remark is also applicable to boundary walls, except where the grounds adjoin public roads.

"Single rooms and airing courts are a remnant of the old-fashioned inhuman method of treating the insane, which though it has from time to time been exposed and brought under the lash of public criticism, is not yet dead."

Somerset and Bath.—When the Commissioners visited this asylum in March there were 764 patients in residence, and it is recorded as a

most remarkable fact that not one of them was considered to be actively suicidal.

Staffordshire. Burntwood.—It has been decided to erect a general dining and recreation hall. Forty acres of land have been added to the asylum estate.

Concerning exercise the Commissioners report :—" We are informed that 134 women walk daily beyond the airing courts, but the laundry patients are taken for a walk only once a week. We think that at least one other afternoon in the week should be devoted to the walking exercise of those patients who undoubtedly do real hard work for the asylum. The men who are taken weekly beyond the grounds are nearly 50 in number, but this privilege is not accorded to any of the women, whilst, on the other hand, no men go for walks daily beyond the airing courts."

In his report Dr. Spence seems to think that the decreased number of patients admitted during the year "may, in all probability, be attributed to the not unnatural reluctance on the part of medical men to undertake the duty of certifying patients in face of the present state of the law." He also states that not one of the patients selected as suitable for treatment in a workhouse has, so far, been sent back.

Every patient is weighed monthly.

Staffordshire. Stafford.—No fewer than 10 patients—six males and four females—were discharged as being not insane, the medical officers not being able to discover any mental derangement on admission. This reflects little credit on the signers of the certificates.

Suffolk.—Extensive additions and alterations are in progress, but the Commissioners point out that the new accommodation for patients is not sufficient for the wants of the county. So far as can be gathered from the reports by the Commissioners and Dr. Eager, it is evident that many structural additions and alterations must be made to bring this asylum at all up to the modern standard of requirements.

No less than 157 women, or over three-fourths of the female patients, are confined to the airing courts for exercise!

A few cases of diphtheria occurred and indicate that the sanitary arrangements are not what they should be. There was a fatal case of dysenteric diarrhœa and another of erysipelas.

All the Tables recommended by our Association are not given.

Surrey. Cane Hill.—Great progress continues to be made in getting this large asylum into thorough working order.

We are glad to find that the chaplain interests himself in friendless female patients when they are discharged. Much truly good work may be done in the direction of " After-Care."

Surrey. Brookwood.—Concerning exercise the Commissioners report : " There does not seem to be here a system of daily exercise beyond the airing courts, but about 200 women walk weekly in the grounds and the neighbouring country. We think highly of extended daily exercise as promoting mental and physical improvement, es-

pecially of insane women, and should be glad to report its adoption in this asylum."

To this Dr. Barton replies : "As few of the patients as is consistent with safety are confined solely to the airing courts. Many patients who might do so do not care to walk out daily unless the weather is warm and fine, and I do not consider it prudent or beneficial to press them to do so against their inclination. About 200, however, walk out weekly beyond the boundaries."

We can only say that in our opinion exercise for women in an airing court is peculiarly harmful, and we know of nothing so good for the patients and the nurses as daily walking in the grounds and beyond them. At least 80 per cent. of an asylum population should have extended exercise every day. Of course patients, like other people, will at first object to do anything, however much it may be for their good, but a little judicious coaxing and pressing will very soon overcome all difficulties. Where such a system of exercise is carried out, the improvement in the condition of the patients and in general discipline is always marked.

Surrey. Wandsworth.—A large sum has been spent in erecting a water tower, laying hydrants, providing a stair to facilitate escape from fire, and remedying defects in the sanitary arrangements.

One case of small-pox occurred. Gratuities amounting to £133 were given to those attendants who deserved them by long and efficient service.

The Commissioners direct attention to a very considerable employment of "restraint" to prevent destructive habits and attempts at suicide. They urge the establishment of a regular system of daily exercise for the patients, especially the women, beyond the airing courts.

Sussex.—In the following paragraph Dr. Williams points out a real evil :—

"The forms of admission accompanying the patients brought for admission are often very imperfectly filled up, and in some cases have been absolutely invalid. The Medical Superintendent, acting on his instructions from the Visiting Justices, has had, in more cases than one, to refuse to admit the patient until the form was amended. The imperfect filling up of these forms is a very serious matter, because, on the one hand, if the asylum authorities admit and detain an alleged lunatic on an imperfect order of admission they may render themselves liable to an action for illegal imprisonment, whilst, on the other hand, the delay caused in taking a patient back to have the imperfect order amended may be of the greatest harm to him, besides causing endless worry to all concerned."

A patient has given much trouble by his repeated and ingenious attempts to escape. On one occasion he cut a key out of a small brass button, tied it on a piece of stick, opened his dormitory door, and thus escaped.

With a view to the more systematic instruction of the attendants and nurses in their duties Dr. Williams has prepared a pamphlet for their guidance, containing plain hints on the management of the insane, which we recommend to other superintendents as useful.

Warwick.—Relative to outdoor exercise the Commissioners hesitate to express an opinion, as the books do not furnish a convenient summary of the actual numbers daily walked out, but a weekly average only.

Wilts.—A fire broke out in an attendant's room, but it was speedily extinguished by the fire brigade.

The diminution in the admissions was so marked that Dr. Bowes considers it may have been due to a greater reluctance to send cases to the asylum, owing to a fuller recognition of the responsibility and risk run in making orders for admission.

Although the general health has been exceptionally good, and there is still evidence of benefit accruing from the improved sanitary arrangements, it cannot be said that all is right, as two cases of a typhoid character have occurred. Although the water is believed to be wholesome it should be remembered that there are many other means by which typhoid may be introduced into a building. Seek and ye shall find.

Exercise beyond the airing courts has been extended ; the infirm and dangerously violent alone being confined to the courts.

Various structural improvements have been effected, but it is quite evident that the Commissioners do not consider the progress in this direction sufficiently rapid.

Warneford Asylum.—A sum is being accumulated to defray the cost of a new wing for male patients.

The Commissioners say :—" This is, indeed, a hospital conspicuous for its charity. The comforts of the establishment are not ostentatious, but very substantial; an excellent work is done here; the supervision is much larger than at most of the hospitals for the insane ; there being two medical gentlemen for the 32 gentlemen and 45 ladies under treatment."

Wonford House.—A branch establishment has been secured at Dawlish. Since it has been in use the average number resident has been 15, and the length of stay has varied from a few days to three months. This seaside residence cannot be regarded otherwise than as a most important addition to the means of treatment.

Many structural improvements continue to be carried out.

Worcester.—The recent additions are now occupied by patients ; it has therefore been necessary to appoint a third assistant medical officer. A new chapel, to accommodate over 700 patients, is nearly finished.

The Commissioners report that the greater proportion of the patients have extended exercise, and they were informed that the numbers not going beyond the airing courts were 67 men and 124 women. They suggest that even some of these might occasionally have longer walks.

Three cases of scarlet fever occurred, and a nurse had a severe attack of typhoid but recovered.

Yorkshire. East Riding.—A hot-water apparatus for heating the asylum has been fixed, and found to do its work well.

A detached hospital, for the treatment of contagious diseases, is about to be erected.

The sanitary condition of the asylum is reported as excellent, and there has been no return of typhoid fever.

The facilities afforded for out-door exercise by the position of the asylum are taken fully advantage of.

Yorkshire. North Riding.—The open-door system is in use here in a modified form on the female side. Only external doors are locked, and it is possible to go through all the wards of the division without using a key. The Commissioners say :—"We highly commend the system as here in use, and hope it may be extended to the male division. No inconvenience has arisen from it, and it is not found that patients desire to stray from their own ward." They also express approval of the bed-making and other domestic work in the male wards being done by female patients under the guidance of special nurses. Relative to exercise they report :—"We are glad to observe that as many as 308 patients of the two sexes have weekly walks beyond the asylum grounds; those, however, who are daily taken for exercise outside the airing courts are but 76, and we think the system of daily extended exercise should be further developed."

Yorkshire. South.—The reconstruction of the drainage proceeds rapidly. In the meantime no new cases of typhoid have occurred.

Every effort continues to be made to keep down the numbers resident by sending suitable cases to the workhouses. Dr. Mitchell directs attention to the diversity manifested by Boards of Guardians with respect to the readiness with which suitable cases are received into workhouses. He says :—

"The tabular statement of the Commissioners in Lunacy setting forth, with respect to each union, the proportion of patients in asylum, workhouse, and in care of friends respectively, may be referred to as demonstrating this fact in a very striking manner. The returns from such unions as Sheffield, Barnsley, Huddersfield, and a few others in this district show, in varying degree, what can be accomplished—and accomplished satisfactorily—in this direction; but as regards the majority of the unions, the number of cases accommodated in the workhouses is very small. Thus, whilst Sheffield, with 173 cases in asylum, has 234 chronic cases in the workhouse wards, we see Halifax with 319 cases in asylum, and 20 cases only accommodated in the workhouse. It is a matter for regret that the policy of providing for suitable cases in workhouse wards, which has the approval of the Commissioners in Lunacy, and which has been repeatedly advocated as not detrimental to the class of patients concerned, is not more gene-

rally followed. The immediate effect of refusal to act upon it, on the part of any union, may relieve local rates, but the course can hardly be right and just towards other unions which adopt a different and, it is contended, a wiser view. One policy has the tendency to avert—the other to render necessary—the call for costly asylum extensions and new institutions out of proportion to the number of cases which require, or can be benefited by, the more expensive accommodation."

Yorkshire. West Riding.—The following paragraphs from Dr. Lewis's report refer to a subject which is of real importance: —

"This probationary discharge of patients to relatives or friends is a fruitful source of anxiety. So many factors have to be considered as affecting the probationers' well-being, factors often unknown, or at best most uncertain in their incidence; and a judicious choice of circumstances favourable for such trial is frequently rendered next to impossible from an unavoidable ignorance of the patient's environment. At the best but fragmentary gleanings can be obtained from the relatives or friends, who are only too prone to conceal the vicious surroundings of the domestic circle. The question of the advisability of such probationary discharge is far from being a simple one in most cases. Apart from a certain amount of risk of a relapse with a return of morbid impulses, there is the question of ensuring adequate support, which, in cases of brain disease, is of imperative necessity; there is the question of congenial employment; of the elimination of circumstances which tend to foster nervous irritation and mental worry; there is the question of vicious surroundings, so frequently answerable for a relapse; and there is the still wider question of domestic relationships of both social and national importance which becomes involved in the discharge, to the freedom of their homes and the license of their former lives, of those who have not fully regained their normal mental stability requisite for moral control.

"It is the imperative duty of the medical advisers to be keenly alive to these facts, and not to ignore the claims of society by an undue leaning to the individual interests of his patient. The consideration of more frequent discharge "on trial" being adopted has come to the fore of late, since the Commissioners in Lunacy strongly advocate the remuneration of friends willing to undertake the charge of cases for whom a suitable home could not otherwise be provided, according to the provisions of the Act 16 and 17 Vict., sec. 79, c. 97. That such a provision in cases judiciously chosen would be a wise one there can be no doubt; but it would be well ere any such inducement were offered that a certificate from a responsible local authority, preferably the medical officer acquainted with the circumstances of the patient and his guardian, should be demanded as a *bonâ-fide* pledge of the necessity for such assistance, and that the grant was not misappropriated."

Additional Reports.

Aberdeen.—Thirty-one fatuous patients were removed to the wards of workhouses, and 30 of the harmless incurable pauper patients were boarded out. A few of the latter had to be sent back, and two returned of their own will.

A death by suicide occurred. A nurse omitted to return to the medicine cupboard a bottle containing belladonna liniment; the patient got hold of it and swallowed the contents.

Buckinghamshire.—The space in the day-rooms for female patients is deficient, but it is proposed to remedy this serious defect. It is reported that exercise beyond the grounds is by no means forgotten; parties of women go out twice a week, and men on Sundays.

Castlebar.—Mr. Finegan considers 35 per cent. of the patients as probably curable. He says: "This may seem a large percentage, but I wish it to be understood that the hope of cure or recovery is more a matter of possibility than probability in a large proportion of the cases. All patients, not more than five years insane, and whose insanity is not concomitant with a congenital epileptic or organic brain lesion, is (*sic*) in this table considered curable, for it is now an established fact that chronic cases, even of 15 years, have ultimately regained their mental health."

Cheshire. Chester.—Thirty acres have been added to the estate. The Commissioners consider the amount of exercise enjoyed by the patients too restricted, and the proportion confined to the airing courts too large.

Cork.—Although there is nothing calling for remark in this report, we cannot pass it over without again lamenting the untimely death of Dr. Eames.

Derby.—The Commissioners have for some time strongly urged the erection of a hospital for infectious diseases, but the magistrates will not vote the necessary funds. The sooner they give in the better, for a hospital must sooner or later be built. In the meantime a disinfector has been put up at a cost of £300.

An organ has been placed in the chapel, and a conservatory has been erected. These are among other improvements effected during the year.

Seventy men and 78 women have exercise only in the airing courts; 145 men and 137 women walk in the grounds; and 75 men and 98 women go at times beyond the walls.

Here, as in various asylums, there has been a considerable diminution in the number admitted. On this subject Dr. Lindsay says:—

"These figures are striking, as exemplifying the uncertain fluctuations in the admissions, and are not easily explained. It is not improbable, however, that in some measure they may be attributable to a variety of causes, and may have some connection with the changing opinions of public boards, the suspense and uncertainty in which lunacy legislation has of late years been kept, and the increasing objection on the part of parochial authorities and relatives of the insane

to look upon the asylum as a curative hospital, combined with the increasing disposition to regard the asylum more as a last resort for the hopelessly incurable, or a prospective cemetery for the dying. The effect of this is not to make legitimate use of the asylum to the fullest extent, but to detain insane persons in workhouses and at home as long as possible, only sending them to the asylum when they become intractable, dangerous to themselves or others, dirty, destructive, extremely debilitated, their malady becoming chronic, and too often incurable. This feeling of objection to the asylum is perhaps also fostered by recent prosecutions and decisions in courts of justice, which tend to create suspicion in the mind of the general public with regard to the admission and detention in asylums even of pauper lunatics."

In this asylum, as in several others, the mortality from phthisis was excessive.

Glamorgan.—The new buildings are nearly complete, though not fit for occupation. More than 200 patients weekly are taken into the country for walks, over 300 walk daily in the grounds, and only three men and nine women, who are physically fit to go beyond, are confined to the airing courts.

Kent. Barming Heath.—One case of scarlet fever occurred, but no other zymotic disease.

It is reported that much good and useful work has been done in the chemical laboratory opened last year.

Every effort is made to take patients walks in the country, and no one, unless physically disabled, is confined to the asylum estate.

Kent. Chartham Downs.—The Commissioners report that the number walking daily beyond the airing courts is 43, and those who go weekly beyond the estate are 187 of both sexes.

One fatal case of typhoid occurred. Some sanitary improvements have been effected since that event, and plans have been prepared for the erection of a detached hospital for infectious diseases.

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2. *French Retrospect.*

By D. Hack Tuke, F.R.C.P.

Lentz on Alcoholism. De l'Alcoolisme, par Dr. F. Lentz.

(Continued from the April number.)

The *medico-legal questions* arising out of intoxication are clearly stated by Dr. Lentz, both in regard to ordinary and pathological drunkenness. It may be remarked in passing that the simulation of drunkenness at a stage which would carry with it complete irresponsibility is so difficult that the author has not found a single case on record. The author's great point in regard to the responsibility of drunkards is that they are punished for their drunkenness, and not for the crime which they commit when intoxicated, just as a man guilty of homicide through carelessness is not punished for the

homicide, but for the carelessness. The drunkard places himself voluntarily in a condition of transitory insanity, knowing beforehand the risks to which he may expose himself, and therefore he must take the consequences. Lentz alike rejects the German law, that intoxication diminishes responsibility, and the English law, which regards it as an aggravation.

It does not seem to us quite consistent to say that a man is punished for his drunkenness and not for his crime, and yet maintain that he must be punished more severely if he commits an injury during his intoxication.

The author holds that if there is complete amnesia, there can be no responsibility; but this, again, seems hardly consistent with the foregoing.

The condition of drunkenness in which hallucinations are present forms a transition between normal and pathological intoxication, and in the author's experience the hallucinations are not, strictly speaking, such, but illusions always excited by external objects. On either supposition, however, the individual should be regarded as irresponsible.

As the pathological intoxication already described is a well-characterized insanity, the question of responsibility rests on a correct diagnosis alone.

But we must pass on to the chapter which describes chronic alcoholism, the definition of which varies from the inclusion of all the consequences of the prolonged use of spirits to that of an affection, slow and chronic, caused by alcoholic excess, and characterized anatomically by inflammation, sclerosis, and fatty liver, and clinically by physical, moral, and intellectual changes. The author, however, prefers description to definition. He treats first of chronic visceral alcoholism with local disorders, hepatic, &c., or with general disorders, as cachexia; and, secondly, of cerebro-spinal chronic alcoholism, which is divided into four forms, namely, alcoholic degeneration, hallucinations, simple dementia, and alcoholic dementia, of which forms the complications are pachymeningitis, epileptic convulsions, cerebral congestion, softening, sclerosis, and paraplegia. These disorders are detailed minutely, and cannot be summarized, but the reader will find them worthy of study. Innumerable as are the phenomena of cerebral alcoholism, they preserve the same type, namely, enfeeblement, wear and tear of mind, and dementia. The first form, the foundation of cerebral alcoholism, is designated alcoholic moral degeneration, the term dementia being scarcely appropriate, seeing that the intellectual weakness is often the least apparent symptom, and it is well remarked that the term moral brutishness would be more appropriate were it scientific enough. This form usually characterizes the first stage of alcoholism, and may never advance further, and is almost automatic in character. More commonly the second form, that of alcoholic hallucination, quickly follows, and constitutes a well-marked emotional and sensorial dis-

order. The third form consists of simple alcoholic dementia; there is real mental weakness, intellectual and, especially, moral, wear and tear of the faculties, and this state may remain uncomplicated with other morbid manifestations. More frequently, however, it is only transitory, and rapidly ends in the last form, alcoholic dementia, with paralysis, which must not in the early stage be confounded with true general paralysis, although it nearly always terminates in it. Anæsthesia, which, as everyone knows, is much more common than hyperæsthesia, is usually present at an advanced period only of chronic alcoholism. Objects fall from the hand unless the patient looks at it, and patients can prick or wound themselves without feeling anything, while tickling the arch of the palate or the uvula excites no reflex action. Affections of the sight, diplopia, polyopia, dyschromatopsy, become marked. The ophthalmoscope does not fully explain the phenomena of amblyopia and amaurosis. Nystagmus or tremor of the eyes is frequently present. The pupils are often uniformly and dilated and react slowly to light; their inequality may occur without any symptom of real paralysis. Affections of hearing occur in chronic alcoholism more frequently in the direction of anæsthesia than of hyperæsthesia. Disorders of smell and taste are well known to arise. Motor troubles appear mainly under the form of cramp and tremor, chiefly in the hand and arm, then the organs of speech and the lower extremities. Paretic and ataxic phenomena pass insensibly into complete paralysis. After death the dura mater is frequently the seat of false membranes. Dr. Lentz clearly distinguishes the changes which may be found in the arachnoid and in the pia mater and the brain itself, some being due to the direct action of alcohol, and others being only secondary. The reader will find them carefully described, as also the changes in the spinal cord. The cases reported are of great value, in conjunction with the commentaries of the author, in illustrating the several forms of inebriety already mentioned, and deserve careful study. The symptoms in that form of chronic alcoholism which the author designates expansive alcoholic general paralysis exhibit all the symptoms of the latter. To diagnose alcoholic general paralysis the previous existence of symptoms of intoxication must be proved; the simple abuse of alcohol is not sufficient. There may have been attacks of delirium tremens, or disorders of motility, or moral dementia. There is no certain sign to indicate the transition from chronic alcoholism to general paralysis, and even the autopsy may not decide the question, for adhesion of the membranes, which is the chief pathological appearance, may be so limited as to escape observation. When alcoholic general paralysis follows upon pre-existing alcoholism, optimism does not appear to constitute the symptom of transition, but rather intellectual enfeeblement. Ideas of grandeur, when present, assume a different character in the two affections—in general paralysis they are more infantile and silly, in alcoholic paralysis more

definite and coherent, and there are frequently at first ideas of jealousy, followed by delusions of persecution and general hallucinations. In general paralysis the motor trouble is scarcely perceptible at first, the tongue and articulation being alone affected. In alcoholic paralysis the fingers and toes are at first affected, extending afterwards to the elbows and knees. Another point is that in ordinary general paralysis the motor trouble is rather ataxic, whilst in alcoholic paralysis it is more of a paralytic nature. In the former the movements are irregular and jerky, while in the latter they are marked by weakness. In the former the patient is active, restless, often petulant, and may be firm of gait; in the latter he is feeble, heavy, and trails along with difficulty. The paralytic will raise a weight which the alcoholic would be scarcely able to move; the one will shake hands firmly, whilst the other's pressure is scarcely felt. The tremor in the general paralysis type is frequently absent or scarcely appreciable early, and when present is limited; in alcoholic paralysis, on the contrary, it is ordinarily generalized, and obvious at first sight, the body, including the head, being affected. The fibrillar tremors of the lips and orbicularis palpebrarum and elevator oris are observed when the patient makes the least effort. The tremor of the tongue is much more marked in the one than in the other form, but the difference in the hesitation of the speech is still more striking, for in alcoholic paralysis the speech is tremulous in consequence of the tremor of the different parts which come into play in attempting to speak, while the hesitation of the genuine paralytic is an ataxic disorder due to defective association, as much physical as mental. When the alcoholic paralytic wishes to speak all the labial muscles tremble, and verbal expression is the result of a painful muscular effort. When, on the contrary, the general paralytic speaks the words come easily, except at intervals when one or other muscle, or even the mind, makes a false step. Again, on the side of sensation, dysæsthesia is almost constant in alcoholic paralysis, while it is rare in ordinary general paralysis, for we rarely meet with formication, pain, cramp, and numbness in general paralysis. Dizziness, vertigo, dimness of vision, muscæ volitantes, buzzing in the ears, are constant symptoms in the one disorder, and rare in the other. The mental symptoms also differ, especially as to the form of dementia, mental weakness being nearly always masked in the expansive form of the insanity. In alcoholic paralysis the dementia occupies the first place, and presents special characters, the delusions being less pronounced and often transitory. Intellectual inertia and moral atrophy predominate, but in spite of this the patient seems to preserve more lucidity and consciousness of his condition. M. Lentz agrees with the opinion of a French physician that general paralysis distinct from alcoholic influence exhibits much oftener than is supposed persistent hallucinations of sight and hearing. But sensorial troubles in alcoholic paralysis present a peculiar aspect. These are rather visions than auditory hallucinations. They are accompanied

by anxiety, agitation, dreams, nightmare, and insomnia, while, on the contrary, the hallucinations of general paralysis are much more disseminated, and are less persistent. In alcoholic paralysis the delusion seems to be directly derived from the hallucinations; in general paralysis it is more spontaneous and the hallucinations do not at all modify it. It must be borne in mind that M. Lentz is speaking only of the expansive variety of alcoholic insanity, the rarest of all, so much so that Voisin is able to write that ideas of grandeur are rare in this form of paralysis. It would, perhaps, be more correct to say that they are not exclusive or predominant, but are very often mixed up with ideas of persecution of a hypochondriacal kind, with ideas of magnetic influence, proceeding from the remains of sensory hallucinations or disordered sensations.

Under the head of complications of chronic alcoholism a careful description is given of pachymeningitis, three successive stages of which are recognized, but our space will not allow of citation from this important section of the work. We must also pass over the valuable observations on alcoholic epilepsy.

After some remarks on spinal alcoholism comprising the hyperæsthesic form of Leudet, and the paraplegic of Wilks, the latter of which is considered better established than the former, M. Lentz enters upon the study of progressive causes of chronic alcoholism, the laws which govern, and the relations between, its different manifestations, in other words the pathogeny. The triple action of alcohol upon the vascular system, general nutrition, and the formative process is fully detailed.

An interesting sketch is drawn of the analogies between chronic alcoholism with insanity and inebriety. Clearly the mental weakness, as also the paralysis of mind and body due to alcohol, present all the characters of ordinary dementia. In that form of alcoholic insanity characterized by hallucinations the enfeeblement may not be so evident, but its epiphenomena remove it from the more clearly-marked forms of insanity of which it presents in other respects the leading symptoms. There remains the first form described under alcoholic degeneration and drunkenness. A man becomes a drunkard, properly speaking, when excesses have produced that moral degradation of which the most advanced state constitutes Dr. Lentz's first form, namely, alcoholic degeneration, and not merely the vicious condition of him who abandons himself to drink. At the same time it is often difficult to say where the point of transition from one state to the other commences. Is intemperance a vice or a disease? is a question which the author scarcely ventures to answer in an unqualified manner. He, however, formulates his position thus: Drunkenness, so far as it consists in that state of immorality which is induced by alcoholic excess, ought not to be regarded as a vice; it is a pathological condition in the same sense that all the modifications of the moral and intellectual being, due to extra-physiological

causes, are pathological; drunkenness ought to be considered as the analogue of the prodromic period of mental maladies, and really constitutes the prodromic period of confirmed chronic alcoholism. It is quite otherwise in regard to the craving for alcoholic drinks. With the exception of cases in which this craving is instinctive, and therefore hereditary, it is only a vice which human nature is capable of resisting and therefore entails responsibility.

In the section on the medico-legal bearing of chronic alcoholism, Dr. Lentz observes that the three forms or stages, namely, acute, subacute, and chronic, are insufficient. The subject is therefore considered on the lines already laid down, that is to say, under the three forms of alcoholic degeneration, hallucination, and dementia. No exact criterion can determine the responsibility of a man labouring under alcoholic degeneration. Different degrees of moral and intellectual arrangements carry with them corresponding grades of responsibility. However degraded may be the moral feelings in this form, there remain sufficient lucidity and self-control to resist the suggestions of the passions. If the drunkard is indifferent to the moral aspect of things, he at least understands them; if the mental functions act slowly and imperfectly, his understanding is at least sufficient to appreciate the character of the acts he commits. Doubtless the power of resistance is diminished, and his perception more limited, but with this we can only associate a corresponding diminution of responsibility. Between the two extremes of very slight change and that of moral degradation and intellectual hebetude, there is a long period during which it would be as unjust as dangerous to absolve the unfortunate men whose faculties have been weakened by alcohol. In the hallucinatory form, acts of violence, usually unreasonable and repulsive, cannot be regarded as involving absolute responsibility if there is any mental obliviousness. If, however, the hallucinations are fleeting, and the memory is preserved, we cannot claim irresponsibility for the individual. In the last form, that of alcoholic dementia, there is, of course, no more responsibility than in ordinary dementia.

The fourth chapter discusses alcoholic delirium, delirium tremens, and alcoholic psychoses. Passing over the two former, it may be stated that the last is divided into three orders, the first being associated with depression, the second with exaltation, and the third comprising chronic alcoholic mental disorders. In the depressive group we have alcoholic lypemania; and in the expansive group, ambitious exaltation, which Marcé was the first to describe; and in the chronic group, the mania of persecution and megalomania. Dr. Lentz regards the last as usually a chronic form of the first group, in which ideas of persecution have been effaced, or at least obscured, by the shadow of ambitious conceptions.

Dr. Lentz, in concluding this chapter, makes the important remark that psychical alcoholism, from the simplest to the most complex form, constitutes a state of genuine insanity presenting no difference what-

ever from that which is of non-alcoholic origin. The only form which assumes a specific difference—delirium tremens—ought not to raise the slightest medico-legal difficulty. Complete irresponsibility is its necessary accompaniment. To record cases would only confirm the rule universally accepted up to the present time that delirium tremens is not a form of drunkenness which can be induced voluntarily, but a mental disorder of which the genesis is independent of the human will, and is often even not immediately dependent upon the alcohol which a man imbibes.

In the fifth, and last, chapter the author speaks of hereditary alcoholism, of which Morel has given the best description. It is treated by our author under two forms: hereditary transmission of the same affection, the hereditary transmission of a transformed alcoholism, or rather of alcoholism transformed into numerous nervous manifestations. Of 379 intemperate patients admitted into the asylum of Binghampton (New York), 180 were hereditary drinkers; but, on an average, the statistics of several countries do not give more than 25 per cent. In the second form, we have the symptoms of chronic alcoholism in the descendants of drunkards without intemperance in the former. Sensation is perverted, the lower extremities are generally affected, cephalalgia and migraine are common; the sight is affected, vertigo and dazzlings are not rare, and sleeplessness is frequent, while there may be chronic indigestion along with complete sobriety. Such persons are subject to hallucinations from slight causes; facial tremor and weakened motor power are also simple. Convulsions are induced with extreme facility, or even epilepsy itself. With women hereditary alcoholism is transformed into hysteria, and with men the peculiar nervous affection denominated "nervosisme" by Bouchut.

Hereditary alcoholism frequently gives a clue to those moral perversions which raise the question of moral insanity. In youth, the descendants have low instincts and evil propensities; they are cruel, vindictive, choleric; the pain and suffering of others gives them pleasure; their greatest happiness consists in tormenting and killing animals; others are never happy unless they can tease, plague, and cause suffering to their little playfellows, whom they fill with fear; they habitually reveal at an early age their evil tendencies by the depravity of their character, by the precocious vices in which they take pleasure. When older, they become indolent vagabonds, and incapable of discipline; sometimes they prove refractory to all education, or, if they have painfully learnt a profession or trade, their capacity vanishes at the moment of mental development at puberty. Indecision, sloth, vagabondage, an obscure moral sense, instability of character, the impossibility of settling to anything, the tendency to intemperance and sexual vice, and, lastly, intellectual enfeeblement are the chief characters of their perverted nature. When this supervenes there is something more than moral insanity, but, as Dr. Lentz observes, many are examples of "folie morale instinctive."

The volume concludes with a notice of dipsomania, which Dr. Lentz, with his accustomed discrimination, distinguishes alike from alcoholism and drunkenness, observing that it has only distant relations with intoxication. He defines it as a true insanity, which should be referred to the class of impulsive affections, the craving for drink being only a simple symptom which might be replaced by any other irresistible desire without at all modifying the essential nature of the mental disease. The only relation it has with alcohol is that it too frequently gives place to alcoholism, whose symptoms efface those of the affection which produced them. Dipsomania is regarded under two forms: the essential and the symptomatic, the latter being the most frequent, and occurs especially at the commencement of certain maniacal states and general paralysis; indeed, the craving for drink is sometimes the most prominent symptom of the latter. In circular insanity the stage of excitement is often characterized by an almost instinctive propensity to excess, and appears to be a veritable circular dipsomania. The invasion of true dipsomania is generally slow, the attacks increase little by little in intensity and duration, and at last the disorder assumes a circular character; the mental condition is absolutely different in the two periods of the circle. Heredity plays nowhere a more important part than in dipsomania. The principal symptoms are the disorders of moral sensibility, returning periodically and accompanied with an invincible tendency to intemperance. At first the character changes, the patient becomes irritable, and even violent, the sleep is disturbed, an indefinable *malaise* renders him anxious and restless, while vague apprehensions put a stop to ordinary occupations. Dr. Lentz forcibly describes the condition as one of *véritable effervescence intérieure*. On the termination of the attack the patient falls into a state of moral weakness, and the patient, conscious of his condition, shuns society, and often seeks admission into an asylum. The medico-legal aspect of dipsomania offers little difficulty; it involves complete irresponsibility. The ordinary abnormal manifestations include an irregular and fantastic character, arrested development, or singular inequality of the intellectual and moral faculties, natural tendency to lying, dissimulation, cruelty, excesses of all kinds, periodical return of various nervous disorders, sometimes always alike, at others variable in their form; with these are often combined physical imperfections, such as malformations of the head, &c. Of course, during the attack the dipsomaniac must be considered irresponsible, but during the remission he cannot be allowed to enjoy the same immunity, although his absolute responsibility must not be assumed without inquiring into the special features of the case.

We have given a full analysis of this very able work on alcoholism, in order that the author's views on so practically important a subject may be accurately followed, and it has been thought that a sketch of the ramifications of alcoholism will prove useful to our readers.

PART IV.—NOTES AND NEWS.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Forty-fifth Annual Meeting of the Medico-Psychological Association was held on Monday, 9th August, 1886, in the Rooms of the London Medical Society, Chandos Street, Cavendish Square, Dr. G. H. Savage presiding. Among the members present were Drs. Charles Aldridge, E. M. Courtenay, P. Maury Deas, Edward East, Henry Hicks, O. Jepson, Thomas Lyle, H. Rooke Ley, George Mickley, W. J. Mickle, J. G. McDowall, Donald Mackintosh, John May, John Moloney, Conolly Norman, Frederick Needham, H. Hayes Newington, David Nicolson, Evan Powell, H. Rayner, James Rutherford, James Stewart, R. Percy Smith, G. E. Shuttleworth, Arthur Strange, H. Sutherland, D. Hack Tuke, A. R. Urquhart, E. B. Whitcombe, T. Outterson Wood, &c.

At the opening of the proceedings Dr. RAYNER, who at first occupied the chair, referred to the mournful circumstance which rendered it necessary for him thus to take the place of the outgoing President, saying that none of the members who saw Dr. Eames at the last annual meeting at Cork, and subsequently at the Belgian Congress, would have anticipated that he would so soon have been called away. He felt sure that all present would unite in an expression of regret at the loss of a fellow-member so well known and respected, while to those who knew him intimately the feeling would be one of very deep sorrow. Dr. Eames' generous qualities, public spirit, and liberal and kindly interest in his work had earned for him the highest esteem. He would say no more on the subject at present, as one of the first proceedings of the business of the day would be to move a vote of sympathy and condolence with Dr. Eames' family. It now remained for him only to instal Dr. Savage in the Presidential chair. That chair had been occupied by many worthy and distinguished men, but by none more worthy and distinguished, intellectually and socially, than Dr. Savage. He (Dr. Rayner) had few greater sources of pride and pleasure than that of possessing Dr. Savage's friendship, and it therefore gave him the greatest possible gratification to now offer him the chair, which was the highest honour their Association could confer.

Dr. SAVAGE, in taking the chair, said that his first impulse was to join with the members in lamenting the death of Dr. Eames, who had so unexpectedly and sadly passed away in the full vigour of manhood. Full of purpose, zealous at his work, and possessing qualities which had endeared him to all who knew him, the loss was, indeed, a grievous one. He also felt it right here to refer to the work which had been thrown upon their Secretary, Dr. Rayner, who, in addition to other heavy duties, had had to take charge of at least two Bills. Sittings of the Parliamentary Committee had been constantly held, and the way in which Dr. Rayner had done his work throughout left nothing to be desired. He (Dr. Savage), now begged to thank the Association for the honour they had conferred upon him, and to express the hope that his year of office would be as successful as those of his immediate predecessors.

The GENERAL SECRETARY submitted the minutes of the last annual meeting, which were printed in Vol xxxi., No. 135, of this Journal (October, 1885).

The minutes, having been taken as read, were confirmed.

Dr. COURTENAY then proposed the following motion:—

> That this Association conveys to Mrs. Eames its deep sympathy in the loss she has so recently and unexpectedly sustained, and expresses to her the high esteem and honor in which our late President, Dr. Eames, was held, as a result of his philanthropic exertions for the welfare of the insane and of his social and intellectual worth.

He would only add that in Ireland Dr. Eames's loss was considered a very grievous one to the Association.

Dr. NEEDHAM seconded the motion, which was carried unanimously, Dr. Courtenay undertaking to communicate it to the family of Dr. Eames.

The TREASURER, Dr. Paul, submitted the balance-sheet of the accounts for the past year, which will be found on the next page, the same having been duly examined and certified as correct. (See p. 450.)

On the motion of Dr. CONOLLY NORMAN the balance-sheet was adopted, and a vote of thanks was conveyed to Dr. Paul, which was suitably responded to by him.

Dr. CLOUSTON proposed a vote of thanks to the editors of the Journal, observing that the editing of the Journal, which was, undoubtedly, one of the most important works in connection with the Association, and required a great amount of care, had been remarkably well carried on during the past year. He had only one suggestion to make, which was, that the editorial staff might some day be strengthened, and perhaps put on a broader basis by the addition of a provincial man.

Dr. DEAS seconded the motion, which was carried.

Dr. HACK TUKE said that it gave Dr. Savage and himself much pleasure to receive this recognition of their work, especially coming from Dr. Clouston, who so well knew the duties of editorship—he might say the pains as well as the pleasures of the post. The editors were always extremely glad to receive any hints, either from former editors or other members of the Association, and had frequently adopted them. He hoped that the Journal carried out what was the original aim and object of its establishment as mentioned at the time it was established, viz., that it should be a means of communication between superintendents of asylums and those who were engaged in any way in lunacy work, the expression used being that nothing should be excluded from its pages which was not opposed to the modern system of the treatment of the insane.

Dr. NEEDHAM proposed a vote of thanks to the Secretaries, saying that it must be obvious that the success of a large Association such as theirs depended to a great extent upon the energy and ability displayed by their Secretaries.

The motion was seconded and carried.

Dr. RAYNER, General Secretary, in response, said that his duties had always been a source of great pleasure to him. He was beginning to feel that he ought really to make way for a younger and more active man, but for some six or seven years he had been led on by the hope of seeing a Lunacy Bill passed. He still hoped for this, and would accordingly continue for the present to do all he could to further the interests of the Association.

Dr. RUTHERFORD said that last year at the annual meeting in Cork he tendered his resignation of the Secretaryship for Scotland, but as there was no other Scotch member present it was thought better to postpone consideration of the subject till the views of the Scotch members were known as to who should be his successor. He, therefore, begged now to resign the office, which he could not do without feelings akin to regret, but having been Secretary for ten years he thought it was time that some younger member should be called upon to take the work in hand. He hoped that his successor would at the end of his Secretaryship have as many pleasant recollections as he had.

Dr. COURTENAY, Secretary for Ireland, also suitably acknowledged the vote of thanks.

The PRESIDENT said that the business now to be dealt with was the appointment of officers and Council for the ensuing year. He explained the mode of voting, and nominated Dr. Paul and Dr. Nicolson as scrutineers. Dr. Rutherford having definitely made up his mind to resign, that gentleman was, no doubt, prepared to propose someone to succeed him, and as Dr. Rutherford knew the work so well, his nominee would be accepted with confidence. Among new members of the Council the name of Dr. S. Mitchell had at first been submitted, but on his declining to serve, and it being considered that the assistant medical officers, that very large, important, and rising class of the Association, should be represented, the name of Dr. J. G. McDowall was inserted, he also coming from the North of England.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Treasurer's Annual Balance Sheet, 1885-86.

RECEIPTS.	£	s.	d.
To Balance—Cash in Hand	234	15	1
To Subscriptions received	253	11	0
By Secretary for Ireland	31	10	0
By Secretary for Scotland	35	14	0
By Sale of Journal	151	16	0
By Interest on £205 7s. 10d. 3 per cent. Consols	5	19	2
	£713	5	3

EXPENDITURE.	£	s.	d.
By Annual, Special, and Quarterly Meetings ...	16	5	10
By Expenses of Reporting at various Meetings ...	12	9	0
By Editorial Expenses	12	12	0
Printing, publishing, engraving, advertising expenses, and postage of Journal ...	420	8	1
Prize—Dr. Greenlees	10	10	0
By Sundry Expenses, Printing, &c.	11	2	8
By Treasurer	6	6	0
By Secretary for Ireland	2	14	7
By Secretary for Scotland	5	5	0
By General Secretary	2	16	6
By purchase of £100 12s. 2d. 3 per cent. Consols ...	101	19	11
By Balance in Treasurer's hands	110	15	8
	£713	5	3

Examined and found correct,

FRED. NEEDHAM
H. HAYES NEWINGTON, } Auditors.

Bethlem Royal Hospital,
August 7th, 1886.

J. H. PAUL,
TREASURER.

Dr. RUTHERFORD said that he had great pleausure in proposing that Dr. Urquhart, Medical Superintendent, Murray's Royal Ayslum, Perth, should be elected Honorary Secretary for Scotland. He knew that this appointment would be gratifying to the great majority of the members in Scotland as well as to the whole Association. Dr. Urquhart's ability and fitness were too well known to require any comment.

Dr. CLOUSTON cordially seconded this, saying that the Scotch members were agreed as to Dr. Urquhart's fitness for the appointment.

The lists were then collected, and the scrutineers retired to examine them, subsequently reporting that the nominations of the Council had been unanimously supported, whereupon the following gentlemen were declared by the PRESIDENT to be duly elected as

OFFICERS AND OTHER MEMBERS OF COUNCIL OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

YEAR 1886-7.

PRESIDENT-ELECT	F. NEEDHAM, M.D.
TREASURER	JOHN H. PAUL, M.D.
EDITORS OF JOURNAL...	D. HACK TUKE, M.D. G. H. SAVAGE, M.D.
AUDITOR	J. T. HINGSTON, M.R.C.S.
HONORARY SECRETARIES	H. RAYNER, M.D. General Secretary. A. R. URQUHART, M.B. For Scotland. E. M. COURTENAY, M.B. For Ireland.

MEMBERS OF COUNCIL.

J. G. MCDOWALL, M.B.	G. E. SHUTTLEWORTH, M.D.
H. T. PRINGLE, M.D.	H. SUTHERLAND, M.D.

The election of ordinary members was then proceeded with. The balloting box having been sent round, and there being no dissentient vote, the list was taken *en masse*, and the following gentlemen were declared to have been duly elected ordinary members, viz:—James Vernon McCreery, L.R.C.S.I., Medical Superintendent, Kew Lunatic Asylum, Melbourne; William L. Ruxton, M.B., C.M., South Yorkshire Asylum, Wadsley, Sheffield; A. L. Fullarton Robertson, M.B., C.M.Ed., St. Andrew's, Billing Road, Northampton; G. Fletcher Collins, M.R.C.S.E., &c., County Asylum, Knowle, Fareham, Hants; R. Leonard Rutherford, M.D., Medical Superintendent, City Asylum, Digby's, near Exeter. E. H. Myddelton-Gavey, M.R.C.S. and L.S.A., Camberwell House, S.E.; R. B. Lydd Stephenson, M.B. and C.M., District Asylum, Perth; A. C. Suffern, M.D., Birmingham Borough Asylnm.

Dr. HACK TUKE moved the election, as Honorary Members, of M. Théophile Roussel, M.D., Paris, Sénateur; Dr. J. N. Ramaer, Haarlem, Inspector of Asylums; and Dr. Godding, Medical Superintendent of the Government Hospital for the Insane, Washington; and as Corresponding Members, of M. Jules Morel, M.D., Ghent; and M. Victor Parant, M.D., Toulouse. Dr. Hack Tuke explained that Dr. Roussel was the proposer and also the reporter of the Committee recently sent by the French Senate to inquire as to the state of the lunacy laws in England. In that capacity he was seen by many members of the Association, and two large and important volumes had since been issued embodying the results of the Committee's inquiries. He was also known as an original author. As to Dr. Ramaer, several members present had met him recently in Antwerp, where he had been one of the honorary presidents of the Congress of Psychiatry. He was formerly Superintendent of the Zutphen Asylum, and subsequently President of the Dutch Psychological Association, being afterwards made Inspector of Asylums in Holland. He had been also for many years an honorary member

of the Medico-Psychological Association in Paris. Dr. Godding was the Medical Superintendent of the Government Asylum for the Insane at Washington, and was a leading man in our specialty in the States. There was a special appropriateness in his case in connection with the coming Congress in Washington, at which their President was anticipating being present. As regards the Corresponding Members, Dr. Jules Morel had been known to many of them, and had been most courteous to those who, like himself, had attended the Antwerp Congress. For many years he had been connected with an institution for the insane in Ghent, and was President of the Society there. He had written many papers and articles. He was now in charge temporarily of the Guislain Asylum at Ghent, in consequence of the death of Dr. Ingels, and he (Dr. Tuke) expected that he would ultimately be promoted to the superintendency. Dr. Parant, who was a nephew of the well-known Dr. Foville, was head of an institution for the insane at Toulouse. He was an able contributor to "L'Encéphale" and the "Annales Médico-Psychologiques." One article was especially valuable, viz., that on the Simulation of Insanity, published not long ago, and analysed in the "Journal of Mental Science."

Dr. NICOLSON supported the motion, saying that he had had the pleasure of meeting Dr. Roussel at Broadmoor at the time referred to by Dr. Tuke.

Dr. CLOUSTON confirmed what Dr. Tuke had said as to the standing and acquirements of Dr. Roussel and also of Dr. Godding The report of the former to the French Senate was a most valuable and instructive document.

The names having been taken *en masse*, the gentlemen referred to were declared to be duly elected.

Upon the question of the time and place of the next annual meeting, the PRESIDENT remarked that probably some of the members might be going to the International Medical Congress in America in September, 1887, and it would be desirable that the annual meeting of the Association should be held before they would have to start.

Dr. RAYNER thought that, on the whole, a meeting earlier in the year than the present one would be advantageous, as by meeting late they lost the use of the rooms of the Royal College of Physicians and the attendance of several London members who started early for their holidays.

Dr. URQUHART suggested that the annual meeting should be held at the end of May in future. It had been formerly agreed that the meeting should be held as near as possible to the time of that of the British Medical Association, but it was also understood that it was not to be an appendix to it, and when, as on the present occasion, the two meetings were held in different places, most Scotch members would prefer to come to the Metropolis in May, when there would be more doing and to be seen.

Dr. JEPSON thought the time of the meeting would be best left to the Secretary or President to decide upon.

The PRESIDENT said that Dr. Urquhart was taking it for granted that the meeting would be held in London

Dr. HACK TUKE suggested that the views of President elect as to the time and place of meeting next year should be solicited.

Dr. NEEDHAM said that, as far as he was concerned, the matter was entirely in the hands of the members of the Association.

Dr. TUKE said that in that case, and subject entirely to Dr. Needham's feeling in the matter, he would propose that the next annual meeting should be held at Gloucester. It would be very interesting to meet where Dr. Needham carried on his asylum work, and it might also be remembered that the proposal to form this Association originally sprang from Gloucester in 1840, when Dr. Hitch was Superintendent of the County Asylum.

Dr. WHITCOMBE said that he was sure provincial members would be much pleased if the annual meeting were held in some other city or town than London. He should be very glad if Birmingham were selected.

Dr. DEAS thought the Association would gain by meeting, as on the present

occasion, on the day before the meeting of the British Medical Association, and at the same place.

Dr. RAYNER referred to the 4th Section of the Rules, and said that of course any proposition in regard to the day of meeting would be taken into consideration by the Council.

Dr. CLOUSTON said it seemed to him that every practical consideration went in the direction of meeting in London or Edinburgh. He, for one, would be most happy to go to Gloucester; but they ought to carefully consider before going to a provincial centre. Old members years ago used to say that in provincial centres the meetings became slower, and the vitality of the Association suffered.

Dr. DEAS said that, on the contrary, one of the very best annual meetings was held at York, and a most successful one was held at Glasgow.

Dr. NICOLSON remarked that the meeting at York was in connection with that of the British Medical Association at Leeds. It would be well to select some place which would attract members who had not previously been present, otherwise their object in going to a provincial town failed.

Dr. DEAS said he was ready to propose that if, as was probable, the meeting of the British Medical Association were next year held at Leeds, the Medico-Psychological Association should meet there too. They would probably thus gain the attendance of many members who could not come to the metropolis. If the British Medical Association should not meet at Leeds, then it might be left to the discretion of the Council.

Dr. NEEDHAM said that although he had no definite choice between Gloucester and London, he should have a distinct objection to another provincial town being substituted for Gloucester.

Dr. HAYES NEWINGTON urged that the convenience of the President elect (Dr. Needham) ought to be consulted.

Dr. Hack Tuke's proposal that the next annual meeting should be held at Gloucester having been duly seconded,

Dr. JEPSON moved an amendment, which was seconded, "That the next annual meeting be held in London."

The amendment having been put to the vote, there appeared: For the amendment, 11; against the amendment, 8. The original motion was then put to the vote and rejected, there being 8 votes in its favour and 11 against it. It was therefore agreed that the next annual meeting should be held in London.

Some further discussion having arisen in regard to the date of the annual meeting and the rule of the Association relating thereto,

Dr. HAYES NEWINGTON said that he thought the better way would be for members having suggestions to make on the subject to address them to the Council.

The PRESIDENT said that the Council would, of course, be prepared to receive recommendations. They would also like to know what would best suit the convenience of the Scotch and Irish members.

Dr. RUTHERFORD said he was sure that the months of May or June would suit the Scotch members best.

Dr. URQUHART said it would place him in a very difficult position if there were no definite agreement come to as to the date of the annual meeting, and he would have to give notice of motion to have the rule bearing on the subject amended. The question had come up frequently before, and the result had not been satisfactory.

The PRESIDENT: Then am I to take this as a notice for an alteration of the rule?

Dr. URQUHART: Yes; unless some means are taken for making the meeting earlier.

With reference to the Parliamentary Committee, Dr. RAYNER reported that meetings had been held on seven occasions, on one occasion lasting all day. The Committee's recommendations had apparently been very favourably re-

ceived by the Lord Chancellor, as a great number of alterations in the Bill followed closely the suggestions which were sent. Many members of the Committee attended most regularly, some from a considerable distance. He then read the names of the members at present comprising the Committee.

A MEMBER said that if it were proposed to add to the Committee he would like to suggest the name of Dr. McDowall, of the Morpeth Asylum.

Dr. NICOLSON thought the present Committee was large enough, and moved that it should be reappointed *en masse* as it stood, and that a vote of thanks should be accorded to the members for their past work.

Dr. T. OUTTERSON WOOD seconded this, and the Parliamentary Committee was then reappointed accordingly.

Dr. RAYNER reported that a scheme was about to be sanctioned by the Charity Commissioners for the administration of the Elliott Charity, the principal provisions of the scheme being as follows:—

THE ELLIOTT CHARITY.

The Charity, to be entitled "The Elliott Charity," to be administered and managed by five trustees, two being *ex-officio* trustees and three co-optative. The *ex-officio* trustees to be the Secretary to the Lunacy Commissioners and the Treasurer of the Medico-Psychological Association. The co-optative trustees to be competent persons residing in England or Wales, but having no interest in any house licensed for the reception of lunatics under the Statute 8 and 9 Vict., c. 100, or any modification or re-enactment thereof. The trustees to meet once a year or oftener, and to keep minutes of their proceedings and books of account. The income of the Charity to be applied for the benefit of such poor persons, whether male or female, as shall have been employed as attendants upon the insane in any house licensed for the reception of lunatics under the Statute 8 and 9 Vict., c. 100, or any statutory modification or re-enactment thereof for the time being in force, and as shall, whilst so employed, have become incapacitated by sickness, accident, old age, or other infirmity, from continuing in such employment.

The term "attendant," as used in this scheme, to mean any person, whether male or female, employed, either wholly or partially, in the personal care, control, or management of any lunatic.

No person to be qualified to become, or continue, a recipient of the benefits of the Charity who, or (if a female) whose husband, shall be in receipt of an income exceeding an amount to be decided upon. The recipients of the Charity to be selected and appointed by the trustees from applicants having the prescribed qualifications; but the trustees, when and so far as practicable, to make it a condition of granting relief, that some payment or contribution towards the support, or for the benefit, of the person relieved, be made, or agreed to be made, either by such person, or by his or her relations or friends.

The clear yearly income of the Charity, after outgoings and expenses, to be applied for the benefit of persons selected by placing, or assisting to place, them, either temporarily or permanently, in some institution for the reception of convalescent or incurable patients, or in an ordinary or special hospital or infirmary, or other institution suited to the circumstances of the particular case, or by the supply of medical or other aid in sickness, or of clothes, linen, bedding, fuel, tools, food, or other articles in kind for the use of sick or infirm persons at their own homes or elsewhere; or, if the trustees shall think fit, by gifts or donations of money, or by the grant of pensions not exceeding £30 per annum to any one person, no pension being continued for more than three years without investigation and renewal.

The trustees of the Charity to make all necessary arrangements with governing bodies of institutions for the reception of poor nominees, and for the exercise of due supervision over them, and to transact all other business in connection with the scheme.

Dr. CLOUSTON suggested that counsel's opinion might be taken to ascertain whether all asylums receiving private patients might not come within the operation of the trust.

The PRESIDENT said that he would take it as a suggestion to the Council.

The action of the Council in regard to the matter was then approved.

Dr. HACK TUKE said that the Council had received, through Mr. Wilkes, one of the executors of the late Mr. Gaskell, an offer which they had gladly accepted, to place the interest of £1,000 permanently at the disposal of the Association for some useful object, which would at the same time serve to connect the name of Mr. Gaskell with the Association of which he was so distinguished a member. The gift was in reality made by Mrs. Holland, of London, the sister of the deceased. In the last circular issued respecting the examination in psychological medicine, it was stated that it was in contemplation to have an additional examination for honours, and the Council considered

that this sum would come in very usefully towards providing a "Gaskell prize" in connection with that examination. It was proposed to apply it, therefore, for this purpose, subject to Mrs. Holland's approval.

Dr. RAYNER said that the Council were of opinion that the sum in question should be accepted and applied to the purpose mentioned by Dr. Tuke.

As regards the examinations for the certificate of competency in psychological medicine, the Council had come to the conclusion that the regulations had been too stringent, and had excluded many who might otherwise have suitably applied for the diploma. It was, therefore, proposed that the examinations should be more widely opened, and that having attained the age of 21, with the possession of a diploma admitting to registration, should constitute eligibility for examination, together with such experience in lunacy matters as might satisfy the President for the year.

Dr. URQUHART said he was pleased to hear that the Council had done this. In Scotland men would not come forward on account of the stringent regulations now in force.

Dr. NEEDHAM begged to suggest that in accepting Mrs. Holland's gift on behalf of her late brother, the Association should express their great regret at the death of Mr. Gaskell, who was one of the most energetic of the Lunacy Commissioners. Mr. Gaskell had encouraged young superintendents, and his advice had been of the greatest possible benefit. He (Dr. Needham) personally felt much gratitude for the encouragement he had had from Mr. Gaskell.

Dr. JEPSON seconded the proposal of Dr. Needham, referring to his own pleasant remembrance of the late Mr. Gaskell.

Dr. CLOUSTON suggested that candidates might be allowed to come up for examination before receiving their diplomas under the Medical Acts, the actual bestowal of the medico-psychological certificate being deferred till after registration. Many students who were cramming for their medical examinations would be glad to be able to pass this examination at the same time. After receiving their degrees they might be going away all over the world, and would not be in a condition to subsequently pass. It would be desirable to catch them just at the right time.

Dr. DEAS said that it would never do for the Association to give a diploma until the student had actually registered. He would support Dr. Clouston's proposal if the diploma were thus withheld.

Dr. STRANGE, referring to Dr. Rayner's explanation of the Council's proposals as to the required experience in lunacy matters, thought that the power of deciding on the sufficiency of that experience should be exercised by the President and Council, and not by the President alone.

Dr. RAYNER said he had proposed that the duty should be imposed on the President and not on the examiners, in order to avoid any suspicion of bias. As the sense of the Council was that the restrictions in regard to opportunities of experience should be as slight as possible, the President's duty in that respect would not be very difficult.

It was then agreed that the examination for the certificate of competency should be open to medical men, whether students or not, if of age; that there should be no restriction as to their being qualified before going up for examination, but that the diploma should not be given until they were actually registered.

Dr. HACK TUKE said it should be clearly understood in regard to the relaxation of the conditions that, although the latter would be no longer insisted upon, they would be preferred, and that the decision of the President whether the antecedents of candidates were sufficient would be an alternative condition. The second rule would now, therefore, end thus:—"*or* they shall give such proofs of experience in lunacy as shall, in the opinion of the President, be sufficient," or words to that effect.

The PRESIDENT said that one difficulty had arisen from finding that men

would apply who had had much practical experience in dealing with lunacy, but who had never been in asylums or attended courses of lectures. For instance, there were many in Workhouse infirmaries who saw a great deal of lunacy. It would be a very easy thing for the President to see that such a person had been for a long time in an infirmary, and was, therefore, qualified in that way to enter for his examination. He was inclined to think that there was a great future before this diploma question. If they could once get a start and let it be known that it was a very important qualification, there was little doubt that a Lord Chancellor would sooner or later take it up, and give the diploma official recognition in a Lunacy Bill. It had been under the consideration of the Council whether some regulation might be framed by which all who held the appointment of medical superintendent of asylums for the insane at the present time might receive the qualification at a very small cost. It would then be for the superintendents to see that their assistant medical officers took the qualification, so that the whole thing might thus be well initiated.

This having been agreed to, the Association proceeded with the appointment of examiners for the ensuing year.

Dr. RAYNER proposed that Dr. Hack Tuke and Dr. Savage should be the examiners for England for the current year.

Dr. URQUHART proposed an alteration in regard to the Scotch examiners for the ensuing year. He was sorry to say that there had been no application for the certificate from Scotland. As far as he could understand, from conversing with assistant medical officers, this was owing partly to the restrictions, and partly to the fee being fixed too high. He should be sorry to see Drs. Howden and Ireland superseded, but he thought that one of their teachers and one of the superintendents who was not a teacher should be appointed on the board of examiners, and he therefore moved that Dr. Clouston and Dr. Rutherford should be appointed for the ensuing year.

