difficult for superintendents to persuade County Councils—to say nothing of the Auditor—to pay patients for their labour. Although I think it is a matter deserving the greatest consideration, I think there are very considerable difficulties connected with carrying out the scheme, because, of course, you cannot compare prisons with asylums.

Dr. MACPHERSON—There is one point that has not been mentioned, namely, that for 35 years the French asylums have paid their patients for labour done in those asylums, and I may say with most beneficial results. There is also this other point. Patients very often find on leaving asylums that they cannot get employment; they are mistrusted by employers of labour. I have over and over again seen patients who were incapacitated by attacks of insanity, and who when they left the asylum went out to find that their tools and, indeed, their surplus clothing had all been appropriated. In the French asylums each patient who works may have a small sum to his credit when he goes out to the world, and that, in addition to the help he receives from society, is a matter of very great help. In this country, of course, we all know nothing of the kind is done.

Dr. MERCIER—With reference to the payment of good class patients, and the way they were paid, I have overcome that difficulty with the greatest ease. I have paid them in money, and I do not find that they dislike it at all. As to expense, of course, if the matter is tried on a large scale it is financially successful. That is settled by the experiment already mentioned. The difficulty will be to persuade County Councils that it will be financially successful, but I submit that with the token coinage I recommend, a beginning may be made virtually without any expense at all. It simply means cutting off the tobacco and beer the working patients at present get, and giving them tokens to purchase tobacco and beer, and other things which may be purchasable also. Of course, no auditor would at present pass an actual money payment made to patients, but the auditor does not, I assume, exercise a very minute supervision over the variety of provisions. (Yes, yes.) There may be a difficulty, but what do we come into this world for but to overcome difficulties? Dr. Lindsay says the patient's work is not worth a shilling a day. If so, why pay them a shilling? I do not see that is any objection at all. The actual amount of payment does not equal the value of the patient's work. If the patient's work is not worth one shilling a day what I say is it will be very soon worth more than a shilling a day if you pay him 1½d. for it, and there you get a distinct profit of 10½d. on the transaction. I did mention the point of payment of money earnt to patients on their leaving the asylum. I said I thought it was a most desirable thing to do, and I think it might easily be arranged.

SCOTTISH MEETING.

A Quarterly Meeting of the Association, Dr. Ireland in the chair, was held at Edinburgh, in the Hall of the Royal College of Physicians, 10th November, 1892. The other members present were Drs. James Cameron, Campbell Clark, Clouston, Elkins, Carlyle Johnstone, Keay, Mackenzie, Oswald, G. M. Robertson, Ronaldson, Batty Tuke, jun., Turnbull, Watson, Yellowlees, and Urquhart (Secretary). Dr. Middlemass was also present as a guest.

The minutes of the last meeting were read, approved, and signed.

Dr. IRELAND made suitable reference to the death of Dr. Aitken, and the Secretary was instructed to write to Mrs. Aitken expressing the sympathy of the members.

Microscopic slides, illustrative of recent work on cerebral anatomy and pathology, by Drs. Bevan Lewis, Goodall, J. C. Mackenzie, and Middlemass, were exhibited.

Dr. G. M. ROBERTSON then read a paper on the treatment of acute delirious mania, which will appear.

Dr. IRELAND said that he had been especially interested in Dr. Robertson's remarks on the value of artificial digestion in dealing with these cases. He always advised the young men to pay more attention to therapeutics than to pathology. They would have the favour of the public on their side, who were obstinate in the notion that medicine was really designed to cure people of their diseases rather than to study the way they died. He referred to his experience of opium and tartar emetic in the treatment of the delirium of fever, and some cases of acute mania. There was a tendency in mania to sinking, which rendered the old physicians cautious in bleeding.

Dr. RONALDSON said that he had found it in the highest degree necessary to obtain proper movement of the bowels, and had lately used glycerine enemata in preference to the more ordinary enemata, with the best possible results, only a teaspoonful of glycerine being necessary. If hæmorrhoids existed they were likewise benefited by this treatment.

