special night nurse has to be placed on duty to take charge of the case. This is actually happening while I write these lines, and thus the very object for which the plan was adopted is defeated. Under this arrangement patients have to be taken from their own wards at bedtime, often a considerable distance, to sleep in this epileptic gallery: it follows that the patients in the day-ward belonging to this gallery have to be sent to fill up the vacancies so caused; and thus the sleeping arrangements of this asylum—not at any time of the best—are rendered very complicated, and when the time for rising in the morning comes the nurses have to leave their wards to fetch their respective patients from the epileptic gallery.

"I have endeavoured to state facts quite fairly, and as I unhesitatingly accepted the suggestions of the Commissioners in the matter, and have ever since carried them out as far as practicable, I feel that I am justified in stating my experience. The system is still in practice, and probably will continue so; but I am fain to confess that I am unable to consider it the unmixed good that it has been stated to be."

LANCASHIRE (WHITTINGHAM).—That female attendants in the male wards has a humanising effect upon the patients appears to be the result wherever the experiment has been tried. The Commissioners report on this subject as follows:—

"To these last [the ordinary female attendants] must be added three more women, the wives of male attendants, who live with them in the male wards, and take charge of the bedding, and are responsible for the general state of the dormitories. Judging from the good order of the wards in which this arrangement exists, there is every evidence of success in the plan, and we are glad to learn that as other male wards are opened, the same system will be adopted. Another arrangement made by Mr. Holland, and followed by the most complete success, is the employment of women only in the male infirmary. This ward now contains 43 inmates, who are attended during the day by four nurses, and who are watched at night by a fifth specially appointed for that purpose, and having no other duties. Nothing could be better than the state of this ward and its inmates."

(To be continued.)

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

The quarterly meeting of the Medico Psychological Association was held on the 13th May, 1875, in the Hall of the Faculty of Physicians and Surgeons, Glasgow. There were present—Drs. Fraser (Cupar), Fleming (Glasgow), Clouston (Edinburgh), Rorie (Dundee), Fairless (Bothwell), Campbell (Carlisle), Howden (Montrose), Skae (Larbert), Grierson (Melrose), Denholm (Dunse), Gairdner (Glasgow), Yellowlees (Glasgow), Brown (Edinburgh), Rutherford (Lenzie), and Dougan (Glasgow).

Professor GAIRDNER, who took the chair, welcomed the Association to Glasgow,

and said he believed he was almost the only member of the Association here—at least one of the very few—not connected with the speciality.

The CHAIRMAN—The first business is the exhibition of pathological specimens.

Dr. HOWDEN, Montrose, exhibited an aneurism of the basilar artery. The man was an epileptic, and had every symptom of syphilitic brain disease.

Dr. CLOUSTON then showed two specimens of tumours of the brain, the one being that of a slowly-growing carcintomatous tumour—and the other that of a syphilitic deposit. He exhibited microscopic sections of both tumours, and of the brain in the latter case, showing that the deposit was composed of ill-formed granular cells lying in the granular matrix. He made some remarks on the symptoms in each during life, showing that the one was a typical example of a slowly-growing tumour, producing few symptoms at first, but setting up a degeneration of the nervous tissue in the shape of grey absorptive degeneration, thickened membranes with long plates, &c., while the other was a typical example of a tumour, or deposit, of quick growth, causing intense irritation of the brain round it. He contrasted the symptoms during life mentally and bodily, the slowly advancing dementia in the one case with the melancholia and stupor in the other; the transient attacks of hemiplegia, advancing gradually to complete paralysis, in the one case with the severe convulsions in the other; the long course of the disease in the one case (three years) with the duration of the other (three months). The tumours in each case occupied the same positions, viz., the front of the anterior lobes. Dr. Clouston also showed the brain in a case of a very rare kind of general paralysis, spreading, by propagation, from the retina. It is now pretty well recognised that general paralysis may arise from locomotor ataxy. I have (Dr. Clouston remarked) three cases of this form of paralysis under my care, though I never saw a case till I went to Edinburgh. One of these is that of a man who was recognised to have laboured under locomotor ataxy, and he is now unquestionably a general paralytic. The other case had existed for seven years as a case of locomotor ataxy. He now is unquestionably a general paralytic. The three cases have a very similar history.

