duct was formed. With reference to the attacks, it will be observed that anything in the form of excitement, which was likely to produce temporary congestion of the brain, resulted in Aphasia.

Dr. BLANDFORD said he should like to know whether the exostosis on the specimen handed round was not due to Syphilis; he did not consider it to be a case of pure Aphasia, and it was important not to confound unwillingness to speak with Aphasia proper.

Dr. DOWN asked if the disease of the third convolution on the left side was well defined?

Mr. KESTEVEN said his definition of "Aphasia" entirely differed from that of Dr. Sabben. He looked upon the case as one of simple dumbness, and the growth to be syphilitic.

Dr. SABBEN, in reply, said that the patient had suffered from syphilis when young, and he considered the growth to be of a Syphilitic origin. Dr. Blandford was mistaken in supposing this to be a case of unwillingness to speak, for the great distress often pictured on the patient's face showed an entire loss of the memory of words. With reference to Mr. Kesteven's remarks, he appeared to be confused as to the localisation of the disease in "Aphasia." Dr. Sabben was quite aware that the power or originator of speech had been stated by different authors to exist in particular portions of the brain, and no two appeared to agree as to the precise locality. In this case it will be observed that both the diseased bone and nervous structure were entirely confined to the anterior lobes of the brain.

A vote of thanks to the President and Council of the Medico-Chirurgical Society for the use of their rooms closed the proceedings.

Report of a Meeting of Members of the Medico-Psychological Association, held at Glasgow, April 27th, 1870.

The second meeting of the Members of the Medico-Psychological Association, resident in Scotland and the north of England, was held in the Hall of the Faculty of Physicians and Surgeons, St. Vincent-street, Glasgow, on Wednesday, 27th April, 1870.

Dr. LAYCOCK, the President of the Society, occupied the chair.

The minutes of the last meeting were read and approved.

The report of the Committee on Therapeutics was then read. (*Printed at page* 223.)

Dr. HOWDEN suggested that it should be printed and circulated among the members, that they might have an opportunity of considering its details.

Dr. ROBERTSON said he had an impression that the plan suggested was too complicated. He did not see how the members of the Association with their onerous duties could go into such details as was proposed—such for instance as observing the state of the patients every three hours. He thought Dr. Howden's suggestion was a very valuable one; and if the table proposed were somewhat simplified, they might arrive at very valuable results.

Dr. HOWDEN said Dr. Robertson had overlooked the fact that he was left to the freedom of his own will, whether he should adopt the method proposed or not.

Dr. ADDISON said he thought the effect of the drugs mentioned in the report should be tried on the sane as well as on the insane, and their effects duly notified. They did not know much about the action of opium for instance, except from its effects.

Dr. ROBERTSON said he would deprecate the idea that they were going to carry out a system of experimentation upon their patients. These drugs had been used since medicine became a science, and they were perfectly conversant with their effects. These observations should be made with regard to drugs recently introduced into practice, and not with regard to those of whose effects they were perfectly well informed.

Dr. HOWDEN then formally proposed that the report should be printed and circulated among the members before next annual meeting.

Dr. BRUCE THOMSON said a very good addendum to that motion would be that every gentleman who received a copy of the report should say what particular part of the scheme he would take up, and then they would know who would be disposed to go into the views of Dr. Clouston, for the purpose of carrying out this experimental system. He could not help thinking that they were much indebted to Dr. Clouston for bringing this matter before them, because as those entrusted with the

care of the insane they had been lapsing away a good deal into merely moral treatment, forgetting medical treatment altogether. He could not say that he agreed with Dr. Robertson that the scheme was too complicated. He thought the whole plan might easily be overtaken by every member agreeing to take a section. The comparison of notes in the practice of medicine was a thing almost unknown; and he thought valuable results might be derived from the observation of the action of these medicines by such a body as the Medico-Psychological Association.

The resolution was then unanimously adopted in the following form:—"That a copy of the report of the Therapeutical Committee be circulated among the members of the Association before next meeting; and that each member be requested to state what particular part of the work he will engage to undertake."

The CHAIRMAN quite agreed with Dr. Thomson that it was incumbent on the physicians in the various asylums throughout the country to show their determination to advance therapeutics in that direction. He was much gratified that his old friend and pupil, Dr. Clouston, had taken this subject in hand. He had had some conversation with him on the subject two or three years ago, and he was happy to see that the idea they then discussed had fructified.

Dr. SKAE said the members on receiving the report might also suggest any limitation or simplification of the plan proposed.

The CHAIRMAN suggested that the word experimental might be left out or modified.

Dr. THOMSON—It is not a popular word.

The CHAIRMAN said it might be thought they were going to make experiments upon their patients, and such a supposition would be quite erroneous. They only meant to test in particular cases drugs which had been tested in other departments of practice, with the view of ascertaining which were most efficient. He thought they could hardly call this an experimental system, but rather a series of systematic observations.

Dr. HOWDEN said it appeared to him that the most important thing was to adopt a regular system of recording observations. He did not think, except it might be in the case of some new drug, that they could expect men who had been treating insanity for the last twenty or thirty years to begin to experiment with opium or morphia—medicines the effect of which they knew quite well already.

On the motion of Dr. ROBERTSON, a vote of thanks was passed to Dr. Clouston and the Committee for their excellent report.

Dr. CLOUSTON, in acknowledging, said he must disclaim altogether the authorship of the report. He had no doubt that many of the most valuable suggestions had been made by individual members of the Committee. He also disclaimed the idea that they were going to experiment upon their patients. All the Committee proposed was that the treatment adopted and its results should be accurately observed and recorded, so that they might see how far they agreed in regard to their treatment and its results.