It was then resolved that the examiners for 1886-7 should be:—

For England ...	...	Dr. Savage and Dr. Hack Tuke.
For Ireland ...	...	Dr. C. Norman and Dr. Ringrose Atkins.
For Scotland...	...	Dr. Clouston and Dr. Rutherford.

Upon the motion of Dr. CLOUSTON, the amount of the fee for the examination was reduced from five to three guineas.

The PRESIDENT submitted a letter addressed to him by Dr. Campbell, of the Garlands Asylum, enclosing a copy of the correspondence with the Commissioners in Lunacy and a proposed draft clause to be inserted in any future Lunacy Amendment Act, with the object of insuring the due removal from lunatic patients, previous to admission, of articles likely to cause injury to themselves or others.

The foregoing communication was referred to the Parliamentary Committee.

AFTERNOON MEETING.

The PRESIDENT read his address, which will be found at p. 313 of this Journal.

Dr. CLOUSTON said he was sure all present would cordially agree with him in a very hearty vote of thanks to the President for his address. He had heard a great many addresses from that chair, but he had never heard an address more carefully prepared or more honestly and fairly stated, nor one more calculated to be suggestive to their minds and helpful to them in their daily work as physicians to the insane. In some respects the address had produced what was perhaps the best effect—not agreement, but mental criticism; that was, it had suggested to them other facts and other views of the subject than those laid down in the address. In regard, for instance, to the President's deprecation of the attempts to classify insanity into various groups, they could not fail to notice that Dr. Savage, after having condemned these attempts, turned round and classified several groups of insanity in the most careful way. After

reproving sin, he himself became the sinner. However, at present they had got to observe facts and reason on them, and they could not take a better example than their President had set them. Dr. Savage had honestly looked at the productions of others, and had endeavoured to get a new light from what he had seen, and that was the right thing to do. The greatest compliment they could pay Dr. Savage was to imitate his state of mind and to do as he had done, looking carefully into the state of disease and striving to make the very best classifications they could. One of their great difficulties was that they were not dealing with an organ regulated from elsewhere, but with an organ regulating itself, being its own vaso-motor centre, and representing and controlling the functions of every organ of the body. He was not quite sure that he should divide the different classifications as Dr. Savage had done. As regards the functional cases and cases depending upon worry, &c., he was not certain that the division was real. The fact was that in the functional cases they simply could not lay their hands upon the particular kind of disturbance present, but in the other cases they could lay their hands upon it. In regard to what Dr. Savage termed functional cases, the question occurred to him whether he could have cured them if he had commenced on the day of admission, before the medical treatment had taken place, or whether, after all, reason did not cure the cases mentioned by Dr. Savage when the disease had expended itself. In conclusion, he felt sure they would join with him in according to Dr. Savage a very hearty vote of thanks for his address.

Dr. C. NORMAN seconded the vote of thanks, saying that Dr. Savage's excellent and well-reasoned address would be better criticized by the members when it appeared in print.

The motion was then put to the meeting by Dr. RAYNER, and carried with applause.

The PRESIDENT thanked the Association for the vote of thanks. He said that he had constantly in his mind a saying of Dr. Gull, that "definition was of the devil." Perhaps he had been somewhat biassed in that way, but it was so easy to acquire fixed notions. As a student he remembered how this was brought about, even by the simple fact that one of their old teachers use to treat pneumonia with "acetate of ammonia, one ounce." The students had got the name of a certain disease, the name of a doctor, and the designation of a remedy, and the result was this fixed association of ideas. Instead of being too ready to crystallize, he felt that they should keep themselves, so to speak, in as saturated a solution as possible.

Dr. HACK TUKE said they were all agreed that the spider's web which the President had woven for them would have the effect of destroying a good many mischievous and irritating flies coming within Dr. Savage's description of "the cramping influence of forms," which influence was, no doubt, very injurious in their department of medical science, as indeed it was in all others. The address should be taken as a whole, otherwise its author would be unfairly judged. If isolated parts were taken, they might be rather disheartening to a student of insanity, and might infuse into his mind a kind of psychological agnosticism which would damp his ardour, whereas, if he took the whole of the address, he would balance what might a little discourage him with the wide field of inquiry Dr. Savage opened up to them. Of the three divisions referred to, the third was the most interesting to him, and, as he thought, the most important, viz., that division in which Dr. Savage spoke specially of functional disorders, and in which he had given his sanction to the use of the term "functional" in the sense in which he had described it. He thought the idea conveyed in the popular term "mental de-rangement" very aptly expressed it. That was to say, just as in delirium it was the plough going in the wrong direction—out of the straight line—so in this third division it was a derangement of the various factors—mental conditions—instead of what they understood as an organic or structural disease. He thought it most important to bear this in mind both in regard to treatment and prognosis. Some twenty

years ago he contributed an article, "Artificial Insanity in Relation to Mental Pathology," in which he endeavoured to show that, under certain hypnotic conditions, all the delusions and hallucinations with which they were familiar in the insane could be produced and dissipated at will, and he had urged the important bearing of these facts upon functional mental disorders. All that Dr. Savage had advanced went to prove that some morbid mental disorders might be removed by what he had spoken of as reason or some other moral influence. This seemed very surprising, but the surprise would be lessened if the hypnotic facts he had mentioned were realized. He thought the effect of the admirable address they had listened to would be very largely useful in this direction. Again, the remark which Dr. Savage made in regard to various mental expressions being associated with precisely the same condition of brain was put very clearly and instructively. The whole of the address, philosophical as it was, and broad in all its directions, would have a most wholesome influence upon the views held in regard to the pathology of insanity.

The PRESIDENT referred to a paper* in the hands of Dr. Courtenay inviting contributions from members of the Association to a fund which it was proposed to raise for the benefit of the widow and family of the late Dr. Eames under the circumstances therein explained, and said that he believed it would meet with the approval of the members if the sum of ten guineas were voted thereto from the funds of the Association.

Dr. PAUL, as treasurer, seconded this proposal, remarking that he was glad that their funds would permit of it, and that it would also show the very kindly feeling which they entertained towards their Irish friends.

The proposition was unanimously agreed to, and the proceedings terminated.

FIFTY-FOURTH ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION,

Held at Brighton August 10th-13th, 1886.†

The following brief summary of the Section on Psychology is from the report in the "British Medical Journal," Aug. 28. Notes of the discussions are in the hands of the Editor of that Journal, and will appear in its pages. For permission to publish the papers read at Brighton we are indebted to Mr. Hart's usual courtesy.

President: T. S. Clouston, M.D. *Vice-Presidents:* C. A. Lockhart Robertson, M.D.; J. R. Gasquet, M.B. *Secretaries:* C. S. W. Cobbold, M.D.; J. M. Moody, M.R.C.S.

Wednesday, August 11th.

The PRESIDENT delivered an address, which was published at page 319 of the Journal for August 14th.

Dr. A. CAMPBELL CLARK read a paper on Experimental Dietetics in Lunacy Practice: a Record of Investigations and Results. The paper was illustrated by printed tables. A discussion followed, in which the President, Dr. J. A. Campbell, Dr. G. H. Savage, Dr. Needham, Dr. Deas, and Dr. Chapman took part; and Dr. Campbell Clark replied.

Dr. G. E. SHUTTLEWORTH read a paper on the Relation of Marriages of Consanguinity to Mental Unsoundness, on which remarks were made by Dr. Ball (Paris), Dr. Langdon Down, Dr. Fletcher Beach, and Dr. Hack Tuke.

* Obituary of Dr. Eames. † See Occasional Notes of the Quarter.

Thursday, August 12th.

Dr. C. E. BEEVOR gave a demonstration of Weigert's Hæmatoxylon Method of Staining the Central Nervous Tissues. Dr. Savage and Dr. Hughlings Jackson spoke on the subject; and Dr. Beevor replied.

A discussion on the question, How may the Medical Spirit be best kept up in Asylums for the Insane? was opened by the PRESIDENT (Dr. Clouston), who was followed by Dr. Savage, Dr. Ball (Paris), Dr. J. A. Campbell, Dr. Hack Tuke, Dr. Urquhart, Dr. Outterson Wood, Dr. Needham, Dr. Campbell Clark, Dr. Lyle, Dr. Whitcombe, Dr. Aldridge, and Dr. Deas.

A paper on the subject of the discussion, by Dr. S. A. K. STRAHAN, was read in the absence of the author by the Secretary.

Dr. D. G. THOMSON read a paper on the Separate Care and Medical Treatment of Recent Cases of Insanity, either in existing Asylums or in Lunatic Hospitals to be Established for that Special Purpose. Dr. Cobbold made some remarks.

Dr. HACK TUKE read a paper on the Alleged Increase of Insanity, the discussion on which was adjourned.

Friday, August 13th.

Dr. TUKE'S paper on the Alleged Increase of Insanity was discussed by the President, Dr. Cobbold, Dr. Outterson Wood, Dr. Fletcher Beach, and Dr. J. A. Campbell; and Dr. Tuke replied.

Dr. COBBOLD read a paper on Suicidal Tendencies in Congenital Imbeciles, which was discussed by the President, Dr. Shuttleworth, Dr. Fletcher Beach, and Dr. Hack Tuke; after which Dr. Cobbold replied.

Dr. PALMER drew attention to Certain Pathological Changes in the Brain of General Paralytics, and exhibited drawings and microscopic preparations.

Dr. FLETCHER BEACH read a paper on the Influence of Hereditary Predisposition in the Production of Imbecility. Remarks were made by Dr. Hack Tuke, Dr. Shuttleworth, and the President; and Dr. Beach replied.

Dr. COBBOLD directed attention to the recently passed Idiots Act, 1886.

Dr, J. A. CAMPBELL read a paper on the Use and Abuse of Seclusion, on which remarks were made by the President, Dr. Outterson Wood, Mr. Whitcombe, Dr. Hack Tuke, and Dr. Deas.

A vote of thanks to the President, proposed by Dr. GASQUET, and seconded by Mr. WHITCOMBE, was carried by acclamation. A hearty vote of thanks was given to the Secretaries also.

The work in the *Section of Psychology* was carried on with exceptional spirit, a lively interest being taken in the papers and discussions throughout the three days. The proceedings opened on Wednesday with the address of the President, Dr. T. S. Clouston, on the Relation of Bodily and Psychical Pain. This address, which was printed at page 319 of the Journal for August 14th, was thoroughly appreciated by the distinguished members of the specialty who were present; a hearty vote of thanks to the orator being proposed by Dr. Hack Tuke, and carried by acclamation. Dr. Savage's paper on alternations of Neuroses excited much interest, the discussion which followed being maintained by Professor Ball (of Paris), Dr. Hughlings Jackson, Dr. Hack Tuke, Dr. Clouston, and others. A paper of interest to the general public, as well as to the profession, was contributed by Dr. Hack Tuke, upon the subject of the Alleged Increase of Insanity. The author presented a series of elaborate tables and calculations, which confirmed the view that the increase in the number of registered lunatics is due to greater longevity and accumulation, but not to any increase in the proportion of new cases to the population. This paper was also the subject of very general and interesting debate.

One of the most prominent features of the proceedings was the discussion on the question, How may the Medical Spirit best be maintained in Asylums for

the Insane? Thursday afternoon was specially set apart for this. The President opened the subject in a speech of great power, illustrating his views by plans of admission and infirmary wards for lunatic asylums. A very large number of members took part in the debate, and papers on the same subject were contributed by Dr. Strahan and Dr. Thomson. Special attention was directed to (1) the separate treatment of recent and curable cases, (2) the training of asylum-attendants, (3) the necessity for an increase in the number of asylum medical officers, with an improvement in the position of the second in command; and (4) the classification of patients in asylums. The Secretary of the Section (Dr. Cobbold) pointed out that the medical spirit in asylums is increasing in strength year by year; that the above subjects are all receiving much attention. Curable cases are treated in special wards; attendants are trained by lectures, demonstrations, handbooks, and examinations (with prizes). Assistant medical officers in some few asylums are enabled to marry, and are encouraged to do good medical work; and the patients in most asylums are suitably classified. There was a general agreement amongst the members that, in large asylums, an efficient assistant medical officer should be styled "resident physician," and should have responsible charge of the purely medical work, his pay and position being such as to encourage him to make a career of this special work, remaining free from the cares of administration. The patients would thus have the advantage of constant medical treatment by a physician of experience in mental disease; this being hardly possible at present, owing to the large amount of administrative work which necessarily falls to the lot of medical superintendents. As the strictly medical treatment of insanity depends largely upon the patient's everyday surroundings, occupations, amusement, companionship, diet, &c., it is absolutely necessary that the chief administrative officer in a lunatic asylum should be a qualified medical man. No layman ever supervises the domestic arrangements in the true interests of the patients; he may possess the best intentions, but he has not the necessary knowledge.

The medical superintendents of the great idiot asylums took a prominent part in the proceedings, each of them reading a paper of interest. Dr. Cobbold also directed attention to the provisions of the Idiots Act, 1886, which has recently become law.

It is not possible within the limits of this notice even to mention the titles of all the interesting papers which were read and fully discussed, but they certainly afforded conclusive evidence that the true medical spirit is largely abroad among our asylum medical officers. Great interest was evinced in some most beautiful microscopic preparations of brain-tissue which were exhibited and described by Dr. Palmer, of Lincoln, and Dr. Beevor, of London; indeed, the members of the Section were to be seen studying these long after the regulation hour for the cessation of business, so much so as to call forth the remark from a well-known member of the profession, that the "Lunatic Section" was the most industrious of any. The proceedings were brought to a close on Friday by hearty votes of thanks to the President and the Secretaries for their highly successful conduct of the business of the Section.

EASTERN COUNTIES' ASYLUM FOR IDIOTS.

In the article upon Admission to Idiot Asylums which appeared in our July Number, reference was made to the difficulty of obtaining admission into the Eastern Counties' Asylum. We are asked to state that this difficulty has been greatly diminished since the enlargement of the asylum, as instead of only eight or nine cases being elected as before, twenty cases were chosen at each election last year, and the number has this year been increased to twenty-five. The

election-list always contains a number of inmates whose friends apply for their re-election for an additional term of five years, so that the cases in the asylum are not increased in the same ratio as the number of successful candidates. Admission by election into this asylum is now rendered easy of accomplishment.

DR. IRELAND'S BOOK, "The Blot upon the Brain," is to be translated into German. The French translation of this work, which is being prepared by Dr. Edgar Bérillon, of Paris, is nearly finished, and will be published in November. The "Blot" has been prohibited by the ever-vigilant Russian censorship. This is no doubt owing to the chapter on the hereditary insanity of the Romanoffs, and the historical illustrations about the miseries which insane monarchs have caused to their subjects. We hope Dr. Ireland's article in the present Number on the late King of Bavaria will not share a like fate in that country.

Obituary.

JAMES ALEXANDER EAMES, M.D.

We believe that the decease of Dr. Eames, at the age of 53, is the first instance of a President of the Medico-Psychological Association dying during his term of office. Those who attended the forty-fourth annual meeting held at Cork last year under his presidency had no reason to foresee that at the next anniversary his seat would be empty. Last autumn he visited Belgium, and was present at the Antwerp Congress of Mental Medicine; he joined the excursion to Gheel, in which he took a lively interest, and returned home in usual health and full of spirits. Nothing, so far as we are aware, occurred to injure his health until June last, when he was attacked with a carbuncle on the neck, which did not for some time excite alarm, but was followed in the course of a few weeks by great prostration, and finally by death on Saturday, the 17th of July. His medical attendants, Drs. Hobart, Townsend, and Deputy-Inspector-General Eames, appear to have taken an encouraging view of the case till nearly the last. In his death a genial warm-hearted physician and a sincere friend passed away. His *bonhomie* and ready speech, his laugh and good-natured expression, will be sorely missed in the family circle and the institution over which he ruled, loved by his colleagues and trusted by his committee. It was after holding the post of assistant-surgeon in the Crimean War, in which position he obtained several marks of distinction, that he studied mental disorders, and was appointed Medical Superintendent of the Lettarkenny Lunatic Asylum. Thirteen years ago the then superintendent of the Cork Asylum (Dr. Power) died, and Dr. Eames, after having been eight years at the above-mentioned institution, was appointed his successor. It is said that this appointment was due in good measure to the influence of the Duke of Cambridge, who, when wounded in the Crimea, received surgical attention from Dr. Eames. That his management of the Cork Asylum was successful, and indicated the fertile resources of the superintendent, will be allowed by those members of our Association who were present at the meeting and had an opportunity of going over the institution.

Dr. Eames contributed several papers to the medical journals of general interest. He was always ready to introduce new remedies and appliances into the asylum, and never despised them, however homely and simple they might be.

We regret to find that Dr. Eames has not accumulated wealth, and that his wife and family are left unprovided for. Under these circumstances an

"Eames Fund" has been started, and we would enlist the sympathies of our readers on behalf of the subjoined appeal:—

THE LATE DR. EAMES.

SIR,—It having come to the knowledge of some of the friends of the late Dr. Eames, Resident Medical Superintendent of the Cork District Lunatic Asylum, that his family, owing to his premature and unexpected death, is left in a very unprovided-for position, it was resolved, at a meeting held at the Mayor's Office, Cork, on the 22nd inst., the Mayor in the chair—

"That this fact should be brought under the notice of Dr. Eames' many friends in Cork and elsewhere, in the hope that a testimonial of a substantial character may be subscribed for, in order to give such assistance as would help towards completing the education of the younger members of the family, and for other purposes."

To carry out this laudable object, a committee was appointed, to whom subscriptions may be sent, as also to the different Banks in Cork.

Earnestly soliciting your co-operation,

Signed on behalf of the Committee,

J. H. CRONIN,
J. G. CURTIS, M.D., } Hon. Secs.

Mayor's Office, Cork,
27th July, 1886.

JOSEPH LALOR, M.D.

It is our painful task to record in our obituary the death of another Irish member of our Association, the late Medical Superintendent of the Richmond Asylum, Dublin, the excellent and kind-hearted Dr. Joseph Lalor. He may be said to have died in harness, having been engaged till within a few weeks of his death in the duties which occupied his time and thought for so many years. Formerly Resident Physician at the Kilkenny Asylum, he was appointed in 1857 to the Dublin Asylum, which is the public institution for poor lunatics in the counties of Dublin, Wicklow, and Louth, the town of Drogheda as well as the city of Dublin.

It is stated on good authority* that at that period, refractory patients were confined in cells for most of the day as well as the night, receiving their food in such a way as best suited the convenience of the attendants. Open-air exercise was rarely permitted, and then only in the dark confined yards or sheds surrounded by stone walls. All this was changed by Dr. Lalor; better grounds were prepared, games were introduced, and the general comfort of the patients was attended to. Dr. Lalor, as is well known, enthusiastically carried out the school system at the Richmond Asylum, and it was an unceasing source of regret to him that so few superintendents would take the necessary trouble to secure its success.

It should be stated that for two years before he became Superintendent a school had been in operation on the female side under an excellent schoolmistress. It was Dr. Lalor who introduced the same system for the male patients, and he obtained additional teachers, trained under the National Board, for the female school. Singing and music were much cultivated, while object and picture lessons were given, as well as others in natural history and geography. At the Exhibition held some years ago in Dublin, drawings, paintings, and industrial work, all executed by the patients, attracted considerable attention. Along with the schools, concerts were given every fortnight, or even weekly, which, common as they now are, were rare when Dr. Lalor organized

* See the "Irish Times," August 5, 1886, to which we are indebted for some of the particulars which follow.

them. The furnishing of the rooms and corridors was vastly improved, although, probably, many English asylums appear to better advantage than the Richmond at its best. But Irish asylums must be judged in this particular by the homes of the class of Irish from which the patients come, and there can be no question that the furniture of the Dublin Asylum was superior to that in the homes of the pauper patients there resident.

On other points than those to which we have referred, such as that of the almost complete abolition of single bedrooms and airing-courts, and the bringing of patients together at dinner, Dr. Lalor entertained strong opinions, and introduced important changes into the asylum. In the last report of the Sligo Asylum, Dr. Petit, formerly Assistant Superintendent of the Dublin Asylum, bears testimony to what he learnt under his old and greatly beloved friend, and to the successful adoption of Dr. Lalor's practice in regard to single rooms and airing-courts (see Retrospect of Asylums in this number of the Journal).

It may, in short, be said that Dr. Lalor's administration was a great success, and no one could visit the institution and the Superintendent without being struck with the general comfort of the patients, and the very small number—if, indeed, there were any—that were lounging about or squatting on the ground dirty and unoccupied; while the man himself could not fail to impress the visitor with his wonderful good nature, fund of spirits and humour, and the complete devotion of his mind to the interests of the patients. During his long period of office he retained the confidence of the Board, the affection of the staff, and, indeed, of all with whom he came in contact.

Although his work drew naturally to a close at his advanced period of life, his loss will be deplored, and it could have been wished that he might have enjoyed a period of well-earned repose in his retirement from the active duties of asylum life ere the fatal scissors cut the thread of the genial doctor's life in two. He retired to Sligo, where, after a short illness, he expired. He had suffered from weakness of the heart for some years past. He became ill in the early part of the night of the 16th of August, having gone to bed as usual, but woke up at half-past ten complaining of spasms of the heart. Three members of the profession were called in, but they saw at once that his case was beyond the reach of medical skill. He passed away at half-past eight on the following day, August 17, 1886.

The Asylum is fortunate in securing, as the successor of the lamented Dr. Lalor, a man of experience and proved ability, Dr. Conolly Norman, who will doubtless preserve all that was good under the late *régime*, and may be able to introduce more clinical teaching, and that special scientific work which is expected from younger men.

M. LEGRAND DU SAULLE, M.D.

This distinguished physician died at Paris, May 6, 1886, aged 56. Born at Dijon, he was formerly *interne* at the asylum there, and subsequently at Rouen and Charenton. After going to Paris he was Trousseau's collaborateur in the "Gazette des Hôpitaux," to which he contributed many papers. He became physician to the Bicêtre in 1867, and afterwards was appointed to the Salpêtrière. He was the author of many works, among which were:—*La Folie devant les tribunaux*, 1884; *Le Délire des persécutions*, 1873; *La Folie héréditaire*, 1873; *La Folie du doute*, 1875; *Études Médico-légales sur les épileptiques*, 1877; *Étude Clinique sur la peur des espaces (agoraphobie)*, 1878; *Signes physiques des folies raisonnantes*, 1878; *Étude médico-légale sur les testaments; Contestes pour cause de folie*, 1879; *Étude médico-légale sur l'interdiction des aliénés et sur le conseil judiciaire*, 1881; *Les Hystériques*, 1883; *Traité de médicine légale*, 1881.

Dr. Legrand du Saulle was physician-in-chief at the Special Infirmary connected with the Dépôt of the Prefecture of Police, where he enjoyed a large field of observation. During the Congress of Mental Medicine in Paris, in 1878, a number of those who attended accompanied him to the Infirmary, and Dr. Legrand du Saulle explained to them the course pursued in Paris, which was in striking contrast with the slip-shod methods practised in London at that time.

The deceased alienist was at one time President of the Société Médico-Psychologique, of Paris.

M. BILLOD, M.D.

Dr. Billod was formerly Medical Superintendent of the Vaucluse Asylum, a large institution near Paris. He was the author of important memoirs, most of which were collected together several years ago and published in two volumes. His Treatise on Pellagra should be consulted by those studying the subject. His death took place Feb. 26, 1886, at the age of 67.

Appointments.

AIRD, C., M.B.Aberd., appointed Medical Officer to the East Riding Lunatic Asylum, *vice* G. T. Broatch, M.B.Ed., resigned.

Dr. T. R. BURKE, late Deputy Inspector-General of Hospitals and Fleets, appointed Assistant Medical Officer, Central Criminal Lunatic Asylum, Dundrum, co. Dublin, *vice* Mr. Taylor.

JAMES J. DWYER, L.K.Q.C.P. and L.R.C.S.I., late of the Mullingar Asylum, appointed Medical Superintendent of the District Asylum, Cork, *vice* Dr. Eames, deceased.

LAW, J. S., M.D.Ed., appointed Resident Clinical Assistant in the North Riding of Yorkshire Lunatic Asylum, Clifton, Yorks.

LICHFIELD, J. W., L.R.C.P.Lond., appointed Resident Clinical Assistant to the Birmingham Borough Asylum, *vice* J. S. Law, resigned.

Dr. CONOLLY NORMAN, appointed Medical Superintendent of the Richmond Asylum, Dublin, *vice* Dr. Lalor, resigned.

RIGDEN, ALAN, L.R.C.P., M.R.C.S.Lond., appointed Junior Assistant Medical Officer to the Salop and Montgomery Asylum, Shrewsbury, *vice* P. M. Earle, L.R.C.P., L.R.C.S.Ed., resigned.

EDWARD TAYLOR, L.K.Q.C.P. and L.R.C.S.I., appointed Medical Superintendent of the District Asylum, Monaghan, *vice* Dr. C. Norman.

WHITE, F. S., M.R.C.S.Eng., L.S A., appointed Junior Assistant Medical Officer to the Barnwood House Hospital for the Insane, *vice* R. D. Ball, M.R.C.S.Eng., deceased.

MEDICAL HONOURS.—Dr. Bateman, of Norwich, has been elected Foreign Corresponding Member of the Académie de Médecine, mainly in recognition of his researches on Aphasia. Dr. Bateman's work, a second edition of which is in preparation, was favourably introduced to the notice of the Académie by Broca, and to that of the Institute of France by Baron Larrey.

CONTENTS OF No. 137.—APRIL, 1886.

PART I.—ORIGINAL ARTICLES.

PART II.—REVIEWS.

PART III.—PSYCHOLOGICAL RETROSPECT.

PART IV.—NOTES AND NEWS.

CONTENTS OF No. 138.—JULY, 1886.

PART I.—ORIGINAL ARTICLES.

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JOURNAL OF MENTAL SCIENCE.

OCTOBER, 1886.

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THE JOURNAL

OF

MENTAL SCIENCE

(*Published by Authority of the Medico-Psychological Association*).

EDITED BY

D. HACK TUKE, M.D.,

GEO. H. SAVAGE, M.D.

"Nos vero intellectum longius a rebus non abstrahimus quam ut rerum imagines et radii (ut in sensu fit) coire possint."

FRANCIS BACON, *Proleg. Instaurat. Mag.*

JANUARY, 1887.

LONDON:

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NEW BURLINGTON STREET.

MDCCCLXXXVII.

H. WOLFF, LEWES.]

To be continued Quarterly.

CONTENTS OF No. 136.—JANUARY, 1886.

PART I.—ORIGINAL ARTICLES.

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Vol. XXXII., No. 140. (New Series, No. 104.)

THE JOURNAL OF MENTAL SCIENCE, JANUARY, 1887.

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PART I.—ORIGINAL ARTICLES.

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The Journal of Mental Science.

Original Papers, Correspondence, &c., to be sent direct to Dr. HACK TUKE, Lyndon Lodge, Hanwell, W. (Town address, 63, Welbeck Street, W.)

English books for review, pamphlets, exchange journals, &c., to be sent by book-post to the care of the publishers of the Journal, Messrs. J. and A. Churchill, New Burlington Street.

Authors of Original Papers (including "Cases") receive 25 *reprints of their articles.* Should they wish for additional Reprints they can have them on application to the Printer of the Journal, H. Wolff, Lewes, at a fixed charge.

The copies of *The Journal of Mental Science* are regularly sent *by Book-post* (*prepaid*) to the Ordinary and Honorary Members of the Association, and the Editors will be glad to be informed of any irregularity in their receipt or overcharge in the Postage.

The following are the *EXCHANGE JOURNALS*:—

Zeitschrift für Psychiatrie; Archiv für Psychiatrie und Nervenkrankheiten; Centralblatt für Nervenheilkunde, Psychiatrie, und gerichtliche Psychopathologie; Der Irrenfreund; Neurologisches Centralblatt; Revue des Sciences Médicales en France et à l'Étranger; Annales Médico-Psychologiques; Archives de Neurologie; Le Progrès Médical; Revue Philosophique de la France et de l'Étranger, dirigée par Th. Ribot; Revue Scientifique de la France et de l'Étranger; L'Encéphale; Annales et Bulletin de la Société de Médecine de Gand; Bulletin de la Société de Médecine Mentale de Belgique; Russian Archives of Psychiatry and Neurology; Archivio Italiano per le Malattie Nervose e per le Alienazioni Mentali; Archivio di psichiatria, scienze penali ed antropologia criminale: Direttori, Lombroso et Garofalo; Rivista Clinica di Bologna, diretta dal Professore Luigi Concato e redatta dal Dottore Ercole Galvani; Rivista Sperimentale di Freniatria e di Medicina Legale, diretta dal Dr. A. Tamburini; Archives Ital. de Biologie; Psychiatrische Bladen; The American Journal of Insanity; The Journal of Nervous and Mental Disease; The Quarterly Journal of Inebriety, Hartford, Conn.; The Alienist and Neurologist, St. Louis, Misso.; Medico-Legal Journal; The American Journal of the Medical Sciences; The Dublin Journal of Medical Science; The Edinburgh Medical Journal; The Lancet; The Practitioner; The Journal of Physiology; The Journal of the Anthropological Society; The British Medical Journal; The London Medical Record; The Asclepiad; Reports of the Psychical Research Society; Brain; Mind; The Canada Medical and Surgical Journal; Polybiblion; The Index Medicus; Revista Argentina; Revue de l'Hypnotisme; Bulletins de la Société de Psychologie Physiologique; Science (New York).

THE JOURNAL OF MENTAL SCIENCE.

[*Published by Authority of the Medico-Psychological Association*]

No. 140. NEW SERIES, No. 104. JANUARY, 1887. VOL. XXXII.

PART 1.—ORIGINAL ARTICLES.

Illustrations of normal and defective development of the multipolar cells of the cerebral cortex; of their degeneration in senile insanity, and of certain albuminous or protoplasmic exudations commonly found in the neighbourhood of the junction of the white and grey matter of the convolutions in cases of general paralysis and ordinary mania, in which the symptoms have been more or less acute. (With plates.)

By EDWARD PALMER, M.D., Medical Superintendent, County Asylum, Lincoln.

Mode of Preparation.

The brain-tissue from which the sections used for these illustrations were made was hardened by Hamilton's process, which, when carefully carried out, secures firmness of substance without brittleness, and a minimum amount of shrinking.

The following solutions were employed:—

1.—A mixture of three parts of Müller's fluid (bichromate of potash, 25 grammes; sulphate of soda, 10 grammes; water, 1,000 cub. cent.) and one part of methylated spirit.

2, 3, and 4.—Aqueous solutions of bichromate of ammonia, containing respectively ¼ per cent., 1 per cent., and 2 per cent. of the salt.

The tissue to be hardened is to be cut into blocks not exceeding five-eighths of an inch in any of their dimensions; and in the case of brain-structure the membranes should not be removed, as they in no way interfere with the hardening process, and subsequently tend to preserve the integrity of the sections. Three or four of these segments are to be placed to rest on cotton-wool (previously moistened with spirit to prevent it from floating) in a wide-mouthed bottle, or other convenient vessel, containing about ten ounces of solution 1, and set aside in a cool place for three weeks, at the end of which time they

should feel tough, and bear handling well. If otherwise, they must remain in the solution until they get into this condition. They may then be trimmed; and are next to be transferred successively into solutions 2, 3, and 4, and left for one week in each of them to complete the hardening. It is very desirable in the first instance that the tissues should be as fresh as circumstances will permit, for if they are softened, even in a small degree, through decomposition, not only is the hardening retarded, but their structural character is altered. For the same reason it is also important that the vessel, with the contained segments, be kept quite cool throughout the process, and to effect this, especially during the summer months, Hamilton strongly and wisely recommends the use of an ice-safe.

The bulk of the chromic salts should be removed from the tissues by soaking them for a few hours in spirit before proceeding to imbed them; and for this purpose cacao-butter is exceedingly well adapted, as it has a low melting point and sets firmly, with but little contraction. It will be found more cleanly, and in many other ways advantageous, to use a special mould for imbedding, instead of pouring the melted material into the well of the microtome. This may be easily made by pasting together several layers of writing-paper, of suitable width, round a smooth cylinder of boxwood of the same diameter as the well, or a trifle in excess of it to allow for a slight shrinking of the mass as it cools. The wood, sliding within the case, serves to form the bottom of a mould of any required depth, and is useful as a ready means of pushing out the block when it has become hard and firm. It is convenient to have half-a-dozen of these moulds at hand, so as to be enabled to imbed that number of segments with one melting of the cacao-butter, which when used should be only just warm enough to flow without congealing. The tissue, fixed on the end of a needle, is to be held in the position desired for making the section until consolidation has fairly set in. When this is completed, the needle is withdrawn, and the block removed from the mould, and kept in spirit until wanted, when it should be fitted closely, but not tightly into the well of the microtome. It is, perhaps, hardly necessary to add that the needle should not be inserted into any part of the segment required for the sections.

The condition of the imbedded tissue is now generally so suitable for cutting thin sections that films from $\frac{1}{1000}$th to $\frac{1}{2000}$th of an inch in thickness are readily obtainable with an ordinary

microtome, provided that the table of the instrument is quite level and smooth, and that the section-knife is ground moderately hollow, and has its back and edge in the same plane, so as to secure absolute freedom from tilting as it passes through the tissue. Before making each section, the knife must be cleansed from smears of the imbedding material, and sufficiently flooded with spirit to enable the film to float smoothly on to the blade.

The sections are severally floated off from the knife by agitating it in a vessel containing one part spirits of wine and two parts distilled water, and are subsequently soaked and rinsed in similarly dilute spirit until every trace of the chromic salts is removed. They are then ready for trimming and staining. This diluted spirit should be employed in all the washings, and as the solvent in all the staining fluids, as it facilitates the penetration and proper distribution of the colouring matters, and gives an amount of distinctness and transparency to the slide that is rarely attainable with simply aqueous solutions and washes.

The staining solutions are very stable, and, irrespective of their age, have been found to give uniform results with sections of like character, while, by varying their strength, or the time during which the sections are immersed in them, they produce equally good results with the soft tissues generally.

The following stock-solutions should be kept:—

1. *Hæmatoxylin solution.*—A slight modification of Kleinenberg's formula.

   a. Prepare a saturated solution of crystallized calcic chloride and alum in 70 per cent. alcohol (or spirits of wine, s.g. 838, six parts, and distilled water, one part).

   b. Prepare a saturated solution of alum in alcohol of the same strength.

   c. Dissolve $6\frac{3}{4}$ grains of hæmatoxylin in two drachms of absolute alcohol.

Mix solution "*c*" with one drachm of solution "*a*" and one ounce of solution "*b*," then add seven drachms of spirits of wine, and $4\frac{1}{2}$ ounces of distilled water, and filter. This solution contains about $\frac{1}{3}$th per cent. of hæmatoxylin.

2.—*Carmine solution.*

Take of carmine, 4 parts.
Strong solution of ammonia, 4 parts.
Distilled water, 96 parts.

Dissolve the carmine in the solution of ammonia, add the water, and drive off the excess of ammonia by the aid of a water-bath. When cold, filter, and add, drop by drop, glacial acetic acid at intervals of a few hours, until delicately reddened litmus paper is just rendered blue by the vapour over the fluid after five minutes' exposure to it.

For use, take one part of this solution, and add to it $4\frac{1}{3}$ parts of distilled water, and $2\frac{2}{3}$ parts of spirits of wine; then filter, and test as before for alkalinity. This solution contains about $\frac{1}{2}$ per cent. of carmine.

3.—*Eosin solution.*

Dissolve one grain of eosin in two ounces of the dilute spirit. One part of this mixed with fourteen parts of the dilute spirit forms the staining solution.

All the solutions should be filtered immediately before use.

The sections are best stained separately in watch-glasses (covered to keep out dust and lessen evaporation), and they should be washed in the diluted spirit before being passed from one colouring solution to another. They require from 35 to 45 minutes in the hæmatoxylin, about 15 minutes in the carmine, and from half a minute to one minute in the eosin solution.

Should the tissue on its removal from the hæmatoxylin be more fully stained than is thought desirable, the colour may be readily reduced by agitating the section for a short time in the diluted spirit, to which half per cent. of glacial acetic acid has been added. In this case it must be again washed before transfer to the carmine solution.

These processes may either be conducted continuously, or any convenient time may be permitted to elapse between each of them. Allowing the sections to remain for a few hours in the spirit and water after removal from the hæmatoxylin solution is beneficial, as it tends to fix the colour, and prevents any liability to blurring.

When the staining process is finished, the bodies of the cells, the nuclei, blood-vessels, protoplasts, and neuroglia will all be found to have received distinctive shades and tints.

Before mounting, each section requires to be dehydrated by soaking for a few minutes in absolute alcohol. It should then be placed *in situ* on a perfectly clean slip of glass, and, when nearly dry, but still moist on the surface, cleared with a drop or two of cajeput oil, which is to be well drained off as soon as it has permeated the tissue. A small quantity of thin benzole balsam is then to be brought gently in contact with the film,

Fig. 1.

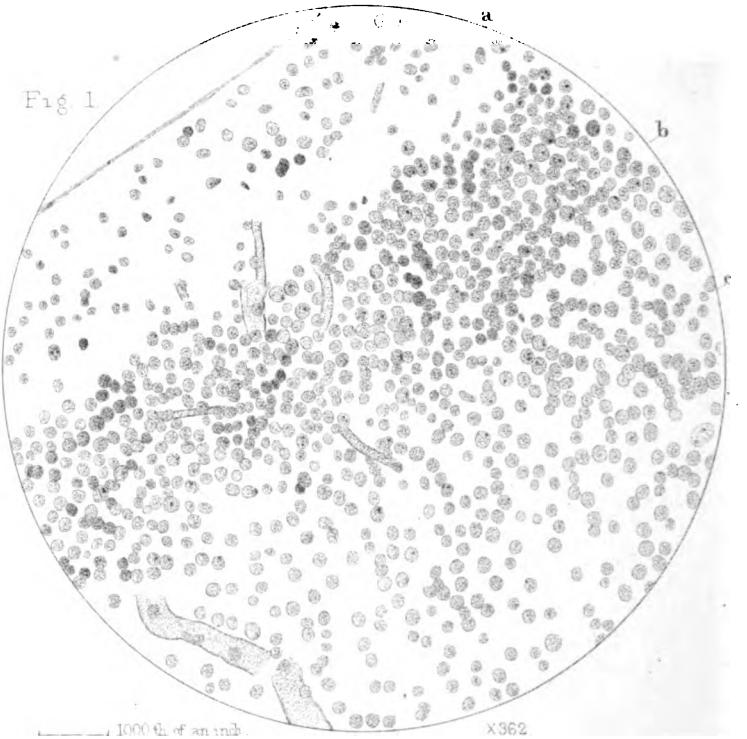


Fig. 2.

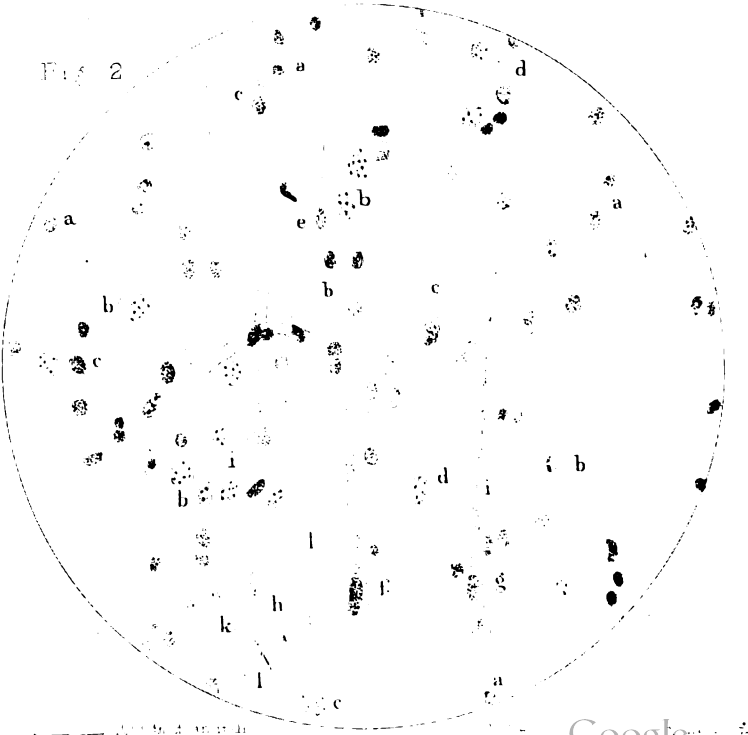


FIG 3

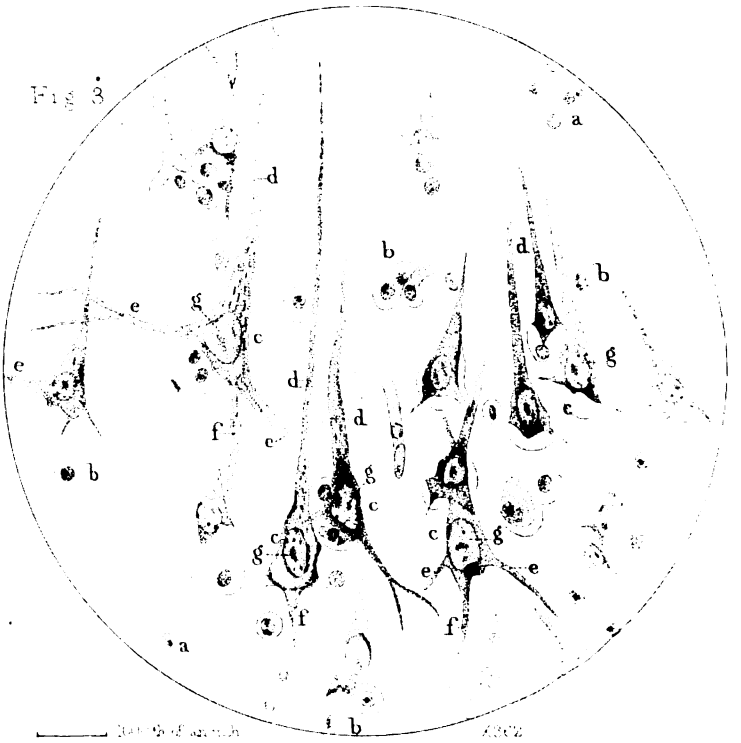
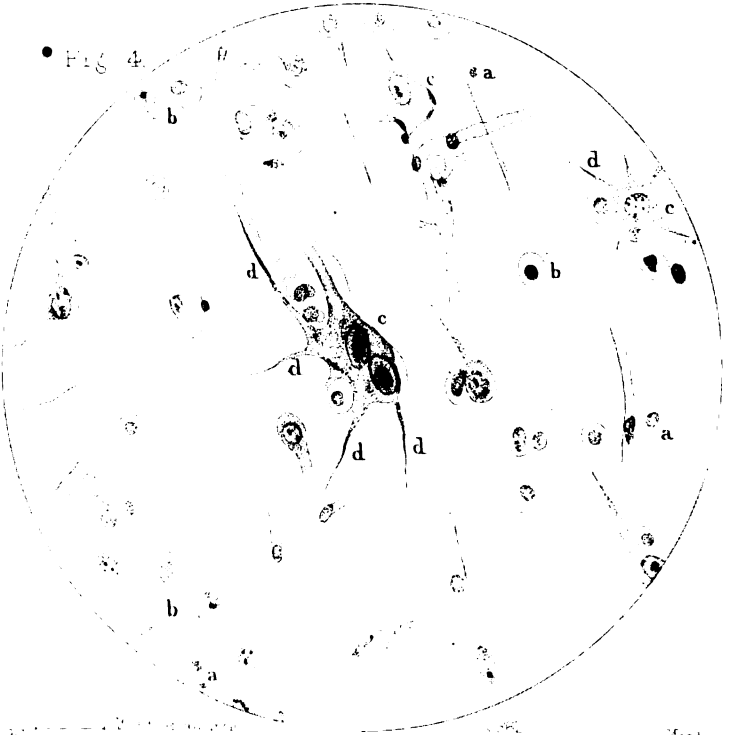


FIG 4



TO ILLUSTRATE DR PALMER'S PAPER

and the covering glass laid on and adjusted, care being taken to avoid undue pressure.

These details might possibly give to the process an appearance of being very long and tedious, but in practice, especially when several sections are being prepared at once, it is very far from being so.

1.—*Fœtal brain.*

Cortex of the left first frontal convolution of a fœtus in the seventh month.

The mother was weakly and anæmic, and had been insane during the whole, or greater part, of the time of gestation; the cell-development is probably, therefore, somewhat less advanced than it would have been under more favourable circumstances, and has not anywhere passed beyond the corpuscular stage. The progressive arrangement into layers is indicated by the varying degrees of aggregation of the corpuscles.

a. Membranes.

b, c. Neurogliar and nerve corpuscles, not as yet differentiated.

2.—*Brain in Infancy.*

Group of multipolar cells from the left ascending frontal convolution of a child, aged 9 months.

a. Neurogliar corpuscles.

b. Nuclei of the nervous tissue proper—many of them, probably, the potential centres of future multipolar cells.

c, d, e, f, g, h. Multipolar cells in progressive stages of development, from "*c*," a nucleus simply surrounded with protoplasm, to "*h*," an active cell provided with its characteristic processes.

i. Receptive process, or prolongation.

k. Medullary process.

l. Intercellular, communicating process.

It is to be observed that neither the medullary nor the intercellular processes make their appearance until the receptive tracts are in a forward state of structural development.

3.—*Healthy adult brain.*

Group of multipolar cells from the third layer of the grey matter in the left ascending frontal convolution of a strong and vigorous man, aged 33, who was employed in a clay-pit,

and almost instantaneously killed by a mass of clay falling on him, and crushing his chest and abdomen.

a. Corpuscles of the neuroglia.

b. Nervous tissue nuclei, with their surrounding lymph-spaces.

c. Multipolar cells, showing their receptive (*d*), intercellular (*e*), and medullary (*f*) processes; their nuclei and nucleoli (*g*).

In the largest cell there is a distinct fibrillation, probably indicating the course of the nerve-currents.

4.—*Healthy adult brain.*

From the same subject as No. 3, and from the same layer of the same convolution, the section having been made nearly transversely, so as to bring into view a greater number of the intercellular communicating processes.

The doubly nucleated cell, which is rarely met with in brain-structure, shows that the multipolar cells do occasionally increase by fission.

a. Neurogliar corpuscles.

b. Nuclei of the nervous tissue proper.

c. Multipolar cells.

d. Intercellular processes.

5.—*Senile dementia.*

Group of multipolar cells from the left superior frontal convolution of a man, aged 81 years.

His mental faculties were almost abolished. He showed only faint traces of memory, evinced no likes or dislikes, and had no comprehension of anything said to him; was occasionally restless and delusional, but never had any acute cerebral symptoms. His mental disorder commenced six years before his death, and advanced without interruption.

a. Corpuscles of the neuroglia.

b. Nuclei of the nerve-tissue.

c. Multipolar cells undergoing molecular degeneration and absorption, their nuclei being as yet only slightly involved, but the processes all more or less decayed, or absent.

d. Arteriole in transverse section.

6.—*Senile dementia.*

Group of multipolar cells from the same subject as No. 5, and from the same convolution, showing further stages of degeneration.

Fig 5

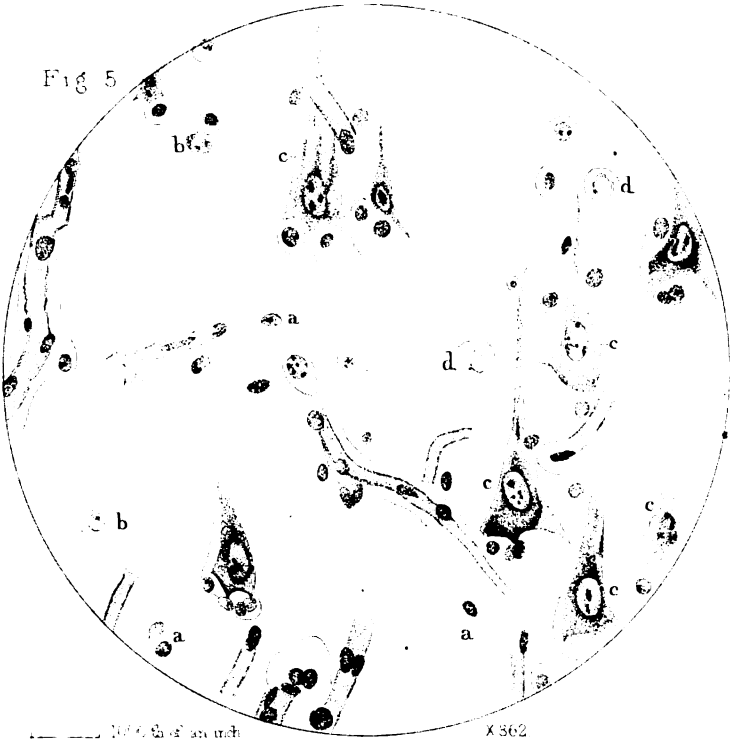


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Fig 6.

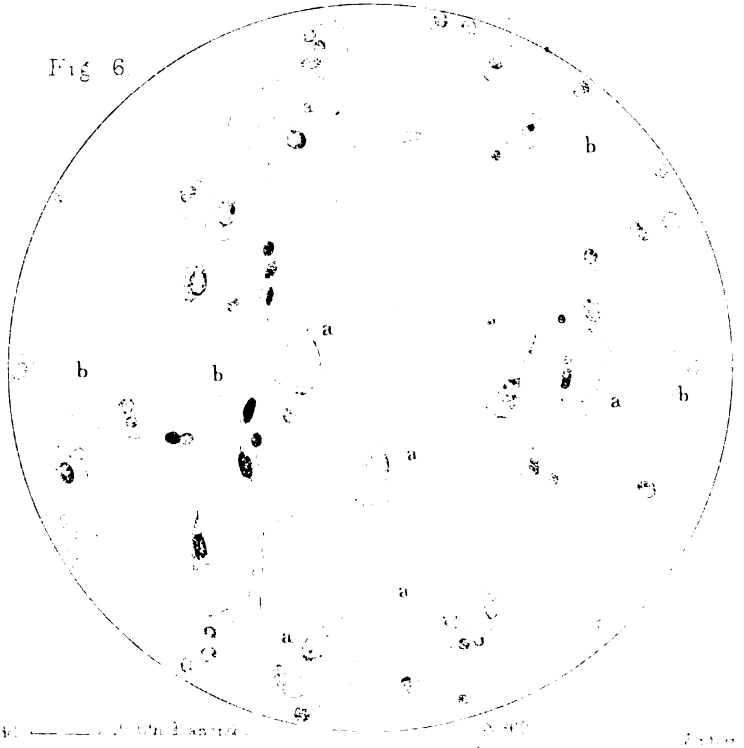

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FIG 7

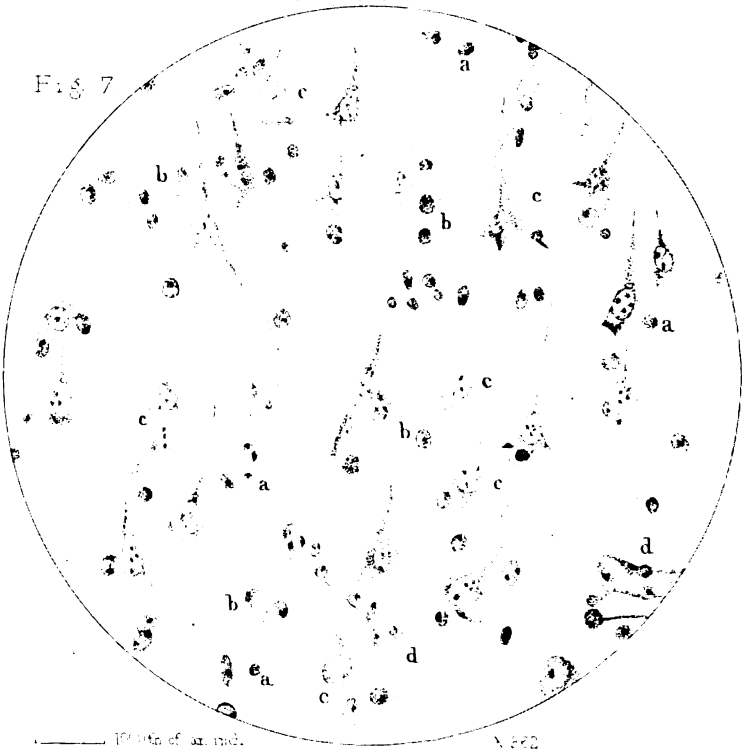
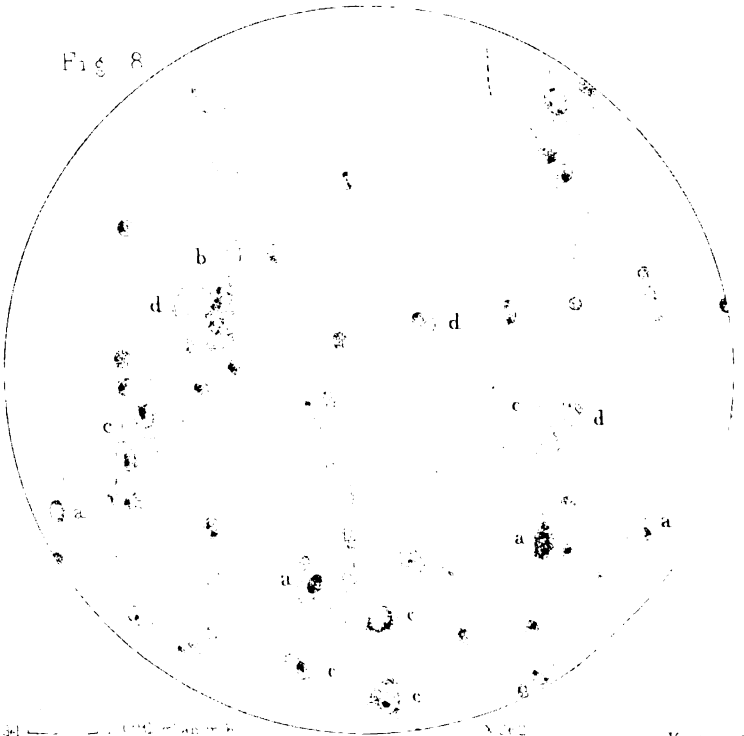


FIG 8



TO ILLUSTRATE DR PALMER'S PAPER

a. In these, the nuclei as well as the bodies of the cells have been reduced by decay and absorption to mere transparent, granular films, with ill-defined outlines, and the processes are nearly all gone.
b. Fragmentary portions of decayed cells.

7.—*Idiocy*.

Multipolar cells from the right superior frontal convolution of a girl, aged 16, who was choreic, and had infrequent attacks of epilepsy in a mild form.

She had no apparent intelligence; manifested only slight temporary attachments; was incapable of speaking, or understanding language; was often noisy, and occasionally morose and spiteful.

The multipolar cells, though not deficient in number, are small and coarsely granular in structure, and their processes are all more or less abortive.

a. Corpuscles of the neuroglia.
b. Nuclei of the nerve-tissue.
c. Multipolar cells.
d. Arteriole.

8.—*Idiocy*.

Abortive and degenerated multipolar cells from the left ascending frontal convolution of a female idiot, aged 30 years.

She manifested neither intelligence nor affections; had never acquired articulate speech; was often noisy, and, during the day, was in constant automatic movement. She had slight epileptic fits at distant intervals. Her habits were extremely degraded.

a. Abortive cells.
b. Large deformed cell, with faintly-marked and degenerated processes.
c. Degenerated cells.
d. Arterioles in transverse section.

(To be continued.)

*Observations with the Sphygmograph on Asylum Patients.** By T. Duncan Greenlees, M.B.Edin., Assistant Medical Officer, The Counties Asylum, Carlisle.

It has been said by some astute critic that "insanity has no pathology," but it would be a nearer approach to scientific truth if he had said that, with our present imperfect means of investigation, there are many cases of insanity in which no pathological changes can be discovered as the cause of the mental phenomena. The microscope, for example, has as yet failed to differentiate the delicate alterations in the protoplasm of the cerebral cells which result in an outburst of maniacal excitement; nevertheless, the ophthalmoscope shows changes in the vascular supply of the brain in many such cases, and, with the aid of the sphygmograph, light has been thrown on many hitherto obscure conditions of the circulation.

In making the following investigations I used Dudgeon's sphygmograph, owing to the ease with which it can be adjusted to the artery of even an extremely excited or restless patient, and, from an extensive experience of its use, I have no reason to doubt the accuracy of the results obtained, the larger and more cumbrous instruments being quite unsuited for such cases. As the tracing in the same individual varies according to the pressure gauge used, I have noted in every case that amount of pressure which is necessary to produce the most characteristic tracing; and, as the condition of the circulation is affected by many extraneous influences, I have endeavoured, by taking several tracings from the same patient at different times and under different circumstances, to obtain as near an approach to the characteristic tracing of the case as possible. By excluding, unless where specially mentioned, cases in which cardiac or other physical diseases exist, I have eliminated many sources of fallacy which might otherwise have interfered with the scientific accuracy of my results.

In a systematic examination of the pulse of the insane, it is necessary that insanity be recognized as a protean condition consisting of several clinical diseases, each, it may be, presenting different pathological lesions. Following this plan, I have taken sphygmographic tracings from patients exhibiting in a marked degree the clinical features of each disease.

