Twenty-eight Years' Lunacy Experience in Egypt (1895–1923).

By JOHN WARNOCK, *C.M.G.*, M.D., B.Sc.Edin., Late Director of the Lunacy Division, Ministry of Interior, Egypt, and Director of Abbâsîya Hospital for the Insane, Cairo.

PART III.

PRESENT LUNACY PROCEDURE IN EGYPT.

THERE being no law on lunacy in Egypt, all procedure is by administrative orders. The Government has the right to take any steps necessary to secure public order. There is no Habeas Corpus Statute in Egypt. The Criminal Code prohibits illegal sequestration, but if the sequestration is done by the Government with a proper motive, it is apparently justifiable legally. The existing public hospitals for the insane belong to the Central Government; the local municipalities and commissions have none. In the local general hospitals, however, under the Public Health Ministry, there are special rooms constructed for the temporary accommodation of insane persons awaiting certification, or too ill to travel. The Lunacy Division of the Ministry of the Interior administers the hospitals for the insane and issues the necessary orders, which are, however, signed by the Minister; it also proposes the annual budget, and expends the sums granted according to the regulations of the Ministry of Finance. Grants for buildings are made to the Public Works Department, which plans the buildings on the instructions of the Lunacy Division, arranges the contracts, and supervises construction. The Division is almost as autonomous as a Government Department can be; and subject to the technical regulations of the various Ministries and the approval of the Minister, can decide its own questions. The legal Counsellor of the Ministry of the Interior advises it in legal questions, and defends it when attacked in Court. For the present the Director of the Division also acts as Director of the chief hospital at Abbâsîya, but the arrangement should be altered on the passage of a Lunacy Act.

Lunacy has been a separate department since 1914, and the change was not made until the impracticability of subordinating it to another technical department had been proved.

It is proposed before long to remove the Lunacy Division from the Ministry of the Interior and place it under the Public Health Ministry, as in England. There is no objection to the change, provided it is recognized to be a totally different subject to public health and ordinary hospital administration, and that circulars on public health matters cannot be applied to it, and that it continues to be as autonomous as heretofore.

Besides the two State Hospitals for the Insane, there are several

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

private *maisons de santé*, chiefly at Alexandria, on account of the cooler climate and the preponderance of Europeans there, but I have not seen one properly constructed for the use of the insane. They are merely villas with gardens often surrounded by other houses. There is no law to regulate their admissions, but I believe their owners exact a medical certificate of some kind. Personally I am against the recognition of private asylums in the East; but as the Government does not provide for all the better-class patients, private asylums are obviously the only alternative.(1)

There being no law, there is no legal obligation to provide medical certificates before admission to the State Hospitals for the Insane. The Lunacy Division, however, insists on their being made on the forms issued by it, the order being signed by the local authority. These certificates are so seldom properly filled in that one cannot allow their defectiveness to entail the rejection of the patient, but after his admission the certificate is sent back to its drawer for completion (which in Egypt may take a long time). About one-fourth of the certificates are not dated; many are not even signed by either the doctors or the local authority. The facts stated by the doctor are sometimes self-contradictory. In the certificate the patient is often shown to be dangerous, while in the "statement of particulars," which in Egypt is filled in by the doctor, the patient is stated to be not dangerous. In fact if we only admitted patients whose papers were correct, our admission-rate would be considerably lowered. Many of the faulty certificates have a humorous side. I can recall at least three occasions when the doctor has certified that he "can find nothing wrong with the mental condition of the patient, and therefore he considers him a fit person to be detained in an asylum." At first sight one might think the doctor's conception of the hospital for the insane to be a refuge for the sane of Egypt. But the doctor probably meant that, although the relatives of the patient alleged his insanity, the doctor could find no corroboration of the allegation during his examination; he therefore passed the responsibility of examining the patient on to the expert at the hospital for the insane—a wrong procedure, as one should not admit an apparently sensible man into a hospital for the insane without previous certification. One hospital doctor misread a letter received about a patient, ordering transfer to "Zagazig," and mistook the destination to be "Magazeeb" (lunatics), and so certified the man as mad, though he was sane, and sent him to a hospital for the insane.

Another certificate read: "My reason for concluding that he is insane is that he *says* he loves the English."

On several occasions the doctor has apparently proved his own

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

insanity by sentences such as—"While the certifier was making this document, he jumped on the table, stripped himself, and struck the policeman."

However, more serious mistakes are, as I have already mentioned, the certification of the delirium of fever as insanity up to half a dozen cases annually, and the certification of moribund cases as physically fit for removal, in spite of repeated instructions to the contrary, and the omission to examine the patient physically, so that fractures are not noted before removal to hospital. Instances occur annually of doctors who, after satisfying themselves that the person is insane, do not believe he is dangerous, and therefore refuse to certify, and the patient is returned to his home, where he commits a crime, and is then sent to the hospital as a criminal. An investigation of these cases shows that there had been in most cases ample evidence of dangerous conduct given by the relatives, or that the delusions expressed by the lunatic were of a kind to show a likelihood of dangerous conduct; yet, because the patient was quiet while in custody, and did no dangerous act in the presence of the doctor, the latter pronounced him safe. This happens in spite of elaborate circulars explaining how doctors are to decide as to dangerousness.

Voluntary patients, if of Egyptian nationality, are admitted at the discretion of the director of the hospital, provided the patient himself signs a demand for admission.

Foreign subjects (including British) are only admitted if duly certified, on the order of their consuls; a special form in French is issued for foreigners. But in the case of British subjects (including Maltese, Indians, etc.), the formalities used in England for private patients are made necessary by an Order in Council, which prescribes that the procedure of the Lunacy Act of 1890 must be carried out for British subjects before internment in Egyptian hospitals for the insane. The consul acts as a judicial authority, and two English medical men grant the certificates. On admission, a notice of right of interview is served. The certificate that the interview would be prejudicial is never used there. The difficulties in getting the British admission papers properly executed before the patient arrives at the hospital caused considerable friction in past years. It was unpleasant to refuse the admission of British subjects arriving from a distant town in the custody of a Kavass, with no institution in Cairo to hold the patient pending completion of the defective certificates and order, and my action in insisting that the requirements of the law should be carried out was misunderstood. Protests to the British agent have resulted in the proper formalities being nowadays carried out.

Criminal lunacy.—The procedure in cases where the patient is accused of offences was gradually evolved. At first these cases were

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

treated as ordinary admissions, and criminals were discharged as freely as anyone else. After numerous consultations with the Government lawyers, an order was issued by the Attorney-General that, in cases sufficiently grave to justify summary arrest, whenever the question of insanity is raised by either side, the accused is to be sent to the hospital for the insane for observation and report, the dossier of the case to be sent to the director of the hospital.

Nearly always the suspicion of insanity is raised by the Government prosecutor (the Parquet), or by the Court; more rarely by the accused's lawyer.

There is no limit to the time the man may remain in hospital under observation. The report is sent to the Attorney-General, and if the report declares insanity and irresponsibility, and also that the person requires detention, the case is filed. The Attorney-General notifies the Public Security Department of the Ministry of the Interior, which makes an order of detention until further notice. Whenever, later on, the hospital director thinks the patient can be safely discharged, he so informs the Ministry of the Interior, which may order his discharge under certain conditions. In the case of murderers, who usually remain at least six years in hospital, the condition is that the patient should appear there every month, two months, or three months for re-examination; and if, at any re-examination, it is no longer considered advisable to leave the man at liberty, the Director has authority to detain him again, and the original order of detention still holds good.

In making orders of detention, the Ministry of the Interior classifies the cases as minor and grave. In minor cases the director of the hospital has authority to discharge, merely notifying the fact *afterwards* to the Ministry.

This probationary system works smoothly, with the exception that the relative who signs to be responsible for the patient and to bring him back for re-examination is usually a fellah whose intelligence is not equal to the position, and a good deal of trouble results from his want of punctuality and inability to understand the importance of the matter.

So far no criminal on leave has committed a fresh crime, and although relapses have occurred, the patient has been brought back in time. The Government pays the cost of transport at the periodical examinations.

The weak point about the present procedure as regards accused lunatics is that the accused is treated as a criminal lunatic, though in fact he has never been proved to be guilty of the crime; he is merely accused. In some cases where the evidence of guilt was slight I have had to point that out, and ask the Parquet to drop the charge

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

and let the case be treated as an ordinary patient; but, of course, I can only guess in most cases as to the probability of guilt. I remember one case of an imbecile accused of murdering his father (also a lunatic) by hanging him, where the father had evidently committed suicide. Merely to report the accused as irresponsible would have entailed his detention in the hospital for at least six years. But, instead, I obtained the withdrawal of the case, and the patient, a harmless case, was discharged. Whenever a law is passed this procedure should be improved, and the "guilty but insane" verdict substituted. Juries do not exist in Egypt, and the question of insanity is decided by the alienist and not by the jury, as has long been the custom in Germany also.

Reports on accused lunatics are sent by letter to the Parquet, and very rarely is one called to appear in Court to be cross-examined on the report except in British Military Courts. I was sworn once and for all before the Egyptian Court, and that oath covered all subsequent reports.

The Criminal Code says little about the insane. Art. 57 merely says, "No person shall be liable to punishment for any act committed at a time when he had lost the power of appreciating the nature of his acts or of controlling them by reason of—

(1) Insanity or mental infirmity.