Dr. HOWDEN read the replies made to certain questions which had been submitted to himself to Professor Gairdner.

QUERIES.

1. Have you had many cases of "General Paralysis of the Insane" under your charge?

2. Have you ever known a case of complete cure?

3. If not, have you ever seen instances of temporary recovery or improvement, and are these instances common?

4. Do you think it possible that during a temporary recovery a person would be capable of giving instructions for making a will, executing it, and understanding its import, especially if that will were a simple and a natural one?

5. What idea would be conveyed to your mind by the fact that a person who was labouring under general paralysis executed a natural will, and one carrying out intentions which he had expressed before there was any question as to his sanity? Would it not raise a very strong presumption that the patient was perfectly capable of making the will and understanding its import?

6. If you ever knew a case of complete recovery, would not the last-mentioned fact be a proof, or at least a strong presumption of it?

7. Have you had any cases under your charge where a general paralytic, who has temporarily recovered, has again been entrusted with the management of his affairs, and was he found capable of such management?

8. If you have not had such cases under your charge, have you not had cases where the patients gave reasonable instructions for, and corresponded in regard to, the management of their affairs?

9. Have you had reason to doubt that it is possible for a patient during temporary recovery or improvement to take the management of his affairs?

10. During the temporary improvement is it not sometimes difficult even for the medical man to say that the patient was not sane?

11. Do you know any cases, either in your own experience or in that of others, where the disease, at first considered to be general paralysis, turned out not to be so, and if so, do you know the cause or the nature of the mistake?

12. What is the longest time you have known to elapse between the first manifestation of the disease and the temporary recovery, and what the shortest time, either in your own experience or that of others?

13. Over what length of time does your experience of the treatment of lunatics extend?

ANSWERS BY DR. GAIRDNER TO QUERIES PUT BY MESSRS. HORNE, HORNE, AND LYELL.

1. I see the disease occasionally in consultation, or in hospitals, or in visiting at asylums.

2. No.

3. Improvement certainly, especially when a patient, removed by a certain amount of seclusion from the exciting causes, but never, I think, what I would call a "*recovery*," even temporary. I believe, however, a larger experience would show such cases, though very rarely.

4. See below, answered at 6th Query.

5. See below, answered at 6th Query.

6. Answers to 4, 5, and 6. These queries relate to the testamentary capacity of general paralytics, and may be answered together thus:—"If a person labouring under general paralysis (or, I may add, any other form of mental infirmity) executed a natural will and one carrying out intentions which he had expressed before there was any question as to his sanity," I should consider, medically speaking, that such a will was entitled to the greatest respect as being the *real* will of the person. This opinion would not be changed even by the fact of the will being made in, and dated from, a lunatic asylum, provided that evidences were forthcoming that the physicians of the asylum, or others equally able to judge, were of opinion that the patient, *at the time of making the will*, fully understood what he was doing and was able to comprehend the effect of, and spontaneously to give expression to, the intentions implied in the will. I should think, in such a case, that the will *proved itself*, as it were, to be a valid document, and this in the face of any and every medical theory as to the name or classification of the kind of insanity supposed to be present. This is also, I apprehend, the opinion of very high legal authorities, to judge from the ruling of the *then* Lord Justice Clerk (Inglis) in the *2nd Maclean will case*, and also from many other cases to which (writing apart from books) I am unable to refer at present. On the other hand, it seems as if the *legal* position above alluded to were not quite clearly defined, or quite generally accepted. And from the medical point of view, I am obliged to confess that a *clearly made out* case of general paralysis would throw more doubt upon a will than any other type of insanity or mental infirmity, because the delusions often latent in general paralysis have so remarkable a tendency to be associated with the idea of property, and to create extravagance and confusion as to the *meum* and *tuum*.

7. See below, answer to Query 9.

8. See below, answer to Query 9.

9. Answers to Queries 7, 8, and 9. For the reasons above stated, I am greatly disposed to doubt the capacity of a general paralytic, under any circumstances whatever, to take the uncontrolled management of his own affairs, though I admit I have known cases where, during limited periods, apparently reasonable directions could be and were given.

10. See below, answered at Query 11.

11. Answers to Queries 10 and 11. The diagnosis of general paralysis is often of very great difficulty, especially in the early stages, and during temporary improvement I freely admit the possibility and probability of error.

12. I cannot answer this.

18. I have always regarded disorders of the mind as a deeply interesting part of medical practice, and have been more or less in the habit of seeing such cases since 1850, or even earlier; but I have never made a *specialty*, strictly speaking, of this practice, or had opportunity of watching cases continuously, on a great scale, for long periods together. Many of my assistants and attached friends in hospital practice have become physicians of asylums, and I have both by consultations and correspondence, as well as by visiting their asylums, kept up communications with them on the subject.

