I submit that this individual, a defective, required, not punishment, but educational treatment, mental and physical, with the teaching of an occupation if possible; and that it was in the first instance a case for a reformatory, upon the lines of the State Reformatory of New York at Elmira. For an account of this I may refer to the last edition of Dr. Havelock Ellis's work on *The Criminal*, from which I gather that the system of Elmira is being extended over the United States.

If the patient developed satisfactorily he would be allowed out on trial to do work previously found for him. Otherwise he would be detained, preferably under the system of an indeterminate sentence of an unconditional kind. Should he show symptoms pointing to the need for asylum care, he would be transferred to the asylum.

Lastly, as regards anthropometric observation in such cases. "A change in the intelligence, a change in the body," said Lélut, in 1844. "The blot upon the brain will show itself without;" and it probably does so in a more exact sense than the poet imagined. It is a correlation to be expected, I apprehend, that between cerebral deficiencies and bodily stigmata (superficial, and of internal organs). At the annual meeting of the Association of German Alienists at Munich, in April, 1902, Wolff, Basel, read a paper, with demonstrations on animals, upon the experimental evidence of the influence of the nervous system upon developmental processes,[1] which bears in an interesting manner upon this point. If there be outward and visible signs of inward and spiritual defect (and my case, I submit, though but one, goes to answer this in the affirmative), then it is our business to find and demonstrate them. And such demonstration will probably be our best argument before the sceptical legal fraternity in our endeavour to prove mental deficiency and irresponsibility.

(1) *Allgem. Zeitschr. für Psychiatrie*, Band lix, Heft 5.

Nomenclature of Mental Diseases. By A. R. URQUHART, M.D.

I HAVE ventured to suggest that we should now consider what we are going to do about the classification of mental disorders. Lately, the Royal College of Physicians of London decided to

revise the *Nomenclature of Diseases*, and publish another edition. The President of this College is on the Committee; as is also Dr. Savage, our colleague in London, who has taken much interest in this question. I was somewhat surprised the other day when I asked for a copy of the *Nomenclature of Diseases* in the Royal Medical Society of London, to find that they did not have a copy in their library—a book which is supposed to guide the profession in the statistical registration of diseases. In 1896, for the third edition, an attempt was made to reform the nomenclature of mental diseases, under the direction of Dr. Hack Tuke and Dr. Savage. In its present state it is still unsatisfactory. The classification with which we have to deal is as follows:—First, there is "*idiocy* (cretinism), and then *mania* (acute or chronic), delirious, hysterical, puerperal, epileptic, traumatic, syphilitic, gouty, from either acute or chronic disease, alcoholic, plumbic, or other poisons." Acute is an absurd word, because we specially want to mark the duration. Acute should be rendered Recent. Then there is "*melancholia* (acute or chronic), delirious, hypochondriac, climacteric, puerperal, epileptic, syphilitic, acute, other diseases." Then there is "*dementia* (primary or secondary), senile, climacteric, puerperal, epileptic, traumatic, syphilitic, acute, other diseases." Then there is "*mental stupor*, anergic, delusional." Then there is "*general paralysis*." That is not a mental disease. Lastly, there is "*delusional insanity*."

I refer now to Skae's classification, and always desire to speak of that with the utmost respect, because it was Skae who first in this country adequately drew public attention to the fact that insanity in various forms might be regarded as variously dependent on physical diseases. Taking the last variation of it from Dr. Clouston's Manual, it runs through the arrangement familiar to you, with a supplemental list of anæmic insanity, Bright's disease, and so on. The whole is mixed up in an olla-podrida, the different forms having no scientific relations to one another.

When Dr. Robertson, of Larbert, heard that I was to speak on classification, he kindly sent me the papers which have been handed round, showing that he had approached the subject from very much the same point of view as myself.

The most important recent development for us is the toxic causes of insanity, and the question now is whether we have

advanced so far as to tabulate these toxic causes. Some of them are indubitable; and I think that, as time goes on, we shall be able to increase the number of cases under toxic causes, and certify them with greater correctness.