(2) Intoxication caused by intoxicants administered to him against his will or without his knowledge.

However, in cases of voluntary temporary hasheesh intoxication the person is held to be irresponsible, though not in the case of alcoholic intoxication; the latter lasts a shorter time, but it is difficult to understand the difference in criminal responsibility.

During the past twenty-eight years about 1,500 accused lunatics, including 143 murderers, have been thus reported on, of whom about 1,200 were examined by me personally. The labour of reading (or rather listening to the reading of) all their dossiers in Arabic has been very great. Many of the dossiers were hundreds of foolscap pages in length, weighing several pounds. One dossier took eighteen hours to wade through. Indeed thousands of hours have been consumed in reading criminal dossiers.

The dossiers have to be read aloud in Arabic at a very rapid rate, while I note in English the important points, and so make a *précis* to be attached to the case-paper. Until I understood Arabic fairly well, this work was very tedious. A large proportion of the accused required long and repeated examination, and hundreds of hot afternoons have been spent in cross-examining these cases, and trying to elicit the real facts. Obstinate malingering is very common in Egypt, and involves much expenditure of time and trouble. After

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

years of experience it was often possible to predict the form of insanity before seeing the patient by merely reading the dossier. The characteristic delusions of sorcery and poisoning of the pellagrous, the repeated thefts by the general paralytic, etc., could not be mistaken. The duty of deciding later on as to the discharge of these cases was also formidable, and involved many examinations. The criminal asylum not only acts as the place of internment for criminal lunatics, but its chief discharges the duties of certifying their insanity and recommending their discharge. Extra remuneration to the extent of L.E. 180 a year is granted for reporting on accused lunatics. I may mention that on my arrival in Egypt I found such cases were examined by a medical commission of three outside doctors, who charged L.E. 25 each per case. The amount of the remuneration soon had to be changed, because, unless I had agreed to a low charge, only a few cases would have been examined; the rest would have had to be condemned without mental examination, as was the custom in the past; and it was a necessary reform to prevent all these lunatics from being condemned to prison unexamined. It has occurred, however, that the whole year's fees have in fact been well earned in one criminal *cause célèbre* that I have had to take part in.

Accused cases are prematurely discharged for want of room, and their readmission for a second offence is not rare. The value of life in the East not being high, a murder by a released criminal lunatic is not so severely criticized as it would be in England, but it is criticized even in Egypt.

Prisoners undergoing sentence whose conduct gives rise to the suspicion of insanity are sent uncertified to Abbâsîya Hospital for the Insane for observation, and certification if found to be insane. A large proportion of them proved to be malingerers who desired an easy life and better food. Their unmasking is not easy. Many prisoners suffer from a special prison psychosis—a sort of desperate reaction against their uncongenial surroundings and prison discipline, accompanied by acts of violence to others and to themselves. In a month or two such cases recover. This disorder is not malingering or hysteria, as the laity often believe. Some of the insane convicts are weakminded people who cannot earn a livelihood, and drift into crime, become habitual criminals, and are sent to prison, where they cannot endure discipline and are unmanageable. Their repeated, easily detected thefts, and their inability to keep out of prison are due to mental weakness; and it is useless to keep them in prison, troublesome as they are in hospitals for the insane.

Out of the 15,000 persons detained in Egyptian prisons, about 25 are admitted annually to Abbâsîya Hospital for examination, and the amount of L.E. 30 is paid annually for this branch of work.

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

Any individuals among the 102,000 *Government employees* (2) who suffer from mental disease, or are suspected to do so, were formerly interned in the hospital for the insane for observation before being invalided or certified to be insane—a very harsh proceeding, and one against the principle that a free man should not lose his liberty without previous proof of insanity or crime. After some years I succeeded in altering this custom, and now for many years such cases have been brought to my office for examination and report, and if necessary I visited them in their homes. About thirty such examinations are made annually, for which work the Government paid the fee of L.E. 22 a year.

Interdiction is pronounced by the Court called Maglis el Hassby for Mohammedans, and by the various Christian Patriarchs having jurisdiction over their adherents, also by the Consular Courts. Interdiction is pronounced for minority, extravagance, and mental incapacity. Many attempts have been made to reform the Maglis el Hassby, but its procedure appears still to require regulation; for once a patient's affairs are placed in the hands of an administrator, it is often impossible to enforce payment for maintenance in the hospital in the superior classes. Years of correspondence have little effect, or only result in the administrator being changed to a new man, who continues in his predecessor's path. 114 interdicted patients reside at Abbâsîya, of whom 63 are treated as paupers.

Frequent requests were made to me to give a certificate of insanity by persons who wish to interdict an insane relative. But the difficulty in learning the truth about the patient's conduct is very great, and it is impossible to either verify or disprove the allegations made in many cases. For many years I have refused to give such certificates, unless the Court appoints me to examine the patient and furnishes me with the dossier containing the allegations of both sides; for in Egypt it appears that in every interdiction one party of relatives applies for, and the other opposes interdiction. I never met a case where all the relatives were agreed, and refrained from making charges of interested motives against one another. However, there are many practitioners who give certificates in these cases, and there are strong reasons for controlling such certification by means of experts. Although the chief expert in Egypt on the subject, I was not called more than twice a year to certify for interdiction outside the hospital. Fees of from L.E. 2 upwards are payable outside the hospital; but if the case is in hospital, no fee is charged for a report for interdiction. Twenty to thirty such reports are furnished gratuitously annually.

The reverse of this certification is the case where certificates of sanity are requested by persons who wish to make trusts (Wakfiya)

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

to take effect after death. By Mohammedan law, if, at the time of making such a trust, the person was already suffering from his last illness, or was insane, the trust is rendered void. To prevent the validity of the trust being upset after death, it is sometimes advisable for the individual, if he is advanced in years, to get a certificate of sanity before signing. I have found it more difficult to certify sanity than insanity. Of course there is always an opposing relative, who, knowing he will not benefit by the trust, alleges all sorts of insane conduct on the part of the testator, and to separate the truth from the false is at times a puzzle. Often the patient is an old lady who understands very little about business, and of course, cannot read or write, and being in the Hareem knows scarcely anything of what goes on in the outside world, and one has to make the standard of intelligence low in these cases. Many of them were Abyssinian or Circassian slaves, now free, but retaining the *morale* of their former state, afraid to tell the truth, credulous and suspicious of strangers.

The examination for interdiction has many farcical elements. To begin with, frequently the patient is hidden away by the party opposing interdiction, and months may elapse before he is found. This happens quite frequently. Next, if his address be given and I call at the house with an agent of the Maglis el Hassby, the patient is often reported to have gone out that day—no doubt taken away by his relatives. Or the relatives refuse to admit us, and after trying persuasion in vain, we have to retire beaten. There seems to be no contempt of court procedure. Or some relatives deny the patient is there, while others assert he is hidden in the house, and we have to search for him.

When the patient is found, he is usually in a room with a lot of people including children, and only with patience and tact can the room be cleared of the majority of them and the doors closed; but at once all the doors are put on the latch, and eager ears listen, while the concealed relatives comment on our conversation and prompt the patient's answers, so we shut the doors again and start afresh. After perhaps long arguments we are able to get rid of the relatives and get on with the examination. Often the lawyers of each side are allowed to be present, and, of course, object to questions that may elicit information unfavourable to their parties. In these cases one has to find out whether the individual knows how much property he owns, what his income is, what near relatives he has, and how his money is being spent. It was amusing to notice how relatives try to teach all this information beforehand to a weakminded individual, who answers like a parrot but cannot explain in detail.

The Egyptians are a very litigious race, and must spend an extraordinary amount annually on legal cases. Even one's servants are

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

at law at frequent intervals. The Mohammedan divorce customs are the cause of much of the litigation; and quarrels about land title are inevitable when neither side can read the deed he signs, so that fraud is continually being committed in land sales. As divorce is effected by merely repeating the phrase " I divorce you " three times, it happens very frequently. In the last census it is stated that 60 *per cent.* of all women between forty and fifty are divorcees, about 25 *per cent.* of those over 40, 10 *per cent.* of those between thirty and forty, and 5 *per cent.* of those between twenty and thirty. Of 140,356 divorced people living, 96,409 were women. About 11 per 1,000 of the population are divorced people who have not re-married; of married divorcees, there are of course great numbers. [Compare 3½ per 1,000 in U.S.A., and 1 per 1,000 in Australia.] The number of divorces among the twelve million Mohammedan inhabitants of Egypt registered annually amounts to over 100,000, *i.e.*, 8⅓ divorces per 1,000 annually (3), or to 46 *per cent.* of the annual marriages (227,000). [In the U.S.A. in 1916 the divorce-rate was 1 per 1,000 of the population, and more than 10 *per cent.* of the number of marriages. The rate in England in 1920 was 0·08 per 1,000. In Australia in 1913 the rate was 0·13 divorces annually per 1,000.] This high divorce-rate in Egypt accounts for much litigation concerning alimony and restitution of dowry and family quarrels. The divorce customs of Egypt affect lunacy in many ways, *e.g.*, when a woman becomes insane she is often divorced at once. When a man has been interned as insane for a long time, the woman can get a divorce as being deserted —otherwise a Mohammedan woman has no right to divorce: it is a man's privilege. Therefore reports are called for as to whether a male patient is likely to recover and return to his wife. The distress, poverty, loss of children and home resulting from divorce are evidently frequent causes of insanity among women, as well as of prostitution. On discharge from the hospital the now divorced female patient has often to return to her parents if any exist.

