THE ANNUAL DINNER.

The Annual Dinner was held in the Hall of the Royal College of Physicians, Edinburgh, on Wednesday evening, July 20.

The Chair was occupied by the President, Dr. Hamilton Marr, F.R.F.P.S.Glasg.

The company were received by the President and Mrs. Marr at 7.45 for 8 p.m., and the guests included the Right Hon. Lord Alness and Lady Alness, the Hon. Lord Fleming, Sheriff and Mrs. Robertson, Sheriff and Mrs. Macphail, the Dean of the Faculty, Councillor Bilton, *C.M.G.*, Dr. Henri Colin (Paris), Dr. Rene Targowla (Paris), Dr. Henry A. Cotton (New Jersey), and Dr. Vernon Briggs (Boston).

Among those invited to attend and who wrote expressing their regret at their inability for various reasons to do so were the Secretary of State for Scotland, the Under-Secretary of State for Scotland, the Earl of Stair, Lord Aberdeen and Temair, Lord Polworth, the Marquis of Douglas and Clydesdale, Lord Ashmore, Lord Murray, the Lord Provost of Edinburgh, Principal Sir Alfred Ewing, Principal Sir Donald Macalister, Sir James Crichton-Browne, Sir Robert Philip, Sir David Wallace, and others.

There was a large attendance of honorary and ordinary members and their guests, and the gathering was thoroughly representative of those interested in psychological medicine and the care of the mentally afflicted, and included Sir Frederick Willis and Dr. C. Hubert C. Bond, of the Board of Control for England and Wales; Sir Arthur Rose and Drs. Marr and Sturrock, of the General Board of Control for Scotland; and Lt.-Col. W. R. Dawson, Inspector of Mental Hospitals of Northern Ireland.

The croupiers were Dr. James Chambers, Treasurer, Dr. David Rambaut, Registrar, and Dr. W. M. Buchanan, Hon. Secretary, Scottish Division.

TOASTS.

The toasts of "The King," and "The Queen, the Prince of Wales, and Other Members of the Royal Family," submitted by the Chairman, were loyally pledged.

"The City of Edinburgh."

Dr. C. Hubert Bond, *C.B.E.*, in proposing this toast: said, That scant time has been given me in which to ponder over the most acceptable words in which to propose a toast, the very thought of which conjures up such a wealth of ideas that time is needed in which to sift them and compress their expression within the limits of your patience, for the toast I have to submit to you is that of "The City of Edinburgh," wherein we have spent a week of unbounded and unforgettable hospitality.

The only possibly valid reason which occurs to me why the honour of having to submit this toast has fallen to me is that, apart from the affection I have for the *alma mater* to which I owe so much, it is known among my friends that, besides sharing the enthusiastic admiration for this supremely beautiful city—the Queen and Metropolis of the North, to which the many thousands who visit it testify—to me she has an attraction which is perhaps best expressed by the fact that ever since I went down from the University, thirty-four years ago, to practise medicine in England, I have never lost a single occasion, great or small, of returning. (Applause.) And there must be many others in this Hall to-night who, like myself, feel to the core the call and the lure of Edinburgh.

It would, of course, fall well within the scope of my toast to ask and to attempt to answer, what is, and wherein lies, this magnetic attraction which Edinburgh so peculiarly possesses. Those here to-night who are responsible for the welfare of this City and its inhabitants, and those who can claim the proud privilege of calling themselves citizens of Edinburgh, will extend their sympathy to me if, despite the fulness with which I feel this magnetic force, I shrink from an attempt to explain it. It has been portrayed in prose and sung in verse in words that have become part of our classics. And often enough in this very room and in other of Edinburgh's historic halls has it been heard from lips of orators. Edinburgh's necklace of charms, in fact, forms a goodly rope of pearls, and it is beyond, at any rate, my powers to pick out the one of great price.

There are two thoughts, and two only that I would like to mention.

One is my first visit to Edinburgh, on a dark, late spring evening, and my feelings on stepping out of Princes Street station, and viewing, after a short walk eastwards, that host of twinkling lights on and around The Mound, surmounted by a huge black, majestic-looking mass which I, of course, at once knew must be the Castle. My recollection of it all, though this was forty years ago, is as vivid as ever, and I always recommend strangers, if possible, thus to try and pay their first pilgrimage by night.

The other thought is my visit, yesterday, to that marvellous War Memorial, which, though unveiled by the Prince of Wales only a few days ago, seems already an intrinsic part of the Castle. To my mind, it is not possible even to imagine anything more beautiful, more deeply moving and soul-satisfying, or more completely fitting. And as I see Edinburgh, it seems to me that throughout the centuries there has been a pervading spirit in her founders and citizens which has responded to the matchless beauty of her site, and has seen to it that nothing shall be added but what is fitting and worthy. It is the unity and union of these attractions which is so delightful. But transcending all—if a reply has perforce to be given to the question as to wherein lies the City's magnetic attraction—the answer lies in the pervading spirit of those who dwell there. And, on the chance of catching something of this for ourselves, I ask you to rise and drink to the health of the City of Edinburgh, and to couple it with the name of Councillor Bilton. (Applause.)

Councillor L. L. BILTON, *C.M.G.*, in replying to the toast, said he did not feel in the least like a City Father; he felt more like a son of it. Born and bred in the City, his first recollections of it was to write an essay on the subject of "Old Edinburgh," and he did not want to do it at all. But as he was walking past St. Giles's Cathedral there was an old gentleman came up to the speaker and said, "My boy, what are you doing?" He told the gentleman, who then took him down the "Royal Mile," and made it so interesting that he never forgot it. The gentleman was Prof. Blackie. From being a son of the City of Edinburgh, he, the speaker, became its devotee. He wished to thank Dr. Bond for the way in which he proposed the toast of the City. Those who were attempting to do something for the City realized the magnitude of the task they had before them. They also realized that they had been preceded by a great number of men who had a very wide vision in that City's interests. He would give only two illustrations.

When one thought of the great Queensferry Road, going out from Edinburgh, a road 60 ft. wide, one realized that it was made at a time when people were thinking of roads the size of the High Street. There was also Leith Street, a great avenue of entry to the City of Edinburgh, and that was made a hundred years ago when people were accustomed to making roads 25 to 30 ft. wide. Such things made one realize that the City Fathers of those days had at least a wide vision of future needs. (Applause.)

He supposed that when at school they all learned what the imports and exports of the great cities were, and he was thinking that day that Edinburgh had been omitted from that list, because he thought that when one looked at the University, at the Colleges, at the various wonderful institutions there were in the City, it must be admitted that the main export of the City of Edinburgh was doctors. (Laughter.) He thought the City of Edinburgh owed a great deal to the doctors. This was the first city in the United Kingdom to appoint a Public Health Officer, and he took it that this was largely due to the influence of the Medical School in Edinburgh. Edinburgh had progressed in sanitation and water supply, and in the care of her people.

He had no wish to speak at length, but he did wish to express to the company the thanks of those who were trying to do something for the welfare of Edinburgh, and their appreciation of the way the toast had been proposed, and the manner in which the assembled company had received it. (Applause.)

"LITERATURE."

Sheriff J. R. N. MACPHAIL, *K.C.*, said it was his duty to propose for acceptance the toast of "Literature," coupled with the name of Prof. Grierson. He could not say anything about that gentleman which his hearers did not know already, therefore he must turn to "Literature."

When he was commanded to propose this toast, he naturally, and very properly,

demurred, on the ground of his entire inefficiency. But all knew how kindly pressure, firmly and persistently applied, caused one's weaker self to come to the front, and so he gave way. Moreover to that sense of inefficiency there had been added a new and rather disturbing element: for he had not originally realized as he would have done had he been a sensible person, that the distinguished Association to which he was speaking was composed of a number of distinguished individuals who made up the whole. He now remembered reading things in newspapers—which, of course, were always true—in which ladies and gentlemen had stated they had been invited to unburden themselves, to give their views on family troubles, upon political matters, on their claims to high position and great estates and even on Literature; and they had succumbed to the suggestion and had confided in some of the distinguished gentlemen who were around these tables. Then rather awful things had happened, and in the seclusion which followed they had regretted having so unburdened themselves. (Laughter.) Hence in his own case to-night he had a haunting fear that what he said and how he looked might be a matter of observation, and that accordingly for a purpose to which it was painful to allude more fully, facts observed and remarks made might have an unpleasant sequel.

With regard to the subject of the toast, if it had been English Literature, he might have been able to say something, for, many years ago, he attended the class of English Literature, and, from note-books still reverently preserved, he might possibly have been able to give the company some wise and witty sayings of Prof. Masson, the well-known predecessor of Prof. Grierson. He might have gone even further than quoting from old note books; he might, for instance, have invited their consideration of sundry very interesting problems.

But this apart, the first thing to consider is what is Literature? Examination of many dictionaries at last gave him an answer. According to the late Mr. Carlyle Literature is "The Thought of Thinking Souls." He did not know whether, by their unaided intelligence, the gathering could quite understand what that meant. It was a remarkably sublime saying, and he did not know whether it could be fully grasped. If some understood it, to the others he would say, "Take courage, Prof. Grierson is shortly going to address you." He, the speaker, was merely here like the boy whose joy it was to ring a bell and run away. He submitted this toast of "The Thought of Thinking Souls," coupled with the name of Prof. Grierson. (Applause.)

Prof. H. J. C. GRIERSON, in responding to the toast, said he had read somewhere that if one wanted to save one's life one must, early in life, learn to say "No." But when, some weeks ago, he received an invitation to reply to this toast, he forgot that excellent advice. The President had been so kind to the speaker that he felt inclined to agree to the proposal. But it had puzzled him to understand why Literature should have been singled out in this remarkable way to be toasted on the occasion of a medical dinner, especially a medico-psychological dinner. If the toast had been that of "Psychology," coupled with the name of Prof. Drever, he would have been able to understand it, for that gentleman, he understood, occupied a Chair which was founded for the purpose of examining the bumps of these people. The Chair should be called that of phrenology—a science which, like many others, was dying out. He was sorry not to have heard the President's address on two great men of letters, Dante and Rabelais. That led him to think of the place that medical men had taken in literature, because he noticed the President chose the two men named on account of their having studied medicine. Glancing back to Chaucer, the speaker found that at that time there was a general indictment of medical men in literature. As far as he could gather, there were about them three main charges. In the first place, they were very fond of gold. Chaucer said that "Gold he loved in especial, for gold in physic is a cordial." He believed it was Cortes who told that unhappy monarch Moteznma that all the Spaniards suffered from a disease of the heart for which gold was found to be a cordial, and that was the reason they were so anxious to carry large supplies of it back from Mexico. Another indictment was that doctors were very fond of bleeding people. At the present day doctors did not bleed the people in a literal sense, but if it was necessary to go to a nursing home, then when at last they emerged they found that, in one sense, they had been severely bled. (Laughter.) Another point was the extraordinary nature of the drugs which they used to prescribe. He remembered finding, on a fishing expedition in the Shetlands, in a house an eighteenth

century book of prescriptions. He would not have thought the human mind could have indulged in such eccentricities. In a mixed audience he would not particularize them. He thought the President, in his address, might well have included, in his representatives of literature at the Renaissance, another man, especially in relation to psychological medicine, and that was Montaigne, because of his interesting essay on "Why sons resemble their fathers." That author said it was strange that there should be hidden away in the germ from which his body grew a particular disease, called colic, which his father had had but which did not appear in his own constitution until he was 47. But there was another hereditary peculiarity of temperament which he was struck by, and that was his inherited and bottomless contempt for doctors. His father had it, also his grandfather, and his father lived to the age of 76, the grandfather to the age of 88, and neither of them had tasted a drug of any kind prescribed by a doctor. Only one of his relations had done so, and he died the earliest of them all, and one was not altogether surprised at that. (Laughter.) And the President might well have taken the work on *The Force of the Imagination*, because Montaigne might claim to be the first of the psycho-analysts, the first to show the extraordinary part played in human medicine by the imagination. The author said that when he saw a man who was young and juicy he himself felt better. (Laughter.)

Continuing he said he thought literature owed a debt to the work of psychological medicine in recent years. One remarkable thing about medicine was that a theory was started one year, and next year people practising in Harley Street were receiving huge fees on account of it. It was the speaker's duty to give a prize for the best novel of the year, and he had found that the psychologists had supplied our young novelists, especially lady novelists, with an enormous storehouse of subjects. He could scarcely take up a novel without finding that it relied, ultimately, on the analysis of the psyche of this or that person, involving discoveries of such a painful nature that it was not for him to touch upon them in a mixed assembly. Whether that was entirely beneficial for the novel, or not, he did not know. Therefore one might say that literature and medicine had always walked arm in arm. Montaigne said he had no dislike of medical men; he had known many excellent ones and worthy to be loved. "Nor," he said, "do I greatly blame them for profiting by our folly, for most of the world does likewise." Doctors appealed to a consciousness of the shortness of our life and the frailties with which it was beset; and it would always be to their honour that those who had done most to help the spiritual condition of men had almost never been able to obtain their effect without being able to show them that they could likewise help them bodily. "The Great Physician" had been the highest title one could have to bring consolation to poor stricken humanity.

He expressed his hearty thanks for his selection to respond to the toast.

"The General Boards of Control."

Lt.-Col. Nathan Raw, *C.M.G.*, in proposing this toast said that, having listened to two very delightful speeches, one on the City of Edinburgh, the other on Literature, they now came to the *pièce de resistance* of the evening, namely, "Insanity." That was a subject which all present were able to discuss, and the toast with which he had been entrusted was a very important one, namely, "The General Boards of Control."

Before speaking to the toast proper, he wished to offer his felicitations and those of his colleagues to to-night's President, Dr. Hamilton Marr, on having been elected to this very distinguished position of President of the Royal Medico-Psychological Association. (Applause).

It would be impossible for him to mention the names of all the distinguished men who constituted the Boards of Control of the two countries, therefore he would merely mention the two Chairmen.

The Chairman of the Scottish Board was Sir Arthur Rose, a very distinguished officer, who had a splendid military record, and who presided over the Scottish Board of Control with great keenness and clarity, and with splendid results. The Chairman of the English Board was Sir Frederick Willis. It was true that both those gentlemen were laymen, *i.e.*, they were not doctors, but the very fact of their success as Chairmen of these Boards showed that in many cases it was a great advantage to have a layman as chairman to a body carrying out such diverse functions as those of a Board of Control of a great country. Sir Frederick Willis,

had had a very distinguished record as a civil servant, and for many years he was in close touch with all the great public health questions of the Local Government Board, which afterwards became the Ministry of Health. Since Sir Frederick was appointed Chairman of the Board of Control of England and Wales his work had always been characterized by zest, to the great satisfaction of all concerned in the administration of the Lunacy Law. He, the speaker, therefore had the greatest pleasure in submitting the toast, coupled with the name of Sir Frederick Willis. (Applause.)

The toast was heartily pledged.

Sir FREDERICK WILLIS, *K.B.E.*, *C.B.*, in reply, said he felt a good deal of embarrassment in being required to respond for two Government Departments, which, after the interesting speeches on other topics, must appear very humdrum. He heard a lady on his left ask, "What is the Board of Control, and what do they do?" If he were to set himself to explain what the Board did it would be voted a very weary catalogue of things, seeing that the Board exercised a general jurisdiction over lunacy. But he would like to say how very grateful he felt to the Royal Medico-Psychological Association for arranging for this toast to be proposed. That Association helped the Board of Control very much indeed. When the latter wished to get the general opinion of psychologists about any particular aspect of the Board's work, they went to the Association, and always received the greatest help from them. But for its help the power and usefulness of the Board would be much less. Of course, occasionally the Board had to do things which people did not like, but he wished to assure the gathering that both the Scottish Board and the English Board were very anxious to advance in every way the treatment of insanity and the proper care of mental defectives. And though some of the work of the Board was of a very humdrum character, it was very human work, because they did get into touch with the individual. And all documents had to be very carefully supervised, and sometimes they were returned because the facts observed and the facts communicated did not seem to justify the final conclusion which was arrived at on the statements. But they did receive very loyal help from the Association and from the medical men engaged in this work, and, on behalf of the General Boards of Control, he wished to express his gratitude for the way in which this toast was proposed and had been received.

