remain unexplained. By way of summary let me say that comparative hemianæsthesia is a much more common symptom in the insane than is usually supposed; that the universal anæsthesia occurring in stuporose cases is spurious; and that a variety of anæsthesia—hitherto undescribed—is liable to occur in melancholia, post-maniacal stupor, and dementia. I submit these observations for discussion, and for suggestions as to the explanation of these obscure but interesting phenomena.

[Read at the Annual Meeting of the Medico-Psychological Association, London, 1899, but not discussed. The consideration of Dr. Stoddart's communication will form part of the agenda at the next General Meeting.—EDS.]

Night-nursing and Supervision in Asylums. By F. ASHBY ELKINS, M.D., Med. Supt., Leavesden Asylum, and JAS. MIDDLEMASS, M.D., Med. Supt., Sunderland Borough Asylum.

WE think it will be generally acknowledged that the problem which the treatment of noisy, destructive, and dirty patients sets to their medical officers is greatest as regards their management at night. It is then undoubtedly that noise, destructiveness, and dirty habits have the greatest chance of getting free play, and it is then that the efforts for reformation have to be greatest. If these efforts are successful considerably more than half the problem will have been solved. It is to this part of the question, viz. the supervision of such patients during the night, that we desire in this paper to direct attention. At the outset it may be stated that our proposals are not theoretical. They are the result of practical experience gained during the past four years in the Sunderland Asylum. The special arrangements we propose to describe were instituted by one of us at the opening of the institution four years ago. At first a few cases were dealt with tentatively, but, as the first results were so encouraging, the number of cases was gradually increased, until all the patients who were restless, noisy, destructive, or of dirty habits came without exception to be dealt with. The asylum, situated at Ryhope, is a small one, containing only 350 beds, and on this account, as well as because it was new,

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it was conveniently suited for such an experiment. It may be well before going further to describe the arrangements now in existence there. There are 175 beds for each sex, made up as follows:—45 single rooms, one fully padded, and 2 half-padded; 2 small dormitories of 7 each, 2 of 13 each, 2 of 19 each, and 2 of 26 each. In the last two there is a night attendant, and one also in one of the dormitories for 19, which is the hospital ward. There is, in addition, a head night attendant who visits the patients in these dormitories and also all the remaining patients every hour, or oftener when necessary. There are thus 4 of a night staff for 175 patients. Though this is probably a large proportion compared to most public asylums, it is not claimed as a new departure in asylum management, as we are aware that in a number of asylums the advantage of having a large night staff is fully realised and acted on. The essential feature of the arrangements at Ryhope, to which we wish to direct attention, is the selection of cases placed in dormitories under constant supervision. Of course, all epileptics and suicidal patients are placed there. But, in addition, all recent cases of whatever kind, all dirty and destructive cases, and those who sleep badly and are in consequence inclined to chatter or be noisy, are also placed under constant supervision. Looked at from the other side, all single rooms and dormitories not under constant supervision are reserved for quiet and well-behaved patients who do not require any special attention during the night. This plan has been found to work exceedingly well, and since it was organised we have never had occasion to think of adopting any other. Another testimony to its effectiveness is that those of the staff who have the actual supervision of the patients and have had experience in other asylums are unanimous in their opinion that the arrangement is a very decided improvement. This opinion, let it be observed, is not based on the ground that now their duties are lighter than they were, because, as a matter of fact, they are more onerous.

The objection to this system of placing all restless and noisy patients in association which will first occur to every one's mind is that the sleep of many patients will be liable to be disturbed by one noisy individual. We readily and without reserve grant that the system is not a specific warranted to be applicable to and to cure every case without exception. But, on the

