THE JOURNAL OF MENTAL SCIENCE.

[*Published by Authority of the Medico-Psychological Association of Great Britain and Ireland.*]

No. 155. NEW SERIES, No. 119. OCTOBER, 1890. VOL. XXXVI.

PART I.—ORIGINAL ARTICLES.

Presidential Address, delivered at the Annual Meeting of the Medico-Psychological Association, held at the Royal Asylum, Gartnavel, Glasgow, July 24, 1890. By D. YELLOWLEES, M.D., LL.D., Physician-Superintendent Glasgow Royal Asylum, and Lecturer on Insanity, Glasgow University.

In ancient times, when superstition was more potent than reason, insanity was deemed a visitation from the gods, and the words and conduct which it prompted were accounted those of the spirit by which the mortal form was possessed.

Less reverent views came as the world grew older, and from being accounted a dwelling-place of the Divine the lunatics were deemed something less than human. A corresponding change took place in the treatment which they experienced. Bereft of man's noblest attribute, the mind, they were regarded as brutes, and were too often treated accordingly. When kindlier and more humane feelings gradually awoke, and the condition was recognized as a disease and not a doom, it was still deemed a disease of mind. Physicians regarded the malady as purely mental, and therefore beyond their reach, and when conjured to banish hallucinations or relieve horrible fears, could only despairingly reply, "Therein the patient must minister to himself."

Long after the malady was deemed within the range of medical science it was regarded and studied only from the mental side, and men spoke of insanity of the emotions, of the intellect, and of the will, without regard to bodily causes or conditions.

The pendulum of progress has now swung to the opposite side. In the pride of pathological research we speak of

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

nothing but bodily conditions as the cause of mental disorders, and the mind is degraded to the level of a secretion, a little more respectable than bile, because the brain is more complex than the liver, but a mere secretion after all, and only what the brain makes it. The notion that mind can influence brain, as truly as brain influences mind, is laughed to scorn; thought, memory, and emotion are brain cells in action, and nothing more, while the call of duty, and the sense of responsibility, and the power and practice of self-control are the result of certain wonderful organisms which no one ever saw, called "cells of inhibition."

These materialistic views have been strengthened in many minds by the wonderful results already attained by physical investigation of brain function. So much has already been gained that men fondly imagine impossible results to be within our reach. They vainly hope to realize, but more wisely, the dream of phrenology, to assign to every spot of brain its power and province in the region of mind, and to crown the triumph by detecting a delusion in a frozen section of the faulty spot.

I yield to none in admiration of the work done in localizing brain areas connected with physical movements and with special senses, or in appreciation of the practical results thus gained in detecting and relieving local brain disease, but I find nothing to warrant the conclusion that like localization of mental moods or manifestations can ever be possible. Has the most enthusiastic physiologist ever dreamed that he could localize in any spot of brain an all-pervading emotion, like joy, or fear, or hope, or love? Has he hoped to discover the cells which give imagination its wings and memory its sweep, or to find the brain area which generates conscience and the sense of right and wrong? Has morbid anatomy given the faintest shadow of a reason for believing that this dream can ever be realized? Can the necroscopist detect cells of love, of memory, or of conscience? Can he distinguish the brain of a scoundrel from the brain of a Christian hero?—nay, he often cannot distinguish an insane brain from a sane one, so far beyond our knowledge are the nature, the limit, and the areas of brain changes in connection with mind. Localization of mental phenomena seems in their very nature to be impossible, for surely thought and emotion, judgment and self-control are attributes of the mind as a whole, and must be subserved by the whole mental area of brain, in combinations and conditions

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

of cell activity utterly beyond our ken. That these inscrutable combinations and conditions do somehow condition and limit the manifestations of mind cannot be doubted, and that derangement of such conditions and combinations induces mental disorder is equally certain. But the converse truth, that mental moods and conditions can and do disturb the normal and harmonious action of brain cells, needs equally to be asserted, and has been far more overlooked.