1. *Mania.*—In this disease, especially when we consider the

* Read at a meeting of the Medico-Psychological Association held at Carlisle on April 8th, 1886.

more acute forms, the face is usually flushed, the pulse quick, and, according to Griesinger,* full, but at the same time small, and the heart-sounds are generally indistinct. Several observers state that the pulse-tracing in mania bears a strong resemblance to that found in fever or acute disease. In *acute mania* the line of ascent is nearly always perpendicular, the apex sharp, and the descent line short, and presenting a fairly prominent dicrotic wave; but I have not succeeded in obtaining the dicrotism so common in, and so characteristic of, acute febrile conditions of the system. The characters of the pulse of a case of acute mania are shown in Fig. 1, which was obtained from a young girl on admission, who, for eight days previously, had been labouring under what is somewhat vaguely termed "uterine or ovarian insanity," but in whom no active physical disease existed on examination; she was acutely excited, noisy, sleepless, and incoherent. The pulse was full and bounding, but could be easily compressed. In another female with the symptoms of acute mania, the result of alcoholic excesses, the line of ascent was slanted, and dicrotism not even so well marked as in Fig. 1; indeed, the tracing presented characters similar to those described by Wolff as the *pulsus tardus*, said to belong only to incurable cases of insanity; the prognosis in this patient was unfavourable, but as she was shortly afterwards transferred to another asylum her subsequent history has been lost. Patients who are acutely excited, and have grandiose delusions, but in whom none of the physical symptoms of paresis exist, I have grouped under this class of acute mania, and Fig. 2 illustrates the character of the pulse in many such cases; the arterial tension is low, and dicrotism is not so marked as in other cases. In the cases of acute mania examined, it would seem that in the majority the cardiac systole is sudden and sharp, and the *vis a tergo* feeble; the sudden ventricular contraction produces a high ascent line, and as the systemic arteries are rapidly emptied, the summit of the tracing forms an acute angle, and the descent line is short, and occasionally interrupted by a dicrotic wave.

The sphygmogram is by no means characteristic in *chronic mania*. When there is a constant condition of more or less congestion of the nerve centres, producing altered psychical phenomena, it is not unreasonable to suppose that in time the circulation accommodates itself, hence the tracing presents little or no deviation from the normal; the high upstroke of acute cases disappears, and although the summit is, as a rule,

* "Handbook of Insanity," p. 288.

formed by an acute angle, the line of descent is more prolonged than in acute mania, and is interrupted by several secondary wavelets.

2. *Melancholia*.—The circulation is torpid and the heart's action feeble in many cases of melancholia, and in some livid and swollen extremities frequently occur, while in others a marked tendency to chilblains exists. The pulse, unless in acutely melancholic patients, where it is more rapid than normal, is slow and easily compressed, and the sphygmographic tracing in the larger number indicates a weak and feeble cardiac systole, and an imperfect filling of the vessels. The upstroke is short and slanting, and the descent line prolonged considerably, the secondary wavelets being either indistinct and unrecognizable or not marked at all. Fig. 4 is a characteristic tracing from a case of acute melancholia. The patient was a female, who, after her first confinement, became extremely dull, and refused her food. The pressure used to produce the tracing was only 1oz.; a greater pressure destroying the pulse altogether. As she improved in her mental and physical condition, the cardiac systole became stronger, and the pulse fuller and more sustained, and the tracing indicated a slight amount of arterial tension.

In those cases of melancholia associated with stupor or hebetude to a marked degree, the bodily health being good, I found in the pulse tracing arterial tension common; in some the apex is prolonged to form a "plateau." In one case (see Fig. 6) this indication of arterial tenseness disappeared entirely after a stimulant or full meal.

Certain cases of melancholia exist in which there is some derangement of the liver, associated with a sallow or even jaundiced condition of the skin; the pulse is weak and easily compressed; the tracing of such a case is depicted in Fig. 7; the line of ascent is low—as compared with a normal tracing; the apex forms a sharp angle, and arterial tension is not prominent.

Chronic cases of melancholia, or those in whom the physical health is good and the circulation active, have, as a rule, a full and sustained pulse; arterial tension existing in many such cases, but never to so marked a degree as in some other forms of insanity.

3. *Epileptic Insanity*.—Whatever may be the ultimate cause of an epileptic fit, there can be no doubt that the circulation within the cranial cavity is altered in some way.

Dr. Gowers* states that ophthalmoscopic examination of the

* "Ophthalmic Medicine," p. 173.

fundus of a patient while in a fit reveals a turgid condition of the veins of the retina, and, according to other observers, the retinal arteries are contracted.* In patients who have succumbed to a series of fits, the cerebral membranes are generally found congested, and the cortex presents a deep pink colour. Microscopically, many of the cerebral vessels are distended with hæmacytes, and occasionally even rupture of the smaller arteries takes place. The pulse-rate in epilepsy is slightly quicker than normal, and its character may be briefly defined as wanting in tone. According to Dr. Thompson,† the pulse-tracing of an epileptic indicates a lax condition of the arterial walls. The ascent-line is seldom high or vertical, the percussion-wave is generally rounded, and the line of descent either prolonged with secondary wavelets imperfectly marked, or else short and presenting a dicrotic wave, which sometimes reaches the height of the primary wave. This description, however, applies more particularly to the tracings of those patients in whom the disease has been of long duration, and the mental characteristics are those of dementia, or to those who, at the time the tracing is obtained, are passing through a rapid succession of fits—the "status epilepticus." Such a condition is illustrated by Fig. 10, a tracing taken from a male patient while in a state of coma after taking a large number of fits. Tracings obtained from patients while in the unconscious stage of an isolated fit present characters similar to Fig. 10.

The pulse-tracing of an epileptic at other times varies according to his mental and physical condition, but, as a rule, it presents characters indicative of feeble cardiac systole and a lax condition of the arterial walls. There were several cases which presented tracings referable to increased arterial tension, but this condition existed only when the general health was particularly good, and the number of fits were few and of slight severity. Fig. 9 indicates a certain amount of tension, which, however, disappears entirely while the patient from whom the tracing was obtained is taking fits. The preceding tracing is a good example of a jerky and almost monocrotous pulse, similar to that usually found in acute pulmonary disease; it was obtained from a male epileptic, who was also the subject of syphilitic disease, while he was in a condition of restlessness and acute melancholia, and a few days before several paralytic

* Eulenburg and Guttman maintain that epilepsy in many cases owes its origin partly to a direct and partly to a reflex irritation of the vaso-motor nerves—the "angio-neurotic" theory.

† "West Riding Asylum Reports," Vol. II.

seizures rendered him quite bedridden. His temperature was above normal, but there was no evidence of either thoracic or abdominal disease of an acute nature.

4. *General Paralysis.*—It is to this disease that psychologists have more particularly directed their attention, partly because it possesses a pathology of its own, and partly on account of its extreme fatality. Some years ago calabar bean was strongly advocated as a specific in the treatment of general paralysis of the insane. Recognizing the disease to originate in increased tension of the arterioles of the central nervous system, the drug was administered with the view of combating this condition, but although it has an obvious influence on the pulse-tracing, I am not aware of a single authenticated case of general paralysis being cured by this treatment, and the drug has now fallen into disuse in most asylums.*

The pulse may or may not be more rapid than normal in general paralysis according to various circumstances—temporary or permanent—which influence the condition of the circulation; but it is characterized by tenseness and hardness very similar to the pulse of chronic renal disease. This high arterial tension is most marked in the second stage of the disease, and generally disappears towards the termination of the case.

Thompson refers the tracing in general paralysis "to arterial contractions, the result of certain pathological conditions," and Spitzka† states that "the pulse in the early stages reveals very high tension in the active forms of the disease. In a large number of patients it is normal, and in the depressive forms unusually low tension in several cases."

Tracings have been taken from patients exhibiting the symptoms of general paralysis at different stages of the disease, and as the characters of the pulse varied at each stage, I have classified them accordingly.

In the *first stage* of general paralysis the upstroke is usually somewhat slanted, the primary wave does not form an acute angle, the descent line is of fair length, the fall is gradual, and

* In the "British Medical Journal," 1874, p. 522, Dr. J. Crichton Browne records the treatment of two cases of general paralysis by the continuous administration of calabar bean. The first case was discharged "recovered" in less than a year; the second, a female, after three years' treatment. I am unable to say whether these were real recoveries or only remissions, as the ultimate history of the patients is not given. Several other supposed recoveries have been published, but in none is a complete life history recorded, and they may have been only remissions in the course of the disease.

† "Insanity," 1883, p. 212.

it presents a number of wavelets varying from 4 to 8; the dicrotic wave is not recognizable, and the aortic notch is either imperfect or it does not exist. Fig. 11 represents the tracing of a male paralytic, recently admitted, exhibiting the psychical phenomena of the first stage of general paralysis; his pulse-tracing is fairly typical, and the undulations on the descent-line are similar to those figured by Dr. Bevan Lewis,* and said to be characteristic of multiple sclerosis.

In the *second stage*, and towards its termination—immediately before the paralysis becomes so advanced that locomotion is impossible and the patient takes to his bed—the pulse becomes remarkably altered. The ascent line is now more perpendicular, but seldom of any great height, as often occurs in hypertrophy of the left ventricle; the wave of percussion, instead of being rounded, is prolonged horizontally, forming in many cases the "plateau" of Voisin. In some rare cases the tidal wave ascends higher than the primary wave; the aortic notch is generally well marked, the dicrotic wave obliterated, and the descent line short. With a few exceptions, it is this plateau-like summit to the tracing that is characteristic of the pulse at this stage, and it indicates a high tension of the pulse, sustaining the lever of the instrument for some time before the emptying of the vessel permits of its fall.

The difference between the pulse in chronic Bright's disease and the second stage of general paralysis is that in the former disease the systole of a hypertrophied left ventricle produces a high and perpendicular percussion line, while in general paralysis the *vis a tergo* is more feeble; in both diseases there is interference with the circulation through the systemic vessels, and this is no doubt the explanation of the tension so common at this stage.

In the pulse-tracings of the second stage of general paralysis, appended to this paper, high arterial tension exists in all with one exception (Fig. 14), which was obtained from a male paralytic dement; no active thoracic disease was present, but his feet and hands were livid and swollen from a torpid state of the circulation, and it is evident that the tracing is that of a jerky pulse of lowered tension, dicrotism being marked. The tracing depicted in Fig. 15 was taken from a male patient in whom paralysis was more advanced than in the other cases, and high tension is even more pronounced than in the other tracings, the apex forming a horizontal line.

I have been fortunate in securing sphygmograms from three

* "Journal of Mental Science," April, 1881.

male patients exhibiting the physical and mental symptoms of the *third* or *last stage* of general paralysis. The first had been bedridden for several months, and was beginning to bedsore; he was very restless, and it was only after many unsuccessful attempts that I obtained a correct tracing; the line of ascent was high and slanting, the percussion-apex sharply pointed, and the descent-line short and almost uninterrupted by wavelets, indicating a forcible cardiac systole, but a lax condition of the arteries producing lowered tension. The second case was that of a patient who died from exhaustion after a large number of epileptiform fits; the tracing was taken while he was unconscious, and bore a remarkable resemblance to tracings obtained from epileptics immediately after taking a fit or while in the "epileptic state." The third patient only recently had become bedridden, but at the time the tracing (Fig. 16) was obtained he was rapidly getting more feeble and paralysed; lowered tension, but with a fairly strong cardiac systole, are the chief characters to be noted in this pulse.

In the *female,* general paralysis has a much more prolonged course, and the symptoms are rarely so intense as they are in the male sex. I have taken tracings from six patients at different stages of the disease, and although they might not have been expected to correspond with the preceding descriptions, a low percussion-wave and a prolonged "plateau" summit existed in four cases. Fig. 13 was obtained from a female patient who, on admission, presented all the characteristic symptoms of general paralysis, but at the time of the tracing, about one year subsequently, she seemed quite well mentally, and, with the exception of slight nervous twitchings about the mouth while speaking, no physical symptoms existed. As there is no evidence of renal or cardiac disease, and as the arterial tension persists, it is to be feared that this amelioration in the symptoms will only be temporary.

5. *Dementia.*—In all cases of insanity where the intellectual processes are impaired, there exists a torpid condition of the circulation, accompanied by a feeble and easily compressed pulse, probably due to inhibition of nerve-impulses along the vaso-motor system of nerves. Twenty cases of dementia were examined, and in only two was there a perfectly healthy state of the circulation; in many the pulse was so feeble that it was with much difficulty that a tracing could be obtained at all. In the majority of the cases the line of ascent was slanted and very short; the apex pointed, and the descent-line prolonged, and, in a few tracings, presenting several small undulations.

In two cases some arterial tension was observed: the first was a female patient (Fig. 18), who about twelve years previously had had an attack of rheumatic fever, which apparently resulted in some valvular mischief; the other case was that of a stout woman with evidences of cardiac hypertrophy.

In several cases of *Senile Dementia* of both sexes examined the upstroke was slanted and not high, the apex was rounded or prolonged somewhat, and the descent-line interrupted by several small notches; these characters indicate a feeble condition of the heart and tense arterial walls, the result either of muscular hypertrophy or of atheromatous deposit along the course of the vessels.

6. *Imbecility.*—Persons with congenital mental defect exhibit a diminished activity of the vital functions. The heart's action is slow and laboured, the circulation sluggish, and the extremities frequently cold and bluish. The pulse is slower than normal, small but tense, and in a large number of cases examined I found arterial tension to exist, not to so marked a degree as in the second stage of general paralysis, but sufficiently constant —quite irrespective of the age of the patient—to justify the conclusion that increased arterial tension is the rule in cases of mental defect.

It is interesting to note that in cases of insanity where we have reason to believe there is an arrest in the development, or an atrophied condition of the cerebral hemispheres, a certain degree of arterial tension is almost invariably present. In this asylum during the past six years, 317 autopsies were made: of these, 15 were cases of congenital defect (including epileptic imbeciles), and the average weight of the encephalon in these cases was 42·2 oz. In general paralysis—although a case occasionally occurs of excessive size and weight of the brain—the brain is no doubt as a rule atrophied, for the average weight in 55 cases was 45·54 oz. (males 48·34 oz., and females 42·75 oz.). According to the latest authorities, the average weight of a healthy brain is 46·75 oz.; Meynert* exceeds this, giving from 1321 to 1375 grms. as the average. I would suggest that a possible explanation of the high arterial tension existing in cases of cerebral atrophy or congenital deficiency is to be found in a similarity of the morbid anatomy of the above conditions and that of cirrhosis of the kidneys. There is a certain amount of destruction of tissue in both cases, replaced in the one by serous fluid or the products of inflammation, and in the other by fibroid changes; in both conditions pres-

* "Psychiatry," by T. Meynert. Translation by Dr. Sachs, 1885, p. 255.

sure is exercised on the arteries within the part affected; this obstructs the systemic circulation, and to overcome the obstacle, hypertrophy of the arterial tunics, and hence increased arterial tension, results.

In several cases of *Circular insanity* ("folie circulaire") pulse-tracings were obtained in the different stages; in the dull and depressed stage there was shortening of the ascent-line, the apex was more or less rounded, and the line of descent was prolonged and wavy, indicating a short and feeble ventricular systole and slight arterial tension. In the excited stage the percussion-impulse was high and perpendicular, and the descent-line short and interrupted by prominent tidal and dicrotic waves, arterial tension being lowered, and the characters of the tracing in many respects similar to that usually present in cases of acute mania.

Two cases of *Syphilitic insanity* were examined, and in them the pulse-tracings bore a remarkable resemblance to that usually found in the second stage of general paralysis. The ascent-line was of medium height, nearly perpendicular, the summit was prolonged as almost a horizontal line, the descent was short, and the dicrotic wave imperfect. Whether, in many cases, it is possible to differentiate between progressive paralysis of the insane and advanced syphilitic disease, as it affects the cerebro-spinal system, is doubtful; both diseases have their focus of energy in the cerebral vessels at a certain period of their course, and in both there is a certain amount of wasting of the cerebral substance. It may be these facts explain the resemblance existing in the sphygmographic tracings of both diseases.*

The sphygmograms of two cases of *Paralytic insanity* were very similar, although one pulse-tracing was obtained from a male paralytic aged 65, and the other from a female aged 42 (see Fig. 21). In both the ascent-line was high, and high arterial tension was prominent, indicating the forcible systole of a hypertrophied ventricle with a certain amount of thickening of the coats of the arteries.

From the preceding remarks I proceed to draw the following conclusions:—

(1). In the various forms of insanity, the influence of the nervous system upon the heart and circulation is such that *in nearly every case the sphygmographic character of the pulse is altered in some way from the normal.*

* In an interesting paper ("American Journal of Insanity," July, 1886), Dr. H. M. Hurd discusses the relationship existing between syphilis and general aralysis.

(2). In acute mania, and in other forms of insanity associated with mental excitement, the nerve-centres are congested, but the walls of the arteries being in a lax condition, there is lowered arterial tension, and the pulse in the tracing is dicrotic. As the case becomes chronic the pulse more or less resumes its usual characters.

(3). Mental depression, if recent and acute, produces a feeble cardiac systole and an imperfect filling of the arteries; if, however, the depression is long continued, or if it is accompanied by mental hebetude or stupor, the systole becomes stronger, and the tracing indicates slight arterial tension.

(4). The arteries of epileptics are lax, and low arterial tension is the rule. During the "status epilepticus," and during the unconscious stage of an epileptic fit, the ordinary characters of the pulse-tracing are lost, and it becomes monocrotic or dicrotic, and the pulse becomes "soft, frequent, small, and running," similar to that found in coma or collapse from any acute disease.

(5). In general paralysis, the pulse varies according to the stage of the disease:—(*a*) in the first stage the systole is strong, but sudden, the tension of the arteries is low, and the descent-line is marked with numerous (4 to 8) undulations, probably the result of muscular tremors; (*b*) in the second stage the percussion-impulse is moderately strong, and the apex presents either a rounded summit or else it is prolonged, indicating marked arterial tension; (*c*) in the last stage the ventricular systole is feeble, and the pulse-tracing resembles somewhat that found in the first stage.

(6). The pulse-tracing of dementia indicates a feeble cardiac action, and a torpid circulation from imperfect distension of the vessels, probably due to the slow evolution of nerve impulses along the vaso-motor system.

(7). Cases of congenital mental defect where it is inferred there is an arrest in the development of the encephalon, as well as cases where it is evident a certain amount of wasting or atrophy of the brain-tissue exists, have tense arteries, and, as a rule, a strong cardiac systole, a condition in many respects similar to that found in fibroid degeneration of the kidneys, and in advanced aortic obstructive disease.*

* It follows also, although perhaps needless to formulate, that the opinion of those who have maintained the scientific importance of pulse-tracings in mental disorders is more than justified.

OBSERVATIONS WITH THE SPHYGMOGRAPH ON ASYLUM PATIENTS.

FIG 1.—Mary A., æt. 22. Acute Mania: pulse 100; pressure used 90 grms.

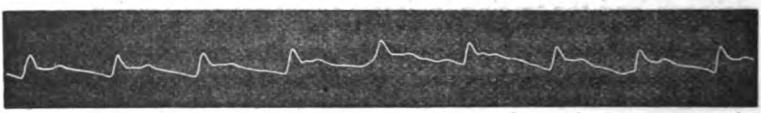


FIG 2.—William M., æt. 30. Acute Mania (G.P. ?): pulse 84; pressure used 60 grms.

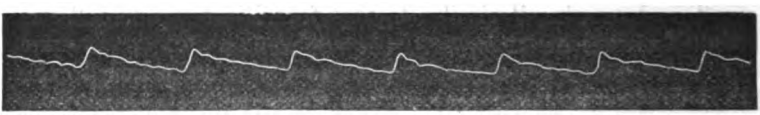


FIG. 3.—William B., æt. 32. Chronic Mania: pulse 96; pressure used 90 grms.

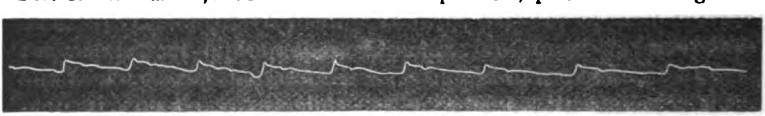


FIG. 4.—Jane D., æt. 30. Melancholia: pulse 90; pressure used 30 grms.

FIG. 5.—Eliza H., æt. 40. Melancholia (acute): pulse 80; pressure used 90 grms.

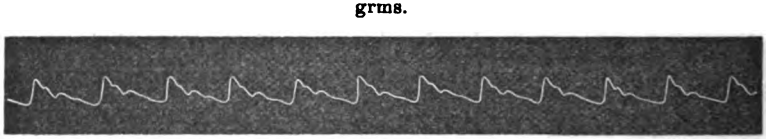


FIG. 6.—Eliza B., æt. 42. Melancholia (G.P. ?): pulse 90; pressure used 120 grms.

FIG. 7.—William B., æt. 40. Melancholia: pulse 84; pressure used 90 grms.

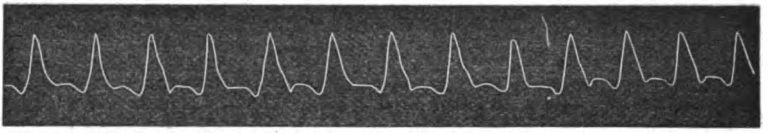


FIG. 8.—Arthur McA., æt. 39. Epileptic Mania: pulse 100; pressure used 30 grms.

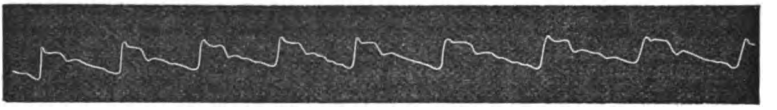


FIG. 9.—Jessie B., æt. 27. Epileptic Mania: pulse 86; pressure used 80 grms.

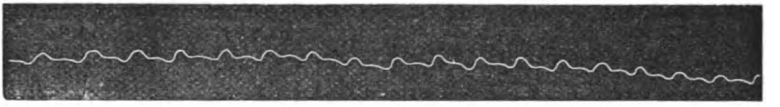


FIG. 10.—Isaac S., æt. 29. Dying from a series of Epileptic Fits: pulse 130; pressure used 30 grms.

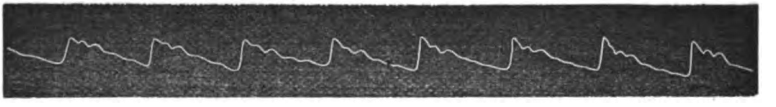


FIG. 11.—John K., æt. 36. General Paralysis (1st stage): pulse 80; pressure used 80 grms.

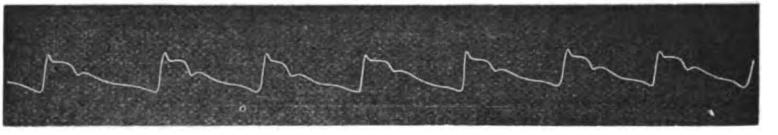


FIG. 12.—Thomas B., æt. 42. General Paralysis (2nd stage): pulse 74; pressure used 120 grms.

FIG. 13.—Dinah G., æt. 40. General Paralysis (2nd stage): pulse 74; pressure used 120 grms.

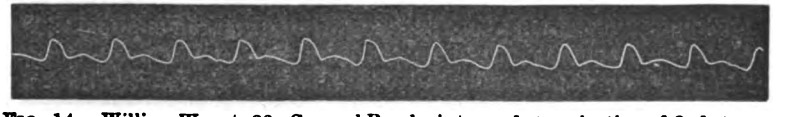


FIG. 14.—William W., æt. 30. General Paralysis towards termination of 2nd stage; pulse 90; pressure used 80 grms.

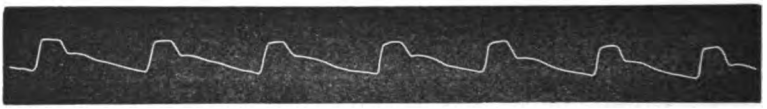


FIG. 15.—William R., æt. 55. General Paralysis (2nd stage): pulse 86; pressure used 60 grms.

FIG. 16.—William G., æt. 38. General Paralysis (last stage): pulse 90; pressure used 40 grms.

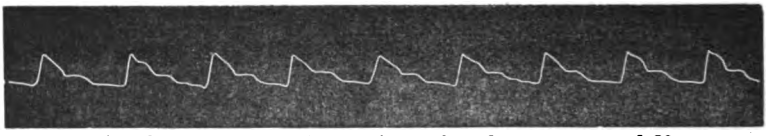


FIG. 17.—Job B, æt. 46. Dementia: pulse 86; pressure used 60 grms.

FIG. 18.—Catherine M., æt. 59. Dementia; has had rheumatism: pulse 80; pressure used 60 grms.

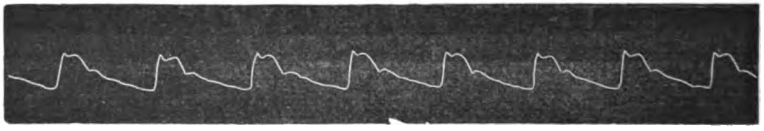


FIG. 19.—Isabella P., æt. 54. Congenital Imbecility: pulse 74; pressure used 60 grms.

FIG. 20.—Mary W., æt. 50. Congenital Imbecility: pulse 80; pressure used 80 grms.

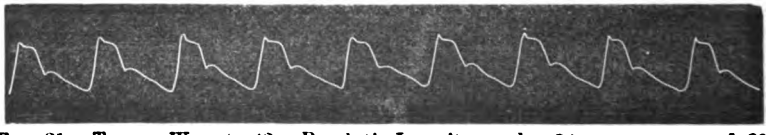


FIG. 21.—Tamar W., æt. 42. Paralytic Insanity: pulse 84; pressure used 60 grms.

*Alternation of Neuroses.** By GEO. H. SAVAGE, F.R.C.P., Bethlem Royal Hospital, London.

I have chosen this title as inferring as little as possible any relation other than that of time between the states of disorder. Night follows day, but is not caused by it, and, as we shall see, in some cases one form of nervous disorder is followed by another form of disorder, both having probably a similar cause, but not the one depending on the other as its cause. It is only necessary to say that I use the term neurosis in a very general way, thereby meaning any well recognized disturbance of the nervous system which might be considered due to direct inheritance, or might itself start a morbid nervous series.

I have very few, if any, new facts to lay before you, but I think it is well to compare fresh arrangements of old facts, as thereby we may arrive at fresh and instructive relations which were not at first recognizable.

All our knowledge is relative and is gained by comparing, and so we go on comparing, hoping that some fresh light may arise in the at present very dark realm of mental and nervous action.

I have been of late very much struck by two very noteworthy relationships; first, those existing between neuroses themselves, and, secondly, those between neuroses and certain states or conditions of the body, as a whole, which do not at first appear to have any direct connexion with the nervous system.

The subject, then, will divide itself into the inter-relations between the neuroses and between certain bodily and mental functions. In studying neuroses I have followed my old teachers, and have constructed a neurotic tree with many branches, and have thus looked upon these varying branches as the various expressions of what we call the neurotic disorder; the stem is one, but the branches are different, and their relationship to the parent stem differs in degree rather than in kind.

We have further, in considering these branches, to remember that just as a twig or a branch under favourable circumstances may develop into a parent stem itself, so with neurotic branches of small size, they may give rise to parent stems of disease having other branches of their own.

* Paper read at the Psychology Section of the British Medical Association held at Brighton, August, 1886.

We have to guard ourselves against considering everything met with in the neurotic as part and parcel of the neurosis. To continue our simile, there are other growths on a stem beside branches, and though these growths may derive their nourishment from the tree, yet instead of contributing to its character they deface and destroy it.

To return to the neuroses, as they may alternate, we have first to consider that various forms of nervous disorder may appear in different members of the same family. It is hardly necessary for me to remind you that an insane parent not infrequently begets an epileptic child, and that an epileptic or insane parent may have an idiotic child.

The insane parent may have over-sensitive offspring, and this over-sensitiveness may be represented by hypochrondriasis, migraine, eccentricity, or the like in the different members.

Several interesting cases have occurred to me in which a nervous parent has had twin children who have suffered from different neuroses. Thus, in one case, one twin was insane and the other was epileptic, such cases go far to prove the distinct relationship by inheritance of nervous diseases.

The fact is, then, that a parent may have a nervous disorder and may pass this on directly to his child, who may suffer at a like age from a similar disorder, or the parent may suffer from one form of nervous disorder and the offspring from another, and the disorder in the offspring may be of a less or greater force than that in the parent, this increase or decrease depending on many conditions connected with the health of the parents at the time of the begetting or upon the constitutional state of the non-neurotic parent.

So far, then, we have considered the fact that from parent to child the insane or nervous disposition may be transmitted, and before leaving the subject I would only sum up my experience.

An insane parent may have an insane, idiotic, wicked, epileptic, or somnambulistic child. Alternation or change of form of neurosis may not only be seen as it occurs in the different generations, but it may be seen in the same individual, and the chief part of this communication will consist of examples of these changes. It seems to me that what is seen in chemistry is also present in disease; there appears a kind of substitution of one nearly allied body or force for another. This may appear rather a far-fetched likeness, but processes of disease are, as a rule, only alternations of natural processes, and are better understood by the study of the normal in its develop-

ment than of the abnormal in its obscurity and definiteness. There is one more interesting fact, that the alternations are, as might be expected, rather between what may be looked upon as the functional than between the more organic diseases—alternations of disorder, not of disease. General paralysis of the insane is not replaced by any other disease, but maniacal excitement may be replaced by hysterical paraplegia. The examples I shall give are taken from—1, Cases of Headache, Migraine; 2, Hysteria; 3, Asthma; 4, Epilepsy.

I shall then refer to certain alternations of gout and rheumatism with neuroses.

1. I have frequently met with cases of severe migraine in the neurotic subjects, and I have found, as a rule, that patients who suffer from this disorder, if they become insane, lose their headaches; and I have seen one man who appeared to improve but relapsed, when he had not redeveloped migraine; but when he began again to improve and had a recurrence of headaches his sanity was assured. In one case only have I seen the more severe nerve storm of insanity leave the nervous sky clear, the patient for some years, during which I had the chance of seeing him, remaining free from both headache and insanity. This is interesting from the fact that I know of one case at least in which epilepsy seemed to clear the mental atmosphere also.

2. As to hysteria, I have often been struck with the rarity of hysterical outbreaks in Bethlem. There we have an average of 160 women, and yet hysteria is very rare in its explosive forms. On the other hand, I have seen several true cases of hysteria alternating with other neuroses. I have seen hysterical paralysis of one limb recover during an attack of insanity, and I have had the opportunity of seeing several cases in which persistent hysterical vomiting and supposed ulcer of the stomach was relieved when insanity developed.

In one case a patient who had suffered from hysterical paraplegia for some months became insane, the paraplegia passed off, but returned with the recovery of sanity. In this first case there were several relapses, the mental state being one of maniacal excitement with great loss of control.

In a second case the woman was bedridden for seventeen years and recovered power of walking, when she became very much depressed in mind. At present there are no signs of the mental cloud in this case passing off, and of the motor paralysis returning.

In another class of cases I have seen marked moral perversion associated with loss of hysterical symptoms, that these

two perversions are not uncommonly seen together is a common experience.

3. Next as to asthma. Attention has specially been called to the fact that there may be an almost regular alternation between the difficulty of breathing and the insanity. I have seen several cases in which the alternation was constant, not only during the one attack of insanity, but whenever the asthma ceased in after years the patient broke down in mind. It is further worthy of interest that I have met hay asthma frequently in neurotic subjects. In one an attack of acute insanity was associated with absence of hay asthma in the spring for the first time for many years. One other point here deserves remark, and that is, or may be, of importance in future treatment. In one case of chronic asthma, the only time the sufferer was well was when he had a severe and painful inflammation on one hand. In this, then, the asthma showed a further likeness to other neuroses.

4. As to epilepsy, my experience is but small in this form of disease, therefore I look to others to support or criticize my work. I have seen at least one case in which nocturnal epilepsy was replaced by insanity, and I have on the other hand seen several cases in which severe epileptiform fits have relieved the mental symptoms.

I have several times seen cases in which the epileptic fits, occurring as they did only at rare intervals, and at night, were of little or no importance; and yet when these fits, either by treatment or from some other cause, have been suppressed, the mind has suffered great deterioration. I know I shall be in the minority in thus speaking, but I have been surprised into this knowledge, if I may use the term, for when I expected to hear that improvement had followed treatment and arrest of fits, I have heard a mother say that she at least thought there were worse things than fits, and that she always looked upon the periods following the fits as those in which the child had most happiness and gave most pleasure.

Epilepsy may, of course, persist without any outbreaks of violence, but we have to recollect that the motor disturbance may be replaced or followed by a mental epilepsy resembling in many ways the motor storm—resembling it in its suddenness, in the symmetrical way in which it develops, and in the constancy with which the symptoms recur in the same order and force, and further by the similar effects of treatment. This, then, may be looked upon as the best example of transformation or alternation. It may appear strange to those who have never met such cases to hear me say that epilepsy has in my

experience not only alternated with other forms of mental disorder, but has also in some cases seemed to re-establish the defective balance or rectify the nervous action, and that fits have been followed by sanity. Now to my second division.

As I have already said, there is at present no fine dividing line between those disorders of the body which depend on disorder of the nervous system, and those in which the nervous system suffers from the primary disease of the body. There is a growing inclination to give the nervous system at least its full share of responsibility for disorder of the body. Whether it will be shown at some future time that some cases of rheumatic fever arise from nervous disorder I cannot say, but I shall have to point out that cases arise in which the rheumatic symptoms are replaced by nervous ones; and again, the nervous symptoms may pass off to be replaced by the pains and redness of the joints. This is what used to be called metastasis.

It does not necessarily follow that because neuroses alternate with other conditions that these latter are also neuroses, though to my thinking if such alternation is common, and recurs several times, it adds greatly to the probability of there being a deep alliance between the two states.

Gout and rheumatism are interesting from this alliance, and it is further interesting to note that these again may be interchanged for other morbid phases such as asthma. So we come to this, that these rheumatic conditions may be allied to neuroses and asthma, and that neuroses and asthma are also allied to one another.

Rheumatic fever has to be noted as a disease prone to develop, associated with insanity. I have had many cases admitted to Bethlem from general hospitals in which the rheumatic fever passed off, in what would in old days have been styled metastasis, to the brain, and in several, the rheumatic attack has recurred more than once on temporary mental improvement.

These cases differ from some others in which the hyperexia has been associated with delirium and loss of all joint pain; what the relationship of rheumatic fever to the neuroses is has not yet been made clear.

With gout, again, I have met cases in which, the gout being suppressed or not appearing, mental disorder has resulted. I know that here I am open to the grave charge of special pleading, for many will be ready to say the patient had his gouty material still circulating through his brain, which was thus poisoned, and naturally gave expression to its complaint.

I can only reply that the suddenness of the alternation is so

very striking that I cannot accept this as an explanation. Is the gouty toe a concentration of all the *materies morbi* in the blood, and is this all poured out in a couple of hours? I think not. Yet I have seen the suicidal melancholic become the gouty but sane man in less than that time.

One more condition deserves notice, and I draw special attention to this for several reasons. First, then, it has been noticed by Maudsley and others that diabetic parents not uncommonly have neurotic children, and I have to point out that diabetic patients may have alternations of neurosis and of diabetes, the alternation in the family and in the individual being parallel.

I have now had some four or five cases admitted into Bethlem with genuine diabetes; these cases have on admission been found to be free from both glycosuria and polyuria; and I am able to go further, and to say that it is almost unknown for me to have a true case with diabetes among my patients. The history has generally been that the patient has suffered from diabetes for some time and then has become insane, and on admission and examination I have found no sugar.

In some of the cases the patients were discharged free from both insanity and diabetes, but in one, an altogether exceptional one, the patient being a general paralytic, the diabetes disappeared only as long as the mental symptoms were acute, but as the nervous disease progressed the diabetes returned. In this particular the case more resembles those cases with phthisis in which the mind clears with the onset of acute lung troubles and becomes clouded again when the lung disease is checked, but in the end when the lung disease is established the mental symptoms and the bodily may both appear and progress together.

This subject would not be complete without referring to the fact that besides what I have called alternations proper, there has to be recognized the fact that certain bodily diseases, when they occur in the insane, often appear for a time, at least, to mask the insane symptoms. I am not in a position to say what conditions govern these changes of symptoms, but here again my experience makes me think that functional not organic troubles are relieved by bodily disease as a rule. Thus a fever will affect the mental state of a patient suffering from acute mania of an emotional type, but will leave the symptoms of the general paralytic unchanged.

Some diseases seem much more likely to change the aspect of the mental symptoms. These are generally painful or of considerable extent, and affecting the skin surface.

But already I have sketched out a very large field which has been but imperfectly tilled, and other workers are begged to come in to contribute to the tilling; and I believe a richer harvest for the philosopher lies in these doubtful and changing lands than in any of the more fixed.

We may be colonists and explorers preparing for a great future.

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*What are the Tests of Fitness for Discharge from Asylums?**

By H. HAYES NEWINGTON, M.R.C.P., Ticehurst.

It is not proposed that the time of this meeting should be taken up by a monologue of mine in the shape of a set paper. I intend only to mark out the ground which can be profitably covered, and after dealing myself with one or two of the questions raised, I shall leave the remainder to other members present. After that it is hoped that there will follow a general discussion commensurate with the importance of the subject.

In the first place it will be well to point out that we shall not touch the question of recovery, for, of course, when that takes place, there will be no need for further test. We shall by this free ourselves from the consideration of a knotty point or two, such as what recovery means, and so on; but I take it that what we have to discuss is far more knotty and serious. If a patient is discharged as recovered, and subsequently causes harm to himself or others, we, when it is sought to cast the responsibility on us, can well say that the appearances of recovery left us no choice in the matter; but when we send out into the world, on our own opinion as to his safety, a man who is confessedly not sane, then the responsibility is as continuous as if he were still under asylum care, a responsibility that we all have to face from time to time.

The broadest and most comprehensive test of fitness for discharge is formed by the question—How far has the residence of the patient in the asylum answered the purpose for which he was sent there? This naturally leads up to the further question—Why was he sent there? For two distinct reasons—first, because he was insane, and secondly, because he needed detention. It follows then that, if the law needs something beyond insanity to justify admission into an asylum, when that something has disappeared, mere insanity need be no bar to his re-

* Read at the Quarterly Meeting of the Medico-Psychological Association held at Bethlem Hospital, Nov. 9th, 1886. See "Notes and News."

moval. This goes without saying as far as we are concerned, but it is a useful fact to bring forward in justifying to outsiders the discharge of a patient before recovery. Then, why does a man need detention? Again, for two reasons—First, for the amelioration of his condition; secondly, for the safety of himself and others. It is the more or less complete success in the first of these two objects, which almost always raises the question of discharge, but the answer must invariably be supplied by a consideration of the second. We can therefore narrow the scope of this discussion down to these points—What are the acts of an insane man, either performed or anticipated, which, by imperilling the safety and comfort of himself or others, necessitate recourse to the asylum? And, what are the signs that he has so far passed from under the influence of the mental aberration which suggested or favoured these acts, that he can be discharged with safety?

It is impossible to give anything like a detailed list of the above-mentioned acts; all we can do is to group them roughly, singling out the most important. I should do this in the following manner:—

1. Suicide.
2. Homicide.
3. Acts not done with homicidal or suicidal intention, which may nevertheless lead to these or other serious bodily mischief, *e.g.*, fire-raising, felonious assaults.
4. Acts more or less serious, which may lead to the annoyance or prejudice of the public, *e.g.*, indecent behaviour, brawling in church.
5. Acts that relate to the injury of estate, social position, etc., *e.g.*, insane extravagance, bad business management.

Besides these groups of, so to speak, active mischief, there is another of passive harm, to which a person may be exposed by loss of intellect, such as through neglect of the first duties of life, ill-treatment or despoiling at the hands of others; but to this we need devote no attention, as such cases but seldom leave us. If this grouping, with all its imperfections of crudeness, can be accepted for the purposes of our discussion, we will take the divisions as far as possible in detail, and consider how we can recognize the disappearance of the particular tendency. I will commence with the study of the first of these groups—the suicidal tendency—which I have chosen as my portion of the work.

Why does a person attempt suicide? Because on the one hand a desire or temptation is set in motion by adverse cir-

cumstances, while on the other hand those natural instincts and emotions which normally protect life, are, by reason of their effacement or enfeeblement, not ready to push him back from such temptation. Thus, there are two distinct conditions required—one, the presence of what I shall call, for convenience, motors; the other, the absence of these restraining agents or *repellers*. I hold that it is essential to recognize the fact that a suicidal desire is not an element, to use that word in a chemical sense—it is not abstract, indivisible, and impossible of analysis. I assert as a definite proposition that attempted suicide is not, and never can be, the product of less than two factors. Were this not so, which of us, sane or insane, would be safe for a moment under trial? That it is so, is clearly demonstrated by the ease with which some are overcome by moderate affliction, while others successfully withstand far greater trials. It is not the severity of the trial which determines suicide, but the manner in which that trial is met. It is also necessary to admit that the mental cachexia which leads to suicide does not lie primarily among the motors, but may always be found among the repellers, and therefore it is to the condition of the latter that we must look for materials on which to found a judgment as to safety. Again, it is most necessary that we should, in a particular case, be able to separate these two conditions, the presence of motors and the absence of repellers, and thus distinguish them as independent of each other; that is to say, we should be able to recognize a distinct enfeeblement of the safeguards, and a clear and definite motor. If we can do so, it is obvious that we gain a large margin of safety, in that we are forewarned as to the probable amount of resistance that will be offered by the mental constitution of the patient. I venture to enunciate, as a practical rule, that, if in any given attempt to commit suicide it is not thus possible to dissociate the respective influences of the two conditions, if we are driven to admit that it is difficult to show that they were not coincident and were not brought about by the same agent, then that patient will be for a long time eminently unsafe, and must be regarded with the greatest possible suspicion and reserve. I will illustrate my meaning by two cases.

A gentleman—by reason of worry and anxiety—fell into a state of ordinary melancholia, becoming apathetic and wanting in interest in his affairs, incapable of extracting anything but misery from his very comfortable circumstances, less thoughtful for his family, and generally less just in appreciation of his duties. He went on thus for some time, no better and but little

worse, having, while travelling abroad, many opportunities of taking his life. When he returned home, he had an attack of severe indigestion, and then the thought came over him that he would land in an asylum for life. The consequence was a deliberate attempt at self-destruction by shooting. He came to us, and for some few days was not suicidal, though his loss of healthy emotion was quite marked. After a time he had another severe attack of 'liver,' which was at once followed by a distinct suicidal wave. During this he was restless, wandering about in hopes of being able to evade observation, and so nervous that he shook like a person with ague. Under treatment this passed off in a few hours, to be followed from time to time by similar attacks, some due to liver and some to neuralgia. After 18 months it was evident that his habit of thought was improving, he became more interested and anxious about family and business, and as this increased he was able to fight off his temptations. Eventually he was discharged, as I thought that he had recovered a sufficient amount of repelling power to enable him to withstand trial. Within three weeks he was put to a rough test, a near relation, in whom he took a warm interest, destroying himself under painful circumstances. Nevertheless he was quite able to bear it, and has never broken down again.

Here we have distinct evidence of the second condition, a sufficient enfeeblement of the repelling elements preparing the ground for the coming of varying motors. When the two met, the attempt came. Now, in this case, not only was the safeguarding perfectly easy, owing to the ability to dissociate the two conditions, but the test of fitness for discharge was easily and satisfactorily applied.

Now, to take a case of an opposite character. A gentleman, also in good and happy circumstances, became dull and apathetic. He feared that he would destroy himself. By advice he came to us readily to be protected from his tendency. On admission he showed no evident symptoms such as were seen in the foregoing case, except on this one topic of suicide. He insisted on having a bedroom on the ground floor, with only one window. He would only walk in a small court-yard, as he would not trust himself abroad. He took his food as other people do; there was no constipation. He slept fairly well; he conversed on indifferent subjects with cheerfulness and point. He took a rational interest in what was going on, and finally he differed from ordinary cases of melancholia in not betraying that selfish concentration of thought on personal troubles which marks that disease. In fact,

his was a case of pure suicidal impulse. One day, after a bright morning, a deliberate attempt was made in the afternoon without any warning, the same agent, whatever it was, appearing at one and the same moment to procure the presence of the motor and the absence of the repellers. Hence the inability to prejudge such a case, and I repeat that the greater the difficulty in recognizing the separate existence of enfeeblement of repelling agencies, from temptation or impulse, the greater is the danger and responsibility incurred by discharge.

But though we cannot demonstrate in such a case the process of abolition of all restraint, we can infer it with certainty. An impulse can only derive its strength from the weakness of self-control. We all have impulses, but we do not all of us follow them out. We know that the rushing of an express train through a station, or the looking over the edge of a precipice, may evoke a curious sensation, amounting in some to an impulse to jump under the wheels or over the edge, the impulse being born of the being brought suddenly face to face with fascinating opportunity. In passing, it is to be noted that opportunity is almost always the parent of impulse. Does not the number of suicides from the Monument in former days, and from the Clifton Suspension Bridge now, point to this? But in the great majority of cases in which such a sensation arises it is put aside as an idle or puerile thought, and choked as soon as born. Choked by what? By an intuitive reflection that things are better as they are, or that a great and needless wrong would be done by giving way to it. In proportion as the power of reflection and self-control is weakened, the silly thought grows in power, till at last it must be ranked as a dangerous impulse. Such was the case, I conclude, with the last patient. Confessedly the same impulse came over him from time to time. Strong as it was, strong enough even to induce him to seek the restraint of an asylum, yet it had failed to gain its end, because it was kept at bay by the repelling influences. But at last the time came when the latter gave way, borne down suddenly and overcome by the intensity of the motor, and then came the determined attack on his own life. I am justified, I think, in reasserting that temptation without impairment of self-control can no more produce suicide than can loss of self-control without temptation. It is the loss of self-control which dominates the question of suicide, and therefore to the loss or recovery of it must we pay the chief attention. I have laboured at this point somewhat dogmatically, because I feel confident that without some such view

we have no power to gauge the probability of suicide, and must then fall back on rule of thumb. In the earlier days of my acquaintance with insanity, suicide was to me a dread possibility which overshadowed all other considerations. I knew that certain states, certain diseases, were often marked by such a feature, and that was all. But, as experience grows, I feel that I begin to see reasons why all such cases do not attempt the misdeed.

I propose to consider shortly the character of the two factors. First, as to the motors, their name is legion, but they can, I think, be referred to three principal groups—mental disease, mental pain, and bodily pain. Under the head of mental disease are ranged impulse, hallucinations, delusions of suspicion, persecution, and unseen agency, etc., and even delusions harmless in themselves, which have been in a particular case associated with a former attempt at suicide. While any of these are present in a person who has proved himself to have been suicidal, we should never undertake the responsibility of advising a discharge unless fully assured of a large margin of self-control under trial.

As to pain, mental and bodily, we all, sane or insane, have to undergo it, and therefore if at the time of the proposed removal a patient is tolerably free from either, he must take his chance of them, as they cannot be guarded against. It is often seen that if self-control is fairly robust, an untoward occurrence does no more harm to an insane person than it does to a sane man; indeed, it frequently happens that positive good arises from trial and affliction. At the same time it would be unwise to send a patient into circumstances in which mental pain is sure to arise. Such a case often recurs to my mind. A lady, who had an attack of melancholia at the age of 20, subsequently married a man in very good circumstances. They had no family, and after a time the husband began to drink heavily; in fact he became little better than a besotted fool. The constant disgust and the worry entailed in looking after him and his affairs, brought on another attack. One night a razor was found under her pillow, whether for use on him or herself was not clearly made out. She came to us deeply melancholic, and without doubt suicidal. She improved slowly, but was evidently kept back by her very real incubus. Her husband came to see her, and on at least one occasion abused our hospitality by taking more than was good for him. After a time he insisted on removing her. Had I had any means of conveniently resisting this, I certainly should have done so. I never heard any more of her, but I have no hesita-

tion in saying that as long as she remained at home with him his conduct would form a standing menace to her safety.

So, also, after suicidal melancholia in a poor person, one would naturally keep him from the worries of a contracted home longer than might be considered necessary for a person in whose house complete rest and freedom from worry could be insured.

Now I will direct your attention to the second element in the production of suicide, the absence of those checks which enable a healthy man to withstand the action of the motors.

I group them as follows, commencing with the lower instincts:—

1. Abstract love of life and fear of death.
2. Physical fear of death.
3. Fear of the future state.
4. A wish to remain in the world for its own sake.
5. Hope for better days.
6. True affection for family and friends.
7. Moral sense.

As might be expected, the higher one gets in this scale, and the nearer we approach the exercise of intellect, the more readily do we see the emotions fall a prey to mental disease. Emotion suffers before instinct; therefore, as a very general rule, if we see evidences of the presence of a true sense of the absolute wrongness of suicide, if we see a restoration of interest in those things and persons to whom interest is due, or other evidences of the emotions being in fair working order, then we may conclude that behind these are the other more substantial checks of instinct.

Every one of these emotions and instincts may be either abolished or rendered practically inert by various phases of mental disease.

It is obvious that advanced dementia will bring this about, though at the same time it will *pari passu* diminish the susceptibility of the brain to the impulse of a possible motor. Nevertheless, a dement who in former times, possibly many years ago, has been undoubtedly suicidal, is not invariably safe. In some such cases during the period of their activity a desire for death has been so intense and prominent a pre-occupier of thought, that it has become a sort of instinct, as it were, which is liable to blaze forth on occasion. Therefore, if it should be proposed to remove a patient of this sort to home care, this possibility should be borne in mind and proper warning be given.

Alcohol, the effects of which, when taken in sufficient excess, may clearly be considered to constitute mental disease, transitory though it be, is an active destroyer, as we know, of restraint. Therefore, if any suicidal case shows a disposition to take advantage of opportunity to drink, that case should be put back.

Another class of mental disease acts strongly in the same direction—that form of misery which, from its association with aggravated mal-digestion, is called stomach melancholia. If there is one part of the human system, the derangement of which tends to cause a supreme concentration on a miserable self, to the exclusion of thought and reflection on other things, it is the alimentary canal. A man thus afflicted is of all men most miserable. He has no hope, nothing to live for, much reason to wish for death. What affection or sense of right can he have? His whole thought is of self, and that self he loathes. He is thus deprived of the assistance of the repelling agents, and is most unsafe, even when considerable improvement may have shown itself. The continuance of obstinate indigestion must, therefore, suggest caution, for it is not difficult for a few hours to bring about a recrudescence of stomach trouble, and with it assuredly will recur suicidal tendency. Of course there are obvious means of gauging the state of the digestion, but the weighing machine supplies the best test of all. If we find that a patient steadily increases in weight, we know that not only does he not suffer from the local pains and penalties of indigestion, but that the ingested food is properly applied, the result of which must be increased cheerfulness and safety.

Time will not permit me to refer to other forms of disease which tend to weaken self-control; but I will mention one other morbid condition—insomnia. This, whether it be cause or symptom, may sometimes be considered to be a direct motor of suicide; but I believe that in most cases it takes its grave action from its power to wear down resistance. One need hardly dilate on the close connection between suicide and sleeplessness; it proclaims itself on all sides. Therefore a prolonged succession of undisturbed nights must be one of the most important tests that we can apply. This condition should be independent of anything like extensive aid from drugs, though where a few grains of chloral are found to be advisable, we need not be so cautious on their account, for very probably the mere change from the asylum will supersede them.

Of course, while it is highly desirable that all the repelling

agents should be present, yet it would be quite unnecessary to insist on this. There are men who have no more physical fear of death than they have of their dinner. Others have no belief in a future, and, therefore, can have no fear of it. So, too, some have no friends on whom to bestow affection; while others who have plenty of friends cannot in their best days be accredited with real affection. I am afraid that there are too many to whom wrong is as good as right, so long as it does not lead them to personal inconvenience. Still, a satisfactory quorum is necessary. A mixture of abstract love of life, desire to enjoy the world as far as is possible, and of hope, will form a good basis to work on.

In reviewing the presence of the repellers, it is necessary to make sure that the true is not simulated by the false. True affection is a powerful agent, but it may by its very power be perverted so as to lead to a desire to relieve relatives by suicide of a sinner, of a disgrace, or of a possible encumbrance. Moral sense may be so exaggerated as to lead to such a perpetual conflict between right and wrong, that a restless and positively dangerous condition may result. I have had to guard against such a possibility quite recently. A mind, to be absolutely safe, should be able to take things moral as well as things temporal without too much fuss.

The evidences of the restoration of these repelling agents to a satisfactory condition of robustness are not difficult of recognition. In place of apathy and disgust for life, more frequent inquiries as to what is going on around, the reading of newspapers and writing of letters, useful work done for a purpose, less talk of sin and hell, and more desire to attend church, less wringing of hands over the fate of the poor wife and children, and more rational anxiety to help them practically—all these demonstrate *pro tanto* increased safety. Further, it is always advisable, though not always convenient, to examine the patient directly, by asking him point blank, and without warning, "Are you now safe from yourself?" If he looks you straight in the face, and answers, "Yes, I am," without hesitation and without qualification, he may be trusted almost invariably. If he speaks with some show of surprise or resentment at such a question being put to him, all the better. But if he looks down, ponders or fences with the question, if he say that he has no reason or no courage for the act, that man is not to be trusted.

Lastly, we must give a thought to the history of the case. If it be one in which the dominating type of disease is

known by clinical experience to have a tendency to recurrence, we should be justified in taking every advantage of the existing insanity to obstruct the removal of the patient, however much he might appear on other grounds to be entitled to a trial. Nor must we neglect to give due weight to a hereditary disposition to suicide. This would suggest a congenital weakness of self-control that is far more formidable than any that may have been acquired by the patient on his own part.

These, gentlemen, are my ideas on the question of suicide. I am conscious that they are somewhat cut and dried by reason of the compression of time. I know that, like all other ideas, they are liable to be upset by individual cases; and I know, too, that in active cases there will be difficulty of application. Nevertheless, I believe that they are applicable to those cases which raise this discussion; and they have helped me in forming opinions which I have not had cause to regret.

CLINICAL NOTES AND CASES.

A Case of "Unconscious Homicidal and Suicidal Impulse."

By Evan Powell, M.R.C.S., Medical Superintendent of the Nottingham Borough Asylum.

A brief notice of the following case may be interesting to the readers of the Journal, and may prove of some use to those who may at some future time be called upon to give evidence in similar cases.

James Walker, aged 42, married, was tried at the Lincoln Assizes on the 12th May, 1886, for the murder of his boy, aged three years, and was acquitted on the ground of insanity.

The following is a short history of the man:—His father committed suicide by drowning; his grandfather is said to have been eccentric; his great uncle was found dead in a dyke, supposed to have committed suicide; he himself at the age of seventeen had what appears to have been an attack of mania; he had to be watched by his sister on account of his peculiar behaviour. He went to sea at the age of twelve, was laid up for five or six weeks from sunstroke, at the age of twenty-one, in the China seas; he got married when twenty-three, and left the sea when twenty-six. Soon after this he came to Nottingham, and got employment as general servant to a firm of hosiers; he continued with this firm up to the day of the murder, and his employer at the trial gave him an excellent character, said that he was thoroughly steady, honest, and careful, and was trusted in every

way like a confidential servant, that he was very careful in not taking much drink, as he said he was afraid to, because he knew it would affect his brain. Once, on the evening of an election, when it was supposed he had had more drink than usual, he got into a "state of frenzy," and had to be restrained; this was the only time during the sixteen years he lived in Nottingham that there was anything wrong noticed in him, but, on the contrary, he was spoken of by everyone who knew him as a very quiet, genial, and sensible man, and an affectionate father.

His married life was a very unhappy one, his wife being a most drunken and dissolute woman, frequently absenting herself from home for days together, and leaving the children (three) to be taken care of by the father. Two days before the murder she had returned home after having been away a fortnight, and for those two days she conducted herself better. At four o'clock in the afternoon of the 24th April (the date of the murder), Walker arranged with his wife to go to market at five o'clock, and he went out to his garden, having told her to be ready at the time named. When he came back to the house, she was gone—had left him again. This seems to have upset him very much; he asked a neighbour to come in and attend to the children, and he went out, and for the next four hours he appears to have wandered about the streets, keeping, as he said, in the back streets, lest he should meet anyone he knew, as he was ashamed of the disgrace his wife was bringing on him. In returning home he called in a public-house, and had three glasses of ale, and then went home, arriving there about nine o'clock; from this time until he was roused by the policeman, two hours after, he declared to me he remembered nothing, although in that time he had gone into the bedroom where his three children slept, two girls aged nine and six, and the little boy aged three. This boy he took out of his bed into his own room and there inflicted, with a razor, such a wound in the child's throat as to cause almost immediate death. Soon after 11 o'clock he rapped at the wall separating his room from that in the next house, in which a Mrs. Fisher lived, and calling out to her, said, "I'll die for the child."

