concentrate his efforts on the hospital and admission wards. They had come to look on the asylum as more of a hospital, and to devote their attention to the hospital department and the admission department in consequence of being able to get rid of the quiet demented cases through the boarding-out and poor-house systems. They would never have a successful boarding-out system in England until there was an enormous increase in the Commissioners in Lunacy or their Deputies, the present staff being utterly inadequate for the proper performance of the duties of a boarding-out system.

SCOTTISH MEETING.

A Quarterly Meeting of the Medico-Psychological Association was held in the Hall of the Royal College of Physicians, Edinburgh, on the 8th November. The President, Dr. Clouston, occupied the chair, the other members present being Drs. Howden, Ireland, Carlyle-Johnstone, G. M. Robertson, Ronaldson, Rorie, Batty Tuke, jun., Turnbull, Watson, Yellowlees, and Urquhart (secretary).

The Secretary was instructed to write to Dr. Rayner, expressing the regret felt that he should have found it necessary to resign the duties of General Secretary of the Association; conveying to him their sense of the able and courteous manner in which he had ever performed the onerous duties imposed upon him; and their hope that he might long enjoy his well-earned retirement.

The following new Members were duly elected:—

R. Cumming, M.B., C.M.Aberd., Asst. Med. Off. Perth District Asylum.

E. H. Ezard, M.B., C.M.Edin., Asst. Med. Off. Royal Edinburgh Asylum.

T. Graham, M.D.Glasg., Med. Off. Abbey Parochial Asylum, Paisley.

J. Liddell, M.A., M.B., C.M.Edin., Assist. Med. Off. James Murray's Royal Asylum, Perth.

Dr. G. M. Robertson, in the unavoidable absence of the author, read a paper prepared by Dr. Macpherson "On a case of Raynaud's Disease with Acute Mania."

Dr. Clouston said that they were much indebted to Dr. Macpherson for his paper, which contained many points of great medico-psychological interest. All were familiar with vaso-motor changes, but this was a case where these changes had reached their acme. The coincidence of paralysis with coma was very striking.

Dr Ireland said that he had never seen anything of this kind, but had often observed ulcers caused by slight friction, especially on the toes. These ulcers were extremely difficult to heal. He had applied electricity, but without much benefit. Low temperature was a very alarming symptom, and to obviate it he put the patient in a warm room and gave stimulating food. He also found that coffee raised the temperature a degree or two.

Dr. Yellowlees, in introducing a discussion on "The Use of Restraint in the Care of the Insane," said: It must be within the knowledge of all here that there has been going on in London during the last few months a good deal of discussion and agitation on the question of "The Use of Restraint in the Care of the Insane." I do not wish to make any remarks at all on the origin of that agitation, or to introduce any personal questions. One of the ablest and best known of our asylum physicians has been arraigned for the undue use of restraint, and he is arraigned by one of the best known and most distinguished psychologists in the

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country, joint-author of the largest and best known of all the treatises on Psychological Medicine. It is very striking, gentlemen, that in the arraignment of Dr. Savage we have in direct antagonism two of the oldest representatives of this department of our profession on the one side, and some of its ablest present representatives on the other; and, more remarkable still, we have the Lunacy Commissioners of the day endorsing Dr. Savage's treatment in words that are very unusual, and not very consistent with former deliverances of their Board. These words are: "We do not overlook the fact that the admissions here of acute cases are very numerous, many needing control which may be more humanely applied by mechanical than by manual means."

Very striking, indeed, is this divergence of opinion — how comes it about? Apparently it is because the older men stand nearer the time when restraint was the most prominent feature in the horrible and cruel treatment which the insane used to endure. Their impressions of the evils which restraint represented are far more vivid than ours. They remember, as we cannot, how fierce the fight was before the emancipation of the insane took place, and they are ready on the least provocation to renew the combat and raise the old battle-cry. I think we who are further distant from that great revolution are able to appreciate its real character better than those who were in the fight; they were so close to it and so involved in it that they cannot even now look at the whole matter so calmly as we at this distance may. They fought in order that insane people should no longer be chained, or controlled by mechanical means; but that was a small part of the victory they gained. It was not a question between restraint and non-restraint at all. Those became representative words, but they only represent a small part of the field which that blessed revolution covered. It was, in truth, a mighty step in the progress of humanity, by which the victims of neglect and cruelty became the objects of thoughtful kindness and of medical treatment. After their victory the old feeling remained strong. They told us that however needful restraint might be under special circumstances, they could not, would not, and dare not use it. They had seen so much of its evil that nothing would compel them to use it again. One can understand and sympathize with that feeling in those who had witnessed the horrors of the restraint period; but if this unphilosophical and unwise view were correct, it would be a conclusive reason against the use of chloral, or opium, or hyoscyamine; we would then never use or order alcohol because men had been drunkards, nor exercise because men had died from over-exertion, nor food because men had been gluttons. It is useless to reason with people who take such extreme views, and who deem the abuse of anything a proof that it has no legitimate use. Even men who knew that they ought in the interest of an individual patient to