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other hand, we would emphatically state that the cases to which it is not applicable are altogether exceptional. Since the system was fully organised at Ryhope it has never proved to be inapplicable to any *recent* case. This, be it remembered, is in an asylum where the percentage of cases admitted who are general paralytics is abnormally high, and where the admissions include many epileptics and acute cases of all kinds. After all, when looked at theoretically it is merely taking one step further along the road towards which all recent efforts to improve the environment of the insane have tended. One thing after another has been done to make life in an asylum as like a sane life as it can be made, and each effort in this direction has, on the whole, been rewarded with success. It has never to our knowledge been objected that, because certain exceptional cases fail to be reached by these efforts, they should on that account all be abandoned. On the contrary, it is or ought to be regarded as a call to put forth fresh efforts to obtain the desired end. As regards the night arrangements which prevail in most asylums—and we say this without the least desire to make invidious comparisons,—it will probably not be contended that they by any means approach those of a general hospital, which we think ought to be the model which we should strive to obtain. The system in use at Ryhope is intended to be an approach to that model, and the results of its practice for the last four years have been such that we think a decided advance has been made.

The practice at Ryhope is to place at night every patient on admission in a dormitory under special supervision, no matter what the mental state may be. We take it for granted that in practically all asylums such a plan is carried out for admissions, except those who are delirious and inclined to be noisy at night. If, however, such patients are treated like the others, it will be found that the idea that they must necessarily be treated otherwise very quickly passes away. A suicidal patient, even if noisy, would not be consigned to a single room, and we consider that noisiness alone ought to be regarded as a sufficiently strong reason for keeping a patient out of a single room. It will probably be a surprise to most people who carry this out systematically to find how very few cases, if any, cannot be so treated. We have often been surprised to find how much custom can do to render a person who is asleep

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oblivious to pretty loud noise. On several occasions we have gone to a large dormitory late at night, and found one patient talking so loudly that she could be heard quite easily outside the door; yet on entering the room we have found every other patient asleep. Common experience also testifies to the same thing, provided the noise be not too loud. It is found, indeed, when put to the test of actual practice, that the disturbance which results from placing all talkative patients in dormitories is seldom of serious importance.

It need not be denied that occasionally a patient is so noisy as to disturb others in the same room. But when it is considered that, as a rule, patients in asylums go to bed at eight and rise at six, being thus ten hours in bed, it seems justifiable to expose them to the risk of occasionally losing two hours' sleep by being disturbed by some noisy person if the patients, as a whole, are benefited. That such benefit does result we are fully persuaded; and even in the best constructed asylum we doubt very much whether a noisy patient in a single room does not frequently disturb a much larger number of people than are to be found in one dormitory. Instead of assenting to the suggestion that there is greater disturbance when patients sleep in dormitories than when they are put in single rooms, we feel satisfied that the exact reverse is the case. A patient in a single room can not only shout, but can hammer the door and shutters so effectually as to be heard all through a large section of a building. On comparison, therefore, the method we advocate is preferable.

Hitherto we have considered the question from the point of view of the other patients. Turning now to those noisy individuals themselves, we hold that there are overwhelming reasons for placing them in associated dormitories. It will, we think, be readily granted that an excited patient shut up in a small room in absolute darkness is much more likely, if awake, to be subjected to the free play of a morbid train of ideas than when in a dimly lighted dormitory in which an attendant is constantly on duty. Under the former conditions there is absolutely nothing to distract the attention from any morbid thoughts which may come into the mind. Hallucinations undoubtedly have little chance of being corrected, and the sense of loneliness also in some cases undoubtedly acts as a disquieting factor. It is true that even the placing of patients

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in a supervised dormitory does not remove all sources of disquietude, but, as a matter of experience, it will be found that it is effectual in decidedly reducing the amount of noisiness. We think this will specially prove to be the case if all new patients are subjected to these conditions, and only removed from them when it is certain that they will behave during the night like ordinary sane individuals. At Ryhope the only patients who are noisy at intervals are those who have been for some time inmates of other asylums; that is to say, there are no patients who are noisy at night except those whose tendency to night-noisiness has become confirmed instead of being corrected at the outset by sleeping under supervision in a dormitory. In contrast with this there is the fact already stated that no case admitted since the asylum was opened has necessitated, on account of noisiness merely, a modification of the practice we recommend. That such cases may be expected to occur, however, we are quite willing to admit.

