On the Treatment of the Insane in the great General Hospitals.(1) By A. R. URQUHART, M.D., F.R.C.P.E.

THIS afternoon we have a wide field to traverse, and it is necessary, therefore, to select certain notable features for discussion, to omit much that might be said. I pray you excuse me if this discourse proves somewhat curt and dogmatic in dealing with the placement of the insane and the present position of psychiatry. Both are really in a state of flux, and we can only arrive at conclusions as provisional findings, to the best of our knowledge and belief, still requiring investigation and confirmation. That, of course, applies to the whole range of medicine as a science and as an art.

The study of the nervous system, normal and abnormal, has advanced at a vast rate in our own time, the literature of neurology and psychiatry is overwhelming, the work already accomplished is daily increasing in volume and energy. It is natural that the question should arise—Have we exhausted all the methods of investigation, have we utilised all the material for that investigation? I think not. I shall have to suggest, to urge, that Dundee should lead the way in Scotland in the treatment of the insane in a great general hospital. But, as a preliminary to treatment, and as concurrent with it, medical observation and research must be regarded as the fundamental necessity, aided and developed by laboratory work in the College. For insanity is an affair of medicine, whatever relations it may have with general sociology.

One does not apply the canons of a severe criticism to an obituary notice or an after-dinner speech; but it seemed to me that, when *The Dundee Advertiser* gave it to the expectant world that this would be the first city in the country to place the treatment of insanity on a rational and scientific basis, the speaker would be the first to repudiate any reflection on those who have already given their lives to the work; and specially that it was time to fence the tables—first, exactly to determine what should be done, primarily in the interests of those labouring under mental disorder, and secondarily, in the interests of the public at large. The rational and scientific basis has been founded and fixed, but the structure is still

incomplete. A definite omission in our methods has become more and more apparent to those who have laboured on that basis and are urgent to see it fortified.

This is, in short, the specialist's appeal to the genera physician. A man does not become insane in an asylum. The asylum is the *dernier resort;* the hospital for the insane is a specialised institution, receiving the failures of the general physician, and stands, subject to keen criticism, as a definite and noteworthy part of our civilisation. It is subject to human limitations, and has to record its failures just as the general hospital has to do.

Let us see how the medical results stand on comparing the two. In their wisdom the registrars of the Dundee Royal Infirmary return those "cured and relieved" in one sum. I, personally, find the word *cured* unsuitable, and prefer *recovered.* Let that pass; the result was that I could not discriminate between those restored to health and those improved in health, in order to compare the medical results of the local infirmary with the local asylum. I found, however, that the discrimination is made in the Report of the Royal Edinburgh Infirmary, and taking at random that for 1903 we find the following statement:

MEDICAL RESULTS.

	Edinburgh Royal Infirmary.		*Perth Royal Asylum.*
	General.	Nervous.	Certified insane
Total Cases	4082	873	982
	Of whom a percentage of—		
Recovered	33·7	23·0	31·8
Unrecovered	55·5	69·3	51·3
Died	10·7	7·5	16·7

It will be apparent that these figures are notably similar in results, nor is this surprising, as insanity is just as much a bodily disease as those recorded in general hospitals. It has, of course, its mental side, by the consideration of which we have been too much distracted; but then you are familiar with the mental concomitants of such diseases as phthisis or cardiac maladies, the undue hopefulness and the undue depression of which have long been recognised. Or, turning to a succinct account of experience in Murray's Asylum, we find that of

