same applied to the sensory pathway leading up to the cerebrum. In Dr. Turner's experience melancholia more frequently than any other class of mental disorders, with the exception of general paralysis, tended in comparatively short periods to pass into dementia.

The Modern Treatment of the Insane.

Dr. Seymour Tuke referred to the difficulties under which alienists in England laboured under the existing lunacy laws. The Lunacy Act of 1890 was, owing to its "too repressive" nature, evaded by many, and unregistered places for the accommodation of insane private patients thus continue to exist. There was a prevailing practice of diagnosing cases of insanity as neurasthenia, hysteria, and as "borderland" cases.

The Diagnosis and Treatment of Feeble-minded Children.

Dr. Francis Warner stated that of the school children between the ages of three and thirteen years in England it was estimated that about 1 per cent. were feeble-minded. The Elementary Education (Defective and Epileptic Children) Act of 1899 had directed attention in many quarters to the necessity of provision for the care and training of children of defective brain power. He then laid down rules for the guidance of those who had to make a diagnosis of cases of brain defect, and indicated the lines of treatment which should be carried out.

Colitis, or Asylum Dysentery.

Dr. T. Claye Shaw contributed a paper on this important subject, in which he contended that only a small proportion of cases of colitis were primarily of bacterial origin, and that ulceration of the mucous membrane of the intestine was commonly met with in the insane, and was a trophic degeneration dependent upon the low nervous vitality of the patient. Such ulcerations might be comparable to bed sores. The disease known as asylum dysentery seldom affected the medical or nursing staff of asylums. The continued occurrence of colitis did not necessarily imply that sanitation was bad in the buildings where it occurred, and cast no discredit on the medical or administrative staff.

Debated Points in Asylum Plans.

Dr. R. H. Steen's paper on this subject gave rise to a lively discussion. He criticised adversely the villa-colony system, stating that (1) it would prove very costly to work in this country; (2) the staff required would be enormous; (3) the patients would not be efficiently supervised at night; (4) the risks of suicide would be greatly increased; (5) escapes would be numerous; and (6) the initial cost would be not less than that of the pavilion asylum.

ASYLUM DIETARY.

(*Abstract.*)

By A. Turner, M.D., Plympton, Devon.

The question of diet is very important in relation to any community of individuals—particularly when sick in mind or body,—more particularly when sick in both. It is a vital question in an ordinary household, more so in a general hospital, and of more serious import still in a hospital for the insane, where *good food*, *good cooking*, and *good service* are specially necessary.

Food.—It is a common remark in asylums that the food is good enough, but spoilt in the cooking. And if to this we add in the service, I think we have found the weak points in asylum dietary. Food materials should be selected for their intrinsic value, and must be critically examined in every respect on delivery, regardless of the vendor or his connections.

Housekeepers.—Asylum housekeepers are as a rule very excellent individuals, but they are often selected for reasons unconnected with housekeeping. Few learn to fulfil their undertaking, even under generous opportunities of learning. There is difficulty in obtaining the services of good *cooks*, and there is often friction between the housekeeper and the cook until compatible inadequacy results. The food of the higher officials engages her attention, so that the patients suffer by the

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delegation of her duties to kitchenmaids. Failure too often results owing to inattention to details. *Potatoes* are spoiled by mere carelessness, although they are a staple feature at dinner. *Cabbage* and similar vegetables require careful cleansing or they are disgusting. *Beef-tea* is by no means satisfactorily prepared, and then, perhaps, it is fortunate that it so often reaches the stomach through a tube. *Soup*, in English asylums, is not given as often as it should be. The English people seldom prepare this efficient and economical diet, which owes much of its unpopularity to careless preparation. *Gravy*, which renders meat less dry and gives relish to vegetables, is rarely seen. I need not refer at length to the humours of our asylum kitchens, and the little mistakes which will occur and are too often repeated

Service.—The dishing up in the kitchen, the carriage from there to the hall or ward, and the carving and final distribution may be spread over thirty minutes, during which the food has been more or less exposed to the cooling influence of the atmosphere. *Heated tables* in the kitchen are by no means universal, and are often inadequate. Suitable *dinner waggons*, *heated dishes*, *plates*, and *covers* are scarcely to be found. The result too often is that meals are served in an unappetising state to patients who at home have their meals served hot, direct from the cooking utensil to the plate.

Sick diet is generally more home-like, and no doubt for that reason is much in favour, not so much because of its intrinsic superiority, but of its special preparation. Still there is often a sad lack of attention in its distribution, for one frequently sees the extra diet placed beside the patient's ordinary meal, and that is not the way to coax a flagging appetite.

