respectable and educated life," have been merged in this eulogy—"very few have expended with such studious selection of purpose, such energetic and self-denying devotion, a sum which has amounted to at least £200,000." A member of an old family, and connected with many counties, his charities were given on a broad principle, for his countrymen; were bestowed in his lifetime for the purposes he wished to advance.

Much was given to the great Clerical Societies; his donations to the Queen's College and Hospital at Birmingham, denoted his christian anxiety for the encouragement of true knowledge. The sympathy of the man for the most neglected and distressing conditions of human nature was manifested in the gifts of which the Warneford Asylum records the receipt. It is thus stated in the report of 1853.

"The successive grants of real and personal property by the Rev. Dr. Samuel Wilson Warneford, in aid of poor patients from respectable and educated life, (besides his original contributions to the edifice, and subsequent advances, from time to time, for completing the wings of the asylum, the Warneford galleries, and the chapel, and enclosing the premises by a stone wall, and for other works.)

	£	s.	d.
Dec. 1853—Interest (Property Tax deducted) upon a mortgage of £4000, held by the Rev. Dr. S. Wilson Warneford upon an estate in Gloucestershire, and by him granted to the charity in 1838 . .	155	6	8
July 1853.—Rents (all charges being deducted) of the farms, &c., of the Broad Estate, Hellingley, Sussex, which estate was granted to this charity by Dr. Warneford 1843	728	3	5
July 1853.—Rents (all charges being deducted) of various lands and tenements in London, Middlesex, and elsewhere, granted to this charity by Dr. Warneford 1852 .	546	7	2
	£1429	17	3

It is currently stated that the income of which the donor deprived himself, by these contributions, would be equivalent to £2000 per annum. At this time the annual receipts derived from his endowments are nearly equal to the payments made by friends for patients in the asylum. In the year 1853, the asylum had not at any time 50 patients resident. The maintenance cost amounted to £2,350. The payments for patients, and the voluntary contributions amounted to about £2600. The rents and interest of the Warneford endowments amounted to £1,429 additional. Little need be said of the claim to the title of patron to the asylum. A statue of the benefactor, a fine work of art by Peter Hollins, sculptor, is placed in the chapel of the asylum.

Si monumentum quæris circumspice!—The asylum needs to be made a fitting receptacle and administrator of such charity. Built nearly 30 years ago, and of comparatively small dimensions, it will not bear comparison with those of recent construction. It cannot command the warm, airy, and equal temperatured exercise galleries, the competent and habituated nursing of many hands, the evenness of management, or the many other comforts which improved architectural arrangement, space, and a sufficient staff afford in the more modern asylums. Such benevolence as Dr. Warnefords asks that it should be afforded to the greatest number of the objects, for whom it was given, to whom it can be efficiently supplied. The monument to his memory should be a building adequate to the reception of such numbers as would display the magnificence of his charity; and an economy by which such numbers could be adequately maintained.

To the Editor of the Asylum Journal.

Dear Sir,—For Dr. Conolly's liberal expressions regarding myself and the institution which I serve (in your last number, page 148), I have only to be grateful. But in the same paragraph, he describes my practice as "an additional example of an adherence to the old ways," in the matter of restraint. He thus mixes me a dose of bitter-sweet which I decidedly object to swallow. I must, if needful, resign the sweet to avoid the bitter, which is presented in the shape of an unfair parallel, which view of the matter I will, with your permission, endeavour to make plain in a few words.

In the first place, Dr. Conolly's remarks upon my Reports immediately follow his animadversions on the practice and principle of restraining in the Yorkshire Asylum for the North and East Ridings. This would be of no importance if Dr. Conolly had not himself described my use of restraint as "an *additional* example of an adherence to the old ways;" which being interpreted means, the North and East Ridings' presents one and the Kent Asylum another example of that adherence.