every ten persons admitted, the probability is that three will be discharged recovered, that four will be discharged unrecovered, that two will die during residence, and that one will remain under care indefinitely. The total recoveries(²) recorded stand at 37·94 *per cent.*, while the permanent recoveries are only 17·18 *per cent.*; for in essence insanity is very similar to rheumatism, one attack does not confer immunity, but rather predisposes to a relapse, and it is to the improvement of this recovery-rate and the prevention of relapse that energies must be bent, whether we have to deal with insanity or rheumatism. There is no room for contentment while these diseases of obscure causation are permitted to flourish. Treatment on general principles is very well so far as it goes, but we cannot rest befogged with ignorance of the underlying determining pathology of disease. Conceive how the matter would stand if those unrecovered patients discharged from the Infirmary had to be kept for life in the institutional extensions so rendered inevitable! Imagination boggles at it. If only one out of ten were to remain resident indefinitely, and thus increase the death-rate and depress the recovery-rate, there would be more than one to declare for a rational and scientific basis of treatment. I cannot do better than quote from the Report of the Queen's Square Hospital for Paralysed and Epileptic, the medical and surgical staff of which is selected from the most distinguished ranks of the profession. In 1906, they said: "Diseases of the nervous system are not the same in their results as diseases of other systems of the body. The nervous system is of a far finer design and a more delicate structure altogether than the other corporeal systems. A lesion which will produce only a temporary effect in one of the latter may, in the nervous system, produce irreparable damage." I concur, but have better hopes of the future than this apology for a strictly limited medical success.

Let us now pass in rapid review what has been done in the placement of the insane, for an historical *resumé* of this kind leads us directly through philanthropic work to the present position and the proposals of to-day.

In the era of enlightenment which followed upon the French Revolution, when Pinel marked an epoch by removing chains and fetters from the insane, the public conscience was stirred, and men set about the care of diseased and disordered persons

with a charity and benevolence which yet redounds to their credit. Dundee has an honourable record in this respect. When we read of the horrors of the mad-houses which engaged the attention of Parliament, and the systematic neglect of the mentally afflicted a century ago, we must also recall the open-handed relief and the commendable motives which prompted it. Kindliness and forbearance were the watch-words of those who designed and supported the Royal Asylums of Scotland. These continue imperative and operative, but the nineteenth century proved wonderful in many inventions. As men knew better, they did better. The improvement in the care and treatment of the insane has been a reflex of the current beliefs and the social conditions.

I throw on the screen a plan of the first Dundee Royal Asylum. You will observe that it was fashioned on the cellular system of the old religious houses. It is rigidly symmetrical, consists mainly of small rooms grouped round courtyards, much the same as were inhabited by cloistered monks. The leading ideas were safety, segregation and social classification. Nothing could be more unlike the plans of to-day. Similarly, Murray's Royal Asylum was designed as a place of strength and adequate power of detention, under the ægis of the law, which naturally and properly is a laggard in our affairs. No doubt the law must determine questions of responsibility, of segregation and so on, but these questions are secondary in importance. They issue consequent upon declared insanity and the conduct of the insane person. They are not fundamental but accidental. I show this plan to indicate what has been done to modernise the institution in opening large airy rooms, in providing dormitories for continous observation and care, in adding hospital accommodation for recent and acute cases. This last was, and remains, an important development of asylums as Hospital-Homes—as hospitals for active medical treatment, as homes for the chronic class in which medical work is comparatively unnecessary. Dr. Clouston adapted certain separate buildings as hospitals at the Royal Edinburgh Asylum, and that first step was followed at Murray's Royal Asylum in 1888 by the erection of buildings designed as hospitals. Shortly afterwards the Montrose Royal Asylum provided a separate hospital, upon the plan of which many others have been modelled. I do not cast any reflection upon those who formerly were content with "sick-rooms," and still adhere

to that method, but we shall see that as medical ideals become more impressive, so the hospital ward or sick-room has become more strongly differentiated and more definitely appropriated to the treatment of acute and enfeebled cases. Still further, there is a tendency to separate the hospital from the infirmary, to reserve the one for the acute and the other for the chronic cases. I insist that early treatment should be hospital treatment after the best model, that the old and out-worn cases of whom we now receive so many, are also appropriate to special medical care, and plead that an asylum should contain all kinds of patients, not by any means under one roof, but certainly under one central domestic authority. Recurrent cases, accidental cases, intercurrent cases may require removal from the buildings appropriate for the chronic insane at any time, and conversely a re-transference to those buildings. I have heard that the patients themselves differentiate between the hospital and the asylum.