It is to be noted that if a man repents of his perhaps hasty action in divorcing his wife, he cannot remarry her unless she first marries someone else, at any rate nominally, and is again divorced by her new husband. This procedure is, I believe, carried out for a small sum of money.

There are also civil cases regarding interdictions, and actions to cancel contracts on account of the alleged insanity of one of the contracting parties. Other actions were made against me for detaining patients, who are alleged by the applicants to be sane. Nearly every year I was served with writs of this kind, and the Government lawyers defended my actions in Court on the reports and evidence contained in the hospital records. These cases usually

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

refer to criminal lunatics, who may be at the time sane, but unsafe to be discharged so soon. No such action has succeeded; and, in fact, judges have held that, provided that the detention order has been properly made, the Government's action in detaining the case is covered by its administrative powers, and cannot be altered by any court. This decision does not prevent new actions being undertaken —in fact, there is usually some such case before the courts.

Litigious paranoiacs (querulants) are met with in Egypt, and some typical cases are under detention after committing acts of violence against judges and other authorities. They are just like the classical cases given in the text-books, and their claims against the Government amount to many millions.

Ordinary patients are certified by the medical officers of the Public Health Department, acting as police surgeons, hospital doctors, and doctors of districts. The younger of these officials have attended my lectures at Abbâsîya. In the case of accused persons, if the medical officer is asked by the Parquet for a report, he is instructed in serious cases merely to give his opinion as to whether or not the accused should be sent to the hospital for the insane for expert opinion.

The certificate form contains instructions as to time limits, etc., but complete instructions are given in circulars issued by the Public Health Department at my instance. In case of doubt a medical officer may send the case to a local hospital for observation, a special form being provided in that case.

Circulars from the Ministry of the Interior control the action of the police, who arrest and remove the insane to hospital, and contain instructions as to the necessity of female patients being accompanied by female relatives, as to the use of camisoles and the feeding of the patient *en route*, and the removal of dangerous weapons. The former custom of escorting the insane in the crowded tramcars or in open carts has been replaced by the use of special motor ambulances; the insane are no longer sent in company with prisoners. The patient's belongings are listed and entered on the back of the certificate form. Handcuffs are now prohibited. On the railways the insane are to be kept in separate compartments. Patients must not be sent naked to hospital. Infants must not be sent to hospital with their insane mothers.

Circulars to medical officers indicate how an opinion is to be formed as to dangerousness and unmanageability, including indecency; they point out the commonest mistakes made in certificates, such as entering hearsay evidence as having been personally observed, and quoting symptoms of physical disease as evidence of insanity, although a special paragraph is reserved for physical symptoms, etc. The removal of patients with fever, severe fractures, or moribund, is prohibited; also the certification of accused persons.

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

The idea that patients can be admitted to hospital without certification provided they pay for their maintenance is refuted. The necessity of sending foreigners to their Consuls for certification is impressed on medical officers.

Government employees requiring mental examination at the hospital for the insane are *not* to be certified beforehand, nor are prisoners requiring examination. Rules for the management of the insane in local hospitals were issued.

Ministerial Orders made on the proposition of the Lunacy Division prescribe the categories of patients to be sent to each hospital, and how they are to be sent. A decree fixes the charges to be made for treatment in the superior classes, and the procedure to discover the means of each patient, so that the Lunacy Division may invite the Maglis el Hassby to protect his interests.

Other orders regulate the transfers between the two hospitals, the notification of admissions, discharges, deaths and escapes, to the Lunacy Office, the procedure for the correction of certificates, the investigation of injuries, the keeping of registers of all cases admitted, and the removal of patients by relatives on discharge instead of by the police as was formerly the case. The detention in local hospitals of undoubtedly insane cases requiring treatment is prohibited. No demand for the expenses of transport or maintenance of a case is to be made unless authorized by the Lunacy Division.

Much of the above procedure is insisted upon for educative reasons, so that when a Lunacy Law is passed, the various authorities may already be in the habit of carrying out what will be rendered imperative by the law.

Forms of Insanity in Egypt.

A comparison of Egyptian statistics with those of English mental hospitals shows important differences in the proportions admitted of the various forms of insanity. These differences are so great that they have changed Egyptian organization in some directions from the English system, and have left their marks on the buildings. Apart from pellagrous insanity, the comparative rarity of melancholia among Egyptians, though it is common enough among Europeans and Jews living in Egypt, is very striking. Seldom do we see a typical Egyptian case of melancholia with delusions of unworthiness. A few cases of frantic agitated melancholia occur among Egyptians; and cases of climacteric melancholia among Egyptian women are seen annually. But really suicidal tendencies are rare among the Egyptian insane; certain cases attempt suicide to annoy their guardians and get them into trouble. This rarity of

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

determined suicidal tendencies has modified hospital structures in this way—that the elaborate precautions taken in English mental hospitals are not necessary there. Iron grills on all the windows furnish an easy means of hanging; suicide by precipitation from trees would be easy to effect here, but I only once saw it tried, and on that occasion the patient was caught in time by using a fire-escape. The rarity of melancholia and suicidal tendencies seem to be racial rather than due

Forms of Insanity of Patients admitted in 1922.

	Abbâsiya.			Khanka.	Total.
	Males.	Females.	Total.	Males.	
Morphinomania	—	1	1	} 51	78
Cocaine insanity	2	3	5		
Hasheesh insanity	3	—	3		
Alcoholic insanity	17	1	18		
Pellagrous insanity	36	47	83	103	186
Epileptic insanity	5	7	12	20	32
General paralysis	7	2	9	18	27
Imbecility, idiocy and congenital weakmindedness	21	13	34	30	64
Senile insanity	5	17	22	—	22
Puerperal insanity	—	9	9	—	9
Adolescent insanity	19	45	64	141	205
Mania	15	93	108	76	184
Traumatic insanity	1	—	1	—	1
Melancholia	8	39	47	27	74
Paranoia	3	1	4	8	12
Chronic mania and dementia	13	14	27	40	67
Post-febrile insanity	—	4	4	5	9
Organic dementia	—	1	1	2	3
Confusional insanity	6	—	6	17	23
Hysteria	—	1	1	—	1
Stupor	—	1	1	—	1
Total	161	299	460	538	998

to religious causes, for the Christian Egyptians (the Copts) are seldom suicidal. The fatalistic belief of the East that no one can die until the day predestined for his decease may have some effect in this matter.

A sudden rage or outburst of bad temper explains some suicides. *E.g.*, an exalted patient once demanded his discharge from me; on my telling him that he must wait until we had observed his conduct a while longer, he rushed head-first against the wall, breaking his neck there and then. Some suicides by imbeciles appear to have been accidental; they only meant to pretend to hang themselves, but did the act too well. One criminal lunatic, having failed in an attempt to escape, forthwith hanged himself.

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

Self-mutilation appears to be more common there than in England: self-castration is often attempted, sometimes successfully; two cases cut their noses off, one of them, a woman, declared she did it to improve her good looks. Swallowing foreign bodies, such as stones, etc., rarely with suicidal intent, is common; and deaths have occurred from impaction and the subsequent operation. One patient was admitted after swallowing a table-spoon and at least one fork. As he had refrained from food for a long time and was emaciated, it was easy to palpate the cutlery in his stomach. Both were got rid of, and he was fed artificially for months, recovered, and was discharged, carrying his restored property with him. The table-spoon was regurgitated during artificial feeding, and a fork was passed per rectum. Swallowing stolen coins is not uncommon, and on several occasions we have been asked to collect the coins for the owners!

However, there is another tendency of the Egyptian insane which effectively counterbalances the relief one might expect from the rarity of suicidal tendencies, *viz.*, their frequent violence and homicidal tendencies. The number of assaults and attempts to kill other patients and attendants that occur is very great. Some attempts have succeeded in spite of elaborate precautions, owing usually to the carelessness of attendants, who failed to search patients carefully for weapons. Occasionally the patients supposed to be inoffensive have suddenly broken out and killed their neighbours; *e.g.*, one anæmic pellagrin who was allowed to sit in a corridor by himself noticed the door of a single room open; he slipped in and seized an imbecile lad and dashed his brains out against the wall. The frequency of homicidal violence among the certified insane is not surprising in view of the high murder-rate among sane Egyptians (about 1,000 a year), especially in Upper Egypt, where fatal fights on a large scale often occur. The intolerance and aggressiveness of the Arab, and his love of force rather than reason as an argument, are daily evident outside the hospitals, and inside them the same tendencies are seen uncontrolled.

The effect of the frequency of this aggressive tendency among the Egyptian insane on the hospital organization is seen in the solidity of the buildings and in the heaviness of the furniture, so that it cannot be used as weapons, also in the limitation of most of the occupations to work that does not require dangerous instruments, such as basket-making, house work, laundry, etc.

