of sound mind, without delusion or morbid depression. On this point also the medical evidence is in our opinion irrefragable.

3rd. That from his first discharge from the Middlesex Hospital to the commission of the crime, a period elapsed, during which there is no medical evidence respecting the state of his mind. Respecting this all important period it may be argued with almost equal fairness, that because he was insane before, therefore he was insane at this time; or that because he was sane afterwards, therefore he was sane at this time. The medical evidence of his sanity during the early part of the present year may be as correct, and not more so, as that which testified to the unsound condition of his mind during last summer. They neutralize each other as to the probable condition of his mind during the winter months which preceded the crime. It therefore remained to the Court to ascertain from other sources than facts observed by medical men, what the condition of the prisoner's mind was during the months which immediately preceded the crime, and especially at the time of its actual commission. In coming to a decision upon this, the critical point of the case, the Court might be aided by medical opinion, but all medical evidence of fact was absent; and the Court had to come to its own conclusion upon data furnished by the conduct of the prisoner towards those with whom he lived, and by the motive of the deed and the manner of its perpetration,—to a conclusion not as to the general soundness or unsoundness of mind of the prisoner, respecting which metaphysicians and psychologists might speculate and split straws for ever, but to a conclusion as to the existence of a certain kind of insanity, of insanity *secundum quid*, of insanity which would exonerate the prisoner from the consequences of his act, according to the traditions and precedents of the English law and the rulings and charges of the English judges; of the existence of a delusion which instigated the crime, or the existence of insanity in some form or other, which prevented the prisoner from distinguishing between right and wrong, or "of knowing what the consequence of the act would be with reference to the crime of murder."

Our own deliberate and impartial opinion is, that the evidence of the state of Buranelli's mind was insufficient to justify his execution, and that it was equally insufficient to authorize his entire acquittal. It was just such uncertain and undecisive evidence as that which has induced Dr. Forbes Winslow to urge the adoption of a middle course, by a verdict of "*guilty, with recommendation to mercy on the ground of presumable insanity.*" [*Psychological Journal*, No. 17, p. 123.]

The not unfrequent occurrence of such cases of balancing probabilities has urged us to advocate for many years past and in various writings, a modification of the present unbending stringency of the law, and especially to urge the adoption of secondary punishments in cases of capital crime, wherein there are "extenuating circumstances connected with the psychological condition of the accused," which although insufficient to justify an unqualified acquittal, are just and legitimate grounds for preventing the infliction of the severest penalty of the law. Such a system of punishment, modified according to degrees of responsibility, is not only recognized as a fundamental part of the law of France, but it has already in many cases been acted upon in Ireland, in consequence of the wise intercession of the Inspectors of lunatic asylums in that part of the kingdom. It appears that the Inspectors of lunatic asylums in Ireland have not only actively interceded with the Government, to obtain a remission of the sentence of death to several persons convicted of murder, on the ground of presumable insanity, but that they have done so from their own personal observation of the prisoners, by frequent visits to whom they have been able to make reports to the Lord Lieutenant, upon which he could act with security. Thus the enlightened humanity and activity of the inspectors have in Ireland supplied the place of the French experts, and provided the government with a mode of escape from the consequences of the defective forms of legal procedure.

The Diagnosis between Melancholia and Hypochondriasis.

In the cross examination of Dr. Sutherland upon the trial of Buranelli, he stated his opinion, that the unfounded and absurd ideas of the prisoner, relative to the slight surgical disease under which he labored, were "*illusions the result of hypochondriasis, and not delusions the result of insanity.*"

We have thought fit to argue the merits of this case in the previous article, solely upon the facts which were elicited in evidence; and not upon the value attached to those facts, either by the advocates or the witnesses. A man of Dr. Sutherland's great experience in mental pathology might be able with certainty to ascertain that a person subjected to his examination was or was not insane; notwithstanding which, in a logico-metaphysical argument with a practised word-fencing barrister, respecting the nature and the value of symptoms which he had not observed himself, he might be forced to admissions at variance with scientific knowledge. As a matter of great practical importance, we shall endeavour to ascertain whether there are any marks by which hypochondriasis can be distinguished from insanity, and whether such marks were present in the instance which has recently excited so much painful discussion.

Until recent times it appears that many cases of true insanity were regarded as instances of hypochondriasis. Galen and other ancient authors described hypochondriasis as a species of melancholy; and in later times Pinel and other authors of authority included it in their classification of mental disorders. "Joseph Frank included among hypochondriacs those melancholics who imagine that their body is made of butter, as did Gaspard Barlœus, a distinguished physician of the 17th century; of mud, like a patient spoken of by Aretæus; of wax, like one who was observed by Grimm; of glass, like a philosopher who was described to Sanchez by Boerhaave. Such persons avoid heat, lest they should be melted; they forbear to drink, lest they should be dissolved; or they continually remain sitting, in order to avoid being

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broken. Frank also confounded with hypochondriacs persons who believe themselves turned into animals (zoanthropes), and all other monomaniacs who have false ideas or perceptions relative to their individuality. This opinion was an error which vanished before a more profound classification of mental disorders." [*Michéa, Traité de l' Hypochondrie.*]

It is therefore certain that hypochondriasis and melancholia monomania were not clearly distinguished by physicians until recent years.