That the word "additional" is incorrect, is, I think, capable of being well sustained by simply opposing different parts of Dr. Conolly's notice, in the same article. Thus, in the first column of p. 148, he says, in reference to the Yorkshire Asylum, "that fifteen years after the total abolition of restraint from the largest asylums in this country, the ancient restraint should be resorted to in every difficulty; to prevent suicide which it cannot prevent; to control destructive tendencies which it cannot remove; and above all, to tranquillise the dangerous, is a matter of astonishment and sorrow." Contrast this with what follows, taken from the first column of the next page (p. 149), "Dr. Huxley anxiously explains that he has never used restraints to prevent violence to others, or, the destruction of property, finding temporary seclusion sufficient to meet such cases; and he distinctly says, 'notwithstanding the exceptions which have annually been detailed, the system of non-restraint has been uniformly, if not universally, pursued and upheld in this asylum, with the same delightful effects on the moral state, domestic love and intercourse prevailing amongst the patients, and between them and the officers and servants, as have happily followed its adoption in other asylums.'"

Nevertheless Dr. Conolly overlooks the antipodal difference between the two systems, and finds himself able to call the latter an additional example of the former.

Mr. Hill explains, that restraint is necessary and something more, to control mischief and violence. I explain, that I have never used it for this purpose, and find temporary seclusion sufficient against them.

But, the grievance of being placed by Dr. Conolly's words in a wrong category, is not all my complaint. The assumption of an adherence on my part to the "old ways," because I resort to a certain kind of restraining, is capable of being refuted to the satisfaction of any impartial person. Although I never saw an instance of restraining in the old way (reform in that important particular having been effectively introduced into the public asylum with which I was first connected before I joined it), I have gathered a sufficient idea of its nature from abundant printed descriptions. And I know enough, therefore, of the old ways to enable me to declare, that between them and my practices there is nothing in common. Would it be just for me to say, because under non-restraint (called entire) boots and clothes are locked on, and remembering that limbs were locked too, in the days of restraint, that the former practice exemplifies adherence to the latter, because each has its lock? Surely this would be extremely wrong.

After all, do not the kinds of restraints used, the objects held in view, and the feelings actuating those who did and those who do use them, constitute the real difference between past and present systems; rather than the circumstance of including, or excluding this, or that, subordinate item in the wide course of treatment required in insanity? For, if this be denied, and the attempt to hold a separate way be carried to its logical ending, what will the *soi-disant* utter abolitionist do with the four walls, locked doors, clothing, &c., which are necessary to his, as to every other system?

My report, which is the basis of Dr. Conolly's remarks, makes it plain that except for surgical purpose, or, the prevention of self-injury, I have not used restraint otherwise than as I would use morphia, henbane, &c., viz: for the sake of an anticipated medical benefit. Dr. Conolly not only fails to recognise this important distinction in my favour but, also, to note the small extent to which I have suffered myself to use restraining even for a medical purpose. He further abstains from noticing the want of evidence as to "these exceptions growing into a rule," whilst he thinks it necessary to administer a caution against the "great danger" of such growth. I have never felt, and do not believe in this danger.

Now, the extent of restraining is a very important matter. The whole question of its abuse will lie in too great extent, until every atom of restraint may have been proved to be in itself abuse. It is the extent when too great, and the inducement when not sufficiently weighty that, alone, can propagate a bad moral effect, whence may spring harshness, uncleanliness, and general neglect. But fellow-patients and attendants are as capable of understanding and being influenced by the sight of restraining for one purpose as for another. If the former have been intimidated and the latter brutalised (as are doubtless true) by witnessing and practising restraining for the mere purpose of coercing the violent and disorderly, they may with equal justice be deemed capable of appreciating in a general, although not in a medical sense, some obviously appropriate recourse thereto, in its innocuous adaptation to distresses which they see and know to have resisted all other efforts at their alleviation. We can look on at a painful surgical operation without a doubt of its propriety and with sympathy for the patient; but without thinking it may be our turn next to submit our flesh to the knife. Could I be assured that only one instance demanding restraint would, hereafter, be presented to me for treatment, I should hold myself no more at liberty to abjure the practice of restraining with the effect of depriving myself of entire freedom of action, at the possible expense of the patient, than if I were sure of meeting with a thousand cases in which, to the best of my judgment, that practice might be beneficial and, therefore, necessary. People do not shoot themselves or others, only because they keep firearms in the house. But when they encounter a burglar in the act, the case is different, and so, also, should be the treatment. And perhaps it has been fortunate for many a man who has met a burglar in his house, and who has had a pistol within reach, that he had not incontinently foresworn the use of firearms under any circumstance whatever.