There is a cabinet full of dangerous weapons manufactured by homicidal patients at Abbâsîya—pieces of metal from tins, large nails, metal from bedsteads sharpened by rubbing on stones, batons of wood obtained by smashing doors or tearing up benches; large stones excavated from the sand, or pulled out of the walls; slings

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

made from clothing; ropes from the tapes of drawers; pieces of glass, etc., which show that many of the insane defeat the alertness of the attendants. I may note that on several occasions patients have stolen the attendants' keys, and so escaped at night. Other patients fashioned keys out of odd bits of metal and so escaped.

Being understood to be responsible for their detention, I have, of course, attracted the attentions of some of these dangerous characters. In the early days one received a good many attacks in the Hareem owing to the disorder in the one big section, one patient especially often breaking the rule laid down so explicitly in Deuteronomy as to fair play in a fight with the opposite sex. On one occasion a fanatical quarryman suddenly seized me around the waist and hugged like a bear until I feared for my ribs; I escaped with merely torn clothing. On another occasion an insane Pasha, whom I visited in his house in Cairo, seized me and tried to throw me out of the window; his servants ran for their lives and I had a lively five minutes holding on to the window-frame until help came. He had anti-European delusions, and had been "potting" Europeans from his window.

A paranoiac once quietly approached me from behind and knocked me down with a vigorous blow. Other attacks were made with brooms, stones in a sling, stones by hand, with fists and sticks. I was luckier than my subordinates, some of whom have been severely injured, indeed nearly killed more than once.

Exaltation (religious and social) is very frequent among the Egyptian insane. Toxic cases especially develop these ideas.

Hallucinations are rarer than among Europeans, and in hasheesh insanity are fleeting, and are often replaced by illusions.

Pellagrous insanity is very often seen in Egypt, and is one of the commonest forms of insanity admitted. It is a disease of the fellaheen, and seems to be almost unknown in the towns. It appears to have some very close relation with the use of maize as the chief article of diet; and countries where the peasants are restricted to the consumption of this cereal usually suffer from endemic pellagra (Italy, Roumania, Southern States of U.S.A., etc.). The number of theories as to the exact cause of pellagra shows how little is known on the subject, but during the war outbreaks of pellagra among Turkish prisoners and Armenian refugees in camps showed that maize is not a necessary factor in its production, a diet deficient in proteins appearing to be the important factor. The association of maize with pellagra may be explained by the low protein value of maize, some necessary amino-acids being absent from the zein of maize. The belief held in some parts of America that the disease is infectious is not borne out by experience in Egypt. Out of the many hundreds

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

of attendants who have lived among the insane there, I have never seen one develop pellagra, though some fellaheen attendants who came from the Provinces were found to have pellagra.

The clinical types of pellagrous insanity vary greatly, and just as the physical symptoms alter as the disease progresses, so do the mental symptoms. The blackened skin with erythematous patches, the dyspepsia, diarrhœa, anæmia and general debility with muscular atrophy are accompanied by mental symptoms which often may be described as an insane interpretation of actual painful sensations. The patient believes himself poisoned or put under sorcery, and tries to prove his belief by drawing attention to the diarrhœa "resulting from the poison," and to the weakness "due to the sorcery." The inflamed skin is proof to him that he has been set on fire; he declares he has a fire inside him and asks for water to quench it, and refuses to wear clothing. These beliefs result in appropriate actions, attempts to murder his persecutors, or acts of revenge against them or their children, and complaints to the police or Parquet about the persecution. He is always complaining and derives little satisfaction from his extra food; he wants more, or may believe it poisoned. He is at the same time miserable and confused, dull and unable to understand what is being done for him. He mistakes the treatment for torture, and he may kill his benefactors from that belief. He may develop organized ideas of persecution, believing that an enemy is inciting the other patients to murder him. Some cases become delirious, like a bad typhoid case, and die in a short time.

In later stages pellagrous patients are often found to present the type of chronic mania, aggressive and degraded in habits; many become demented. Some develop the exalted delusions characteristic of general paralysis, with exaggerated reflexes and facial tremors and impaired speech.

If not too advanced, most cases of pellagra improve mentally and physically in a few months on receiving a good diet; especially is it necessary to give them plenty of milk and fresh meat. They pick up flesh and become cheerful and rational and are discharged, to revert to their maize diet, and return with a relapse in a year to two. Even when apparently recovered there remains a certain mental change. They remain rather heavy and slow in manner; they do not spontaneously smile, and the *joie de vivre* is diminished. The advanced cases, who arrive shrivelled and blackened like mummies, or delirious, die in a short time; and the chronic cases, who have not mentally recovered, waste away slowly, develop dysentery and diarrhœa at intervals, and die in a few years. Pellagra is the chief cause of deaths in Egyptian hospitals for the insane (43 out of 188 deaths in 1922), producing three times the number of deaths caused

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

by general paralysis. Probably pellagra costs the country several millions a year in loss of labour and life. A crusade against it, as in America, is necessary when funds are available, and further field work has demonstrated its incidence. The anti-pellagrous crusade in Italy does not seem to have produced much result; and I doubt if anything less than a total prohibition of the use of maize as an article of human diet will have much effect. The difficulty of enforcing such a measure in a country where maize is the staple food would be immense, and would entail the cultivation of another cereal, preferably wheat, in its place, or the importation of cheap wheat in large quantities. I am persuaded that millions of one section of the Egyptian people—the fellaheen (4,000,000 men actually working in fields, with their wives and families, out of a total of 13,000,000 people, according to census)—are really being starved: although a sufficiently large diet is taken by them, its quality is so defective owing to its large maize content that it does not supply the nutritive elements required, and gradually the fellah in thousands of cases is attacked by pellagra and other diseases. The poorest class suffers most, for the more prosperous fellah supplies the deficiencies of maize by adding other more expensive articles of food. Thus the poorest class supplies thousands of insane and criminals. It is to be remembered that only a small percentage of the total pellagrous output ever reaches a hospital for the insane. Many cases are quiet, dull, weak persons who remain at home to die. In Italy it was calculated that 10 *per cent.* of the pellagrous are insane, and some thousands die of pellagra annually in Italy. In Egypt the total death-rate from pellagra must be very high, but in the villages the causes of death are seldom verified.

In view of the care taken in Egypt to control cotton-parasites of various kinds, some attention should be given to this disease, which ruins so many of the cotton cultivators.

After all, pellagra is undoubtedly a disease of poverty: without poverty there would be no pellagra. It is poverty that drives people to eat maize. Egypt is overcrowded with 13,000,000 people on a small area of 12,000 square miles. The density reaches the extraordinary figure of 1,083 persons per square mile. The population has rapidly increased under the protecting care of Great Britain; it was only 7,000,000 in 1882, and the cultivated area has not been proportionately increased since that date.

The struggle for existence of these extra millions must be very severe, and the least fit must fail in the struggle, and be destroyed by some disease, unless war equalizes the population to the productive powers of the country. Pellagra, bilharzia disease, ankylostomiasis and dysentery are all busy keeping the economic equilibrium from

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

being too much disturbed, and perhaps we should not blame them for the high death-rate, which is really the inevitable result of populating a country beyond its capacity. The advocates of birth-control would have a difficult task if they tried to convert the fellah to their views.

Hasheesh insanity is a form often met with in Egypt. Hasheesh smoking and drinking are common also in India, where hasheesh is sold under Government licence, while in Egypt it is prohibited since the time of Mohamed Aly, though extensively smuggled in from Greece, tons at a time—four tons were seized in 1919. In Indian asylums insanity from hasheesh did not appear to be common, when the Hasheesh Commission examined the question many years ago in India, few definite cases of hasheesh insanity being found in the asylums. Those interested in the subject may refer to the report of that Commission, and to the works on the subject in French, as hasheesh smoking was one of the vices of a certain literary set in Paris, and Baudelaire gave a full account of his sensations. More recently I have seen it stated that one-third of the insane cases certified in the Punjab are caused by hasheesh. The Indian hasheesh is derived from a different plant. Experiments by English observers vary much from those of Oriental devotees, the erotic illusions and feeling of happiness not being so marked in Englishmen. Monkeys subjected to its fumes developed a love for its use, and appeared to enjoy it, becoming fatter while using it. In Egypt it appears to be used for its euphoric and aphrodisiac effects. It is also said to increase the appetite for food. In spite of its prohibition, it is still used quite freely in various forms: besides being smoked, it is often eaten in sweets mixed with other drugs, *e.g.*, opium, or datura. The hashash becomes somewhat drunk and stupid, while enjoying his gorgeous dreams; but he at times becomes excited and aggressive, especially if interfered with. The alteration in the perception of time and of spatial relations is characteristic. Patients describe their experience as like watching a cinema for a hundred years. Objects also appear to be immense, and distorted into fantastic and often alarming shapes. All sorts of ecstatic visions are described—temporary paradises. It would appear that, unlike the morphia habit, that of hasheesh taking is easily thrown off, and I have noticed many patients give it up after one stay in hospital. There seemed to be no deprivation symptoms. Some hashasheen commence the habit as a remedy for depression in the onset of insanity, and the habit was more a symptom than a cause of the mental disease, as one has noticed in certain cases of insanity associated with the abuse of alcohol.

