symptoms which constitutes the *délire chronique* of Magnan. In dealing with dementia præcox, we note that he is of opinion that "there is no recovery in an unqualified sense" from this form of disorder, a statement which we take leave to doubt. We are inclined to agree with him however, as to the expediency of restricting the name—a bad one at best—to the hebephrenic form. Under the heading of Pathology we miss any allusion to L. Bruce's observations. A chapter on Secondary and Organic Dementia is followed by a not wholly satisfactory section on the Puerperal Insanities, the treatment of which, considering their practical importance, should have been dealt with more at length. Climacteric and Senile Insanities are next described, and a chapter on Alcoholism, Morphinism, Cocainism, and Plumbism is followed by an excellent description of General Paralysis, in which, however, the author seems to us to be too much "on the fence" with regard to the etiological importance of syphilis. The pathological section is enriched with copious illustrations, mostly reproduced from the *Archives of Neurology*. The short accounts of Neurasthenia and Acute Hallucinatory Insanity are good, but personally we lean to the theory of a toxic origin for the latter. Epilepsy, Hysteria, and Traumatism in relation to insanity next receive attention, and then the subject of Obsessional Insanity. Of the necessity of making the last a distinct form we are doubtful. The Section on Syphilis in the chapter on Insanity and Physical Diseases leaves something to be desired. Other chapters follow on Idiocy, Imbecility, and Moral Insanity, on Feigned Insanity, and on Law in Relation to Insanity. Oddly enough, the subject of certification of patients is dealt with, not in this chapter, but under the head of Case-taking, while this latter subject receives scant notice. The book ends, as before mentioned, with a chapter on Treatment.

Dr. Craig's English is not beyond criticism at times, and he does not invariably escape the tendency to diffuseness which is the bane of writers on psychiatry; but his views, which are almost always very sensible, are often forcibly expressed, and his book is both readable and interesting, while his facts are up to date.

Part III.—Notes and News.

ADJOURNED (1904) ANNUAL MEETING.

Held at 11, Chandos Street, London, W., 19th July, 1905.

Dr. PERCY SMITH, President, in the Chair.

The following members were present:—Drs. Fletcher Beach, C. Hubert Bond, Arthur N. Boycott, James Chambers, Maurice Craig, Thomas Drapes, Charles C. Easterbrook, Charles K. Hitchcock, Theo. B. Hyslop, J. Carlyle Johnstone, Robert Jones, Harold A. Kidd, Alfred Miller, H. Hayes Newington, Bedford

Pierce, Henry Rayner, Arthur Rotherham, R. Percy Smith (President), Robert H. Steen, David G. Thomson, Alex. R. Urquhart, Lionel A. Weatherly, Ernest W. White, T. Outterson Wood, David Yellowlees.

The minutes of the last adjournment of the Annual Meeting were confirmed and signed by the President. Thereafter the General Secretary read the notice summoning the meeting.

The PRESIDENT having arranged the order of business, and announced the Committee meetings, called upon Dr. Yellowlees, Chairman of the Statistical Committee.

Dr. YELLOWLEES.—It falls to me to move, "That the further Report of the Statistical Committee be received, and that the definitions, tables, and registers as therein set out be finally adopted by the Association, with such additions or amendments as the Association, at this adjourned annual meeting, may now order." I do not need to enter upon this Report; it has been placed in your hands. I would say on behalf of the Committee and myself that our very earnest desire throughout the last three years has been, not to insist upon our own individual opinions, but to embody in our tables, as far as possible, the needs and wishes of the Association. We began by consulting every individual member of the Association by circular. We have twice consulted all the Divisions, we have had a great deal of private correspondence; and we have tried to frame those tables in a way which shall be acceptable to the majority. No one member of the Committee has got his own way, and no member of the Association can expect to have all his own way. (Hear, hear.) Our great desire was that we should get something which would be a valuable record of the work done in our asylums. Individuality must be to a certain extent sunk if we are to achieve that end. I suggest that if there are any objections to the whole scheme they should be disposed of first, and then that the individual tables should be taken *seriatim*. We are extremely anxious, as a Committee, to be relieved from the long labour which we have willingly and earnestly tried to perform.

Dr. BOND seconded the motion.

The PRESIDENT.—This resolution has been duly proposed and seconded. At the meeting in November last it was definitely carried that the principle of altering the form of the Register be approved and adopted, and that the alterations in the Registers proposed by the Committee be provisionally adopted. The general arrangement of the Tables proposed by the Committee was also approved and adopted at that meeting. Since then, I understand, the Tables have been altered in number, but, I gather, not in general arrangement.

Dr. CARLYLE JOHNSTONE.—Were the general principles approved? I took exception to them, and asked what "provisional approval" meant.

The PRESIDENT.—"Provisionally" was the word used for the Tables. "The principle of altering the form of the Register" are the words on record.

Dr. CARLYLE JOHNSTONE.—I think the word "approval" was qualified.

The PRESIDENT.—Not in regard to the Registers. I refer you to the JOURNAL, but I think that the principle of altering the form of the Registers was approved.

Dr. CARLYLE JOHNSTONE.—I think they had *general* approval.

The PRESIDENT.—It is proposed that we should first discuss general objections to the principles, then objections to definitions, then objections to the tables in detail, and finally objections to registers. I now invite members to state any objections to the principles of the proposed alterations.

Dr. BOYCOTT.—Personally I object to the entire tables, taking them altogether. In my individual opinion they are much too elaborate. We ought to go on the principle that we want to obtain certain definite facts, which will be useful when finally summarised for asylums throughout the kingdom. There is the local interest, and the general interest; but many of these tables, it seems to me, are neither of general interest, nor of local interest. They are most carefully and thoughtfully drawn out, but they are very much too elaborate; they are not simple enough. The Committee do not seem to be certain whether they submit these tables as final or not. For instance, on page 6 they say "Certain of these Tables, notably B1, B2, and B5, now detail the same information for the Transfers as for the Direct Admissions. This involves, to some extent, an increase in labour, but it is in compliance with the strong desire felt by some to attain a local completeness of portraiture." And, a little further on, "As the Committee previously pointed

out, proper inquiries into the antecedents of the Transfers are generally impossible, and the relative number of this class seems to be increasing; moreover, the medical facts-on-admission will have already been once recorded and tabulated by both the central authority, and locally by the asylum into which the case was originally admitted, and the repetition of these facts involves a grave false statistic." That is the Committee's argument against their own tables, and against tables showing particulars about Transfers, for instance. (Hear, hear.) On page 7 they say "It is a method of treating the cases to which it attaches no small importance, and, if the Association will acquiesce in restricting its request for information upon certain points to the First Attack cases, a very considerable saving in labour to the compilers will ensue." That evidently means that the Committee do not wish their tables to be carried out as set forth. I rather thought that these Tables were submitted as final, not as a try-on to see if they are acceptable. Certain tables are submitted as "optional." I think that they ought to be accepted entirely, or not at all; it would be preferable to each man saying he was going to do one table and not another. In regard to Table C6, page 10, the Committee say "The suggestion of Dr. Chapman has now been incorporated, but the Committee recognises that the compilation of this Table, as a whole, will be very laborious," etc. Evidently the Committee are not very keen on that Table. I have a strong objection to the extreme amount of printing involved. The annual cost will amount to a considerable sum. In small asylums it will be very, very heavy. It will amount to some hundreds of pounds in the whole kingdom. Excluding those marked "optional," there are twenty pages of print, many are large double sheets, while the old tables were only thirteen in number. The amount of labour in compiling these tables will be immense for assistant medical officers. They do it very willingly, and we who are superintendents know the labour entailed, which will be enhanced by these very elaborate tables, which really do not bring out any facts of definite importance. (Hear, hear.) I therefore beg to move as an amendment, "That the Report of the Committee be received, and that the Committee be thanked for the trouble and care which they have expended, and that the Report be allowed to lie on the table for future reference."

Dr. KIDD.—I beg to second the amendment, and associate myself with what Dr. Boycott has said. This matter has been in gestation for a very long period, and we have all waited anxiously for the result of the labours of the Statistical Committee. But I, for one, was entirely surprised at this amazing litter of tables. I expected that the original tables would be simplified and modified, but they have been enormously increased. They are now twenty-five in number, as against fifteen or sixteen, and the tables themselves are longer and more complicated; and the work which these tables will entail upon the medical officers will be very greatly increased without any corresponding advantage. Some of the tables are marked optional, but there is a suggestion that the Committee could add a few more if necessary. One cannot but appreciate the work of the Statistical Committee and the way in which the scientific information required by the Association has been gathered together. What I object to is that it should be imposed upon us to return these facts in this particular way. Why not return the facts in the form of registers, not in the form of tables. The English Commissioners in Lunacy draw up their statistics from very simple returns; the same method should apply to the Medico-Psychological Association. The registers are excellent. The Civil Register remains very much as it was, with the omission of religion. It is a small point, but it should be included. (Hear, hear.) I do not know why it has been omitted. The Committee starts by saying "it does feel that the Tables and Registers now presented are reasonably full and sufficient for their purpose," etc. And later "Certain forms have been prepared for the purpose of facilitating the expedition and accurate expiscation of the Registers in such shape as to render tabulation a merely mechanical operation." It is that "mechanical operation" to which I so strongly object. The process by means of which all these facts are gathered is extremely difficult; it is one which requires very great care, but tabulation in the form of registers is what every medical officer does more or less, and which could very well be done in such a way as to embrace all the facts required. The mechanical operation of tables should be done by a non-medical clerk. (Hear, hear.) My own clerk, on considering these proposals, said: "We get off very lightly; we have less work to do." If the registers are full and complete, anybody

can do this work of tabulation. I believe that, abroad, there are bureaus where the statistical tables are made up, and I do not see why we should not adopt this method. If the Association think it is right to return the facts in these tables, the Association should appoint a clerk to collect them annually, and tabulate them for the Association. I am sure that there is a very strong body of opinion outside this room against these tables, and if there were a referendum you would receive that opinion from medical officers and superintendents. I hope that the tables now submitted will not be passed by this meeting.

Dr. URQUHART.—As a preliminary question I desire to be informed if this amended Report has been submitted to Professor Karl Pearson, and if he has had brought under his notice all the relative objections which have been raised, in correspondence or otherwise. (Hear, hear.)

Dr. BOND.—Yes, I have interviewed Professor Karl Pearson, who has now the "Further Report" and the objections that have been raised to it. But he is a busy man, and I have not yet had his reply. It is not many days since he received it.

Dr. URQUHART.—I would point out that three years have passed since the Committee began their arduous work, and, after the very many meetings they have had, we must have the profoundest sympathy with the Committee in the sacrifices which they have made in coming to their conclusions. But it is necessary for me to oppose the motion with an amendment to the effect—

The PRESIDENT.—You cannot move another amendment now.

Dr. URQUHART.—I am not prepared to vote for the first one.

The PRESIDENT.—We are now hearing objections to the principles.

Dr. URQUHART.—I ask whether the amendment is not applicable to the methods of the Committee rather than to the principles. The principles they have acted upon are stated in their first Report, *e. g.* saving of labour and guarding against ambiguities of expression (page 2).

Dr. YELLOWLEES.—This amendment illustrates very strikingly how little those gentlemen understand what the Committee have deemed their duty, and the way they have tried to discharge it. And it is also very remarkable how little they understand the work which the Committee have done. The very thing which Dr. Kidd insists we ought to have done is exactly what we have done, and he blames us for not having done it. If he will look at our Register he will see it is exactly the thing which he desiderates; it embodies all the facts which are in these tables, and it gives all the facts required to compile those tables. It was the very object and purpose of the Committee that there should be less clerical work by the doctor, and, if he keeps the Medical Register, the clerk can do the rest. As for the extension of the tables, it is the Association's fault, not ours. We have only tried to carry out the will of the Association, as communicated to us through its Divisions. The object has been to simplify and lessen the work, and the "optional" tables have been added, so that as many as possible should find what they want in these tables. It was by no wish of ours that they were extended. Quite otherwise. We would have been glad to have shortened them, but we followed not our own desire, but what was the expressed wish of the Association as communicated to us through letters and through its various Divisions. And to tell us now that the whole thing is useless seems not only to come rather late in the day, but it somewhat fails in courtesy. We recognise the appreciation which has been expressed as to the trouble we have taken. We honestly have taken a great deal of trouble, and we do not expect you to agree without discussion. You are invited to modify and alter. But to throw the Report overboard in that sweeping way would scarcely be what is due to the Association, which has already provisionally approved it. (Applause.)

Dr. KIDD.—I should like to make a correction. The Chairman of the Committee, in referring to me, said that I fail to recognise the object of the medical registers. I distinctly stated that they were extremely good, and that they embraced all the points, with some omissions, and that they would be excellent alone. What I said was that these registers could be kept by the medical officer, but that the rest of the work should be done by a clerk, *not* the asylum clerk. The Tables have to be made up to December 31st, and this is a difficult time for everybody. They should not be thrust on the clerks of the asylums. Copies of the compiled registers should be submitted to the central authority, the Statistical Committee, if you will, and they should have the Tables constructed in accordance with their scheme.

Dr. YELLOWLEES.—There is another mistake in what Dr. Kidd has said. The clerk would not have all the work to do in December, but he would do it as the year goes on. The registers would be kept up month by month, not left over till the end of the year. A month after the patient's admission all the details about him are in the register, and when they are so entered, the clerk can begin to compile his tables. It is in the month of February that he works them out, but the information is compiled all along, and easily. In a short time at the end of the year he can present them completed. That is one very important value of the registers, which, I am sure, Dr. Kidd had overlooked.

Dr. KIDD.—If that is the case these Tables will be useless. It is absolutely impossible to record the information in relation to admissions within a month or so.

Dr. HAYES NEWINGTON.—With regard to that last point, I would say that we have consulted with the Commissioners as to the possibility of altering the register on the receipt of better information chiefly on the point of diagnosis. But I do not think that affects the main point. The preparation of one of these Tables from the material in the register with the help of a compilation form has been tried, and it was found to be perfectly easy. The main suggestion of Dr. Kidd has a good deal in it, that all the registers should be sent to a central authority. But the effect of that would be not very happy, because it would be really a substitution of general information as to statistics to the exclusion of information locally applicable in a particular asylum district, and it would cause much more trouble to send up faithful copies of registers to a central authority to expiscate.

The PRESIDENT then put Dr. Boycott's amendment to the meeting, when 5 voted in favour, and the amendment was declared lost.

Dr. URQUHART.—I now move "That no resolution of the Association passed to-day shall be final and binding until a report on the whole matter has been received from Professor Karl Pearson or some expert of equal eminence, after consideration of the report of the Committee and all relative documents submitted to them."

The PRESIDENT.—Is Dr. Karl Pearson a member of the Association or of the Committee?

Dr. URQUHART.—No.

The PRESIDENT.—Our Annual Meeting of 1902 refers this to a special Committee, and it has been adjourned to 1905. It seems to me rather a serious matter at this time to refer the report to somebody entirely outside the Association.

Dr. URQUHART (in reply to a remark by Dr. Jones).—I quite understand that Professor Karl Pearson is one of the busiest men in the country. So is Mr. Francis Galton, and both of them are interested in the questions which are raised by the Association in this particular report. Mr. Francis Galton, as you know, has done yeoman work in similar research for many years, and his advice would be most valuable. I put it long ago to the Statistical Committee that this Association positively must induce an expert in biological statistics to examine their proposals and report thereon. It is all very well for the Statistical Committee, not one of whom is an expert in statistics or in biology any more than myself who criticise, to bring forward a report. But things have changed altogether since the last tables were promulgated by the Association. Even then a statistical expert was consulted, who showed definitely what ought to be done in regard to matters of arithmetic. And whether the arithmetic of the proposed tables is as brief and as simple, and is as duly directed to the points at issue as it ought to be, is still a question. If we were careful in this respect twenty or thirty years ago, surely much more ought we to be careful to-day, when biological science has advanced so greatly, and when biological methods have become of so much intricacy as to require expert opinion. I suggested Professor Karl Pearson; and believe that if he were asked he would, especially in regard to these hereditary tables, give us good guidance. If he could not do it himself, surely those who are working under him would be available to aid us with his authoritative sanction. If Professor Karl Pearson is not interested, why have the Committee gone to him? Why have they taken up his valuable time? It shows that we must go a step further, and have his answer as an expert in the doctrine of probabilities. Are we dealing with these statistics in the briefest way so as to elicit scientific truth? Are we dealing with them by the least possible expenditure of energy so as to get what the biologists of the present day require? While this is in doubt I must move, not for the negation of these tables which the Committee have produced, and

which I personally think are a very great improvement upon our present tables—I could not be a party to stopping the discussion prematurely—but I must, in the interests of the Association, move that we do procure expert opinion. My only interest is the interest of the Association. I beg the Association to note that these are not local tables; they are national tables. They will be received by every country in the civilised world and criticised. We must make no *fiasco* over them. If we regard the honour and interests of the Association we shall take every precaution that they are the very best statistical tables the world has yet seen, that they are best adapted for the elucidation of the problems of insanity.