Two or three other points in Dr. Conolly's remarks demand notice. In reference to my reported case, wherein the patient had endeavoured to bite off one of his fingers, but was prevented by the imposition of gloves after he had inflicted considerable injury, he says, "some active medical treatment might, however, have removed the temporary propensity to mutilate the hands"—and active medical treatment *was* steadily pursued after, as it had been before, the injury; with a view to remove the inclination to mutilate and to relieve the maniacal symptoms generally; but without success. Yet, after a few days, the gloves were continued far less as a preventive against fresh attempts at mutilation, than as an indispensable surgical protection to the wound, from the patient's interference, his indifference to and restless conduct of the limb. Every day the wound was dressed in opposition to the most strenuous resistance, and the patient in nowise spared the injured hand as an instrument of violence and gesticulation.

In remarking on my case of melancholia, in which enforced recumbency seemed of so much benefit, Dr. Conolly says—"I think I have known numerous cases of this kind, in which the difficulties were overcome without restraints being applied."

Allow me to say that I, also, have known many, of the same kind, but not of the same intensity, in which the difficulties *were* overcome without restraints. I merely reported an extreme instance which had baffled all our other means and in which restraints, the last resource, showed indubitable power in prolonging life. I could not have entertained the possibility of further existence, in this case, during only two days more, when the restraint was employed; but the patient lived fourteen days. And, although it is impossible to say, she would not have lived during this period, under any, or, no treatment; it is wholly incredible that she could have so lived in the absence of that general, physical improvement which was so strikingly mani-

fested after the first night passed under restraint. Nor was it possible for me to disconnect the improvement and the only ostensible means thereof, from the relationship of cause and effect. If I could have procured lying down by any other means than that used, all may believe that I would not have resorted to restraint. But when life is flickering in the wasted body and a single thing seems possessed of the nature of a remedy, it is not a time to be bound by any restrictive, foregone conclusion (however meritorious that might be, as long as practicable and entailing no risk); it is, however, the time to sacrifice every private wish to the safety of the patient.

Dr. Conolly proceeds to speak of the success which in similar cases, had attended the application of a blister behind the neck, the use of a tepid shower bath, not too violent, sedative medicines, variously prepared food, and very patient persuasion. The blister I will try willingly, next time, on his recommendation. But on what ground of professional reasoning is blistering to afford relief in these cases? Have we deep seated congestion, calling for counter-irritation or local depletion; or is the blister to act as a stimulating irritant? The blue skin, sluggish circulation, and general coldness of surface, the injected conjunctivæ, the œdematous ankles and feet, seem to me to offer no evidence of congestion within the skull, but rather the opposite state, and to tell their history thus: first, cerebral energy was reduced by an ever present idea, exciting terror and banishing sleep; next, the heart, participating in this reduction, and soon further enfeebled by the want of healthy blood (due to the same cause as the emaciation), failed, to a great extent, in carrying on the circulation; and, last, the consequent absence of the due movement and supply of blood—healthy blood—in the brain, reacted on that organ, largely hastening the exhaustion. What is the first thing necessary to the relief of a heart labouring, not with too much blood, but with too little power? Lying down, which takes off from both heart and arteries the weight of their contents; and the brain is that portion of the body which can profit the most by the horisontal position. Dr. Conolly recommends sedatives. I freely used them throughout (under the great disadvantages, however, of the resistance to swallowing, and of the sustained erect posture), but not without conjoining stimulants. I do not hesitate to express my belief, that a sedative cannot take effect in such cases, without a stimulant. For a sedative to act, the organ must be in a condition, greater or less, to be laid at rest. In a state of almost lifelessness, it can hardly assume an artificial condition, the taking on of which is an act of life. But a stimulant, applying first to the heart, and through the circulation reviving cerebral function, may enable the brain to recover power and sensitiveness approaching to what it possesses in health; and then the combined sedative may obtain a response. The "tepid shower-bath, not too violent," would, I believe, at that stage, have killed the patient outright. Whether a course of such baths, at an earlier period, might have done good, I am not prepared to say.