Dr. RORIE showed a piece of wood which a patient in the Dundee Asylum swallowed, and œsophagotomy had to be performed. (See "Clinical Notes and Cases," p. 282.)

Dr. HOWDEN—I doubt whether general paralysis does spread from the retina. It is so general a disease that you can scarcely say it commenced there and spread like a cancer. My notion of this malady has always been that it is a disease of the brain affecting all the motor, and, to a certain extent, the mental faculties of the patient.

The CHAIRMAN—I do not think we can admit anything like a pathological propagation from one side to another, but in reference to Dr. Clouston's theory that the marriage was the exciting cause in his case, it is pretty well established that there are certain cases of locomotor ataxy in which there is a stage of very greatly increased sexual excitability.

Dr. YELLOWLEES—I think there is a spinal disease extremely like locomotor ataxy that accompanies some cases of general paralysis, and I have a case of a man respecting whom I do not know whether his disease began in locomotor ataxy or began in general paralysis. He also mentioned a case in which a patient had broken a table spoon, and first swallowed the handle and then the bowl of the spoon, which stuck in the œsophagus. The only symptom was a certain amount of irritation and frequent coughing. The tube of the stomach-pump easily passed the obstruction. The patient died.

Dr. CLOUSTON—My theory is that it is a direct pathological propagation, which is the very reverse of what Dr. Gairdner holds.

The CHAIRMAN—I remember when there was a paper read at the Clinical Society in London. I remarked that we were dealing with entities that were not well understood. I said, as showing the essential difference in the two diseases I had been in the habit of observing, that in cases of general paralysis the patients could shut their eyes when standing and looking up and not fall, while in locomotor ataxy they at once become unsteady. At a meeting in Oxford afterwards the same question was raised, and we went to Colney Hatch Asylum and found my views confirmed. In one case which I published I remarked that after the man had become so unstable that he could do nothing for himself he became amaurotic, and he walked fully better than before.

The CHAIRMAN—Before leaving this department I should like to say that in consequence of being in London up till yesterday I have not been able to make any

preparations for this meeting, otherwise I might have presented some specimens. But I should like to mention that the case of athetosis which I presented at the former meeting—a very interesting and rare form of nervous disease—remained under view and treatment, and was tried not only with the suggestions made here but by various other suggestions, with no good effect. Now the lad has escaped my notice, in consequence of his having gone with his family to America. It is possible somebody may pick up this case in America, and identify it with the facts presented here.

Dr. JOHN A. CAMPBELL read a Paper on the "Discharge of Recovered Patients," which will appear in the October number.

The CHAIRMAN regretted he had to leave this meeting at this point, but if after the meeting was over members are going westwards, and should desire to look into the Western Infirmary, he should be most happy to play the cicerone.

Dr. YELLOWLEES then took the chair, and invited remarks upon Dr. Campbell's very interesting and practical paper.

Dr. FAIRLESS said that very often a want of money was a strong reason for persons to have patients back soon. He had experienced this over and over again. When people saw the least indication of recovery they were only too glad to receive their friends, often against the advice of the medical man, but he had no other alternative than to let the patient go, however much he might protest against it. In many cases the patient was brought back within a month. If instead of the pauper patients only receiving the Government grant, the middle class were receiving it, many who are now paupers would have been assisted. Any suggestion from this Association upon that point would be valuable. I think amongst the middle class there is great need of help being extended in this way. I had an application last week from a man in a southern county, whose brother is a licentiate of the Church. I was asked if I would receive the patient if he were sent by the inspector of the poor, for in that case the Government grant would be given. I said, "Certainly not; if you pauperise the patient I cannot receive him. You would have to send him to the district Asylum."

Dr. RORIE—There is only one remark in Dr. Campbell's paper to which I wish to allude—that is about allowing patients to go out and keeping their names on the books for 28 days. I have found that to answer well. It is not on probation, but allowing them to remain out.