Dr. CARLYLE JOHNSTONE.—I second the amendment. I do so with considerable diffidence. The idea involved in Dr. Urquhart's motion is one which I have supported ever since this subject was brought before the Association, but every time I have endeavoured to make my voice heard on the subject I have felt I was being regarded as reflecting upon the Committee in a more or less improper way, and was accused more than once of saying things and implying things which were disrespectful to the Committee. I had no intention of speaking to-day, but I think this motion is one which may be seconded and supported. I do not feel competent to express an opinion upon these tables. Personally they appear to me to be hopelessly elaborate, complicated, and laborious, but my impression may of course be wrong. I do think they must be submitted to the opinion of a scientific expert in statistics, and that is our only hope. I have no desire to discuss the tables; my feelings are pretty strong, and, I think, final. Still I would most willingly yield to Professor Karl Pearson or anyone of his eminence. I cannot, for my own part, accept those tables; and I do not think that in Scotland we shall accept them as they are. If this amendment of Dr. Urquhart's is not passed, and the meeting approves of the tables, and finally adopts them, it will mean that they will not be carried out in Scotland.

Dr. BOND.—It may be convenient for me to explain a little further the steps we have taken in consulting an expert or experts. The Committee have not overlooked that point, and have gone further at the desire of the Association, or at any rate of certain members of it. The Association will remember that before the previous report was submitted Dr. Chapman, one of our own members, and, I believe, an acknowledged statistician, had the tables under review, and was good enough to send us his criticism. In addition I have had more than one opportunity of discussing certain points with a statistician at Somerset House. He could not formally associate himself with us, neither have I his authority to quote any words which he used, but on several points we were distinctly guided by his views. I do not think that he would undertake the review of the tables as a whole. With regard to Professor Karl Pearson, I wrote to him, and his reply was that he would be glad to aid the Committee if it were in his power; but in a very kind and lengthy interview which he granted me I do not know that I gathered that he was willing to give a formal report on the tables. Of course he may be willing. He knew that we were still engaged on them, and before saying anything further, I gathered that he would like to see what we were doing. Therefore I sent him our further report, and such critical remarks as have reached us, and also the original tables now before the Association. But there has not yet been time for Professor Karl Pearson to reply.

Dr. NEWINGTON.—Dr. Urquhart mentioned only one way in which such a reference would be of use, and that is in regard to biology. It is a little extreme for him to want to hang up the system for a table or two. If you look through the report you will see the Heredity Table is optional, and there are certain suggestions with regard to alcohol, and in all these things we can get the best expert opinion. But that we should go to one who is an expert in certain lines and ask him to review tables which are drawn up on other lines, and many of which are administrative, I fail to see. A reference to an expert like Dr. Karl Pearson would mean the immediate eviction of all information as to transfers. (Hear, hear.) There is another point which I think we ought to take some exception to, and that is the statement which Dr. Carlyle Johnstone made just now, a most serious one to make. I cannot think it is made in a spirit which is calculated to at all facilitate the use and manufacture of tables. The statement was that he felt sure that Scotland would not adopt these tables unless they were altered to suit his views—

Dr. CARLYLE JOHNSTONE.—I did not say so. That does not, in the least degree, resemble what I did say.

Dr. NEWINGTON.—Dr. Carlyle Johnstone certainly said he felt that the tables as at present would not be generally adopted in Scotland.

Dr. CARLYLE JOHNSTONE.—I did not say that unless they were made according to my ideas and views they would not be adopted in Scotland. I never made the slightest reference to such a thing.

Dr. NEWINGTON.—What I was saying when he interrupted was in accordance with his views and those of others. And I think I am right in saying what I did, that Dr. Johnstone feels that Scotland will not adopt these Tables as they are.

Dr. CARLYLE JOHNSTONE.—Yes, that is so.

Dr. NEWINGTON.—What are we to make of such a statement as that? I cannot believe it. From a study of the reports of the Scottish Divisional Meetings held to consider these Tables I do not find any such unanimity which would justify him in saying that or justify any one person speaking in the name of Scotland.

Dr. WEATHERLY.—I think what Dr. Bond stated has thrown some light on what we ought to do. The Committee felt that they would like the opinion of Dr. Karl Pearson, and they have asked him for it. They have not got that yet, they are waiting for his report. It will be of no use if we pass the Tables to-day. They have asked for something which they have not got, and which Dr. Urquhart by his amendment wishes to get.

Dr. BOND.—The Committee have no promise of a definite report from Professor Pearson. He expresses his willingness to give advice and to aid the Committee on several points in the Tables. But at my interview with him, the difficulty, which any man who is not a medical man must feel, in understanding all in a moment many of the points in the report, was felt. I do not like to repeat the interview, because it was informal, but I do not think I am wrong in saying that, which must appeal to us all, the most able statistician in the world, if he is not a medical man, must find difficulty in this report, and even a medical man must have difficulty without some special knowledge of mental diseases.

Dr. URQUHART.—Did you read Professor Karl Pearson's article in the *British Medical Journal* in the end of May?

Dr. BOND.—Yes. I feel some diffidence in making the remarks I just have, but I think that Professor Karl Pearson would bear me out in what I have stated in connection with our interview.

Dr. URQUHART.—May I make a personal explanation with regard to Dr. Chapman? There is nobody who appreciates Dr. Chapman's work more than I do. Dr. Chapman, for many years, has been *the* statistical authority of the Association, and when anybody approached Dr. Chapman for the elucidation of any question of the kind he was always received with the utmost courtesy, and Dr. Chapman took the greatest interest in the questions which might be put to him. We know Dr. Chapman of old, but Dr. Chapman is now interested in quite another series of biological questions, he is not in touch with the present-day work of psychiatry, and nobody knows that better than Dr. Chapman himself. We want the latest information that the world of science can give. (Hear, hear.)

Dr. ERNEST WHITE.—Surely there is no absolute finality in these Tables. They are always subject to revision if passed to-day. (Laughter.) We have had these Tables before the Association for several years, and we ought to come to some definite conclusion now. I think that we should not be taking a false step by adopting these Tables, and if we find any of them are not working as we imagined they would, surely they can be revised at an early Annual Meeting. ("Heaven forbid.") I think we ought to support the Committee upon that ground.

The PRESIDENT, having put the amendment to the meeting, 7 voted in favour of it and 10 against. The amendment was declared lost.

Dr. URQUHART.—I move that the names of those voting be taken down.

Dr. CARLYLE JOHNSTONE.—I second that motion.

The PRESIDENT.—I first call upon those who are in favour of the amendment.

Dr. Urquhart, Dr. Carlyle Johnstone, Dr. Kidd, Dr. Boycott, Dr. Steen, Dr. Rotherham, Dr. Weatherly.

The PRESIDENT.—I now ask those who vote to the contrary to stand.

Those voting were Dr. Outterson Wood, Dr. Ernest White, Dr. Chambers, Dr.

Bedford Pierce, Dr. Hyslop, Dr. Drapes, Dr. Yellowlees, Dr. Bond, Dr. Hayes Newington, Dr. Robert Jones.

Dr. URQUHART.—I direct your attention to the general principles. There has never been a single discussion upon the general principles of this report until this morning. (Hear, hear.) The main principle adopted by the Committee, which gave rise to the greatest difficulty, is the division into direct and indirect cases, which the Committee sometimes call "not direct," and which they sometimes call "transfers." We are not quite sure what the Committee even yet mean by direct or indirect cases. What is a direct case? It is a case admitted under a new order and new certificates. And if you turn to the diagram—

The PRESIDENT.—May I refer you to the definition given by the Committee? They define direct admissions as "Persons received into an asylum on new certificates and a new order."

Dr. URQUHART.—That is exactly what I said, only I put the order differently. What constitutes these direct admissions? These direct admissions are the most heterogeneous mass of patients of all kinds to the exclusion of certain transfers, *not all transfers*, but certain transfers, because transfers are understood in a purely local sense, that is to say, in the sense which is employed by the Commissioners of England, and the Commissioners of Scotland, and the Commissioners of Ireland, returns of which we make each in our own countries every year. Now, these transfers are not a complete statement, but they are called "indirect" or "not direct" cases. It will be evident from the diagram, which I have submitted, that you may have first-attack cases and not-first-attack cases, first-admissions and not-first-admissions amongst the direct cases. So that the whole of the cases received into an asylum are not, in any way, discriminated for the purposes of science, they are merely discriminated for purely local purposes, that is to say, for the parliamentary purposes of England, Scotland, and Ireland. We make these returns, and we quite understand that they are essential for the purpose locally. These transfers are dealt with very briefly in the first report of the Committee, and in the amended report of the Committee they are inserted in the Tables to some extent. But still we have no complete statistics of the whole of the admissions. If one is making an inquiry into any point in reference to insanity it is absurd to suppose that we shall lose all count of the transfers. I fear that this has been an arrangement conceived under the shadow of the enormous asylums which have grown up of late years. The Committee say if every asylum gives an accurate account of direct admissions, you will have from other asylums an accurate account of the transfers. But the Committee do not expect, they surely do not expect, after all their experience of asylum reports and the errors that are found in statistics of the present simple type, that they can ever take asylums reports and condense them into one accurate return. (Hear, hear.) If you venture to investigate any question from asylum reports you must be careful to select the asylums from which you draw your information, and there are many asylums which give no statistical information at all. Further, if we do not construct a statistical report which is correct for purely local purposes what is the use of our printing it? I agree with Dr. Kidd that it would be preferable to appoint a permanent Statistical Committee who would receive full information of transfers and direct cases, and deal with them as the Association may think fit, but is it to be expected that asylum authorities will make returns exclusive of transfers as descriptive of their annual work in the vain hope that somebody else will make good the omissions? The Committee themselves express the gravest doubt of getting any information from any asylum with regard to any transfers. That is to say they cannot get from the asylums from which transfers come definite reports upon the condition of these cases fit to find place in a statistical inquiry. It does not matter to me personally, because under no consideration whatever shall I omit transfers from my annual report. Further, on no consideration whatever shall I undertake three sets of Tables for direct cases, indirect cases, and totals. The scheme is a lop-sided arrangement to suit official purposes. Very well, let us suit official purposes, as we do every year of our lives. What does the Committee want in regard to indirect cases? The only thing, in my opinion, which is of the slightest interest is the recovery-rate of these indirect cases. Let us, therefore, regard these cases as constituting a side issue separately stated only for that purpose. If you turn to the second diagram you will understand the proposal which I laid before the Committee,

and which I ask the Association this morning to decide one way or the other. By this means the whole scheme is simplified. In the last edition of the Committee's report they have accepted many suggestions, they have done their best to enter all that could possibly fit in with their general plan, and if the report is complicated, as we have heard this morning, it is complicated by the deluge of suggestions that everyone who is mad enough to have any interest in statistics has showered upon the Committee. (Hear, hear.) My proposal is a mere plea for simplification. By the second diagram I propose that all the cases coming under review should be considered from the point of view of heredity, and from the point of view of environment.

The PRESIDENT.—Are you moving an amendment to that effect?

Dr. URQUHART.—My amendment is that, except for the purposes of recovery-rate, there shall be no notice taken of indirect cases separately. That is to say, a consideration of all the cases admitted without addition, and without deduction. I similarly regard as a side-issue the question of "persons" admitted, and the recovery of these "persons" I regard also as a side-issue. Again, the discharge and death tables would be similarly simplified by the consideration of all the cases in one group to the end that they may be separated into those who have recovered, those who did not recover, those who died, and the residue. Is the method of the Committee the method which is to be adopted this morning, or are you to simplify these tables by the omission of all separate reference to indirect cases?

Dr. CARLYLE JOHNSTONE seconded the amendment.

Dr. BOND.—I have listened very carefully to all that Dr. Urquhart has said, and I cannot help feeling more and more convinced that in reality we are in considerable agreement. Dr. Urquhart said "that there is nothing else about the transfers of interest except in reference to the recovery-rate." That is almost identical with the Committee's opinion at the very outset of their work, and the lines on which they framed their first report. Add to that one thing, and you have expressed one of the Committee's principal feelings in the matter, namely, that transfers are of importance only, or almost only, when you come to frame the residue tables. Take a man who has been under certificate in an asylum, and transferred to another asylum at the age of seventy. The record as a scientific fact of his age being seventy is, *qua* the admission, nothing; it is of no scientific value, and therefore the Committee decided in their first report that that man's age should not appear in their admission tables; but it is of importance to the individual asylum that they get an additional man in the senile period. It is of importance then, and therefore he was included in their residue tables, and, I think, quite rightly so. On that argument the Committee carefully separated the cases primarily, so as to differentiate "direct" from "transfers." Then Dr. Urquhart called the direct admissions a heterogeneous mass. Yes, they are a heterogeneous mass, and the Committee, recognising that, carefully divided them into certain groups. They screened off the congenitals from the others. Having screened off the congenitals, the balance is also a heterogeneous mass. They include "first attacks," which are really fundamentally important for statistical purposes; and they also were carefully screened off. But there are other cases who may have had two, three, or more attacks, who had to be screened off; and in trying to do that, we came across cases in connection with which there was no information as to whether it was their first or second or their third attack; and thus there is a fourth column to include those. It is because they are a hetereogeneous mass that the Committee have dealt with them in the manner they have. Dr. Urquhart used the words "to suit official purposes." The whole object of the tables has been to separate the official side of the question, and to so divide the cases that they can be examined for scientific purposes. Dr. Urquhart thinks that our division into direct and transfers is conceived under the shadow of the largest asylums. There may be some truth in that; but after receiving a letter he kindly wrote me, in which he mentioned that view, I did take the trouble to consult the Commissioners' Blue Book, and I found that the percentage of transfers stated in our first report to be eleven is gradually increasing, and in the last Blue Book—that may be an accident—it is something like 24 per cent. of the whole admissions for England and Wales, showing the vital importance of separating transfers from the others for scientific purposes. I endeavoured to see which asylums contained those. It is true the large ones had a very fair share, but smaller asylums had them

too. There is a table which the English Commissioners supply showing to which asylums these transfers belonged.

Dr. HAYES NEWINGTON.—The real reason for knocking off the transfers is that it is all very well for people connected with small asylums where there is a large proportion of private cases, cases about which one can see friends. But where you get 400 or 500 cases from transfers only, and where all the information you become possessed of has possibly been obtained only through the relieving officer, the information is not only useless, but it is dangerous, because you give the same value to uncertain facts as you do to those which you have ascertained yourself at the cost of trouble and thought.

Dr. URQUHART.—When the leader of this house stands up at the eleventh hour and says that false information is got from relieving officers, I would ask, what is the good of proceeding further with the discussion?

The PRESIDENT.—The amendment is, "That the detailed statistical information for indirect admissions shall be carried no further than the recovery-rate of these cases, and that one set of tables only should be prepared, inclusive of all cases."

Dr. CARLYLE JOHNSTONE.—I think Dr. Urquhart's proposal is that indirect admissions as indirect admissions should only be separately treated with regard to their recovery, and that in all other respects they should be grouped with the so-called "direct admissions." That is an amendment which I shall be glad to second, now that I have heard it read. I agree with all Dr. Urquhart has said. His diagrams are so very graphic and clear that I do not think one requires to say anything further with regard to them. If members have taken the trouble to consider them, they will see at once that this arbitrary division by the Committee into direct and indirect groups has this result, that each group includes all the different kinds of insanity, both groups including the same and different kinds; that is to say, one group is in no respect exclusive of the other group, but each of those two groups includes the first attack, congenital, recent, chronic, curable, incurable, and every sort of case. I think, as I said at the November meeting, nothing could be more unscientific, and although apparently the Committee is endeavouring to satisfy official requirements, there is a certain limit beyond which science cannot go in yielding a principle to official requirements. Personally, I am not prepared to go that length.