The learned Pritchard himself distinguished between the two affections with his usual clearness and precision.

He observed, "that an hypochondriac is in full possession of his reason, though his sufferings are not so dangerous or so severe as he supposes them to be; *but if he declares that his head or his nose has become too large to pass through a doorway, or displays any other hallucination, he has become a lunatic*; his disorder has changed its nature; and this conversion takes place occasionally, though by no means so frequently as is supposed. "Hypochondriacs, however low spirited or dejected, also suffer differently from persons affected with melancholy. The apprehensions of the former are confined to their own feelings and bodily health. On other subjects they converse cheerfully, rationally, and justly. But melancholics view all things through a gloomy medium. They despond on all subjects, and are mentally miserable, and independently of any severe bodily suffering. The affections and sentiments of the hypochondriac, especially to his former friends or to his connections, are not in the unnatural or perverted state, observed in all the forms of insanity."

We must not omit the diagnosis between these two diseases drawn by the masterly pen of Cullen, than whom no medical writer has ever been more accurate and logical in his discrimination of disease, according to the light which he possessed. He says,

"Hypochondriasis I would consider as being always attended with dyspeptic symptoms, and though there may be at the same time an anxious melancholic fear arising from the feeling of these symptoms, yet while this fear is only a mistaken judgment with respect to the state of the person's own health, and to the danger to be from thence apprehended, I would still consider the disease as a hypochondriasis, and as distinct from the proper melancholia; but when an anxious fear and despondency arises from a mistaken judgment with respect to other circumstances than those of health, and more especially when the person is at the same time without any dyspeptic symptoms, every one will readily allow this to be a disease widely different from both dispepsia and hypochondriasis, and it is what I would strictly name melancholia."

"In this there seems little difficulty; but as an exquisitely melancholic temperament may induce a torpor, and slowness in the action of the stomach, so it generally produces some dyspeptic symptoms, and from thence there may be some difficulty in distinguishing such a case from hypochondriasis; but I would maintain, however, that when the characters of the temperament are strongly marked, and more particularly when the false judgment turns upon other subjects than that of health; or when, *though relative to the person's own body, it is of a groundless and absurd kind*; then, notwithstanding the appearance of some dyspeptic symptoms, the case is still to be considered as that of a melancholia, rather than a hypochondriasis."

Crichton maintains that the different origin of the two is the most characteristic distinction between melancholia and hypochondriasis; the former seldom arising except mental causes join themselves to corporeal ones, the latter ensuing in the first place from bodily ailments alone.

Romberg, one of the most experienced and learned of writers on nervous diseases, lays stress upon another mark which distinguishes hypochondriasis from melancholia.

"Diagnostic errors are frequent from psychical hyperæsthesia being confounded with melancholia and hysteria. The characteristic peculiar to the former, as of insanity generally, consists in an alienation of the feeling of identity and consciousness, as regards sensations and impressions, and this in melancholia is combined with a tendency to self-negation.

"In hypochondriasis, on the contrary, the egotistic principle is exalted, and in no ways estranged to some other sensation or impression, so as to render this an apparent reality. The difference is clearly expressed in all the patient's relations, not excepting his relation to his physician. The hypochondriac looks upon his physician, however often he change his medical attendant, as his guardian and saviour; while the person laboring under melancholia treats him as if he were a hostile or ignorant individual, and constantly tries to avoid him." [Romberg, vol. I. p. 181, Sieveking's Translation.]

If these authorities, which might easily be multiplied, may be accepted as conclusive upon the marks of distinction between melancholia and hypochondriasis, we venture to affirm, that the erroneous opinion of Buranelli, as described by Mr. Mitchell Henry, was demonstrably attributable to melancholia and not to hypochondriasis.

1st. The cause of Buranelli's mental condition was grief, the common origin of melancholia; and it was not dyspepsia, the usual origin of hypochondriasis.

2nd. It was an obvious hallucination representing things to exist which did not exist, and "though relative to the person's own body it was groundless and absurd." It was therefore, according to Cullen and Pritchard, a clear mark of melancholia.

It was not a mere exaggeration of sensation, like that which exists in hyperæsthesia, æsthetics, or hypochondriasis: for be it remembered that when the patient was under Mr. Henry's care, and when he declared that his bed was swimming with water, which passed from the supposed perineal fistula, the slight abscess under which he had suffered had become healed, and there was no fistula or solution of continuity whatsoever.

3rd. The patient took antipathies to his medical men, a mark of melancholia; and did not cling to them as his guardians, and persecute them to afford him relief, like a hypochondriac.

4th. The absurd ideas did not change from one symptom, and from one organ to another, as they invariably do in hypochondriasis; but one erroneous,

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one persistent idea remained, to mark the mental infirmity, as long as this appears to have existed; an occurrence which is usual in true melancholia.