Dr. YELLOWLEES—If the patient commits suicide during a visit out, the responsibility rests upon the man who let him out. The question is extremely important. There remains a certain amount of responsibility upon the Asylum, and it depends upon one's personal experience how he is affected towards such experiments. If a patient commits suicide whilst absent upon trial, and while his name is still upon the books, you get the credit of a death to which you have no right. Besides, what do you gain by it? I question whether the patient recovers any better, and whether his feelings are more kindly towards the Asylum. I question whether the friends thank us for it. I question, also, whether the local doctor should be deprived of his fee.

Dr. HOWDEN—For many years I have almost given up the practice of sending out patients upon probation, because it is a very troublesome thing upon our books; and if the patient is not sent back you don't know whether he has recovered or not. Instead of sending out patients on probation, the way I discharge unrecovered patients is by a minute of the parochial board.

Dr. CLOUSTON—Since I came to Morningside the general tendency of my experience is to make me less afraid of discharging patients, either unrecovered or very soon after recovery, than I was previously. In an Asylum that is always near the point of being over-crowded, you get into a state of mind that you discharge patients more readily. I have not seen any particular disadvantage from doing so. Only a small proportion of them come back. [Dr. RUTHERFORD—A smaller proportion return than of the recovered patients.] I agree with Dr. Howden that the system of discharging on probation in Scotland seems to be cumbrous in its working and not very satisfactory, because you don't know whether the patient has been kept well. Therefore, instead of discharging pauper patients on probation, I really very seldom do it. I discharge private patients on probation, when their friends specially desire it. I think that cases of mania could be discharged sooner than those of melancholia. I once had a suicidal case of a young lad who was employed as an assistant to a butler. One Sunday afternoon, being apparently quite well up till that moment, the lad was washing dishes, when his master heard a noise, which

caused him to go into the pantry. He found he had suspended himself to a towel roller behind the door. He was cut down, and was unconscious for a time. He was brought to the Asylum next day, where he never showed the slightest sign of insanity. He denied all knowledge of the event, and said that he remembered everything up till a certain point that he was washing the dishes, but after that he remembered nothing more. It was exceedingly difficult to know what to do with the case. His friends came from Lincolnshire, and wanted him home. We kept him a month, and then discharged him.

Dr. RORIE—I think the patient should be sent out when he is free from all danger. The patient needs to be dangerous to himself and others to be kept in the Asylum. The great majority of out-patients in Dundee are dangerous to themselves and others.

Dr. SKAE—I think Dr. Rorie is right according to the Act. It is so soon as it shall appear to the Superintendent that a patient is so far recovered that he can be discharged without risk or injury to himself and others, the Superintendent shall grant a certificate to that effect, and so cause him to be discharged.

Dr. YELLOWLEES—We have heard a great deal about the management of Asylums, I will now ask attention to the medical aspects of the paper.

Dr. HOWDEN—So far as my experience goes, you will have to judge each case by itself. I think, in puerperal cases, when the patients begin to recover, they continue to do well. But, as I said, each case must be decided by itself. The condition of the patient at home after discharge must be considered. I do not think you can lay down any rule. I had a case this last year of a Post Office clerk. He had been very much annoyed by the other clerks, and being rather a weak lad it affected him greatly. After leaving his work one day he went to play at golf; but when upon the Links he lost consciousness, and had an attack of mania transitoria. A policeman was got, and the lad was taken to the police office. He came out to the Asylum next morning raving mad. But he was not a quarter of an hour in the Asylum till he was sane. In two or three days he wanted to go out. I was not justified in keeping him, and I let him out. The event proved I was right. About 20 years ago I remember a patient who was brought to Morningside. He was a maniacal patient when admitted. He was a butcher from Fife, and had attempted self-destruction. He was very excitable, but, like this lad, he got perfectly well. He was kept for six or eight months. He had knives and scythes at his command, and did himself no harm. He was discharged as recovered. He went out and cut his throat the night he was discharged. You cannot keep such a man all his life in an Asylum.

Dr. CAMPBELL—I think you are justified in keeping for a fortnight a man who was quiet after an attack. I know of a case of a man who had insanity in his family. He had made a bad bargain, and tried to hang himself. Luckily the rope broke. He repented, and did not any more repeat the attempt.