When the neighbours and policeman got into the house the prisoner was found lying on the bed alongside of his child, and bleeding from a slight wound in his own throat. When asked by the policeman what he had done, he threw his head back and said, "Can't you see what I have done?" Asked what he had done it with, he said, springing from the bed and seizing a razor, "I'll show you what I did it with, and for two pins I will serve you the same." He was secured, it would seem, before he had actually made any attempt to attack the policeman. When the doctor arrived, the prisoner asked him if the child was dead, and when told he was, he threw himself on his knees by the side of the body and sobbed and kissed it, saying, "I have done it, and I'll die for him." On his way to the police-

station he told the policeman that it was all on account of his wife that he did it, that he intended "doing" for the three of them (meaning his children), but that his heart failed him.

Four days before the trial, and fourteen days after the murder, I examined the prisoner at the request of the Public Prosecutor, and found him in the following condition: He looked anxious and distressed, but was calm and collected; he answered all my questions rationally, and I failed to detect any delusions, nor could I find that he had suffered at any time from any delusions or hallucinations. When spoken to on the subject of his criminal act, he became very much affected, wept bitterly, and said that he supposed he had done it, because everybody said so, but that he remembered nothing of it. He described to me minutely, all that he did that night, up to the time that he returned to his house, but that from that time all appeared to be a blank, until the people came in and found him lying on the bed by the side of his dead child. He assured me that the thought of injuring his child or himself never entered his mind, and how he came to do it he knew not, that he would rather have done or suffered anything in the world than kill his favourite child. This seems a little inconsistent with what he is reported to have said to the policeman on his way to the station, namely, that "he meant to 'do for' the lot of them, but that his heart failed him."

At the trial I stated in my evidence, that I was of opinion that, at the time I examined the prisoner, he was rational and collected, and apparently in a sound state of mind, but that at the time of the murder he was insane, and not responsible for his actions. I based this opinion upon the consideration of the whole surroundings of the case—his hereditary predisposition to insanity, his past history, the terrible mental anxiety which he experienced for the three or four hours prior to the commission of the murder, his actions after the deed, namely, his attempting suicide, his lying down by the body of his child for some time, his not attempting to escape, or shield himself, and his apparent maniacal excitement when the policeman and neighbours went into the house. With all these facts before me, and taking into consideration the man's character, which was in every respect far removed from that of a criminal, I had but little difficulty in arriving at the above conclusion. Mr. Aplin, of the Notts County Asylum, who gave evidence for the defence, was of the same opinion.

The case I think is a very interesting and important one, as

illustrating that form of disease which is so well described by Dr. Clouston in his book on Mental Diseases, under the head of "States of Defective Inhibition." Here we have a man who inherits, somewhat strongly, a neurosis, whose brain is also weakened by sunstroke; he is subject for a long time to extreme mental pain on account of his wife's behaviour; this mental pain is aggravated one evening to such an extent that his brain is suddenly and completely overthrown, and in his unconsciousness he murders his favourite child, and attempts to commit suicide. Why his passions should have run in this direction on the overthrow of his higher mental faculties I know not, but it is, I think, a good example of the insane impulse, accompanied by unconsciousness.

Another interesting point in the case is the late reappearance of insanity. The only other attack he seems to have had was as far back as 1861, and it was 21 years ago that he had sunstroke. Besides this, what appears to have been the exciting cause, namely, mental anxiety, had been present for a long time, some years in fact. Whether the small quantity of ale the man took that night helped to bring on the attack or not, I don't know, but I should hardly think so, because he told me that he not unfrequently took a pint or so at a time without feeling any ill effects.

The Judge (Mr. Justice Matthew), in summing up, directed the jury in the law as to criminal responsibility, and said that that law must be administered as it stands. He pointed out that the jury must be satisfied, in order to acquit the prisoner on the ground of insanity, that at the time of the murder he either did not know the nature of the act he was doing, or did not know that it was wrong. The medical evidence fortunately succeeded in convincing the jury that the prisoner was unconscious at the time of what he was doing, otherwise, according to the Judge's ruling, the plea of uncontrollable impulse, if established, would not have been sufficient to bring about an acquittal. I think it is a great pity that all our judges do not admit this plea into their charges, as Mr. Justice Hawkins did not long ago in the case of Ware.

Two Cases of Recovery from Chronic Insanity. By LLOYD FRANCIS, M.A., M.D. Oxon., Senior Assistant Medical Officer St. Andrew's Hospital, Northampton.

I venture to add the following to the list of recorded cases of recovery from long-standing mental disease. In both the illness was of at least five years' duration, dating from the first appearance of symptoms; in both the restoration to mental health was complete, improvement, once established, being steady, rapid, and decided. Both were transferred from other asylums, apparently incurable. In each instance the primary condition was one of melancholia, with marked suicidal tendencies, giving place, after a considerable interval, to a definite and prolonged maniacal phase. In one case the resumption of pursuits, abstention from which had presumably brought on the attack, seemed to be the main agent in restoring the mental balance; in the other the shock of a physical injury appeared to be the starting point in the road to convalescence.

CASE I.—M. B., aged 59, married; no occupation, formerly a steward. Admitted August 26th, 1883. The previous history being as follows:—

Beginning life as a common labourer, he, by dint of energy, perseverance, and shrewdness, gradually improved his position, and in the course of years amassed a comfortable fortune. Having acted for a considerable time as steward and general manager of a large ladies' college—with profit to himself and satisfaction to his employers—he decided to retire on his savings, leave London, and settle in the heart of the country. The new life and surroundings, widely different from the former ones, proved very uncongenial to a man of his energetic temperament. Of imperfect education, lacking refined tastes and intellectual resources, he gravitated to the village alehouse, and contracted very intemperate habits—the outcome being a state of extreme depression, with suicidal tendencies, lasting for nearly four years. At the end of that period his symptoms underwent a change. He became restless, garrulous, incoherent; entertained various delusions, more particularly as to his own financial position and physical strength; became extravagant, purchasing all kinds of useless articles; and was violent to his wife and other members of his family. Coincidently, his suicidal propensities became intensified; and on one occasion he attempted to throw himself in front of a passing train. Being regarded as dangerous to himself and others, his friends removed him to an asylum. After remaining there ten months without any improvement, he was transferred here.

On admission he was described as follows:—"A well-built, sturdy man, well nourished; grey hair, greenish eyes, pupils equal and

Medico-Psychological Association.

THE PRIZE DISSERTATION.

A BRONZE MEDAL and TEN GUINEAS will be awarded, on the following conditions, to any Assistant Medical Officer of any Lunatic Asylum (Public or Private), or of any Lunatic Hospital in the United Kingdom, for the BEST DISSERTATION on any Clinical or Pathological Subject relating to Insanity.

The following are the Conditions :—

The Dissertation to be in English, and the number and importance of original observations will be considered as principal points of excellence.

Each Dissertation to be distinguished by a motto or device, and accompanied by a sealed envelope containing the name and residence of the author, and having on the outside a motto or device corresponding with that on the Dissertation.

The Dissertation shall not exceed in length twenty pages of the ordinary type of the Journal of the Association.

The Manuscript *Prize Dissertation*, and every accompanying drawing and preparation, will become the property of the Association, to be published in the Journal at the discretion of the Editors.

Those Dissertations which shall not be approved, with their accompanying drawings and preparations, if any, will, upon authenticated application within the period of one year, be returned, together with the unopened envelopes containing the names and residences of the respective authors.

The unapproved Dissertations which shall remain one year unclaimed, with the drawings and preparations, will become the property of the Association. In such cases the envelopes containing the names of the authors will be burnt unopened in the presence of the Committee.

The Dissertations for the Association Medal and Prize for the present year must be delivered to DR. SAVAGE, Bethlem Hospital, London, before 30th June, 1887.

No prize will be awarded if in the opinion of the adjudicators none of the Dissertations are of sufficient merit.

The name of the successful author shall be announced at the Annual General Meeting of the Association, together with the title of the Dissertation.

H. RAYNER,

Hon. Gen. Sec.

His friends were warned of the danger of a return to the old monotonous, objectless country life, and advised to secure for him brighter and more varied surroundings and congenial occupation. This counsel has been followed, and he remains perfectly well.

Case II.—M. C., single, aged 40; an artist. Her illness, said to be caused by domestic affliction, dated from midsummer, 1879, and commenced with marked melancholic symptoms. She became restless, agitated, desponding, silent, and morose, lost interest in her usual occupations; and, though of blameless life, and esteemed by all who knew her, spoke of heavy crimes weighing on her conscience, and begged for something to put an end to her existence. She attempted to drown herself in the water cistern, swallowed large quantities of aperient pills, secreted a case of razors and a knife in her bed, and made other attempts at self-injury. She remained an inmate of a metropolitan asylum a little over two years, and was thence transferred to St. Andrew's.

The features of the case had by this time very considerably altered. There was no particular depression. She was restless and fidgety, constantly picking and biting her nails, which were worn down to the quick; sleepless and noisy at night; very irrational—constantly repeating such phrases as that "she wished she had done it before, wished she had stayed there," &c., or asking why she had not done this or that. Her physical condition also was extremely unsatisfactory. With an excellent appetite, she was pale and thin (weight, 7st. 11lb.); her feet were œdematous; urine free from albumen.

Within the first year from admission she suffered from frequent bronchitic attacks, with hæmoptysis, but no clear indications of graver mischief. Later, in the second year (May, 1883), she was confined to bed with physical signs of phthisis, from which, however, she recovered, afterwards remaining free from all lung-symptoms with the exception of occasional cough, gaining weight and otherwise improving in physical condition.

Mentally, however, she made no progress, being in some respects worse than on admission. She was irritating and meddlesome, constantly touching other patients, pushing them about and annoying them in various ways; destructive; faulty in habit; occasionally violent.

During the autumn of 1884 she showed some tokens of amendment by occupying herself with needlework, and improving somewhat in habits. But she retained all her other objectionable characteristics, and was regarded as a very unfavourable case until November 11th, when, in rising suddenly from a garden seat, her right forearm became caught between the bars, the radius being fractured near the wrist.

From the date of this accident there was a distinct change for the better; so that within a month she is noted as "improv-

ing mentally; much cleaner in habits; no longer bites her nails; and has very much more power of self-control."

Her subsequent progress was rapid and continuous. She became pleasant, amiable, vivacious, energetic, industrious; was natural in behaviour, rational and intelligent; took abundant outdoor exercise, and was to the fore at dances and other entertainments. She evinced, too, a gratifying and unusual sympathy for her fellow-patients, consoling, helping, and encouraging in every possible way those whom she had formerly teased, annoyed, and now and then maltreated.

She herself was convinced that the accident was the turning point in her illness. She declared that it was the first severe physical shock she had ever experienced, and it "brought her to her senses."

On March 28th, 1885, she was discharged recovered, after nearly six years of asylum treatment.

Two Cases of Syphilitic Insanity occurring after Alcoholism, and presenting Paralytic Symptoms. By A. R. Urquhart, M.D., Physician Superintendent, James Murray's Royal Asylum, Perth.

I desire to place these cases of syphilitic insanity on record, as they fully illustrate the difficulty of forming a speedy and accurate diagnosis from general paralysis when the personal history is not at once fully and fairly stated. There has been of late a series of admissions of syphilitic patients into this hospital, and in grouping these according to their clinical features we have found the two now to be described forming a definite class. Both were set down as general paralytics on their first reception. I had, however, the consolation of erring in the very good company of the experts who sent me these cases; and to some it may yet remain an open question whether the first impression is not correct, and whether their present recovery may not be a mere remission of true general paralysis.

Before proceeding to detail the results of observation and treatment, and to point out how the symptoms conformed to the generalizations of the authorities on these diseases, I may be permitted briefly to urge the importance of making it part of our routine practice to carefully examine the genitals of newly-admitted male patients for scars of chancres or other sores. The sexual history of such patients as these now under

consideration is, of necessity, of prime importance, and I have more than once found such scars explain what would otherwise be obscure and difficult cases, and give the necessary clue to causation and treatment. Dr. Buzzard lays it down as a fundamental rule in the investigation of every case of nerve disorder that the possible association of the symptoms with syphilis should be duly considered, and his book on this subject fully bears out the justness of his observation.*

Case I. (From the notes of Dr. Greig, late Assistant Medical Officer.)—X., a retired bank clerk, æt. 46, was admitted on the 30th September, 1885. He had been living for three years in a comfortable country house, with his wife and two young children—the elder three years, the younger three months old. Two years ago his wife had a miscarriage; and the elder child has a large head and a peculiarly "deep" voice.

History.

Family history.—No hereditary neurosis. Parents both died in middle age, his mother of cancer. One brother and one sister, both alive and healthy.

Personal history.—Naturally of a kindly but reserved disposition. Till eight years ago was steady and industrious, but about that time began to lead an irregular life, and drank heavily. His sexual excesses resulted in syphilis, for which he was then imperfectly treated. He left the banking business in 1882. Nine months ago excessive drinking and smoking (4oz. of strong tobacco a week) culminated in an attack of delirium tremens. From this attack he made a partial recovery. It left him subject to intense headaches, red eyes, deafness, a very slow pulse, and contracted pupils. Mentally, he became restless and irritable, being especially excitable on taking stimulants, even after half a glass of whiskey. During this period the patient has gradually fallen off in health and condition. It should also be noted that he has lately been considerably worried by money losses.

Five weeks ago, while working in the garden, he had an attack of transient loss of power, accompanied by a feeling of burning all over the left side, as "if his coat were on fire." This loss of power was only partial, as he was able to walk from the garden to the house.

Since then patient has gradually become weaker, mentally and physically; he has been occasionally very violent, and dangerous both to himself and others. He developed delusions of many kinds, of hearing, and especially of suspicion. Ideation is now slow, he has difficulty in understanding what is said to him, and replies after hesitation.

Present condition.

Physical.—Patient looks ill and haggard, but younger than his years. Complexion fresh. Height, 5ft. 8in.; weight, 10 stones.

* "Clinical Aspects of Syphilitic Nervous Disorders," 1874.

Slight intertrigo between scrotum and thigh. No injuries discovered.

Circulatory system.—Pulse 80, regular and weak. The first sound of the heart is feeble, the second is accentuated over the aortic area. He has slightly varicose veins over the calves.

Respiratory system—in a normal condition.

Digestive system.—The breath is very offensive; the tongue foul; the teeth good, but coated with tartar. The bowels are slightly constipated.

Genito-urinary system.—Urine acid in reaction, colour high, becoming muddy on standing, of sp. gr. 1035, and deposits on standing a very large quantity of amorphous urates.

Nervous system.—There is marked dysphagia, thickness of speech, and staggering and uncertain gait. The pupils vary much, and are irregular.

Mental.—Patient labours under considerable depression. When asked a question he answers generally after some time, or after two or three repetitions. His memory seems good; he is not always coherent. He labours under many delusions—sees flashes of light, hears voices, imagines that he is to be killed, that his children are to suffer some dreadful fate.

History of Case.—On the day of admission, and that following, the patient was dull and depressed, slept badly, and wept a good deal.

About midday on October 2nd he brightened up a little, and became more animated. At dinner he suddenly got up and tried to stab himself with a knife, but fortunately failed in his object. Almost immediately afterwards he had a sudden and violent attack of excitement, in which he required to be held. This attack wore off, and the patient became quiet and had a better night. Writes the following letter in a shaky hand.

The Murray, Perth.

My Dear J.,—I have been thimking our, ourpossessions & imcomee I ann made rather anxiones thereeefore has kunkly promiseed the forward the further forward.

I think dear J. the extra extra premses I will have to expennd this year will thereefore warrantyre The sale of carramges.

October 3rd.—In the morning he was depressed and weeping. During the day he became more rational. He observed and recognized the carriage in which his wife had come to visit him, but said that he "would rather not see her."

October 4th.—He was to all appearance quite rational and sane; he remembered perfectly everything that happened while he was excited, and explained his violent conduct, which he described as being caused by some imaginary tormentor. Thus, he says that on October 2nd, when he seized the knife, he saw a man before him with a naked knife in his hand, and his child's head stuck on a wire on the opposite wall, the body being in the coal-box. He wished to kill this imaginary man, and when the assistant medical officer entered the room the man went to the coal-box, brought the child's body out,

fastened the head to it, and thereupon the whole vanished. All this the patient described graphically and coherently. He also observed that when harassed by these delusions, he saw bright flashes of light, and suffered great pain and heat in the head.

October 7.—At 11.15 p.m. he had what he called a "shock." According to his own account "he felt as if a bundle of nerves were gathered together and dragged towards his heart." There was pain in the cardiac region and a "peculiar feeling" up the left side of the neck and left arm. This spasmodic attack lasted only for a few seconds, then passed away, leaving him quite well.

October 15th.—He had another similar attack. During the interval he had been quite well, was on parole, and in the convalescent ward. This attack he described as follows :—"It began with a peculiar painful sensation on the left side of the tongue, and gradually spread to the left cheek, which began to contract and move about. At the same time the saliva began to flow from the left side of the mouth, and the left eyelids were also convulsed, causing rapid winking. There was heartburn, waterbrash, and nausea, and a burning sensation over the whole of the left side. The left arm became 'dead' and powerless for some time. There was inability to speak intelligibly. The twitching never passed below the collar-bone." All passed off after a few minutes, and patient was able to walk upstairs. About seven minutes later it began again. He was then seen by the assistant medical officer. The phenomena were those described by the patient; his pupils were equal; both hands gave a strong grasp; the tongue could not be protruded steadily, but was rapidly extended and drawn in again. He could not speak one word intelligibly owing to the spasmodic condition of the muscles of articulation. He was immediately put to bed, when the symptoms passed off, except for a slight contraction of the muscles at the left angle of the mouth, which persisted for about two hours. Again at noon he had another slight spasmodic attack, characterized by slight twitching of the left eyelids and of the left arm and hand. At midnight he had another very slight attack.

October 20th.—He awoke with a very severe frontal headache, which persisted all the morning. At 7.20 he had a spasmodic attack exactly similar to those described above, the spasm coming on and passing off twice within 20 minutes. Hydrarg. Iod. Vir. (gr. 3 per diem) was prescribed to-day.

October 22nd.—He had again a severe frontal headache, which was accompanied by nausea and vomiting, relieved by sharp purgation.

October 23rd.—He was to-day well enough to visit home, a railway journey of some 25 miles, accompanied by the assistant medical officer. He was very well all day, but about 7.30 p.m. it was noticed that his left naso-labial fold had disappeared. Shortly afterwards he complained of a pricking sensation in his left thumb,

and his mouth was slightly drawn to the left. This condition persisted for about an hour, when he had an attack of clonic spasms. It lasted for about three minutes and presented the usual features, but left his speech thick for about two hours.

October 24th.—The nape of the neck was blistered.

October 26th.—Severe headache, relieved by sharp purgation. Blister kept open by Ungt. Sabinæ.

November 4th.—Patient began to be salivated. The dose of Hyd. Iod. Vir. was consequently lowered to 1 gr., and on the 15th to ¾ gr.

December 15th.—As patient continued perfectly well, mentally and physically, he was discharged recovered, and readmitted for a few weeks as a voluntary patient. On the 21st December he left perfectly well, and better than he had been for years according to his own account. When discharged finally he was taking ¼ gr. Hyd. Iod. Vir. thrice daily.

1886, August 28th.—The patient writes: "My head is now as clear as a bell, and my general health excellent. I got a young horse the other day, and being misbehaved I had an exciting fight with him, and had afterwards what I think was a very slight attack of my paralytic friend. I felt a gritty sensation in my hand, and afterwards it apparently settled in the shape of a tingly feeling in the point of my toung." (*Sic*).

November 2nd.—Dr. Turnbull writes: "X. says he is well in mind. The one thing he spoke about as indicating a shortcoming is that he is not able for so much mental concentration as he was formerly. If he has to think long or deeply about anything which involves a difficulty, he feels that he gets confused and cannot work it out. On at least one occasion he had peculiar sensations passing up his left arm, which he describes as similar to what he felt in the transient attacks of paralysis he had while at Perth.

"Mrs. X. thinks her husband is as well as ever he was, except that he is certainly more irritable than he used to be. He will flare up very suddenly on slight provocation.

"Dr. Constable has seen Mr. X. occasionally during the summer, and considers that he keeps remarkably well, though at times he still complained of 'that load on the top of his head.'

"For myself, I think Mr. X. is very well indeed just now. He spoke most pleasantly and correctly, and in a perfectly natural and sane way. He transacts all his own business himself. He spends his time mostly in his garden and greenhouses, being practically his own gardener; and he has a capital result in flowers to show for his labour. He also goes in for riding a good deal. I have above mentioned all the symptoms he shows now; and in every other way, so far as I could learn from himself and from his wife, he seems to be perfectly sane both in speech and conduct.

"Of course I was on the outlook for some change in his articulation. Occasionally I fancied there was a slight defect, but it was very

slight—not enough to warrant one in drawing any conclusion from it, *if* it existed at all.

"Certainly, I did not expect when I first saw Mr. X. that he would ever get rid of his illness so remarkably as he has done. He himself says that there was no alcohol and no chloral or other drug in his case, and I believe his statement on that matter implicitly. It will be interesting to watch how he goes on."

Case II.—Z. (From the notes of Dr. Murray, Assistant Medical Officer.) Mr. Z., cashier in a large office in Glasgow, aged 34, was admitted on the 20th February, 1886. He previously lived in good hygienic circumstances with his wife and one child, about two years old.

Family History.—No hereditary neurosis. A brother and sister died in infancy. One child of the patient—the eldest—died at full time of pregnancy; the second is alive and healthy; the third died fourteen days before birth, and when born was in a state of desquamation, but there was no rash. This was in February of 1885. Since then there has been no child.

Personal History.—Till 18 months ago led a regular life as a rule, but was occasionally dissipated. About that time, however, he began to drink heavily—according to his own account beer only—led a fast life, and had promiscuous sexual intercourse. This went on for six months, when he was suddenly seized with very severe headaches, and had to lie up. These became continuous, and drowsiness and partial stupor set in. For this he was treated by Dr. Tennant, Glasgow, who applied blisters along the back, which were kept open for a lengthened period. Under specific treatment the headaches disappeared, but dulness and stupor remained, and have never been dissipated. The bodily health at the same time deteriorated; his appetite became very bad, and finally nervousness, with tremors of the hands, set in, accompanied by polyuria and great thirst. About four weeks ago he went to the country, being unable to work in Glasgow, and since then his bodily health has somewhat improved. Mentally he became steadily worse; his memory deteriorated and his ideation slowed. Latterly he developed delusions of suspicion regarding his wife. In this state he came to visit friends in Perth. Three days ago he had a succession of epileptiform fits, which lasted all night, and left him violent and acutely maniacal. This condition was followed by a period of stupor or semi-coma. These conditions have since alternated at short intervals. During his maniacal attacks he has violently tried to strike anyone near, and struggled when held. Delusions regarding his wife are firmly fixed; he thought that she was transferred to other men. He also has had delusions of suspicion that he was to be poisoned by chloroform, &c. The general practitioner in attendance thought that he was suffering from uræmic convulsions, having found albumen in the urine. About a week subsequent to admission it was ascertained from Dr. Tennant that he had diagnosed the attack of a year ago to

be syphilitic meningitis, and had treated patient for that complaint.

PRESENT CONDITION.

Physical.—Stoutly built, well nourished, but flabby. Height, 5ft. 2½in.; weight, 9st. 8lb. His expression is dull and stupid; his skin is smooth and pale, almost waxy in appearance, hot and dry, and presents no appearance of an eruption of any sort. Temp. 102° in the axilla.

Circulatory System.—The pulse is 118, weak, quick and jerky. The heart-sounds are clear and sharp, the second rather accentuated over the pulmonary area.

Respiratory System.—Normal.

Digestive System.—The breath is very offensive, the tongue is dirty and furred, the mouth dry, and taste seems impaired. No abnormality can be made out in the abdominal viscera, on physical examination. The bowels seem in fair order. Patient has an excessive thirst.

Genito-urinary System.—Genital organs normal. Urine: 10 to 11 pints passed daily; (faintly acid); pale straw-colour; of sp. gr. 1005; containing no albumen or sugar.

Nervous System.—The limbs are shaky, especially the hands and arms, when the muscles are put on the stretch; his gait is uneven; the speech is thick and indistinct, especially when long words containing sibilants are used; he is distinctly aphasic. The patellar reflex is much exaggerated, and ankle clonus is present; the pupils are regular and equal, and the sight is good. Ophthalmoscopic examination reveals a normal fundus, except that the retinal vessels are tortuous and the disc a little congested. The hearing on the right side is defective. There is incontinence of urine, the desire to micturate coming on suddenly and being "too strong for his powers of retention."

Mental Condition.—When first seen he was excited and struggling between two men who were holding him. When they were told to leave him he sat down quietly and answered coherently when spoken to. He seemed dull and stupid, did not know the day of the week nor the month, did not know where he was. His memory was very defective. He seemed afraid about his wife, said that she would be sent to other men.

HISTORY OF CASE.—On the day of admission patient was placed in bed in a single room. He seemed dull and very confused, but was not violent, and was in the evening removed to the sick room, with instructions that he was to be kept in bed. He slept badly, but was quiet.

February 21st.—Breath very offensive and tongue foul. He was ordered Pil. Podoph., containing gr. ¼ of the resin, with Pil. Coloc. et Hyoscy., gr. 4. This caused free purgation. The stools were dark and bilious; the urine measured about 10¾ pints, and no albumen was found. The mental condition was one of quiet stupor unaccompanied by sleep.

February 22nd.—Slept better. The liquid ingesta being restricted, he passed only 6½ pints of urine, which contained blood. On examination with cold nitric acid it was found to be loaded with albumen, to the extent of about one-third. Microscopic examination revealed epithelial cells in considerable numbers, crenated blood-cells, and epithelial and granular casts from the renal tubules. Sp. gr. 1008; temp., M. 101·5, E. 101·0. Patient's mental state unchanged. He dozed a good deal, and seemed very drowsy. His memory was very bad; he did not remember reporter, though he had seen him only a few minutes before, and he had no idea where he was. His delusions about his wife persisted, and he was very anxious to see her. At the instigation of the reporter he tried to write to his wife. This he did sensibly and coherently, but very shakily, and with difficulty in remembering words. He was put on nourishing diet, with custard, and barley water *ad lib.*

February 22nd, 1886.
The Murray, Perth.

My Own Darling Wife,—I wish you would call up here and see me, for I do not understand what all this means. Come up as soon as you can. I will not write more just now, but will tell you all when I see you. Do come immediately.

I remain, my own darling wife,
Yours very faithfully,
———.

February 23rd.—The urine had again increased to 11 pints, but patient was drinking a great deal of barley water. There were traces of albumen and fewer casts, probably owing to the dilution. He seemed a little better mentally.

February 24th.—He was considerably better after a good night's rest; his temperature was reduced to 98·4 in the morning, 99·6 in the evening. He passed 13 pints of urine of the same characters as before. Mentally he was much improved. He spoke quite rationally, inquired affectionately about his wife, said he had thought most unworthily of her, that he remembered his delusions regarding her, and was now quite free from them.

February 25th.—Little change; the temperature rose in the evening to 100·8, the pulse to 105. The urine measured 15 pints, of sp. gr. 1003. Albumen only existed in a very slight trace. During the day he consumed 13½ pints of fluids.

February 26th.—He seemed slightly better, but the aphasia, with difficulty of pronouncing words, still persisted, though lessened. On carefully tapping his head it was found that there existed a tender area over the left coronal suture, about its centre, and about one inch square. There was no permanent headache at this or any other part. The tongue was still foul and dry, and the appetite weak. Urine measured 19 pints, was of sp. gr. 1005, and contained a proportionately larger quantity of albumen. Total of fluids consumed was 16½ pints. Temp., M. 99·9, E. 101.

February 27th.—Temperature was somewhat lowered, being—M.

99·8, E. 100·4; while the pulse was 98 and 108. The urine measured 18 pints, and was of the same characters as on the 26th. The fluids consumed measured 14 pints 2 ounces? Pot. Iod. gr. 10, ter in die, prescribed.

For the next few days the condition varied very little. The quantity of urine was from 6 to 10 pints. The decrease was owing to the fluids consumed being limited to six pints.

February 28th.—The last traces of albumen disappeared from the urine. The temperature varied from normal to 100°.

March 4th.—Considerable improvement, mental and physical, was manifested. His temperature was normal, and remained so in the evening; his appetite, which had heretofore been very poor, began to improve, and he seemed stronger. The memory remained very bad. He kept continually complaining of the fluids being restricted, and would beg one of the other patients to bring him a cup of water.

March 6th.—As improvement continued, he was allowed up for a little. He seemed refreshed by the change, but was very weak and shaky; he could not stand on one leg, and was very unsteady if his eyes were shut. From this time he steadily improved; his memory and mental faculties gradually, but very slowly, became stronger, and his temperature and pulse remained normal. The urine, however, kept about 10 pints daily, and rather increased than decreased, because while he was up and about the fluids consumed could not be so absolutely restricted. His tongue also remained foul, and his appetite not so good as it ought to have been.

March 12th.—He was removed to the convalescent ward. Here he continued to gain strength mentally and physically, but continued to wet the bed at night and pass a great deal of urine.

March 19th.—He was kept under observation for 24 hours, and his urine measured, when it was found to amount to 22½ pints of sp. gr. 1003, and to contain no albumen or sugar. The fluids consumed measured 20 pints, and even then patient complained of thirst. He was now granted full parole within the grounds.

March 24th.—Patient was put on three pints of water daily. He continued to improve, and weighed 2 lbs. heavier than on admission.

From this time patient continued to improve slowly but steadily, and increased in physical strength. His memory became very much better both for recent and remote events, but he said that the first three weeks after he came here seemed to him like a dream, and he could hardly remember anything that occurred during that time. He was gradually able to take long walks and visit friends in Perth, which he did frequently.

April 26th.—Was still improving steadily, but the polyuria continued and he constantly wetted the bed. The exaggerated patellar reflex and ankle clonus were still present, and his appetite was poor. His hand was much steadier, and he could now play a good game at billiards.

May 10th.—As the improvement had continued, and he was very well mentally and physically, with the exception of the polyuria and the weakness of occasionally wetting the bed, he was discharged on pass for one month. On the day of leaving on pass his physical condition was very good, he was strong, his limbs were muscular and firm, his eyes were normal, the fundus clear, and the vessels natural; but the thirst and polyuria continued with the exaggerated patellar reflex and slight ankle clonus. He was instructed to continue the Potassic Iodide in 15 gr. doses three times a day. From the first day of admission there was never any excitement. He went to the country with his wife and improved still further; the polyuria diminished and with it the thirst. On June 10th he was accordingly discharged from the books recovered, with instructions to carry on the course of Potassic Iodide under medical observation, and to be strictly regular and temperate in habits. On July 20th the accompanying letter was received, affording a marked contrast in steadiness to that dated February 22nd, 1886.

Mental state on discharge.—Memory very good, patient read intelligently and with interest, and talked intelligently upon many subjects. He seemed only weak in one thing—he could not overcome his desire for water; the thirst overcame his power of self-control.

19th July, 1886.

Dr. Urquhart,

Dear Sir,—Many thanks for your kind letter, which reached me here this morning, and I am glad to be able to inform you that I am still keeping well and persevering with my medicine, which I take three times a day.

I am, dear sir,

Yours faithfully,

———.

Nov. 11th.—At this time he continues perfectly well, is able for his work, and writes in good spirits.

At first sight both these cases resembled general paralytics in a striking degree, although neither presented the more common symptoms of expansive delirium. It was only on a thorough study of the symptoms and a searching investigation into their past history that the diagnosis was fully established. In both cases there was an absolute denial of syphilitic infection at first, and the wives would scarcely admit irregularities of life, although fully aware of the pressing importance of appropriate treatment and an accurate forecast of the future.

We have fortunately accumulated in the records of brain-syphilis a set of differential symptoms, the observance of which serves to guide us in forming a correct diagnosis in these perplexing cases. And if, in spite of inaccurate or insufficient evidence as to actual syphilitic infection, we arrive at the con-

clusion that the symptoms point to that cause, there can be little doubt that active specific treatment should be fully tried. I am not aware that evil results have been recorded as following the use of Potassic Iodide with or without Mercury and Counter-irritation in cases of general paralysis. Until experience proves it wrong I shall therefore continue so to treat every doubtful case.*

Dr. Wille ("Journal of Mental Science," 1873), points out that the mental symptoms often occur *after* the motor and sensory derangements. He remarks on the unfavourable prognosis, when convulsions, epileptiform attacks, and fits with loss of consciousness set in, although, even then, a cure may be effected. Erlenmeyer, however, dissents from this very bad prognosis. Dr. Wille has seldom observed monomania of grandeur in syphilitic mental disorder, and notes that partial paralyses are pretty frequently found in these diseases, while they are seldom observed in cases of true general paralysis of the insane.

Dr. Müller has pointed out ("Journal of Mental Science," 1874) the leading points of differential diagnosis between syphilitic disease of the brain and general paralysis. He insists on the importance of persistent headache and hyper-æsthesia in the first named, also on the curability of brain syphilis—although it is a somewhat roundabout means of diagnosis to place the curative treatment in the first place.

Dr. Braus ("Hirnsyphilis," 1873) collected 100 cases of brain syphilis, and remarks that the cerebral symptoms generally appear at a considerable time after infection. Among the points mentioned by him headache and weakness of memory have a prominent place. A large proportion suffered from incomplete paralysis of various nerves, and in 45 out of 100 there was mental derangement.

Dr. Mickle has treated the subject of intra-cranial syphilis at length ("Brit. & For. Med. Chir. Review," 1877), and points out the frequency with which in these cases marked motor or sensory disorders precede the mental symptoms—usually of acute mania or hypochondriasis. Optic neuritis, and paralysis of individual cranial nerves are valuable signs, and in more advanced cases the affection of the speech is paralytic rather than "of the nature of mingled weakness and inco-ordination," and when dysphagia occurs it is usually sudden. These and similar points agree with the description of the cases I have

* See "Mickle on General Paralysis," 1st Ed., p. 172.

laid before you, but in other directions Dr. Mickle's experience does not tally with them. For instance, he says ("General Paralysis of the Insane," 1st Ed., p. 72)—Palsies are often complete, limited, and independent of convulsive action in syphilis, and again, the motor impairment of limbs is usually paralytic, localized, and unilateral. In the first case the paralysis was incomplete and convulsive as regards the head, and the gait was as ataxic as any general paralytic.

Dr. Hughlings Jackson, ("Journal of Mental Science," 1874) lays stress on the valuable evidence of syphilis obtained in the clinical course of the case, and says that "a random association or a random succession of nervous symptoms is a very strong warrant for the diagnosis of syphilitic disease," and the value of this dictum is evident on a brief investigation of the above detailed cases.

Finally, I have placed the chief symptoms of X. and Z. in parallel columns for ready reference.

X.	Z.
Age 46.	Age 34.
No hereditary neurosis.	No hereditary neurosis.
Dissipation. and syphilitic infection eight years ago.	Dissipation and syphilitic infection 1½ years ago.
Miscarriage of child.	Miscarriage of children.
Delirium Tremens recently.	Tremors of hands.
Headache intense and recurrent.	Headaches intense and persistent. Tenderness of head on percussion.
Pulse slow.	Pulse rapid.
Left hemiplegia transient.	Epileptiform fits.
Delusions of suspicion.	Delusions of suspicion.
Ideation slow.	Ideation slow.
Memory good.	Memory bad.
Acute mania following other nervous symptoms.	Acute mania following the other nervous symptoms.
Thickness of speech. Dysphagia.	Thickness of speech. Aphasia.
Paresis of lower limbs.	Paresis of limbs.
Not observed.	Patellar reflex exaggerated. Ankle clonus present.
Irregular pupils. Flashes of light.	Regular pupils, congested disc.
Urine containing amorphous urates.	Polyuria, incontinence, albumen, blood. Thirst intense.
Recovery from mental symptoms rapid.	Recovery from mental symptoms rapid.
Recovery from paralysis gradual.	Recovery from paralysis gradual.

*Cases illustrating the Sedative Effects of Aceto-phenone (hypnone.)** By CONOLLY NORMAN, F.R.C.S.I., Resident Medical Superintendent Richmond District Asylum, Dublin.

The chemical name of this substance in full is phenyl-methyl-acetone. This is generally abbreviated into aceto-phenone. It belongs to the aromatic series. Its formula is C^8H^8O. It was discovered in 1857 by Friedel, and its physiological properties have been investigated by Popof and Nencki. These observers have demonstrated that aceto-phenone, in its passage through the body, is transformed into carbonic acid and benzoic acid, and that it reappears in the urine in the form of hippurates. M. Dujardin Beaumetz, to whose account I am indebted for the above-mentioned facts, was the first to make use of it as a sleep-producing agent. Conceiving that it possesses marked powers in this direction, he proposed for it the name of hypnone, and as the result of my experiments has been to confirm his opinion, I shall throughout this paper make use of that convenient short title.

M. Dujardin Beaumetz states that hypnone, in doses of three or four drops for the adult, produces profound sleep, and he says that with the victims of alcoholism its hypnotic properties seem superior to those of either chloral or paraldehyde. The only unpleasant effect that he observed after its administration is the disagreeable odour which it communicates to the breath. Injected subcutaneously in the guinea-pig in doses of half a gramme to a gramme, it produced profound torpor, passing into coma, wherein the animal died at the end of five or six hours.

M. Laborde, on the other hand, maintains that hypnone, hypodermically injected, does not produce perfect sleep in animals, even in the guinea-pig, which seems the most sensitive to its influence, save in relatively large doses; and goes on to say that sleep once having been produced, the animal cannot be roused, but dies asphyxiated. He has produced light sleep in the dog by the introduction of hypnone into the stomach. He finds intravenous injection in the dog produces deep sleep with complete analgesia and anæsthesia, marked diminution of the oculo-palpebral reflex, constant

* Read at the Quarterly Meeting of the Medico-Psychological Association, Dublin, Nov. 18th, 1886.

fall of the intra-vascular pressure, both central and peripheral, enfeeblement of pulsation of heart, accelerated and irregular respiration, and finally asphyxia and death. Post-mortem the following changes are found: very intense apoplectiform infiltration of the lungs, the liver, the spleen, and the kidneys.

The drug has been, I believe, little used in this country. Its abominable taste has been found to be a great drawback. When administered in capsule it produces unpleasant eructations, and communicates a strong disagreeable perfume to the breath. It is also found to produce headache and loss of appetite (*vide infra*). These symptoms are, perhaps, sufficiently intelligible when one takes into account the pungent and irritating properties of this class of combinations.

My experience of hypnone is almost entirely confined to its administration hypodermically, and although my observations have unfortunately not been very numerous, I am inclined to think that it is when thus employed a safe and useful hypnotic. I therefore wish to draw the attention of my colleagues to this comparatively new preparation, and I hope that more extended experiments than I have as yet been able to carry out will soon definitely establish its true value.

The following is a brief abstract of the cases of insanity in which I have used hypnone to procure sleep:—

B. S., male, aged 29. Admitted March 24th, 1886. He presented symptoms of acute mania of a somewhat hysterical type. Noisy and incoherent. Talked much on religious topics, the coming of the Messiah, &c., interrupting himself with silly jokes. Laughed and wept alternately without cause or apparent deep emotional disturbance. Indulged in grotesque and theatrical attitudes. Inclined to be careless of natural calls. The course of the illness had been acute, the first symptoms having appeared about a week before admission. He slept very badly, and was restless and noisy nearly all night. Bodily he was thin and pale, but presented no signs of any organic disease. From an early date a vigorous attempt was made to procure sleep by enforced exercise in the open air, and as soon as it was ascertained that the patient was not really dangerous, he was put to work at agricultural labour. He was so restless that this was rather a failure, however. No improvement at night was produced by these means. On June 17th he received 5 minims of pure hypnone hypodermically at about 7.30 p.m. He fell asleep in about three-quarters of an hour, slept till about 2.30 a.m., was restless and noisy for about half an hour, and then slept till six o'clock a.m. The same dose was repeated nightly till the 4th July. For the first few nights he slept from seven

to eight hours, with short intervals, never more than two nightly, of noisiness. On June 24th he was removed from a single room to a dormitory, and from that date he remained in bed all night, and appeared to sleep quite tranquilly. He became attentive to natural calls both by night and day. After the first week of this treatment he became more tractable and quiet during the hours of day, would reply much more coherently, and exhibited general mental improvement. In the beginning of July his appetite, which had been capricious on admission, is reported as "excellent," and he had gained colour and body weight. Hypnone being discontinued, he still slept well, and there appeared to be a slight progressive improvement in his mind, but he remained insane when last seen by me in September.

A. K., male, aged 33. Admitted March 3rd, 1886. This was a case of intense melancholia of recent origin. He almost wholly refused food. He was intensely depressed, sometimes torpid, making little response, except by tears, when spoken to; at others, restless, wringing his hands, bewailing his sins, invoking judgment on his head, and so on. These conditions varied within a few hours by day. At night he was almost constantly agitated, praying loudly, howling, singing hymns, reciting Scripture, &c., and tearing his bedding to pieces. On June 17th he was put on hypnone, 5 minims hypodermically at bed-time. He kept in bed that night, and seemed to get some sleep. The following nights he fell asleep at periods varying from twenty to forty minutes after the injection, and was noted as "sleeping well." The drug was continued in the same dose till middle of July, when it was withdrawn without apparent injurious effect. On one night only while he was receiving hypnone was he restless. On that occasion he did not sleep for three hours after the injection, and was noisy towards morning. The reason for this variation was not obvious. While under hypnone treatment he gradually came to take food well, though there was no marked improvement in his condition, which remained spare. By day the intervals of agitation became certainly less frequent, and there was no increase of dulness. I am inclined to think there was some improvement in intelligence, interest in his surroundings, &c. No change for the worse in any way was observed to follow the discontinuance of the medicine.

T. B., male, aged 28, strong hereditary taint. Second attack of insanity within seven years. Admitted April 14th, 1886. This illness, which is a very exact reproduction of the former attack, is characterized by much restlessness and great incoherence. Not dangerous, but very troublesome on account of disposition to tear his clothes, strip himself, pull the other patients about, and so on. After admission he slept very little, sang and shouted nearly all night, tore his bedding, and filthied his room. He received hypnone subcutaneously in five minim doses for about six weeks, from the 17th June. For the first week he was recorded as being less restless at night, and was often found asleep, yet he was very noisy and destructive at intervals.

With the continuance of the treatment he became much calmer at night, ceased to tear, kept his room clean, and slept ordinarily about seven hours. At the same time he grew so much more tranquil by day that it became unnecessary to keep an attendant constantly with him, which had to be done at first. Recovery may, I think, be anticipated, and progress so far has been much more rapid than on the occasion of his first illness. No change of appetite or physical condition was observed.

A. L, male, aged 22, admitted May 17th, 1886. A recent case of mania. A very intractable patient, not markedly incoherent, and rarely giving expression to delusions. Believing himself to be illegally detained, he refused food and required to be fed forcibly. For the sake of having his case investigated, or for no assigned reason at all, he used to make desperate assaults on his fellow-patients and others. He slept little, and used to lie in wait for the night attendant's visit to assault that officer or endeavour to escape. Hypnone was administered under the skin in five minim doses nightly from the 17th June to the 4th July. During that time he seemed to sleep soundly from seven to nine hours each night, and he was not found out of his bed on more than one occasion. From the 27th of June he took food voluntarily. There was from the same date a very marked improvement in general tranquillity.

R. J., male, aged about 50, a chronic inmate of asylums. Many years ago he suffered from an attack of melancholia with tendency to suicide. He recovered imperfectly, remaining weak-minded, a useful worker, not usually depressed while employed, but liable at intervals to outbursts of passion passing into a subacute maniacal condition of short duration, which again is followed by intense depression. One of these outbreaks, apparently depending upon a well-marked emotional cause, was succeeded by the customary depression. He became acutely conscious of his recent violence, which he loudly and incessantly deplored. From the state of agitation he began to pass into a duller condition, was silent, stood for a length of time in one place staring fixedly before him, &c. He said he "had nothing to complain of, for nothing could be bad enough for him." At this time he had slept little or not at all for the previous seven nights. He got five minims of hypnone under the skin at bed time; fell asleep in about an hour, and slept five hours with an interval of about half an hour's wakefulness. Next night, after the same amount of hypnone, he dozed in about half an hour, but his sleep was light and broken all night, and he did not sleep more than half an hour at a time. Hypnone in the same quantity was continued for seven nights. On the third night he fell asleep in half an hour and slept for six hours. The following nights he was reported as sleeping well. Meanwhile he was certainly less depressed by day. He spoke freely, and could be roused to smile and talk cheerily of the future. Improvement con-

tinued after the disuse of the drug. He slept well, and gradually returned to the *status quo ante.*

W. M., female, aged about 55. Intense hereditary taint. Has had several attacks of insanity. During one previous attack she was under my care. She then exhibited the most violent maniacal excitement continuously for about seven years. Somewhat suddenly she improved. Was discharged recovered, and was readmitted in about a year and a half. The present illness was never characterized by the same extreme degree of restlessness and excitement that she formerly presented. Her ordinary condition is one of moderate incoherence with great garrulity; she generally sleeps well. On the night of June 20th, 1886, she was very noisy. Next day extremely incoherent, noisy, violent, and obscene, recalling the features of her former illness. Hypnone, eight minims, hypodermically at bed-time. A tranquil night. June 21st, rather more calm, still very incoherent. Hypnone as before. Slept two hours; then noisy for about an hour; then slept about four hours. June 22nd, decidedly more tranquil. Can be got to give a coherent answer. Hypnone as before. June 23rd, slept eight hours. Seems to have quite returned to her ordinary condition.

B. M., female, aged 50, admitted August 24th, 1885. Melancholia agitata. Constantly endeavouring to escape, rushing for doors and windows, clinging to those about her, screaming and bewailing herself. Extremely restless. Pulled out almost all her hair. Got little or no sleep, and hardly lay down at night. Exceeding thin, skin dry and shrivelled. No sign of organic heart disease. Feeble pulse. Superficial arteries hard and tortuous. Morphia by the mouth seemed to have no effect. On June 17th, 1886, she received hypodermically four minims of hypnone. Little or no sleep, but she appeared somewhat more disposed to stay in bed. June 18th, very restless all day, hypnone five minims at 8 o'clock p.m. Fell asleep about 12 o'clock and slept till 4 a.m. June 19th, six minims at 7.30 p.m. Asleep at 9.30, slept with short intervals till 4 a.m., altogether about six hours. June 20th, seven minims at 8 p.m. Slept about seven hours at intervals, but was out of bed two or three times, and somewhat noisy. June 21st, eight minims at bed time. Slept in half an hour, and continuously for about seven hours. The dose was not further increased. With eight minims of hypnone nightly, continued for some time, she slept well and did not get out of bed. No loss of appetite. Much less agitation by day without any sign of drowsiness.

K. M., female, aged 58, admitted May, 1882. A case of extreme melancholia. Symptoms vary from the agitated condition to one approaching to stupor, and have been getting worse of late. Physical condition wretched. Steadily losing flesh. Complexion of ashy pallor. Appetite very bad. By night sometimes agitated, sometimes quiet, but almost quite without sleep. Hypnone in this case was used in five minim doses hypodermically with good effect, June, 1886.

It produced with promptitude undisturbed sleep. After it had been used for some nights the appetite began to improve, and the patient gradually gained colour and weight, though there did not appear to be any improvement in the melancholic symptoms by day.

Five other cases of which I have scantier notes may be referred to. Three were women suffering from mania, acute in symptoms, chronic in course, in whose cases sleeplessness and destructiveness at night were troublesome features. In all three, hypnone in five minim doses hypodermically produced sleep. In two it seemed to have no effect on the general mental condition. In the third, a young woman suffering from her second attack of insanity, considerable amelioration appeared to follow the induction of sleep, and I am glad to learn that this improvement continued, and has, since I saw her, culminated in recovery.

Another case was one of chronic weak-mindedness in a man about thirty years old. He has been for many years liable to recurrent attacks of maniacal excitement, characterized by restlessness, noise, and excitement, and ushered in by sleeplessness. On three occasions at intervals, when he had had a sleepless night and was beginning to show signs of excitement and turbulence, he was put on hypnone, and on each occasion sleep was produced, and I thought the threatened maniacal condition was warded off.

The last case on my list was one of intense melancholia with strong suicidal tendency. The patient, a man of 26 years of age, believed that his soul was lost, and he also suffered from a continual dread of some impending catastrophe. He neither slept nor generally kept his bed at night. Morphia in moderate doses had little or no effect. Cannabinon, as recommended by Vogelgesang, was used on a few occasions, but without result. Hypnone in five minim doses under the skin did not produce sleep. The dose was cautiously increased to 12 minims. Less appeared to have little effect, but with that amount the patient used to fall asleep in about thirty minutes and sleep for seven or eight hours. When this result was attained the dose was gradually diminished, and finally discontinued. Sleeplessness, the habit being broken, did not recur. No general improvement in the mental state could be observed.

The above is an account of all the cases in which I have made use of hypnone systematically, and, however imperfect it may be, is not in any way a selection. Circumstances prevented my investigations being carried out with the minuteness which I should have desired, nor would I have been able to carry them out at all but for the zealous and intelligent co-operation of my former colleague Dr. Lockhart Donaldson, Assistant Medical Officer of the Monaghan Asylum, to whose kindness I am indebted for the bulk of the foregoing notes, as well as for much other valuable aid.

I think the cases go to prove that hypnone is a sleep-producing agent of some power. I have never seen any un-

pleasant results from its use subcutaneously. I am disposed to think it may be found specially valuable in cases of recurrent excitement associated with sleeplessness. The proper mode of administration is evidently the hypodermic. Thus employed it does not interfere with the digestive processes. In several of my cases, on the contrary, appetite returned and nutrition improved while the drug was being used, though I am far from thinking that hypnone had necessarily any specific action in bringing about this result. Bearing in mind the effects that former experimenters had found aceto-phenone to have upon the kidneys, Dr. Donaldson carefully and repeatedly examined the urine of the patients who were the subjects of our observations, but was never able to detect the presence of albumen.

In experiments which we made upon two young men who were not insane, we found that a pleasant sensation of drowsiness appeared in from 15 to 40 minutes after injection, according to the amount used. The pulse became accelerated about 10 minutes after injection, and sank to its former rate in from 10 to 20 minutes later. This agreed with the results observed in the insane. Numerous sphygmographic tracings were taken, but in these I failed to detect anything special. Sleep seemed natural and was not followed by headache or discomfort of any kind. The injection of hypnone is painless. I have almost always found after some hours a discoloration at the seat of injection, much resembling the mark of a bruise, unaccompanied by any pain or swelling. Having in my first experiment, performed on a sane person, diluted the hypnone with spirit, I found that a small abscess resulted from my over-caution, but when pure hypnone was injected there was never any trace of inflammation. Hypnone largely diluted with glycerine, and administered by the mouth, was found to give rise to a very unpleasant burning sensation in the throat and stomach. Sleep was produced and seemed natural, but was followed by slight headache and loss of appetite.

OCCASIONAL NOTES OF THE QUARTER.

Judge and Doctor.

We venture to think that there was recently a considerable *rapprochement* between the judicial and the medical mode of viewing certain criminal acts. Friendly intercourse between judges and mental physicians has had the beneficial effect of opening the eyes of some of the former to the real nature of crimes committed by the insane, while very possibly the latter have derived benefit from the free intercommunication of ideas in regard to a just judgment of matters upon which lawyers and physicians must at bottom have a common object—simple justice. We are sure that no judge really wishes an irresponsible man to be punished, and it is very certain no medical man wishes the guilty criminal to escape the penalties of the law. There are occasions, however, when we think that judges are somewhat unduly disposed to set aside the evidence of medical men, and not only to lay down the law, but to go out of their way to influence the jury in a direction contrary to that of the medical opinion given in evidence. As an example of judicial discourtesy we might instance the petulant language of Baron Huddleston in the course of a trial at the Devon and Cornwall Assizes last November, in which he seemed to us to forget the golden rule in his brusque treatment of a medical witness. And, again, the same judge more recently acted in a way which has somewhat rudely shaken the hope and belief above expressed, and made us fear that our judges may sometimes "indifferently minister justice" in the least favourable construction of that phrase. At the Winchester assizes, in November, a young man (Russell) was charged before Baron Huddleston with murdering his grandmother. Among other witnesses, Dr. J. G. Symes, for thirty years Superintendent of the Dorset County Asylum, who had examined the prisoner by desire of the Home Office, alleged that he was of low intellect, from his mode of answering questions and his general appearance. He appeared indifferent to his position and to the act he had committed. He did not display any excitement or delusions during the interview, and appeared to know right from wrong, but, in his report to the Treasury, Dr. Symes stated that at the time of the murder he was, in his belief, of unsound mind, an opinion the judge would not allow him to express in Court.

The prisoner had had fits. In his summing up, the judge animadverted upon the evidence of medical men, and he thought it proper to assert that they usurped the functions of a jury in getting into the witness-box to show their knowledge and ventilate their own fancies and theories without being able to give the reasons on which they based their conclusions. Happily, the jury, while finding the prisoner guilty of murder, strongly recommended him to mercy on account of weak intellect, and he has been reprieved.

The heading of this "Occasional Note" has, however, been suggested by a trial in Scotland, in which one Thomas Lamb, twenty years of age, was charged with indecent assault. The plea set up in the prisoner's defence was that he was insane at the time the offence was committed. Evidence was given that at eight years of age he had scarlatina, and for some weeks afterwards was very deaf, there having been a discharge from his ears continuously from that time. His memory, never good, became much worse after his illness. A year afterwards he had measles, and soon afterwards whooping cough. Subsequently he fell from some bales of jute and was brought home insensible, remaining in that condition for two days and a night. When his mother stated that there was a mark on the back of his head, in consequence of the fall, Lord Young humorously observed, amid the laughter of the Court, "I suppose most boys have marks or cuts about their heads." The mother also stated that her father was insane and had to be confined on two occasions. On being recalled Mrs. Lamb stated that her husband's uncle was insane, and a grand-uncle was silly.

His Lordship, addressing Mr. Guy, who defended the prisoner, said: I am sorry to have to interrupt you, but the question just at present is whether this young man at the bar is insane. We do not require to go back to the prisoner's birth to discover this; you should lead the medical evidence.

Mr. Guy: I will lead the medical evidence after.

His Lordship: Do begin with the medical evidence now.

Mr. Guy: I have placed this witness in the box, and must proceed with her examination.

His Lordship: No, no.

Mr. Guy: Well, I won't go on with this any further.

Dr. Rorie, the Medical Superintendent of the Dundee Royal Lunatic Asylum, stated that he had examined Lamb in prison, and had drawn up a report, dated August 30th, 1886, which was signed by himself and Dr. J. W. Miller. In this

report it is stated that the prisoner is unable to distinguish right from wrong, and is otherwise insane. The opinion was expressed that he was also insane when he committed the alleged crime. Prisoner could not tell his age, and in counting came to a standstill at sixty, and in other respects showed great mental stupidity.

Dr. Miller, the jail surgeon in Dundee for fifteen years, stated that he had seen the prisoner daily, and was quite satisfied as to the prisoner's insanity.

Lord Young, while admitting that the prisoner was a stupid lad, his stupidity being increased by his deafness, said that he should have thought it a very questionable thing to put forward a plea of insanity, and decided that the case must go to trial.

The prisoner was then asked to plead, and on being requested to stand up, he gazed vacantly around the Court; he paid no heed to the plea, "Are you guilty or not guilty?"

Lord Young: You must answer the question.

Prisoner: Am I guilty or not guilty?

Lord Young: Yes, you know what you are charged with.

Prisoner: Ah.

Lord Young: Do you know the crime charged against you?

Prisoner: Ah.

Lord Young: You know what you are said to have done?

Prisoner: Know what I did?

Lord Young: Yes; did you do it or not?

As nothing could be elicited from the prisoner beyond his having been told in Forfar what he had done, his Lordship directed the Clerk to record the plea of "Not Guilty." A jury was empanelled, and evidence was given which is not published. The jury found the prisoner guilty. In passing sentence the judge observed to the prisoner that he did not think him by any means an intelligent man, but that as a matter of fact he very rarely did see intelligent persons at that bar. "They are unintelligent persons who act so as to bring themselves under the pains and penalties which are inflicted in this Court." The prisoner was sentenced to penal servitude for five years. During the passing of the sentence the prisoner acted in a dull and careless manner, and did not appear affected by the result of his trial.

We are informed by Dr. Rorie that neither he nor Dr. Miller had the slightest difficulty in arriving at a conclusion about the nature of this case, viz., that it was one of dementia, mental arrest having followed severe delirium during an attack of scarlatina in a boy hereditarily predisposed to insanity.

Much surprise was felt by the medical witnesses at the course adopted by Lord Young; their evidence being completely set aside, and the question of the prisoner's insanity being referred to the jury, who by their verdict decided that the prisoner was sane.

After the prisoner's sentence, steps were taken to obtain an independent medical examination of the convict, and the result was that he was examined and certified to be insane.

In this case, the result of a conflict between judge and doctor has proved ultimately a triumph for the latter, although, as often happens, the triumph of the former seemed secure at the time of the trial. It would have been strange indeed if the deliberate opinion of a superintendent of an asylum for six-and-twenty years, and of a doctor of a prison for fifteen years, should have proved less correct than that of a legal functionary who thought himself competent to express a dogmatic opinion on the prisoner's mental condition from his observation of him in Court.

Actions against Medical Men for signing Lunacy Certificates.

Two instructive trials having an important bearing upon the responsibility of medical men signing certificates in lunacy, have recently occurred, which ought not to be allowed to pass without notice in this Journal.

