by attempting to unravel questions of heredity as concealed in the very unreliable data mostly furnished by the relatives of insane patients.

Gartloch.—Dr. Parker gives, as usual, some interesting tabular information bearing on his population. This must be, unfortunately, somewhat discounted by the fact that many cases are treated at Duke Street, and thus do not reach him. But, of those admitted by him, he finds that the period of life from thirty to fifty supplies a greater proportion than the antecedent or subsequent groups of ages. He also continues to find increasing support of former experience that heredity of alcohol tends to early breakdown. Of the 112 cases in which he found a complete history, 78 *per cent.* of those who became insane before and at the time of adolescence (fixed at twenty-six years of age) had alcoholic heredity, while this was associated with only 40 *per cent.* of those of a greater age. Dr. Robert Jones found exactly the same facts. Of course these figures, which have become reliable by their long accumulation, cannot be taken to controvert Dr. Karl Pearson's findings as to the heredity of alcohol. They only go as far as establishing that among those who have an alcoholic heredity the predisposition is to break down early. It would seem, at least, that if alcohol has no direct deleterious effect on offspring, it must have some share in producing an inborn condition of non-resistance to other ætiological factors.

Dr. Parker points out, again, the bad effects of boarding out on the residue of asylum population, and suggests that these might be met by boarding out some of the troublesome but not dangerous cases, under a carefully prepared system of grouping, with medical supervision. He thinks that the freer life under these conditions would tend to reduce troublesomeness, and seeing that experience goes to show that lunacy tends to adapt itself to environment, we should think that such an idea is worth trying if a suitable locality can be found.

A Scottish Chartered Asylum.

Royal Edinburgh Asylum.—We turn with much interest to this report, as no doubt will be the case with many others, lay and medical, who have been accustomed to study it in a long series of years as the exposition by skilled observers of interesting and important points occurring in the practice of the year. We are glad to see that the managers are able to report a continuance of the good and successful fight against the common enemy. Dr. Robertson's own report breathes progress in every part; it is quite certain that he will take every advantage of his present great opportunities to give full scope to those original ideas which mark his attitude to the insane. One would have wished to be able to lay down his report without any feeling but that of complete satisfaction. This, however, cannot be the case, for in pointing out aims which are undoubtedly right, and have been endorsed by the practice of all his compeers, he has been indiscreet in classing as undesirable some practices which have been shown to be incontrovertibly sound, on grounds of reason as well as of emotion, and only to be inapplicable when wrongly applied. It is in no carping spirit that we make this criticism; we desire only to speak in the interests of

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all those who have, like himself, to face most anxious responsibility, those who may well to some extent feel themselves condemned in the sight of the public.

Asylum being hospitalised.—Under the supervision and direction of these new officials, trained, as almost all of them have been, in hospitals, the work done by the staff has naturally assumed features of a more hospital character. This is our aim nowadays, and nothing has aided us more in attaining this object than the introduction into asylums of hospital-trained nurses. My own policy for many years has been openly to put under suspicion every practice that is in operation which is peculiar to asylums. If I find I can do without it I abolish it, and if I find it cannot be done without, but that it can be replaced by another method of a hospital character, then I introduce that. Subjected to this stern criticism it is surprising how many anachronisms and unmedical traditions have been exposed, and with a policy of hospitalisation so definite and active, progress towards the goal we strive for is a comparatively simple matter.