A few facts in regard to the actual results at Ryhope will no doubt be interesting. We have gone carefully through the returns for last year made from each supervised dormitory, of which there are six, and the following is the result. On the female side there were 159 nights in the year when there was absolute quiet throughout the whole of the wards. Taken individually the various wards show a still better condition of things. In Ward I there were 310 absolutely quiet nights; in Ward V, 292; and in Ward VI, 241. There were only five nights when four people were noisy or even talkative, and fifteen when three people were so. In the remaining nights only one or two people were noisy, and in most cases for short periods only. If a patient merely chattered for a quarter of an hour, and though no other patient was disturbed by it, the night was counted as an unquiet one. Further, we may state that it is a very rare thing for any patient to complain of being disturbed, though it is well known that many patients are ready enough to lodge complaints in regard to this and other matters, and often with very little ground.

On the men's side the facts are even more satisfactory. On 339 nights they were all quiet, and only once were there two patients noisy the same night. In Ward I there were only 12 nights in the year when there was any noise; in Ward V, 8 nights; and in Ward VI, 7 nights. These figures, we think,

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speak for themselves. They also demonstrate very clearly how much more noisy the women are than the men.

That this state of general quietude is not due to giving hypnotics freely, so as to make sure that noisy patients are put to sleep, is proved by the amount of these drugs dispensed, of which an accurate record is kept. In 1898 the only hypnotics given to women were 102 draughts of paraldehyde, and twelve doses of sulphonal. The majority of these were given in the case of one or two patients who were troubled with sleeplessness, but it was very rarely that drugs were given to quiet noisiness. To the men there were given eight draughts and three powders, and in no case were they given merely for noisiness. No draughts or powders are entrusted to the attendants or nurses to be used according to their judgment. They are given, as they should be, on the order of the medical officer on each occasion that a patient is deemed by him to require it. It may further be stated that the number of draughts given has been steadily diminishing, as the chronic patients, who have been inmates of other asylums, are becoming accustomed to sleep better at night.

There is still another advantage in having the patients under constant supervision at night, which should be mentioned. The nurse in every dormitory receives an allowance of milk and other simple foods which she can give as she thinks desirable to any patient who is restless or talkative. It is well known that sleepiness is induced by taking food, and this is taken advantage of when occasion arises. The nurse can also devote herself to small personal attentions, such as making the bed comfortable, brushing the hair, talking quietly for a minute or two, or in many other little ways treating the patient like a child and getting her to sleep. Such kindly attentions are also a good thing for the nurse, as they make her interested in her work, call out her nursing instincts, give occasion for the exercise of tact, prevent the time from hanging heavily on her hands, and so obviate any tendency to drowsiness on her part. Her mental alertness is also assisted by the fact that it is made her duty to enter in her report every hour whether certain patients under her charge are asleep or not, and in the morning she has to make out sleep charts regarding individual patients, whose habits in this respect it is desirable that the medical officer should see from day to day.

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Another benefit which we think results from this plan is that there is less noisiness during the day. It is our opinion that this has been demonstrated at Ryhope, and we attribute it chiefly to the fact that the patients as a whole, and especially the restless patients, get more sleep than by any other plan, though we think it may be partly due to the smallness of the wards, the largest of which contains only thirty-two patients.

In the case of patients who are apt to be destructive, the advantage of the method advocated will be obvious. In a single room there is practically no check to this habit, and the result in many cases is that in the morning the floor of a room may be literally covered with fragments of sheets, blankets, bedding, and everything the patient can get hold of and tear. This may add to the picturesqueness of the clinical features of a case, but it is costly and wholly unnecessary. In a dormitory under supervision it will be obvious that such a thing could not possibly occur, and as a matter of fact at Ryhope the number of things torn during the night has been abnormally small. During last year they numbered only three shirts torn by two male patients.