The first was the case of "Tanfani v. Spurgin." The plaintiff, Louisa Tanfani, the wife of Signor Achille Tanfani, alleged that Mr. Spurgin, without taking due care, and without reasonable cause, and for the purpose of causing the plaintiff to be imprisoned as a person of unsound mind, signed a certificate under the Lunacy Act, whereas she was not of unsound mind, and was therefore falsely imprisoned. The plaintiff further declared the statement made in the certificate to be libellous. The defendant traversed most of the allegations made against him. As to the alleged libel, he said that the words complained of were true in substance and in fact, that the action had not been brought within twelve months, and that the plaintiff was the wife of an alien, and therefore was not entitled to bring the action.

Dr. Charles E. A. Semple stated in evidence that he was called upon to examine the plaintiff in 1878, to ascertain the state of her mind, and that he had refused to certify that she was insane. Dr. Ruddiforth had also declined to write a certificate. Mrs. Douglas, the wife of a Superintendent of Police at High Barnet, stated that she had taken plaintiff to Brandenburgh Asylum in a brougham; she was greatly excited, and called the police, but she considered that the plaintiff

was insane. Elizabeth Smith, an attendant in the asylum, stated that she seemed rather strange, and thought people were putting poison into her food. To Mr. Justice Denman's question, "Any other sign of insanity?" this witness replied, "She was very excited and talked a great deal," which gave his lordship the opportunity of making the court laugh by the characteristic judicial utterance, "So do a good many sane people."

In addressing the jury for the defence, Mr. Crisp observed that it was not alleged that Madame Tanfani was now insane, the case for the defendant being quite the contrary, namely, that she had been perfectly sane ever since her discharge from the asylum. She had been placed there, and previously at two other asylums, with the fullest sanction of her family, not because she had any suicidal or homicidal symptoms, but that she might be under a wholesome restraint in order to cure her of certain delusions. Dr. Spurgin had, after careful examination of this lady, given his certificate in which he stated nothing but what he believed to be true, and, having exercised a reasonable judgment, he came to the conclusion she was at that time insane. Dr. W. Rhys Williams, a Lunacy Commissioner, was called, and proved that he visited Brandenburgh House in company with Mr. Phillips, another Commissioner, when they made an entry in the visitors' book that they had no doubt of the insanity of Madame Tanfani. Mr. Phillips gave similar evidence.

Dr. Edis, who signed the other certificate, gave evidence in support of Madame Tanfani's insanity, and stated that he believed the plaintiff would be better in an asylum.

Mr. Justice Denman, in summing up the case, said that if the complaints were true, it was very hard upon the plaintiff. The action was brought for something done some eight years ago, and owing to the state of the law it was very hard to meet a case of this sort so long after the events had taken place. By an old statute of James II. a married woman could not sue in her own name without joining her husband's, although her husband might have joined with her, but the Married Women's Property Act of 1883 gave a married woman power to sue in her own name alone, and the Court held in a case that that was retrospective. His Lordship said he thought the decision was wrong, but that he was bound by it. In this action two questions arose for them—first, was it affirmatively made out by the plaintiff that the certificate had been given without due and proper care? His Lordship then went on to say that the law had been very clearly laid down in the judgment in the case of "Hall v. Semple" (3, Fos. and Fin. 352). The negligence must be culpable negligence, and unless they believed upon such evidence as they had heard that the defendant had been guilty of such improper, unreasonable want of care, they should not find a verdict against him on that point. The second question was raised upon a technical plea, that of libel. On this point his Lordship told the jury that the occasion was privileged

unless some malicious wicked motive against plaintiff could be made out on his part. What was the state of defendant's mind as to this lady? Did he exercise proper care? They need not go into the question as to whether or not the plaintiff was of unsound mind. The learned Judge then commented on the evidence adduced on both sides. He told the jury they were to consider plaintiff's demeanour, and the story she told, and whether from what they saw she was likely to have been of unsound mind in 1878. He said he could quite imagine a gentleman like Dr. Semple, who had been mixed up in several actions by Mrs. Weldon, would be chary of giving his certificate, and the same applied to Dr. Ruddiforth. Having observed on the evidence of the defendant and other witnesses, his Lordship then left the case to the jury, saying that the question of damages was entirely for them, but if the defendant had been guilty he ought to suffer very smartly for it.

After having retired for some time, the jury sent in to inquire if the verdict of the majority would be taken. This being refused on the part of the plaintiff, they were left to further consider their verdict. In about two hours' time, at five minutes past six, the jury came into Court, and stated they were still unable to agree. The learned Judge thereupon said he would discharge them, but he would adjourn the case until Saturday morning in order to consider whether he should not give judgment upon the evidence for the defendant, and expressed some doubt whether he ought to have left the case to the jury at all.

Eventually Mr. Justice Denman gave judgment for the defendant, and observed that the action ought never to have been brought.

To the non-legal mind it seems strange that if it were in accordance with law for a Judge to decide the question himself, he should go through the formality of referring it to the jury at all. What would have happened if the jury had given a verdict for the plaintiff? The Judge we suppose would have been obliged to accept it, although thinking "that the action ought never to have been brought."

Madame Tanfani also brought an action—which was tried before Baron Pollock and a special jury—against Dr. Edis, who signed the other certificate. At the close of the case for the plaintiff, Mr. Raymond submitted that upon the facts proved, the defendant was entitled to the verdict. By Section 105 of the Lunacy Act, 1845, it was provided that any action for anything done under that Act should be commenced within twelve calendar months of the release of the party bringing the action. In this case the plaintiff was released November 11th, 1878, and the action was not commenced until 22nd of December, 1884. He would submit, if necessary, hereafter

that there was no evidence of want of due care on the part of the defendant, but he contended that even if there were such evidence, or even evidence of malice, the lapse of time was an absolute bar to the action.

Baron Pollock asked Mr. Hewitt, who appeared for the plaintiff, what answer he could make to the defence of lapse of time. Mr. Hewitt submitted that what was done was not authorized by the Act. The Judge, however, held that the lapse of time would be an answer even if the acts complained of were not authorized by the Act. He thereupon directed judgment to be entered for the defendant. As regards costs, Mr. Hewitt, drawing his Lordship's attention to the fact that the defendant, under the Lunacy Act of 1845, would be entitled to double costs, asked him to certify to deprive the defendant of them. The Judge, however, stated that the law had said that in such a case as this the defendant should have double costs, and he did not think that he should affect to be wiser than the law.

It is difficult to understand why the plea of lapse of time was allowed by Baron Pollock although disallowed by Mr. Justice Denman in the precisely similar case of Tanfani v. Spurgin. It appears that a former Statute enacts that actions may be brought within four years of the alleged act. This, again, would not justify Madame Tanfani bringing her action eight years afterwards. But then, again, there is the provision that a married woman, having a grievance for which she could not sue while married, should be allowed four years after her husband's death in which to lay an action. In the trial Lowe v. Fox, it was held that this provision applied, under the Married Women's Property Act, to a woman, although her husband had not died; she having, therefore, four years from the passing of that Act in which to bring her action. Mr. Justice Denman said he was bound by it. Again, no order for double costs was made in the case of Dr. Spurgin. A different course was pursued by the two judges, although the cases were precisely similar. The Act referred to is Vict. 8 and 9, c. 100, s. 105. It would be interesting to know upon what grounds Baron Pollock allowed double costs for Dr. Edis, while Mr. Justice Denman refused them in the case of Dr. Spurgin.

The next action, that of "Hughes v. Langmore and others," was tried before Mr. Justice Manisty and a special jury. The plaintiff claimed damages against Dr. Langmore for improperly signing a certificate that she was of unsound mind and a proper

person to be placed under control, after which certificate an order was made by Mr. Flowers for her removal to Banstead Lunatic Asylum as a pauper lunatic. The case against the other defendants, Thomas Hughes, the plaintiff's brother, and Dr. Armstrong, was one of conspiring to procure Dr. Langmore's certificate. Judgment was, however, given for Dr. Armstrong in the course of the trial.

Dr. Langmore stated in evidence that Miss Hughes had delusions about slime, and refused to put on her clothes because they had slime upon them. Dr. T. Claye Shaw, Superintendent of Banstead Asylum, spoke to the same delusions. Dr. Murchison, Deputy Superintendent, who had examined the plaintiff an hour or two after her admission, stated that Miss Hughes was distinctly insane, and was discharged as soon as she was fit to be so. Dr. Armstrong, who had attended the plaintiff regularly from 1876 to 1882, stated that she had suffered from neuralgia, hysteria, sleeplessness, and blood spitting. In August, 1884, Thomas Hughes called on him, and he went to see the plaintiff's father, who told him he had made up his mind that his daughter must be put away.

Mr. Justice Manisty, in summing up, said that the case had a wider bearing than the parties immediately concerned in the action. It was one of the same kind as several others which had lately been brought, some of which were well founded, while others had no foundation whatever. The case as against Thomas Hughes was that he had wrongfully and maliciously obtained Dr. Langmore's certificate for the purpose of bringing about what followed. The first question was whether on the 20th and 21st of August, 1884, the plaintiff was of unsound mind and not under proper control. Mr. Justice Manisty then characterised the Lunacy Act as an intricate and, to all but lawyers, an incomprehensible statute. [Instances have occurred in which even "lawyers" have not understood it.] It was a confused jumble, which mixed up different cases and different modes of procedure in a most improper manner. It provided, however, that if any person gave information to a relieving officer that a certain person was a lunatic and not under proper control, he was bound to lay information to the same effect before a magistrate. That was done in this case. Thomas Hughes, at his father's request, went to the relieving officer and took with him an informal document, unfortunately destroyed, signed by Dr. Armstrong, stating an opinion that the plaintiff was of unsound mind. Thereupon the magistrate was required to order a medical man to examine and report to him the patient's condition. Upon such report the magistrate ordered the said lunatic to be brought before him. This also was done. This was how Dr. Langmore was called in. He was an independent medical man, and was bound in duty to go. And it was in consequence of what he then did that he had to defend himself against this terrible charge.

We direct especial attention to the Judge's succeeding observations, and it affords us the greatest pleasure to point out that in this instance at least a Judge recognized the present injustice done to medical men in the absence of any restriction upon discharged lunatics bringing vexatious actions against medical men who sign certificates.

It was frequently said that it was not the business of a Judge to make observations upon the law—that he ought to go straight on and take the law as he found it. But he (Mr. Justice Manisty) thought it sometimes was the duty of a Judge to make observations upon the law, and in this case he did make an observation which he hoped might reach the ears of those in whose power it was to amend the laws. The observation was that in a case of this sort some security should be given by the party who brings the action, if the Court thought fit, for the costs of the parties brought before the Court. It was a terrible thing for a gentleman in Dr. Langmore's position to be called on to defend himself from a charge of this sort on the chance of a party being able to get something out of him, and with the certainty that if successful he could only get his taxed costs, and would be still out of pocket. He thought it would be well if the Court had a discretionary power to order security for costs to be given in such cases. Mr. Justice Manisty then referred at length to the evidence of Dr. Langmore as to his interview with the parents and subsequent examination of the plaintiff, and then the order of the late Mr. Flowers, which recited that he had personally examined the plaintiff and found her to be of unsound mind. The present was not a case of a private asylum, the proprietors of which kept lunatics for reward. It was a case of a public asylum, where patients were kept at a heavy charge on the rates. It was the last thing anyone would suppose that gentlemen who had charge of these establishments would keep people in them who were fit to be at large. There could be no doubt that the plaintiff had acted in a most extraordinary manner, and in the most common parlance anyone hearing some of the things she admitted would say, "Why, she is mad; she ought to be in an asylum." There was not a particle of evidence to support the statement now made, that the mother of the patient (Mrs. Hughes) protested against and resisted what was being done. After some further remarks his lordship asked the jury before going further to say whether the plaintiff was or was not of unsound mind on August 20th and 21st.

The jury at once answered the question in the affirmative.

Mr. Justice Manisty said that this answer disposed of the case.

Mr. Lumley Smith, in asking for judgment for Dr. Langmore, said that by the statute of 8 and 9 Vict., provision was made for double costs to be allowed on an action for anything done in pursuance of that Act. That, he believed, was done last year in the case of an officer of Bethlem Hospital. The acts, however, were very involved,

and before the decision was given he asked for time to look more fully into the subject.

Mr. Justice Manisty said that that was done away with. If there was any doubt about it, it was unnecessary for him to make an order. The defendant would have his proper costs. His lordship was strongly of opinion, however, as he had said before, that something ought to be done to meet the case of medical gentlemen sued under circumstances such as these.

Judgment was then entered with costs in the case of each of the defendants.

The importance of the result of this case can scarcely be over-estimated. It is one in which, fortunately, no aspersion can be thrown upon the character of the defendant, and an opportunity has occurred, of which the Judge happily availed himself, of pointing out to the legislature the necessity for there being clauses in any Lunacy Bill which may be introduced, protecting members of our profession from such unjustifiable actions as that of "Hughes v. Langmore and others."

The After-Care Association.

As an important stage has been reached in the history of "The After-Care Association," in the appointment of a paid Secretary, we think it advisable to place on record a brief retrospective sketch of its past proceedings, from its foundation, seven years ago, to the present time. For this we are indebted to the Rev. H. Hawkins, the chaplain to the Colney Hatch Asylum, whose unflagging interest and untiring efforts in the promotion of the objects of this Association, with very little to encourage, and much to depress, the energies of an honorary secretary, deserve special recognition, and can best be appreciated by those who, like ourselves, have watched the proceedings of the Association from its commencement.

A Retrospect of the History of "The After-Care Association," 1879-1886.

1879.—The first meeting of "The After-Care Association" was held on the 5th June, 1879, at the house of Dr. Bucknill. Amongst those present were Drs. Bucknill, Lockhart Robertson, Hack Tuke, and W. G. Marshall. A paper on the subject of the "'After-Care' of Poor and Friendless Female Convalescents on leaving Asylums for the Insane" was read by the Rev. H. Hawkins. This paper was afterwards printed in the "Journal of Mental Science." It was moved by Dr. Lockhart Robertson, and seconded by Dr. Hack Tuke,

"That this meeting do form itself into an Association." Dr. Bucknill was invited to take the office of President, and the Rev. H. Hawkins that of Hon. Secretary. Shortly afterwards a ladies' meeting was held at Mrs. Müller's, 86, Portland Place, when Miss Cons consented to accept the office, temporarily, of co-Secretary.—On 27th November of the same year another meeting was held at Dr. Bucknill's, at which a letter was read from the Earl of Shaftesbury, in which occur the words: "Your letter entitled 'After-Care' has deeply interested me. The subject has long been on my mind. . . . Tell my friend Dr. Bucknill that I shall be happy to serve under his presidency in so good a cause." It was proposed by Dr. Savage, and seconded by Dr. Claye Shaw, "That the object of this Association is to facilitate the readmission of female convalescents from lunatic asylums into social and domestic life." The annual subscription was fixed at five shillings, and Dr. Claye Shaw accepted the office of Treasurer. The annual meeting of the Association was appointed to be held on the first Thursday in July, at 3 p.m.—At the close of the year, Lord Shaftesbury accepted the office of President of the Society.

1880.—The anniversary meeting was held at Dr. Bucknill's. Amongst those present were Lady Frederick Cavendish, Miss Agnes Cotton, and Miss Cons. Dr. Bucknill, at the close of his year of office, retired from the chairmanship, and Mr. W. G. Marshall was appointed in his place. Announcement was made of Lord Shaftesbury's consent to act as President.

1881.—July 7th. The annual meeting was held at Dr. (Sir) Andrew Clark's, Cavendish Square; the Earl of Shaftesbury presided. Drs. Andrew Clark, Lockhart Robertson, Bucknill, Mickley, &c., were present; and of ladies, Lady Lyttelton, Brabazon, Frederick Cavendish, Mrs. Gladstone, &c. Among the speakers were Drs. Lockhart Robertson, Bucknill, and Andrew Clark, who enforced the importance of "After-Care" as a frequent condition of complete restoration to health.

1882.—The anniversary meeting of 1882 was held at 30, Cavendish Square, by the kind permission of Dr. Ogle. The Earl of Shaftesbury presided. Dr. D. Hack Tuke, Dr. Shaw, &c., were present; and of ladies, Mrs. Gladstone, Lady Lyttelton, Lady Cotton, and many others. Lord Shaftesbury and Dr. Hack Tuke called attention to the need of some *house* or *room* in which the Association's business could be transacted.

1883.—Lord Cottesloe received the Association at their annual meeting in 1883 at Eaton Place. The President dwelt upon the desirableness of making the work known, and the difficulty of awakening interest. He stated his belief that the "After-Care" Society was required to supply *a real want*, and that it was a "seed-plot," from which, in time, good results would spring.

1884.—In the following year the annual meeting was held at Lord Brabazon's, who, though absent from home, placed a room at the dis-

posal of the Association. This meeting was memorable, as being the last occasion when Lord Shaftesbury (who had presided at the annual meetings since 1881) was in the chair. Earlier in the year his secretary wrote: "I am directed by his Lordship to say that he is decidedly in favour of a 'Home' for friendless female convalescents on leaving lunatic asylums." At the meeting, the Hon. Secretary stated that among more than 200 existing Convalescent Homes not one was specially designed and available for mental convalescents. The President remarked that he considered a "Home" a necessity, and did not see how such a resort could be dispensed with.—In the autumn of this year a meeting was convened at the Mansion House, when (in the Lord Mayor's absence) Dr. Norman Kerr was in the chair. This gathering was due to Mrs. Ellis Cameron, Hon. Sec. of Ladies' Committee, who also arranged a bazaar at the Kensington Town Hall in May, 1885, which resulted in £100 being added to the "After-Care" account.

1885.—Bethlem Royal Hospital, by the kind arrangement of Dr. G. H. Savage, received the annual meeting in July of the same year; Dr. Ogle presided (a message having been received from Lord Shaftesbury that he should be unable to attend). A letter was read from Sir W. H. Wyatt, Chairman of the Colney Hatch Asylum Committee of Visitors, in which he said, "The effort to promote an 'After-Care' Home has my sincere sympathy." At this meeting a resolution with respect to a "Home" was carried, to the effect "That the time has now arrived for taking steps for the commencement of actual work without further delay."—In October an adjourned meeting was held at Bethlem Hospital, the Treasurer, A. J. Copeland, Esq., being in the chair, when it was proposed by Dr. Norman Kerr, and seconded by Dr. Hack Tuke, "That the Committee be authorized to take steps to raise funds for the equipment, &c., of the projected Home." It was further resolved that Lord Brabazon be requested to accept the office of President in succession to the late Earl of Shaftesbury. The Association's invitation having been referred to Lord Brabazon, his lordship made his acceptance conditional upon a *preliminary* satisfactory report of the accounts by his lordship's own auditor, and upon subsequent reports being periodically rendered.

1886.—At a meeting, also at Bethlem Hospital, held at the beginning of 1886, Lord Brabazon's conditions were respectfully accepted, and subsequently his lordship intimated that it would give him pleasure to undertake the presidency. His actuary, Mr. Gerard Van de Linde, had previously reported a balance of about £271 to be standing at the Association's bankers, Union Bank of London, Argyll Place, W. The Hon. Secretary had, for several successive years, pressed on the attention of the Association the necessity of appointing a secretary who could devote due time to the business of "After-Care," which his own occupations prevented him from doing. —The yearly meeting was held at Lord Brabazon's, 83, Lancaster

Gate, his lordship presiding. He remarked that Lord Shaftesbury's interest in "After-Care" had influenced him to undertake the work as a "legacy." A resolution was carried "That the Committee be authorized to employ a paid secretary to carry on the work of the Society;" and a communication was read from Rev. Edgar Sheppard, Sub-Dean of the Chapels Royal, that H.R.H. the Princess Christian had graciously consented to become patroness of the "After-Care" Association.—At a meeting in the autumn, at Bethlem Hospital, Dr. Savage in the chair, for the purpose of selecting from the candidates the most eligible person for secretary, the choice fell unanimously on H. W. Roxby, Esq., Emblewood, Osbaldeston Road, Stoke Newington, N., whose appointment was ultimately confirmed by the President. He enters upon his work provisionally to the end of 1886. Thus the review of the Society's history—1879-1886—is completed.

Acknowledgments are due to Mrs. Ellis Cameron for her exertions on behalf of the Society, and to the ladies of the "After-Care" Working Society for their help in aid of friendless female convalescents. The Association is under special obligations to Dr. D. Hack Tuke and Dr. G. H. Savage (among others) for the active interest they have evinced in its promotion.

If it be inquired whether the seven years of its existence has been fruitful in any results, it may be replied that not a few convalescents have been benefited, directly or indirectly, through the action of the Association; that some "Homes" have shown themselves kindly interested in the "after-care" of mental convalescents; that the approval of physicians, well qualified to appreciate the value of the movement, has been accorded; and that the attention both of the Press and of the public is being awakened in a project which its first President (long and intimately acquainted with remedial measures on behalf of the mentally infirm) considered to possess a real *raison d'être*, and of which he predicted the ultimate success.

To the foregoing sketch by Mr. Hawkins, we have little to add. The whole question of the success of such a society rests, in our opinion, upon whether a case has been made out for its existence. If the "after-care" which it proposes to apply is not really wanted, the sooner the fact is realized, and the operation of the Society suspended, the better. The limited enthusiasm which it has evoked from the Superintendents of Asylums, the small number that have enrolled themselves among its members, and the sparse attendance of those most nearly interested in county asylums at the meetings of the Association, might seem to imply that the question we have raised must be answered in the negative. Among the exceptions, however, must be reckoned the Superintendent of the Banstead Asylum, Dr. Claye Shaw, who has all along been convinced of the importance of the objects of this Association, and

has been indefatigable both as a member and as its treasurer in helping on its progress. The fact that a man of Dr. Shaw's large experience, not only at Banstead, but at Colney Hatch and Leavesden, should hold the strong opinion which he does, appears to us a most important argument in favour of the energetic support of this attempt to provide "after-care" for a certain class of convalescent pauper lunatics. It remains now for the Society, after having tided over the difficulties of its formation and infancy, to place itself in a position to show to a much greater extent than it has hitherto been able to do, the beneficial results of its organization, in the shelter afforded to recovered female patients in the interval between leaving the asylum and entering into service. Lord Brabazon has shown not only a warm interest in the Association of which he has consented to be President, but has been willing to sacrifice his time and to give the Society the benefit of his judgment in matters of practical detail, facts which augur well for the future success of its operations.

It is intended to open a Home for the class of poor women for whom temporary care is desirable, as soon as sufficient funds are obtained. It is believed that they will be forthcoming when the object in view is fully known to the benevolent and philanthropic. We now make an appeal for donations and subscriptions. These may be paid to the Treasurer, Dr. Claye Shaw, (Medical Superintendent, County Asylum, Banstead, Surrey), to the "After-Care," Account at the Union Bank of London, Argyll Place, W.

Idiots and Imbeciles in Lunatic Asylums in England and Wales.

In the July number of the Journal, Dr. Ireland published an article on this subject, read to a meeting of the Medical Psychological Association, at Carlisle, in April last. The result of the reading of this paper was the issue of a number of circulars with the object of obtaining information as to the number of idiots and imbeciles in asylums and workhouses, classified as to age, whether under or above fifteen. A few statistical returns were given in the number of the Journal already referred to. Dr. Ireland has forwarded to us a continuation of these valuable reports, and we are sure that they cannot fail to prove both important and interesting to the readers of this Journal.

Returns of the number of Idiots and Imbeciles in Lunatic Asylums and Workhouses in England and Wales.

We publish the completed returns of the inquiry made through a circular signed by Drs. J. A. Campbell, Clouston, Rutherford, and myself, with a view to ascertain the number of idiots and imbeciles in lunatic asylums and workhouses in England and Wales, as explained in the postscript to the paper "On the Admission of Idiotic and Imbecile Children into Lunatic Asylums," in the July number of the Journal. Of the fifty-two county, united county, and borough asylums, we received answers from thirty-three, viz.:—Berks, Reading and Newbury, Bucks, Cambridge, Chester, Cornwall, Cumberland and Westmoreland, Denbigh (North Wales), Derby, Dorset, Durham, Glamorgan, Gloucester, Hants, Hereford (County and City), Kent, Leicester and Rutland, Lincoln, Middlesex (Colney Hatch), Norfolk, Northumberland, Nottingham, Oxford, Abingdon, Oxford City and Windsor, Somerset and Bath, Stafford, Stafford (Burntwood), Suffolk, Surrey, Warwick, Wilts, Worcester, York, East Riding, West Riding, and South Yorkshire.

Thus the number of idiots and imbeciles under fifteen years in the thirty-three asylums was 191; the number above was 1,995. Of the four borough asylums from which we get replies—Birmingham, Ipswich, Leicester, and Nottingham—there were 14 idiots and imbeciles below fifteen, and 112 above that age.

In Broadmoor Criminal Lunatic Asylum there was one imbecile under fifteen and seven above that age.

The number of answers received from lunatic hospitals and licensed houses was only fourteen. Of these, six had idiot or imbecile boarders, making a total of 24, all above fifteen years of age.

Thus the total number of idiots and imbeciles in the lunatic asylums and hospitals from which we had replies was: Under fifteen years of age, 206; above fifteen years, 2,138.

The returns from the asylums and training schools for idiots were pretty complete.

	Under 15.	Above 15.
Earlswood	114	459
Royal Albert, Lancaster	225	317
Midland Counties Asylum, Knowle...	21	29
Western Counties Asylum, Exeter ...	56	53
Eastern Counties Asylum, Colchester	50	78
Metropolitan Asylum for Young Imbeciles at Darenth	376	224

In this last asylum most of the inmates above fifteen would be under sixteen years of age.

Leaving out the Metropolitan Asylum, which holds its existence under a special enactment, there were found to be in England and Wales, receiving proper training, 466 idiots and imbeciles under fifteen, and 936 above that age.

In the Metropolitan Asylum of Leavesden for chronic and harmless lunatics and epileptics, there were 774 idiots and imbeciles above fifteen and none under that age.

In the circulars sent to the superintendents of asylums, they were asked to give any information in their power about the number of idiots and congenital imbeciles in neighbouring workhouses. To these inquiries there were few replies.

Dr. J. A. CAMPBELL has made special inquiries as to the numbers of idiots and imbeciles in his district with the following result:—

Name of Workhouse.	Total No. of Congenital Imbeciles.
Cumberland.	
Alston ...	1
Bootle ...	5
Brampton	3
Carlisle...	7
Cockermouth	12
Longtown	1
Penrith ...	11
Whitehaven	10
Wigton...	8
Westmoreland.	
East Ward	2
Kendal...	11
Milnethorpe	13
Total	84

In Dorsetshire there were in January, 1886, in fifteen workhouses, 84 idiots and 38 imbeciles. In workhouses in Hants there were known to be 127 idiots and imbeciles, 55 males and 72 females. In the annual report of the Somerset and Bath Asylum, there are stated to be 251 idiots, 124 males and 127 females, in seventeen workhouses.

In Dartford Workhouse there are 21 idiots and imbeciles; in Oxford, 12 above fifteen; in Headington, seven above that age; in Hereford, 28 idiots and imbeciles in the neighbouring workhouses; in Sedgefield Union Workhouse, five idiots and imbeciles; in the Colchester Workhouse there are about 45 idiots.

We have not reproduced the statistics where the number of idiots and imbeciles are given along with the number of lunatics, such mixed statistics being of no use in our inquiry.

Dr. BARTON, Superintendent of the Surrey Asylum, at Brookwood, in his Annual Report, 1886, thus writes:—

"Amongst those sent to the Union were two girls, aged respectively ten and twelve years, who had been admitted during the year. Both of these were congenitally deficient, and were stated to be very

troublesome and dangerous to others, but proved, with a little management, to be quiet, tractable, and docile, and to possess a certain amount of intelligence. *The associations of an ordinary lunatic ward are very bad for such children, as they pick up objectionable habits with great facility,* and it is to be regretted that they cannot be either retained in the workhouse or sent to an institution where they could be properly trained."

Dr. LLEWELYN F. COX, Superintendent of the North Wales Counties Lunatic Asylum, Denbigh, who has two idiots under fifteen and 78 above that age, writes :—

"With reference to the male and female who are under 15 years of age (male 11 and female 14 years), I would wish to remark that in these particular instances it would be very desirable to place such cases in an institution for the training of idiots and imbecile children, with the object of instructing them in some useful and remunerative trade, with the probability of their being ultimately enabled to contribute in some degree to their own support.

"Such cases cannot be satisfactorily cared for in an asylum for the insane, where it would be impracticable to introduce special arrangements for the training of idiots, in addition to the injurious influence which necessarily results from the daily residence of idiots with insane patients."

Dr. W. C. HILLS, of the Norfolk County Asylum, writes :—

"After 32 years' asylum experience I have no hesitation in saying that idiots and imbeciles should be provided for in a separate establishment, and not, as at present, associated with lunatics; they neither require the same liberal diet nor the same expensive staff."

Dr. Wm. W. HIGGINS, Superintendent of the Leicestershire and Rutland Lunatic Asylum, writes :—

"The few children here are all epileptics, and therefore are little likely to be better off elsewhere, or to improve mentally, and they are otherwise great pets with all the other inmates, and I think a relief to the wards. Our idiots are not ugly or repulsive."

Dr. PRINGLE, Glamorgan County Asylum, writes :—

"The admission of idiots to ordinary asylums is, I think, greatly to be deprecated. They cannot possibly have the patient care they need or the training necessary to make them useful to themselves and others, and they are more apt to deteriorate than improve, to learn evil rather than good. Moreover, their presence, repulsive appearance, and habits are very irritating to patients who have any self-respect left, and who feel degraded by having them as enforced associates. On the other hand, I am not at all sure that it would be wise to mix all kinds of idiots and imbeciles together—the improvable and teachable with those of confirmed habits or with epileptics."

Dr. A. L. WADE, Superintendent of the Somerset and Bath Lunatic Asylum, writes :—

"We badly want a *cheap* place where idiot children who are in-

capable of training would be received, including the dumb, blind, halt, and epileptic ; such patients can only be properly cared for in county asylums at a great expense, and are not received into the present idiot asylums. Though incapable of 'fancy training,' they are quite capable of being trained into cleanly habits, and even of learning, in some cases, useful mechanical trades, *e.g.*, a dumb idiot worked for many years in our upholsterers' shop, making and stuffing mattresses, and an epileptic idiot works with our tailor. These, however, are exceptions. Children ought never to be placed with adult lunatics."

Dr. Gasquet, St. George's Retreat, Burgess Hill, writes :—

"I am strongly of opinion that idiots and congenital imbeciles should not be received into asylums, in ordinary circumstances.

"I should say that idiots or congenital imbeciles should only be placed in an ordinary asylum when they are beyond the hope of benefit by training in special establishments, or when their violence or other propensities would make it unsafe to place them in such institutions."

Dr. Tate, the Physician Superintendent of the Coppice, Nottingham, writes :—

"In my opinion idiots and congenital imbeciles of low type are prejudicial to the comfort and welfare of the ordinary inmates of an asylum, and should not be received."

Mr. W. Locke, Western Counties Idiot Asylum, Starcross, Exeter, writes :—

"My own experience (now ranging over a period of twelve years) of cases coming to us from lunatic asylums, shows that it takes longer to eradicate faults of temper, habits, and language copied from, or learnt by association with the insane, and to teach and instil better things instead, than it does with cases coming to us from private homes. In many cases the harm thus done to them is never remedied.

"Idiots especially are naturally great imitators. With lunatic asylums I would also couple the insane wards of workhouses.

"What is sadly wanted is more homes and institutions for idiots and imbeciles, and withdraw idiots from contact with the insane. If your efforts, as I doubt not, tend to this end they deserve all praise, and will, I trust, eventuate in success."

The passing of the Idiots Bill, which has now become law, should be an encouragement to persevere in pushing the claims of imbecile children to farther consideration. It is to be hoped the matter will form the subject of legislation next Session, either in a clause in the Counties Boards Bill or in a separate enactment.

PART II.—REVIEWS.

Fortieth Report of the Commissioners in Lunacy. 31st March, 1886.

The fortieth report of the Commissioners in Lunacy, though, from special causes, less voluminous than any of its immediate predecessors, contains a large amount of valuable and suggestive matter.

Its detail shows that the legitimate and proper work of the Commission, as distinguished from the more showy and perhaps more attractive functions which some of its critics urge it to undertake, has been discharged, as usual, with conspicuous industry and ability.

Of late it has been far too commonly assumed that such defects as experience has shown to exist, or the unreasoning clamour of a clique has denounced, in the legal enactments which affect the care and treatment of the insane, are due to the action or inaction of the Commissioners. And it cannot be too frequently pointed out that, as they are not the makers but only the administrators of the law, it is grossly unfair to attribute to them real or imaginary defects in the structure of that law.

The report before us plainly shows that in this aspect the Board has more than justified its claim to the continued confidence of the public.

It tells that the number of persons of unsound mind on the 1st January, 1886, as reported to the Department, amounted to 80,156 persons, exclusive of 248 Chancery lunatics residing with their committees, and 81 insane convicts, their classification and distribution being as shown on opposite page.

These numbers differ from those of the preceding year in the following particulars.

The private patients have increased in County and Borough Asylums by 18, in Registered Hospitals by 83, in Naval and Military Asylums by 20, and as single patients by two.

They have decreased in licensed houses by 85.

The pauper patients have increased in County and Borough Asylums by 395, in Registered Hospitals by 15, and in Metropolitan licensed houses by 174.

They have decreased in provincial licensed houses by 24, in ordinary workhouses by 10, in the Metropolitan District Asylums by 72, and as out-door patients by 30.

Summary of Insane Patients, 1st January, 1886.

Where Maintained on 1st January, 1886.	Private.			Pauper.			Criminal.			Total.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
In County and Borough Asylums	338	403	741	21,228	26,014	47,242	125	31	156	21,691	26,448	48,139
In Registered Hospitals ...	1,586	1,468	3,054	107	58	165	—	—	—	1,693	1,526	3,219
In Licensed Houses:												
Metropolitan	896	818	1,714	236	475	711	1	—	1	1,133	1,293	2,426
Provincial	680	847	1,527	189	290	479	6	1	7	875	1,138	2,013
In Naval and Military Hospitals, and Royal India Asylum	289	20	309	—	—	—	—	—	—	289	20	309
In Criminal Lunatic Asylum (Broadmoor)	—	—	—	—	—	—	401	136	537	401	136	537
In Workhouses:												
Ordinary Workhouses ...	—	—	—	5,060	6,808	11,868	—	—	—	5,060	6,808	11,868
Metropolitan District Asylums	—	—	—	2,464	2,868	5,332	—	—	—	2,464	2,868	5,332
Private Single Patients ...	179	268	447	—	—	—	—	—	—	179	268	447
Out-door Paupers	—	—	—	2,302	3,564	5,866	—	—	—	2,302	3,564	5,866
Total	3,968	3,824	7,792	31,586	40,077	71,663	533	168	701	36,087	44,069	80,156

The criminals have decreased in County and Borough Asylums by 21, in Registered Hospitals by 2, in Metropolitan licensed houses by 2, and at Broadmoor by 12.

The variations thus recorded show a gross increase during the year of only 452 patients, of whom no more than 41 were of the private class, the average annual increase of patients of all classes during the last 26 years having been 1,651, and that of private patients alone 124.

The total number of patients admitted into asylums, hospitals, licensed houses, and single care, but excluding transfers and admissions into idiot establishments, during the year was 13,354, which is an actually lower number than in any year since 1880, and 958 less than last year. The average of the preceding seven years was 13,655, and the admissions this year have thus been 301 below that average, the population having meanwhile increased 2,470,068.

These are striking figures, and it would appear that the Commissioners have perhaps scarcely appreciated their full significance in relation to the difficulties and dangers with which the present unsatisfactory state of public opinion with reference to the Lunacy Laws has surrounded medical men and others in their duty of certification and general action. They say: "It is noteworthy that every year until January, 1886, there has been a slow but steady increase in the proportion of total lunatics to population. The ratio to population of the admissions was last year 4·85 per 10,000, a lower proportion than has occurred since 1873. The reluctance or refusal of many medical men to sign certificates of lunacy may have prevented a certain number of insane persons from being placed legally under care and brought under official cognizance, but this number has probably not been sufficient materially to affect the general statistics, and we are of opinion that the figures of 1885 tend to support the observations made in our last previous reports—that though the total number of the insane under care has gradually increased, the increment has been due to accumulation, chiefly among pauper patients of the chronic class, and has not been the result of the annual production of fresh cases of insanity out of proportion to the increase of population."

Without wishing to controvert the opinion expressed in the latter part of this quotation, which is, no doubt, borne out by facts, we cannot but think that the figures which we have summarized seem to bear a remarkably suggestive relation to the widely spread disinclination of medical men to give certifi-

cates of lunacy, which is within the experience of probably every member of our specialty.

Excluding transfers and admissions into idiot asylums, the proportion of stated recoveries to admissions would seem to have been not unsatisfactory. It was 41·99, as compared with a percentage of 40·33 in the previous year, and an average of 39·19 in the preceding nine years.

The recoveries were distributed between the males and the females in the proportion of 38·14 to the former, and 45·56 to the latter.

The percentage of deaths was also below both that of last year and the average. For males it was 10·70, for females 8·24, and for both sexes 9·37, upon the average numbers resident, as compared with a ten years' average percentage of 9·62.

In the following table, from which all transfers and admissions into idiot establishments have been excluded, are shown the percentages of recoveries and deaths in the several classes of asylums and in private care.

	Proportion per Cent. of Recoveries to Admissions.			Proportion per Cent. of Deaths to the Average Numbers Resident.		
	M.	F.	T.	M.	F.	T.
County and Borough Asylums	38·44	45·76	42·26	11·39	8·60	9·86
Registered Hospitals	34·51	54·91	45·56	7·97	3·90	5·69
Metropolitan Licensed Houses...	31·72	44·86	39·07	12·20	8·98	10·46
Provincial Licensed Houses	32·70	39·19	36·48	8·26	6·85	7·44
Private Single Patients	15·55	8·00	10·83	8·52	6·36	7·22

The valuable series of tables which of late years has formed so important a part of the Commissioners' report, has this year been omitted, in consequence of an earlier presentation of the report at the request of the Home Office. We are, therefore, unable to repeat the interesting statistics which have been presented on previous occasions with reference to the causation of insanity, the percentages of epileptics and general

paralytics, and the details as to suicidal disposition, duration of disease, occupations, and social condition. It is satisfactory to know that the various tables thus excluded will be given in the Commissioners' report for next year.

That the post-mortem examinations made in the County and Borough Asylums during the year under review bore the large and very satisfactory proportion of 71·7 per cent. to the total number of deaths, is recorded with approval by the Commissioners.

Fourteen suicides are reported as having occurred during the year. Of these, nine were in county asylums, one in a hospital, two in licensed houses, and two in single care. Twelve unattended, and what the report calls "probably preventible," deaths are also placed on record as an unsatisfactory feature of the year's proceedings.

There has again been some decrease in the average cost of maintenance in the County and Borough Asylums.

The returns furnished by the clerks show that the average cost per week of the maintenance of a patient in these asylums was :—

	s.	d.
In County Asylums	8	10¼
In Borough Asylums	9	11⅞
In both taken together	9	0⅝

The following are the details of the average weekly cost :—

	County Asylums.			Borough Asylums.		
	£	s.	d.	£	s.	d.
Provisions (including malt liquor in ordinary diet) ...	–	3	8	–	3	11⅛
Clothing	–	–	8¾	–	–	9¾
Salaries and wages	–	2	3⅝	–	2	6¼
Necessaries (*e.g.*, fuel, light, washing, &c.)	–	–	11¼	–	1	3
Surgery and dispensary	–	–	¾	–	–	¼
Wine, spirits, porter	–	–	¼	–	–	¼
Charged to Maintenance Account :						
Furniture and bedding	–	–	5½	–	–	7¾
Garden and farm	–	–	6¾	–	–	4¾
Miscellaneous	–	–	4½	–	–	6¾
	–	9	1	–	10	1¾
Less monies received for articles, goods, and produce sold (exclusive of those consumed in the Asylum)...	–	–	2¾	–	–	1¾
Total Average Weekly Cost per Head ... £	–	8	10½	–	9	11¾

"A further reduction is thus apparent in the weekly cost of maintaining the above patients, amounting for the year 1885, in comparison with 1884, to 2½d. Comparing this average with that for the year 1873 (10s. 5⅝d.) we find there is a saving of 1s. 5d. over the rates which obtained 12 years ago. The magnitude of this reduction will be appreciated when it is considered that it represents an annual saving of £3 13s. 8d. per patient, or a total gain to the country of somewhere about £180,000 for the year.

"As regards the general items of expenditure, the decrease on the year 1884 is mostly in 'Provisions,' while 'Salaries and Wages' show an increase.

"The higher rate in the Borough Asylums, in contradistinction to the County Asylums, is due in part to the fact that in some of the former, but not in the latter, repairs to the building are charged to the Maintenance Account."

The Commissioners report favourably in general with reference to the condition and management of the County and Borough Asylums, and the Registered Hospitals.

Their remarks upon the Metropolitan and provincial licensed houses are interesting, especially at the present time, and we give them at length.

"These houses have generally been conducted to our satisfaction during the past year, and in some, in compliance with our suggestions, substantial improvements have been effected beyond the ordinary repairs necessary for maintaining them in a proper state. The accommodation afforded varies of course with the payments made, which in some cases are very low; but on the whole we are of opinion that, having regard to these, the proprietors are liberal in their treatment of the persons placed in their care.

"The Metropolitan houses receive frequent visitation from us, and we are satisfied that the impression which has got abroad as to the undue detention of patients in them is wholly unfounded. Our visitation of provincial licensed houses is less frequent, but as to these, too, we can express the same opinion; nor has any suggestion of the improper reception or unduly prolonged detention of a patient in any of them been brought to our notice by the Visitors, whose inspection is more frequent than ours, and whose reports, made after every visit, are regularly read and considered by us.

"We think these remarks not out of place at the present time in view of the public feeling which has recently been expressed on the subject, and which has led to the proposal of a more

stringent process for placing insane persons of the private class under care and treatment."

The Commissioners devote some space to a reference to the New Lunacy Bill which is here alluded to. We reproduce their observations *in extenso*.

"A Bill for amending the Lunacy Acts, which, if passed, was intended to have been followed by a Consolidation Bill, with the effect of embracing in a single Act of Parliament the whole of the statutory enactments as to private and pauper lunatics, and those so found by inquisition, and their care and treatment, was introduced into the House of Lords during the Session of 1885 by Lord Chancellor Selborne.

"This measure passed several stages in the House of Lords, but was withdrawn in consequence of the resignation of the Government.

"The majority of the provisions of this Bill originated either in the recommendations of the Select Committee of the House of Commons of 1877, of which your Lordship was a member, or in suggestions made from time to time by ourselves. So far as regards this portion of the late Bill we have no special observations to offer.

"We cannot, however, pass by unnoticed a proposed alteration of the law as to the admission of private patients into asylums and other places for care and treatment, which emanated neither from the Select Committee nor from ourselves: but in its main features followed the proposals of a Bill presented in 1880 by Mr. Dillwyn and others.

"Ostensibly framed on the procedure adopted in Scotland, where the signature by the 'sheriff' of orders of reception of private patients is required, the Bill of 1880 required for the admission of a private patient an order signed by any justice of the peace. In the Bill of 1885, the authority to make such order was restricted to certain justices, but was also given to county court judges.

"Our objections to Mr. Dillwyn's Bill as stated at length in our Thirty-Fifth Report, p. 118, applied in still greater force to Lord Selborne's Bill of last year. We say in greater force, because the intervention of the judge or justice was now no longer to be 'ministerial' only, but he was to have quasi-judicial authority, with power even to insist on visiting and examining the alleged lunatic, wherever he might be, and of determining, irrespective of medical opinion, the question of his insanity.

"It was on this question that our late Chairman thought it

his duty to resign his seat at this Board, and sharing his views as to the likelihood of early treatment suffering, if the clauses in last year's Bill became law, we took occasion to represent officially to Lord Chancellor Selborne our objections to these clauses. We were, however, unable to obtain any material alteration in them.

"The interference of a magistrate with the private concerns of a family was especially felt by Lord Shaftesbury to be a thing which would be much resented by parents and relatives of insane persons of the upper and middle classes. The result would most probably be—concealment of the lunacy, retention at home with greatly diminished chance of recovery, or else removal beyond the seas and so beyond the reach of friends."

In concluding our notice of this Report, it will be interesting to transfer to, and preserve in, the pages of the "Journal of Mental Science," the following summary of the relation of the late Chairman of the Board of Commissioners in Lunacy to the formation and work of the Commission.

It is the record of a noble life devoted to philanthropic ends, and securing them.

The insane have had no greater benefactor, and we who are engaged in their care and treatment have reason to regard with grateful affection the memory of Lord Shaftesbury, who was always ready to repel attack upon the dignity of our specialty and the honour of its members.

"Among all the philanthropic objects to which this very distinguished man devoted the best part of his life, none possessed for him greater interest than the improvement of the care and treatment of the insane, to secure which this Commission was established, and to which end, under his presidency and guidance, it has now laboured for forty years.

"But Lord Shaftesbury's first introduction to the subject of lunacy and lunatic asylums dates back to a much earlier time.

"Circumstances had induced Mr. Robert Gordon, M.P., and one of the Governors and Directors of the Poor of St. George's, Hanover Square, to institute, about 1826, an inquiry into the state of the insane poor of the County of Middlesex, in the course of which he personally visited the licensed houses, which were in those days, for want of a county asylum, the only receptacles for this unfortunate class.

"Lord Ashley, as he was then styled, was at that time a young man of about five-and-twenty, and already a member of the House of Commons. He accompanied Mr. Gordon in some of

his visitations, and in 1827, when, upon the account given to Parliament of the infamous management of the licensed houses in question, and the want of proper provision for pauper lunatics, a Select Committee was granted for inquiry, Lord Ashley was nominated as one of its members.

"It was on the Report of this Committee that, in 1828, Mr. Gordon brought in and carried the Act 9 Geo. 4, c. 40, amending the Laws for the erection of County Lunatic Asylums.

"The inquiry of the previous year had brought into clear view the imperfections of the existing system for licensing and inspecting private establishments for the insane, and for their general supervision.

"This had hitherto been conducted under the 'Act for regulating Mad-houses,' passed in 1774. The licensing and visiting authority in London and the neighbourhood was a Board of Commissioners appointed annually by the College of Physicians out of members of their own body.

"This Commission was shown to be thoroughly inefficient; but it is only fair to the memory of those who acted on it to remark that their powers were extremely limited. They had, for instance, no discretion whatever in granting licenses; they were to visit the houses licensed, but were strictly limited to the hours between 8 a.m. and 5 p.m.; they could notice and report abuses, but had no authority to redress them, especially as neither the Commissioners themselves, nor any public authority on their report, had the power of revoking a license for misconduct. Notice of admission of patients was to be sent, it is true, to the Commissioners from all houses, whether licensed by themselves or by the justices; but there was no provision for intimating to them the escape, discharge, or death of the patient.

"Concurrently with the Lunatic Asylums Bill another measure was introduced repealing the Act of 1774, and instituting a mixed Commission of physicians remunerated for their services, and of laymen acting gratuitously, to be appointed annually, and with much enlarged powers for licensing and inspecting.

"Lord Ashley was nominated on this Commission in 1829 and subsequent years. His attendance at Board meetings was frequent, and (on the retirement of Lord Granville Somerset) he first took the chair on 21st November, 1833. He usually occupied this position until the Act of 1828, renewed from time to time with various modifications, was finally repealed in 1845.

'The Commissioners in Lunacy' were then made a permanent body, with power to elect their chairman out of the unpaid members of the Board.

"Immediately on passing of the Act 8 & 9 Vict., c. 100, Lord Ashley was voted to the chair, which (except for a few weeks last year) he continued to occupy to the day of his death.

"The first general report of 'The Metropolitan Commissioners in Lunacy' (the body created in 1828) was presented to Mr. (afterwards Sir Robert) Peel, as Home Secretary, on 1st July, 1829.

"This document is but brief; it is signed by Lord Ashley and the rest of the Commissioners, and contains the following remarkable passages:—

> The number of patients either cured or materially relieved is so small compared with the total number of those under confinement, as to strengthen our own observations of the imperfection of the present system, so far as it is connected with restoration to reason of those who may be justly considered capable of recovery.
>
> It must not, however, be supposed that the managers are as negligent on this point as the returns would imply; the permanence of the disease may be accounted for by the tardiness of the parishes and of the relations of poor persons in sending them to these establishments, where they can in no way contribute to their own support, and where they are necessarily maintained at a greater cost than they would be either in a parish workhouse or in their own houses; the malady is thus allowed to become inveterate before it is subjected to regular treatment.
>
> It is also but just to observe that no inconsiderable number of the patients in these private asylums have been received into them when discharged as incurable from public institutions for the cure of madness.
>
> In establishments for a more wealthy class of patients, their cure is more attended to. The results are, nevertheless, less satisfactory than might be hoped. For as considerations of economy may be supposed to cause delay in the other class, so in this, the indisposition to cast the imputation of insanity on a near relation, and the natural feelings of reluctance at being separated from their objects of affection, are not unfrequently the cause of recourse to these establishments being deferred until the disease of the unfortunate patient has become so formidable and permanent in its nature as to be with difficulty, if at all, subdued.

"The vital importance of early treatment had thus forced itself on Lord Ashley and his colleagues at the very commencement of their labours, and to the end of his career he never lost sight of this as a first principle of lunacy reform.

"In the course of the Parliamentary Session of 1885, Lord Shaftesbury's deeply felt apprehension of the mischievous effects upon 'early treatment,' which certain provisions of Lord Selborne's Lunacy Acts Amendment Bill (noticed in another part of this Report) were likely to have, induced him, after much consideration, to tender to the Lord Chancellor the resignation of his seat at this Board, rather than appear to acquiesce in, much less to concur with, a project of legislation which he considered destructive of one of the great principles of lunacy treatment for which he had so long contended.

"With the following extract from a resolution passed at the meeting of the Board on 13th October, we conclude this head of our Report:—

Under the Act of 1845, Lord Ashley became the first permanent Chairman of the Board. Never has an official duty of an absolutely honorary nature been discharged with greater assiduity, zeal, and discretion.

Lord Shaftesbury's supervision of the working of the Commission, particularly in the early days when new points were constantly requiring decision, was real and effective. In later years, when the frequent recurrence of similar circumstances had naturally established a regular uniformity of procedure, relieving the Board from the constant discussion of details, his great experience, both in public affairs and in the special work entrusted to the Commission, was of the utmost value to his colleagues in the discussion of all those important questions which from time to time they have had to decide.

It is not too much to say that, if through the agency of this Commission the treatment of the lunatic has been rendered more humane; if any improvement has taken place in the arrangements and internal economy of lunatic asylums of whatever kind; if the general tone of professional and public opinion in regard to the care and treatment of the insane has been raised; in a word, if any good has come of the legislation of 1828 to 1845, it is to Lord Shaftesbury, and to his personal share in the work, that any credit which has been deserved is mainly due.

His death will nowhere leave a greater blank than at this Board, where, until lately, his presence was very constant, and where his keen intelligence, ripe judgment, and vigorous assertion of principle commanded respect and admiration, and where his kindness of heart and consideration for others secured the regard and affection of all."

Twenty-eighth Annual Report of the General Board of Commissioners in Lunacy for Scotland. Edinburgh, 1886.

The report of the Scotch Commissioners in Lunacy for the year 1885, closely resembles, in its main features, that of the preceding year.

The total number of registered lunatics in Scotland on 1st January, 1886, apart from 62 persons in the lunatic department of the general prison at Perth, and 230 imbeciles in Training Schools, who are registered separately, was 10,895. The corresponding number on the 1st January, 1885, was 10,627, thus giving an increase for the year of 268.

The number of private patients having decreased by three, the increase among pauper patients is really 271, and exceeds the increase during the previous year by 99.

The changes which have occurred in the manner of distribution of the insane during the year were, on the 1st January, as follows:—

In Royal and District Asylums there was an increase of 16 private and a decrease of 24 pauper patients. In private asylums there was a decrease of nine patients. In parochial asylums there was an increase of 10, and in lunatic wards of workhouses an increase of 88 pauper patients. In private dwellings there was a decrease of 10 private, and an increase of 197 pauper patients. There has thus been a total increase of 74 registered pauper lunatics in asylums and other establishments, and an increase of 197 of the same class in private dwellings. The increase of 74 in asylums and establishments is 22 less than the corresponding increase of the previous year.

The following table shows the proportion of recoveries per cent. of the numbers admitted into each class of establishment during 1885, and the corresponding percentages for the preceding quinquenniad:—

Classes of Establishments.	Recoveries per cent. of Admissions.	
	1880 to 1884.	1885.
In Royal and District Asylums ...	41	37
„ Private Asylums	37	50
„ Parochial Asylums	42	41
„ Lunatic Wards of Poorhouses...	6	7

The percentage of recoveries among private patients wherever treated is 36; that among paupers 44·6, and of both classes combined 43·1, when transfers are excluded; including transfers, the percentages are 33·8 for private cases, 35·8 for pauper cases, and 35·5 for both classes combined. To obtain these figures, it may be noticed that it is necessary to refer to several tables and to work out the percentages.

Of private patients 141, and of pauper patients 506, were discharged unrecovered.

The death-rate for the year has been 8 and 8·1 per cent. of the number resident among private and pauper patients respectively.

As in their report for 1884, the Board recommend that the discharge of patients on probation, for longer periods than four weeks, should be more frequently adopted by Superintendents than hitherto. Now, while there can be no doubt that the discharge of patients on probation is often a useful test of their fitness for final discharge, it seems dangerous and unreasonable that the period of probation should be extended beyond six or eight weeks, and it would be interesting to know how long the names of some of these patients remain on the registers of the asylums, after the individuals have left these institutions. The following sentence from the report is somewhat ambiguous:—"At 1st January, 1885, 54 patients were absent from asylums on probation. Of these 22 have been finally discharged as recovered, three were sent back, 26 remain under the care of friends, and three died." Are the 26 remaining under the care of friends discharged, or are their names still on the asylum registers, or if their names have been removed from the registers of the asylums, are they still registered lunatics in private dwellings? If still on the registers of the asylums their period of probation must have extended to nearly fourteen months.

The changes among attendants have been 481, or 38 less than the previous year. In referring to this the Board says:—

> We continue to regard it as unfavourable to the interests of the patients that these changes should be numerous, and think it is deserving of careful consideration by the administrators of those institutions where changes occur very frequently, whether some addition to the wages or some increase of the comforts of the attendants is not desirable.

On the present condition of the various establishments for the insane, the comments of the Visiting Commissioners are

altogether favourable, but in many cases the importance of discharging patients who have ceased to require asylum treatment is urged. In certain of the Royal Asylums where this system of discharging unrecovered patients to private dwellings has been vigorously carried out, much valuable space has been secured for the reception of private patients of the poorer class, for whom there has of late been a great want of suitable accommodation. At the Edinburgh Royal Asylum, by the discharge of unrecovered patients, and by "the increased accommodation obtained by internal changes, the overcrowding from which the asylum was suffering has been removed and facilities have been afforded for the reception of the poorer class of private patients, to many of whom, in the earlier part of the year, admission had, under deplorable circumstances, to be refused." In the Glasgow Royal Asylum also the pauper patients have decreased, and there has been a corresponding increase of private patients.

The number of pauper patients resident with relatives continues to increase, having risen from 935 on January 1st, 1885, to 967 on January 1st, 1886. This increase has been steadily going on since 1875, previous to which there had been a regular annual decrease. The decrease of the earlier years was undoubtedly due to the provision of suitable asylum accommodation; the increase of the later years is said to be due to the Parliamentary grant of 1875. The increase of the present year is nearly entirely due to the removal of patients from the asylums in the counties of Edinburgh, Forfar, Inverness, and Lanark to the care of their friends, when they were believed to have ceased to require asylum treatment.

There has been a large increase in the number of pauper lunatics under the care of strangers during the past year. In January, 1885, they numbered 926; in January, 1886, they numbered 1,091. As the progress of this mode of providing for the insane forms the most interesting feature of the report, the remarks of the Board on its past and on its possible future are given in the following paragraph:—

> The increase from 560 to 1,091 during six years indicates, as has been said, more than usual activity in the placing of pauper lunatics under the care of strangers in private dwellings; but it is proper to note that this activity has in the main been limited to a comparatively small number of counties, and in these counties again it has been limited to a small number of parishes. Of the 531 of which the increase consists, the counties of Inverness, Edinburgh, Forfar, Lanark, and Renfrew contribute 402. It is to be regretted that

parochial authorities generally are still insufficiently alive to the propriety of relieving asylums of those patients whose condition makes them suitable for being adequately provided for without detention in an asylum. It is also to be feared that the injustice of unnecessary detention as regards the rights of the patients themselves is not so fully appreciated as it ought to be. In the case of a large number of patients the active delusions and the tendency to violent conduct which characterized their condition when they were placed in an asylum, give place after a time, should complete recovery not take place, to a condition rather of feebleness of intellect than of active insanity. And it is undoubtedly true, in a large number of such cases, that had that condition of mere feebleness been the condition from the first, it would never have been thought proper to consign the patients to an asylum. The extent of relief to asylum accommodation which a due recognition of this may lead to is well illustrated, to take one out of several recent instances, by the case of the parish of St. Cuthbert's, in Edinburgh. The authorities of this parish up to the year 1880 had proceeded upon the view that none of their pauper lunatics were unnecessarily detained, and in that year only 21 out of a total of 293 were provided for in private dwellings, 12 being with relatives and nine being with strangers. Since then, however, the authorities of St. Cuthbert's have seen reason to change their view in regard to what is necessary to justify detention in an asylum, and have recognized the duty that lay upon them to restore those who were fit to the ordinary conditions of social life. The result of this has been that on the 1st January of this year instead of 21 being in private dwellings the number so provided for was 112, 17 being resident with relatives and 95 with strangers. If a similar change of view were to take place in the case of all the parochial authorities who still fail to take the view now taken by St. Cuthbert's, it is evident that the continually recurring demand for additional asylum accommodation would be greatly diminished.

