For three days after admission he improved, became more coherent and rational, and was able to answer questions. Three days later he relapsed into the former rambling, restless and incoherent state, and gradually sank. Throughout the day of his death he was unconscious, with stertorous breathing, and died somewhat suddenly at 9.15 p.m.

Post-mortem examination.—Thirteen hours after death. Calvarium normal. A large quantity of serous fluid escaped on opening the dura mater, which was firmly adherent along the sides of the superior longitudinal sinus. Arachnoid and pia mater normal.

There was an effusion of blood on surface of brain in the Sylvian fissure and adjoining sulci on both sides, also on surface of left frontal lobe. The left cerebral hemisphere was congested, the right pale. There was also a small effusion of blood in the floor of the fourth ventricle on the left side.

The left lung contained a small calcareous tubercle. The aorta was atheromatous; calcareous nodules were noted on an attached border of the semi-lunar valves; slight incompetency in consequence. Liver large, fatty and friable. Spleen normal. Small cysts in right kidney.

Remarks by Dr. Lawrence.—The large quantity of serum underneath the membranes had probably been accumulating for some time before the accident, and was coincident with, and the cause of certain mental symptoms which had been observed for a few months previously. At the time of the accident rupture of capillaries had taken place; there had been a gradual oozing of blood, which, mixing with the serous fluid already in the Sylvian fissure and adjoining sulci, retained its fluid condition and ultimately produced the symptoms of compression which ushered in death. No symptoms directly traceable to the small clot in the floor of the fourth ventricle were observed.

The degree to which recovery of consciousness was manifested for three days is noteworthy.

Notes of a Case Introducing a Discussion on the Making of Wills by Certified Patients, and the Duties of Medical Men in regard to this. By W. B. Morton, M.D., Resident Medical Officer, Brislington House, Bristol.*

The subject of these notes was a gentleman who was admitted under the care of Dr. Deas, at Wonford House, in

* Read at the Autumn Meeting of the South-Western Division, 1897.

June, 1895, and remained there until his death in July, 1896.

I do not propose to give a minute description of his symptoms, which were those of a typical case of mental stupor, but to note chiefly those which were of medico-legal interest.

He was a gentleman of private means and no occupation. He was 50 years of age, and had a marked history of insanity in his family, both his mother and maternal grandfather having been insane. There was no history of any exciting or other predisposing cause.

For several months previous to his admission his manner had been peculiar and his conduct eccentric, so much so that in January, 1895, a petition for an enquiry was presented.

At this time his mental condition varied much. At times he was morose, preoccupied, and almost taciturn; at others excitable and confused, without apparently knowing what he was doing. He wrote many extraordinary and unintelligible letters, incurred liabilities greatly exceeding his income, burnt newspapers in an hotel, threw the bedding out of the window, and wandered about at night time. Some days he ate little, but at times had as many as three dozen raw eggs in twenty-four hours.

Shortly after the presentation of the petition, improvement in his mental condition occurred, and he quickly became apparently quite himself again, so that no further steps were taken. However, in June a relapse occurred, and he was certified on the 15th and admitted into Wonford House.

His mental condition then was one of melancholia, with a tendency to stupor.

After his admission the stupor rapidly increased and became the most marked feature, and this was essentially his condition until June, 1896, the exceptions being:—

(1) For a few days in August he began to eat his food, and seemed brighter and apparently intelligent, but still taciturn.

(2) In December he spoke once or twice voluntarily, but quickly relapsed.

(3) In February he whispered a few sentences intelligibly, but apparently with difficulty, and occasionally when pressed to answer he would whisper, chiefly in monosyllables.

In May and June his health began to fail, and he was confined to bed with recurring attacks of pleurisy and basic pneumonia, probably of a tubercular origin, and at the height of one of these attacks he was said to have conversed quite intelligently for an hour with his night attendant.

Quite suddenly on June 29th the stupor passed off, and having been sent for I found him dressed and eating his breakfast. He said he was quite himself again, and I satisfied myself that this

really was so, for, during an hour's conversation, he spoke clearly and intelligently, and gave me details of his property, and commented on events which had occurred both in and out of the house during the time when he was apparently unconscious of his surroundings. He could give no explanation of his long silence, except that he felt that it was impossible for him to speak, and I could get no suggestion that it had been due to delusion, nor was there any evidence of the existence of delusion at any time during his illness.

During the afternoon of the same day he relapsed into his former condition of stupor. It took place quite suddenly whilst he was talking with his attendant.

This was clearly a genuine lucid interval, and it appeared to me that he was for the time "of sound mind, memory, and understanding."

Two days later he had another interval, which lasted several hours, and which was quite as lucid. He was very weak and ill, and said he knew he would not live long, and would like to make his will. This was drawn out two days later, but whilst it was being read over to him by his solicitor he again relapsed into stupor, and could not sign it. Four days later another interval occurred, and he sent for his solicitor and signed his will.