"THE GUESTS."

Sir HUGH ARTHUR ROSE, *D.S.O.*, said he did not know why he had been selected to propose this toast, but the President was a peculiarly persistent person.

Gracing this board were many charming ladies, and he would speak of them first. He would like to have dealt with them in a heartfelt manner—(Laughter)—but as his wife was present he must pass on. There were also present distinguished foreign guests, and, on behalf of the company, he extended to them a cordial welcome. There were Dr. Colin and Dr. Targowla from France. Those two gentlemen demonstrated, and improved, the age-old alliance between France and Scotland. There were also present Dr. Henry Cotton and Dr. Vernon Briggs from the United States of America, which, he believed, was known locally as "God's own country." On every other day in the year they were members of the Association—to-day they were honoured guests. The United States had been credited with having acquired three-fourths of the gold of the world, but, in the present instance, in the persons of Dr. Cotton and Dr. Vernon Briggs they had sent us something of sterling value. The company had already heard Sheriff Macphail, and there was present, too, his own ex-colleague, Sir John Prosser. Also there was Mr. Cockburn, the Chairman of Morningside, who was generosity itself; and there was the Dean of the Faculty, who could not be got on to his feet. And the company was honoured by the presence of Lord Fleming, a distinguished Judge of the Court of Sessions—distinguished in the fact that he was the only judge carrying a war decoration earned as a fighting soldier. He also wished to mention his old friend Lord Alness, through whose fault the speaker was here at all to-night. He only hoped that should fate bring him before Lord Alness in his present sphere, he would extend to the speaker the same consideration that he always had in the past.

He had to couple with the toast the name of another legal luminary, Sheriff Robertson, and it took the speaker a little time to make up his mind why the President selected that gentleman to reply to the toast. But a careful perusal

of the daily Press a few days ago gave him the clue. The reason seemed to be that a very short time ago there appeared before Sheriff Robertson in his Court a gentleman who was driving a motor car while in a condition not usual in drivers, and with rather unfortunate results. And the words of Sheriff Robertson were so eminently wise, so typically Scotch, that probably that was the reason he was selected to reply to this toast. He said, "The man who paid £15 for a motor car and took it out on the highway was guilty of negligence," and, he proceeded, "at any rate he should see that the steering gear and brakes were in good order before taking it on a steep hill."

Sheriff J. A. T. ROBERTSON, in replying to the toast, said he had frequently wondered at the temerity of the layman who ventured to address the members of a learned society, and he was now amazed to find in himself the latest example of it. When he realized that the society in this case was the Royal Medico-Psychological Association he was somewhat afraid, and he would tell his hearers why. It happened to be his duty, as Judge-Ordinary of the Western Division of Stirlingshire, every week to sign several warrants for the detention of persons in mental hospitals. The certificates upon which these warrants proceeded set forth the symptoms which had been discovered by these learned gentlemen, the mental doctors. He always read the certificates very carefully, so that he was almost a past master in the knowledge of the symptoms of mental alienation. He was free to confess that on many occasions he had displayed similar symptoms himself. Sometimes the statement was that the unfortunate patient spoke rapidly and incoherently; at this stage on such an evening, that might be a common fault. (Laughter.) On the other hand, it was sometimes said that the patient talked trivialities in a stilted and pompous manner. The result was that he, one of the humblest of the guests, was there to reply on behalf of a large number of people, men and women who were much more able to stand in his shoes than he was himself, who represented life in many of its aspects and interests, beauty and grace, learning, wit, eloquence, judicial capacity, administrative ability, industrial enterprise, and if he was to get home that evening without a keeper, he had to do it in a speech which, on one side, would steer clear of the Scylla of stilted pomposity, without on the other being sucked into the whirling Charybdis of incoherent rapidity. (Laughter.) Fortunately for him, and perhaps for the company too, he remembered the dear old tag about the soul of wit, and, finding that the organizers had followed the Apostolic precept and had allowed him "a little for my stomach sake," he took his courage into his hands, and hope appeared on the horizon.

On behalf of all the guests, he took the opportunity of saying how thankful all were for the hospitality which had been extended to them, and how much they appreciated the cordial and generous terms in which Sir Arthur Rose proposed the toast, and the kind way in which the members of the Association had honoured it.

The PRESIDENT said he was sure the company would be interested in hearing a few words from Dr. Colin, one of the French delegates.

Dr. HENRI COLIN (Paris), in response, said he was glad, in the name of the Société Médico-Psychologique, of the opportunity of answering the cordial welcome which had been extended to him and Dr. Targowla. He and his colleague considered it a great honour and a delicate pleasure to come and meet their colleagues of the Royal Medico-Psychological Association. He was the President-elect of his Society, in the year 1918, when France was striving for final victory, and it was at its monthly sitting, on November 25, 1918, just after the Armistice, that he proposed that a special message be sent to the sister-societies of Great Britain, Belgium, Italy and the United States of America, to assure them of their heart-felt sympathy, and hoping to meet in the future. Later it was resolved to send delegates, and he and others came in that capacity to the annual meeting of this Association at York, and he would never forget the kind and cordial reception the President, Dr. Bedford Pierce, gave them. In 1921 he, the speaker, came to the London meeting, and again at this year's meeting (with Dr. Targowla), in the Edinburgh festivities they were charmed by all they saw. As they said in France, "Ils vout de surprise en surprise." So as the years passed on, the solidarity of friendship between the countries, which had been so much hoped for, became ever stronger. Whenever any great commemoration took place in France, colleagues there knew they could count on the presence and sympathy of British colleagues and friends. His thanks went out specially to the President,

Dr. Hamilton Marr, Dr. Donald Ross, Dr. Bond, and Prof. Robertson, all of whom attended the Pinel celebrations in Paris.

"THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION."

The Hon. LORD FLEMING, *M.C.*, in proposing this toast, said he believed it was the present Prime Minister who said that no man was qualified for the high office of Chancellor of the Exchequer until he had learned to say "No." He, the speaker, was conscious that for many other reasons he was disqualified from holding that high office, but certainly he could not say "No" to this request from Dr. Hamilton Marr. However, he intended to carry out Dr. Marr's instructions, to propose this toast in a few words, recognizing the fact that he was speaking in the presence of many alienists.

The Association to which his toast referred had been in existence, he understood, eighty-six years, and that when it was first formed the membership was a little over 40. To-day it had reached the 800 mark; and he considered that fact alone was eloquent testimony to the increased interest in the treatment of those afflicted with mental disorder. During that period a revolution had taken place, not only in the methods of treatment, but also in the public outlook towards those so afflicted. Eighty-six years ago mental disorder was regarded in these isles as a kind of crime against society, and those afflicted with it were locked up, and subjected to restraint in order to prevent them doing injury to themselves or to others. That had now all been altered, and mental disorder was now universally regarded as a form of disease, and, as in the case of other diseases, those who suffered from it received suitable treatment in institutions intended for that purpose. It was recognized that, in order to obtain success, the disease must be dealt with at the earliest possible stage. For that reason, he believed the aim of this Association had been to promote out-patient dispensaries and clinics for dealing with this disorder, just as they were provided for cases of ordinary disease. Also, as in the case of ordinary disease, nurses had to be trained to deal with these mental cases. In the old days it was thought that all that was needed for a mental nurse was a man who had sufficient physical power to restrain the patient; but now it was recognized that for such a duty mental as well as physical qualities of the highest order were required. The certificate granted by this Association to mental nurses, he understood, was the highest it was possible to possess. He wished to say, as a member of the public, how much the valuable work of the Association was appreciated, and he wished the members God-speed in that work.

He had the honour of associating with this toast the name of the President of the Association, Dr. Hamilton Marr, who was the Senior Medical Commissioner of the General Board of Control in Scotland. In his official capacity he had come in contact with Dr. Marr on several occasions during the last few years, and he had formed a very high opinion of the ability and care with which he performed the responsible duties of that office. And, apart from that, he had had a long and valued personal acquaintance with him. They were at school together, and it was a great pleasure to him to learn that Dr. Marr had been made President of this Association. He coupled the toast with Dr. Marr's name.

The PRESIDENT, in responding to the toast, thanked Lord Fleming for the kind things he said about him (Dr. Marr). He felt somewhat like the clergyman who was often seen crying during his sermon. A little boy said to his father, "Why does the clergyman cry?" The father replied, "Perhaps if you were up there and had as little to say for yourself as he has, you would be crying too." (Laughter.) But if the speaker had little to say for "himself" there was much he could say about the Royal Medico-Psychological Association—too much, indeed, for the company to listen to this evening. Therefore he would confine his remarks to one or two pertinent facts.

The Association, if any association did, knew perfectly well the meaning of the word "cure." In its original it meant taking care of the sick. The Association knew that the only path it could follow was the path of service. One of the most important services was the endeavour to hospitalize all the mental institutions, and in this endeavour they had, as Lord Fleming indicated, tried to raise the standard of nursing. Wherever possible women nurses had been put in. He remembered a deputation of disabled soldiers coming to him and objecting to the fact that women

were being employed to nurse men in asylums. He asked them what was their reason for objecting, and they said that it displaced male labour. He replied that, as a Board, they were not concerned with that; that their concern was with the interests of the patients in the institutions. But he told them he would ask them all, individually, a question: "You are a soldier who has been wounded in the war. You have been in a hospital and have had nurses to look after you, and you have had orderlies to look after you. Which of these two did you prefer?" Every one of the men said, "We preferred the nurse." He then said to them, "Why do you deny your brother who is sick in mind the same privilege?' (Applause.) His hearers would remember the maid-servant in Cranford who, when she was asked by Miss Jenkins at the party to attend to the ladies first, said, "I will do that, ma'am, but I like the lads best." (Laughter.) Both men and women, when they were sick in mind, preferred women. Nobody knew better than the Royal Medico-Psychological Association that this path of service was the only one which could be followed; and time would fail him to tell of the work done by the Association in the direction of caring for the mentally afflicted. All along, the Association had shown progress in this respect; they had answered in many ways that question, put long ago by Macbeth:

"Canst thou not minister to a mind diseased,
Pluck from the memory a rooted sorrow?"

He wished to thank Lord Fleming for the honour he had done the Association in proposing this toast, and to tell him how much the Association appreciated what he said regarding the work done in it.

He then invited the assembled company to drink to the toast—

"Floreat res Medica."

This was done with much enthusiasm, and the festive evening terminated with the usual rendering of "Auld Lang Syne" and the National Anthem.

MORNING SESSION, Thursday, July 21.

(Conjointly with the Sections of Neurology and Mental Diseases of the British Medical Association.)

In the Chemistry Theatre, University New Buildings.

Prof. Edwin Bramwell, M.D., F.R.C.P., President of the Section of Neurology, in the Chair.

DISCUSSION ON EPIDEMIC ENCEPHALITIS.

Dr. Ivy Mackenzie (Glasgow) opened this discussion by reading a paper (*vide* p. 567).

Dr. J. Goodwin Greenfield, supplementing his opening paper on "The Pathology of Epidemic Encephalitis" (*vide* p. 575), said that as Dr. Ivy Mackenzie had opened up the very interesting field of the anatomical changes of encephalitis lethargica, he, the speaker, had better deal with that part of the subject first, and later proceed to questions of ætiology.

Though he could not follow Dr. Mackenzie in his psychological and physiological excursions, he did not agree with that gentleman as to the distribution of the disease. He agreed in so far as the brain-stem was, primarily, often chiefly affected, and he thought that was due to the means by which the virus got into the nervous system. He did not hold, with him, that once it was in the nervous system it kept to one part of it. He thought it might spread very widely. It was clear that the anterior horns in the cord were more widely involved than were the posterior horns. He had looked through his specimens to see whether there was any evidence of damage in the posterior horns in this disease, and he failed to find that they were more affected than the anterior horns.

He showed several slides. The first was a longitudinal section of the cord, showing the lesion in the anterior horn-cells. In another there were lesions from the cortex down to the lumbar cord and the cuffing of vessels could be seen in the anterior horns. In those of his series which he was able to look through, he found much more disease in the anterior grey matter, but it could affect the white matter also.

With regard to the basal ganglia, it was extraordinary how early the mid-brain

was affected. Diplopia was often the earliest symptom. And it had been interesting to follow the French school and workers in Germany, showing how rapidly and to what extent the substantia nigra was destroyed. In one of the cases the destruction was almost complete as early as the twentieth day of the disease. It was easy to see destruction of the nerve-cells in the substantia nigra, as there were melanin granules which were left scattered about, and cuffing of the small vessels. In a case 21 days from the onset of symptoms, the substantia nigra had disappeared, a vessel was cuffed, and all round the region were numerous granules of pigment. It was more difficult to trace the destruction in the cortex and in the basal ganglia. Many cell-counts of the basal ganglia had been done in cases with the Parkinsonian syndrome, and they showed very little destruction of cells. In many of the cell-counts general shrinkage had not been taken into account. And in the mid-brain, in the basal ganglia, and in the cortex there might be destruction of nerve-cells in this disease, which was apparently toxic, and not necessarily associated with inflammatory exudate. He showed a slide with the exudate coming along a cortical vein and being poured into the meninges. A section from a case seven days after the onset showed a nerve-cell surrounded by satellite cells, the nucleus being displaced to the side and almost extruded. Recently he was given a specimen from a patient who had diplopia and other symptoms, from which he recovered. The patient was sent away for a holiday, but died of acute mania. He was only given the upper half of the brain, and he made a frozen section, stained with Scharlach, and he found an extraordinary condition. Many vessels in the cortex were ringed with lipochrome pigment; there was no cellular exudate, but here and there were cuffed vessels. The lipochrome pigment was attributed to degeneration in the nerve-cell; he thought it almost certainly meant a breaking down of nerve-cells, because the pigment was very difficult of solution during life and in the laboratory, and it did not seem to be dissolved by any of the cells in the nervous system. The only way, therefore, it could be carried to the vessels was by phagocytosis.

He recently examined another case, in which also there had been pronounced lethargy, and he found a similar condition there, particularly in the occipital region.

Therefore he regarded this disease as one in which the nerve-cells throughout the system were poisoned, and many nerve-cells were destroyed and fell out. This conception was not a new one, and it had been strengthened by experimental work, of which he would speak presently. Many of those who had worked on encephalitis in rabbits had considered that the virus attacked nerve-cells in the same way, without necessarily causing interstitial inflammation. He thought it was a very useful view to have in mind when considering some of the mental sequelæ of lethargic encephalitis.

With regard to the ætiology of the disease, he thought one could now well discount all the work of Lœwy and Strauss in New York, and Kling in Sweden, as the symptoms in rabbits had been proved to be due to a different disease. Experiments showed that these rabbits, after injection, had a form of inflammation of the brain, and it was proved that the rabbits of the "stock" had that, and that the organism was a parasite affecting rabbits alone. It was different when one considered the work of Levaditi and others, which correlated the virus of the disease with herpetic encephalitis of rabbits. In other words, the virus of encephalitis lethargica was considered by them to be a more virulent form of the virus which occurred in ordinary herpes labialis and similar lesions occurring in febrile conditions in man. Those papules of herpes contained a virus which, if injected into brains of rabbits, caused a fatal encephalitis in a few days; and a virus which must be regarded as identical had been found by a number of people. There was no question that the virus which they had transmitted from the encephalitic brain to rabbits was identical with herpes labialis, or at least belonged to an allied family. He had not time now to enter into all the evidence for and against that, but it was worth keeping in mind that encephalitis lethargica was not a new disease, as it was developed from this common affection herpes labialis through an exaltation of virulence, particularly against the nervous system.