The number of cases of hasheesh insanity admitted to hospital is much less than was formerly reported to be the case; and as a cause

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

of insanity it does not seem to be of great importance in Egypt. Formerly it was alleged to be the cause as a matter of course in nearly all cases where no other cause appeared to be likely, and all sorts of well-known signs of chronic insanity were considered to be characteristic of hasheesh insanity, *e.g.*, talking aloud to oneself, foolish laughter, incoherent talk, etc. In India stress has been laid on three characteristic marks of hasheeshism :

(1) Complete forgetfulness of what happened during the acute attack.
(2) Erotic visions or dreams.
(3) A peculiar hyperæmia or a brownish discoloration of the eyeball where it is exposed between the half-shut eyelids, *i.e.*, a reddish or brownish equatorial patch (Ewens' sign).

I have only found the second symptom to be of value in Egypt. Experience there showed the third symptom to be common in chronic lunatics who sit and beg in the dusty roads. The first symptom appears to be equally common in alcoholic and other deliria.

Hasheesh cases are usually violent, exalted and quarrelsome. They boast and defy authority. Nearly all deny using the drug, and on recovery profess surprise at being accused of the habit. Like other drug users, they are cunning liars and morally callous where the drug is concerned. Many have temporary delusions of an exalted kind, social or religious, and also persecutory ideas. They soon recover from their early attacks. Later on they become so morally degraded, lazy and reckless in behaviour that they are no longer responsible. The delusions may remain permanently. Hallucinations occur, and seem to be usually unpleasant, and quite different to the visions of the sane hashash.

Hasheesh is smuggled into hospital at times by patients' relatives or by employees. Hashasheen conceal the drug in their ears and also in less desirable parts, or hide it in the sand for future use. Hashasheen commit a good many crimes of violence and thefts, and many of them become vagrants.

A few cases of insanity are caused by the use of morphia or cocaine, but only a small percentage of the cases occurring in Egypt reach hospital. Of late years cocaine has become more used in Egypt, and cases of cocainism are now more frequently brought in.

Insanity due to alcohol has increased of late years; and a good many Egyptians break down from the abuse of alcohol. A total of 48 cases caused by alcohol were brought to Abbâsîya in 1920.

Epileptic insanity seems to be as common in Egypt as in England. 6,300 epileptic fits occurred in the two hospitals in 1920.

Adolescent insanity is quite common in Egypt and in the near East generally. The number of students and sons of well-to-do

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

Egyptians who suffer from this disorder is remarkable. I am convinced from examining the history of many cases that hereditary predisposition is the main factor in its production, although ill-usage, fright, over-study, disappointment and bad education may be exciting causes, without which the youth might not have succumbed.

What used to be called acute delirious mania, but which is more melancholic than maniacal in tone, occurs in Egypt, especially in the hot weather. After riots and street massacres we get a case or two of this type. The sudden shock and overpowering terror at seeing people shot dead in front of the individual sends him (or more often her) acutely insane within 48 hours. Nearly all die in a few weeks.

Post-febrile insanity is common in Egypt, where typhus and relapsing fever are rife; but only a fraction of the occurring cases need to be sent to a hospital for the insane. Hysteria is met with among Egyptian men, even soldiers. Puerperal insanity occurs among Egyptian women, but is more common among Europeans.

In a country where politics are of such absorbing interest, and cause such intense excitement, lunacy of course cannot escape from being coloured by them. A number of political cranks and rabid reformers, who wish to reform everyone but themselves, and who take their ideals from the exalted visions induced by hasheesh, are brought to hospital.

Much of the insanity in Egypt appears to be due to physical causes, poverty, semi-starvation and toxic agents. Malnutrition is a far more obvious factor in the production of insanity in Egypt than in England. The extreme prevalence of exhausting diseases such as pellagra, bilharzia disease, ankylostomiasis, and of many kinds of intestinal parasite, keeps millions of people in low health, and eventually a breakdown of the nervous system happens to many of them.

The literally universal eye-disease—out of 12,780,000 people, 155,000 are completely blind, *i.e.*, over 1 *per cent.*,(4) and nearly 400,000 have only one eye, *i.e.*, over 3 *per cent.*—and the endemic vermin and parasites, external and internal, of the lower classes give some idea of the low hygienic state and low *morale* of the majority of the Egyptians. Yet with all these drawbacks, and with an inefficient dietary, and with only rags to cover many of them, the fellahin are usually a cheerful race, who think little about to-morrow, and accept their lot with resignation, enduring excessive heat in summer and cold in winter without a murmur.

The psychology of the sane Egyptian requires a few words. Being half Arab and half Egyptian, he has a mixture of the restless, excitable, violent character of the Arab and the plodding, stupid, apathetic nature of the fellah of the Delta, who from ancient times has lived as a serf, and has been conquered by all his neighbours.

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

The type varies in different parts of Egypt, as does the pronunciation of the language. The fellah of Upper Egypt with his harsh gutturals is a more excitable and violent person than his fellow-countrymen in the Delta. If annoyed, he easily gets into a rage and kills on small provocation. He works hard and lives hardly. Many of his class emigrate periodically to the Delta to find work.

Egyptians are excitable, and easily translate their feelings into actions. The fellah who forms the bulk of the population is conservative in ideas, obstinate, credulous and yet suspicious. He believes in sorcery, but does not like to admit the belief. He spends money in buying charms, which are often merely a text from the Koran on a scrap of paper. He is land-hungry and holds on to his bit of land tenaciously—Egypt is a land of small holders—he marries young and often, and has a large family with a high death-rate. Unable to read or write, he takes his beliefs from the local sheikhs. He is strict in religious observances, but his belief in his creed seems more important to him than carrying out its moral code. Of hygiene he shows more ignorance than even some of the lower animals, in spite of his religious ablutions. He lives in a mud hut without any windows, often near a stagnant pond of foul water which he uses for domestic purposes. He is stupid and slow in catching up ideas, and questions have to be repeated before he can grasp them. On many subjects it is useless to converse with him, his ideas and vocabulary being so limited.

The educated Egyptian usually acquires a veneer of European civilization, and can often talk fluently in French or English. He is polite in manners, sociable, hospitable, and apparently frank; but he is somewhat changeable in principles. Keen about money affairs and at bargains, he works best where there is a direct monetary interest. Work in itself does not usually interest him much. He is talkative, and given to express rather high-falutin' ideas. He has too little sense of responsibility towards inferiors and usually not enough sympathy for them. As a Government official he sometimes does not fully appreciate that he is a trustee and servant of the public. Fortunately there are many Egyptians whose integrity, sense of honour and conscientiousness compel our respect and esteem.

One saving grace of the Egyptian is that he has a great sense of humour; he is always ready for a joke and laughs readily. Indeed, he has the defect of that quality; he often seems to treat life as a joke, while we perhaps regard it too much as a tragedy.

Treatment of the Insane in Egypt.

The insane are said to be well treated in the East as being specially blessed by God. I have met imbeciles of degraded habits so treated

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

by people who came to be blessed by them, and I have seen attendants who believed a certain patient to be divinely inspired. But the majority of the insane in the East have a poor time. In Tripoli they are driven out of the town and stoned, and in the villages in Egypt they are sometimes tormented until they turn on their enemies and rend them. The insane fellah is chased about by the village children; he is often only able to live by stealing. If kept in his house he is sometimes tied up until his limbs are ulcerated. His friends poultice his head, cauterize his temples, vertex and back, and tie charms round his neck. Many of the insane, unable to understand the good intention behind their tortures, take revenge on being released, and many a murder has thus resulted. In one year I noticed seventy-six admissions suffering from cautery marks, usually done by a hot iron or nail. It is to be hoped that the removal of some thousands of the insane from the Provinces to the hospitals has reduced their sufferings to some extent.

The fact that the number of cases annually admitted suffering from serious injuries has diminished from nine in 1906 to four in 1922, is a hopeful sign, but the number of cauterized cases is still great.

I gave thirteen clinical lectures annually to the senior students of the Cairo Medical School and demonstrated how the insane can be managed by mild methods, and in time it is hoped that the Egyptian medical profession will pass on the message to the public. In these lectures the chief forms of insanity were described and illustrated by cases. Certification was explained, and the precautions necessary in the treatment of the insane in private houses were pointed out. The Egyptian insane are more humorous than the English, and it was difficult to keep the class serious when showing Egyptian cases. More than once the patient has insisted on continuing the lecture, indicating me as a patient suffering from criminal lunacy because I would not release him. The jolly demeanour of the general paralytic produces answering smiles, and his wild claims meet with peals of laughter from the students.

As to treatment in the Egyptian hospitals for the insane, an endeavour has been made to follow that usual in English mental hospitals, but *longo intervallo*, owing to local disabilities. However, the important principle of no mechanical restraint has been enforced since 1896. A few rare instances occurred up to 1917. Since then none has been used for any purpose whatever. In my opinion it is only justifiable when used as an extension of the restraint necessary in surgical cases, *e.g.*, while a sane man with a broken leg requires to have the leg restrained from movement by a splint; if he is insane, the restraint may have to be extended to preventing his moving his

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

leg by means of his hands, for which purpose a camisole may be necessary for an excited case. Manual restraint in a cool climate might be used if trustworthy attendants are available. In Egypt manual restraint in such cases might end in disaster. The great objections to mechanical restraint are, that it exhausts the patients, and he so often considers it to be punishment.