A parent's grief at the death of a child is a natural sorrow which no one would deem inconsistent with mental health, but if the sorrow be unduly pondered, and be indulged by contemplating objects which recall and renew it, it becomes engrossing and habitual, and a groove of thought is established which we recognize as morbid and call melancholia. In other words, a mental mood has grown into a disease, because the mood has created, through constant use and habit, undue activity in certain brain cells, or has relaxed the activity of others. To ascribe the original sorrow to these brain-grooves of perverted or diminished activity would be as reasonable as to deem the ruts in a highway the cause of the traffic which had produced them. Further illustration is easy; a merchant has invested in a speculation which must either make or mar him—success means a fortune, failure means ruin. His great anxiety is natural and well-founded, but after the sudden news of a successful issue, the excitement culminates in temporary mania. A young lady mistakes the affectionate courtesies of a friend for the attentions of a lover, and when undeceived loses all interest in life, and sinks into apathetic stupor. Or a wife misjudges her husband's polite attentions to a lady friend, and broods over the fancied wrong till her life is wrecked by delusions of jealousy and suspicion.

Such cases prove that insanity often begins in mental conditions, which at first may be perfectly sane and normal, but by undue continuance or undue intensity they establish grooves of thought so deep as to create a disturbance or perversion of normal brain activity, which in time becomes truly morbid, and out of which grooves the mind is shunted with a difficulty proportioned to the degree of brain perversion which the mental habit has established.

Such grooves of thought may not originate in mental states, but in bodily conditions, by which the mental moods are prompted; or, again, bodily conditions or disorders may disturb the brain without the intervention of consciousness

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

or with consciousness utterly perverted. These bodily conditions and disorders may be associated with natural changes in growth, reproduction, and decay, or with morbid conditions in organs other than the brain, and may occasion brain disorder through defective or perverted nutrition, or by what, for want of better knowledge, we call irritation or sympathy.

If it be objected that brains so susceptible to emotions of sorrow, anxiety, love, or jealousy, and so easily moved to extremes, must have been always sensitive and unstable, that is, of course, admitted; but then it is equally true that only sensitive and unstable brains develop the insanity which is awakened by bodily changes or disorders. The objection is merely another way of saying that brains differ inherently in their degree of liability to insanity, and it does not alter the fact that the possible insanity is often awakened from the mental as well as from the bodily side.

When mental causation is traced in so many cases, and when the urgent symptoms in all cases are mental, even where a bodily origin is recognized, it would be strange, indeed, if the medical treatment were not largely from the mental side, and if it did not include such moral guidance and management as would tend to calm excitement, and soothe fears, and assure of safety and help, and if it did not strive by personal influence, surroundings, and occupation to lead the disordered mind back to health again. But it would be utter folly to do all this and to neglect the underlying bodily cause, if such can be discovered or treated, on which the insanity depends, and so the medicinal and the moral treatment must go together, else the patient is culpably maltreated.

These remarks have been suggested by a contribution which has been made to the literature of our speciality since the last annual meeting of the Association, a contribution so unique and important in the views it expresses, the opinions it collates, and the questions it suggests that it deserves our most careful consideration.

It appears in the unpretending form of a report of a Committee of the London County Council, and is addressed to non-professional men, but it is in reality a popular lecture on insanity, an exposure of real and alleged shortcomings in the present asylum system, assurances of the great advantages to the patients and the public which would be secured by placing the insane under the care of the physicians and

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

surgeons of general hospitals, and a recommendation that a special hospital under this arrangement be established in London. With the object of the Committee in desiring to improve the treatment of the insane and to advance our knowledge of insanity we are all in fullest sympathy, and it is to be regretted that a spirit of antagonism should have been needlessly aroused at the beginning of the movement by the exaggeration of too familiar facts, the presentation of unattainable results, and the implied reproach on professional brethren. This feeling of antagonism should not prevent an unprejudiced consideration of the elaborate report to the London County Council which the movement has produced, and in which the proposals of the committee and the evidence on which they are based are fully stated. It is a document of much interest, and although it misrepresents the facts of the present system, and mistakes the remedy for its failures, it yet may have an important and beneficial influence on the study of insanity and on the treatment of the insane.