Dr. GEORGE RIDDOCH, supplementing his opening paper on "Chronic Encephalitis" (*vide* p. 582), said that Dr. Ivy Mackenzie's opening remarks were very interesting, and, as Dr. Greenfield said, they raised questions of importance, though he feared he could not agree with Dr. Mackenzie's interpretations.

He took it that Dr. Mackenzie viewed the disease as an infection which did not progress, and interpreted the phenomena, such as Parkinsonism, as due to some factor other than the infection remaining in the nervous system itself —a view which the speaker found great difficulty in understanding, not only clinically, but also histologically and pathologically. For he believed it to be now established that even in long-standing cases, and before a year's duration, active foci were found with stationary lesions. He, the speaker, supported the view, based on clinical and pathological experience, that the disease was essentially a chronic one comparable to neuro-syphilis and disseminated sclerosis. It might begin with an acute phase, or a subacute one, or it might be chronic from the outset. It showed a marked tendency to go on smouldering in the nervous system, and to be manifested clinically by either a progressive disablement, or with stationary periods and recrudescences during the course of the disease. These recrudescences, in their clinical form, might vary, but, in essence, the disease was still within the nervous system.

His part in this discussion had no connection with the acute phase of the disease; he had to deal merely with the chronic phenomena, and he had only time to touch on one or two of the more important of them.

Dr. Mackenzie said it was impossible to classify the disease, and Dr. Marshall agreed with that, as did the speaker. And he thought the reason was that it was so chronic in its course, and had so varied a clinical picture. There was a danger now, in describing these clinical forms, of laying too much stress on the polymorphic picture, and in ascribing to chronic encephalitic phenomena disorders which could not be diagnosed during life.

In conclusion, he said there was no need for him to touch on treatment. Nothing, apart from dealing with symptoms, was known about it. And prognosis was in an equal state of chaos. He regarded the disease as a chronic infection, which might appear after a long remission.

The PRESIDENT of the Royal Medico-Psychological Association in the Chair.

Dr. R. M. MARSHALL read a paper on "The Mental Aspects of Epidemic Encephalitis" (*vide* p. 589).

Prof. GEORGES GUILLAIN (Paris) said that at different periods in the evolution of chronic epidemic encephalitis, soon after the onset of the disease, or a long time after the development of a Parkinsonian syndrome, it was not exceptional to observe symptoms which resembled those of myasthenia. When they were localized only to the limbs, or to isolated groups of muscles, the diagnosis of myasthenia gravis did not occur to one; in more numerous cases, however, the myasthenic symptoms, beginning in muscles supplied by mesocephalic nerves, and later becoming generalized, revealed a clinical picture identical with that of the Erb-Goldflam syndrome. In such cases, either a history of typical acute epidemic encephalitis before the onset of the condition or certain symptoms of the Parkinsonian syndrome indicated the true nature of the myasthenia.

Th. Alajouanine and he had described such cases, and recently A. Wimmer (Copenhagen) had recorded a series of similar observations. He wished to recall briefly the clinical characteristics of the myasthenic aspects of chronic epidemic encephalitis.

A first case was that of a man, æt. 57, after a period of diplopia, without drowsiness or fever, some months later felt that his eyelids at the end of the day were paralysed, also with variable diplopia. At the same time lumbo-crural neuralgia appeared, and after one week he noticed abnormal fatigue in walking when following his occupation of gardening—all these symptoms being especially marked at the end of the day. At meal-times he also felt a difficulty in masticating solid food. Speech was weak after a long talk. On examination we found bilateral ptosis, paresis of the right external rectus, paresis of the masticatory muscles, fatigue in the muscles of the upper and lower limbs in successive movements. The beginning of a Parkinsonian syndrome pointed to the encephalitic ætiology of this myasthenic picture.

A second case presented an identical clinical picture after a typical onset of epidemic encephalitis.

He had recently observed at the Salpêtrière, with Dr. Thévenard, a bulbo-pontine syndrome with myasthenic symptoms.

These three cases disclosed three different aspects of abnormal myasthenic

syndrome. The first two cases closely resembled myasthenia gravis; in the first one a Parkinsonian syndrome, in the second a recent epidemic encephalitis, demonstrated the infectious ætiology of the myasthenic syndrome. In the third case the clinical picture was partly that of an alternate syndrome of the bulbo-pontine region, and partly that of myasthenia according to the character of the paretic troubles and their variability. The history of the disease and the effect of sodium salicylate treatment again suggested the encephalitic ætiology.

Encephalitis lethargica seemed, therefore, able to produce symptoms similar to those of myasthenia. And furthermore, in encephalitic sequelæ it was not exceptional to meet with isolated myasthenic symptoms which were absent in the clinical picture of the Parkinsonian syndrome. Such cases were interesting from the point of view of diagnosis and prognosis; they did not seem to evolve progressively and severely as did myasthenia gravis. The diagnosis, too, was made easy by the knowledge of an acute period of infection or by the observation of sequelæ of encephalitic type. Meanwhile, certain cases presented difficulties in their interpretation. In such the electro-diagnosis did not give any real help, but with Bourguignon's technique the study of chronaxy would give new reasons for supposing an encephalitic ætiology.

This series of observations showed the great variability of syndromes depending on encephalitis, and allowed a new conception to be formed of the still obscure ætiology of myasthenia.

Dr. E. MAPOTHER said that as a psychiatrist his experience of encephalitis was necessarily warped by the fact that he only saw the cases in which special treatment was called for on account of the mental symptoms. He had seen only six cases in the acute stage, as against probably two hundred with the residua or sequelæ. Hence his experience of the acute stage was really negligible. But there was one point which was brought out by considering the history of the chronic cases, also by the facts of one or two of the acute cases he had seen, and it was the ease with which the organic nature of the condition might be missed if attention were focused on spurious psychogenesis and the physical examination neglected. He was referring specially to two cases which came into the Maudsley Hospital as cases of neurosis, though in both the patients had minor ocular palsies, which had been overlooked. One was that of a young girl, whose condition was thought to be due to mental stress connected with her approaching marriage, which event she was awaiting with the usual mixed feelings. The other was the case of a girl who worked in a factory where, it was supposed, a boiler explosion was liable to occur at any moment. Both were clearly cases of acute encephalitis.

For the rest, he thought the acute phase of encephalitis lethargica had very little concern for the psychiatrist. There was but little correlation between the severity, or type, or duration of the acute attack and the severity or type of the later mental symptoms.

Concerning chronic encephalitis, he had had a fairly large experience drawn from a number of different sources. Particularly interesting were the cases he had seen in an observation ward, where the poor of East London were dealt with, and where he had seen a number of adult delinquents who had passed through Brixton Prison, and had been discharged because of their mental state.

He would not waste time in echoing things about which there was agreement; he rather wanted to emphasize the points of difference between the various papers.

One of the points on which there was a difference was whether, as Dr. Ivy Mackenzie suggested, the chronic manifestations were a mal-adjustment after a destruction occurring during the acute phase, or whether it was a continuing infection. He had seen one or two cases which supported the view put forward by Dr. Greenfield, that there was a continuing infection. He had seen cases in which chronic delinquency had existed for years, and, later, there had occurred a short febrile illness, which it seemed reasonable to regard as a recrudescence of the infectious process. And that had been followed by an exacerbation of the delinquency. He had seen this in both the child and the adult, and at least two cases of the kind came clearly to his memory.

He thought the openers of the discussion differed also about the exact localization which determined the Parkinson syndrome, but that had little importance for the psychiatrist, seeing that the intensity of the mental syndrome was independent of physical syndromes. He had seen practically every type of neurological syndrome with—also without—mental accompaniments.

The most obvious reason, to him, was that the mental sequelæ had a localization of their own. There seemed to be an excessive tendency to ascribe delinquency, in a vague and general way, to the occurrence of the disease before ethical codes were organized. That was not in keeping with the fact that a fair number of the delinquents had been well-behaved adult citizens—a definite regression, not a mere arrest. Anyone who had had experience with cases of delinquency would agree with that.

Of course, it was not necessary to postulate a special " moral centre " ; he was thinking that it depended on destruction of some part of the brain which governed, or underlay, foresight. That was supported by the fact that a number of delinquents also manifested a reckless disregard of danger or consequences. The pathology of delinquency was a very large question, with large theoretical implications. Allied problems were whether moral imbecility was a specific condition, and the exact causation of those curious cases of moral reversal which one saw after injury to the head.

He would like to question Dr. Marshall's tendency to identify post-encephalitic restlessness with delinquency. One saw many cases in which the delinquency was paroxysmal, and not associated with continual restlessness—cases in which the person behaved most of the time in a normal way, yet occasionally broke out and did some outrageous act, like rape, or theft.

He questioned the attempt to identify post-encephalitic restlessness with mania. The mania of the manic-depressive was a joyous excitement, and he had not seen that in a late stage of encephalitis. Dr. Menzies surprised him when he said, on the previous day, that euphoria was characteristic of Parkinsonism, and built a theoretical structure on that foundation. The speaker, Dr. Mapother, thought euphoria was very uncommon. Many post-encephalitics committed suicide—surely insanity, but certainly not euphoria.

The real difficulty about the diagnosis of functional mental disease and post-encephalitis was between melancholia and Parkinsonism. It was a double one. It was partly because, in many melancholics, conative impediment was the striking thing, and that was very like that of Parkinsonism. On the other hand, a large proportion of Parkinsons were profoundly depressed. He had seen a series of cases admitted to the Maudsley Hospital as recent melancholias, and in a few months they turned out to be clearly post-encephalitic Parkinsonian cases. The mistake was also most apt to occur where an apparent psycho-genesis was behind it. He wished to refer briefly to two cases.

One of them, after having been seen by four medical men, was eventually diagnosed by the parlour-maid who opened the consulting-room door and said, "There is one of those sleepy-sickness cases waiting for you." He was a man of strong religious feeling who had been in prison as a conscientious objector during the war, and had gone through a terrible time in prison. After the war he had had a severe mental conflict owing to his having taken up with another woman. His wife deserted him. This led to his having profound mental depression, and it was regarded by the doctors in question as a full explanation for his behaviour. But the eagle eye of the parlour-maid detected it at once !

The other striking case was that of a young woman who came into the Maudsley Hospital. She had recently procured abortion on herself after *liaison* with a married man. Severe hæmorrhage followed. She was living at home, and was terrified that the facts might come to the knowledge of her mother, or that she might bleed to death. She said she adopted the stooping posture and limitation of movement as a means of averting recurrent hæmorrhage. She made that statement without any prompting. It became obvious that she was a case of post-encephalitic Parkinsonism.

His last point was to dispute Dr. Marshall's identification of Parkinsonism with katatonia. The speaker thought the resemblance between the two was a superficial one ; he thought there was no more resemblance than between hysterical hemiplegia and organic hemiplegia. Katatonia was definitely a mental syndrome, Parkinsonism was not. To him, that only meant a difference of level, though it was a very definite difference. He did not think anyone who had seen a katatonic syndrome suddenly pass off in a morning, as it might, could readily agree that it had any fundamental resemblance to Parkinsonism. And certainly the two were not alike in their accompaniments. One never saw, in association with Parkinsonism, any of the meaningless eccentricities of language and action which were

seen in the other state; one never saw negativism or flexibilitas cera. He thought the striking thing about Parkinsonism was a defect in habitual and automatic activity. By effort the patient could temporarily reduce it. If, however, one asked the hysteric or the katatonic to overcome apparent incapacities, the result was invariably an increase of the disability. There was one accompaniment of katatonia which he had rarely seen, namely hallucinations, but he was told, by those who had had more opportunity of seeing advanced examples than he had, that hallucinations were not uncommon in very late stages of post-encephalitis.

Dr. BERNARD SACHS (New York) expressed the pleasure he felt at being able to participate in this discussion, and though it would be difficult to add much to what had already been said, he would like to allude to his experience of the disease during the time he was in charge of a neurological clinic in New York. Encephalitis appearing in epidemic form had revolutionized the practice of neurology, so that in the future it would never be quite the same as hitherto. Epileptiform seizures were regarded as an expression of some vascular disease, or as an accompaniment of conditions like brain tumour, etc. Because of the light which this disease had shed on many neurological conditions, it was well worthy of discussion from every angle. The disease had been persistent in America in its acute form, and its sequelæ are evident. The earlier American cases were lethargic, whereas the more recent ones were characterized by restlessness and insomnia. The lethargy was never complete, nor very deep; at any time a patient could be aroused from his lethargy by vigorously talking to him, though immediately afterwards he would sink back into his lethargic state. It seemed likely, he thought, that studies of this disease would reveal the location of the chief sleep centre in the brain. In later years in America the myoclonic and choreic symptoms had been marked. There seemed to have occurred a gradual attenuation of the virus. In 100 cases in his own wards the pupillary reactions were found to be defective in 35, and paresis of accommodation without dilatation of the pupil was frequently noted. Ramsay Hunt was of the opinion that there existed two striated systems, one pallidal, one non-striatal, and that when both systems were involved there occurred a combination of two types of disorder. He believed that some infantile types of cerebral palsy were of ganglionic origin. Infantile apoplexies were often associated with choreic and athetoid movements, whereas such were rare in adult apoplexies.

An important distinction in the spinal type of encephalitis was that the symptoms were those of a complete acute transverse myelitis, and were never those of poliomyelitis.

He could endorse Dr. Marshall's remarks about the restless, naughty child.

A study of the literature showed, without doubt, that epidemic encephalitis and acute poliomyelitis were separate entities. His own experience was that since the appearance of epidemic encephalitis, acute poliomyelitis had become a rare disease. If there was no relationship between the two diseases there might be a definite antagonism. Some had isolated the virus of herpes in cases of encephalitis. In this investigation he thought animals higher in the scale than rabbits ought to be used for experimentation. Similarity of lesions produced was no argument for the identity of the causal virus. The whole problem was ripe for study by means of experimentation on higher animals. Certain cell-groups were less resistant than others, and melanin-bearing cells were particularly susceptible.

When the causal organism had been found, the greatest difficulty would be to provide a therapeutic agent. It was a great scourge, and the disease might be latent in the body for years.

The association of liver disease with striatal disease had led some to suspect that disordered liver function might be a factor which determined whether or not patients would develop encephalitic symptoms. But O'Flynn, in a thorough investigation of 34 cases, showed that there was no biochemical evidence of any gross derangement of the functions of that organ in this disease.

He had found that ocular manifestations were usually the first signs of the disease. Not a few cases, however, might begin with an apoplectiform seizure. He thought the term "central and basilar encephalitis" was a better designation of the disease than "encephalitis lethargica."

Dr. W. A. POTTS said that though he had come to oppose some of the statements made in some of the opening papers, he would not be ploughing a lonely furrow,

as he was in almost complete agreement with Dr. Riddoch, Dr. Sachs, and especially with Dr. Mapother, who had said many things he would himself have liked to say if it had been necessary.

He differed slightly from Dr. Mapother as he understood that speaker. If he meant that the extraordinary conduct, from the moral standpoint, was due to destruction of the highest moral centres, the speaker suggested that in the early stages, and often for many years, the peculiar immoral conduct was due rather to a numbing of those centres than to their destruction, and that, with appropriate treatment, it could be entirely got rid of, even at a late stage.