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use restraint refused to adopt it under the influence of that feeling which they could never forget. I learned from one of the English Commissioners that about twenty years ago he saw a patient held down with two attendants night and day because he was determined to destroy his eyes. He remonstrated with the superintendent, saying it was at once kinder and safer to fasten the man's hands. The superintendent replied that he had never used restraint, and never would. The result was that in spite of constant watching the man succeeded in destroying both his eyes. Possibly there are persons equally obstinate still. They would justify restraint for (so-called) "surgical reasons," to prevent further injury to the ruined eyeballs, but with strange inconsistency would utterly condemn it if used to *avert* the mutilation! Restraint would be deemed utterly wrong while the patient was only making desperate attempts to injure himself, but perfectly right the moment he succeeded!

Another unfortunate result of that strong feeling was that the use of restraint under any circumstances was regarded as an opprobrium. To have it entered in the asylum records that you had to restrain a patient was to hold yourself up to obloquy. I have experienced such censure from medical journals before now. Some strange methods, it is said, were sometimes taken to avoid restraint being entered in the register, and stories were told of an attendant sitting against a door instead of locking it, or of patients being undressed and put to bed, or held by relays of attendants, because seclusion or restraint must not disfigure the journal of the Institution! I think anyone who gives way to this feeling does a morally wrong thing. If he believes the use of restraint to be the best thing for his patient he has no right to shirk it, whatever his feelings may be, or whatever criticism it may entail.

I cannot assert too strongly that the restraint which is merely a part of neglect and cruelty, and which is used as the easiest way to get rid of a troublesome case for the time, is a totally different thing from the restraint used by the physician after calm deliberate conviction that it is the best thing for the patient under his care. Restraint when dictated by harshness, irritation, or mere convenience is utterly wrong, but restraint when part of a well-considered plan of treatment may in special cases be perfectly wise and right. My demand is that we should all be free to exercise our own judgment as to the cases where restraint is needful and justifiable. I suppose nobody will question that restraint is justifiable in surgical cases; and if so, then the use of restraint depends on the reasons for it and on the judgment of the medical attendant.

As to *forms of restraint*, it is curious that there should be such difference of opinion between the Lunacy Board of Scotland and that of England as to what constitutes restraint. In the South, padded gloves are regarded as restraint, and must be entered as

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such. In Scotland they are not regarded as restraint at all, even if locked on. This fact has a direct bearing on Dr. Savage's case. Dr. Bucknill writes: "Eighteen patients were restrained in one month." This did sound very startling, but I had the curiosity to ascertain *how* these patients were restrained, and to find out what dreadful things had been done to arouse the wrath of Dr. Bucknill. I found that ten of these patients wore gloves, which in Scotland would not be regarded as restraint at all. Four wore side-arm dresses with sleeves sewed, so that their hands could not get free. Two of them had a dry pack, and the other two had what is called a modified dry pack, which seems not a very severe form of restraint. To me the significance of the whole case was greatly lessened when I found that ten out of the eighteen simply wore gloves. My own opinion as to the value of gloves is very decided. Four of my patients wore gloves last night, and I do not see a shadow of a reason why if gloves seem desirable the patient should not wear them. Of my patients who wore gloves last night two are women, chronic maniacs, who at times destroy everything they possibly can, and at most serious expense. We make no trouble about using gloves for them. If they cease their efforts to destroy, the gloves are taken off, and if they begin they are at once put on. The two men are advanced general paralytics, mindless and bedridden, who get no rest from continual efforts to destroy, but who rest quietly, or at least harmlessly, with gloves. In these cases I see no reason why the gloves should not be used. It is fantastic philanthropy that talks of such treatment as a grievous and terrible evil, whether you call it restraint or not.

