were in the asylum, now returned; both were discharged just over twelve months ago, and they have remained perfectly well. Since their discharge I have seen them on two or three occasions. I have tried the same treatment on four or five other patients, and regret to be unable to report permanent improvement, although one was temporarily benefited.

Dr. DAWSON.—With regard to Dr. Havelock's remark, that new drugs should not be tried on cases curable by other means, I think that would be just as fallacious as the opposite contention. It is quite possible that a new drug may be of more value at an early stage of the disease than later, and certainly it is a matter of some moment whether we keep patients for a few months or for a few years in an asylum. The real test is the experience gained with a large number of patients. If the consensus of opinion upon the whole is favourable, that is a more trustworthy criterion of a remedy than if it were only tried in cases that are incurable. Although suprarenal extract is a powerful drug, I do not think there is any risk of doing harm by overdosing. I took it myself, and felt a little depressed perhaps; but that might mean a certain amount of gastric discomfort which is caused by large doses, discomfort which I never observed consequent on small. I think that the state of the blood-pressure is a legitimate indication for treatment in certain forms of insanity.

The Care of the Insane in Asylums during the Night.

By JOHN KEAY, M.D., Medical Superintendent, District Asylum, Inverness.

THE district or county asylum patient spends nearly half his time in bed. As a rule he goes to bed at or before eight o'clock at night, and rises at six in the morning.

The question whether his hours in bed might not with advantage be shortened is not one for discussion at present. The obvious difficulty at once presents itself that such a change would involve either a lengthening of the hours on duty of the day staff, which are already too long, or additions to the staff, with a corresponding increase of expenditure.

The care of the patients, therefore, during these ten hours out of each twenty-four is a problem of such importance that its introduction to this meeting needs no apology.

It is hardly too much to say that for many a long year, speaking of Scotland at least, the great bulk of the insane in asylums were without proper nursing or effective supervision at night. When bedtime came the acute or troublesome patients were locked away in single rooms, and the others in dormitories, with a touching trust that through the care of a watchful Providence they would be found all right in the morning.

For example, so recently as seven years ago in the asylum

at Inverness the night staff consisted of two persons, called the night watches—an attendant who had under his care about 250 male patients, and a nurse with an equal number of women. The night work was managed in this way: the patients were divided into three great classes, viz., (1) the sick in the sick ward; (2) the acute, suicidal, epileptic, dangerous, destructive, noisy, or untidy, locked up in single rooms; (3) the quiet, tidy chronics in dormitories.

The night watch had his headquarters in the sick ward, which contained fifteen beds, and was supposed to attend to the wants of the sick in the intervals between his rounds. He was understood to visit the other 200 or 230 patients in their single rooms and dormitories every hour. As it took about three quarters of an hour to walk round these single rooms and dormitories, it will be evident that he had but little time for sleeping, or for attempting anything in the way of nursing for any of the patients under his care. If, occasionally, a suicide occurred or an epileptic was smothered—well, we all know that accidents *will* happen sometimes.

I take it that the kind of arrangement above described no longer exists in any asylum. All have night nurses or attendants to take care of the sick in the hospitals, and in all our asylums the recent and acute cases, suicidal patients, and epileptics are under continuous supervision at night.

Some of us, perhaps, go a step further, and place also in dormitories, under supervision, all untidy, destructive, noisy, or excited patients, and those with faulty habits of any kind. This arrangement, advocated by Drs. Elkins and Middlemass at the annual meeting of the Association two years ago, and so completely carried out at the Sunderland Asylum, constitutes in my opinion one of the most important advances yet made in the care of the insane at night, and I can corroborate every word said in its favour. At Inverness, by placing untidy and troublesome patients under supervision in dormitories, the number of wet beds has been reduced from twenty to thirty per night to the vanishing point, and a mattress drying chamber, which had been in existence for many years, has been done away with. And not only this, but there are dements in the asylum who formerly in their single rooms were noisy all night and disturbed their neighbours, and who now sleep all night under supervision and are quiet, decent members of the

ward. Not only are they tidy, comfortable, and restful at night, but they are better behaved, quieter, and more manageable during the day.