There is no doubt whatever that we must, as yet, stand by Griesinger's classification, and arrange mental disorders from the point of view of symptoms. Broadly, we have never got beyond that, and we would be doing well, I think, generally to continue to use the words and the classification which he formulated. Meynert tried to introduce a pathological classification, and I did my best for some years to pigeon-hole all cases under that tentative scheme, but had to give it up, because the time is not yet ripe. The question to-day is whether we can improve upon Griesinger's classification, connecting it with Skae's classification; that is to say, adopt a classification which will characterise the symptoms, and which will also indicate the etiology, exclusive of the facts of heredity, which, of course, should be noted in every case. The benefit of describing our cases more minutely, and without cross-entries, would be undoubted. The classification, of course, must be logical—I *cannot* classify rivers, horses, blacksmiths, in one gross lot. There must be some sort of definite relation in the classification, and I think that we might agree on the main features. The proposed scheme which is now before you is not evolved out of my inner consciousness; it is the result of an extended examination of our records in case-books and clinical sheets. We have been using it in Murray's Asylum for four or five years, and have found it to be a practicable method of dealing with the classification of cases of insanity. As above indicated, the facts regarding heredity are noted in addition to the symptomatic and other etiological details, as well as the facts regarding neuroses.

It is difficult to decide what constitutes neurosis, *e. g.* whether such diseases as apoplexy are to be excluded. It is remarkable how many of our patients have had ancestors who have succumbed to apoplexy; and I think it should be included amongst neuroses, as well as the more ordinary forms of hypochondria, somnambulism, etc. I have not attempted to deal with these in detail, because the College does not include these milder cases of disorder, but we must consider them in regard to the revised statistical tables of the Medico-Psychological Association

now in progress. I had the advantage of hearing the first debate of the committee which is preparing these tables, and it seemed to be full of promise. There will be more useful results if men will put down only what they know, and only deal with figures that are true. There is really a necessity for that discrimination. I hate the word "idiopathic." It is a mere attempt to cloak our ignorance. Therefore you will not find that word in this scheme. Far more effective is the term "unknown," frankly stated.

Diagnosis of Mental Disease, as Classified.

1. Melancholia—recent, chronic, recurrent.
   - (*a*) Simple (without delusion).
   - (*b*) Hypochondriacal.
   - (*c*) Hysterical.
   - (*d*) Delusional.
   - (*e*) Excited.
   - (*f*) Resistive.
   - (*g*) Apathetic.
   - (*h*) Abstinent.
   - (*i*) Suicidal.
   - (*j*) Homicidal.
2. Mania—recent, chronic, recurrent.
   - (*a*) Simple.
   - (*b*) Hysterical.
   - (*c*) Acute.
   - (*d*) Acute delirious.
   - (*e*) Delusional.
   - (*f*) Abstinent.
   - (*g*) Suicidal.
   - (*h*) Homicidal.
3. Confusional insanity.
4. Stupor.
   - (*a*) Primary melancholic.
   - (*b*) Primary anergic (? lethargic).
   - (*c*) Secondary.
5. Periodic (? alternating) insanity.
   - (*a*) Circular, intermittent or continuous.
   - (*b*) Katatonia.
6. Delusional insanity (paranoia)—primary progressive, or secondary.
   - (*a*) Grandeur.
   - (*b*) Suspicion.
   - (*c*) Unseen agency.
   - (*d*) Persecution.
7. Volitional insanity.
   - (*a*) Obsessions.
   - (*b*) Impulsive.
   - (*c*) Moral.
8. Dementia.
   - (*a*) Primary.
   - (*b*) Secondary.
9. Idiocy and imbecility.

Note.—The above classification is descriptive of mental symptoms, purely clinical, and, proceeding on the decision of Griesinger, "the natural basis of classification must be founded on observed facts—states of depression, elevation, or weakness."

