a magistrate not in all cases being required. Asylums have thus gradually become, after many successive additions, virtually workhouse infirmaries for their respective counties, and can no longer be considered hospitals for the cure of the insane, their great size and number of inmates rendering them past the management of one individual, who, in many instances, is unable to recollect the names, much less the cases of all his patrons. The acute cases, whilst in a curable stage, are utterly lost sight of in the crowd of incurables amongst whom the lot of the curable is now cast.

My friend Dr. Manley, of the Hampshire Asylum, has suggested that instead of making an addition to that immense establishment in the Isle of Wight, patients should be provided for near the workhouse, and that both institutions should be placed under one superintendent, by which means the risk and expenses of a passage to the mainland would be saved, a most desirable object also for friends who may wish to avoid even so short a sea passage.

The enormous expenses entailed on ratepayers from the constant enlargements of pauper asylums would be lessened, and a better classification of cases obtained, by utilizing for chronic cases some workhouses and prisons, where available.

The workhouse officials having in many instances got the troublesome aged and helpless paupers transferred to asylums, it would be much better if medical relief as a whole were placed under the same visitors as asylums and workhouse infirmaries, entirely under their control—the sick and insane poor under one management.

There is no just reason for making a difference as regards expense in the treatment of the sick and insane pauper. Both should be treated with equal liberality; of the two indeed the sick pauper is likely to become the more useful member of the community, and ought at least to be as well cared for as the insane, which has not been the case.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

A Quarterly Meeting of the Medico-Psychological Association was held in the Hall of the Faculty of Physicians and Surgeons, Glasgow, on Wednesday, 8th May.

There were present: Drs. Ireland (chair), Gairdner, Campbell, Clark, Fraser (Paisley), Carlyle Johnstone, Mitchell (Cupar), Rutherford, Batty Tuke, Yellowlees, &c.

The following gentlemen were duly admitted members of the Association:—

John McNaughten, M.D., Medical Officer General Prison, Perth.
Dr. Huxtable, Assistant Medical Officer Roxburgh District Asylum.
James Hyslop, M.B., Assistant Physician Royal Edinburgh Asylum.
David Lennox, M.B., Assistant Physician Royal Edinburgh Asylum.

Dr. CARLYLE JOHNSTONE read "Notes of a case of fæcal accumulation of 14 years' standing with enormous distension of the large intestine." The ascending colon, which was exhibited measured 26½ inches in circumference, and the rectum, which during life was tightly packed with hard fæces, occupied the entire pelvic cavity. (See Clinical Notes and Cases.)

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Dr. R. B. MITCHELL read a paper entitled "Case of general paralysis with aphasic symptoms and extreme ataxia," remarking that he had put a mark of interrogation after the title, as he was not sure that the case was really one of general paralysis. (See Clinical Notes and Cases.)

DISCUSSION ON DR. MITCHELL'S PAPER.

The CHAIRMAN—Our thanks are due to Dr. Mitchell for his well-written and carefully considered paper. The pathological examination especially shows great research. Dr. Mitchell must have cut to pieces the whole brain and placed sections from every part under the microscope. He has correctly stated that there may be some doubt as to the diagnosis of the case. It seems to me that the symptoms did not follow the same sequence as those of general paralysis, and that many important symptoms of that disease were absent. I doubt whether general paralysis can be made out through physical symptoms alone. In this case the characteristic *manie des grandeurs* was not present. It is difficult exactly to define what general paralysis is, but it is generally believed to depend upon diffused inflammation of the brain and its membranes, a distinctive characteristic being that the inflammation is diffused and not localized, as shown by the symptoms of mental weakness, of impaired motor power, and sometimes of irritation as evidenced by epileptiform and apoplectiform seizures. I think that in this case the disease has commenced in a certain portion of the brain, probably in the left motor convolutions, and has gradually spread over the whole organ, and latterly to the spinal cord. The case deserves study and attention.

