Mercier chooses to call the withdrawal of tobacco and certain privileges "punishments," and if this definition existed only in his own mind as regards the insane, no harm would be done; but, unfortunately, his opinions were widely published, and the general public will very quickly get into their heads that we are going back to the time when the insane were very severely treated. Dr. Mercier also said that the medical witnesses should be able to give the judge so much assistance that mitigated punishments should be inflicted. That means, under some circumstances, the insane should be punished because in his opinion all insane people are not totally insane. I absolutely disagree with him. If a person is insane, I maintain it is impossible for any one to say how far he is insane, how far he is responsible or irresponsible. (Hear, hear.) As to the case mentioned by Sir James Stephen as having had a delusion that his finger was made of glass, no one could say how far that delusion might affect that person's mind. I maintain that if the person is insane at all, he is totally insane, and that we cannot recognise any such thing as partial insanity. Dr. Mercier says, "Is the thief to be punished if he becomes insane?" I do not see why the thief who has become insane should be differently treated from any ordinary person.

Lunacy in Private Practice. By H. C. BRISTOWE, M.D., Wrington.

I DESIRE to-day to show, to some extent, the difficulties the general practitioner of medicine has to contend with in the treatment of lunacy; difficulties certainly unknown in public asylums, and only partially appreciated in private institutions.

The first, and I may add the natural impulse of every medical man in private practice, on being called to a case of insanity, is to relieve himself of a certain amount of responsibility, and at the same time to do what he considers best for his patient, by sending him to an asylum with the least possible delay. No doubt that in itself is a very proper course to pursue, but there are many difficulties in the way. The case may be of such a character that certification is a difficult matter; then the relations raise objections; perhaps the magistrates refuse to make the order, or finally the patient may be of the quiet demented type better fitted for treatment at home, or in the lunatic ward of a workhouse. This accommodation, however, is often wanting, and the patient becomes one of those unfortunate outcasts who is unfit to be kept at home, and is yet unfit for asylum care.

I may say at once, as a foundation on which to build my whole subject, that in private practice the treatment of an insane

https://doi.org/10.1192/bjp.45.188.66 Published online by Cambridge University Press

person is essentially the treatment of his friends. Many patients who become hopeless dements might never have been lost to the intellectual world had their friends been persuaded of the necessity of prompt and active treatment. I cannot over-estimate the dangers of delay, both immediate and remote. I was called to see a patient one Sunday morning—a man who had been sent a distance of many miles from his home for a change of air, because he was depressed and unable to manage his business. He was suffering from acute melancholia of a suicidal type. I gave the friends full directions, and warned them of the apparent dangers, and left with the relieving officer to make arrangements for his immediate removal. In an hour, before a magistrate could be seen, the patient had cut his throat. Was he sane when he left his home? Why was the patient sent for a holiday instead of to an asylum? The answer can only be a presumptive one. Another point arises from this case—why should not urgency orders exist for pauper as well as for private patients?

Delay is more often caused by the unwillingness of friends to have the patient sent away. In some cases the prejudice is so strong that treatment must be carried on in a private house, which is generally most unfit for such a purpose. For instance, a case of puerperal insanity was kept at home because at first the husband would not believe his wife to be mad, and later on could not be persuaded to part with her, believing she could be just as easily cured at home. Eventually he did consent, but too late, for though she has now left the asylum she has never properly recovered.

Why, in the many courses of lectures given under the auspices of the St. John's Ambulance Association, cannot one lecture be added to teach the public the seriousness of mental alienation, and the dangers caused by the delay of active treatment? Most uneducated persons would prefer that their relations had a limb amputated in their own homes than allow them to spend a month or two in an asylum, even with the prospect of their eventually becoming useful members of society; when too late they are glad enough to be rid of them.