Dr. BEDFORD PIERCE.—I think this subject was pretty thoroughly discussed before. I think one justification for the Committee's recommendation is that we ask for particulars respecting patients which the superintendents themselves have investigated, and not for second-hand information. In a large number of transfers it is impossible to get first-hand information, and that is one justification and reason why only the patients that we ourselves have admitted under a new order should be taken as the basis of our tables. A more important reason is, that the same person under the same order should not be counted in two asylums, and so falsify the statistics of the country. If I wanted to inquire into statistics on insanity in the West Riding of Yorkshire, I ought to be able to feel that I was not counting some persons twice.

Dr. CARLYLE JOHNSTONE.—But a person is counted twice if he is transferred from Scotland to England.

Dr. BEDFORD PIERCE.—Transfers across the border are so very few that they are not at all likely to vitiate the statistics.

Dr. NEWINGTON.—It is simply following the law.

Dr. YELLOWLEES.—It seems to me that if we are to have tables at all it is preposterous not to expect to receive from them, that they should not convey, information of a more definite and exact character than the grouping of all our admissions together. It seems to me it is going back. It certainly is not going forward. Dr. Urquhart says that they are a heterogeneous mass, consisting of all kinds of people. So they are, and realising that, realising exactly what he has said about them, we tried to separate them, and we do separate them. Surely it is very important to do that. We separate them into direct and indirect. We give transfers, first-attack, and not-first-attack, and it is for the Association to say whether that is worth doing. If it is not worth doing we have taken a lot of trouble for nothing. (Hear, hear.) But it will diminish immensely the value of your tables if you do not have it. ("Question.") There is no question at all about it. The man who is insane for the first time is a more important case medically; and more

important for the information we get from him, by far, than one who has had a previous attack. And if you limited the tables to that one thing alone they would be very valuable tables indeed. Perhaps it would be better than having all these, but you cannot do that. Some people are very rabid for complete statistics, and here is Dr. Urquhart who wants slumped statistics, and yet when I speak of first-attack cases, he is in agreement with me.

Dr. URQUHART.—How delightfully Dr. Yellowlees has argued our case. It is most important to find out about first attack cases, but if they become transfers they are of no importance.

Dr. BEDFORD PIERCE.—They have been taken already.

The PRESIDENT having put the amendment to the meeting, 2 voted in favour and 12 against.

Dr. STEEN.—I move, "That the statistical tables be referred to the Committee, and that they report one year hence, and that in the meantime a ballot be taken by post of each member of the Association as to whether he or she is in favour of the tables being passed as they now stand." There are twenty members of the Association here, and the Association numbers 600 or 700 members. Shall we decide on these tables which will regulate the Association for the next ten years without the other members having a voice in the matter? They certainly have a right to be present if they have had a notice of the meeting, but they may not have been able to come. I feel that there is a very strong opinion in this Association against these tables altogether. (Hear, hear.) There will be a great waste of time in preparing them without any good whatever resulting to the Association; and I strongly feel that if the registers as recommended by the Committee, both Civil and Medical, be kept, that the Committee will have done a great deal of good work for the Association. I think the Committee have done very valuable work also in showing what tables should be prepared by those who are keenly interested in statistics. But that every asylnm should prepare these tables I do not think anybody desires. Therefore I think each member of the Association should be asked his opinion by post.

Dr. WEATHERLY.—I have very much pleasure in seconding that. I think it is a serious matter that we should accept these tables to-day, that there should be any finality about them, at least for some years. It is equally a pity that the objections to principle which were raised to-day were not raised a great deal earlier. The feeling is very strong, and the minority in favour of having the tables referred to some further expert is a very large minority.

Dr. NEWINGTON.—There is one fact which has been forgotten, that is, that the general principles of these tables were discussed at very considerable length at the meeting last November.

Dr. URQUHART.—Never.

Dr. NEWINGTON.—The tables and general principles, as shown in the report, and as inferred from the tables, were discussed by a large meeting, by medical superintendents who have been through the statistical mill. I call your attention to the fact that this meeting is an extremely small one, and that I interpret as a compliment to the Committee (oh), showing that those who are absent think the Committee has done its work pretty well, and are inclined to leave the matter in their hands.

Dr. URQUHART.—Will you point out in the report where the general principles were discussed?

Dr. NEWINGTON.—In our first report, which was put up in November, we state what our broad principles were. (Reads Report.) All these principles were adopted.

Dr. URQUHART.—There is nothing in the report about the discussion of any general principles whatever.

The PRESIDENT.—The amendment before the Committee is that the statistical tables be referred back to the Committee.

Dr. URQUHART.—Might I ask if the effect of the success of that amendment will be that the discussion will be closed?

The PRESIDENT.—It depends upon what the view of the Committee is. If the Committee are willing to receive them back, and it is carried that they do receive them back—

Dr. URQUHART.—I appeal to the mover of the amendment not to press it at the

present moment so that we complete the discussion of the report. Some of us have come a considerable distance for the purpose.

The PRESIDENT.—If that resolution is carried we do not discuss the matter again to-day.

Dr. CARLYLE JOHNSTONE.—Will the mover be allowed to put it later if he withdraws it now.

The PRESIDENT.—The business will never finish if we do that. If the mover and seconder wish to withdraw it it will depend on the meeting whether it will sanction their withdrawing it.

Dr. ROBERT JONES.—I hope Dr. Steen will ask permission to withdraw it, because if the resolution were carried one can see complications ahead. The Committee might resign, and then the whole thing would be left.

Dr. STEEN.—I should like not to withdraw it, but to postpone it.

The PRESIDENT.—It is of no use discussing the tables if at the end the whole matter is to be referred back to the Committee. The resolution ought to be either withdrawn or put.

Dr. ERNEST WHITE.—It could of course be withdrawn and reintroduced.

Dr. STEEN.—I do not withdraw it.

The PRESIDENT.—Very well. I put it to the meeting.

6 voted in favour and 10 against.

Dr. CARLYLE JOHNSTONE.—I ask has "indirect" the same meaning as "transfer"? Apparently on p. 4 "indirect" includes transfers and some other groups. Subsequently a transfer seems to be equal to indirect.

Dr. NEWINGTON.—"Indirect" certainly includes "transfers," transfers forming the most considerable portion of indirect admissions, the balance being lapsed orders, and so on.

Dr. CARLYLE JOHNSTONE.—What is the meaning of "transfer" on p. 17 and the same word on p. 18? Does "transfer" mean indirect?

Dr. NEWINGTON.—No. I can give you the reason for that. First of all you get in the Civil Register all admissions; then on the Medical Register only direct admissions; then under transfers you get the actual transfers; but that does not sum the whole of the admissions. There are still the readmissions after discharge for statutory reasons.

Dr. CARLYLE JOHNSTONE.—So the totals in these tables are not the total admissions?

Dr. BEDFORD PIERCE.—It does not say total admissions. On p. 17 the word "indirect" does not appear.

Dr. URQUHART.—Then this table does not represent the total admissions to the institution.

Dr. BOND.—Not the grand total.

Dr. NEWINGTON.—It represents the total persons.

Dr. URQUHART.—It does not say so.

Dr. NEWINGTON.—It excludes the person who is turned out for statutory reasons at five minutes to twelve to be admitted at five minutes past twelve.

Dr. URQUHART.—Is it preferable not to have the total number of persons?

Dr. NEWINGTON.—In the Civil Register, yes, but not in the Medical Register.

Dr. URQUHART.—It is preferable that Table B2 should not represent the total number of cases.

Dr. NEWINGTON.—Yes.

Dr. YELLOWLEES.—You have the total number of admissions in this Table.

Dr. URQUHART.—No.

Dr. YELLOWLEES.—You get the persons, but the man who would be counted again by a technical readmission is already entered in this Table for his first admission, and his second admission is not repeated, because it is the same individual, and he was only out a few hours. What kind of statistics would you have if such cases were frequent and always entered as two admissions.

Dr. URQUHART.—Do I understand that the term "Direct Admissions" on page 17 means persons and not cases, and why is it not so stated?

Dr. BOND.—There is some confusion in the point at issue. Dr. Urquhart's question is, if the same man is admitted twice over in the same year, having been discharged once recovered, does he count one or two under Direct Admissions? He counts two.

Dr. NEWINGTON.—What I meant by persons was, that it excludes the man who is admitted twice because his certificates were wrong.

Dr. CARLYLE JOHNSTONE.—It is the simple fact that a single-care case in England is a transfer, and in Scotland is a direct admission. John Brown in England is indirect, and in Scotland is direct. And there are a great many John Browns. Every one in Scotland is a direct admission, every one in England is indirect. And that appears to show the utter futility of this arbitrary arrangement.

Dr. BEDFORD PIERCE.—I think John Brown in England is a very rare person.

Dr. URQUHART.—It will be understood that it is proposed we should use these tables in Scotland, and therefore we ought to know something about them. Are Darenth or Caterham Asylums within the meaning of the Act in England? If you turn to the Discharge Table C1 you will see that the metropolitan asylums are especially named there, but they are not named in the page referring to definitions.

Dr. ROBERT JONES.—Where the patient is discharged from the asylum he is discharged absolutely, and he is retained in the metropolitan asylums as if he were in a workhouse infirmary.

Dr. URQUHART.—He is a direct case; he is not a transfer.

Dr. NEWINGTON.—The Committee quite recognise the difficulty on the point. There must be always a little want of absolute accuracy in all these points, a little copper with your sovereign, a little chicory with your coffee. We must discount small differences like that.

Dr. URQUHART.—Why is it not included in the definitions, so that everybody shall know it and act in unanimity.

Dr. NEWINGTON.—It is included under the head of transfers.

Dr. URQUHART.—There is no remark upon metropolitan asylums whatever in the definitions.

Dr. NEWINGTON.—In England they are under different authority.

Dr. URQUHART.—Under this definition of direct admission a patient under private care admitted to an asylum is regarded as a direct admission in Scotland, but in England he is regarded as an indirect admission. (No.)

The PRESIDENT.—They may be transferred from single care under the same order.

Dr. NEWINGTON.—There are only about 400 single-care patients in England; they are a negligible quantity.

Dr. EASTERBROOK.—But in Scotland, where there are nearly 3000 certified patients in private dwellings, and nearly 1000 certified patients in lunatic wards of poorhouses who, when sent to an asylum, are required to come in under a new order and new certificates, and would be regarded therefore, as direct admissions, to the falsification of medical facts. I suggest that the definition should include words showing that there has not been previous certification for the particular attack of insanity.

Dr. URQUHART.—What is meant by the words "from asylums." Does that include metropolitan asylums?

Dr. NEWINGTON.—There is no reason why we should put in all the workhouses.

Dr. EASTERBROOK.—I suggest that if a clause were added to the definition of direct admissions it would specify all cases in England, Scotland, and Ireland, namely, "Direct admissions are persons received into an asylum on new certificates and a new order, and on account of an attack of insanity for which there has not been previous certification." That covers everything, and makes it definitely clear. You eliminate the boarded-out cases in Scotland, you are dealing with fresh cases of insanity, which is what you want to make sure of. These patients may have had any number of previous attacks, but in relation to the existing attack they have not already been certified.

Dr. YELLOWLEES.—I do not see why the Committee should have any objection to that being added to the definition of direct admissions.

Dr. NEWINGTON.—It might be dangerous to accept words of that sort without very full thought. I believe the Committee would be willing to adopt the suggestion if found to be practicable.

Dr. URQUHART.—I move that the definitions be remitted to the Committee for amendment. We have no information as to how we are to return admissions from poor-houses in Scotland. Poor-houses receive chronic harmless patients only from asylums. They are sometimes re-transferred to asylums from poor-houses, and new certificates and a new order are then required. Are they direct admissions?

These questions have already been submitted by me in my communications to the Committee, and they have not been answered. Directions are essential to enable us to make these returns properly. We do not yet know whether a patient coming from single care in Scotland is to be regarded as direct or as indirect.

The PRESIDENT.—Do I understand you want to refer the definitions to the Committee for report again.

Dr. URQUHART.—For amendment.

The PRESIDENT.—An amendment by the Committee would have to come up again before the Association, and this is the last adjournment of the 1904 annual meeting; and I do not know that it is open to us to continue the Committee indefinitely. We cannot adjourn the 1904 annual meeting to receive their report.

Dr. BOYCOTT.—To the 1906 meeting.

Dr. YELLOWLEES.—I admire very much Dr. Urquhart's persistence, and the care with which he has gone into every minute point in this matter. But I think there ought to be a limit to that kind of thing. Dr. Urquhart appears to be one of those delightful men who never know when they are answered. I think that the clause which has been suggested by Dr. Easterbrook—and which he ought to have suggested at one of our meetings, as he is on the Committee—meets Dr. Urquhart's difficulty about what constitutes a direct admission. Dr. Urquhart talks about direct admissions from workhouses. A workhouse patient cannot, in Scotland any more than in England, be received into an asylum without a new order, and I think what Dr. Easterbrook has added promptly and completely meets Dr. Urquhart's difficulty. The case having been already certified insane, it cannot be a direct admission. That is the meaning and significance of the suggestion.

Dr. EASTERBROOK.—Already certified insane during the existing attack as previously submitted by me in Committee.

Dr. YELLOWLEES.—Therefore it is clear it is not a direct admission.

Dr. CARLYLE JOHNSTONE.—But that alters the principle of division, and will alter the whole scheme of the Tables. So I agree with Dr. Hayes Newington in pointing out that it requires careful consideration.

The PRESIDENT.—Dr. Easterbrook has moved, as an addition, "Direct admissions are persons received into an asylum on new certificates and a new order on account of a distinct attack of insanity for which certification has become necessary for the first time during the attack."

Dr. KIDD.—For the purposes of discussion I second it.

Dr. URQUHART.—I agree with Dr. Hayes Newington that it is extremely difficult and dangerous to accept any definition on the spur of the moment, and therefore moved for a remit to the Committee.

Dr. NEWINGTON.—There is one reason why I think that is absolutely impossible. You say "For which there has not been previous certification." A patient comes from Leavesden into a county asylum, and we say that he must be treated under law as a direct admission, but because he has been treated and previously certified for the same attack the amendment would compel us to treat him as "indirect."

Dr. BOYCOTT.—The case might be sent from a London County Council asylum to Caterham, having been certified by the Medical Superintendent as fit for the workhouse, and he may be sent back to the asylum re-certified; but he has already originally been certified under the existing attack of insanity.

Dr. EASTERBROOK.—Unless these definitions are interpreted in the *medical* sense it will be impossible to satisfy legal requirements. These Tables are medical, not statutory.

The PRESIDENT.—I feel strongly that we cannot refer these things indefinitely to the Committee for report again. There is nothing for them to report to unless they are re-appointed to-morrow till another Annual Meeting. I now put this amendment.

Dr. EASTERBROOK.—Is it an amendment? I do not want it to be voted on as an amendment; it is more a suggestion than an amendment.

The PRESIDENT.—It must be moved as an amendment and put.

Dr. BEDFORD PIERCE.—I should not like it to be recorded that the Committee entirely approve of this amendment. I see many difficulties, and I think the original wording is clearer.

Dr. NEWINGTON.—If you take the term "direct admissions" as it stands there, it excludes everything which you feel a difficulty about.

Dr. URQUHART.—No.

The PRESIDENT.—There is evidently great difference of opinion, therefore this amendment must be put to the meeting.

Dr. EASTERBROOK.—The whole object of the Statistical Tables is to ascertain medical truth about insanity, and especially about "direct admissions," which in my opinion should signify those who are labouring under fresh attacks of insanity. As the definition stands it does not ensure medical accuracy.

The PRESIDENT.—I now put the amendment.

There voted in favour, five; against, six.

Dr. HAYES NEWINGTON.—If there is any difficulty when it comes to be worked out for each division of the kingdom, surely we can make a special motion, before the next annual meeting, to modify this.

Dr. URQUHART.—I very much object to that. Let us have some finality. We have squeezed out certain definitions here, at an immense loss of time. Why cannot the Committee give us these definitions in the instructions which they promulgate? That is all we want. Let us know what it is that the Committee ask of us.

Dr. BEDFORD PIERCE.—We do not say what are transfers exactly; everything else is not a transfer. Consequently it is obviously inferred that metropolitan asylums are places from which patients cannot be transferred. But if we are to specify things which are otherwise, institutions not for the reception of the insane, we shall have to put the whole list of institutions in, "except the following."