Dr. BATTY TUKE—I heartily agree with you in congratulating Dr. Mitchell on the production of his careful and interesting paper. It is by the accumulation of such papers that we may hope to gain a deeper insight into the nature of insanity. I think, with you, that Dr. Mitchell exercised a wise caution in refraining from an absolute diagnosis of general paralysis in this case. It is not so much the absence of the typical mental symptoms which weighs with me in not regarding this as a case of general paralysis. It is that there are certain anomalies in its method of incidence and in its progress which cause me to regard it as a case of endo-arteritis. And I submit to you that this opinion is supported by the pathological appearances. The various modifications of motility described are to be accounted for by the implication of the blood supply in various motor centres being greater or less according to the extent to which the lumen of the vessels was diminished. It is true there is no specific history, but we all know how difficult it often is to obtain accurate information on this point. Dr. Mitchell's paper and preparations are of special and particular interest to myself on account of the demonstration afforded of the presence of miliary sclerosis, for I notice that in the report of the Medical Congress, Dr. Savage read a paper in the psychological section which must have a tendency to throw doubt on the observations of Professor Rutherford and myself on that and other lesions. I have waited somewhat anxiously for the publication of this paper, but as yet nothing but an abstract has appeared, in which it is stated that in the brains and spinal cords of men and animals, changes not to be distinguished from the so-called miliary sclerosis had been noticed by Dr. Savage. This may be so. Of course I have no doubt that it is so. But if Dr. Savage means to imply that the appearances described by Professor Rutherford and myself were due to this method of preparation, the ground is cut from underneath his feet by the statement of the fact that in no instance were our specimens immersed in spirit for more than twenty-four hours. Dr. Mitchell's preparations, as he has told us, were in spirit only for a few hours longer, and he assures me that when submitted for a longer period, the demonstration of the lesion became more difficult. I may mention that Professor Rutherford and myself, after working for many months with spirit preparations, set a long series aside as practically useless because we found in

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them invariably appearances which we soon recognised to be artificial; but when we came to use chromic acid these were not observable, nor were the appearances presented in any way uniform. If I am wrong in imputing to Dr. Savage the implication that miliary sclerosis, colloid and amyloid degeneration as described by Professor Rutherford, myself, and others, are not due to disease, but to artificial production, I have nothing more to say; but I think that any one who reads the abstract of this paper will not think me hasty in supposing that some doubt was thrown on the accuracy of our observations. If he does not deny the implication, I am quite prepared to submit a series of preparations to a jury, leaving them to decide the question between us. Under any circumstances, I think it would have been better if Dr. Savage, before reading his paper, had studied my preparations alongside of his own.

The CHAIRMAN—With reference to Dr. Tuke's observations, I may state that I was present at the Congress when Dr. Savage read his paper. My impression was that the argument went to show that appearances resembling many so-called lesions of the brain might be produced by the spirits of wine used in the preparation of the specimens, and that the object of the paper was to warn young pathologists against mistaking changes produced by alcohol and re-agents for morbid processes. The paper did not certainly appear to me to be any attack on the views of distinguished pathologists like Dr. Tuke and Professor Rutherford.

Dr. YELLOWLEES—I have listened to Dr. Mitchell's paper with pleasure, and shall read it with still greater interest. I do not say that the case is certainly one of general paralysis, although it presents many symptoms that might lead to that conclusion. I do not attach much importance to the absence of grandiose ideas, for we often see cases of general paralysis without them.

Dr. MITCHELL—I am not surprised that many present are not decided as to the case being one of general paralysis. I think, with Dr. Tuke, that it would be more accurately described as a case of endo-arteritis and aphasia.

(The proposed Statistical Tables were then discussed, and various amendments *adopted for the consideration of the English Statistical Committee.)*

GUITEAU'S TRIAL.

THE SUMMING UP OF JUDGE COX.

The indictment charged the defendant with having murdered James A. Garfield, and it was the duty of the court to explain the nature of the crime charged. Murder was committed when a person of sound memory and discretion unlawfully killed a reasonable being, in the peace of the United States, with malice aforethought. It had to be proved, first, that the death was caused by the act of the accused; and, further, that it was caused with malice aforethought. That did not mean, however, that the Government had to prove any ill-will or hatred on the part of the accused toward the deceased. Wherever a homicide was shown to have been committed without lawful authority and with deliberate intent, it was sufficiently proved to have been done with malice aforethought; and malice was not disproved by showing that the accused had no personal ill-will to the deceased, and that he killed him from other motives—as, for instance, robbery or through mistaking him for another, or, as claimed in this case, to produce a public benefit. If it could be shown that the killing occurred in a heat of passion or under provocation, then it would appear that there was no premeditated attempt, and, therefore, no malice aforethought, and that would reduce the crime to manslaughter. It was hardly necessary, however, to say that there was nothing of that kind in the present case. The jury would have to say either that the defendant was guilty of murder or that he was innocent. In order to constitute the crime of murder the assassin must have a reasonably sane mind. In technical terms, he must be "of sound mind, memory, and discretion." An irresponsibly insane man could not commit murder. If he was labouring under a disease of the mental faculties to such an extent that he did not know what he was doing, or did not know it was wrong, then he was wanting in that sound mind, memory, and discretion that was a part of the definition of murder. In the next place, every defendant was presumed innocent until the accusation against him was established by proof. In the next place, notwithstanding this presumption of innocence, it was equally true that a defendant was presumed to be sane and to have been so at the time the crime was committed; that is to say, that the Government was not bound to show affirmatively, as a part of its proofs,

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