To correlate mental with bodily conditions, the following should also be used:

Etiological Classification.

A. Epochal—
   - (*a*) Adolescent.
   - (*b*) Climacteric.
   - (*c*) Senile.

B. Exhaustive.
   - (*a*) Pregnancy, puerperal, lactational.
   - (*b*) Masturbation.
   - (*c*) Sexual excess.
   - (*d*) Over-exertion, mental and physical.
   - (*e*) Neurasthenia.

C. Visceral—
   - (*a*) Anæmia.
   - (*b*) Cardiac.
   - (*c*) Pulmonary.
   - (*d*) Ovarian and uterine.
   - (*e*) Other visceral disorders.

D. Toxic—
   - (*a*) Exotoxic—alcohol, morphia, cocaine, lead, etc.
   - (*b*) Autotoxic by deficiency—myxœdema, cretinism, ovarian, etc.
   - (*c*) Autotoxic by excess—gout, rheumatism, chorea, diabetes, albuminuria, etc., ? constipation.

(*d*) Microbic — syphilis, phthisis, septicæmia, fevers, influenza, etc.

E. Degenerative—
- (*a*) Developmental arrest, mental and physical—idiocy, imbecility.
- (*b*) Morbific habits of life.
- (*c*) Epilepsy, congenital or acquired.
- (*d*) General paralysis of the insane.
- (*e*) Other organic diseases of the encephalon — atheroma, thrombosis, embolism, apoplexy, tumours, etc.

F. Accidental—
- (*a*) Traumatic.
- (*b*) Insolation.
- (*c*) Fright or shock — post-connubial, post-operative, etc.
- (*d*) Deprivation of the senses.
- (*e*) Communicated.

G. Unclassified—
- (*a*) General.
- (*b*) Metastasis.

Note.—The facts of heredity should be noted with this classification, either insanity or neuroses—anæsthesia, hyperæsthesia, capricious temper, eccentricity, hysteria, hypochondria, neurasthenia, insomnia, somnambulism. Other manifestations of cerebral or nervous instability or disease, *e.g.* apoplexy.

1. I now suggest that the first class ought to be "*melancholia*," and separated into recent, chronic, and recurrent cases, reserving the word "acute" to indicate the severity of symptoms rather than the duration of the disorder. Acute delirious mania is a very marked form of mental disorder which requires no further symptomatic indication, but "acute" signifies that it is something more than recent. Then we have to consider whether the word "recent" will be held to include cases that have occurred within twelve months or within six months; the term "recurrent" must also be defined for our statistical purposes. In my opinion, a second attack may be considered a relapse, but a third attack should be classed as recurrent. This arbitrarily affects the duration of the disorder. In a recurrent case we must go back to the date of the first attack as a basis. It is not quite clear whether this should be done in reference to a second attack; perhaps my custom to give the benefit of the doubt and state the shorter period may be upheld.

Then melancholia in this suggested nomenclature is divided into simple, hypochondriacal, hysterical, delusional, excited, resistive, apathetic, abstinent, suicidal, and homicidal. These are descriptive words as regards the form of mental disorder.

2. "*Mania*" is similarly dealt with, as follows:—Mania (recent, chronic, recurrent), simple, hysterical, acute, acute delirious, delusional, abstinent, suicidal, and homicidal. 3. "*Confusional insanity*" is inserted here in deference to the generally expressed desire of the meeting. 4. Fourth, we have "*stupor*," primary melancholic, primary anergic (? lethargic),

secondary. Primary anergic is an unsatisfactory term, but I have seen no better suggested to differentiate it from that stupor which is the result of an intensely delusional condition. 5. Fifth, we come to "*periodic insanity*" (circular), intermittent or continuous, katatonia. "*Alternating insanity*" has been proposed as a more definite term for this class of cases. 6. Sixth, we have "*delusional insanity*" of grandeur, suspicion, unseen agency, persecution, querulous. "*Paranoia*" is suggested as a more convenient term—primary progressive, or secondary. 7. Seventh, we recognise "*volitional insanity*," obsessional, impulsive, moral. 8. Eighth, there is "*dementia*," primary, secondary. 9. Ninth, "*idiocy and imbecility*." Imbecility is not a statutory word; if a patient is returned to the Board of Lunacy under form A 1 as an imbecile, that is not accepted, because the imbecility may be too slight to justify detention. The term must be strengthened by facts indicating *insanity*. Dr. Robertson has divided these cases into high-grade and low-grade degenerates.