Dr. URQUHART.—Especially it might be explained why it is that single-care in England, which is certificated single-care, is treated in one way, and single-care in Scotland, which is also certificated, in another way. I am not referring to the incipient insanity cases, but to the 2600 boarded-out cases. Why this difference in statistical methods?

The PRESIDENT.—Because there are different laws.

Dr. NEWINGTON.—I made a suggestion, with the consent of the President.

Dr. CARLYLE JOHNSTONE.—The whole of the terminology applies to England, and the report has not been adjusted to Scotland.

Dr. NEWINGTON.—Will you give concrete instances of that?

Dr. CARLYLE JOHNSTONE.—I could give many instances.

Dr. BOYCOTT.—If we leave this to the Committee it will be with certain amendments which the Committee are going to make. I understand we are so leaving it.

Dr. NEWINGTON.—My recollection of it was that an amendment was moved to the definition, and the amendment was defeated; therefore the definition stands. But I think the Committee undertook that if a grievance did arise we would take steps to report to another meeting for rectification.

Dr. YELLOWLEES.—Dr. Carlyle Johnstone is entirely mistaken if he thinks that in this matter we have been subservient to the English Commissioners. If his remarks did not mean that, they sounded very much like it. If he is under that misapprehension, I would like to tell him that it is not the case. We have worked under no known bias. We are extremely anxious, if we can, to carry the English Commissioners with us, and we have been received by them with the utmost courtesy. They have listened to us and we have listened to them; and I am sure they have gone far further in the way of meeting us than we have gone in meeting them; I am sorry to hear the suggestion that there has been anything of that kind in the Committee's doings.

Dr. CARLYLE JOHNSTONE.—That has not been suggested by me.

Dr. URQUHART.—Dr. Yellowlees' remarks are not germane to the subject. There are certain conditions affecting Scotland which have not been properly explained in these definitions. We are endeavouring to amend these defects.

The PRESIDENT.—You have had the opportunity of putting that, but the Committee may not have been able to adopt it. We shall now consider the Tables *seriatim*.

TABLE A 1.

The PRESIDENT.—It is understood that all the Tables have been moved by Dr. Yellowlees. If anyone has any amendments, now is the time to move them.

Dr. BOYCOTT.—This might very well be combined with Table II. They both

give the same information, and Table A 2 is in a rather better tabulated form. Practically the only information not in Table A 2 which is in A 1 refers, in the first place, to the number on the asylum registers on January 1st, and a column to that effect might be added to Table A 2. With regard to the column for Voluntary Boarders, my own feeling is that as the majority of county asylums do not receive these patients it would be well to omit reference to them, and to leave those asylums which have voluntary boarders to use the columns prepared. With regard to the annexe relating to certified persons, it is absolutely fallacious to deal with these numbers year by year. And it is useless, because if a person is discharged in December, and readmitted in January, he counts as two persons in summarising tables over a series of years. If he is discharged in December and readmitted in December he counts as one person; but if he is discharged in December, and readmitted in January, he counts as two persons. I suggest that it be incorporated in Table A 2.

Dr. KIDD.—I second Dr. Boycott's amendment.

Dr. BEDFORD PIERCE.—The argument in favour of the Table as it is is that it is simpler than the selection of a series of figures at the end of a large table. The objection, I think, only involves a matter of printing.

Dr. YELLOWLEES.—Those two Tables are intended more for the public than for the profession.

Dr. Boycott's amendment was then put, and there voted in favour 3, against 7.

Dr. CARLYLE JOHNSTONE.—I move that a distinction be made between first admissions and not-first-admissions in the individual asylums.

Dr. DRAPES.—What are the Committee's grounds for removing that from the previous Tables?

Dr. BOND.—They removed it on two grounds. First, being a general table, it was removed to simplify the Table. The second reason is, that steadily through the set of Tables we have used the term "first-attack" in preference to "first admissions." The term "first-attack" expresses a scientific fact, and is different from first admission.

Dr. CARLYLE JOHNSTONE.—Does Dr. Bond object to the division of persons and cases?

Dr. BOND.—No, we do not object, but we have carried it out in more scientific tables.

The PRESIDENT.—It was provisionally accepted in November. I now put the amendment.

On being put to the meeting, 5 voted in favour, 7 against.

Dr. CARLYLE JOHNSTONE.—Why do the Committee wish to distinguish between persons and cases for one year, and object to so distinguish for a term of years?

Dr. BOND.—I believe we were under the same pledge to add this item. In our Report it did not appear.

Dr. YELLOWLEES.—Yes. Somebody was very anxious for an optional table; and if Dr. Urquhart desires that table there it is.

The PRESIDENT.—We are on General Table A 1; is there any further amendment?

Dr. BOYCOTT.—What is the reason for this information about certified persons applying to the actual year in question? Would it not be better to have that summarised for several years?

Dr. YELLOWLEES.—I do not see how Dr. Boycott's difficulty can be met, unless we make our statistical tables for a longer period than one year. If we could make our tables for three years or five years it would minimise that difficulty. The information was put in by earnest desire—for the Committee have been guided by the earnest desires of other people—at the foot of Table 1; and Table A 3 gives that information over a series of years, so that those who are devoted to that Table can give it more fully than the foot-note requires. It is a question whether it is not better to count the attacks of insanity, rather than to count the individuals that have them. If a man has acute rheumatism twice a year, you do not regard him as once ill. And why should you do so when you are dealing with insanity? The analogy of crime, which has been mentioned, has nothing to do with it. Insanity is disease, crime is wilful evil.

Dr. BOYCOTT.—If the Statistical Committee are going to consider any points they might consider this, and report next time.

On being put, 9 voted in favour of the Table as it stands, and 6 against.

TABLE A 2.

Dr. URQUHART.—We desire to get the information which we have had hitherto. We still desire to record admissions and readmissions in two extra columns, from which the Optional Table A 3 is compiled. I move accordingly.

Dr. CARLYLE JOHNSTONE.—I second it for the same reason.

On being put to the meeting, 4 voted in favour of the amendment, 7 against.

Dr. BOYCOTT.—There is a column showing total number under treatment. I do not know what the scientific value of it is, and I think it might very well be omitted. It increases the size of the tables more than necessary. I propose that it be omitted.

There being no seconder, the amendment was not proceeded with.

Dr. URQUHART.—I object to the third last column, calculating the total recoveries on a moiety of the admissions. It is not justifiable. I move for omission.

Dr. CARLYLE JOHNSTONE.—I second.

Dr. NEWINGTON.—The adoption of that amendment would mean asking the Commissioners in England to tear up their system altogether. It has been going on for many years. It is as right as any other way. If individually we get the advantage of including recoveries of transfers, we have had the disadvantage of losing cases by transfer, which may have recovered elsewhere. On the average altogether we come to very much the same results. But when you add asylum to asylum you get the absolute truth; and that is the reason it has been adopted in England.

Dr. URQUHART.—That is an argument for the official report of the Commissioners, which is justifiable, but it is not an argument for this our purpose.

Dr. NEWINGTON.—But the Commissioners have their own experts, and they know more about statistics than we do as a body. With the advice and experience they have got and the practice they have had they know what they are about better than we do, and I should be disposed to follow the Commissioners.

Dr. DRAPES.—It is unnecessary, but it cannot lead to mistaken ideas in the matter, because we have the percentage of the total recoveries on the total admissions, so nobody can be deceived. It cannot do us any harm.

On being put to the meeting, 3 voted for omission, 9 against.

Dr. BOYCOTT.—In the last column but one, "Percentage of recoveries yielded by direct admissions on the direct admissions," you might add, "Excluding congenital cases." I move the insertion of those words.

Dr. STEEN.—I second that.

Dr. BOND.—There is much force in what Dr. Boycott says. We considered the point, but it opens up questions as to the exclusion of other cases which are not absolutely, but almost certainly, irrecoverable, *e. g.* general paralytics.

The amendment was then put to the meeting, when 3 voted for and 7 against.

Dr. BOYCOTT.—I move for the addition of a column showing recoveries on first-attack admissions.

There being no seconder the amendment dropped.

The PRESIDENT.—I put it that Table A 2 be approved.

Nine voted in favour, 5 against.

TABLE A 3.

Dr. URQUHART.—Why are the transfers omitted by the Committee? I recognise that the Table is optional, but those who are interested in the differentiation between persons and cases should have opportunity. Dr. Yellowlees said that analogies had nothing to do with this differentiation. I do not agree with him. The number of attacks of rheumatism occurring in England is not very important, but it is very important for us to know how many persons have suffered from rheumatic attacks. I ask you to recognise that we are dealing with individuals. You regard disease as an entity, that is a retrogressive step in medicine. The number of crimes occurring is one question, the number of criminals who commit these crimes is another. I move that Table A 2 be reproduced exactly in the present series.

Dr. YELLOWLEES.—That was the intention of the Committee because so many were anxious to have it retained as optional. I am not aware of any change.

Many men have used it faithfully, like Dr. Urquhart, and if this Table departs from the old form it is a mistake.

Dr. CARLYLE JOHNSTONE.—I second the amendment.

Dr. EASTERBROOK.—There seems to be a difference in practice in the ways in which it is actually made up. For instance, some people take persons, say in the year 1869 and the persons in 1870, and so are dealing with the persons *qud* each year, and arrive at total persons by simply adding the persons for each year. But, in some asylums, if X— appears in 1869 and again in 1875, and again in 1896, they eliminate him in those subsequent years. This second way is a more laborious method, but there are some who will take that trouble, so that their total at the foot of their table means the total number of different persons who are referred to during all the years covered by the Table. But there should be a clear statement at the foot of the table as to which is the correct way of interpreting it.

Dr. CARLYLE JOHNSTONE.—The second way is the only correct way, but how are you to obtain the numbers of these persons in the new tables?

Dr. YELLOWLEES.—Dr. Easterbrook's difficulty was one of the reasons which led the Committee to make it an optional Table; it was rarely and variously done.

Dr. BOYCOTT.—I have an asylum report in my hands. It shows recovered patients 14·18 *per cent.* of the patients admitted, and, omitting persons transferred, 20·23 *per cent.* I do not see that there is any value in stating that 14·18 *per cent.* of the patients admitted have remained well, because that asylum may have hundreds of transfers one year, and in another year none at all, and such information is useless and absolutely misleading. Another point in regard to which this Table should be revised is not only in cases relapsing and being readmitted to the same asylum, but it should refer to cases relapsing and going elsewhere. The statement that so many patients have remained well is absolutely erroneous.

The PRESIDENT.—It has been moved and seconded as an amendment that the Table be restored to its original form.

On being put to the vote the amendment was carried.

Dr. CARLYLE JOHNSTONE.—Will the Committee now tell us how we are to get at the number of persons?

Dr. BOND.—Any superintendent, from year to year may publish records of this kind. The Registers, as they stand, provide full details for getting out the Tables as a set such as we recommend, excepting these optional Tables.

Dr. BOYCOTT.—I propose, sir, that the Committee be requested to amend Table A 3 by including cases which are relapsed and sent to other asylums.

Dr. ROBERT JONES.—These relapsed cases are very difficult to trace. The London asylums take special pains about the registration of relapsed cases, and there is a standing resolution for the London asylums that cases discharged recovered, should go back to the asylum whence they came when relapsed. Although this resolution is in vogue, I find Claybury cases may have gone to some of the others, and cases from other asylums may be received into Claybury, because the relieving officer, who is responsible for filling in these details, knows nothing about the previous history of the patient, and consequently fills up the form "no previous attack," when in reality many cases are afterwards found to be relapsed cases. I find that during the last twelve years 13·2 *per cent.* of all discharged as recovered have relapsed; that is to say, they have relapsed during the twelve years covered by the table. If you take a very long period—and that is the essence of statistics, namely, to get a correct record of a large number of facts based upon collective investigation,—if you take a period covering say, thirty years you will have a relapse rate from the recoveries of 27 *per cent.* It is practically impossible to trace many of these, and it is a pity to have tables where we think we show these, and find afterwards that the conclusions are fallacious. I am in agreement with Dr. Boycott as to the necessity for indicating relapses.

Dr. CARLYLE JOHNSTONE.—The Table says "Recovered persons sane at the present time so far as the statistics of this asylum show." I do not think we can go further than that; it is correct as far as it goes.

The PRESIDENT.—I now put it that Table A 3, as an optional table, be accepted. (Carried.)

TABLE B 1.

Dr. NEWINGTON.—I move that it be adopted. It has been altered to meet a certain amount of objection, and I do not think there can be any other points to raise in connection with it. (Carried.)

TABLE B 2.

Dr. URQUHART.—I rise to point out that this table is not a correct account, because it comprises direct admissions and only part of the indirect admissions, therefore it will not balance the former tables headed "Direct and indirect admissions;" and I move that the transfers be dealt with as shown in the table, and that lapsed orders, etc., be inserted in a column by themselves so as to make the table balance.

Dr. CARLYLE JOHNSTONE.—I second it.

Dr. YELLOWLEES.—It would be sacrificing truth to arithmetic to do that. It is true there are only direct admissions and transfers; it is true there is a third category of patients, those who have been admitted and who are readmitted on account of a lapsed order. The interval between discharge and readmission is an hour or two, perhaps, and they have already been entered as direct admissions. They are already counted in this table, and to count them a second time because they had technically been re-admitted would be vitiating the whole table.

Dr. URQUHART.—The result of that is that we are not to be allowed to enter the total admissions in this table.

Dr. BOND.—There could be no mathematical objection to putting in another column to show the statutory readmissions, and it could not alter what we have already provided they are in another column. The only thing is, is there any advantage just for the sake of balancing figures?

Dr. URQUHART.—Is it not better that you should be able to balance your figures? Is it not a check upon them? Anyone may make a slip in compilation, and this would be a check upon accuracy.

Dr. NEWINGTON.—It would necessitate two columns; one for the cases to be so added, and another for a grand total. There should be no risk of the latter being taken as the basis of the calculations.

Dr. BOYCOTT.—I propose that the particulars about transfers be omitted altogether. I do not know what scientific value it would be to get to know whether a certain number of persons, who have perhaps been in asylums twenty years, have been transferred. At the end of a few months they may be transferred back, and the same process will have to be gone through. I maintain there is no scientific value attaching to such a record, and I therefore propose that the particulars referring to transfers be omitted.

Dr. STEEN.—I second that.

Dr. NEWINGTON.—That amendment expresses very much the feeling of the Committee when we first started.

Dr. URQUHART.—I agree with that, because the Association has decided that the attention shall be directed to direct admissions to the exclusion of transfers. That is the general principle, and now I should think it would be better, having accepted the general principle, to leave out the transfers altogether. Let it apply to all the Tables.

The PRESIDENT.—The amendment is to omit all these columns referring to transfers in these Tables.

Dr. NEWINGTON.—And the total.

Dr. BOND.—We had a column of transfers before, but not differentiated. We recognised that transfers did, as regards this table, make their weight a little felt. There is a difference in receiving transfers of many years duration as compared with transfers which have only been under certificates for a year, and some of whom may recover. And for that reason we put a single column headed "transfers." But we did not think they were important enough to subdivide into "first-attack," "not-first-attack," etc.

The PRESIDENT.—The amendment is to omit all the columns after the first total column.

On being put to the vote, 8 voted in favour, and none against.

TABLE B 3.

Dr. CARLYLE JOHNSTONE.—Why are the congenital cases given in the direct admissions section of the table only?

Dr. BOND.—They are included in the others, not differentiated.

Dr. CARLYLE JOHNSTONE.—Why are they not taken out of the indirect as well as out of the direct so as to be shown separately?

Dr. BOND.—Congenitals were placed there to save an extra Table for showing their precise age. It is difficult to discuss a succeeding Table when we have only Table B 3 under consideration, but in Table B 4 we have differentiated between "first-attack" and "not-first-attack" cases, and it would have required another table to show the ages of the congenital cases and the direct admissions in the same way.

Dr. CARLYLE JOHNSTONE.—I do not understand what is the object of giving the ages of the direct congenital and not the ages of the indirect congenital.

Dr. BOND.—The object is to give the ages of the direct admissions subdivided in the manner we have adopted throughout.

Dr. BEDFORD PIERCE.—It is only to prevent an additional table corresponding to B 4. It is simpler to put it in B 3 Table than to make another table.

