to add those of the minister of religion, who performs divine service in the asylum, which we are assured "is of a character suited to the intellects of those who attend." We suspect that there are not a few asylum chaplains in England of whose discourses the same might be said with too much truth. It may be stated, for the benefit of those assistant medical officers in our own country who are desirous of becoming superintendents in the Colony, that while the wages of attendants are thrice as high as in the old country, the salaries of superintendents are lower than those paid in England.

There were in the asylums of New Zealand on the 1st Jan., 1885, 1,452 patients. During the year 454 were admitted, while 171 recovered, 15 were relieved, 102 were discharged not improved, and 95 died, leaving 1,523 patients in the asylums December 31st, 1885.

It only remains for us to express our regret that Dr. Grabham's energetic and well-intentioned efforts should have been thwarted by local ignorance and parsimony, and our hope that in whatever field of labour he may enter in future, he may meet with more encouragement and success in endeavouring to carry out the work in which he may be engaged.

D. H. T.

PART IV.—NOTES AND NEWS.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The quarterly meeting of the Medico-Psychological Association was held at Bethlem Hospital on Tuesday, the 9th November, 1886, the President (Dr. Savage) presiding. There were also present Drs. S. H. Agar, A. H. Boys, G. F. Blandford, David Bower, Edward East, Hyslop, W. M. Harmer, D. G. Johnston, A. Maclean, W. J. Mickle, H. Hayes Newington, Percy Smith, H. Sutherland, H. R. O. Sankey, A. H. Stocker, C. W. Sherrard, Hack Tuke, Thos. S. Tuke, Charles M. Tuke.

Mr. A. Aplin, M.R.C.S. Eng., L.R.C.P. Lon., Medical Superintendent of the Notts County Asylum, Sneaton, Nottingham, was elected a Member of the Association.

The PRESIDENT exhibited the brain of a woman who died from general paralysis of the insane, the whole symptoms running their course within twelve months. Its chief interest was that it showed extremely well the local wasting about the motor areas. There were in life marked symptoms of exaltation and marked tremor, the reflexes greatly exaggerated. The lower extremities became so contracted and the muscles so wasted that one expected to find very great degeneration in the lateral columns of the cord, but they showed next to nothing to the naked eye. There was, in the brain, a very marked wasting just behind the ascending parietal convolution; and there were two large lakelets marking wasted convolutions. So, in this case, we had, with marked wasting of motor cortical areas but slight evidence of secondary cord degeneration, and this was probably due to the rapidity of the whole process. There was excess of fluid, and but few adhesions.

Dr. HAYES NEWINGTON read a paper on "What are the Tests of Fitness for Discharge?" (*See* Original Articles).

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The PRESIDENT read the following short paper on the same subject as the above, considered principally from the homicidal point of view.

When should Homicidal Patients be sent on Leave or Discharge?

The cases must be divided into those in which the patients have committed murder and those who have only threatened. As to those who have been pardoned on the ground of insanity, many doubtless are as curable as any other patients suffering from acute forms of insanity, but there is, I believe, a very strong feeling against the release of such patients. They are, as a rule, credited with the tiger's supposed lust for human blood when once it has tasted it, but at the bottom of the whole matter is the uncertainty of medico-psychology. If a doctor could say, on the one hand, "There will be no return of insanity" in a given case; and on the other, "The murderous act was due to insanity which has now passed off," the duty of the doctor would be simple and safe; but as it happens now, the doctor has to take upon himself the responsibility of returning a past and possibly future murderer to society. At Broadmoor, there is power for outside physicians to report upon the sanity of a criminal lunatic, and thus relieve the Superintendent of some responsibility. It seems a pity that many young women should remain in criminal asylums in consequence of infanticide committed during puerperal insanity. Doubtless they belong to unstable stocks, but that is not enough to cause a woman to be confined for life. To me it seems very terrible to think that not only has the woman the hell of memory, but the purgatory of her surroundings, and all as the result of an act for which she was no more responsible than the warders who guard her.