Dr. SKAE said he was not prepared to say much on this paper; but to begin with the last remark made by Dr. Howden, he might say that he had seen one or two cases, particularly of hard drinking, in which the symptoms very much resembled those of general paralysis. In one instance, the case of a person now in the asylum, he was at first quite misled. All the symptoms disappeared, and the man became comparatively well, but with an impaired mind, and he had remained in that condition for a good many years. In regard to those other cases referred to by Professor Gairdner and Dr. Howden, of temporary remission of the disease, he had seen a considerable number, and was acquainted with several others. He himself had discussed this subject in a paper which he read before the College of Surgeons of Edinburgh, a good many years ago. In that paper he referred to several cases that had been the subject of legal inquiry. There was one well-known case, the case of Sir Henry Meux, who undoubtedly laboured under general paralysis, and who, apparently under a temporary remission of the disease, left a legacy of £30,000 to his sister-in-law, and then relapsed and died, with all the symptoms of the disease. That will was held good, on the evidence of the solicitor, the gamekeeper, and several others who had associated with the legatee during the few months that the remission lasted. He conducted himself in every way correctly, and everyone expected and believed that he had fully recovered. He (Dr. Skae) had seen several similar cases, where the friends were all satisfied of the patient's recovery. He had known wives, fathers, brothers, persons of great eminence, take their friends out of the asylum, associate with them, travel with them, and write him that they were perfectly well. He was never able to satisfy himself in any one of these cases that the patient was perfectly well; and he found that the friends themselves showed a want of confidence in the parties. They assisted them in doing little bits of business which they would not otherwise have done, and in a number of little ways they showed a doubt of their being perfectly restored. In all these cases the patients relapsed after a certain length of time. Regarding the testamentary capacity of these persons while they enjoyed such remissions, he had no doubt that they would be capable of giving instructions for a will, particularly if their money or property was left in conformity with their known intentions previously, and such wills had been held to be good in general, even when there existed express delusions. Wills had actually been held to be good which had been signed in lunatic asylums; and in one particular case, a will was held to be good which was signed in an asylum where the strait jacket had to be taken off the person before he could affix his signature. The law went a great length in this respect in regard to the capability of persons executing wills, the principle being this, that as long as the delusions they laboured under were not such as to influence them in leaving their money, the will should be held to be good. If a person, for example, was under the belief that his daughter or son had attempted to poison him, and under that delusion willed his money away, then the will would be held to be invalid. If he, on the other hand, held the same delusion in reference to his nurse, and in other respects appeared to be sound, the will would be held to be good. These were the principles which were generally recognised in law with regard to the testamentary powers of the insane.

Dr. HOWDEN said he thought the principal point which Professor Gairdner wished to know was, whether it was the opinion of the members of the Association, that in general paralysis it was likely a person would have an interval of such a nature as to be able to execute a will. As to the point of law, of course there was no doubt that an insane person could not make a will; but he presumed, from what Dr. Skae had said, that he was of opinion that in general paralysis persons were capable of making wills at certain times.

Dr. SKAE did not know that he would go so far as that. If a person who had an attack of general paralysis, at least of the kind of which he had spoken, had to originate any work that he had not thought of before; if he had to exercise his mind with regard to it, to decide, for instance, to whom he was to leave his money, he

never having thought of the subject before, he was of opinion that in these circumstances he would break down under it. In all those cases to which he had referred, whenever any work was given to the patient which required the exercise of spontaneous thought, he always broke down under it. If, however, the person had previously made up his mind as to how he was to leave his property, he was likely to carry out his intention quite correctly.

Dr. MACKINTOSH, Gartnavel, said he would agree with his friend Dr. Skae in everything he had said with regard to the testamentary capacity of those labouring under general paralysis. He was satisfied that in certain forms of general paralysis there were lucid intervals, during which it would be competent for the patient to make a will, during which he would be able to express himself coherently and intelligently. He also agreed with Dr. Skae that the kind of delusion determined very much the question—in point of fact, it was a question of common-sense. If a man expressed his intention of leaving his money in a certain way, and if it was not contrary to nature, and if it was, in fact, in accordance with nature, why should he not have power to leave it in that way because he was in ill health, because he was sick? If the will was in accordance with the previously expressed intention of the testator, it was merely the carrying out of a resolution come to while the patient was in health, not an insane act at all. With regard to the state of the brain, it varied very much. In those cases to which reference had been made, he believed the disturbance was not structural in the first instance. In the early stage, a person might have paralytic attacks, for a time longer or shorter, and so persons in the early stage of general paralysis might manifest lucidity and coherence and yet not be cured or curable. Structural disease constituted the essence of general paralysis; and in those cases he would look on them very much as general paralytics. In the later stages, there could be no doubt the patient was really incompetent for any effort of thought.

Dr. CLOUSTON asked Dr Skae whether he had many cases in which the patients had been sent into the asylum at first as ordinary cases of acute mania, with all the symptoms of acute mania, and none of the symptoms of paralysis, where they had appeared as if they had quite recovered for a few months, and then returned to the asylum general paralytics. He knew of one such case, in which the man seemed quite well and returned to his work, and yet suffered a relapse of this nature. He was glad that Dr. Howden had brought forward general paralysis as a sort of test disease, with regard to which they could express their opinion as to the testamentary capacity, because in none of the forms of insanity did they know the morbid anatomy so well as in general paralysis. He thought that in general paralysis, where the disease was determined, that a man could not make a will. Could they allow that a patient, the structure of whose brain was diseased, if they agreed that the cortical structure of the brain was the organ of the mind, could in these circumstances make a will? Dr. Skae mentioned that in cases of remission of general paralysis, the patients manifested a want of power, a want of elasticity, a want of the originating capacity of the mind. If a man in that state was making a will, could it be held that he was mentally perfectly healthy?

