control. With regard to Ireland and its claims for inclusion in the Bill he was in complete sympathy, and the memorandum drawn up by the Irish Division and the suggestion that a new clause 62 relating to Ireland should be incorporated in the Bill would, he had no doubt, meet with the approval and support of the Medico-Psychological Association. In conclusion, he proposed that to the Special Committee to watch over this Bill there should be added Dr. Corner and Dr. Douglas Turner.

Dr. HAYES NEWINGTON seconded the proposition, and it was carried.

(1) *Schwachbegabte*; in Norway *Svaktbegavede* is contrasted with *aandsvake*—"mentally defective."

Dementia Præcox in Relation to Apraxia. By ROBERT JONES, M.D.Lond., F.R.C.P.Lond.

THE above was the subject or text of the Presidential Address delivered by Dr. Mabille, the Medical Director of the Asylum at La Rochelle, in France, on the occasion of a Congress of the French-speaking alienists at Tunis in April, 1912.

The address has suggested the following criticisms, primarily I may say with the view of simplifying, if possible, the pathological and clinical aspects discussed, also of justifying, if this be necessary, the relationship suggested between these conditions, and finally, to point out the view taken of the origin of Apraxia by the French school of neurologists and psychiatrists.

It is inevitable that with the progress of knowledge new terms should be invented or selected to describe and to define any knowledge which may have been freshly acquired, or any observations which may have been newly recorded. But it is unfortunate that many of the terms used in medical science should give offence, not only because they fail to convey a definite and strictly limited meaning, but also because they jar and grate upon the ear of the pedant.

Sufficient has been said in this Journal and elsewhere in regard to the use of the term "dementia præcox," which has

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been well described as an "ataxia" between concepts and the affective division of mind, giving rise to an inadequate emotional tone, or to what is better described as emotional atrophy; but the term "apraxia," though less frequently used, has also received various interpretations. It was first used by A. Starr a quarter of a century ago, and then in relation to agnosia. The latter term implied an inability to recognise an object, because of a dissociation of the sensory centres from each other, or from the higher psychical centre in the pre-frontal lobe; whereas apraxia implied inability to use the object because of this failure in its recognition. Upon this interpretation apraxia is dependent upon agnosia, apraxia representing on the motor side what agnosia corresponds to on the sensory. In agnosia there is stated to be a loss of the understanding (or perception) of the nature of things, while pure tactile and other sensations are still preserved. The primary memory picture of an object is preserved and persists, whilst the secondary sensory identification is absent or disturbed. Physiologically expressed, agnosia is the difficulty experienced in recognising cortical sensory impressions owing to an interruption between the memory centre and the sensory centre in the cortex.

Monakow, Pick, Marie, Rhein and especially Dr. S. A. K. Wilson have written fully upon the subject of apraxia, and the term has been variously defined by almost each author. Some authors have described both a sensory and a motor form of apraxia. By some—Monakow for instance—sensory apraxia is used as equivalent to agnosia, and Pick has further described a form known as ideatory apraxia, which he considers to be always of bilateral origin, and to be manifested during voluntary effort in the performance of certain complicated acts. More recently, and within the last seven or eight years, a new meaning attaches to both agnosia and apraxia, owing to the researches of Liepmann of Berlin. He considers agnosia to be the failure of recognition of an object, whilst common sensation in regard to it is fully preserved. A coin is held in the hand; its weight, colour and shape are appreciated, but it remains unrecognised. He considers apraxia to be the condition a person may experience when able to recognise an object—a watch, for instance, or a banana—as well as its use, but is still unable to put it to its common use by any voluntary effort; that is, in Liepmann's opinion, the apraxic person is not

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necessarily agnosic. Although in the apraxic there is no loss of motion—the limbs being readily moved, and there is no wasting of the muscles—innervation being intact, there is yet complete inability to move the leg or arm as the will may command or direct, and the proper and general use of the object contemplated is impossible of attainment.

In one of Liepmann's cases both agnosia and apraxia were associated. For instance, when the eyes were closed there was no knowledge of the position of the right arm. This was not the case when the eyes were open and the aid of sight was possible; then the patient succeeded in surmounting the difficulty and became eu-praxic.

Difficulty in performing voluntary actions is distinguished from inability by the use of the term "dyspraxia," and when purposeful movements are unaffected the term "eupraxia" has been used. Speaking generally apraxia implies an inability to effect a purposeful movement, through an incapacity to form a clear idea of the movement desired, although there is no inco-ordination or paralysis.