To the practical point as to when I would let out a woman who had committed a murder, I would say after about twice as long probation as if she had been insane without committing the murder, and then only after careful consideration of the surroundings to which she is to return. This much I think society has a right to insist upon, beyond the mere medical dictum of sanity restored. There must be a distinction made as to ordinary murder and infanticide, and though, as a rule, a life is said to be a forfeit for a life, yet, as we know that it is rare to execute for infanticide, so for the insane crime of child murder I think the probation should be less than after other forms of murder committed during insanity. I admit that in some ways the risk is almost greater of relapse, for most of these cases are young women who will very likely have other children, and we all know the tendency there is for similar delusions to arise when the insanity arises under similar conditions. Next it is well to consider whether persons who have committed murder should ever be let out of criminal asylums when persons murdered have been adult. This should depend on the cause of the insanity to some degree, and also on the nature of the insanity, that is the form it had assumed; I should retain the person who as the result of some vice, such as opium or alcohol taking, had bereft himself of his reason and then committed the crime, but if the crime were the result of a delirium allied to fever, I think it wicked to retain a man on the possibility of his having another feverish attack. Again, if the crime were committed by an epileptic, I should be inclined to keep him for life, and also if the crime were the result of recognized mental weakness, whether the result of age or youth; whether the result, as so many crimes against the person are, of unrestrained passion of old age or youth. So far, then, for the distinction between the infanticide and the homicide, and for those who have attempted violence to the person. But beside these there is a very large class to which I must refer, as in my mind the too timid superintendent is likely to be guilty of grave injustice in retaining certain patients who may have threatened to do violence to their friends or relatives; we must not be guided by the threats alone, but by general principles as to whether a person is likely to be injurious to society.

In my experience those require most care and observation who have been

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subject to hallucinations of hearing, or have had ideas of being followed or persecuted.

It will not do to say that such never become again trustworthy, but I would say that it is not very common, and needs ample evidence before liberty is granted. In some cases these hallucinations may persist in a stage of dementia into which the patient has passed, and may then cease to be active agents. As hallucinations of hearing are the most dangerous, so I believe the delusions as to tampering or interference with the body, especially with the sexual organs, increase the danger. The man who believes that he is being rendered impotent is a very dangerous man, and is not easily cured.

There is another nearly allied group of cases, of young persons who have with general weakness develo ed sexual vice, especially masturbation, and then become impulsive and violent. These patients are very dangerous, and there is no means of calculating when or against whom the outbreak may occur, so that there is little chance of being on one's guard. These cases, however, are very frequently curable, and the permission to go on leave must be given when physical health is restored and the basis of mind made more firm—when, in fact, attention is increased, sleep and appetite are better, and will to work is developed. This leads me to consider the so-called impulsive cases. There are certain cases, some epileptic and others non-epileptic, in which impulse, like a very tornado, sweeps over the will and leaves the man perfectly helpless. He does in a moment what he will regret for his life. Such cases we see among the sane in a less marked degree, but among certain lunatics we meet well-marked, very dangerous examples. In most of these cases the patient's own feelings will be a guide to the treatment and the liberty to be granted. I have very often said to such persons, "Can you trust yourself yet?" and if they say "yes," I almost always give them the chance. This would hardly do in criminal asylums, for "impulse" is used rather loosely when a man is on his trial for life.

But already I have more than exhausted my time, and would sum up thus, that though we must always take extra care in granting leave to patients who have either made or threatened violence of a homicidal character, yet we must above all judge whether the patient has recovered, and then do as best we can to decide whether the patient is likely to have similar attacks of homicidal violence. I should grant leave when the symptoms were part of an acute process which has passed off, but would hesitate when the symptoms depended on brain degeneracy as seen in age, in undeveloped youth, or in epileptic conditions, and for other reasons when the symptoms depended rather on some vicious course of life or habit.

In opening the discussion, the PRESIDENT expressed his regret at the absence of Dr. Nicholson, whose experience on some of the points involved would have been very valuable. The importance of the subject would be felt most strongly. It appealed to most of them more from the suicidal side than from the homicidal side. All present could tell tales. There were instances in which they had felt a regret that could not be wiped out where they had recommended patients to be taken home, and had afterwards heard that those patients had committed suicide. So strong was this feeling that the late Lord Shaftesbury had a dictum that patients who had once attempted to commit suicide ought not to be at large again. There seemed to be some classes of cases which ought never to be allowed freedom. Adolescent cases were very difficult to decide about. He had seen in general and special hospitals cases of young men of 18 or 20 years of age who had attempted to blow out their brains. At Bethlem they had yearly such cases admitted with scars on their foreheads, and his experience was that they were very untrustworthy. He particularly remembered one, an Oxford student. This young man was at first carefully watched, but his liberty was increased until he was allowed to go out for long walks. There were no signs of the recurrence of the suicidal tendency. He was sent out on leave, and a week afterwards was in a hospital with a