If you accept this scheme, it is further necessary to supplement it with etiology, beginning with the facts of heredity, so that the case is further explained on your being informed whether the mania is (A) *Epochal*—adolescent, climacteric, or senile; or (B) *Exhaustive*—pregnancy, puerperal, resulting from masturbation, sexual excess, over-exertion, mental, physical neurasthenia; or (C) *Visceral*—anæmia, cardiac, pulmonary, ovarian, etc.; or (D) *Toxic—exo-toxic*, alcohol, morphia, etc.; *auto-toxic*, by defect, myxœdema, or by excess, acute rheumatism; *microbic*—phthisis, syphilis, etc.; or (E) *Degenerative*—epilepsy, general paralysis, etc.; or (F) Accidental, traumata, etc.; or, lastly, (G) Unclassified, general, and metastatic.

Sometimes there is no difficulty in placing cases; *e.g.* a young lady became maniacal after a double ovariotomy. Treated with ovarian extract she rapidly recovered. Similarly, ovarian extract relieves certain cases of insanity at the climacteric. It is the cure for this autotoxic mental disorder by deficiency. We may well refer to the work of Schroeder van der Kolk, in the middle of last century, in which he correlated mental disorder with somatic conditions, and specially sympathetic mania proceeding from the colon. We know how common intestinal disorder is in our practice, how the bacteriological importance of this condition has been insisted on by Dr. Ford Robertson.

Is this condition to be described as autotoxic by defect; by defective protection against the toxic elements; or by excess of these elements? I trust that Dr. Robertson will give us some indication of his opinion on this point.

I think that we might venture to recommend some such scheme of classification as now submitted to the College of Physicians through our representative on the new committee appointed by the College, and that we should ask our Statistical Committee to consider it for their purposes.

Discussion

At the Meeting of the Scottish Division, in the Royal College of Physicians, December, 1902.

Dr. Ireland.—We may congratulate ourselves that we have had three subjects for discussion to-day, each of which might have filled an ordinary meeting. I don't know any man in the Association whom I would trust more to draw up a classification of insanity than Dr. Urquhart, who has great experience, great clinical skill, and great learning in the lore of insanity. When I first became a member of this Association, and that is some time ago, there was a great deal of discussion regarding the classification of insanity. Dr. Skae's classification was the one which was most favoured here, and Sir John Batty Tuke improved on Dr. Skae's. There was also a memorable debate between Sir J. Crichton Browne and Dr. Clouston on this subject. I would be very well pleased to see the younger members take an interest in classification, which is a very important question. I quite agree with Dr. Urquhart that you still must classify by the symptoms. There is talk of a scientific classification of insanity based on pathology, but we are not ripe for that, although, as time goes on, our classifications based on symptoms are bound to be deposed by the advance of pathology. Take myxœdema, for example; Dr. Urquhart has separated idiocy from dementia. Sporadic cretinism goes along with myxœdema; it has the same pathology, and we cannot afford not to take notice of the connection between the two. I also would remark upon Dr. Urquhart's classification that in almost every book which I have read upon insanity, general paralysis is treated as a special form. Now here Dr. Urquhart puts it in the etiological list so far as divided, syphilitic and other forms of general paralysis. Perhaps he is right, but general paralysis has such specific symptoms that he would be a bold author who did not treat of general paralysis in one of his chapters. As to the term "imbecile" not being recognised by the Board of Lunacy, it is mentioned in a report that under certain regulations a licence shall be given for the education of imbecile children. Here the word is used by the Board of Lunacy.

