the space of a brief notice it is not possible to give the reader an adequate idea of the manner in which he has acquitted himself of his task. In order to do that, it would be necessary to enter into an elaborate discussion of the complex and difficult subjects with which his essay deals—in fact, to write an essay almost as long as his.

PART III.—PSYCHOLOGICAL RETROSPECT.

Public Asylum Reports for 1873.

(*Continued from page* 307.)

NEWCASTLE-ON-TYNE.—*Ninth Annual Report.*—Mr. Wickham enters into the following defence of Australian tinned meats, which they, perhaps, hardly required:—"The Australian tinned meats, which are now freely used, at first met with much opposition, and, even now, a few of the more ill-humoured patients object to them. To some of the better disposed ones the flavour is at first a little disagreeable, but the same may be said of fairly intelligent people outside, and they are so very few here that it is impossible to consider them in the arrangement of a diet table. As for its nutritious qualities, I have only to say that the patients eating it (excluding those suffering from wasting diseases) gain, or at least retain, their weight. The recovery rate for the three years I have held office has been 45·9 per cent. as against 33·5 per cent. during the previous five years, and the death rate has been steadily decreasing, while the necessity for ordering extras for the sick is reduced to the very lowest minimum. The Australian meat has been largely used during that time, and, though I do not wish to ascribe these satisfactory results to its agency, it must be apparent that it has not interfered with the primary objects of the institution."

The argument to be derived from the statistics of the several years is, however, fallacious. It is of course true that the use of the meat, and other points in the management, did not obviate the apparently good results quoted, but an examination of Tables III. and IV. will show that the higher recovery rate and lower death rate depends really on a falling off in the admissions. The recoveries of any year are largely derived from the admissions of previous years; when the admissions fall, the rate is each year calculated in a smaller number of admissions than that of their own year, and so appears larger than it would if the number of admissions continued uniform. Similarly for the deaths, the death rate is higher among recent admissions than among chronic residents. An average of asylums, calculated by us some years ago, showed a death rate among patients of less than one year's residence of 15·5 per cent., among those of five years' residence of 5 per cent. In Scotch asylums, the figures given by the Scotch

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Commissioners in Lunacy are 16·9 for the first year, and from 3·9 to 6·4 after the fifth year. Therefore, with a regular decline in the number of admissions, the death rate should *(cæteris paribus)* decline also.

The question of seclusion takes a prominent place in this report. The following is from Mr. Wickham's report, and, apart from the fact that the seclusion in question ought to have been duly recorded, is by no means a mere apology, but to a great extent a vindication of his treatment. Such a case as he describes cannot be treated except by restraint or seclusion or by some worse means, as, for example, large doses of morphia. Cases of other types requiring seclusion as the most humane means of treatment, must from time to time occur in every asylum.

The treatment pursued has been much the same as in former years. Seclusion has been largely employed with beneficial results, both as regards the recoveries and the small number of the deaths. In one case to which the Commissioners specially refer—and to whom I beg now to express my deep sense of obligation for the forbearance with which they treated the omissions in the Medical Journal—the seclusion was more than usually prolonged. Perhaps I may be permitted to quote a portion of the letter which I addressed, at the request of the Commissioners, to the Secretary of the Board in explanation of this circumstance:—

"With reference to the prolonged seclusion of E. T., I have to inform you that she on two occasions nearly killed a nurse, injuring her so severely that she never was the same woman up to the day of her death, in a struggle with another patient, M. T. E. T. is one of the most intensely homicidal patients I ever saw, and no one's life is worth five minutes' purchase when she is at large. After she had made several dangerous assaults, I, having given the case my most anxious consideration, and having made repeated and prolonged examinations of the patient, was reluctantly compelled to order her to be placed in seclusion. It must not be supposed, however, that she looks upon her seclusion as a punishment, which certainly was never intended. The poor woman is, I firmly believe, far happier in her bedroom than she was before, when she was constantly being irritated; and, so far from expressing any wish to get up, it is with difficulty that on the few occasions that I have three nurses to spare, she can be got to take a walk. Latterly this has been given up, because I believe she suffers from valvular disease of the heart, and it was thought inadvisable that she should be put to a struggle every time she was desired to go out—a struggle with her being of the most exhausting kind—and the weather has been such as to preclude regular exercise in the open air during the last six months. I only adopted this manner of treating her case after carefully weighing all the facts, when I was obliged to come to the conclusion that, as her homicidal propensities had so much developed themselves, the safety of the patients and of the nurses seemed to me to demand that in so exceptional a case exceptional means should be taken, more especially as the poor woman herself appeared to be happier alone than in the company of others."