He would challenge Dr. Mackenzie's statement that the disease showed a tendency to run a very definite and peculiar course, and that the anatomical damage was wrought once and for all. He suggested that Dr. Mackenzie's theory did not apply to those not uncommon ambulatory cases which, often, were not diagnosed until some years later; sometimes because they were not properly examined, but sometimes because they never consulted a doctor as they had been ill only one or two days, and then were able to be up and to carry on more or less satisfactorily. He thought that the reason some of these cases were not diagnosed was, partly, because many practitioners were looking out for cases of a definite type, and their attitude was somewhat like that of the man whose dog barked in the night, but who, because the bark was not a typical one, did not get up and investigate, but went to sleep again, and did not realize, until he got up in the morning, that valuable assets had been removed. He agreed with Dr. Riddoch that the disease was comparable in behaviour to neuro-syphilis, and also in the fact that specific and satisfactory treatment was able to produce results if thoroughly done, and continued sufficiently long, even at a late stage. Instead of following a definite path in the later stages, it always had a choice of at least two, probably more, different paths, according to the type and temperament of the person. There was the path typically followed by dementia præcox cases, with its variety of types, but with few intermissions. On the other hand, there was the manic-depressive type, alternating between the manic and the depressive states, with, frequently, long lucid intervals, sometimes of weeks or months, occasionally of years. He, like Dr. Menzies, had had the good fortune to see many cases of the euphoric or manic type, which were undoubtedly sequelæ of this disease. His own common experience had been to see cases which alternated between the manic and the depressive type.

He would like to call attention to two pathognomonic symptoms, one of which had already been referred to. In the ambulatory cases which did not go to a doctor in the first instance, there was always, if inquired for, one absolutely pathognomonic symptom, namely, the feeling—even if it lasted no more than two or three hours—of being desperately and hopelessly ill. A friend of his, whose illness took the form of a very severe hiccup, had such a severe attack in the night that it was uncertain what might have happened if his wife had not been a medical practitioner, and got up and applied chloroform to stop the spasm. He got well, and there had never been a recurrence.

The other symptom he wished to call attention to—it had already been mentioned—was the diminished sense of responsibility. He regarded that as simply due to the toxæmia. This resulted in the most bizarre and often unsatisfactory type of conduct, both in the young and in older cases. He had no hesitation in saying, in contrast to what had been said by others that in the case of the restless, naughty child who had had encephalitis, it was of no use to attempt to treat her by drill, training and "moral talks," but extraordinarily good results followed the administration of an autogenous vaccine from throat or nose, or by some form of non-specific therapy.

With regard to the most important aspect, that of treatment, he considered that the only hope was to treat the case on the lines of a septic psychosis. This was, to deal as far as possible with the original infection, and, in addition, to deal with every other unsatisfactory condition of the patient, especially any infection of the nose, throat or teeth, intestinal tract, urine. The treatment must be thorough and prolonged. Patients were often said to have been examined and attended to, but in many cases there had only been treatment of a perfunctory kind. Once he was laughed at for treating cases with influenza vaccines, but the laugh was now on the other side, because Dr. Graves and many others had proved that, even in the chronic cases, one of the most efficient forms of treatment was

non-specific protein therapy, in addition to dealing with all local infections, for this was one of the most important items in the treatment. It was of no use to make two or three applications to the nose of an aqueous solution of an antiseptic: there must be the daily application of some oily preparation which would maintain contact. This might not actually reach the infection, which might have already passed through the ethmoidal cells into the brain, and often, on its way, set up ethmoidal sinusitis, to remain a chronic source of infection. But he was sure this would prevent the entry into the brain of fresh organisms, which otherwise might be continually introduced.

In regard to intestinal treatment, too, this was often carried out in the most perfunctory way. There must be prolonged and thorough Plombières treatment. A few days ago he saw a case of encephalitis lethargica which was first diagnosed as such three years ago, and the patient had been under treatment ever since, and was so still. Practically all his teeth were taken out, in the first instance, without an X-ray examination, and the tonsils were removed, but the doctor did not proceed to give intestinal treatment. He thought it would be interesting to take a swab from the nose in that case, also from the throat, and a profuse infection by a hæmolytic streptococcus was found to be present. What was the use of excising the tonsils when the throat was readily invaded again by a condition which had not been dealt with? He found that patient was very constipated, and had been so all his life, as he often went without a motion for three days. During the whole of their married life the wife had been troubled by the patient's extraordinary indiscretions in diet, but that condition had never been attended to. When the speaker sent specimens of the patient's urine to a biological chemist, he said that the outstanding feature in the case was the intense intestinal infection and failure to eliminate the toxins produced there.

Prof. R. CRUCHET (Bordeaux) said that the polymorphism of epidemic encephalitis or encephalomyelitis, which we distinguished in 1917 in describing for the first time this hitherto unknown disease, is no longer under discussion. This is the principal reason why Prof. Euzière, Dean of the Faculty of Medicine of Montpellier, recently said that there was no better name for this disease than the name of the author who first described it.

Of the many different aspects of the disease I will consider only one which I mentioned in my London lecture on the bradykinetic syndrome in 1925. Many authors admit that the slowness of movement in post-encephalitic Parkinsonism, as well as in Parkinsonism in general, is an effect secondary to the peripheral muscular hypertonus. So understood, bradykinesia should be but a simple and particular case of movements which are executed against resistance. This point of view could not be maintained, and many facts show perfectly the independence of bradykinesia.

For a long time Verger and I have noticed the existence of sequels of encephalitis which are characterized only by slowness of movement without real muscular hypertonia; in such patients the postural reflexes and tendon reflexes are quite normal. It is not rare to discover hypertonia in such patients after several months. It is ordinarily of the type of Parkinsonian hypertonia, characterized by exaggeration of postural reflexes. We call by that name the postural reflexes described by Foix and Thévenard, also called by Delmas-Marsalet elementary postural reflexes.

With old Parkinsonian cases hypertonia can be transformed into a pyramidal type, characterized by ankle clonus and Babinski's sign.

Whatever the type of case, and whether the patient is not hypertonic or his hypertonia is a Parkinsonian or a pyramidal one, bradykinesia remains exactly the same. This clinical observation, therefore, shows well the independence of bradykinesia and the variable state of the muscular tonus.

These facts, undeniable from the clinical point of view, needed an experimental demonstration. This has just been given by one of my pupils, Dr. Delmas-Marsalet. His test is as follows: By subcutaneous injection a solution of scopolamine bromhydrate is given; this provokes in Parkinsonians a progressive abolition of postural reflexes, which is complete in about forty-five minutes. It is well seen in diagrammatic curves. At the moment when the scopolamine injection has completely abolished the postural reflexes, different segments of the limb are in flaccidity, and there is no longer hypertonia.

It is most important to note that if the patient is asked to execute movements

these remain distinctly slow, in spite of the disappearance of hypertonia. What is equally remarkable is that the abolition of postural reflex leaves the tendon reflex and general sensitivity completely intact. It even permits, when pyramidal irritation and Parkinsonian hypertonia are associated, the reappearance of pyramidal excitation (clonus of the knee and ankle, and exaggeration of the patella reflex), which this hypertonia had inhibited.

These different facts indicate clearly that it is useful to separate bradykinesia from hypertonia. Bradykinesia, just as much as bradypsychia, must be considered as an alteration of special nervous functions which have nothing to do with the tonus. It seems that bradykinesia represents, as Verger has said, a deficit of a general function of the brain—the automatic habit function.

Delmas-Marsalet's test in experimentally isolating the postural reflex gives a rational explanation of the action of scopolamine, known for a long time in Parkinsonians, and of the irregularity of this action. With the ordinary bradykinetic patient, without postural hypertonia, the effect of scopolamine is only moderate; the best result is obtained with the bradykinetic with postural hypertonia. When this condition is complicated by pyramidal signs the result is bad, because the abolition of postural reflexes will increase the pyramidal contracture still more. It is only in the cases in which pyramidal contracture, clinically absent, is discovered by the scopolamine test that the result is good; if this contracture is slight, it is right to use scopolamine. If this contracture is strong, it is better not to employ it.

Lt.-Col. J. R. LORD, *C.B.E.* (Vice-President of the Section of Mental Diseases) in the Chair.

Prof. KARL PETREN (Lund, Sweden) said it was important to remember the *rôle* of phagocytosis. In encephalitis one did not find phagocytosis, and the anatomical difference accorded with the clinical course of the disease.

With regard to diagnosis, he drew attention to the value of the naso-palpebral reflex of Guillain, namely, an increasing blinking of the eyes; he had found it very helpful in diagnosing Parkinsonianism.

Dr. Riddoch had alluded to the fact that there was often an interval between the acute attack of encephalitis and the occurrence of Parkinsonism. When that was so, it was of the highest importance to know how long that time could be, *i.e.*, how long after the acute attack there was reason to feel anxious that Parkinsonism might result. He had had cases in his clinic in which Parkinsonism came a fairly long time after the prime attack, but in no case had it been longer than four years. He would be glad if others could confirm his hope that after four years from the acute attack there was no need to fear Parkinsonianism.

Dr. ROYLE (New South Wales) gave a cinematographic demonstration of the good results achieved by the operation of ramisection for post-encephalitic rigidity, this treatment having been carried out three years after the incidence of the disease. A definite result ensued when one side was operated upon, and a more definite one when the double operation was carried out. Patients who were very rigid, and moved with obvious difficulty, were shown after the operation to be able to run and mount steps with apparently a normal gait. He said that the effect of this sympathetic operation was similar to that temporarily produced by giving hyoscine, but the result of the operation was permanent.

Dr. J. M. WOLFSOHN (San Francisco) said that the clinical manifestations of chronic encephalitis had been well described in this discussion, but little had been said about its treatment. Dr. Riddoch had said there was no cure for the chronic encephalitic—a view universally accepted. But what impressed him, the speaker, was how many of these cases could have been prevented had treatment in the acute stage been properly carried out? In 1918, in London, he saw many of these cases. The disease had not then reached California, and he had spoken about the disease as he saw it in London, but little interest was shown. Since then, however, there had been two serious epidemics of the disease in California, and the sequelæ had been such as were described in this discussion. In 1925 there were many hundreds of acute cases there. In the epidemic of 1923 the doctors were looking for a focal infection and channels of entry to the nervous system. He took 25 cases in the acute stage and worked out their intestinal flora. Then a polyvalent vaccine was given, after the subsidence of the febrile state. Twelve of the

cases, within two years, showed certain of the chronic sequelæ which Dr. Riddoch had described. In the 1925 epidemic he again had 25 cases, which were treated in the same way, but instead of allowing these patients to get up and be about their work after six weeks, they were kept under close observation for six to eight months. The result had been that only two of those patients had any sequelæ.

In order to illustrate what happened in an acute case when it was not carefully managed, he mentioned the case of a sailor, who came into hospital with acute encephalitis and mild diplopia, also some mental hyperactivity. At the end of a month he had to return to his work. In six weeks, however, he was back in hospital, with diplopia and vertigo, and within three months he had acute Parkinson syndrome. He had now reached the chronic stage, and his case was practically hopeless.

Another case was that of a woman who had mild symptoms of acute encephalitis. Within a week she had given birth to a child, and there followed symptoms of myasthenia gravis, the severity of the symptoms probably being due to difficult labour.

Careful consideration of 50 acute cases treated had led him and his colleagues to feel that with the use of polyvalent vaccine and antiseptics, with a prolongation to six months of the convalescent period, so as to avoid all undue physical and mental stress, some of these cases could be saved from the distressing manifestations of the chronic stage.

Dr. T. S. Good (in a written communication) indicated the types of encephalitis described by Von Economo. Stress was laid upon the lethargic and hyperkinetic types, and an endeavour made to show that, although both were only types of the same disease, differences existed in the ætiology and pathology. The importance of the element of previous emotional stress as a determinant of the hyperkinetic type should not be overlooked.

The mental after-effects depended upon the stage of the mental development reached, the degree of infection, the layers of the cortex most affected, and the influence of environment. Four main groups were defined: (*a*) Hysterical and neurasthenic; (*b*) moral imbecility; (*c*) paraphrenic; (*d*) deep dementia.

The hypothesis was advanced that many cases, hitherto described as dementia præcox of the katatonic variety, were in reality post-encephalitic, and that all cases of acute amentia (Tanzi) were probably encephalitic.

Dr. T. A. Ross said that both Dr. Riddoch and Dr. Mapother had touched on the diagnosis of so-called neurasthenia, and both gave the criterion for diagnosis, which was no doubt most important, namely, careful examination. But the speaker thought there was another thing which should be considered, namely, the enormous importance of the history. If one took what Dr. Riddoch and Dr. Mapother said, one would be driven to the conclusion that when nothing physically wrong could be found about the patient, he would be considered to be suffering from neurasthenia—a view he was very much opposed to. Neurasthenia was as positive a condition as any other in medicine, and it was not to be diagnosed by negative signs. What had led people astray was attaching importance to events like something going wrong with a girl's marriage; or that a woman lost her son and thereafter became rigid and feeble. The biography of the patient was important, not little events here and there; it was a question of how the individual reacted to the stress of life. Such a case was that of a lady who was one of the tired people. She had been getting more and more tired for years. At the age of 6 she apparently suffered sexual assault, an older boy putting his hand up her clothes. When she reached the age of 13 an old lady carefully explained to her about her periods and the meaning of sex. She now remembered and began to dwell on the incident which occurred when she was 6 years old, remarking that she must have nothing to do with any man, as she was unworthy; no man must fall in love with her, and she must not fall in love with any man. She was now aged 37, and the affection she had enjoyed was that from her own sex, though there had been no homosexuality. She was so affectionate with one woman that the latter got "fed up." She was in need of affection, but could not get it, and so she had taken refuge in a neurosis. The key to the diagnosis was provided by the way she had reacted to the ordinary situations of life. In the diagnosis one had to consider not only the absence of physical signs, but the presence of psychological elements which might be termed stigmata.

Dr. Poston (Oldham) said that Parkinsonianism, in outward appearance at any

rate, was essentially a derangement of posture. He mentioned two cases, the first of which showed " spasmodic cramp of the upward glance " and indication of some vestibular excitement which was influenced by posture or position, and which reacted upon the centres controlling eye movements. The second case was one of complete external ophthalmoplegia with diplopia of six months' standing. Simple syringing of the ears with cold water enabled the patient temporarily to move his eyeballs in every direction and caused the diplopia to disappear. These and other findings led the speaker to urge that a vestibular lesion not only existed, but that it was responsible for the commonest group of symptoms—namely, the ocular manifestations.

Dr. P. C. CLOAKE said his remarks dealt with mental symptomatology, but were, he believed, capable of wider application.

Dr. Greenfield had given him a lead for what he had to say by his description of the widespread changes throughout the cortex, as in other grey matter, and the importance of these observations when considering mental changes.

The mental symptoms of encephalitis lethargica were of toxic-infective type, and resembled in some features the acute mental effects of such toxins as alcohol, because neuro-toxins depressed all nerve-cells, and especially those of the highest levels.

In encephalitis, in addition to the severe local lesions, there was evidence of a depression of highest cortical functions in the characteristic organic mental reaction of lethargy, weakened attention, weakened " grasp," etc., and Dr. Greenfield had shown that there might be *visible* evidence of cortical cell degeneration, too.

He thought the mental changes could best be understood by utilizing the conception of " neural energy," and thinking of mental and nervous phenomena as evidences of orderly evolution and distribution of energy derived from the activity of the neurons at different levels in the nervous system.

He would like to recall a conception of Sir Henry Head's which he thought had not received the attention it deserved. Head observed that the decerebrate cats of Bazett and Penfold responded to stimuli reflexly and purposefully, so that a drop of water placed in the ear led to shaking of the head, while touching the ear with a finger produced a different, but appropriate response.

This purposeful, adaptive character of reflex response to stimulation was only seen when the internal and external environment of the animal was good (it was abolished temporarily, for example, when the cat was given a little chloroform or suffered from sepsis), and the nervous system was said to be in a state of " vigilance."