5th. An intense desire to be cured of his supposed malady, which is a characteristic and universal symptom in hypochondriasis, was so far absent, that before the patient was cured of his trifling disorder he tore off the bandages and prevented the wound from healing.

6th. The love of life and the fear of death, which is the prevailing mental characteristic of hypochondriasis, was not only absent in this case, but it was replaced by a strong and undoubted tendency to the commission of suicide, which, when it is motiveless, is one of surest marks of insanity.

On this subject Michea, whom we have before quoted says, "one may at first be tempted to confound certain hypochondriacs with persons affected with suicidal melancholia, but when one looks beneath the surface on the psychical condition of the two disorders, the *immense interval* which in most cases separates them is at once perceived. If hypochondriacs do indeed sometimes speak on the subject of suicide, and request their neighbours to put an end to their existence, all this is a mere feint, pure comedy. They see their friends and physicians little disposed to agree with them as to the dangerous nature of their supposed maladies; they see doubt imprinted upon the faces of those to whom they relate their sufferings, and they feign the desire to quit this life in order to induce in others the exertion of efforts to preserve them. They entertain in so slight a degree any real intention to embrace death, that the idea very rarely passes into the act, and even when it does come to this pass, the attempts they make are almost always abortive. Another proof of the correctness of these views is, that their features expand, and they gain rest to the very soul, if you are able to convince them of the reality of their cure; or if you boast with zeal and assurance the certain efficacy of this or that remedy, which they have not tried."

How completely opposed is description of an hypochondriac threatening suicide, to the account given by Mr. Henry of Buranelli to whom he demonstrated the impossibility of the existence of his supposed disease by the use of the catheter, but without the slightest effect; on whom the arguments and the proofs of the surgeon that he was cured, had as much effect "as if they had been addressed to a stone wall," and whose tendency to suicide was proved by the result, to have been removed in the furthest possible degree from a feint or a comedy.

We must therefore come to the conclusion, that the opinion of Buranelli respecting the existence of a fistula communicating with his bladder and swamping his bed with urine was a *delusion the result of insanity, and not an illusion the result of hypochondriasis*, That this delusion had ceased to exist, when after the lapse of many months Dr. Sutherland examined this unhappy man, only affords an example of a circumstance which that able physician must be in the constant habit of observing, that recent insanity often gives way under the influence of time and of change of place and circumstance.

Case from the Radcliffe Infirmary, Oxford, by E. L. Hussey, F.R.C.S. *one of the Surgeons to the Infirmary.*

Severe injury of the Arm in an Epileptic Woman—Amputation at the shoulder-joint on the tenth day—Maniacal exhaustion.—Death in 28 hours.

A woman, aged 45 years, the wife of a laboring man, was admitted into the Radcliffe Infirmary, Oxford, under my care on the 24th of April, 1855, on account of a severe injury to the soft parts of the right arm and shoulder, caused apparently by fire, though said to be the effect of boiling water, three days before admission. A large round patch of integument, in the subclavian region, extending upon the shoulder over half the breadth of the deltoid muscle, was blackened, hard and dry; on the inner aspect of humerus, the integument was white and gangrenous; around and below the elbow the limb presented the appearance of moist gangrene. The tendons at the wrist were all exposed, and the fingers were contracted upon the palm of the hand.

The history given by the friends who brought the woman to the Infirmary, (a distance of 20 miles,) was, that she had been found in this plight in her cottage, laughing and tearing the ragged skin from her hand. Afterwards, upon further enquiry, we learned that she was subject to "fits," which came on at irregular intervals, from various trifling causes of irritation or excitement. During the attack, she was generally very violent, sometimes for five or six days together; and the fit often ended in her rushing to the fire and raking the burning coals out with her hands, and clinging to to the hot bars of the grate when her neighbours tried to remove her. In some of these former fits she had burned her hand and forearm severely. It seemed as if great part of the true skin of the forearm and back of the hand had been destroyed; and as if the only covering before the present injury had been the cicatrix formed of the fascia and superficial layer of muscles.

There was some feverishness about her, and the circulation was depressed. The usefulness of the limb seemed clearly to be lost beyond hope of recovery. From the appearance of the integuments in the upper part of the arm, an effectual covering for a stump could not be ensured, unless by removing the limb at the shoulder joint,—an operation I was not willing to urge in her state at the time. Good diet, with a little wine, was ordered, and opium was given at night. The limb was wrapped in cotton wool, and a bandage applied round it.

Her manner was odd, but without exiting any special attention, till between 2 and 3 o'clock in the morning of the 26th; when, after tossing the bed clothes about in a restless state, she jumped out of bed, frightening the other patients in the ward, and broke the glass of the nearest window. After carrying her back to bed, the nurse summoned the house surgeon. She continued her violence in his presence: she threw the injured arm about like a flail, and gave him several blows in the face with it, trying to scratch his face with her contracted fingers. At length she was subdued by the inhalation of chloroform, followed afterwards by

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