The report of the Committee states (I quote the words) "that the suggestion actually submitted to them, is neither more nor less than to place a certain number of the insane under conditions similar to those which have been conducive to progress in the study and treatment of other diseases; that is to say, to subject them to the ordinary influences of a hospital, and to bring the methods, the *personnel*, and the equipment of a hospital to bear upon the study and the cure of the changes which underlie or occasion their insanity. It is not proposed to surrender any of the advantages which an asylum now affords (unless it be those incidental to a rural situation), but simply to supplement them by others of which asylums have hitherto been deprived, or which they have possessed only in an imperfect manner, and which have been proved by experience to be eminently conducive to the advancement of knowledge with regard to the causes of disease, and with regard to the methods by which it may be prevented or cured."

I venture to say that this proposal, as thus expressed, would have received most careful and unbiassed consideration if it had been brought before our speciality in a different manner, with less suggestion of superior wisdom on the part of its advocates, with less implied reproach on their professional brethren, with greater appreciation of the differences which must always exist between an asylum for

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

the insane and an ordinary hospital, and without the unworthy attempt to awaken popular prejudice, and influence public feeling.

The Committee were instructed "to inquire into, and to report to the Council upon, the advantages which might be expected from the establishment as a complement to the existing asylum system of a hospital with a visiting medical staff for the study and curative treatment of insanity."

The last sentence implies, of course, the reproach that the existing asylum system has neglected or has failed in "the study and curative treatment," and this reproach is abundantly manifest in the report itself. It was not, therefore, to be expected that the leading men in the system thus arraigned would be called in evidence, and of the sixteen eminent physicians and surgeons who were examined as witnesses, only two had any experience as asylum superintendents. Had the leaders of this movement been wiser and less prejudiced, and had they taken into their counsels the leading asylum superintendents, they would have found no men more ready to consider, and to co-operate in, whatever promised to advance the knowledge and improve the treatment of insanity, and certainly none so able to understand the difficulties of new modes of treatment.

The popular lecture on insanity, with which the report is prefaced, explains to the County Council that insanity is "the direct result of material changes affecting the brain, and that in considering insanity with reference to preventive or curative treatment, these material changes are all that need be taken into account." This is illustrated by the very ancient story of the sailor who, when trephined in Haslar Hospital, is alleged to have finished the sentence which was interrupted long previously by a blow on the head during a naval engagement. Drunkenness, rheumatism, and lead colic are supposed to illustrate the occurrence of insanity through changes in the blood. The progress of medical knowledge, the consequent decrease of the death-rate, and the important part which hospitals have borne in improving the treatment of disease are next dwelt on. The Council is then informed that the treatment of insanity has not shared in this great progress, except as regards nursing and environment, and that "the present currency of the word 'lunacy' in daily talk is alone an evidence of how much, in a scientific sense, the ordinary conception of the nature of insanity has lagged behind the conception of the nature of other morbid con-

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

ditions." The argument from philology, by the way, is not convincing. One might as well say that electricity had made no progress because its name perpetuates the ancient notion that it was the special property of electron or amber.

The Committee inform the Council that the amelioration in the surroundings of the insane has been due to humanity rather than to medical skill, and that from being "shut up in asylums" the insane were "removed from the ordinary scope of medical observation, and from the influence of the progress of medical science." The excuse for this statement is found in the assertion that asylum superintendents are mere administrators or house stewards, and have neither the training, the time, nor the capacity for medical investigation.