She now, I may add, spends the greater part of the day in an airing court, by herself, or in her bedroom, with the door unlocked, which is not, I understand, according to law, "seclusion," though from the fact that she never leaves the room unless invited to do so, the isolation is as complete as if the key were turned. It is proper to observe that this is a case of chronic insanity, in which there is no hope of recovery. She is supplied with books, knitting, &c., and is, to all appearances, perfectly happy; but, at the same time, her homicidal attacks are so sudden and so extremely violent, and the body of the patients in whose ward she lives are so averse to associating with her, that it would be unjustifiable to sanction it. With reference to the case, I venture to make two remarks. First, that it is not a proper case for the wards of an ordinary lunatic asylum. This woman inflicted

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such injuries, in the course of her savage assaults on a nurse, that she never held up her head again, and shortly afterwards died in a struggle with another patient. Had E. T. killed the nurse herself she would have been sent to Broadmoor; but because she has been by my adopting measures which appear severe—although it happens in her case they are not so—prevented from taking anyone's life, she is kept here, virtually a criminal, but not so in the eyes of the law. Surely such a case—and she is only an example of many—should be provided for in the State Asylum, where the staff of nurses is very large. It would be easy to form regulations for the admission of such cases, so that the law should not be abused by the sending of patients for whom such a provision is not necessary. And, secondly, with regard to seclusion itself. That there has been a reaction lately in this matter is evident. Dr. Rogers, the Medical Superintendent of the County Asylum at Rainhill, in Lancashire, read a most able and interesting vindication of this form of treatment at a meeting of the Medico-Psychological Society, in 1872, and the discussion which followed, in which some of the ablest members of the medical profession in the specialty of mental disease took part, showed there was a general feeling among those present that Dr. Rogers was in the right. The indiscriminate outcry against seclusion marks an interesting epoch in the history of empiricism, and those whose boast it is that they never employ it at all, in season or out of season, are as reasonable as if they should say that they never prescribe a blue pill because forty years ago it was the fashion to saturate one's patients with mercury. It is a matter of common observation with the medical officers of asylums that certain irritable and mischievous patients are never so quiet and happy as when they are confined to bed, or, in other words, placed in seclusion for the treatment of some trifling complaint which calls for rest and consequent isolation during the day, whether in a dormitory or in a single-bedded room. Patients who have recovered from insanity have often told me how they wished I had secluded them more, as the having to get up when they felt themselves unable for it, and the having to mix with the rest, was a constant source of irritation to them; and, besides, they could never look back on the exhibition they made of themselves to their fellow creatures with any feelings but those of disgust and horror. Asylum life itself is but a vast seclusion, and those who dream that the days of seclusion are numbered, should also advocate the abolition of the Lunacy Acts. No doubt it is a form of treatment which is liable to be abused, and it is no answer to this objection that so is any other; because medicines and instruments of restraint may be kept under lock and key, and served out to the attendants in such a way as to leave them no chance of misusing them, while seclusion is in every attendant's power. And as an experienced hospital surgeon can decide in an instant on a capital operation, and so lead his students to imagine that he has not bestowed any thought on the case, so the practised medical officer of an asylum may, without hesitation, order a patient to be secluded in such a way that the attendants may think there is no responsibility incurred. But if a valuable, a safe, and in some respects an unequalled remedy is to be thrown aside for such considerations as these, there is an end of scientific treatment. The proper way to meet the abuse of seclusion is to assure oneself, by selecting conscientious and humane overseers for the subordinate officers, and by well-timed personal visits to the wards, that no patient is ever secluded without the immediate knowledge of a medical officer, and not to indulge in vague dreams of its abolition, which can never be realised, even if it were desirable that they should be.

Although we agree with Mr. Wickham in his main argument, we do not desire to be understood as thinking a frequent recourse to seclusion or restraint at all inevitable or necessary. With judicious and experienced attendants a difficulty may be tided over without the necessity of resorting to it. But, unfortunately, such attendants are not always at hand. Occasionally a patient is found utterly unmanageable until placed under the care of some particular attendant, who possesses precisely the temperament suited to him. In small

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asylums there are but few changes of wards and attendants possible, and this may to some extent account for the fact that seclusion is rather more common in the smaller than in the larger asylums, though it may be that the closer supervision leads to a more accurate record.