Dr. FAIRLESS—I had a case not long ago, certified to be a case of mania. The day after the patient came he seemed to be well. On inquiring into the case I found that he had been suffering from rheumatism. No doubt he took narcotics. In less than 48 hours he was perfectly well. I asked the friends to remove him, for I considered it was a mistake to send him to the Asylum. In a week he was out again. He was at Church partaking of the communion, and has never been ill since. He was almost commencing an action for damages against the medical men for sending him to the Asylum.

Dr. SKAE—Yet we do see cases which, at first, we think it is a pity should have been sent to an Asylum but which, eventually, turn out to be incurable. I remember a woman who, on admission, seemed merely hysterical, but who got worse and worse, and eventually became incurable. It is difficult to say when a case should not have been sent to an Asylum.

Dr. YELLOWLEES—I agree strongly with what has been said as to the discharge of unrecovered patients. Nothing more proves the force of the statements made than the fact that as regards some patients who escape you expect to hear of suicide next day; but in a month or two you find that the patient has been at home and self-sustaining. That has happened again and again. As to the sudden recurrence of suicidal symptoms, I do not know that the law allows us to do anything else. The patient had ample opportunities of committing suicide in the Asylum, and did not use them; but uses the first opportunity when he gets out. I had the case of a blacksmith in Wales. Apparently he had no such thought as that of self-destruction. I discharged him on probation. In a few days after he left the Asylum his body was found in the shaft of a coal mine. I think some of the senile cases should not

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come to us at all. The trouble of nursing them should be taken at home. There are two classes of such cases. One class should never come to us; and the other class, especially where there are complications, it is not fair to expect friends to manage them. We have all had cases of general paralysis where the recovery was so perfect that you felt compelled to discharge, and yet with a moral certainty that some day there would be a relapse and that the man would die of general paralysis.

Dr. JOSEPH J. BROWN read a paper, "Two Cases of Apoplexy of the Pons. (Originals, p. 265.)

Dr. SKAE said that the very excellence of the paper rather interfered with its discussion, for there was a great deal of work and close anatomical reading in it, fitting it more for patient study than for discussion off-hand.

Dr. CLOUSTON said that there were many interesting points in the paper. One was that in the case of J. B., we had a man with very long-continued insanity of a rather peculiar and distinct type, and also long-continued motor symptoms, apparently of syphilitic origin. We had this man going on for between thirty and forty years still living with this disease upon him, whatever it was, mental and bodily; and at his death we find a distinct pathological basis for the symptoms present. I think great credit is due to Dr. Brown for working out the pathology of this case with regard to the vessels and nerve cells, showing the physical and pathological explanations of this chain of symptoms, mental, motor, sensorial and nutritive. We can put our hands on the actual disease, the degeneration of the cells and vessels, and the evident presence of apoplexy. We have a very decided and beautiful disease of the spinal cord, which I recommend all to see for themselves in these specimens. The interest of the case was heightened by the fact that the man lived so long, and so that we are able to see the changes in the most evident way. If the man had died early we should not be able to see all this degeneration; but he lived long, and degeneration gradually proceeded. It was a strong addition to our pathological arguments as to the cause of insanity that in this exceptionally long case we are able to demonstrate those changes which in many recent cases we had ground for believing, but were not able to demonstrate in this way. Perhaps that is the most important point of the case as regards our own view of it as alienists, all the functions of the nerve system having gradually become affected in this man. With regard to the cause of death in the recent case of J. W., Dr. Brown's theory is the only point upon which I would venture to take issue. I am not sure the man did not die of apoplexy in the pons, though there are many grounds for Dr. Brown to conclude he died of congestion and effusion. I am willing to admit it is an open point. I think it will be found that J. B.'s was the only case on record of that form of syphilitic insanity, which is manifested at first by delusions as to unseen agencies, being found to depend upon demonstrable disease of the nervous tissues. The paper is very interesting, and well worked out.

Dr. YELLOWLEES—The microscopic preparations must appear along with the paper. These illustrations are so perfect, that unless one saw them one would think they were made for the paper than otherwise. The man was kind enough to live so long as to make his whole pathological history very valuable. The history of nervous degeneration was very interesting. The syphilis was discovered afterwards; but it would have been as satisfactory if one had thought that syphilitic insanity was the type and expected something of that kind in the *post-mortem* examination.