Conceive what " vigilance " implies physiologically and apply that to high cortical levels, and the speaker thought they would see a close parallelism between high vigilance in the cortex and high mental efficiency, with its heightened attention and ability to respond appropriately to whatever stimuli might arise in the changing environment of the individual.

Attention did, indeed, imply in psychology largely what " vigilance " did in physiology, namely, that condition of the mind (nervous system) in which a selective response to a stimulus can be obtained at its optimum.

Without detailing further the characters of " vigilance " at high levels, one might state that it was precisely these psychic characters that were impaired in mental disturbances of toxic and infective origin. Hence arose lethargy, defective power of concentration, loss of interest, that inability to organize his reactions according to social standards that characterizes the child sufferer from encephalitis lethargica, head injury, etc., and possibly the same accounted for the asthenic syndrome described by Dr. Riddoch.

With regard to what had been said by Dr. Sachs about the lethargy of epidemic encephalitis having peculiar and distinctive features, he could not agree with this observation. In other conditions producing lethargy such as cerebral tumours or abscess, it was also possible to speak with and rouse the patient momentarily and get a rational answer, unless the condition had passed over to the deeper stage of mental obliteration—coma.

Dr. IVY MACKENZIE, in reply, said he still adhered to his view, though some confusion might have arisen as to the spread of the lesions. His explanation of localization to the posterior roots of the cord had to do with cases which had begun as disseminated sclerosis, and there was no question of affection of the anterior cornua. He considered it was a function disorder on an organic basis.

BALL AT CRAIG HOUSE.

On the evening of Thursday, July 21, many members and ladies availed themselves of the kind invitation of the Board of Managers of the Royal Hospital to a ball at Craig House.

MORNING SESSION, FRIDAY, JULY 22.

THE PINEL CENTENARY.

Before the resumption of the scientific meetings the President and members assembled at the West House, Royal Hospital, Morningside, and witnessed the placing of a memorial wreath, by Sir Arthur Rose, *D.S.O.*, the Chairman of the General Board of Control for Scotland, on the bust of Philippe Pinel, situated over the entrance arch of the Pathological Department.

The doorway was adorned by the French Tricolour and the Flag of St. Andrew. Among those present were Dr. Henri Colin (Paris) and Prof. R. Cruchet (Bordeaux), also the staff nurses of the hospital.

In opening the proceedings, the Chairman of the Hospital (Mr. J. S. COCKBURN) said:

We have met here to celebrate the Centenary of the death of Philippe Pinel. It was he who initiated the great reforms in the care of the sick in mind. I do not intend to give you an account of his life and of his reforms, as I do not wish to encroach on the speech of Sir Arthur Rose, who will presently speak, but I have, however, to explain how it is that this gathering takes place to-day at West House. The story goes back a very long time.

In the beginning of the last century the Paris School of Medicine was the most distinguished in the whole world, and many of our Scottish doctors went to Paris to complete their education. Among these was Sir Robert Christison. In the year 1820 he went to Paris and attended Esquirol's lectures on mental diseases, and saw the excellent way in which the patients were cared for in the wards of Pinel at the Salpêtrière. This made a deep impression upon him, which he records in his autobiography. Sir Robert became famous, and was elected President of the Royal College of Physicians in the year 1838, and, in consequence, a Medical Manager of the Royal Asylum at Morningside. At that time only East House, for private patients, existed, which has since been pulled down. The Managers determined to build West House, and it was while it was being constructed that Sir Robert Christison, owing to his admiration of the work that Pinel had done in reforming the care of mental patients, almost certainly induced the Managers to place a bust of Pinel on the entrance arch of the building.

There have been great changes at West House since 1838. What was at one time the front of the building has now become the back, and so it happened that the bust of Pinel, which is veiled at the moment, was placed over the archway which looks into the courtyard. It is interesting to note that the bust does not look outwards, but inwards, as if Pinel were still watching over the welfare of the patients, and seeing that his humane methods were being carried out.

The Managers have under consideration the question of removing the bust to the front of the building, but as it forms the keystone of the arch it will be a difficult matter.

With these introductory remarks, he then called upon Sir Arthur Rose to unveil the bust.

Sir ARTHUR ROSE said it was a little difficult to speak adequately as a layman on such an occasion as this, because, no matter how sympathetically a layman might watch the work of the medical and nursing professions, he could never fully apprehend the work of such an institution as this. He conceived, also, that it would be almost impossible for a layman to throw back his mind to the years when the conditions which Pinel did so much to improve. When one read that his first action on being put in charge of a large mental hospital in Paris was to strike the chains off fifty patients, frankly he could not conceive, knowing the modern mental hospital as he did, what the conditions in that day were like. They must have been very bad, otherwise there would not have been

the great mass of legislation on the subject in Scotland and England, which had been gradually built up in the endeavour to ameliorate the conditions of mental patients. Acts of Parliament were all very well, but they were only the dry bones. Unless the spirit of sympathy, kindness and great skill were dominant, the improvement in the treatment of mental patients could never be achieved. He thought that they in Scotland had reason to be proud, for one thing, of the fact that the inception of this great institution began concurrently with Pinel's vision on the matter. He conceived it to be a very appropriate symbol that this institution in Scotland was the only place, out of France, where Pinel was commemorated in this manner.

He spoke with much diffidence, but he thought his audience were aware of the feelings of the General Board of Control towards Morningside. It was realized by the Board that the spirit of Pinel continues to animate this hospital. On occasion there might be small differences, but, in a large sense, those on the Board of Control did their best to co-operate with those who were actually engaged in the work of the mental hospitals.

He thanked the Association for the honour it had done him in asking him to place this wreath on Pinel's bust. It gave him very much pleasure to do so in the presence of their French friends, Prof. Colin, of Paris, and Prof. Cruchet, of Bordeaux. That was not only symptomatic of what France did in this great work, but it was also pleasant to remember it as a token of the ancient and still existing friendship between the two countries.

Dr. HENRI COLIN said: Mr. Chairman, Sir Arthur Rose, Ladies and Gentlemen,—I can hardly find words in which to express our gratitude for the magnificent homage which you have rendered, and still continue to render, to the great Frenchman, Philippe Pinel. The greetings you sent us when we commemorated the Centenary of the death of the great alienist will be preciously kept by us, and, moreover, we intend to have them reproduced in a book, which will be an everlasting souvenir of our mutual friendship.

Pinel's reform had a world-wide effect, and its influence in Great Britain was immense, so that Morel could write, after his travels in England in 1858, that the British were the first to profit by Pinel's ideas. And it is true that Great Britain immediately took the first place in the humane care and treatment of the mentally afflicted with Tuke, Charlesworth, Gardiner Hill and Conolly, so that the splendid asylums of England and Scotland have ever been a pilgrimage which must be accomplished by foreigners and others who may be concerned with the treatment of mental diseases.

I see before me the staff nurses of this old and world-famous hospital, which brings to mind another aspect of the Pinel Centenary, namely, the rendering of a well-merited homage to Pinel's lay assistant, whose name was Pussin, and whose name is inseparable from that of Pinel. Pussin, who was the chief assistant at Bicêtre, knew the patients he had to care for, and Pinel did nothing without taking his advice. I will only recall the story of a famous patient, an English captain, a sort of giant, with tremendous strength, who was fettered in Bicêtre for several years, as was Lieut. Norris in Bethlem. Pinel asked Pussin if he could be unfettered, and the chief assistant said he thought it was possible, and to read the account of the patient who was at last free from his bonds is impressive.

What was the result of Pinel's reform? Before him, as Kraepelin recalls in one of his books, attendants in asylums were forces more than individuals. They were ill-paid, and were allowed to exhibit the patients to visitors for a few pence. In some places they had dogs and carried big sticks during their visit. They were common, coarse, and unsavoury people. After Pinel's reform there was a total change.

Pinel always consulted his staff when something had to be done, and I believe we all do the same. That is what I have done during the past forty years. But in order to give proper answers the staff must be trained and educated. I believe the *rôle* of a good asylum nurse is more difficult to fill than that of the ordinary hospital nurse. Not only must a trained mental nurse observe the delusions and deliria of the patients, she must also be on the look-out for the occurrence of various physical diseases, as many patients never complain when they suffer. This is one reason why we train and educate our nurses. I have often heard it said that there was a danger of making pseudo-doctors of them, but there is no danger of that. What we require in our nurses are active and intelligent

collaboration, of the type of Pussin, and for this special education and practical training are necessary.

Now, in the address concerning Pinel by the Royal College of Physicians of Edinburgh, it is recalled that ancient bonds of friendship existed between Scotland and France. I will add that these bonds are ever being strengthened, and that whenever the merits of some of my illustrious countrymen are to be recalled, the Scotch are first in the field. For instance, it was my friend Prof. Robertson who was the first to suggest that the Centenary of the discovery of general paralysis in 1822 should be commemorated, as well as the name of Bayle. In Paris, Pinel's statue was only planned in 1877, and erected in 1886, sixty years after the death of Pinel, but we see that here in Morningside his bust was put on the then main arch of the Hospital in 1838.

The PRESIDENT of the Association said that no one could form a clearer idea of the condition of the insane in the closing years of the eighteenth century than was to be found in the following lines of one of the mad songs given in Disraeli's *Curiosities of Literature:*

" In the lovely lofts of Bedlam
'Mid stubble soft and dainty,
Brave bracelets strong,
Sweet whips ding-dong,
And a wholesome hunger plenty."

France, at that time, was suffering from the aftermath of the Revolution, and the social conditions in Britain were not much better, when Pinel, in France, and Tuke, of York, simultaneously broke the bonds of the insane. In the celebrations of the Centenary of the death of Pinel, which were held recently in Paris, of which he was himself one of the spectators, several things struck his imagination forcibly. One was that, like Lister, Pinel was appalled and horrified by the devastating effects of sepsis, but it was a mental and moral sepsis. As a member of the National Guard which witnessed the execution of Louis XVI, as one who saw all the horrors of that terrible revolution, Pinel's sympathies went out to all who were in sorrow and distress. One incident in the life of Pinel greatly interested the speaker. Pinel, in going his rounds in the Bicêtre, was struck by the miserable situation of a huge man, a perfect giant, bound hand and foot with chains. Because of his strength he had on several occasions broken the chains which anchored him to a slab of stone. I would like to quote to you exactly what Pinel said to him. He said: " Listen, my friend. To prove that I have confidence in thee, and that I regard thee as a man made for good, help me to free those unfortunates who have not their reason like thyself. And if thou conduct thyself as I have reason to hope thou wilt, I shall take thee into my service, and thou wilt never leave it." The effect of that was wonderful; the giant, free from his chains, became the devoted and obedient servant of Pinel. And so Pinel scattered the seeds of humane kindness in the treatment of the insane and a new and better era dawned for them. From this lowly but strong foundation had been built such a munificent institution as this hospital, at whose head was Prof. Robertson, a true follower of Pinel, where he was encouraged and aided to the fullest extent by a body of citizens, not a few of whom were excellent business men. He referred especially to Mr. Cockburn, the Chairman. The institution could have no better head than that gentleman from a business point of view in the guidance of those more mundane affairs to which Prof. Robertson could not devote more than a part of his time.

He had much pleasure in proposing that a vote of thanks be given to the Managers of the Royal Hospital and Prof. Robertson, the Physician-Superintendent, for the opportunity thus afforded them of paying a tribute to the memory of Pinel.

This was carried by acclamation.

The CHAIRMAN briefly acknowledged this courtesy, and the proceedings terminated.

In the Chemistry Theatre at the University New Buildings.

(Conjointly with the Section of Mental Diseases of the British Medical Association Meeting.)

The PRESIDENT of the Royal Medico-Psychological Association in the Chair.

DISCUSSION ON "POINTS IN THE REPORT OF THE ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER (ENGLAND AND WALES)" (pp. 50–60).

The PRESIDENT said the issue of the Report of the Royal Commission on Lunacy and Mental Disorder came at a psychological moment in the history of the treatment of mental disease, and the section of the Report which had been chosen for this discussion dealt with problems of the greatest importance not only to psychiatry, but to the practice of medicine generally. He pointed out that psychiatry as a branch of medical science, from his own personal experience as a specialist in nervous and mental diseases to the Forces in the Mediterranean, was tardily recognized during the war, but its great importance had finally to be conceded. Generally speaking it had not been accorded the same status as public health, for the practice of which a special qualification was a *sine qud non*. His Association had for many years held that the same conditions should apply to the practice of psychiatry. If this came about it would contribute towards the solution of the problems they had before them for discussion that day. He laid down the time allowances for speakers, to ensure as many expressions of view as possible.

He called upon Prof. Robertson to open the discussion (*vide* p. 534).

Dr. E. MAPOTHER said he regarded the Report of the Royal Commission as profoundly disappointing. He thought it was, to an extraordinary extent, devoted to the prevention of non-existent abuses in a rather inconsistent way, The general principles which it laid down and to which it paid tribute were not always promoted by its concrete recommendations. He thought it had especially gone wrong by focussing attention on procedure. For his own part, the speaker was not largely concerned with the treatment of the unwilling case. He felt strongly that the public were more concerned as to where and how they were treated than under what procedure they were treated. He even thought there would be much less difficulty than was generally thought in having voluntary boarders admitted into county mental hospitals.

The Royal Commission left him rather doubtful about the prospect of improvement in treatment. There were very many suggestions for the generalization of benefits which existed somewhere, and that they should exist everywhere. And there was much with which everybody agreed, from the improvement of pre-graduate and post-graduate medical education to such things as an adequate supply of toilet-paper. (Laughter.)

Many of the recommendations were matters within the routine province of the Board of Control. It was in respect of constructive proposals, in which some imagination was needed, that the Commission seemed to have gone wrong. Prof. Robertson had spoken of the clear-cut distinction between the voluntary and the involuntary case, but he, the speaker, denied that it was clear-cut. He believed Prof. Robertson said he hoped nobody would object to it, but the speaker objected to it intensely. He thought the worst feature of the Commission's Report was the ignoring of the non-volitional case. (General assent.)

Of profound importance was this third class; it included many of the recoverable cases, and precisely those which should, in his opinion, have an opportunity of treatment elsewhere than in a chronic mental hospital, and under different procedure—a procedure which should not involve any kind of intervention by a justice. The Royal Commission Report not only failed to increase the opportunities of treatment of such cases, it would positively restrict them. In the one institution at the present time which was treating voluntary cases in England extensively and nothing else (the Maudsley Hospital), it was assumed that if a patient had voluntarily placed himself under control and he subsequently became not unwilling, but in a state in which he was incapable of expressing his opinion, the consent for treatment which he gave or ginally still held. But the Royal

Commission laid it down that within one month the procedure essential for certification must be gone through, *i.e.*, he had to be put under a Provisional Order. What was this Provisional Order except a certificate? (Applause.)

In what way did the Provisional Order, except in name, differ from a certificate? The patient must be seen by a magistrate within seven days, again at the end of a month, and if he had not recovered or become a voluntary patient, again at the end of six months. On that Order the patient was committed to an asylum for further treatment. What was required was a method of treating the non-volitional case outside the asylum temporarily by procedure which was definitely distinguishable from a certificate, and which did not involve the intervention of a magistrate. The proposed Provisional Order seemed to be entirely indistinguishable from a certificate, except that the magistrate saw the patient three times, instead of once.

One of the objectionable things about the Provisional Order was the following: The patient *must* be seen by a magistrate—it was not merely that he *might* be so seen—and the magistrate had to see him within seven days. The doctor should not have to wait, perhaps, seven days to get his patient seen by a magistrate. It seemed to the speaker that that was going to drive most of them to the use of the Emergency Order, which remained unaltered except that it would apply also to pauper cases. That was a fairly serious thing, because he felt that the doctor's responsibility when he supported an Emergency Order was a different responsibility from that he incurred when he signed a certificate supporting a Magistrate's Order. He was in favour of having a special certifying medical man for the certificates needed for the Provisional Order. That was a suggestion, and not a definite recommendation in the Royal Commission's Report.