I pass by the West Green Asylum, a type which is as much out-of-date and as discredited as those older institutions, but we might glance at the best London could do a quarter of a century ago. The general plan of the London County Asylum, Claybury, shows a disposition of the various parts of a large institution round the administrative buildings, planned to receive the maximum of air and light. These miles of communicating corridors afford access in all directions for some 3,000 persons resident. The buildings for sick and acute cases occupy a central position on the south front. Some idea of this vast construction may be gained by a view of the east front; but the next slide is more important on this occasion, as it shows the Pathological Laboratory, which is under the superintendence of Dr. Mott, whose work is familiar wherever insanity is the subject of serious study. The London County Council were convinced that pathological material would yield notable results if properly studied, and the erection of this laboratory has been justified in scientific experience.

The plan of Canehill shows a similar design to that of Claybury; while that of St. Albans, which is of more moderate size, follows the same principles.

We may now glance at the special hospitals which have been added to Scottish asylums of late years. The first was that at Montrose, a separate building specially designed for the pur-

pose. There is a considerable proportion of single rooms, and a few of them can be cut off for the treatment of infectious diseases, which are sometimes introduced from the general community. The elevation forms a pleasing frontage, and it will be noted that it is open to the south in detached blocks in accordance with modern ideas. The latest of those Scottish Hospitals is that erected at Ayr County Asylum at a very moderate cost. I feel that to some extent it has been sacrificed on the altar of cheapness. The double wards accommodate four lines of beds between the outer walls, which cannot be regarded as desirable in hospital planning. On the other hand, there are ample sun rooms for day space and open-air treatment in bed, which are most valuable adjuncts from the medical point of view.

The Bangour Hospital, recently completed for the Edinburgh District Asylum, shows special features in respect of the Electrical Department, the Research Rooms, and the Lecture Hall, where the nurses are instructed in systematic work. The development of nursing as a science and art has been a gratifying feature of asylum administration for nearly a quarter of a century. Instruction in theory and practice go hand in hand, and the qualifying examination is directed from London on behalf of the Medico-Psychological Association. In this sphere also medical ideals are paramount.

The general plan of Bangour has been adopted from German models. The asylum at Alt Scherbitz long ago convinced me that the crowding of hospital and asylum buildings of considerable height on a limited space could no longer be regarded as desirable. Just as architecture has done all and more than all that was necessary, as we have attained the maximum benefit from farms, from nursing and general principles, we come face to face with new facts in science which open the door to new efforts in prosecution. Distinctively, however, these newer models in planning require illustration before concluding this part of my discourse.

I exhibit the general plan of Annsbach, which shows the tendency to scatter the buildings over the estate, and Kingseat Asylum, built for the Aberdeen Parish Council, demonstrates the modern design still more clearly. I first call your attention to the Central Hospital, where the medical work is concentrated. Round about it are grouped the houses for chronic patients,

administrative buildings, and so on. The central and important fact precisely is the Hospital (122 beds), and the experience gained since the whole institution was opened is entirely favourable. I need not detain you with views of the simple buildings which go to constitute it, but cannot omit the plans of the Woodilee Reception Block and Sanatorium, added to the Lenzie Asylum of the Glasgow Parish Council. These buildings were inexpensive, they are simple, and they are practical. One can hardly show a greater divergence in structure than is here represented as compared with the old Dundee Asylum. This is, in brief, a hospital building of the simplest kind, and it has been in use for some years, during which it has fulfilled all requirements.

We may now pass to a consideration of buildings still more germane to the present purpose. In one way or another, in different centres, it became apparent that the gap between the insane person's home and the asylum should be avoided or bridged over. I first refer to the Hospital Commune of Copenhagen, where some 900 patients are under treatment daily. The building is of a simple form. In the rear are two pavilions, A and B, the former for insane, and the latter for other diseases of the nervous system. Pavilion A is really a reception house for the asylums of Denmark, which are situated at some distance from the capital; but care and treatment are extended to the patients from the time they are received until their immediate future is determined.