In Liepmann's special case, which is generally quoted as the basis of the latest conception of apraxia, there were subcortical lesions between the frontal and Rolandic area, also between the parietal and the Rolandic area, as well as between the latter and the corpus callosum.

I have observed the condition described in several senile cases suffering from dementia, and recently in a male patient in the early stage of general paralysis, the disease being made evident somewhat suddenly by the occurrence of a congestive seizure, but he has temporarily recovered from the direct motor effects of the fit. At present there is little impairment of the reasoning powers and none of sensation; his general conversation is now coherent and intelligent. Neither is there any loss of the sense of location; but he is unable to carry out simple co-ordinated movements which may be of a complex character, especially such as may have an end or object. He cannot button his waistcoat or lace his boots; he cannot fasten his shirt and collar, and cannot fix his braces, although he puts on his garments and knows their proper sequence. I have also quite recently under my care a case of typical ideational apraxia in a man, æt. 56, with commencing but well-marked arterio-sclerosis. There is "short-circuiting" of ideas, and the form of "apraxia by

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anticipation" is very evident. The patient believes all the time that he is performing the right act, although there is complete inability to do so.

The most common forms of apraxia are found in persons with vascular lesions of the nature of an embolus, which implies a more complete cutting off of a group of neurons from their normal associations than is the case in thrombotic lesions consequent upon arterial degeneration as met with in senility, or as occurs in syphilitic endarteritis. On the mental side there is in apraxia a deficient power of concentration and a failure of the attention, and the condition is well known in a variety of lesions without much uniformity. It is found, for instance, in some cerebellar lesions; in association with cerebral tumours, internal hydrocephalus, in certain forms of insanity, particularly in post-epileptic phenomena and in some who suffer from severe obsessions, also in those who suffer from the variety of dementia known as primary or precocious; also after great exhaustion, as in some cases of melancholia; in cases of hemiplegia, and in senile dementia with arterio-sclerosis in the early period of involution, also in some cases of general paralysis. The French school, with Marie at its head, regards apraxia as due to an intellectual deficit, to some affection of the intellectual powers and as being in the main psychic in its explanation. The psychic element is certainly important, and has not received the attention and study it deserves. It is definitely known that loss of perception may be connected with a false interpretation. For this reason the present consideration of Dr. Mabille's address may be timely and appropriate.

Possibly the most typical form of apraxia would be that following an attack of left hemiplegia (Liepmann states it is rarely bilateral), where the lesion is an embolus or a hæmorrhage in the right Rolandic area. Such a lesion destroys not only the power of voluntary movement in the left arm and leg, but may also destroy the power to perform certain voluntary movements in the right arm, such, for example, as the execution of a purposeful and accustomed act already referred to in my case. Ordinary movements on the right side are unimpaired and motor memories in regard to them are preserved, but they are not sufficiently connected with the other cortical neurons to permit of complex and voluntary acts being put into execution, *i.e.*, there is a dissociation between the motor memories

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and ideatory processes. In left hemiplegia there is no loss of power on the right side corresponding to the paralysis on the left, but there may be apraxia—an inability, or dyspraxia—a difficulty in performing voluntary acts on the same side as the lesion. There is thus in motor apraxia from this cause a dissociation of the kinetic memories by reason of an organic focal lesion, and the loss of voluntary power on the right side is probably due to some interruption of the commissural fibres connecting corresponding portions of the opposite hemisphere. This voluntary impairment applies more particularly to the action of groups of muscles, and especially when the acts are in series and somewhat complex, *e.g.*, the loosening of a knot, lacing one's boots, buttoning one's clothes, or lighting a cigarette. The anatomical lesion in apraxia is thus an interruption of one or the other of the groups of association fibres or those described as commissural. There are, as we know, five more or less well-defined groups of association fibres in the brain, the fronto-occipital or superior longitudinal bundle, the fronto-temporal or inferior, the girdle-fibres round the corpus callosum, those which have a perpendicular direction, and the short fibres connecting adjacent convolutions. Liepmann believes there is a centre in the frontal lobes for the execution of complex motor movements, and that a destruction of the left frontal lobe may cause apraxia. It is admitted, I think, that to the left side of the brain is generally ascribed precedence over the right (in right-handed persons) for the direction of movements in manipulative actions.