This wholesale slander is based on remarkable evidence given by the Lord Chancellor's Visitor, who tells of a youth who had never seen an insane patient being placed in entire charge of one department of an asylum; of a patient who, after four months' residence, did not know who the superintendent was; and of the multifarious duties discharged by himself at the Wakefield Asylum, including signing cheques for £40,000 a year. Surely he did not allege that this was the practice in all asylums, surely his modesty kept him silent about the West Riding Reports, which prove how the medical spirit can triumph over such administrative burdens, and surely he forgot the splendid scientific work done by the present Medical Director at Wakefield in spite of like hindrances.

The mode adopted by the Committee to ascertain the views of asylum physicians was peculiar. Instead of asking evidence from the acknowledged leaders, they sent a series of questions to every asylum superintendent in England and Wales, and to a few others similarly qualified. The Committee anticipated opposition to their proposal, conscious, perhaps, that it had been provoked, and certainly the questions were not framed so as to disarm it, nor does it appear that they were accompanied by any such exact statement of the Committee's proposal as I have just quoted. Nevertheless, out of the sixty-five who replied forty-nine were dissatisfied with the time available and facilities provided for the scientific investigation of disease in asylums, forty-one were dissatisfied with present facilities for individual treatment of patients, twenty-four approved of the proposed

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

hospital, and seventeen approved with some qualification. These figures sufficiently indicate how willingly our speciality would have considered the scheme had it been more wisely brought forward. Those who objected in whole or in part to the Committee's proposal did so because they deemed moral influence and suitable occupation and surroundings more important than medicinal treatment, or because they believed that the daily visit of outside physicians would be a mistake, or because they were convinced that by the removal of incurable cases to workhouses or to special asylums, and by an increased staff, both lay and medical, the existing system could be made thoroughly satisfactory and efficient. Their views were admirably expressed by Dr. Clifford Albutt, Commissioner in Lunacy. It is significant that his evidence was, "in some sense, a surprise" to the Committee, and led them to ask their witnesses "whether the establishment of the hospital would be conducive to a greater command over the causes of insanity than is now possessed, and that by the application of directly medical agencies."

The London physicians were clear on this point, and Dr. Batty Tuke informed the Committee that by treating the cases on strict hospital principles, and applying himself to the patients instead of to administration, he had obtained over sixty per cent. of recoveries. The allegation that the insane are not sick in the ordinary sense the report explains by saying that the asylum superintendent has not skill enough to detect the sickness. Great scorn is bestowed on the suggestion implied in the word "drugging," but the need for and the blessings to be procured by "medicine out of a bottle" are strongly asserted, for does not calomel banish despondency, and was not Lord Shaftesbury accustomed to say that if people would only "take a little more blue pill there would soon be an appreciable diminution in the gross amount of madness?" The skilled hospital physician is to be the Saviour of the insane.

The report next adverts to the ignorance of medical practitioners on matters connected with insanity, to the present inadequate means for obtaining such knowledge, and to the importance of the proposed hospital as a means of medical education.

It is certainly a scandal that some knowledge of insanity is not a compulsory part of medical education. The power of depriving a fellow-citizen of personal freedom and of

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

liberty to manage his affairs is by law entrusted to medical practitioners, and yet a man may be licensed to practise who never saw a case of insanity. Among the witnesses examined there were four members of the General Medical Council, one of them being its president, and they testify with one accord as to the great need for such education. Then why, I ask, in the name of our Association, has not the General Medical Council insisted long ago on such education for every student? There is ample material in the public asylums, and at least ten asylums within easy reach of London would welcome a weekly clinique, the systematic lectures being given at the schools. The proposed hospital is to contain only one hundred patients, and would thus be totally inadequate to meet the teaching requirements of London. These one hundred patients are to be cared for by four visiting physicians, who must be on the staff of a general hospital, two resident physicians, who are to work with, though not under, the visiting physicians, a surgeon, an oculist, an aurist, a laryngologist, a gynecologist, and a pathologist. Would it be for their benefit to endure, in addition to all this, the attentions of an eager crowd of students?