Another serious difficulty lies in obtaining orders from the justices. At the same time I must say that some of them take a great deal of trouble over the matter. Some, on the grounds that they are not experts, take a judicial view of the

https://doi.org/10.1192/bjp.45.188.66 Published online by Cambridge University Press

case; but others, not content with weighing the evidence put before them, attempt to test the mental condition of the patients. The result is often disastrous. These same justices, when seated on the bench, pass judgment on the evidence before them as a matter of course, and do not require that they shall themselves have witnessed the crime before convicting the prisoner. They seem to forget that a medical certificate of insanity is a statement on oath.

A very different form of difficulty which we have to contend with is the inability that many persons, even members of our own profession, have in detecting insanity in its earlier stages. Indeed, not infrequently are well-marked cases of insanity regarded by the medical attendant as cases of hysteria. Perhaps some of the greatest mistakes in this respect are perpetrated by specialists in diseases of women.

The following case gave me much trouble and anxiety. A young lady begins to show morbid mental symptoms, and her mother, as we should expect, discovers that her menses have ceased. The unfortunate patient is taken at once to the gynæcologist, who straightway treats her for amenorrhœa. Her mind is at once fixed on her sexual organs, and from that date erotomania to a greater or less extent ensues, and in addition to the risk of permanent mental aberration she runs a risk of being dishonoured by the first reprobate thrown in her way.

I must deal shortly with those patients who must be treated in their own homes. In the houses of the well-to-do, after the proper treatment by their friends, which is by no means an easy matter, there is very little to be said which does not hold good for those cases removed to an asylum. One's time is taken up in preventing or counteracting the injudicious actions of those around them. But in this class a trained attendant is so easily obtained that one can count on a good deal of assistance. In the lower middle classes, however, trained attendants are too expensive, and when space is limited the difficulties become far more serious. It is common to find that an injudicious act has caused a relapse in a patient who was progressing favourably. If there is a well-marked suicidal tendency we are often told that the patient does not really mean to carry out his threats. His friends consequently fail to have him properly watched, and the disastrous results are recorded in the daily press. Although in adverse surroundings it is difficult to bring moral influences to

https://doi.org/10.1192/bjp.45.188.66 Published online by Cambridge University Press

bear on a patient, a good deal can be done to guide him along the right path.

In the lower classes the outlook is almost hopeless unless the patient can be removed to an asylum. But in this very hopelessness a gleam of hope arises, for the burden of an insane relation is so great that relief is soon sought, but only if the ease be acute and troublesome.

My experience confirms me in the belief that the proper treatment of insanity can only be conducted satisfactorily in asylums. Where wealth is at command of course much may be done by careful home treatment, or well-regulated travelling; but how much better asylum treatment is can only be judged by those who have known both. Where wealth is wanting it is appalling that the prejudice wrongfully attached to the name "asylum" should cause so many hopeless cases. To the general public the lunatic asylum has a portal over which is written the dread motto, "Abandon hope, all ye that enter here." We may in the course of years teach people the real nature and the value of these institutions, but meanwhile it is this difficulty of a name which fetters the action of the general practitioner, and causes accumulation of the chronic insane.

As regards those on the border between sanity and insanity, in my experience the majority are much better treated outside the walls of an asylum, so long as they are capable of such self-control as maintains them useful members of society; but when they pass beyond this boundary they should be placed in asylum care if medical men are found bold enough to certify them.

No doubt it was for the benefit of these borderland patients that the law as to voluntary boarders was made. Does this law help them? In my limited and unfortunate experience it does not, for in such cases certification has nearly always proved ultimately necessary.

Finally, what is to be done with aged harmless dements? Many are kept quietly and peaceably at home, and do well there; but where homes are cramped and money scarce, and the workhouse impossible, it becomes our duty to send them to an asylum, although many of us in general practice are just as unwilling to do this as the authorities are to receive them.

Discussion at the meeting of the South-Western Division, Bath, October 19th, 1898. See "Notes and News," *infra*.

https://doi.org/10.1192/bjp.45.188.66 Published online by Cambridge University Press