In their remarks on the "Position of Districts," the Board gives an interesting account of the changes which have occurred in the provision of establishments for pauper lunatics since 1858, and of the effects these changes have produced in the number of lunatics in establishments in the various districts. On the 1st January, 1858, when the Act of 1857 came into force, there were in Scotland 2,953 pauper lunatics, of whom 1,594 were in public institutions specially created for the treatment of the insane, 526 were in private asylums, and 833 were in poorhouses. The public institutions were the Royal Asylums of Aberdeen, Dundee, Edinburgh, Glasgow, and Montrose, the Crichton Institution, Murray's Asylum at Perth, and a pauper asylum at Elgin, in association with Gray's Hos-

pital. All these institutions still exist, and all except Murray's Asylum continue to receive pauper patients.

The private institutions were, in 1858, fifteen in number, and were, with the exception of two for idiots, conducted for profit. All these institutions have ceased to exist, except the two for idiots, and one other which has long ceased to receive pauper patients.

Twenty-seven poorhouses received lunatics. In some, special wards were put apart for these patients, and both quiet and excited cases were admitted; in others the lunatics were placed among the ordinary inmates, and in these only harmless cases were received. Of the 833 pauper lunatics accommodated in poorhouses on the 1st January, 1858, 569 were in the seven poorhouses containing patients labouring under every form of insanity, and 264 were accommodated in poorhouses containing chiefly harmless and incurable patients. The Lunacy Act of 1857 did not sanction the placing of pauper lunatics in poorhouses; but in 1858 the detention of lunatics in poorhouses was legalized for five years, to allow of the erection of district asylums for their reception. The Lunacy Amendment Act of 1862, however, gave the Board power to grant licenses to poorhouses to receive harmless and incurable cases, and also to grant licenses for the reception of all classes of patients. At present six poorhouses have such unrestricted licenses, and constitute the class of establishments generally known as parochial asylums. Fifteen poorhouses possess the restricted license.

Since 1857 twelve district asylums have been erected.

From January, 1859, to January, 1886, the number of pauper lunatics in Royal or Public Asylums has increased from 1,687 to 1,951. In 1859 there were 621 of these patients provided for in private asylums; in 1886 no pauper lunatic was in a private asylum. In parochial asylums the number has increased from 561 to 1,445, and in poorhouse wards, with restricted licenses, from 284 to 836. The district asylums which have been built since 1859 contain 3,016.

In 1859 the eight counties which possessed asylum accommodation of a more or less public character had on an average 129 pauper lunatics in establishments per 100,000 of population, and the other counties, which did not possess such accommodation, had a corresponding average of only 81. At the beginning of the present year the group of eight counties had an average of 191 per 100,000, and the other group of counties, which had in the interval been provided with asylum accommo-

dation, an average of 199 per 100,000. It will thus be seen that the number of paupers in establishments in proportion to the population has increased as accommodation has been provided for their reception. The following paragraph relating to this topic is quoted from page 42 of the Report:—

It is an instructive fact, in connection with the arrangements for the accommodation of pauper lunatics and their number, that the number for the county of Midlothian, including the city of Edinburgh, in 1859 was 193, being in that year the highest number in Scotland; and that in 1886 the number has not changed to any important extent. It has, indeed, fallen slightly, being now 186. The reason for the number having remained nearly stationary during these twenty-seven years may be fairly attributed to the circumstance that, though a district asylum has been provided for the rural part of the county, no great change has been made in the arrangements for providing for pauper lunatics in Midlothian since the present lunacy system came into operation. The bearing of such a fact on the question of the alleged increase of lunacy is apparent. There is no reason to suppose that if there were such an increase as is alleged the inhabitants of Midlothian would have been exempted from it; and unless they had been so exempted it would show itself in an increase of the number of persons requiring asylum detention as pauper lunatics.

But the conclusion which appears to be arrived at in this paragraph can scarcely be adopted without a more complete statement of the whole facts. The alleged increase of insanity, as generally understood, means the increase, in proportion to the population, of insane persons in a district, whether confined in establishments or in private care. Now the single parish of St. Cuthbert's has admittedly transferred large numbers of its patients from asylum to private care, and by its single action must have had a great influence in keeping down the numbers in establishments in the county of Midlothian.

The accommodation for private patients who belong to the more opulent classes is stated in the report to be abundant, but for the poorer classes this is not the case. The Royal Asylums, in which it is desirable such patients should be received, have to a great extent been filled up by pauper patients, contracts for their reception from various districts having been entered into by the Directors. As a result, cases for which a high rate of board could not be paid have hitherto, in many instances, remained unsuitably provided for under the care of their friends, while pauper cases less urgently requiring asylum treatment have been adequately provided for. During the past year in some of the Royal Asylums it has been found pos-

sible to reduce the numbers of pauper patients and thus increase the accommodation for the poorer class of private patients, and it is stated to be the intention of the Directors to proceed further in this direction. At present there is little difficulty in finding suitable accommodation for patients for whom upwards of a guinea a week can be paid.

Dr. Fraser and Dr. Lawson having made an interchange of the districts which they visted during the year, the reports of the Deputy-Commissioners are unusually short, and are limited to a record of their visits, but both reiterate their belief that the patients in private dwellings are happier and, as a rule, better off generally than those in asylums.

The average daily rate of maintenance in Royal, District and Parochial Asylums during the year has been 1s. 3¼d., in lunatic wards of poorhouses 1s. 1d., and in private dwellings 9¾d. The general average rate was 1s. 3¾d., the same as the previous year.

In the year 1882 there were in establishments as pauper lunatics 188 per 100,000 of the population, in 1883 the proportion fell to 185, and has remained at the same figure ever since. On the other hand the proportion of the same class in private dwellings was 45 in 1883, and is now 53. From these numbers it will be seen that the policy of the Board in promoting the placing in private dwellings all those patients who are deemed fit to be removed from asylum treatment has been increasingly successful, and that thus the immediate demand for increased asylum accommodation has been, to some extent, postponed, and increased accommodation afforded for the reception of the poorer class of private patients in Royal Asylums. It appears remarkable that while offering so many advantages, the system of boarding-out should have been adopted by only a few parishes in only a few counties. Is it that the parochial authorities, having their insane paupers comfortably placed in asylums, desire to leave well alone, or is it that they wish to avoid the responsibility of distributing a number of insane persons within their districts? For the patients themselves and for those with whom they are lodged there is probably, in the majority of cases, distinct advantage, but it is difficult to see what advantage the sane population can derive from having numbers of chronic lunatics distributed over the country; and it is easy to imagine much uneasiness and discomfort arising to some who, against their will, have to come into contact with those people. Should a few serious accidents result from the presence of the chronic insane among the sane, and parochial authorities

insist on the return of a large number of these patients to asylum care, great difficulty would probably arise in finding accommodation for them. Until the system of boarding-out has been much more generally adopted it will be impossible to judge whether it is to prove beneficial or the reverse. So far, the care and vigilance of the Board have secured for their system a large amount of success, and it is to be hoped that by their continued efforts in this direction, the difficult question of how to accommodate the increasing numbers of the chronic insane may be solved.

Thirty-fifth Report of the Inspectors of Irish Lunatic Asylums, 1886.

The Inspectors commence their report by stating that the statistical tables, supplied *in minute detail,* in the appendices, differ but little from those given in the preceding year—that for 1884. In the report for 1883 we were informed that the "*more elaborate*" tables introduced in the year 1882 had to be omitted; and as no attempt has been made to again introduce them, we must once more lament the absence of any attempt to harmonize the statistics of insanity in Ireland with those given in the Blue Books for the other divisions of the United Kingdom, and the meagreness of these returns in so far as they treat of the scientific study of psychology. It is truly lamentable to see such disregard for useful information and united action.

On January 1st, 1885, the insane in Ireland were distributed as follows:—

In District Asylums, 9,687—5,322 males and 4,365 females.

In Dundrum Criminal Asylum, 178—146 males and 32 females.

In Licensed Houses, 639—245 males and 394 females.

In Workhouses, 3,775—1,518 males and 2,257 females.

Totals, 14,279—7,231 males, 7,048 females.

The Inspectors, as in last year's report, draw attention to the curious fact that while each sex is almost identical in the general population, the male inmates in Irish asylums are seven per cent. over the female, whereas females in workhouses are twenty-three per cent. more numerous than males.

"A further disparity may be added, namely, that moral causes of lunacy are a third more prevalent among women

than men, with whom physical causes stand nearly in a two-fold excess."

As no statistics, showing the causes of insanity amongst the insane in Ireland, are given in the report, we can only take this latter statement on the Inspectors' dictum.

The admissions to District Asylums amounted to 2,850 cases. Adding them to the numbers already found in these institutions at the beginning of the year, we find that the aggregate treated amounted to 6,798 males and 5,739 females, with a daily average of 9,781. Of the admissions, 2,240 were cases of first attack and 610 relapses.

With reference to admissions, the Inspectors state that, from their own observation and the opinions of the resident physicians, they consider that in the past year, much more than previously, acute attacks of insanity were caused by want of nutritious food, and at the same time by a continuous indulgence in raw spirituous liquors of bad quality. The patients so affected, and physically of good frame, were recognizable from their pallid, emaciated features, extreme irritability, waywardness, and disposition to violence. Some few cases proved speedily fatal. It is to be regretted that no further information, or statistics, accompany these statements, which must be of the greatest interest, not alone to psychologists, but to all who are engaged in the pursuit of medical or sanitary science.

No details are given of the locality in which these cases occurred, whether in the urban or rural districts, nor is any explanation to be found of why want of nutritious food, which certainly cannot be said to have been unknown in Ireland in years gone by, should have in the year 1885 produced an outbreak of insanity, whereas it was on former occasions followed by outbreaks of fever of various forms. Nor are there any statistics to show any increased consumption of alcohol, nor any reasons given why its quality should be supposed to have deteriorated. All this is very irritating to the simple reader in quest of information.

The recoveries during 1885 were 1,196, and the discharged improved 516; 89 were removed to the care of friends—a change which, on the grounds of humanity, and as likely to prove beneficial, the Inspectors would be glad to see more generally carried out, especially amongst the better circumstanced in society.

The proportion of recoveries on the daily average of patients in 1885 was 12 p. c. If, however, the recoveries were

estimated as is ordinarily done, on the basis of admissions, they would stand much higher, or at about 53 per cent.—a high rate accounted for by the rarity of general paralysis in Ireland. Though these statistics would appear of the most favourable character to all who are accustomed to study the returns of the treatment of the insane throughout the world, still the Inspectors consider that the Irish public are not satisfied with the utility of hospitals for the insane, or that a recovery rate of over fifty per cent. is an equivalent for the large outlay in the building and maintenance of public asylums for the insane. "It must be borne in mind," they say, "as already on principle upheld by us, that lunatics deprived of liberty and personal privileges, from the character of their affliction, not only have peculiar claims on the public, but require for their own, and alike for the protection of society, the unremitting care that can only be afforded in establishments specially adapted to their detention, in a curative and protective point of view."

These statements cannot be gainsaid, but to us it would appear a useless labour to reason on behalf of the insane with those who would take so little interest in their treatment as not to consider a recovery of fifty per cent. ample remuneration for the expenditure involved in the maintenance of public asylums.

The deaths, amounting to 856, were lower than those which occurred in the previous year. Four were from suicide, but not from any culpability on the part of those in charge. The Inspectors consider that "the stealthy and studied ingenuity of a person bereft of reason when bent on self-destruction, or as the result of a sudden impulse in the feelings of a lunatic though seemingly quite contented with his surroundings, cannot be well obviated on some occasions."

No death during the year resulted from accident, and only two permanent escapes were effected.

A very favourable report is given of the interior organization of district asylums in Ireland under the judicious control of their medical superintendents. The subordinate staff also receive their portion of praise, though many are said to complain of their pay and allowance, still more of "hopes deferred," and the Inspectors would appear to consider that the attendants on the insane are deserving of a higher rate of wages than they at present receive in Ireland.

They prefer the system which prevails in England, where Boards contrasting, in their different localities, from personal observation and experience, the relative value of money with services rendered, can requite the latter accordingly. Thereby a better educated class of attendants can be procured, "not one, however, more humane, better conducted, or more faithful than are to be found in Ireland." The meaning of the latter paragraph is not quite plain. The wages of the staffs are regulated by the Lord Lieutenant on the application of the different Boards of district asylums; the Inspectors, therefore, either mean that the Castle supervision should be abolished, and that the rate of wages should be fixed by the local authorities, or that the members of these local Boards should look about them, and observe the value paid for labour in other parts of the country.

During the year 1885, 12,537 patients were under treatment in district asylums. Subtracting from this number the discharges, deaths, escapes, and transferences, 9,872—5,402 males and 4,470 females—remained.

Contrasting the expenditure for the past two years, we find that during 1884, with a daily average of 9,614 patients, the expenditure on maintenance and incidental expenses amounted to £221,753 17s. 7d., being at the rate of £23 0s. 11d. per head.

In 1885, under parallel circumstances, with a population of 9,799, being an increase of 162 on the average, the cost of supporting district asylums was £216,799 17s. 4d., or £4,954 less than that of the preceding year, being at the rate of £21 19s. 5d. per head for each patient, the decrease of expenditure being due to cheaper contracts.

The audit of accounts, which in Irish district asylums is carried out under 31 and 32 Victoria, cap. 97, by the Government auditors, and which gave employment to these officials for 78 days, resulted in no reduction or disallowance in any of the accounts. "It could not well be otherwise," say the Inspectors, "looking at the social position of Governors appointed by the Executive, who in the control of these establishments devote much time, and not unfrequently at personal inconvenience, to self-imposed duties.

It is evident that, notwithstanding the growing democracy of the age and the popular cries for local government, we find the Inspectors still uphold the old *régime*, "social position" and "Government selection." The next sentence, however, does not bear out their laudatory statement, as they

point out how some asylum boards are inclined to reduce the expenditure below that of the workhouse, by making the Government grant suffice for the support of the unhappy inmates. To this the Inspectors object, insisting that the grant was given, not so much for the sake of keeping down local taxation, as to increase thereby every hope of the recovery and improvement of the insane population, so that the "social position" of the governors does not in all cases render them liberal guardians of the insane poor.

Attention is next called to the quantity of land attached to the twenty-two district asylums, which amounts to 978 statute acres—697 of which were under spade cultivation, or in grass; and 281 were occupied by buildings. The area of land divided amongst so many asylums, averaging 32 acres for each institution, seems very limited in a country such as Ireland, where agricultural labour is the general employment of the people; and it is to be regretted that the farms, on the score of economy, were not sufficiently large to afford means of occupation to double the number now employed out of doors. But to make up for the deficiency, useful employments are perceptibly on the increase, in the way of trades and handicrafts; while amusements are liberally afforded—music and dancing both in and out of doors.

A special return was presented to the House of Commons last January, "showing moneys ordered to be expended on sites and buildings of lunatic asylums in Ireland for a period of twenty years to January, 1885, as well as the dates of Orders in Council for sanctioning increases of additional land." It is to be regretted that this return was not published in the appendices, as it would have elucidated the question of the amounts advanced to each asylum district by the Treasury.

The number of persons mentally affected in the 153 union workhouses of Ireland amounted, on December 31st last, to 3,733, being 42 less than at a like date for the year before. Of these, 714 males and 1,182 females were lunatics, 786 males and 1,051 females were idiots and epileptic imbeciles. In some workhouses the Guardians are anxious to have all the insane transferred to asylums—a scheme which, if carried out, would, according to the inspectors, entail a large outlay on new buildings, or an extensive addition to the existing ones, independent of an increased local taxation, and a fresh call on the Government rate in aid; whilst they are of opinion that it is quite inexpedient to erect costly institu-

tions as abodes for this class of our fellow-creatures. Some thirty years ago it was proposed to erect large provincial receptacles for idiots, epileptics, and demented lunatics, but the inspectors objected to this, as, independent of the outlay for their construction, the number of counties and cities attached to them would cause much embarrassment in their working, with continuous expense for the transportation of these patients backwards and forwards. The scheme suggested by the inspectors for the proper care and protection of these classes of the insane is the conversion of an unrequired poorhouse, if one existed, with some acres of land in each district, that the poorhouse should be adapted to its new object by addition and alteration, and be supported as at present out of the union taxation. What has been done in the Belfast Workhouse is quoted as an example of the satisfactory result to be derived from this scheme. There the Guardians erected a suitable, commodious, and well-furnished structure for 360 inmates, at a total cost of £8,600, for their idiots, epileptics, and the like, on an open and elevated site close to the main building.

It is, however, difficult to follow the Inspectors in these suggestions. They first of all object to any outlay on the erection of new buildings for the harmless incurable insane, and advise the appropriation of an empty workhouse for their accommodation, but bring forward as an example of this scheme the only case in which the Guardians found their workhouse so full as to be obliged to erect a totally new building at a cost of £8,600.

We have only further to remark that the Inspectors must be aware that empty workhouses are not to be found in the populous districts, where accommodation for the insane is required.

It is also proposed to erect in Dublin one establishment in a healthy situation for the insane paupers in the North and South Dublin poorhouses, as few in Ireland are more unfavourably circumstanced.

In England, or rather within the Metropolitan Counties, intermediate establishments between regularly-organized hospitals for lunatics and ordinary institutions for the destitute poor have been provided, suited to the reception of chronic or hopeless cases of insanity, as also for imbeciles and persons affected with epilepsy of a marked but not dangerous character. Thereby some large asylums have been disembarrassed to a considerable extent of persons not requiring a special or more expensive mode of treatment, and being

conducted by smaller and much less expensive staff, effect a considerable saving to the public rates. What we would advocate is a somewhat similar system, but practically rendered more economical by taking advantage, where available, of poorhouses in separate districts, and fitting them up becomingly to their intended purpose.

Perhaps the Inspectors are not aware that the Metropolitan District Asylums at Leavesden, Caterham, and Darenth afford accommodation for the insane equal to anything to be found in any of the Irish public asylums, with much more costly furniture and surroundings. On the score of economy it is difficult to understand how, with so small a number as 300 or 400 inmates, a saving could be effected if an adequate staff were provided under separate medical control, at a distance from any other institution for the care of the insane, and unless some provision were made for the proper supervision of their attendants, no useful object could be obtained by the erection of such establishments.

As to the treatment of the insane in workhouses, the Inspectors are disposed, making due allowances for manifold deficiencies, to record from personal knowledge a not-unfavourable judgment on them, as means to an end. However, they continue to point out the absence of paid attendants; the want of facilities for washing and bathing; the rooms inhabited by day—dark, gloomy, restricted, and opening into very "circumscribed and walled-in yards, which, generally speaking, constitute the sole exercise or airing-courts."

The Inspectors conclude this description of the treatment of the insane inmates of workhouses by a proposition which certainly seems to differ from the generally received ideas on the subject.

> All circumstances considered, their condition, in fact, presents an anomaly as regards result of their treatment and that of patients in asylums, who, as a rule, notwithstanding a studied attention to their wants and wishes, are discontented, ever seeking to be liberated, whereas in poorhouses they seem to be satisfied with their position, scarcely ever thinking of its amelioration or their own freedom. Thus philanthropy in their regard is altogether a gratuitous sentiment in public feeling.

Thus, according to the Inspectors, all the liberality shown in the erection of costly edifices, all the expenditure of time and money in the care of the insane, all the labour and skill applied in their treatment, is thrown away, because the inmates of workhouses are contented with their lot, whilst the greater number of those under care in asylums are

anxious for their freedom. This argument appears a dangerous one to lay before the public in a report of the charitable institutions for the benefit of the insane poor, and if carried further might be made to advocate the abolition of asylums *in toto*. That the human mind can be reduced to such a condition as to become insensible to suffering, might be a more natural explanation of the contentment of the larger number of lunatics who are inmates of workhouses.

On the subject of the condition of the Central Asylum at Dundrum, the question of the advantages to be derived from a special asylum over invalid prisons is discussed, and from the remarks made it may be presumed that a recommendation has been made to the Government to abolish Dundrum, and to relegate its inmates partly to a special prison and partly to the district asylums.

Towards the close of last year, a Commission, after an inquiry of many weeks, reported on the condition of the asylum, and recommended the various improvements suggested in previous reports and Parliamentary papers, viz., the elevation and repair of the boundary wall, an increase of attendants (the ratio to patients being under that of Broadmoor and Perth), an addition to the size of the dining-room, and enlarged accommodation for men.

The twenty-two private asylums contained, on December 31st, 1885, 632 patients—243 males and 389 females—or seven less, between both sexes, than at a like date in 1884. For many years very slight variation has been perceptible amongst the numbers in private asylums in Ireland.

The admissions amounted to 176. Of these 136—73 males and 63 females—were cases of first attack, and 36—18 of either sex—relapses. The total under treatment during the twelve months amounted to 811, of whom 71 recovered, 25 were discharged improved, and 24 unimproved; 59 died. The percentage of recoveries and improvements is on a par with public asylums, whilst the death-rate is in excess by one per cent.

Private asylums are, in the Inspectors' opinion, well conducted in Ireland. The houses on charitable foundations also receive their share of commendation.

The Inspectors, when terminating their remarks on the condition of district asylums, state that ample information is supplied in tabular form in the annexed appendices, not only of general expenditure, but of all matters connected

with the domestic economy of district asylums. We must, however, repeat that no attempt has been made to introduce any new tables throwing light on the study of insanity in Ireland, or to harmonize the statistics with those introduced in the study of mental science in other parts of the civilized world.

We are surprised that (were it from no higher motive than the *amour propre* natural to the human breast) the Inspectors do not make an effort to produce as complete a report as that issued by their *confrères* in England and Scotland.

Psychiatry, a Clinical Treatise on Disease of the Fore-Brain, based upon a Study of its Structure, Functions, and Nutrition. By THEODORE MEYNERT, M.D. Translated by B. Sachs, M.D. Part I. (continued)—The Anatomy, Physiology, and Chemistry of the Brain.

(*Continued from p.* 405.)

We must resume the study and summary of Meynert's valuable book.

The loss of fore-brain causes loss of recollection of former experiences, which constitutes a process of induction, the repeated association of simultaneously experienced sensations giving rise to the idea of necessary association, thus the sight of the lamb and the hearing a bleating sound are associated, and either sight or sound may recal the idea of lamb, and these associations are doubtless connected with fore-brain function.

Meynert says it is safe to suppose in regard to all inductive processes that certain obstacles which impede the excitation of cells in full repose are very much lessened after a single, and particularly after repeated, identical excitations of association-bundles uniting the cells of two distinct areas of the cortex; while the transmission of such stimuli to association-tracts which have been called upon to unite together previously-established groups of associations becomes well nigh impossible.

Loss of spontaneity also follows loss of fore-brain, spontaneous movements being the result of innumerable registered images, the residual effect of past motor stimuli. Goltz has shown that animals can stand or fly though they have had

the medullary substance of their hemispheres removed; in these the sub-cortical motor apparatus remains intact.

All excitations of the fore-brain are secondary to the primary impressions in the sub-cortical centres. In consequence of its connections with the sub-cortical centres, and as a result of the sensations of innervation deposited in its substance, the cortex becomes a spectator of the reflex acts evolved in the sub-cortical centres. When speaking of the effects of innervation, Meynert eloquently says "the motor effects of our consciousness reacting on the outer world are not the result of forces innate in the brain. The brain, like a fixed star, does not radiate its own heat; it obtains the energy underlying all cerebral phenomena from the world beyond it. Movements which were originally reflex can be set in action by any one of a larger number of associated impulses." The functions of the thalami optici are exemplified by a good pathological case, and Meynert shows that the lenticular nucleus alone is the ganglion of the fore-brain; the optic thalami are signal stations for sensations of innervation akin to those contained in certain cortical centres.

The observation of Soltmann that the so-called motor areas of the cortex when stimulated in new-born animals are not excitable, and not yet motor in function, is important, and supports Meynert's idea that centripetal tracts connecting the cortex with the sub-cortical centres of innervation, such as the thalamus, constitute the anatomical link in the chain producing secondary movements. From the reflex foundation, and the second or conscious action, we pass to what Meynert calls a third grade of innervation; this is what we have got used to talk of as inhibition, and the example given is that of the cool and collected person who submits to an operation on the eye, not allowing the sphincter palpebrarum to act when the knife is seen to approach the eye, but innervating the levator palpebræ superioris to oppose the closure.

It is worth quoting what our author says of the "ego" of abstract psychologists: "Individuality implies the sum of firmest associations which under ordinary circumstances are well-nigh inseparable; the aggregate of memories forming a solid phalanx, the relation of which to conscious movements can be defined apparently with mathematical precision. This unequal activity of the fore-brain constituting individuality varies as regards contents and degree

with each person; it is designated the character of the individual."

We are glad to find Meynert supporting one of our favourite theories, that the "self-feeling" is started in gastro-intestinal sensation.

He says Kussmaul believes the fœtus feeds itself *in utero* on amniotic fluid, connoting sensation; next comes perception of self, and other things which are not self. It is fair to expect that frequent and simultaneous sensations which emanate from the body itself will enter into firm connections which they will never again be able to dissolve, and which will thus form the primary conception of the "ego," based upon the perceptions of the body's circumference.

Meynert does not mince matters when he adds that there is no order of movements which, under the cover of instinct, can be "pushed in between conscious and reflex movements." We are not quite so sure of this point as our author. A good deal of space is filled with a rather witty study of the nucleus of the "ego," as he supposes the sensations limited to the child's body may be called, and naturally passes to the study of the "non-ego."

The primary "ego" expands through permanent and intense secondary perceptions, joined to it by association; so that intimately related persons, property . . . patriotism, and honour become part of the "ego."

This is all very true, but it appears to us to confuse the whole point, and pass from the starting point of self-feeling to the relativity of all feeling and being.

The one determinative motive allowed man is the avoidance of the greater pain. There is no objection to accepting Lotze's views as to the perception of space as a result of association of retinal images and eye motor innervation, and we like the description of the part taken by the cerebral cortex in space perception.

We quote the following eloquent expression of opinion, which comes so naturally from the experienced alienist:—

> To this account of the widespread activity of the fore-brain, not only as the recipient, but also as the creator of sensations, I wish to add that it is the boldest hypothesis, shared alike by the ordinary mind and by scientific realism, to assume that the world is such as it appears to the brain to be; that the latter can be likened to a mirror, which simply reflects the forms of the outer world; that the world as it appears to the brain exists independently of the presence or absence of mind. Indeed, it seems to me to be a crucial test of an individual's

power of thought, to determine whether he can conceive or not of the unreality of the world clad in forms which our minds have bestowed upon it. It should be reiterated that the idealistic conception of the world is supported by physiological facts, and still more positively by the facts of cerebral architecture before alluded to.

Residual images would not furnish adequate motives without the inherent phenomena of feeling; and associated with this we have the emotional developments to study, and these are studied under the heads—movements of aggression and repulsion; the pleasure or pain is associated with perfect or imperfect "respiration of nerve cells." Here, again, we have the graphic statement of mental and bodily satisfaction going together: the ease of health and disease of illness. Though neither pain nor pleasure may be present in the decapitated animal, there is still evidence of the effect of stimulating sensory nerves; thus there may be movements of repulsion, inhibition of nerve-conduction, increased arterial pressure, and dyspnœtic stimulation of nerve cells on the one hand, and an embrace, as in a frog, on the other.

In the reflex centres aggressive and repulsive movements inhibit one another; thus in the croak experiments of Goltz, the croak cannot be elicited if painful stimuli be simultaneously applied.

Besides conduction through the association bundles, we have irradiation of the stronger stimuli through the grey fibres. The two processes differ, as irradiation interferes with association.

Stimulation of the cortex will affect the vascular states, irritation of cortex being vaso-constrictor, and removal of cortex vaso-dilator; and in the same way we know that the conduction of strong sensory stimuli into consciousness increases the arterial pressure and artificial constriction, thus setting up anæmia. Whether this lead to actual unconsciousness or not, we may say that the sensation of pain is associated with narrowing of the arteries.

Strong sensory stimuli excite in a reflex way conscious movements of repulsion, and in originating sensations of pain introduce inhibition, arterial contraction, and dyspnœa of the elements of the fore-brain. Besides actual pain, sensations related to the causes of pain may produce a similar set of actions; hence we have feeling without physical pain, which we call emotions. Mere perception cannot excite emotion without association; to go further,

the revival by memory of the painful emotion, or even the meeting the record of the past, may cause similar though less marked physical changes in the nervous system.

Though we admit that frequently repeated pleasurable impressions associated with a dear friend, when lost or inhibited by his death or defection, may interfere with the free course of thought and cause a considerable amount of confusion, yet it is striking to read that marked inhibition of nervous impulses from the fore-brain excites like the inhibited conduction of painful sensory stimuli, or the suggestion of torture, a concept of the impossibility of counteracting this inhibition, which may ultimately lead to suicide. We have certainly often been struck, in cases of melancholy in old men who have after long periods of monotonous labour retired on pensions, with the confusion produced by this kind of inhibition, and doubtless similar experience has caused Meynert thus to write.

Sensation is, according to him, the subjective form of perception of all the above-named physiological processes; it is, as it were, the expression of a special sense concerned with the nutritive phases of the cortex. The sensation of happiness is, no doubt, to be ascribed to a determination of arterial blood to the busied fore-brain, to functional hyperæmia.

It would take too long to follow our author in his many interesting speculations in detail, and, therefore, we must glance only in passing at some of his facts and theories. He points out the fact that in animals who have large olfactory lobes, and who, in fact, depend greatly for their safety on their power of smell, have large lenticular ganglia, while animals with specialized fore-limbs have more developed lenticular ganglia. The excessive development of the posterior part of thalamus opticus in man is thought also to have a relation to the high development of the hand, &c.

There is good reason to believe that all forms of sensibility are represented in the thalamus and corpora quadrigemina.

Only so long as the thalamus is uninjured, are animals able to avoid obstacles thrust in their way.

The multiplicity of relations of the thalamus as a centre of automatic movements, and as such its relations to the sensations of innervation, its bearing on the sense of smell, and its relations to sight, are in keeping with the anatomy of this ganglion.

The functions and relations of the thalamus and corpora quadrigemina as sub-cortical centres are studied and exemplified. The oblongata impresses Meynert with its importance as a vaso-motor centre, so that slow sectional removal of this part causes the blood pressure to fall before the pons is reached, the blood pressure not depending so much on cardiac innervation as on capillary tone.

Attention is called to the fact that the auditory nuclei are placed near the motor masses which control the production of sound as well as the respiratory centres.

Reference to the fact that the auditory fasciculi and the cerebellum are closely connected, is made, and its physiological significance noted. The cerebellum was shown by Hamilton to be far more developed in animals able to take care of themselves at birth than in others.

He thinks the so-called diabetic centre is identical with the vaso-motor centre for the arteries of the liver.

Following the part on the function of the brain and its special parts, we have the division on "nutrition of the brain," and here again we have vigorous expression of painstaking observation, and we think it hardly necessary to do more than say the work is well done. The great importance of the lymph-cushions on which the brain rests, and their relationship to the sub-arachnoid spaces and the sinuses, are all clearly described, and the various movements of the brain are examined, and the importance of these movements in removing effete material and inducing healthy action and healthy repose—sleep—are made clear. Swedenborg long since studied these movements, and, in fact, left little about the brain unobserved, and it is refreshing to compare the work of two such opposite men and yet get similar impressions.

The Pacchionian bodies once more are described, but once more we are not satisfied that their function is understood.

For us the chemistry of the brain has little interest. This is the result of our ignorance of the whole matter, and partly of our profound disbelief in any chemical solution of the facts of mental disorder.

Meynert does not in any way convey similar want of faith, but certainly his chemical considerations are not too full.

There is an appendix on the mechanism of expression, which hardly calls for notice here, though suggestive enough.

The perusal of this work impresses one with the vast field of work before the alienist, but it encourages us to hope that where one has wrought so earnestly others will gladly follow on.

Disorders of Digestion, their consequences and treatment. By T. Lauder Brunton, M.D., D.Sc., F.R.S. Macmillan and Co. 1886.

The present volume includes the Lettsomian Lectures delivered by the author in 1885; these form the first three chapters. The rest of the book consists of miscellaneous papers on matters for the most part therapeutic. The volume in its structure is necessarily disjointed; indeed, this is freely acknowledged in the preface; it stands, in fact, simply as a collection of papers which, with the exception of the first three, own no other bond of union than the book-binder's.

The Lettsomian Lectures are, of course, public property, and have received already their due praise, but as they have been reprinted, and are well worthy of it, they may be reconsidered with advantage. Dr. Brunton possesses the very valuable gift of seeing things as it were in their essentials; he is firmly persuaded that things material do not put off their physical properties when they enter the vortex of life, but possess them as before; and, added to this, he is a most able physiologist. It results that whatever he writes is worth reading, and is always suggestive. As an example of Dr. Brunton's mode of looking at things, we will quote from p. 4. Speaking of food whilst within the alimentary tract being really outside the body, he says: "For we sometimes find that food which has been swallowed passes through the intestine and is evacuated almost, or entirely, unchanged. *It has simply fallen, so to speak, from the mouth to the anus*, much as it might have fallen from the neck to the feet if it had been laid against the skin."

Truly a physicist's view! One needs but to demand the rate of passage of the particle, its weight, and the co-efficient of friction between it and the alimentary tract, and we have the data for a simple mechanical problem. And honestly we think this physicist view is a sound one, for such food-particle never really entered the organism. Of course there are also the elements of a physiological problem in the above,

viz., the action of the particle upon the *sentient* surface; this Dr. Brunton does not forget, but for the moment we need not consider that.

But are there dangers belonging to this physical viewing of things vital? We think there are. Thus, a little further on, speaking of diffusion, Dr. Brunton suggests that much of this process is quite mechanical, and that the size of the molecule is the determining element, that "the real cause why some substances diffuse and others do not is that the molecules composing them differ much in size." According to this view, diffusion through a moist membrane would not differ from the sifting of sand through a sieve. No doubt bulky molecules will be less diffusible on the whole than small molecules, but one would rather look *to the properties which go with the bulk* to explain this want of diffusion than to the mere bulk itself. Indeed, Graham's division into colloids and crystalloids, and his view of the process of diffusion, if not quite so simple, commends itself more to us. Add to this that the moist animal membrane is a *living* membrane.

With regard to some other points of interest. A very notable statement is made as to the effect of mastication on the circulation in the carotids. According to Marey, whom the author quotes, the rate of blood-flow increased by three times in the carotid of a horse during mastication. A tracing in demonstration of this is given. Of course one feels great diffidence in questioning such an authority as M. Marey, but for us the difficulty consists in the tracing itself. Is a pulse tracing anything more than the record of the *tops* of a series of waves which have fused through the greater part of their height? If this be so, variations in the height of the *tops* can give no true comparative values till we have found the true base line. And we do not think the zero line in the tracing gives this. Prof. Lister drew attention to this some years back in a lecture given at King's College.

On the functions of the liver as a gate-keeper to the rest of the blood vascular system, we find some very instructive statements, also a diagram which illustrates the subject very clearly. This part is of great value, for not nearly sufficient attention is paid, or used to be, in books on physiology to the portal cycle: absorption by the portal radicles, transmission to the liver, excretion along the bile ducts, reabsorption from the mucous membrane, and so forth.

In Lecture II., we must notice a diagram of the portal and

systemic circulations, for Dr. Brunton, we think, excels in diagrammatic representation, and this is by no means easy, whilst it is extremely useful. This lecture deals chiefly with bilious forms of dyspepsia. Many points of interest are touched upon—amongst others the curious one of flatulence, its source. Here, as in so many other departments of pathology, hysteria presents the hardest problems; witness the rapid and enormous distension of the bowels in certain hysterical patients. In the same chapter, glycosuria and albuminuria, in what may be termed their non-organic forms, are discussed, also the interesting but obscure subject of oxaluria.

On the nervous depression which so frequently attends dyspepsia in its various forms, Dr. Brunton offers the suggestion that we have to deal, actually, with a poisoning of the system by the products of digestion, and he points to the analogy existing between these effects of indigestion and the effects of curare. At first Dr. Brunton had thought that peptones were the poisonous elements, but since the discovery of the formation of alkaloids in the tissues, and as the result of the decomposition of albuminous bodies, he is inclined to think that the poisoning in indigestion is by alkaloids. The interest which this question excites lies for the moment rather in the *fact* of poisoning or not than in the nature of the poison.

Chapter III. deals with the treatment of digestive disorders.

Passing to the miscellaneous essays, we must content ourselves with a selection here and there. A chapter on the action of alteratives opens up one of the most interesting of therapeutic problems. The date of this chapter is 1876, when it appeared as a paper in the "Practitioner." It has, however, the warrant of 1886 for its republication. Dr. Brunton first points out that all medicines alter, and that strictly speaking a purgative is as truly an alterative as mercury or iodide of potassium, but that by consent we restrict the meaning of the word alterative, and exclude "from the class all medicines which give external signs of vigorous action by purgation, sweating, or diuresis," and limit the term "to such remedies as do their work slowly and secretly, but none the less effectually." Dr. Brunton next proceeds to consider the meaning of nutritives and the process of nutrition, and he likens in a way the nutritives to the alteratives. Here are his words:—"Our remedy has

corrected the nutrition of the body in some mysterious and secret way, as mysterious and secret as the manner in which a hearty meal sustains the nutrition, and we class our medicine among the alteratives just as we class the substances composing the meal among the nutritives." The all-important function which is subserved in nutrition by ferments is next dealt with, and finally the author suggests that it is by modifying the ferments that the alteratives act upon nutrition.

Now, to examine these propositions. An alterative—what is it? A substance which modifies tissue-change *for good.* Is it akin to a nutritive? Is there any likeness? Let us take iodide of potassium as an example. It enters the system as potassium iodide, and it leaves the system as potassium iodide, and *en route* it modifies tissue-change, *i.e.*, itself not undergoing change it causes change. This function is more of the nature of the old mysterious catalytic or "presence" action than of anything akin to nutritive action, for the nutritives enter the system as unstable, complex molecules of low oxygen holding, and they leave the system as stable, comparatively simple bodies and more highly oxygenated, and this breaking-down of the molecules with fixation of oxygen means, of course, the evolution of energy. In addition to this there is, it is true, a reverse process, viz., the building-up of complex molecules to repair waste, but the latter is a comparatively subordinate process in higher animal life. The above then holds for the proteids, fats, and carbo-hydrates, but whilst these are the true nutritives, food stuffs, there is an element of food (there are others) which, whilst not being a nutritive, is yet necessary to nutrition—to wit, chloride of sodium. This enters the organism as such and leaves as such, but it is a necessary condition for nutrition. Chloride of sodium is strictly analogous to iodide of potassium. Nutrition, then, demands both nutritives and *elements which condition nutrition*—in health chloride of sodium is such; in disease iodide of potassium may be such. May not this be given as the definition of alteratives, *bodies which in disease condition nutrition?* Having made the first step, the next will be to consider how they condition nutrition, and here it is very possible we may have to fall back on Dr. Brunton's hypothesis of modification of the ferments, though at first sight it would seem, perhaps, improbable that the modification should be *limited to the ferments.*

We shall need to stay here. Tasting ever has proved

dangerous, and even now has led to a yet deeper, though hasty, draught than was perhaps wise. There is much that still calls for notice, but we must leave it unnoticed now, and it only remains for us to thank Dr. Brunton for the fertilizing pollen of his thoughts. May they prove a very gold dust, and no lack of carriers.

The Functions of the Brain. By D. Ferrier, M.D., F.R.S., &c. 2nd Edition. Rewritten and Enlarged. Smith, Elder, and Co. 1886. pp. 498.

Die Functions-Localisation auf der Grosshirnrinde. Von Dr. L. Luciani und Dr. G. Seppilli. (Original in Italian. Translated into German by Dr. Fränkel.) Leipzig. Denicke. 1886. pp. 413.

After perusal of the above titles, our readers, we are sure, will not expect of us more than a brief sketch of the purport of the above-named works, supplemented by a very few critical remarks. It is further very unnecessary for us to notice at length Dr. Ferrier's new edition, for his first edition was reviewed in these pages in detail. We cannot refrain, however, from pointing out that Dr. Ferrier has with immense labour entirely rewritten his invaluable work and brought it up to the present level of knowledge in the fullest and most thorough manner. In accordance with his avowed intention, his work presents a digest of the latest researches on each point—not an encyclopædic collection of results—with critical remarks as a judicial summary of the whole evidence. While such a mode of handling the subject undoubtedly admits of the main facts being presented in a much more connected and, therefore, more explicit fashion, still it is impossible for any author to sink his individual opinions when he treats of a matter which is scientifically *sub judice.* A large margin of liberty, however, must be given to Dr. Ferrier in this direction, for probably no work of an equally brilliant and highly scientific nature has been received on the one hand with such meaningless scepticism, and on the other hand opposed with such absurd arguments and perverted facts. So that if, as we think, Dr. Ferrier has written with rather too liberal employment of adverse adjectives to enforce his meaning, we must not forget that the provocation has been severe. Dr. Ferrier must have felt in rewriting his book the great satisfaction of finding the main lines of his early investigations confirmed almost to the letter by workers during the last decade. Nowhere does this

appear more clearly than in the other work which heads this notice, viz., the volume issued by Profs. Luciani and Seppilli, although in the *interpretation* of some facts these writers are inclined to take a view which differs somewhat from that of Dr. Ferrier. Prof. Luciani's work on the Experimental Production of Epilepsy, and on the Cerebellum, &c., is well known in England, and it is a matter for congratulation that, with the aid of Dr. Seppilli, he has in the volume put forward his general ideas on the more doubtful problems of localisation from a comparatively independent standpoint. For while the most widely divergent views of the proper interpretation of the facts (experimental) of this subject may be said to be those of Dr. Ferrier on the one hand and the German School on the other, the Italian observers have always approached the subject with little or no bias, and the value of their work has thus been greatly enhanced.

In Profs. Luciani and Seppilli's monograph an attempt is specially made to define the representation of the special senses by two methods of research, first from exact experiments on the lower animals, and secondly from the crude material of clinical and post-mortem observation of disease in man.

The clinical cases collected with much research are, however, conspicuously wanting (no doubt in the original reports) in one respect of absolute importance; we refer to the exact deep limitation of the lesion. It is almost hopeless to generalize concerning the symptomatic importance of this or that lesion of the cortex, when we are absolutely ignorant of what fibres coming from other parts of the cortex are injured or not. Most especially is this the case with observations on the representation of the special sense of touch. Of course the knowledge gained from the post-mortem room will always be most elementary, but if the material which is now daily thrown away were properly reported upon, and, what is much more important, if practitioners would urge on the laity the importance of examining the brains of persons dying accidentally or of some intercurrent disease who have been the subjects of nervous diseases and most especially if the neurosis has but lately shown itself, such a reproach would be in part removed from this sphere of observation.

Charcot and Pitres have shown what can be done in this direction after exact experimentation had made the way clear.

In conclusion we cannot too strongly urge those who wish

to obtain a complete knowledge of cerebral localisation to combine the reading of the two works which we have had the pleasure of thus referring to.

Dr. Fränkel is to be complimented on his painstaking translation.

Betty's Visions, and Mrs. Smith of Longmans. By Rhoda Broughton, author of "Cometh up as a Flower," &c. London: George Routledge and Sons, 1886.

We assume that the primary reason this volume has been sent us to review is the narrative of Betty's Visions, but there surely must have been another, namely, to explain the fact, psychologically, that any author's mental capacity can be so limited as this production shows it to be without being placed under the kind care of someone accustomed to treat the weakminded.

The visions are real or fictitious; if the former they should be guaranteed by the authoress, if the latter they are totally devoid of merit as products of the imagination. It is really extraordinary that anyone can deliberately write such unmitigated trash, or that the book should have been thought worth adding to even a "shilling fiction series," as it assumes, but we trust incorrectly, that it will find a sufficient number of readers to make it pay. On the title page appear in conspicuous letters the warning words, "All rights reserved"—a melancholy proof of an *idée fixe*, that namely of supposing that there is the remotest danger of anyone wishing to usurp them.

L'Homme et l'Intelligence. Par Charles Richet. Paris, 1884.

Les Maladies de la Mémoire. Par Th. Ribot. Paris, 1884.

Illustrations of Unconscious Memory in Disease, including a Theory of Alteratives. By Charles Creighton, M.D. London: H. K. Lewis, 1886.

Different as are the works we have grouped together, they have a certain *vraisemblance*, the first two from a psychological and the third from what may be called a psychophysical point of view.

M. Richet, the author of several well-known works, has brought together a mass of interesting matter, including a very valuable chapter on induced somnambulism, in which he refutes the objections frequently adduced against it by

those who having never studied the subject, think it clever to be incredulous, and a necessary part of fashionable scientific manners. Under the head of "the personality and the memory," he speaks of conscious and unconscious memory, and observes of the latter —

> It consists in this. A. is in the hypnotic sleep. I say to her: "When you awake, take this book, which is on the table, read the title, and return it to my library." I arouse her. She rubs her eyes, looks around her in astonishment, puts on her bonnet to go out; then before going she throws a glance upon the table, sees the book in question, takes it up, reads the title, and says to me: "Stop, you read Montaigne; I am going to put it back in its place." And she places it in the library. I ask her then why she has done so. She remembers nothing of the command I had given her, and my inquiry seems to puzzle her greatly. She says: "Couldn't I look at this book?"

M. Richet points out that an act is here done without the motive being known. It is an unconscious motive, and unconscious memory has induced her to perform the act. Although it appeared to be spontaneous, it was really determined by a cause of which the actor could give no account. A similar experiment has succeeded after the lapse of ten days. There is then such a thing as a *souvenir ignoré*. But, as the author says, this phenomenon is not confined to somnambulism. There is only the difference of degree between unconscious memory in normal and abnormal conditions. Every day we are the subject of an influence of which we are ignorant, and which often directs our will. For our present purpose this brief reference to the excellent work of M. Richet must suffice. Its bearing upon what follows will be evident.

The little book on "the Disorders of the Memory," by M. Ribot, is characterized by the accustomed ability and acuteness of the author. It is his object to insist upon the memory being a biological fact, and that what is generally understood by that name is only the last term of a long period of evolution, and resembles the efflorescence of which the roots have been long ago planted in organic life. That it enters the domain of psychology is an accident. The author, dismissing the metaphysics of the unconscious as treated of by Hartmann, declares that he is unable to explain the transition from the unconscious to the conscious. Although the author treats mainly of the disorders of the memory in its ordinary sense, he does not overlook the relation between unconscious memory in its relation to life and

organization. He has profited by Sir James Paget's writings, and quotes the often-cited passage from the "Lectures on Surgical Pathology" as to the continuation of the memory, notwithstanding the constant changes in the brain and the destruction of its cells, by the perfect assimilation which takes place in the nutritive process, the impression being exactly reproduced in succeeding cells. M. Richet's commentary upon this process is, "however paradoxical it may seem to admit a relation between an infectious malady and the memory, it is rigorously exact in a biological point of view."

With the propositions laid down in this book that the memory is a general function of the nervous system, that psychical memory is only a complex form of the memory which pervades the body, and is a biological fact, that there is an unconscious memory in disease, it is easy to proceed to the third work in our list.

The publication of these books is another indication of the increased interest felt in and importance attached to phenomena of unconscious mental life. What the change has been in the intelligent study of this most interesting field of psychology will be best appreciated by a comparison of medical and metaphysical works prior to the time of Leibnitz and Unzer on the Continent with those of Hamilton and Professor Laycock in our own country. We find the doctrine of "mental latencies" in Leibnitz, and it is curious to notice that Sir William Hamilton, while doing him honour for having originated this opinion, criticizes him for using the terms "*perception without apperception or consciousness*" and "*insensible perceptions.*" And yet this paradox is essentially the belief of the present day among physiologists and psychologists. These terms, as taught by Laycock, apply to vital sequences occurring without the individual's knowledge. He complained that critics refused to admit the possibility of his great and original doctrine of unconscious cerebral action, "on the ground that unconscious mental action is a contradiction," and that they denied the conclusion that vital successional states and conscious successional states are due to a common law, the vital phenomena which correlate mental conditions necessarily implying the notion of what he terms material or biotic ideas. His doctrine supplied the connecting link between the phenomena of consciousness and the molecular changes in organic matter, upon which the phenomena of life depend. With him ideas

were the causes of order in all molecular phenomena, and of growth, development, and nutrition, as well as consciousness and thought. The tissues had their latent consciousness, or, as later writers term it, unconscious memory. The writings of Laycock, now more than forty years old, followed by those of Dr. Carpenter, and the endorsement which both gave of the main facts of mesmerism as set forth and explained by Mr. Braid, encouraged the study of unconscious acts, whether spontaneous or induced. Dr. Creighton, in his little book, does not, it is true, enter upon the consideration of hypnotic phenomena, and it might seem as if there was little in common, in hastily glancing through the work, between the matters discussed and those of the writers to whom we have referred; and yet in truth the connection is much closer than might be supposed or than the author himself is, we think, aware. Whether, however, this be the case or not, Dr. Creighton has written freshly and philosophically on unconscious memory, and made a detailed application of Richet's and Ribot's doctrines. In doing this, he has extended his consideration of unconscious states quite beyond the limits of the psychological aspect of the question, and, indeed, the first sentence of his preface emphasizes the fact that none of his illustrations of unconscious memory in disease are psychological. The author would say that his views are based on the metaphysical system of Hartmann, only so far as that system in this connection is the mere negation of consciousness, and he points out that this philosopher exalts unconscious will, while he ignores unconscious memory.

Dr. Creighton, after maintaining that whether "unconscious will" be a paradox or a mere figure of speech, unconscious or organic memory is not anything of the sort, grounds the doctrine upon the biological phenomena of generation. We give the words of the author himself on the application of the latter to the doctrine which he maintains:—

"If generation is the acme of organic implicitness, what is its correlative in nature, what is the acme of organic explicitness? Obviously it is the fine flower of consciousness. Generation is implicit memory; consciousness is explicit memory; generation is potential memory; consciousness is actual memory." Premising that memory underlies every manifestation of consciousness, "we may speak of our unique experience always by the synonym of conscious memory, and therein find the means of bringing it into relation with something else. It

may be brought into line with the process of unfolding or becoming actual which starts from the other end, namely, with organic development and growth; and it may thus be styled the acme of organic explicitness and actuality. Memory touches the highest point of implicitness in generation and the highest point of explicitness in consciousness. Development and growth are the unfolding of the one; the retreat behind the scenes into the domain of the unconscious is the upfolding of the other. By thus interchanging the members of the correlative couples we obtain a material support for the two subjective terms; we pair off Conscious Memory with Development and the Unconscious with the Germinal" (p. 14-15).

Dr. Creighton is careful to point out that it is in no figurative sense that memory is a general function of organized matter. The illustrations are ingeniously brought together to illustrate his position, and to these we must refer the reader.

We have received the following communication, entitled, "Hunter and Shelley on Habit and Unconscious Memory," from Dr. Samuel Wilks, F.R.S., which we append as thoroughly germane to the foregoing Review:—

In the exceedingly interesting life of Shelley by Professor Dowden (which no doubt some of your members will review in its psychological aspect) there is a remarkable passage showing how philosophers of the Shelley stamp had a firm belief in the hereditary transmission of human faculties—that a child was in possession of powers held by its forefathers, and that it wanted but a little stimulus to bring them out. In his own wild and fantastic way, when a mere boy at Oxford, he gave a remarkable exposition of his belief. Although having a mind as opposite as possibly could be to that of the scientist, it is remarkable to see how the same ideas as his are now current and promulgated by the natural philosopher and physiologist. And although the baby (as will be seen in the narrative) would not relate, as Shelley hoped, its past experience, yet it is this very experience used unconsciously, according to modern notions, which prompts the young animal to certain actions which have hitherto been vaguely styled instinctive. Thus Mr. Butler, in his "Life and Habit," refers the picking up of seed by the chick, and its running away from the fox when but just out of its shell, to the remembrance of like acts on the part of its parents. German writers have familiarized us with these ideas, and it may be remembered

that Dr. Creighton has written an interesting and important work in which he carries the doctrine into the domain of pathology under the title of "Unconscious Memory in Disease." He shows how the protracted nature of a morbid state may continue long after the cause producing it has ceased to act, and how the only way to cut short the disease is by the use of some powerful agency which will arrest the habit. In this way he sees an explanation of the treatment by alteratives.

It is interesting to observe in reference to this subject how our great master, Hunter, had views which led him a long way towards these more modern doctrines. Unfortunately Hunter's style is so involved, and his lectures such unpleasant reading, that his words of wisdom have not always impressed us as they should. In his lectures on the "Principles of Surgery" it will be seen with what penetration and judgment he grasped the idea of the influence of custom and habit on the functions of the human body, and how he saw that the habit would remain long after the causes which had produced it had ceased to act.

It seems strange to place together two such opposites as Hunter and Shelley, and yet both of them were looking in the same direction from different points of view. The one had cautiously, and by close observation, seen the unconscious working of many actions of the human being in response to stimuli which had long ceased to be in operation; the other saw the same thing transmitted through many individuals. The two ideas are allied, and constitute a modern doctrine now taught in our schools.

First of Hunter on Habit or Custom. "Memory, or recollections of past impressions, has, I believe, been principally applied to, or supposed to be, an attribute of the mind only, but we know that every part endued with life is susceptible of impressions, and also that they are capable of running into the same action without the immediate impressions being repeated. Habits arise from this principle of repetition of, or becoming accustomed to, any impression, and the same thing exactly takes place in the mind. The memory of the body is of much shorter duration than that of the mind. The mind not only goes more readily into action the second time of an impression, though a considerable distance of time has taken place since it went into the same action before, but seems to take up the action with more ease, from nearly collateral causes, from a recollection of

the similarity, or often without any possible recollection whatever, as if the actions in consequence of the former impression were taking place in the brain again.

Custom is with me the negative of habit. By custom comes an insensibility to impression, the impression diminishing although the cause is the same, and the parts becoming more and more at rest; whereas from habit there comes an increased facility to go into action, and also an acquired perfection in the action itself, the impression continuing the same, although the cause is diminishing.

Habit is the continuance of actions we have been accustomed to produce without any immediate assistance, or even continuance, of the first cause, as a body set in motion continues to move after the cause of motion has ceased to act.

A habit of acting arises from a repetition of acting, which repetition of acting is custom, and which becomes the cause of the continuance of the same action; so that custom is always prior to habit, or, as it were, forms habit, which may be ranked as one of the secondary principles in the machine.

The first action being produced by a disposition in, or force upon, the part, this being repeated or continued a sufficient length of time, the action at length goes on, when that original disposition or force is gone, until some other power counteracts it or it wears itself out. This principle in the animal is similar to the old inertiæ in matter, for by it a motion began is continued, and their remaining at rest is from the same cause. This principle becomes the cause of the actions of the mind; it does not allow men to think differently from what they have been accustomed to think. Men in general go through life with the same modes of thinking, and thus it becomes a cause either of the retardation or improvement of the understanding. It retards improvement because it gets the better of even present sensations, and does not allow men to wander into novelty. It promotes improvement because it makes men perfect in what they have been long employed about."

Now of Shelley. "In a whimsical way he would apply the Platonic doctrine that all knowledge is reminiscence, so as to justify an interest in babyhood, which is not a usual characteristic of undergraduate philosophers. Strolling one day in the neighbourhood of Oxford he stood still to watch a bare-legged, bare-headed gipsy girl of six years old at her

play of collecting snail shells, and was struck by the intelligence of her wild and swarthy countenance, and the glance of her fierce black eyes. "What an unworthy occupation (snail shell gathering) for a person who once knew perfectly the whole circle of the sciences!" At this moment a ragged boy —guardian of his sister—emerged above the roadside bank, and brother and sister presently disappeared. Shelley was charmed with the intelligence and marvellous wildness of the pair. "He talked much about them, and compared them to birds, and to the two wild leverets which that wild mother, the hare, produces. By and by the wild things came to view again, the boy bearing a bundle of sticks, unlawfully gathered, and dreading a rebuke or a blow. Shelley's demeanour soon showed that he had nothing to fear. He laid a hand on the round, matted, knotted, bare and black head of each, viewing their moving mercurial countenances with renewed pleasure and admiration, and, shaking his long locks, suddenly strode away. 'That little ragged fellow knows as much as the wisest philosopher,' he cried, 'but he will not communicate any portion of his knowledge. It is not from churliness, however, for of that his nature is plainly incapable, but the sophisticated urchin will persist in thinking he has forgotten all that he knows so well. I was about to ask him to communicate some of the doctrines Plato unfolds in his "Dialogues," but I felt that it would do no good. The rogue would have laughed at me, and so would his little sister.'"