Dr. CAMPBELL CLARK spoke of the necessity of diagnosing acute delirious mania from typhoid fever. In his practice he had found several cases of typhoid simulating acute delirious mania in every way, and at least one of these cases had been proved by post-mortem and microscopic examination to be typhoid. He laid special stress upon the liability of puerperal patients to specific diseases. There could be no doubt that dietetics were most important, and he confirmed Dr. Robertson's experience in regard to the benefits to be derived from the use of digested food. In order to avoid any mistakes in the preparation of peptonized milk he ordered half-a-pint to be boiled, then half-a-pint of cold milk to be added, by which method the temperature for peptonizing was obtained without further trouble. In case of a difficulty of feeding by the mouth he used zyminized suppositories of meat and milk. He confirmed what Dr. Ronaldson had said about glycerine suppositories, and recommended morphia suppositories as an effective and safe manner of treating peripheral irritations. Although there can be no doubt that sulphonal obtains a high place in every-day practice, in these cases he preferred hyoscine.

Dr. MACKENZIE briefly described a fatal case of acute delirious mania, which was characterized by extreme exhaustion, high pulse, sighing respiration, and nearly abolished reflexes of the eyes. He injected $\frac{1}{250}$ part of a grain of strophanthin with 30 minims of brandy subcutaneously, and hot milk was administered by the stomach tube. At first the patient appeared to rally, but in a few hours she died, with a maximum temperature of 109°. The strophanthin was given with the idea of increasing the cardiac systole, but its effects were evidently transient. At the post-mortem examination intense compression of the brain and hyperæmia, especially in the cerebellum, were the chief features. He believed that alcohol should be more frequently used to allay excitement.

Dr. BATTY TUKE, jun., referred to two successful cases in which he had bled to the extent of 10 to 12 oz., both being young and strong men. He could not corroborate what had been said in favour of sulphonal. He preferred to create counter irritation on the surface of the chest and back with turpentine, or a blister or large mustard plaisters. This, along with the use of hot baths, he had found in many cases procure sleep when hypnotics failed.

Dr. OSWALD spoke of the value of paraldehyde, combined with bromide of potassium, in obtaining sleep in these acute excited states. The addition of bromide had this advantage, that it obviated the excitement that was apt to occur as an after-effect of paraldehyde. He considered that the free action of the skin was only secondary to the free action of the bowels in allaying irritation and excitement and inducing sleep. Enemata containing turpentine were in his experience valuable, and he recognized the importance of maintaining the alimentary canal in as aseptic a state as possible. A case diagnosed before admission into Gartnavel as one of mania was shown afterwards to be really one of typhoid fever.

Dr. CARLYLE JOHNSTONE said that he would not again refer at length to the value of sulphonal in these cases, but while he regretted that it remains necessary for us to treat symptoms, there was no doubt in his mind that in sulphonal we possessed a most valuable drug.

Dr. CLOUSTON referred to the difficulty of classifying cases of mental disease. He would ask if acute delirious mania were really a distinct disease from acute mania? He believed that there was no real distinction between the two conditions, although some authors were satisfied that such existed. Dr. Clouston compared these cases of acute delirious mania with some cases of alcoholism dying with very similar symptoms. There can be no doubt that certain cases of epilepsy, and also general paralysis, pass into a similar state, and he had seen puerperal, lactational, and even cases of mental shock exhibiting very similar symptoms. He would urge that different pathological conditions should be ascertained before mental diseases should be so divided, and it is a question if such exists in regard to the cases now under review. It must be kept in mind that in five cases of delirious mania out of six the disease began and ended with ordinary mania. He sometimes asked himself if we should not allow acute delirious mania to run its course without using soporific drugs, just as we did the delirium of typhoid fever. The microscopic sections (prepared by Dr. Middlemass) placed on the table to illustrate Dr. Robertson's paper showed the extreme degeneration of the nerve cells to be found in some cases of this kind. Dr. Clouston was hopeful that even such degenerative changes might be curable, and that the recuperative power might build up nerve cell contents, even if the organic change had advanced to a similar stage of what has occurred in this particular case. This case had deeply impressed him, for if a really "curable" case could have such advanced cortical cell degeneration it gave new hope where men were hopeless at present. Looking at those cells, they were more degenerated and changed than in early general paralysis. He would emphasize the fact that up till the last the prognosis in Dr. Robertson's case had remained good. There was apparently no reason why the patient should not have recovered until it was evident that death was very near at hand. Replying to Dr. Ireland, Dr. Clouston could not say that the variety of acute mania called delirious mania ran a definite course like an infectious fever; but in some cases the course of the symptoms was fairly certain. As a matter of fact they expected that these patients would recover within three months if they recovered at all.