Dr. SKAE, in reply to Dr. Clouston's question as to attacks of acute mania, said he had seen several cases such as he described. The first case that occurred to him was that of a clergyman, who was in Dumfries Asylum under acute mania, and who was discharged distinctly cured. Within a few weeks afterwards he was brought to him with all the symptoms of general paralysis well manifested. His case ran the general course, and he died within a year. To illustrate what he meant by those intervals when the general paralytic was apparently cured, he might refer to one or two cases. He had under his care some time since an officer who had just come from India. His father was a distinguished clergyman, and his brother a distinguished medical man. He was placed under his charge a pronounced case of general paralysis. In a few months he was returned to his friends, who insisted that he was perfectly well. He (Dr. Skae) said that he was not. He exhibited a want of activity of mind, a want of the power of originating thought; but in all the ordinary conventionalities of life he conducted himself like anybody else. He went to live at Portobello, and subsequently he went to travel. His wife and father came to him and showed him his letters, asking, "Is there now any evidence of insanity in that letter? Is it not perfectly rational?" He said, "Let me read it." He accordingly read the letter, and found that the gentleman had been to see some park in the neighbourhood of London—the trees were magnificent, the walks were so fine, the park so splendid. All these expressions went through it; and though

none of the friends noticed this it was patent to him. A short time afterwards the gentleman came back to Edinburgh, and one day he went over to Burntisland with his wife, and between that place and Aberdour he lost his keys. He returned to seek them; but previously his brother remarked, "Give him a memorandum of the places where he is to inquire," and all the while they believed he was quite as well as he had ever been in his life, yet they never would have acted towards him in that way before, showing that they admitted a certain amount of weakness. In all these cases where recovery was supposed to have taken place, there was apparent weakness of the mind, but not to ordinary observers. He therefore thought that a will not in accordance with the previously expressed intentions of the individual was not a rational will, and ought to be set aside, as the person was not capable of making it in these circumstances.

Dr. A. R. ROBERTSON read a paper on Boarding the Insane in Private Licensed Houses.

The CHAIRMAN said this was a very interesting paper; brief and forcible, saying much in little. There was a good deal of agitation at present in the public mind as to the building of Lunatic Asylums, and in connection with this subject he directed the attention of members to an interesting article in the current number of the "Edinburgh Review." It was headed "Restraint or no Restraint;" but it discussed the question of the general management of Asylums. It was especially strong as to the great number of persons who had been put into lunatic asylums, who might be boarded out, at all events to the extent Dr. Robertson had stated. It was a subject which was peculiarly Scotch in the history of psychological medicine in this country. Various authorities had taken up the Gheel system of Scotland, but the Scotch system was a considerable improvement upon the system so-called.

Dr. TUKE said he was entirely at one with Dr. Robertson on the importance of boarding out patients in private dwelling-houses. He had taken a considerable amount of interest in this matter, and he intended to test it practically very shortly in the neighbourhood of his own asylum. From the remarks Dr. Robertson had made he felt more than ever convinced that what he himself proposed in a paper read before the late meeting in Edinburgh was a correct suggestion, namely, that the care of the patients boarded out in private houses should be put more immediately under the care of the superintendent of the County Asylum. He believed the great success Dr. Robertson had attained was very much due to the interest he had taken in the organization, carrying out, and supervision of the scheme. The objection he (Dr. Tuke) put forward in his paper was that the supervision was not sufficient; but in the colony Dr. Robertson spoke of, the supervision was exactly double what it was in the insane colony in Fife. Dr. Robertson mentioned that two visits were made by the Deputy-Commissioner every year, while in Fifeshire there was only one visit, and he believed there had been no visit made by members of the general Board for a considerable time. He was convinced that this was the system by which (if improved) they were to prevent the overgrowth of asylums; it was a system which must come into very general force in Scotland, and one from which great benefit would be derived; but there must be thorough organisation, and the superintendents of district asylums must obtain very much the powers at present possessed by the Deputy-Inspectors of Lunacy.

Dr. HOWDEN thought superintendents of lunatic asylums should take a leaf out of Dr. Robertson's book, and endeavour to increase the accommodation in their houses in that way. He thought, however, that of the number of cases that were actually in the asylums there were not very many that were suitable or fit for being boarded out in the way Dr. Robertson had adopted. That at least had been his own experience. He had always wished to adopt that system, but he could not get suitable cases to send out.

Dr. MACKINTOSH said he very much approved of Dr. Robertson's paper. He assisted him a little in carrying out the system which he had described, and he hoped the Parochial Boards would prosecute it still further. They would thus effect a saving to the ratepayers, and conduce to the benefit of a certain class of patients. He thought the system would prove quite successful in Scotland, and if it proved successful here he did not see why it should not be equally so in England, thus relieving the overgrown asylums of that country. He quite agreed with Dr. Tuke, that the superintendents of districts asylums should have very considerable powers in looking after the patients who were boarded out, as well as the parochial surgeons.

Dr. TUKE said as to the matter of expense the adoption of this system would effect

a great saving in building alone. Then £19 a year was the cost to the Glasgow parish for the maintenance of their patients. In the asylum with which he was connected the charge was £24, but the rate was being gradually lowered, and he believed in a few years they would be able to reduce it to £20. There was one item which Dr. Robertson had forgotten to include in the charges, probably because it did not come upon the parishes, namely the charge for visitation. The Deputy-Commissioner had £1,200 a year. There were other expenses amounting to about £800, making in all £2,000 a year, or about 24s. for each visit to every lunatic boarded out.

Dr. SIBBALD said that in the county of Argyll it would be quite impossible for the medical superintendent to take an interest in the outlying lunatics.