Variously prepared food, and all the patient persuasion we could muster, had entirely failed before the feeding instrument was used, as described in my Report. I find it difficult to reconcile the notion of exciting temptation out of variety in food, with the cause why all food was rejected; *viz.* an overwhelming sense of unworthiness and desire of making expiation. Amongst the same, absorbing emotions often destroy all appetite. They do not simply render the palate hard to please, and demand its temptation; they destroy the power of appreciating food, inclusive of all its varieties. Is the reign of delusion in insanity less absolute than the occasional abstraction in the healthy mind? I should think not; and I see no psychological impropriety in reasoning from the one to the other.

Dr. Conolly seems to think that the plan of associating suicidal with other patients in the bedrooms, is not followed in the Kent Asylum, for the sake of the security which it offers. His idea is probably founded on the case of restraining to prevent the commission of suicide, and on the case of actual suicide, both mentioned in my last Report, and both patients having occupied single rooms. The concurrence may seem to afford ground for his conclusion, which, however is still not in accordance with the fact. I do not allow the newly-admitted to sleep, whilst they are unknown to us, otherwise than alone, for a plain reason.

In the case restrained, the first attempt at suicide was made on the third night after admission; and, from its nature (knocking the head against the bedstead), the padded-room was resorted to. On the second attempt, at the end of one month, a strip of binding, torn from a mattress, was used for strangling. Very close watching was employed as a safeguard, and to its faithful performance we were indebted for a timely detection. In the variety of this patient's resources, coupled with the extreme earnestness of her attempts, I could see little prospect of security in any but the last resource. In the case of suicide, the woman had been resident twelve days, which may or may not be thought too long a period for judging of the existence of an inclination hurtful to other persons, of which there was some slight evidence in the history of the case. These isolated instances have misled Dr. C. as to the general practice.

This question of restraining has unfortunately become too controversial. The ground of dispute has been narrowed to the single proposition of 'All or none.' At a time when party has gone out of fashion, must a domestic question have its settlement deferred by a spirit very like that of the partisan? Are not all men striving to dispense with what all would rather do without? The tables are being turned, and restraint transferred from the insane to those who yet withhold entire conformity with extreme opinion; because of some opposing convictions affording the prospect of a more temperate settlement of the point in dispute, when time may have sifted all the human incentives that help to determine opinion, and rejected any which may have been found not to harmonize with the indisputable truth. It has seemed to me a bad thing to have to stand or fall by a rigid opinion, except in reference to an eternal truth; an opinion that may admit no fellowship without identity,

and which must denounce every approach short of uniformity, as being no approach *at* all. All men have been striving for years, in asylums, to get rid of restraint. It is utterly distasteful to them; to him who must still acknowledge the necessity of restraining and act upon it, as to the most ardent disciple of non-restraint. There is, there can be no doubt of this; and, may the question be allowed to rest. The active elements for its settlement are at work, and will infallibly prevail in the right direction; but time must be allowed. It might seem enough for the prime of life of one generation to have witnessed the grand step already taken and secured. The disuse of restraining for any but surgical or medical purpose is a settled conviction, not susceptible of disturbance. Let it be well remembered that with the riddance of restraint for any object not in the legitimate way of medical treatment, or preservation from self-injury under circumstances of great extremity, the *old wrong has been redressed.*

It remains for experience to determine, whether restraining is *ever* a true, eligible, indispensable remedy in the treatment of insanity; but long before we may possess an authorised "practice of medicine in insanity," that will have been determined.