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bullet in his brain. That was not an isolated case, and it was noticeable that the patients seemed to seek a similar way of killing themselves. As to gauging the powers of the motors with the repellers, that was a difficult matter. He certainly agreed with Dr. Hayes Newington that it was best not to discharge a patient who argued about suicide, but there were some patients who would say that they had not the pluck to do it and who were then speaking the truth. A great friend of his, a doctor in London, passed into a condition of most profound melancholia, from which he recovered. When this gentleman was ill, he (Dr. Savage) asked him whether he had suicidal inclinations, and he replied, "Oh! leave me alone. I am not going to kill myself. I cannot *will* to eat my food. I cannot *will* myself in any way." Upon his recovery Dr. Savage again questioned him on the subject, and he said, "I could not have killed myself if you had put a pistol in front of me." It seemed that the least possible trust was to be placed in men, who, at about middle age, developed the idea that they had become impotent. In certain other suicidal cases, on the other hand, it was able to be asserted, almost absolutely, that the patient would not commit suicide. For instance, taking such cases as depended upon the existence of bodily disease; he remembered an old captain who had suffered from gout. This old gentleman had tried most ways of killing himself. Even at Bethlem he was quietly screwing things into his neck. One day, however, he had a bad attack of gout, and he was then as cheerful as possible. In after years he came round and said, "You were right, doctor; while I have the gout I am all right." So in this case, as in others, the bodily disease was a safeguard. Then, again, one may judge from the way in which a man looked upon his life policy. There was a patient who improved, but who looked dull and slow. This man said, "You need not be afraid. I shall not kill myself. I have paid into an insurance office for the last twenty-five years. I love my family well, and am not going to leave them penniless." Probably in a case of that sort they would run much less risk of suicide than where the man was callous about the honour and welfare of those dependent upon him.

Dr. BLANDFORD said that both the papers were very interesting and dealt very ably with a most important question. He wished that even more had been said on the subject. The question, both as it related to suicide and to homicide, was one of great difficulty. Personally, he had a great deal more to do with it from the point of view of suicide than from that of homicide. He took it that suicidal melancholia was the easiest of all to decide on. Where a patient got rid of that condition and recovered his cheerfulness, his disease passing off, and with it the suicidal tendency, they might have good hope. But there were other kinds of cases which were not cases of melancholia. There were cases of true suicidal impulse, without any delusion whatever. That was a very curious condition of things. It was extraordinary how men who were not melancholic at all, whose intellect was intact, and who were absolutely cheerful, so far as a man could be cheerful who was out of his mind, would try to destroy themselves or to injure others in every conceivable way. This was a condition of things which was very apt to recur. He remembered a very dear friend of his who had that suicidal impulse, and it used to recur very frequently. That gentleman, having been kept out of an asylum for a long time, at last went into one, and there became epileptic, and eventually died. In that case, there was, no doubt, a strong connection between the epileptic taint and the recurring impulse. It would have been a case which it would have been very difficult to keep in an asylum, and yet it would be extremely hazardous to let such a patient out. Then there were patients who heard voices. He knew some who had heard voices for years who were out and about in society. They did not always hear the voices. When they were pretty well, the voices went for a time, but the voices came back again at very short notice, and those persons were then in a dangerous condition. Now, were they to keep those cases in asylums for life? He thought all those cases must be judged on their own merits. In one class of cases it seemed to him that there was very great

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difficulty in judging, viz.: that class, with which he had no doubt all present were familiar, in which they could not be sure that attempts supposed to be suicidal were really of that nature. He had in his mind one or two cases in which at first he did not think that attempts at suicide were really made; cases where the attempt was very trivial or committed under such circumstances as led to the impression that the patient did not really mean it. Yet in one or two of such cases attempts had been afterwards made of such a character that all doubt was dispelled as to the real nature of the early attempts. These were cases of difficulty, especially where the patients were not in any asylum at all, and medical practitioners had the care of them without the safeguards of asylum treatment. He merely threw out these points for consideration.