"One morning," writes Hogg, "we had been reading Plato together so diligently that the usual hour of exercise passed away unperceived. We sallied forth hastily to take the air for half an hour before dinner. In the middle of Magdalen Bridge we met a woman with a child in her arms. Shelley was more attentive at that instant to our conduct in a life that was past or to come than to a decorous regulation of the present, and with abrupt dexterity caught hold of the child. The mother, who might well fear that it was about to be thrown over the parapet of the bridge into the sedgy waters below, held it fast by its long train. 'Will your baby tell us anything about pre-existence, madam?' he asked, in a piercing voice and with a wistful look. 'He cannot speak, sir,' said the mother, seriously. 'Worse and worse,' cried Shelley, with an air of deep disappointment, shaking his long hair most pathetically about his young face; 'but surely the babe can speak if he will, for he is

only a few weeks old. He may fancy, perhaps, that he cannot, but it is only a silly whim. He cannot have forgotten entirely the use of speech in so short a time; the thing is absolutely impossible.' The mother declared that she had never heard him speak, nor any child of his age. Shelley sighed deeply as he walked on. 'How provokingly close are those new-born babes,' he ejaculated; 'but it is not the less certain, notwithstanding the cunning attempts to conceal the truth, that all knowledge is reminiscence. The doctrine is far more ancient than the times of Plato, and as old as the venerable allegory that the Muses are the daughters of Memory; not one of the nine was ever said to be the child of Invention.'"

Paralyses: Cerebral, Bulbar, and Spinal. By H. Charlton Bastian, M.D., F.R.S. H. K. Lewis, London, 1886.

We suffer from a plethora, and books nowadays, succeed each other so rapidly and out of proportion to the novelty of ideas, that each writer, before giving what is new, has to drag in all the experience of his contemporaries and rivals. The difficulty at the present moment is the selection of the best book on nervous disorder and diseases of the brain and cord. Author after author of repute has given to the public the ripe experience of years, and, as it happens, each seems to have acted as a stimulus to the other, so that all have come out, either as first appearances or as revivals with fresh dresses, about the same time, and the reviewer finds himself placed in a difficulty as to how to do justice to all.

Ferrier, Ross, Gowers, and Bastian, what a galaxy of neurological talent, and yet each author has his peculiarity. The brilliant work and daring speculation of the Scotchman is contrasted with the painstaking, almost toilsome, labours of Gowers, and of Bastian we can truly say that his reading, and his experience, not only of patients, but of students and of examiners, have fitted him for the task he has undertaken and has carried to a successful issue.

Thus, each observer in nervous pathology gathers together the heaps of facts and arranges them according to his fancy, or according as he thinks they will best be understood by those for whom he caters.

It seemed at first startling to look into Ross's splendid

book to find that it was very incomplete, though so large. Yet knowledge of facts grows too fast for the philosopher, and even the fact-heaper cannot get all together and in order. We, the principal readers of this journal, expect to find under the head of paralysis our old friend "general paralysis" in some body and shape, but in Ross it is not, and in Bastian it is without shape and void. We feel it a direct compliment to us when we find such skilled observers afraid to handle that which we certainly look upon as the crux of our science. Fortunately we have our own able writer in Mickle, and can well afford for the present to learn more of allied paralysis from the general physicians, while we go on studying our own special forms of disease and decay.

To begin with, the book by Dr. Bastian is pleasant to read, being very well arranged.

The paper and type are not quite so good as that in Ferrier's, and the cuts are in some cases old and poor. They do not compare at first sight favourably with those of Ferrier, but they are very graphic, and for the student are most useful.

The book is, as it professes to be, a manual of diagnosis for the student and practitioner, and is intended as an aid when brought face to face with cases of paralysis of different kinds.

The first point in reviewing a book is to look to the author's object, and if he fulfil that, he at least is praiseworthy. We can most sincerely say that we believe that neither time nor trouble have been spared to make the book what it professes to be, a help to diagnosis. Dr. Bastian has so long been recognized as a careful worker that no one was surprised that his work on the physiology of the brain should be followed by the one on the pathology of the nervous system.

To begin with, our author contrasts the two very opposite conditions of paralysis and convulsions. He does not confine himself to motor paralysis, but claims a right—from custom—to speak of sensory paralysis. As a teacher it is necesary to be dogmatic, and we only repeat a truism when we say that all dogmatism must include some partial truths. It seems in this light a pity to say "almost if not quite all paralyses are invariably caused by definite morbid conditions appreciable by the naked eye or by the microscope, or by both."

This is not true of a good many functional paralyses of motion, and still less of those of sense.

Very neatly and clearly our author distinguishes between the advance in diagnosis, which demands now a regional apart from a pathological diagnosis. We should like to have had time, or rather space, to go in detail through the work, pointing out our agreements and disagreements with the author, but it must suffice for us to point out the lines on which the book is planned, and to advise all students wishing to have their facts ready to hand for practice or examination to master the book.

One great feature of the book is the number of carefully and usefully arranged tables of diagnosis. These are eminently practical, and give the required knowledge in a nutshell, so that the hard-worked student can get his food in a concentrated form, and the busy practitioner can keep himself from rusting, or on emergency refresh his failing memory. Dr. Bastian is not too blind a follower of new lights to believe that the physiologist can, without clinical practice, supersede the physician, and we quite agree with the way in which he trusts to what is found rather than to what might have been or ought to have been. We have seen so many brilliant physiological diagnoses of nervous disease proved to be inaccurate that we are always prepared for the unexpected to turn up on the post-mortem table. After the general introduction, which is to the point, and not diffuse as a German would have it, we have among the preliminary data a scheme of the circulation, general and minute, followed by a section on the relation of the principal fissures and convolutions to the outer surface of the scalp. Most of this depends on the observations of Reid, but we find no notice of some made by the late Prof. Rolleston at Oxford many years ago, and, we believe, published in the "Transactions of the Royal Society." Of course, after all, the best facts are best for the purpose, and Reid's are careful and good.

Under Pathological Diagnosis we have all the general conditions which cause paralyses of encephalic origin. These are tabulated carefully and systematically, and the development of the symptoms in similar conditions contrasted. Many slight remarks are full of deep clinical interest, and show the power of our author to cut adrift from general opinions. Thus he says that disseminated sclerosis may arise from traumatic injuries to the head. This is very interesting, but yet there are difficulties in understanding why this occurs so commonly in young persons.

Almost every symptom of paralysis which may occur as a

result of brain, bulbar, or cord disease is discussed fully and systematically, as well as the relative temperatures and the values of contractures, the methods of investigating reflexes, and the values of the results obtained. A specially good table is the one for testing the quality of aphasia or amnesia.

The book is on paralyses, and therefore we do not expect to find complete studies of all the other symptoms which may occur with paralyses. All that is necessary is given, and we can as thoroughly recommend, as we heartily welcome, this book.

General Paralysis of the Insane. By W. J. Mickle, M.D. H. K. Lewis, London. 1886. 2nd Edition.

We have rarely welcomed a book more heartily than we have this by Dr. Mickle. The first edition was admirable, but now that it has grown into a much larger and more pretentious volume, we give it a bigger welcome. We hope, at some future time, to do ourselves justice by reviewing it in detail, but we should not like the coming months to be neglected by those who may not have seen the new edition, and yet who wish to be up in the best work done in our speciality.

We recommend all our readers to get this book, as it is certainly the best summary of the history of the disease, and the symptoms which may occur, and the respective value of these symptoms as they arise, which exists in the English, and we believe it will rank with the best in any, language.

The book has grown from 250 to nearly 500 pages, and has been re-written; though the general order is maintained, yet the fuller details and the wealth of authorities given, make the book what it is meant to be—a text book for workers, and a repository of knowledge for all who seek it.

There are many points still to be settled, and though Dr. Mickle hardly decides any questions himself, he gives the evidence up to date. He is free from bias, and ready to look at both sides of the question.

We leave the book for the present, wishing it every success.

A Manual of Diseases of the Nervous System. By W. R. Gowers, M.D., F.R.C.P. J. and A. Churchill, 1886, Vol. I.

(*First Notice.*)

This, the first of two volumes which will form the complete work, treats of diseases of the spinal cord and nerves. A very short introductory chapter deals with the principles of classification; in this, on p. 2, we find four pathological classes of disease set forth:—

1°. Organic disease (or coarse organic disease); such as tumour, hæmorrhage, softening.

2°. Structural disease; such as most forms of sclerosis.

3°. Nutritional disease; such as general paralysis of the insane, paralysis agitans, chorea.

4°. Functional disease; such as reflex convulsions and many forms of hysteria.

Has this classification any real advantages over the usual and simpler classification into organic and functional, the functional section representing, we may hope, a more or less vanishing quantity as our means of investigation go on? We must not, however, blind ourselves with the expectation that in time the functional section will quite disappear, for till we are able to discover the structural basis of polarity, as, for instance, in the case of the magnetized and unmagnetized steel rod, so long we may expect that some functional diseases will lack a structural basis. With reference to Dr. Gowers's classification we must also ask the question, Is general paralysis of the insane so without a structural pathology as to be inadmissible into class 1° or 2°? In passing, we may note the introduction of the word "colossal" in the sense in which it is familiar to German readers. Is it required? It can never be as imposing as the German word with the long drawn "a," and at best it is not elegant.

The chapter on General Symptomatology, dealing with motor and sensory symptoms, and the reflexes, true and doubtful, is very clearly written, and the careful reader gains definite notions on these fundamental points as well as on the methods of investigating, and, not the least, he learns to appreciate the importance of systematic examination, though, of course, other works of the author, more essentially practical, may be advantageously consulted on this point. The changes in the electrical excitability of nerves and muscles are in this chapter broadly stated; this includes the reaction of degeneration, which generally in text books suffers under

mysterious formulæ, KOC, etc. Of course these cannot be absolutely done away with, but to the student it is of great benefit to have the essential truth, which they hide, extracted and plainly set forth.

The muscles individually are then considered, and the results of their palsy well shown by a number of illustrations. This forms a useful reference chapter, for few, we fear, are so fortunate as to be able to carry all these mechanical problems in their heads. Should they seek to?

Part II. takes up the diseases of Nerves—first, in their general pathology, and then in the symptomatology of their lesions. In this chapter we cannot quite escape formulæ, but they are not unduly dwelt upon, and small charts after Erb assist the letter-press very considerably.

With regard to the illustrations generally, we think that many of them are too pale, and have a rather washed-out appearance; this, however, is a detail, for they are nearly all clear in essentials.

Chapters on Neuritis and on Morbid Growths in Nerves precede the diseases of special nerves. Among the latter sciatica is treated of in a chapter by itself. The author regards this affection as being in most cases a true neuritis, and not a neuralgia, as it is frequently stated to be. In evidence of this Dr. Gowers points to the conditions under which sciatica occurs as being "very different from those that attend unquestionable neuralgia in other situations;" further he insists that the morbid anatomy is that of neuritis, though, of course, he admits the scantiness of the data here; lastly, he brings forward the symptoms, tenderness over the nerve trunk, wasting in the muscles, and anæsthesia as proving the presence of neuritis. Dr. Gowers admits that cases of sciatic neuralgia do occur, but considers them extremely rare; he excludes all cases of sciatica, "with persistent tenderness of the nerve, as really neuritic."

The subject of "multiple neuritis" is dealt with at some length; five classes are distinguished:—

1°. Diphtheritic neuritis.
2°. Tabetic neuritis.
3°. Leprous neuritis.
4°. Endemic neuritis.
5°. Primary multiple neuritis.

Class 2.—The tabetic form is explained as being doubtfully a true neuritis, but provisionally it is ranked as such. The interest of this chapter lies in the 5th class, "the primary multiple neuritis." A very curious point in the

etiology is here touched upon, the relation, viz., of the disease to chronic alcoholism. This is considered to be undoubted, and yet, as the author points out, the disease is far more frequent in women. With regard to this, one may probably take it that more prolonged experience of what at present is a new disease may alter somewhat the statistics as to sex, or failing such, throw some light on the meaning of this apparent discrepancy. The symptoms of the disease are given rather fully, and a very admirable outline illustration shows the characteristic "wrist and foot-drop." Œdema of the limbs is stated to be frequent, but it is not very clear from the text whether such cases at all simulate ordinary anasarca, or whether the œdema is characteristically distributed over nerve areas. Of course the fact that the disease is the result, in many cases, of chronic alcoholism, will entail a coincidence of many symptoms belonging to the alcoholism apart from the neuritis—the author hints as much.

A brief notice of the endemic form of neuritis, known both as kak-ké and as beri-beri, follows; the relation of this to malaria is touched upon, and the author states that in two cases of malarial neuritis coming under his own observation, he observed the remarkable fact that the paralysis was not attended by anæsthesia. Such obtains also for beri-beri. The suggestion is made that perhaps malarial neuritis may affect the motor fibres chiefly. If it should be so, the fact will be a very remarkable one.

Leprous neuritis is then shortly considered, and this closes Part II.

Sketch-book for Ophthalmoscopical Observations of the Fundus of the Eye. By Dr. O. Haab, Lecturer on Ophthalmology at the University of Zurich. Zurich: Hofer and Burger, 1886. London: Trübner and Co.

This small book will be found very handy for those who make use of the ophthalmoscope and desire to sketch at the moment the appearance presented by the eye. The ground is coloured red to commence with, and a rubber is provided by which patches, &c., can be readily shown. A coloured pencil also accompanies the sketch-book, and is essential for the drawing of lines and spots. One end of the pencil, being of light red, is employed to represent the arteries, while

another, of dark red, marks the veins, &c. Should grey or blue colours be required, it is only necessary to rub some lead pencil powder with a leather stump, and run it lightly over the patches which may be made. One recommendation is that the pictures so produced last an indefinite time without any special pains taken to preserve them. A sketch having been made in this little book, it can be cut out and attached to the history of the case. This ingenious production can be obtained at a trifling cost, which its utility will many times repay. We strongly advise all readers of the Journal who make use of the ophthalmoscope to obtain this sketch-book and to make frequent use of it.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

By D. Hack Tuke, F.R.C.P.

La Criminalité Comparée. Par G. Tarde. Paris: Felix Alcan, 1886.

It is one of the characteristics of the science of to-day that crime is studied from the standpoint of organization, and takes its place among the scientific and medical, as well as the social and religious, problems of the age. M. Tarde commences with the consideration of the anatomical characters of the criminal type, one in direct contrast to the ideal of Hegel, according to whom the form of the nose is all important in explaining the beauty of the Grecian profile. Between the forehead, where the spiritual expression of the human face is concentrated, and the jaw, where animalism finds expression, the nose appears to Hegel to be the intermediate organ which powerfully contributes to turn the scale in favour of one or the other. It tends, according to him, to render the animal or spiritual nature predominant, according as it is intimately connected, by almost a straight line, with a vertical forehead, or is detached from a retreating forehead, marked with wrinkles, by a broken line, the nose being of the snub order, or even it may be aquiline, and incorporated rather with the mouth and the jaw, especially if these are heavy and prominent (p. 15). The author maintains that the beautiful classical head, forms, by the forehead and rectilinear nose, by the small and gracefully-arched mouth, by the moderate size of the jaw, by the small ear closely applied to the temples, a perfect contrast to the type of the criminal,

whose ugliness is, indeed, the most marked characteristic. Of 275 photographs of criminals given in Lombroso's *L'Uomo delinquente*, M. Tarde could only discover one beautiful face, and this had a feminine expression; the remainder were mostly repulsive, and the number of monstrosities was very large. *Méfiez-vous des laids encore plus que des glabres!* It seems to M. Tarde that after having sought to explain the criminal physiognomy by *comparing* it to that of the primitive man, always more or less conjectural, one ought to be able to *contrast* it with the ideal type of human beauty which for long has been much better known to us, and in this way to complete or rectify the first interpretation of its characters (p. 16). The expression of the assassin is described as dull, cold, and fixed; while with the thief it is restless, oblique, and wandering. Much stress is laid by Lombroso upon the frequency of the wrinkles on the forehead, and of the development of the superciliary ridge. It is this character which, joined to a retreating forehead, appears to explain the curious resemblance between the Italian criminals and those of France and Germany (p. 16). At any rate, Lombroso's plates reveal an astonishing resemblance between the criminals of different European races.

It is shown that criminals are very subject to disease of the heart, and to various affections of the sight, such as Daltonism and strabismus. In regard to sight, however, the criminal, like the savage, sees to a great distance; he is much more frequently ambidextrous than others. In this respect, as in his great agility, the author compares him to the monkey. He approaches the animal by his insensibility to pain and cold. Rarely is a blush seen on his cheek.

Psychologically, the criminal is represented as resembling the savage rather than the lunatic; and certainly it is true that plots are as rare in asylums as they are frequent in prisons. His intelligence is limited—he can imitate, but cannot invent. As Lombroso says —a man is *born* a criminal, he *becomes* a lunatic.

M. Tarde speaks of the possible attenuation of the criminal virus in the future, and observes that in watching for its departure, the varieties of human nature on which it now feeds, and which, when reunited, compose the criminal type, will not have disappeared in consequence. They will be dispersed and distributed among other types. In awaiting this time, the type which they form loses nothing of its reality from its indestructible permanence being regarded as very doubtful (p. 62).

Passing over criminal statistics, we pass on to some observations made by the author under the head of "Suggestion and Responsibility." In regard to hypnotism, M. Tarde observes that it is a phenomenon so exceptional that the legislator is justified in taking no account of it. A prisoner who should make it an excuse for having committed a murder under an irresistible influence originating in an order received some days or months before, should be obliged to bring forward proofs of such an exception (Binet and Feré). It is related of a hypnotic subject that when asleep he received the order to display

his fingers on the nose of a bust of Gall. He was awakened, and he acted in conformity with this order, of which, however, he remembered nothing ; but in order to conceal from himself the irresistible influence, he hastened to say that the bust was "disgusting." If an order is given to the same subject to fire a revolver at her brother she will obey the command after she is aroused. Here, again, so far from being at a loss to account for the act, she would explain it by saying that she had killed her brother because he had wronged her, or from some other motive. A monomaniac, in a similar way, who obeys an invincible idea is never at a loss, according to M. Tarde, to give reasons to justify his insane act ; but this is putting it a little too broadly, for the plea urged by the patient may be its irresistibility. The original source of the impulse is, however (as the author says), a cerebral lesion, whilst in the foregoing examples the determining cause is an external order communicated by hypnotism, but the two cases are analogous. The sole difference, according to this view, between the suggested conduct of the somnambulist when awake and the ordinary conduct of men (as when a person defends his politics in a *café* with eloquence and sincerity he does so not in consequence of the good reason he alleges, but in consequence of family and personal influences acting upon a certain docile organization) consists in this, that the suggestions which the normal man obeys are much more numerous, and much less external—two characters intimately connected, and which give to him a false impression of autonomy. But by a series of transitions; hypnotism under these two relations is associated with ordinary life. Both Dr. Liébault and Dr. Beaunis have been struck with the logic of the hypnotised and the rapidity of their productions. All these characteristics combined render a hypnotic subject, with his head full of suggestions from innumerable sources from his childhood, nowise different, according to our author, from a reasonable and free man, especially if among these innumerable suggestions there are certain strongly-rooted and more powerful ones to which the others are subordinate. M. Delbœuf has attempted to show that the hypnotic dream, like the ordinary dream, is sometimes a spontaneous reproduction of facts perceived when the subject is awake, and more frequently their arrangement is determined according to a certain logic, and induced by an external stimulus such as words, gestures, sounds, odours, muscular sensations, &c. Hypnotism, then, is only—like dreaming—a simplification. What is truly wonderful at bottom is not the dream—not the hypnotic suggestion—but the state of normal waking, which is itself a state of hypnotism or dreaming so immensely complexed, and at the same time so harmoniously co-ordinated. Without carrying this original idea into the details adopted by the author, we must add some of the consequences in regard to the penal law which result from this hypothesis. The responsibility of the hypothetical subject, absent in the beginning, will go on increasing in proportion as his suggestions sink so deeply within (s'intérioriseront), that the hypnotised and the hypnotisers become identified in him.

Thus it is, according to M. Tarde, that the acts accomplished by a man in the period of transition between the deep ordinary dream and the being completely awake will involve more and more responsibility. Legislation seems to place itself unconsciously at this standpoint when it regards a father or a master as to some extent responsible for the act committed by a boy. It is not forgotten by the writer that the responsibility of such an act has relation, not to this act itself, no longer changeable, but to the possible acts of the same nature, or equally mischievous ones, which it is our object to render less probable in future. To prevent the repetition of a criminal act, whether by the perpetrator himself or by another, it is necessary to strike at its causes, as much as possible, within or outside him ; but it behoves us to attack differently the moral or social causes which require the exercise of the will and physical or physiological causes. The penalty, so far as the treatment is social, ought to be restricted to the first causes. A doctor orders a somnambulist to assassinate someone whom he detests, a crime which he commits when awake. Whose will is to blame? The doctor's. The social cause of the act is here quite external to the agent. To prevent the return of similar acts it will not suffice to shut up the doctor in prison, decapitate him, or prevent him hypnotising this or some other subject. It becomes necessary to place the somnambulist in an asylum, and to withdraw him from the influence of certain criminals who would try to make him their docile instrument. However, if the homicidal somnambulist is placed in an asylum and not in a prison, although in committing an assassination he is himself regarded as free and capable of having acted otherwise, why do we not place his hypnotiser in a prison rather than an asylum? He himself, it is true, in suggesting the criminal act to the hypnotised, believes himself to be autonomous, but, according to our author, he is himself deceived. He has yielded, like the somnambulist, to an internal impulse, and what matters it that it has not passed through a medium, but an *ensemble* of hereditary instincts deposited in his cerebral cortex and derived from his ancestors? *Voilà la question*. In short, what is clearer than that the true cause of the act—that is to say, of the order of assassination—is not external to the agent, *i.e.*, the hypnotiser, but is internal and peculiar to himself. In fact, it is not a question of liberty, but of identity. All this seems very theoretical, but the author maintains that it is eminently practical, namely, that in order to act upon social causes it is necessary to employ social agencies. The depraved will—the permanent source of fresh crimes which the hypnotiser carries within him—in what does it consist if the physiological conditions are put aside? The reply is that it consists in beliefs, and desires, and at first in a more or less favourable opinion of himself which the criminal entertains. This pride must be broken by public opinion of a precisely opposite character, an energetic blame, which, communicated by imitation, always weakens at bottom to some degree, and always causes a terrible blow. Society must simply decide whether

the cause of the punishable act is included within the area of that unity which is designated social. And what is that? Now-a-days it is the individual, the special organization *en bloc*, without establishing any distinction between the organs which compose it, and notably between the different parts of his brain.

M. Tarde's next chapter is devoted to criminal geography, which contains many interesting statements, for which, however, we have not space in this retrospect.

The subsequent chapter treats of homicide and suicide, the relation between which is intimate, though at first sight they would seem to stand far apart.

The future of crime is considered with much care by the author, who concludes that if all civilization were once fixed in a moral groove, and able to expel all kinds of immorality contrary to its principle, and if in consequence, demoralisation in an old society could only proceed from inoculations of a virulent kind, by contact with what is foreign to it, it follows that the stability of a civilization, as well as a special morality born within itself, would only exist at the beginning and the end of civilized humanity: at the beginning when the town-centres of civilization were separated from each other by considerable distances, so that each could preserve itself intact; at the end when, after the long period of wars and revolutions, of conquests and of purifications, which we call history, a single and unique State, a single and unique Civilization, will exist upon the earth. Such is our author's ideal of the future. Whether he really brings us any nearer to its attainment, many will be disposed to doubt. Tennyson should study M. Tarde.

In the last section, which discusses civilization and falsehood, the author contemplates the religion of the coming age. What is to be done, he says, when the torrent of faith which falls upon men is dried up? Well, science appears. We hail it. However, in order to be a true belief—faith in which implies invariable altruism—we ought to be not only penetrated with the importance of certain truths, but also to be persuaded that to know them is the greatest good, and to be ignorant of them the greatest evil, and that to bear witness to them by acts is the first and sovereign duty of man. The religious man is full of such a faith. How long a time will elapse before scientific or philosophical truths become the objects of such convictions? In the meantime, calmly awaiting a durable and definite philosophical synthesis, in the presence of which humanity at last is at peace and exempt from crime as from all other evils, we are to console ourselves with belonging to our present age, and we are not to expect that we can purchase too dearly, even at the price of all our faults and crimes and lies, light and new discoveries, if at least the most respectable delusions are not, in our estimation, the most dangerous truths. Ethics and æsthetics are traceable in the end, from M. Tarde's point of view, to logic. Unfortunately man is not, after all, a logical animal. And what of women?

2. *Italian Retrospect.*

By J. R. Gasquet, M.B.

The following are the chief articles in the "Archivio" since the last Retrospect in this Journal :—

Dr. Majorfi describes a melancholic form of *acute delirium*, which seems to be the condition known here as "typhomania," "Bell's disease," &c. He urges the free use of chloral or opium, aperients, and as much nourishment as the patient can be got to take; and he appears to have been particularly fortunate in having been able to administer nutritive enemata with opium, when food by the mouth was refused. Peli of Bologna gives the *cephalometry* of 670 insane persons. Comparing them with sane persons of the same place and class, it appears that the head is slightly longer, higher, and broader in the insane; and that anomalies in the shape of the skull are three times more frequent in them, the frequency of such anomalies being greatest in the hereditary forms of insanity, and in males.

Luasana publishes some experiments, of considerable physiological importance, on the *tactile sensibility* of a surface stripped of skin. His observations were made upon a lady who, in consequence of an old-standing burn, had the muscles, fascia, and aponeuroses on the outer side of the right leg, laid bare over a space of 10 × 12 centimeters. He found Weber's "tactile circles" completely absent wherever the cutaneous papillæ had been destroyed, and the thermic sense was much lessened. On the other hand, the sense of mere contact, and of pain, is independent of the cutaneous papillæ; and the muscular sense is neither lessened nor perverted by destruction of the skin.

Professor Verga gives a very interesting example of "*folie à quatre;*" in which a poor servant converted her mistress, her mother, and her husband to a belief in her delusions as to her being of illustrious descent, and entitled to a fortune. The mother died before she had fully developed her insanity, and the mistress returned to her native country (France) under the full influence of these delusions; but the husband and wife had to be placed in the asylum at Milan, where they improved on being separated, but did not recover.

The septennial *Report of the Roman asylum* is particularly full and satisfactory in its account of the medical treatment of the patients. Salicylic acid appears to have yielded good results to Dr. Fiordispini in cases of rheumatic and gouty mania; inhalations of oxygen and opium in anæmia; paraldehyde is recommended as an ordinary hypnotic; frontal douches, and counter-irritation to the nucha, in other cases. He looks upon acute mania as a hyperæmia of the cerebral cortex, and treats with cupping over the mastoids, ice-cap, and subcutaneous injection of ergotine; later on, with blisters to the neck, and counter-irritation to the scalp. In cases where hallucinations are

prominent, arsenic, belladonna, and iodide of potassium have been most useful.

From Dr. Verga's analysis of the *statistics* of insanity for the year 1883 (the last published), I gather the following facts: On the last day of December in that year there were in all the asylums in Italy 19,656 patients, of whom 10,291 were males and 9,365 females. The males are therefore slightly in excess in the whole kingdom; but in Venetia the excess is on the side of the females, this having been the case ever since 1874. The increase of insanity in the whole population, and in different provinces, is obscured by the varying amount of asylum accommodation throughout the country; but it seems to be wholly apparent, not real, and due simply to the collection of the insane in asylums. The proportion of readmissions cannot be calculated exactly, owing to irregular registration in the past; but it lies between 25 and 30 per cent. of all admissions.

The "Rivista Sperimentale" contains the following, among many articles of importance:—Professor Luciani gives an account of his extirpation of the *cerebellum* in a bitch. After the animal recovered from the shock of the operation, there was found to be no loss of intelligence or sensation; sexual excitement recurred in the normal manner during heat; the ataxic movements which were noted appeared to be due to loss of tone and energy, rather than to loss of sense of equilibrium, which seemed unimpaired. The most unexpected symptom was rapid emaciation, which began six months after the operation, and ended in death three months later. This could be ascribed to no other cause than the loss of the cerebellum. It perhaps throws some light upon the emaciation of the last stage of general paralysis, and other diseases of the nerve-centres.

Dr. Poggi has very carefully examined the *cerebral convolutions* in fifty brains of persons who died insane. Anomalies are more common in them than (according to Giacomini) in the brains of the sane, in the proportion of 7·27 to 5·89. They are more frequent in the left than in the right hemisphere; and the most frequent is a double calcarine fissure, or communication between the internal occipito-parietal sulcus and the sulci of the cuneiform lobule (in 40 per cent.). On the whole, he considers insane brains belong to the type described by Giacomini as having "numerous anastomotic folds."

Dr. Algeri gives an account of "Raynaud's disease" *(local asphyxia of the extremities)* in a case of chronic insanity. Its frequency in the insane, as noted especially by French authors, seems to point to its cerebral origin.

Professor Baistrocchi, of Parma, has taken up again, with more elaborate care and instruments, the study of the *specific gravity* of the encephalon. It is unfortunate that this (like other papers in this Review) is not susceptible of analysis; but the following are the chief results of his examination of 43 brains: The great ganglia at the base of the brain have a higher sp. gr. than the hemispheres; the

pons and cerebellum being higher still. The white substance of the hemispheres has always a higher sp. gr. than the gray matter. The sp. gr. of the encephalon increases progressively from fetal life until old age; that of the spinal cord, on the contrary, is highest in the fætus, and then diminishes until adult life, when it remains stationary.

There is an exceedingly full and clear account by Drs. Tanzi and Riva, of the form of insanity which, under the name "*Paranoia*," has been gradually evolved of late years by German and Italian alienists. They define it to be "a functional insanity, starting from a degenerative condition; characterized by a special deviation of the highest mental functions, but not implying either serious weakness, or general disorder, of mind; it is almost always accompanied with hallucinations and more or less systematized delusions. . . . Its course is neither continuous nor uniform, but essentially chronic, and does not generally end in dementia." They start with a critical examination of Griesinger's well-known views as to chronic insanity, objecting that they are contrary to facts; his "partielle Verrücktheit" (out of which "paranoia" has been evolved) is frequently primary, and, on the other hand, mental weakness does not usually end in paranoia. These two conclusions are sufficient to refute Griesinger's idea, that they stand to each other in the relation of cause and effect. So far our authors follow the more recent German school; but they include under the term "paranoia," not merely "Verrücktheit," but also those less advanced cases of chronic hereditary insanity, where systematic delusions have not been developed. Many of the characteristic symptoms of paranoia are very ingeniously ascribed to the reversion to ancestral conditions ("atavism"); such are unfounded credulity, fetichism, and animism, symbolical and allegorical expressions and figures; even delusions of persecution are looked upon as a survival of a struggle for existence, necessary in more lawless times than ours. This is only a very meagre sketch of the most elaborate series of articles in the "Rivista," which go, in detail, into the various types of paranoia, and into the nature of systematized delusions. One of the most acute remarks of the authors is upon the "apparent dementia," which they consider a frequent termination of such cases. By this they mean the patients' loss of confidence in themselves, and the consequent apathy, which long confinement in an asylum produces (so to speak) physiologically, but which are quite distinct from true dementia.

Guicciardi and Tanzi have made a series of observations on the "*reaction period*" in fourteen cases where there were hallucinations of hearing. Fifty observations were made in each case, and they were controlled by the same number of experiments upon persons of sound mind. The reaction is found to occupy less time in the insane than in the sane in a series of only ten observations (·0947 of a second in the insane, ·1012 in the sane). But in a larger group of observations (forty) this result is reversed, the times being respectively ·1403 of a second in the insane, ·1259 in the sane. These results imply a greater intensity of the power of attention in the

insane, but a diminished capacity for prolonged attention. They would be interesting as only showing so much ; but they are further used by the authors to support the theory of hallucination which has been most lucidly expounded by Binet ("Revue Philosophique," Avril, 1884), which looks upon it as a centrifugal or peripheral, rather than a centric, condition.

The "Archivio di Psichiatria ed Antropologia Criminale" deals, as usual, particularly with the physical conditions of habitual criminals. Some of the details, discovered by the industry of Dr. Lombroso and his disciples, are very suggestive and interesting. Thus left-handedness and ambidextrism seem to be decidedly more common in criminals than in ordinary members of society, this peculiarity being connected with a greater symmetry between the two sides of the brain. This symmetry can hardly be due to reversion or atavism, since Dr. Daniels, of St. Petersburg, shows that it does not exist in the crania of microcephalic idiots, or of the quadrumana. Pain seems to be less clearly felt by criminals, and vaso-motor action is less marked ; the weight of the body ranges higher, and the duration of life is longer than in the average of mankind. Lombroso points out that all these characteristics may be observed in moral lunatics as well as in habitual criminals, whence he concludes that these inhabitants of our prisons and asylums belong to the same class. It is, however, to be noted that some 35 per cent. of criminals examined do not manifest the physical conditions connected with habitual criminality ; these are they who have broken the law under the temptation of some favourable opportunity or external suggestion. The most serious objections made to Lombroso's method have been based upon the fewness of cases examined—about 1,200 in all. He is, however, probably right in answering that such a number is sufficient at any rate to establish the chief characteristics of a variety, since the more important these are, the smaller will be the limits within which they fluctuate. Perhaps one of Lombroso's most interesting speculations is on the relations between habitual criminality, moral insanity, and epilepsy. He considers these three conditions as fundamentally related, and indeed identical in their least-developed stages. Epilepsy is a general term, applicable to a number of different conditions, and its "larvate" species only can be termed the acute form of moral insanity. Left-handedness and Daltonism seem to be as common in epileptics as in habitual criminals.

The following are the only articles of special interest to our readers in the excellent "Rivista Clinica" of Bologna. Dr. Musso publishes an account of Friedreich's *hereditary locomotor ataxia*, which affected six persons. These were all descended from a common maternal grandmother, who died in a condition of dementia following melancholia, and whose brother apparently suffered from ataxia. She had two children, a son and daughter, both free from nervous disease ; the former had one son, who escaped the disease, and three daughters who suffered from it. The daughter, on the other hand, transmitted it to

three sons, having four daughters, and one other son, who escaped. But, besides the predisposing cause—heredity—there were exciting causes in both cases, one family living in a damp house, and the other being apparently healthy until after an attack of small-pox. I refer only to the ætiology of these cases, because that alone is of interest here, from its similarity to the causation of insanity; but the symptoms are well described. The author looks upon the disease, with Charcot, as *sui generis* and intermediate between loco motor ataxia and disseminated sclerosis.

The same author describes five cases of what he terms "*pseudo-general paralysis*," due to slow poisoning by carbonic oxide. Four of the patients were men, cooks; they as well as the fifth case—a sempstress—had been habitually exposed to the gases given off by burning charcoal. The motor symptoms seem to have been strikingly like those of general paralysis (inequality of the pupils was noted in three cases); the mental symptoms were dulness and slowness of mind, varied in the case of the woman by occasional paroxysms of excitement. Similar cases have been recorded, especially by Moreau (de Tours).

Dr. Lachi, of Sienna, records the case of an epileptic demented woman, who died at the age of 44, in whose brain—post-mortem—there was found to be no *septum lucidum*; and the Sylvian fissures communicated with the lateral ventricles. This case differs from all but one recorded, in the absence of any abnormality of the corpus callosum.

Dr. Fenoglio reports a case of injury to the right fronto-parietal region, followed by psychical disturbance, by left hemiplegia and rigidity, and by epileptic attacks. All these symptoms were cured by trephining the skull over the affected part. But the interesting part of the case is, that the mental condition, which had been one of gloom and melancholy, returned also to its normal state of cheerfulness, and that this symptom, as well as the motor ones, was temporarily reproduced by the pressure of a dressing.

Dr. Silva, of Turin, writes a very able paper on *Hypnotism*. There is, I believe, nothing new in his experiments; but he compares the phenomena of hypnotism with those of disease in a very instructive manner. Besides hysteria, he brings it into relations with "Thomsen's disease," the "myriachit" of Russia, Hammond's "jumping mania," and the various psychical paralyses. His conclusions are, that in all these conditions the power of inhibition (which he locates, with Ferrier, in the anterior cerebral lobes) is totally or partially suspended. The hypnotized subject becomes thus an automaton, played upon from without, or immovable if there is no external impression. This is to some extent supported by some of his experiments, in which pressure on the parietal region in a hypnotized subject produces spasms of the other side of the body, and pressure on the frontal region arrests these spasms.

8. *Colonial Retrospect.*

By Frederick Needham, M.D., and D. Hack Tuke, M.D.

New South Wales.—Report of the Inspector-General of the Insane for 1885.

Dr. Manning is able to give an encouraging account of lunacy matters in the Colony which has been fortunate enough to secure his services, and of the several asylums which have come under his supervision during the year 1885.

Many of the defects which formed the subject of his unfavourable comments in previous reports would appear to have been remedied, and in his remarks, and in the details furnished to him by the superintendents of the various institutions, there is very satisfactory evidence of efficient administration and progressive improvement in the care and treatment of the insane, which are creditable to the Colony and its officials.

"The number of insane persons in the Colony under official cognizance on 31st December, 1885, was 2,643.

"The increase in number during the year was 119; but large as this increase is, there was a decrease in the proportion of insane to the general population, which increased by 59,444 during the year.

"The proportion of insane to population in the Colony was, at the close of the year, 1 in 374, or 2·67 per thousand, and compares favourably with the proportion in England, which, on 31st December, 1884, was 1 in 345, or 2·89 per thousand, and in the neighbouring colony of Victoria, which was 1 in 297, or 3·35 per thousand, at the same date.

"There has been no real increase in the proportion of insane to population during the last fifteen years. The proportion increased slightly up to 1881, when it was 1 in 352, but has since receded to exactly the same proportion as at the end of 1871.

"The admissions numbered 567, 338 males and 229 females, and were 74 more than in any previous year. The proportion of females was more than usually large, the number being 46 in excess of that for 1884. So far as can be seen there is no special reason for this influx of female patients, but it is evident from the unusual number of idiotic and imbecile children and old and demented people of both sexes among the admissions, that the general condition of depression throughout the Colony has continued to operate in inducing people to send to hospital helpless relatives whom they are able and willing to maintain in more prosperous times.

"The admissions for the year, though unusually numerous, have not been much in excess of the average for the last fifteen years in proportion to the general population, so that neither in the accumulated

nor in the 'occurring' cases does there appear any reason to think that insanity is increasing in this Colony.

"The following returns show, 1st, the number of insane persons and the proportion to the population in New South Wales and in England during the last fifteen years; and, 2nd, the ratio of admissions into institutions for the insane to the population of the Colony for the same period :—

Year.	Population of New South Wales.	Total Number of Insane in New South Wales on 31st Dec.	Proportion of Insane to Population in New South Wales.	Proportion of Insane to Population in England.
			Per M.	Per M.
1871	519,182	1,387	1 in 374 or 2·67	1 in 394 or 2·53
1872	539,190	1,440	1 in 374 or 2·67	1 in 387 or 2·58
1873	560,275	1,526	1 in 367 or 2·72	1 in 381 or 2·62
1874	584,278	1,588	1 in 367 or 2·72	1 in 375 or 2·66
1875	606,652	1,697	1 in 357 or 2·80	1 in 373 or 2·68
1876	629,776	1,740	1 in 361 or 2·77	1 in 368 or 2·71
1877	662,212	1,829	1 in 362 or 2·76	1 in 363 or 2·75
1878	693,743	1,916	1 in 362 or 2·76	1 in 360 or 2·77
1879	734,282	2,011	1 in 365 or 2·74	1 in 363 or 2·75
1880	770,524	2,099	1 in 367 or 2·72	1 in 353 or 2·83
1881	781,265	2,218	1 in 352 or 2·84	1 in 352 or 2·84
1882	817,468	2,307	1 in 354 or 2·82	1 in 348 or 2·87
1883	869,310	2,403	1 in 361 or 2·77	1 in 345 or 2·89
1884	921,129	2,524	1 in 364 or 2·74	1 in 345 or 2·89
1885	980,573	2,643	1 in 374 or 2·67	

Year.	Admissions.	Population.	Proportion to Population.
1871	340	519,182	1 in 1,527
1872	303	539,190	1 in 1,779
1873	342	560,275	1 in 1,638
1874	330	584,278	1 in 1,770
1875	356	606,652	1 in 1,704
1876	360	629,776	1 in 1,749
1877	457	662,212	1 in 1,449
1878	424	693,743	1 in 1,636
1879	440	734,282	1 in 1,668
1880	476	770,524	1 in 1,618
1881	494	781,265	1 in 1,581
1882	473	817,468	1 in 1,728
1883	476	869,310	1 in 1,826
1884	493	921,129	1 in 1,868
1885	567	980,573	1 in 1,729

The deaths bore a proportion to the average number resident of 6·58 per cent. The recoveries amounted to 41·26 per cent. of all the admissions and readmissions of the year; but excluding one hospital which is specially set apart for imbecile and incurable cases, the percentage was 42·39.

The following statistics and remarks as to the nationality of the patients under care during the year are interesting :—

"Out of the 3,203 patients under care during the year, only 856 were natives of New South Wales, and 105 of other Colonies. The number born in Great Britain and Ireland was 1,887, and of these 947, or more than one half, were natives of Ireland. The number of Irish patients is, as I have before shown, out of all proportion to the number of persons of Irish birth in the general population. The total number of Foreign patients, 56 of whom were admitted during the year, was 355; they include 23 French, 77 German, and 70 Chinese, together with representatives of almost all the European States, South Sea Islanders, African blacks, and a motley assemblage of wanderers from every part of the world. A large proportion of the Foreign-born patients, exclusive of the French and Germans, are able to express themselves only very imperfectly in English. Not a few are in all but complete ignorance of it, and some when most insane will only speak in their native tongue. Owing to these circumstances, and to a want of knowledge of their peculiarities of thought and feeling, on the part of both officers and attendants, and to the impossibility of making any impression by kind and timely persuasion or advice, they are most difficult to deal with, and form on the whole an intractable class among whom the recoveries are comparatively few. Those among them who belong to the darker-skinned races are often dangerous, vindictive, and uncertain. When recovery does take place, it is found extremely difficult to find for them a fresh start in life, and the opportunities of getting them returned to their native countries are few."

Dr. Manning gives the following particulars with reference to the proportions of epileptics and general paralytics among his patients :—

"On the 30th June, 1885, at which date the number of patients under care was 2,579, 1,573 males and 1,006 females, I caused special returns to be prepared showing the number of epileptics and general paralytics among them. They show that about $\frac{1}{13}$ of all the patients under care suffer from epilepsy, and that this disease is about equally common in each sex. The number of general paralytics was 42, and only 8 of these were women. At the close of the year the number of general paralytics had fallen, owing to the death of a considerable number, to 25. Taking the admissions for the year, it appears that the percentage of epileptics and general paralytics admitted to the total number of patients admitted was 6·3 and 2·1 respectively.

"The number of epileptics among the insane in this Colony appears

to bear about the same proportion to the general asylum population as in England ; but the proportion of general paralytics, taking into consideration the number admitted and the number under care, is decidedly less, and would, so far as can be judged from the English returns, appear to be not more than $\frac{1}{3}$ or $\frac{1}{4}$ of the proportion in England."

Such are some of the most generally interesting contents of Dr. Manning's comprehensive and practical report.

F. N.

Dr. Manning, in a paper read before the Medical Section of the Royal Society of New South Wales, entitled "A Contribution to the Study of Heredity," gives a result of an inquiry into the family and life history of the idiots and imbeciles in the New Castle Hospital for the Insane, his object being to determine the cause, more especially in regard to heredity. Unfortunately, no history was forthcoming, many of the inmates being deserted children, picked up by the police, and therefore Dr. Manning restricted himself to those cases in which there were two or more of a family weak-minded, as being more probably congenital than accidental. As the distinction between idiots and imbeciles is very indefinite, it may be useful to state that Dr. Manning found it the most practical to class under the former those who can speak and under the latter those who can not.

We regret that we have only space for the following conclusions :—

1. Idiocy is, in a large proportion of cases, due to heredity.
2. Cases of direct heredity are as common as those in which it is transmitted in the collateral or reversional form, a conclusion differing entirely from that of Dr. Seguin.
3. Double heredity much more potent than when on one side only.
4. Nervous disorders are often transformed in their transmission ; the children of an insane or epileptic parent being sometimes idiots or paralytics.
5. Consanguineous marriages lead to idiocy and imbecility more than to insanity. Dr. Manning believes—at the same time agreeing with Mr. Huth—that such marriages are not injurious by the mere fact of consanguinity. Unfortunately, however, comparatively few persons are free from some physical or mental imperfection, and in the marriage of relations such imperfection will probably be intensified. Hence Dr. Manning holds that the marriage of persons who come of families in which insanity exists in a pronounced form should be discouraged, and that the intermarriage of persons from neurotic or insane families, and the marriage of near kin, especially when there is any mental peculiarity, should be discountenanced by medical men.

We avail ourselves of this opportunity of conveying our thanks to Dr. Manning for a series of beautiful photographs illustrative of the

Hospital for the Insane at Gladesville. One of these represents the administrative building and offices; another the gardens and the Medical Superintendent's house; and the third the "Cricket Paddock," with a number of patients engaged in play. One represents the entrance-gate and lodges, another the Branch Hospital for 160 patients, while another shows one of a ward of the Hospital with some patients standing and sitting in front.

New Zealand.

We have before us the report on the lunatic asylum of this Colony for 1885, and we regret to observe that the Inspector, Dr. G. W. Grabham, takes leave in it of his office. In his retrospect of his work during the period he has held the appointment, he observes that many plans and suggestions made by him from time to time remain unacted upon, although approved by the Ministry of the day. It appears that no provision has been made for the future increase of insanity in New Zealand. This is certainly a short-sighted policy. It is satisfactory, however, to find that some improvements have been effected during Dr. Grabham's tenure of office, though bearing a small proportion to those suggested by him. The superintendents are men possessed of special knowledge and ability, but it would seem that they are underpaid, and that the asylums are overcrowded. Fortunately, however, the proportion of the insane to the population has decreased from 1 lunatic to every 390 persons, to 1 in 401. The overcrowding is, therefore, due to accumulation. At Auckland this is "positively disgraceful." In buildings intended for 217 patients, there are stowed away no less than 347, the cubic space for each person in the bedrooms averaging 350 feet. Dr. Grabham does not hesitate to assert that five of the single rooms resemble fowl-houses in all respects but the roosts, the only window being an aperture made by knocking out a brick from the back wall. Strange to say the funds necessary for enlarging the asylum have been voted by the Legislature for some time, but there the matter ends. It must be a thankless task for an inspector to be continually proposing reforms and rarely seeing them adopted by those whose duty it is to carry them out, who have not even the excuse of being refused money by the Legislature. Of the Seacliffe Asylum, containing 450 patients, for whom the provision is sadly insufficient, Dr. Grabham writes, "I take this last opportunity of stating that the whole of my previous statements are correct, and borne out by the facts of the case; and although I have been openly contradicted in Parliament, and received hints of intended law proceedings with demands for apologies, I will again assert that the site of the asylum is ill chosen, the establishment badly designed, and out of date, the buildings defective in construction, and showing everywhere bad workmanship, which should never have been accepted." The only satisfactory feature about this institution is the efficient services rendered by the superintendent and other officers. We ought

to add those of the minister of religion, who performs divine service in the asylum, which we are assured "is of a character suited to the intellects of those who attend." We suspect that there are not a few asylum chaplains in England of whose discourses the same might be said with too much truth. It may be stated, for the benefit of those assistant medical officers in our own country who are desirous of becoming superintendents in the Colony, that while the wages of attendants are thrice as high as in the old country, the salaries of superintendents are lower than those paid in England.

There were in the asylums of New Zealand on the 1st Jan., 1885, 1,452 patients. During the year 454 were admitted, while 171 recovered, 15 were relieved, 102 were discharged not improved, and 95 died, leaving 1,523 patients in the asylums December 31st, 1885.

It only remains for us to express our regret that Dr. Grabham's energetic and well-intentioned efforts should have been thwarted by local ignorance and parsimony, and our hope that in whatever field of labour he may enter in future, he may meet with more encouragement and success in endeavouring to carry out the work in which he may be engaged.

D. H. T.

PART IV.—NOTES AND NEWS.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The quarterly meeting of the Medico-Psychological Association was held at Bethlem Hospital on Tuesday, the 9th November, 1886, the President (Dr. Savage) presiding. There were also present Drs. S. H. Agar, A. H. Boys, G. F. Blandford, David Bower, Edward East, Hyslop, W. M. Harmer, D. G. Johnston, A. Maclean, W. J. Mickle, H. Hayes Newington, Percy Smith, H. Sutherland, H. R. O. Sankey, A. H. Stocker, C. W. Sherrard, Hack Tuke, Thos. S. Tuke, Charles M. Tuke.

Mr. A. Aplin, M.R.C.S. Eng., L.R.C.P. Lon., Medical Superintendent of the Notts County Asylum, Sneaton, Nottingham, was elected a Member of the Association.

The PRESIDENT exhibited the brain of a woman who died from general paralysis of the insane, the whole symptoms running their course within twelve months. Its chief interest was that it showed extremely well the local wasting about the motor areas. There were in life marked symptoms of exaltation and marked tremor, the reflexes greatly exaggerated. The lower extremities became so contracted and the muscles so wasted that one expected to find very great degeneration in the lateral columns of the cord, but they showed next to nothing to the naked eye. There was, in the brain, a very marked wasting just behind the ascending parietal convolution; and there were two large lakelets marking wasted convolutions. So, in this case, we had, with marked wasting of motor cortical areas but slight evidence of secondary cord degeneration, and this was probably due to the rapidity of the whole process. There was excess of fluid, and but few adhesions.

Dr. HAYES NEWINGTON read a paper on "What are the Tests of Fitness for Discharge?" (*See* Original Articles).

The PRESIDENT read the following short paper on the same subject as the above, considered principally from the homicidal point of view.

When should Homicidal Patients be sent on Leave or Discharge?

The cases must be divided into those in which the patients have committed murder and those who have only threatened. As to those who have been pardoned on the ground of insanity, many doubtless are as curable as any other patients suffering from acute forms of insanity, but there is, I believe, a very strong feeling against the release of such patients. They are, as a rule, credited with the tiger's supposed lust for human blood when once it has tasted it, but at the bottom of the whole matter is the uncertainty of medico-psychology. If a doctor could say, on the one hand, "There will be no return of insanity" in a given case; and on the other, "The murderous act was due to insanity which has now passed off," the duty of the doctor would be simple and safe; but as it happens now, the doctor has to take upon himself the responsibility of returning a past and possibly future murderer to society. At Broadmoor, there is power for outside physicians to report upon the sanity of a criminal lunatic, and thus relieve the Superintendent of some responsibility. It seems a pity that many young women should remain in criminal asylums in consequence of infanticide committed during puerperal insanity. Doubtless they belong to unstable stocks, but that is not enough to cause a woman to be confined for life. To me it seems very terrible to think that not only has the woman the hell of memory, but the purgatory of her surroundings, and all as the result of an act for which she was no more responsible than the warders who guard her.

To the practical point as to when I would let out a woman who had committed a murder, I would say after about twice as long probation as if she had been insane without committing the murder, and then only after careful consideration of the surroundings to which she is to return. This much I think society has a right to insist upon, beyond the mere medical dictum of sanity restored. There must be a distinction made as to ordinary murder and infanticide, and though, as a rule, a life is said to be a forfeit for a life, yet, as we know that it is rare to execute for infanticide, so for the insane crime of child murder I think the probation should be less than after other forms of murder committed during insanity. I admit that in some ways the risk is almost greater of relapse, for most of these cases are young women who will very likely have other children, and we all know the tendency there is for similar delusions to arise when the insanity arises under similar conditions. Next it is well to consider whether persons who have committed murder should ever be let out of criminal asylums when persons murdered have been adult. This should depend on the cause of the insanity to some degree, and also on the nature of the insanity, that is the form it had assumed; I should retain the person who as the result of some vice, such as opium or alcohol taking, had bereft himself of his reason and then committed the crime, but if the crime were the result of a delirium allied to fever, I think it wicked to retain a man on the possibility of his having another feverish attack. Again, if the crime were committed by an epileptic, I should be inclined to keep him for life, and also if the crime were the result of recognized mental weakness, whether the result of age or youth; whether the result, as so many crimes against the person are, of unrestrained passion of old age or youth. So far, then, for the distinction between the infanticide and the homicide, and for those who have attempted violence to the person. But beside these there is a very large class to which I must refer, as in my mind the too timid superintendent is likely to be guilty of grave injustice in retaining certain patients who may have threatened to do violence to their friends or relatives; we must not be guided by the threats alone, but by general principles as to whether a person is likely to be injurious to society.

In my experience those require most care and observation who have been

subject to hallucinations of hearing, or have had ideas of being followed or persecuted.

It will not do to say that such never become again trustworthy, but I would say that it is not very common, and needs ample evidence before liberty is granted. In some cases these hallucinations may persist in a stage of dementia into which the patient has passed, and may then cease to be active agents. As hallucinations of hearing are the most dangerous, so I believe the delusions as to tampering or interference with the body, especially with the sexual organs, increase the danger. The man who believes that he is being rendered impotent is a very dangerous man, and is not easily cured.

There is another nearly allied group of cases, of young persons who have with general weakness develo ed sexual vice, especially masturbation, and then become impulsive and violent. These patients are very dangerous, and there is no means of calculating when or against whom the outbreak may occur, so that there is little chance of being on one's guard. These cases, however, are very frequently curable, and the permission to go on leave must be given when physical health is restored and the basis of mind made more firm—when, in fact, attention is increased, sleep and appetite are better, and will to work is developed. This leads me to consider the so-called impulsive cases. There are certain cases, some epileptic and others non-epileptic, in which impulse, like a very tornado, sweeps over the will and leaves the man perfectly helpless. He does in a moment what he will regret for his life. Such cases we see among the sane in a less marked degree, but among certain lunatics we meet well-marked, very dangerous examples. In most of these cases the patient's own feelings will be a guide to the treatment and the liberty to be granted. I have very often said to such persons, "Can you trust yourself yet?" and if they say "yes," I almost always give them the chance. This would hardly do in criminal asylums, for "impulse" is used rather loosely when a man is on his trial for life.

But already I have more than exhausted my time, and would sum up thus, that though we must always take extra care in granting leave to patients who have either made or threatened violence of a homicidal character, yet we must above all judge whether the patient has recovered, and then do as best we can to decide whether the patient is likely to have similar attacks of homicidal violence. I should grant leave when the symptoms were part of an acute process which has passed off, but would hesitate when the symptoms depended on brain degeneracy as seen in age, in undeveloped youth, or in epileptic conditions, and for other reasons when the symptoms depended rather on some vicious course of life or habit.

In opening the discussion, the PRESIDENT expressed his regret at the absence of Dr. Nicholson, whose experience on some of the points involved would have been very valuable. The importance of the subject would be felt most strongly. It appealed to most of them more from the suicidal side than from the homicidal side. All present could tell tales. There were instances in which they had felt a regret that could not be wiped out where they had recommended patients to be taken home, and had afterwards heard that those patients had committed suicide. So strong was this feeling that the late Lord Shaftesbury had a dictum that patients who had once attempted to commit suicide ought not to be at large again. There seemed to be some classes of cases which ought never to be allowed freedom. Adolescent cases were very difficult to decide about. He had seen in general and special hospitals cases of young men of 18 or 20 years of age who had attempted to blow out their brains. At Bethlem they had yearly such cases admitted with scars on their foreheads, and his experience was that they were very untrustworthy. He particularly remembered one, an Oxford student. This young man was at first carefully watched, but his liberty was increased until he was allowed to go out for long walks. There were no signs of the recurrence of the suicidal tendency. He was sent out on leave, and a week afterwards was in a hospital with a

bullet in his brain. That was not an isolated case, and it was noticeable that the patients seemed to seek a similar way of killing themselves. As to gauging the powers of the motors with the repellers, that was a difficult matter. He certainly agreed with Dr. Hayes Newington that it was best not to discharge a patient who argued about suicide, but there were some patients who would say that they had not the pluck to do it and who were then speaking the truth. A great friend of his, a doctor in London, passed into a condition of most profound melancholia, from which he recovered. When this gentleman was ill, he (Dr. Savage) asked him whether he had suicidal inclinations, and he replied, "Oh! leave me alone. I am not going to kill myself. I cannot *will* to eat my food. I cannot *will* myself in any way." Upon his recovery Dr. Savage again questioned him on the subject, and he said, "I could not have killed myself if you had put a pistol in front of me." It seemed that the least possible trust was to be placed in men, who, at about middle age, developed the idea that they had become impotent. In certain other suicidal cases, on the other hand, it was able to be asserted, almost absolutely, that the patient would not commit suicide. For instance, taking such cases as depended upon the existence of bodily disease; he remembered an old captain who had suffered from gout. This old gentleman had tried most ways of killing himself. Even at Bethlem he was quietly screwing things into his neck. One day, however, he had a bad attack of gout, and he was then as cheerful as possible. In after years he came round and said, "You were right, doctor; while I have the gout I am all right." So in this case, as in others, the bodily disease was a safeguard. Then, again, one may judge from the way in which a man looked upon his life policy. There was a patient who improved, but who looked dull and slow. This man said, "You need not be afraid. I shall not kill myself. I have paid into an insurance office for the last twenty-five years. I love my family well, and am not going to leave them penniless." Probably in a case of that sort they would run much less risk of suicide than where the man was callous about the honour and welfare of those dependent upon him.