It is claimed that this experiment in Egypt has proved to a large extent that the principle of non-restraint can be successfully applied to every race, even to the most violent criminal insane, and in hot climates as well as in cold, and I trust that the principle will soon extend beyond the few countries where it now obtains.

I am aware that my views on this subject are not shared universally in the East, for in a recently published manual of lunacy, it is stated that the strait waistcoat is an excellent means of restraint, especially in patients addicted to certain bad habits or to assaulting other patients. "It has, however, to be used with caution . . . and often reduces such patients to a condition of extreme exhaustion. Even in this latter class its application is often of great use, for the moral effect is marvellous, and gives one a means of stimulating efforts at self-control, also a last resource, where all efforts at persuasion have failed. . . . It should never be used as a punishment."

Seclusion was still used at Abbâsîya Hospital, especially for dangerous criminals, and for aggressive and indecent female patients, and for some of the non-criminal men who become a nuisance to their neighbours. The seclusion was often only partial, as the patient can talk through the grilled window. Much of the seclusion is voluntary, and much is in order to keep patients out of the sun in summer, and to prevent their exhausting themselves in frequent quarrels with their neighbours. Seclusion also prevents accidents among vindictive patients. On an average, less than two patients were secluded for eight hours every day in 1922 at Abbâsîya. Khanka Hospital, under Dr. Dudgeon's guidance, dispenses with seclusion altogether.

Padded rooms are unsuitable for the Egyptian climate, but a removable padded floor is in use at Abbâsîya for restless, delirious cases.

The use of hypnotics at night has greatly diminished to three doses per head per annum in 1922 at Abbâsîya, and almost none at Khanka.

Artificial feeding is used at Abbâsîya, and on an average five patients are fed thrice daily there. At Khanka this procedure is seldom found necessary.

The open-air life all day long in Egypt is very different from the indoor life necessitated in English mental hospitals for much of the

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

year by the cold climate here. Patients in Egypt remain out of doors all day except at meals or when ill in bed.

The occupations of patients are a good deal limited by the fact that all patients quiet enough to be trusted have to be discharged at once to make room. At Abbâsîya the accumulation of the worst cases during the past twenty-eight years, and the presence of so many criminal patients, prevents any but the simplest work from being undertaken. However, the patients do all the house work, help in the kitchens, stores and artisans' shops, work at tailoring, and do nearly all the laundry work; some make baskets and others help in gardening. At Khanka the patients also bake the bread; they also work on the farm and have much outdoor occupation.

While observing the varying methods of treatment, I have often felt the lack of any precise figures as to the existing practice in English mental hospitals, *e.g.*, regarding the amount of seclusion (not used at all in many English hospitals), the number of night draughts given, and the statistics of artificial feeding. If these details were given in the annual reports, they would be, in my opinion, of practical use.

The fixing of a proper diet for the insane in Egypt has caused a great deal of thought; luckily the presence in the Egyptian Government Service of an expert physiologist, Prof. W. H. Wilson, has made the problem easier. Although a diet, the analysis of which looked on paper satisfactory was given to the patients, various symptoms made one suspect that it was in some way inefficient. Occasional cases of scurvy and fresh cases of pellagra developing in the hospitals required explanation. Prof. Wilson's report in 1918 showed that probably a number of chronic pellagrins did not absorb the protein provided, or that much of the protein was destroyed instead of being absorbed. To make up for this defective absorption he recommended more protein, and suggested an addition to each diet of 50 grm. of milk and 45 grm. of meat. This was made in May, 1919, at Abbâsîya, and the death-rate there fell from 18·3 in 1918 to 9·7 in 1919, and 7 *per cent.* in 1920; 7·3 *per cent.* in 1921, and 6 *per cent.* in 1922. At Khanka only the meat was added in 1919, and the death-rate fell from 27·2 *per cent.* in 1918 to 16·2 in 1919, and 15·3 *per cent.* in 1920. On October 25, 1920, the milk was also added at Khanka, where the death-rate was 15·4 in 1921, and 9·75 in 1922.

Diet.—The ordinary diet consists of 200 grm. of vegetables, 50 grm. each of onions, fresh salad, rice, sugar, lentils, and of beans, 100 grm. of milk, 30 of flour, 560 of bread, 18 of salt, 20 of oil, 195 of beef, and 25 grm. of margarine. Before the use of green salad was introduced a good many cases of scurvy occurred. Prof. W. H. Wilson gives the following as the value in proximate principles of this diet:

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

Gross protein.	Available protein.	Biological value of protein.	Animal protein.	Fat.	Animal fat.	Carbo-hydrate.	Available calories.	Gross calories.
107·4	86	57·4	30·4	68·5	14·2	446·4	2,813	3,053

The causation of insanity being apparently so frequently physical in Egypt, its treatment will improve to some degree as the treatment of the physical diseases on which it depends improves. Important advances have been made, *e.g.*, in the treatment of ankylostomiasis and bilharzia disease. Indeed wonderful results from injecting tartar emetic in the latter disease are already being obtained on a large scale. I have no doubt that Dr. Christopherson's discovery of this treatment will save millions of lives, and an incalculable amount of suffering. One wonders how the State will reward him for this immensely valuable work.(5) A glance at Dr. Dudgeon's report on Khanka Hospital for 1922 will show the terrible prevalence of bilharzia among both the sane and the insane in Egypt.

Future Developments.

From the foregoing account of the work, it will be apparent that much remains to be done by my successors before the treatment of the insane in Egypt can be brought up to the English standard. In certain respects it is ahead of some continental countries, *e.g.*, in the absence of mechanical restraint. I believe it to be in advance of any other country in the near East as regards the treatment of native patients. In legislative enactments it is far behind India.

The evolution of the treatment of the insane in a country advances by steps, and it is impossible with one leap to reform the system of treatment and bring it to the most advanced level. In the beginning, the insane have been throughout almost the whole world treated by mechanical restraint. That crude means of control finally disappears under humane considerations, and the second stage, that of control by seclusion with chemical restraint (*i.e.*, narcotics), takes its place. Later on, as attendants become better trained, seclusion is given up, and the insane are managed without seclusion by tact, and by well adapted structural arrangements, but with locked doors and often with the aid of chemical restraint. This is the third stage. A further stage is reached when doors are left unlocked, and the patient is allowed almost as much freedom as in an ordinary hospital. This stage is now reached in certain modern mental hospitals. In Egypt the first stage was passed in 1896; and treatment entered the second

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

stage—that of control by means of seclusion, modified by chemical restraint. At Abbâsîya, where the problem is complicated by the presence of hundreds of criminal lunatics, and the selected most dangerous insane of Egypt, it may be difficult to advance further towards a more liberal *régime*—at least until further funds are available.

But it might have been expected that in organizing the new hospital at Khanka a jump would have been made to the fourth stage. Consideration shows that our means and local conditions did not yet justify such an advance. With better-class (which implies better-paid) attendants and a more liberal budget, the fourth stage may be reached later on, at any rate as regards certain so-called "open" sections, but at that time it was felt to be unwise to attempt it. Khanka Hospital was therefore built with locked doors and fenced-in courts. It is, however, far in advance of Abbâsîya Hospital as regards absence of prison-like construction for the above-mentioned reasons.

Further developments should include an extension of the accommodation to such a degree that the number of beds can contain the annual admissions.

To determine the probable future admission-rate is somewhat difficult. Experience there shows that as the accommodation increases the admissions rise in number, as though a vacuum were created which draws in more and more cases, as has happened in other countries. The number of admissions of 1922, 1,073, will no doubt be exceeded before long. The census of Egypt gives the number of the insane existing in the country as 14,387, of whom 2,100 were in the hospitals for the insane, leaving 12,287 in the outside world. In the 1907 census the number given was 5,447. Even the higher figure of 1917 gives probably only a fraction of the real number of insane existing in the country. Why the census returns of 1917 should be so much higher than in 1907 is not clear. It certainly does not represent so great an increase in the incidence of lunacy.

Even if the hospital treatment of the insane in Egypt remains limited to that of only the dangerous and unmanageable, as at present, a moderate estimate of the annual number of admissions to hospital in the future might be 1,500. If the number of beds required is taken as four times that of the admissions, the total establishment required is seen to be 6,000 beds. In English mental hospitals the proportion of admissions to beds in 1922 was about 1 to 5 (23,026 admissions to 119,679 beds). The death-rate being now almost the same in the two countries, vacancies so caused will be about in equal proportions, but it will probably be long before it becomes necessary

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

to detain nearly all uncured cases in hospital in Egypt, as is done in England. Thus a freer discharge-rate might be held to justify the reduction of the proportion of admissions to beds to 1 to 4. There being now 1,841 beds provided, there remain 4,159 beds to be added. Experience will show how far this forecast is accurate long before it will be necessary to commence all the projected buildings, so that the figure can be modified according to the changing conditions. Of course only a portion of these extensive additions is required forthwith. Perhaps the addition of about 200 beds annually for twenty years would cope with the admission-rate; by that time I hope an equilibrium would be nearly reached between the admissions and the discharges and deaths. The readmission rate will fall when the present free discharge of uncured cases ceases—in 1922, 222 of the admissions were readmissions of old cases.