The following extracts show that in some of the larger asylums seclusion is largely resorted to. The two first are respectively from the Medical Superintendent's and Commissioners in Lunacy Reports at Prestwich :—

> The isolation of a patient in a room during the day has been resorted to in the treatment of the majority of admissions, and in all cases of maniacal excitement where the necessity of mental quietude is indicated. Where many persons are gathered together, as in an asylum, and where epileptics constitute nearly a fifth of the entire number, seclusion or separation is at times necessary to protect the quiet and orderly from the disorderly. In these cases, and in the paroxysmal and impulsive forms of insanity, rest with seclusion has been prescribed with the best results. I consider seclusion an important aid in the moral treatment of the insane, and in many stages of the malady a most merciful and beneficial means of cure. No matter from what cause it is adopted, its occurrence is faithfully recorded.
>
> We found four men and five women in seclusion ; one of the latter seems to pass most of her time in seclusion, and, according to the Medical Journal, has now been secluded for nine weeks without interruption. A male patient appears some time since to have been secluded for twelve consecutive weeks, and in many other instances seclusion seems to have been adopted, from one to several weeks in succession. Such prolonged seclusion must, we think, be prejudicial to the patients, and every effort should be made to diminish it.

Dr. Hearder, at Carmarthen, finds that the increased experience of the attendants gained by years of training is enabling him to reduce seclusion to a minimum :—

> As I have before stated, the health of the community has been remarkably good. There has been no serious accident. Many of the chronic cases, which in past years were noted for noisy, violent, and destructive habits, have been quiet, orderly, and easily managed—a result of the improvement in their surroundings, and of the increased tact and experience of the attendants, acquired by the training of years. It has been necessary to resort to temporary seclusion in but few instances, and these chiefly with epileptics, on account of paroxysms of excitement following their convulsive attacks. In the case of one woman modified restraint was deemed needful. This was accomplished by merely sewing the sleeves to the waistband of her dress. For several weeks previously she had required the unremitting attention of two nurses, and restraint was employed to avoid the risk of injury which was incurred during oft-repeated struggles with her. While her hands were confined she was quiet, cheerful, contented, and happy ; when they were at liberty she was sullen, abusive, violent, persistently destructive, and unceasing in her attempts to nudify.

At the Cornwall Asylum, also, seclusion is being practically abolished, apparently merely as an arbitrary measure, as we do not find any circumstance noted as rendering this more possible now than formerly ; nor is any effect resulting from the abolition, good or bad, recorded. The Commissioners say :—

> No one was yesterday in seclusion, and only one – a man—was restrained, but so treated for surgical reasons. With reference to the great alteration which has taken place in the treatment of patients here, both in regard to the number of patients secluded and the extent of such seclusion, during the 15 years ending

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in 1871, a table, drawn up by Dr. Adams for quinquennial periods, shows that from 1857 to 1861, 1,868 patients were under treatment, and the amount of seclusion was 4,157 hours; from 1862 to 1866, with 2,324 patients, seclusion was reduced to 1,514 hours; and for the five years from 1867 to 1871, with 2,715 patients, to 179 hours.

Mr. Adams says:—

Seclusion has been had recourse to in the case of three men and seven women. The total duration for the year has been less than 20 hours. With regard to this question of seclusion, the Commissioners in Lunacy, in their last annual report, state (referring to some asylums) that in a remedial point of view it is in many instances employed unnecessarily and to an injurious extent, and for periods quite unjustifiable; and that, while not doubting its utility in certain cases, they consider that it should be had recourse to as seldom as possible, and that its frequent employment is not only bad for the patients, but that it does injury to the attendants by leading them improperly to seek relief from the duties and responsibilities involved in a constant and vigilant supervision of those committed to their care. Believing such to be the case, it has been the practice here for some years to use seclusion as little as possible, and never to permit its employment except by medical order. The result is that the amount of seclusion during the past year has been less than was often found necessary in a single day some years ago, and this notwithstanding a very large increase in the number of patients treated. There are, however, and always will be, cases in which its use for short periods is the most suitable, as well as being the most humane, method of treatment.

At Rainhill, the Visiting Commissioners note the large proportion of inexperienced attendants as probably increasing the amount of seclusion.

The greatest variation appears to exist not only as to number of instances in which seclusion is resorted to, but also as to the duration of the individual instances. At Lancaster, we find the average duration stated to be 1 day 3½ hours over 395 instances. In the majority of cases an instance of seclusion is spoken of as a day. In others the periods appear to be reckoned by hours, as at Abergavenny, where two-thirds of the instances were for less than three hours.

