Systematic Case-taking.

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THE analysis and arrangement in a statistical form of the various entries made in the case-books of the different asylums would form a valuable synopsis of clinical, therapeutical, and pathological significance. But the labour involved would be something enormous, and might dishearten the most enthusiastic statistician; even the work of arranging and tabulating the entries in the case-books of one of the large asylums would be very great.

If, however, it were possible to frame some simple, uniform method of case-taking and persuade the superintendents of all the asylums to use it, which possibly might be the most difficult of all tasks, then some definite and valuable statistical facts might be obtained.

Keeping up the case-books simply for the satisfaction of the Commissioners, as a check on any charge of *malpraxis* or neglect, for reference in case of inquiries, or as an evidence of work done in the asylum is one thing; doing it from a scientific point of view for the advancement of the study of insanity is quite another thing. Yet it may be well to consider whether there may not be a possibility of combining these two objects, and so making the entries that they will be of use both legally and scientifically, at the same time saving both labour and time in keeping the case-books.

There are few superintendents, or at any rate assistant medical officers, who have to do the work, who do not consider the trouble of case-taking, if not a perfect nuisance, at least as occupying much valuable time which otherwise might be more usefully employed. In fact many of them will cordially endorse the remark made by one of the Commissioners when inspecting the case-books of one of the large asylums—"What nonsense!" The idea of two Commissioners in a few hours going into the details of an asylum, examining all the patients, and carefully scrutinising the elaborate entries relating to several thousand patients in the case-books is too absurd; they cannot do it satisfactorily. With a simple method of

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case-taking, so that the state of each patient on admission, the progress of the case, the treatment adopted, and the result could easily be referred to, or even seen, as it were, at a glance, their labour and difficulties would be considerably reduced.

There is a decided lack of uniformity as regards clinical and therapeutical observations in the different asylums. The study of insanity and the proper treatment to be carried out cannot be made exact or satisfactory if it only depends, as it does now, on the labours of a few earnest men working in isolated grooves. There must be a collaboration of the observations of a large number, and this can only be achieved by an uniform, systematic method of case-taking. The vexed question of a proper scientific nosology, a correct classification of disease, and the most satisfactory treatment, might in some measure be arrived at by a combined system of medical book-keeping. Most of the scientific work done in asylums is pathological; but, though pathology is most important, it has no significance without clinical histories of the cases.

Dr. Clouston, in a very interesting paper read at a meeting of the Association in November, 1869, strongly urged the advisability of adopting a systematic plan of treating cases, so as to arrive at some accuracy in the treatment of insanity. This plan, I believe, was never attempted to be carried out, though it had in it the germ of what ought to be done if asylums are to be not merely institutions for the care, but hospitals for the cure, of the insane.

Possibly nothing has been done because, as Dr. Clouston suggests, the various medical officers "have had no time to do this; that their book-keeping and building, their multifarious superintendence of servants and stewards, their distraction of mind from theatricals and water-closets, is such that they cannot devote attention enough to carry out such a scheme of treating their patients." This is very true, and he considers it would be well if they were to neglect some of these things and give the patients themselves a fairer share of their time and mind. "Surely," he says, "we have been long enough organising and beautifying our *asylums*. It is the *patients'* turn for an innings now." In conclusion he adds, "surely it is no mean ambition that we should all try and raise our department of medicine up to the level of its other branches in scientific progress. And if we could succeed in placing the treatment of

insanity ahead of all other branches of our art, resting it on a sure basis of carefully observed fact and irrefutable generalisation, this would be a noble reward for much hard work and self-denying drudgery."

The majority of asylums, no doubt, have an elaborate system of medical case-taking, with entries notifying the almost daily state of each patient. The case-books of the Royal Asylum, Perth, are models of completeness in this respect, so arranged that though the particulars as to the history and mental and bodily condition, with the progress of each case, and also the pathological appearances after death, are most minutely recorded, they are made with as little trouble as possible. This is done by having all the possible particulars printed for each case, and then all that is necessary in making record of the cases is to score out some parts and enter a few words at other parts. Dr. Urquhart also has for his own private use check cards giving a synopsis of each patient, the particulars of which are culled from the case-books. These cards enable him to easily arrange the patients under different states, and are most useful.