Notwithstanding these arrangements for the care of the sick, recent and acute, suicidal, epileptic, and troublesome patients, it cannot yet be said that sufficient has been done, and that the insane are as well looked after at night as need be.

I would submit—

1st. That the night nursing of patients suffering from serious bodily illness is not what it should be.

2nd. That many patients need no night supervision, and could with advantage be relieved of it.

3rd. That the supervision of the night staff is insufficient.

As to No. 1. Let us consider the case of these sick people, say in the female ward. During the day there are probably two or three nurses, more than likely trained nurses, looking after, say, twenty beds. The medical officers visit the wards three or four times. The matron, probably a trained nurse, is constantly in and out. At night, on the other hand, for ten or twelve hours there is no medical visit, no matron's visit, and the same twenty patients are left in charge of one half-trained asylum nurse, or perhaps even a probationer.

In the case of the male sick ward the contrast between the day and night nursing is still more marked. During the day the patients probably are, as at Inverness, under the care of trained female nurses, and at night, when the guidance and direction of the higher officials are withdrawn, one ordinary untrained male attendant takes their place.

Such an arrangement cannot be regarded as satisfactory. As one visits the sick wards for the last time at night, one cannot feel confident that any particularly serious cases will be as well nursed at night as they were during the day. The fear is bound to come up that any benefit resulting from skilled attention during the day is more than likely to be lost at night.

The remedy, of course, is to have women trained in sick nursing in charge of the patients in the sick wards—male as well as female—at night, and this we are endeavouring to arrange at Inverness.

2nd. Unnecessary night supervision. It has been the rule at Inverness, as at most asylums, that every patient is to be

visited by the night attendant at stated intervals. At Inverness this is done every hour. The attendant or nurse walks through the dormitories, opens the door of each single room, and in fact sees every patient ten or eleven times every night. It appears to me that there is too much of this, and that these frequent visits to dormitories and single rooms are no longer necessary now that all anxious and troublesome cases have been picked out of them and concentrated in observation dormitories.

The patients who sleep in ordinary dormitories and single rooms now, are chronic cases of mania in their quiet moods—cases of delusional insanity or dementia. Many of them are quiet and trustworthy, and are allowed a great deal of liberty by day. They sleep soundly as a rule, and it seems absurd to suppose that they require to be looked at every hour of the long night.

We are therefore selecting all these quiet and trustworthy patients and placing them in dormitories and single rooms, in which they will be exempt from night supervision. The doors of these rooms open with ordinary handles and are not locked, and the patients have control of the electric light. There is a bell by which a night attendant can be summoned in a case of emergency, or one of the patients can go for him.

Other dormitories occupied by patients not so trustworthy are visited by an attendant or nurse, but not so frequently as was formerly the case.

I need hardly say that there are no attendants sleeping in patients' dormitories, although only a few years ago this was the rule. One could hardly conceive of a worse arrangement both for patients and attendants.

Nor have we at Inverness attendants' rooms adjoining patients' dormitories and opening from them—a common and objectionable arrangement. The patients and attendant disturb each other and interfere with one another's rest. It is not fair to an attendant, who has already done his day's work, to expect him to exercise supervision over a dormitory at night, or to attend to the patients in any way. A tired attendant, wakened out of a sound sleep, is apt to be cross and irritable and to use summary measures in dealing with the disturber of his rest. Then, again, I think the fact that an attendant occupies a room adjoining a dormitory is likely to give a false sense of security. If he should be a

sound sleeper a patient might murder another in the dormitory without his knowing anything about it.

3rd. The insufficiency of the supervision of the night staff. When we increase the night staff in an asylum of 600 patients from two to ten or twelve, the question of the supervision of this staff forces itself upon us.

Take, for example, the case of the sick patients in hospital. During the day the nurses in charge of these patients are constantly under the eye of the higher officials, and we know that in order to obtain efficient nursing this is absolutely necessary. Why should it not be thought necessary at night also? Yet during the night these patients are left in the sole charge of a comparatively inexperienced and untrained nurse or attendant for eight or ten hours.