We know that every part of the brain cortex in one hemisphere corresponds to, and communicates with, identical parts in the other through the commissural fibres of the corpus callosum, and we believe that every movement performed by neurons in the Rolandic area has its image or picture — its kinæsthetic equivalent—in the frontal or prefrontal lobe. By an effort of the will this picture can be revived in memory, and the movements which caused it may also be voluntarily repeated. This presupposes that the commissural fibres between corresponding parts of opposite hemispheres are intact. These fibres are usually described as of four kinds, those of the corpus callosum, which are direct prolongations of collaterals or axis-cylinder processes from projection fibres. When any part of the cortex is destroyed by a thrombotic lesion, an embolism or a tumour,

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some of these fibres always undergo degeneration, and according to most authorities who have described cases of apraxia the destruction of some part of the corpus callosum plays a definite and distinct part in its pathology—a view, however, which has not been assented to by Monakow. Then there are commissural fibres of the anterior commissure between the temporal lobes, also those between opposite hippocampal convolutions (psalterium), and those belonging to the olfactory region (fornix). In typical motor apraxia some of the commissural strands described above are always interrupted, and the barrier or lesion separates their cortical origin from their final terminations.

I have said enough about apraxia to bring me to Dr. Mabille's address, which was based upon considerable experience and which introduced many points of interest, such, for example, as the question of "perseveration," the power of the "will" and its possible tract within the brain, the influence of obsessions, the delayed mental reaction, and the relation of the will to the memory in cases of dementia precox or primary dementia.

The address referred to relied mainly upon one case, which, although quoted *in extenso*, was yet incomplete in so far as it had not terminated, and no opportunity had occurred for describing the minute anatomy of the brain. The case was somewhat of an enigma from the point of view of diagnosis, but the main features were briefly as follows:

A student, æt. 30, consulted the President for "an affection of the will" which had commenced some years since, and still persisted. The case was described as a conscientious, hard-working undergraduate, who obtained a poor degree after two or three checks, but in this it was believed he was badly rewarded for his industry. As to his mental state he was evidently not highly endowed, and he was the object of occasional satire and mirth to his fellow-students. He had no hobbies or curiosity outside his work, and he took little interest in music, reading, politics, or games. His remote memory was described as relatively faithful, but his recent memory was bad, his power of attention and of concentration were feeble, his judgment was fair for simple facts, and he had no hallucinations or delusions. His bodily state was satisfac-

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tory. The urinary system, also the respiratory, cardiac, and digestive systems were all normal. His muscular system was peculiar. In regard to simple movements such as raising the arm or opening the eyes, when the order was given for these, there was no response for 5 to 60 seconds, and until the actual movements were produced he did not modify his position. The movements, when elicited, were precise, quick, and took place quite suddenly, attaining their maximum quickness from the commencement—there was no poising, deliberation or time of effort. In regard to complex movements in series, adaptive to an end and requiring co-ordination, there was a pause. He got up like a Dutch doll, in a series of jerks, his movements being interrupted. He sat up in bed, first on his elbows, then on his haunches, there he remained for a time, then got his feet out of bed, again deliberated, and eventually stood up. Asked to get up and pick a pencil off the table, he rises, then pauses, then picks up the pencil quickly after a definite pause. There was a tendency to decompose a total act into its fragmentary stages. The duration of acts was not measured by their complexity; the same time was taken to open the eyes as to pick up a pencil; sometimes the simplest act was the longest. His mother once asked him to open his eyes at 7 a.m., but he could not do so before 1 p.m. He could walk, play the piano, write letters of his own accord and in the usual manner. If asked to copy he took a long time, and when he started on anything it was as difficult to stop as to act. He once made his scalp bleed because he could not stop brushing his hair. Here the symptom of "perseveration" was noted.

Passive movements of the limbs were easy, and their tone and mechanical excitability were good. There was no sign of recent or past paralysis. The reflexes—knee, plantar, and pupillary—were normal. There was no "Babinski" and no "Rombergism." Sensation, cutaneous and deep, was normal. Sense of location normal. Heat and cold sensation normal, and there were no trophic troubles. His sleep was good, and he stated he would be exactly like others if only "I had control of my will." What he really complained of was: "I can't act freely." His ideas were expressed slowly, and as if after laborious maturation. He was awake at six in the morning, but could not open his eyes for an hour to an hour and a half.