Dr. Robertson (Larbert).—I have been called into this discussion quite accidentally. I saw from the billet that Dr. Urquhart was to speak on classification, and sent to him the classification which I adopted, and which is very similar to his. The point about "imbecility" which has cropped up just now is not a question of whether the term is recognised or not. The reason of the objection of the Board of Lunacy is that it is not allowable to send imbeciles to asylums. Those who are sent to asylums are *insane*. An imbecile is not an insane person by the law. Imbecility is not recognised as a form of insanity in the Statute, but if you enter on the certificate that the person is imbecile and insane, then that will be accepted. The term *imbecile* is useful as signifying a difference of degree between imbecility and idiocy; an imbecile is not such an idiot as an idiot, and there is a lesser degree of feeble-mindedness. I suppose that this discussion is to assist the Registrar-General in classifying the causes of death. The curious thing is that in asylums mental diseases are never stated as the causes of death. No one certifies melancholia as the cause of death; it may be phthisis or typhoid fever, or anything except the form of mental disease under which the patient happens to labour.

Dr. IRELAND.—Would you not state it as a secondary cause?

Dr. ROBERTSON.—You can enter as many causes as you please, but I do not think that the form "mental disease" is ever mentioned; yet it is in these very cases it should be mentioned, if the tables are to be of any value. I agree with Dr. Urquhart that in the nomenclature of insanity you should always mention the distinct features of the insanity, the symptoms, and the etiology. No system of nomenclature is perfect, but it is very imperfect if you only mention one feature. There is no difficulty in stating that a person suffers from melancholia brought about by alcohol or some other cause, and such a statement gives a much more accurate and complete knowledge of the disease than the mere fact that it is melancholia. With regard to the proposed position of general paralysis, Dr. Ireland says that it is usually given under a heading of its own, and that Dr. Urquhart has placed it in the etiological list. I think that the mental symptoms should be stated, and say that a patient is suffering from acute mania or from dementia with general paralysis. Although it is general paralysis, that is no reason why you should not make a statement as to the mental symptoms under which the patient is labouring; there may be symptoms of melancholia or dementia. Then, if I might criticise the table of suggestions, I should say that periodic insanity is not a distinct type of insanity according to symptoms. It is either melancholia or stupor, and to put it down as a separate variety is quite wrong, from the point of view of symptoms. You are taking one feature of insanity, its periodicity, and placing it in a distinct class, whereas with regard to all the other varieties you are taking the symptoms and not the periodicity. I would not include periodic insanity as a type of insanity. Then I think there is an omission. We in this country for a long time past have been guided by Dr. Clouston's book with regard to the classification of insanity, and very properly so; but he has also omitted cases which are more confused than maniacal. These have been referred to, but I think that Dr. Clouston has not laid the stress on this particular class of cases that he might have done. The patients appear to be more or less demented, but we do not use the term dementia because the patient recovers; we cannot use the term stupor, and I think the term "confusion" accurately describes the condition. In my opinion there should be recognition of a new form of insanity under that heading. I have called it delirious insanity, and classify it into simple and acute delirious insanity.