Similarly a pavilion has been erected attached to the Albany Hospital, New York State, where great activity has been manifested and notable results have been gained. The plan of the Pavilion is much too complicated in my opinion; but it is in the American manner, and no doubt adapted to the American climate and ideals.

The arrangements in Glasgow are well known, and I need not enter into details, which can best be studied in the annual reports of the physician, Dr. Carswell. I would merely say that the parochial insane are reported to him, are visited by him, and are dealt with by him in a systematic manner. It is unnecessary to remove every patient so afflicted from his home, it is unnecessary to send him to an asylum. The doubtful cases are admitted to the Eastern District Hospital of the Glasgow Parish Council, are there placed under observation,

care and treatment until recovery takes place, or removal is essential. Simplicity is the note of this establishment. There are larger and smaller wards, and six side rooms, giving a total accommodation of fifty beds. I show the entrance to the Mental Wards, which is free from all adornment, also the interior of a ward which could not be less complicated. Finally, I show the medical results, which issue in 44 *per cent.* of recoveries on a total number of 1,077 admissions. No doubt many of these cases are alcoholic, of transient nature; but their maladies are properly treated without legal certification and all that entails.

The result of this consideration of asylum methods is that there has been a decided tendency to simplify structural features, to differentiate the various parts of the buildings, and to concentrate medical treatment in special hospitals. We have also seen that wards for insane patients in general hospitals neither aim at, nor require, specialised arrangements, indeed, the less there is of apparent difference the better. If a patient requires Asylum treatment a general hospital is no place for him—a couple of side rooms for use in emergency is ample provision for such exceptional cases. Therefore, I suggest that two small wards would be sufficient for the requirements of Dundee, if they can be devoted to the purpose. If fifty beds are sufficient for Glasgow with a population of half a million, and sixty beds for Copenhagen with a similar population, thirty beds should be ample for Dundee. The arrangements of the Local Government Board have been generally approved by experience, especially the term of residence, six weeks, extended under special approval on medical certificate. Personally, I would prefer that these wards should contain all cases of disease or disorder of the nervous system. Even the name of these wards is important. In everyday life the appellation of "Psychiatrical" or "Neurological Department" would never come into common use. The "mad wards," or the "asylum wards" must never be permitted, and I venture to indicate that a short and distinctive name might be found in the word *Royal*, if the Royal Infirmary and Royal Asylum Directors happily agree to initiate the undertaking which I recommend to their favourable consideration, and the medical profession send for treatment the suitable cases which come under their observation.

We pass now to a brief consideration of the nature of insanity in the light of scientific research, using the term in its fullest significance. I believe that, as hospitals for the insane have been simplified, in like manner our science will be simplified.

I put aside metaphysics as irrelevant and unnecessary from the medical point of view.

> "Myself when young did eagerly frequent
> Doctor and Saint, and heard great argument
> About it and about; but evermore
> Came out by the same door as in I went."

For me it is *chose jugée*. Psychology, normal and abnormal, is another affair, progressing on the lines of physiology and pathology. For instance, if we consider the curve of fatigue, we find it illustrative of normal and abnormal conditions. A man runs in excessive proportion to his strength; at first the effort responds to the demand of the will, the curve ascending until signs of distress are apparent, and the curve somewhat sharply descends. He then gets his second wind and effort again responds, the curve describing a longer and higher ascent, until fatigue supervenes, when the curve falls rather suddenly and deeply in proportion to the exhaustion. Fatigue has become pathological, the urine becomes toxic, and capable of conveying its poisonous properties to other animals. Nor is this all; the curve for mental fatigue is of the same nature, as Kraepelin has shown by various experiments—there is a similar rise in ability, a slight fall, a longer second rise until fatigue causes the final fall; while Hodge has shown confirmatory evidence in the nervous cells of the exhausted honey bee. The circumstances are identical in result, and the army and schools of Germany have re-arranged their methods in view of this pregnant observation. It will not do to sandwich hard bodily work between terms of mental effort—the fatigue is progressive through both periods of labour. Thus, in the insanity of over-exertion it is necessary to prescribe rest in bed, to endeavour to break into the vicious circle of undue effort and its toxic sequelæ, that is to say, to adopt ordinary hospital treatment. Of course the time comes when it is more suitable to place the patient in the convalescent home, and to undertake the "after-cure."