The care of wet and dirty patients during the night has always been a problem which has called for solution. While we do not claim that the method we advocate will entirely solve it, we have no hesitation in saying that it will reduce the evil to very much less appalling dimensions. It is quite patent that a partly demented patient put in a single room on account of a tendency to such habits is being placed under the worst conditions possible for their correction. In a dark room it is little wonder if the calls of nature go unheeded when there is no ready means of finding the necessary vessel. And even when the room is lighted, the patient may be so demented that he will not avail himself of what means exist. In such cases the attendant who only visits occasionally during the night must often be absent when the calls of nature ought to be attended to, and he is therefore likely at his visit to have his time occupied in changing bed linen already foul. In a dormitory, on the other hand, the attendant is always present. He can go at regular intervals to any patient with faulty habits and rouse him, or he can at once attend to any indication that his services are required. If, in spite of this, the patient's evil

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habits continue, he can be roused more frequently, and it will be found that even a dement is capable of a very surprising degree of education in this respect when he is raised pretty frequently, every hour if necessary. Again, however, we do not claim that this plan will succeed in every case, or that wet and dirty linen will be unknown if it is adopted. But we do claim to have effected so great a reform in the case of patients who came to Ryhope with a bad reputation in this respect, that it is quite a usual thing to have not a single wet sheet in the morning. Under the term wet is included any wetting or soiling greater than two or three square inches. There are occasional occurrences which are probably unavoidable, such as epileptic fits, attacks of severe diarrhœa, of feeble old people with paresis of the bladder and rectum, and of spinal disease with paraplegia. All others, however, we look on as the result of carelessness or want of attention, and therefore as avoidable. If a patient shows any tendency in this direction he should at once be placed in a supervised dormitory and special attention paid to him. The result will more than repay any trouble taken. One of the most obvious good results is that the patients always have a clean dry bed to sleep in, and that correct and cleanly habits, instead of the reverse, are maintained. It may here be stated that the raising of patients is never carried to such an extreme that they are rendered miserable by it. On an average only 15 patients out of about 330 are raised oftener than four times in a night, and over and over again we have seen patients fall asleep within two or three minutes of their being replaced in bed. Another good result is the diminution of foul linen requiring washing. We consider it is a change in a good direction to reduce the laundry staff and make a corresponding increase in the number of night nurses and attendants. Still another desirable result will be that the odour inseparable from a room which has been occupied by a dirty patient need no longer have a chance of occurring.

An analysis of the returns already referred to gives the following results. On the women's side there were 171 nights when no foul linen was reported. Taking each ward separately the figures were—for Ward I, 216 nights; for Ward V, 338 nights; and for Ward VI, 309. For the whole year there were 277 wet sheets and 103 wet night-dresses. On only

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3 occasions was there a wet mattress. As regards the men the figures were—224 nights without any wet or foul linen. In the individual wards they were respectively—in Ward I, 291 nights; in Ward V, 312 nights; and in Ward VI, 354 nights. During the whole year there were 141 wet sheets and 124 wet night-shirts. On 4 occasions the mattress was wet.

We give these figures as correct because the way in which the beds are made up is such that a dirty sheet is seen on our frequent inspections without the blankets being turned down; and because of the way in which the dirty linen is checked. The night return for each ward is signed by both day and night attendants, and the foul linen is marked on it. As these individuals are frequently changing it is well-nigh impossible that there should be a wholesale conspiracy to make false returns. Further, the returns of articles washed in the foul laundry, where there is absolutely no inducement to keep down the amount of linen returned as such, have been examined, and found to correspond with those made from the wards.

There is no doubt that as in the case of noisiness, so with dirty habits; chronic patients, accustomed for long to sleep in single rooms, will give a great deal of trouble before they are satisfactorily reformed, although reformation is more easily accomplished in the case of the dirty than the noisy. At first some patients got violent and strongly resented being roused. But as they came to understand why they were roused, and that if they kept themselves clean they would not be disturbed, their habits improved, and we find that some of them can safely be allowed to sleep in dormitories not under constant supervision without the habit again manifesting itself. If it did they would at once be removed to a supervised one. It will be seen that these facts completely meet any objection that might be urged to the very frequent rousing of patients with consequent disturbance of sleep. This may be necessary for a time in order that the habit may be broken, but our experience is that when once this has been accomplished frequent raising is not required. As in the case of noisiness, it is the chronic patients who give the most trouble; but the reward of persevering attention to faulty habits is much more certain of being reaped than in the case of noisiness, and we have no patient, except those subject to organic disease accounting for it, who gives any trouble by reason of dirty habits.