There was the dreadful recommendation that when the Provisional Order had to be followed by a definite Reception Order the patient had the right to claim the attendance of any one person chosen by himself, and that the justice could be assisted by his clerk, and the justice might call upon the medical man to justify his certificate, etc. It meant the institution of a trial before the patient could be committed to a mental hospital—a trial in which the patient could be represented by counsel, while the medical man could not. (Applause.)

Dr. T. B. HYSLOP said it was with extreme pleasure that he found himself at that University after a lapse of forty years. He had appreciated enormously the paper read by Prof. Robertson, for he had put before his audience many matters in a temperate yet strong manner. (Applause.)

With regard to the medical aspects of the question, there were many important considerations. As medical men, their first duty was to the patients, then to the community, and lastly to themselves. In dealing with mental cases one had always to realize that in depriving a person of liberty the doctor was taking away all social, civil and economic rights, and, in addition, putting a label round the person's neck which would last him throughout his life, and would stigmatize the family "to the third and fourth generation." There were many families going about with heads bowed down with invisible albatrosses round their necks because of the knowledge that one of their number had been certified, and they are afraid lest the same thing should happen to them. That anticipation went more than half-way to realization in themselves. He stressed this because we wanted to ask whether it was always a family taint, or was it a taint of insanity itself? In the majority of cases he would say "No" to the latter. When one took the bodily conditions it must be admitted that the label of insanity was applied to cases of faults in the endocrines and conditions due to toxæmia, etc., when they should really be called medical cases with a few mental symptoms. This was an important difference. Without wishing to boast, he could say that he had removed many albatrosses from the necks of many families by pointing out that immense difference. Certification did the deed. He held that in mental cases due to bodily conditions the medical man should be given a sporting chance of relieving these patients of their physical disabilities, and should not be compelled to label them as insane. Hence the profession welcomed the report of the Royal Commission, as it enhanced the idea of early curative measures. He believed that if certification, in its present form, could be abolished, an immense amount of good would be done to the community; it would be raised in its self-respect, and tend to get rid of this anticipation of the albatrosses of which he had spoken. In addition, it would lessen the number of those who were certified as being of unsound mind. He thought that the Report, in addition to pouring oil

on troubled waters, would help as a means of lightening the enormous burden of lunacy which the British race had undertaken.

With regard to the judicial authority, he was of the belief, as were most of those present, that insanity was essentially a medical matter. It was anticipated when the Lunacy Act of 1890 was passed that some of the responsibility would be shared by the legal profession; but not so; the whole of the burden still rested on the medical profession. He remembered, at Bethlem, an aged magistrate who came to see a patient: "I know nothing about it," he said. The speaker replied to him, "It is your duty to examine the patient." He said, "This is simply awful." He spoke to the patient, a lady, and said, "Madam, have you any delusions?" She replied, "You silly fool. If I knew I had delusions they would no longer be delusions. Good morning." (Laughter.) Whether the judicial authority was wiser now he was unable to say. If there were judicial authorities who had a knowledge of the subject it would be another matter.

With regard to medical men and their knowledge of mental diseases, his experience was that there were qualitative and quantitative differences, the second not being so evident as the first. In regard to qualitative differences he was speaking of specialization. It was not to be expected that the general practitioner would have knowledge on special subjects in every direction. Therefore on this question he thought that the general practitioners' position should be made stronger by the help of those who had had more individual experience in regard to the insane. How to bring this about was another matter. It was open to County Councils and various local authorities to appoint these men who had a knowledge of the subject as certifying officers.

Dr. W. F. MENZIES said he was under the same disadvantage as Dr. Mapother. Until he entered the room he had no intention of speaking to-day. He intended to limit his remarks to one or two points concerning his own experience.

He spoke, not as a member of the deputation of the Royal Medico-Psychological Association, which gave evidence before the Royal Commission, but as an individual, and he desired to direct attention for a few minutes on the Provisional Treatment Order and its sequelæ.

As Dr. Mapother had already said, three interviews with a justice might be necessary before a patient was certified, the last one with the justice's clerk and family practitioner present. The latter, poor man, was perhaps in the middle of his round and was hailed away maybe a distance of twenty miles, to give up half a day, or a whole day, to the question as to whether a mental patient under a provisional order should be certified or not. He was not sure whether the Government intended to bring in an Amended Mental Treatment Bill, or an Amended Lunacy Bill. He had always been sceptical about the attempts of all politicians. He thought the Association should stick to its views about the non-volitional case, as that formed the crux of the whole situation. No one would object very much to the chronic paranoiac being dealt with the utmost severity of the law, and not even a lawyer or a crank would interfere with the volition of the voluntary patient.

As regards the non-volitional case, there would be no advantage gained by opposing the Royal Commission's recommendations absolutely, but it must be recognized that if the justice and medical man had to see the patient three times an impossible situation would be created, no justice could be found to act and no medical man to certify. He thought an attempt should be made to get an amendment, which provided that the committees of visitors of county and borough mental hospitals, and the boards of management of private mental institutions, clinics, etc., should be appointed *ad hoc* the judicial authorities under the Act. The result would be that at the weekly or monthly visit of the committee or board the second medical certificate, *i.e.*, that of the medical officer of the hospital, would be ready, and the order would be signed, without trouble or publicity, or calling in any special justices from the outside. The committee or board would see or not see the patient just as it was deemed necessary. He thought that people generally were not apprehensive of improper detention, and that the whole of the agitation had been fomented by a noisy minority, many of them unrecovered patients. (Applause.)

Dr. J. S. RISIEN RUSSELL said he had listened with the greatest possible interest to the address with which Prof. Robertson opened this discussion. Had the profession in England enjoyed the privileges Scotland possessed on this matter, he,

the speaker, would have been content. He had long contended that the laws of England and Wales ought to be altered in order to allow doctors to treat patients affected mentally for at least a year without any interference by the law, and he had always held that certification ought to be the last resort.

As the law now stood in these countries, one was constantly hampered in the treatment of these patients because of the ever-present fear of coming into conflict with it. He found that the general practitioner was even more perplexed.

Two distinct issues were engaging the attention of the profession and of the public. The first was as to whether the doctor should have the whole say in the matter of certification in the case of a person supposed to be of unsound mind, without legal intervention. The second was whether the doctor who certified a person as of unsound mind should be regarded as immune against the possibility of a civil action being brought against him for damages in a court of law for alleged wrongful certification. When the question was merely one relating to the treatment of a patient, the medical profession was well within its rights in claiming to be the proper judges of what was required. But when it became a question of depriving an individual of his civil rights, the matter passed out of the sole province of medicine and became a legal one. Doctors were fully justified in claiming protection against civil actions for damages in respect of alleged wrongful certification, but they could only reasonably hope to secure this protection if they were prepared to accept the interposition of a legal authority, on whom the whole responsibility must fall. Moreover, if the medical man was to expect the protection he claimed, it seemed a reasonable proposition that he must be prepared, in conformity with all other instances in which he was called upon to give evidence, to do so on oath.

Even in so comparatively unimportant a matter as the saying whether a man was drunk or sober, a doctor's certificate was not enough, and such a certificate would not be accepted in lieu of his—the doctor—appearing in the witness-box to give his evidence on oath. How much more, then, should this be required in a case in which the decision carried such grave consequences? It was necessary to remember that a lasting damage was inflicted, and it was one which might have far-reaching consequences; for instance, as to other members of the family in regard to their status in general, questions as to marriage, life assurance, and a variety of matters which closely affected their success in life.

The suggestion that there should be the interposition of a representative of the law, and that he should be compelled in all instances to personally see and examine the person supposed to be of unsound mind, did not carry with it the least need for any publicity, for the person in question need not appear in open court.

It had been suggested that it might be an advantage for the legal representative in those cases to be a man who had been trained in both medicine and law, and that probably there were a sufficient number of barristers with medical training who could possibly be secured to fill these posts. The idea seemed a reasonable one, but it had since been pointed out to him that this would leave the matter "too medical"; that what was wanted was that the question should be viewed from different standpoints, hence the importance of having a justice, a man who had had no medical training. The "welfare" of a patient might be a purely medical question, but his safety or the safety of the public was a matter for laymen.

Important recommendations by the Royal Commission in regard to such enquiries were: That the judicial authority should always actually see the patient, and that the person whose case was being investigated was at liberty to have a friend present, and that the justice should be called upon, further, to exercise what was termed a directed discretion, which the speaker understood to mean that he must consider and state his decision on the face of his order as to whether the allegations on which the person was regarded as insane were proved, whether he had seen the doctor, and whether the patient should be told of the allegations against him.

To Dr. Russell's mind the most important recommendation of the Commission in the interest of the patient was that which, if adopted, would allow of treatment without certification having to be resorted to for at least a month, possibly six months. That was a matter he had contended for many years, and which he earnestly hoped he would yet see fulfilled in England and Wales, those in Scotland apparently having already what was wanted in this direction.

How the Urgency Order was in many instances abused and made use of as a

convenience, instead of being strictly reserved for cases of real urgency, had been so strongly brought out by evidence before the Commission that there was every justification for the interposition of a magistrate before the person was sent to an asylum, even in the case of an Urgency Order. (Dissent.)

The medical profession should welcome anything which would offer the public a sense of security in these matters, so long as what was suggested did not conflict in the opinion of the doctor with what was necessary for the good of the patient. Hence no reasonable safeguard should be rejected by the profession. That one of the two medical certificates should be supplied by the doctor who possessed special knowledge of mental diseases seemed to the speaker to be reasonable in the highest degree. If found practicable, what possible objection could there be to having doctors specially appointed under the Act to fulfil this function? The object of the profession ought to be to suggest a way out of the present difficulties. In this, three objects should be kept in view, namely, what was best for the patient, what was acceptable to the public, in conformity with the law, and what would give full protection to the doctor. This was preferable to having something unacceptable to the profession forced upon it by law.

His own suggestions for meeting these three requirements were as follows:

That there should always be two doctors supplying the evidence, except in the very rare event of a case being of such urgency as to make this impracticable, and that one of those medical men should have special knowledge of mental diseases.

That the judicial authority should, in every case, see and examine the person who was supposed to be of unsound mind, and also the doctors.

That in order to secure protection against civil actions, the doctors should give their evidence on oath, and be subject to cross-examination, in the same way as was any other witness. (Dissent.)

But what the speaker regarded as of paramount importance was that doctors should be allowed to treat patients mentally affected without certification and away from asylums for six months at least, and, if possible, twelve months.

The PRESIDENT said the meeting was highly honoured by the presence of Sir Robert Philip, the President of the British Medical Association, and who had just then entered. (Loud applause.) Not only was Sir Robert a great physician, but a great man of affairs in other directions, and everywhere his name was held in the highest respect.

Dr. DONALD ROSS said he was offering some remarks on this subject with considerable diffidence. But it did one good to know what was going on in other countries.

In Switzerland, in the Canton du Valais, there was a small hospital where things were done with an admirable simplicity. The hospital was the Maison de Santé de Malévoz. Dr. Repond, the medical superintendent, said to the speaker, "Thanks be to Heaven, we have no lunacy laws, no inspectors, no boards of control." (Loud laughter.) Still, those who practised in Scotland knew that the Board of Control were the doctors' real friends and *confrères*. (Applause.) In Valais there was a very simple and workable code of rules drawn up by a former superintendent in collaboration with one of the members of the Cantonal Legislative Council. The admission and discharge of a patient were governed by the superintendent's opinion as to the suitability of the case; if that functionary thought a patient was fit to be admitted he was admitted; if he thought the patient was fit to leave, he went away. Relatives, however, were not always willing to receive a patient back until he had recovered, and in such a case his further detention for a period meant that the relatives had to pay a much higher rate for his board—a course which was usually quite effective. Dr. Repond said that every law for the insane acted against the interests of the insane, and those in the practice of the specialty knew that a good deal of truth underlay the words.

Dr. Risien Russell had spoken of the desirability of having medical men with experience of psychiatry to deal with these patients. One of the speaker's recovered patients—from whom he had learned much—always maintained that two medical certificates ought to be obligatory, the second certificate being signed by somebody who had a knowledge of psychiatry, the first being signed by the family physician. That man considered that nowhere would such an expert be found outside a mental hospital, as no others had had the proper experience for the task.

In conclusion he said he would like to quote one definition of insanity he heard in the course of a conversation. He was discussing with a medical friend the difference between sanity and insanity, and his friend said, "The law has provided us with a clear-cut dividing line: the sane are those who have not yet been certified." (Laughter.)

The EARL RUSSELL, who was heartily welcomed, said that the Commission had the advantage of evidence from Prof. Robertson, which much impressed them. They also much admired the system which that speaker was able to administer. He, Lord Russell, did not wish his audience to think, from anything he might say, that he at all undervalued the doctors' evidence and the medical point of view. But he did wish, at the outset, to make this perfectly clear: that when one was dealing with legislation and with amendments to the law, it was of no use to discuss the matter solely from the medical aspect. That was somewhat overlooked in Prof. Robertson's paper, because he did not know the difficulties which were suffered from in England; it was also overlooked in some of the other speeches he had heard. The attitude of the public must not be disregarded. The Royal Commissioners had to bear that in mind. There were members on that Commission who represented, and felt to some extent, what he might call the anti-medical view. Whether it was still the effect of Charles Read's book he did not know, but there existed, in England among the great mass of the population, a certain amount of suspicion of doctors in connection with cases of insanity; and legislation could not be got through unless that attitude was recognized and allowed for. Those concerned with legislation had to remember not only the medical aspect—with which he was himself in entire sympathy—but the attitude of the House of Commons and what legislation could be got through that representative Assembly. That represented not only the intelligence, but also the stupidity and the prejudices of the nation. (Applause.) He took some exception to Dr. Menzies' description of those who were opposed to the medical view as consisting entirely of lawyers and cranks. Dr. Menzies should add a much larger, and, from the point of view of legislation, a much more important class, namely, the vast class of uninformed and uneducated public opinion.

Their duty on the Royal Commission was not to consider merely the procedure for certification, important though that was, but also to consider the happiness and well-being of that very large body of patients who spent years and years under institutional treatment. And in that respect they had to have regard both to their complaints and their feelings, especially in such matters as their opportunity of sending out reasonable letters to their friends, and in comparative privacy, *i.e.*, letters which were looked at only by the medical superintendent, not by the nurse of the ward. One of the first remarks he heard from Dr. Mapother was on the matter of toilet-paper. If any of his hearers found themselves in a strange hotel, at a critical moment, without toilet-paper, they would probably not regard the omission as a trifle. Evidence of that sort of neglect came before the Commission. And in the matter of bathing arrangements it was felt that in some cases the patients were treated in rather a brutal and inhuman manner, and the Commissioners considered it was their duty to deal with that.

When he came to certification he was approaching an extraordinarily difficult question. Many of his colleagues would have been perfectly satisfied with the opinion of two medical men, if not, indeed, in some cases with the opinion of one medical man. But they had to consider, as his hearers would have to consider if they were going to make a useful contribution to legislation, the prejudices of the public. The point of view of the public was that the medical man was one who was only too ready to certify, and without reason. Those at this meeting knew that the doctor was honest, that his one object was the treatment and benefit of his patient. This was not recognized by the general public, and they desired the intervention of some such person as a magistrate, or some judicial authority, to represent what was termed the liberty of the subject, and to prevent a man being wrongfully put away. If the judicial authority could be dispensed with, no doubt matters would go on very well. For his own part he looked upon the real safeguard for patients in England as the Board of Control, and not the judicial authority. (Applause.) The Board of Control consisted of well-informed people, with ample powers and ample opportunities of inspection. They were of much more use than any judicial authority. (Applause.)