Is there room, then, for a fatalistic, pessimistic argument?

Heredity and environment are certainly powerful factors in mental degradation. Extremists will even say—no morbid heredity no true insanity, and aver that it is Nature's method for the extinction of the unfit. But the sheet anchor of the profession is the recuperative power of Nature, in spite of inherent defects in the organisation of the patient. The baleful heredity of insanity is manifested in a failure of metabolic processes or somatic defences. Men are not born mad, but like the tuberculous, the gouty and the rheumatic, fail in metabolism or on bacterial invasion. It is a neurotic heredity, inclusive of eccentricity, etc., of all that is meant by the expression, "want of mental balance." One must also include the effects of tubercular and syphilitic and alcoholic parentage. But it will be objected that this opinion has not found its way to universal acceptance, that mental overstrain, sudden or prolonged, is a factor in causation. I do not believe that a normal nervous system can be driven to insanity by such causes, but if I find such a case I cannot doubt that the derangement or the failure of the soma can be demonstrated.

For our present purpose, however, let us suppose that I misread the signs of the times, and that you prefer the mystical origin of madness in sin, or any such theory, then I put it to you that, until science has been exhausted, we are in exceptionally favourable circumstances in Dundee to enable the physicians of the infirmary and the laboratory workers of the college to elucidate the whole matter in cases of incipient mental disorder, in which, indeed, these questions of metabolism and bacterial invasion can be best determined and combated. That is a proposition for which I claim your assent.

Turn to the other maleficent factors of environment, of vice and crime, poverty and disorder—failures in social conditions. These cannot be discussed to-day, but the very mention of them implies their importance; yet we must remember that the results of amelioration of environment are successful beyond expectation, that hygiene, bodily and mental, that eugenics are now subjects of the most serious study. While I have shown that the incidence of heredity is much the same in intensity in urban and rural localities, I have also shown the more evil effects in the insanity of urban life.

These lions in the path roar dreadfully, but not altogether effectively. For instance, out of 145 children whose parents

were both insane, out of that most disastrous class I found 33 *per cent.* alive and sane, 44 *per cent.* insane, and 22 *per cent.* dead. If heredity were absolute in its effects, not even one-third of these children could escape alive and sane.

Take this curve of averages, it does not matter what character you observe, whether bodily or mental, you will find that the maximum number increases rapidly from both ends. The curve may represent stature, then the giants and the dwarfs are represented by numbers that become negligible, while the vast majority are represented round the maximum height of the curve. Exactly the same observation may be made in the scale of ability, and consequently we find that men of average intelligence are represented by the greatest numbers. The decay and ruin and extinction of families are balanced by the rise and progress and distinction of other families. Prepotent blood is quite as strong a factor as decadent blood. Were it not so civilisation would have been extinct as the proverbial dodo, and we, its ultimate heirs, incapable of discussing these questions of racial importance. At least we prefer that our doctors should profess a cheerful optimism in face of death and disaster.