The disuse of padded rooms.—As an instance of characteristic asylum practices which have been discarded, the disuse of padded rooms and of the practice of locking up patients in single rooms by day may be mentioned. Strange as it may seem, the padded room, of which we are now beginning to feel ashamed, was apparently invented about sixty-six years ago by Conolly, the great apostle of the non-restraint and the humane systems of treatment for the insane. It is quaintly described by him in his sixth report as "a room of which the floor is a bed and the four walls are padded." In his day its employment was without doubt a step in advance, as it was a substitute for the less humane methods of mechanical restraint by strait jackets and straps which he had discarded, and was a sheer necessity. Owing to the ill-treatment which his patients had previously received at the hands of their attendants, many were revengeful and aggressive, and considerable risk was run when restraints were removed for the first time. For ten years the system of non-restraint was not officially recommended by the authorities because of this danger. At that time the padded room was no doubt needed, and its use was to be commended, but now that the art of tactful management is practised, and patients from the first moment they enter the wards are treated with consideration and kindness, it has become practically unnecessary. Cases of furious or raging mania, such as were described in those days, are never seen now, because they were goaded into being by the vile treatment they received, whereas skilful treatment has a tranquillising effect. We now employ a very much larger staff than was done in those days—probably two or three times as great—and we have a large night staff, while they had none. Our attendants and nurses are not only more numerous, but they are carefully trained and highly skilled, and they are of a more intelligent and respectable class. Conolly writes of the nursing staff of that day that they "were worse dressed and wilder looking than the generality of the patients." With a staff such as we now have and good supervision, we rely on constant personal care and attention by night and day to tranquillise the excited. We are glad to see these symbols of the past disappear, not so much on account of any direct harm they actually did to the patients when not abused, but because their influence on the *morale* of the nursing staff was not elevating.

Is it in accordance with medical science to say that cases of furious or raging mania are never seen now? Let us take the admissions into Morningside itself during the year (Table XI): three cases of acute delirious insanity in each sex are shown, and among the recoveries one male, and among the deaths one female—the latter should read as two females if "exhaustion from delirious insanity," assigned in the death-table (Table V), may be taken to refer to these cases. There is an obvious inaccuracy in the figures of Table XI. It may be that these cases are to be excluded by the saving clause of "such as were described in those days." But even if this is so, can we exclude the cases of furibund epilepsy and of alcoholic illusions which are liable at any time

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to come under our notice? Then what is to be gained by preaching that such cases can be manufactured by forms of treatment that are dead and gone long ago? We all know that any case may be spoilt by wrong treatment, but as such intra-asylum treatment is now impossible, is it right to suggest that failure to tranquillise by skilful treatment points this way? We entirely object to the terms in which Dr. Robertson has spoken of (*a*) the padded room and (*b*) seclusion. With regard to the former, he seems to have completely forgotten that second purpose for which the padded room is now generally used—the care of the weak and feeble, whose tendency to fall about and injure themselves has been so mercifully obviated. And as to the latter, surely the occasional use is dictated by consideration of what is proper for the patient, for the other patients, and for the staff itself. For the patient we know that continued exposure to the operation of external stimuli in a state of excitement is prejudicial, and that its bad influence can be modified and often removed by withdrawal of the patient from them, by his being placed by himself in an unlocked room, and that therefore it is called for as a medical procedure. If, as often happens, the patient cannot be got to see this for himself, and continues to expose himself, common sense demands that the treatment adopted shall be made efficient by turning the lock on him. We need say nothing about the good of the other patients; environment is too important an element nowadays to be neglected. Why should a sick patient, sent to an asylum for tranquillisation, be distracted and injured by preventable noise and alarm? As to the staff, there can be no more demoralising agent than continued hopeless waiting for better things. Nurses are but mortal, they themselves are liable to mental injury, they work in bad environment, and should be saved that continued mental stress which ranks highest among recognised ætiological factors, outside heredity and alcohol. It is not the influence of such "discarded practices" as padded room and seclusion that is bad for their *morale*; it is the wrong spirit in which they are used. It is the fatal ease of their use that engenders a wrong frame of mind. The same arguments apply precisely to the bed-treatment of acute insanity, which Dr. Robertson uses with approved effect. At one time this was decried by many, officials and others, as leading to a lazy, trouble-saving attitude, but now it is freely adopted as the best of all treatments when used remedially. So far from the *morale* of the nursing staff being injured by these practices, we should imagine that it would be fortified by their use when it is clearly seen that they are adopted by a strong man who is known to be utterly opposed to their improper use. Nothing could better demonstrate serious but determined consideration of the patient's needs on his part. The present writer had the advantage many years ago of being told by a Commissioner, who had acquired his physicianly frame of mind in a general hospital and not in an asylum, that it is most unphysicianly to neglect the use of any form of treatment, such as restraint if it was called for, however distasteful it might be. When reading that one patient was secluded at Morningside "on account of maniacal and dangerous excitement," we cannot help feeling that Dr. Robertson himself has recognised the justice of this view.

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