I think the Scotch Commissioners are right in not regarding gloves as mechanical restraint, when the hands are otherwise free. If they are included, then locked boots and any article of dress specially fastened, and even the waist belt which prevents an excited woman from denuding herself, are in the same category. The line must be drawn somewhere, and our Commissioners have wisely drawn it at gloves. Their use should be recorded, of course, but not under the heading of restraint.

In what cases is restraint justifiable? Of course much depends on the personal opinion of the medical attendant. I think it is justifiable (1) *in cases where the suicidal impulse is intensely strong.* I have no hesitation whatever in putting gloves on these patients for their own safety and the protection of the attendants in charge of them. It often makes all the difference to the patient between lying gloveless in quilted blankets and untearable attire, or sleeping in all his wonted comfort but with gloves on. I have not a doubt as to which is preferable. (2) *In cases of extreme and exceptional violence.* I think the use of gloves often wise in such cases. Once or twice I have used side-arm dresses, although not for many years. I well remember the beneficial effects resulting

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from the use of such a dress in the case of a man who thought he was Jesus Christ, and that all around him doubted his divinity. He was a furious and most violent maniac, and it was a choice between endless seclusion or getting him out of doors with the other patients under partial restraint. I had a dress made for him, and the result was very satisfactory. In a short time he found his divinity unheeded, the violence abated, and he became as manageable as the others. (3) *In extremely destructive cases.* I do not think that a heap of rags over the room is a thing to be proud of or for the patient's good. In cases like those already mentioned there is no reason why gloves should not be used, especially if the patient knows better, and shows a certain amount of deliberate intention in the destruction. To those I add (4) another class of cases where I believe we could sometimes avert death if we used restraint, I mean *the helpless and incessantly restless patients* who, day and night, roll about the room, and thus slowly kill themselves, just as truly kill themselves as if we allowed them to commit suicide. These patients must be kept still if we are to save their lives. The protection bed which Dr. Lindsay of Perth, thought so highly of may be useful in these cases instead of restraint. I remember two cases where this mode of treatment was extremely valuable. I have a restless lady patient at present who by night rolls about the padded room or wanders feebly about the ward by day, knowing no rest or peace, and unless the restlessness subsides I must make a protected bed for her, or roll her up in blankets and secure her in that position, which Dr. Savage calls a dry pack. Either course would be perfectly right.

The alternative to mechanical restraint is manual restraint; and just because attendants are human it is neither so constant, so effectual, so patient, nor so safe. There is, of course, one way in which you could avoid all restraint and save all trouble; you could prostrate and paralyse the patient's energies by some potent drug, and call it "treatment;" but this is the way to dementia or death, not to recovery. I am no advocate for mechanical restraint, and in ordinary cases regard it as unnecessary and wrong, because not the best thing for the patient. I think it needful only in very exceptional cases, but we can accept no dictation as to its use. We claim entire freedom of action for any educated and conscientious physician who is trying to do the best for his fellow-men. We are not only entitled, we are bound, to do what we deem best for our patients irrespective of tradition or prejudice. It is simply absurd to say that we have the power to dose a patient with the most deadly drugs, but can *never* be permitted to fasten his hands or to swathe him in blankets and secure him in bed.

Dr. Ireland said he had listened to Dr. Yellowlees with great pleasure. He thought the present generation was wanting in nerve, and shrunk from employing some remedies which proved useful in some cases, because of their abuse in

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the past—such as blood-letting, the use of antimony and mercury. He said there was certainly a feeling against restraint, and they did not like to enter many cases in the register, because it might be thought that there was too much excitement in the asylum. He agreed with Dr. Yellowlees that the abuse of restraint had left the impression that it was a bad thing, and also that in restless cases the patients should be restrained, as they were wearing themselves out by constant motion, and that they shouldn't allow the patient to die merely to gratify a dislike against the use of restraint. He recalled Dr. Yellowlees' vigorous defence when attacked on this question several years ago, and had kept in mind his powerful expression, "Is a heap of rags a thing to be proud of?" At the same time he would warn young physicians to be cautious against making themselves martyrs, and to put restraint on an occasional lunatic. The reaction was sure to come. If a man placed his wife, or son, or daughter under the care of a physician in an asylum, and through needless risks, or want of restraint, the patient was suffered to commit suicide, or was killed, or seriously injured, he thought it scarcely a sufficient reply on the part of the medical superintendent to say: "My system of treatment implies an extra amount of risk. I think it advisable to add to the delusions of the insane the farther delusion that they are at liberty." He was strongly of opinion that each physician should be allowed to use his judgment in regard to the use of restraint.