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He commenced to dress at eight in the morning, and finished at four in the afternoon. When in the streets he would avoid obstacles, but could not pass street corners or cross the road. To dress, eat and drink took the whole day, and once after he had used his pocket-handkerchief he kept it on his nose for four hours. His general appearance was sad, and he related his condition in misery. He took a long interval before giving his answers, but he understood perfectly, as he answered correctly. He seemed to be in a state of fixed meditation before he could perform any act. He betrayed no emotion, and often sat in his chair in a state of immobility as if screwed to it. There appeared some "stereotypy."

The condition he was in was believed by his friends to have been caused by the shock, some five years previously, of having been taken home and put to bed by "friends" after a party, when his sense of direction was convivially impaired, and these friends of his student days rewarded themselves by taking away his clothes. He was soon afterwards seized with an indescribable fear. He could find in his room no cause for this. He could not leave his room by any effort, and he was mistrustful about remaining in it. He got distracted, could not remember what he read, and the least mental or physical exertion fatigued him. He felt unable to do anything until he had washed, and this he did constantly and almost continuously. After intense emotional disturbance his "fears" gave way to this obsession about being clean. His condition remained one of absolute paralysis of the will-power.

There is no antecedent history in the case apart from a broken leg at seven years of age, and one attack of articular rheumatism during his period of military service. There is no family history of insanity or neurosis.

Such a case presents several clinical symptoms which are well known in the synthetic affection termed "dementia precox." The retardation of mental reaction certainly suggests "ideational dyspraxia," and the symptom known as "perseveration" shows the persistence of obsessions and their overwhelming influence and power to retard or to paralyse the will. The impediment to the action of the will and its obstruction or interruption in this case furnishes adequate reason for the term "psychic hindrance," which was applied to it by Finzi and Vedrani, as also the phrase "damming the will" which

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was applied to it by Kraepelin. The description "apraxia by suspension," given by M. Dromard to the state when, owing to inattention, the ordinary actions are suspended at any point in their execution, corresponds to that found in Dr. Mabille's case, and for which two explanations may be offered: Firstly, the full possession of the mind by an unduly powerful impression or obsession which overshadows any other motive to action, and which consequently inhibits the original mental process by acting as a strong distraction, and, secondly, the inhibition of an act because the directing idea has vanished. The person has ceased to hold in his memory the final representation of the end to be attained, and action is consequently suspended. The question whether the memory only is at fault, or whether the attention be deficient, was raised in this case.

The fully developed condition certainly favours the diagnosis of dementia præcox, in which there is "inadequate emotional tone," yet the elementary emotions of fright, pleasure, anger, shame, etc., are often unaffected: the apathy, loss of will-power, the retarded mental reaction, the loss of intellectual activity, and the general unemotionalism, all mark it as of this description, though, as Dr. Mabille suggests, the loss of will-power or abulia is characteristic also of psychasthenia, hysteria, and melancholia. The early appearance of anxiety and depression would tend to favour the latter form of insanity, whereas the accentuated emotional disturbance points to an exhaustion psychosis or neurosis. In abulia from obsession action ceases, because the patient's attention has been drawn away by something he has not chosen, and imperative ideas, obsessions or phobias are all of this kind.

If one examines any voluntary act it is found to be in itself different from a reflex or an impulsive one: there is in it firstly the cognitive stage, involving an idea of the end to be attained. An image of the aim or end is present in the mind, also images of the movements necessary for securing this end. Then a desire for the end is present, which implies an aversion from present experience and an appetition (as it is called) towards the desired end. This is the conative factor which prompts to the act. The desire is always associated either with a painful feeling, so long as the desired experience exists unattained, or a pleasurable one, when the act is in process of