The President having to leave, the chair was taken by Dr. Rayner.

Dr. RAYNER asked Dr. Hayes Newington whether he included in his remarks those patients whom they were frequently unavoidably obliged to discharge to the care of their relations.

Dr. HAYES NEWINGTON replied in the negative, adding that in those cases where the discharge was against the doctor's advice, he did not recognize any responsibility. His observations related to patients who might be considered sufficiently improved to have a chance at all.

Dr. RAYNER said that in cases of discharge upon the request of friends, he was often guided very greatly by the conditions in which the patient would be placed by the change. In some cases from what they saw they could be quite certain that the conditions would break the patients down, as in one or two cases advanced by Dr. Hayes Newington, while in others the conditions might improve the patient.

Dr. HACK TUKE said it might be that in some cases, although a patient were suicidal, and fear might be entertained that he would commit suicide, yet at a certain period it would be allowable to run some risk instead of keeping the patient always in confinement. He thought there was some distinction between what was really best for the patient and the course one might be tempted to pursue in the fear that blame might be incurred in the event of suicide. He thought they would all agree that there were cases in which they could not but think it best for the patient to be free, and yet they hesitated to recommend this on account of the great blame which might accrue. He remembered a case in which he most strongly endeavoured to dissuade the friends from allowing a medical man to return to his practice. The patient was at that time suicidal. He had recently taken laudanum. Therefore he (Dr. Tuke) felt it was a case in which it was absolutely necessary to take every precaution. However, entirely against his advice, the patient resolved to return to practice, and his friends allowed him to do so. The result was that he threw himself thoroughly into his work, and continued to practise successfully for more than six years, certainly. It so happened that a very few days after his return to his practice he was called to a case of suicide, but it had no injurious effect upon him. He seemed to enjoy good health and spirits, and was busy from morning to night. Eventually he became somewhat depressed, and came up to town for advice. During the very day on which arrangements were being made for his being placed in a medical man's house, he went out and deliberately committed suicide. Even in that case the course taken by the patient in remaining at large appeared to be justified. The patient had the enjoyment of life for many years, and that was a great deal better than if he had been shut up in an asylum or with an attendant all that time. The very great difficulty of having reliable tests of fitness for discharge was shown most forcibly by the fact, very often observed, that it was frequently those patients who were not expected to commit suicide who did so. When the Commissioners suggested special dormitories for suicidal cases, some medical superintendents objected to them on that very ground. Then take such a case as the following as bearing on a remark of Dr. Blandford's:—An English lady, apparently sane, and concerning whom no fear was entertained of suicide, got up one night when abroad

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and attempted to cut her throat, and opened several vessels in the arm. She was found in bed bleeding from her wounds next morning. It was a question whether there had been foul play, whether she had done the act in a state of somnambulism, or whether she had committed it intentionally. No doubt it was an attempt at suicide. He saw her two months after the occurrence, and on examination she seemed perfectly sane. Her mind was, she said, a blank as regarded the particular night in question. The difficulty arose as to whether she should be placed under care. His own advice was that she should be carefully watched day and night. That continued to be done, but there was no definite mental affection which could be laid hold of to warrant certificates of lunacy. With the knowledge of the Commissioners she resided in a medical man's house, voluntarily, without certificates, and was carefully watched. She eventually left England and died, but there was no recurrence of any suicidal act. In such cases as these the question raised was an extremely difficult one. To be ostentatiously watching patients and irritating them with the feeling that someone was continually dogging their footsteps was in itself calculated to intensify the suicidal feeling. He (Dr. Tuke) would say in conclusion that medical superintendents who chose to run a certain amount of risk ought not to be in any degree blamed, whatever happened. On the contrary, he thought they deserved the greatest credit when they did run some risk in the interests of the patient, although knowing that people who are wise after the event would censure them if the patient did die by his own hand. They were all very much indebted to Dr. Newington for his excellent paper.