Dr. GEO. M. ROBERTSON expressed his sympathy with Dr. Savage. From his knowledge of Dr. Savage's views and practice he was sure that he had not used restraint unduly. He thought it hard that the man who was doing something to cure his patients should be abused, when it should be the man who did nothing. On this account he held Dr. Savage deserved the sympathy of the Association.

Dr. TURNBULL said the meeting was much indebted to Dr. Yellowlees for his interesting remarks on the very important subject of the use of restraint in the care of the insane. In their discussion of the subject it was to be expected that the speakers would bring forward mainly the points on which they differed from Dr. Yellowlees in order that these might be more fully considered. While differing from Dr. Yellowlees on some points of detail (to which he would refer), and especially in not being prepared to go quite so far in using restraint as Dr. Yellowlees does, he (Dr. Turnbull) wished to say that he agreed most thoroughly and emphatically in the general line of argument and in the general conclusions which Dr. Yellowlees had put forward. Though there was a strong feeling against the use of restraint in asylums, it was a fact that in some general hospitals restraint was used on a much larger scale and more indiscriminately than in asylums, and was never recorded in any register or officially known. But remembering the history of restraint it was advisable that its use in the control of the insane should be carefully recorded, and the records be subject to inspection. The first point on which he differed from Dr. Yellowlees was in the use of the gloves not being regarded as restraint. Dr. Yellowlees said the Lunacy Commissioners had stated that the use of the gloves did not constitute restraint, and acting on that ruling he (Dr. Yellowlees) did not enter it as such in the statutory register of restraint, though he kept a record of it for his own information in a daily register. This was entirely new to him (Dr. Turnbull), and he could not subscribe to the view that the use of the gloves did not come under the head of restraint. In a recent case he had placed a locked glove over the bandages of a fractured finger, and made an entry in the statutory register for each day on which the glove was so used. The Commissioner at his next visit discussed with him the question of this being restraint, and remarked that, though he would not have said it was necessarily wrong if the use of the glove had not been registered, he thought it was better to have the entries made. He (Dr. Turnbull) therefore, held that the use of the gloves should always be regarded as restraint, and entered as such. As to the class of cases in which restraint was advisable, he agreed with Dr. Yellowlees in using it (1) in

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surgical cases, and (2) in suicidal cases in which observation by the attendants was not sufficient to guard against the suicidal impulse. In these latter cases he preferred mechanical restraint to manual force, as often the latter could not be resorted to without grave risk of the patient being injured in his struggles. In one of his female cases the patient had a persistent desire to force her hand into the vagina and tear the parts there, producing serious bleeding. This could be prevented during the day by the attendants; but when the patient was in bed at night the dangerous habit could not be effectually guarded against by simple supervision by the attendants. In this case he used restraint at night for a period of three months, but did not use it at all during the day. He did not agree with Dr. Yellowlees in considering destructive habits an indication for the use of restraint. In such cases he thought the restraint of the muscular action sometimes had an irritating or prejudicial effect on the patient's condition, and, even at the cost of some torn clothing, he preferred to do without it.

Dr. YELLOWLEES remarked that he did enter cases treated by gloves, but neither he nor the Commissioners considered that the entries should be in the restraint column of the register.