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As a result of our experience at Ryhope we think that the number of single rooms in asylums may be reduced with safety to a much smaller proportion than is at present usually recognised as necessary. The only patients who, in our opinion, require single rooms are those with homicidal tendencies, and these are comparatively rare. Such cases can be placed, as they are at Ryhope, in rooms opening off the dormitory. We would also consider it advisable that a few single rooms, some of them padded, might be provided for cases of acute excitement or of restlessness associated with senility, although there has been no necessity at Ryhope to use a single room for such a purpose. Every patient should be placed in a dormitory as a matter of routine, and only removed from it when there is a decided advantage to himself or others to be gained thereby. Thus the cost of a new asylum may be very considerably reduced by limiting the number of single rooms; and it will be a wiser policy to devote some of the money so saved to increase the night staff.

As to the number of patients who can be looked after at night by one nurse in a dormitory, we would say that, in a hospital ward with acute and feeble patients, we would place the limit at 25; of quiet chronic patients requiring raising or attention during a fit the number might be between 40 and 50. For those who are not under constant supervision smaller dormitories of 6 to 15 are better.

We would suggest, then—(1) That the night arrangements in asylums be closely approximated to those which exist in general hospitals. (2) That all acute, noisy, dirty, and destructive patients be placed at night in dormitories under constant supervision, and be removed only when it is evident that they have ceased to require such special care.

The adoption of this method is, of course, attended by a good deal of initial difficulty and complaint; but we have no doubt of its ultimate success if fairly tried. It has been seen at Ryhope by several whose opinion is entitled to great weight, and their favourable comments as well as our own experience have encouraged us to prepare this statement.

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Discussion

At the Annual Meeting of the Medico-Psychological Association, London, 1899.

Dr. Hitchcock: In the York Asylum this system has been in use for the last twelve years with entirely beneficial results. I have never given any sleeping draughts, and for many years have entirely abstained from giving any sedatives whatever, for I am quite satisfied that in asylum treatment that is the best course. Sedatives or narcotics may be required in incipient insanity, or in cases of sleeplessness which might terminate in insanity if not so treated; but those patients who have been treated with large doses of narcotics are invariably more difficult to deal with, and their mental condition is all the more unfavourable in my experience.

Dr. Conolly Norman: There are a number of things in this paper which commend themselves to all of us, and express the views that most of us entertain. It is now the general rule to treat patients, when they first come to us, as much as possible on the lines of a general hospital until some circumstance arises to justify other methods. I had lately to record in one house, containing 780 patients, seven consecutive nights without a wet bed. But there are other things to consider besides these elementary questions; and it surprises me to find that proper supervision is supposed to connote large dormitories. Owing to my asylum being old and badly built, I have vast dormitories, and I find them very inconvenient. Many patients complain of disturbances occasioned by a number of persons sleeping, or trying to sleep, in one room. I had an eloquent letter recently from one complaining of the noise made by an occupant of his dormitory, whom he designated an emissary of Satan. I remember an accident which happened in a dormitory where, when the nurse's back was turned, the exasperation which had been produced by noisiness led to the fracture of the noisy patient's skull. Going through the dormitories at night—as I sometimes do—I feel very much for the victims of this system of treatment. It is an old system which has been forced upon me; it is one which in my experience is entirely bad; and I sincerely hope it will never be my fate to be one of a number in such a dormitory. I could not answer for the consequences.