Believe me to remain, dear Sir, your faithful Servant,

JAMES E. HUXLEY,

Kent County Lunatic Asylum.

Maidstone, Jan. 15, 1855.

Pathological Appearances Resembling Bruises.

Birmingham Boro' Asylum, Jan. 22*nd*, 1855.

Dear Sir,—I was much pleased with your paper on "cutaneous discoloration occurring in the insane," in the last number of the *Journal*, having often observed, and sometimes been much perplexed by, similar phenomena.

I have at this time under my care two cases so strikingly corroborative of your opinion, that these marks are pathological changes and not produced by violence, that I am induced to trouble you with them.

One is a married woman, 48 years of age, who within the last 8 years has had five or six attacks of acute recurrent mania, from the last of which she recovered several months ago, but since then she has been much depressed, rational in her acts and language, but unusually quiet and inert. On the 23rd of Nov. I found her complaining of pain in the back and right groin, and on the following day I was told that there was a large bruise in the groin; on examining the part I found a uniform purple discoloration as large as the palm of my hand, upon and to the right of the angle of the pubis. The patient was certain that she had not been struck or injured in any way. Her pulse was rather frequent, tongue clean but dry, face a little flushed, skin somewhat hot; she said the pain in the parts had kept her from sleeping. In the course of the next few days the discoloration gradually spread down the inside and back of the thigh, preceded and accompanied by pain. On the 8th ult. it covered nearly the whole posterior part and back of both thighs, and at this time a little sponginess of the gums was first observed. The face had become blanched and waxy, very like that of a lying-in woman who had suffered from profuse flooding.

The colour did not begin to fade in the parts first affected until the early part of this month, and fresh spots are still coming out lower down the leg. The patient has been in bed all the time, but one day thinking a little change desirable I prevailed upon her to get up. The consequence was an attack of syncope, from which I had some difficulty in rousing her.

The other patient is also a married woman, paralysed and demented, age 35. Three weeks ago I noticed a slight purple discoloration on the back of each hand, extending from the two forefingers nearly to the wrist, *both just alike.* Two days after the nurse reported a large bruise on the left gluteus, about which she was very much concerned, not knowing how it had been caused. Had I not been prepared for this, and recognised the nature of the affection I might have blamed the nurse unjustly. In this case the marks did not spread much further and they have now nearly disappeared.

Two years ago a circumstance occurred in connection with these marks, which at the time gave me a great deal of annoyance.

A private patient who was paralytic, and so unmanageable at home that for five days before she came she had been tied in bed with cords, was admitted covered with what I then, knowing the restraint to which she had been subjected, very naturally considered to be bruises. They soon went off, but two months afterwards similar marks appeared under circumstances which prohibited the supposition of their being the result of violence. They spread rapidly, and soon affected more or less nearly every part of the body. In this condition she was seen by her friends, who thought the marks were caused by violence, and I was unable to convince them to the contrary. In a fit of indignation the husband removed her, and, as you may suppose, the whole family did not fail to talk loudly of the gross treatment to which she had been subjected. I have, however, the satisfaction to think that they subsequently changed their opinion, for not very long afterwards I was asked to take her back again, but of course refused.

I give you these cases without comment,

And remain, dear Sir,

Very truly yours,

THOS. GREEN.

To the Editor of the Asylum Journal.

Birkfield, Ipswich, Jan. 10.

Dear Sir,—I have much pleasure in being able to confirm your opinion as to the causes of discolorations of the skin resembling bruises, noticed in the last number of the *Asylum Journal*, as the same thing occurred to a patient of mine on board the ship of which I was surgeon. The man was a private in the 9th Lancers, and one of a detachment of Queen's troops of which I had medical charge during the voyage from India. He was invalided for chronic dysentery and general cachexia, and after having been about a week on board, I discovered, what, at the time, I thought was a bad bruise, on the outer side of the thigh and leg.