Dr. NEWINGTON.—It is complementary to B 4. They are put underneath as a very convenient spot.

Dr. CARLYLE JOHNSTONE.—It seems to me to be a clumsy arrangement.

Dr. ROBERT JONES.—I think Dr. Carlyle Johnstone means that in the first part of Table B 3 you have to class direct admissions and transfers, whereas in the second part you have only direct admissions.

Dr. NEWINGTON.—But it is absolutely plain, and, I think, no one could make a mistake about it. Therefore what is the objection?

Dr. CARLYLE JOHNSTONE.—I think ninety-nine out of every hundred people would make a mistake about it. You only give specifically the direct congenital cases.

Dr. NEWINGTON.—What purpose would be served by altering it?

Dr. BOYCOTT.—I think the line showing congenital cases in direct admissions might very well go into the next Table.

Dr. BOND.—There is no objection whatever if the Association is content not to have any information of the civil state of the congenital cases in the direct admissions.

Dr. ROBERT JONES.—I agree with Dr. Carlyle Johnstone in this matter. I should prefer another little paragraph added to B 3 as suggested, direct admissions and transfers of congenital cases. Why stop at the direct admissions of congenital cases? Why not add a subsequent paragraph to B 4, and say, "A, congenital cases with direct admissions; B, congenital cases with transfers"? Then you will have the congenital cases entirely.

The PRESIDENT.—Do I understand that the Committee is prepared to accept some suggestion about putting this into the next table?

Dr. BEDFORD PIERCE.—I think it is the simplest way of doing it, and gives the least trouble. I shall be willing for the congenital cases to go into table B 4.

Dr. URQUHART.—But why are not we to have the ages of all the congenital cases in this table? The congenital cases in the table are only representative of the direct admissions, while the upper part of the table deals with all the cases received.

Dr. BEDFORD PIERCE.—There is one good reason. There is a difference between the congenital case that is admitted because of some acute attack of insanity, and another congenital case that is transferred for administrative reasons.

Dr. URQUHART.—There is no such differentiation in the upper part of this table, and it begs the question to say that many are transferred for official reasons.

Dr. ROBERT JONES.—I propose that a subsequent paragraph or column should be left, not only for the direct admissions, but for the transfers, so as to get the ages of congenital cases.

Dr. BOYCOTT.—Congenital cases are all included in the first line.

Dr. ROBERT JONES.—I move an amendment that the second paragraph of

table B 3 shall read "A, congenital, direct admissions; B, congenital cases including transfers."

Dr. YELLOWLEES.—I second that.

The PRESIDENT.—It means the introduction of another line.

On being put to the vote, 10 declared in favour and none against.

Carried.

The PRESIDENT.—I now put Table B 3 as amended.

Carried.

TABLE B 4.

Dr. BOYCOTT.—I move as an amendment that the words "single" and "unknown" be omitted from both sections of the table.

Dr. STEEN.—I second that.

Dr. BOND.—Does Dr. Boycott suggest that the civil state should be omitted?

Dr. BOYCOTT.—Yes. You have already the information in B 3.

Dr. ROBERT JONES.—I think it is important we should know the actual ages and the civil states of patients, *e. g.* in boy or girl marriages, from a sociological point of view. Although it is an elaborate table, it will give us a great deal of information. I have been working on this line, and I should be glad to have such assistance as this would give us.

Dr. BOND.—Is the knowledge of the civil states of our cases in general diseases, apart from mental ones, of the slightest value to us? Presumably it is, otherwise we would not record it. But I thought all statisticians would agree that if you attempt to trace the influence of the civil state you can only do so when you know the ages, preferably in quinquennia. I quite see that it would simplify this if you would be content with broader periods than quinquennia, but then to be logical you would require to carry that out in succeeding tables, recoveries and so forth, because part of our aim in arranging these tables has been to make a certain amount of comparison with similar columns.

Dr. CARLYLE JOHNSTONE.—Is it the civil state at the commencement of the disorder?

Dr. BOND.—No, on admission.

The PRESIDENT.—The amendment is to omit the civil state.

Dr. BOND.—It should be the civil state at the same age as is expressed in the table.

Dr. YELLOWLEES.—Age at the commencement of the attack.

Dr. BOND.—If Dr. Carlyle Johnstone thinks there will be a large number of cases which become insane prior to tabulation, and then marry, we can meet this point. I quite see that it can occur, and if with any probability of frequency we should definitely state that the civil state is taken at the same time as the age, namely, the commencement of the attack.

The PRESIDENT.—I will now ask you to vote on the amendment.

It was put to the meeting and *lost*.

Dr. CARLYLE JOHNSTONE.—What is the object of having the statement as to the attacks put at the bottom of this table? There is the statement saying, "number of previous attacks, in the non-first-attack direct admissions, known to have been treated to recovery in an institution or elsewhere."

Dr. BOND.—It came conveniently here, and we were under pledge to express the age on first attack of the non-first-attack cases in the way we have provided. And in doing that one of the tables which was embodied in our previous report has been abolished.

The PRESIDENT.—I now put Table B 4.

Dr. ROBERT JONES.—From some work on puerperal insanity I have found that it is only by knowing the number of attacks that you can find out what was the duration between them. I think it is important that we should have this registered.

Dr. BOYCOTT.—In this addendum there is a note "known to have been treated to recovery in an institution or elsewhere." The other tables are confined to the asylum.

Dr. BOND.—Our idea is that the attacks should be registered irrespective of any

particular asylum, and I think it is erroneous to say that the facts in the other tables are confined to the particular asylum recording them.

The table as a whole was then put and agreed to.

Table B 5.

The President.—It was understood at the November meeting that although we might not regard Table B 5 as ideal at the present time, yet that it ought to remain in the form proposed here until another annual meeting had opportunity of appointing a committee on the whole question of classification.

Dr. Urquhart.—The younger school of psychiatrists are generally of opinion that if the Association would wait for ten years an adequate classification would be possible; but the most advanced and hopeful of them say that in the meantime they are not prepared to make any suggestion. It is evident that we may proceed as the Committee has proposed with a classification, expressed in terms of symptoms and time, and in the simplest possible words. The objection to adding pathological forms of insanity has been that it is thereby made an absurd classification; but if it were distinctly understood that the symptomatic groups were one thing, and such pathological forms as we have been able to detach were another thing, I think we might very well accept this classification for quite ten years to come. A proposal which I made to the Committee, and which I make to-day, in accordance with the papers submitted, is that there should be a distinct division between the congenital and infantile forms of insanity and the acquired forms—melancholia, etc. I should prefer if, in this particular table dealing with the admissions, the pathological group could be correlated with the symptom groups, so that it would be evident at a glance how many general paralytics had been received, and at what stage of the disease, differentiating melancholia from mania. Dr. Clouston, at our meeting in Scotland, was willing to accept this Table if the pathological groups were placed at the bottom, but he did not like the idea of placing them at the side. He could not recognise that any general paralytic could be an acute maniac. Yet in his clinical lectures he deals with general paralysis in the acute maniacal stage, and so on, taking the symptoms of general paralysis in terms of time and in terms of mental symptoms.

Dr. Carlyle Johnstone.—I second it.

Dr. Robert Jones.—It is an absolute impossibility and premature to have a pathological classification. What is the difference between acute delirious mania or acute mania and the nature and pathology of paranoia or acute insanity? If you come to speak of the pathology of general paralysis, Dr. Mott will tell you that it is due primarily to neuronic change, and that the other conditions are secondary, while Forbes-Robertson will say it is an arterial condition primarily, and that secondarily there are neuronic changes. By adopting this temporary classification we shall be doing the greatest service to asylum statistics and to ourselves. What does it matter? We know melancholia cases last a little longer and are equally fatal. I think, as far as our knowledge goes at present, the Committee have made an excellent suggestion, although capable of amendment. I think toxic cases may be mentioned.

Dr. Newington.—One reason the Committee have taken the course they have is to prevent what is absolutely impossible now, and that is an adequate debate on the classification of insanity. It was understood last time, subject to further remarks, that this Table was put up confessedly as a temporary Table, and that it should not be interfered with except by the direct authority of the Association acting through a committee. If we begin to give our opinion as to causation of insanity we shall never finish. I think it would be a fraud on Dr. Mercier if we interfered with this Table, because he is away, and he is under the full belief that it is to be left alone until the Association appoints a committee to deal with it. We certainly are not strong enough to-day to deal with it.

Dr. Drapes.—It has been stated that this classification would hold good for ten years. I think nearer a hundred years will be required before we can arrive at a scientific classification of insanity, because it is only a symptom after all. You cannot classify it any more than you can classify cough. Everybody will be agreed that it is best to adopt this classification, imperfect as it is, rather than make any

serious alterations in it. Still, there are two or three things that I think might be improved. One of the principles which the Committee started with was guarding against ambiguities of expression. But delusional insanity is as ambiguous as anything you can mention. I understand the Committee to mean that what formerly was called monomania or paranoia is now to be "delusional insanity." But we may have delusions as well in acute mania, or melancholia, or general paralysis. And if you get a case with delusions, under which of these heads will you place it? If delusional insanity is to be in future the term for what we now know as paranoia, then put "systematised" before it, and we will know what we are talking about. I maintain that dementia is the same thing, whether it occurs from organic disease such as tumours or coarse disease, or whether it is senile, or whether it is secondary. I do not see the object of putting dementia in that first section of the classification instead of in its proper place where dementia properly comes, at the bottom. It would be better if we had all dementias classified together in one group, and not separated. I do not think that primary dementia should be there at all. Dementia should be limited to incurable conditions.

The PRESIDENT.—Dr. Urquhart's amendment is, "That the congenital and infantile conditions be separated from the acquired, and reported in terms of symptoms and time, and correlated with the pathological groups of general paralysis, epilepsy, and other organic cerebral diseases."

On being put to the vote, 2 voted in favour of the amendment and 10 against.

Dr. DRAPES.—I move that the word "systematised" be placed before "Delusional Insanity."

Dr. KIDD.—I second that.

On being put to the meeting, 3 voted in favour and 6 against.

Dr. DRAPES.—I beg to move that Dementia from Coarse Brain Lesions be placed under the others.

Dr. ROBERT JONES.—I second that.

Dr. URQUHART.—I feel very strongly that this should not be done. The Committee have first entered Epileptic Insanity, General Paralysis of the Insane (two very distinct pathological conditions), and then Dementia from Tumours, Coarse Brain Lesions, etc., all three being probably perfectly distinct from the succeeding groups of mania, etc. I cannot understand why the Committee object to dividing these forms into Congenital and Acquired, as they made such a point of doing so in other parts of their work; and I would also say that anybody could write in any fancy names he liked, under the most appropriate headings. I think this is as good a solution of the difficulty, next to mine—(laughter)—as can be arrived at, and I hope it will be accepted now.

Dr. YELLOWLEES.—The reason for putting Dementia there was exactly what Dr. Urquhart stated, and I think it was largely in deference to Dr. Urquhart's views expressed to us that we placed it there in close connection with diseases the pathology of which was practically known. I do not know why we omitted Paralysis as a form of coarse brain disease. It is certainly the most frequent cause of that "paralytic dementia" which Dr. Craig, following others, identifies with general paralysis—a serious confusion, which is greatly to be deprecated. I think that "senile" ought to have been put in after "secondary dementia."

The PRESIDENT.—The amendment is, "That Dementia from Tumours and Coarse Brain Lesions, etc., be put at the bottom of the table."

On being put to the meeting, 6 voted in favour and 7 against.

Dr. THOMSON.—Do I understand that we are committed, out of deference to Dr. Mercier, to these terms for classifications for years to come.

Dr. NEWINGTON.—No, but it would be such an awful matter to alter a classification to suit everybody.

Dr. THOMSON.—But why introduce these new terms, such as Alternating Insanity, and Delusional and Volitional? That is not scientific at all. These are forms of mania and melancholia as we understand them. You cannot diagnose alternating insanity on admission. I suggest that, if this classification is temporary, we should adhere to our generic terms, Mania, Melancholia, etc. The English Commissioners, in their Death Tables, have very wisely dealt with Mania and Melancholia together. We constantly meet with cases in regard to which we cannot say whether they are mania or melancholia. I beg to move that the new-fangled ideas in this table, such as Alternating, Delusional, Volitional, and Moral

Insanities, should be deleted. They are all mania. I would not put figures under Alternating, Volitional, or Delusional. Stupor I am in doubt about.

Dr. BOYCOTT.—I second that. The Commissioners have adopted certain forms, and I do not know whether they will alter them.

Dr. NEWINGTON.—We think it very likely that they might.

Dr. CARLYLE JOHNSTONE.—Will the Committee say what is meant by alternating? Does it mean recurrent?

Dr. NEWINGTON.—Folie circulaire.

Dr. URQUHART.—Should it not be so stated? I understood it meant folie circulaire or recurrent. Dr. Thomson says you cannot diagnose that on admission, but surely we should ascertain whether it is recurrent or not. Once more I think we should ask the Committe to define their terms.

Dr. YELLOWLEES.—It would be extraordinary to adopt Dr. Thomson's amendment. I should be very much startled, because to each one of us they all three mean something quite definite and recognisable. Moreover, other men know what we mean when we so speak. Gentlemen question alternating insanity. Certainly that means periods of depression and periods of exaltation alternating with a shorter or longer interval. We did not adopt *folie circulaire* because it is a French term, and the English term we consider better. As to Volitional Insanity, insane hesitation and insane impulse cannot reasonably be included in Mania. Where can you put insane perversions except under Moral Insanity? We know what we call Delusional Insanity, and that it is not mania. There is no excitement about the person, and you allow him to go about; yet he is as insane as he possibly can be. It is a condition so definitely and universally acknowledged, that it should certainly be expressed here. I cannot understand upon what principle those three should be cut out. We cannot classify, but we can so arrange our nomenclature that it shall indicate certain mental conditions with which we are all familiar, the groups in which we almost unconsciously arrange our patients. I think so long as these groups are definite, and sufficiently understood by ourselves and all other alienists, that we should maintain them. They are not pathological groups. It is not a scientific classification. None of us pretend that we can work out a scientific classification with our present knowledge.

Dr. URQUHART.—Will Dr. Yellowlees kindly inform us whether recurrent mania or melancholia should be entered, and if the Committee will undertake to make it perfectly clear what is meant by the words used?

Dr. DRAPES.—That is a different question from the amendment before the meeting.

Dr. URQUHART.—I ask it as arising out of the term alternating insanity.

Dr. YELLOWLEES.—Each superintendent must decide for himself, and say this particular case is alternating, or recurrent, or relapsing, and if he cannot regard it as an alternating case he must place it as one of mania.

Dr. EASTERBROOK.—I suggest the term alternating and recurrent insanities.

The PRESIDENT.—Dr. Thomson's amendment is before the meeting.

On being put to the meeting, two voted in favour and six against.

The PRESIDENT.—I declare the amendment to be lost.

Dr. NEWINGTON.—I beg to move that the table be put as it is.

Dr. ROBERT JONES.—I second Dr. Newington's motion.

Dr. URQUHART.—I move that the word "recurring" be added to "alternating."

Dr. CARLYLE JOHNSTONE.—I second it.

On being put to the meeting, four voted in favour and nine against.

Dr. EASTERBROOK.—This is a table showing the form of mental disorder, and you introduce duration as a new idea. Duration is dealt with in the previous Table B 2, and I move that "recent and chronic" should be omitted here. If they are retained we should introduce also "subacute," because the "period of one year" in insanity is too long for recent, and yet it is too short for chronic.

Dr. BOYCOTT.—I second the motion.

Dr. DRAPES.—I think the confusion arises in connection with "chronic," as involving the double meaning of duration or intensity or curability. I agree that there should be a subsection for subacute.

On being put to the meeting, there voted in favour two, and the amendment was lost.

The PRESIDENT.—Therefore I now put Table B 5.
Nine voted in favour, and one against.

TABLE B 6.

Dr. URQUHART.—Will the Committee give us a little information about this table? For instance, our General Secretary required definite information relating to lead workers. Will any of the Committee kindly tell us where lead workers find a place here? There are others, squires of the land, and tramps without visible means of support. There is also the publican, who is entirely occupied with selling drink, provocative of questions as to environment; he is included in "Board, Lodging, and Dealing in Spirituous Drinks." What we want is the exact occupation of persons coming under care, with the exact instructions where they are to be placed under these headings in the table.