A word about the suggestion of Dr. Menzies that members of a Visiting

Committee should be appointed members of the judicial authority. That would be absolutely fatal, because it would mean at once adding to the suspicion already entertained by patients' friends and by the general public. They would say, "These are all in the same gang." What was required was somebody from outside who was independent. And the Royal Commission did make a recommendation in regard to our judicial authorities to which the speaker attached great importance. It was that they should be persons, more competent than the justice who put the wrong construction on things, or who merely put his head into the taxicab in which the patient was seated.

Dr. Risien Russell had suggested that the justice for this purpose should be a person with medical knowledge. He, Lord Russell, thought that was entirely undesirable. (Applause.) It was not the province of a justice to form a medical opinion; he had to consider the medical opinions, and he must consider them judicially. It was not for such a justice to say, from an imperfect medical diagnosis of his own, whether a patient was sane or not. All he had to be concerned with was whether the matter had been proceeded with properly, and was it in order?

With regard to the discretion of the justice, it did not mean what Dr. Risien Russell said. It meant that he should not be left at large to perform his duties in a slovenly manner. That was what the Commission meant by it.

His lordship had also heard, in the discussion, objections to a public trial. There were the greatest objections to a public trial, or anything resembling a private trial, in the forensic sense. (Applause.) But there were the strongest representations by those who claimed to speak on behalf of ex-patients that they desired, at some stage, to state their case. It was well known that the paranoiac would state his case volubly, and he would not help one. But the Commissioners felt there were occasions on which the patient should be given an opportunity to state his case. The less that procedure took the form of anything like a trial, the better. Almost every member of the Royal Commission would agree on that.

With regard to the question of the voluntary patient, it had been suggested—and he gathered it met with the approval of his audience—that the treatment of a man as a voluntary patient should be continued when he had no volition at all. (Applause.) It was a very difficult question. He was inclined to think—it might be a lawyer's point of view—that when a man was said to be doing a thing voluntarily one should mean what one said. A man could not be doing it voluntarily if he did not know he was doing it. If the voluntary patient question was to be a success it was necessary, above all things, to avoid frightening the public into thinking that a voluntary patient might really be an involuntary patient. If that were so, it would destroy the value of the voluntary system. It was true that a voluntary patient would have moments of rebellion in which he would declare that he would not stand it any longer—that he would leave. It was to deal with such moments that the 72 hours' delay was suggested. It was hoped that in that period of 72 hours the patient would come to a better mind, or it might be decided that the patient should be certified. But if voluntary patients were treated involuntarily, public confidence would be shaken.

He would be glad, personally, if public opinion in general, in England, would allow much greater freedom in the treatment of the insane; he considered it would be to the advantage of the insane themselves. But public prejudice in the matter had to be considered. He agreed that there was no chance of new legislation on the subject this year nor perhaps next year. But the prejudices he had spoken of must be recognized. Attempts at improvement must first be made by not claiming control by the medical profession alone, for to make such a claim would not be very helpful.

Then there was the question of the Urgency Order. One speaker had suggested that a justice should always intervene before the patient's removal to an asylum. But one could not always wait for the justice before restraint had to be carried out; there were cases in which the patient had to be put under control instantly, before either a justice or a doctor could be procured. In such instances control was effected on the initiative of the relieving officer or the policeman. The liberty of the subject was maintained by requiring that doctor or justice must see the patient in three days. If the Emergency Order to which Dr. Risien Russell alluded referred to a private patient, in which he was signed up by one doctor and taken to an asylum, where he was seen by a second doctor, his lordship was of opinion

that the Emergency Order was often employed in cases in which it was not necessary, there being sufficient time to carry out the ordinary procedure. If this Order was abused it might result in it being withdrawn and not available for cases in which it really was required.

He had only intervened to impress on this audience that when discussing the matter they should not consider merely the view-point of the doctor, and that when considering the possibility of legislation the attitude of the public which was not yet educated up to the professional standard in these matters must be considered. (Loud applause.)

Sir DAVID DRUMMOND said that Lord Russell had so fully and admirably expressed his, the speaker's, views on the matter that he would only make two remarks, and say what pleasure it had given him that this Association had received so well the Report of the Royal Commission, and that personally he was very sorry the Royal Commission were unable to safeguard the certifying practitioner more than they had done.

Sir FREDERICK WILLIS, *K.B.E.*, *C.B.*, said he understood Dr. Menzies to doubt whether any legislation was in view concerning lunacy. He, the speaker, knew that the Government were considering what legislation they should propose, and Mr. Neville Chamberlain, Minister of Health, was very anxious, during his term of office, to have a new Lunacy Act passed. In view of that fact the speaker particularly welcomed this discussion. It was one of his duties as Chairman of the Board to submit a memorandum to the Minister saying what he thought should be done, and it was a great help to him and to his colleague, who was also present, Dr. C. Hubert Bond, to have heard the various views which gentlemen had expressed. As Lord Russell had just said, politicians in these matters were largely governed by public opinion. Mr. Neville Chamberlain might hesitate to do what he considered was best if he thought it seemed impracticable, and not likely to be carried. In lunacy matters the public were still very superstitious, and in some respects we had not yet got away from the view of lunacy which was generally held a hundred years ago.

He, personally, was extremely anxious to avoid all formalities in the treatment of the insane as far as that was possible. But, though he thought legal formalities deterred numbers of people from getting treatment, yet there was something more, *i.e.*, they dreaded to recognize that there was anything at all wrong with them. They were possessed by the idea that insanity was—as it was—a dreadful thing, and that, once they started to consult doctors for a mental illness, they would be looked upon as people who should be locked up for the rest of their lives.

The Royal Commission divided patients into two classes—the involuntary, the voluntary. In regard to the voluntary patients, there was nothing more to be said; the Commission had recommended what most of his colleagues had recommended—that there should be complete freedom. They at the Board of Control put to the Royal Commission the view that patients should be divided into three classes—voluntary, non-volitional and unwilling; and they suggested that in the case which had no volition, one was not taking away that patient's liberty by giving him treatment. They tried to get the Commission to accept the view that in such a case the patient might get treatment without any intervention by a justice. Their basic ground for proposing that was that everybody was satisfied that people did not seek treatment early enough. Under the English Lunacy Acts the rate-aided case could not get treatment at all at the public expense until he had been certified. In the public asylums a case could not be taken in until it had been certified. But there was an earlier stage than that, in which the patient needed treatment, and one of the features of a new Lunacy Bill would be to give to public authorities freedom to treat early mental cases as out-patients, and, if they were voluntary, as in-patients, without a justice being brought into the matter at all. He much regretted that the Royal Commissioners did not take their courage in both hands and recommend what he was sure many of them thought should be allowed for the involuntary cases. The Report said that some witnesses, whose views were entitled to the most careful consideration, had urged that in dealing with incipient insanity admission should be carried out without the intervention of a magistrate, and they went on to say that if they were free to consider exclusively the medical treatment of the patient, they would have no hesitation in accepting this suggestion. The speaker regretted they had not, because he thought the Royal Commission could have done much to educate

the public in that matter. If, instead, the Commission had gone on to say, "It was the right thing to do," that would have helped the politicians. Many people would now be saying the Royal Commission thought of it, but turned it down. It was for the Royal Commission, he contended, after they had stated what they thought was right, to recommend accordingly. (Applause.)

He agreed that it was very difficult for any medical man to say that a patient was very likely to recover, and he, the speaker, thought that early treatment without certification should be given, because it was a desirable thing to do. In the view of the Board adequate safeguards could be secured without a justice.

The Board of Control recommended, in regard to these involuntary cases, that they should only enter institutions or homes which the Board had approved as suitable for giving the required treatment. The Board also asked that they should be immediately informed of the reception of those cases, and should have the right to visit as they thought necessary. He regarded those safeguards as adequate—more adequate than the present arrangement, because, having seen much work of the justices in connection with this matter, he thought that, in many cases, their intervention was no safeguard at all. (Applause.)

Another point was that if the safeguards were adequate, he did not see why the treatment of these cases need necessarily be limited to six months, as the Royal Commission recommended. Many of the cases required treatment for eighteen months, and if one was satisfied that there was no abuse, why not let them remain under those conditions? He did not know why any time-limit was needed. (Applause.)

There was another point which was exercising those at the Board in connection with the drafting of new legislation, namely, what further protection should be given to the doctors. He had been much distressed by some of the cases which had come before the Courts in recent years. He could not help thinking that the jury, in England at least, was an unsuitable tribunal for testing cases of this sort. (Applause.) He did not know how it worked in Scotland. There was a notorious case in which, after the lapse of twelve years, a trial took place which lasted three weeks. And all through that case it was obvious that the jury were in great sympathy with the patient—they were always against the doctor in these cases—and they were satisfied that twelve years ago this man was not insane. That seemed to him absurd. (Applause.) He hoped there would be forthcoming some practical suggestions in regard to that. It might be that the power should be taken away from British juries to decide such matters. If such cases were left to the judges, much greater justice would be done. Expert evidence had been called, and it was distressing to see the sort of evidence which one doctor gave against another. If the Royal Medico-Psychological Association and the British Medical Association could make useful suggestions on that point, they would be welcomed by the Board. He did not know whether it would not be well to say that such a case should not proceed unless the General Medical Council gave its sanction, but something of the kind was necessary.

On the question whether there should be two certificates, or one, there was a financial point behind that. Prof. Robertson asked what it would cost, and seemed rather to scorn considerations of cost in such a matter. It would cost £20,000 a year more in England if in these cases two certificates were demanded instead of one. That was a sum which politicians would look at, especially as under the one-certificate system the Royal Commission had found that no case was wrongly detained. So the Commission had no ground for recommending it, except that of satisfying the public sentiment in the matter.

He came to the meeting to listen to other people rather than to speak himself, but he was glad to have had the opportunity of saying these few words. It was extremely important that every effort should be made to break down superstition in regard to mental illness; it was a rock on which the ship foundered every time. People would not recognize that it was like any other illness, especially in its early stages. It was for that very important reason that he wanted to see swept away every barrier which could reasonably be removed in order to ensure the prompt treatment of mental illness. (Loud applause.)

Sir ARTHUR ROSE said he had little expectation of being asked to speak to-day, because, like Sir Frederick Willis, he came to learn, and he had learned a lot. He confessed himself a whole-hearted admirer of the findings of the Royal Commission.

His special reason was that he looked upon it as a very valuable strategical contribution to this great subject, in which all were interested. He was impressed during the long and happy day he, with Dr. Marr, had spent before the Commission, by the nature of some of the questions put. They thought there might easily be a marked divergence of opinion on that Report, and he was immensely relieved, though somewhat surprised, to find that the Report of the Commission was a unanimous one. The reason for that unanimity he conceived to be that it went as far as it thought it was likely the public would go. If the more progressive view had been stressed, as probably Lord Russell and Sir David Drummond and Mr. Macmillan would have done, there would have been serious risk of a minority report, possibly a somewhat virulent one, and that would have done much to retard any progressive legislation which it was hoped shortly to see. He would add his request to the Association's that any legislation forthcoming from the Report would be considered sympathetically. He, the speaker, did so to a certain extent with a selfish object in view. In Scotland a certain amount of amending legislation was required, and while he saw no possible chance of Scotland successfully going forward in getting an Amending Act on its own, he was very hopeful that if a reasonably progressive measure were passed in England, Scotland would be able to follow—not necessarily adopting the same measure, but perhaps going a stage or two further than England.

Dr. C. O. HAWTHORNE said his title to speak on this matter was not that of an expert in lunacy administration, but he happened to have been appointed by the British Medical Association a member of a Committee elected to prepare a memorandum of evidence to submit to the Royal Commission on Lunacy, and, subsequently, to examine the Report of that Commission. What he had to say he was without any intimate personal experience of the carrying out of the provisions of the Lunacy Act. It was with considerable sympathy that he heard the speech which had just been made to the meeting by Earl Russell, who brought his hearers down from the somewhat academic level to the facts of the situation viewed in their broadest aspect. He, the speaker, had learned, in studying this subject under such circumstances as he had mentioned, that there were certain broad views which had to be considered in dealing with the situation.

The first of these was the unhappy interpretation which the public mind attached to the certification of the patient. It was an aspect of the subject which had to be most carefully considered. It had been said that notification to the Board of Control was a sufficient safeguard, but that Board arrived on the scene too late; the stigma was imparted by the certificate, even though that certificate might in two or three days be reported to have been unnecessary. The shadow hung over the patient when once he had been certified. Hence one could not get away from the seriousness of the step taken when a patient was certified. And the stigma would not be removed by calling the certificate a "recommendation."

The second consideration was the importance widely attached to the protection of the liberty of the subject.

The third consideration was the position of doctors in respect of lunacy certification. Here was an impracticable situation created, as could be illustrated in the reluctance, even determination, in many cases, not to sign, under present conditions, lunacy certificates. He heard of deeds of partnership between medical men in which one of the conditions was that neither partner should sign a lunacy certificate. It might be argued that that was a stupid and prejudiced view to take, but when it was claimed that sentiments which were widely held must be respected in practical legislation, he replied that here was a body of sentiment which must be similarly respected. The B.M.A. Committee presented to the Royal Commission a view of the situation in which the doctor would be completely protected, and they believed that it had been argued on a logical basis. What led them to that view was somewhat as follows: There were only two positions which could be logically defended when considering the doctor's relation to lunacy. It was defensible for doctors to take up this position: Mental disorder, like physical disorder, was a medical matter. Doctors alone were competent to judge when a mental disorder existed and how it should be dealt with. That was a position which could be argued, and one should try to educate the public to that position. The other position, which also was sound and logical, was that the State came in and said, "This was a form of medical diagnosis and treatment which invades the liberty of the subject, and we will not allow medical

treatment of that kind to be imposed until we are satisfied that such treatment is necessary." When the State had once said that, it was for the State and not for the doctors to say what was the legal machinery by which the State itself could be satisfied that this treatment was essential. The State might ask the doctor's advice, but it was for the State to accept the responsibility when it had once said that this was a matter in which medical treatment must not take its normal course unless the State was satisfied as to its necessity. When the State stepped in and said it now assumed authority, the State must, at the same time, recognize that it assumed responsibility. Doctors might he asked their advice and opinion upon the whole situation or about a particular case, but that was simply a contribution in the shape of evidence towards the solution of what had been made a legal issue. If that was the true position, then the doctor should have the same immunity enjoyed by any other witness. Dr. Risien Russell had urged that the doctor should give not only a certificate, but an opinion under oath. Why did he not do so now? Simply because the representative of the law did not call upon him to do so. Under the existing Lunacy Law it was competent for a justice to require that the evidence given before him should be on oath. The B.M.A. Committee said emphatically that when the State intervened and had erected machinery for the purpose of determining whether this treatment should be applied in any particular case it must accept its own decision, and must not allow the responsibility to be imposed in the shape of penal consequences upon the shoulders of the medical practitioner who had given to the State his honest opinion and advice. (Loud applause.)

Dr. C. HUBERT BOND said he would try and avoid touching on the points dealt with by Sir Frederick Willis, except just to say that it was pleasant to notice how warmly Sir Frederick's remarks had been endorsed by the meeting, a fact which would be an encouragement to those who worked at the Board.