Dr. RAYNER referred to the case of a boy who endeavoured to shoot the Queen. After he had had this boy under his care for some months he felt it would be an injustice to the lad to detain him longer, although it could not be said that he was of perfectly sound mind. It was possible that worry or anxiety might upset the balance. Nevertheless he (Dr. Rayner) felt obliged to take the responsibility of discharging him, although in this particular case a very serious responsibility was involved in pursuing this course. Fortunately the lad retained his health for some time, and ultimately went abroad. In that case Dr. Rayner felt impelled to discharge the patient, because the bodily health had been so far restored that it was thought he could stand a considerable amount of strain without breaking down again. That test of bodily health came into action very strangely in cases of hallucinations. He had discharged cases in which hallucinations continued active because the patients were restored to excellent health. On the other hand he had sometimes found it quite safe to discharge the patient when bodily health had been restored and only delusions founded on past hallucinations continued, with the result that the delusions had either passed away or been forgotten. In some of these latter cases the hallucinations were caused by conditions which existed only for a short period. One patient he had in his mind who only had the hallucinations for a few hours, and it did not appear that he had them at any other time. He was detained so long as he was because the delusion was directed against his wife.

Mr. C. M. TUKE mentioned the case of a lady who, after an attack of puerperal melancholia, developed homicidal tendencies, and, on one occasion at least, made a most dangerous attack upon the nurse. This lady improved very rapidly; her expression, at one time very wild and fierce, entirely altered, and she developed quite a sweet and placid countenance. The menstruation, which had been absent, was established, chiefly by permanganate of potash, and she quite recovered. Only a few days ago, her husband being very anxious to remove her, and having exceptional advantages for her care, no objection could be raised to his doing so, although they knew that, while she appeared well, delusions still existed, which she only mentioned to her nurse. She went away in the most natural manner, but in three days she returned, having made a violent homicidal attack. Although the difficulties in this case were pointed out by the doctors before the patient went home, still no one could have imagined there would have been such a sudden relapse. In

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another case, a young lady had attempted to cut her throat. The wound healed, and she recovered very much her general health. Menstruation was not re-established in this case, but she was very natural, received her friends, and asked if she might go back with them. She seemed to have absolutely improved in every respect. He mentioned this in the Case Book, and also the fact that on the last visit of her friends she received them very well indeed. It was only yesterday that a letter was written by her friends saying that she had slipped into a packet a paper asking them to send her a little chloral for a raging toothache. The toothache was, however, fallacious. The lady, on being questioned said, indeed, that she had no intention of committing suicide, but the circumstance made a great impression on his mind. She had previously written to an old nurse asking for salts of sorrel, but had otherwise made no attempt on her life. It would seem, however, that the tendency remained.

Dr. RAYNER said that the question of dissimulation had scarcely yet been touched upon, so he might mention a very striking case. A melancholic patient very nearly succeeded in hanging herself, but was cut down. From that time she became perfectly cheerful, and even gay. The change was so sudden that the medical officers did not believe in it. The friends, however, believed in it, and removed her from the asylum, it being pointed out to them that she should be kept under constant supervision. At the end of six weeks her sister left her alone for a few minutes, and she killed herself. Up to that time she had perfectly deceived her friends.

Dr. HAYES NEWINGTON, in reply, said that he was sorry that the President had had to leave the meeting early, because he had first of all to deal with Dr. Savage's remarks as to patients who talked about suicide. It was certainly a common idea that patients who said they had no pluck would not commit suicide. It must, however, be borne in mind that certain influences sometimes forced people into action, and in somewhat the same way as the Russian soldiers in the Crimean war were known to do very plucky things, being driven into them by their officers, so he had known cowards to be driven to suicide. He believed that those who did talk were those who might insist on it, and were unsafe. A year or two ago he knew a lady who talked of it very frequently. She made two or three attempts both before and since she came to him, and, with her, suicide was a common cry. Moreover, in the second case he quoted, the gentleman came to him for protection, and certainly his talk about it did not prevent him from making an attempt upon himself. As to bodily disease, he did not mean to say that it was no guide. It had a very important bearing on the subject. A person with toothache might be a very dangerous case. Bodily disease he put rather as a motor. It was not the motor which made the danger; it was rather the weakening of the repellent. A life policy was undoubtedly a good thing to keep a person from attempting to destroy his life, but it would act through one of the agents he had mentioned. The case Dr. Savage referred to acted from family affection, which in that instance must have been very strong, the gentleman having put by his money for twenty-five years. As regarded Dr. Blandford's remarks, he (Dr. Hayes Newington) found it difficult to say more than he had done. In dealing with the hallucination cases he should be guided first of all by whether the patient had made an attempt. If a serious attempt had been made under the influence of the hallucination—not under the influence of the melancholia—he should be reluctant to send such a person abroad in the world. The same with impulse. Numbers of persons had impulses, but never made attempts. If such a patient once made the attempt he should not feel inclined to take the responsibility. Of course, in some private cases, when the friends do not make a move, the doctor's feeling of responsibility must give way, and the patient be allowed a trial. The responsibility was enormous. No doubt they were sometimes mistaken in keeping some of these cases. At the same time he thought they were thoroughly justified. In the following case of discharge he was, on the other hand, egregiously out in his reckoning, but he