Dr. ROBERT JONES.—It would be well if the Secretary or the Chairman of the Committee would give us some little information. I think that this table was extracted from the tabulated occupations of the census; if so, it should be most comprehensive and inclusive, with the details as seen in the original table of census occupations.

Dr. BOND.—The table as set forth gives precisely what Dr. Urquhart is anxious to obtain. In each of these subdivisions you will see a numeral. For instance, take J, "Metals, Machines, Implements, and Conveyances." Then under that take c, or, as we should indicate it, J c 12, "Engineering and Machine Making." The numeral 12 indicates that in the Registrar-General's list of occupations there are twelve subheadings, the names of which, of course, it would be impracticable to have printed here. To compile this table one requires an index of occupations from the Registrar-General's return, which latter fortunately is the same for the three kingdoms.

Dr. URQUHART.—There is nothing about all that in this report.

Dr. BOND.—The Committee felt that the labour necessary to tabulate all the individual occupations found in the admissions would be too great. They did get a mandate on the question. We have not had a chance of again consulting the other two boards.

Dr. URQUHART.—I move that we do not accept this table until full information is before each member of the Association.

Dr. CARLYLE JOHNSTONE.—I second that.

Dr. YELLOWLEES.—I think Dr. Urquhart is a little unreasonable. Is it not true that our insane people are drawn from all classes of the community? And to include all the occupations which people can be engaged in would imply a list of quite impossible lengths. Let us take out of the complete list what each man does.

Dr. URQUHART.—Until we get that complete list we do not pass it.

Dr. YELLOWLEES.—It is already published in the census returns. This table is a mere synopsis, to show how wide that document is. If we printed it, it would take more space and paper than we can afford. I think that we make too much of the occupations. I would be content with the divisions in our first report, because, except in special cases like lead workers, occupation has little to do with the insanity. It is certainly not of so much importance as to require such an enormous table. I do not see how we can get what we want, except in the way we propose.

The amendment was put to the meeting, and two voted in favour, the majority being against.

Dr. BOYCOTT.—I suggest division into twelve headings to get the information required.

Dr. STEEN.—I move as an amendment that the ages be omitted.

Dr. CARLYLE JOHNSTONE.—I second that.

Six voted in favour and eight against.

Dr. BOYCOTT.—I move that columns be added for ages under ten.

There being no seconder, the amendment dropped.

Table B 6 was then put, and carried by eight votes against two.

TABLE B 7.

Dr. BOYCOTT.—I move that this table be omitted, as the necessary information is contained in Table B 8.

Dr. CARLYLE JOHNSTONE.—I second that.

Four voted for the amendment, nine against.

Table B 7 was then put, and carried by 10 against 1.

Dr. CARLYLE JOHNSTONE.—I decline to vote, because the subject was discussed hurriedly and inadequately. ("No.")

The PRESIDENT.—The subject was discussed.

TABLE B 8.

Dr. BOYCOTT.—I move that Table B 8 shall, under the heading "Mental Instability," show previous attacks of instability, and that "previous attacks of insanity" be added.

Dr. KIDD.—I second that.

Dr. BOND.—The Table excludes previous attacks by referring only to first-attack cases.

On being put, the amendment was lost, 3 voting in favour, 7 against.

Dr. URQUHART.—One would desire to know what is the exact mind of the Committee about this Table. In the left-hand column we have a certain number of factors, and on the rest of the page we have got correlated conditions. Will the Committee say if they would regard the correlations as optional, and be content as a minimum with the left-hand column?

Dr. BOND.—The correlation is of extreme importance in the mind of the Committee. Recognising that it will require, to carry out this Table, considerable clerical labour, they did agree to limit the correlation to first-attack cases.

Dr. BEDFORD PIERCE.—We are not making speeches about these points, because we are leaving the time of the meeting to those who wish to ask questions. Would it compromise matters to consider part of the Table as optional?

Dr. YELLOWLEES.—This Table was divided and amplified so as to make it more intelligible, and as the result of representations from Divisions and from private persons. The extent to which it is used will depend altogether upon the energy and the inclination of the men who make it up. It is possible to give what you may suppose are the principal causes, and a list of contributory causes, such as those under the headings we have given. It is possible to do that and nothing more. But even that is something, and an important something, because it impresses the fact that insanity is not a condition due to any one cause, but the result, often, of two or three or many causes; and it is important to know and to notice with what chief causes the contributory causes usually occur. But it is going very much further if you correlate the contributory causes with each other, and if you are able to say, *e.g.* how often alcohol occurs with the climateric as contributing causes. I think there is thus very valuable information to be gained. The Committee all think it would be the right thing to do. I hope none will grudge the labour. The Committee is of opinion that those two tables would give us fuller information about the ætiology of insanity than other ætiological forms which we have been able to devise.

Dr. URQUHART.—Five causes demand twenty-five entries.

Dr. YELLOWLEES.—Yes, the entries number the square of the causes.

Dr. NEWINGTON.—The Committee are in favour of everybody doing it. The Committee must not be understood to allow laxity on this point, or on any other which is not marked "optional." We have to settle in regard to each case what the number of causes is. If in the course of our inquiries we only find two causes we can fill up the Register with two causes. But if we find five causes we are bound to put them down. The difficulty for us is to find the causes. The tabulation is clerical work and not difficult. But even if there is some trouble that trouble must be taken if the table is to be of any use. This Table makes us to put in every possible cause that can be found; and the truth with regard to the ætiology of insanity can only be learned by putting down every cause. If we find say only two causes it tells us something that we know already. We know, for instance, that drink and certain things go together, but we wish to do work which will go beyond what we now know. We want the enumeration and correlation of all the factors, so that when the great statistician comes along and finds all this information, his attention will be attracted to certain sequences of events. If we stop short we shall only be proving what has been proved a hundred times before. We want work which will lead to new ideas.

Dr. URQUHART.—Under the column "Ætiological Factors and Associated Conditions" Dr. Newington has very well said we want to record everything relative to the cases. Under "Heredity," in that column, we have "Insanity, Epilepsy, Neuroses, Eccentricity, and Alcoholism." I propose that heredity of paralysis should be reinserted.

Dr. CARLYLE JOHNSTONE.—I second that.

Dr. BEDFORD PIERCE.—I hope it will not be included.

Dr. ROBERT JONES.—I think that as the Committee have given so much time to this it really is an indication of considerable temerity that we should suggest that so many alterations should be suggested.

Dr. URQUHART.—But the Committee took it out.

Dr. BEDFORD PIERCE.—I was largely responsible for that, because I urged it was of very little importance from the point of view of heredity, and I said it was important that we should not make it longer than it was absolutely necessary.

Dr. URQUHART.—It is one of the most important factors.

The amendment was then put to the meeting, when 4 voted in its favour and 7 against.

Dr. URQUHART.—I note the expression "Mental Instability." How can this be an ætiological factor of the conditions which we are considering?

Dr. NEWINGTON.—Is Dr. Urquhart inclined to say that all forms of moral deficiency are insanity, or that all mental deficiency is insanity? If not, you have the two different quantities, the preceding or the associated condition and the overt disease. I can understand his argument if eccentricity is insanity.

Dr. URQUHART.—So it is.

Dr. NEWINGTON.—Therefore, all moral deficiency is insanity? If moral deficiency is not insanity may not we give it as an associated factor of insanity?

Dr. URQUHART.—If we know anything about the heredity of insanity we know that eccentricity is almost as productive of insanity hereditarily as is insanity itself. It is the inability of the person to conduct himself in accordance with his surroundings.

Dr. YELLOWLEES.—I regard this Division B as one of the most important of all the factors in the production of insanity. You first ask yourself what sort of a person was the patient before he became insane? You find he has been a man of uncertain mind, a man of unstable mental balance, and therein is the whole explanation of his illness. His mental want of balance did not come out fully until he became insane. It may have been only odd conduct or silly vanity until then. Is there anything unintelligible in that?

Dr. URQUHART.—Under heading B, I suggested before, and I think it was accepted by the Committee, that all the critical periods of life should be inserted as puberty, adolescence, maturity, climacteric, and senility. Why do the Committee decide to omit the stress of maturity, a period when men, and most women, are labouring under the greatest stress? I move its insertion.

Dr. CARLYLE JOHNSTONE.—I second it.

Dr. NEWINGTON.—Surely maturity can hardly be given as a cause. Immaturity might be. Real maturity implies the perfection of health; the period of greatest strength, both physical and mental.

The PRESIDENT.—I put this amendment to the meeting for the insertion of the word "Maturity."

Two voted in favour and 11 against.

The PRESIDENT.—I now put Table B 8 again.

Ten voted in favour, 2 against.

TABLE B 9.

The PRESIDENT.—The next is Table B 9. If there are no amendments I put it. Agreed.

TABLE B 10.

Dr. URQUHART.—Again in the pursuit of information I ask on whose suggestion and by whose authority this Table has been prepared. It is impossible now, at 4 o'clock in the afternoon to discuss this effectively. Was it prepared in accordance

with the views of some expert in biology? The collateral mental affections of the children and grandchildren are omitted, but the children, sane and insane, are often the very persons about whom you can get information, which afterwards becomes of scientific value.

Dr. ROBERT JONES.—There is much to be said with regard to Dr. Urquhart's remarks, although it is an optional Table. I have been in conversation with an eminent biologist in reference to it, and the reply was "Your statistics are absolutely valueless. You may ask how many insane relatives there are, but I want to know also how many sane relatives there are, so that I may know whether insanity is more common in the family under investigation than in the families of others not represented in asylums."

Dr. NEWINGTON.—Does not B 11 answer that?

Dr. ROBERT JONES.—That is not before us.

Dr. URQUHART.—Do the Committee take the responsibility for this Table? And were they assisted by any eminent biologist?

Dr. NEWINGTON.—I do not know whether Dr. Bond is an eminent biologist, but it was approved by the members of the Committee who were present, and it may be taken to represent the skilled labour of people who probably understand the matter. It may be desirable to go to an eminent biologist, but it is not necessary in order to get a decent working Table. You might as well get a statistician to add up your daily books.

Dr. BOND.—Some of the points which, I think, are in Dr. Urquhart's mind have been kept in mind in framing the Table, and after consultation with an eminent biologist. I have not authority to say more than that the question of consulting others has not been omitted.

Dr. URQUHART.—There is, therefore, a qualified approval of this most important Table?

Dr. BOND.—Not yet of the Table but of the principles upon which it was drawn up.

Dr. URQUHART.—The Committee take the full responsibility for it, and they put it before us this afternoon for final acceptance. I can only move in these circumstances that the Table be not adopted.

The PRESIDENT.—You can vote against it, which will be the same thing.

Dr. BOYCOTT.—Does it refer to all admissions or only direct admissions?

Dr. BOND.—It refers to whatever set of cases you elect to elucidate. The Committee were asked to suggest lines on which heredity could be better expressed than at present. It is optional, and strictly in accordance with promise, and to the best of our ability. Anyone who goes into the question of adequately tabulating heredity will find himself beset with many difficulties.

Dr. NEWINGTON.—It is shown in page 9 of the Report:—"Since it recognises that a really reliable inquiry can only be made by those who are more or less enthusiastic in working out intricate histories." That is the attitude of the Committee; they have done their best. Those who do not like it need not work it.

Dr. URQUHART.—The question is whether it is the best Table which could be obtained by this Association. We urgently desire to work out this Table if it is the best. There can be no more important question for us. But is it not a little premature for us, unaccustomed as we are to latter day questions in biology, to decide this afternoon whether it should be finally accepted? It is all very well to say it is an optional Table, but, for that matter, all the Tables are optional. Many of us desire that the Committee should give us the best they can obtain by their own endeavours, and also by reference to other authorities. I do not like to vote against the Table, because it looks as if we were belittling the enormous amount of trouble which has been expended on it. I would very much rather refer it to the Committee for further authoritative criticism.

Dr. YELLOWLEES.—Being an optional table, it could be improved on from year to year if improvement were found to be desirable; and we should not occupy time in discussing tables which are optional. It is important to discuss those which are essential.

The PRESIDENT.—I now put Table B 10.

Carried.

TABLE B 11.

This was put, and agreed to.

TABLE C 1.

Dr. YELLOWLEES.—Complaints were made at the last revision that C 1 was too meagre, and it is now much fuller, and I hope it will be more satisfactory.

Carried.

TABLE C 2.

Dr. BOYCOTT.—I move that the "total length of this attack of mental disorder" column be omitted from this table, *i.e.* all underneath the double black line.

Dr. ROBERT JONES.—I hope Dr. Boycott will withdraw that. With regard to prognosis, it is most important we should have the duration of the mental disorder. Much more remains to be said, and it is only by statistics of this kind, correlated from the various asylums, that we shall get the information.

There being no seconder, the amendment dropped, and Table C 2 was put and carried.

TABLE C 3.

This was put, and carried, without discussion.

TABLE C 4.

The PRESIDENT.—It is arranged precisely as Table B 7, except that the columns for the congenital cases will be omitted.

Dr. BOYCOTT.—I propose that this table be omitted. I spoke before with regard to the previous table of a similar nature, and I thought it might be omitted. All the information necessary could be got from the next table, slightly altered, that is C 5.

Dr. STEEN.—I second that.

Dr. YELLOWLEES.—This table was urged upon us from various quarters to meet the inquiry, what kind of cases recover? What are the causes of insanity from which you derive most recoveries? It is a right and proper question. What is the use of telling us about your recoveries if you do not tell us what kind of insanity was recovered from, and what caused the insanity? I do not see that we can refuse that, if we want anything like complete information about our cases. It is not so serious as the Admission Table B 7, because it applies to a smaller number of patients, and I do not see that we can omit this without destroying the completeness of the tabulation.

Dr. ROBERT JONES.—Would you not get this in the next table (C 5)?

Dr. BOND.—It is limited to first attack cases.

Dr. BOYCOTT.—It might be altered to include all.

Dr. BOND.—Personally I have done these correlations for some years, and I know exactly what the labour is. The saving of labour by limiting the work to first attack cases is considerable. And, conversely, the labour of including your congenital cases, not-first-attack cases, and cases unknown whether first attack or not, would be very considerable, and of doubtful value, because the cases where you do not know whether it was the first or not first attack, if at all numerous, would vitiate any deductions.

Dr. BOYCOTT.—I remember proposing in the previous table, B 8, that the addition should be made of a small heading showing the previous attacks in that table. And in altering the heading of the table to cover all cases it would show those which had previous attacks, and they would be one of the associated conditions of the insanity. And the same with the recoveries. By a slight alteration of Table C 5 it would cover all cases of recoveries from all possible conditions. I think you would get full information without Table C 4.

Dr. BOND.—Yes, but with infinitely greater labour. All you ask the printer to do is to put in an additional column vertically and one horizontally. But for the compiler of the Table, you will include immediately all your cases which are not-first-attack cases, and you are asking him to give the total correlations for each of those. We did that originally, and it is with the view of saving labour and conducing to accuracy that we have put the Table into two forms instead of one.

On being put to the meeting Table C 4 was carried by 8 against 2.

TABLE C 5.

Dr. BOYCOTT.—I propose that it be not optional. I think that B 8 and C 5 are the most important tables in the report.

Dr. BOND.—*Qua* the recoveries?

Dr. BOYCOTT.—As Dr. Yellowlees has said, we want information as to the kind of cases which get well. But this table does not show the classification of insanity.

Dr. YELLOWLEES.—I agree it is important, but it demands a full correlation of all contributing factors. I am sure, with all respect to my *confréres*, very many of them will not do that full correlation, and therefore Table C 5 will not show it. I agree that the table cannot be compulsory.

Dr. BOND.—These tables were not in our original report, but representations were made to the Committee that they should be adopted. We felt, as a Committee, that we should compromise, that we were bound to do so.

Dr. BOYCOTT.—I move that the word "optional" be omitted.

Dr. CARLYLE JOHNSTONE.—I second that.

On being put to the meeting 3 voted in favour of the deletion of "optional" and 4 against.

The PRESIDENT.—I now put Table C 5 as it stands.

Carried.

TABLE C 6.

Dr. BOYCOTT.—It is an optional table, and seems to be a very long one, and it requires a lot of work. Is it worth while including this table among the tables of the Association or not? I move that it be omitted.

Dr. STEEN.—I second that.