Dr. EASTERBROOK.—I desire to call attention specially to one point, and that is the use or abuse of the word "acute" in psychiatry, as meaning "severe." The word "acute" is used in the terminology of other diseases as referring mainly to duration, and as the antithesis of chronic. It should be similarly used in psychiatry. Every disease may be regarded as the action of an irritant on the organism. On the one hand we have the *intensity* of the irritant, and on the other hand the *duration* or length of time during which it acts. These are two distinct aspects, and the classifying adjectives that are used in clinical descriptions are, as regards *intensity*, mild or simple, moderate, and severe; and as regards *duration*, acute or recent, subacute, and chronic. In cases of mania, if you use these qualifying adjectives from the combined points of view of duration and intensity, you can describe all cases with precision and accuracy thus. A person may be suffering from mild or simple mania, or moderate mania, or severe mania, according to its intensity; and according to its duration, from acute or recent mania (say up to six months), or subacute mania (say six months to two years), or chronic mania (say any period over two years). Combining these two aspects in any particular case, a person may be described, with a clear conception of the condition present, as suffering from acute (recent) mild mania, acute moderate mania, acute severe mania, and similarly for subacute and for chronic mania; and also for melancholia, stupor, and so on. As an instance of the abuse of the term "acute" in psychiatry, it is common to see a chronic maniac during a relapse of severe mania described as in a state of "acute mania." Now a lunatic can hardly be described as both "chronic" and "acute" at the same time without an abuse of language.

The SECRETARY.—My difficulty is to know when a case is one of melancholia and one of mania. If you get a case of acute mania it is all right, and you can classify it, and if you get recent melancholia you can classify that; but there are a great number of cases which lie on the borderland. In fact, to such an extent does this occur that I am beginning to believe in the American idea that melancholia and mania are different phases of the same disease. I go against Dr. Robertson's

opinion that periodic insanity should be cut out, because I think it differs entirely from the continuous mania that you get in the adult and from the ordinary forms of melancholia. It has many different symptoms. I think that confusional insanity is an omission from the table, and it should be added.

Dr. URQUHART.—It is there.

The SECRETARY.—Not as a heading.

Dr. URQUHART.—No, but it comes under these symptomatic types.

The SECRETARY.—But the confusional insanity I refer to is a distinct type of disease. A paper was written on the subject by Dr. Conolly Norman, and quite recently I have seen several cases. I believe it to be a disease by itself. The patients have a distinct febrile attack, which is followed by many symptoms, many of which are nervous symptoms. It is one of the few forms of insanity in which you do get nervous symptoms. It is a form of disease that is easily diagnosed once you have seen it and have had the symptoms pointed out to you. I think there ought to be a number 9 in the table. I am thoroughly in favour of Dr. Urquhart's scheme, and I think that this classification should be adopted. It is a great advance on the old classification, and of course if we are to wait until we reach finality, then we will almost have to wait until the end of time.

Dr. TURNBULL.—I would like to refer to the question which has been raised regarding congenital insanity. Two or three years ago, if you made returns to the General Board of Lunacy in which only congenital imbecility was certified, your reports were returned to you for amendment. Surely that is not done now? Lately I have sent in returns of congenital imbecility, and they have not been sent back to me for amendment. Then as to the word imbecile not being statutory,—no more is the word mania, which we often use. If you look up the Statute you will find that the person who comes under the Lunacy Acts is a person certified by two medical men; and it does not say what the exact mental condition is.

Dr. ROBERTSON (Larbert).—The Statute says that you shall not admit imbeciles into asylums. Asylums are for insane people, and not for imbeciles.

Dr. TURNBULL.—But where is the definition of insanity which excludes congenital unsoundness of mind?

Dr. ROBERTSON.—The law excludes imbeciles. You may say that it is something else.

Dr. TURNBULL.—I speak subject to correction, but when the point was raised I looked into the Statute, and you will find that there is no definition making a distinction between so-called ordinary insanity and congenital insanity.

Dr. ROBERTSON.—You have to certify the patient.

Dr. TURNBULL.—But you have to state what the patients are suffering from. My impression is that of late the General Board have not adhered to the practice referred to. I have sent papers certifying congenital imbecility only, and they have not been returned to me, although, of course, when I did find mania added to the congenital insanity, then I put in both. Speaking more to the subject of the paper, we have to take a symptomatic classification, because one founded on pathological processes, which would be the ideal, is not possible in the present state of our knowledge. The cross-classification according to causes which Dr. Urquhart introduces adds much to the value of his table. A point one feels is that all these classifications are only temporary. A patient may be suffering from mania at one time and melancholia at another, and therefore the classification is so far imperfect, but it is the nearest one can come to perfection at present. I agree that confusional insanity should be added to the list. It is somewhat different from what we understand by melancholia, mania, dementia, and stupor. The clinical group indicated by periodic insanity is, I think, properly included.