From then to the time of his death, which occurred after ten days, he had periods of stupor separated by distinct lucid intervals during one of which he made a codicil to his will.

His death was due to disease of the lungs, as is said to occur so often in cases of stupor. No post-mortem examination was made.

The will was contested by two relatives who had not been so well provided for as they would have been had the will been upset, but, unfortunately for present purposes, after a short hearing the case was settled out of court, and what promised to be an interesting trial was cut short.

The chief feature in the case is the lucid intervals, which were so distinctly separated and sharply marked off from the states of stupor. During the former he was seen by four medical men, who were all agreed as to the lucidity, and in the latter there was no doubt as to his complete incapacity, whilst the transition from the one state to the other occupied but a few minutes.

The question of will making by certified patients is always an interesting one. In this case the duties of the medical attendant were easy, but I have no doubt we shall hear of cases where the course was not quite so clear, and for this purpose these notes have been read as a means of introduction.

Discussion.

Dr. DEAS said, taking the case now reported as their text, it was a question that perhaps might be regarded as somewhat narrow and limited. That was so no doubt, but at the same time very difficult questions might arise in connection with such cases, and he thought it was a class of patients in regard to which it would be well for all of them to have, if possible, some definite ideas as to how they would deal with such cases when they arose. The first point that suggested itself was as to the legal question. Was there any legal reason, he asked, why persons in asylums should not make their wills? He thought the general public, and even some of themselves, had ideas which were not quite in accordance with the law in regard to these matters. There was a general feeling that as soon as a person was certified and entered an asylum he was, practically and legally speaking, dead, and had no further civil rights. That, he thought, was certainly a mistake. They knew very well that one important legal right was reserved to those who were inmates of asylums—the right of being tried for any crime which they might have committed in the same way as the members of the outer world. One might go a little further, and say that if the present legal version of the criminal responsibility of the insane were pushed to its logical limit there was no reason why an inmate of an asylum should not have the further advantage of being hanged for a crime which he might have committed, and thereby be on an exactly similar footing with those who had not the great advantage of being placed for protection within the walls of an asylum. There was no reason in law why any patient in an asylum could not make a will. The whole point was a question of fitness, and his own opinion was that in this respect a person within the walls of an asylum was in exactly the same position as a person outside. A man might make a will if he had the requisite amount of intelligence to properly express his desire to do so, and to give instructions for it to be drawn up, recording those instructions or communicating them to a solicitor. Everyone who made a will was liable to have it disputed, and to have his mental condition taken into consideration. The next question was as regards medical officers of asylums. What were their duties in connection with this matter? Supposing a patient communicated to the medical officer a desire to make a will. Was the medical officer to place himself in the position of opposing the patient's wish, or was he to place himself in the position of trying to comply with it? Personally he was rather in favour of the medical officer stretching a point in favour of the patient making a will. Of course a great deal depended on the individual circumstances of the case, but he thought they might perhaps formulate one or two propositions which would help them. He himself should say that if a patient in an asylum had sufficient mental capacity to say in a reasonable way that he wished to make a will he should be allowed to see a solicitor if he so requested. Of course one would naturally communicate with the relatives of the patient in the first instance, but he did not think that the medical officers of an asylum should put themselves in the position of opposing or interfering with the legal right of an asylum patient, subject to the opinion that might be formed as to his mental condition. Very often cases arose when a patient was dangerously ill. Now it might so happen that the relatives of the patient could not readily be communicated with. The patient's condition might be very critical. If a person in that state communicated to the medical officer the desire to make a will and asked that a solicitor should be sent for, would the medical officer be going beyond his functions by complying with the wishes of the patient at once? He thought they should reserve to themselves a wide liberty of action, and if they thought a patient was in a state of mind to be able to give intelligent instructions for the drawing up of a will, and was evidently labouring under mental anxiety to settle his affairs, surely it was their duty to take such steps as to enable the patient to carry out his wishes.

He knew that a great many people would say they would be taking a good deal too much on themselves by doing this, and interfering in matters that might lead them into great trouble afterwards. His own opinion was, however, that in such cases the medical officer would be not only justified in taking action, but that it was laid upon him to do so in the sense of a moral duty. Another point to which he would like to refer was as to the particular kind of patients who might be considered mentally capable of making a will. The case brought before their notice by Dr. Morton was, he thought, a typical case in which lucid intervals might occur, and might be looked for. They all knew how a person might remain for months in a state of intense stupor and then the whole condition was changed, and the person was practically and to all intents and purposes in the same condition as before the cloud descended. It was surprising the amount of knowledge and consciousness which patients of this kind had of what had passed in the stuporose interval. These were typical cases in which, if this clearing up took place, patients were quite capable of exhibiting testamentary powers. Then as to the number of cases one might have in the course of his experience. It would not be very large certainly, but he had three cases of the kind within the space of some seven-and-twenty years. In all these three cases the wills were held to be good, and two of the three cases were those in which the patients were in the condition alluded to by Dr. Morton—in imminent danger. In one of the cases he wrote out the will at the patient's dictation, and signed it as a witness. One of the wills was upheld on trial in spite of the fact that he gave evidence that he thought that it was tinctured by the delusions from which the patient suffered. He mentioned this as showing the wide view the law took of such matters—that there was nothing in the administration of the law to put any impediment in the way of patients in asylums making wills. In the case to which he was alluding the patient was undoubtedly suffering from insane delusions, and he gave it as his opinion that the will was, as he had said, tinctured by these delusions. Still the jury upheld the will.