At Carlisle, we find the following in the Commissioners' entry:—

The instances of seclusion for maniacal or epileptic excitement, or for violent propensities, have been on the male side 225 applicable to 21 men, and on the female side 102 applicable to 33 women. Of the men, one, an epileptic, was secluded upon 60 of the occasions, usually for a whole day at a time; and another, of homicidal propensities, and since removed to Fisherton House, accounted for 67 of the occasions, for the most part of a day's duration each. The amount of seclusion for the above causes is no doubt large, but it must be remembered that it refers to a period of 18 months. Besides the above-recorded seclusion, 21 men and 19 women are entered as having been kept in their rooms on account of bodily ailments—the former upon 133, and the latter upon 121 occasions.

We find here a classification of the reasons for seclusion, which reminds us that there is still room for improvement in recording seclusions, if fair comparisons are to be made between different asylums. We believe there are still several asylums where seclusion is largely resorted to, but not so called, except it be for violent propensities. If for maniacal or epileptic excitement, or to prevent the

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intrusion of others, it is called "medical treatment," and no notice taken of its being also seclusion.

At Brookwood a somewhat ingenious escape from the name of seclusion is effected. We think, however, that if one attendant can manage a patient in a single room, one, or at most two, might do so in an airing court or in an open field. If, however, the procedure is for the attendant to act as a lock to the door, we hardly detect the distinction.

There is no record of any instance of seclusion or restraint since last visit, and both, indeed, have for some time past been practically disused in this Asylum. Excited patients are placed in single rooms, where they are kept in special charge of an attendant, but the doors are not shut. We found one man yesterday who was in a single room under these conditions. It may be well here to allude to the fact that there are no padded rooms in either division, and that the proportion of single rooms is much below what is usually deemed necessary, in other county asylums, there being only 56 such rooms here, or rather less than one-twelfth of the total accommodation. Dr. Brushfield is of opinion this is sufficient, and that as a principle association at night is preferable to isolation.

We find references in nearly all the other reports to the amount of seclusion, as this is more or less distinctly referred to in the entries of the Visiting Commissioners. It appears to us that to proscribe seclusion as seclusion is a mistake. It is unquestionably the best and most humane treatment of certain cases, or if we said of certain symptoms we should, perhaps, more correctly express our opinion of the proper place of seclusion. Treating symptoms must be had recourse to when they assume an urgent character, and pending the effect of treatment directed by the real nature of the case; often, also, symptoms are all we have to treat, an accurate further diagnosis not being possible. The special symptoms calling for seclusion are chiefly noise, violence, and other manifestations of excitement, and these are often in an asylum more frequent than they need be from the absence of proper treatment, due usually to the want of sufficient means of occupation and amusement and of experienced attendants; at times possibly to the inappropriateness of more strictly medical measures. A large amount of seclusion points, therefore, to an unsatisfactory state of the patients from some of these reasons, but it is not itself to be condemned. The absolute abolition of seclusion must, we fear, be purchased sometimes by injury to the patient himself, or more often to those about him from his noise and violence. For example, the recommendation to treat a case of acute mania by prolonged walking exercise, when he is really in some danger from exhaustion, has always seemed to us very mischievous.

Prolonged seclusion can, however, rarely be justifiable, as it must be attended by serious risks to health. We should consider seclusion prolonged that extended beyond one, or at most two, consecutive days.

We find in these reports only two or three casual references by the Commissioners in Lunacy to the subject of shower or plunge baths, but no statement anywhere as to the extent to which either of these

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are used either with medical or punitive intentions. Yet these are as open to abuse as seclusion, and require, we think, equally jealous watching. We know that in many asylums the shower bath is never used, and that in some such an apparatus does not exist; but we should like to know to what extent it is employed in those asylums where it is a staple article in the treatment.

BERKSHIRE.—*Third Annual Report.*—We miss from this the report of the Visiting Commissioners; we suppose it has been crowded out by the pressure of other matter. We note throughout all the reports we have examined a marked absence of strictly medical observations, and hope to find our clinical columns the richer for it. We hardly, however, appreciate the following, either as material for our clinical column or as instruction for the Visiting Magistrates:—

Four males and four females were affected with epilepsy, and one female with chorea. The latter, who was in feeble health, pale, and much reduced, presented that characteristic adventitious modification of the heart sounds called a "bellows murmur," so often found co-existent with chorea, and which, in such cases, is generally considered to depend upon anæmia—a diseased state, indicated by debility, pallor of the face, and impoverishment of the blood.

A partly medical, partly domestic, history of several cases is given at some length. With regard to two of these, we are told "Any details regarding the method of treatment adopted in these two very successful cases would be foreign to a report of this kind; but it may be remarked that they have produced the conviction that it is not alone in those diseases of the nervous system, due to a specific animal poison, that the administration of certain well-known therapeutic agents, in large doses, is likely to be productive of signal benefits."