Dr. URQUHART.—I would deprecate omitting that table. It is marked "optional," and I take it that these tables are preferred for the general guidance of the Association. It might happen that some worker might want to elucidate this particularly. The word "optional" signifies that it is not of the first importance to the Association.

Dr. YELLOWLEES.—I hope it will be kept, because it brings a strong point before us, namely, the duration of the attack, no matter where it was treated, or whether it was treated or not. And as it refers only to the recoveries it is not a very large table.

The Table was then submitted to the meeting, and, by 8 votes against 2, retained as optional.

TABLE D 1.—*Causes of Death.*

Dr. URQUHART.—This is again a question of definition of terms. I suggest that "principal" means intensity, and that "primary" expresses time. We have to return deaths to the Registrar-General for Scotland under the headings "Primary Cause" and "Secondary Cause," which are comparatively easily determined. The principal cause and contributory cause are not quite so easily dealt with. Unfortunately the Registrar-General in Scotland selects one single cause, and of course that selection must be left to himself. I do not see that we can alter our attitude towards the Registration Acts by accepting the words "principal" and "contributory," and I feel sure that in Scotland we shall continue to use the terms "primary" and "secondary."

Dr. ROBERT JONES.—That is a very important point. However many causes are put in, only one cause is used by the Commissioners, and I think it is very important to have principal and contributory causes, for this reason: one has frequently to certify causes of death in cases of general paralysis of the insane, in which the immediate cause of death was broncho-pneumonia. The principal cause would probably be broncho-pneumonia, but the condition from which the patient was suffering primarily was general paralysis. You would say then that the contributory cause was broncho-pneumonia. It is a better classification than into primary and secondary.

Dr. NEWINGTON.—There are many instances in which difficulty does arise, and people use the term secondary in two ways, although they are supposed to use it in point of time. Take the case of a general paralytic committing suicide. In such a case as that all those difficulties are enormously raised from point of time, and not altogether removed from other considerations. It is difficult to say which is the

principal cause. Perhaps Dr. Bond will be able to tell us more about the words chosen.

Dr. BOND.—It is of paramount necessity to express the age at death. We must have a table which will express age at death combined with the cause of death. That compels us to select one cause of death, as the Commissioners ask us to do, and as the Registrar-General does. We found that the words "Primary" and "Secondary" did not indicate which was to be selected, because of the two senses in which those words are used. "Primary" strictly means in point of time, but very many people use the terms differently, and take it that "primary" means principal. We therefore thought it best in the Tables to use the words "Principal and Contributory." The Registrar-General in compiling his tables does what we do here. He does not use the words "principal and contributory," but he virtually does that when he selects one cause from among those which are returned to him; he selects that one which is in his mind the principal cause. We do not know what determines his decision.

Dr. YELLOWLEES.—I think the three Death Tables should be taken together. The second one gives the principal cause of death, with the age at death, and the third gives what was so much desired at the last discussion, the form of mental disorder on admission in the cases who died. It was specially asked by our Secretary, and by some others, on account of the definite view as to its value in regard to life assurance. The form of disease under which the patient laboured, and the length of his life during that disease, was asked to be given.

Dr. YELLOWLEES.—They do not mean anything special; they merely indicate any kind of illness which you find contributory to the death.

Dr. URQUHART.—If there were entered in these columns the different bodily systems (cardio-vascular, etc.) one would understand them.

Dr. NEWINGTON.—These were selected as things which did occur, and this question has been debated by the Committee not once, but at least six times. These points have all been carefully considered.

Dr. BOND.—Space was left there so that there should be no mistake that the figures which expressed correlation referred to the total incidence, and not one or other of the two columns. I would mention that as a matter of fact those selected causes *are* in a very definite order, namely, the order of the Registrar-General. The actual systems are not expressed, such as "cardio-vascular" or "respiratory," but if the names of the diseases are looked at again they will be found to be in a strictly scientific order.

Dr. URQUHART.—I note the cause of death "as grouped by the Registrar-General and using the nomenclature of the Royal College of Physicians." Of course the nomenclature of the Royal College of Physicians in relation to mental disease is very unsatisfactory.

Dr. NEWINGTON.—There is a new edition coming out shortly.

Dr. URQUHART.—Would it not be possible to give the College of Physicians a lead in this matter of nomenclature as applied to mental disorder?

The PRESIDENT.—They have had a Committee sitting during the last two or three years, and their Report is coming out shortly.

Dr. NEWINGTON.—We have not proposed nomenclature dealing with the cause of death.

Dr. URQUHART.—I thought you had proposed general paralysis as a form of mental disorder? We adopted that and epileptic insanity.

Dr. NEWINGTON.—That is a view which had not struck me, but now you have put it, I think the Committee are against putting anything like a mental cause of death. In England the Registrar General has been trying to get from us a mental cause of death, and the superintendents have objected to that, and we want to eliminate anything referring to mental disease from the return of the death.

Dr. URQUHART.—When I served in English asylums a very common cause of death was "exhaustion from melancholia or mania." But, although you say there is no such thing, the College will have their list, albeit we do not desire to name insanity in our returns. You have got general paralysis, you have got epilepsy. I move an amendment that we use our own nomenclature as far as necessary.

The PRESIDENT.—Our own nomenclature for mental diseases?

Dr. URQUHART.—Yes.

There being no seconder, the amendment was not pursued.

The PRESIDENT.—I now put Table D 1.
Five voted in favour, and none against.
Table D 2 and Table D 3 were carried without discussion.

TABLE E 1.

Dr. STEEN.—I propose that the word "optional" be placed after this table. I do not see what benefit is to be derived by going over all the patients in the asylums. It is a tremendous labour, and I do not think that any good purpose has been served by it in the past.

Dr. BOYCOTT.—I second that.

Dr. YELLOWLEES.—In what way do you know the ages of the patients? Is there any return made to the Commissioners at the end of each year giving the ages of the patients?

Dr. ROBERT JONES.—I think so.

Dr. YELLOWLEES.—So this is the information required?

Dr. NEWINGTON.—The matter in the horizontal line is all old material, which we do year by year. The only point is as regards the correlation. The clerk will do it.

Dr. BOND.—Does not the Table give rather a striking picture of the cases? It is of very little value, to know how many there are aged between sixty and sixty-four, fifty and fifty-four, etc., unless you know the duration of the attack. But if you know the duration of the attack, in addition to the present age, you have a useful picture of your asylum population, and you are able to compare two asylum populations clearly, with remarkable effect and avoidance of all ambiguity of terms.

Dr. BOYCOTT.—It is of no scientific value.

Dr. STEEN.—I suggest that the picture is not worth the painting.

On being put to the meeting, 3 voted in favour of the word "optional" being added, and 5 against.

Dr. BOYCOTT.—I propose as an amendment that the first column "Total Duration of Present Attack of Mental Disorder" be omitted.

Dr. STEEN.—I second it.

Dr. ROBERT JONES.—A paper was lately read by Sir William Gowers to the Medical Officers Life Assurance Association, and he called upon our President and several others to take part in the discussion, so that they might give some information as to the duration of life in the various forms of insanity. I think if this table were allowed to stand as it is one might get some assistance. I see that the form of insanity is not stated, it is merely the patients in residence.

The amendment was put to the meeting, when 4 voted in favour, and 5 against.

Dr. BOYCOTT.—The last age given in the table is "70 and over." If you give a picture at all you should go higher than that age, because one of the great questions in asylums is in regard to the senile cases, and if you give a picture at all of any ages, it is as well to give the highest ages which are in residence.

Dr. BOND.—I suggest, then, that it should be agreed to continue the quinquennial periods beyond the age of seventy.

The proposition was agreed to.

The PRESIDENT.—I now put this Table E 1 as altered in that way.
Carried.

TABLE E 2.

Dr. STEEN.—I propose that this be regarded as optional. I think the return arrived at by giving every case on the 31st December is never a true one. It is done in a hurry, and is of no value.

Dr. NEWINGTON.—I may mention that "Prospect of Mental Recovery, Favourable, Doubtful, Unfavourable," were inserted as the result of a pledge. We were asked to state those facts as to prognosis.

Dr. ROBERT JONES.—I have persistently declined to give this information in the annual tables for Claybury, and have had a long correspondence with the authorities. At best it is only guess work, and I have been talking to Dr. Savage about it, and he told me that even in cases of general paralysis, and the cases of what seemed to be typical alcoholic dementia regarded as irrecoverable, that you should never give an unfavourable prognosis. Therefore, to make us guess as to whether a case is

favourable, or doubtful, or unfavourable, suggests a prophetic power which we, as medical officers, have not got.

Dr. YELLOWLEES.—When you have doubt, why not call it doubtful? It is very important, partly from an insurance point of view, because it refers to the residuum of the asylums, and nine-tenths of them are dements. It seems simple, and it is worth rendering the information for insurance considerations.

Dr. THOMSON.—You supply this same information to the friends daily.

Dr. STEEN.—It has been stated that this return goes to the Commissioners.

On being put to the meeting, 2 voted in favour of the Table being made optional, and 6 against.

Dr. URQUHART.—This Table refers to the form of mental disorder on a particular date. It has no relation to the mental disorder on the admission of these persons. I have always thought it was very important to see the drift of these cases from their admission towards the date of their departure.

Dr. YELLOWLEES.—It is given in the Table D 3.

Dr. URQUHART.—It does not refer to this point. Why have the Committee thought it of insufficient importance?

Dr. NEWINGTON.—In the former tables it was the intention of the Committee to record the form of the mental disorder on admission in the residue; but many asylums treated it as we have treated it now. It was open to two constructions, either the form of mental disorder on admission, or at the time of the report. So, to avoid doubt, we have now decided as reported.

Dr. URQUHART.—I move that the mental disorder on admission be entered into this table in another column.

Dr. ROBERT JONES.—It gives no indication of the progress of your cases if you go back to what they were. You want to get information for your committee, or for administrative purposes, that you have so many cases of epilepsy, so many cases of dementia, and such may possibly be adolescent mania on admission. It would give you no information after the lapse of many years to have the form of insanity on admission stated.

The PRESIDENT.—I will now put Table E 2.

Carried.

CIVIL REGISTER.

Dr. URQUHART.—With regard to the Civil Register, the headings are not appropriate to Scotland. I do not suppose——

Dr. YELLOWLEES.—It was understood that the Civil Register would be arranged according to the civil laws of the three divisions of the kingdom.

Dr. URQUHART.—It is not so stated.

Dr. YELLOWLEES.—You cannot alter the law of the country.

Dr. URQUHART.—We have nothing to do with the date of the reception order or of the continuation order, or with the irregularity of the order. We do not know what a criminal is. I ask what is in the minds of the Committee, for the guidance of the Association. They are bound to define these terms and to tell us what they mean. Is it proposed that we should enter criminals in the registers? And if that be intended we should know what is exactly meant by a criminal. Then we have a column headed "Usual place of abode." What does that mean? The town, the parish, the number of the street, or the county, or what? Similarly there is another column headed "Whence brought." I hope the Committee will now set questions of that sort at rest.

Dr. NEWINGTON.—The registers which we are now considering differ essentially from the tables we have been considering. We can adopt the Tables as an association, but these registers must be the result of a conference and an agreement with the Commissioners. This Civil Register, although we put it as a specimen, must be adapted to the requirements of England, Scotland, and Ireland.

Dr. URQUHART.—I can only consider it for the purposes of Scotland when it is set forth in black and white.

The PRESIDENT.—You do not have continuation orders in Scotland.

Dr. CARLYLE JOHNSTONE.—It is not suitable for Scotland.

Dr. YELLOWLEES.—It was known we could not prepare a form which could bind any of the authorities; they are already bound by laws, and they must follow their own law in the Civil Register. It is only here as showing the completeness of the

registration, and we are thankful to give them the Civil Register and to let them put anything they like into it. We want the medical register, and this is submitted simply that you may see what is the English civil register. The Scottish register would be different, and the Irish would again be different. It is not in our power to approve or disapprove, that is beyond our sphere, and is in the hands of the boards of the respective countries.

Dr. URQUHART.—You have given no explanation of the word "criminal."

Dr. NEWINGTON.—Have you got a Scottish explanation of it?

Dr. URQUHART.—I want the Committee's explanation.

Dr. NEWINGTON.—A criminal lunatic, in the ordinary acceptation of the word, is subject to legal explanation given by the various authorities. We cannot give a definition of that. A criminal is one who would be deemed a criminal lunatic by the Commissioners in their report. We do not invent an explanation, and we do not know any other term.

Dr. URQUHART.—Is a criminal lunatic always a criminal lunatic?

Dr. ROBERT JONES.—No. A person may be sentenced to a year's imprisonment, and while undergoing sentence become insane. He is taken to the county asylum, probably to the county asylum where he is chargeable to. During the time of his sentence the prison commissioners pay for him. A month prior to the expiration of the sentence the clerk of the asylum in which he is has to summon a justice, and an order is made for his continued detention if he is still insane, and he becomes chargeable to the parish. He is then paid for by the parish; failing a settlement he is paid for by the county. He ceases to be a criminal lunatic at the expiration of his sentence, and, speaking generally, I understand the term to apply to those whom the law takes cognisance of.

Dr. URQUHART.—We require the Committee to tell us in what sense all these words are used, so that we may each record on the same understanding.

Dr. NEWINGTON.—You must look up the definitions in the various parts of the kingdom. We should not want to differentiate between criminal and other lunatics, but we are bound to take cognisance of them here, because the law takes cognisance of them.

Dr. CARLYLE JOHNSTONE.—Is it not the case that the Commissioners in Scotland, Ireland, and England must approve of the new set of registers? And if that is so, we do not know anything about civil registers. What are these forms and registers which you wish the Commissioners to adopt.?

Dr. YELLOWLEES.—Dr. Carlyle Johnstone is mistaken. The Scottish Commissioners are perfectly aware that the Civil Register would be a legal document in each country, and would be arranged according to the legal requirements of each country. Nobody thought anything else. I do not know why we should be wasting time over a register we cannot alter; we are not altering it at all. The Civil Register is a thing over which we have no control. Our report would have been absurd without some form of Civil register as against the Medical Register, to show that the history of the patient is complete. The Civil Register is the medico-legal record of his existence under care as an insane man; the Medical Register is the register of the medical facts about him. We have nothing to do with the first, but we have everything to do with the second.

Dr. URQUHART.—I move that the words "Not applicable to Scotland" be printed under the words "Civil Register."

Dr. YELLOWLEES.—Why not say, "This Register must conform to the laws of the countries concerned"?

Dr. CARLYLE JOHNSTONE.—I second Dr. Urquhart's amendment. We have a general register in Scotland, and the Committee apparently proposes to alter it.

Dr. YELLOWLEES.—We never proposed to alter the Scottish register; we could not if we did. The Commissioners are tied to it. The civil register must be according to the Acts of Parliament under which they exist, and we have no power to touch it.

Dr. NEWINGTON.—Dr. Urquhart will find it in a former report. We do not, of course, explain to the Association what ninety-nine out of every hundred people know, namely, that we propose a division of the register into two elements. The first must be regulated by the law. It will require a reference to Parliament to alter either the English, the Scotch, or the Irish Register, and, in the course of

alteration, surely this matter will be put straight; and it is arguing a very small point.

Dr. URQUHART.—What is the question before us, Mr. President?

The PRESIDENT.—I understand there is a Civil Register in Scotland, and it is a new principle to introduce it into England, and I gather that the recommendations of the Committee mainly apply to England in this.

Dr. URQUHART.—I have moved as an amendment that under the words "Civil Register" the words "Not applicable to Scotland" be inserted.

Dr. NEWINGTON.—Shall we say it is liable to alterations in the three kingdoms?

Dr. URQUHART.—Yes.

The PRESIDENT.—Do you withdraw your wording in favour of that suggested by Dr. Newington? It is, "This will be liable to alteration to meet the authorities of the law in each kingdom."

Dr. URQUHART.—I agree to that.

The PRESIDENT.—I put this amendment now.

The amendment was put to the meeting and carried.

Dr. BOYCOTT.—Is this the present Civil Register of England, or is it the revised one?

Dr. NEWINGTON.—It practically agrees with what the Commissioners have asked. We have seen them twice on this point.

Dr. BOND.—And the Scottish Commissioners were willing to do it in the same way.

Dr. YELLOWLEES.—The Scottish Commissioners said there would be no objection to dividing their registers into civil and medical.

Dr. ROBERT JONES.—Does this Civil Register agree with Register "A" of the Lunacy Commissioners?