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accomplishment, and the difference between these two emotional states develops into an activity within the field of consciousness to the exclusion of all other thought. If instead of the voluntary activity there is a loss of memory for the desired end, or the presence of a diffused activity with a strongly painful emotional tone, then the will is affected, action is suspended in the conflict, and inaction results; but the affection of the will in melancholia is a true motor abulia, in obsession it is the result of conflict, the will is checked by hesitations and doubts; and when psychasthenia is present there is inattention and a failure of mental concentration. In cases of psychasthenia as well as in melancholia the emotional aspect is intense, but in dementia præcox on the other hand emotion is absent and the movements are "stereotyped." There is no emotion, but there are indifference and apathy. The patient in melancholia falls into a morose indifference, but in dementia præcox the indifference is "unemotional" and the patient neither cares for himself nor others, and he is in a state of true lethargy. The indifference of the psychasthenic, on the one hand, is being constantly criticised and deplored by himself; he consults a number of doctors many times over until they are absolutely weary of him. All these persons may pass off as eccentrics or as persons with a mental "tic," and they perform strange acts in public in an automatic irresponsible manner, without heed or reflection. It needs the physician of wide experience to classify them. The patient described by Dr. Mabille was conscious of his state, and he recognised his subjective insufficiency. A knowledge of this insufficiency creates agitation and diffuse anxiety. The mind, by means of the power of attention, is able to concentrate upon itself introspectively, and is conscious of having forced upon it doubts and hesitations against which precautions are being taken; the will is thus checked and becomes incapable of directing the conative tendencies on normal lines. Without attention all the elements of mind are in a state of flux or molecular disintegration. The cognitive faculty is unable to apprehend reality owing to a deficiency in the focussing power of the mind, *viz.*, apperception, which is the power to unify in one composition new sensations and past memories. Normal apperception synthesises the numerous full and complex elements of consciousness into one whole, and in insanity this may be impossible or only

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delayed. In this case simple or reflex acts were correctly interpreted, but complex acts forced a doubt, hence the dreamy indifference, the state of reverie, musings and automatism. This condition is typical of primary dementia as it is of psychasthenia; the highest level of mental efficiency is wanting in both, attention fails, beliefs are impossible of being sustained, a state of unreality results, and there is a difficulty in assimilating new perceptions. In psychasthenia the obsessions usually come from within and relate to the personality, to his actions or to his ideas. In hysteria the fixed ideas are usually from without. It is not related by Dr. Mabille whether Freud's method of psycho-analysis was attempted or not. The French school of Pierre Janet and others might have explained the obsessions, not as a cognitive defect, but as a rise of morbid factors or a "morbid constellation" as he has termed it, a conflict between the personality and some repressed complex in the patient's past life, owing possibly to some affective shock, but no "irradiations" from any morbid complex and no antagonistic movements appeared in this case, although there was a distinct loss of objective interest and power of concentration, indicating a weakening of the "will." Dr. Mabille raises one very important point, and that is, "What is the cause of the difficulty to realise, 'I wish?'."

Let us for a moment digress to consider the anatomical pathway of the "will," in order, if possible, to locate the delayed reaction. It is admitted that all conscious processes take place in the cerebral cortex. In this cortex we know sensory tracts end and motor ones begin. Within the same cortex also travel the association fibres connecting them. Similar association fibres, as we have seen, unite two or more areas of the cortex which are of different functional significance, and although sensory fibres may arborise round motor neurons, the probability is, as can be demonstrated microscopically, that trans-cortical or intercalary neurons connect the two. Flechsig, by his special staining of the white matter, has shown that the first movements effected (*viz.*, those connected with sense impressions through deglutition, respiration and circulation) are carried out reflexly, the tracts served by these movements being the first to medullate or to obtain their insulating covering of phosphuretted fat; then follows the medullation o sensori-motor tracts connected with the sense of voluntary

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effort and desire. When a group of muscles contract to cause movements the memory of them is stored as a kinæsthetic memory-picture, the neurons connected with the central motor tracts having the specific property of preserving impressions which can be reproduced as images. Images of sound waves are stored for instance as memories in the superior temporal convolutions, visual images in the calcarine area of the occipital lobe, taste and smell in the uncinate and hippocampal areas, and speech memories in the posterior third of the lowest left frontal convolution. All these different kinds of memories are stored in spatially separated portions of the cortex, but they are connected with one another by association fibres in the same hemisphere and by commissural fibres with the opposite hemisphere. It is further known that visual speech is located in the angular gyrus and heard speech in the supra-marginal area. Any affection involving the neurons or the fibres in these centres also affects the power of speech, so far as word-deafness and word-blindness are concerned, that is, there is mind-blindness—the patient sees and hears, but is unable to recognise words or objects seen or heard. In several cases of apraxia in which the morbid anatomy has been described after death, lesions of these areas have been noted. By association all senses, as well as their memory pictures, are able voluntarily to elicit movement. When these memory-pictures are associated together they give rise to ideas, and these form the logical processes of thought. The sum total of all these associations at any particular moment—together with new impressions entering the cortex—form the content of consciousness. If they do not reach the threshold of consciousness they are unconscious images. The cortex is full of such unconscious impressions; dreams, reverie, musings, are of this class. The will through attention is able to fix the mind upon any of these, but when attention is feeble, confused images bring about ideational apraxia. The chief factor in "adaptation to environment" is the power of "attention," for objects which are not attended to and which do not excite the affective reaction cannot permit the adequate and necessary selection of intellectual associations. When, even in spite of effort, memories are slow in reproduction, the ideas representing them in muscular movements are also delayed and a condition described as "psychic impediment" or "barrage of the will" is experienced, a state