The proposed Hospital is to have an out-patient Department as soon as practicable. Such a department would become the haunt of hypochondriacs and malingerers, and could do little or no good to the insane, but it carries out the Hospital idea, and gives the scheme a false air of completeness which may commend it to the ignorant, though benevolent, public. The site of the hospital is to be "in London." Those who deem moral treatment, including occupation and exercise in the fresh air, of great importance, of course prefer a country situation, but the report tells us, with that lofty superiority which is so foreign to true wisdom, that these are "conditions which have unquestionably been shown by experience to be of great advantage inpromoting RECOVERY from insanity, but which would not ofnecessity be equally important with regard to CURE."

The estimated cost of the hospital is £315 per bed, for erecting and furnishing, and £57 10s. per head per annum for maintenance, exclusive of clothing, laundry, and visiting physician's fees. It is recognized that the maintenance rate may run up to £70 or £80 yearly, but that is deemed of little consequence, for the recovery rate is to be raised at least ten

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

per cent. by the skilled hospital physicians, and as the county of London pays £300,000 annually for its insane poor, there will be a saving of £30,000 a year.

The recovery rate of the proposed hospital should not be ten, but twenty or thirty per cent. above the average, and it is well to discount beforehand the shout of triumph with which this will be announced. It could not be otherwise, and for two reasons :

1st. Only selected cases will be received. The imbecile and the senile, the chronic forms of paralytic or epileptic insanity, the confirmed melancholics and dements will rarely be admitted, and these are the very cases which crowd our asylum wards and lower our percentage of recoveries.

2nd. The hospital standard of recovery is quite different from the asylum standard, and much lower. As soon as the acute symptoms have subsided and he has attained comparative health, the ordinary hospital patient eagerly seeks his discharge, deeming himself recovered, or, as the report would say, "cured." It may be the mere temporary arrest of a disease which is too certain to recur, but for the time the patient is well, and is so regarded. An asylum patient cannot be thus dealt with. The safety and welfare of others are involved in his restoration to freedom and self-guidance, and mere arrest of the disorder would not justify discharge nor warrant the term recovered (we do not pretend to "cure") while there remained a likelihood of its sudden or dangerous reappearance.

The underlying idea of the whole report is that insanity, being an illness, should be treated like other illnesses, that the benefits which a general hospital affords in the cure of a patient and the better knowledge of his disease have been wrongfully withheld from the insane, that asylum physicians have promoted the recovery of the insane, but have quite failed to expound the pathology or accomplish the cure of insanity, and that by the adoption of the hospital system and the skill of hospital physicians the meagre results and the blind gropings of the past will disappear, the number of cures will be greatly increased, and a more exact knowledge of insanity will certainly be obtained.

This idea at once captivates the popular mind which fully recognizes the blessing to humanity and gain to science which a hospital affords, and, in humane pity for the afflicted, desires instantly to extend the same blessing to the insane.

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

A member of Committee, evidently with the ancient Haslar hospital story still in his mind, expressed surprise that only one consulting surgeon should be required in the proposed hospital, and seemed to imagine that the surgeon would become the good genius of the insane, and would always appear, trephine in hand, ready to drill holes in the skull to let the insanity out.

In considering the recommendations of the Report, it is necessary to remember the inevitable differences between an asylum and a hospital, for they are inherent alike in the conditions of residence, in the malady, and in the treatment.

1. The patients in an asylum do not seek asylum care, and often resent it, but they cannot leave when they wish. They are usually not conscious of illness, cannot co-operate in treatment, and often rebel against it. Even when recovery is unattainable they cannot be dismissed with the sad verdict that nothing more can be done, but must be kept and cared for, even to life's end. Picture a general hospital under like conditions, where every third patient was rebellious, and every incurable case a fixture.