Dr. URQUHART said that he would express his pleasure in the dignified, able, and impressive speech in which Dr. Yellowlees had addressed them that day. He was entirely of one mind with him in this matter, and would neither add to nor detract from his conclusions. While they acknowledged with gratitude—and founded upon the experience and labours of the men who had shown that asylums could be conducted absolutely without restraint and seclusion—they must guard against becoming "hide bound" by tradition. They had secured a greater liberty with increased knowledge, and claimed to use that liberty as educated physicians responsible for the well-being of those committed to their care. He found that the register of restraint and seclusion in Murray's Royal Asylum showed an apparently erratic use of these means of treatment. In 1887, for instance, there had been no shower baths; in 1888 already 28 had been recorded. Entries varying from year to year with the necessities of the cases under treatment might (as the late Dr. Gilland would have said) prove a record of the conscientiousness of the medical superintendent; they would certainly not prove the absence of minute consideration of the indications of treatment of individual patients. It was surely the very irony of fate that had selected Dr. Savage, one of the apostles of increased liberty, as the type of a retrograde physician. He (Dr. Urquhart) had been pilloried as a recusant Scotsman in the "British Medical Journal" for using the protection bed. Well, that case was at the point of death, rest in the recumbent position was plainly indicated, and, with no more doubt than a surgeon applying a splint to the broken leg of a fractious child, the protection bed was brought into use. That lady was now at home in perfect health, the happy mother of her family, and such a result assuredly sufficiently justifies recurrence to forms of treatment of proved value. That was not the time to dilate upon the manifest evils of restraint, and the objectionable results of seclusion; but the time to insist upon the necessity of a well-judged middle course, the time to demand freedom of action for the asylum physician regardless of the sentimental prejudices of the day.

Dr. HOWDEN said he used restraint and seclusion whenever he thought it necessary, and did not consider himself bound by any rule or by public opinion in the matter. There were cases in which he considered both seclusion and restraint necessary, though in his own experience these were very few.

Dr. RORIE said in his practice the only means of restraint he used were the gloves, and these only in extreme cases. He formerly used seclusion very freely, but since going to the new asylum he had abolished it altogether. No patient was ever allowed to be in a state of seclusion—that is in single bedroom with door shut—after ten a.m. In extreme cases it might be necessary to use seclusion, but he would be sorry to have now to resort to it. He looked at the shower bath in the same way. Although sometimes beneficial, there was always a tendency to abuse it.

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Dr. RUTHERFORD said he regretted not having been present while Dr. Yellowlees was speaking. He thought there were certain cases in which mechanical restraint was necessary, and in such hands as Dr. Yellowlees he would be inclined to support and uphold its use. But still, he thought the principle was deleterious, because it was so liable to abuse, and that they should, as far as possible, do without it. He had occasionally used a camisole, and occasionally gloves, but in the cases of only four or five patients in twenty years. He did not like to use seclusion, but preferred to put the patient in a room with an attendant. There were rare cases in which, for the good of the individual patient, restraint might be beneficial, but, as the principle of restraint was deleterious, being so liable to abuse, everything should be done to avoid its use. We were all very much at one on this question of restraint, and the difference seemed to him to be only in the different way in which each expressed his opinion. It came to this—use restraint when necessary, but only when necessary, and he is the best physician who by dint of good treatment and nursing, best succeeds in making it unnecessary *in each individual case.*

Dr. WATSON agreed with Dr. Yellowlees that it ought to be left to the individual opinion of the physician attending the case to decide whether or not restraint should be used. In some cases of restlessness, restraint was one of the best means of procuring sleep. He had invariably entered gloves in the book as restraint, but as the Commissioners did not insist on it, he would be sorry to do anything of the kind in future. Restraint did not look well in the blue book, unless in urgent cases.

Dr. JOHNSTONE could not agree with Dr. Rutherford, who, while admitting that he felt it right to use mechanical restraint in certain cases, held that the principle was deleterious. It appeared to him that, if the practice was right, the principle must be right also. He considered that mechanical restraint was a perfectly legitimate means of treatment, and that they should have the same freedom and discretion in using it as they had in using opium or castor oil. The outcry against restraint seemed to him very unreasonable. Society could not exist without restraint, and the insane required it only more than the sane. In treating disease, as members of the most philosophical of professions, they should not allow themselves to be swayed or governed by any fashions of the moment. The physician should know no fashion. He had simply to treat each case on its own merits, and do whatever was best for his patient. Restraint, airing-courts, seclusion, etc., might be right or wrong, but their unpopularity had nothing at all to do with the question. He had listened with much pleasure to Dr. Yellowlees' remarks, and he agreed with him that mechanical restraint might wisely be employed in extreme cases of violent excitement, suicidal attempts, destructive habits, and restlessness. In his own somewhat brief and limited experience, however, while being perfectly prepared to use mechanical restraint whenever necessary, he had found that cases requiring it rarely occurred.