Dr. ROBERTSON.—You have a classification there according to symptoms. Now periodicity is not a symptom; I would call it either mania or melancholia, or what it was at the time. I quite recognise the clinical type; it is not a new form.

Dr. URQUHART.—This discussion is extremely valuable to me, because it is a criticism of these proposals. I maintain that general paralysis is not a mental disease. We must report it separately, and it is proposed in the new tables to return it like epilepsy, in a column by itself, so that, for instance, you will be able by these new tables to tell how many cases of general paralysis are syphilitic and how many are not; you will be able to combine the various cases in a table in a way you could not do formerly, even in large asylums. Periodic insanity was

inserted to meet a common and frivolous objection to all classification—namely, that you cannot tell what an acute maniac will be in the future; therefore you must not classify him as an acute maniac. Katatonia is surely as clearly to be differentiated as confusional insanity. I am perfectly willing to place confusional insanity after mania as No. 3 of the list. It is a very definite disorder, and might therefore be removed from the subordinate position originally assigned to it.

Dr. ROBERTSON.—Seeing that you have mentioned the figures just now, I think that *stupor* should come in after mania. I would make stupor No. 3.

Dr. URQUHART.—Then about this question that Dr. Easterbrook raised; it does not very much matter to us whether we use the term "recent" or "acute" if we are agreed as to the meaning of each.

Dr. EASTERBROOK.—Yes, and that is why we should keep acute as meaning recent.

Dr. URQUHART.—I fancy from what I heard the other day that "recent" will be adopted. I am afraid you cannot get rid of the term "acute" in favour of "mild, moderate, or severe." If the Board of Lunacy have accepted "imbecility" only in a return from Dr. Turnbull, it has been accompanied by strong certificates. There is no doubt that "imbecility" is not a statutory term, and unless you add something to bring it within the statutory meaning it will not be accepted, for imbecility does not necessarily mean that degree of mental unsoundness which demands detention in an asylum. "Imbecile children" are mentioned in a Scottish Act, as Dr. Ireland said, but I presupposed that the debate was in reference to asylum returns.

Dr. ROBERTSON.—Imbeciles have been distinctly excluded.

Dr. TURNBULL.—I would like to get the reference.

Dr. URQUHART.—I think that our division should recommend this classification generally, without committing themselves to the details, for the consideration of our committee in London. That is all I desire to be done with it. I shall approach the President of this College myself.

Dr. IRELAND.—I daresay there would be no objection to Dr. Urquhart's classification as a whole; in fact, there has been a general approval of it, and there would be no difficulty in recommending what he has suggested.

Dr. EASTERBROOK.—As the only member of the Statistical Committee present, I can assure you that it will be submitted for their consideration. I suppose that that is all that one can do, and I would mention to them that it met with general approval here.

Dr. IRELAND.—Of course Dr. Urquhart knows about paranoia? It has been frequently patronised in this country. You put that under delusional insanity?

Dr. URQUHART.—Yes, but that will be a question for the Statistical Committee. It is a much more convenient term than "delusional insanity," but whether it should be accepted finally I am not prepared to say.

Dr. IRELAND.—I remember one German putting half of his cases down as paranoia.

Dr. URQUHART.—Probably he was pleased with the blessed word.

The Care and Treatment of Persons of Unsound Mind in Private Houses and Nursing Homes.[1]

By ERNEST W. WHITE, M.B.Lond., M.R.C.P.Lond., President Elect of the Medico-Psychological Association of Great Britain and Ireland; Professor of Psychological Medicine, King's College, London; Resident Physician and Superintendent, City of London Asylum.

MY paper to-day is the natural outcome of the address by Sir William Gowers upon "Sanity and Insanity, Lunacy and