2. The malady, while scientifically an illness, and frequently due to temporary or to hopeless bodily disorder, is often associated with robust bodily health, and often affords —whatever skilled hospital physicians may imagine—not the least pretext for dealing with the patient as with an invalid. The closest scrutiny of organ and function can often detect no bodily ailment; the patient is morbidly depressed by his child's death, or deems his wife unfaithful, or dreads that he will die a beggar; he announces the day of judgment, or sees visions of angels, or interprets the singing of birds as the language of inspiration, but his condition often affords no indication for special medicinal treatment.

3. The medical treatment differs essentially from that of a hospital. It should be *medicinal and addressed to the body* in every case where the closest investigation can discover need for such treatment, or can give hope of benefit from it, but it must in ALL cases be *moral and addressed to the mind*, and must seek, by persistent personal influence and by suitable occupation and environment, to overcome insane habits, banish insane moods and ideas, and restore normal thought and feelings.

The antithesis between "medical" and "moral" treatment, so often repeated in the report, is entirely false. The real contrast is between "medicinal" and "moral," for

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

medical treatment includes both. Medicinal treatment, when required, is of the utmost value, and no asylum superintendent worthy of the name would neglect it, but as a general rule the influence of sane minds, suitable occupation, and pleasant surroundings, the sense of sympathy, of safety, and of guidance, the power of system, authority and example are more valuable to the insane, and more beneficial by far than the most skilful selection from the pharmacopœia.

There is another antithesis in the report which is, if possible, worse. Asylum physicians are reproached because they have been satisfied to promote the RECOVERY of the insane, but hospital physicians despise this attainment and mean to CURE INSANITY. To the surgeon who removes the physical cause of the disease, the word "cure" may perhaps be permitted, but a wise physician seldom uses it. His function is to help nature to cure, and he is content to be her minister and interpreter.

The question of Visiting Physicians is brought forward in the report as if it were entirely a new departure and of the utmost importance. The Committee utterly ignore the fact that in the principal medical schools of Europe the insane have long been treated in general hospitals and by hospital physicians. Neither in the care nor in the cure of the insane have any special advantages followed from this arrangement, and in neither respect are results equal to our own. The Committee also strangely overlook the fact that in Ireland every public asylum has the advantage, if such it be, of a visiting physician, and that one of their witnesses, Sir John Banks, holds this office now. The report alleges that visiting physicians, where they existed, were either specialists in insanity, and thus no better than the resident physician, or that their function was merely to treat any intercurrent bodily disease; and it thus explains the fruitlessness of their labours. In the case of the Irish visiting physicians these specious excuses cannot be urged. They are not "specialists" in insanity, and they are expressly bound by the Government regulations to see all the new cases, to visit any who are in seclusion or under restraint, and regularly to examine into the mental condition of every patient in the asylum who is under special medical treatment. What is the result? There is no reason to believe that Irish lunatics have benefited vastly by the introduction of outside skill; no striking advance in mental medicine has been achieved by these officers; the medical treatment in Irish asylums is not con-

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

spicuously better than in those of Great Britain, and the proportion of recoveries is nothing greater.

Sir John Banks evidently deems the medical and scientific work the province of the resident physician, and says he would doubtless do it admirably if relieved of departmental and administrative work. The Wakefield Asylum, according to Dr. Albutt, had an admirable visiting physician for many years, but without any marked advantage to science or treatment, and the same is true of the Aberdeen Asylum. Any noteworthy work in either place was done by the resident superintendent, and not by the visiting physicians, from whom the report expects such great things. In truth, as Dr. Albutt's evidence clearly shows, there is little place for a visiting physician in an ordinary asylum. The majority of the patients require no medicinal treatment, and he can do little to help the moral treatment in an hour's visit. As for scientific investigation, he can accomplish it only through other officers, and he is not more likely to indicate the best directions for it than the resident physician, who dwells among the patients and knows them far better.