Dr. Oswald: I have given the plan advocated a trial, and I believe it is the general custom not to put new patients into single rooms; they are almost always placed under observation. I do not think that a row of eight or ten single rooms permits of a fair trial. More attention should be paid to "sleeping rooms"—that is to say, rooms so constructed that the patients occupying them shall have the best chance of sleeping. I have been compelled to remove noisy patients from dormitories because they were disturbing others, and have had to place them in single rooms. I have done this reluctantly, because observation in these rooms is less efficient than in dormitories. I do not think that we ought to sacrifice the sleep of many for the sake of one, and cannot agree with Dr. Middlemass and Dr. Elkins when they say that in the construction of new asylums the single rooms ought to be fewer. They ought to be differently designed. Every ward should have a number of bedrooms opening from it. I prefer to call these "privilege rooms." I think it is a privilege for a patient to have a bedroom of his own, not only from a social point of view, but also because such an arrangement distinctly increases the chance of recovery.

Sir John Sibbald: I have listened with much interest to this suggestive paper, and to the discussion upon it. One of the most important things which I have observed in the management of the insane is the great improvement in the nursing. Night nursing especially has made very great progress during my experience. The first asylum with which I was acquainted contained about 800 patients. A man—called the "night watch"—was the only representative of a night nursing staff. We have made very great progress since then, but we have still a great deal more to do in the development of this department. Although Dr. Campbell Clark has at Hartwood as large a night staff as there is in any asylum of the same size, and although Dr. Oswald has also a well-organised night staff, and although the night staffs in Scottish asylums are very much larger and better than they used to be, at the same time I think that in many asylums still further improvement can be made. It seems to me that the paper under discussion is an honest attempt to

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develop night nursing, and to make the personal care of the nurses for the patients more thorough than it has been.

Dr. HUGHES: From the experience which I have had in the management of the insane, I am of opinion that dormitories, as a rule, are objectionable. I mean associated dormitories, where an individual is cognizant of the fact that he is constantly under the personal surveillance of some other person. You know how it feels to a sane man to be under the impression that he is constantly being shadowed by some one. Now in the psychical therapy of mental aberration it is important that in all our dealings with the insane we should, so far as practicable, prevent the patient from receiving the impression that we are constantly shadowing him. For that reason, in the institution over which I have the honour and pleasure to preside, I have invented a lock that does not necessitate the turning of the key upon the patient. I am opposed to associated dormitories even in large hospitals, because of the insanitary psychical influence that one patient in an adjoining bed with his suffering and ailments has upon another. Generally patients, like ourselves, have troubles enough of their own. Melancholic patients may be benefited in asylums, but not by the use of associated dormitories. If you can associate them with other patients who will sympathise with them, they will have the most elevating impression upon this mental condition, but there is an objectionable feature about constant observation. The whole question of the management of the insane, so far as we are concerned, resolves itself into one of psychical therapy, and it is one of individual as well as collective psychical therapy. Wherever we can adapt our rooms in such a way as to ensure the most salutary effect, here we have progressed in the direction of proper therapeutics. In conclusion I will say that as sleep, which does so much for men in all states of life, is the best therapeutic agent that we have in the treatment of mental aberration, anything that will conduce to that end in hospital arrangement is right, and anything that violates the principle of securing tranquillity and rest is wrong.

Dr. JONES congratulated the authors of the paper upon the very excellent results obtained, and which his own experience confirmed as due to painstaking personal supervision.

Dr. MIDDLEMASS: I am glad that the paper has met with favourable appreciation. We did not wish to claim any credit for the arrangements made, but wished merely to record that the experiment had been eminently successful, and to encourage others to try for better results than we have at present obtained.

Punishment the Painful Consequence of Conduct. By CHARLES MERCIER, M.B.Lond.

THIS question of the punishment of the insane is one which has gone through certain stages. You will remember that in Edinburgh I read a paper in which I laid down three propositions. The first was that no insane person should be punished with the same severity as a sane person; the second was that some insane persons ought not to be punished at all; and the third was that the majority of insane persons ought to be punished for a large number of their wrong-doings. To these I added a fourth as a rider, that, as a matter of fact, punishment is already largely used in the treatment of dealing with

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