Or consider the patients in the observation dormitories. Here we concentrate all the most troublesome and anxious cases in the asylum. During the day they are most vigilantly looked after. They are in wards where the staff is numerically strong and particularly trustworthy. The medical officers are careful to pay these wards special attention. They have experienced and careful charge attendants or nurses. The head attendant or matron keeps a strict eye upon them. But at night these patients are gathered together and twenty or thirty of them are placed in a dormitory under the care of one ordinary attendant or nurse. During the day one attendant or nurse to five or six such patients would not seem an extravagant proportion. For ten or twelve hours they are seen neither by the medical officer nor by any of the higher officials, and the attendant in charge of them is left with practically a free hand. How do we know that he does his duty? How does he spend his time when he has reason to believe that the coast is clear and the doctor has gone to bed? How does he deal with a restless patient who is inclined to get up and walk about the dormitory? Does he deal gently with him and endeavour to soothe him to sleep, or does he give him a hammering and a promise to repeat the dose if he is not speedily quiet? Will he get a hot-water bottle for a man who cannot sleep on account of cold feet, and a glass of milk and a biscuit for one who feels hungry?

No doubt there are exceptional men and women, kind,

good-hearted individuals, who take a real interest in their patients, and will be kind to them and will attend to the little niceties of nursing, which mean so much to them; but I fear that if we expect the general run of ordinary asylum attendants and nurses to do so we shall be disappointed.

Supervision is no less necessary in the case of the attendant or nurse on patrol duty. He is probably just an ordinary attendant, and he has thrust upon him a responsibility which we should not think of asking him to bear during the day. If he occasionally fails in his duty we cannot be surprised. In a few years' experience I have known a night attendant deliberately lie down to sleep night after night, having bribed a patient by tobacco to remain awake and to call him at a stated hour. The drowsiness of the patient during the day led to the discovery of this plan. An attendant has been found asleep who had taken bedclothes off the patients wherewith to make himself comfortable. It has been discovered that a night attendant on finding a patient's bed wet early in the night was in the habit of leaving it unchanged until the morning, in order to save himself trouble and to keep down the number of wet beds recorded in the report book. Another attendant has been known to make a quiet working patient get up and clean the room and change the bedclothes of an untidy patient, while the attendant looked on and smoked his pipe. Another has been known to remove the bedclothes from the room of a patient who was excited and likely to be destructive, leaving the patient without covering. Repeatedly it has come to my knowledge that night attendants have been harsh and even cruel to the patients under their care, and they have been dismissed for it. An occasional walk round the dormitories and single rooms in the middle of the night has been to me very instructive. The agility shown by patients, who were in the habit of being raised regularly, in jumping out of bed and making for the chamber utensil almost before the door could be opened, bears eloquent testimony to the rigid and stern discipline to which they have been accustomed.

I would plead, therefore, for the really effective supervision of the night staff.

The practical question is what form of supervision should be employed.

The mechanical contrivance known as the "tell-tale clock,',

in universal use in England and unused in Scotland, so far as I am aware, may be dismissed in a word as an interesting and ingenious toy. I do not suppose that there are many who use them who have faith in their efficacy. It is hard to see what information can be obtained from the record of a tell-tale clock, further than that an attendant was in a certain place in the asylum at a certain hour, and that when there he devoted a certain amount of attention to the clock. Without further information, showing what attention he gave to the patients, I do not know that the knowledge regarding his movements is of any particular value. He may cuff the ears of a restless patient, but the tell-tale clock looking on is reticent on the subject. Tell-tale clocks are a bad substitute for effective supervision of the night staff. Let us have this effective supervision and such contrivances will disappear as being out of date and no longer required. Not long ago, in a Scottish asylum, a patient was assaulted by attendants during the night and died from the effects. Had there been a tell-tale clock in the vicinity it would neither have prevented nor recorded this occurrence, but with effective night supervision it could not have taken place.