Dr. TUKE—It may be so at present, but as the scheme becomes developed it may be that the patients may be congregated in cottages near the asylum. In certain counties it might not be found suitable, and it may be that Argyllshire might be one of the exceptions, but that should be no objection against the adoption of the system in districts where it is found possible to carry it out.

Dr. HOWDEN said that in comparing the cost of maintenance it was scarcely fair to take the average rate in asylums. That rate was of course struck upon the total cost of the inmates of an asylum, and he did not believe that it cost 19s. a year to keep an imbecile patient, whereas many of the patients might cost four times that amount. If they removed the quieter patients from the asylums they would just make it more expensive to keep those who were violent,

Dr. HUGH THOMSON said he had had much pleasure in being present at the meeting of the Association that day, and he had to thank the members for giving the fellows of the faculty the privilege of attending. He had listened with great pleasure to many of the remarks that had been made. This paper of Dr. Robertson's opened up a little of the question of the treatment of the poor generally. Of course a lunatic patient, although he went to the Asylum, must be treated in the same way as any other pauper. It therefore came to be a question whether, seeing that Asylums had been erected for the treatment of the insane poor, it would be any economy to board out these patients; for, as Dr. Howden had well said, those who were merely imbecile did not require the same care and superintendence as the others, nor the same expense, and that should be taken into account. He would not put too much reliance on the statements of patients as to the way in which they had been treated. There were some cases which he had himself observed in which patients stood in considerable awe of those having charge of them. They were very reluctant to state anything that would be objectionable to those parties (hear, hear). He knew of one person who was boarded in that way in a house in the country. She was very fond of getting food at any time when it could be given to her, but she always pretended, before the people who kept her, that she got plenty. If her friends came about she never said a word against those with whom she lived, but to his own servant she declaimed against them. He did not, therefore, think that much reliance was to be placed on what these poor people might say as to the way in which they were treated.

Dr. ROBERTSON in replying remarked, with regard to the expenses of the Deputy Commissioners in Lunacy, that it was well known that a large number of the insane were boarded throughout the country. Some of those, of whom he himself knew, had not been sent from the Asylums. Of course it was the duty of the Deputy Commissioner to visit these patients, and it would not be any additional expense to visit the others at the same time. As to Dr. Thomson's remarks about the feeling of awe in which the patients stood of their guardians, he mentioned that it was the practice of the Visitors to send the guardians out of the room when they asked the patients about the food and the general treatment they received.

The CHAIRMAN said the only point which it occurred to him to notice was the utilisation of the labour of these poor people. He feared it was in some degree slavery. This was a hard term to use, but they were subjected to their guardians to such an extent as to justify it. These persons might be well selected, but they knew well what a tendency there was in the human mind to develope itself in the direction of power; and unless there was very strict supervision over those guardians there was a danger that the stronger man would oppress the weaker. At the same time, this manifest weak point in the system only required to be fortified by careful supervision and by the careful selection of suitable persons to take care of these poor people.

Dr. CLOUSTON read a paper on "Two Cases of Rheumatic Insanity." *(See Original Articles.)*

The CHAIRMAN said he had listened to Dr. Clouston's paper with great interest, although he differed from him on some of the points which he had brought forward. He differed in opinion very much as to the phraseology Dr. Clouston used. He spoke of rheumatism being a cause of insanity; now he could not realise what he meant by such language. He also said something about rheumatic poison in the blood, which he supposed was synonymous with rheumatism being the cause of insanity. It might not perhaps be unknown to Dr. Clouston and other members that some newer views about rheumatism were current. At all events in his (the Chairman's) own class and in his own teaching he had given up the theory of a rheumatic poison altogether. He thought it was one of those theories which, current for a time, was useful for hanging facts upon, but which, when it had done its work, was like all other used-up things, consigned to the limbo of useless crotchets. What struck him, however, as so interesting in Dr. Clouston's paper was its bearing upon those newer theories about rheumatism—namely, that rheumatism was essentially a disease of the nervous system, not of the blood at all. What Dr. Clouston said about the rheumatic poison being carried from one part of the system to another, was a pure delusion of the scientific mind. There was no poison carried from one part of the system to the other. There was not the slightest proof that this took place, and he said this after the most careful consideration of the theory. He himself used to teach that theory. Dr. Clouston might have heard him do so; but when he found it untenable and intolerable he had dispensed with it. Now the whole of the facts which Dr. Clouston's paper illustrated pointed to this—that the disease of the system termed rheumatism changed the nutrition of certain tissues. Dr. Clouston spoke of the connective tissues. Now this was one of the serous fibrous tissues which were very emphatically affected in rheumatism; so that what was called rheumatism was connected with two great effects—changes in the nervous system and changes in certain tissues. Now these changes in the nervous system lay at the root of these changes in the tissues; and all the symptoms which Dr. Clouston described depended upon these changes. The only question that arose in his mind was, what particular tissues in the brain and nerve centre—what particular portions of the brain—were involved in those two cases which had been brought before them; in other words, what part of the nervous system was affected in that part of the case in which there were rheumatic symptoms proper. They found that there was no disease of the heart, and this fact set aside the theory, which he believed was a very limited one, which attributed choreic movement to rheumatism. He thought Dr. Clouston's paper was satisfactory on this point. This was the conclusion to which he had come, and to which anybody would come from the investigation of cases of *chorea* (?). He had had cases of chorea from fright, without any disease of the heart; indeed, the most common cause of this disease was fear of danger to the person, when there was no disease of the heart whatever; and so they might set aside that theory as perfectly insufficient. The question then came to be, what was the cause? Dr. Clouston thought some inflammation of the connective tissue. Now, that was the old theory of cerebral affection connected with rheumatism of the membranes. But that did not satisfy the requirements of the problem. It did not satisfy them as to the interaction of the symptoms, showing the relation of the symptoms to each other. Before they could determine what particular tissue was affected they must be able to determine what particular portion of the cerebral spinal centre was affected. Now, he did not gather that Dr. Clouston gave any indication as to the localisation of the choreic movement. Defective nutrition was shown by the sloughing and all these symptoms, but the particular part affected was not noticed, and Dr. Clouston, with his acute powers of observation, might be able to throw some light upon the subject if he turned his attention to it.