The theory that the resident superintendent is to work "with, but not under" the visiting physician *sounds* well, but he must be a young and very sanguine person who imagines that the plan would often *work* well. The position is entirely different from that of the resident physician of a general hospital, whose function it is to carry out the wishes of the visiting physician. Where both are in authority, and in spheres which overlap, friction is inevitable, and the stronger man must rule. The importance of the office to the visiting physician was emphasized by one of the witnesses who, seeing that private asylums must gradually disappear, asked how consultants in insanity were to obtain their experience in future except in such a hospital as that proposed. It is usually the opponents of hospitals who suggest that they exist for the physicians as much as for the patients, but the question shows the foolishness of the rule which debars the superintendents of public asylums throughout the country from consultation practice under proper restrictions. London is not the only place which requires consultants in insanity, and this rule is unfair to the public, as well as unjust to asylum physicians.

Asylum physicians are too well aware that they do not cure half of their patients, and that they often fail to discover the pathology of insanity, but they claim that they

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

earnestly try, and that the failure results, not from their neglect or incapacity, but from the very nature of the malady. When anatomy and physiology have expounded the structure and function of the healthy brain it will be time enough to reproach the physician with failing to understand and cure their derangement. When these handmaid sciences defined localities of sensation and movement, medical treatment took immediate advantage of the knowledge. Let them render, if they can, like aid in the mental areas of brain, and we shall then be in a position better to understand insanity, even if like power to heal may not follow.

Asylum physicians also know far better than their critics the defects of the present asylum system. They daily feel the worry of administrative details, the weakness of their medical staff, and the incubus of chronic cases which they cannot get rid of and cannot cure. Administrative work may be a curse by engrossing the time and thought of the superintendent, and hindering his medical work, but it may be a blessing by affording just that relief and change which his medical duties require. No superintendent should be without responsible officers for the three departments of Administration, the Stores, the Workshops, and the Outdoor department, and with such help no superintendent need make administration a burden. It may be true that some superintendents have sunk themselves in such details, and have become purveyors, architects, or farmers, which only proves that they have mistaken their vocation and had better change it. Square men get into round holes in all departments of life.

The medical staff of asylums is almost universally deficient, and especially in two respects. There is too great a gap between the superintendent and his first assistant, on whom the duties of the chief are not sufficiently devolved, and there is so much visiting and recording that there is little time for scientific work. Clinical clerks can aid in visiting and in recording cases, and additional assistants would make research possible for any of the medical officers who desired to undertake it. Scientific instincts cannot be created by giving time and opportunity for their exercise; but certainly time and facilities for such work should be afforded in every asylum, and such work should not be exclusively the province of the pathologist, but of any member of the staff who desired it and was fitted for it.

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

The accumulation of incurable cases is perhaps the greatest defect of all, for it causes or aggravates all the others. It increases administrative worries, adds to the routine medical work, covers up from observation the new and curable cases, and tends to make the institution a place of residence instead of a place of recovery, a shelter for wrecks instead of a place where vessels are refitted for service. This accumulation has been greatly favoured by the Government grant which leads to patients being sent to asylums who only require care and nursing, and who are incurable from the first.

It was not left to a Committee of the London County Council to reveal these defects in the present asylum system; they have been too long familiar; their growth, causes, and remedy have all been discussed, and Cure-Hospitals, such as it now proposes with such an air of novelty, and such an array of witnesses, were recommended long ago, though without a staff of four visiting physicians. I may be allowed to quote what I wrote in 1881:—

"The history and circumstances of many of our increasing counties or districts, as regards provision for their pauper insane, are unfortunately similar. An asylum is built which seems more than sufficient for all the needs of the district, and for a time it can receive patients from other districts also. Gradually, as each year adds its quota, the incurable cases accumulate. Then the out-district patients are expelled. Then a wing is added here and another there. Then the economic department is found unequal to the unexpected growth of the population, and must be remodelled. Then additional wings are required, until the asylum grows to twice or thrice its original size, is cumbrous and inconvenient in working from the dislocations of its original plan, and is less efficient as a place of cure since individual treatment has become increasingly difficult, and the new cases are easily overlooked amid a multitude of incurables.