Dr. BROWN—There was a distinct history of syphilis recorded in his case, and I got it from himself also; but in reading up the case there is distinct statement that the patient suffered from syphilis, and was treated with mercury when he was 17. I knew this long before he died. I think this case goes to prove that there is no definite lesion in the vessels in syphilis.

Dr. CAMPBELL read, on behalf of Dr. M. D. Mac Leod, a paper, "Report of a case of cut-throat, nourished by enemata Recovery." (See Clinical Notes and Cases, p. 277.)

Dr. YELLOWLEES—I happen to know only one case parallel to this. The reason for adopting that mode of feeding was quite similar. A man thought a jar containing carbolic was whisky, and took a draught of it. He vomited promptly, and the stuff he vomited was so purely acid that it blistered his breast. The fauces and the throat were terribly inflamed, and for eleven days he could not swallow. He was fed by enemata, and his life saved. The case was under the care of my successor, Dr. Pringle. It is only when the throat passage is closed that you are compelled to resort to such an unusual mode as that of the enema.

Dr. HOWDEN—A case may occur in which the patient refuses to take food. You force it into his mouth, but he immediately vomits it. In that case it is useful to try to feed by enemata. With regard to feeding by the stomach pump, I was asked lately by one of the Commissioners whether any who had been artificially fed died by gangrene of the lungs. I looked up the death register, and found that nearly every patient who had died of that disease had been artificially fed. It does not follow that the feeding is the cause of the gangrene, but the subject is deserving inquiry. Then in administering ordinary enemata to the excited patients, do any accidents occur? I had one case in which I think the patient died from rupture of the bowel during the administration of an enema. He took an epileptic fit, and died. He never had such a fit before.

Dr. CAMPBELL said that the tube he used for feeding with the stomach pump is entirely of india rubber. I think this prevents injury. You dip it in glycerine, and it goes down of itself. Arnold and Sons, London, make them.

Dr. YELLOWLEES—I had to make them myself.

Dr. RUTHERFORD—Five years ago I was struck by the number of deaths in the Birmingham Asylum of those who had been fed artificially, and by the fact that the cause of death in nearly the whole of the cases was gangrene of the lungs. They were generally fed with bread, milk, and brandy. In the Argyle Asylum I don't think during the whole three years I had more than three cases that required artificial feeding.

Dr. ROBIE—I never had occasion to feed with the stomach pump—I fed my patients with the spoon. I have been 15 years in the Dundee Asylum, and have never failed in one case. I vary the means. In a few very stubborn cases I have employed the steel instrument to open the patient's mouth, regulating deglutition by occasionally compressing the nostrils. I never found a case which we did not manage. The patient whose case I read to the meeting was fed seven or eight days by enemata. It supplied sufficient nourishment all the time. I was struck with the fact that when she felt thirsty an injection of a tea cup full of warm water relieved her at once. I have tried feeding by the nose, but in some cases found the patients ejected the food by the mouth instead of swallowing it.

Dr. SKAE—About three years ago a patient of mine was removed to Fife and Kinross Asylum. Dr. Tuke told me he fed him with the stomach pump, and that the patient died of gangrene of the lungs. He said he had noticed very frequently that patients who had been fed with the stomach pump had died from gangrene of the lungs.

Dr. CLOUSTON thought it was impossible for particles to get into the lungs if a patient is properly fed by means of the stomach pump. I decidedly think that stomach pump feeding is a capital thing. I think we feed far too little in that way. Whenever there was any difficulty with a patient from his taking no food or too little I had no hesitation in using the stomach pump. I have fed patients one hour after admission. In no other way could you administer food, except by a struggle of a quarter of an hour. I have tried nose feeding with unfavourable results. Occasionally you can get a patient fed for a few days by the nose, but then he holds his breath and spits out the food. Then with regard to enemata, surely in any case if we can get food into the stomach we should put it in rather than in the rectum. In puerperal cases we often get poor, weak women almost at the point of death, it being long before they are sent to the asylum. In such cases, when I cannot get them to take sufficient food, I feed them with the stomach pump. I had such a case lately, which was almost moribund. She was at once fed with the stomach pump, and she recovered. I can recall two cases of death by gangrene of the lungs, and the patients had not been artificially fed at all. They were cases of melancholia and of great deficiency in nervous power. It is in these cases rather than in cases of feeding with the stomach pump that gangrene of the lungs occurs. But this would be a suitable subject to bring up at the next meeting, and in the meantime we can look up our post-mortem registers. I am strongly in favour of feeding with the stomach pump, thinking it is better than feeding with the spoon when there is difficulty. I can confirm Dr. Campbell's opinion as to the efficiency of the india rubber tube. We have used it for three months. In many cases the hard tube is more easily passed. Can anyone tell the case of a person who has long been fed artificially?