Remedies.—A more carefully selected and supervised kitchen staff, and a better system of service, are obviously required. I would have the staff understand that there is a way to a patient's heart through the alimentary canal.

Meals.—The breakfast and tea must remain as at present notwithstanding the waste involved. In dealing with the insane—even in small numbers—the only way of insuring that every patient gets enough at each meal is to put enough before him individually. Jam, marmalade, or syrup might more often take the place of butter, and for some of the patients the tea and coffee might be served with the option of milk and sugar. Porridge is little used and unpopular in England because it is badly made. Dripping, as often used by the poor, might supplement the necessarily scanty supply of butter. *For dinner*, beef, mutton, and pork must form the basis, but these should not always be boiled or roasted. Onion sauce, caper sauce, and savoury stuffing are too rarely in evidence. Rice should be used as a second vegetable or made into shapes served with jam or fruit. Rice suggests *curry*, which might sometimes be supplied. *Fish* is not a popular dinner because it is seldom well cooked and served with some approach to daintiness. *Puddings* are not generally given in variety, yet women especially often prefer them to meat. Jam, marmalade, apple puddings, and tarts are surely not beyond the possibilities of asylums. Even in summer-time too little fruit is used.

I believe that we have not progressed in dietary as in other departments of asylum administration. A fair ideal has not been generally recognised or faithfully acted upon. Were this done we should add to our remedial, possibly to our curative agencies. Think how a spoilt dish disturbs an epileptic ward or disappoints a convalescent when he finds that removable sources of worry are permitted to exist. I plead that the sick should be fed as well as nursed.

In asylums generally the diet scale is the same for all patients, whether they be able-bodied or infirm, young or old, active or sedentary. I suggest that they might be classified with advantage to the individual and to the general economy of the institution.

Discussion

At the Spring Meeting of the South-western Division, April 23rd, 1901.

Dr. MacDonald said—With much that Dr. Turner put forward I am in hearty agreement. I think it will be admitted that the larger the asylum the more likely are those evils to which Dr. Turner referred. You have to a large extent to fix your diet and to base it on the district in which you live. It is a mistake to fix the same dietary for the south as for the north. You have a different class of people to deal with, and what pleases one does not please the other. We all know what

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a very wholesome article of diet fish is, but I find the people with me won't take it, and in consequence it is only given occasionally. I agree with Dr. Turner that it would be a good thing if it were possible to vary the dietary more. I find there is one little article of diet which pleases the people immensely. That is when eggs are cheap and plentiful, to give eggs and bacon for dinner instead of beef or mutton. You cannot cook enough to go all round the asylum at one time, but spread it over the wards. I feel rather pleased that I am not hampered in any way as regards a fixed diet for the staff. This enables one to vary their diet, which is such an important question as regards contentment and loyalty.

Dr. MILLAR said—The question of variety in meat has been touched upon. Of course, in killing your own animals there is a great deal which appeals much more to the patients than mutton and beef,—for instance, liver, heart, and kidneys; and I find that patients prefer a dinner of bacon and liver, even cow's liver, to a sirloin of beef. I can bear out what Dr. MacDonald said about the bacon and eggs. I tried to think out some plan by which I could give the patients more fat, and I find that the simplest way of doing it is by the introduction of pudding with suet in it. Fish is a most unsatisfactory article of diet in an asylum. A patient not very long ago told me it was only fit for manure. As regards the point touched upon by Dr. MacDonald, who said the position of the asylum had a great deal to do with the diet you give to your patients, I am confident that Warwickshire would not look at porridge. So far as the staff go, there are one or two points I have found successful. During the summer, when "green meat" (radishes, lettuce, and that sort of thing) is abundant nurses especially appreciate these things very much, two or three times a week. It is not the amount of food which you give the staff, but the way you send it to them. They would sooner have a small piece of meat well cooked than a large piece insufficiently cooked.

Dr. PIETERSEN.—My experience has been that of sixteen years in private asylums, and, of course, the conditions are very different. In the institution in which I have been for the last ten years I have only under my care thirty patients, but to give some idea of the trouble you would have if you were to separate your patients out, the active, suspicious, melancholic, acutely maniacal, and so forth, I may say that for the thirty patients I have to order sixteen dinners a day. To do this in an asylum of 1500 patients you would require at least seven or eight medical superintendents. Dr. Turner's suggestions are such as I have long attempted to practise.