But he would like to devote the few minutes allotted to him to a consideration of Prof. Robertson's attitude on the question. He, the speaker, would like to go a step back, specifically to the year 1884, when the Earl of Shaftesbury was still Chairman of the Lunacy Commission in England. In those days the Earl was mentally as alert as ever, and was devoting nearly the whole of his time and energies to the welfare of the insane. But he was in failing bodily health, and was, indeed, feeling the weight of his 85 years. Then, as was the case which led to the appointment of the Royal Commission whose Report was now being discussed, a section of the public might be said to have been suffering from what might be termed an anxiety neurosis in mass form, which manifested itself by a fear of wrongful detention for alleged mental disorder. As a result of that feeling, Lord Miltown carried a motion in the House of Lords for the institution of a Committee of Inquiry into the administration of the Lunacy Acts. It was not intended as an attack on the Lunacy Commissioners, any more than was the recent Royal Commission; but the great-hearted Earl was hurt to the quick. He knew and felt the complete integrity of his Department, and he felt that, to use his own words, "God had manifestly blessed the efforts of the Commission." He felt, as he wrote, that "he had everything else on his side except self-confidence in his own power to meet" what he felt to be a charge, and that "the defence would be perfect in any other hands." And he saw, in the drift of such an inquiry, and in the legislation which it was proposed should follow it, especially in the proposed intervention of a justice, again to use his own words, "the labour, the toils, the anxieties and the prayers of fifty years had been, in one moment, brought to nought." So far as the speaker knew the history of those days, Lord Shaftesbury had the support of each of his colleagues on the Commission, legal as well as medical, and all the leading psychological physicians; and the depth to which his emotions were stirred had its echo in the prayer which he was not ashamed to record in his diary: "Cast me not off in the time of old age; forsake me not, O Lord, when my strength faileth." No one could read or listen to a recital of that prayer without reverence and respect. To Lord Shaftesbury, though a layman, the proposals, especially the intervention of justices, were anathema, and he took the strong step of resigning the Chairmanship of the Board of Commissioners. This was in May, 1885; but in June, upon the Bill of 1885 being withdrawn, he was induced to withdraw his resignation. Death, however, withdrew him from the fight shortly afterwards. It was at least permissible to speculate whether, had he been spared, and with sufficient bodily powers to play his part in the fight

when it did come, the intervention of the justice would ever have come about. At any rate, inured as we were in a sense in England to the justice, the audience could not listen to Prof. Robertson's magnificent and virile appeal to their medical instincts without feeling a desire to pause and ask whether, even now, it was too late to relieve the justice of a task for which, he believed, the majority of them had no love, or even taste. It might be that if the uninformed part of the public—whose importance Lord Russell had emphasized—really knew this and other historic cognate facts, and would read Prof. Robertson's presentation of the medical needs and the medico-legal aspects, this might give a swing to the pendulum in the direction of the dictum, *Floreat res medicinæ*.

Sir Frederick Willis had touched upon some of the thoughts entertained by those in the office of the Board regarding early treatment and notification and inspection of early cases. He thought if he were to say a word on that it might be a satisfaction to some.

With regard to the inspection of early cases—cases who were voluntary patients, or those who, having no volition, were termed involuntary, and he was not referring to those in the institutions which are already visited by the Commissioners, but to those who under future legislation might be in approved nursing homes or private houses. As the Board viewed the matter, they believed that their task should be entirely medical, unless some legal point arose. And, further, that the Law should not impose upon the Board the duty invariably to visit these cases. They wanted a free hand. The Board, when the house and its standard of treatment was favourably known to them, might not often trouble them, but when they did, it would be by a visit from a medical Commissioner.

Dr. VERNON BRIGGS (Boston, Massachusetts) spoke as a deeply interested member of three different boards in America which were concerned with mental disease, and under three political administrations. He was now on the Advisory Committee of the State Commission of Mental Diseases. He had followed the discussion of this subject in the medical press of this country, and he hoped that England will advance further than the States have done.

As to certification, the plan there was that cases considered to be dangerous to themselves or to the public and needing care and treatment were certified by two medical men. But a man was allowed voluntarily to enter a hospital for treatment and remain there an indefinite time, so long as he did not become irresponsible. Magistrates had a right to see the patient, but they seldom exercised it. He only remembered one case in which a legal action was instituted by a patient against a physician. Some damages were awarded against the doctor, but the verdict was afterwards set aside on the ground that some of the evidence tendered was not legally admissible. At present, in the case of criminals who had been to jail before and criminals arraigned on a capital charge there was an examination, before the trial, of the prisoner by two alienists of standing appointed by the State Commission of Massachusetts on Mental Diseases. The clerk of the Criminal Court was bound to report the case to the Commissioners of Mental Diseases, and failure to do so was met with a fine. In the five years this had been in operation there had been only two cases for trial before the courts in which medical men appeared against each other in the witness-box, and in that way the status of the profession had been raised. He was hoping to learn something as to the treatment of the early mental case before he left this country. In his State the sum of £20,000 was set aside for clinics for early cases and examinations of accused persons. It was considered an economic expenditure, as the clinics would prevent many cases becoming a burden on the State.

Dr. C. A. MORTLOCK-BROWN (Braunton, N. Devon), who was desirous of speaking and was prevented by lack of time, handed in her remarks as follows:

As it is impossible to compress into the space of ten minutes all I wish to say, my remarks will be limited to (*a*) and (*b*) of the matter under discussion.

As to initial detention under certificates of the certifiable patient I am entirely against Prof. Robertson's recommendation of a "purely medical" procedure, and equally averse to the "judicial inquiry" suggested by the "National Society for Reform." I consider that, as to initial detention, the existing safeguards are, in the main, adequate, and merely offer the following comments on—

(1) The Urgency Order: (*a*) The title should be "Temporary Order," as the Chairman of the Royal Commission suggested to the British Medical Association's witnesses. (*b*) Time Limit: Should be strictly seven days. (*c*) Sequence: In

case of certifiable patients received into mental institutions, it should be followed as now by the " Reception Order on Petition," not by a " Provisional Order."

(2) Reception Order on Petition: (*a*) Presentation: It is not quite clear whether the Commission (Part III, s. vi (*a*), p. 159, and Part II, s. 108, p. 54) recommends any alteration in the wording of s. 5. I trust not, since it is the patient's first safeguard that none but a relative can petition unless cause is shown. (*b*) Medical certificates: These must at present be signed by doctors who have each examined the patient " separately from any other medical practitioner." Further, neither the petitioner nor his relative nor medical superintendents may certify. These provisions form the patient's second safeguard against collusion between unscrupulous doctors and unscrupulous laymen. Therefore I deprecate the Commission's recommendations that the two certifying doctors should be entitled " to consult together " and that medical superintendents of public institutions should certify. (*c*) Prognosis: I deprecate the recommendation (Part III, s. vi(*a*), p. 159) that a prognosis be submitted with the medical certificates. (*d*) Patient's property: Similarly I deprecate the recommendation that the petitioner's " Statement of Particulars " shall include " a disclosure of the patient's property."

As to wrongful detention at a later stage after the patient has recovered or is no longer certifiable, no real safeguards exist.

One medical man told me he had not adopted the line of refusing to certify, but his difficulty was that the relatives objected to the patient being sent away. Sir Frederick Willis, speaking for the Board of Control, had said " there existed a terrible feeling of superstition, and people who had mental trouble were afraid to consult doctors, because they thought they would be locked up for the rest of their lives." This fear is more than a superstition, for whereas the path is made smooth for a petitioner to send his relative, who is certifiable, to a mental institution, insuperable difficulties may be put in the way of the patients' return home on recovery.

Lack of time prevents me from reminding you how the petitioner's right under s. 72, to recover his relative, is reduced by other sections of the Act to a mere semblance of power. The Commission's recommendations (s. xvi, p. 164) would dissipate even this semblance.

I agree with Mr. Parker, a barrister, who maintained before the Commission that the *standard* for certification and discharge should be the same (s. 162, p. 84). Apart from the question of stigma and sentiment, there are strong medical and psycho-logical reasons against prolonged institutional care.

It is natural that recovered patients should make complaints of wrongful certification, but it is detention after recovery about which the relatives and public are rightly suspicious. If one could assure the relatives that if at any moment they are not satisfied with the Institution they can make other provision for the patient —and also that immediately on recovery he will be allowed to return home—some objections to institutional treatment would be removed. A recovered patient returned to his home within reasonable time is the best possible advertisement for mental institutions. The powerlessness of the petitioner to recover the patient from such institutions and the general lack of safeguards against detention after recovery are the obvious causes of unwillingness on the part of the relatives and patients to make use of them.

Prof. G. M. ROBERTSON, in a written communication,* remarked that the observations of Dr. Risien Russell were paradoxical and self-contradictory, and indicated the interaction of unsolved conflicts in Dr. Russell's mind.

Dr. Russell began by saying that he would be content to enjoy the privileges available in Scotland. The chief of these was that medical men are paramount in a medical question, and that no layman ever sees the patient or encroaches on the domain of the physician to prescribe what course is required for the treatment of an illness. Dr. Russell was fully aware of these facts; nevertheless, with this knowledge he next proposed that no patient should ever be placed in a mental hospital for treatment without a full trial before a representative of the law, in

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* [Time did not permit of Prof. G. M. Robertson summing up the discussion, and as certain observations made by Dr. Risien Russell urgently called for reply, Prof. Robertson did this through the correspondence column of the *British Medical Journal* of August 13, 1927, from which these are excerpted.—EDS.]

which the medical man should give evidence on oath, as in a criminal trial, and be subjected to cross-examination like any other witness. While content to enjoy the privileges available in Scotland, he proposed the very antithesis of the practice in Scotland, and what all Scotsmen would regard as anathema.

Dr. Russell had had some experience of mental trials; he knew how the subject stimulates forensic fury, so that they might go on for days and even weeks. Did he imagine that any busy practitioner would ever allow himself to be involved in such a waste of time or expose himself gratuitously to such offensive observations as he might expect in cross-examination?

To carry out Dr. Russell's views to their logical conclusion had as little regard for the welfare of the sick patient as for the time and feelings of his doctor. In a case of urgency, in which the patient required immediate care and treatment, Dr. Russell would allow no action to be taken by the patient's natural guardians and his family doctor under the certificate of emergency until a lay official visited the patient and had granted authority for this. How many certificates of emergency, if any, had Dr. Russell signed? Had he any experience?

To keep the legal procedure pure and undefiled, Dr. Russell considered that the legal representative who presides at this mental trial should not be a barrister trained in medicine; that, he said, would leave the matter too "medical," "hence the importance of having, as justice, a man with no medical training." Medicine, according to Dr. Russell's views, was a source of contamination, and if a barrister was unfortunate enough to have become infected with the virus, he was, if not debarred from this judicial post, at least deemed unsuitable.

The next paradox was that mental hospitals were naturally better equipped for the treatment of mental disease than most nursing homes or hospitals; their staffs had special knowledge and skill, and they were regularly inspected. Whilst the greatest obstacles were to be placed in the way of patients obtaining treatment in mental hospitals, every facility was to be given for their treatment in places in which the accommodation, equipment, staff and management might be anything or nothing, and there was no inspection of these. Dr. Russell had had some experience of mental disease, but some physicians might not have had as much, and others none at all. All medical men, however, were to be allowed to treat mental patients, according to him, in any place they wished and without any interference from the law for at least a year; but not so physicians in mental hospitals. Many people would be prepared to say that such a rash and unjust proposal could only have come from someone ignorant of the problem and of the history of the care of the insane. It was simply throwing the door open to exploitation of the insane and to every kind of abuse.

Dr. Russell had no faith in the members of the honourable profession of medicine. Yet it was no more than the truth to say that in no country in the world did the average standard of care and treatment in mental hospitals stand higher than in our own. While in our courts of law, the perfect justice of which had never been questioned, there had been in recent times an Adolph Beck and an Edalji case, in our mental hospitals a Special Committee and a Royal Commission had both failed to find a single instance of wrongful detention, and for seventy years and more no such instance had been found in Scotland. Such a record of careful and honourable service in a very difficult problem was beyond all praise. Fortunately for the profession of medicine and for the sick in mind, there would be few who would support Dr. Russell's views.

LUNCHEON.

Members, foreign guests and ladies again lunched at the Royal Arch Halls, 75, Queen Street, this time the hospitality being extended by the District Boards of Control of Lanark and Stirling and Midlothian and Peebles.

The guests were received by Sir Robert King Stewart, Chairman of the Lanark District Board of Control, and H. M. Cadell, Esq., D.L., Chairman of the Stirling District Board of Control.

Mr. CADELL, who presided at the luncheon, welcomed the members of the Association, and later proposed the toast of "The Board of Control, England, and the General Board of Control for Scotland," which was suitably responded to by Sir FREDERICK WILLIS, *K.B.E.*, *C.B.*, and Sir J. ARTHUR ROSE, *D.S.O.*

The PRESIDENT of the Association proposed the health of the Chairman, and on behalf of the Association thanked the District Boards for their hospitality.

THE WORK OF THE LADIES' COMMITTEE.

In connection with the Annual Meeting of the Royal Medico-Psychological Association, a ladies' committee was formed to arrange for the comfort and entertainment of the members and the ladies attending the Annual Meeting.

The Committee consisted of: Lady Wallace, Lady Rose, Mrs. Macphail, Mrs. Sturrock, Mrs. Keay, Mrs. Campbell, and Mrs. Hamilton Marr, as convener, had several meetings. When the final programme was arranged they had the assistance of Dr. Buchanan, Secretary to the Scottish Division of the Association, in carrying it out. The realization of some of this programme we have already reported and it does not call for further mention.

Members had the opportunity of taking a part in all the social amenities provided for those attending the British Medical Association meeting, which included civic and university receptions, dancing at the Palais de Danse, dinners, excursions, etc.

A garden party on July 19 at Tipperlinn House, by kind invitation of the chairman and managers of the Royal Hospital and Prof. G. M. Robertson, was a most enjoyable function.

Another delightful day was spent at Larbert, Mrs. Campbell being the kind hostess. After luncheon at her house the party went on to inspect Linlithgow Palace under the guidance of Mr. Wilson Paterson, of the Board of Works. After the visit to Linlithgow Palace, Mr. and Mrs. Cadell entertained many members of the Association and their friends at the Grange to afternoon tea.

VOTE OF THANKS.

Owing to lack of time at Friday morning's joint session, the customary votes of thanks for hospitality had to be postponed until the next general meeting of the Association in November.

The general view taken was that the whole meeting, with its somewhat unique arrangements, had been an unqualified success.

IRISH DIVISION.

THE SUMMER MEETING of the Irish Division of the Royal Medico-Psychological Association was held, by the kind invitation of Dr. J. O'Conor Donelan, at St. Dymphna's, North Circular Road, Dublin, on Thursday, July 7, 1927.

Prior to the meeting the members paid a visit to the adjacent Gardens of the Royal Zoological Society in Phœnix Park.

The following members were present: Dr. J. O'Conor Donelan (in the Chair), Drs. F. J. Deane, J. Dunne, P. Dwyer, H. Eustace, L. Gavin, S. J. Graham, T. A. Greene, G. H. Keene, D. L. Kelly (Inspector of Mental Hospitals, I.F.S.), R. R. Leeper (Hon. Sec.), J. Mills, C. B. Molony, P. Moran, M. J. Nolan, H. R. C. Rutherford, C. H. Wilson.

The minutes of the previous meeting were read, approved and signed by the Chairman.

A lengthy communication was received from Dr. Owen F. McCarthy, with an apology for unavoidable absence.

Apologies for absence were also received from Lieut.-Col. Dawson and many others.

The meeting then proceeded to consider a letter from the General Secretary of the Association, *re* the proposal of the President for the appointment of Vice-Presidents who would act as Chairmen of Divisions, and also two documents embodying this proposal. The proposal was discussed fully.

It was proposed by Dr. M. J. NOLAN, and seconded by Dr. GRAHAM: "That the proposal *re* the appointment of Vice-Presidents who would act as Chairmen of Divisions to hold office for three years be approved."

The question of payment by the Association of railway fares of the Hon. Secretaries and the proposed Vice-Presidentswas was raised, as it not considered justifiable that Hon. Secretaries and Vice-Presidents should be put to this expense.

It was the sense of the meeting that the Vice-Presidents should be eligible for re-election one year after vacating office.