The chief requirements are as follows:

(1) A hospital near the town of Alexandria has long been wanted to accommodate the many cases arising there and in the neighbouring Mudirias, so as to relieve the excessive pressure at Abbâsîya and Khanka.

(2) An asylum for male criminal lunatics only is very desirable. The female criminal lunatics number only fifty-three, and for the present at least may be left in the ordinary sections.

The effect of the proposed Lunacy Law on the annual influx of these cases (130 in 1922) is problematical.

Possibly the male side at Abbâsîya will be eventually devoted solely to criminal lunatics and weak-minded prisoners, of whom many must exist in the various prisons for want of means of segregation. Already 475 of its 543 male beds are occupied by criminals.

Also the proposed Lunacy Law assumes the setting apart of a special asylum for criminals.

(3) A hospital for chronic, evidently incurable, fairly quiet insane idiots and imbeciles of the pauper class, who could be more cheaply managed thus than when kept in hospitals for the acutely insane.

(4) Proper separate provision for the European insane will be needed if the capitulations are abolished. It would be provided as part of item (1) above.

(5) Reception wards in various provincial towns.

(6) Central reception houses in Cairo and Alexandria, as foreshadowed in the Lunacy Law.

(7) Provincial hospitals for the insane at large centres like Tanta, Asyut, etc.

The suggested programme is as follows:

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

	Net addition of beds.
(1) At Khanka, two sections for fifty first- and second-class natives	50
(2) Convert whole of the male side at Abbâsîya to the use of male criminal lunatics	—
(3) Reception house at Alexandria for 45 patients	45
(4) Reception house at Cairo for 45 patients	45
(5) New hospital at Alexandria to hold 600 beds	600
(6) Khanka, add 400 beds, making total of 1,050	400
(7) Reception house at Tanta	45
(8) Reception house at Asyut	45
(9) Hospital for chronic insane turned out of acute hospitals	1,000
(10) Alexandria hospital extension to 1,000 beds	400
(11) Extend Khanka Hospital to 1,200 beds (?)	150
(12) Hospital at Tanta (?)	600
(13) Hospital at Asyut (?)	600
(14) Various additions for special purposes and small local reception wards, etc., say	179
Total	4,159
Existing accommodation	1,841
Total final accommodation	6,000

The above programme deals merely with the actual accommodation (beds) necessary, and no mention has been made of numerous necessary buildings required at the two existing hospitals, and at all the proposed new institutions.

No exact estimate is possible as to the eventual total cost of providing the 4,159 additional beds and the necessary buildings. Some idea may be obtained from the fact that the 1,841 beds already provided have so far cost L.E. 414,038, which sum, however, includes a small proportion of current repairs. The existing hospitals were, however, built when material was far cheaper than it is likely to be again, so that the cost per bed will probably be higher than L.E. 225 as heretofore. Perhaps about L.E. 391 per bed, as at Khanka, will be nearer the truth, in which case the expenditure necessary would be L.E. 1,626,000, or, if the programme is divided over a period of twenty years, an annual expenditure of L.E. 81,300. These figures do not cover the cost of sites and the provision of access by road or rail.

The reception houses at Alexandria and Cairo should each contain accommodation for about forty-five patients, and should be complete

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

hospitals with a resident staff, divided into admission, infirmary and acute sections, with four separate rooms for paying patients. Each might cost about L.E. 25,000.

The additional hospital at Alexandria should be situated on the coast towards Aboukir, and should hold 600 beds with separate annexes for 130 Europeans.(6) The site should be convenient to road and rail, and be of at least 130 acres. The villa-colony arrangement is recommended.

The cost of such a hospital might be L.E. 235,000.

These extensions, when completed, will rapidly raise the recovery-rate, which is the ultimate aim of all our efforts. At the same time further room for the paying classes will be provided; the pressure for room for them is now quite embarrassing, and I have spent a lot of time writing excuses for keeping people of social position with the paupers from want of room in the special villas. Better accommodation for the insane in the local hospitals will also have to be provided.

The transport of the insane should be undertaken by trained attendants of the hospital instead of by the police as at present.

The medical certification of insane interdicted cases for the Maglis el Hassby should be controlled by the lunacy authorities.

The institution of a pathological laboratory for the hospitals will be necessary.

The investigation of pellagra by field work, diet experiments and laboratory work awaits attention.

The attraction of a better class of attendants, especially of female attendants, and their better training may be found possible.

The Director of the Lunacy Division should have the status of a Director-General, and should no longer have to direct one of the Hospitals.

The Government Commission to revise salaries in the Egyptian Civil Service has recently decided that the salary of the post of Director of the Lunacy Division is to be reduced from the class L.E. 1,500–1,800 to the lower class of L.E. 1,100–1,300, so that he will no longer have the pay of a Director-General like the chiefs of the Prisons Department and of the Public Security Department—indeed, of most other Departments. In fact, the head of this division, which requires special professional as well as administrative capacity, is to be paid less than the heads of merely administrative sections, who have not spent much time and money in acquiring expert professional knowledge to fit them for their posts. This treatment of lunacy by the Government shows how little its importance is appreciated in Egypt. An even more glaringly inadequate salary is that fixed for Directors of Hospitals for the Insane, by which the Director of Abbâsîya Hospital of 1,500 patients, admitting more

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

patients annually than any mental hospital in the British Empire, and more criminals than Broadmoor, is to have a salary of L.E. 720–960, the same as that granted to a director of stores in another department.

The promulgation of a lunacy law is required to make permanent the present administrative procedure, which depends now merely on personal initiative and energy, and will alter as the *personnel* changes, and to limit the responsibilities of those in charge of the insane and so protect them from futile lawsuits. Even mechanical restraint is not yet made illegal in Egyptian Hospitals for the Insane; its disuse depends merely on the *personnel* in authority at the time.

Proposed Lunacy Law.

The law as at present drafted will recognize State hospitals (civil and criminal), prospective State reception wards (central and local), and private licensed houses. All to be directed by medical men. The conditions of licences follow English precedents.

An Inspector-General of the Insane is to be chief of the lunacy administration, and also have the general powers of an English Commissioner in Lunacy. A board of visitors will visit every institution for the insane every six months, and the Inspector-General must furnish them with information as to any case.

Voluntary boarders are to be admitted on demand. All other private patients shall require an order of internment by a judge on petition accompanied by two medical certificates, under the conditions mentioned in English Lunacy Acts. A judge may order detention in a reception ward pending his decision, and he may call for further evidence. Proceedings to be secret, and petition to be valid for fourteen days only.

Patients may be admitted into reception wards on the demand of relatives supported by a medical certificate for ten days.

Local authorities are to bring dangerous and wandering insane before the Governor, who, if (1) the person is destitute, or (2) wanders at large, or (3) is cruelly treated, or (4) requires detention in his own interest or in that of the public, will cause him to be examined by a State medical officer. He can meanwhile detain the person for three days.

If the medical officer certifies insanity or suspects insanity, the Governor may order the patient's detention in a reception ward, if the Governor considers the case to fall into one of the four preceding categories. The Inspector-General can also order detention in a reception ward. Such detention may be prolonged beyond ten days by a judge under certain conditions up to a total of thirty days. This is to cover the cases of transient attacks, drug cases, etc.

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

The medical officer of a reception ward will notify the local judge of cases requiring internment in a hospital for the insane, and the judge will make an order of internment in his discretion, after personally interviewing the patient.

Medical certificates, time limits of orders and of medical certificates, and corrections follow English precedents; interested and related persons are prohibited from certifying. Orders justify internment up to a year, and continuing orders by the Inspector-General will be necessary every year on reports by the directors of hospitals.

The Inspector-General is given authority to inspect alleged lunatics in unlicensed premises, and to call for evidence, lay down rules for their periodical medical examination, etc., or may set them free. He may order transfers between institutions and permit absence on trial. Directors of hospitals are to discharge all patients they consider recovered, excepting criminals. The Inspector-General may order the discharge of any case in a hospital or licensed house or in single care. The petitioner has power to order discharge unless the Director certifies dangerousness, and the Inspector-General confirms such certificate.

Applications to courts to compel release must have the previous permission of the Attorney-General.

Escape and recapture are dealt with as in England.

Criminal lunatics.—Judges have power to order the removal to a reception ward or to a hospital for the insane for mental examination any accused person whenever lunacy is alleged. His dossier is to accompany the accused. The period of observation is not to exceed one month unless the Inspector-General permits its extension up to six months. If the director of the hospital reports the accused to be insane and irresponsible, the court may make an order of internment, or ask for further evidence; the order is not to be made unless the evidence of guilt is satisfactory to the court.

Insane convicts whose sentences expire may be further interned as criminal lunatics by a judge's order.

The Inspector-General can only discharge criminal lunatics with the consent of the Ministry of Justice.

General.—Detention in licensed houses for payment is illegal except on an order of internment as above.

Temporary clauses arrange for using existing hospitals for the insane as reception wards, until separate reception wards are built.

