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

https://doi.org/10.1192/bjp.32.138.296 Published online by Cambridge University Press

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.