Dr. BOWER considered that what they had to consider were the conditions they might be placed in at any time, and the course they would take in the event of having to come to a hasty decision as to whether they should grant these facilities or not. Thrashing out such subjects at a meeting like that naturally placed them in a better position to come to a right conclusion as to what to do when these emergencies arose. He thought the cases mentioned were just those where one would be inclined to send for a solicitor and allow the patient to make a will. There were no doubt difficulties in the way, and the last case mentioned by Dr. Deas rather weakened his propositions, by showing that sometimes they might do mischief, and be the means of an injustice being done. The more they saw of the views of lawyers about lunatics the less one wanted to have lawyers coming to see their patients. As a rule a lawyer never could understand that a lunatic asylum was a place for treating disease. His only idea was that it was a place of confinement, and what he wanted to know was merely whether a patient was dangerous to himself or others; otherwise he was sure to do all he could to get him out. From their point of view an asylum was a place for the treatment of disease, and the treatment of a disease such as insanity was very much hindered if there were all sorts of arguments going on as to the necessity for a person being kept in an asylum or not. Where there was a case of serious illness probably then there would be no difficulty in having a solicitor present, but it might result in many persons who wanted to agitate for a patient's discharge having solicitors brought up on these pretexts. Personally he had had no experience of any patient making a will, except very informal wills with regard to directing the disposal of very small property in which no legal questions were ever involved.

The CHAIRMAN instanced the case of a patient under his care who made a codicil to a will at the suggestion of his brother, a medical man, who urged that

the will the patient had made was defective, in that it did not provide for his sisters. The old gentleman had sisters dependent upon him, and the brother suggested that a codicil might be made to provide for these sisters. He supported his wish by the fact that the Court had in apportioning the patient's income apportioned £100 a year to be divided among the sisters. He pointed out that the effect of the death of his brother under this old will would be that these sisters would be left practically destitute, and the patient's assets would go to his nieces—daughters of married sisters. The old gentleman was a simple dement, but he had remarkable intelligence when one could awaken it. The avenues of his senses were practically closed, he was nearly blind and nearly deaf, but he seemed to thoroughly understand what was said to him, and the circumstances under which he made this will, and other points which were to them and the solicitor unintelligible, he explained. He explained why certain conditions had been inserted in the will, and they were of a decidedly intricate nature, but he was perfectly clear, and they had interviews with him on the subject of the will, he believed on three occasions, the patient always manifesting the same intelligence. He grasped the situation with regard to the sisters, and said it was an omission, and that he would like to make a fresh will and correct it. His memory, however, was quite defective, and between the interviews he never once referred to the subject again. A codicil was drawn up, and he signed it, and the lawyer felt perfectly convinced that the patient thoroughly understood what he was doing, and considered the thing safe, in view of the fact that the Court of Chancery had already during his lifetime disposed of a portion of his income in the way he would be disposing of it in the codicil. He had no doubt if this old gentleman were not in an asylum, and he was one of those who at the present time might be out if his friends would look after him, there would be no likelihood of dispute. The case was a different one to that Dr. Morton had instanced. In this case they had, as it were, to open the man's senses; it was very seldom he made a remark unless he was spoken to, but he was tolerably intelligent when approached.

Dr. Fox remarked that he had had wills made at that asylum, but none that had been contested, all being on the face of them perfectly reasonable.

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*Notes on a Case of Fracture of the Fibula in a Melancholic Patient, with Remarks on Treatment in Fractures Generally.** By J. F. Briscoe, M.R.C.S., Westbrooke House, Alton, Hants.

The object of this communication is to draw from the members of the Association the modern treatment of fractures as adopted in institutions for the insane. It is obvious that the various plans, as practised in hospitals, must be considerably modified in asylums. For instance, to strap and bandage a case of fractured ribs, *secundum artem*, taxes any medical officer, unless the patient is quietly disposed and clean in his habits. However, with skill and a fairly docile patient, there should be little difficulty in the management of ordinary fractures of the bones below the elbows and the knees. From time to time one reads of

* Read for the author by Dr. Macdonald, at the Autumn Meeting of the South-Western Division.

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