Dr. TUKE said he had listened to Dr. Clouston's paper with great interest, more especially as he thought he had got upon the right course for tracing the cause of rheumatic insanity. He was much delighted when he found that Dr. Clouston recapitulated the symptoms of such cases as described by Sander.

Dr. SIBBALD said he was more than delighted to hear Dr. Clouston's paper and Dr. Tuke's remarks. If he did not mistake, he referred to Dr. Sander, of Berlin. He himself happened to have seen one of the cases that Dr. Sander described; and while Dr. Clouston was reading the report of his male case, he found that it corresponded almost exactly to the case which he saw in Berlin, and which he watched for about a month in 1867. He rose, however, at present, more for the purpose of expressing his delight at finding a case of insanity described so thoroughly as an

ordinary case of disease would be described, and at finding that the mental symptoms in the case were put in their proper places. The different disorders of the functions of the brain were placed in the same way as one would expect any pathological theory to place them. They were placed on the same level with disorders of the functions of the other organs. It was very seldom that they had the diseases involving insanity described in such a thoroughly scientific manner, that he wished to express his delight at hearing Dr. Clouston's paper.

Dr. SKAE concurred in all that had been said with regard to the admirable paper which had been read by Dr. Clouston. Nothing could exceed the excellent manner in which it was drawn up, and the careful observation which it evinced. In every respect it was a most instructive and suggestive paper. He quite agreed with Dr. Clouston in calling those cases which he described cases of rheumatic insanity, although he did not think that name involved the theories to which the President referred. There was only one other point to which he would refer, namely, the use of chloral in one of these cases. He had known of several cases of chorea in which chloral acted as a very charm, seeming to subdue the symptoms instantly.

Dr. CLOUSTON said he supposed it was a received axiom in medicine that hypothesis was only a stepping stone, and notwithstanding the remarks of the President, he was not yet convinced that the humoural hypothesis of rheumatism was not the more useful one; he did not say that it was the true one. At the same time they had certain facts to go on. Although he was sorry to differ from the President in opinion, he did not think he had brought forward a sufficient number of facts to support his theory. In regard to localisation, if there was one thing more than another that struck him in these cases, it was the universal affection of the cerebral and spinal centres. Every function that they knew was affected.

Dr. J. BATTY TUKE read a paper on "The Classification of Mental Diseases on a Pathological Basis." *(See Part I. Original Articles.)*

The CHAIRMAN thought Dr. Tuke was a very bold man to take up this subject at all, for he did not know a more difficult or a more impracticable one. He had himself attempted, though Dr. Tuke did not seem to be aware of the fact, a classification of insanity.

Dr. TUKE said he was quite aware of it.

The CHAIRMAN continued that he had in short attempted three classifications, and therefore he spoke with some experience on the subject. What they wanted in classification was a series of general terms which expressed proved facts. Now Dr. Skae had alighted on a very practical classification—the etiological. But then when they came to look at Dr. Skae's classification, they found that important facts were left out, and left out without any regard to any principle that he could see. For example they had nymphomania, which was a particular mental condition in which individuals had an impulse leading them to desire sexual intercourse; then there was kleptomania, an impulse to appropriate the property of others. If they adopted a classification of that kind, then Dr. Skae's was quite incomplete. Then he did not see melancholia throughout the whole of that classification, and yet it was one of the most common forms of insanity. Everybody knew what melancholia was. In Dr. Clouston's time he thought they had melancholia as indicating a certain condition of the brain, generally associated with certain mental states, as insanity by lactation for example.

The PRESIDENT thereafter went on to say that he agreed with Dr. Tuke's classification under the first head. It was good so far as it went; but in such a classification they should develope hereditary tendency, degeneration of the brain, and general manifestation of morbid instincts. Take the case of the boy Baker, who took a child into a wood, cut it to pieces, and made an entry in his note-book—"Killed a little girl; weather fine and hot." Under what heading would that form of insanity be classified by their two philosophers?

Dr. TUKE I had not the pleasure of Baker's acquaintance; but very likely it was a case of insanity of pubescence.

The CHAIRMAN said the lad Baker was, no doubt, of a certain age, but there were thousands of individuals who came to the age of 18 who did not commit such acts.

Dr. HOWDEN—But are they insane?

The CHAIRMAN said, of course, that might be a question; but whether they were insane or not, a classification of insanity should in some degree explain these cases. It was not customary for a man of 17 or 18 to make an entry in his note-book—"Killed a little girl; weather fine and hot." There must be some abnormal con-

dition connected with the commission of such an act. He believed such cases were accounted for by hereditary tendency or defective nutrition of the brain.

Dr. SKAE.—It is predisposition in that case.