Many are the definitions and classifications of insanity, and I would not lead you on slippery places were it not requisite to indicate the nature of the thing itself. I believe that it is less complicated than its protean manifestations—that it almost always begins with melancholia, sometimes progresses to mania, and tends to end in dementia. Further, that the malaise, insomnia and similar symptoms of the initial stage are almost always accompanied by alimentary disturbance. As it has lately been suggested that the bacterial invasion of tubercle is by the mouth, so I believe it is in respect of mental disorder. Dr. Rayner, who for many years conducted the Psychiatric Out-patient Department in St. Thomas's Hospital, found that the attentions of the dentist were the first need, that recovery often ensued when mouths were rendered aseptic. Similarly we require the services of the surgeon, the gynæcologist, the ophthalmic surgeon—in fact the aid of all the specialists. Insanity of obscure pathology is being cleared up on that method, as we shall see later. Insanity of gross pathology has been fairly well worked out, but in spite of excellent results at the laboratory of the Scottish asylums (to which Dundee, a notable exception,

does not contribute), some of us are less interested in pathological findings than we were, and encourage Dr. Ford Robertson in his studies of life and current disease. That is a feeling which is generally manifested in the ranks of the profession; the evidence of final wreckage is less important to us than the causes which led to the bitter end. It is the honourable, professional endeavour so long expressed in the maxim—*obsta principiis*. It is precisely that movement which brings us together to-day in the hope of prevention or timeous intervention. I pray that it may be fulfilled.

I have said that insanity is like rheumatism—one attack does not confer immunity in future. No one lives on a uniform dead-level of efficiency—sometimes he is above himself, sometimes not quite up to the mark. The curve of recurrent or alternating insanity is an exaggeration of this every-day fact—an attack of mania passing to melancholia which may be succeeded by a lucid interval which may be of indefinite duration. Here, again, I discern some specific toxic influence, and look to the discovery of a vaccine or antitoxin which shall combat the recurring attacks. It is in this field that much work is being prosecuted, and here again we call on Dundee to come over and help us.

Assuredly we cannot rest on general principles when we glance at this chart (closely corresponding with the curve for rheumatism), which shows the ages on first attack of those who have been under my care. It is melancholy to note that the greatest damage is done at the age of thirty, just the age at which I fain would have remained. It is tragical to know that the expectation is worst at the earliest ages, just as the gouty young man is most greviously burdened. Can youth and early vigour not be brought into efficiency? I dare not answer in the negative.

I show you a normal cerebral cortex—no doubt it is sufficiently familiar; and again, cells demonstrating the Nissl bodies, which are first of all impaired. The question is whether these delicate structures, once injured, can be restored effectively. That also can best be determined in cases of incipient insanity. Certainly the death of brain-cells is fatal to mental soundness even if bodily improvement occurs. In this particular case of acute delirious mania death ensued after a few days of the disease. It is a most fatal malady — on general principles almost

hopeless. Can that prognosis be improved by experimental research? I believe it may.

You will understand that we are not by any means exempt from the mistake of taking a wrong turning. Some time ago it was commonly found that patients suffering from melancholia showed the indoxyl reaction in their urine to a marked extent. This vice of metabolism was thought to have a special significance, but further research showed that although it was perhaps deleterious, the condition could be cleared up by the administration of a judicious aperient. This was determined by repeated observation, and the tide turned in another direction. I show you the urine of a melancholic person before and after the purgation, which is still too often necessary on the admission of a patient to an asylum. The indoxyl reaction and its resolution is evident.

I shall not detain you with a consideration of that miracle of medicine, the treatment of myxœdema (in itself a complete justification of vivisection), or the efficacy of ovarian tabloids after operative removal of these organs, but pass to an exhibition of the diphtheroid bacilli in general paralysis, and the phenomenon of phagocytosis. Here are facts, however they may be interpreted, which bring insanity into the category of other somatic diseases, such as arterio-sclerosis, which is also of the nature of an intoxication, and eminently qualify the sufferers for admission into the general hospitals. Further, I show you the bacteria of saliva grown from an insane patient whose mouth had been cleared of decayed teeth, in order to compare the culture obtained from the mouth of a healthy person. Similarly I exhibit the bacteria of fæces in insanity as compared with health. These preparations by Dr. L. C. Bruce indicate that a bacterial invasion is in progress. Again I plead for your assistance to determine the facts and search for the remedies.