But the very completeness of detail in case-taking is a bar to comparative study of cases. It makes the difficulty of searching through the mass of material and obtaining facts for classification or for comparison so much greater than if the system of case-taking were simpler, although possibly not so complete. Now, supposing the cases were so entered in the case-books that, as it were, a bird's-eye view could be obtained as to the particular state of each patient; this, I think, would be a great step towards a scientific investigation of insanity.

It is with some diffidence that I venture to offer the following plan for a systematic method of case-taking, which is far from being complete or perfect. But I offer it with the hope that it may be suggestive, and I trust that others who have better opportunities of framing a more useful one may be able to formulate a plan which will meet the requirements of the majority, and enable them to inaugurate a thoroughly satisfactory system of case-taking which will be applicable to every asylum, so that the entries may be on an uniform plan and so comparable one with another. I venture to think that if some such plan as this were adopted, it would relieve the assistant medical officers of much onerous work, which only those who have actually to do it can appreciate. I know from experience

how terribly trying the labour was of keeping the case-books; in fact at one time I suffered from an attack of scrivener's palsy (which was only relieved by the use of the continuous galvanic current), and also had a ganglion form at the extensor tendons of the wrist. It is very possible that others who have to perform this disagreeable duty of keeping the case-books will agree with me that it would be a great boon to them if there could be a simpler and easier method of case-taking.

My suggestion is to have the case-books of foolscap size, ruled according to the accompanying scheme on one sheet, or two pages; this would afford space for the entries of the particulars of thirty patients. The two next pages would be blank for special particulars of the cases—such, for instance, as peculiar delusions, more definite treatment, etc.,—attention being called to these entries by a number in the appropriate column or by an asterisk.

This plan necessitates the use of ciphers or letters, and the objection might be urged against this that they would not be easily remembered or understood. But this objection could be easily overcome by making these ciphers as simple as possible; and with a little practice anyone would soon be able to read them as well as, if not better than, if the entries were made in full.

That the plan is a feasible one I have proved, having some years ago collected a large number of cases in this way.

Judging, however, from the number of valuable suggestions which have been from time to time offered in the JOURNAL for the advancement of the study of insanity, but which have never been acted upon, it is to be feared that this scheme, or even some such, will never be carried out.

Superintendents of asylums as a rule are too conservative in their ways, and prefer to jog along the same old worn-out grooves which have been followed for so many years. Many will say that they prepare the statistical tables of the Association, which are all-sufficient. It is a question whether these tables are of much value; at any rate no one seems to use them for any real practical purpose. They are printed in the asylum reports at considerable expense and trouble, and these reports are distributed to the other asylums, where they are glanced at, thrown into the waste-paper basket, or shut up in some obscure cupboard, eventually to be taken out at some

future time to serve the only useful purpose of which they are worthy, namely, to light the fire.

MALES.

COL.		
1.	Registered No.	
2.	Initials.	
3.	Age.	
4.	Condition of life.	
5.	Date of admission.	
6.	Occupation.	
7.	Religion.	
8.	Duration of disease.	
9.	No. of attacks.	
10.	Suicidal.	
11.	Homicidal.	
12.	Epileptic.	
13.	Hereditary.	
14.	Relations insane.	
15.	Intemperate.	
16.	Habits of life.	
17.	Assigned cause.	
18.	Expression.	
19.	Complexion.	
20.	Pupils.	
21.	Pulse.	
22.	Temperature.	
23.	Bodily condition.	
24.	Weight	On admission.
25.		On discharge.
26.	Skin.	