"To transfer these incurables to the lunatic wards of a poor-house is no solution of the difficulty. They are thus merely moved from one asylum to another, and either the one building or the other must be enlarged to meet the growing numbers.

"The 'boarding-out' plan has been strongly advocated, and has been adopted with some satisfactory success. The incurable patient is discharged from the asylum, and

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

through the agency of the parish officials, is placed as a boarder either with relatives or in the homes of strangers, being still supported by the parish and under the supervision of the Lunacy Authorities. The fatal defect in this method is its inadequacy to meet the difficulty. While it answers admirably for some patients, there are many more for whom it would be quite unsuitable. It would not be possible to dispose properly and safely of one-half—probably not even of one-third—of the incurable cases in this way, even were it possible to find for them trustworthy guardians and suitable homes.

"All experience seems to prove that every country or district should have two asylums, or rather two types of asylums for its pauper insane. One of these should be distinctly a Hospital, possessing an ample staff of officers and attendants, and fully equipped with all the best means and appliances for the treatment of recent insanity. It should be central, or easily accessible from all parts of the district. It should receive all the new cases as they arise, and should retain only a sufficient number of old cases to give the new comers the necessary example of industry, order, and obedience. Its population should not exceed 250 or 300 at most, so that the utmost possible effort may be made for the restoration of each individual patient. Its chronic cases should be drafted off as they arise to the other and larger asylum. In very large districts several such cure-asylums would be required near the different centres of population.

"The other asylum should be distinctively a Home. It should be situated in a country district, and be surrounded by ample lands for spade cultivation and for milk supply. Its central portion should be fitted for infirm and for excitable patients, and the wings should be a series of blocks capable of almost indefinite extension for the ordinary cases. It should receive no patients except from the cure-asylums. Such a building should be erected at about half the cost per bed of the cure-asylums, and the utmost economy consistent with the welfare of its inmates should be a prominent feature in its administration.

"This plan of providing for the insane poor of a district would secure, I believe, at once the greatest benefit to the patients and the least expense to the ratepayers."

The real obstacle in the way of providing these two types of asylums is the financial one. It is felt that a very large

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press

capital is already sunk in the existing County Asylums, that far less costly buildings than they are would have sufficed for chronic cases, and that the cure-hospitals to be provided would be more costly still, so asylum visitors have recoiled from the outlay. The County Councils may be bolder, and it is fitting that the London Council, where financial considerations weigh least, should take the first step. May theirs be but the first of many cure-hospitals yet to be established, but on wiser lines than they have laid down. Asylum physicians only need such opportunities to show that they can use them worthily.

I cannot sit down without alluding to the suggestive comment on this report, which is supplied by the annual meeting of our Association to-day. While the report desiderates hospital physicians we have matured and approved a scheme for providing better nurses; and while the report reproaches us with want of scientific spirit, the essays sent in this year from assistant medical officers of asylums are so admirable in the quality and amount of original scientific work, that we have awarded the usual prize of a medal and ten guineas to *two* of them.

The Heating, Ventilation, and Electric Lighting of the Hospital at the Montrose Royal Asylum. By James Howden, M.D., Physician-Superintendent of the Asylum.

In connection with the description of the new hospital in the *Journal of Mental Science* for January, 1889, I have now to add a detailed account of the heating, ventilation, and electric lighting as now completed.

The heating and ventilation are effected by steam on the low pressure principle, by which all the condensed water is returned into the boilers by its own gravity.

There are two steam boilers 14 feet long, by 4 feet 6 inches diameter, placed in an underground chamber outside the main building, working at a pressure of 10 lbs. per square inch, and arranged with a system of valves, by means of which the whole of the heating radiators, ventilating coils, and cooking apparatus can be controlled by the man in charge.

From these boilers main steam and return pipes are carried throughout the various corridors in tunnels 4 feet square under the floor. These tunnels are built of brick,

https://doi.org/10.1192/bjp.36.155.473 Published online by Cambridge University Press