Lastly, I would desire to show four charts which Dr. L. C. Bruce used in his Morison Lectures on Insanity before the Royal College of Physicians a year ago. My purpose is primarily to impress upon you that the obscure pathology of insanity is gradually giving place to enlightenment, and secondarily to impress upon you that the research in progress is difficult, laborious and determined—yet hopeful. Already it may be stated that a high polymorphonuclear leucocytosis is of good

omen in insanity; I hope and trust that means will be found to stimulate that reaction, and I finally commend this study to your attention.

Dr. Timothy Bright, who published his *Treatise of Melancholia* in 1586, said: "If you will descend into the consideration of the effects of poisons in our nature, as of henbane and such like, by which the mind seemeth greatly to be altered and put quite beside the reasonable use of her ingenerate faculties, which being mastered by convenient remedies it recovereth those gifts whereof it was in danger to suffer wreck before." You must follow out these indications, through a multitude of observers, before you can appreciate the great development of medical thought and belief in these matters. To henbane and such like you must add elusive poisons which are no less deadly and destructive, and are yet in process of revelation, but hardly provided with antidotes. To sum up you must regard insanity as an affair of medicine, and recognise that social conditions impose restrictions on observation which at least Dundee has opportunity of removing. I beg of you not to be diverted or obstructed by the law in your proper office of medicine. The law imposes on you a primary consideration of conduct and the consequences of conduct. Medicine, on the other hand, imposes upon you the recognition and investigation of disease, the endeavour to remedy, or at least assuage, its ravages. This is not a question of law, and I do not discuss it as such. If the directors decide of their charity to play their part, they need not consult with the law—their course is clear; their plain duty is the recovery of the curable, the care of the incurable, and, I would fain add, the after-care of the convalescent.

I have detained you too long with a mere sketch of what one would desire to say on an important issue. If I have persuaded you that insanity ranks with other somatic diseases and disorders; that it is amenable to care and treatment in like measure; that the signs and portents betoken the near advance of improvement in our knowledge and methods; that there is a definite field for cultivation, hitherto almost untouched; if I have persuaded you that a determined, informed and sustained attack upon the enemies, disease and death, is to be made with good hope of brilliant success, then I ask you, members of the Forfarshire Medical Association, to bring the weight of your

authority and influence to bear on the happy solution of these problems, to strengthen and confirm the directors of these Royal Institutions in their deliberations concerning the best course opportunity affords.

If we cannot sing with debonnair Horace—"Exegi monumentum ære perennius," we may at least console ourselves with the wisdom of Montaigne—"For we cannot be obliged beyond what we are able to perform, by reason that the effects and intentions of what we promise are not at all in our power, and that we are indeed masters of nothing but the will, in which by necessity all the rules and the whole duty of mankind is founded and established."

(1) An address to the Forfarshire Medical Association, on November 12th, 1908. —(2) This statement includes recoveries which occurred among those convalescent on discharge from asylum care.—(3) The address was illustrated by lantern slides, showing plans of asylums and hospitals, diagrams and statistics, etc.

Note on General Paralysis. By W. JULIUS MICKLE, M.D., F.R.C.P.

As mentioned in the careful summary by Dr. Wilcox in this Journal, October, 1908, p. 761, Drs. Clarke and Atwood remark that "not a few English writers fail to diagnosticate general paralysis in the absence of euphoria during some stage of the disease, a view we believe to be largely due to Mickle's teaching two decades ago" (*Journal of Mental and Nervous Diseases*, September, 1907).

How my genial critics came to the belief expressed in the passage quoted above I do not know. The view impeached by them is disclaimed by me.

Nevertheless, one's experience teaches that euphoria exists in some form or degree, on some occasion or occasions, in the very great majority of examples of general paralysis, *if and when the whole course of the cases is carefully observed.*

And there are examples in which even the depressed delusions of general paralysis, whether of hypochondriacal or of melancholic type, have a species of exaggerative inflation; gloomy delusions depicting disaster or ruin; delusions, grotesque, monstrous, or as if inflated with misery; lurid in extravagance