COL.		
27.	Reference No.	
28.	Page in case-book.	
29.	Mental state	Speech.
30.		Sensation.
31.		Reflexes.
32.		Consciousness.
33.		Excited.
34.		Depressed.
35.		Stupor.
36.		Coherence.
37.	Memory	For recent.
38.		For past.
39.	Delusions	Senses.
40.		Morals.
41.		Emotions.
42.		Intellect.
43.	Stated disease.	
44.	Treatment.	
45.	Employed.	
46.	Amusements.	
47.	Relapses.	
48.	Discharge.	
49.	Date.	
50.	Cause of death.	
51.	Reference No.	

Abbreviations—to be placed on first page in Case-book or on a separate sheet:

RELIGION.—A. Church of England. S. Church of Scotland. B. Baptist. C. Calvinist. D. Dissenter. I. Independent. J. Jew. N. None. P. Protestant. R. Roman Catholic. W. Wesleyan. X. Unknown.

RELATIONS.—F. Father. M. Mother. S. Sister. B. Brother. A. Aunt. U. Uncle. Gm. or Gf. Grandmother or grandfather. Ap. Paternal aunt, etc.

INTEMPERATE=I. S. Sober. M. Moderate drinker. T. Teetotaler.

HABITS.—A. Active. L. Lively. M. Mischievous. Q. Quiet. S. Studious. D. Dirty. B. Bestial.

HEALTH.—G. Good. F. Fair. I. Indifferent. B. Bad. W. Weak. P. Phthisical. S. Syphilitic. R. Rheumatic. D. Dying.

EXPRESSION.—V. Vacant. D. Dull. B. Bright. F. Foolish. M. Melancholic.

COMPLEXION.—R. Ruddy. P. Pale. C. Congested.

PUPILS.—E.=Equal. V. Unequal (a thick stroke to left or right indicates which is the larger). C. Contracted. D. Dilated. I. Insensible.

MIND.—E. Excited. C. Childish. D. Deluded. L. Low spirits. M. Morose. R. Rational. S. Suspicious. V. Vacant. I. Inhibition + or −.

MEMORY.—B. Bad. F. Fair. G. Good. D. Defective. I. Indifferent. L. Lost.

DELUSIONS.

SENSES.—A. Auditory. F. Feeling. O. Ocular. N. Smelling. T. Tasting.

EMOTIONS.—E. Erotic.

ÆSTHETIC.—R. Religion. G. Grandeur.

MORAL.—M. Monetary. D. Domestic.
INTELLECTUAL = I.
PULSE.—R. Regular. I. Intermittent. D. Dicrotic. F. Feeble. B. Bounding.

For further notes see overleaf. An asterisk in any column would mean refer to notes or a number.

The Relation of Alcoholism to Suicide in England, with Special Reference to Recent Statistics.

By W. C. SULLIVAN, M.D., Deputy Medical Officer, H.M. Prison, Pentonville.

IN the following paper it is proposed to study the influence which alcoholism exerts upon suicide in this country, so far as that influence can be traced in recent statistics of the movement of these social phenomena. Our discussion will aim more particularly at determining the *rôle* which alcoholism may have played in the late increase of suicide in England, and at establishing the distinctive characters which constitute the type of alcoholic suicide.

Before, however, entering on the proper matter of our inquiry, it will be desirable to refer briefly to the views of some of the chief authorities who have dealt with the question of the alcoholic influence in suicide. It is premised, of course, that these introductory remarks have no pretension to be a complete summary of the extensive literature of the subject—an essay far beyond the limits of this paper.

Introductory.—In the classic work in which he fixed the clinical outlines of alcoholism, Magnus Huss(1) indicated among the characteristic symptoms of the disease its special proneness to the development of suicidal tendencies. "I venture to assert," he says, "that the suicidal impulse is a more frequent accompaniment of the melancholia of drunkards than of melancholia from other causes; and, further, that amongst the uneducated classes suicide frequently follows on the disordered emotional tone, which, sooner or later, results from the abuse of alcoholic liquors." All subsequent clinical observation, whether directed primarily to suicide or to alcoholism, has confirmed the accuracy of this statement.

Naturally, the community being but the aggregate of its

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