Dr. BENHAM.—I suppose our remarks are largely based upon our own experience. One of my difficulties in facing the diet problem was to get the food hot to the patients. We have hot-water plates in the dining hall, and I am in favour of patients dining in a central hall in the neighbourhood of the kitchen. The meat is brought in and carved at the head of each table and served there. Of course it takes a minute or two to do this, but on the whole we get the food fairly warm to the patients. I was interested to hear about the eggs, but I cannot say that I am always able to get sufficient fresh eggs for myself. Our nurses and attendants dine out of the wards. We vary their dietary frequently. We have no stated diet for them, and I am able to spend any reasonable sum for that purpose. The male attendants sent a deputation to me and said they would not eat fish. I told them that, personally, I liked fish very much, and I provided it for them, but if they said they would not eat it they could go on with the beef and mutton. I must agree that a fish dinner is not popular.

Dr. TURNER.—I am very much obliged for the kind way in which you have received the imperfect paper in which I have dealt with this subject. The question of cost has been touched upon, but I do not see that there should be a remarkable expenditure. All that is required to improve asylum dietary on the lines I have mentioned—I mean a better staff, more variety in their dishes, and better appliances for serving things hot—would not involve an enormous expenditure. I am afraid it is such a long time since I was in Dorset that I have forgotten many of the good things I learnt there, but I know of no asylum where the staff are better fed. Of course, a universal diet is out of the question. You cannot give eggs and bacon all round, but you could take the wards in turn from time to time, although that would mean more work for the staff. I did not deal with the staff because, naturally, if the patients' diet were improved theirs would be. In many of the large asylums the way the meals are served out to the staff is a crying shame, and

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it is nothing uncommon to see a joint of meat flung across the mess-room. I was very pleased to hear Dr. Benham's remarks about the hot-water plates. He suggested margarine, and I would suggest that he should label it: no one took up my suggestion of dripping. I used to find that it was in great demand by the staff. I would suggest that patients might be allowed to add milk and sugar to suit their own tastes when tea or coffee is served Of course, it would be impossible to deal with large numbers, but in dealing with saner patients in the convalescent wards it might be feasible, especially if they sat at small tables.

RECENT MEDICO-LEGAL CASES.

REPORTED BY DR. MERCIER.

[The Editors request that members will oblige by sending full newspaper reports of all cases of interest as published by the local press at the time of the assizes.]

Rex v. *Scott.*

William Scott, 38, farm labourer, was put on trial for the murder of his wife, whom he shot with a revolver,—facts were undisputed. For the defence it was proved that the prisoner had been subject to depression, which had got worse the last few years; that three instances of insanity had occurred among his relatives, and that a few days before the crime he had lain down in a furrow in a ploughed field for two hours. It was proved also that he was addicted to drink. Acquitted on the ground of insanity.—High Court of Justiciary, Aberdeen, June 24th, Lord Kincairney.—*Scotsman*, June 25th.

The evidence of insanity seems to have been very slender, and the case is an instance of readiness of judges and juries to accept the plea of insanity even where the evidence is not very strong.

Rex v. *Wickham.*

Walter Wickham, clerk, 30, was indicted for the murder of Jennie Russell. The prisoner and the deceased had been drinking on the night before, and had been heard quarrelling. Shortly after midnight the prisoner cut her throat in the street, from which she died on the spot. When the prisoner was arrested and charged there seems to have been something peculiar about him, for the inspector asked him if he understood the charge. The prisoner answered, "Yes, yes. You can charge me with being drunk and disorderly or anything else." The plea of insanity was set up in defence, but the jury found him guilty. When the judge was sentencing him to death the prisoner tried to get away, shouting. "I won't hear any more." When the sentence of death was completed he shouted, "A good job."—C.C.C., Mr. Justice Wills.—*Manchester Guardian*, July 24th.

There seems to have been *primâ facie* evidence of insanity in this case, and no doubt the prisoner was medically examined subsequent to sentence. There was, however, no evidence of insanity adduced at the trial.

Rex v. *Johnson.*

Mary Elizabeth Johnson, a married woman, 29, was indicted for the murder of her 14 months old child. Prisoner had been summoned for stealing and pawning a coat. The charge was not pressed, and she was bound over in her own recognisances and left the court in company with the neighbour who had preferred the charge. She seemed very much distressed, and on her way home she said she must poison herself and the baby, and the next morning she actually did so. To the neighbour who came in and found the baby dead and the prisoner in great pain she said, "Jennie is dead, I gave her some rat poison in warm milk; I won't live myself, I have taken too much poison. No one knew my mind, I was ashamed to go out. I have bought a night-dress for Jennie and a chemise for myself. The night-dress is to be put on Jennie." When committed for trial she said, "she did not know what she had given the child, and everything seemed like a dream. She suddenly found the child dead in her arms and laid it on the bed." The defence was insanity. Dr. Price, Medical Officer of Walton Prison, said that the prisoner had been suffering from acute melancholia, was suicidal, but had homicidal

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