The popularisation of medical histories for annual reports is perhaps useful in attracting subscriptions to various charitable institutions, though, even then, we always read them with pain; but we doubt whether there is any necessity whatever for their presentation in the report of a county asylum.

A history is given of the case of a criminal lunatic. We read, "At the time of his admission, as well as after he had been under observation some weeks, *beyond the mere fact of his insanity* the medical officers of the asylum could not discover anything in his general state which, in their opinion, seemed imperatively to demand his removal from gaol to the asylum." The italics are ours. The judges at the ensuing, and again at the following assizes, wished him to be produced:—

Prior to this, the medical superintendent had expressed his opinion that the patient was quite capable of being put upon his trial, and of fully understanding the proceedings, although he was not prepared to say that he was a person of sound mind. A certificate was produced from him to this effect, besides a statement that he was coherent, able to converse sensibly on ordinary topics, and that the insanity in his case was of such a nature that a difference of opinion might probably arise in regard to its existence. This certificate was forwarded to the Home Secretary, but he refused to grant a warrant for the patient's removal to Reading for trial, and laid down the law that such a warrant could not be granted unless the patient was certified to be of sound mind by two medical

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men. The patient and his wife were naturally much chagrined, and inveighed bitterly on the cruelty and injustice of the law, which prevented the former, who was both capable and desirous of being tried, from appearing before a jury. The circumstances of the case having excited commiseration, a short time previous to the next assizes, which were held in July last, the patient's wife was advised to have her husband examined by two neutral local medical men, which was accordingly done, and they being of opinion that he was of sound mind, wrote certificates to that effect, which were forwarded to the Secretary of State, who then granted the long-desired warrant for his removal to Reading Gaol. The prisoner was in a few days afterwards tried at the assizes, and acquitted by the jury on the ground of insanity, although the judge, in summing up, remarked that no evidence had been given, and nothing had been adduced, to prove that at the time when the prisoner fired the gun at his brother he was insane. As a necessary consequence of the verdict returned, he was ordered to be detained in custody during her Majesty's pleasure. The facts in connection with the history of this case, which have just been narrated, appear to lend weight to the opinion entertained by many that the entire law relating to criminal lunatics stands much in need of revision. It is likewise hoped that it will not be considered presumptuous to express an opinion that any prisoner committed for trial should not be transferred from gaol to the asylum unless his symptoms are of so aggravated a kind as to preclude the possibility of his being retained in prison. Also, that if from that reason the prisoner's removal to an asylum becomes absolutely necessary, he should be removed to the State Criminal Asylum, and should, as a matter of course, be brought back to stand his trial at the assizes, without it being necessary to have him certified to be of sound mind, which it is obvious in the majority of cases would be an impossibility.

This case is interesting from several points of view. From the peculiar nature of the man's insanity, Dr. Gilland succeeded by a sort of side wind in evading the present state of the law, which, in case of any prisoner being found to be insane before trial, brands him as a criminal, without trial, and leaves him so, so long as his insanity continues. Dr. Gilland's suggestion that these cases should be sent to the State Asylum we fully endorse. Now that it appears to be admitted that the criminal (?) insane at Broadmoor have a fair claim to be relieved from association with the insane criminals there, we hope that the contaminating presence of not a few of the latter in our county asylums will not be much longer overlooked.

(To be continued.)

PART IV.—NOTES AND NEWS.

ANNUAL GENERAL MEETING OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Council met at the Royal College of Physicians at 10.30 a.m., Dr. Harrington Tuke, president, in the chair.

THE MORNING MEETING

was held in the Library of the Royal College of Physicians at eleven a.m., and the afternoon meeting at two p.m., of Thursday, August 6th.

Members and *Visitors* present:—Dr. Rogers (president), Dr. Guy, Dr. Ferrier, Dr. Harrington Tuke, Dr. Maudsley, Dr. Boyd, Dr. Paul, Dr. Blandford, Dr. Sibbald, Dr. Monro, Dr. Wood, Dr. Mould, Dr. Hack Tuke, Dr. Sutherland, Dr. Christie, Mr. Bayley, Dr. Gilland, Dr. Wickham, Dr. J. A. Campbell, Dr. Batty Tuke, Dr. W. Williams, Dr. J. Stewart, Dr. Jepson, Dr. Stewart (Dublin), Dr. Rayner, Dr. Mickle, Dr. Yellowlees, Dr. Grant Wilson, Dr. Stilwell, Dr. Sankey, Dr. E. S. Willett, Dr. Orange, Dr. Brushfield, Dr. T. O. Wood, Dr. Adam, Mr.

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