Dr. BLANDFORD said that both the papers were very interesting and dealt very ably with a most important question. He wished that even more had been said on the subject. The question, both as it related to suicide and to homicide, was one of great difficulty. Personally, he had a great deal more to do with it from the point of view of suicide than from that of homicide. He took it that suicidal melancholia was the easiest of all to decide on. Where a patient got rid of that condition and recovered his cheerfulness, his disease passing off, and with it the suicidal tendency, they might have good hope. But there were other kinds of cases which were not cases of melancholia. There were cases of true suicidal impulse, without any delusion whatever. That was a very curious condition of things. It was extraordinary how men who were not melancholic at all, whose intellect was intact, and who were absolutely cheerful, so far as a man could be cheerful who was out of his mind, would try to destroy themselves or to injure others in every conceivable way. This was a condition of things which was very apt to recur. He remembered a very dear friend of his who had that suicidal impulse, and it used to recur very frequently. That gentleman, having been kept out of an asylum for a long time, at last went into one, and there became epileptic, and eventually died. In that case, there was, no doubt, a strong connection between the epileptic taint and the recurring impulse. It would have been a case which it would have been very difficult to keep in an asylum, and yet it would be extremely hazardous to let such a patient out. Then there were patients who heard voices. He knew some who had heard voices for years who were out and about in society. They did not always hear the voices. When they were pretty well, the voices went for a time, but the voices came back again at very short notice, and those persons were then in a dangerous condition. Now, were they to keep those cases in asylums for life? He thought all those cases must be judged on their own merits. In one class of cases it seemed to him that there was very great

difficulty in judging, viz.: that class, with which he had no doubt all present were familiar, in which they could not be sure that attempts supposed to be suicidal were really of that nature. He had in his mind one or two cases in which at first he did not think that attempts at suicide were really made; cases where the attempt was very trivial or committed under such circumstances as led to the impression that the patient did not really mean it. Yet in one or two of such cases attempts had been afterwards made of such a character that all doubt was dispelled as to the real nature of the early attempts. These were cases of difficulty, especially where the patients were not in any asylum at all, and medical practitioners had the care of them without the safeguards of asylum treatment. He merely threw out these points for consideration.

The President having to leave, the chair was taken by Dr. Rayner.

Dr. RAYNER asked Dr. Hayes Newington whether he included in his remarks those patients whom they were frequently unavoidably obliged to discharge to the care of their relations.

Dr. HAYES NEWINGTON replied in the negative, adding that in those cases where the discharge was against the doctor's advice, he did not recognize any responsibility. His observations related to patients who might be considered sufficiently improved to have a chance at all.

Dr. RAYNER said that in cases of discharge upon the request of friends, he was often guided very greatly by the conditions in which the patient would be placed by the change. In some cases from what they saw they could be quite certain that the conditions would break the patients down, as in one or two cases advanced by Dr. Hayes Newington, while in others the conditions might improve the patient.

Dr. HACK TUKE said it might be that in some cases, although a patient were suicidal, and fear might be entertained that he would commit suicide, yet at a certain period it would be allowable to run some risk instead of keeping the patient always in confinement. He thought there was some distinction between what was really best for the patient and the course one might be tempted to pursue in the fear that blame might be incurred in the event of suicide. He thought they would all agree that there were cases in which they could not but think it best for the patient to be free, and yet they hesitated to recommend this on account of the great blame which might accrue. He remembered a case in which he most strongly endeavoured to dissuade the friends from allowing a medical man to return to his practice. The patient was at that time suicidal. He had recently taken laudanum. Therefore he (Dr. Tuke) felt it was a case in which it was absolutely necessary to take every precaution. However, entirely against his advice, the patient resolved to return to practice, and his friends allowed him to do so. The result was that he threw himself thoroughly into his work, and continued to practise successfully for more than six years, certainly. It so happened that a very few days after his return to his practice he was called to a case of suicide, but it had no injurious effect upon him. He seemed to enjoy good health and spirits, and was busy from morning to night. Eventually he became somewhat depressed, and came up to town for advice. During the very day on which arrangements were being made for his being placed in a medical man's house, he went out and deliberately committed suicide. Even in that case the course taken by the patient in remaining at large appeared to be justified. The patient had the enjoyment of life for many years, and that was a great deal better than if he had been shut up in an asylum or with an attendant all that time. The very great difficulty of having reliable tests of fitness for discharge was shown most forcibly by the fact, very often observed, that it was frequently those patients who were not expected to commit suicide who did so. When the Commissioners suggested special dormitories for suicidal cases, some medical superintendents objected to them on that very ground. Then take such a case as the following as bearing on a remark of Dr. Blandford's:—An English lady, apparently sane, and concerning whom no fear was entertained of suicide, got up one night when abroad

and attempted to cut her throat, and opened several vessels in the arm. She was found in bed bleeding from her wounds next morning. It was a question whether there had been foul play, whether she had done the act in a state of somnambulism, or whether she had committed it intentionally. No doubt it was an attempt at suicide. He saw her two months after the occurrence, and on examination she seemed perfectly sane. Her mind was, she said, a blank as regarded the particular night in question. The difficulty arose as to whether she should be placed under care. His own advice was that she should be carefully watched day and night. That continued to be done, but there was no definite mental affection which could be laid hold of to warrant certificates of lunacy. With the knowledge of the Commissioners she resided in a medical man's house, voluntarily, without certificates, and was carefully watched. She eventually left England and died, but there was no recurrence of any suicidal act. In such cases as these the question raised was an extremely difficult one. To be ostentatiously watching patients and irritating them with the feeling that someone was continually dogging their footsteps was in itself calculated to intensify the suicidal feeling. He (Dr. Tuke) would say in conclusion that medical superintendents who chose to run a certain amount of risk ought not to be in any degree blamed, whatever happened. On the contrary, he thought they deserved the greatest credit when they did run some risk in the interests of the patient, although knowing that people who are wise after the event would censure them if the patient did die by his own hand. They were all very much indebted to Dr. Newington for his excellent paper.

Dr. RAYNER referred to the case of a boy who endeavoured to shoot the Queen. After he had had this boy under his care for some months he felt it would be an injustice to the lad to detain him longer, although it could not be said that he was of perfectly sound mind. It was possible that worry or anxiety might upset the balance. Nevertheless he (Dr. Rayner) felt obliged to take the responsibility of discharging him, although in this particular case a very serious responsibility was involved in pursuing this course. Fortunately the lad retained his health for some time, and ultimately went abroad. In that case Dr. Rayner felt impelled to discharge the patient, because the bodily health had been so far restored that it was thought he could stand a considerable amount of strain without breaking down again. That test of bodily health came into action very strangely in cases of hallucinations. He had discharged cases in which hallucinations continued active because the patients were restored to excellent health. On the other hand he had sometimes found it quite safe to discharge the patient when bodily health had been restored and only delusions founded on past hallucinations continued, with the result that the delusions had either passed away or been forgotten. In some of these latter cases the hallucinations were caused by conditions which existed only for a short period. One patient he had in his mind who only had the hallucinations for a few hours, and it did not appear that he had them at any other time. He was detained so long as he was because the delusion was directed against his wife.

Mr. C. M. TUKE mentioned the case of a lady who, after an attack of puerperal melancholia, developed homicidal tendencies, and, on one occasion at least, made a most dangerous attack upon the nurse. This lady improved very rapidly; her expression, at one time very wild and fierce, entirely altered, and she developed quite a sweet and placid countenance. The menstruation, which had been absent, was established, chiefly by permanganate of potash, and she quite recovered. Only a few days ago, her husband being very anxious to remove her, and having exceptional advantages for her care, no objection could be raised to his doing so, although they knew that, while she appeared well, delusions still existed, which she only mentioned to her nurse. She went away in the most natural manner, but in three days she returned, having made a violent homicidal attack. Although the difficulties in this case were pointed out by the doctors before the patient went home, still no one could have imagined there would have been such a sudden relapse. In

another case, a young lady had attempted to cut her throat. The wound healed, and she recovered very much her general health. Menstruation was not re-established in this case, but she was very natural, received her friends, and asked if she might go back with them. She seemed to have absolutely improved in every respect. He mentioned this in the Case Book, and also the fact that on the last visit of her friends she received them very well indeed. It was only yesterday that a letter was written by her friends saying that she had slipped into a packet a paper asking them to send her a little chloral for a raging toothache. The toothache was, however, fallacious. The lady, on being questioned said, indeed, that she had no intention of committing suicide, but the circumstance made a great impression on his mind. She had previously written to an old nurse asking for salts of sorrel, but had otherwise made no attempt on her life. It would seem, however, that the tendency remained.

Dr. RAYNER said that the question of dissimulation had scarcely yet been touched upon, so he might mention a very striking case. A melancholic patient very nearly succeeded in hanging herself, but was cut down. From that time she became perfectly cheerful, and even gay. The change was so sudden that the medical officers did not believe in it. The friends, however, believed in it, and removed her from the asylum, it being pointed out to them that she should be kept under constant supervision. At the end of six weeks her sister left her alone for a few minutes, and she killed herself. Up to that time she had perfectly deceived her friends.

Dr. HAYES NEWINGTON, in reply, said that he was sorry that the President had had to leave the meeting early, because he had first of all to deal with Dr. Savage's remarks as to patients who talked about suicide. It was certainly a common idea that patients who said they had no pluck would not commit suicide. It must, however, be borne in mind that certain influences sometimes forced people into action, and in somewhat the same way as the Russian soldiers in the Crimean war were known to do very plucky things, being driven into them by their officers, so he had known cowards to be driven to suicide. He believed that those who did talk were those who might insist on it, and were unsafe. A year or two ago he knew a lady who talked of it very frequently. She made two or three attempts both before and since she came to him, and, with her, suicide was a common cry. Moreover, in the second case he quoted, the gentleman came to him for protection, and certainly his talk about it did not prevent him from making an attempt upon himself. As to bodily disease, he did not mean to say that it was no guide. It had a very important bearing on the subject. A person with toothache might be a very dangerous case. Bodily disease he put rather as a motor. It was not the motor which made the danger; it was rather the weakening of the repellent. A life policy was undoubtedly a good thing to keep a person from attempting to destroy his life, but it would act through one of the agents he had mentioned. The case Dr. Savage referred to acted from family affection, which in that instance must have been very strong, the gentleman having put by his money for twenty-five years. As regarded Dr. Blandford's remarks, he (Dr. Hayes Newington) found it difficult to say more than he had done. In dealing with the hallucination cases he should be guided first of all by whether the patient had made an attempt. If a serious attempt had been made under the influence of the hallucination—not under the influence of the melancholia—he should be reluctant to send such a person abroad in the world. The same with impulse. Numbers of persons had impulses, but never made attempts. If such a patient once made the attempt he should not feel inclined to take the responsibility. Of course, in some private cases, when the friends do not make a move, the doctor's feeling of responsibility must give way, and the patient be allowed a trial. The responsibility was enormous. No doubt they were sometimes mistaken in keeping some of these cases. At the same time he thought they were thoroughly justified. In the following case of discharge he was, on the other hand, egregiously out in his reckoning, but he

thought that others would have acted as he did. It was a case of some ten years back. The two sets of certificates disclosed an attempt at homicide by strangling a gentleman in an hotel, and one at suicide by the patient throwing himself down two flights of stairs. The patient made a subsequent homicidal attempt, while under care, by endeavouring to strangle an attendant. He was, therefore, both suicidal and homicidal. He had epileptiform convulsions. Up to within a few days of his discharge he was very much under the influence of hallucinations. He was removed by his friends, contrary to advice, for a fortnight's trial. He was then released, went about his business, and, strange to say, got quite well, as in Dr. Tuke's case. In cases where the friends were obstinate, the best way was to call in a second opinion. With reference to Dr. Tuke's remarks, they must, of course, take risk, but they had to consider not only the patient's interest and one's own reputation, but the friends and the public. In the case referred to by Dr. Tuke which went on all right for some six years, or more, surely no one would have done otherwise than he did in counselling his being placed under care of some kind. About twenty-three years ago, there was a most interesting case, reported in the Commissioners' Blue Book. A man had been fourteen years under supervision. For the first part of that time he was absolutely suicidal, but he improved, and used to go out and enjoy himself. He had plenty of opportunities of procuring poison, had he been so disposed. At the end of the fourteen years, his mother sent him an old-fashioned writing-desk. He went to a secret drawer, and withdrew from it a little bottle of prussic acid, which he had secreted there fourteen years before. He did not take the poison at once, but walked off with it into a wood, and there took it and died. As to its being the unsuspected patients who committed suicide, he (Dr. Hayes Newington) thought it would be a very great reflection upon themselves if this were not so. He took it that the same risk of suicide prevailed among non-suicidal patients within asylums as existed in the outside world, so that if, for instance, in an asylum with a thousand patients four hundred patients had suicidal tendencies, the remaining six hundred patients would still be subject to the ordinary risk. With respect to Dr. Rayner's remarks, the question of dissimulation had been incidentally touched upon, but if they adopted the view that the repellent agents were to be looked to it was scarcely possible that the patient could pass such a test as would be laid down. There were many little domestic incidents which would be crossed by some of the motors. Of course, if it were impulse, it was all explained, but if the suicide of the person referred to by Dr. Rayner was due to a continuous action, probably a very close review might disclose something which would cause suspicion. The case of the lady who asked for chloral, mentioned by Mr. C. M. Tuke, was no doubt a difficult one, but it might be, if they could get a true conception of her mental condition and lay hold of a basis of some really moral value, such as a proper sense of religion or affection for friends, of which it appeared she had evinced signs, that she would be safe. At the same time there had been a previous attempt to get poison, and it would seem that she must have lost her restraining influence on that point.

The members dined as usual at the Holborn Restaurant after the meeting.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—SCOTCH MEETING.

A Quarterly Meeting of the Medico-Psychological Association was held in the Hall of the Royal College of Physicians, Edinburgh, on the 11th Nov., 1886.

There were present: Dr. Ireland (in the chair), Dr. Bramwell (Edinburgh), Dr. Campbell (Carlisle), Dr. Campbell Clark (Bothwell), Dr. Clouston (Morningside) Dr. Fraser (Dumfries), Dr. Carlyle Johnstone (Melrose), Dr. Keay (Mavisbank), Dr. Maclaren (Larbert), Dr. Macdowall (Morpeth), Dr. Macpherson (Morningside), Dr. Richardson (Isle of Man), Dr. Rorie (Dundee), Dr. Rutherford (Dumfries), Dr. Spence (Morningside), Dr. Turnbull (Fyfe), Dr. Urquhart (Perth), Dr. Watson (Govan).

The following gentlemen were elected members in conformity with the rules of the Association:—Robert William Dickinson Cameron, M.D., Medical Superintendent Midlothian and Peebles District Asylum; Thomas Fraser, M.A., M.B., Assistant Physician Crichton Royal Institution, Dumfries; Henry Bruce Melville, M.B., C.M., Assistant Physician Crichton Royal Institution, Dumfries; William Reid, M.D., Medical Superintendent Royal Asylum, Aberdeen.

The SECRETARY (Dr. Urquhart) stated that, by desire of several of the members, he had written to Dr. Jamieson (Aberdeen), asking him to be present at the meeting, in the hope that he might again preside. He had received a letter in reply, expressing his regret that he must decline the honour, although as loyally attached to the Association as ever.

Dr. URQUHART was instructed to write to Dr. Jamieson, conveying to him the best wishes of the meeting for the long enjoyment of his honoured retirement.

Dr. BRAMWELL showed a large number of interesting photographs of brain sections, explained a ready method of examining the brain in a fresh state; and asked the members of the Association to aid him in his investigations by sending whole brains or bits of brains for the purpose he had indicated.

On the motion of Dr. CLOUSTON, Dr. Bramwell was thanked for his interesting communication, and it is hoped that he will receive every possible assistance from the pathological departments of the asylum physicians to whom he has appealed.

Dr. RORIE read a paper on "The Treatment of the Insane Sixty Years Ago, as illustrated by the Records of the Dundee Royal Asylum."*

Dr. IRELAND remarked that, when he saw Dr. Rorie's paper on the circular calling the meeting, he had certain misgivings, because in statements of what was done sixty years ago there was generally a good deal of boasting on the part of us who possessed the world, at the expense of our predecessors. There was an idea entertained by some to magnify the horrors of the treatment of the insane in past times, and to dilate in glowing terms on the treatment they received in this philosophic age. These evil things had been done by a generation that had passed away, and some of the great improvements had been carried out by men they remembered, although now in their graves. When we considered what we ourselves had done, there was extremely little to boast of. Dr. Ireland also felt that what had been stated as to the horrors to which the insane were subjected in the last century was, to a certain extent, untrue. He held that it was imprudent to show manacles as asylum curiosities, as was sometimes done, and to refer in strong terms to those means of treatment in the past. It was possible that non-professional visitors might not only be considerably shocked—which might, indeed, be what was desired—but that they might also go away with the idea that these instruments and these practices were still used in some asylums. He therefore was glad that Dr. Rorie had worked in a different vein, and had shown that good and faithful work was done in former times, and that our ancestors were anxious to provide for the insane according to their lights, although, of course, they had not the experience accumulated in later times to guide them. Dr. Ireland concluded by urging the present asylum authorities to try to realize the abuses, wrongs, and deficiencies in their treatment that posterity would point out sixty years hence, and to look critically at their own efforts in order to maintain a steady advance. He did not think that the treatment of insanity, from a medical point of view, had kept pace with the work of the general body of the profession, although he admitted the improvement in asylum buildings, and the advance in pathology.

Dr. CLOUSTON was sure that they were all very much indebted to Dr. Rorie for his paper, for he was convinced of the importance of their knowing the history of their institutions. The Royal Edinburgh Asylum, like that of Dundee, was founded entirely at the instance of the medical profession, mainly by the exertions of Dr Duncan. The Royal College of Physicians was second only to Dr. Duncan in starting the establishment; and in the original rules, individualized medical treatment and medical teaching were recognized as among the chief

* This we hope to publish in the next number of the Journal.—EDS.

purposes for which the asylum was built. Such facts proved that the original conception of the Scottish chartered asylums was connected with the medical and therapeutic idea. Dr. Clouston referred to the very successful discussion on the subject of "How the Medical Spirit can best be promoted in Asylums," at the last meeting of the British Medical Association, and expressed his pleasure in then finding that the medical view of the treatment of insanity was enthusiastically maintained without a dissentient voice. The numerical inadequacy of the medical staff in the larger asylums was there specially insisted on. In spite of this, however, he could not think that it would be desirable to lighten the labours of a physician superintendent, as, by exempting him from most of the fiscal work, the governing arrangements, and the selection of the staff. These duties should be rather looked upon in a medical light. For instance, take the decoration and furnishing of a ward. He thought it quite wrong to say that these matters had not a directly medical aspect. They had diseased mental action to deal with, perverted sensibility, and changed emotions. There was no doubt that all the surroundings had a most important effect on the brain and mental condition, and therapeutics must include the whole of the conditions of their patients. They were therefore entitled to look on these general arrangements in a medical light, and he thought it wrong to describe them as non-medical and beneath the dignity of their profession. Dr. Clouston urged that it would be a very narrow view of their medical duties if they looked upon them as the mere giving of medicine. He was far from depreciating systematic individual treatment, but held that it was at the same time necessary to take a medical view of the general circumstances of their patients. Meynert maintained that the act of looking at a pleasant, bright object, was followed by an increase of the blood in the capillaries of certain portions of the brain. If that were so, it would be absurd to believe that it would be more philosophic to give a dose of medicine to produce the same effect. Dr. Clouston then proceeded to defend large asylums as institutions where much medical work was done; and where, with an efficient body of assistants, it was quite possible for an active man to individualize his patients. He also refused to take the pessimistic view of Dr. Ireland, and believed that there had been great improvements of late. He was of opinion that their patients were happier, especially some of the worst class of patients, and better cared for and lived in more wholesome institutions. He thought that the tendency of the day was to apply individualization in large asylums by having special wards for the recently admitted and the sick. By thus segregating these cases they could to a very great extent overcome the inherent defects of large institutions. He could remember the effect of going into the ordinary pauper wards of a large institution when a student, and there could be no question that there was a vast improvement now. The quiet was greater, the general effect was brighter, the conditions of life were ameliorated, the nursing staff more numerous, and the dietary improved. While acknowledging the large grasp of principles that their predecessors had, he did not think that they applied them as we do now.

Dr. MACDOWALL referred to Dr. Strahan's paper, contributed to the discussion mentioned by Dr. Clouston, and said that, in his opinion, it was extremely heretical. If Dr. Strahan's intention was to deprive the medical superintendent of his medical work to a large extent, he could by no means agree with him. He quite recognized the importance of the proposal to improve the position of the assistant medical officer, but could not entertain the idea of his monopolizing the medical charge of the patients to the exclusion of the superintendents.

The CHAIRMAN—That is not Dr. Rorie's view.

Dr. J. A. CAMPBELL took exception to some of Dr. Rorie's remarks. He thought that too much stress had been laid on their having too many patients. He was of opinion that 500 or 600 was not too large a number for a medical superintendent to know individually. With regard to assistant medical officers, they might find that it would be injurious to have too large a medical staff; and he was not sure that there might not now be a tendency to run to excess in

this direction. Dr. Campbell concluded by indicating that much of the routine work of the medical superintendent might be handed over to other officials.

Dr. RICHARDSON thought that it would be impossible to get a physician and a lay superintendent to work together; and that, therefore, the patients would suffer.

Dr. RORIE, in reply, said that he did not intend to convey the impression that the physician should limit his work to the administration of drugs, for he believed that other duties, such as the cheerful decoration of wards, were of equal importance. He, however, thought that he ought to be relieved of the fiscal details, in order that he might confine his attention to medical work. He would certainly not deprive the physician of the whole management.

Dr. MACLAREN read a paper on "Louis XVI.: A Psychological Study."*

Dr. IRELAND, in thanking Dr. Maclaren for his very admirable paper, said that he had clearly demonstrated the irregularities of mind of Louis XVI., and that these possibly showed a tendency to mental derangement. Michelet had said that the family to which he belonged was thoroughly depraved, and he certainly had a very bad heredity. The most learned of those authors who had studied the degeneracy of royal families was Dr. Jacobi. He came to the conclusion that there was a tendency to insanity in all the royal families of Europe, except the Stuarts, who, however, were sufficiently wicked instead.

Dr. CAMPBELL CLARKE read a paper on "An Asylum Provident Scheme." He first criticized the principle of pensions, then described at length the Railway Clearing-House Superannuation Fund Association, and concluded with a statement of the pros and cons of an asylum service provident scheme.

Dr. IRELAND said that they had much reason to thank Dr. Clark for the hearty interest he had taken in attendants. No doubt they all admitted that it was half the battle in managing an asylum to get good attendants; and, although it was generally assumed that it was of great importance to retain them as long as they possibly could, he had found that they generally fell off about the fifth year, and if they left about the sixth or seventh year it was an unmixed good. He was not sure that if Dr. Clark obtained what he wanted things would be much better than at present. Dr. Ireland then referred to the difficulty of discharging a servant who had a vested interest in his situation in such a manner as proposed. There were deferred pensions in the army and navy, but there the men served under articles of war, and so were bound by stringent regulations and subject to court martial.

Dr. J. A. CAMPBELL presumed that the scheme propounded by Dr. Clark provided something similar to pensions for the Scottish District Asylums. If that were so, he thought that it would have a most mischievous effect. He believed that if united action were taken by the Scottish superintendents, and if the Board of Lunacy aided, the District Asylums would be placed on the same footing with the Royal Asylums and the English County Asylums. The Irish were in a better position, because they were granted pensions on the basis of the Civil Service superannuations. He suggested that the matter should be brought before the Society as a whole; and thus, instead of a small body of aggrieved men (as on last occasion) waiting on the Lord Advocate, the weight of the Medico-Psychological Association would be brought to bear on the question of the omission of pension clauses in the Acts dealing with the Scottish District Asylums.

Dr. MACLAREN thought Dr. Clark's paper most practical and valuable, but was of opinion that the scheme would turn on facts which were not in the possession of the meeting. They would require to know the numbers who would join before predicting whether it would be successful or not. The answer to Dr. Ireland's objection was that a man who had a vested right in the funds of the Board would be very careful not to offend, get dismissed, and so lose the money.

Dr. MACDOWALL strongly sympathized with Dr. Campbell's remarks. If

* This paper will appear in a future number of the Journal.—EDS

asylum officials in Scotland wished to form a Provident Association they could apply to an Insurance Company, with whom arrangements could be made for annuities being paid at 50, 60, or 70 years of age; but he thought that the idea of asylum officials providing insurances for themselves out of their scanty salaries was monstrous. They should rather agitate by every means in their power to secure pensions by law. He thought that Dr. Clark's scheme would be a very great hardship on the attendants and their families, and held that the pensions granted by every asylum in England (except perhaps one) was a very wholesome encouragement, and he would add that the scale of wages was better there than in Scotland. Dr. Macdowall concluded by urging a movement for securing pensions as in England, and offering his cordial help in the matter.

Dr. RORIE thought the subject of great importance, and thanked Dr. Clark for bringing it forward. Formerly he used to pay the attendants according to their ability, and without a fixed scale; but latterly he had adopted a sliding rate, according to length of service. He preferred the latter plan. He thought that pensions should be granted as in the civil service. At present the clause in the Act was permissive, because the Government, having no control over the funds, was not in a position to make it compulsory. He related the favourable experience of the deputation that waited on the Lord Advocate some years ago, and urged that the whole of the Scottish asylums should combine to bring this important matter before Government.

Dr. URQUHART was sure that all present would agree that no one took more interest in the attendants than Dr. Clark; but, while acknowledging his unselfish and laborious work, he entirely objected to his proposals as set forth on that occasion. They had on record the favourable reception by the Lord Advocate of the deputation who had some years ago represented the Scottish asylums in regard to this question. They had also the entire sympathy of the Board of Lunacy. That being so, he thought that a strong combination should be made, to deal with this subject on the first favourable opportunity. He wholly objected to amateur actuarial calculations, and would shun provident schemes floated by a limited population. At Murray's Royal Asylum for some years the housekeeper had been successful, as quarter day came round, in inducing many of the attendants and servants to place part of their wages in the local savings bank, and to that extent he had encouraged in every way in his power "an asylum provident scheme;" but he would by no means look upon that as superseding the pensions promised by the Directors.

Dr. WATSON did not think that they were nearer getting pensions than they were five years ago. The results of recent deputations seemed to be against the granting of pensions. The Poor Law Officials who waited on the Secretary of State for Scotland the other day got the same answer as in former years. He paid his attendants according to their ability, and thus induced good men to stay. Dr. Watson concluded by referring to the facilities given by the Post Office for saving money and securing annuities in old age, and by stating his belief that self-help would prove much more satisfactory than the elaborate scheme drawn up by Dr. Campbell Clark.

Dr. CAMPBELL CLARK, in reply, stated that he had not intended that Asylum Boards in their official capacity should have anything to do with this scheme, but that he expected that they would arrange it themselves. It would not be compulsory. He thought that the deputation of asylum superintendents to the Lord Advocate had done nothing. They were just in the same position as they were fifteen years ago. The tone of politics would not be less Radical in the future, and more pensions would not be given.

Dr. URQUHART asked if Dr. Clark was aware of the London Police Superannuation Bill.

Dr. CLARK replied that it had not yet passed, and instanced the recent deputations from the Poor Law officials and Scottish police as having been sent away with polite speeches only. He thought that his scheme would reward those who had not served for fifteen years, but who might have worked well and faith-

fully for seven or eight years. These were the great proportion, and they did not always leave by reason of any fault of their own. He thought that there was a good deal of arbitrariness on the part of superintendents, and would wish to see them more hampered in the dismissal of servants and attendants. It would make them less hasty in sending those under them away, and lead them to do to others as they would wish others to do to them, and so attendants would be better treated. He regretted that he did not see any prospect of their receiving pensions; and as he was not sure that the principle of pensions was a sound one, he wished to learn the ideas of the members of the Association regarding it. The discussion had been exceedingly satisfactory to him.

Dr. URQUHART read clinical notes of two cases of Syphilitic Insanity occurring after alcoholism, and presenting paralytic symptoms. (See Clinical Notes and Cases in the Original Articles of this number.)

Dr. IRELAND said that, although the connection between syphilis and general paralysis had been often discussed, it still remained a somewhat obscure subject; but as he had previously made some remarks on the point at issue, he would not now repeat them.

Dr. RORIE had been in the habit of treating cases of general paralysis with iodide of potassium and mercury. It could do no harm, and might do good. He related a case of a male general paralytic who was admitted in an apparently moribund condition. He, however, improved, and was taken home, where he remained perfectly sane for a year. He then returned to the asylum of his own accord, as he found that he was "going wrong," and the disease ran its usual course. Another male case, with grandiose delusions, similarly recovered and similarly relapsed.

Dr. J. A. CAMPBELL thought it extremely difficult to differentiate between general paralysis and paralysis with insanity. He related a case where recovery from general paralysis was very complete. That patient's articulation had been affected; he had slop diet; he could not walk; yet under treatment he recovered, was discharged some ten years ago; and had been seen walking about Carlisle quite lately.

Dr. URQUHART then read the following contribution by Dr. C. M. Campbell (Murthly):—

"I am indebted to Dr. Smith, of the Durham County Asylum, for these notes of an interesting case that occurred while I was assistant medical officer there.

"Mrs. S. C., admitted June 21, 1880. 34; married. Had been depressed for one and three-quarter years. Worse since last confinement recently. Had delusions of religious exaltation. Was 'too weak to walk,' but recorded as presenting no symptom of paralysis.

"Oct. 8.—To infirmary on account of weakness. Pupils at times unequal.

"Nov. 27.—Getting up in afternoon. Appetite ravenous; steals other patients' food.

"Dec. 30.—Speech impaired. Pupils unequal. Happy delusions. Increasingly feeble.

"1881. Jan. 28.—Left pleurisy; sac quite full. Paracentesis performed. Three pints fluid removed. Relief; no bad symptom.

"Jan. 30.—Sac filled up again. Heart displaced, and breathing much impeded. Operation repeated, and two and a half pints clear straw-coloured fluid withdrawn.

"Feb. 8.—Sac again filled. Operation for third time; 22 oz. fluid removed. Troublesome coughing relieved by morphia.

"Great improvement in pulse and breathing followed each operation, which was done antiseptically.

"Feb. 15.—Slowly improving. On large doses of iodide of potassium (I think 20 grs. *ter die*). Mental condition improving since administration of iodide.

"Mar. 1.—Improving physically; also mentally.

"Ap. 6.—Iodide continued. Improving mentally.

"May 7.—Fluid almost entirely absorbed. Left lung acting fairly. Is up for a time daily. Iodide stopped.

"June 14.—Steadily improving in bodily condition; mentally, well.

"1881. July 12.—Discharged recovered.

"I remember this case well. We could not ascertain any syphilitic history. I first saw her a few months after admission, and looked on her as an undoubted general paralytic. Dr. Smith, who concurred in that view, has made inquiries regarding her history after discharge, and received the following reply from the relieving officer:—

"'South Shields, Nov. 5, 1886.

"'DEAR SIR,—I saw the husband of Mrs. C. yesterday, and learnt from him that she is well in body, but that mentally she is variable—sometimes depressed and at other times excited—but that he has hitherto been quite able to manage her. She has not had any children since she came home.'

"The question seems to be, Was this a case of syphilitic insanity improved by iodide or a case of general paralysis arrested by the counter-irritation of the attack of pleurisy? On the one hand, I remember a female, also at the Durham County Asylum, an undoubted general paralytic, who recovered so far after an attack of enteric fever as to be discharged. On the other hand, I have frequently given iodide of potassium to general paralytics, and have in no case, save the doubtful one above recorded, obtained satisfactory results.

"I am now inclined to the belief that S. C. was and still is, a general paralytic, and that the disease was arrested by the attack of pleurisy."

Dr. TURNBULL said that he had seen the first of Dr. Urquhart's cases, and had thought him suffering from organic disease of the brain and general paralysis. He could corroborate Dr. Urquhart in all he said. He would not be quite sure that these cases were recoveries, although the one he referred to was certainly a remarkably good recovery at present. Dr. Turnbull related a case of temporary recovery from general paralysis, where the patient was removed from the asylum books and was employed as a clerk for many months. That patient, however, broke down and died. It was not a syphilitic case, as proved by post-mortem examination.

Dr. CAMPBELL CLARK said that he would not diagnose syphilis of the brain unless he could trace the disease from its inception, and thought it risky to come to any conclusion in such cases without a post-mortem examination. He believed that they were too apt to arrive at the decision that a case was syphilitic because of improvement under specific treatment. Would they not get as good results if there were no syphilis? They might discharge general paralytics and lose sight of them for a year or eighteen months, but if they were genuine cases they would return with well-marked symptoms.

Dr. MACDOWALL held that it was quite impossible to differentiate between general paralysis and general paralysis associated with syphilis. They saw paralytics with a syphilitic history, but could not in every such case say that the syphilitic infection was the cause of the paralysis. Because a case improved under anti-syphilitic treatment it was no proof of its syphilitic origin.

Dr. URQUHART, in reply, indicated the difficulty of pigeon-holing these complex cases. There was first a history of alcoholism, then of syphilitic infection, and then of paralysis. He had classed them as syphilitic cases because he believed that the insanity directly depended upon the syphilitic infection, fostered, no doubt, by the alcoholism and other concomitants of a fast life. He hoped that the facts as detailed and the experience of the authorities cited supported his view.

The members dined at the Royal Edinburgh Hotel after the meeting.

The next quarterly meeting will be held in Glasgow on the second Thursday of March.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—IRISH MEETING.

A quarterly meeting of the Medico-Psychological Association was held at the College of Physicians, Dublin, on November 18. There were present Dr. Duncan, Dr. Patton, Mr. W. Zachary Myles, Mr. J. Molony, and Mr. Conolly Norman.

Dr. PATTON having been voted into the chair, a letter was read from Dr. Maziere Courtenay, the Secretary, apologizing for his unavoidable absence, and requesting Mr. Norman to act for him.

The following gentlemen were elected members of the Association :—W. Rutherford, M.D., Visiting Physician Ballinasloe District Asylum; Thomas H. O'Shaughnessy, M.D., Assistant Medical Officer Ballinasloe District Asylum (both the above having been proposed by Dr. Maziere Courtenay and seconded by Dr. Fletcher); George P. Cope, L.R.Q.C.P.I., &c., Junior Assistant Medical Officer Richmond District Asylum (proposed by Mr. Conolly Norman and seconded by Mr. W. Z. Myles).

Mr. CONOLLY NORMAN read a short paper "On the sedative properties of aceto-phenone" (hypnone), which he had injected hypodermically in several cases to produce sleep. (See "Clinical Notes and Cases.").

Dr. DUNCAN asked whether the drug possessed any advantages over morphia used in a similar way?

Dr. PATTON inquired as to the chemical constitution of hypnone, and wished to know whether it had been observed to communicate any particular odour to the urine.

Mr. MOLONY inquired as to the local effects of the injections, also as to the age and physical condition of the patients with whom hypnone had been used.

Mr. MYLES said that he had, in conjunction with Mr. Norman, used hypnone in the manner described in a couple of cases. The experiments made were few, but he was inclined to think that the medicine had decided hypnotic properties.

Mr. CONOLLY NORMAN, in replying, said that he was not disposed to attribute any specific virtues to hypnone. In some cases he thought he detected an odour in the urine similar to that produced by turpentine. He had never found any local effects from the injection of pure hypnone further than a discoloration of the skin, resembling an ecchymosis. Several of the patients were young, some middle-aged, one was an old broken-down woman with atheromatous arteries. In the last case great caution had been used, and the dose was never increased beyond six minims. Untoward consequences had not in any case been observed.

Obituary.

ROBERT NAIRNE, M.D., F.R.C.P.

Dr. Nairne has not long survived his resignation of the post of Commissioner in Lunacy, which he held for so protracted a period, namely, from the year 1857 to July, 1883. His death occurred at his residence, Mosley, Beckenham, November 5th, 1886. He was educated in Edinburgh, and at Trinity College, Cambridge, graduating in 1832. Six years afterwards he obtained the Fellowship of the Royal College of Physicians, London, and in the following year he was appointed Physician to St. George's Hospital, where he became lecturer on medicine. He was not, we believe, altogether successful as a physician in the Metropolis, and in 1857 the Lord Chancellor presented him with the office of Commissioner in Lunacy. In 1856 he married a daughter of John Gott, Esq., of Leeds, who survives him. It is singular that Dr. Nairne should, like the late greatly respected Mr. Gaskell, have been knocked down by a cab in one of the London streets, and it seems probable that this unfortunate accident had something to do with his death. This, however, can hardly be regarded as pre-

mature, he having attained the advanced age of 82. If Dr. Nairne was somewhat formal and distant in his bearing to those having charge of asylums for the insane, we believe that he endeavoured to perform the duties of his post to the best of his ability, with fairness and assiduity, but at the time of his appointment he laboured under the disadvantage of not having had any practical acquaintance with Lunatic Asylums.

JOHN P. GRAY, M.D., LL.D.

We record with great regret the death of Dr. Gray, the superintendent of the New York State Hospital for the Insane. His removal creates a vacant space in American medical psychology which is not likely to be soon filled by a man with like characteristics. Few men possessed more striking individuality, and foes as well as friends will admit that he had enormous force of character and occupied a remarkable position in the United States. We will not go so far as to say *De mortuis, nihil nisi bonum*, but this is not the occasion on which it would be seemly to discuss the right or wrong of the many questions in regard to which he came into fierce conflict with the opinions of others, both in regard to his management of the asylum at Utica or the position he took in the *cause célèbre*, still fresh in the memories of all on both sides of the Atlantic, for the points then raised were of universal interest and importance. In person the terse description often given of Dr. Gray was not by any means inapt, and would no doubt be accepted by his best friends—"the head of Jupiter and the body of Bacchus." It expresses at any rate what caricatures are intended to express, the salient features of the man's character, intelligence, and jollity. In social life he was certainly "jolly," and could tell a good anecdote as effectively as anyone. His lectures on mental disorders were clear and forcible, and retained the attention of the class during their delivery.

We proceed to condense from the obituary in the "Utica Daily Press," Nov. 30th, 1886, some of the particulars of his life:—He was born in 1825 at Halfmoon, Pennsylvania. His first post was that of a resident physician at Blockley Hospital, to which he was appointed in 1849. In 1850 he was appointed third assistant-physician at the New York State Asylum. In 1852 he was promoted to be first assistant, and the health of the superintendent, Dr. Benedict, failing, Dr. Gray was soon after appointed acting superintendent during the illness of that officer. Subsequently the State of Michigan, having determined to erect an asylum, offered the superintendency to Dr. Gray in January, 1854. This he accepted, and prepared a plan of the projected building. In June, however, Dr. Benedict not having regained his health, resigned, and Dr. Gray was appointed to succeed him, July 14th, 1854, and retained the post until his death.

Dr. Gray was a permanent member of the American Medical Association; an ex-President of the Medical Society of the State of New York; a member of the Association of Superintendents of American Institutions for the Insane; an honorary member of the Société Médico-Psychologique of Paris; an honorary member of the Societa Freniatrica Italiana; and an honorary member of the Medico-Psychological Association of Great Britain. In 1874 he was appointed lecturer on psychological medicine and medical jurisprudence in Belle Vue Medical College, New York, and in 1876 he was appointed to the same position in Albany Medical College. He was the second President of the New York State Medical Association, and in that character delivered an address on "Insanity and some of its Preventive Causes." He wrote a paper on "Mental Hygiene," and on "Heredity" among others. In the latter article he opposed the doctrine that insanity is hereditary. "His paper showed that the many thousands of patients who had been in the asylum under his supervision had afterwards become the parents of many more thousands of children, and of these

children none had ever been returned to the asylum insane." Such a sentence tempts criticism, but we pass on to remark that in 1879 Dr. Gray visited this country, Switzerland, and France, inspecting on his journey some of our principal lunatic asylums. After his return home he wrote an article on mechanical restraint, the use of which, under certain circumstances, he has always defended. At the Utica Asylum, however, the amount of restraint was of late much reduced. There can, we believe, be no doubt that Dr. Gray's life was shortened in consequence of the attack made upon him about four years ago. This occurred in March, 1882, soon after he returned from Washington, where he had given evidence in support of Guiteau's soundness of mind. He was shot in the face by one Henry Renshaw, a lunatic. The ball passed through the nasal passages, partly destroying them. He was unable to breathe through the nose until about two years ago, when an operation was performed, which greatly relieved him. He did not, however, fully recover from the shock and the consequent prostration, and in February last the state of his health induced the Board of Management to give him six months' leave of absence. He went to Georgia, and returned to the Asylum in April. He went abroad in July, and remained most of the time at Carlsbad, where the treatment was directed to reduce his corpulency. From thence he wrote to England in good spirits, and looked forward to visiting his friends in London and renewing their acquaintance. This, however, he failed to do, and returned to Utica in October last in apparently good health. A month before his death he caught a severe cold, and had bronchitis. He went, however, to Baltimore on business, and complained on his return of being much tired. About the middle of November his illness assumed a serious form, and it was found that he laboured under renal disease (Bright's). On Saturday, the 27th November, he seemed much better, and remained so on Sunday. About midnight he was worse, and became delirious; and at 3 a.m. on Monday morning, the 29th, he became unconscious, remaining so until 9 a.m., when he recognized one of his sons. Uræmic coma supervened at 10 a.m., and he died without pain at 2.48 p.m.

To the family who mourn his loss we tender our sincere sympathy, and we trust that the Institution over which he presided for nearly 33 years will prosper in the future, and be superintended by an able physician devoted to the insane, who will worthily fill the place rendered vacant by the death of Dr. Gray.

[Since the above was written we have received intelligence of the appointment of Dr. Blumer, the Senior Assistant Physician at the Utica Asylum, and one well qualified for the office of Superintendent.]

THE EAMES MEMORIAL FUND.

The following subscriptions to the Eames Memorial Fund are thankfully acknowledged, and an earnest appeal is made on behalf of the family of our late President for further contributions. The list will not close till February 1st, up to which time further donations will be received by

E. MAZIERE COURTENAY,
Limerick Asylum.

	£	s.	d.
The Medico-Psychological Association	10	0	0
Adams, Josiah O., M.D.	5	5	0
Atkins, Ringrose, M.D.	10	0	0
Baker, Benj. Russell, M.R.C.S....	1	1	0
Beach, Fletcher, M.B.	2	2	0
Blandford, George Fielding, M.D.	2	2	0
Bower, David, M.B.	5	5	0

	£	s.	d.
Campbell, John A., M.D.	2	2	0
Chapman, Thomas Algernon, M.D.	1	1	0
Clarke, Archibald C., M.D.	1	0	0
Clouston, T. S., M.D....	5	5	6
Cooke, Edwd. Marriott, M.B.	2	2	0
Courtenay, Edwd. Maziere, M.B.	10	0	0
Deas, Peter Maury, M.B.	2	0	0
Deane, T. Vincent de, M.R.C.S.	0	10	6
Down, J. Langdon Haydon, M.D.	2	0	0
Dwyer, J., L.R.C.P.I.	10	0	0
Eager, Wilson, L.R.C.P.	2	2	0
Eustace, J., M.D.	2	0	0
Finnegan, A. D. O'Connell, L.K.Q.C.P.I... ...	1	0	0
Fletcher, R.V., F.R.C.S.I.	3	3	0
Garner, W. H., F.R.C.S.I.	10	0	0
Hatchell, George W., M.D.	10	0	0
Hearder, George J., M.D.	1	1	0
Hetherington, Charles, M.B.	1	1	0
Hickson, A. L., M.D.	3	3	0
Hingston, J. Tregelles, M.R.C.S.	1	1	0
Howden, James C., M.D.	2	0	0
Humphry, John, M.R.C.S.	1	1	0
Johnstone, J. Carlyle, M.D.C.M.	1	1	0
Kay, Walter S., M.B.	1	1	0
Lindsay, James Murray, M.D.	1	1	0
Major, Herbert, M.D....	1	1	0
Marshall, William G., M.R.C.S.	5	5	0
McDowall, John Greig, M.B.	1	1	0
Merson, John, M.D.	2	2	0
Merrick, A. S., M.D.	10	0	0
Mickley, George, M.B.	2	2	0
Mitchell, S., M.D.	5	5	0
Moody, James M., M.B.	2	2	0
Moore, E. E., M.B.	1	1	0
Murray, Henry G., L.K.Q.C.P....	1	0	0
Myles, W. Tuckery, L.F.P.S.	1	0	0
Needham, Frederick, M.D.	5	5	0
Neil, James, M.D.	1	0	0
Newington, Alexander, M.B.	2	2	0
Newington, H. Hayes, M.R.C.P.	5	5	0
Norman, Connolly, F.R.C.S.I.	10	0	0
Oakshott, J. A., M.D.	3	0	0
O'Meara, T. P., M.B.	3	0	0
O'Neil, E. D., L.K.Q.C.P.	3	0	0
Patton, Alexander, M.B.	5	0	0
Petit, Joseph, L.R.C.S.I.	5	0	0
Powell, Evan, M.R.C.S.	1	1	0
Pringle, H. T., M.D.	3	3	0
Rayner, Henry, M.D....	5	5	0
Richardson, B. W., M.D.	1	1	0
Rogers, Thomas Lawes, M.D.	5	5	0
Rorie, James, M.D.	1	0	0
Rutherford, James, M.D.	5	5	0

	£	s.	d.
Sankey, E. Heurtley H., M.R.C.S.	1	1	0
Savage, G. H., M.D.	5	5	0
Seward, W. J., M.D.	2	2	0
Sheldon, T. S., M.B.	1	0	0
Squire, R. H., B.A.	1	1	0
Stewart, Robert L., M.B.	1	1	0
Stewart, James, B.A....	1	1	0
Sutherland, Henry, M.D.	5	5	0
Spence, J. Beveridge, M.D.	3	3	0
Tate, William Barney, M.D.	2	2	0
Tuke, D. Hack, M.D....	5	5	0
Turnbull, Adam Robert, M.B.	1	1	0
Ward, J. Bywater, B.M., M.D....	2	2	0
Whitcombe, Edmund Banks, M.R.C.S.	1	1	0
Wilson, G. V., M.D.	1	1	0
Wood, Thomas Outterson, M.D.	2	2	0
Woods, Oscar T., M.B.	5	0	0
Worthington, Thos. Blair, M.B.	2	2	0

CERTIFICATE OF EFFICIENCY IN PSYCHOLOGICAL MEDICINE.

We are glad to be able to announce that there is every reason to believe that the recently instituted examination for this certificate having become more widely known, there will in future be a large number of candidates for it in England, Scotland, and Ireland. That its possession will be a great advantage to any young man seeking a lunacy appointment is self-evident. It is also obvious that it will be of use to the public as affording some guarantee of the fitness of a practitioner to deal with mental cases, and to sign medical certificates.

Of the first examination, which was held at Bethlem Hospital, the following record appears in the "British Medical Journal," Dec. 4th, 1886:—

"*Certificates in Psychological Medicine.*

"The following is a list of the candidates who have passed the examination for the certificate of efficiency in Psychological Medicine, held at Bethlem Royal Hospital, November 29th and 30th:

"Percy Smith, M.D., Bethlem Royal Hospital.
"Thomas B. Hyslop, M.B., Bethlem Royal Hospital.
"G. M. Robertson, M.B., Edinburgh.
"James Neil, M.D., Warneford House, Oxford.
"Alan Rigden, M.B., County Asylum, near Shrewsbury.
"Walter Pearce, M.D., Maidenhead.
"J. Walter Scott, M.R.C.S., Fareham, Hants.
"G. D. Symes, M.R.C.S., Dorchester.

"This Examination has been instituted by the Medico-Psychological Association of Great Britain and Ireland, and demands a practical as well as a theoretical knowledge of mental disorders. It consists of a written and oral examination, including the certifying of an insane patient, and occupies a portion of two days. Candidates must be registered medical men, who have resided in an asylum, holding the office of clinical clerk, or as assistant medical officer, for at least three months, or have attended a course of lectures on insanity and the practice of an asylum (where there is clinical teaching) for a like period, or they must give such proofs of experience in lunacy as shall, in the opinion of the President, be sufficient. The following are the written questions, at the recent examination conducted by Dr. G. H. Savage and Dr. D. Hack Tuke:

"1. Enumerate various methods of classification of mental disorders which have been proposed, and discuss their merits, specifying that method and the forms it comprises which you prefer.

"2. What are the symptoms and previous history of an insane patient which would lead you to give an unfavourable prognosis?

"3. What forms of mental disorder are most frequently associated with epilepsy, and what do you understand by masked or larvated epilepsy?

"4. What are the questions you would especially ask, if treating a man's testamentary capacity? What would lead you to suppose him to possess this capacity, although his mind might not be sound on all points?

"5. What treatment would you adopt in a case of acute delirious mania?

"6. Mention the statutory forms required for the admission of a private patient into an English or Scotch asylum, and the conditions attaching to them."

An examination for the same certificate was held at the Royal Edinburgh Asylum on the 10th and 11th Dec., Drs. Clouston and Rutherford being the examiners.

The following were the questions at the written examination (it not being necessary to answer more than four):—

1. Give the Chief Diagnostic Points, Bodily and Mental, in a case of General Paralysis; and state the Pathological and Physiological reasons why such symptoms should occur in this disease.

2. A case, A. B., female, æt. 34, married, five children, youngest six months old, being nursed, father insane, had the following as her chief symptoms:—Headaches, sense of weariness, loss of flesh, anæmia, flashes of light before her eyes, and irritability at first; those symptoms being followed by mental depression, loss of interest in family, spurts of uncontrollable excitement, sleeplessness, loss of appetite, and suicidal tendencies. Give—1. Classification according to different systems; 2. Prognosis; and 3. Treatment.

3. Define shortly the terms "Mental Exaltation," "Mental Enfeeblement," and "Insane Delusion," as commonly used by writers on Mental Disease.

4. What are the chief points to be considered in determining the question whether a patient is a "proper person to be detained under care and treatment," and to be observed in granting the statutory Certificate for admission into an Asylum? Criticise and correct the accompanying faulty Certificate.

5. In what forms of mental disease are serious crimes most apt to occur? What considerations would you give most weight to in determining the question of legal responsibility?

6. Under what circumstances is forcible feeding sometimes necessary? Describe the methods usually adopted, and mention the foods commonly used.

The following gentlemen passed the examination to the satisfaction of the examiners:—

John Macpherson, M.B., Assistant Physician, Morningside.
Robert Howden, M.B., Clinical Assistant, Morningside.
Thomas Fraser, M.B., Assistant Physician, Crichton Royal Institution.
John Cram, M.B., Assistant Medical Officer, Larbert Asylum.
Henry B. Melville, M.B., Assistant Physician, Crichton Royal Institution.

Reference has been made in a former number of this Journal (Oct., 1886) to "The Gaskell Memorial Fund," and its intended application to a prize in an Honours examination, in addition to the pass examination for the certificate above mentioned, which the candidate must have passed before being eligible to compete. This fund is about to be placed at the disposal of the Medico-Psychological Association, and we expect that the first examination for Honours will take place at the close of the next ordinary examination, which falls in due course in July next.

The general object of the prize is declared to be "For the Advancement of the Practical Knowledge of Mental Disorders and their Treatment."

It will be called "The Gaskell Prize."

The prize will be restricted to candidates submitting to examination in England.

Candidates must be at least 23 years of age, and must produce a certificate from the Superintendent of an asylum for the insane of having been a qualified medical officer in such asylum for at least two years.

The prize to be offered annually and to be accompanied by a suitable medal.

The prize to be withheld if, in the opinion of the examiners, no candidate's paper reaches a certain measure of excellence, the amount to be either carried forward to increase the prize or prizes next year or added to the capital.

STEWART SCHOLARSHIP IN MENTAL DISEASE.

UNIVERSITY OF DUBLIN—TRINITY COLLEGE.

At the examination for the above Scholarship, held at Michaelmas last, the successful candidate was—

Geo. Revington, M.B., Assistant Medical Officer, Prestwich Asylum, near Manchester.

Appointments.

BLUMER, Alder, M.D., appointed Medical Superintendent of the New York State Asylum for the Insane, *vice* Dr. Gray.

FRASER, THOS., M.A., M.B., appointed Assistant Physician to the Crichton Royal Institution, Dumfries.

GRANT, JOHN, M.B., C.M.Edin., Assistant Medical Officer to the Inverness District Asylum, appointed Assistant Medical Officer to the East Riding Asylum, Beverley, Yorkshire.

HALL, BEN., M.B.Lond., Second Assistant Medical Officer at Banstead, appointed Superintendent of Brook Villa Asylum, Liverpool.

KEAY, JOHN, M.B., Assistant Physician to the Crichton Royal Institution, Dumfries, appointed Superintendent of the Mavisbank Asylum, Edinburgh.

KINGDON, E. C., M.B., C.M.Edin., Assistant Medical Officer to the Colney Hatch Asylum, appointed Assistant House-Surgeon to the General Hospital, Nottingham.

LICHFIELD, JAMES WM., L.R.C.P.Lond., appointed Junior Assistant Medical Officer to the Hants County Asylum.

MELVILLE, H. B., M.B., C.M., appointed Assistant Physician to the Crichton Royal Institution, Dumfries.

STEWART, R. C., appointed Assistant Medical Officer, County Asylum, Leicester.

Several Reviews are left over to the next number for want of room.

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(Continued from No. 99, Oct., 1885).

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MEDICO-PSYCHOLOGICAL ASSOCIATION.

CONDITIONS AND REGULATIONS RESPECTING THE EXAMINATION FOR THE CERTIFICATE IN PSYCHOLOGICAL MEDICINE.

I. Candidates must be at least 21 years of age.

II. They must produce a Certificate of having resided in an asylum (affording sufficient opportunity for the study of mental disorders) as Clinical Clerk or Assistant Medical Officer for at least three months, or of having attended a course of Lectures on Insanity and the practice of an asylum (where there is clinical teaching) for a like period, or they shall give such proofs of experience in Lunacy as shall in the opinion of the President be sufficient.

III. They must be Registered under the Medical Act (1858) before the Certificate is actually bestowed.

IV. The Examination to be held twice a year, at such times as shall be most convenient, in London, Scotland, and Ireland.

V. The Examination to be written and oral, including the actual examination of insane patients.

VI. The fee for the Examination to be fixed at £3 3s., to be paid to the Treasurer, for any expenditure incurred, including the Examiners' Fees.

VII. Candidates failing in the Examination to be allowed to present themselves again at the next and subsequent Examinations on payment of a fee of £1 1s.

VIII. The Certificate awarded to the successful candidates to be entitled "Certificate in Psychological Medicine of the Medico-Psychological Association of Great Britain and Ireland."

IX. Candidates intending to present themselves for Examination to give Fourteen Days' Notice in writing to either the General Secretary of the Association, the Secretary for Scotland, or the Secretary for Ireland, according as they desire to be examined in London, Edinburgh, or Dublin.

X. The Examiners shall be two in number for England and Wales, for Scotland, and for Ireland.

XI. They shall be appointed annually by the Council of the Association from Members of the Association. They shall not hold office for more than two years in succession.

XII. Form of Certificate to which the Seal of the Association is to be affixed:

THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

Examination for the Certificate in Psychological Medicine.

This is to certify that Mr. ———— has satisfied the Examiners as to his knowledge of the subjects of the Examination.

Dated

N.B.—Candidates intending to present themselves for Examination must give notice thereof Fourteen Days prior to Examination—

In England, to Dr. RAYNER, Hanwell.
In Scotland, to Dr. RUTHERFORD, Dumfries.
In Ireland, to Dr. COURTENAY, Limerick.

For ENGLAND the Order of Examination of Candidates for the Certificate in Psychological Medicine will be as follows:—

FIRST DAY.

MORNING, FROM 11 TO 1.

Written Examination in Psychological Medicine. Questions will be asked on the—

Definition, Classification, Diagnosis, Prognosis, Pathology, and Treatment of Mental Disorders. Also the main requirements of the Lunacy Law in regard to Medical Certificates and Single Patients.

AFTERNOON, 3 TO 5.

The same.

SECOND DAY.

MORNING, FROM 11 TO 1.

Clinical Examination of Insane Patients. Candidates will be required to fill up Medical Certificates, and to write a short commentary on each case.

AFTERNOON, FROM 3 TO 5.

Vivâ-voce Examination.

The next Examination will take place on MONDAY and TUESDAY, November 29th and 30th, 1886.

Candidates for this Certificate will not be Examined in Cerebral Anatomy, Physiology, Mental Philosophy, or Microscopy.

It is intended eventually to have an additional Examination for Honours in these subjects, of which notice will be given.

Particulars respecting the Order of Examination in SCOTLAND and IRELAND can be obtained on application to

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Dr. COURTENAY, District Asylum, Limerick.

H. RAYNER, M.D.,
Hon. Secretary.

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CONTENTS OF No. 139.—OCTOBER, 1886.

PART I.—ORIGINAL ARTICLES.

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