The PRESIDENT said that on the whole Dr. Yellowlees' address was the most eloquent and the most comprehensive he had been privileged to listen to on this subject. In regard to the opinion of Dr. Bucknill, and other men of his age and standing, about Dr. Savage's mode of using restraint in the Bethlem Asylum, he thought they had passed into a different era from that in which those gentlemen had been trained. They had passed into a more scientific era, and were free from the passions and prejudices of Conolly's great struggle, and, while sympathizing with their philanthropic views, he thought their medical ideas to a large extent wanting in courage and scientific basis. In fact, they were largely obsolete. He held, emphatically, that a medical question like this should not have been opened up by a medical man in the "Times" newspaper. They must almost all agree with most of Dr. Yellowlees' general principles. The real difficulty lay in the application of those principles to individual cases. A man with any self-respect as a physician must claim liberty to use any means he may think fit to promote the recovery and prevent the death of his patient.

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In doubtful cases few men agree as to what exactly ought to be done, but all concur that restraint is certainly justifiable in surgical cases. They should, in suicidal cases, as far as possible endeavour to effect a cure without restraining the muscular motions, but there were exceptions. He had used restraint to prevent attempts at suicide, in and out of asylums, with and without the patient's consent. In extremely violent cases he would commonly apply seclusion rather than restraint, but in less violent cases hard work in the fresh air was the better, and the more scientific treatment. They thus provided a physiological "outlet" for the excessive motor energy of the cortex. He thought "destructive" cases more doubtful than any of the other classes mentioned by Dr. Yellowlees, and that nothing was better for them than hard work. In "restless" cases he thought restraint should very seldom indeed be used, not even the "protection" bed. A simple protection of mattresses on the floor was enough, or a padded room. Restraint was unquestionably liable to abuse, and they, therefore, ought to use it with caution. The beginning of it, like whisky on some people, tended to make them crave for more. It irritated some patients very much indeed. It was a very repulsive sight to see insane patients severely restrained, and in an asylum with modern contrivances, trained attendants, and medical skill, other means should in nearly all cases be taken first to effect a cure, rather than the use of restraint. In some exceptional cases, however, restraint was the only remedy, the most humane resource, and the most scientific application of the principles of modern brain therapeutics. If by it we could really conserve energy or save life in any case, he would be deeply blameworthy who did not use it. But let it be used like any other surgical or medical measure, after careful consideration of the whole consequences, and to the very best judgment of the man who ordered it. On no account should it be allowed to be used but by direct medical order in every case, and on every occasion of use just as a dangerous medicine is used.

IRISH MEETING.

The Quarterly Meeting of the Irish Branch of the Medico-Psychological Association was held at the King and Queen's College of Physicians, Dublin, on Thursday, November 29. Drs. Ashe, Ringrose Atkins, Maziere Courtenay, Drapes, Eustace, Finnegan, Garner, Hethrington, Molony, Nolan, Conolly Norman, Patton, and Thornley Stoker attended.

Dr. Eustace having been called to the chair, and the minutes of the preceding meeting read and signed, the Secretary (Dr. Conolly Norman) read a letter from Dr. Clouston apologizing for his inability to be present and to preside at the meeting.

Walter Bernard, Fellow of the King and Queen's College of Physicians, Ireland, Visiting Physician to the District Asylum, Londonderry, was proposed for membership by Dr. HETHRINGTON, seconded by Dr. MAZIERE COURTENAY, and elected.

Dr. DRAPES read a paper on "Psychology in Ireland."

Dr. RINGROSE ATKINS said that the *fons et origo* of the comparative absence of scientific work in Ireland was the absence of organization. He suggested that the medical officers of asylums should endeavour to arrange to meet together in a friendly way, examine each other's work, and compare notes. Dr. Atkins also suggested that each member should take up some particular topic and endeavour to work it out, the results to be published subsequently in a form like the West Riding Reports. An increased number of assistant medical officers would be needed if any really good medical work was to be done.

Dr. FINNEGAN complained that post-mortem examinations were absolutely discouraged by the authorities in Ireland. He was of opinion that clinical assistants would be a useful addition to the staff even where there are assistant

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