Dr. URQUHART agreed with Dr. Clouston in believing that acute delirious mania or typho-mania was not a distinct disease, but he held that it was a convenient name for these severe cases which from time to time occur in asylum practice. On looking over the records of Murray's Asylum he found that only one case of acute delirious mania had occurred out of four hundred, and that would seem to be the usual proportion. That case did recover after an extremely severe attack, but the patient had relapsed two or three times in the intervening ten years, and the subsequent attacks were not characterized by the very severe symptoms of the original seizure. Dr. Urquhart referred to the benefits of the wet-pack, especially when the skin is dry and harsh, and the necessity for the treatment of the urgent symptoms.

Dr. TURNBULL concurred in the importance of studying the clinical history of the disease. Certain forms of acute mania tended to run a definite course, just like the specific fevers, and hence the necessity of watching for the different symptoms as they arose, treating these as far as possible, and placing the patients in the best possible conditions for weathering the storm. With regard to sulphonal and hyoscine, he had found sulphonal more generally useful than the other, but had also obtained good results with hyoscine in toning down the attacks of excitement in recurrent mania.

Dr. ROBERTSON briefly replied. He said he could not agree with Dr. Clark as to the relative danger of sulphonal and hyoscine in these cases, for he was of opinion that the latter was more depressing. He also believed it to be neces-

sary to run some risk even with sulphonal in trying to stop the motor excitement when a patient was running down and exhibiting symptoms of exhaustion. He would be unwilling to adopt such remedies as hot baths and blisters.

After the conclusion of this discussion an informal conversation took place regarding asylum dietaries, which will be reported by Dr. Turnbull to the committee now engaged in considering that question.

Dr. TURNBULL moved, and it was unanimously resolved, that the Secretary should intimate to the Council at their next meeting the desire of the members then assembled to hold the spring Quarterly Meeting in Liverpool, or some convenient town in the North of England.

Dr. WATSON then exhibited and explained the plans of the Govan District Asylum now being erected, the chief feature of which was the separation of acute and sick cases in a hospital block, placed at a convenient distance from the building for chronic patients.

After the meeting the members dined as usual in the Edinburgh Hall.

THE INTERNATIONAL CONGRESS OF CRIMINAL ANTHROPOLOGY.

The third International Congress of Criminal Anthropology was held at the Palais des Académies, Brussels, from the 7th to the 14th of August. Dr. Semal very ably organized the Congress; M. Le Jeune, the Minister of Justice, presided at the opening session, while the King of Belgium attended one of the meetings and invited the Congress to meet him. Various prisons and asylums were visited, and the papers and discussions generally were of great interest. A large number of foreign Governments were officially represented at the Congress, including France, Italy, the United States, Russia, Holland, Denmark, Hungary, Switzerland, Portugal, Mexico, Brazil, China, Japan, etc., and many medical and scientific societies sent delegates. A notable feature of the meetings was the considerable number of lawyers present, and the harmonious manner in which the medical and legal elements in the Congress worked together. The prominent members of the Italian school were on this occasion absent; and although the congenital "criminal type," in a very narrow and rigid sense, is not accepted by criminal anthropologists generally, on the other hand honour was paid to Lombroso and his followers who have, indeed, created the study of criminal anthropology. While in the narrow sense of the word there is no definite and distinct "criminal type," the very frequent association of a large number of anatomical characters with criminality is now almost universally recognized. At one of the meetings of the Congress a photograph was passed round by M. Cuylits (who argued that crime is an exclusively social phenomenon) as that of an "honest man" exhibiting a large number of the features usually associated with criminality; this "honest man," however, was recognized by Dr. Warnots as a hospital patient who had been frequently in prison. The incident was an amusing illustration of the careless manner in which evidence is sometimes brought forward in these matters.

It is impossible within the limited space at our disposal to give an account of the various papers and discussions, but some reference may be made to a few of the more important. At the first meeting Dr. Magnan, of Sainte Anne, presented his report on "Morbid Criminal Obsessions," dividing them into homicidal, kleptomaniac and kleptophobiac, pyromaniac and pyrophobiac, and sexual obsessions, giving several examples of each variety, and concluding that mental degeneration is the soil from which all, though differently coloured, emanate. Dr. Ladame, of Geneva, followed with a paper on the special "Obsession of Murder," as a division of the great class of hereditary insanity, like dipsomania or kleptomania; he divides such subjects into those whose obsessions remain