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thought that others would have acted as he did. It was a case of some ten years back. The two sets of certificates disclosed an attempt at homicide by strangling a gentleman in an hotel, and one at suicide by the patient throwing himself down two flights of stairs. The patient made a subsequent homicidal attempt, while under care, by endeavouring to strangle an attendant. He was, therefore, both suicidal and homicidal. He had epileptiform convulsions. Up to within a few days of his discharge he was very much under the influence of hallucinations. He was removed by his friends, contrary to advice, for a fortnight's trial. He was then released, went about his business, and, strange to say, got quite well, as in Dr. Tuke's case. In cases where the friends were obstinate, the best way was to call in a second opinion. With reference to Dr. Tuke's remarks, they must, of course, take risk, but they had to consider not only the patient's interest and one's own reputation, but the friends and the public. In the case referred to by Dr. Tuke which went on all right for some six years, or more, surely no one would have done otherwise than he did in counselling his being placed under care of some kind. About twenty-three years ago, there was a most interesting case, reported in the Commissioners' Blue Book. A man had been fourteen years under supervision. For the first part of that time he was absolutely suicidal, but he improved, and used to go out and enjoy himself. He had plenty of opportunities of procuring poison, had he been so disposed. At the end of the fourteen years, his mother sent him an old-fashioned writing-desk. He went to a secret drawer, and withdrew from it a little bottle of prussic acid, which he had secreted there fourteen years before. He did not take the poison at once, but walked off with it into a wood, and there took it and died. As to its being the unsuspected patients who committed suicide, he (Dr. Hayes Newington) thought it would be a very great reflection upon themselves if this were not so. He took it that the same risk of suicide prevailed among non-suicidal patients within asylums as existed in the outside world, so that if, for instance, in an asylum with a thousand patients four hundred patients had suicidal tendencies, the remaining six hundred patients would still be subject to the ordinary risk. With respect to Dr. Rayner's remarks, the question of dissimulation had been incidentally touched upon, but if they adopted the view that the repellent agents were to be looked to it was scarcely possible that the patient could pass such a test as would be laid down. There were many little domestic incidents which would be crossed by some of the motors. Of course, if it were impulse, it was all explained, but if the suicide of the person referred to by Dr. Rayner was due to a continuous action, probably a very close review might disclose something which would cause suspicion. The case of the lady who asked for chloral, mentioned by Mr. C. M. Tuke, was no doubt a difficult one, but it might be, if they could get a true conception of her mental condition and lay hold of a basis of some really moral value, such as a proper sense of religion or affection for friends, of which it appeared she had evinced signs, that she would be safe. At the same time there had been a previous attempt to get poison, and it would seem that she must have lost her restraining influence on that point.

The members dined as usual at the Holborn Restaurant after the meeting.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—SCOTCH MEETING.

A Quarterly Meeting of the Medico-Psychological Association was held in the Hall of the Royal College of Physicians, Edinburgh, on the 11th Nov., 1886.

There were present: Dr. Ireland (in the chair), Dr. Bramwell (Edinburgh), Dr. Campbell (Carlisle), Dr. Campbell Clark (Bothwell), Dr. Clouston (Morningside) Dr. Fraser (Dumfries), Dr. Carlyle Johnstone (Melrose), Dr. Keay (Mavisbank), Dr. Maclaren (Larbert), Dr. Macdowall (Morpeth), Dr. Macpherson (Morningside), Dr. Richardson (Isle of Man), Dr. Rorie (Dundee), Dr. Rutherford (Dumfries), Dr. Spence (Morningside), Dr. Turnbull (Fyfe), Dr. Urquhart (Perth), Dr. Watson (Govan).

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