Penalties are prescribed for aiding escapes, impeding the access of the Inspector-General to alleged insane persons, refusing to produce alleged insane persons, keeping them for profit without licence, refusing to obey an order of discharge, for all detentions contrary to

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

the provisions of the law, for fraudulent statements or certificates, for ill-treatment of the insane by the person in charge, for the unauthorized introduction of intoxicants, hasheesh, opium or alcohol into institutions for the insane. The Inspector-General of the Insane, being the head of the Lunacy Administration, has the general power of issuing rules for the institutions in his charge. Therefore the minute directions of the English Lunacy Act are not embodied in this law. The Inspector-General will select the registers and forms suitable, and issue them for use; they are in fact already in use, having been issued under this general power; nevertheless, I think that mechanical restraint should be definitely prohibited by law, except under stringent conditions. It is more necessary to make this prohibition in Egypt than in England.

Personal.

Private practice in lunacy.—There was some private practice offered on my arrival in Egypt. But in a short time it was apparent that all my time and energy would be required by the hospital work. However, when supposed to have an afternoon free for recreative purposes, I occasionally saw a few cases, and up to 1914 an average of L.E. 100 a year was earned in private fees. The majority of cases seen were treated gratuitously. During the war this work ceased except in urgent cases brought to my house, and in 1919 it was given up altogether, as my reduced energies were fully occupied by Government work. Medical consultations in Cairo are often peculiar. A number of medical men speaking different languages meet in the room of a patient. In this polyglot meeting it often requires tact to get near the patient, let alone examine him. French is preferably the medium of communication, but spoken in different accents by Germans, Austrians, Italians, Egyptians and English it is not easy to understand. After some experience of these meetings I kept clear of them as far as possible.

Hours of work.—The necessity of having to work on all seven days a week, without any Government holidays, Christian or Moslem, for twenty-five years, except one's annual leave, which was often used as sick-leave for recuperation from the exhaustion of previous over-work, left little time for recreation and social relaxation. But in 1920 I was enabled to depute some branches of my hospital work to an Assistant Director, and at last enjoyed a weekly holiday like the rest of the staff. Physical disabilities indeed rendered it necessary to pass some of the ward work on to a deputy. An attempt to blind me that might have succeeded, made by a criminal lunatic in 1920, decided me to make the change. At the same time I reduced my

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

office hours from 7 to 6 per day. Besides office work I had been present on the Hospital premises for an average of 23 hours out of the 24 daily, ready for emergencies, telephones, visitors, messages, etc. No week-end or Sunday holidays could ever be taken.

Until 1914 my office hours were on an average 7½ per day, *i.e.*, from 9 to 1.30 p.m. and from 3 to 6 p.m. all the year round; these hours do not sound very long to English ears, but in the months of November, December and January much longer hours were worked, up to 310 office hours per month (equal to 12½ hours daily for six days per week), while in the summer afternoon hours were curtailed.

Emoluments.—It may interest you to hear how lunacy specialists are paid abroad. I commenced in 1895 with a salary of L.E. 600, a partly furnished house, a food ration covering half of my messing requirements, two house servants, lighting, laundry and fuel. By 1904 the salary had risen to L.E. 1,000, and fees for criminals *expertises* were paid by the Ministry of Justice to the amount of about L.E. 200 annually. Since 1908 as lecturer on clinical psychiatry I was paid L.E. 50 a year. In 1911 I added the unpaid post of Director of the Lunacy Section to my work; but I had in fact already acted as such for years, planning the new Hospital and pushing its construction on, and advising the Government on all Lunacy questions. In 1914 I discharged the duties of Director of the Lunacy Division of the Interior as well as those of Director of the chief Hospital, but I only drew the emoluments of the latter post. In 1915, after eleven years' salary at L.E. 1,000, my pay was raised to L.E. 1,200, pensionable; fees for examining criminals and employees and travelling expenses were fixed at L.E. 250 a year. In 1917 the pensionable salary was raised to L.E. 1,300, and in 1919 to L.E. 1,500; and when later on a permanent 20 *per cent.* rise was given to all civil servants, it rose to L.E. 1,800.

The pension legally due after my twenty-eight years' toil amounted to L.E. 840.(7) Of course the extra period amounting to over four years, worked on Fridays and Government holidays, does not count for pension. In England the pension on the same salary and emoluments, with the same length of service, would probably be considerably higher, with possibly an addition for special service. The pension being so small, I, like other Anglo-Egyptian civil servants, had to remain at my post, even when I could no longer work at high pressure, simply to earn a better pension. It is bad both for the Government and for the official that this should be necessary. British officials in the East should only hold office in their prime, when they have ample energy, optimism and good health. Young blood is needed to face the trials of an enervating climate and Oriental fatalism. Twenty-one years of service should be enough, and should secure an

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

adequate pension of at least L.E. 1,000 a year, as in India. Fortunately the Egyptian Government eventually awarded me the maximum pension of L.E. 960 (nearly £1,000) in view of special services. In 1917 the medical profession in Egypt had the unusual experience of seeing *two* of its members in the Government service decorated with the C.M.G. in one year, I after twenty-two years', and a *confrère* after eleven years' service, receiving that honour. The Egyptian Government has recently shown its appreciation of my work by awarding me the 2nd Class Order of the Nile.

Conclusion.—For forty years the British have laboured in Egypt, and they have reformed the administration of the country to a considerable extent, Lunacy Reform being one of the smallest items in the programme; but the Egyptians apparently remain morally unaltered; and, be it remembered, it was their moral failure, producing of course material and administrative failure as a consequence, that brought in European intervention, and finally British occupation. The same *morale* that prevailed in Egypt up to 1882 remains unchanged. Meanwhile the population has increased from 7,000,000 to 13,000,000.

The past twenty-eight years have seen an attempt to apply British methods to the management of the insane in Egypt. The same attempt is now commencing in Palestine, where I suppose the same path will have to be trodden; but luckily the small population there will limit the problem.

Lunacy work in Egypt has repeated the experience of our predecessors in that country, the ancient Israelites, who had to make bricks without straw. The lack of permanence and finality in nearly everything, the rapid relapse of a reformed abuse if not watched, the great personal responsibility where no law or appeal exist and the consequent gravity of a single mistake, and the amount of routine work due to the inefficiency of the subordinate officials, have often rendered the life almost a slavery. There being such little expert assistance, one has had to work at high pressure, always in a hurry. What will happen to the insane in Egypt when independence is completely carried out—nearly all English officials can be removed legally by April, 1927—is a matter for speculation. It is difficult to suggest any safeguards for the rights of this category of minorities.

Before closing I must mention gratefully my obligation for unfailing encouragement and support to my life's partner, without whose help I would have long ago given up the task.

(1) Some years ago the State of Victoria, Australia, passed a law prohibiting private asylums; but the relatives of well-to-do insane refused to put their patients in State asylums, and removed them to other countries. The law was soon repealed. —(2) Not far from 2 *per cent.* of the total male population. This is surpassed by Switzerland, 1¾ *per cent.* of total population (male and female) being Government

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press

servants.—(3) I have estimated the number of married Moslems alive in Egypt in 1920 to have amounted to 4,823,000. The ratio of divorces to married persons thus becomes 20·7 per 1,000 per annum, or more than one in every 50 married persons was divorced during the year, or one out of every 25 marriages became dissolved during the year; at which rate, if no other factors were at work, all Mohammedans would be divorced people in 25 years' time!—(4) The proportion in another hot and dusty country, Australia, is 7 blind persons per 10,000 of the population.—(5) More valuable indeed than the political services for which so many beer and whisky makers have received peerages!—(6) The present European population of Egypt being 181,500, the number of beds allowed would be about 7 per 10,000. In England 25 per 10,000 are provided.—(7) To obtain which I have contributed 6 *per cent.* of my salary, *i.e.*, an average of L.E. 60 per annum.

Clinical Notes and Cases.

Two Cases illustrating the Conception of Moral Imbecility. By Ian D. Suttie, M.B., F.R.F.P.Glas.

Case 1.—R— is of working-class parentage. His father is said to have taken alcohol, but there is no evidence of excess. He is one of the younger ones in a family of fourteen, of whom three died young, and three in adult life. The remaining members of the family are all married or working, and have no psychopathic history. R— himself was not very robust, but was intelligent and ambitious; he had a good school record, but had to leave at 14 to earn his living. After a short service as a shopboy, he became a *colporteur*, and later—probably by the assistance of friends—he managed to put in a certain amount of training at a University, studying for the ministry. He was appointed a collector and organizer for Church charities (?); this brought him into touch with the "good and the great," and in a short time he obtained an appointment as a sort of lay assistant missionary.

Prior to this time we have no record of wrong-doing. He now, however, attempted to combine the pursuit of material interests with the Church work he professed and was paid for. He retailed tea as a sort of side-line, though, having no shop, he seems to have relied at first upon personal interviews with the members of the congregation to do business. He soon became more enterprising and carried on trade by post. He recognized the necessity for advertisement, and also showed his intelligence by circulating a leaflet and by issuing numbered coupons with his wares. In connection with these there was a regular "drawing"—money prizes—and the names of winners were advertised. There is no evidence that he did not run this lottery fairly (even though it was illegal), but one might conjecture that the distribution of prizes was such as to increase business. Then came rumours about the condition of a lady in the neighbourhood, and the Church, fearing worse scandal, decided to dispense with his services. He was told that he was a whole-time employee, and was expected to be this or resign. R— was loth to lose the prestige of his semi-ecclesiastical status, and determined not to give up the prospects held out

https://doi.org/10.1192/bjp.70.291.579 Published online by Cambridge University Press