The CHAIRMAN said when they came to look at causation, they must include all causes, and it was a well-known fact there was no one cause for disease, therefore any classification which was founded on any one cause must be defective. There was no disease of which he knew that could be attributed to one cause. There were predisposing causes; for instance, long lactation was an exceedingly common cause of insanity in a person predisposed to disease. This was so important that he thought no classification could be perfect without such a heading. Passing over sympathetic insanity, about which he had not much to say, except that the same objection applied to it that applied to the former section, he came to diathetic insanity. This classification was good so far as it went. There were various forms of insanity associated with that department. There was also syphilitic insanity. There was no doubt that persons were insane from syphilitic disease of the brain, but such cases were rare; accordingly, this form had not been so well observed as it should have been. Then there was metastatic insanity, and there was the very ancient insanity of the healing of old ulcers. Dr. Tuke would excuse him quizzing him a little on this last form. He did not know that he would allow this as a cause of insanity. He thought they would all admit that the healing of an ulcer which was associated with a change in the nervous system, was dependent on some other condition, and it was the effect of the same condition which induced insanity. It was true that this classification expressed a fact. It was true that after the healing of ulcers certain diseases had been known to be set up. But what he ventured to question was, the relation between the healing of the ulcer and the insanity. He thought they did not stand in the relation of cause and effect, but concurrently with the outward illustration a change took place in the nutrition of the nervous system. Then alcoholism was not a sufficiently discriminating classification. It was not a scientific term. Nobody drank alcohol, but alcohol mixed in some way—in beer, for instance. Now the insanity that was often attributed to beer was really attributable to the poison in the beer, such as nux vomica and belladonna. He mentioned this because they were adopting the popular phraseology, when they should deal with these matters with strict attention to the facts. Of late there had been great adulteration of fermented drinks, and he thought that had tended to insanity more than the alcohol that was in these liquors. Beer was a wholesome drink, let the teetotallers say what they would, but for the nux vomica, belladonna, and strychnine that was put into it. He ventured to put forward these few remarks on a subject that would engage the attention of psychologists for the next half century, with little better result than Dr. Tuke, whose paper showed a great deal of ingenuity and a great deal of painstaking, and if he had succeeded no better than those he criticised, it was because the subject was an impracticable one.

Dr. HOWDEN wished to know on what authority Dr. Tuke made the statement that the proportion of recovery was the same under the old system of restraint as it was now.

Dr. TUKE - I don't think that I said so. I said "it is said that it was," and I have not been able to disprove it.

Dr. SKAE said he believed the proportion was now 34, as against 26 per cent. in the earliest statistics they possessed.

Dr. HOWDEN said there was another thing which would tend to reduce the proportion of recoveries now, namely, that there were a larger number of incurable patients in the asylums.

Dr. SIBBALD—And also of the curable.

Dr. CLOUSTON said he had listened with great pleasure to Dr. Tuke's most able, ingenious, and well-written paper. He was sorry, however, to say that he could not agree with his principle of classification. He thought in the first place that he started with a fallacy. He could not have drawn up such a classification except he had started upon the hypothesis that insanity was a symptom. Now insanity was not a symptom as they treated it. As they treated it, a great many of the diseases he had spoken of in his paper were not symptoms, they were diseases. His (Dr. Clouston's) motion about classification was that it was only a means for bringing together a certain number of cases that had a real affinity with each other. Pinel saw that there were certain cases in which there existed a certain amount of depression and enfeeblement, and therefore he classified them under the name of dementia and melancholia. This was a classification by symptomatology, the best that had

ever been brought out. Skae's classification was the one next. Skae's idea was causation, and accordingly his cases were classified in that form. That also was very important, and marked an advance in their specialty. Certain French observers had the good luck to find out that in certain cases of insanity they could lay their finger on a particular portion of the brain as the diseased part. He thought the most philosophical classification to adopt would be to say that they had certain classes of insanity which were well known. They had general paralysis, general paresis (?), they had a certain sort of spinal (?) insanity, they had insanity on account of degeneration of the arteries, and he hoped it would be found that rheumatic insanity consisted of a certain pathological condition of the nervous system. They could thus get a very general classification. The next best thing they could do was to sort up their knowledge of these cases for practical purposes into these groups. They were not really classifications, for they did not represent pathological entities, and therefore they did not deserve that title.

Dr. SKAE said he thought a mistake had been made by Dr. Tuke as to his classification. It was founded on an etiological basis. What he sought in his paper was to point at natural groups. They were founded on causation, but not on that alone. He described climacteric mania. He did not say that that was the cause of insanity; but at that particular period of the life of the female, insanity occurred which ran its natural course, and they had just to look for the symptoms. It was the same with many other causes of insanity. He could tell a case of puerperal mania the moment he saw it. He did not mean to say what caused puerperal insanity, but where it occurred there must be predisposition. He believed that predisposition existed in every case of insanity. No remarks occurred to him with regard to Dr. Tuke's re-arrangement of his classification. It would require consideration, but it seemed to be very good. He agreed with Dr. Clouston that they could only arrange those forms of insanity he had mentioned in certain groups or natural families. He did not think that they would gain much by dividing them into seven different classes.