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met with in hysteria, melancholia, obsessional insanity and particularly in dementia præcox, in which a lengthening of the normal reaction time is characteristic. The patient here described was able ultimately to perform all the movements requested of him and without substitution or change; they were performed in their entirety and correctly, and the title "apraxia by suspension" is applied by M. Dromard to the condition. The movements in some apraxic cases appear to be purposeless and amorphous, *i.e.*, the direction may be wrong and the form of movement inappropriate, although the patient believes them to be correct; but in this case there was only a delay, the movements were perfectly and properly completed in their integrity, but when once started he could not readily cease the movements, the condition described and well known as "tonic perseveration" obtaining. In regard to this condition Monakow states that the sense of muscle position or the muscle sense is in the parietal region of the brain, but Liepman prefers to locate it in the motorium or the ascending parietal lobe. When an impulse is conveyed to this region it persists after the normal stimulus has ceased to act, owing to some pathological interference or "blocking" of the synapse.

The case is certainly a most interesting one and worthy of comment, as it points out the possibility of dissolution of separate mental faculties, *viz.*, those of the attention, the will and memory, a condition which has been described as partial dementia. Possibly it is not one of true apraxia, as there was not "complete impossibility to realise movements adapted to the end proposed." It is probably also not one of ideational apraxia as the understanding was not affected, but, as suggested by Dr. Mabille, one of apraxia by suspension or ideational inertia. It is by "stereotypy" of movements, by its unemotionalism and by the impairment of voluntary effort, more characteristic of dementia præcox or primary dementia than of obsessional insanity or psychasthenia, and it is less suggestive of hysteria or of simple melancholia than it is of primary dementia.

The pathology of this state is involved in much obscurity. The published results of Messrs. Waldemar Koch and Sydney A. Mann suggest no marked chemical changes so far as the phosphorus elements of the brain are concerned, but the neutral sulphur showed a great diminution, while the inorganic and protein sulphur is relatively increased, indicating a general

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bodily inherent deficiency for oxidation processes. Pighini also confirmed this research, for he found an increase of neutral sulphur associated with the same disease. Microscopic observations have indicated a feeble appearance of Nissl pattern in the large pyramidal Betz cells of the ascending frontal convolutions and the nucleus of the cells was eccentrically placed. In other recorded observations there was also an increased local proliferation of the neuroglia nuclei. The same degenerative changes were noted also in the smaller and medium-sized pyramidal cells of the cortex. Microscopic examination of thirty cases of cerebro-spinal fluid in this disease by Dr. Harper-Smith reported no organism and no cells in the centrifuged deposit of the fluid. The test for proteins was also negative in all the cases. Yet there must be some metabolic toxins connected with the decay of the large pyramidal cells. In the case under review the only suggestion made by Dr. Mabille is a selective lesion of the neurons co-ordinating the representation of an act with its execution, and it would seem at present impossible to describe more clearly such a diffuse lesion as must occur among the very delicate cortical cells and their processes. It is a reflection upon our pathology that so grave an affection of the will, of the memory and of the attention should remain hitherto undescribed and undiscovered.

A Report on the Conditions of the Lunacy Service and of the Teaching of Psychiatric Medicine in Germany.

By R. G. ROWS, M.D., Lancaster.

THE position of the assistant physicians in the German asylum service and the conditions under which they worked were investigated by a Committee of the German Society for Psychiatry in 1908. In January of that year a meeting was held in Berlin at which Dr. Hans Wachsmuth introduced the subject under the title " Conditions of the Medical Service in Asylums—Independence of consulting physicians (Oberärzte) and hospital physicians (Abtheilungsärzte) and the duties of the assistant physician (Assistenzärzte)." This paper was published in the *Psychiatrisch-Neurologische Wochenschrift* in February, 1908, and in a letter which I received recently from

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