Dr. RUTHERFORD mentioned seven years.

Dr. CLOUSTON—I have a friend who tells me of a patient who has been fed 8,300 times. This would be probably over 11 years. I once passed the tube into the trachea, and, of course, at once withdrew it, the patient being none the worse.

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Dr. SKAE—I think it is common to feed with the stomach pump long after it is unnecessary, just because the patients desire to be fed that way.

Dr. HOWDEN—I had a patient who lay down upon the bed and passed the stomach pump herself; she would not take food in any other way. As to accidents occurring by artificial feeding, I do not mean that these are confined to the stomach pump. I mean any kind of forced feeding—by Dr. Rorie's spoon or otherwise. I gave up the stomach pump for five years, but took to it again. I thought the annoyance to the patient was greater in the one case than in the other.

Dr. YELLOWLEES—I think it is a very happy thing we departed from the immediate scope of the paper, for we have had some interesting practical conversation about artificial feeding. I have not seen dangerous results from enemata, and I am surprised that Dr. Rorie has never found a patient whom he could not feed with the spoon. I feel very strongly that there are cases where the spoon is a total failure unless you push its use to such an extent that it becomes positively perilous. I have no hesitation in preferring the stomach pump as being the least exciting to the patient. I have never seen dangerous results from stomach pump feeding, and I am surprised that it is affirmed there is a connection between stomach feeding and gangrene of the lungs. I think the conditions in which you find gangrene of the lungs are just the conditions in which you will find artificial feeding necessary. But it would be interesting further to investigate the subject, and therefore I think we should all look back on our death registers. I believe there is more danger from forcible feeding by the spoon, in consequence of the food getting into the air passages, than by the stomach pump. I would not allow any patient to go a week without food; I would feed artificially sooner than that, but I hold it is a state of mind to be deprecated to allow patients to get into such a condition as to lie down and pass the stomach pump themselves.

Dr. GAIRDNER, speaking of fever patients, said that as a general rule the whole alimentary and digestive systems go together, and it did not seem that putting food into the stomach would enable it to be digested.

A vote of thanks to the Faculty of Physicians and Surgeons for the use of the Hall concluded the proceedings.

Obituary.

ROBERT STEWART, M.D., BELFAST.

The Medico-Psychological Association has sustained a severe loss in Ireland by the death, on the 6th April, of Dr. Robert Stewart, the Resident Physician Superintendent of the District Lunatic Asylum in Belfast. The late Dr. Stewart was born in 1803 in Dublin, and received his professional education at the College of Surgeons' School of Surgery in Dublin, and took his medical degree after studying at the University of Glasgow. He entered the profession in 1829, and for the first six years of his professional career he was engaged in general practice in Dublin. In 1835 he was appointed Superintendent of the Belfast District Asylum, the first of the Irish asylums that had the advantage of a Resident Physician. For many years Dr. Stewart, was the "Father" of the Irish Asylum service, and was looked up to with feelings of the greatest respect and confidence by his colleagues in the profession, and by the general body of Irish Superintendents. From the outset he was a warm supporter of the Medico-Psychological Association, of which he was the first branch-secretary for Ireland, an office that he retained up to the last general meeting of the Association. The duties connected with the honorary secretaryship were discharged by Dr. Stewart with so much zeal and efficiency that when he tendered his resignation it was found extremely difficult to induce any of his Irish brethren to allow their names to be submitted to succeed him, as a general feeling existed that it would be impossible for anyone who did not enjoy the wide popularity of Dr. Stewart to attempt to perform the duties after him. Dr. Stewart, early in

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