Dr. BOYCOTT.—With the statutory Register of Admissions which the clerk has to keep?

Dr. NEWINGTON.—This is half of it, the civil half amplified.

Dr. BOYCOTT.—In the sixth column it says, "Date of Continuation order." This should be date of *last* continuation order, because it goes on for different years. What you want is the date of last continuation order.

Dr. THOMSON.—I second that.

Carried.

Dr. CARLYLE JOHNSTONE.—Is "religion" to be put in the Civil Register?

Dr. YELLOWLEES.—We have no power to amend it at all.

Dr. NEWINGTON.—I do not think the religious persuasion is in the Register itself, but is in the list of questions in the Statement of Particulars.

Dr. URQUHART.—Why did the Committee omit it? I submitted to the Committee that it was highly desirable, especially in Ireland, that religion should be noted in the register. It has been left out, and I have no doubt it has been left out after the full consideration of the Committee. Might we now ask for their reasons.

Dr. BEDFORD PIERCE.—I think you might just as well ask a man's politics.

Dr. DRAPES.—I think it is very important.

Dr. ROBERT JONES.—It is in the statement accompanying the patient coming to the asylum, and if there it should have some place on the Register.

Dr. URQUHART.—I move that it be entered here.

Dr. YELLOWLEES.—We have no power to alter the Civil Register. This is wasting time, because we have no power to alter it in either country. We have suggested some things to the English Commissioners, and they have met us most cordially. We should go on to the medical parts of the Register.

Dr. CARLYLE JOHNSTONE.—In Scotland we have one general register, and the Committee propose to upset that altogether. And they have brought forward two instead, namely, the civil and the medical. Yet they say they cannot touch the Civil Register. There is no Civil Register as yet properly speaking.

Dr. ROBERT JONES.—I do not know where we are in this matter. If we have no power to alter the Civil Register, and it is statutory, why is the recommendation of the Committee made suggesting that alterations should be effected.

Dr. NEWINGTON.—These are not very important points. It is most important to us that we should get through our work to-day. Our quorum is so small now, and it is a pity to wreck the whole of this scheme, and I am afraid it will be

wrecked on small points. I suggest that we take a vote on the question. It must be understood that we cannot put it in. You can only inform the Commissioners that it is the view of the Association that it should go in.

The PRESIDENT.—I will now ask for those who are in favour of inserting a column providing for the mention of the religious persuasion of the patient, to vote.

Five voted for the amendment and 4 against.

Dr. BOYCOTT.—Dr. Newington says we cannot alter these registers, that we have simply to ask the Commissioners in Lunacy if they will settle it. How long will that take?

Dr. NEWINGTON.—It will take eighteen months at least.

Dr. BOYCOTT.—If that is so I think we could employ that eighteen months profitably, while we are waiting for the Commissioners' dictum, in revising the Tables still further.

The PRESIDENT.—That must be brought up again at the Annual Meeting to-morrow, if you want to proceed with it.

Dr. BOYCOTT.—No, only the urgency is not so great as I thought it to be.

Dr. NEWINGTON.—The reason I say that it will take eighteen months is that the alteration of these registers will require a notice to be put on the Table of the Houses of Parliament and to lie there for a month. Parliament will be adjourning shortly, and, therefore, what has to be done will have to be done in the next session if the Commissioners agree. But neither the Commissioners nor we will go forward unless the ground behind us is absolutely certain, and in order to start this statutory action next year we must have finished this work. Therefore it is absolutely necessary to close it now, and if we open it again it will make it two and a half years instead of one and a half years of delay.

The PRESIDENT.—The principle of altering the form of the register was taken in November dividing it into civil and medical. The difficulty is about details. I now put it that the Civil Register as amended be approved, as far as we can approve it.

Carried.

MEDICAL REGISTER.

Dr. URQUHART.—Will the Committee facilitate matters by giving us a little information? What is an index symbol? What is decimal of a month?

Dr. NEWINGTON.—I can tell you that. Three days would be ·1 of a month, as near as may be.

Dr. URQUHART.—What about February? Why is not that explained in the Report? You see how to-day's proceedings have been lengthened out because we never knew what the Committee exactly meant.

Dr. NEWINGTON.—The Committee cannot be responsible for the failure of certain people to understand what should be perfectly clear.

Dr. BOND.—We agreed that an index of occupations would be necessary, and that it would facilitate tabulation if each occupation were provided with a numeral. But it will be still easier if, as explained already in the Report, that be not simply a numeral but a composite symbol. For instance, A *b* 3 would represent one particular occupation. The Association will be provided with an alphabetical list compiled from, and strictly in accordance with, the Census Returns, each occupation automatically providing its own symbol.

Dr. URQUHART.—I understand we are in future to have a list of occupations. We will reserve any discussion until we see the list. It might have been in our hands to-day, and I think it should have been. With regard to decimals of a month, in the interests of the men who have to make up the Tables, the expression should be in years, months, and days, not in decimals of a month. I move an amendment that the period be stated in days, and not in decimals of a month.

Dr. BOYCOTT.—I second that.

Dr. ROBERT JONES.—It is the usual thing to refer to the duration of an illness in days, not in decimals of a month.

The PRESIDENT.—I will put this amendment.

Five voted in favour of the amendment and 3 against.

The PRESIDENT.—That is carried.

Dr. BOYCOTT.—It says, "Form of Mental Disorder (no entry to be made here in respect of congenital cases)." Why is that?

Dr. BOND.—Because they are expressed already to the left hand in "Attack." I may say with regard to that, that at an informal meeting with the English Commissioners it was evident it had their sympathy. They are willing to take this as it stands in regard to that particular point.

Dr. BOYCOTT.—I propose that the "Congenital" column be taken from the Attack column, and placed just before the column headed "Instances of Epilepsy" in the class "Congenital."

Dr. DRAPES.—I second that.

Dr. BOND.—Anyone who has worked the tables from the Register would be glad to see the four columns together, "Congenital," "First Attack," "Not First Attack," "Unknown whether First Attack or not." If you separate them it will be a thorn in the hand of the clerk who will have to prepare the tables.

Dr. DRAPES.—I think it should be put immediately before Congenital, so that there is one entry and not two. Put the original congenital cases with epilepsy, or without epilepsy, and the others afterwards.

Dr. BOYCOTT.—I agree with that.

The PRESIDENT.—What is it?

Dr. BOYCOTT.—Instead of the column entitled "Instances of Epilepsy" in the class Congenital, I propose that there should be two columns, both put under the form of mental disorder, stating, one, Congenital with Epilepsy, and one, Congenital without Epilepsy.

Dr. BOND.—There is a danger there, because the cases would then have to be placed in both columns, and the inserter of the cases might be in doubt whether it should be so or not. The Committee would deprecate any ambiquity as regards the scope of any column in the Registers.

Dr. NEWINGTON.—That was in our original Report.

The amendment was put to the meeting, and 1 voted in its favour and 6 against.

Dr. URQUHART.—What is the reason that the homicidal cases are omitted?

Dr. NEWINGTON.—The necessity for putting it in never came across us in that relation. The question of suicide there arose from the form of the Schedule A of the English Commissioners, in which they ask "Suicidal?" and we put to them, as we put to ourselves, the question as to when a person was supposed to be suicidal, whether on admission, during the course of the care, or at the time of the Report, and so on. Eventually they agreed to leave it as it is here. Many of these cases come in which are reported suicidal by outside people who are not so, and it was to get rid of error in that way, and to fix the opinion as to suicidal tendency, that it was put in this form. But the question of homicide never arose in this connection, because it was not in the original document.

Dr. URQUHART.—"Dangerous to himself or others" I think applies to that, and you should complete this statement by saying which are dangerous to others in the opinion of the medical officer.

The PRESIDENT.—There would then have to be two columns.

Dr. URQUHART.—Yes, that is what I propose.

Dr. HYSLOP.—I second that.

On being put to the meeting, 2 voted in favour and 6 against.

Dr. URQUHART.—We have not yet considered the Heredity Tables in this relation. The proud boast of the Committee is, that you can find in the Registers anything you have to tabulate.

Dr. BOND.—Not necessarily the material for Optional Tables, they do not include that.

Dr. URQUHART.—Is it not worth while having them if there is space? One should enter the exact relationship.

Dr. BOND.—We propose in our Report a special register, which should be employed by those who carry out the Optional Heredity Table.

Dr. NEWINGTON.—You recommend that we have publication of the Table and the Report. It is not any use trying to get collaborated work on this point, you cannot get it in bulk, but you can get it in a Special Report.

Dr. URQUHART.—I shall regret if heredity is not noted in the Register, if there is to be any effort on the part of our members to prepare these optional tables.

The PRESIDENT.—I will now put the Medical Register as already amended.

Carried.

Register of Discharges and Transfers.

Dr. Boycott.—Is this a Civil or a Medical Register?

Dr. Newington.—There is no need nor opportunity to divide this in this direction. We have divided the present Register, as it now is in England. The facts of discharge and death are all recorded in separate Registers in Scotland, and we propose to follow this.

Dr. Urquhart.—What is meant by "Rate Paid"? Is it payment in part, or in whole?

Dr. Newington.—It is to get rid of the horrid word "pauper." In certain places, if patients pay a weekly maintenance rate, they are private cases. In others they would be still paupers. We use the word "Rate Paid" instead of "Pauper."

Dr. Boycott.—I have an amendment to the Register of Discharges and Transfers. It does not show the mental disorder of the cases which have been discharged, except in respect of those discharged recovered. I do not know whether it is desirable to have that in.

Dr. Bond.—It is desirable to leave it as it is, because no table asks for that information, and, as it at present stands, the information can be totalled. It states, "Columns to be filled in only in respect of those Discharged Recovered." If you add to that the cases which have been transferred from the asylum, or other cases which have been discharged and not recovered, those columns will not be capable of being totalled, which is a great assistance in making the tables.

Dr. Boycott.—I do not move any amendment, but I would point out that "Decimals of a Month" is given here again.

It was agreed to substitute "Days" for "Decimal of a Month."

The Register of Discharges and Transfers was agreed to.

Register of Deaths.

This was agreed to without discussion.

The President.—There are two or three other resolutions, not involving debate, which will be put to the meeting.

Dr. Newington.—I move the second resolution. It runs, "That the Association approves of the preparation by the Committee of Compilation Forms."

Dr. Yellowlees.—I second that.

Dr. Newington.—Here you have a form which makes it easy to collect facts.

The resolution was carried.

The President.—We now come to Resolution 3, which Dr. Yellowlees will propose.

Dr. Yellowlees.—I propose "That the Association approves of the principle of the gratuitous supply annually of the Definitions and Tables, and of Compilation Forms to the Institutions named in the Report, and to such others, and to such other persons or authorities as the Council may direct, if on further inquiry it shall appear that the expense thereof be not more than the Association can conveniently undertake." This means a recognition on the part of the Committee that these Tables are somewhat complex and troublesome, and that until we get somewhat accustomed to them it will not be easy to get all to compile them. The idea is that the Association should spend some of its money in issuing blank forms of compilation tables and definitions to each asylum each year. That is the resolution proposed by the Committee, and now submitted to the meeting. Of course it is a resolution which involves considerable expense. I do not know how much, and the matter would require a special sanction on the part of the Council, but it would doubtless be given if you approved it, and thought it necessary for the carrying out of the system in the Tables.

Dr. Urquhart.—I second that, if it is understood that all the equivocal terms which have been now explained by the Committee are included in the definitions which the Committee will prepare.

The resolution was put and carried.

Dr. Boycott.—Are they to be sent without request, or only at request?

Dr. Newington.—To be sent automatically to all asylums and registered hospitals, and private asylums of a certain size, and any others who may ask for

them, and also to Leavesden, Caterham, and other big places which the Council may point out. The asylums will all have a right to have them automatically sent, but some other institutions will have to ask the Council for them. It will be a considerable expense. Of this particular one, 2000 copies will cost £6; the next 2000 will cost £4, so that 4000 will cost £10, and they will last for twenty years. It may cost £70 or £80 to begin with, but that additional cost will carry us over four or five years, and possibly more.

Dr. YELLOWLEES.—The next resolution is somewhat of a personal nature. It is "That it be recommended to the Annual Meeting of 1905 that the Committee be reappointed for another year to facilitate the initiation of the scheme as finally settled, and that the Committee be empowered to confer with the proper authorities as to the date on which it shall come into action." It enables us to wait upon various bodies concerned, and to arrange as well as we can for getting these tables into use.

Dr. HYSLOP.—I second that.

Dr. BOYCOTT.—There is nothing else to be done, but I specially wish to express my strong sentiment that the Tables require a considerable amount of revision before they are passed.

The resolution was carried.

Dr. NEWINGTON.—No doubt to-morrow we shall hear a vote of thanks passed with acclamation and with heartiness to our President for his work during the year; but I do think that we want to pass him an *ad interim* resolution of many thanks, and great thanks, for the long and careful attention which he has given to the work, and for his very great skill in piloting us through not only to-day, but in November. I move a very hearty vote of thanks to our President for his conduct in the Chair at this adjourned Annual Meeting.

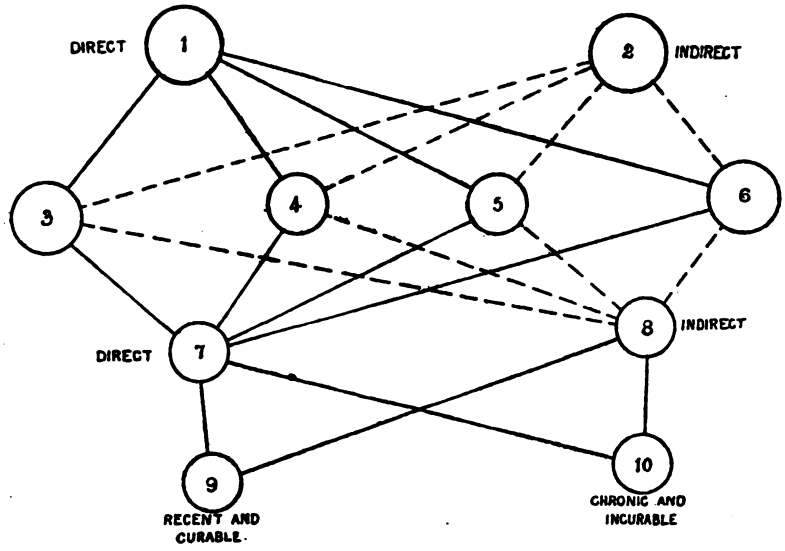
Dr. ROBERT JONES.—May I have the privilege of seconding this resolution which has just been proposed by our Treasurer? No one more than the Honorary Secretary knows what work the President does, quite apart from sitting in the Chair. All Minutes of Committees have to be submitted to him, also the Agenda, and it is only his great keenness and his methodical way which have enabled us to get through so successfully to the end of this year. I very cordially second this vote of thanks, which I have no doubt you will carry unanimously.

The vote was carried by acclamation.

The PRESIDENT.—You will not expect me to make a speech to-day as well as to-morrow, gentlemen, but I must say I thank you very heartily for your kind expression of thanks.

The meeting terminated at 6 o'clock.

I. *Diagram, prepared by Dr. Urquhart, showing the impossibility of arriving at definite scientific conclusions by dealing with Admissions as Direct and Indirect Groups as proposed by the Statistical Committee.*



3 represents First Attack, 4 not First attack, 5 First Admissions, 6 not First Admissions.

In Group 1 there are all kinds of cases; these may have been under care previously, they may suffer from organic cerebral diseases, they may be incurable recurrent cases, or senile cases of the worst type.

In Group 2 there are also all kinds of cases, recent and curable, as well as transfers of chronic cases and accidental acute cases from lapsed orders, etc.

It is apparent that all these may be referable to groups 3, 4, 5, and 6, and again they may be gathered into Direct and Indirect Groups 7 and 8.

The distribution of Groups 7 and 8 may be Groups 9 or 10. Group 9 will necessarily contain many chronic and incurable cases, and Group 10 may contain certain recent and curable cases. Group 7 does not represent the occurring insanity even—it is subject to all kinds of exceptions.

It is evident that to exclude Group 10 from detailed consideration among the admissions, and at the same time to include the recoveries from Group 10 as applicable solely to Group 9 is a faulty calculation. Cf. Report, General Table II, column 11.

It is to be noted that the definition of Group 2 is entirely arbitrary; it is not a scientific nor a true classification.