Dr. SIBBALD said he had listened to Dr. Tuke's paper with great interest, the more so that he had recently been paying considerable attention to the classification of insanity. He had begun from various points six elaborate classifications, none of which, he was happy to say, were published (a laugh); and he was coming gradually to the conclusion that Dr. Skae's classification was the only one that came anything near the truth. He did not think it was a good classification (a laugh). Dr. Skae, he believed, did not consider it good himself; but he thought it was the most practicable classification we had yet got. The practical point for the profession was this. They got such a description as Dr. Clouston gave them of his rheumatic insanity. That showed them a pathological entity. They did not mind what the classification was, they had got a disease. They had got at something of which, as Dr. Skae very properly expressed it, they could give the natural history. Then they found some other form of insanity, such as puerperal mania in its typical form. They could recognise that, and so they took it and lifted it out of the general mass of unclassified insanity. In that way they must go on picking disease after disease out of the unknown heap until they got the whole arranged.

Dr. TUKE said there was a general mistake, as Dr. Skae himself had said, as to the principle of Dr. Skae's classification of causation. His general principle was to take a certain series of symptoms and put them in certain classes.

Dr. SKAE—No, quite the reverse of that. I take a case which is connected with some physical cause, such as tuberculosis or rheumatism. If you examine the symptoms in these cases you will find that they form themselves into natural groups. I attach these to a physical cause, such for instance as the period of life.

Dr. TUKE—But you take the symptoms as the grouping principle?

Dr. SKAE—No, I find these as the result.

Dr. TUKE went on to say that Dr. Laycock objected to certain groups, such as the insanity of pubescence, syphilitic insanity, and the insanity of tuberculosis. His great objection to the insanity of pubescence seemed to be that all young men were not insane. That objection would apply equally strongly to syphilitic and rheumatic insanity, for they knew that all syphilitic and rheumatic people were not insane either.

Dr. SIBBALD read a paper on "Clinical Instruction in Insanity."

Dr. WOOD, Durham, said he might mention that a special course of lectures on insanity had been given in the burgh asylum, Newcastle-on-Tyne, by Dr. Grainger

Stewart. His classes were not largely attended, but his lectures were given regularly once a week. These lectures were originated he believed by Dr. Crichton Browne, and had been carried on by his successor.

The CHAIRMAN said Dr. Crichton Browne had also done good work at Leeds, and he likewise gave a course of lectures at Wakefield. Then he saw that Dr. Davy, a member of the Association, gave a course of lectures at Bristol, and Dr. Jameson told him that he gave a course of lectures at Aberdeen, but he could not say whether they were still continued. A course of lectures was also given at Cambridge in connection with the county asylum. He was not sure if the latter were continued, but they were announced a year or two ago.

Dr. SIBBALD said his statement with regard to the class at Aberdeen was taken from a letter from Dr. Jameson.

Dr. ROBERTSON said that about eight or ten years ago Dr. Mackintosh proposed to give a course of lectures; but in consequence of the distance of Gartnavel from the schools of medicine he believed the class was never instituted.

The CHAIRMAN said Dr. Sibbald had placed the whole subject of clinical instruction in insanity very lucidly before the Association, and he hoped he would in some way or other make his views public, so that they might be brought under the notice of the authorities of the Edinburgh and Glasgow University. He understood that a clinical hospital was to be built in connection with the University of Glasgow, and he hoped this subject might be included. As the result of experience as a teacher of the practice of medicine, and also of this particular department, he testified to the importance of Dr. Sibbald's suggestions. He took his class every year to the asylum. Dr. Grierson very kindly placed at his disposal the use of Millholm Asylum, where they saw a number of chronic cases sufficiently varied to illustrate all the leading forms of insanity. The difficulty he experienced was in regard to the treatment; but Dr. Grierson was kind enough, when any acute case came in, to bring it under the notice of the class. They had a consultation as to the treatment to be adopted. That treatment was adopted accordingly, and the class had the opportunity of seeing the result. These were mere chance cases, however, as the visits were only made once a week; and the particular state of the patient, which it was important that the general practitioner should know, was not brought under the notice of the student. The Chairman went on to say that there were certain things wanted for the encouragement of clinical teaching. He could do very well without an asylum if he could only get a class of zealous students. It was not so much in the tools with which a workman wrought as in the efficiency with which he used them that his success lay. A great deal might be learnt in an asylum, but still more might be learned in the way which Dr. Sibbald pointed out. Since the publication of Sir James Clarke's book attention had been called to the state of asylums, and certain hard things had been said about the superintendents, about their limited views of their specialty, and about their being hardly acquainted with the general practice of medicine. Some of these things perhaps were hardly true; his own impression was that they were seriously unjust; but it was a great defect that the practice of medicine was separated from the practice of insanity. When he gathered a class about him, and attempted to point out the great importance of a knowledge of this subject, the answer was that they had no idea of becoming superintendents of asylums. It was difficult to impress students that the treatment of insanity was a part of the practice of medicine; that cases of insanity would occur in their practice that might influence their success and reputation to a greater extent than they had any reason to think. It was difficult to impress this upon the minds of students, because the medical authorities of schools and colleges had no knowledge of the subject. He knew a gentleman of great eminence, who declared in his own hearing that melancholia was not a disease at all, that it was a mere depression of the spirits which any one might suffer from. He had already referred to an article in the "Edinburgh Review" on this subject, and one of the points which the writer dwelt upon was the necessity for the general practitioner becoming acquainted with the diagnosis of insanity, with the express view of preventing the agglomeration of lunatics in asylums. He was glad that so influential a journal as the "Edinburgh Review" had taken up this subject. He hoped that public feeling would be stirred on the subject, and that they would live to see a great change in this respect.

The reading of this paper exhausted the business on the programme, and a vote of thanks having been awarded to the Chairman, the meeting separated.

The Members dined with Dr. Mackintosh, of Gartnavel, at the George Hotel.