Another form of supervision is that by a head night nurse and head night attendant. It is, I think, common experience, that head attendants or head nurses, whether for day or night duty, when drawn from the ranks of the asylum attendants and nurses are not satisfactory. The ordinary asylum attendant and nurse are accustomed to work under the eye of a superior, and when this is withdrawn, as when they are on night duty, they with few exceptions fail in their duty. I do not think they can be depended upon to report one another for breaches of regulations. My experience, at all events, is that asylum attendants and nurses will screen one another at all hazards, and I have even known them to lie freely in defence of one of their number who had committed a fault, even though a patient had thereby suffered injury. I would not trust a head night attendant or nurse drawn from an asylum staff to report, for instance, that a nurse or attendant in charge of an observation dormitory had been found asleep. There are, of course, noble exceptions, but I am speaking of these officials as a class.

The solution of the difficulty is to be found in taking another

step towards the general hospital model and in having ladies, trained in sick nursing, as superintendents of night nurses and attendants. In fact nothing else will do when we have women as night nurses on the male side of the asylum. One such night superintendent would be sufficient for an asylum of say 600 or 700 patients. Her particular function will be the supervision and direction of the nursing of the sick, male and female, in the sick wards, but she will in addition pay several visits to the observation dormitories male and female, and will, perhaps, twice during the night, visit with the attendants and nurses on patrol duty all the dormitories and single rooms in which are patients requiring night attendance. When going on duty she will receive from the medical officers directions regarding any special cases, male and female, and she will leave a written report regarding those cases for their inspection. She will be, in fact, responsible for the care and supervision of all the patients during the night. The chief points are :

1st. That the night superintendent shall be a lady trained in sick nursing.

2nd. That she shall receive her instructions from the medical officers, and be subordinate to them only. She should be on an equality with the asylum matron and head attendant, and should, of course, have her rooms and table in accordance with her position.

The only asylum, so far as I know, where an arrangement such as this has passed beyond the experimental stage is at Larbert, and I have been told by Dr. Robertson that it works admirably, and that the night nursing in his asylum has been immensely improved since its adoption. I trust we shall be able to say the same at Inverness.

To sum up, then, the arrangements which we consider necessary for the proper care and supervision of the insane at night, and which we are endeavouring to carry out, are—

1. The sick, male and female, nursed by women trained in sick nursing.

2. The recent, acute, epileptic, suicidal, excited, noisy or troublesome in dormitories under constant supervision.

3. Those requiring some, but not continuous, supervision in ordinary dormitories which are visited periodically.

4. Quiet, harmless, trustworthy patients in dormitories and single rooms with open doors, without attendants' inspection.

5. A lady, a trained nurse, as night superintendent for the whole asylum.

Lantern Demonstration of Gross Lesions of the Cerebrum. By JOSEPH SHAW BOLTON, M.D., London County Asylum, Claybury.

(*Abstract.*)

I. THE GROSS LESIONS OF MENTAL DISEASE.

THIS demonstration was a further report on the subject laid before the Association at the meeting at Claybury in February last, viz., the morbid changes occurring in the brain and other intra-cranial contents in amentia and dementia. In a paper read before the Royal Society in the spring of 1900, and subsequently published in the *Philosophical Transactions*, it was stated, as the result of a systematic micrometric examination of the visuo-sensory (primary visual) and visuo-psychic (lower associational) regions of the cerebral cortex, that the depth of the pyramidal layer of nerve-cells varies with the amentia or dementia existing in the patient. At the meeting of the Association referred to it was further shown, from an analysis, clinical and pathological, of 121 cases of insanity which appeared consecutively in the post-mortem room at Claybury, that the morbid conditions inside the skull-cap in insanity, viz., abnormalities in the dura mater, the pia arachnoid, the ependyma and intra-cranial fluid, etc., are the accompaniments of and vary in degree with dementia alone, and are independent of the duration of the mental disease. Since that date the pre-frontal (higher associational) region has been systematically examined in nineteen cases, viz., normal persons and normal aments (infants), and cases of amentia, of chronic and recurrent insanity without appreciable dementia, and of dementia, and the results obtained form the subject of the present demonstration. A paper on the whole subject will shortly be published in the *Archives* of the Claybury Laboratory.

In the table (Fig. 1) is given a summary of the results,